

**ETHNOGRAPHY IN THE PRE-HOSPITAL FIELD: AN EXPLORATION
OF THE CULTURE OF HOW PARAMEDICS IDENTIFY, ASSESS
AND MANAGE PSYCHIATRIC PRESENTATIONS
IN THE COMMUNITY**

Louise Roberts

Bachelor of Health Sciences (Paramedic) Hons.
Bachelor of Nursing

School of Nursing & Midwifery
Faculty of Health Sciences
Flinders University
Adelaide, Australia

Submitted for requirements of the award of Doctor of Philosophy
September 2012

Contents

Table of content		
Tables and figures		ix
Abbreviations and key terms		x
Summary		xii
Declaration		xv
Acknowledgments		xvi
Chapter 1	Introduction	1
1.0	Introduction	1
1.1	The research question and objectives	3
1.2	The rationale for the research and its significance	4
1.2.1	Personal significance	5
1.2.2	Literature review	6
1.3	Methodology—the theoretical stance	7
1.4	Research method	8
1.5	The findings	9
1.5.1	Part 1: Dispatch, arrival and the approach	9
1.5.2	Part 2: Assessment, assumptions and influences	10
1.5.3	Part 3: Handover and case cards	11
1.6	Discussion and conclusion	12
Chapter 2	Literature review	14
2.0	Introduction	14
2.1	Section 1: No health without mental health	17
2.1.1	Prevalence	17
2.1.2	Comorbidity and disability	24
2.1.3	Mortality and suicide	26
2.2	Section 2: Resources for mental health— scarcity, inequity, and inefficiency	27
2.2.1	Community resources	29
2.2.2	Discrimination and stigma	34
SUMMARY		2

2.3	Section 3: The mental health system—where are we now?	37
2.3.1	National policy and reform	37
2.3.2	Australian’s National Mental Health Report	40
2.4	Section 4: Care of mental disorders: Culture and demand	42
2.4.1	Emergency departments and emergency service demand	42
2.4.2	Emergency services: ambulance / emergency medical services	50
2.5	Conclusion	54
Chapter 3	Methodology	55
3.0	Introduction	55
3.1	Research methodology: Crotty’s definitions	56
3.2	Symbolic interactionism	60
3.2.1	The nature of symbolic interactionism	60
3.2.2	Nature of human society or human group life	64
3.2.3	The human being as an acting organism	65
3.2.4	Pragmatism as the intellectual basis for symbolic interactionism	68
3.3	Epistemology—how the world is known in symbolic interactionism	70
3.3.1	Constructionism and constructivism	70
3.3.2	Critical stance towards taken-for-granted-knowledge	72
3.3.3	Historical and cultural specificity	73
3.3.4	Knowledge is sustained by social processes	74
3.3.5	Knowledge and social action go together	75
3.3.6	Anti-essentialism	76
3.3.7	Anti-realism: relativism vs. realism	77
3.3.8	‘The publicly available systems of intelligibility’: culture and the individual	79
3.4	How theory meets method	81
Chapter 4	Research method part 1: The framework—ethnography and culture	84
4.0	Introduction	84
4.1.	Ethnography and culture	85
4.1.1	A brief account: ethnography and relevance to practice	85
4.1.2	Ethnography: the holistic perspective	88
4.1.3	The insider and outsider: the emic and etic perspectives	89
4.1.4	Ethnography as a means to explain work life	90

4.1.5	Culture	91
4.2	The use of focussed ethnography and how the research fits the method	94
4.2.1	Why description is relevant to practice	97
4.3	Conclusion	99
Chapter 5	Research method part 2: The process—access, ethics, observation, interviews and documents	100
5.0	Introduction	100
5.1	The process: The beginning—access, gatekeepers and ethics	100
5.1.1	Access to field sites	100
5.1.2	Hierarchy and gatekeepers	104
5.1.3	Ethics	106
5.1.4	The collaborative, emergent research design and prior informed consent	108
5.2	The challenges encountered	110
5.2.1	Participant consent: the challenge of prior informed consent of paramedics	111
5.2.2	The interview and interview questions	114
5.3	When, where and how of data collection	116
5.4	Profile and recruitment of study participants	118
5.4.1	Profile of study participants	118
5.4.2	Recruitment of participants	119
5.4.3	The potential sample	120
5.4.4	Duration of the study	120
5.5	Principles behind the ethnography techniques	120
5.5.1	Non-participant observation	120
5.5.2	Interviews	124
5.6	Documents in social research	128
5.7	Data analysis: ethnographic analysis	134
5.7.1	Analysis	134
5.7.2	Domain analysis	134
5.7.3	Taxonomic analysis and coding: Interviews and observations	136
5.8	Conclusion	138

Chapter 6	Findings part 1:	
	Dispatch, arrival and the approach	139
6.0	Introduction	139
6.1	Theme 1: Dispatch, on arrival and first impressions	142
6.1.1	Reason for attendance	143
6.1.2	Certainty vs. uncertainty: what you get told and what you find	148
6.2	Theme 2: The approach	151
6.2.1	Attempt to approach professionally: a challenge and a case-by-case approach	152
6.2.2	Do or do not engage, matter of fact and keep it simple	164
6.2.3	Communication and adaptability:	
	Not what you can learn from a textbook	169
6.3	Theme 3: Compliance and non-compliance:	
	explaining the options	174
6.3.1	Risk to themselves, to others and whether to involve the police	177
6.3.2	The patient's choice and whether they can make decisions about their health	179
6.3.3	Offer to take the patient to hospital on 'medical grounds'	181
6.4	Theme 4: Caution, risk, safety and the ultimate goal	182
6.4.1	Situations we enter and being an unexpected arrival	185
Chapter 7	Findings part 2:	
	Assessment, assumptions and influences	189
7.0	Introduction	189
7.1	Theme 5: Assessment—what they see, hear and search for	190
7.1.1	What they see and hear	190
7.1.2	The measured observations	201
7.2	The scene	203
7.2.1	The search and filling in the picture	205
7.2.2	History, history from others and social history	209
7.3	Complexity and comorbidity: a process of elimination and can we treat any underlying medical causes of the disturbed behaviour	215
7.3.1	'Body' first	220
7.4	Conclusion	223

Chapter 8	Findings part 2: Assessment, assumptions and influences (Section 2—assumptions and influences)	224
8.0	Introduction	224
8.1	Treatment: strategies, interaction and provision of care (Can we clinically provide care?)	224
8.1.1	The traditional role of emergency care versus changing practice	224
8.2	Managing the consequences of patient actions and alternative strategies	226
8.3	Keeping it calm and using diversion	228
8.4	Focusing on the relevant information	230
8.5	The interactions and actions	232
8.6	The broader social reasons behind the need for care	236
8.7	Theme 6: Is it genuine, assumptions and influences	239
8.7.1	‘Is it genuine?’ attention seekers, regulars and are we just a taxi service?	240
8.7.2	The patients behaviour and knowing the system	241
8.7.3	Are we the right people to help?	243
8.7.4	How paramedics see their role	244
8.7.5	The reasons for the frustration and disconnection with psychiatric patients	248
8.7.6	Drug and alcohol use, fatigue and shift work	253
8.7.7	The ‘regulars’	255
8.8	Assumptions and influences: what you see, general perception, what do others model, life experience and past and present ‘on-road’ experience	257
8.8.1	The emergency department: not the right place	260
8.8.2	‘Life’ experience versus ‘on-road’ experience	261
8.9	Role modelling and the dangers of categorising	267
8.10	Education	270
8.11	Conclusion	272

Chapter 9	Findings part 3: Handover and case cards (Section 1—Handover)	274
9.0	Introduction	274
9.1	Handover: the place, space and information transfer	275
9.1.1	Theme 7: Place and space: the ‘ramp’ and the ‘fishbowl’	275
9.1.2	Ownership of space	277
9.2	Negotiation of space and time: the busy ED	280
9.2.1	Peak times: the eleven and three rush (‘you can almost set your clock by it’)	282
9.2.2	The paramedics: how they get the process done	284
9.2.3	The communication and negotiation of the handover process	286
9.3	Availability of space and resources	287
9.4	Relationships within the fishbowl	291
9.5	Theme 8: Handover	293
9.5.1	Information received and information given: The process and the social history	294
9.5.2	The limited information from the scene and the acknowledgement from ED staff	302
9.6	The police, ‘detained’ patients and the handover	305
9.7	The double check by the ED staff	309
9.8	The judgement and the regulars	312
9.9	Conclusion	315
Chapter 10	Findings part 3: Handover and case cards (Section 2—case cards)	317
10.0	Introduction: the case card (the patient report form)	317
10.1	Presenting complaint	318
10.2	Past history and current event/history	321
10.3	On arrival (O/A) and on examination (O/E)	328
10.3.1	On arrival: the scene—the patient	333
10.3.2	On examination: seen, heard and measured	334
10.4	Conclusion	341
10.5	Summary of the major themes	342

Chapter 11	Discussion	348
11.0	Introduction	348
11.1	Defining role	352
11.2	Defining 'emergency' and the context of pre-hospital work	354
11.2.1	Comorbidity: Drug and alcohol use in conjunction with mental illness	356
11.3	Transition work: Caught between episodic and long- term care	358
11.3.1	Traditional versus changing role expectations: tensions and confusion	359
11.4	The scaffolding: industry constraints	364
11.4.1	Organisational structures, procedures and professional boundaries	364
11.4.2	The influence of organisational structure and policy: the gap between national and state direction and 'on-road' reality	368
11.4.3	How to define and develop the professional boundaries	370
11.4.4	Education	373
11.5	Thwarted identity: Balancing personal and public expectations and 'on-road' reality	376
11.5.1	Psychiatric patients as anti-heroic work	376
11.5.2	Ambulance work as risky and repugnant: safety and caution first	378
11.6	Attributed identity: dangerousness, legitimate vs. illegitimate need for care, assumed liberty in gathering the history, stigma and consequences of action	379
11.6.1	Risk, caution and safety	380
11.6.2	The concept of dangerousness	381
11.6.3	Stigma: mental illness and spoiled identity	384
11.6.4	Rationalised self-interest and trading of patient care and scene safety	388
11.7	Assuming control: taking the offensive position to gain certainty in the uncertain and unpredictable	389
11.7.1	Compliance	390
11.7.2	Gaining control of the physical and social space	395
11.7.3	The activities in the physical and social space: the use of continual monitoring	396
11.7.4	The trading of responsibility	398
11.8	Collateral (continual) monitoring and how it relates to Mead's symbolic interactionism	399

11.9	Conclusion	401
Chapter 12	Conclusion and Recommendations	403
12.0	Introduction	403
12.1	Recommendations	405
12.1.1	Collaboration and communication with the mental health sector	405
12.1.2	Organisational structure and protocols: alternative to the patient report card	409
12.1.3	Education	411
12.2	Limitations	414
12.3	Conclusion	415
Appendix A	Paramedic Participant Information Sheet	417
Appendix B	Consent to Participation in Research—Paramedic Participants	420
Appendix C	Flinders Medical Centre Emergency Department Staff Participant Information Sheet	421
Appendix D	Consent to Participation in Research—Emergency Department Staff Participants	424
Appendix E	Paramedic and Emergency Department Staff Interview Guides	425
Appendix F	Paramedic Participant Details	428
Appendix G	Duration of Case Interviews	429
Appendix H	Observation Overview	430
Appendix I	Field notes	433
Appendix J	Emergency Department Floor Plan	435
Appendix K	SA Ambulance Patient Report Form (The Case Card)	436

Tables and figures

Table 2.1	Assumptions and realities of deinstitutionalisation	33
Table 2.2	South Australian inpatient beds and community residential services numbers	42
Table 5.1	Case card and GCS criteria	132
Table 6.1	Overview of dispatch categories and expected response times	144
Table 10.2	Past history and history/current event	323
Table 10.3	Medications	328
Table 10.4	On arrival and on examination	330
Figure 3.1	Blumer's lines of communication and meaning	67
Figure 6.1	Summary of the major themes and subthemes from the findings	141
Figure 10.1	Overview of the findings: The nature of information collection and delivery	347
Figure 11.1	Discussion overview	351
Figure I.1	Field notes sample 1	433
Figure I.2	Field notes sample 2	433
Figure I.3	Field notes: transcribed with reflective notes	434

Summary

Over the last decade there have been marked increases in the utilisation of ambulance services nationally in Australia. These increases have been attributed to factors such as the shift in health care provision from acute settings to the community, pressures on the primary health care sector, an aging population, health workforce shortages and the prevalence of chronic conditions. These social and structural changes present the paramedic workforce with changing demands, expectations in service delivery and greater responsibility for clinical decision making and treatment. Paramedics attend and care for an increasing number of lower acuity presentations and those with complex needs which dictates triage, management and referral decisions. The shift from institutional to community based care in mental health reform has seen increases in emergency attendance to individuals needing mental health care. Patients that present with complex needs require extended scene time and care provision and do not fit the traditional mould of emergency care which is forcing organisational and structural changes. These changes include a move to becoming a profession, university based training, electronic documentation and further training both at graduate and post graduate levels.

This thesis explores the culture of paramedic work when identifying, assessing and managing individuals with changes in behaviour attributed to mental health concerns (psychiatric presentations) in the community. As the link between pre-hospital and further

care, paramedics have a vital role to play, but to date paramedics' 'on-road' experiences and culture when attending psychiatric presentation has not been widely researched.

This ethnographic account of paramedic actions and beliefs, their culture, is based in the theory of symbolic interactionism and social constructivism which asserts that human interaction is central to how individuals construct meaning and knowledge. The data was collected over an eleven month period from 2009–2010 at a tertiary public hospital in South Australia. The ethnographic methods used were observation of the ambulance arrival and emergency department triage areas, interviews with paramedics and emergency department staff, and document analysis. Using thematic analysis based on cultural domains, the findings follow a linear case history, beginning from dispatch and arrival, paramedics' first impressions and their approach, assessment, and finally to handover and reporting.

This demonstrates how paramedics are caught between the provision of traditional acute care and extended scene times and management of complex presentations such as mental illness. It outlines how the changing expectations and demands place paramedics in a conflicting position and challenges the concept of their role and their identity. Key findings include the paramedics' reliance on their first impressions and 'on-road' experience due to the limited information they receive from dispatch when attending psychiatric presentations. Findings explore how organisational structures such as the communication system (dispatch), documentation, and handover shape their approach and subsequent assessment. This includes the importance of their role as emergency clinicians and the high priority placed on risk, safety, and caution. The heightened perception of risk and the need

to control the unpredictable through strategies which assume control tends to promote actions which focus on transport to further care and compliance. The thesis explores the limited care paramedics feel they can provide due to the nature of the environment, their scope of practice, their limited education and professional development in mental health, and associated patient comorbidities. This leaves paramedics dealing with the consequences of the patient's behaviour, such as self-harm while aiming to meet their duty of care by transporting the patient safely to further care, usually the emergency department (ED). These cultural considerations placed an emphasis on the paramedics overriding duty of care, generated feelings of frustration with the patient and the mental health system, and created a situation where paramedics were forced to practice between their traditional role of acute care and managing those needing complex care.

Documenting the nature of paramedic work with patients suffering a mental illness assists with identifying the structural, educational, policy, and resource needs required to make operating in this environment more tenable leading to better patient care and outcomes.

Acknowledgments

First and foremost I would like to acknowledge the support, time, and honesty given by the paramedics and the ED staff who participated in this study. Without their willingness to share their stories and beliefs, which gives this thesis its narrative, the research would not have happened. Through the stories I have been privileged to hear the whole process has been both professionally and personally rich and rewarding.

To the senior management of the SA (South Australian) Ambulance Service and the ED thank you for the opportunity, access and support in conducting the research. Again without your crucial contribution the research would not have been possible.

To my three supervisors a heartfelt thank you. To my principal supervisor Professor Eimear Muir-Cochrane for all her patience, feedback, encouragement and willingness to undertake the long PhD process with me. To Dr Julie Henderson for her belief in me, her mentorship, compassion, and friendship which she managed to keep separate (most of the time) from the job of supervisor with a critical eye on my thesis. To Associate Professor Eileen Willis who brought social and theoretical concepts to life for me with creativity and genuine enthusiasm. I am grateful to all three for providing a safe and exciting environment for lively debate and discussion which has created a love of research and critical thinking and a passion for ideas and the area of mental health.

My love and thanks goes to my amazingly talented and giving parents, Peter and Geraldine Roberts, for their love, patience and thoughtful discussion. To my dad for being the considered, well-read thinker who posed many questions and counter arguments which helped me to clarify and structure my thoughts. You have taken to the assumptions of my philosophical stance with grace, although you come from the 'dark side' of quantitative research with its numbers and statistical reasoning. To mum for your passion and wisdom in all things people orientated. Here is to your practical and pragmatic approach to the subject of care and mental health and protective counsel on keeping the balance in my life during the PhD process.

I would finally like to acknowledge my supportive and loving sisters and brothers Karen, Andrew, Rachel, and Matthew for their encouragement and debate.