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INCONGRUENT PERCEPTIONS AND TRAINING STYLES: THE PARAMEDIC IN CONFLICT WITH THE EMOTIONALLY CHARGED BYSTANDER

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by

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MAJOR PROFESSOR: Nilanjana R. Bardhan

Incongruent perceptions can exacerbate conflict situations with emotionally charged patients, family members, and bystanders when the paramedic is providing treatment to a critical patient. This bestows the paramedic with the responsibility of not only working to save the life of the patient, but also working to resolve conflicts that may constrain medical treatment. Therefore, in these situations, paramedics must have the communication skills that allow them to provide quality patient care.

This phenomenon is investigated through a native anthropologist perspective by asking paramedics to give their personal accounts of conflicts they have had with emotionally charged stakeholders when treating a critical patient. These stories, depicted in this study, show how paramedics commonly use multiple conflict styles sequentially, in a matrix form, or concurrently to negotiate conflict situations. Findings have also shown that no one-conflict style is paramount, and the best choice of which conflict style to use is situational or an on the spot decision. Due to inadequate training, however, these decisions are found to be difficult for a paramedic who has not had extensive experience dealing with this type of conflict. Expert paramedic instructors corroborate this claim by attributing much of the lack of conflict

training emphasis on algorithm style training that is related to curriculum standards and inexperienced instructors.

Finally, this study finds paramedics who are inadequately trained, in conflict communication skills, have a tendency to make poor conflict style choices when conflicting with an emotionally charged stakeholder and can succumb to burn-out. This syndrome produces a loss of caring, thus putting the paramedic in a psychological position to make additional conflict style choices that are poor. The result is a paramedic who is inadvertently set up to cause a compromise in patient care.

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CHAPTER 1

INTRODUCTION

The work of a paramedic is conducted outside the hospital setting and observed, in most cases, by people who have limited medical knowledge. As a result, many people do not remember the precise clinical actions that are performed to help the patient. Instead, people remember the emotions they experience during the event as they watch the paramedics work (Kendrick & Ozimek, 1992). "The image and actions of EMTs [emergency medical technicians] have lasting impressions on everyone with whom they come in contact" (Neal, 1997, p. 55).

Researchers have found that patients focus on the caregiver's interpersonal skills to judge the quality of the medical care they are receiving (Gillette, Byrne, & Cranston, 1982; see also Ben-Sira, 1976; Heightman, 1999). Therefore, doing a job the right way by correctly diagnosing and treating the patient is not the way a paramedic can project a positive or expected image. It seems like paramedics must also look and act the way people are accustomed to seeing them look and act on television. This is what the community expects from paramedics (Swan, 1989). This study will look at the conflict that may ensue between a paramedic and the public when this expectation is not fulfilled due to incongruent perceptions of the paramedics' role in healthcare.

The inspiration for this research comes from my personal experiences of working on an ambulance for the past 5 years. I have been a part of several conflict situations that have arisen when communicating with people I was

working to help. My own frustrations with this difficult communication task resulted in the exploration of the topic presented in this research.

My journey down this road started much earlier, however. At the age of 16, I told my mother that I wanted to work on an ambulance. She, an experienced registered nurse and patient educator, told countless stories of her encounters with paramedics who were unprofessional and deficient when providing patient care. I soon found that her perception of ambulance workers was only valid at the time of her dealings with them and is not necessarily true today. Thus, my first realizations of conflicting perceptions related to the field of emergency medical services (EMS) started taking shape.

CHAPTER 2

LITERATURE REVIEW

The present study will try to partially fill the gap in the available literature on the incongruence between the constructed and situated realities of the layperson, as perceived by paramedics, while communicating in an emotionally charged environment. For example, let us say a man named John has limited contact with EMS other than watching television. He may believe that ambulances respond to every 911 call using lights and sirens because that is what he has seen on television. This belief is reinforced every time he sees an ambulance drive past him using lights and sirens. If John calls 911 to request an ambulance he will expect the ambulance to quickly arrive in emergency mode. However, if the dispatcher determines that the request for the ambulance does not warrant an emergency response then the ambulance may arrive 15 minutes later without any lights or sirens. John's expectation based on his constructed reality would be in conflict with the situated reality. Unmet expectations may cause those, like John, who have a media constructed reality, to take issue with the emergency responders and thereby impact patient care. As mentioned earlier, this incongruence between mediated and situated realities is the focus of this study.

Therefore, more specifically, this study will investigate the interpersonal conflict between paramedics and the people they serve, conflict that is generated by the incongruence between constructed and situated realities of the paramedic and the emotionally charged patient, family member, or

bystander. This is a conflict phenomenon that can be easily exacerbated due to time constraints that are imposed by a critical patient needing rapid medical treatment. This issue is important because paramedics must be prepared to quickly and effectively communicate with people who have perceptions about healthcare that are different from their own in order to prevent dissatisfaction with the service being provided and improve patient care. Therefore, this study will also examine how adequately, or inadequately, paramedics are trained to manage conflict situations. Finally, it is my intent to situate this research as a flagship for other scholars to pursue the communication interaction between paramedics and the people they serve.

The literature review pulls from areas of communication research such as healthcare, power, conflict, and perception. This was necessary because of the insufficient research available on the specific communication phenomenon under investigation. The construction of this review shapes the issue from the researcher's perspective as a paramedic. The first sections give an overview of the history and development of EMS. This is followed by a discussion about how conflict can be a key element in the communication process between paramedics and the publics they serve due to power struggle issues. The discussion on conflict then moves into conflict styles followed by a section on how emotionally charged bystanders may react counterproductively when faced with an emergency medical situation. The next subsection under conflict highlights how some members of the public formulate their initial impressions of the paramedics' role in healthcare. Next, two full sections are offered to give

examples of proven problems that have arisen in the field of EMS that can be related to differing perceptions between the paramedic and the general public. Finally, paramedic education is uncovered as an area that has potential for taking on the role of preparing paramedics to diffuse conflict situations.

History of EMS

Emergency medical services, or EMS, in the United States has traditionally been a service that was offered by the local funeral home to rush a critically injured person to the doctor. Prior to 1967, ambulance personnel lacked both training and equipment. Victims were frequently whisked away to the hospital without any type of medical treatment (Hutchinson, 1983). In fact, most people who worked in this field were known only as "ambulance drivers." The paramedic profession has matured so quickly that many paramedics know people that worked as "ambulance drivers" not so long ago. These retired trailblazers tell stories about the "good old days" when all that could be done for the victim were fast trips to the hospital. Eventually, high costs drove many of the funeral home ambulance services out of business and volunteer groups formed to fill their place. This resulted in communication problems between multiple agencies, forcing the government to step in and take control (Cherry, 1994a).

The most significant contributing factor that led to the governmental regulation of EMS, however, took place in 1966. That year, a major research project conducted by the National Academy of Sciences, National Research Council, led to the publication of a landmark paper entitled "Accidental Death

and Disability: The Neglected Disease of Modern Society." This document, also called "The White Paper," described the poor conditions of emergency medical treatment in this country that included emergency department and ambulance provider inadequacies. Some of the findings included a lack of standardized treatment, unnecessary and expensive equipment, inadequate supplies, no standard of competence or training of ambulance attendants, and a lack of communication between the ambulance and the emergency department (National Academy of Sciences, National Research Council, 1966; see also Narad, 1990).

Modern EMS

Today, thanks to government intervention, most paramedics would consider the term "ambulance driver" to be an insult to their profession. Over the last 30 years, EMS has quickly developed into a respected profession within the medical field. The hospital emergency department was extended so that medical care came to the patient (Limmer, O'Keefe, Grant, Murray, & Bergeron, 2001). Paramedics are trained to deliver skilled patient care that, in many ways, can be compared to what a registered nurse does in the hospital. In the United States, when an ambulance is summoned by dialing 911, most every city is equipped with an advanced life support (ALS) or paramedic ambulance that responds to the scene of the emergency (Cady & Scott, 1995). This type of ambulance provides the highest level of patient care possible in the civilian world by taking advanced cardiac life support to the patient in the field (Cherry, 1994b).

In addition to governmental control, a private agency, The National Registry of Emergency Medical Technicians (NREMT), registers emergency medical services providers from across the nation. According to their official web site (National Registry of Emergency Medical Technicians, 1998):

> The NREMT is a not-for-profit, non-governmental, free-standing agency led by a Board of Directors comprised of members from national Emergency Medical Services (EMS) organizations or with expertise in EMS systems. … The Registry began in 1970 and has examined over 750,000 Emergency Medical Technicians (EMTs) in this country throughout the years. Currently there are approximately 155,000 EMTs who have met the NREMT requirements. … The NREMT's registration services are part of the licensure process for EMTs in 39 states. The Registry works closely or directly with State Offices of EMS in all 50 states to accomplish their mission. (3)

This agency has done a great deal to facilitate the process of a nation wide standard training curriculum that sets a national standard for patient care.

In addition to NREMT, the National Association of Emergency Medical Technicians (NAEMT), founded in 1975, works to support legislative initiatives and promote the professional status of the emergency medical services worker (National Association of Emergency Medical Technicians, 1997):

> The mission of National Association of Emergency Medical Technicians, Inc. is to assure a professional representative organization to receive and represent the views and opinions of pre-hospital care personnel and to

> thus influence the future advancement of EMS as an allied health profession. NAEMT will serve its professional membership through educational programs, liaison activities, development of national standards and reciprocity and the development of programs to benefit pre-hospital care personnel. (1)

Governmental controls, along with these two agencies, have helped deliver EMS out of infancy. Today, the real struggle is not trying to figure out how to run EMS; our biggest struggle may be trying to figure out how to educate the public on how much better we have become (Swan, 1989). Expectedly, this will take a great deal of time. Therefore, until we figure out how to get to this next step, it is important to look at how we can deal with the conflicts that are resulting from paramedics arguing with a public who, for the most part, has never met us.

Conflict Within the Phenomenon

Power Struggle

According to Beck (2001), people, in general, no longer trust the healthcare system in the United States. “Increasing skepticism about science and medical authority, exacerbated by quakes in the health care industry and the constant deluge of information through the Internet and other mediated sources, have worked to fragment traditional power structures” (p. 273). This has resulted in a growing public perception that views doctors as consultants and less godlike. Today people are taking more conscious responsibility for their bodies and becoming more involved in their healthcare choices (McQueen,

2000). This consciousness is still at play during a medical emergency. People want to choose what ambulance service to call, what emergency department to use, and what treatments they will undergo. The rights of the patient and family to make their own choices are becoming more and more recognized as an essential patient care consideration (Falconer, 1980). This democratic as well as consumeristic behavior (Wilson, 2001) is a comfortable and empowering feeling for the family member that healthcare workers must take into account when treating patients (Hulsman, Ros, Winnubst, & Bensing, 1999; Ryder & Wiltshire, 2001).

However, paramedics have a harder time dealing with this attitude toward healthcare, especially when a patient is in need of immediate treatment for a potentially life threatening condition. The paramedic is faced with the tension of negotiating between allowing the patient or family member to impose this attitude, thereby, causing a potential delay in patient care or, alternatively, jumping in to save the patients life. Conceivably, if doctors are thought of as consultants and not as demigods, as they once were, then paramedics who may still be thought of as only "ambulance drivers" may have no credibility whatsoever. During "medical crises, a persistent tendency to equate families with trouble is evident in both the literature and the practice of medicine" (Levine & Zuckerman, 1999, p. 148). One of the main reasons for this tension, between healthcare workers and the people they serve, is the differing perceptions for the roles that each should be playing in the situation (Levine & Zuckerman, 1999). Therefore, a strong power differential can easily cause

conflict if the bystander or family member has a dissimilar idea of how patient care should be rendered. This power differential fulfills the definition given by du Pre (2000) who states: “Conflict results when people perceive that some goals are incompatible with others” (p. 196). Within this conflict, the paramedic must deal with the incongruence between the person’s constructed reality and situated realities against the backdrop of power differentials. In a heightened emotional state, bystanders may not be aware of their threatening behavior. Also, in most cases, the paramedic and subject in question have the same goal – fixing the problem or taking care of the patient.

The discrepancy comes into play due to differing perceptions of how the problem will or should be handled. The most obvious way for the paramedic to deal with this dilemma is to explain the reasoning behind the intended means for treatment (Roloff, 1987). Communicating the rationale of the treatment course has proven to positively influence patient satisfaction, therefore reducing conflict (Arnston & Droge, 1988; Kreps, 1988; Street & Wiemann, 1988), and increasing the perception of a higher quality of care (Cleary & McNeil, 1988; Laine & Davidoff, 1996; Rosenthal & Shannon, 1997). However, the situational dynamic at work in these situations, or communication deficiency, creates ambiguity that reduces acceptance and tolerance among the other parties involved (Smock, 1955).

Nurses in hospitals, especially those in critical care units, deal with the same time demands that can keep family members from being informed, consulted, or involved in the care of the patient (see also Astedt-Kurki,

Paavilainen, Tammentie, & Paunonen-Ilmonen, 2001). Burr (1997) describes the impact this situation has on families:

> Eventually, when confronted with the discrepancy between their perspectives and those of staff, they consider it a breach of trust, which leads them to view some staff members as rivals or opponents. This adversarial stance heralds the onset of the 'disenchantment' phase of the relationship, when families become more assertive in their patient advocacy. Manifestations of interference and conflict during this phase are based on frustration and anxiety and families are then labeled 'demanding', 'suspicious', 'controlling' and 'over-anxious'. (p. 125)

Nurses in hospitals are, in most cases, in a better position to deal with this problem. The perceived institutional legitimacy and structure of the hospital setting compiled with the advantage of having more staff available to communicate with family members gives nurses an advantage over paramedics to handle differing perceptions and conflict situations. Long and Greeneich (1994) suggest ways that nurses can promote positive perceptions of care. These suggestions include the use of active listening techniques, working to evaluate family expectations for care, and watching for increased family anxiety.

Unlike nurses, who have greater resources to commit to family members, paramedics must focus more attention on the patient and may choose to use their expert and coercive power, outlined by Raven and French (1956), to take control of the situation by not allowing the patient or family to have a voice in

treatment or transport decisions. Reduction in the amount of control over one's environment can make people feel helpless, threatened, and vulnerable. "Persons experiencing helplessness no longer believe that their actions and their outcomes are related. . . . they feel that no matter what response they make or do not make, they will suffer consequences over which they have no control" (Rodin & Janis, 1979, p. 63). This conflict takes the form of retaliation against the paramedic resulting in actions that would be against the patient's own best interests. According to Molm (1997), retaliation by a person of lower power status is a common reaction when presented with a coercive move by the higher power status individual (see also Raven, 1988; Rogers, 1983). This retaliation is justified by the feeling of control that has been lost due to the encounter.

Paramedics wear uniforms that serve as signifiers of power. These uniforms display a badge similar to that of police officers. This symbolic status cue serves as a reference for others to categorize and organize their perception of the bearer (Berger, Webster, Ridgeway, & Rosenholtz, 1998). However, this badge or shield worn by a paramedic holds much less validity as a display of power as compared to a police officer's badge because most paramedics do not carry a gun or enforce the law. According to Samuel and Zelditch (1998), displaying symbols of power that are "less institutionalized … will create less certain expectations in either users or objects of power" (p. 294). Many paramedic ambulance services, nevertheless, issue shields to their staff to instill tradition and grant paramedics a feeling of power and responsibility.

Hence, there is a great potential for paramedics to feel like they have a great deal of power. After all, paramedics are in the profession of saving lives. Accordingly, paramedics who boast this ability come to be known, sarcastically, as “para-gods.” The paramedic serves as a surrogate care provider for the emergency room physician (Paturas, 1997); the responsibility given to the paramedic is enormous. For example, some of the same procedures carried out by a paramedic in the ambulance are so invasive that only a doctor would perform them if the patient were in a hospital. A paramedic that embodies this power can have a hard time dealing with people who denounce this authority.

Taking on the intense responsibility that is involved when caring for a critically ill patient requires a person with a strong level of self-efficacy. Self-efficacy may be described as “a person’s feelings and thoughts about his/her own capability of accomplishing any given task” (Buchmann, 1997, p. 133). Paramedics need this trait so they will have high self-esteem and confidence when practicing emergency medicine in a pre-hospital environment. This environment is not structured like an emergency room where the family is escorted into the waiting room until life-saving interventions can be initialized or the patient is stabilized. The paramedic must be able to provide the same level of care that would be offered in the emergency room, a structured setting, by organizing the pre-hospital environment.

Two types of power displayed by paramedics while structuring the pre-hospital setting include legitimate and expert power (Raven, 1993). The paramedic has legitimate power due to his or her official position as the

paramedic in command of the scene, and with the understanding that he or she is responsible for anything that happens to the patient while under his or her care. For example, the paramedic takes responsibility for even the actions of other medical care personnel who assist in treatment. The second form of power, expert power, is also linked to the paramedic due to his or her actual knowledge base in emergency medical care. This would include a paramedic's veteran experience and classroom training background in how to handle medical emergencies. However, just because the paramedic is aware of this appointed power and responsibility does not mean that everyone, especially those who are not a part of the interpretive community of paramedics, will recognize it or obey every command. Therefore, healthcare professionals commonly find conflict when encountering people that have a consumeristic orientation toward healthcare who lack the expert or legitimate power that is embodied by healthcare professionals (Wilson, 2001).

Power is something that is socially constructed during the communication event (Mumby, 1988). This "power as praxis" concept (Banks, 1995) requires a look at the environment, social structure, and language used in the moment. In this moment of power allocation the paramedic is, many times, inside the patient's home communicating with the patient and other family members. The paramedic must remember that the people who live in the house inherently rule that environment. For example, Palmer (1994) documented the following EMS call:

> The patient was in respiratory arrest and the EMT opened an airway and started "bagging" (ventilating with a bag mask) over the shouts and objections of the wife. When the EMT on the radio to ER could not hear due to the noise in the room, he said, "Lady, why don't you set down and shut up! I've done this a few times and I know what I'm doing. Just get out of here." The wife responded, "You can't tell me where to get. This is my kitchen you know." "Just get out of our way," the EMT said. (p. 170)

A paramedic who is called to take care of a sick or injured family member is trained to assume control of the situation, but a family member or bystander who has been taking care of the situation prior to EMS arrival may feel an obligation to remain involved or in control (Krohmer, 1999). Similarly, various scholars have identified this negotiation of control as a key factor in interpersonal relationships (Danziger, 1976; Kelly et al., 1983).

Control Realized

Taking control is something that paramedics frequently initiate by using coercive communication styles with others. The use of this method, when dealing with conflict situations, is a natural response for someone bogged down with high conflict intensity or a perceived time constraint (Tedeschi & Bonoma, 1977). Some words, directed to the patient or other significant stakeholders, that the paramedic may use to express this coercive attitude include: must, should, have to, have got to, ought to, unavoidable, and necessary. Paramedics use these words to impose structure on people who have asked for, and are in need of control over their environment. It is ironic, however, to see

how people resist this external control in an effort to regain power over the situation even if this effort is not in the best interest of the patient. Sometimes this loss of power can be augmented by a loss of face. People inherently resist intimidation that is perceived as undeserved and/or as an attack (Deutsch & Krauss, 1962). This loss of face can swamp the issue and unconsciously seem more important than the primary goal of patient care (Brown, 1977).

Intense conflict can create a great deal of distrust for an authority figure (Tedeschi, Schlenker, & Bonoma, 1973). This is especially problematic when the person has an intense involvement in the conflict because of the stance they have taken on an issue (Sereno & Mortensen, 1973; Sherif, Sherif, & Nebergall, 1965; see also Deutsch & Krauss, 1962). When obviously under tension or threat, people find it difficult to appropriately respond to a changing environment (Pally, 1955). People who are in a stressful situation find it harder to interpret perceptions within their normal cognitive framework. This cognitive structural disorientation forces people to revert back to a primal way of understanding their perceptions (Postman & Bruner, 1948). Therefore, stressful situations like those described above are a common catalyst for eliciting irrational automatic reactions to the stimuli (Zillman, 1993), thereby making it harder to use focused problem solving approaches (Ray, 1965).

Conflict Styles

Five broad categories of conflict management styles were first introduced by Blake and Mouton (1964). These styles include avoiding, accommodating, compromising, collaborating, and competing. Although not always seen as

exhaustive (Knapp & Putnam, 1988), several studies have been conducted that help validate the prominence of these conflict style categories (Kilmann & Thomas, 1977; Ross & DeWine, 1988; Volkema & Bergmann, 1995). These five categories and descriptive phrases were presented by Wilmot & Hocker (1988) and later compiled into a tabular form that simplifies the central aspects of each category (Devenish, 1999, p. 173). These common conflict styles are described in Table 1 (see pg. 19). Examples of each of these conflict styles can be seen in the everyday communication practices of paramedics. The coercive strategy, discussed above, most closely relates to the competing style that fosters the idea that the outcome will generate a winner and a loser.

Table 1

Common Conflict Styles

Style	Typical behaviors associated with style
A. Avoiding/Distracting	denial of conflict; avoiding topics; changing the subject; joking; sidestepping the issue
B. Competing/Pouncing	"I'm right—You're wrong;" "one-up;" win-lose attitude; criticism; blaming; fault-finding; threatening; hostile
C. Accommodating/Placating	yielding to someone else; forego own needs and interests; sometimes a martyr; whiner; giving in/ giving up
D. Compromising	results in some gains and some losses for each party; shared power (When power is unequal, compromising is often more accurately giving in or giving up); suggest trade-offs; maximize wins—minimize losses; desire to appeal to fairness—quick term solutions offered
E. Collaborating	try to work with other person to find new options; concern for your goals and other person; win-win attitude

According to Deetz and Stevenson (1986), parties that use the avoidant and accommodating strategies do not discuss the issue. They state that the competing and compromising strategies involve open discussion where both parties accept the issue. Both of these strategies, however, have more

outwardly noticeable impacts that may be seen as negative. The competing strategy forces one of the conflict participants to loose. Using the compromising strategy forces both parties to loose because both are ultimately equally dissatisfied. The collaborating style takes the most energy to adopt and put into practice (Deetz & Stevenson, 1986). Collaboration is a style that creates a win – win situation for both parties in the conflict by opening up the issue in a discussion format that allows goals to be identified objectively by both parties, and for a new and innovative solution to be discovered and implemented (Filley, 1975). The final result is a positive and effective conflict resolution scenario (Crum, 1987; Fisher, Ury, & Patton, 1991). This collaboration style could be implemented in a situation that has controlled variables. Unfortunately, however, controlling variables does not seem to be an easy task. One such variable is the bystander who is emotionally charged.

Emotionally Charged Bystanders

When civilians can no longer organize their environment, they call out for help, "SOMEONE DIAL 911." This is when the paramedics come into the picture and attempt to correct the situation that is unmanageable for the layperson. For those who live a life outside of a medical career and are not accustomed to dealing with the reality of life and death, especially when the event involves a friend or family member, the event can be even more stressful. Paramedics may be seen as saviors to some civilians who have encountered a situation where a family member may not be breathing or their coworker has just collapsed. On the other hand, when a paramedic goes to the scene of a

medical emergency, many times he or she must interact with family members and bystanders who are emotionally charged (Krentz & Wainscott, 1990). Usually this intense emotional state is combined with the previously discussed feeling of helplessness or inability to control environmental factors.

In some cases, the paramedic must deal with confrontations with family members and bystanders who want the patient to be taken to the hospital immediately. Many civilians, dealing with a life threatening situation that has placed their life in turmoil, want to fix the situation on their own, with good intensions, and get the family member to the hospital as quickly as possible so they can see a real doctor who will fix them. Many times this situation may cause people around the patient to "express their feelings of helplessness as rage and direct it at the person who's closest to the patient" (Sachs, 1999, p. 73). In this case, that person is the paramedic. Additionally, when the families have high levels of stress, they may be unable to support the patient and, in fact, may transfer their stress to the patient (Frederickson, 1989). Strong emotional outbursts do a good job of getting peoples' attention and showing others that a particular issue is important (Planalp, 1999). In this case, however, an emotional outburst by a bystander or family member can directly impact patient care by distracting the paramedic and intensifying the stress level of everyone involved.

While on the scene of a motor vehicle accident, I once cared for an older woman who had pain in her neck and had undergone a brief loss of consciousness. Her husband became angered when he was told that his wife

needed to go to the hospital and that the paramedics would be staying on scene to immobilizing her head, neck, and back in addition to starting an intravenous line before transporting her to the hospital. My partner told the husband to back off, and the husband immediately shoved him. Next, my partner began yelling at the man and telling him that he was trying to care for his wife. Before the man knew it he was handcuffed and placed in the back of a police car. This incident caused the patient to become even more upset. Her body reacted with increased blood pressure and her medical condition worsened.

After the trip to the hospital, my partner and I were told by the police officer that the husband was upset because of his past experience with paramedics when his wife had had a heart attack. The paramedics that cared for his wife spent almost 20 minutes in the ambulance before they took her to the hospital. In our case, the man was concerned about his wife and did not want my partner and me to "waste time" that could be spent taking her to the hospital. Unfortunately, scenes like this are common due to conflicting ideas about what should be done when the ambulance arrives. In this case, the patient's condition worsened due to the stress of the argument.

The Associated Press, in January 1981, told of an incident that may have cost the life of a patient due to an outburst from a bystander:

> In Chicago … a man allegedly told a paramedic crew entering the building for a heart attack case that if his 'mother died, the crew would

not leave the building alive.' The paramedics retreated, and while they waited for an escort, the woman died. (Metz, 1981, p. 133)

Most paramedics have never been placed in this extreme predicament; however, dealing with bystanders that are stressed and in increased emotional states is an everyday reality. Many of these conflicts can escalate out of control if the variables are not managed properly. It is no wonder that violent assaults occur more in healthcare settings than any other work environment (Elliott, 1997). Everyone, including the violent emotional bystanders and the paramedic, has formulated a perception of an emergency medical situation long before one occurs.

Public Perception

As stated earlier, the high-speed maturing of the EMS profession has left many members of the general public unaware about what paramedics actually do during an emergency (Cherry, 1994b). In fact, most people do not even understand what emergency medical technician (EMT) means (Hatfield, 1997). People form meaning and understanding of the world through communication with others (Berger & Luckmann, 1966; Gergen, 1985; Schutz, 1970). If members of the public have not personally observed or interacted with a paramedic on the scene of a medical call, they must rely on other outlets to construct expectations for the event. For these people, television may be their only source of information to construct a reality of what will happen if they ever need to call for an ambulance. Television shows such as "Emergency," "240-

Robert," "Rescue 911," "ER," "First Watch," and "Paramedic" are used as a reference for constructing this reality (Swan, 1989).

In Gerbner's (1998) study on how television content influences our perceptions of the world, he found that the amount of time spent watching television is positively correlated to the impact that this medium has on social perception. This finding augments a previous study on social learning that found that the more a viewer is secluded from the world, the more he or she will adopt a view of the world based on television programming (Leckenby & Surlin, 1976). Both of these studies support the notion that people who have not had past experiences or interactions with a paramedic during an emergency call can have a perceptual constraint that is cultivated by the media. This constructed reality fostered by the media is perceived as fact when it serves as a sole reference point to aid in negotiating the situation.

The media are seen by many other scholars as playing a vital role in shaping audience conceptions of social reality. In this regard, Allen and Hatchett (1986) argued that we depend on the media as secondhand sources to provide us with information about the remote and abstract zones of the world that are beyond our perceptual grasp. Parenti (1993) cited several techniques used by the media, which, according to him, misleadingly represent reality. Among these techniques is the dissemination of "outright lies" and face-value transmission. In doing so, according to Parenti, the media not only suppress information, but they create disinformation.

Hawkins and Penigree (1983) argued that the relationship between television viewing and the construction of social reality is reciprocal in the sense that television viewing causes reality to be constructed in a certain way, but this construction of social reality also directs the viewing behavior (see also McQuail, 1994). Therefore, once a belief is formed in the mind of an individual, his or her reality is supported by what he or she selects to view on television. Many times people choose to watch things that make them feel comfortable through correlation with existing beliefs.

According to Weerakkody (2000, August), "People create knowledge in order to function pragmatically in life" (p. 5) and the meaning that they create out of media messages "is based on their own attitudes, values and affect (emotions)" (p. 6). Weerakkody states that people use their own experiences, values and beliefs as a filter for media messages. Each person who selects the information, therefore, interprets these messages differently.

The process of constructing social reality is determined by what Rokeach (1966) called "frame of reference." According to Rokeach, one's frame of reference precedes social interactions, and determines the ways in which the experience in the interaction will be organized in the thought process. Therefore, one's general approach or mental set toward the situation is used as a framework to evaluate what is important in the situation. This means that there is an expectation to find a correlation between the constructed reality and the situated reality (see also Gerbner, 1974; Rokeach, 1972; Youniss, 1981). This correlation of expectations is also known as "shared awareness" (Samuel

& Zelditch, 1998, p. 286). The following two sections each highlight disturbing examples that are common problems in EMS due to this lack of shared awareness.

Lights and sirens – paramedics submit to public perception.

Paramedics know that the general public expects an ambulance to transport a critical patient to the hospital using lights and sirens. Most people would be upset to see their loved one taken to the hospital, in critical condition, by paramedics who calmly drove to the hospital. One study that looked at pediatric transports found that inappropriate use of lights and sirens is common for even stable patients, and that 39.4% of the emergency transports involved patients in stable condition (Lasher & Bausher, 1997). Hence, it is possible that a good portion of these inappropriate emergency transports were undertaken to meet the expectations of concerned parents. Such transports are carried out at great risk to the occupants of the ambulance and other vehicles on the road. These studies provide evidence that the majority of EMS workers are making it more and more difficult for the public perception of paramedics to change because of their own perceptions on beliefs that are held by the public.

On the way to an emergency call, an ambulance uses lights and sirens to get to the patient as quickly as possible. This driving practice is called “running hot,” “driving code 3,” or a "10-39 response.” During this time, the driver takes control over normal driving responsibilities while running the master panel that activates the emergency lights and powers equipment in the patient

compartment. The driver must also anticipate busy intersections, initiate evasive maneuvers around other vehicles, look for street signs and house numbers, check the side door mirrors, and communicate with dispatchers and other emergency personnel such as police and firefighters on multiple radio frequencies. This is a complex job for one person to handle considering the size and weight of the vehicle. Fortunately, the driver has a partner who shares in these responsibilities by serving as the navigations officer, assisting with communications, and operating the siren and air horn. Finally, one of the most important jobs of the passenger-side occupant is to make sure there are no obstacles, like pedestrians or other vehicles, entering into the path of the ambulance. This is a task that can be difficult for the driver who has a limited field of view due to the width of the vehicle and sizeable blind spots.

When an ambulance transports a patient to the hospital using lights and sirens, the driver is usually alone in the cab of the truck. This means that all of the responsibilities discussed above are placed upon the driver. During this time the driver must also warn the crew taking care of the patient in the back of the ambulance about any sharp turns, jolting bumps, or sudden stops. Warning the crew is especially important because paramedics do not usually wear seatbelts so they can move freely about the passenger compartment to provide treatment. When treating the patient, a paramedic may be using a needle to start an intravenous line, draw blood, or administer medications. The paramedic may also be using the paddles from the cardiac monitor to deliver a shock of electricity to the patient. All of these procedures become

dangerous in the back of an ambulance during a high-speed transport to the hospital (Levick & Li, 2000).

A study by Custalow and Gravitz (2000) found that using lights and sirens, although intended to reduce transport time, is associated with a high risk for injury and death. Due to this risk, emergency driving is said to be the most dangerous part of the job for an EMS worker (Miller, 2001). A significant risk to the public has also been established not only due to collisions with ambulances, but also collisions with other vehicles that take place when the ambulance is moving through traffic, called the "wake-effect" (Clawson, Martin, Cady, & Maio, 1997). Given the degree of danger involved when transporting a patient to the hospital, the practice must be justified. This justification is usually satisfied by the need to get the patient to the hospital as quickly as possible. However, one study found that transporting the patient to the hospital using lights and sirens got the patient to the hospital only 43.5 seconds faster than without lights and sirens (Hunt, et al., 1995). Another study found that the ambulance was faster than a car by 60 seconds (Quinlavin, 1993). Finally, an estimated 12,000 annual ambulance crashes are found to be related to the use of lights and sirens in the United States and Canada (Clawson, 1991). All of this overwhelming evidence combined with the fact that paramedic ambulances are providing, in most cases, the same patient care as the emergency department, emphasizes how the dangers outweigh the benefits for this mode of transport.

Staying on scene – paramedics balking public perception

Another kind of perceptual incongruency is at work when the paramedic ambulance spends extra time on the scene to treat a patient. It is the paramedic's job to initiate life-saving interventions that cannot wait until the patient gets to the hospital. Advanced life support (ALS) units, or paramedic ambulances, are equipped with sophisticated assessment and treatment equipment that can stabilize many medical conditions. Therefore, similar to terminology used in the hospital, medical workers now use the word "patient" to describe a sick or injured person in the prehospital setting. In contrast, prior to having paramedics who extended medical care from the emergency department to the prehospital environment, sick or injured people were identified as "victims" by emergency workers. This change in terminology, as well as perception has come about as a result of the quick maturing process in EMS. However, an injured person may still perceive him or herself to be a victim while he or she is already a patient from the paramedic's perspective. This incongruence of perception may lead to conflict because the "victim" may wish to be treated by the hospital as soon as possible. This treatment by the hospital will satisfy their exogenous media constructed expectations but has led to a problem for paramedics who must deal with the uninformed public.

Obviously, as medical professionals, paramedics cannot always follow the requests of family members and bystanders when they could have an impact on patient care. This issue can be examined by looking at those patients who are in the most critical circumstance, cardiac arrest. According

to one study that looked at 604 incidents of cardiac arrest outside the hospital over a 16-month period, the chances of survival rose by 40% when a paramedic began advanced cardiac life support in less than 8 minutes. The chances for survival decreased to 13% if they could not be reached within that period of time. Although other factors were considered, like cardiopulmonary resuscitation (CPR) prior to EMS arrival, the need for fast definitive care is indisputable (Eisenberg, Bergner, & Hallstrom, 1979; see also Narad, 1990, p. 9).

This definitive care is the responsibility of the paramedic who is trained to provide the same care for cardiac arrest patients that they would receive in the hospital emergency room. The only difference is that a hospital must "rapidly mobilize available personnel to continue the attempt of resuscitation" (Kellermann, Staves, & Hackman, 1988, p. 63). This resuscitation effort requires resources from the emergency department, laboratory, x-ray, and sometimes anesthesia. The paramedic ambulance, however, is designed to have all of the required equipment at hand so all of the resuscitation interventions take place at a faster pace with fewer personnel. Therefore, it is important for the paramedic ambulance to spend the necessary time in the field working to revive patients in cardiac arrest (Jones, Nesper, & Alcouloumre, 1989).

One of the only situations that would require a rapid transport to the hospital would be in the event of a traumatic injury. In this case the paramedic team must work quickly to get the patient to the hospital so that

surgical interventions and advanced assessment may begin. On-scene times during these situations are limited even though many more invasive procedures may be performed (Honigman, Rohweder, Moore, Lowenstein, & Pons, 1989; Jones, Nesper, & Alcouloumre, 1989; Tse, Spaite, Valenzuela, Criss, Meislin, & Mahoney, 1989). The studies cited above show that paramedics do a good job identifying and performing a quick transportation to the hospital when the need arises. This quick transport decision is based on the skill of the paramedic to decipher when to "stay and play," and when to "load and go" (McSwain, 1990).

Education and Training

Often paramedics are not skilled in communicating with others on the scene of a medical emergency. This is supported by Soreff (1979) who emphasizes the need for additional training for paramedics in the area of family relations and to help them "view the family as part of their treatment and transport responsibility" (p. 323). Other scholars have also emphasized the importance for healthcare providers to have good interpersonal communication skills (Di Salvo, Larsen, & Bakus, 1986; Kreps & Thornton, 1992). One recently published EMT textbook even suggests that interpersonal communication could be presented as a separate course before offering six suggestions for communicating effectively with people in crisis (Limmer, O'Keefe, Grant, Murray, & Bergeron, 2001, pp. 284-285):

1. Use eye contact
2. Be aware of your position and body language

3. Use language the patient can understand
4. Be honest
5. Use the patient's proper name
6. Listen

Although some EMS textbooks offer a larger section on communication, the suggestions outlined above are the standard guidelines offered in most textbooks. While these suggestions may be important prescriptive communication tools, they seem lacking when one takes into consideration the magnitude and interpersonal complexity of the communication event.

Jeff Cole, an aeromedical paramedic from Florida, describes his paramedic education:

> The school doesn't teach you about life. They don't teach you that people are going to spit on you and try to beat you up and are going to hate you even when you do the right thing. … no matter how good your paramedic course is … It's impossible to teach common sense in paramedic school. It's interesting to me that they call it "common sense," and yet it's so uncommon. (Theisen & Matera, 1996, pp. 20-21)

Paramedics are trained to look at a patient and identify what actions are needed to correct the problem. This training is done through rote memory that requires paramedics to recall the information on demand. Commonly this information takes the form of algorithms and protocols (Davis, 1998). These algorithms and protocols are so important that many paramedics carry a field guide on their person that outlines the order of interventions that must be

carried out in different situations. Because most of paramedic training focuses on assessing the patient to find a problem and immediately react with the proper intervention, this memorized algorithm can be the most prevalent thought on the paramedic's mind.

With all of the developments in technology that impact changes in treatment standards, it is now all the more important to be able to deliver patient care using what Naisbitt (1984) calls "high-touch" skills. This means that paramedics need to be more in touch with patients and their families than ever before (high-tech requires high-touch). For example, for a stable patient who is showing a narrow-complex supraventricular tachycardia on the cardiac monitor, it may be easier for a paramedic to just tell the patient to "bear down like you are having a bowel movement," thereby lowering the patient's heart rate and initiating a vaso vagal response,[1] than it would be to explain to the patient why they are being asked to do something that may embarrass them.

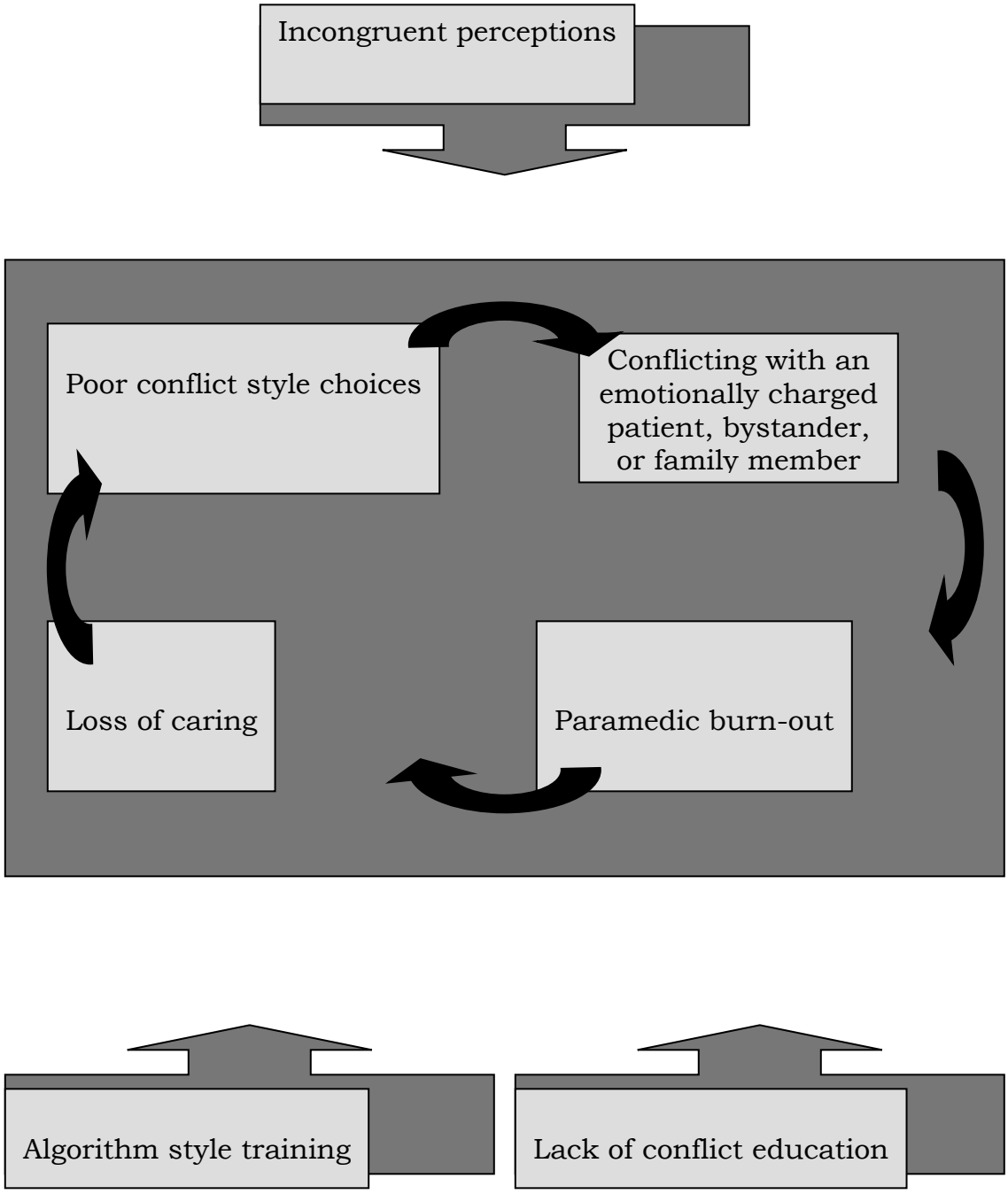
According to Tracy (2000) this high-touch skill, like identifying with the patient (Tracy & Tracy, 1998) or explaining what treatments you will do for the patient before starting, is especially important for a paramedic when trying to establish rapport with the patient. "This will reduce paranoia and anxiety and continue to build trust" (Tracy, 2000, p. 70). Unfortunately, as discussed above, the current training for paramedics may not be the best way to prepare paramedics to communicate with emotionally heightened patients or even bystanders that have a different perception of quality care.

[1] ACLS guidelines for the treatment of supraventricular tachycardia (American Heart Association, 2000, p. 18)

A second problem, in addition to algorithm style training practices, is a loss of caring. This loss of caring, described by Maslach (1979), leads to psychic numbing (Schwartz, et al., 1975) or a detachment or dehumanized contact with patients, is a well documented result of paramedic burn-out (Scott, 1980). "Paramedic burn-out" is a common phrase used among paramedics that describes a high level of emotional exhaustion that leads paramedics to attrition and a lack of caring about their job (Graham, 1981). This is a syndrome that can occur in jobs that require people to give too much, too often, to other people in need (Maslach, 1979). Paramedics who believe they give all that they can give to a public that has an incongruent perception of what their job involves may increase burn-out, thereby escalating loss of caring and psychic numbing. Therefore, a family member, patient or bystander who is emotionally charged and in conflict with the paramedic serves as a significant contributive component in a never-ending cyclical process (fueled by incongruent perceptions, a lack of conflict education, and the sole reliance on algorithm style training) that leads to poor patient care (see Figure 1). This process that is depicted in Figure 1 will be revisited and broken down further in the final chapter.

Figure 1

Cyclical process of poor EMS patient care



Conclusion

This literature discussion has opened up a gap for research that links conflict communication with how paramedics engage in conflict situations within an emotionally charged environment. Hence, I have framed this issue from the communication perspectives of healthcare, power, conflict, education, and perception. Although available literature indicates that it is necessary for paramedics to incorporate effective interpersonal communication skills when providing patient care, once again, little exists beyond anecdotal evidence, thus highlighting the need for significant research in this area. The remainder of this study attempts to bridge the gap in current literature by focusing on three key areas. The first focus is the analysis of incongruence between the constructed and situated realities of individuals who are communicating in an emotionally charged environment. The second focus is an analysis of the interpersonal conflict between paramedics and the people they serve that is generated by this incongruence, a phenomenon that is intensified by a patient needing rapid medical treatment. The third focus is an analysis of input from paramedic instructors to better understand if paramedics are taught to negotiate this type of conflict. To this end, I intend to address the following research questions:

Research Questions

RQ 1a

Do paramedics perceive incongruence between their own reality and the emotionally charged patient, family member, or bystander's reality during the treatment process of a patient who has a life threatening condition requiring immediate intervention by the paramedic?

RQ 1b

Do incongruent realities directly or indirectly play a role in compromising patient care during the treatment process of a patient who has a life threatening condition requiring immediate intervention by the paramedic?

RQ 2

What conflict management styles are used by paramedics when interacting with an emotionally charged patient, family member, or bystander during the treatment process of a patient who has a life threatening condition requiring immediate intervention by the paramedic?

RQ 3a

Do paramedics think they are adequately trained to deal with conflict situations during the treatment process of a patient who has a life threatening condition requiring immediate intervention by the paramedic?

RQ 3b

Do paramedic instructors think paramedics are trained to adequately deal with conflict situations during stressful conditions when caring for a

critical patient and communicating with the emotionally charged patient, family member, or bystander?

CHAPTER 3

METHODOLOGY

This study seeks to reach a deeper understanding of the communication styles that occur within the paramedic culture through descriptive and interpretive analysis. Interpretive inquiry is commonly associated with qualitative research where elements of communication can be conceptually broken down into forms suitable for non-positivist analysis. According to Denzin and Lincoln (2000):

> The word qualitative implies an emphasis on the qualities of entities and on processes and meanings that are not experimentally examined or measured (if measured at all) in terms of quantity, amount, intensity, or frequency. Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is being studied, and the situational constraints that shape inquiry. … They seek answers to questions that stress how social experience is created and given meaning. (p. 8)

The need to endogenously investigate this social experience by looking within myself and at others like me is the central motivation for using a qualitative approach. For people to make sense of experience they must organize these accounts into memory. It is the memory of such past events that I wish to reveal and explicate. The way this memory is organized is explained by the narrative paradigm:

> The narrative paradigm proposes that human beings are inherently storytellers who have a natural capacity to recognize the coherence and fidelity of stories they tell and experience. I suggest that we experience and comprehend life as a series of ongoing narratives, as conflicts, characters, beginnings, middles, and ends. The various modes of communication—all forms of symbolic action—then may be seen as stories, interpretations of things in sequences. (Fisher, 1987, p. 24)

EMS workers reside in a storytelling culture that supports open discussions that relate to experiences they have on the job. Storytelling is an important part of this culture especially because it promotes debriefing, creates solidarity, provides information, fosters socialization, and serves as entertainment (Metz, 1981, pp. 45-46). Many of these stories address not only experiences paramedics have had when dealing with patients who are critical but also with how they handled conflict situations with family members and bystanders. Furthermore, paramedics have intense and continuous exposure to the conflict communication phenomenon that I have selected for study. Therefore, I propose that a productive way to study conflict situations, occurring between paramedics and the people they serve, is to engage in talk with veteran paramedics.

Creating an environment that would allow these narratives to be disclosed and recorded for further analysis was not a difficult task because many of the participants had a previously established rapport. The experience was designed to feel just as natural for the participants as if they were sitting

around a meal at their ambulance post. These stories, I argue, would have been difficult to cultivate by an out-group researcher because the paramedic would see him or her as an outsider to this community. Metz (1981) endorses this view by saying that this culture "is a unique combination of values, concepts, assumptions, and customs that the personnel share with each other but not with outsiders" (p. 38). Hence, my preexisting membership in this community gave me an advantage that helped foster the desired interactions.

Narayan (1993) talks of research that allows the researcher to work towards "belonging simultaneously to the world of engaged scholarship and the world of everyday life" (p. 672). Similarly, as a researcher and paramedic I see my role in this study as dichotomous, reflexive, and interactive in nature. My membership within the community gave me a better understanding of the stories that are told by the paramedics, and as a researcher I was able to relate those narratives with high fidelity and offer my own experiences as a way to clarify those isolated voices. An outsider who studies this culture would have a different orientation to the subject and would not have the same interpretive voice of authority (Bakalaki, 1997).

Some views of qualitative research seem to discredit this approach. For example, according to Morse (1994), researchers who already have an association with the participants do not have the ability to have the same degree of "sensitivity one would have when seeing it for the first time" (p. 27). This view of researcher positionality has been contested by native anthropologists who believe that researchers who study subjects of

unfamiliarity walk into a haze of confusion. This confused researcher is at greater risk of overlooking the richness of the culture (Ardener, 1987). Therefore, I opt for the position of the native anthropologist who belongs to the culture under exploration.

Stage One

The method I used to collect the core data for this study resembled a focus group format. This group interview:

> Takes advantage of group dynamics to produce new and additional data. In addition to the respondent-interviewer relationship, the evolving relations among group members can be a stimulus to elaboration and expression. An additional phenomenological dimension is added to the interpretation and understanding of an event, activity, or behavioral pattern that takes place in the field. (Frey & Fontana, 1993, p. 32)

A focus group is unique because it has the checks and balances to test the information presented (thereby increasing internal validity) because the moderator has the option to request on-the-spot clarification from the participants (Lunt, 1996). Unlike most traditional focus groups, however, the participants in this study were limited in number, at least 2 but no more than 4 members formed a "minigroup" (Greenbaum, 1998, p. 3). This small group dynamic was important because it allowed each participant to have the time and opportunity to tell his or her stories. Also, in some cases, the participants were acquainted with each other and the moderator. As previously discussed, this only helped to create the atmosphere that allowed each group to reenact

the everyday storytelling that continuously permeates this culture. Furthermore, the group dynamics allowed this research method to be called an ethnographic group interview. Moreover, I also see this research method as a form of autoethnography because, as a paramedic, I have years of experience in the life world of paramedic cultural interaction (see also De Andrade, 2000). This means that I have an emic perspective and understanding of the narratives but at the same time I have positioned myself to negotiate my role at an etic level in order to be reflexive and assume critical distance as a researcher (Boyle, 1994).

Some focus group experts believe that a moderator who is too familiar with the research topic may threaten the quality of the study. For example, Krueger (1993) has found moderators who fit in this category to be problematic because he or she may be looking for specific categories of interest that are different from those of the participants. Secondly, he contends that another threat to quality is the probability that participants may think that the moderator has a bias towards the issue. For example, in the literature review section, I have outlined examples that I have found to be common sources of conflict. Some of those examples include spending an extended amount of time on the scene of a call or using lights and sirens to transport someone to the hospital. These examples of conflict that I have provided were not presented in the group interview, and were only discussed if a participant initiated the discussion on that topic. It is also important to note that the group interview was carefully designed (see Appendix) to record the narrative examples of

conflict that paramedics have personally encountered. Examples of conflict that are presented in the literature review do not need to be representative of the examples discussed prior to the commencement of the fieldwork. This strict commitment to my concern for validity and qualitative rigor is reflected in my desire to aptly and fluidly negotiate my role as a researcher who embodies both emic and etic perspectives.

Study Participants

The participants were selected through a non-random snowball sampling procedure of paramedics from Southern Illinois. Participants were asked to volunteer for the study and did not receive any type of compensation for their participation. To ensure eligibility, participants had to have at least one year of full-time work experience as a paramedic on an ambulance and had to be employed as a paramedic during his or her involvement with the study. This provided a consistent research sample of paramedics that had similar experiences with conflict.

The group interview guide was formulated so that the moderator could insure that the paramedics would paint the most descriptive pictures possible. The main aim of the group interview was to encourage the participants to talk about their experiences in conflict that have occurred while trying to provide care to a critical patient. The questions (see Appendix) served as clarification aids to secure rich descriptions (Denzin & Lincoln, 2000).

Traditional focus groups are usually conducted until the information gathered from the groups reaches saturation point (Lunt, 1996). In this case,

however, group interviews could be continued indefinitely. This is due to the nature of the study; everyone has multiple stories to tell and no two stories were ever the same. Therefore, I conducted six group interviews before moving on to the second stage of fieldwork (explained on p. 48). This was necessary because locating participants in Southern Illinois who would agree to participate became difficult.

There were a total of 13 participants in the group interviews, 7 of who were females, and 6 of who were males. The mean age for a group interview participant was 37. The youngest participant was 23 and the oldest participant was 55. The sum in years of experience in EMS for all group members was 137. The least amount of EMS experience found in any group member was 3 years and the most experience found was 22 years.

Experience in EMS is significantly different than the experience one would gain from working in EMS as a paramedic, because, as stated earlier, the paramedic is the member of the crew who has the brunt of the patient care responsibilities. Therefore, due to the paramedics' legitimate and expert power role, he or she will have a different perspective of the conflict event. The sum in years of experience as a paramedic for all group members was 50. The least amount of paramedic experience found in any member was 1 year and the most experience found was 11 years.

The group interviews were audio taped with two recording devices to reduce the chance of equipment malfunction and lasted approximately 1 hour each. The participants were given a number and letter that served as the only

identifier in the transcripts and the final thesis, thereby concealing each participant's identity. A number is placed as an identifier for a specific group interview session, and a letter is placed as an identifier of the specific participant within the group, for example, "7a." The data sheet that served as the only link from the coding system to the actual participant was destroyed after the study was completed.

Next, I coded the transcripts to identify conflict styles.[2] The conflict styles used to code the transcripts included avoiding, competing, accommodating, compromising, and collaborating styles that are described in Table 1. Additional styles that were added to the coding process include mediation, physical aggression, explaining, and the coercive style discussed extensively in the literature review. In addition to these conflict styles, the group transcripts were coded for emergent themes, examples of perceptual incongruence affecting patient care, and perception of paramedic training. Finally, the coded data was analyzed to address the research questions posed earlier.

Stage Two

After completing the group interviews, findings were used to frame a rough list of further inquiry questions. The majority of my questions focused on answering the last research question and addressing any additional issues, discovered during the group interviews, that demanded further inquiry. This last research question is charged with determining if paramedics are

[2] The transcription process was modeled after the steps emphasized by Myers (2000) that helped simplify this procedure.

adequately trained to deal with the types of stressful situations that were discussed in the group interviews. Experienced individuals, or experts on this topic, were interviewed to fulfill the objectives for this final stage of the research project.

For the purpose of this study, I define an "expert" to be an individual who has been a full-time paramedic on an ambulance for at least 5 years and is a state-recognized paramedic instructor. Additionally, the participant had to have either previously taught or be currently teaching a paramedic class. The participants were selected through a non-random snowball sampling process through a word-of-mouth inquiry, and all of the expert participants were given the option of a confidential interview, but all of this participant pool agreed to an open interview that identified their name within the study and certified their expert status. Much like the process in the first stage, participants were asked to volunteer for the study and did not receive any type of compensation for their participation. The total size of the participant "expert" population was determined by the availability of consenting participants. However, the search for participants continued until the participant responses became noticeably repetitive. Due to the narrow topic under investigation, this was achieved after four interviews.

One of the four interviews, however, was conducted prior to the completion of the first stage due to time limitations and participant availability. This interview was segregated and set aside until all of the interviews were completed. At that time I decided to include the interview because it was rich

in data and no negative implications were found that would impact the validity of the interview. For example, there were no significant topics, uncovered in subsequent group interviews, which were not addressed by this interview. Therefore, this interview that was conducted ahead of schedule was treated like all of the other individual interviews that were conducted for this study.

Similar to the group interview, the individual interview participants were asked to discuss their own experience with conflict. This ensured that the experts had their own experiences fresh in their memory to use as examples to support their claims. Subsequently, participants addressed the last research question through engagement in an informal discussion. This type of interview would fall under what would be considered a narrative approach by Hollway and Jefferson (2000) where "the agenda is open to development and change, depending on the narrator's experiences" (p. 31). The interviews were tape-recorded and transcribed using the same format as the first stage of the project but they did not have a pre set time limit that could have constrained the interview. The interviews each lasted between 30 and 90 minutes. Finally, the interviews were coded for recurrent themes and analyzed for the purpose of answering the final research question and illuminating claims made in the group interviews.

The first expert interview was with Chuck Albright, a paramedic instructor who has been in EMS for 21 years and has been a paramedic for 16 years. He currently works as a paramedic supervisor and a field paramedic. The second interview was with Jennifer Haner, a paramedic instructor who has

been in EMS for 22 years and has been a paramedic for 10 years. She currently works as an ambulance service administrator and field medic. The third interview was with Tom Banks, a paramedic instructor who has been in EMS for 21 years and has been a paramedic for 19 years. He currently works as the lead paramedic instructor for a resource hospital in Southern Illinois, a flight medic on a helicopter, and a field medic. The fourth interview was with Myra Seets, a paramedic instructor who has been in EMS for 12 years and has been a paramedic for 11 years working as a field medic.

Now that I have laid out the background literature and discussed the method of investigation, I would like to introduce the results compiled from paramedic narratives. The next chapter will work to compare the similarities and differences between all of the data yielded through fieldwork and overall, this is accomplished with the aid of the work accentuated in the literature review, the stories, of course, from paramedics, insights from paramedics and experts, and my own experience as a paramedic and a researcher.

CHAPTER 4

RESULTS

Out of a thick pile of transcribed group interviews I found a total of 38 stories that served as examples of conflict situations that were encountered by paramedics. The stories that I have selected to relate in this chapter were chosen as narrative units because of their descriptive quality and connections with the criteria under exploration in this study. More specifically, the main criteria included finding examples of conflict that occurred between a paramedic and a family member, patient, or bystander who was emotionally charged during the treatment of a critical patient. In some cases, however, stories that involve people who were not emotionally charged were selected for the purpose of highlighting common conflict styles that are used by the paramedic.

I had originally planned to cluster the stories, related by paramedics, under their respective conflict style categories. However, while coding the narratives, I found that when paramedics are faced with a conflict situation they commonly use any number of conflict styles. Therefore, the stories were categorized in a ground up manner according to emergent themes and are connected by common conflict elements.

The first story opens this chapter with a depiction of my first exposure to the world of conflict in EMS and is illustrated because of its graphic nature and conflict style choice. A group interview participant, who shared this experience with me, also narrates this conflict experience. The first section serves as an

illustrator of instances when the paramedic must retreat with the patient due to the resistance encountered on the scene. The second section represents situations when the paramedic comes across a dispute revolving around the transport of a patient to the hospital by ambulance. The third section paints a picture of how some paramedics instigate conflict situations. Finally, the last section describes how medical professionals who work in the hospital can influence conflict situations with EMS personnel.

Stories Uncovered

When I was 17-years-old, I was riding on the ambulance and trying to learn all I could about EMS. My first code (cardiac arrest call) was a big shock to me. I had already been in class and learned how to take care of a person who had no pulse and was not breathing, but I had no preparation for what was to follow. One of the paramedics I interviewed was at that scene, and he narrates the following story:

> I had a call where a patient and his son had gotten into a verbal conflict and [the] patient sustained cardiac arrest. The patient therefore was unresponsive; the son was pissed off, drunk, inebriated and wanting to fight. … Nobody was on the scene, just the police wanting to know what was going on. … The son came in, upset, pissed off, drunk, wanting to know what was going on, got into a conflict, came in the back door with a weapon [knife]. … I grabbed hold of him and slammed him out the back door, which is not the way things are supposed to be done but that is the way it was done due to self-preservation to take care of my partner and

> the rest of the crew on hand. … He was pissed off and upset because he had an argument with his father and was afraid that he had caused his death due to the conflict. … He was afraid that he was going to get into trouble, he didn't know what we were doing, and he he was basically trying to save his own self from getting into trouble and the only thing he did was increase his problem by getting into a conflict with the EMS personnel. (1a, personal communication, January 27, 2002)

In this case physical aggression is used as a reaction to the emotionally charged family member who presents himself in a threatening manor with a deadly weapon. Similarly, this use of physical aggression in subsequent narratives depicts its use as an approach to avoiding physical harm.

Probably, because this was my first code, I remember the same scene in vivid detail. Therefore, in order to further elucidate the graphic nature of the situation, I offer my own account of the call. When I walked into the house the patient was sitting on the couch, unresponsive, pulseless, and apneic (not breathing). The paramedic shoved the coffee table out of the way and I heard a crash of something breaking from the table hitting another piece of furniture. The patient was violently jerked down onto the floor, and they cut off his shirt. While the paramedic was working frantically to set up his equipment, a man came from the back of the house through the kitchen and was yelling as he knocked objects on the floor. Next, this shirtless man came down the hallway towards the living room where we were trying to save his father's life. I was doing chest compressions and could see him furiously stabbing holes in the

wall and coming in my direction. The next thing I saw was the crew member (1a) tackle the "crazy guy" with such force that it threw the man back down the hall, through the kitchen, and out the back door. Despite our best effort, the patient was later pronounced dead at the local emergency room; my EMS career was off and running. This was my first exposure to physical aggression directed at an emergency crew trying to save a patient's life.

Retreating With the Patient

Another situation where a paramedic crew chose the use of physical aggression takes place in a bar with a drunken family member. The crew was called to care for a sober female patient who was having chest pain. The drunken family member assaulted the paramedic and the crew was forced to retreat with the patient. This situation is another example showing what can happen when incongruent perceptions are mixed with alcohol:

> He pushed me because he wanted an ambulance. He didn't think what we were doing was appropriate, which all we were doing was putting her in the ambulance, putting her on O2 [oxygen] and trying to get him out of the ambulance. That did halt patient care because we had to quickly stop what we were doing with this patient to try to get him out of the ambulance. … Then you hear the cussing, hear the threatening, "I am going to call my lawyer," "I'm going to have your ass," "I am going to have your license." That is when you just have to get very stern. "You don't sign my paycheck. This is my ambulance … this is my territory. Outside apparently in a bar is your territory. Go back to your territory." … We

> pushed the family member out, shut the doors and drove a block up the street so we could stop and start an IV and then drove two more blocks to the hospital. It works. You have to. … you get yourself out of the situation because the PD [police department] couldn't have gotten there quick enough. … This is all simultaneous. When you are getting the PD here you're throwing the family member out the back door, slam the door and trying to drive. Getting out of the situation calms the patient down and calms you down so you can focus on your patient. Sometimes that is the only thing you can do. … First and foremost you are thinking about you or your partner's safety. You have to get yourself out of the situation then you look at your patient and they are freaking out because everybody else is freaking out. You look at your safety and your partner's safety and then you worry about your patient. Sometimes getting completely out of the situation, out of the area, is the best thing you can do. (3b, personal communication, February 3, 2002)

"Retreating" with a patient is an option that paramedics choose even when not threatened with physical harm. The next narrative describes a situation where a paramedic crew retreated because the verbal abuse from the family was interfering with patient care.

A common call for the paramedic is a diabetic patient who has a low blood sugar. Frequently when a patient's blood sugar drops they will become unresponsive, triggering the bystanders into a panic. This is a serious medical condition that, in most cases, is simple for the paramedic to correct through

intravenous drug therapy. The conflict between the paramedic and a family member during the treatment of one such diabetic emergency was so severe that the paramedic had to remove the patient from the scene so she could render treatment. The patient's husband, who wanted her taken immediately to the hospital, instead of undergoing treatment on scene, reacted as follows:

> The first thing he wants is to load and go. I have to explain to him we are going to be sitting for a few minutes. We are going to take vital signs and I am going to get an IV. She is a very hard stick. He goes, "You guys waste your time with that every time." I tell him, "You don't understand, I can help her if I get this IV and now we are going out to the ambulance." He takes a deep breath and sighs. He ain't a real happy camper. We go ahead and get in the ambulance. … He opens the door and goes, "You're going to sit there and let her die." (3a, personal communication, February 3, 2002)

The paramedic responded by telling him that his wife would die if she did not give her the drug. The man, who was extremely frustrated by this point, responded by telling them that they should "get the hell out and stop wasting time" (3a, personal communication, February 3, 2002). As a result, the paramedic stopped patient care so they could relocate the ambulance about a block away and finish treatment.

The paramedic who encountered this resistance explained the husband's behavior:

> A lot of people think we just roll like the old days. In the old days you throw a patient in the back …when it first started you didn't even sit in the back with the patient. It was a hearse. …They still have that in their heads. (3a, personal communication, February 3, 2002)

Another "retreat" situation can be observed when looking at a paramedic crew that was faced with a gunshot wound patient and a group of approximately 10 bystanders, including the patient's family, who were interrupting patient care. The patient was gunned down in a "bad part" of town; the assemblies of people were emotionally charged and seeking vengeance:

> They were pushing around, pushing away at the crowd trying to get in the ambulance. The police officers there did have to physically restrain some people. … Everybody kept coming up asking if he was all right and talking about how they were going to go get the motherfucker and find out who did it. … We were just saying, "Be quiet, be careful, don't worry about it the cops are here they will deal with it." Trying to calm them down and keep them away from the patient. … Basically what we did for that was pick him up, put him on the cot, got in the ambulance. I closed the back doors, locked them, got in the front seat and drove about two blocks away to get away from the family and everybody else. (4a, personal communication, February 4, 2002)

The paramedic initially tried to use coercive styles to calm the crowd down. When the bystanders would not comply, he was forced to find a way to avoid

the situation altogether by leaving the scene with the patient. Sometimes, as in the next situation, the police officers can be of more assistance.

While on a call for a male patient having a possible heart attack, the paramedic crew was met with resistance from people on the scene:

> They were trying to tell me what I should be doing. I said, "I am trying to do my job here, I am trying to look at the monitor."[3] … They were in the side door trying to upset the patient. Patient was calm until they opened the side door and got my patient all upset and I physically had to yell out the back door to tell the police officer to get them out and take them. … They were telling me, "Well they've had this happen before and its just ya know … they just need to take an antacid that's all … It ain't your heart, tell them that there's nothing wrong with them and they are just pulling it, trying to get attention." And whoever this person was actually having an MI [myocardial infarction[4]]. … They were saying, "Ah, you're faking it, get out." (5b, personal communication, February 11, 2002)

Fortunately, the patient "calmed down as soon as they were gone and then I got back to what I was doing with the O2 and everything and [the patient] calmed right back down just like [he was]" (5b, personal communication, February 11, 2002).

Sometimes, as in the next section, there are situations where the paramedic must convince the patient to go to the hospital by ambulance.

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[3] A cardiac monitor is used by Advanced Cardiac Life Support providers to evaluate the electrical conduction of the heart to aid in patient diagnosis and treatment.

[4] Commonly known as a heart attack, an MI takes place when a portion of the heart muscle is dying due to inadequate blood supply.

Usually, the paramedic works to persuade the patient to go to the hospital based on the perceived significance of the injury or medical condition and, to a lesser extent, the concern for legal liability. The title for this section was chosen in an effort to portray the feelings of frustration that paramedic's sometimes experience when performing this task. The stories of this section serve as an explanation for why a paramedic may have this quote on his or her mind when trying to convince the patient to just "get in the ambulance."

"Get in the Ambulance"

The city council of one Southern Illinois town chose not to fund their local ambulance service, leaving only one ALS unit on hand to cover the entire county. As a result, the project medical director restricted the ambulance from leaving the county so the citizens would have a better chance of having an ambulance available. This became a big source of conflict because a patient who called an ambulance and was located on the border of the county could not go to any hospital outside the county, even if it was within close proximity to the patient.

A paramedic had just talked about an incident where he went to the home of a patient whose husband met the crew at the door demanding to take his wife to a hospital out of district. The paramedic explained that his ambulance was the only emergency unit in the county and he could not leave the district to go to a hospital that was out of the way. The husband, in turn, said he would take her in the car and the paramedic never saw the patient (4b, personal communication, February 4, 2002). This story set the stage for and

triggered the following example of a family member who demanded that his wife be taken to another out of district hospital:

> The worse one down here was I got a call out to a possible stroke. I walk into the house. The husband is on the phone. He is on home 02. He is a [retired] doctor in this area: "My wife is going to _____ [a hospital that is located a significant distance from the scene]." "No she's not sir, she is going to _____ [the local hospital]." He would not let me touch his wife. … Basically he called me everything but a white woman. "Basically, sir I am not going to do that. As is my license I am not forfeiting my livelihood for you. It is not going to happen." He said, "Then you need to get off your lazy ass and do it anyway. I am a doctor so and so and this is the way it's going to be." I said, "No its not." I said, "I will call someone higher up and you can deal with them." I had not seen the patient's wife at this point at all. I get on the phone. I get the doctor [at medical control] on the phone. He is still cussing at me. I am trying to explain to the doctor [at medical control] with my back turned to him [the family member] because I am so infuriated that I cannot let him see my face. You know how patients are. I am talking to the doctor [at medical control]. This doctor ripped the phone out of my hand, the one sitting in the chair. He [the family member] is telling him [the doctor at medical control] that she [the paramedic] can go check her [the patient] if she wants now. I go in there and this lady has swelled bigger than life. She has right-sided full involvement, gasping, hurling, the

whole nine yards going on. I said, "Can I use that [oxygen] tank please?" "No that's mine." Okay, so I send my basic [EMT] out to get my tank. He said, "The doctor wants to talk to you," and throws the phone at me. … He was just irate. The son is apologizing, the daughter is apologizing, the wife [the patient] is answering me, she is apologizing for her husband's attitude. I am on the phone. (4c, personal communication, February 4, 2002)

The above story depicts a family member, a retired doctor, who was so concerned about maintaining control of the situation that he jeopardized patient care. As a paramedic who knows how important it is to get the patient to the nearest hospital as quickly as possible, so that fibrinolytic[5] care can still be an option to reverse the stroke, I was so struck by the actions of this family member that I asked the paramedic if the husband was drunk. She responded by saying, "No, this is 10 o'clock in the morning" (4c, personal communication, February 4, 2002). Ironically, in fact, the retired doctor accused the paramedic of not knowing what fibrinolytic care is. Fibrinolytic care is only effective if administered within a short amount of time after the stroke onset. The retired doctor was the one who was prolonging the time to get the patient to a setting where this treatment could be provided. As the story turned out, the patient was taken by ambulance to a medical helicopter that transported the critical patient to the requested hospital, therefore, compromising with the husband.

[5] "In 1996 the AHA recommended the use of fibrinolytic (drug) therapy *within three hours of symptom onset for selected patients* with **ischemic** (inadequate blood flow) **stroke**" (American Heart Association, 2001, p. 187).

This compromise only took place after the paramedic had used mediation, accommodation, competing, and coercive conflict tactics during the encounter. The paramedic perceived this encounter to be fueled by the husbands need "to throw his weight around … being not only a doctor but also being male" (4c, personal communication, February 4, 2002).

In another part of Southern Illinois, an ambulance was called to the scene of a car roll over where they found a male trauma patient who was in his mid-20s:

> He didn't want to go to the hospital. He needed to go considering it was roll over. He needed to go. We finally talked him into going. When he got in the back of the rig he said, "I am not getting on your cot." "You need to get on the cot so we can get your blood pressure," [the paramedic said]. I am not getting on the cot. I will sit right here," [the patient said]. We never did convince him or get him on the cot. (6a, personal communication, February 13, 2002)

The patient and crew both used a compromising conflict style. The patient agreed to go to the hospital and the crew agreed to let him ride on the bench seat of the ambulance, but they did make him wear a seat belt. The use of this compromising conflict style could have caused irreversible harm to the patient. One possible reason the EMS crew would have been so insistent about transporting the patient to the hospital would be a potential cervical spine injury. This type of injury is always a consideration due to the mechanism of injury endured by the patient during a car rollover. According to the

Prehospital Trauma Life Support Committee of the National Association of Emergency Medical Technicians and the Committee on Trauma of the American College of Surgeons (1999):

> During a rollover, the car may undergo several impacts at many different angles, as may the occupant's body and internal organs. … Injury and damage can occur with each one of these impacts. It is almost impossible to predict the injuries these victims may receive. (p. 19)

The text later goes on to state, more specifically, that:

> For every trauma patient with a significant mechanism of injury, the EMT must suspect spinal cord injury until it has been conclusively ruled out. Excessive movement could cause neurologic damage (or additional neurologic damage) because bony compression may occur in the presence of a fractured spine. (p. 41)

Therefore, patient care was compromised due to the use of a compromising conflict style that is seen by the patient being allowed to sit on the bench seat and not lie on a device that would immobilize his spinal column. Hence, poor patient care may be the result of the paramedic giving in to the other party in the conflict.

Sometimes, as in the next situation, the paramedic must devise a way to convince the patient as well as the bystanders that the medical condition in question is serious enough, and that it is crucial to go to the hospital by ambulance.

Another paramedic crew was faced with a patient who wanted her daughter to help her make a decision about going to the hospital. The crew waited on the daughter, a modestly trained medical professional, to arrive at the house. When the daughter showed up, the paramedics began dealing with an even worse conflict situation:

> We were 100% aware that this patient had had a heart attack. She did not want to go to the hospital and it was more of a lack of understanding, ignorance on the patient and husband's part. They are elderly; they didn't have the knowledge. Back when they grew up 8th grade was the best education you got and you deal with what you did. They thought since their daughter had managed to become either a first responded or EMT or nurse aid, what every the hell she was, that she had superior knowledge and that they trusted her and she didn't know us, therefore she didn't trust us. … She [the daughter] didn't want to let in that she was over her head, that she could take care of the situation because her parents had put so much trust into her and we were the outsiders. In a rural community, family above all else rules. We had repeatedly told her that her mother had had a heart attack. … She had had leg surgery, she was diaphoretic, she had major, major symptoms of a cardiac event and that is why we stayed there a half-hour. Most of the time will just get a refusal,[6] walk out. … We pleaded with the patient that basically you need

[6] This is a legal document that is signed to release the EMS personnel, the ambulance service, and the resource hospital of any liability related to the patient who refuses to go to the hospital by ambulance after being assessed by the responding medical team.

> to go to the hospital, not so much for us to cover our end of it so we wouldn't get in trouble but the simple fact that we knew the patient needed the care. We were running up against a brick wall and the daughter was the brick wall. (1a, personal communication, January 27, 2002)

The conflict was resolved when the paramedic crew gave in and asked the patient to sign a refusal of treatment form. Both paramedics left the scene worried about the patient and trying to figure out how they could have done a better job of convincing the woman to go to the hospital. This patient died 12 hours later in her home even though the paramedic crew did the best they could to convince the patient by explaining the significance of her signs and symptoms, the importance of treatment, and offering other alternatives like going to the hospital by private vehicle.

In this situation, the demise of a patient resulted when the "pleasant" conflict styles like explaining and attempting to collaborate were used unsuccessfully. Events like this can move paramedics toward the use of "harsh" conflict styles like physical aggression, competing, or coercive moves. At other times, however, as in the next example, a paramedic may have external circumstances that influence the development of these "harsh" conflict styles.

The ambulance was called out to an annual horse trail ride, to care for an injured woman who was found in an extremely rural area. The paramedic knew that her niece was at the event and was fearful that she would be the

patient. This caused the paramedic to become more aggressive than normal; in fact, the paramedic's niece later told her that when she came out of the ambulance she looked like the "terminator," "The look on your face and your body language … everybody in the crowd shut up. … you could have heard a pin drop. … you were scanning the crowd. I knew instantly you were looking for me" (6b, personal communication, February 13, 2002). Upon arrival, the paramedic discovered that her niece was unhurt, and was met by an off-duty EMT from her department who described the accident and gave a brief report. The off-duty EMT told her that after the patient was thrown from the horse, her eyes were going in two different directions. The paramedic narrated the initial patient assessment:

> The patient is on the ground. She is on her knees, sitting on her knees. I am checking her out real quick. Her husband is standing right beside her going, "She's okay, she's okay, she's not hurt. She has been thrown from horses many, many times. She is okay." (6b, personal communication, February 13, 2002)

The patient, however, was not okay and the paramedic knew that the patient badly needed to go to the hospital:

> I am sitting there going [telling her husband], "Well she needs to go to the hospital." He said, "No, no. … if she needs to go to the hospital, I'll put her in the truck and take her." I just kind of like stood up. It wasn't anything I said it was my manner. It was the intimidation mode that I was in. I just looked at him square in the eye and I said, "Look, I don't

have x-ray vision, but I think she is hurt and I think she is hurt bad. She is going with me. She is not going with you in your truck." I know he took a step back. I remember seeing him kind of take a step back. (6b, personal communication, February 13, 2002)

After the patient was immobilized to protect her spine, she was taken to the ambulance and the patient became extremely critical and "was going down fast," (6b, personal communication, February 13, 2002):

> This is so bad that I can't hardly speak I am so shook up, I am so scared. I hollered at the driver and I said, "You get me a helicopter and you get it now and have them meet me at _____ [the closest hospital]. … I tried to call _____ [medical control and] after about two to three sentences it is like, "I will contact you later, I can't get it out." I throw the mike out of the way. [My partner] and I are working our tails off trying to keep this woman alive because she is just bottoming. The pressure in her head is building so fast that she is headed for ground and she is heading fast.[7] (6b, personal communication, February 13, 2002)

The crew rushed the patient to the closest hospital:

> We pull up real fast, sling the doors open and of course he [the husband] is already out of his vehicle … He said, "Well I guess she wasn't hurt as bad as you thought she was." Of course we don't have time to talk. We hit the latch on the cot to bring her out … [and] she quit breathing, just like that. So now we are really scrambling. We are jerking the cot out,

[7] Referring to Cushing's Triad, a late sign of increasing intracranial pressure that is associated with a rising blood pressure, slowing pulse rate, and changes in respiratory pattern.

> moving it, getting her into the ER, rolling in there with her … [and telling the doctor], "She just quit breathing she needs to be intubated." He is still standing in ER and he is watching all this time with this complete look of denial on his face. They are intubating his wife. She is almost at the bottom now. They are intubating. We leave ER. (6b, personal communication, February 13, 2002)

The family member did not come to grips with the severity of his wife's accident even after watching the emergency room crew furiously working to save her life and seeing the medical helicopter arrive to fly her out to the trauma center. After the helicopter arrived, the doctor had a chance to talk with the man and explain the severity of the problem:

> He said, "Your wife has a severe, severe problem with pressure in her head." He still doesn't get it. … [The doctor] just says it like this, "Her skull is cracked, she is not breathing, her respiration, heart beat are stopping. We are flying her to [the trauma center] right now so they can relieve the pressure off her brain. If we don't do it right now she is going to die." (6b, personal communication, February 13, 2002)

It was not until this moment that the man completely understood the severity of the accident.

The paramedic knew that her nonverbal stance and stark words, the competing and coercive conflict style, had potentially saved the patient's life.

> I know, I didn't let him interfere with my patient care but he could have very easily if it had been anybody else besides me, anybody else that is

> the least bit intimidated by people. She probably would have died because he wouldn't have let anybody else … take her because I didn't give him a choice. (6b, personal communication, February 13, 2002)

Another situation where a "harsh" conflict style had a positive result was on a motorcycle wreck where the crew found a drunk 18 or 19-year-old male. The patient was screaming and trying to assault the emergency workers:

> He was having a heck of a fit. Some of the most filthy language you ever heard. Of course you try your best with a drunk to be calm, be positive and try to diffuse the situation. … In the back of the rig I kind of lost my temper that night. … We were trying to start an IV on him and he was jerking and a hollering and carrying on. I had had just about enough of it. The only reason he calmed down after that is that I had such a mother tone in my voice. It was kind of like I turned into … my mother. … I will admit it, I chose the wrong words. I was trying to start the line and he was hollering before I even tried to start the line. He was jerking his arm and stuff. Finally, I just jerked his arm straight and I told him, "I am going to tell you something. … if you make me miss this IV … I am going to show you what hurt is and it isn't going to be real pleasant." I said it in such a horrible tone of voice. I was in my momma mode. I was looking around for my mother after I said that. I said it and both of my partners just sat straight up and looked at me because I don't usually do that kind of stuff but I don't deal with drunks well. He laid still after

> that. There was no more cussing. He got along with all of us. (6b, personal communication, February 13, 2002)

Although "harsher" conflict styles have been found to be beneficial in some cases, in other cases the paramedic may only foster a negative atmosphere or encourage a conflict to take place.

The Paramedic Who Picks a Fight

Many examples of conflict exacerbation can be directly linked to the conflict styles deployed by the paramedic. This is one theme that surfaced in every group interview, either from a direct comment on the topic or from revealing examples of this phenomenon in action. The participants from the second group interview, however, devoted extensive time discussing how a paramedic can exacerbate conflict. "Most of the time when there is a major conflict between the EMS personnel and the family that probably most often it is fueled by the EMS' response to the family or bystanders" (2b, personal communication, February 1, 2002).

> It is like you said it is usually instigated by the EMS personnel by saying something smart, snappy with somebody when they say something. You are not thinking it is going to offend them but you are thinking about the patient and don't intentionally mean to be hateful or whatever to the bystander but it happens. (2a, personal communication, February 1, 2002)

The conversation continued with further insight, by the other participant, on how he experiences this phenomenon.

> The situations that we are usually placed in an emergency is extremely stressful and when you are under that much stress, especially if it is a critical situation, I think the last thing that is on a lot of people's mind, I know probably the last thing that is on my mind, is whether or not I am going to hurt the family member's feelings or not. I really don't care. That is not a statement [that I would say to people]. … It is not that I intentionally set out to offend someone, it probably happens that way a lot of times. In that situation you don't have the time it takes to stand there and explain to someone the entire process that we are going through and because the family then hasn't been explained what is going on they don't know and therefore they think we are just killing time sitting on the scene. (2b, personal communication, February 1, 2002)

The following story is an example how some paramedics have such a strong commitment, or even compulsion, to take care of the patient that they respond to any obstacle, in this case a bystander, by using language that could instigate a conflict:

> We went to Wal-Mart the other night and there was a guy, who had abdominal pain … I asked him the question I always ask, "Do you want to go to the hospital, sir?" The Wal-Mart girl, the receptionist or whatever you call that person, the greeter, sits there and goes, "Why I think he should go to the hospital, I think he needs to do this, I think he needs to do that." I kindly told her, "M'am he needs to make his own decisions, we can't take him unless he says so." She continued on then

> my partner jumped in and said, "Look we need you to step away from the situation. If you continue I will remove you from the situation;" and that pretty much solved the conflict. … She was hanging all over the sick guy, kind of like motherly. Just as soon as my partner said that, she kind of backed away. (1b, personal communication, January 27, 2002)

This narrative depicts a lady who is obviously worried about the patient. According to the paramedic, she was going to pray for the man and was giving him the names of some good doctors in the area because he was from a different state (1b, personal communication, January 27, 2002). Obviously, this bystander had no intention of causing any problems but her display of caring was met with strong resistance from the paramedic who used coercive and competing conflict style tactics.

Another situation involved a paramedic treating a 23-year-old male who was unresponsive, breathing shallow, diaphoretic,[8] and had pinpoint pupils. The patient took "three days worth of Vicodin in ten minutes" and overdosed (4b, personal communication, February 4, 2002). During the time patient care was being rendered by the paramedic, the bystanders opened the door of the ambulance and were making statements like, "Let's get him to the hospital," and asking questions like, "Is he going to live?" The paramedic responded, "I said yes (he will make it) if you will leave me alone" (4b, personal communication, February 4, 2002).

[8] Perspiring heavily

Possibly due to his own stress, the paramedic met the question posed by the concerned bystanders with a threatening and hostile response. The paramedic's response serves as an example of his use of the competing conflict style. If I reword the response made by the paramedic, based on the context of the dialogue, a possible meaning that could be derived by the bystander is illuminated. For example, the paramedic might as well have said, "Go away or your friend will die." This hostile response is problematic because it seems to be sending out a perceivably unwarranted threat.

One paramedic, who has 22 years of experience in EMS and a bachelor's degree in psychiatric social work, believes that paramedics that have a caring attitude are the most successful at dealing with conflict:

> It totally depends on the characteristics of the paramedic on how that situation is going to go. You can escalate it or you can decelerate it depending on your personality. We can set here and pick out the paramedics in this ambulance service who are going just going to accelerate the situation, make it far worse and the ones who are going to come away with a much calmer outcome. I think it is totally a matter of the personality of the person involved a lot of times. (5b, personal communication, February 11, 2002)

One paramedic revealed a conflict he had with some members of a nursing home staff. He was called to an unresponsive patient that was being administered a low level of oxygen through a nonrebreather mask. A patient will suffer from a decreased intake of air when oxygen therapy, through a

mask, is not set at a high concentration. In this case, the nursing home staff was depriving the patient of oxygen:

> The patient was hypoxic.[9] I went to the nursing station, yelled out the staff, went back to the room and decided to take care of the patient. I got the patient on the cot, took care of the situation, got reoxygenation established. The nursing staff decided to cop an attitude and asked me if I had a problem, which was mistake number one because I am short tempered to start with. … [I told them] that they were incompetent and that they didn't deserve to be the rank of a secretary and I wouldn't let them take care of a dog. My partner … basically told me to simmer down and this was not the time nor the place and to leave it for the supervisor to deal with and leave the building. … If it wasn't for the fact that he had stepped in, I would probably have hit one of the staff members, lost by job, lost my license, and created more of a problem for the patient because it would have delayed treatment. (1a, personal communication, January 27, 2002)

This competing conflict style, exhibited by the paramedic, had escalated the scene to the point where his partner had to step in and diffuse the situation. I have been on a similar call where the nursing home staff was depriving the patient of oxygen. My partner, a paramedic supervisor, explained to the staff why the treatment they were rendering was causing harm to the patient. As a result, in sharp contrast with the previous example, the staff appreciated the

[9] Suffering from a lack of oxygen.

opportunity to learn how to treat a patient who needed intensive oxygen therapy in an emergency situation.

Medical Personnel Out of Their Element

Medical personnel who work in a structured clinical setting, in some cases, can make an already bad condition worse when they try to assist paramedics on the scene of an emergency, thereby inadvertently causing a conflict. On one call, a nurse who stopped to help the emergency crew at a severe car accident "ended up being a pain in the ass" (3a, personal communication, February 3, 2002):

> There was a nurse on scene and yeah, I'll grant you, the patient was very critical, very bad, very busted up patient. But I knew that, so, when she thought she would become somebody to tell me when to do, how to do and what to do. Well we don't do things the same order out here that they do in there. I kept trying to tell them, I know this. I know this, it's okay. … I don't think it is always handled the best way we could handle it but I don't think we always have enough time to handle it the best way. We have a limited amount of time to spare at the moment, a few seconds and deal with it the best way we can a lot of times. Other times you are lucky enough you have someone who half way understands when you are dealing with a doctor or nurse and when you explain to them, "I understand what you are saying but I need to do my job," they usually, if they respect paramedics in the first place, they will usually try to back down. (3a, personal communication, February 3, 2002)

Treating patients in the field is much different from treating a patient in the hospital. The order of doing things varies and the equipment, in some cases, is also different:

> They have a whole different set of rules and a whole different atmosphere, whole different set of guidelines than we do. So always if you get a doctor or nurse on scene it doesn't matter what the situation is, what the injuries are, they are wanting a stethoscope. Every time I have ever had a doctor or nurse on scene that is what they are wanting. Okay that's familiar to them. (3b, personal communication, February 3, 2002)

The paramedic went on to reiterate and emphasize the same point, "We are in a field we deal with all the shit, deal with all the blood and guts. We see everything first hand before they see it but they are always wanting their stethoscope" (3b, personal communication, February 3, 2002).

Prior to this study conflicts between nurses and paramedics have been documented as a phenomenon generally occurring in the vicinity of or in relation to the hospital environment. For example, Palmer and Gonsoulin (1992) found the most prolific response from nurses in their study on conflict between nurses and paramedics was on the topic of knowledge depth. Nurses felt they had more medical knowledge than paramedics. Paramedics, however, contend that nurses are jealous because they are not in a position to perform tasks like endotracheal intubation and do not have the same autonomy given to paramedics when carrying out treatment protocols. However, with the exception of power struggles, other conflict elements outlined in the Palmer and

Gonsoulin (1992) study, like jealousy, or depth of knowledge, among others, did not emerge from the group interviews that were conducted for this thesis.

To conclude this section, I would like to offer my own experience with nurse conflict, a situation that occurred less than one week prior to the completion of this thesis. It was a Saturday night and my partner, a basic EMT, and I were called by the police to an "assault." When we arrived at the residence and got out of the ambulance I saw a large number of cars on the street surrounding a house swarming with people. The crowd had just come from a wedding reception earlier that evening. I greeted the two police officers that told me they had just arrested the man who had started the fight. Evidently, the detained 24-year-old young man had gotten in a fistfight with a 40-year-old man over who had the larger penis. The younger man wanted to show off his penis to the older man's sister. The officers told me that it was all under control and I would find an elderly female in the house who was having difficulty breathing. I lugged my equipment through a crowd of 12 loud adult bystanders into the house, also full of people, and finally I located my patient.

When I walked in the living room I saw an elderly woman crying, face flushed, and breathing rapidly. Sitting next to her, on one side, was a man covered in blood. Sitting next to her, on the other side, was a woman who identified herself as a nurse, the same woman that was offered a view of the young man's penis. The nurse began "barking orders" by yelling, "You need to get out your blood pressure cuff and take her blood pressure now because if you aren't going to do it then I will." I tried to assure the nurse that I would

assess the patient and take her blood pressure. Next, I took out a pulse oximeter, placed it on the patient's finger, and began to talk to the patient. During this time the nurse was yelling out to all of the other people in the room, explaining to them that I was using this finger probe to determine the oxygen level in the patient's bloodstream. Next, I tried to pretend as if the nurse was not present and began to take the patient's blood pressure. When I had the stethoscope in my ears I could hear the nurse shouting at my partner, but her voice was inaudible and muffled. After taking off the blood pressure cuff I asked my partner to place the woman on oxygen and immediately the nurse yelled, "No she doesn't need oxygen, that's just going to make her more upset, put that away, she doesn't need that." My partner put the oxygen away at my request and I asked the patient if she wanted to go to the hospital and get checked out. The nurse responded for her in a loud demanding voice saying that she did not need to go to the hospital and that she would take care of her. After confirming that the patient wanted to follow the advice of the demanding nurse I went back out to the ambulance to prepare the paperwork to show that the patient was refusing medical treatment.

Finally, I walked back in the house and asked the patient some simple questions like name, address, and date of birth. The nurse immediately began loudly answering these questions for the patient even though she did not know all of the correct answers. When I wrote down the patient's date of birth, one of the numbers given was "33." The nurse thought I had written down "53" and began screaming at me and telling me I had the numbers wrong. I corrected

the nurse and told her that the number I had written down was, indeed, "33." The paperwork was completed and I asked the patient to sign the form, but was interrupted again by the nurse in a loud voice who told me that she wanted to sign it. I told the nurse that she could not sign for the patient and I obtained the signature from the patient. Immediately after the signature was executed, I turned and walked out.

At her every breath this nurse seemed to solicit conflict. She had already taken charge of the situation and would not let me perform a normal patient assessment. I believe some reasons for her behavior could include her charged emotional state, her lack of familiarity with an out-of-hospital environment that lacked a physician's supervision, her incongruent perception of my role as a paramedic, and her desire to maintain a feeling of power and control. Unfortunately, I was not in a position to be confrontational with the nurse because I noticed that the crowd identified her as a medical authority. If I had tried to violate her authority, I would have placed my partner and myself at considerable risk for physical harm from the bystanders who were in the house.

I have had many medical professionals assist me in delivering patient care while in the prehospital environment and have found them to be a valuable resource. However, working in the prehospital environment with medical professionals who have an incongruent perception of the job that a paramedic must complete can be more difficult than working with a layperson. When a medical professional like a doctor or nurse is emotionally charged, they

can have a tendency to make irrational choices just like a layperson. The only difference is that they may know what is wrong with the patient or know what the patient needs but do not have the training or experience to care for the patient in an unfamiliar setting. In these cases, therefore, the knowledge can be dangerous.

Perceived Incongruence

Most every conflict experience, shared by paramedics above, confirm their belief that the general public and some medical professionals have a much different view of the paramedic role in healthcare differing from the paramedic's own perception of their role in healthcare. This belief is confirmed not only explicitly, but more commonly by implicit accounts of the actions that are taken by the paramedic to overcome the incongruent perceptions that are held by patients, family members, and bystanders. The efforts to inform these significant stakeholders, while caught up in the treatment process of a critical patient, worry many paramedics because they feel like they are wasting crucial time. One paramedic, expressing this view, talked about how she feels about the efforts she makes, or does not make, to change family members' perceptions:

> It slows patient care. … that's still 4 or 5 seconds in there where I could have been doing something else. I could have been trying other sources, other things to help [the patient]. … It may start with us but how many times can we take the time on a scene like that to fully explain what you

are going and to make the person believe that they can get care in the ambulance. (3a, personal communication, February 3, 2002)

Although this study found only a few cases where patient care was compromised due to incongruent realities, paramedics are keenly aware of their role in emergency healthcare and of the time benefits they can provide a critical patient. Both members of group 2 discussed how time is an important factor for all paramedics by detailing how differently emergency care is provided in the ambulance versus the hospital emergency room. "What we have given treatment-wise in a total of 15 minutes while sitting on scene would take at least another 30-40 minutes [in the hospital]" (2b, personal communication, February 1, 2002). That time spent by the paramedic with the patient includes the time the ambulance is put in park at the scene until the truck starts moving to the hospital. This means that within this brief time frame, the paramedic performs a complete ALS assessment and treatment régime on the patient while "deal[ing] with a bunch of crazy ass family members" (2b, personal communication, February 1, 2002).

Chuck Albright, the first "expert" who was interviewed, believes that much of what people see on medical television programs can give them a false impression of what actually happens during a medical emergency. According to him, although some programs show correct treatment procedures, many of these programs are geared to draw ratings that come from depicting medical emergencies in a dramatized manner that are not realistic (personal communication, February 4, 2002).

Tom Banks, another "expert" interviewee, agrees with this view of medical programming on television and explained that another problem with the depictions is that these depictions also have a tendency to show paramedics rushing off to the hospital "and the patient lives. …real life is when we get there [and] there are many things that we have to do" (personal communication, February 18, 2002). Some medical programs that are more realistic, however, "have lended a lot of help to us because they have shown them not throwing and going" (T. Banks, personal communication, February 18, 2002).

The impact of, what paramedics would consider to be, "realistic" medical programming has many limitations, however. People who watch this type of programming must still struggle with the plethora of incongruent, and more exciting, paramedic depictions that are available through the media in general. For those who have not had a good deal of exposure to the world of EMS and have based their understanding of paramedics on television programs that show overly dramatized depictions of paramedics will have a difficult time adjusting to a reality that is congruent with the paramedic. This is supported by the literature review, which concluded that once a belief is formed in the mind of an individual, his or her reality is supported by what he or she selects to view on television. Therefore, no matter how the paramedic is depicted by the media, it is easier for members of the public to hang on to their preexisting beliefs. Hence, congruent depictions of emergency medical care are difficult to acquire from a strictly media based exposure when a preexisting perception

exists. This is compounded with the many people who choose to watch things that make them feel comfortable through correlation with existing beliefs.

Paramedics talk about this incongruent perception element as an issue that they face on a daily basis. Hence, over time, this issue engenders in some paramedics a harsh view of the public that propels them towards burn-out:

> After enough years of doing this and dealing with people you just come to think of the general public as just being so stupid that you don't even want to be bothered with them. … Because, just ignorance. They don't have the understanding of what our job is. I think that frustrates us because people think for the most part still we are ambulance drivers. (2b, personal communication, February 1, 2002).

Dealing With Incongruent Perceptions

Some paramedics develop, what some may consider, unhealthy coping mechanisms, like directing anger at the patient (Graham, 1981), in order to get through stressful conflict situations with members of the public.[10] For example, one paramedic who has worked in EMS for 17 years, revealed one of his coping mechanisms:

> I have this real neat quality at my age that I can say something to somebody and be thinking something totally different and it makes me feel like I said what I was thinking. It makes me feel real good when I tell someone to please be quiet so I can ask the patient, I am really saying,

[10] This same coping mechanism is also illustrated in the explanation for the section titled "Get in the Ambulance" (p. 60-61).

> shut the fuck up stupid I don't want to hear it. (2a, personal communication, February 1, 2002)

His negative attitude, directed at members of the public, illustrates the results of an accumulation of negative experiences this paramedic has had with people who have a perception that is incongruent from his own. This coping mechanism also seems to work as a shield from those who may affect his self-confidence.

Albright feels that a good and seasoned paramedic must be able to control his or her emotions. A big part of that is making sure that instructors teach paramedic students to be confident. Albright has found it to be sometimes difficult to teach paramedic students to be confident without them becoming arrogant. He says that paramedics who display this confidence without being arrogant will be in a better position to ease the minds of the other people on scene who are emotionally charged:

> When a … very well seasoned paramedic … comes in, he is calm, he doesn't get excited, he doesn't seemed rushed or in a real big hurry, … he is methodical, he walks in and you can see the confidence, you can see okay, this guy knows what he is doing. He is going to be able to take care of that situation. The family member and the patient pick up on that and that helps to calm them down. They are like; okay, this guy can help me. (C. E. Albright, personal communication, February 4, 2002)

People who are emotionally charged are not always easy to deal with because they tend to be verbally abusive. Paramedics must have "the self-

confidence enough to … let that roll off your back like water off a duck's back" (C. E. Albright, personal communication, February 4, 2002). The opposite of this duck adage or the coping mechanism, described above, would be for the paramedic to use harsh language. "It doesn't matter what you think, they want their loved one to be taken care of a certain way … and … getting all up in their face … generally doesn't do anything but exacerbate the situation," according to Albright (personal communication, February 4, 2002).

The coping mechanism, described above, may be interpreted as advice for paramedics to use "softer" conflict styles like avoiding, accommodating, or compromising. The expert paramedics that were interviewed for this study, however, feel that there can be a time and place for "harsh" conflict styles like competing and coercive moves when dealing with a critical patient and emotionally charged bystanders who have incongruent perceptions. This usually works best when the paramedic is courteous and professional:

> As far as conversing with them, no matter how mad and how violent and how many slurs they throw at you, they are baiting you. Whether it's intentional or whether it's just emotional they are baiting you. If you fall to that and loose it with them then you are right in the same boat with them. I think paramedics need to learn to keep their composure, you can be stern, you can be confident and forceful without yelling. (T. Banks, personal communication, February 18, 2002)

Banks went on to describe some steps that he would suggest to the paramedic for dealing with conflict that involves incongruent perceptions. The

first would be for the paramedic to use softer conflict styles like explaining, then moving up through harsher styles like being coercive and then, finally, using retreating tactics or removing the patient from the source of conflict. For example, if the conflict revolves around staying on scene to treat the patient versus immediately transporting the patient to the hospital, the paramedic must know when to move up to the next step. Recognizing that sometimes the "longer you stay there … to convince them that what you are doing is right, you are not doing your job with the patient, and then their complaint …that you are not going anywhere is justified," Banks explained (personal communication, February 18, 2002). Therefore, working to change a significant stakeholder's incongruent perception of the paramedic role, by explaining or working to diffuse the person's resistant attitude, has limitations.

All of this advice, however, is not useful if not put in the hands and minds of paramedic students. The next section illuminates the topic of how paramedics perceive their training on how to handle conflict situations.

The Paramedics' Voice on Training

Paramedics who participated in the group interviews, in every case, related the deficiencies in their paramedic training program in teaching them how to combat incongruent perceptions or conflict of any type. Most of their responses to questions about how they were trained focused on experience on-the-job or on other educational backgrounds that provided them with skills needed to deal with conflict situations. One paramedic described how he believes paramedics generally react when they are fresh out of school:

> What I think is we are not taught. When we go into these situations, especially when you are a new medic, you are going to be nervous. We are going to be just as scared as the family and more often than not you are going to go in, you aren't going to say anything to anyone else. You are going to start treatment on this patient and everybody around is wondering what is going on. They are scared to death. (1b, personal communication, January 27, 2002)

This description reminds me of my own fearful first-time conflicts. At 19-years-old, I became one of the youngest paramedics in the state of Illinois. I worked to find the right way to negotiate conflict situations when, in my mind, I was only a kid, and the people yelling at me were adults. Conflict situations are more difficult for new paramedics because at this early stage, they are still not always comfortable with their patient assessment and treatment skills and may have doubts about how to treat some patients. Fortunately, 5 years later, I have gained the experience base to prepare me for most medical problems and many conflict situations.

One paramedic who talked about learning how to deal with conflict while on the job explained that learning on the job "…is like trial by fire. You have to just get out there and hope you are with people that have enough experience and enough people skills that you pick up some pointers" (6b, personal communication, February 13, 2002). This on-the-job experience is, according to some paramedics, the only way to learn how to deal with conflict situations:

> There is nothing that can be taught on how to deal with those situations because every situation is different. You can have the same scenario right down the line with … two different partners … and it's all going to turn out different every single time. There is nothing that you can do to absolutely train someone for that. You just have to deal with it as you go along. (5b, personal communication, February 11, 2002)

If paramedics have not had any training in classes, because they are expected to learn these skills when they are out on their own, then perhaps we can ask what the point is behind exploring this phenomenon. One of the paramedics talked about how some paramedics may react when faced with a hostile situation. He explained that he was not taught how to handle hostile situations, and learned only to stand by and wait for an officer to go into the scene and diffuse a hostile situation before entering:

> But if the police believe it is safe and then all of a sudden you get a factor thrown in where it is unsafe, you are not trained for that. [Then] it is just basically survival instincts, you know, the animal instinct for self-preservation. (1a, personal communication, January 27, 2002)

At least half of the group interview participants made reference to having a police officer intervene or waiting on an officer to make sure the scene was safe before proceeding. This, however, is obviously not the best answer for avoiding conflict situations because, as demonstrated throughout this study, many conflicts do not start until the paramedic makes contact with the patient.

Although all participants discussed problems or deficits in their paramedic instruction on the topic of conflict, one group talked about having some of their class time devoted to practical application role-play exercises. In these exercises, they were taught to not just treat the patient, but to also treat the family and bystanders. They were also told to keep the scene under control, but they did not think they were taught enough skills to know how to undertake a conflict negotiation (6a & 6b, personal communication, February 13, 2002).

The Expert Instructors' Voice on Training

There are many things that may draw a person to a career in EMS, but the most popular reason for an influx in EMS workers, according to EMS professionals, is the excitement (Graham, 1981). Jennifer Haner (personal communication, February 17, 2002), who has been in EMS for 22 years, believes that this is a draw for paramedics but it is not a sustaining element for paramedics in the career:

> I think we use that as an old saying. Oh I want to go lights and siren, big traumas, get on TV, and 911, and all that other [stuff]. I don't think so. Oh yeah we have some, we've got some paragods we've got some, ya know what we call rabbits. They jump if they hear a siren thinking that that's just glory. Those that seek the glory don't stay in EMS long. Because there is no glory in EMS if you are going to stay a paramedic and actually do your job. There are very few that actually stay in it, do

their job, and fight through all of the emotional things and family things and have the ability to go through it.

This draw of excitement for many people getting into the field of EMS is one thing that instructors must help their students overcome without losing the passion for the job. Albright says that one of the things he loves so much about his career in EMS is the excitement of a continuously changing environment:

> You have to roll with the punches; you have to be able to be on top of your game enough to modify things for each different situations. One of the things that I love about this profession so much is that everything is different. Everything has to be handled differently. There are not two patients the same. There are no two calls the same. (C. E. Albright, personal communication, February 4, 2002)

One thing that Albright tells his students is that "there is only one rule of medicine, and this is the only rule that will never change, and that is that there is an exception to every rule" (personal communication, February 4, 2002).

Therefore, according to Albright (personal communication, February 4, 2002), it is the instructor's job to not only teach the book, but, also teach students how to deal with the "reality" of problems like conflict situations that thrive within the paramedic's continuously changing environment. Haner agrees with Albright on the issue of students not getting enough reality-based instruction from paramedic instructors. This problem partially stems from people who are allowed to become paramedic instructors after only working as

a paramedic for 2 years, people who have not been a paramedic long enough to have the experience to teach effectively:

> You are creating a robot. You have taken these people out of class and they have their heads full of knowledge then they get this paragod syndrome I am gonna save the world I know everything, I've got my head full of all this knowledge just busting out to wanting to be able to use all of these new high-tech skills they teach us in class and they crammed it down our throats for so long. And they get out and they see that well its not like it was in class not every call is a major life-threatening emergency. (C. E. Albright, personal communication, February 4, 2002)

Mock scenarios are used by some paramedic instructors, including Albright and Haner, as a component to reality-based instruction to train students to be ready for a changing environment. This component, however, still has limitations. Setting up scenarios for students is a time consuming process that still leaves gaps because "there are so many different factors and each situation you come into is [going to] be different" (T. Banks, personal communication, February 18, 2002). Hence, all four expert paramedic instructors agree that on-the-job experience is the best classroom situation. One common approach that Albright commonly uses with his students is to say, "Okay, this is what the textbook tells you, this is what you need to know for the paramedic boards … take this with a grain of salt … and then deposit it in file 13. … [Now let me tell you] what real life is like" (personal communication, February 4, 2002). Banks agrees with Albrights statement

saying, “What’s textbook and what’s real life is different, and a lot of that is on the job training. … There is a lot of street smarts that you can’t teach [in the classroom]” (T. Banks, personal communication, February 18, 2002). Therefore, Banks contends, that it is important for paramedic students to have an experienced street paramedic serve as a mentor.

Fortunately, this mentored experience is already included within the paramedic curriculum from a requirement that compels paramedic students to work with a preceptor. A preceptor is an experienced paramedic who serves as a field instructor to condition students to work independently. Students must work with this person for a period of time or for a specific number of emergency calls. Especially if a student has an inexperienced paramedic instructor, the only “reality-based” training he or she may receive comes from working with a preceptor. Fulfilling this paramedic curriculum requirement, however, takes place over a limited amount of time and preceptors, themselves, are not trained to teach students how to handle conflict situations.

Issues of conflict management, according to all four paramedic instructors, are not taught in the state or national curriculum. The closest material that would marginally relate to conflict is scene safety, teaching students to only go into a scene if it looks safe, and otherwise calling the police. Other marginally related aspects of the curriculum include death, dying, stress, and dealing with patients who have psychological disorders.

Three out of the four expert paramedic instructors talked about the importance of “reality-based” instruction and how, in most cases, paramedic

students are not getting sufficient conflict resolution training. Myra Seets, the final expert interviewee, did not express the same view of paramedic conflict, however. She found it difficult to remember any conflict situations that she had encountered while working as a paramedic. Seets describes this conflict phenomenon as something that may be a common experience for other paramedics, but one that she does not remember encountering. One explanation she gave for her not recalling such encounters is her intense focus on the patient when assessing and treating a critical patient. This intense patient focus may limit her perception of any other event happening concurrently. Therefore, due to her experience, she believes it is more important for an instructor to focus on making sure the paramedic student acts professionally, is highly trained in performing medical skills, and has a solid base in medical knowledge (M. Seets, personal communication, February 18, 2002).

Although Seets has had 11 years of experience, her perception of conflict while treating patients in the prehospital setting is different from the three other experts. Therefore, just because an instructor has significant work experience as a paramedic does not mean he or she will subscribe to a "reality-based" training method that will allow students to gain exposure to ways of negotiating conflict situations. In fact, Seets seems to be advocating for an algorithm based learning style that places great emphasis on rote memory of the medical knowledge and the ability to perform the mechanics of medical treatment.

According to Haner (personal communication, February 17, 2002), knowing the algorithms of the assessment and treatment for most medical problems are skills that every paramedic will have grasped by the time they get out of paramedic class. The true test comes when the paramedic must be able to evaluate a scene and know how to move through conflict situations and other distractions so he or she can holistically treat the patient:

> [Paramedics get focused] in on what is being said to them or how they are being talked to or they get tunnel visioned, they don't look around what's going on before they step forward. … Having to deal with what you know as far as LOCABC[11] and trying to get that done while you have disruptions, interruptions, whatever beside you. You can't get to step one, you can't get anywhere. … Organization of workload is a difficult thing for many people to understand. That no matter what they are saying you can talk about anything in the world, if you know how to start an IV, you know how to start an IV that's just the way it is. So you can explain how to bake a cake while you are starting that IV. (J. Haner, personal communication, February 17, 2002)

Overall, this section has established how expert paramedic instructors do not believe paramedics are adequately trained to deal with conflict situations. Therefore, the same paramedic student who started out in the class wanting to experience all of the excitement of being a paramedic may be left

[11] This is a common algorithm that stands for the initial steps to be completed during patient assessment. The LOCABC acronym stands for: level of consciousness, airway, breathing, circulation.

without the communication and conflict resolution skills needed to navigate this new, continuously changing, environment. He or she would only have the core medical knowledge from the paramedic textbook and would function as a "robot."

CHAPTER 5

CONCLUSIONS AND DISCUSSION

This chapter is shaped by a focus on interpreting Figure 1 (p. 36) that depicts a cyclical process leading to poor patient care. The contributing elements of this Figure parallel the research questions, posed by this study, which have been independently addressed and summarized in earlier chapters. Therefore, instead of revisiting each research question directly, I will conclude this study by molding together elements from the research questions into a pattern that further clarifies and expands the research findings. This arrangement will build a foundation of support that will help further explain Figure 1.

This thesis has made a concerted effort to share the isolated voices of paramedic storytellers. Through these stories we have found evidence for the claim that paramedics perceive incongruence in the way the public perceives them. Additionally, incongruent perceptions, depicted through numerous narratives, were found to impact or cause conflict. Furthermore, this thesis provided, through the voice of paramedics, two possible explanations for this incongruence. These explanations include influences from media sources and the recently changed history of EMS, explanations that are also backed by previous research (see literature review).

Stories of conflict, told by paramedics, also elucidate how different conflict styles are used when communicating with the emotionally charged patient, family member, or bystander. These conflict styles (see Table 1, p. 19)

were found to be useful when coding the narratives. The paramedic who, in most cases, attempted to covertly sidestep the issue most commonly represented the avoiding / distracting style. The second part of the name used for this conflict style, "distracting," was not found, however, to be fitting of any tactic used by a paramedic to describe an encounter that involved conflict. The competing / pouncing conflict style was commonly used by paramedics who were hostile and threatening. The accommodating / placating conflict style, along with the compromising conflict style, seemed to be most commonly used by paramedics who gave up on trying to "win" the conflict. Finally, a paramedic who was involved in a conflict seldom used the collaboration conflict style. This is understandable, because, collaboration is a conflict style that is time demanding. Hence, a paramedic who is under time constraints, due to a critical patient, is in a position to forgo this style.

The other conflict styles used to code the narratives, not described in Table 1, include mediation, physical aggression, explaining, and the coercive conflict style. The mediation conflict style was most commonly used by paramedics who were doing exactly what they are trained to do in a conflict situation, call out for help. The mediator, in most cases, was the on-line medical control hotline that linked the paramedic to the resource hospital. Other attempts at mediation utilized mediators that included EMS crewmembers, firefighters, police officers, other family members or bystanders, and even, in one case a doctor. Although not all the examples of this mediation

conflict style could be selected as examples to be included in Chapter 4, this was a frequently used conflict style.

Physical aggression was used in only a few depictions and was the preferred conflict style of choice, for paramedics, when it was seemingly the only way to resolve a conflict when a threat of physical harm emerged. The explaining and coercive conflict styles were the most represented styles in the narratives chosen. Explaining was represented more than any other conflict style. In fact, this conflict style was addressed by all of the expert paramedic instructors and was found to have positive and negative results when used by a paramedic during a conflict. Finally, the use of the coercive conflict style was commonly employed in conjunction with the competing / pouncing conflict style, and was prevalent in situations that required the paramedic to be "insensitively sensitive." For example, a paramedic might use the style to "harshly" respond to a significant stakeholder who was preventing the paramedic from providing the most appropriate patient care. Therefore, the paramedic could be sensitive to the medical needs of the patient while being insensitive to any objectionable party.

The stories, depicted in this study show how paramedics commonly use multiple conflict styles sequentially, in a matrix form, or concurrently to negotiate conflict situations. Findings have also shown that no one-conflict style is paramount, and the best choice of which conflict style to use is situational or an on the spot decision. These decisions, however, were found to be difficult to make for a paramedic who has not had extensive experience

dealing with conflict. Experience that has accumulated over time allow the paramedic to teach him or herself how to choose conflict styles that elicit a positive, or desired, outcome.

A confident correlation claim can be made between the suppositions of inadequate conflict training, made in the literature review, and the overwhelming expressions of paramedics proclaiming program deficiencies in conflict training. This finding was supported by expert paramedic instructors who believe this element in paramedic education to be deficient because of paramedic instructors who lack significant experience as a paramedic. In addition, conflict training is currently not an issue addressed within the paramedic curriculum. Furthermore, the widespread use of algorithm based teaching methods without significant time devoted to "reality-based" instruction became apparent. Finally, one instructor, who does have considerable experience working as a paramedic, served as an example of how some instructors use and truly believe in an algorithm based teaching approach. In this case, the instructor did not acknowledge the prevalence of conflict situations, or the importance of classroom training on the issue.

The pervasiveness of algorithm style training along with a lack of conflict training, in general, and the prevalence of incongruent perceptions between a paramedic and a patient, family member, or bystander have all been found to be contributing influences that impact a potential "trap" for the paramedic. This "trap," represented in Figure 1, is a cyclical process that paramedics may endure if some or all of these influences are present. This figure indicates how

a paramedic who makes poor conflict style choices when conflicting with an emotionally charged patient, bystander, or family member can become burned-out. This syndrome produces a loss of caring, thus putting the paramedic in a psychological position to make additional conflict style choices that are poor. The result is a paramedic who is inadvertently set up to cause a compromise in patient care.

Each of the stories illustrates a different set of events whose outcome may or may not involve a compromise in patient care. In some cases, this compromise in patient care can be attributed to a significant stakeholder who refuses to give in to the paramedic. In other cases, a compromise in patient care may result from a paramedic making allowances or giving up. This finding of patient care compromise that can result from conflicts is significant, however, no direct causal claim can be made that shows a strong correlation between incongruent realities and compromise in patient care. In spite of this, when other elements, depicted in Figure 1, reveal the complete picture of the phenomenon, incongruent perceptions can be partially linked to a compromise in patient care.

This finding, which evolved from multiple elements investigated by this study, places emphasis on the high level of importance that needs to be placed on incongruent perceptions, an issue whose implications were not fully conceptualized at the onset of this study. This research has reinforced the significance of how much influence one's perceptions of an event, or a future event, can have on decisions that are made and the results that those decisions

affect. Paramedics who may find themselves within this cycle now have a conceptual framework for understanding how conflicts are negotiated within an emotionally charged environment and can actively work to reverse or limit some of the influences that can lead to the cyclical process of poor patient care. However, a large-scale transformation must begin with a change in attitude towards how paramedics are trained.

Future studies are needed to further investigate how this movement away from algorithm style training and a lack of conflict education can positively impact patient care. For example, a longitudinal study would be helpful to determine how paramedic students negotiate conflicts with emotionally charged bystanders by conducting group or individual interviews with students who are in classes that have instructors who have opposing views on how to negotiate and/or teach on conflict issues. Interviews could be conducted at the commencement of the course, during the course, directly after the course is completed, and in subsequent time allotments thereafter. This type of study would allow a researcher to juxtapose the differences in perception and conflict style choices between paramedic students who are concurrently meeting the same requirements to become a paramedic. These paramedic students could be going through training programs that differ in any number of polar extremes, for example, strict "reality-based" training versus strict algorithm style training. Other ways of studying this topic include survey research of paramedic students and instructors, textual analysis of

paramedic journals, or even autoethnographic approaches that would expand on the partial use of this methodology in this study.

To conclude, I would like to share my desire for establishment of public information campaigns that would work to deconstruct incongruent perceptions that shape many conflict situations. Finally, I would like to also express my desire for this study to be released into a world of academicians and EMS professionals who will independently determine how this work may best be used to, hopefully, have a positive influence on patient care that is provided by the paramedic.

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APPENDIX

Group Interview Questions

1. Can you relate any situations where you had conflict on an ambulance call when treating a critical patient?
2. What started the conflict?
3. Who was involved? (Patient, family, bystander, or other)
4. Would you consider the person involved to be emotionally charged?
5. What signs did they portray that made you think they were emotionally charged?
6. What kinds of nonverbal behavior characteristics were they displaying? (proxemics, haptics, paralanguage, kinesics, chronemics)
7. What types of language did the subject or subjects use during the communication?
8. What were some of the words they used to express their position?
9. What types of language did you use during the confrontation?
10. What were some of the words you used to express your position?
11. What made you choose those words?
12. What kinds of nonverbal behavior characteristics did you use? (proxemics, haptics, paralanguage, kinesics, chronemics)
13. Did you and the subject have the same ultimate goal?
14. Did the subject give a reason behind the differing position?
15. What were you thinking and feeling before, during, and after the conflict?
16. Was physical aggression used by anyone in the conflict?

17. Did the conflict cause you to change the treatment regime?
18. Did the conflict delay patient care?
19. Did the conflict compromise patient care?
20. Did the conflict escalate?
21. If yes, what caused the escalation?
22. How was the situation diffused or resolved?
23. Have you experienced similar conflict situations that stemmed from the same issue?
24. How were they similar / different?
25. How were you trained to deal with situations like this?
26. Is there anything else you would like to bring up that deals with this topic?

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Incongruent Perceptions and Training Styles: The Paramedic in Conflict With the Emotionally Charged Bystander

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