AN INVESTIGATION INTO THE NEEDS OF EMERGENCY MEDICAL WORKERS AND HOW THESE COULD INFORM MANAGEMENT PRACTICES

by

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DEDICATION

To the men and women serving in
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ABSTRACT

Literature on the Emergency Medical Services (EMS) has paid much attention to stressors, stress and symptoms, coping, and support of Emergency Medical Workers (EMWs). However, it has paid little attention to the needs of EMWs, and the satisfaction thereof, which should result in their improved well-being and motivation.

In an attempt to rectify this imbalance, this study investigated the needs of EMWs as suggested by descriptions of their experiences within the EMS. Interviews were conducted with EMWs employed by a private EMS company. The interviews were analysed for emerging needs by means of interpretive analysis. These needs comprised the Need for Freedom, the Need for Competence, the Need for Recognition, the Need for a Challenge, and the Need to be Understood. The findings were linked with theory and it is proposed that the relevant EMS company incorporates participative management into its management approach. In addition suggestions are made for future research.

KEY WORDS:

Coping strategies; Emergency Medical Services; Emergency Medical Workers; Interventions; Needs; Needs satisfaction; Needs theories; Participative management; Self-determination theory; Stress; Stress reactions; Stressors; Support

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CHAPTER 1

INTRODUCTION AND BACKGROUND

The study aimed to uncover and describe a range of inherent needs suggested by factors such as stress symptoms, coping behaviours, challenges, satisfactions, and dissatisfactions as experienced and described by Emergency Medical Workers (EMWs). It is a relevant study as it may inform managers on what provisions to make for EMWs dealing with occupational exposure to trauma, and on how to optimally structure the Emergency Medical Services as an occupational environment. The uniqueness of the study lies in its focus on paramedicine, which is a novel approach in the South African literature.

1.1 THE EMERGENCY MEDICAL SERVICES (EMS)

The EMS is an occupational field in which EMWs deal with trauma and medical emergencies on a daily basis. They therefore have to switch from low energy activities to high adrenaline performance and absolute focus in a matter of seconds. The environments in which EMWs work are unstructured, they often work irregular hours, they travel at high speeds, and they are frequently exposed to traumatic incidents. On top of this, they have to deal with the public and collaborate with various services such as the fire brigade, police, and tow-in services.

Overall, EMWs manage their occupational environment very well – it seems as if they have built-in coping strategies that enable them to manage an excessive degree of stress. However, at times this stress does take its toll in forms such as substance abuse, broken marriages, burnout, posttraumatic stress disorder (PTSD), or suicide.

Is this price acceptable? Can EMWs, their families, colleagues, or employers afford this? Can the public afford the threat posed by an EMW whose high stress levels result in substandard patient treatment or unsafe driving?

Reflecting on these issues raised a few questions: Are systems in place to assist EMWs in dealing with prevalent stress and trauma? Do these systems contain the interventions that are needed? If so, are they effective? Are the factors that we assume affect EMWs negatively really posing a threat? Are there other possible factors such as company politics, finances, and life circumstances that are more bothersome?

Based on my own experiences within the field of emergency medicine I asked the questions and found the issues worth investigating. As the questions have developed over a number of years, I will take you on a journey of my involvement within the EMS. The dual purpose of this journey is to provide a better understanding of the context, and to build a foundation for the challenge to be investigated.

1.2 MY JOURNEY

1.2.1 Getting involved in the EMS

I am passionate about two fields of study – psychology and paramedicine. The former introduced me to the latter, and ever since there was an interesting reciprocal relationship between these two passions. Before commencing my final year of the Bachelors Degree in Psychology (BPsych), I had to complete a six-month practicum consisting of placements at two institutions. With the module *Psychotraumatology* behind my name, my first three-month placement took place at the Tshwane EMS. The placement entailed responding to emergency calls with EMWs and performing trauma defusing and follow-up debriefings with members of the public. It became

clear that some incidents did not allow for defusing and as a result I often found myself assisting the EMWs, even if it was only acting as a drip stand or carrying equipment.

I became hooked on this work, and on completion of my degree I became involved as a reserve counsellor at Tshwane EMS. The following year I qualified as a Basic Ambulance Assistant (BAA), and the year after that I completed the Fire Fighter I and Hazmat Awareness training. In 2006 I qualified as an Ambulance Emergency Assistant (AEA). By then I was in my first year of the Social Sciences Masters programme in Research Consultation, and to me it was a given to combine these two passions in my dissertation.

1.2.2 Noticing the cracks

When our group of eight psychology students were placed at the EMS we were welcomed, but with cynicism. We often heard: *'Just don't counsel me, I don't need you', 'I don't believe in psychology'*, and *'You don't understand our work'*. I found myself being tested by means of black humour and gruesome stories, and often found my nose stuck inside crashed cars with dead bodies. I had to survive, and to achieve it became the student in this environment too. With the rest of the group I learnt the names of the equipment, the meaning of the radio codes, the ranking system, the names of the officers, the names of the stations, the vehicle registration numbers and models, and their alpha numbers. In addition, we asked questions such as *'Why are you doing this job?', 'How do you cope with the trauma?',* and *'Which incidents are the worst?'* Gradually we were drawn in and became part of the *us*. The EMWs waited while we dealt with the public, invited us to join them on their night shifts, and informally started to discuss the challenges they experience.

Becoming part of the system meant becoming part of the politics and developing an awareness of the challenges within the system. Most of the EMWs I met enjoyed their work, but still many were unhappy. I saw that EMWs were undervalued and poorly treated by patients and other members of the public, who had problems with management and colleagues, and who experienced family problems. Over time, I saw this escalating into a tragedy. EMWs with valuable years of experience resigned and took up jobs outside South Africa. They left their (mostly young) families behind – not because they did not love or value them, but because *something* became too much. In some instances this *something* contributed to attempted suicides and, unfortunately, some successful ones.

Could the EMWs not handle the trauma and tragedy they were subjected to? This is a simplistic question to a complex reality; and to keep the answer simple I will give my personal, simplistic point of view: yes, they can handle the trauma and tragedy. If not, they would have left the occupation a long time ago. In an interview, which took place after the above sentence was written, one EMW participant said:

If it disturbed me that much I would have given it up long time ago.

I do not wish to undervalue the role of the trauma and tragedy to which EMWs are subjected, but my experience indicated that something else besides exposure to trauma contributed to the negative outcomes mentioned above. Therefore I would like to contribute to your perspective regarding the issue by asking you a question: What do you think when you hear sirens and see ambulances? If your answer is death, dying, and horror, my comment is that EMWs are trained on a practical level to deal with physical trauma and tragedy. This is their work, which most of them are passionate about. In exploring why some EMWs struggle to cope with their work, two points are relevant. First, the EMWs who resigned left their employers, not

their occupation. Second, they did not join another local EMS, they left South Africa. When these two points are put into perspective, exposure to trauma becomes only one aspect of the trauma, and the focus shifts to the occupation as a whole. It is therefore unlikely that the distress experienced by EMWs is due solely to their high on-the-job stress levels. The traumatic situations that EMWs see and experience could not have these consequences, otherwise they would have left the occupation. Therefore I have to ask: *What is wrong? What are we missing here?*

1.3 THE CHALLENGE EXPERIENCED AND THE PURPOSE OF THE STUDY

The purpose of the study was to investigate what we were missing in understanding why some EMWs seem unable to cope with some aspects of their occupation. To taper down the perceived challenge and the purpose of the study to something I could work with, I highlighted two issues which bothered me for quite some time. First, the direct exposure to occupational trauma does affect EMWs. This is well stated in the literature and is discussed in the literature review. However, many (if not most) EMWs have never consulted a counsellor or a psychologist. In addition, most of the South African EMS do not provide their employees with these crucial services. Second, when psychological services are provided, these are either on ad hoc basis[1] or the services are not utilised to their full potential. The reasons for this are unclear. In my experience, other people, usually superiors, decide if and when interventions are needed, how they are needed, and in which form. The superiors assume to know what the needs of the operational EMWs are. I wondered if it was not time to find out from the emergency medical

[1] It is specifically requested by the employee or the employer decides when it is needed. The latter is often determined by the severity of patient injuries, the scale of the incident, suicide attempts by colleagues and visible signs of stress in employees.

workers themselves what they need. Consequently, the missing link, the challenge that drove my study, became apparent: the *needs* of the EMWs.

Who am I, who is management, and who are psychologists to decide what EMWs need? Even with my experience – limited because I am only a reserve member of this community – who am I to decide? Although I would like to believe that my assumptions are correct, I would rather verify my assumptions empirically. Therefore, in the course of this research, I tried to push my assumptions aside and listen to the people who are employed to kneel on the tar to treat their patients.

1.4 THE CHALLENGE EXPERIENCED AND THE PURPOSE OF THE STUDY – SIMPLIFIED

The challenge was that the needs of EMWs have been under-investigated in the literature, if they have been investigated at all. The purpose of the study was therefore to determine the needs of EMWs as suggested by descriptions of their experiences within the EMS.

1.5 THE RESEARCH QUESTION

The research question derived from the purpose of the study is: *What are the needs of EMWs, which are suggested by descriptions of their experiences within the EMS?*

1.6 THE IMPORTANCE OF THE STUDY

The importance of the study may be clarified by making a few assumptions. First, we cannot render psychological services and support to people if we do not know what their needs are. We can provide people with the best psychologists, but if they have a greater need for properly

functioning equipment, our efforts are no good. If managers have insight into the range of needs that EMWs experience within their occupation, they will be better equipped for strategic decision making. Having the right foundation for making decisions could improve employee well-being, improve services rendered to the public and could save taxpayers and private EMS companies considerable sums of money.

1.7 THE SCOPE OF THE STUDY

The study focused on a private EMS company with which I had no affiliations. I interviewed EMWs on two levels of registration and who operated from various bases in Gauteng. Important terms used in the study are defined below. This is followed by a survey of the literature in chapter 2.

1.8 DEFINITION OF TERMS

9/11: This refers to the attacks that took place in the United States of America (USA) on September 11, 2001, when aeroplanes were crashed into the Twin Towers in New York and several other sites in the USA.

Advanced life support (ALS) practitioner / paramedic: This refers to a practitioner registered with the Health Professions Council of South Africa after qualifying as a Critical Care Assistant or after obtaining either a National Diploma or a B.Tech in Emergency Medical Care. These practitioners have received advanced pre-hospital training and are allowed to administer a wide range of drugs and perform advanced techniques such as endotracheal intubations and cardioversions.

Alpha numbers: Each ambulance at the Tshwane EMS is marked with an A for Ambulance followed by a number, for example, A114. This is referred to as the Alpha number and is used to identify the ambulances.

Ambulance emergency assistant (AEA): This refers to a practitioner who has successfully completed the Ambulance Emergency Assistant course and who is registered with the Health Professions Council of South Africa. AEAs provide pre-hospital care on the intermediate level, are allowed to administer certain drugs, and are trained to perform more advanced skills than BAAs (basic ambulance assistants), such as defibrillation, chest decompression, and intravenous fluid therapy.

Base: The building where EMWs are stationed, and from where they respond to the emergency scenes they are called to.

Base manager: The ALS practitioner who manages the base where he or she is employed.

Basic ambulance assistant (BAA): This refers to a practitioner who has passed the Basic Ambulance Course and who is registered with the Health Professions Council of South Africa. BAAs are trained in basic human anatomy, cardiopulmonary resuscitation (CPR), how to handle trauma patients, and how to make observations that will indicate the requirements of a more advanced level of emergency care.

Basic life support (BLS) practitioner: This is another term for a basic ambulance assistant (BAA).

Burnout: A psychological condition in which the individual presents with symptoms such as exhaustion and emotional distancing. It is usually related to the individuals' work context.

Counselling: This term indicates any form of psychological therapy or counselling rendered by either professionals or lay people.

Counsellor: This term refers to the individual who renders counselling.

Critical care assistant (CCA): See Advanced Life Support Practitioner.

Emergency medical services (EMS): These are services that render pre-hospital emergency care to patients and which, in South Africa, are performed by advanced, intermediate, and basic life support practitioners.

Emergency medical technicians: In practice the equivalent of South Africa's AEAs.

Emergency medical worker (EMW): A term that refers collectively to practitioners on the Advanced, Intermediate and Basic levels, who deal with trauma and medical emergencies prior to patient hospitalisation.

Emergency workers: When used in the literature, this term usually refers collectively to emergency medical workers, fire fighters and police officers.

Fire fighter I and Hazmat awareness: Fire Fighter I is the first training course when individuals train to become a fire fighter. Combined with this course is Hazmat Awareness training that creates awareness for hazardous materials and teaches the fire fighter what measures to take until specialised support arrives.

Intermediate life support (ILS) practitioner: An ambulance emergency assistant.

Interventions: Actions taken and services provided to EMWs to assist them with coping with their occupational exposure to trauma, for instance. This may include counselling.

Medical emergency: An acute medical condition requiring immediate care (e.g., heart attacks, severe asthma attacks, and diabetic emergencies).

P1, P2, and P3: These abbreviations refer to the priorities of patients. A Priority 1 patient is injured seriously and critically, a Priority 2 patient is seriously injured, but not in a critical condition, while a Priority 3 patient is referred to as a 'walking wounded'.

Paramedic: see Advanced Life Support Practitioner.

Paramedicine: The occupational field of paramedics and other EMWs.

Patient report form (PRF): This refers to the record kept for a patient for the duration of his or her treatment by EMWs. This form captures information such as the patient's personal information, mechanism of injury, presenting signs and symptoms, and treatment received.

Posttraumatic stress disorder (PTSD): An anxiety disorder that could develop after exposure to a critical incident.

Resuscitation: Attempts to return heart and/or lung functions after cardiac or respiratory arrest.

Trauma emergency: A condition caused by an external force, which requires immediate medical care (e.g., motor vehicle collisions, shootings, assaults, and burns).

Tshwane EMS: An ambulance service provided by the City of Tshwane Metropolitan Municipality, South Africa.

1.9 SUMMARY

Chapter 1 provided an overview of the EMS, my own involvement within the EMS, my motivation for conducting the current study, and the purpose, importance, and scope of the study. The research question was stated, and relevant terms were defined to improve the understanding of the content of the study. Chapter 2 presents a review of the literature relevant to the study.

CHAPTER 2

LITERATURE REVIEW

I am Sorry if I woke you in the middle of the night,

But someone in my community is fighting for their life.

Sorry if I block the road and make you turn around,

But there's been a bad wreck with dying persons strewn across the ground.

When you see me coming you'll have to understand,

Lend me the right-of-way – so I can save the day.

Somewhere a child is choking, somewhere a broken leg.

Sometimes a heart stops beating, but when I get there it's far too late.

So if you see me crying when I think I am alone,

You'll know I had a "bad" one and I am feeling mighty down.

I don't do it for the money or any form of gain.

I don't do it for the glory, but for a life that might be saved.

Somewhere deep within us, our souls cry out loud.

I am here to help my neighbors in their hour of need and doubt.

God gave me something special to help see you through,

I do it because I love you, and I care about you too.

(Moyer, 2004)

2.1 INTRODUCTION

The literature review aims to support and motivate for a study investigating the needs of EMWs. To structure the study I found it useful to refer to the work of Malach-Pines and Keinan (2006). Although the work of Malach-Pines and Keinan (2006) focused on Israeli Border Police and not on EMWs, I found the majority of the literature on emergency workers covered the same topics in principal. The difference is the dispersion of focus on these topics as well as the content. Therefore the structure of the discussion was guided[2] by the study of Malach-Pines and Keinan (2006) in which they discussed *typical* (job) *stressors*, *outcomes resulting from these stressors* (reactions), and *ways of coping* (coping with stress). In addition, suggestions for support deriving from their recommendations were added.

The focus and content of the discussion were guided by the literature on the EMWs. This could imply that the definition of a topic might differ from what was intended by Malach-Pines and Keinan (2006), but in general the deviation should not be great. The discussion of the literature focuses both on emergency workers collectively, and on emergency workers according to their various occupations.

The *job stressors* discussed by Malach-Pines and Keinan (2006) are subdivided into four main categories, namely task-related stressors, organisational stressors, external stressors, and personal stressors. They cite both Anshel and Dick, who subdivide task-related stressors into acute stressors and chronic stressors. For the purpose of the current study trauma-related stressors are considered synonymous with acute stressors, and chronic occupational stressors are equated with chronic stressors.

The *reactions* to these stressors were found to be mainly physiological, emotional, and behavioural. In addition, Malach-Pines and Keinan (2006) discuss burnout.

[2] The literature review moved to and through these topics.

Coping with stress is subdivided into problem-focussed and emotion focused coping. In their own study Malach-Pines and Keinan (2006) looked at the typical stressors Israeli border police were subjected to and their reactions to these stressors. Finally Malach-Pines and Keinan (2006) make suggestions on ways of coping that should reduce stress and burnout. Although they do not label these ways as such, I will refer to them as *support*, as these refer primarily to external inputs. I distinguish between coping, which comes from within the individual, and support, which derives from outside people and structures.

An important aspect that is neglected in Malach-Pines and Keinan's (2006) study, and assumingly all the studies that informed their research, is *needs*. Although the authors referred to needs in their work, an in-depth discussion of the topic was lacking. In light of this dearth of information in the literature, and given the identified importance of needs in this context, as discussed above, this hitherto neglected aspect forms the main focus of the current study. For these reasons needs are discussed prior to examining the literature directly related to EMWs. This is done to establish the tone of the study and to enhance understanding from the outset.

2.2 NEEDS

Murray, whose work was published during the 1930s and 1940s, and who developed the Thematic Apperception Test, is seen as the father of modern needs theory (James & Mazerolle, 2002). In the literature on the EMS very little reference is made to the needs of workers in this field. This could be explained by the history of motivation theories as described by Deci and Ryan (2000). Formerly, the study of motivation centred around the concept of needs. Needs specified the content of motivation and controlled action. However, the popularity of the

cognitive theories during the 1960s lead to the replacement of the needs concept by the concept of goals as dominant motivator.

It could be that by the time investigators started to study the EMS, the era of the needs theories had mainly passed, forcing the focus away from needs. Even in the recent literature, very few references are made to current needs theories. When needs literature refers to needs, it is mostly within the context of organisational psychology. In this context, needs are generally described as functions within groups when focusing on their motivation (e.g., Haslam, 2004). Simply stated, in-depth discussions of needs theories and the concept of needs are lacking in the recent literature.

In discussions on motivation, references to needs revolve around a few authors' work. These included Murray (e.g., Beck, 2000; James & Mazerolle, 2002), Maslow (e.g., Beck, 2000; Haslam, 2004; Whiteley, 2002), Herzberg (e.g., Beck, 2000; Haslam, 2004; Whiteley, 2002), McGreggor (e.g., Beck, 2000; Haslam, 2004), Gawel (e.g., Whiteley, 2002), and Alderfer (e.g., Haslam, 2004; Whiteley, 2002). The 1938 publication by Murray (cited in Beck, 2000; James & Mazerolle, 2002) is the oldest in the canon while the most recent is Gawel's 1997 publication entitled *Herzberg's Theory of Motivation and Maslow's Hierarchy of Needs* (cited in Whiteley, 2002).

Attempts to define the concept of needs are mainly found in the older literature. *Needs* is not easy to explain as it is an ambiguous concept (Lederer, 1980; Roy, 1980). It seems that the general consensus is that the satisfaction of needs is important for a happy, healthy life. Bay (1990) states that the satisfaction of needs is a requirement for the safety, well-being, and growth of the individual, and Masini (1980) notes that it is necessary for survival and development within societies. Needs are also linked to being human, and could be material needs or non-

material needs (Galtung, 1990). Rubenstein (1990) defines basic human needs as *'universal, permanent, imperative, and an essential part of the definition of what it means to be human'* (p. 340). Although some authors, such as Moon (1991), conceptualise basic human needs as those required on a material level (e.g., food, water, and shelter), the basic human needs referred to by Rubenstein (1990) are not limited to only the physical. Davies (1988) terms this *basic but non-physical needs*.

Needs are theoretical constructs and cannot be observed in a direct physical way (Lederer, 1980). Heller (1980) refers to true and false needs. If one says that needs cannot be observed in a direct physical way, and if individuals often do not know what their own needs are (see discussion below), false needs can only exist when researchers draw the wrong conclusions.

2.2.1 Building blocks of the needs concept

Lederer (1980) states that self-fulfilment and human motivation are inherent to the needs concept. However, there are many approaches to needs which all add to the richness of a picture of the human condition (Galtung, 1980). With this in mind, and as *needs* is a theoretical construct, I would not conclude that needs are only inherent to human motivation and self-fulfilment. For instance, there is evidence that *development* could also be included in such a list (should one try to compile one). Rist (1980) refers to the *need approach to development*, and several other authors (Galtung, 1980; Masini, 1980; Mitchell, 1990) describe the relation between needs and development.

It seems as if the list could be infinite, and that additions to the list could easily be made. Such additions should be able to hold up in theory and practice, and therefore be supported by

research and through references in the literature. I will attempt to illustrate this in the remainder of the section.

The notion that self-fulfilment is inherent to the needs concept is supported by the popularity of Maslow's (1959) needs hierarchy, in which he arranged basic needs into a hierarchical structure. Maslow (1959) states that b*asic needs* are different from *needs* in the sense that basic needs are shared by all. But the way in which these needs are satisfied depends on what he refers to as the individual's *capacities*. In other words, if one has the capacity to doing something, one has to do it in order to feel healthy; and if one has something, one must use it in order to feel healthy. The goal of needs satisfaction is ultimately to reach self-actualisation – to become fully human.

Looking at the numerous references to the relationship between needs and motivation, it is easy to see why Lederer (1980) describes motivation as inherent to the needs concept.

Deci and Ryan (2000) postulate a theory that focuses on human motivation called the self-determination theory (SDT). Certain conditions are required for human growth, integrity and well-being. To know what these conditions are, it is necessary to know what the needs of people are. If the needs of people are known, one would also know how to manage the environment for the optimal growth, integrity, and well-being of those functioning in that environment.

According to Deci and Ryan (2000), the psychological needs for competence, autonomy, and relatedness underpin people's motivation, and influence whether goals are pursued and reached or not. Ultimately, meeting these needs helps ensure psychological health. Specific needs underpinning motivation may include the need to achieve and the need to avoid failure (James & Mazerolle, 2002). These needs work in opposition to each other to create approach-avoidance conflicts. In addition, needs influence individuals' traits. Combining theories of

motivation and the topic of *needs* is not a recent trend. This makes sense if one keeps in mind Lederer's (1980) position that motivation is inherent in the needs concept.

One of the most well-known motivational theorists is Frederick Herzberg. His motivation-hygiene theory was initially derived from a study focusing on engineers and accountants (Herzberg, Mausner, & Snyderman, 1959). The study was replicated at least sixteen times and from these findings, as well as findings from other studies, it was found that the same factors did not lead to both job satisfaction and job dissatisfaction. The causative factors for each are different. Therefore the opposite of job satisfaction is not job dissatisfaction, but rather *no* job satisfaction. Herzberg then drew the conclusion that different *needs* are involved, and he coined the terms motivator factors and hygiene factors. The former is intrinsic to the job and, if met, leads to job satisfaction; while the latter is extrinsic to the job and leads to job dissatisfaction (Herzberg, 2003).

Development also earned its place in the list of elements inherent in the needs concept. If the aim is to improve the condition of human beings through their development, needs have to be satisfied. Said differently, the satisfaction of needs gives rise to development. Development is a continuous process as there will always be needs to satisfy (Galtung, 1980). Mitchell (1990) agrees with Galtung that needs have to be fulfilled in order for development to take place (Mitchell, 1990). Although not explicitly stated, Masini (1980) believes that needs guide development by motivating changes in society in order to satisfy these needs.

2.2.2 The nature of needs

Mitchell (1990) asks whether specific needs are equally important, or whether there are differences in the values individuals attach to needs. This question can be asked in terms of the

needs of EMWs and the hierarchical approach to needs. The importance of this question is that if a hierarchy of needs does exist, then the most important ones should be dealt with first. However, if needs carry different values for different individuals, provision should be made for dealing with all relevant needs at any moment in time (Mitchell, 1990).

When looking at needs hierarchies, the more physical needs are usually at the bottom of the hierarchies, and the non-physical needs at the top (Galtung, 1990). However, Galtung (1990) argues against a hierarchy of needs under normal circumstances, stating that in situations of extreme deprivation a hierarchy might arise, but in general people will strive to fulfil the so-called higher-order needs even if the lower-order needs are not satisfied. Sites (1990) indicates that people experience either negative or positive emotions based on the situation they find themselves in and whether it poses a threat to the individual. If emotions are negative, people try to get rid of them, and develop a need for the conditions that will satisfy them and result in healthy survival.

In line with the above, basic human needs are argued by some to be static, and by others to be dynamic. Should one assume that needs are static, the question is: how could this explain human behaviour that is not static? If it is assumed that needs are dynamic, one also assumes that needs and need hierarchies can change, and that people will differ in terms if their needs and need hierarchies. Time and circumstances influence the changes in needs and need hierarchies (Mitchell, 1990); and even minimum needs can change (Masini, 1980).

Some theorists such as Kelman (1990) do not make any assumptions about hierarchies of needs and which ones should be satisfied first. Kelman does assume that the frustration of basic human needs could threaten peace and social order. Although this refers more to large scale frustrations, this position does point to the effect of frustrated needs on the well-being of the

individual. He also does not assume that the needs identified by theories are universal, but rather suggests that some needs are to be found across social and cultural borders. He further states that it is not always possible to satisfy all needs, but he regards the satisfaction of needs as essential for the functioning of institutions and as being a reflection of their quality. In the long run the satisfaction of needs influences the stability and effectiveness of institutions, and the quality of life for individuals (Masini, 1980).

2.2.3 Satisfiers of needs

Klineberg (1980) relates human activities to needs and what people do to satisfy them. There are two approaches to satisfiers. The first tries to pair needs and satisfiers, which means that each need has a specific satisfier. If not, the need can either not be satisfied, or is not vital (Friedman, 1980). Friedman initially suggested that satisfiers are scarce most of the time. Later he stated that satisfiers could either be *hard* (e.g., food), fulfilling material needs, or *soft* (e.g., freedom), fulfilling immaterial (non-material) needs. When hard satisfiers are scarce, the quantity is not enough, while the scarcity of soft satisfiers points to limited access. The arguments highlighted here are that material needs are satisfied by material (hard) satisfiers; that needs and satisfiers are paired; and that satisfiers are scarce. However, these statements are not applicable to all situations. For example, food as a hard satisfier satisfies a physical or material need which one becomes aware of through the sensation of hunger. But food can also satisfy non-material needs such as comfort or relaxation. Therefore, a type of need is not necessarily satisfied by a satisfier of the same type; and needs and satisfiers are not necessarily paired. Based on this, although specific satisfiers might be scarce, the range of satisfiers which could satisfy a specific need is not necessarily limited.

The second approach therefore argues, amongst other things, that needs do not necessarily have specific satisfiers. Galtung (1990) believes that satisfiers are not universal, a point supported by Lederer (1980), who states that the satisfaction of needs depends on culture. Klineberg (1980) goes further to propose that needs depend on the standards and finally the culture of a group, while Roy (1980) argues that needs differ based on society and time, and that needs are shaped by social context. Masini (1980) also relates needs to groups within societies. He cites the example of a village who chose leaders who maintained the rural character of their village. In this village the hierarchy of needs was identified as food, housing, health, and religion. Through their culture, they unknowingly maintained their needs. As circumstances around them changed, work and political identity became part of the hierarchy.

Inter-group relations are affected by basic human needs. To improve these relations and to resolve conflict, needs have to be handled correctly (Fisher, 1990). Relevant to this is that needs themselves do not directly lead to conflict. Rather, conflict is caused by a shortage in whatever is needed to fulfil those needs (Mitchell, 1990).

Needs may be fulfilled to various degrees; if fulfilment is not adequate the altered state will only be temporarily. The assumption is that various routes may be followed to satisfy needs, and that the success of each will differ in terms of degree of fulfilment. Other assumptions are that needs could *stand in* for each other – an adequately fulfilled need can decrease the intensity of another need (Mitchell, 1990), and that satisfiers are formed (Potapchuk, 1990). Potapchuk (1990) believes that this is good news considering that there is often a shortage of satisfiers.

2.3 THE EMS

With all the above in mind we now return to the EMWs. As stated before, the literature on the EMS makes very little reference to the concept of needs. However, prior to discussing the literature, attention will be given to the EMS and research conducted within the field. An understanding of this may aid an understanding of the need to investigate the *needs* of EMWs

2.3.1 An overview of paramedicine

In earlier days, ambulances were mainly used to transport patients to health care facilities. Today, ambulance personnel (in the current study collectively referred to as EMWs) immediately assess patients and provide emergency medical care prior to and while transporting patients to appropriate health care facilities (Aasa, Brulin, Angquist, & Barnekow-Bergkvist, 2005; Okada, Ishii, Nakata, & Nakayama, 2005).

EMWs in South Africa respond to various emergency situations involving trauma (including accidents, assaults, gun shots, burns, and suicides), medical emergencies (including epilepsy, asthma, heart attacks, strokes, diabetic emergencies, maternities and miscarriages, and anaphylaxis), and disasters. Moran and Massam (1997) portray the work of EMWs as difficult, arduous, exhausting, and perilous. Emergencies are charged with tension, and the environment is incongruent due to the unexpected, the exaggerated, and the extreme. Regehr, Goldberg and Hughes (2002) describe the work of EMWs as follows: '*They work to rescue individuals trapped in crashed vehicles, they extricate people from fires, they collect the remains of suicide victims, they care for victims of assault'* (p. 505). Researchers have found that EMWs do not only deal with traumatising situations (Smith & Roberts, 2003), but are subjected to violence (Brough, 2005; Vettor & Kosinski, 2000), and potentially dangerous environments (Revicki & Gershon,

1996). In addition to having a difficult, dangerous and emotional profession (Wagner, 2005), EMWs do not work in well-equipped hospitals but in multiple practice settings (Revicki & Gershon, 1996; Vettor & Kosinski, 2000). Emergency workers are routinely exposed to stress-inducing and traumatic events which involve human pain, tragedy, and suffering (Burke & Paton, 2006; Regehr et al., 2002; Vettor & Kosinski, 2000). These events are often referred to as *critical incidents* (Monnier, Cameron, Hobfoll, & Gribble, 2002; Moran & Massam, 1997) or *critical events* including multiple casualties and violence (Regehr et al., 2002), injury (Vettor & Kosinski, 2000), mutilation (Vettor & Kosinski, 2000), and death (Regehr et al., 2002; Vettor & Kosinski, 2000).

2.3.2 Stress

Stress in general

Stress enjoys considerable attention in the literature from various subject fields, and many authors have tried to define this concept in order to capture its totality. One can speculate about the reason for this, which might be that stress, as a normal part of life, may cause overwhelming undesirable effects. These effects can threaten the individual's health by playing a role in initiating, maintaining and aggravating various physical and mental disorders (Rose, 1994).

Stress in the EMS

The EMS is inherently a stressful occupational setting (Revicki & Gershon, 1996). This is also true for other emergency services and a number of non-trauma-related jobs. In other words, exposure to trauma is not the determining factor, or even the only factor implicated in the development of stress. Ironically, when a person employed in an inherently stressful environment

develops symptomatic behaviour, the job is most often seen as the causative factor (Toch, 2002). Within the field of paramedicine this is probably the reason for the strong focus on occupational exposure to trauma, its consequences, how it is dealt with, and how to intervene.

Although the duties of paramedics include a range of highly stressful incidents (Lowery & Stokes, 2005), these incidents constitute only a fraction of the duty-related stressors they have to cope with (Beaton, Murphy, Johnson, Pike, & Corneil, 1999). Only recently have researchers started to pay more attention to the broader occupational environment of paramedics, and how this influences them. Unfortunately, in South Africa many emergency services and even counsellors still over-emphasise occupational exposure to trauma when dealing with emergency workers. The occupational environment of EMWs, in my opinion, subjects them to experiencing trauma-related stress, occupational stress, and organisational stress. Trauma-related stress is in essence part of occupational stress, but for the purpose of the study these are seen as separate entities. Organisational stress is considered separate as it refers to stress experienced due to organisational factors, and which could be experienced by any employees, no matter the environment they are employed in. However, the literature makes no distinction between trauma-related stressors and chronic occupational stressors, or between chronic occupational stressors and organisational stressors. At times it is a question of labelling the constructs, and at other times it is a question of grouping constructs belonging to different labels together. To explain the first notion I refer to the study by Vogel, Cohen, Habib, and Massey (2004). In this study Vogel et al. (2004) mention administrative issues (which may be considered organisational stressors), and then describe the issues as scheduling changes, shift work and partner switches, which are in essence chronic occupational stressors. An example of the second notion comes from Bennett, Williams, Page, Hood, Woollard, and Vetter's (2005) study. Tension with colleagues,

responding to false alarms, and conflict between work and home are grouped together under the same stressor type. However, these constructs fall more appropriately under organisational stressors, chronic occupational stressors, and personal stressors respectively. This type of reasoning might seem technical and unnecessary if the reasoning is that no matter the type of stressor involved, it causes stress that individuals have to react to and deal with. However, I suggest that distinguishing between stressor types has implications for the level and kind of support needed, and more so, for the underlying needs of EMWs. In this case, an increased awareness of the variety and kind of stressors becomes crucial.

Trauma-related stressors. The stressful environment EMWs find themselves in puts them at great risk for work-related stress, resulting in psychological distress (Revicki & Gershon, 1996). This environment was discussed under the section *'An overview of paramedicine'* and the relevant point here is that many of the incidents paramedics are exposed to are tragic and gruesome (Regehr et al., 2002).

Consequences of traumatic stress. Although it was found that psychological distress affects paramedics in both the short and the long term (Smith & Roberts, 2003), not all are affected by traumatic incidents to the same degree (Moran, 1998). Nevertheless, in response to stress, symptoms develop which could reduce productivity and effectiveness (Okada et al., 2005) and can affect both employers and colleagues (Vettor & Kosinski, 2000). Even if EMWs learn to deal with these incidents, the impact of some events is long-lasting, and symptoms of traumatic stress even increase under certain circumstances (Regehr et al., 2002).

Risk factors. Circumstances under which symptoms of traumatic stress develop and increase constitute the category of risk factors. The mere fact that paramedics are exposed to

trauma puts them at risk for developing stress-related symptoms, although they are not usually victims themselves (Weiss, Marmar, Metzler, & Ronfeldt, 1995). Posttrauma symptomatology may be elicited by cardiopulmonary resuscitation (CPR), which is seen as a routine procedure performed by emergency personnel (Genest, Levine, Ramsden, & Swanson, 1990). Another risk factor is the increase in traumatic stress when an emotional bond is formed with the victim or the victim's family (Regehr et al., 2002). In a study by Regehr et al. (2002), respondents indicated that events which cause emotional distress to be mostly those involving the death of a child or the death of a colleague. Other examples are a lack of social support, worries about work conditions, and psychological demands (Aasa et al., 2005), as well as exposure to mental stress (Okada et al., 2005), and the paramedics' personality (Moran, 1998). A study on student paramedics led to the development of a path model of PTSD relating duty-related trauma exposure, dysfunctional peer social support, and students' negative attitudes toward emotional expression directed towards each other (Lowery & Stokes, 2005).

These findings do not reflect the expectation that it is the mass casualty incidents that have the most lasting effects on paramedics; and it becomes clear that it is often the less sensational events that trigger greater emotional responses (Regehr et al., 2002). Still, mass casualties such as terrorism and disaster should not be ignored. During these incidents, it is more likely that paramedics become both service providers and victims (Vogel et al., 2004), which places them at greater risk for developing stress-related symptoms.

Even the coping strategies EMWs use may constitute important risk factors (Moran, 1998). Peritraumatic dissociation was found by Weiss et al. (1995) to be indicative of future problems. When someone *dissociates*, traumatic experiences are compartmentalised and the memory stores elements of the experience as isolated fragments. Dissociation may be protective

during the experience of a traumatic event, but later may cause difficulties in dealing with the event. In the long term, this coping mechanism may result in unbidden intrusive imagery and affect states, nightmares, obsessive ruminations, or behavioural re-enactment (Marmar, Weiss, Metzler, & Delucchi, 1996).

Marmar et al. (1996) compiled the following list of predisposing traits for peritraumatic dissociation:

> Rescue workers who are shy, inhibited, uncertain about their identity, or reluctant to take leadership roles, who have global cognitive styles, who believe their fate is determined by factors beyond their control, and who cope with critical incident trauma by emotional suppression and wishful thinking are at higher risk for acute dissociative responses to trauma and subsequent posttraumatic stress disorder. (p. 94)

A study performed on emergency response workers on duty at the Pentagon during the 9/11 period suggests that those who experienced recent bereavements had the most intense reactions (Ruzek, 2002), which emphasises the importance of the psychological well-being of EMWs. The emergency workers were in the situation of being victims and service providers at the same time. As victims they were on duty at the Pentagon during the crash and lost colleagues. As service providers they were in close contact with distressed families, had long working hours, were separated from their own families and had the responsibility of providing services.

Symptoms. As seen from the previous section, developing symptomatic distress following traumatic exposure is not a linear process. It is rather a complex phenomenon influenced by many variables (Weiss et al., 1995). The 9/11 emergency workers reported various reactions to

the stressors, including crying, intrusive thoughts, an increased sense of vulnerability, fear of returning to work at the Pentagon, activation of personal grief unrelated to the attack, sleep difficulties, irritability and anger, guilt, and difficulty in relating to the triviality of ordinary activities (Ruzek, 2002, p. 74).

Traumatic stress that develops because of the everyday duties of paramedics can manifest in various symptoms, including alcohol-related problems, a reduced capacity to handle stressful events, intrusion, anger and fear, as well as avoidance symptoms such as emotional blunting, psychological arousal, and concentration difficulties. Tearfulness, shortness of breath, flashbacks, and night terrors may also occur (Regehr et al., 2002). Physiological symptoms such as sleeping problems, headaches, and abdominal complaints are also associated with the psychological demands of response and station work (Aasa et al., 2005). In a study performed by Bennett et al. (2005), up to two-thirds of the participants had troubling work-related memories, of which almost half were experienced during the survey period. Paramedics also experience physical stress. Lower back pain especially can affect the health and functioning of paramedics (Okada et al., 2005).

Most of the literature focusing on the effects of paramedics' experiences highlights PTSD and burnout – both maladaptive psychological syndromes resulting from traumatic exposures and everyday demands (Miller, 1995). As this section covers traumatic-related stressors, only PTSD, a syndrome related to traumatic experiences, is discussed. PTSD may be a significant factor in the attrition of emergency workers (Bennett et al., 2005). The incidents paramedics are exposed to during the course of their duties are related to and predictive of PTSD (Lowery & Stokes, 2005; Vettor & Kosinski, 2000). Therefore they are constantly at risk for developing symptoms of PTSD (Vettor & Kosinski, 2000). Although PTSD is overtly tied to a specific

psychological stressor, it seems impossible to find the causal relationship between appraisal, coping and posttraumatic morbidity (Olff, Langeland, & Gersons, 2005). Coping strategies tied to the development of PTSD include dissociation (also called peritraumatic dissociation). There is strong evidence that troubling memories are related to dissociation during traumatic events (Bennett et al., 2005).

In 1996 Marmar et al. found that avoidance after critical incidents was used less by older subjects. They ascribed this to greater training, experience, and emotional preparedness. More recent studies, though, indicated that people do not get used to incident-related stress based on frequent exposure, length of service, or level of qualification. Rather, the risk for PTSD progressively increases for these people (Bennett et al., 2005; Okada et al., 2005).

Coping strategies. Paramedics have to deal with exposure to critical incidents (Beaton et al., 1999) and use various coping strategies to deal with the consequences of this exposure (Moran, 1998). There was a stage when emergency workers were believed to have an individual strength enabling them to cope with any event. This image was replaced with the view that emergency workers were vulnerable. Now it is known that emergency workers react differently to the same event; and that these differences are influenced by personality, coping strategies, and resources, among others (Moran, 1998).

Research on coping strategies used by emergency workers is commonly reported in the literature. These studies cover a range of strategies such as practical, cognitive, behavioural and avoidance strategies (e.g., Olff et al., 2005). These may be active or passive coping strategies, with the former being associated with better adaptation to stress (Olff et al., 2005). A study performed on male shift workers compared ambulance officers with other groups who were not exposed to traumatic incidents as part of their job. The former group’s repertoire of personal

resources was much more diverse than that of the latter (Shakespeare-Finch, Smith, & Obst, 2002).

A popular but often misunderstood coping strategy is humour (Moran & Massam, 1997; Vogel et al., 2004). It is used by individuals as well as groups and could contribute positively to individual adjustment. If humour is used to mask feelings, distress may result; but healthy use of humour may enhance communication, facilitate cognitive reframing and social support, and have physical benefits. This coping strategy appears to arise spontaneously and is therefore seldom a deliberate coping strategy (Moran & Massam, 1997). Another potentially positive coping mechanism is optimism. In one study, rescue workers with an optimistic disposition had more positive outcomes with less distress, less avoidance, more problem focused coping, and more social support available (Wagner, 2005).

Many factors influence the ways in which emergency workers cope with exposure to critical incidents. Two such factors are the organisation that employs emergency workers and the coping styles modelled by more experienced workers (Moran, 1998). To compensate for the lack of control over the job some paramedics ensure that other aspects of their lives are under control (Regehr et al., 2002). To reduce the psychological impact of trauma, deliberate coping strategies are used such as taking breaks or leave, talking to close friends or family, sleeping, keeping a journal, exercising, reading, avoiding media coverage of the incidents, and listening to music (Orner, King, Avery, Bretherton, Stolz, & Ormerod, 2003; Ruzek, 2002). These strategies seem mostly effective. Some often ineffective deliberate coping strategies include working long hours, poor dietary habits, using alcohol as a sleep inducer, and high intake of caffeinated coffee (Ruzek, 2002).

Avoidance of the impact of traumatic incidents leads to the use of distancing, avoidance, or dissociation to cope with exposure. Avoidance strategies include eating, drinking, smoking, and emotional dissociation or disengagement (Olff et al., 2005). Emotional distancing is frequently used, and traumatic events are rather managed on a cognitive level. In this case the EMW will visualise the sequence of steps to perform. This method might be protective, but over time it may have negative effects on interpersonal relationships as it may not be easy to shift between emotional distancing and emotional openness. A more constructive strategy is the positive reframing of an event. The event becomes a learning experience and an opportunity to improve services (Regehr et al., 2002). In contrast to this, Hyman (2004) found avoidance to often be effective.

As an important coping strategy, paramedics value talking to their support systems (Regehr et al., 2002). This disclosure or discussion of traumatic events has beneficial effects and is seen as an active coping strategy (Olff et al., 2005). Lack of support may thus be a risk factor for the development of trauma-related symptoms, and could even add to the development of PTSD. Therefore, seeking support as a coping strategy, and receiving support from support systems, are both very important for healthy functioning. This aspect is investigated further below.

Occupational and organisational stressors. Studies on paramedics and emergency workers have identified a whole range of stressors. Some are referred to as occupational stressors and others as organisational stressors. Unfortunately, clear distinctions are not made between these two and thus for the purpose of the current study it is not advisable to try and separate these

two concepts, although it is recommended that future studies attempt to draw a clearer distinction between these concepts.

Organisation-related stressors include tension with colleagues, responding to false alarms, and conflicts between work and home (Bennett et al., 2005). Administrative issues such as changes in scheduling of shifts, shift work and partner switches are other organisational stressors related to the work of paramedics (Vogel et al., 2004). The literature often compares organisational stressors with traumatic stressors. One study (Bennett et al., 2005) identified both organisation-related and incident-related stressors as particularly stressful in ambulance work and predictive of psychological distress. Alongside frequency of exposure to traumatic incidents, length of service, and dissociation, organisational stress was found to be an important predictor of the severity of symptoms of PTSD (Bennett et al., 2005). This study also identified a relationship between organisational stressors and degree of dissociation.

The studies comparing the contributions of organisational and traumatic stressors to the psychological well-being of EMWs do not always reach the same conclusions. In a study focusing on emergency workers (Brough, 2004), organisational and traumatic stress were found to be equally predictive of psychological strain. When the findings were compared between the occupations comprising the sample group, this finding was only relevant to the police officers and the fire fighters. The organisational stressors did not influence the psychological strain of ambulance officers. For them, the organisational stressors were more predictive of job satisfaction. Overall, comparisons between organisational stressors and trauma symptomatology show that the former is much more predictive of job satisfaction than the latter. A recent study conducted with personnel in the protective services (police, ambulance, and fire fighting personnel) (Burke & Paton, 2006) showed that the organisational side of the job was experienced

as far more stressful than the operational side, and the organisational climate was the strongest predictor of job satisfaction. Organisational stressors were also found to predict job performance, problems with family relationships, and health (Maslach, 2006). In job settings where expectations are clear, and where the work units are supportive and cohesive, psychological distress due to occupational stress seems to decrease (Revicki & Gershon, 1996, p. 395). Low workloads and waiting to be dispatched are, maybe surprisingly, also associated with stress (Aasa et al., 2005).

Under the symptoms related to trauma-related stressors reference was made to burnout. It was not discussed together with PTSD as it is not related to traumatic experiences. Burnout is related to everyday demands, and is therefore be discussed in this section.

Burnout in the helping professions consist of three components: (1) emotional exhaustion, (2) a tendency to deindividuate and depersonalise patients, and (3) a tendency to negative self-evaluation when assessing work with patients (Maslach & Jackson, 1981). It is described as a syndrome which develops due to ongoing occupational stressors and therefore differs from responses related to specific incidents. Elements affecting the development of burnout are related to the social environment, and include recognition of employees and the match between the nature of the work and the people (Maslach, 2006). Other risks for the development of burnout in professional staff are continuous exposure to clients' problems, which could lead to chronic stress and feeling emotionally drained (Maslach & Jackson, 1981).

In Malach-Pines & Keinan's (2006) study on Israeli border police a significant correlation was found between burnout and general stress. Further investigation indicated a strong relationship between general stress and job stressors, and between burnout and various physical and emotional symptoms, as well as a desire to leave the force.

Personal stressors and external stressors. Needs are diverse and may be related to one or more aspects of an individual's life. As the focus of the current study is on the needs of paramedics as they relate to their occupational environment, personal stressors and external stressors are not discussed in depth. However, these were be kept in mind during the process of investigation.

The paramedics are not the only ones who suffer the consequences of their secondary traumatic stress. Family members are also affected. Paramedics might feel disengaged and emotionally distant from their family members, and may even vent anger and irritability on them. They may also become overprotective due to fears for the safety of family members (Regehr et al., 2002; Vettor & Kosinski, 2000). Studies on EMS personnel performed after 9/11 indicated the effects of the inherent danger of emergency work for the families of EWs. This was especially applicable to the children of emergency workers. There were also issues regarding the inability of families to understand the experiences of emergency workers (Vogel et al., 2004).

Eustress versus distress

Although the majority of studies in the literature focus on trauma-related stress, occupational and organisational stress is increasingly enjoying attention, which brings balance to the picture. Still, something is missing; and that is the positive aspects of the job. Most of the people in this career enjoy the work and derive much satisfaction from it. EMWs save lives and often this is the reason for choosing a career in the EMS and staying there (Bennett et al., 2005; Palmer, 1983).

The Israeli border police were found to obtain satisfaction from their work despite high levels of stress (Malach-Pines & Keinan, 2006). This may be explained by the notion that they

perceive their work as important. This brings us to the topic of eustress and distress. In this regard Nelson and Simmons (2006) refer to their holistic model of stress, which states that the outcome of the stressor – eustress, distress, or a combined outcome – relies on the cognitive appraisal linked to the stressor. As such, it is ironic that outsiders often decide what experiences should be stressful to EMWs. This might not be said explicitly, but the focus of research within this field supports such an approach to EMWs.

Relating the effect of stressors to cognitive appraisal is not an attempt to simplify the management of stressors. Rather, it is an indication of the diverse range of effects that stressors may have on EMWs. Focusing on the primary stakeholders – the EMWs – may change the approach to research and interventions, and may create an opportunity to make a true difference.

2.3.3 Support in the EMS

As the majority of the literature focuses on trauma-related stress, the stress-related support rendered to EMWs mostly deals with their exposure to trauma. Support is either formal or informal, and is either sought or provided.

Support is rendered to emergency workers almost as a matter of fact after mass casualty incidents as they are expected to have lasting effects. But as previously pointed out, it is often the smaller and less sensational events that trigger emotional responses (Regehr et al., 2002); and paramedics also have to cope with these occupational demands. Support is a multiphase concept within the emergency context; and there are various support systems which provide varying degrees of effectiveness. These are discussed in the remainder of this section.

Social support

Seeking social support from colleagues, friends, and family members is a method used by EMWs and fire fighters to cope with their occupational demands (Beaton, Murphy, Pike, & Corneil, 1997). The variety of paramedics' personal support systems includes partners and children as some of the most important ones, as well as parents, friends, religious leaders and extended family members. They provide assistance by offering themselves as people to share experiences with, and by providing a refuge from the stressors of work. This is why frustration might develop if EMWs are not able to obtain support at home (Regehr et al., 2002). Moreover, tension may develop when family members do not show understanding for the experiences of the emergency worker (Vogel et al., 2004).

The exact influence of social support on coping has not yet been established, but it seems as if it does not mediate the intensity of depression or traumatic stress. For example, a study performed on Israeli police forensic technicians indicated that secondary traumatic stress levels were not significantly associated with either the perception of, or the satisfaction derived from social support (Hyman, 2004). Another study could also not identify a significant association between individual measures of perceived social supports and the intensity of depression and traumatic stress (Regehr et al., 2002). Nevertheless, in the last case, interviewees time and again mentioned the importance of family members and friends as support systems.

Organisational support

Important support systems identified through the interviews conducted by Regehr et al. (2002) included not only family and friends, but also organisational support.

Organisational support: Informal

Colleagues form important organisational support systems (Brough, 2005). This is supported in a statement from Regehr et al. (2002): 'A good partner is 99% of the job' (p. 510).

The shifts emergency workers work together makes them very dependent on each other for both practical and emotional social support (Brough, 2005). This links with humour as a coping strategy. Being a communication tool, humour promotes peer support and may directly decrease anxiety (Moran & Massam, 1997). Once again the exact benefit of colleagues and supervisors as organisational support systems has not yet been established. Some have found that it reduces occupational stress (Revicki & Gershon, 1996), while others have found that it predicts job satisfaction (Brough, 2005). Yet another study found that the 'macho' nature of emergency work may prevent discussion of real concerns and fears among colleagues, which are rather addressed through joking and sharing stories (Regehr et al., 2002).

In a study on the effect of workplace violence on paramedics, Brough (2005) concluded that effective management of workplace violence could influence the outcome more than the actual experience of the violence does. However, in many cases paramedics receive little or no support from their employers or unions (Regehr et al., 2002). It appears as if direct access to colleagues and loved ones is of utmost importance, followed by the availability of formal support if and when needed (Orner et al., 2003). A prerequisite might be the ability to speak comfortable with the support system of choice.

Organisational support: Formal.

Formal support includes mental health services provided by psychologists or through debriefings (Regehr et al., 2002). The necessity for formal support has been investigated and confirmed. In

Japan, Okada et al. (2005) found that paramedics and emergency medical technicians discuss situations with colleagues and managers, but most indicated a need for debriefing. In international emergency organisations debriefing enjoys considerable support (Moran, 1998).

Even though formal support seems to be important in dealing with occupational exposure to trauma, formal support systems often only respond to large scale incidents, and seem unaware of the less dramatic events affecting individual paramedics (Regehr et al., 2002). In addition there is a general reluctance to ask for help. This might reflect a reluctance to utilise organisational support, confidentiality issues, and fear of stigmatisation or being labelled as unfit for duty (Miller, 1995; Ruzek, 2002).

Psychological debriefings. Debriefings are a family of interventions that take place at various stages after traumatisation, and that take on various forms. In essence debriefing includes formal and informal support rendered at any time in the context of a critical incident: on the scene right through to some time afterwards (Moran, 1998).

Psychological debriefing (PD) is seen as a once-off preventive intervention to mitigate acute stress reactions, in an attempt to prevent PTSD (Lewis, 2003). During debriefings participants are required to give detailed descriptions of traumatic events (Ruzek, 2002). The strategies include ventilation of feelings, social support, and acceleration of cognitive reframing. This gives individuals the chance to discuss their reactions, both positive and negative, and exposes people to information and opportunities for referral they might not otherwise encounter during informal sessions (Moran, 1998). In theory it should help to avoid and lessen traumatic stress; however, the evidence supporting the effectiveness of psychological debriefing is lacking (Macnab, Sun, & Lowe, 2003). Moreover, some studies indicate negative and worsened outcomes after debriefing (Moran, 1998; Ruzek, 2002). It is clear therefore that the effect of

debriefing has not yet been established (Lewis, 2003). Although the principles of debriefings seem to be aligned with those involved in the coping strategies used by emergency workers, Orner et al. (2003) found few points of convergence; and Moran (1998) found that at times they even worked in opposition to each other.

Nevertheless, debriefings do enjoy considerable support within the emergency work context. This might be due to the origin of the most popular model of psychological debriefing, the Critical Incident Stress Debriefing (CISD). This method aims to diffuse the stress resulting from exposure to critical incidents (Wagner, 2005). Although it was developed as a group intervention for emergency workers (Lewis, 2003), it is applied in many contexts. The developer, J.T. Mitchell, was a fire fighter himself, and propagated his model on the grounds that it may prevent the development of PTSD. A fundamental assumption about emergency workers on which this model was built is that emergency workers are a homogenous group with the so-called *rescue personality* (Wagner, 2005). But neither this homogeneity nor such a personality seems to exist (Moran, 1998; Wagner, 2005). The success of CISD is discussed in the literature (Shakespeare-Finch et al., 2002) and the beneficial properties of debriefing seem to be inconclusive (Lewis, 2003), especially when it comes to the reduction of posttrauma symptomatology (Moran, 1998). Consequently, it seems that psychological debriefing is not the only preventative measure for stress reactions and ultimately the development of PTSD.

Other formal interventions. As the credibility of CISD was brought into question, researchers and counsellors applied other methods of intervention which they claimed to be effective. For example, Ruzek (2002) used a new approach after the plane crashes at the Pentagon on 9/11, called *brief education and support*. This was deliberately used as a replacement for debriefings to prevent the opening up of trauma-related emotions. This new

design aimed to explore reactions, to reduce concerns about these reactions, and to support positive coping. It seemed to be useful in widening the repertoire of participants' coping strategies, as well as normalising reactions to traumatic experiences through sharing emotional and behavioural reactions. Systematic evaluation of the effectiveness of this approach is still needed.

Also in the aftermath of 9/11 support was provided to EMS personnel through the collaboration of a Department of Psychiatry and a Centre for Emergency Medical Services in New York. The support included psycho-educational workshops for EMS staff and their families, and consultative work-related support for EMS personnel (Vogel et al., 2004).

2.3.4 User-focused studies

Studies on interventions within the EMS seldom focus on the needs of EMWs as the primary stakeholders. This means that the scope of the studies is often narrow and does not cover or recognise all aspects required for supporting EMWs. One such example is early intervention and debriefing. This does not refer to the once-off preventative measures mentioned earlier. To explain this I will adapt the Chain of Survival, used in the EMS to explain the importance of acting fast and effectively, to the context under discussion.

The links in the chain are early awareness, early access, early CPR, early defibrillation, early advanced life support, and early analysis. Workers need to be aware of things that could go wrong and take steps to prevent it. They also should be able to recognise danger signs and symptoms, and access help as soon as possible, followed by early initiation of CPR. CPR keeps the brain and heart alive to ensure better outcomes of further much-needed interventions such as defibrillation and advanced life support. In other words, CPR alone is often ineffective.

Therefore we must recognise that further interventions might be indicated, and we have to provide for that. Finally, the actions performed have to be analysed in terms of their effectiveness, and should be improved if indicated.

Early intervention and debriefing can be seen as the CPR in the chain. As such, these procedures contain EMWs until more specialised support (defibrillation and advanced life support) is indicated and accessed. Ultimately, prevention is better than cure; and our initial attention should be directed at early awareness and early access in an attempt to prevent negative consequences of emergency work. Although exposure to traumatic incidents cannot be prevented, early awareness and access can lead to innovative measures to minimise the effects of trauma. Thus, as the exposure to trauma cannot be controlled, other aspects of the environment can be managed in order to mediate the effects of exposure to critical incidents. An important part of this process is taking the needs of the stakeholders into account.

A few interventions take these primary stakeholders into account. Orner et al. (2003) studied the preferences of emergency workers when dealing with trauma. They compared the preferred coping and adjustment strategies with the principles underlying the delivery of debriefings, and found that the similarities were few. One such example is talking about events. The debriefing protocol indicates adherence to an agenda of successive stages when talking about events. In Orner's research, most of the participants deliberately talked about the events, but some preferred to avoid reminders thereof. Worthy of notice is that those who deliberately talked about the events preferred to do so on their own terms. The researchers in the end argued that service users, in this case emergency workers, have to be consulted in order to establish informed, evidence-based interventions.

Another important study focusing on these stakeholders was conducted by Burke and Paton (2006). They argued that studies on organisational stress mainly focused on pathogenesis, which led to an oversupply of interventions during the tertiary phase of stress development. Thus, interventionists try to prevent stress pathology in the emergency services *after* exposure to critical incidents. This approach to interventions led to the belief that stress follows incidents, leaving organisational factors out of the picture. Burke and Paton (2006) expressed the importance of seeing all experiences as having the possibility of being either negative or positive, which implies a focus on both the negative and positive experiences of employees after incidents. Second, they emphasised the importance of organisational climate to employee well-being. In their study, Burke and Paton (2006) found that organisational climate is predictive of job satisfaction, which ultimately influences employees' interpretation of their experiences. Finally, these authors stressed that positive outcomes had to be recognised, that organisational processes had to be included, and that stress prevention should start before exposure to critical incidents.

2.4 RETURNING TO NEEDS

Investigating preferences regarding coping and adjustment strategies (Orner et al., 2003) comes close to investigating the needs of paramedics. Even though their findings did not apply to or explore needs specifically, they did recognise the importance of establishing the needs of the end-user of interventions. Few studies came closer to this than the study performed by Orner et al. (2003).

Important to notice is that needs are more fundamental than preferences. Preferences are what we wish for. Unfortunately what we wish for is not necessarily what we need. Bay (1990)

categorises needs separately from wants, demands, and preferences, while Galtung (1980, 1990) not only categorises needs separately from wants, but also distinguishes them from wishes, desires, and demands. Although these aspects are not *necessary* they may also communicate needs. This is noteworthy as we often do not know ourselves what our needs are, and therefore cannot express them. Sometimes we do not have the opportunity to express our needs. If our needs could be determined, the principles underlying them may be applied more diversely within the EMS. It is pertinent that emergency workers are not only concerned with the performance of their job, but function as part of an organisation. It seems as if researchers and psychologists overemphasise the negative aspects of the job – the guts rather than the glory. Maybe because we do not get the chance to be the heroes, we try to distort the image of the heroes in reducing their experiences as ultimately negative with inevitably poor outcomes. However, emergency workers do not see themselves as heroes. They like their job and they chose it for the passion of it. It also is their means of income and the means by which they support their families. Ultimately, it is not heroic, but neither is it disabling.

Moran (1998) stresses that individuals do not react to traumatic stress in the same way. This already indicates that there will be differences in the interventions required for various individuals. However, few studies have investigated the needs of EMWs before implementing interventions, while some studies only mention establishing the needs of stakeholders in passing. If these studies did investigate needs, they omitted to describe this process, which indicates the level of importance ascribed to the needs of EMWs. An example is the study by Vogel et al. (2004), which explored needs, but only with reference to the crisis support team and not other relevant parties. In this study, the researchers joined paramedics on the road to improve their understanding of emergency work, as well as the emergency workers' concerns and needs.

However, the investigation of these concerns and needs seemed limited to the actual performance of the job and to needs of the paramedics' patients.

I propose that researchers go a step back and investigate the needs underpinned by preferences, as well as other aspects so often studied in relation to paramedics. It will not be easy to return to the findings of investigations in an attempt to determine the participants' needs, as the context and processes are important when drawing such conclusions. For instance, in Orner et al.'s (2003) study the majority of the officers preferred to talk about events in a free and flexible manner. Very simplistically it could be labelled as a need for freedom, but in context it could have been a need for respect for individuality. A history of generalisation and mass interventions within an organisation could underlie such an inherent need. Additionally, studies often use questionnaires with the aim of confirming theories and therefore limit the depth of the investigation. Needs have no limits and proper investigation thereof is dependent on the methodology applied.

2.5 SUMMARY

This literature review indicated that the literature on the EMS mainly focuses on stress and stressors, risk factors, symptoms, coping, and support. Looking at the occupational context of EMWs, this focus is understandable. But if it is assumed that needs are inherent to aspects such as motivation, self-fulfilment, and development, it is crucial to include needs in studies on the well-being of EMWs.

Based on the reviewed literature and for the purpose of the current study, other assumptions were also made regarding needs. These include that needs are shaped by context and can change over time. The satisfaction of needs is important for an individual's well-being in

various domains of life. These needs may be either material or non-material. Needs are not paired with satisfiers, and satisfiers can be formed. The implication of this is that specific satisfiers may be scarce, but the range of satisfiers which could satisfy a specific need is not necessarily limited.

Needs influence inter-group relations, and if handled correctly, relations can improve and conflict can be resolved. Unsatisfied needs influence the individual's emotions, which in turn stimulate actions aimed at the satisfaction of the needs. If needs are satisfied inadequately, an altered emotional state may result, but only temporarily. Alternatively, an adequately satisfied need can diminish the intensity of others needs.

There is no universal hierarchy of needs. For an individual or even for a company a hierarchy of needs may be drawn at a given point in time, but needs are dynamic and therefore hierarchies may change. The aim of hierarchies is thus to indicate the most important needs for the time being. This does not imply that needs are unstable and can change every other day. If this is the case, it may be that these feelings are better referred to as desires, wants or demands. Thus, the value an individual or a community attaches to needs determines the importance thereof. Moreover, it does not indicate a sequence to be followed in which only the satisfaction of a preceding need allows for the satisfaction of the following need.

It was also mentioned that needs differ from wants, demands, preferences, wishes, and desires, and can often not be expressed by the owner of the needs. Needs can also not be observed, as they are theoretical constructs. This implies that researchers have to draw conclusions about possible underlying needs; and false needs may then occur if the researcher draws wrong conclusions. These aspects are discussed further in the following chapter (chapter 3), which describes the methodology followed in an attempt to answer the research question stated in

chapter 1, namely: *what are the needs of EMWs, which are suggested by descriptions of their experiences within the EMS?*

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

Chapter 1 stated the purpose of the study as being to determine the needs of EMWs, which are suggested by descriptions of their experiences within the EMS. Chapter 2 explored the concept of needs, and noted that needs are theoretical constructs that cannot be observed. Therefore researchers have to draw conclusions from other observable aspects when investigating needs.

Some authors who conducted research on needs have made comments worth mentioning[3]. Mitchell (1990) refers to needs as being *discovered.* This process of discovery works retrospectively and is based on the physical and verbal behaviour people engage in. From this behaviour, needs may be deduced, as needs steer these behaviours. Bay (1990) also believes that needs should be deduced as they are empirical in nature. Galtung (1990) states that needs underlie behaviour and therefore behaviour cannot be taken at face value.

Galtung (1990) also encourages conversations as ways of data gathering. As stated in chapter 2, people are often not aware of their own needs and thus the process of investigation cannot be to ask subjects what their needs are. In line with this, Galtung (1990) suggests that the theme of such a conversation or interview should be *'what is so important that we cannot do without it?'* (pp. 327–328). Probing should then be used to facilitate an in-depth conversation. Lederer (1980) reasons that deduction is required to establish needs and that needs are either deduced from presenting satisfiers or from frustrations that manifest due to unsatisfied needs.

[3] Some of these sources are outdated; however, due to changes in research focus in this field (as discussed in Chapter 2) few recent sources focussing on the analysis of needs could be found.

The above information indicates a qualitative approach to the research, and the use of interviews for the purpose of generating data from which needs may be derived. A qualitative approach is further the approach of choice because even though the language used is less precise, the information obtained is far richer than statistical data (Gummeson, 2003). Investigating the needs of EMWs requires rich data to broaden the scope for interpretation.

3.2 THE PILOT STUDY

Before commencing my dissertation I conducted a pilot study on *'Exploring the needs of paramedics with regards to occupational exposure to trauma'*. It involved a single in-depth interview conducted with an advanced life support (ALS) practitioner. This practitioner, who will be referred to as Nico, has been in the emergency services for eleven years during which he worked in fire fighting for six years and in the EMS for five years. At the time of the interview we had known each other for about five years and had spent many shifts on the road together. The advantage of this was that he shared much information with me that he otherwise might not have. The interview elicited several needs. Some of the prominent needs were the need for a challenge, the need to protect, the need to be appreciated, the need for competence, and the need to be understood.

3.2.1 The need for a challenge

The field of paramedicine provided Nico with the opportunity to be challenged. No scene is ever the same as the previous ones. The patients differ, the presentations of their symptoms differ, and the environments in which they are treated are never the same. Compare the treatment of a patient in a house with multiple rooms and electricity with a patient lying in a shack, surrounded

by darkness. Compare the treatment of a patient who survived a motor vehicle accident sitting on the pavement with only a broken leg, with the same patient entrapped under the dashboard of his car. Each scenario creates a new challenge and requires paramedics to solve new problems. When Nico was challenged, more than just his theoretical knowledge was required. He had to use his brain power. The fulfilment of this need contributed to his job satisfaction.

3.2.2 The need to protect

This need mainly manifested in Nico's reaction to incidents in which children were injured. Safety is one of the most important aspects of any scenario paramedics attend to; and Nico found scenarios with people who were supposed to be protected difficult to handle on an emotional level. His inherent need to protect and conserve life was violated and all he could do was to prevent further damage. Being in a position where he could take control helped him to manage his feelings of helplessness evoked by the scenario. When his need to protect was fulfilled he gained a sense of control in an otherwise unpredictable environment.

3.2.3 The need to be appreciated

Appreciation gave Nico a sense of being. This manifested in the recognition for a job well done, as well as in his perceptions about a management structure who recognises the effects of the job on the well-being of the EMWs.

3.2.4 The need for competence

This mainly referred to interactions with colleagues and partners. Competent colleagues and competent partners diminish the stress, frustration and worries paramedics are subjected to.

Competence in a colleague refers to being an up-to-standard practitioner. Competence in a partner is to understand your partner and to have a constructive work relationship.

3.2.5 The need to be understood

Nico used conversation as a way of discarding his frustrations. However, if he felt the person who acted as his sounding board did not understand him, the conversation would add to and not diminish his frustration. Therefore he has a need to be understood, and in order to understand him, his job and the effects it has on him must be understood. Only when this need had been fulfilled, can he effectively shed his frustrations.

3.2.6 The pilot study informing the study

Several needs emerged from the pilot study, although I felt that interviews with multiple participants could help to better round off and define forthcoming needs. I reasoned that overarching needs consisting of several sub-needs could exist. If so, these could only be determined from multiple interviews.

The findings furthermore indicated that a focus primarily on occupational exposure to trauma would not do justice to the rich environment in which paramedics find themselves. This motivated my broad focus on EMWs' needs within the occupational environment, which includes both occupational and organisational aspects.

3.3 DATA GATHERING

3.3.1 The procedures followed

To obtain consent for conducting my study within the structures of the particular EMS company, I approached the Human Resources Manager of the company. Consent was granted and I was brought in contact with the various base managers. A letter of invitation to participate in the study was sent to the bases and distributed among the EMWs. Interviews were conducted at the participants' venue of choice, provided that I felt comfortable with the location. Consequently some participants arranged independent meetings with me, while others obtained consent from their base managers to be interviewed during shifts at their bases. Participation in the study was voluntary and informed consent was obtained from all participants.

3.3.2 The participants

As participation in the study was voluntary, I did not have the luxury of predetermining how many participants on which level and from which base I was to interview; neither had I control over the gender, race, and language of the participants. I also had to turn down one participant as he was a recently qualified BAA who did not have much experience on the road.

ALS practitioners were excluded from the current study due to the vast differences between them and the other practitioners, namely basic life support (BLS) and intermediate life support (ILS) practitioners. The most important difference was that the majority of ALS practitioners were functioning on the level of junior management. This differentiated their functioning quite significantly on both operational and organisational level.

In the end I conducted interviews with three BLS and six ILS practitioners, stationed at three bases in Gauteng (which will be referred to as Base A, Base B, and Base C). Base A had

three participants – one male BAA, one male AEA and one female AEA. Base B had two female participants – one BAA and one AEA. Base C had four participants – one male BAA, one male AEA, and two female AEAs.

The participants' years of service varied between three and eighteen years. Five interviews were conducted in Afrikaans and four in English. All participants were white, except for one African female. It might be that EMWs from other racial groups were reluctant to be interviewed by me, a white female, due to cultural and language differences.

3.3.3 The interviews

The interviews were not structured, but based on my own experiences, the literature review and pilot study. I decided beforehand on certain topics to be covered during the interviews. These included the reasons why the participants chose a career in paramedicine, why they were still in this field of work, what they liked and/or disliked about their work, what they would keep and/or change about their work, and their views on counselling within the EMS.

I began the interviews by asking each participant how he or she came to work in the EMS. Usually, the rest of the topics came forth spontaneously. If not, I asked direct questions pertaining to one of the topics indicated above. Two questions which gave valuable information were: *'If you were in management what would you keep?'* and *'If you were in management what would you change?'* These questions were used only once the participant's previous line of thought had come to an end, and enough probing had been done. The use of this method of interviewing also allowed for other topics to emerge. One such a topic was the participants' interactions with other people in the course of their duties.

3.3.4 The investigation

I recorded and transcribed the interviews, and used the method of interpretive analysis to investigate the needs suggested by the content of the interviews. This form of analysis was chosen as it allowed for interpretation of the content into a perspective (Terre Blanche, Durrheim, & Kelly, 2006). Another appealing aspect of this method mentioned by Terre Blanche et al. (2006) is that it is 'a back-and-forth movement between the strange and the familiar' (p. 322) as well as some other dimensions. With my knowledge of and experience in the EMS, the findings based on the accounts given by the participants could be presented to them as being both familiar and strange, and could help the participants to develop a new perspective on the challenges they experience.

Interpretive analysis as described by Terre Blanche et al. (2006) includes the steps of (1) immersion and familiarisation, (2) inducing themes, (3) coding, (4) elaboration, and (5) interpretation and checking. These are the main steps included in various qualitative analytic traditions, collectively described as interpretive analysis.

The hermeneutic process sets the tone for the interpretive analysis used in the current study. This process requires that the description of data be transparent, rich, and complete. Furthermore, interpretation and meaning must be provided through conceptualisation and condensation of the data. The research findings have to be reported to the target audience; and contradictory data and alternatives to interpretation should also be provided (Gummeson, 2003). This is in line with the prominent stance of the interpretive tradition that reality can not be perceived objectively (Addison, 1989).

Heidegger is a well-known hermeneutic philosopher and various authors have referred to his work (e.g., Koch, 1995; Misgeld & Jardine, 1989; Packer, 1989; Packer, 2000; Packer &

Addison, 1989). Some of the notions he described as fundamental to the hermeneutic process are relevant to the current study. These notions were translated from his original German work, *Sein und Zeit*, as fore-having, fore-sight, and fore-conception (Heidegger, 1962). Heidegger himself explained these terms as being 'something we have in advance', 'something we see in advance', and 'something we grasp in advance'. (p. 190). This implies that researchers always have knowledge and understanding of the data they are to interpret. The phenomenon we work with has an involvement in our understanding of the world, and this involvement has to be interpreted. The interpretation is thus grounded in our fore-having, fore-sight, and fore-conception, which forms the structure of our understanding of the phenomenon. This understanding opens up possibilities for interpretation, and interpretation is the further development of this understanding.

My long-term involvement in the EMS gave me an in-depth understanding of the context investigated. Within the hermeneutic approach I had to try and distance myself from this understanding, but could also make it part of the process. This brings us back to the back-and-forth movement between the strange and the familiar mentioned by Terre Blanche et al. (2006). Now the familiar can be seen from a new perspective.

Immersion into and familiarisation with the content of the interviews started when I conducted the interviews, and it continued during the process of transcription. After transcription I once again read through all the interviews. This was an important step for developing a relationship with the content of the interviews as well as for developing an understanding of what was said. Another aspect of immersion, described by Addison (1989), is to understand the context in which the participants function from day to day. Unknowingly, this started when at first I entered the EMS (described in chapter 1).

The literature supported both the processes of induction and deduction followed during the investigation of needs (e.g., Bay, 1990; Lederer, 1980; Mitchell, 1990; Terre Blanche et al., 2006). Thus, these processes, which started during the step of immersion and familiarisation, and which were finalised when a point of saturation was reached, were used reciprocally throughout the investigation of and elaboration on the themes.

Because needs are theoretical constructs and thus not easy to extract, the first round of analysis focussed on general themes that emerged. To prevent confusion, this are referred to as *categories*. These categories were mainly investigated through a deductive process and gave an overview of the topics that the participants generally discussed. The information contained in the interviews was coded according to these categories. In some instances information pertained to more than one category and was thus included in both, and in other instances categories were either merged or divided into more categories.

During the step of elaboration the categories were explored, mainly through an inductive process, for emerging needs themes. Some needs themes emerged in multiple categories. The needs themes that came forth most prominently were selected, and the categories were once again sifted to ensure that all instances referring to these needs were drawn into the supporting evidence. This was done to add to the richness of the descriptions.

The next step was to write down, explain, and discuss the findings (interpretation), and the final step was to check the interpretation of the findings for accuracy. Checking was accomplished by reading through the interview once more and comparing it with the interpretation thereof. Two questions were kept in mind: *Did the interpretation make sense with regards to the interview?* and *What was the influence of my personal experience and my pre-understanding of the field on my interpretation?* I had to make sure that although my own

experiences would have had an influence on the interpretations, they did not overshadow the thoughts, feelings, and experiences of the participants.

3.4 CREDIBILITY, TRANSFERABILITY, DEPENDABILITY, AND CONFIRMABILITY

3.4.1 Credibility

The credibility of the findings is supported by the overall approach to the investigation. I had a proper understanding of the research context, the interviews allowed the participants to express what they truly felt, and the analysis was performed with rigor and with a continuous critical view on my own involvement in and influence on the processes. To maintain a critical view I made use of back-and-forth movement (Terre Blanche et al., 2006). I moved back and forth between myself as the researcher and myself as an AEA while reflecting on the analysis of the interviews and the interpretation of the findings. In addition, discussions with my supervisor ensured a credible approach towards the analysis and interpretation of the data, a process which promotes credible findings.

3.4.2 Transferability

Although I believe that these data are likely to be transferable to other contexts, it is not necessarily advisable to do so. The reason is that each population may present with another group of needs, which is important for them in their context and time. Should these findings be transferred, it should be done with a thorough understanding of the context in which the needs were derived, as well as the context in which the findings are to be applied. In addition, it should be remembered that these needs may present themselves in another way; and that other needs

may exist and be more important within the new context. The transferability of the findings to new contexts in the current study is enhanced through the provision of rich and detailed descriptions of the context of investigation (Van der Riet & Durrheim, 2006) and the findings themselves.

3.4.3 Dependability

Rich and detailed descriptions of the investigation and the findings were used to indicate the dependability of the investigation's findings. The ways in which the data were collected and analysed were also grounded in theory, which adds to the dependability of the findings (Van der Riet & Durrheim, 2006). Even if this research were repeated with exactly the same participants, the findings may differ without devaluating the current findings. As shifts within the context occur, shifts with regards to the needs experienced may occur as needs are dynamic. This does not mean that the present needs seize to exist. I believe strongly that these needs will exist forever as they are inherent to the population – I would even go as far as to suggest that they are inherent to humankind. However, the importance of the present needs might change; and needs which were not even mentioned in the current study may come to the fore. This does not mean that they did not exist prior to this; they might merely have been overshadowed by needs more important at that stage, or it might have been fulfilled until that point.

3.4.4 Confirmability

This study did not attempt to confirm the findings. However, confirmability was enhanced by describing the steps followed in the data analysis. The findings were also linked to existing literature, which also adds to the confirmability.

3.5 ETHICAL CONSIDERATIONS

Participation in the current study was voluntary and based on informed consent. The nature of the interviews was humane and ensured that participants were not traumatised. The identity of the participants was kept confidential and measures were taken to make the participant unidentifiable from the manuscripts. The participants will be informed on the findings of the study and given the opportunity to comment on them. The findings will also be communicated to the management of the participating EMS company and recommendations made on how these findings could be optimally used within the company.

3.6 SUMMARY

This chapter provided an overview on how the literature suggests research should be performed on needs as a theoretical construct. This was followed by a description of the pilot study that preceded this investigation. The approach applied to this investigation of the participating EMWs' needs was explained, followed by an explanation of the concepts of credibility, transferability, dependability, and confirmability as they relate to the findings. Lastly, the ethical considerations of the study were highlighted. In the following two chapters, the results of the analysis are discussed.

CHAPTER 4

IDENTIFICATION OF CATEGORIES

4.1 INTRODUCTION

Needs are theoretical constructs. As such, merely naming and defining needs, and giving examples on how they may be satisfied, cannot communicate a thorough understanding of these needs. In order to understand a need and where it comes from, background knowledge is necessary.

As means of gathering data for the study, interviews were conducted with three BAAs and six AEAs employed by an EMS company. The interviews were unstructured and guided by both the topics I wanted to cover and the responses of the participants. From the analysis of the interviews, categories emerged from which the needs themes were derived. Thus, the categories provide an impression of the topics the participants discussed, although they also provide background information necessary for understanding the needs. In this chapter these categories are discussed.

Due to the nature of the study, these categories are not necessarily representative of the EMW community as a whole; and this discussion presents the various views held by the EMWs who were interviewed. Rather, this discussion could be seen as an extension of the literature review, drawing one closer to the context in which the study was performed.

4.2 THE CATEGORIES[4]

4.2.1 The tasks of EMWs

It is a hard, physical work, because when you work, you work.

(AEA 4)

The participants who were interviewed have a wide range of tasks to fulfil during their shifts. The first and most important task is the treatment of patients experiencing emergencies. The vehicles and equipment used for patient treatment have to be kept clean, and in addition to emergency treatment, patients have to be transferred between hospitals. A task stemming from working with patients, and which is probably self-imposed, is that of consoling family members. Other important tasks are administrative tasks. These are key elements during shifts and include filling in patient report forms (PRFs), opening patient files at hospitals, filling in trip sheets, and receiving payments from private patients. When an EMW is on light duty due to an injury the tasks are usually administrative in nature and include checking and filing PRFs.

As in most jobs, and regardless whether they like the *job* or not, some *tasks* are liked and others are disliked. EMWs consider the treatment of patients to take priority over PRFs. Maintaining a balance between these two tasks is seen as a challenge which, at times, becomes a point of conflict between the EMWs and their managers.

4.2.2 Job motivation

Each call you do is making a difference…

(BAA 3)

[4] Quotes from the interviews with BAA 1, AEA 1, AEA 2, AEA 4 and AEA 6 were translated from Afrikaans (see Appendix A).

The category of job motivation included reasons why EMWs chose this job and remained in it. The main reasons that emerged from these interviews are an interest in the medical field, the perception of the profession as a calling, enjoyment of the work, the flexibility the job provides, and collegial bonds.

The latter three reasons are most relevant to the study and are discussed briefly below.

Enjoyment of the work

Not all the participants were equally optimistic about the work, but the elements of enjoyment and excitement inherent to this job motivated the EMWs to stay. This enjoyment was not necessarily due to the action, the adrenaline rush, the excitement of responding to calls, or a thrill of seeing blood:

> *I definitely do not like the blood.*
>
> (AEA 2)

> *…after five years it really takes a lot to get me into an adrenaline rush.*
>
> (AEA 3)

The enjoyment rather came from the challenge the job posed to the EMWs, and the opportunity it gave them to make a difference. The latter included helping other people, seeing a badly injured patient recover, and the satisfaction experienced when a patient was pulled through:

> *In the evening when my head touches the pillow…my last thought is: I meant something good to somebody today.*
>
> (AEA 6)

> *…just the helping of the people…there is something about it which I enjoy.*
>
> (AEA 5)

> *The adrenaline, responding…rushing to go help someone…and eventually helping someone and seeing them after a few weeks having recovered…it gives you that thing…that at least you do something out there to people.*
>
> (BAA 2)

It is important to be realistic about the amount of enjoyment gained from this job, as a love-hate relationship with the job sometimes exists:

> *… there's been a couple of times I've regretted it* [choosing this career path]*…but I love my job, so I wouldn't change that.*
>
> (AEA 3)

Job flexibility

The inherent lack of routine and the flexibility of the job was a positive characteristic. As long as they were available during their shifts, very few obligations rested upon the participants when they were not attending to calls. The shifts they worked also provided them with flexibility in their private lives.

Collegial bonds

The bonds between colleagues as well as the way they worked together were elements they liked and which motivated some of the participants to remain in this job.

> *Because most of the people we work with…they are willing to work.*
>
> (BAA 2)

Togetherness and a sense of belonging came through strongly; and many of the participants referred to the EMS as being a family:

> *…this is like my second home and my second family…you are really, like, dependent on that feeling of being…the emotional bonds you form with people…they are like family and I love coming to work to be with my colleagues because they are like my friends.*
>
> (AEA 3)

4.2.3 Remuneration

> *They pay us okay. They pay us better than, like, some services.*
>
> (AEA 3)

Not much of the discussions revolved around remuneration. Some participants felt they were paid reasonably, and others felt they did not get enough for what they did. The general feeling seemed to be that their salaries could be improved, although they did not expect to get rich from this line of work. One participant explained that in South Africa there is no money in this job – it is a calling, and it is the love for the cause which draws people to it.

4.2.4 Work conditions

> *…this is an evil building…Move the staff out of the building, put them somewhere else and find it will be better. This building is bad.*
>
> (AEA 5)

The discussions touched on perceptions of optimal work conditions. The participants specifically referred to the base, their uniforms, and the vehicles they operated from. Conditions at the base

are influenced by the environment, the neatness and organisation of the base, as well as the provision of necessities such as a gym, which promote both physical and spiritual strength. Delegation of administrative duties to a specific person was also included here.

An issue which came forth was that the participants reported never being consulted about the design and practicality of the new uniform. The uniforms were described as being hot, heavy, thick, and uncomfortable. The issue of being consulted also arose with regards to the vehicles. As EMWs work in the ambulances every day, the participants felt they should have a say in the design of the ambulances' interior. The participants felt that air conditioning and enough space would make a significant difference to their work conditions, and ultimately positively impact the treatment of their patients. Vehicles in proper working condition were a prerequisite. These findings suggest that the participants want a say in the practical decisions that influence their work conditions.

4.2.5 Professionalism

> *That person pays for that quarter of an hour and I owe him my full attention during that time … Whether he pays or does not pay, that is what I owe him.*
>
> (AEA 6)

Rendering a professional service as an EMW includes providing proper patient treatment, attending at incidents you were dispatched to, proper handover of ambulances, and proper completion of paperwork. The participants felt that this extended even further to professional interaction with the public and with colleagues. Appropriate conduct towards the public is considered vital.

Where people work as closely together as EMWs, they might feel like a family, with the consequence that they also might fight like a family. Incidents such as arguments and shouting at each other were reported, as well as rumour-spreading and back-stabbing. Internal and inter-company politics were cited as a reality that influenced the professionalism of the service rendered. Arguments between companies that revolve around who was first on scene and who is to treat and transfer patients could be detrimental to the patients. These arguments are often located in company policies.

4.2.6 Ignorance

> *I don't like people's ignorance on the roads when it comes to emergency vehicles.*
>
> (BAA 3)

Closely related to the previous category is the category of ignorance. An example in this category is the following:

> *…when you respond and people tend to think … we are not rushing to go help someone … some people won't even give you a right of way.*
>
> (BAA 2)

This statement refers not only to people who underplay the role of EMWs, but also those who are unaware of the tasks EMWs fulfil, as well as those who deliberately abuse the availability of EMWs. An example is people faking illness to be booked off from work. Another is when people phone for an ambulance despite having their own transport, living very close to a hospital, and not having a condition that could be classified as an emergency.

4.2.7 Appreciation and respect

The categories of appreciation and respect were pillars for one of the needs identified in chapter 5 and therefore these discussions were incorporated in the discussion of the need in chapter 5.

4.2.8 Management

> *… there's a big gap between the crews on the road, and management.*
>
> (AEA 5)

> *… there's a gap between the guys on the ground and management.*
>
> (AEA 6)

The discussions on *Management* as a category touched on issues such as listening to employees and reacting to what they had to say, informing EMWs on decisions, being in touch with what was going on at ground level, and the trust invested in management and its structure.

The participants seem to value managers who are in touch with their employees and informed about what occurs at ground level. The participants felt that getting to know the EMWs at each base should be a priority to management. Management should be aware of their whereabouts, support them when it is deemed necessary and show appreciation for work performed under adverse conditions such as heat waves. In addition they mentioned the value of having the opportunity to give input to management on aspects related to their job, and to have management take notice of this input.

> *Some of the management doesn't work on the road … so what they think … looks nice, is not practical. What they wanted to work is not practical … that's frustrating.*
>
> (AEA 5)

The participants liked complaints to be noted, and to be informed of decisions made by management. Management is also expected to consider the effects of their decisions on the EMWs on ground level. Improved communication between the various structures in the company was seen as a solution to most challenges experienced within the company.

> *Problems will get sorted out better. What works, what doesn't work will get sorted out quicker. Unhappiness will get sorted out quicker…if the communication chain actually worked…your channel of command will probably work better as well…if communication worked better.*
>
> (AEA 5)

4.2.9 Training and development

> *I want to get to CCA and I want to be a damn good CCA.*
>
> (BAA 3)

Many EMWs completed their training and then, due to circumstances, seldom or never performed some of the procedures for which they were trained. Internal training and further development were some solutions suggested to tackle this challenge. It was felt that this could motivate the EMWs to further their knowledge, while developing their professionalism.

The participants felt the company should more readily send their employees on courses which would enable them to obtain higher qualifications. The financial implications of the courses prevented certain EMWs from enrolling privately for courses; and those who could afford them often had to deal with the scarcity of both the courses themselves and the places available on courses due to the quotas imposed on colleges.

> *…and the frustration of not being enough AEA courses and the cost of courses…thus difficult to further myself.*
>
> (BAA 3)

Sometimes EMWs were expected to leave their job or to take unpaid leave when they did obtain a place in a course.

4.2.10 The influence of the job on the EMWs

> *You see horrible things and experience dreadful things…it comes back. You think you have put it behind you and got over it, but it comes back some time or the other.*
>
> (AEA 4)

The emergency medical work they perform influences these participants on a physical and psychological level (with stress excluded for now). Injuries and the day-to-day strain of the work were the physical influences mentioned. The emotional influences and the influences of the job on their relationships were seen as both positive and negative. One participant said the work taught him to put his personal problems in perspective and to be much more relaxed at home. Another mentioned the respect she developed for cars and speed, and also the interaction it initiated in her relationship as her boyfriend was very eager to learn more about her job. On the negative side a participant mentioned that she lost perspective of what *bad* meant when it came to patients and their injuries. This *bad* related specifically to the emotional experiences of the patients:

If I was in an accident and I broke my arm for me that would be…

pretty bad. But if I get a patient: 'Oh, it's a broken arm.…You'll live'.

You downplay a lot of things.

(AEA 3)

This was supported by other participants who mentioned that they had become hard, desensitised people, who would easily say that someone was only pretending.

Also mentioned were recurring memories about bad scenes, dreams about calls, paranoia, less time spent with families, and anger and frustration that were taken home.

4.2.11 Stressors

You know what? Yes, the stress caught up with me.

(AEA 6)

Any element within the domain of the EMS could act as a stressor. In other words, work-related stressors or on-the-job stressors, such as giving emergency treatment to children through to family members interfering on scenes, may be stressful. Even management and colleagues could act as stressors.

Violent acts against EMWs were some of the observable stressors mentioned by the participants. These included aggressive and psychotic patients, ambulances being stoned, EMWs being shot at, and large crowds surrounding EMWs, especially in communities known for violence.

A stressor that could almost form a category on its own was incompetence encountered during the performance of duties. This included incompetence of colleagues, other EMWs, dispatchers, and incompetence encountered at medical facilities. The incompetence of EMWs

makes the work difficult and increases the work load of their colleagues. The incompetence of dispatchers increases response times, and incompetence at medical facilities could make EMWs' efforts to stabilise or improve the condition of their patients worthless.

Another reported stressor was the lack of *willingness* to use competence, as well as the *inability* to make use of competence. The following quote from one of the participants (AEA 1) summarises both these aspects:

> *Hospital A told Hospital B that the patient was P3* (instead of P1)

This part of the quote indicates a lack of *willingness* to make use of competence as the priority of the patient was incorrectly conveyed.

> …*when we arrived there* (at Hospital B), *they did not have ICU beds available.*

The second part of the quote indicated the *inability* to make use of competence as the facility did not have space available for another ICU patient.

There were discussions around differences, which focussed on colleagues of a different sex, culture, and language. The bottom line of these discussions was the theme of competence. Differences were tolerated as long as competence, and to a lesser degree willingness, were displayed. For instance, as the EMS traditionally was a male-dominated occupation, the benchmarks were set according to the strengths of men. Even though the strength of men and women might differ quite significantly, the lesser strength of a female was tolerated if she was otherwise competent. Tolerance increased if she displayed a willingness to try.

4.2.12 Stress reactions

> …*I become emotional*
>
> (AEA 2)

A diverse range of reactions to stress was described. A female participant said that she became emotional, cried, and did not want to talk to anybody. She would also say things to people she did not mean. A male participant told about a child he treated who looked like his cousin. For two weeks afterwards he could not sleep without seeing the child's face. The stressors the participants encountered did not differ significantly from those described in the literature.

4.2.13 Coping

EMWs are diverse in what they experience as stressors, how stress manifests, and how they deal with stress.

> *Everybody is different. I go home and garden. Some people go home and gym…I think it depends on your personality.*
>
> (AEA 5)

Knowledge was found to be beneficial to coping. This knowledge refers to knowing what happened to a person who was exposed to critical incidents and who was experiencing stress. By being knowledgeable about these processes the participants felt they understood what was happening to them, knew what to expect, and how to deal with it.

A prominent strategy used to cope with stress seems to be *distancing*. The EMW participants distance themselves either physically or emotionally from people who do not understand, from elements acting as stressors, and from other people in general. One participant consciously built into her repertoire a diversity of identities reminding her that she was not only an EMW, but also an ordinary citizen doing ordinary things outside the EMS. A form of distancing is *rationalisation*. For example, EMWs tell themselves that, with their expertise, they have done as much as possible for the patient. In other words, the patient had reached a point

where the EMW's intervention could no longer make a difference between life and death. When this point was reached, it was easier to cope with the stress evoked by incidents.

Various examples of physical activity were highlighted as means of coping with stress. More passive strategies for coping included talking, writing, reading, watching television, and listening to music. Passive coping strategies that may be considered destructive included smoking and excessive intake of alcohol.

4.2.14 Support systems

> *You must have someone you can talk to.*
>
> (AEA 4)

In the interviews the participants portrayed their colleagues as important support systems. Handovers were vehicles for informal debriefings. During these times colleagues act as sounding boards for each other. This seems to be a function that developed from a day-to-day task, and it appeared that these *debriefings* occurred often on a practical level, which seldom accessed the deeper emotional content.

> *Your colleagues are your best sounding boards because we talk about scenes until we are blue in the face…that helps a lot…but it, sometimes it is hard to go to your colleagues and say: You know, I'm feeling emotional about this.*
>
> (AEA 3)

During these talks feedback on scenes are exchanged and the scenes are reasoned through to determine what the optimal patient treatment would have been. It is important to remember that

opinions regarding this differ. Some participants did not value colleagues as sounding boards and therefore did not get involved in these discussions. As one participant reported:

> *In general people do not often talk about scenes, except for now and again when something interesting happened.*

(BAA 1)

That colleagues are seen as important support systems does not always have a positive outcome. When participants started to 'hide out' at work because their colleagues understood them, a vicious cycle ensued as the same environment that contains the stressors also provides sources that help with stress relief. The downside is the lack of a clean break from work-related stressors, and a resulting cumulative effect on stress levels.

Family and friends were also mentioned as important support systems. In addition, the provision of some kind of support from the company's side was both valued and expected.

4.2.15 Interventions

> *…I think counselling is necessary, because…the methods other people use (to cope with), even myself, are not always the best methods.*

(AEA 2)

The participants were aware of the long-term psychological effects that their occupation could have on them. They admitted that they did not always have the ability to cope with the stress on their own and that an uninvolved sounding board had a place within the EMS. Counselling was perceived as necessary, and as some participants went for therapy on a private basis the importance of support through interventions was indicated. The participants indicated a desire for interventions, including psychological services that were made available by management.

This reflected the expectations of the EMWs regarding management's responsibility in supporting them. However, the participants reported a lack of available formal interventions. Although debriefing was a well-known concept, some participants had never received debriefing. As one participant stated:

> *It's only a nice thing you read in the books.*
>
> (AEA 3)

Very few EMSs in South Africa make psychological services available to their employees. Therefore debriefing is not a common practice within the services and EMWs often experience it as a threat. Adding to the threat is the stigma surrounding psychological interventions. For this reason, one participant claimed that she would never ask her manager to see a counsellor. Other participants feared discrimination, being teased and labelled as weak and unable to cope. These are all factors that prevent some EMWs from seeking psychological help.

Ultimately, the participants wanted to be able to place their stressors in perspective. They felt that interventions were necessary, but the implementation thereof would determine the rate at which EMWs would use of them. A 'macho' attitude and toughness still seem prevalent in the EMS. When the discussion investigated the requirements set by the participants should interventions be made available, it became clear that they felt interventions should not be forced on EMWs. They should be confidential to prevent stigmatisation, and the participants voiced a preference for being informed of both the availability of the interventions and the options to choose from. Attendance should not be initiated through management as it might decrease the likelihood of some EMWs making use of it. It was suggested that in some cases it would be appropriate for management to approach a person and recommend interventions. This was suggested because sometimes individuals themselves do not recognise the need for psychological

assistance. Some participants felt that sometimes it was justified to insist that individuals give proof of their attendance of sessions. Another instance when psychological interventions were considered necessary is after big scenes (not all EMWs would agree with this view). In such instances one participant felt that it would be useful to have the whole group talking about the incident, without the main idea that it should be a psychological debriefing. Afterwards an open invitation for assistance could be made to the group. Such an approach could familiarise EMWs with the concept and the advantages of debriefing and other forms of intervention.

Counselling after each scene was not recommended by the participants as not all calls influence individuals to the same extent. They also foresee that too frequent interventions could lead to boredom with the process and decreased effectiveness thereof. In addition, the use of a *blueprint process* should be avoided. As EMWs would be subjected to counselling multiple times, they might get used to the process. Rather, some participants felt that the counsellor should listen to what they have to say, rather than forcing them into a direction. Since EMWs are frequently exposed to critical incidents, the event that initiated the debriefing might not necessarily be what they would like to talk about.

4.3 SUMMARY

This background into the identified categories might facilitate a grasp of the needs that were derived from the analyses. As these categories also formed the basis for the induction of the needs themes, reference will be made to them when the most prominent emerging needs are defined and discussed in the next chapter.

CHAPTER 5

IDENTIFICATION OF THEMES

5.1 INTRODUCTION

The purpose of the study was to investigate what we were missing in understanding why some EMWs seem unable to cope with some aspects of their occupation. The focus finally became to determine the needs of EMWs as suggested by descriptions of their experiences within the EMS. Nine EMWs were interviewed and the interviews were analysed for underlying needs portrayed by the participants. Several needs emerged from the analysis, although only those which came forth most prominently were focussed upon. This was done as substantial evidence existed for the further investigation of these needs. In addition, the spontaneity with which these needs came forth was an indication of the value it carried with the participants at the time.

The needs discussed in this chapter manifested in various arenas related to the lives of the participants. As such, the discussion aims to indicate the far-stretching influences of needs within the totality of the individuals' lives. Although these needs might guide management in their decision-making processes, some needs explain behaviour and frustrations but do not necessarily influence management procedures.

5.2 THE NEEDS[5]

The most prominent needs which came forth, and which are described below, are:

- The need for freedom
- The need for competence

[5] Quotes from the interviews with BAA 1, AEA 1, AEA 2, AEA4, and AEA 6 were translated from Afrikaans (see Appendix B).

- The need for recognition
- The need to be understood
- The need for a challenge

5.2.1 The need for freedom

The need for freedom was a fundamental need that emerged from the analysis. To be free in this regard meant to not be limited unreasonably on either a physical or a psychological level. The need for freedom emerged from various categories, including the categories of job motivation and EMWs' tasks.

The elements of job motivation that related to freedom were the variety of tasks that could be performed, the lack of a routine, the flexibility of the job environment, and the wide range of people with whom the participants worked. Despite issues that had to be dealt with, the participants' job motivation kept them in the EMS – therefore one could say that despite some unsatisfied needs, fulfilment was experienced. In this case the fulfilled need was the need for freedom.

One participant (BAA 3) who had worked in a number of position before entering the EMS said about his previous jobs:

> *It's all like the same routine. I cannot handle that.*

And about the EMS:

> *That's not coming to work and sit at a desk doing the same thing everyday…*

On asking the same participant what (else) he liked about his job, the reply was:

> *…dealing with people, the patients, family…consoling people, listening to them…dealing with the hospital staff...Not just dealing with the patient, but people and other staff in general.*

How the EMWs experienced their tasks indicated the need for freedom. Working shifts was generally experienced as positive, while tasks such as completing PRFs and receiving payment from patients were seen as aspects that limited their time available for patients. Freedom was either provided or restricted, resulting in either a positive or a negative experience, and indicating an underlying need for freedom.

Although the shifts were generally seen as giving freedom to the EMWs, one participant mentioned that she did not like shift work. Her reason was that it placed boundaries on her leisure time and doing what she liked to do. Once again, though, the need for freedom was accentuated and confirmed by this participant.

Indications of participants wanting to have a say in things, to have a voice, was seen as another indication of the need for freedom. The categories of *work conditions* and *management* clearly indicated this need. Complaints about vehicles and uniforms were brought up. For example:

> *It* [an ambulance] *is maybe small or not correctly laid out.*
>
> (AEA 4)

The participants wanted the opportunity to give input into the layout of vehicles and the design of uniforms. One participant implied that they had a top-down managerial structure who did not know what the effects of their decisions were on ground level, and another participant felt that management should listen to the people on the road, as they know what will work and what will not.

When asked what they would change if they were in management, two participants stated the following:

> *If I was in management? I would have listened more to my crews.*
>
> *Much more.*
>
> (AEA 1)

> *I'll take a lot of what the crews say more seriously. I will look into it far more than they actually do. They* [the crews] *are the ones that work on the road. They know the issues they hit, the problems they hit, the altercations they come across, what works, what doesn't work.*
>
> (AEA 5)

When the participants felt they had no voice they became frustrated. Take away a person's voice and you take away his or her freedom.

Since managers have a wide range of duties and make decisions that directly influence the EMWs, the participants had much to say about them. The participants perceived management as a stressor when they felt that management imposed restrictive boundaries and were too prescriptive. The frustrations which came forth in this category were thus related to the limiting effect of the management styles and decisions they experienced. Frustrations based on perceived limitations were indications of the need for freedom. Related to this was the finding that participants disliked interventions being forced upon them, and believed that blueprint procedures should not be followed. This was a view that also suggested the need for freedom. These findings are based on the perceptions of the participants and thus refer to subjective experiences. This implies that management does not necessarily limit them excessively, but that the participants experience it as such due to the nature of their need. It also does not falsify the

experiences of the participants – what they experience is true. Part of the role of managers is to set boundaries, so it is easy for them to violate the need for freedom. The findings indicate two violations of the need for freedom. First, boundaries by implication place limits on freedom, and the frustration the EMWs experience leads to a sense of decreased psychological freedom.

> *We know what we need. We know what we have to do.*
>
> (AEA 1)

The second violation refers to situations when equipment is out of order, when there are stock shortages or when stock is substandard. The frustrations expressed here referred to the limitations they experienced in terms of performing their duties and the scope of treatment they could render.

In the category of *training and development* the need for freedom also emerged. The frustration due to a lack in opportunities for further training and development was the main focus in this category. The further an EMW is qualified the fewer the boundaries imposed on him or her. In this case it is true that knowledge sets you free. The lack in opportunities for training was ascribed to the lack of courses and to financial constraints. Some participants indicated the frustration they experienced due to quotas that were imposed by the colleges.

The category of *stressors* did not contain significant indicators of the need for freedom. It rather acted as an example of how the need for freedom was violated. Stressors gave rise to stress; stress had a limiting effect on the participants, and therefore violated their need for freedom. Coping strategies were used to fight stress caused by these stressors; and in this category the elements of distancing, rationalisation, and gaining knowledge indicated that the need for freedom existed. The participants applied these strategies to get rid of their stress. Stress limited the individual; and coping with and relieving stress allowed them to regain their freedom.

Some participants mentioned using coping strategies that could provide individuals with a false sense of freedom, and therefore compromise their freedom. These included such strategies as drinking and smoking, upon which some people become dependant. A person who is dependent on a specific substance for a sense of freedom is in essence not free.

The coping strategy of distancing was a clear indication of the need for freedom. As stressors bind the individual, distanciation from stressors removed the limitations imposed by them and ensured freedom from the negative effects thereof. It seemed as if EMWs distanced themselves from stressors by either facing or avoiding the stressor. Examples where stressors were faced are captured in the following two quotes, which also indicates the perceived importance of talking to others:

> *…the more you talk about something the more you get it off your chest and then the easier is becomes to handle.*
>
> (AEA 3)

> *I normally talk to my friends. And as I talk about whatever I saw I feel better. Unlike just keeping it to myself.*
>
> (BAA 2)

The following quotes illustrate how participants avoided stressors:

> *… and sometimes you have to fully get away from the work circumstances. Often I take a weekend off and leave my jump bag at home. On purpose…otherwise what are the chances I would drive past an MVA?*
>
> (AEA 1)

> *I really try to keep like work and my private life separate. When I leave I make it a point. On my way home I go under the N1 bridge, and when I go under it's like I'm not going to think about work anymore. I'm leaving it there. And in the mornings when I drive underneath it then I can think about it again.*
>
> (AEA 3)

> *You get the guy at hospital, hand him over…then you walk out and forget about it. It's a conscious decision – forget about it.*
>
> (AEA 6)

Another form of distancing used by the participants, discussed under *Background*, was to distance oneself from other people in general. Not only is this a function of the need for freedom on a physical level, but also on a psychological level. Rationalisation could be seen as a form of distancing: by having done all I could, I can walk away from the incident without being haunted by it, and therefore keep my freedom. Knowledge as a coping strategy also supported the existence of the need for freedom.

> *It helps if you have done victim support courses*.
>
> (AEA 1)

Gaining knowledge on the consequences and management of stress gave the EMWs the ability to know what to expect, and how to deal with it. It helped the participants to remove the limits set by stress and its consequences. Therefore, the desire to know more in order to deal with limitations placed upon the participants indicated the need for freedom.

Described under *background* was the category of *incompetence*.

> *And these people (paediatricians) are supposed to be better than you are…and I have done everything I could, what more can I do?*
>
> (AEA 1)
>
> *Then you think … why am I not a CCA? Then I can do it and finish it. Why should I be dependent upon others? That's very frustrating.*
>
> (AEA 4)

Elements which interfered with proper patient treatment came forth as being frustrating. The perceived incompetence at medical facilities and the resulting frustrations were an indication of the need for freedom. When the EMWs perceived the staff at medical facilities as incompetent it became clear that they felt frustrated with the limitations imposed on them by their scope of practice. In this case the need for freedom grew from the desire to provide optimal care.

An example on the physical level of the need for freedom is found in the quote below, which indicates that the hoards of people surrounding the participant represented a physical boundary and a direct infringement of this participant's freedom:

> *If you do accidents there, the people just come out in hoards…I really feel, like, terrified when I'm like surrounded by people. I don't feel safe.*
>
> (AEA 3)

Although most of the indications of the needs for freedom referred to a psychological level, this does not mean that physical freedom is less important. Within this context, however, it may be that the need for freedom might have been satisfied to a greater degree on the physical level, and therefore it emerged more strongly on a psychological level.

5.2.2 The need for competence

To be competent refers to the ability to perform, and to actually perform, those tasks for which the participants were trained and employed to fulfil. Competence refers to the competence of others, as discussed under *stressors*, as well as to the self-competence. The need for competence surfaced on physical, emotional, and knowledge levels.

The first and most important task of EMWs is patient treatment; and the EMW therefore has to be competent to ensure an optimal outcome for the patient.

> *…what is the outcome? When you leave hospital, what is your condition? Because if I start my treatment correctly, you will walk out. If I do my treatment well and correctly, you will heal quickly and soon walk out of hospital. If I do not do it correctly, you will stay longer in hospital or come out of hospital in a wheelchair. This is how I evaluate myself – what is your condition?*
>
> (AEA 1)

Moreover, to fulfil the purpose of their existence, EMWs not only have to be competent; they *need* to be competent.

Another indication of the need for competence was found in the category of *training and development*. This was in addition to its indication of the need for freedom. One participant felt very strongly about EMWs using their free time to update their skills. He stated that some procedures, such as delivering babies, were taught during formal training. Unfortunately, in the private sector this procedure was seldom performed, and the skill weakened. The desire to practice these skills indicated a need for competence.

In the category of *professionalism,* the importance of behaving in a professional manner was accentuated. One of the cornerstones of professionalism was to be able to perform one's duties effectively; thus indicating the need for competence. This linked with the *stressors* category, in which the need for competence emerged strongly.

Incompetence was strongly associated with being as a stressor, most probably because of the need for competence. Incompetence adds to stress, and may instigate bad relationships between various groups within the EMS.

> *…they are appointed above us, but they are not able to perform the task.*
>
> (AEA 6)

> *I've sent BAAs back to the ambulance to go sit in the ambulance because I knew if they, like, stay any longer with me, that I was going to have to throttle them…*
>
> (AEA 3)

From the requirements some participants set for interventions, their need for competence emerged. In order to cope effectively, they had to place stressors into perspective, and thus required a counsellor who was able to help them with that. This indicated the need for competence in relation to others. Furthermore, if the EMWs felt the counsellor did not understand them or their situation, the counsellor was seen as unable to help them and therefore as incompetent. This is an indication of two things: how one's own needs shape perceptions about others; and how needs interlink with each other. The need to be understood (discussed later) could be violated by counsellors. Because the participants felt the counsellor did not

understand them, they perceived the counsellor as incompetent. The perception grew from the need for competence.

The preceding discussions involved aspects of the need for competence which related either to others, or the self and others. The following aspects of the need for competence involve only the self. As EMWs have an inherent need for competence, the participants themselves wanted to be seen as being competent. In the *intervention* category, it was said that EMWs feared stigmatisation when asking for help. Therefore they avoid asking for help, as stigmatisation is disrespectful and violates the need for recognition. In addition, stigmatisation goes hand-in–hand with seeing the EMW as incompetent in coping with the stressors they are subjected to. Avoiding stigmatisation therefore also served the purpose of satisfying the need for competence.

5.2.3 The need for recognition

Emerging from the analysis of the interviews was a need for recognition. In this case recognition could be described as valuing the existence of the EMW and seeing the EMW as being important. The Need for Recognition came forth in several categories such as *appreciation, respect, ignorance, interventions, support systems, management,* and *remuneration.* The categories which best explains the need for recognition are *appreciation* and *respect*.

Respect

The importance of respect, as communicated by the participants, demonstrated first, followed by an explanation of how this indicates the need for recognition.

Respect from members of the pubic was viewed as important. The participants told how disrespectful acts, such as racist comments, threats, rudeness, and being sworn at, negatively influenced their job motivation.

Respect among colleagues was also valued:

> *I know how I was treated as a BAC and I do my utmost not to do the same to mine…So I treat my BAC with respect because I know what it is like not to be.*
>
> (AEA 5)

Through this action, the participant indirectly but consciously regained the respect she was never granted. It was also important to the participants that colleagues listened to the each others' opinions and valued them, even if their qualifications were not on the same level. Rumours are often spread in the small community of the EMS due to its close-knit structure. The participants viewed this as an invasion of the privacy of individuals and ultimately disrespectful.

Respect from management was valued. The desire to have managers who were concerned about their employees came through prominently. Such a concern from management would indicate respect towards their employees. To be concerned meant that the management had to be in touch with its employees and their well-being:

> *…nobody asked me if I wanted to take any leave or anything like that.*
>
> (AEA 3)

Being in touch with employees included knowing what was going on at ground level, valuing the opinions of the EMWs, listening to the people on ground level, and taking their expert opinions and expertise into account when making management decisions that affect the

functioning of the EMWs. In addition, the EMWs felt that they should be informed about managerial decisions. This would display respect.

The participants believed that psychological interventions were necessary. It was felt that management's acknowledgement of the value of interventions would indicate an awareness of the impact of the EMWs' occupational exposures to critical incidents, and would communicate concern about their employees. Again, in this context concern was considered a sign of respect.

Further indications of the importance of respect came forth in the discussion on interventions. When support was sought, the participants felt that it was vital that confidentiality was maintained, and that the EMW was not teased, discriminated against, or labelled as week and unable to cope. If individuals are stigmatised because they ask for help then they are not respected. To maintain respect therefore, the EMW might decide against seeking help or attending counselling. This is a significant consequence and strong indicator of the importance of respect.

Respect linked with the need for competence. The inherent need for competence meant that the EMWs themselves wanted to be seen as competent. Thus, other people who violate this image of competence act disrespectfully towards the EMW and therefore violate the need for recognition. In this regard, one participant was quite pessimistic about people expecting EMWs to sit in a group and discuss their deepest emotions:

> *…sitting and going 'How are you feeling?', 'What emotions do you feel?' and then go to the next one 'How are you feeling?' and then to the next one. I am not going to tell you how I feel with everybody else working with me… the guys will never speak in a group.*
>
> (AEA 5)

Significant stigma is associated with counselling and psychological services in general. Therefore, their own stigmatising view of seeking help in the form of counselling or psychological services could exacerbate the sense of incompetence when seeking help, and fear of losing respect if stigmatised for seeking help. Unconsciously, many participants seem to both attach stigma and fear being stigmatised themselves.

With the importance of respect explained, the question now is how respect and the need for recognition relate to each other. If someone is respected, his or her being is recognised. Therefore, the extent to which the participants prize respect indicates their need for recognition.

Appreciation

As with respect, the importance of appreciation is first demonstrated, before the link between appreciation and the need for recognition is explained.

The participants sought appreciation from patients:

> *And when you get that sort of one in three hundred that thanks you and they mean it – now that just makes my day.*
>
> (BAA 3)

This quote illustrates that their efforts were worthwhile, and gave them the emotional strength to carry on with their work.

Valued interactions with colleagues also indicated the need for appreciation:

> *…and volunteered with them a couple of times…wasn't fun because they were all…full of nonsense…and then I came down here and they just welcomed me…*
>
> (BAA 3)

Appreciation from management was also felt to be vital. This was seen in actions, such as when managers went to some trouble to get to know them, were interested to know what was going on at the base, and thanked them for working hard and working under extreme conditions such as through heat waves. Appreciation also motivated them to go the extra mile. As another BAA said on her often helping out:

> *…it was not appreciated. So I just left it. I did not do it again.*
>
> (BAA 2)

She felt unappreciated and therefore became demotivated, which influenced her behaviour.

The link between appreciation and the need for recognition is as follows. When the inputs of a person who delivers a service are appreciated, the person is recognised in his or her professional capacity. The references of the participants to appreciation therefore also indicated the need for recognition. With reference to the participant who did not feel appreciated, it is possible that her need for recognition was not satisfied, which demotivated her and influenced her behaviour.

Respect and Appreciation

When people are respected, they are recognised as a human being. When people are appreciated for rendering an important service, they are recognised as being professional.

Diversity

In addition the need for recognition, references to diversity emerged. Recognising the diversity encapsulated within the EMS requires taking note of the variety of reactions to stress, the ways in which EMWs cope, and the types of support that EMWs require. If the need for recognition is

satisfied in this domain, the consequence will be a diverse range of approaches to EMWs who are exposed to critical incidents.

Other

It has been mentioned that the participants not only value but also expect some sort of support and the provision of support from the company's side. Such support allowed the EMWs to feel that management was aware of the effects of exposure to critical incidents, and that they were being taken care of. This demonstrated the need for recognition.

This was especially true during difficult times when trauma hit close at home:

> *You can expect from us to cope with the death of strangers, but when it's like your boss…and your colleagues…just to have that sort of 'Oh, they're dead' sort of attitude is not thoughtful.*
>
> (AEA 3)

The public's ignorance of the functions of EMWs surfaced as a frustration. This ignorance becomes apparent through the public's misuse of the services rendered by the EMS. If people ignore something, it means that they do not recognise its existence, or value it as unimportant. The frustration that surfaced in response to such treatment supported the existence of the need for recognition.

The participants did not often refer to remuneration. If they did, it was in terms of appreciation, which supports the need for recognition. Remuneration is a tangible (physical) form of demonstrating appreciation for effort. One participant mentioned the frustration of not being paid enough, while another said:

> *… for what we do I think I am not getting paid enough.*
>
> (BAA 2)

Apart from occasional references to remuneration as a physical manifestation of the need for recognition, this need seems to occur chiefly on the psychological level.

5.2.4 The need to be understood

> *Other people…they think you are a freak because you are: I did the most amazing accident! It was so good!*
>
> (AEA 3)

The need to be understood was another prominent need which came forth. To be understood means that another person is able to identify with the nature and totality of the EMWs' experiences. Although the terms *understood* and *understand* were often used by the participants, they not only wanted to be understood; they *needed* to be understood. The *support* category supported the existence of need to be understood the most. The consequences of the feeling that someone did not understand decreased the support available to the EMW. Role players portrayed in this need were mainly friends, colleagues, family, and counsellors. The need to be understood is therefore discussed accordingly.

Friends

Some references to friends indicated the need to be understood. This included a reference to a friend who understood and to whom the participant spoke when she felt she could not handle her feelings any longer. When one participant spoke about his friends as part of his support system, he mentioned that they were most often familiar with the journey he had undergone to get where he was. Therefore he felt they could identify with him on a certain level. This was important for him and thus indicated the need to be understood.

Another participant mentioned a number of friends that she felt could identify with her and who played an important role when she needed support:

> *I have a friend who works in the police, friends who work at the fire department and a couple of friends who don't work at the same service as me. And I have a friend who's a nursing sister. So I've got lots of people that, like, if something bothers me I can go to talk about it.*
>
> (AEA 3)

The above illustrated the various roles friends could play in the need to be understood. The first participant did not mind if his friends could not identify with the content of his experiences, as long as they could identify with him as person, and with his journey. The second participant referred to other emergency workers as her supporting friends. This implies that she wanted friends in her support system to be able to identify with the *content* of her experiences. These friends seemed to fulfil a *counsellor role* for this participant, as most participants wanted counsellors to be able to identify with *content* of their experiences.

Colleagues

> *Because your colleagues…they understand…they are in the same circumstances. They understand your frustration or what the circumstances are.*
>
> (AEA 1)

This participant explained why he preferred his colleagues to function as part of his support system, and a pertinent reason was that they understood. They knew what his circumstances were

and could identify with the content of his experiences because they shared this with him. Furthermore, they spent much time together during their working hours and got to know the details of each other's personal lives. This intensified the support role they played for each other. This was of great value to him when it came to support and indicated a need to be understood.

Family

To spent quality time with family was of great value, but when it came to support most of the participants preferred someone who understood the nature of their work. The participants in marital relationships had various opinions about the support they received. The theme of the need to be understood is communicated clearly in the following quotes:

> *I won't really talk to my husband about it because…he can't understand.*
>
> (AEA 3)
>
> *That the family can develop empathy and sympathy…that they can understand what it is about.*
>
> (BAA 1)
>
> *I've spoken a lot with my wife about it. She understands. I use her a lot as a sounding board.*
>
> (AEA 6)

The need to be understood could have detrimental effects. When some participants feel that their colleagues are the only people who understood them, they tend to *seek refuge* at their base among colleagues who *understand*. In other words, the same environment that contains the

stressors also provides sources that help with stress relief. The downside, though, is the lack of a clean break from work-related stressors, and a resulting cumulative effect on stress levels.

Some participants believed that if other people had not experienced what they had, they could not understand them. This point is debatable; however, the relevance of this lies in the fact that this reflects a belief that may be difficult to shift.

Counsellors

Previously it was said that friends sometimes fulfilled the role of counsellors, as some EMWs wanted their friends to be able to identify with the content of their experiences – a characteristic most of the participants require from a counsellor.

> *…an outsider will have no idea on exactly what you are talking about…very difficult to explain gruesome calls and that if they themselves have never seen it. Then I'd probably get more out of the brick wall.*
>
> (AEA 5)

> *What is the use of speaking to somebody who does not understand what you are talking about? You must first explain…So I think it will cut more time on it.*
>
> (BAA 2)

With counsellors, time constraints do not allow for getting to know the EMWs in depth, as friends can do in time. Because some EMWs feel that counsellors can not identify with them, this might be the reason why counsellors are expected to identify with the content of the EMWs' experiences. To identify with the content of experiences is to know what the EMWs are talking

about and to have a basic background of the occupation – the stress, the terminology, the scenes and sights they encounter.

Most participants saw the role of counsellors as giving advice, which from their point of view cannot be done if the counsellor cannot identify with the EMS environment. It might be that misconceptions about how counselling proceeds could prevent EMWs from accepting the help of counsellors. Alternatively, these comments could be an indication of the strength of the need to be understood.

Other indications of the need to be understood

Some methods of coping related to the need to be understood. Distancing, and more specifically creating distance from people who do not understand, was an indication of this need. In addition, gaining knowledge could be a consequence of the need to be understood. As the participants had the need to be understood they could also need to be understood by themselves, which represents *coping through knowledge*.

5.2.5 The need for a challenge

> *… and there are some accidents that are more exciting than others and unfortunately the ones that are more exciting are the ones where the people got more seriously hurt…the reason why you said it was a good scene is because it challenged you.*
>
> (AEA 3)

This is an example where a need was directly expressed. The nature of the job is challenging, which implies that people who choose (and remain in) this career have a need for a challenge. The participants explained it as follows:

> *This work is not easy…it is a hard, physical work, because when you work, you work.*
>
> (AEA 4)

> *I lost one, two, three patients in that week…Now you have to work with the family and explain to them how it worked…it takes a lot from you…it takes a lot from you.*
>
> (AEA 6)

The most important challenge was to render treatment that would ensure an optimal outcome for each patient.

> *My aim is to improve your condition, or to keep it the same.*
>
> (AEA 1)

In the category of *job motivation* a participant mentioned that he liked the job because of the occasional challenge that came along when dealing with other people. Some participants referred to the lack in routine and the diversity within the work, which also indicated the need for a challenge. On being asked which scenes she did not like, a participant mentioned MVAs. Her reason was that it did not require much from her on a cognitive level. She rather preferred medical emergencies where she had to work with symptoms and had to think to reach a diagnosis. In other words, she had a need for a challenge that was communicated through her reason for preferring medical emergencies, and which was satisfied through attending to these emergencies.

One participant mentioned that now that she had seen a lot and knew what to expect, she was not that excited about the job anymore. For her, the challenge may have been to learn new things and to be confronted with new situations. Thus, it may be the growth curves that she found challenging. During the growth curve her need for a challenge was satisfied, but now that she finds herself on a plateau the satisfaction has ceased.

The attempt to satisfy this particular need could easily become frustrating, and may lead to stress when the challenge is not handled satisfactorily. Alternatively, a challenge that appears as a potential satisfier of the need may lead to dissatisfaction, frustration, and stress. In short: some challenging situations may cause frustration and stress rather than satisfying the need for a challenge. An example of this comes from the category *explaining the tasks of EMWs*. Balancing paperwork with patient treatment may look like a challenge that could satisfy the need for a challenge, but actually only causes frustration.

Dealing with management could pose a challenge without satisfying the need for a challenge. According to some participants, facing a challenge that relates to intra-company communication builds up frustration from the start. One participant states this as follows:

> *Communication is probably the biggest problem in this company.*
>
> (AEA 5)

This participant sees communication in the company as a problem rather than a challenge. Should this problem be solved, other challenges could be faced that may better satisfy the need for a challenge:

> *Problems will get sorted out better…what doesn't work will get sorted out quicker. Unhappiness will get sorted out quicker…if the*

> *communication chain actually worked. Your channel of command will probably work better…if communication worked better.*
>
> (AEA 5)

Other challenges referred to included the vehicles that were not properly designed, which made the treatment of patients a challenge; as well as the impractical uniforms, designed without consultation. The challenge of correctly designing the vehicles and uniforms may hold the potential to satisfy the need for a challenge by involving the EMWs in the design process. This may turn a currently frustrating experience into a more positive one.

> *Do they actually ask us, who work with the (vehicles) from morning to evening: 'Won't it be more practical to equip the vehicles like <u>that</u>, or to turn it like <u>that</u>?' What will be more comfortable for us over the longer run?*
>
> (BAA 1)

The sentiment expressed in the above quote is also applicable to other aspects of the management function. Involving the EMWs in the management process and presenting them with a healthy challenge may provide them with additional opportunities for growth.

Some situations are experienced as challenging without satisfying the need for a challenge or frustrating the EMW:

> *(Blood) is not something I look forward to seeing everyday. If I have to see it I have to see it. If I have to treat a person I have to treat a person. But if I have the chance not to see it, it's better.*
>
> (AEA 2)

This section shows that although various challenges are posed to EMWs, not all satisfy the need for a challenge.

5.3 SUMMARY

In this chapter the categories identified in chapter 4 were used to identify the needs suggested by descriptions of the EMWs' experiences within the EMS. In this chapter those needs were presented and defined, and the process of deriving the needs was indicated. In some cases, examples of how the needs were satisfied or violated were given. Chapter 6 discusses these needs in relation to the theory, after which recommendations to management as well as suggestions for future research are made.

CHAPTER 6

DISCUSSION

6.1 INTRODUCTION

During the analysis of the interviews it became clear that some needs were more important than others at that time. These needs were the Need for Freedom, the Need for Competence, the Need for Recognition, the Need to be Understood, and the Need for a Challenge (referred to here as the Needs)[6]. The identification of these needs constituted the purpose of the study, which was to determine the needs of Emergency Medical workers (EMWs) as suggested by descriptions of their experiences within the Emergency Medical Services (EMS). The findings are useful as they contribute to our understanding of EMWs and their needs, and open up possibilities for future research. They may be of further use should management structures within the EMS purposefully draw on these findings to inform day-to-day functioning and formal management processes.

6.2 DISCUSSION

Before the findings are used as a basis for making recommendations, it is necessary to revisit the discussion on needs and to see how constructs equivalent to the Needs identified here are described elsewhere in the literature. In so doing, I attempt to link the Needs with established theory to facilitate the process of integrating the findings into the management process.

[6] When reference is made to one of the needs identified in this study, uppercase letters are used, e.g., the Need for Recognition. Needs to which other authors refer are cited in lowercase.

6.2.1 Revisiting needs

In the introduction (chapter 1) and literature review (chapter 2), *needs* were highlighted as the missing link in the approach to EMWs. Little recent literature was readily available on *needs* in general, and more specifically on needs experienced by EMWs. This seems to be due to the shift in focus during the 1960s from needs theories to motivation theories.

Based on the available literature, several assumptions about *needs* were made. Needs are important for a happy, healthy life; and are inherent to aspects such as motivation, self-fulfilment, and human development. Needs hierarchies do exist but are not fixed. The top of the pyramid consists of the more important needs that are fewer in number, while the bottom of the pyramid consists of the less important needs that are greater in number. In the case of the participants in this research, the top needs should be attended to first, as the bottom needs do not require immediate attention. (The needs identified in the current study would have formed the higher structures of the hierarchy). Needs are dynamic and therefore the organisation of the hierarchy will change over time. The dynamic nature is related to people's attempts to rid themselves of negative emotions; and they therefore develop a need for the conditions that will alter them. Any situation instilling negative emotions in an individual creates an opportunity for another need to surface. The individual's needs hierarchy might differ from that of the group, but identifying the most important needs occurring within a group and making provision for satisfying these needs should ensure satisfaction of the majority's top-line needs. A specific need may be satisfied by more than one satisfier.

6.2.2 Needs as they manifest in the literature

Authors important to mention in this section are Herzberg (Herzberg et al., 1959), and Deci and Ryan (2000). The factors in Herzberg's motivation-hygiene theory (described in chapter 2) seem a logical choice for comparison with the Needs identified in this study. However, it appears that the dynamic with which Herzberg approached these factors was too far separated from the approach to the current study to allow for a comparison that would do justice to the findings of either of these two studies. For example, the motivator factors refer to *'man's relationship to what he does'* while the hygiene factors refer to man's *'relationship to the context or environment in which he does his job'* (Herzberg, 1968, p. 74). The Need for Freedom may relate to both the motivator factor of *work itself* and the hygiene factor of *company policy and administration*. It contains elements of both people's relationship to what they do and to the context in which they do their job. The same applies to the Need for Recognition as it relates to both the motivator factors of *recognition* and *promotion* and the hygiene factors of *pay benefits* and *status*. Further analysis would be needed in order to draw a reliable distinction between the present study and the motivation-hygiene theory.

On the other hand, the self-determination theory's (Deci & Ryan, 2000) innate psychological needs – competence, autonomy, and relatedness – could be linked to the Needs in totality, and provide a useful foundation for categorising the Needs. Examples of attempts to categorise needs are found in the literature. Rader (1990) refers to *social needs*, which represent a category, while Bay (1990, p. 238) refers to needs categories which he describes as the *most basic categories of human needs.* Galtung's categories (1980, 1990) are labelled slightly differently, but they seem essentially the same as Bay's categories (see table 1).

Table 1: A comparison between the needs categories of Bay and Galtung

	Bay (1990)	**Galtung (1980, 1990)**
1	Survival needs	Security needs
2	Safety or health needs	Welfare needs
3	Dignity of social identity	Identity needs
4	Liberty or freedom needs	Freedom needs

Although there is an overlap between the first two needs presented by these authors (survival and safety or health needs, and security and welfare needs), the core of physical care is the same. In each case, the third need (identity) and the fourth need (freedom) match each other. A categorisation such as the above seems a useful route to follow as a simplification should ease the process of integrating the findings with management practices.

Except for providing evidence for the categorisation of needs, the above categories, as well as research by other authors, include needs that corresponded with the Needs identified in this study. Even though the Needs reflect those experienced by the participants, these may carry more weight if linked with the work of other authors, indicating a sound foundation for their existence over the years. This is especially important should management practices choose to be informed by these findings. Under the next few headings links are drawn between the Needs identified in this study and needs discussed in the literature, after which these are brought in line with the self-determination theory.

The need for freedom

In the current study the need to be *free* was expressed as not wanting to be unreasonably limited on any level. This implies that boundaries must be balanced with freedom in such a way as to provide space for the fulfilment of the Need for Freedom.

One of the social needs Rader (1990) refers to is a need for freedom. The needs category of freedom that Bay (1990) and Galtung (1980, 1990) refer to is divided by Galtung into more specific needs. Those related to the current study are the *'choice in receiving and expressing information and opinion'*, and the *'choice of way of life'* (Galtung, 1990, p. 309). This breakdown indicates needs for choices that give freedom. Scimecca (1990) also refers to a need for freedom. According to him, other theorists define freedom as a satisfier of needs; he sees freedom as a basic human need. He subdivides the need for freedom into various categories that could be either positive or negative. Positive freedoms imply freedom from restraint and freedom to develop, while negative freedom is experienced as a burden. He concludes that the individual could be free without being liberated from all restraints. He further claims that the need for freedom is the proviso for self-reflexivity to develop in full. The explanation of the Need for Freedom may be further enriched by adding that within a social context and within boundaries, the individual should be able to make choices that will lead to positive experiences of freedom.

The need for autonomy in the self-determination theory (Deci & Ryan, 2000) requires the sort of freedom that enables the individual to perform activities leading to an internal perceived locus of control. If individuals engage in activities that they find interesting, and if they have a sense that these activities are self-determined, intrinsic motivation should be the result. The need for autonomy thus entails the provision of space to perform activities by own choice and to have some form of control over them. Deci and Ryan (2000) explain this concept in the context of motivating employees. They propose that if an individual is rewarded for self-determined activities, their intrinsic motivation may be lost as the perceived locus of control shifts to the extrinsic side of the motivational continuum. The need for autonomy is violated by an act which implies an external perceived locus of control.

Thus the Need for Freedom relates to the need for Autonomy. If freedom did not exist the individual could not engage in self-determined activities, intrinsic motivation would not be reached, and psychological health and well-being would be negatively influenced.

The need for competence

To be competent emerged as the need to be able to perform, and to actually perform, those tasks that an individual is trained for and employed to fulfil. In the current study, this need mostly reflected behaviour that is expected from others. The effort EMWs invest in treating their patients decreases in value when the other role players are not competent. Although the participants want to be competent it seems that they need others to be competent in order for they themselves to experience some degree of job satisfaction. It is a situation where the total is greater than the sum of the parts. If one part is defective, the contribution of all the others diminishes in value.

The competence of EMWs as a need not only for the self but also for others could also be a projection of the competence EMWs need for themselves. By questioning the competence of others, their own incompetence may be hidden, or the perception of their competence could be strengthened. A projection that creates an image of competence equal to perceived competence could occur when positive feedback is lacking.

Eccles and Wigfield (2002) refer to White's assumption that the need for competence is a need basic to all humans. Hall and Lawler (1970) refer to Lawler's work in which he links motivation and the satisfaction of this need for competence. The anticipation of satisfying the need for competence due to the job satisfaction stemming from it will motivate the employee.

The need for competence is explained by the self-determination theory (Deci & Ryan, 2000) as a need for events that reflect the effectivity of the individual. The indication for this effectivity is positive feedback; and the competence only needs to be perceived. These authors further propose that competence, in addition to autonomy, contributes to intrinsic motivation. The contribution of competence to intrinsic motivation is that it prepares the platform for any type of motivation. When autonomy is added, the motivation becomes intrinsic.

It now becomes possible to streamline the Need for Competence identified in this study with the need for competence postulated by the self-determination theory, provided that a shift in focus occurs. The Need for Competence as defined above refers to competence in the actual performance of duties, while the self-determination theory's need for competence refers to a perceived effectivity when attending to events. The need for competence that contributes to intrinsic motivation should refer to both real and actual effectivity. The gap is bridged with, significantly, the Need for Competence being equal to the *category* of the need for competence.

The need for recognition

From the present study, recognition could be described as valuing the existence of the individual and portraying the individual as being important. The participants mainly communicated this Need for Recognition through their emphasis on respect and appreciation. A need for recognition is another social need specified by Rader (1990). Other references to a need for recognition include Brentano's *Versuch einer Theorie der Bedürfnisse* dating back to 1908 (Glaeser, 1980), and Dudycha's (1963) need for personal recognition, a need which grows from experiences within families and communities. Mitchell (1990) refers to the work of De Reuck in which he lists, amongst other needs, the need for recognition and respect. In his category of identity

needs, Galtung (1990) lists a need for *'a sense of purpose, of meaning with life'* (p. 309). One can argue that this is a form of the Need for Recognition, as valuing an individual's existence and portraying him or her as important gives that individual a sense of purpose and confirms the meaning of his or her life. Davies (1988) includes the need for recognition under self-esteem or dignity needs, which has to be negotiated with other human beings. This recognition reflects that a person merits respect and dignification. Recognition is sought when individuals doubt the significance of what they are doing. In an earlier work, Sites (cited in Coate & Rosati, 1988) mentions recognition as one of eight human needs, and as part of the group of needs that could not be satisfied immediately and consistently. In 1990 he omitted this and included instead a need for self-esteem[7] – the need he described as the most evasive human need, and one which results in depression if not gratified. Individuals evaluate and then either approve or disapprove of each other – an action that influences the self-esteem of the individual.

Burton (1988) borrows the need for recognition from Sites and describes it in his work on conflict resolution. In this context recognition means to confirm that the individual's reaction to stimulation is relevant and approved of. Both Sites' (1990) description of the need for self-esteem and Burton's (1988) definition of the need for recognition involve approval of individuals or their actions. Therefore it is taken that both these authors describe needs that are synonymous with the Need for Recognition. The EMW's behaviour (reaction to stimulation) is appreciated (approved of) and therefore her or his existence at that moment is valued. The EMW's Need for Recognition is therefore satisfied.

To enrich the description of the Need for Recognition, it is said that it is satisfied within a social context as the value and importance of an individual is transacted with other human

[7] As the need for self-esteem is basically the same as the need for recognition, it could be that his work evolved to the degree that it necessitated a change in the label of the need involved.

beings. Satisfaction and dissatisfaction of this need occurs through approval and disapproval (or no-approval), and satisfaction can therefore not be continuous. Satisfaction of this need should give the individual a sense of purpose and meaning.

When the self-determination theory and the present study are brought together, the Need for Recognition reflects the positive feedback proposed by the self-determination theory as important for the need for competence and indicating effectivity (Deci & Ryan, 2000). Thus, positive feedback is a form of recognition which may either instil a sense of competence or reflect true competence. No matter which one it is, EMWs should perceive themselves as competent. In their discussion of the need for competence therefore, although Deci and Ryan (2000) refer to positive feedback as an event indicating effectivity, the current study proposes that the Need for Recognition should be a building block of the *category* of the Need for Competence.

The need for a challenge

From the analysis of the interviews, it seems clear that many situations pose challenges to the participants. The Need for a Challenge requires challenges that lead to some form of progress. When EMW face a challenge, they have the opportunity to apply skills such as problem solving, conflict management and decision making, and have the opportunity for growth and accomplishment. Although not explicitly stated, the Need for a Challenge could form part of Davies's (1988) self-actualisation needs. These needs are fulfilled when individuals became absorbed and proficient in what they do. Burton (1988) refers to a need for stimulation – a label borrowed from Sites – and states that to be able to learn the individual must be stimulated. Challenges could provide the stimulation necessary for learning. The individual will learn

something by confronting a challenge, and therefore growth will have taken place. Nudler (1990) also writes about a need for growth, which seems closely related to the Need for a Challenge. Satisfaction of this need should enable individuals to unfold their potentialities.

In the description of the Need for a Challenge, it was noted that it is easy to violate this need. This might be explained by the need for latency, a need taken from the work of Ader and described by Sites (1990). Over a long period, stress might harm the individual both physically and psychologically, and therefore latency is needed. Although the Need for a Challenge is important, challenges increase stress; and prolonged stress might harm the EMW. Stress may be prolonged through several unsuccessful attempts to address a challenge. During such times, the need for latency might enjoy importance above the Need for a Challenge.

In enriching the description of this need, one could add that the Need for a Challenge makes the EMW aware of opportunities to grow. These opportunities should thus stimulate the EMWs and unfold their potentialities. In terms of the self-determination theory's need for competence (Deci & Ryan, 2000), an event has to occur through which effectivity may be reflected. A challenge provides this required event. Therefore the Need for a Challenge relates to the event required to be able to reflect effectivity; and the Need for Recognition relates to the positive feedback which is required. Thus, the Need for a Challenge, together with the Need for Recognition, could form part of the *category* of the Need for Competence.

The need to be understood

To be understood, as it is derived from the present study, means that other people can identify with the nature and totality of the EMWs' experiences. Mallmann (1980) states that as humans are *members* of the human species, they have a need for understanding. In a social context, this

need refers to understanding other human beings. The present study inverted this, and the need does not mainly require the self to understand, but the self to be understood by others.

The need for social bonding (Clark, 1990) also referred to as the need for social intercourse, is described as an absolute need of humans. Although not synonymous with the Need to be Understood, a strong link exists between these two needs. If the Need to be Understood is not satisfied within a certain community or context, individuals may withdraw themselves from the situation. Social bonding is then hampered and the need for social bonding violated. The importance of social bonding lies in the companionship and the purpose it provides to life.

In a similar fashion, the Need to be Understood is connected to the self-determination theory's need for relatedness (Deci & Ryan, 2000), which has a maintenance role, but is not essential for the occurrence of intrinsic motivation. This need for relatedness involves a need to connect with people in a way that fosters a sense of security. Understanding is important for relatedness to occur. If a person is not understood by another, the ability to reciprocally relate to each other is hampered, and the need for relatedness cannot be satisfied. If the need for relatedness is seen as a category, the Need for be Understood will form part of the needs that comprise this category.

6.2.3 The self-determination theory (SDT)

The above discussion constitutes an effort to provide the reader with a broadened understanding of the Needs and how they have manifested in the literature over the years. Earlier in the chapter it was said that the innate psychological needs of the self-determination theory provide a useful

foundation for categorising the Needs. The previous section categorised and explained the Needs, and this is visually presented in table 2.

Table 2: The categorisation of the Needs under the innate psychological needs of the SDT

Needs categories	Constituent needs*
Need for Autonomy	Need for Freedom
Need for Competence	*Need for Competence:* Need for Recognition Need for a Challenge
Need for Relatedness	Need to be Understood

* Only those forming part of the Needs in the current study

What makes this fit unique is that Deci and Ryan (2000) accentuate the importance of needs and the satisfaction thereof when dealing with employees. In other words, they hold the same point of view on needs as was reasoned in chapters 1 and 2. Even though they mainly focus on the influence of needs on motivation, they do state that needs are also important aspects for psychological growth, integrity, and well-being. Fulfilment of these needs should thus enhance these aspects and contribute to the mental health and self-motivation of employees. In the opposite scenario, the consequences may be pathology and ill-being (Ryan & Deci, 2000). The categorisation simplifies the findings, which may also simplify the implementation thereof in managerial practices as it may be easier to remember and recall a simplified categorisation when dealing with employees on a day-to-day basis.

However, it should be noted that when individuals perform actions in which they are interested, intrinsic motivation is usually at work; while extrinsic motivation applies when individuals perform actions that are expected (Deci & Ryan, 2000). Employees' intrinsic motivation alone may not help a company to achieve its goals. Extrinsic motivation is also

needed. Managers may therefore prefer employees to internalise extrinsic motivation so that their performance related to management expectations is self-determined. In order to achieve this internalisation the three needs of autonomy, competence and relatedness should be satisfied when conforming to these expectations (Deci & Ryan, 2000). Therefore, satisfying these needs should not only enhance intrinsic motivation and mental health, it should also lead to the internalisation of extrinsic motivation, leading to improved work performances. As such the actions performed would be self-determined and should include both those actions that the EMWs find interesting and those that management expects them to perform.

In the following section recommendations based on the findings are presented. In this section it should be noted that the needs categories may most probably consist of more than only the needs that were sorted under them in the current study. This is especially relevant when focussing on needs categories, as the specific needs experienced by the EMWs might not be fulfilled if actions address the less prominent needs within a category. The nature of the other needs could be speculated about based on literature reviews, and could be determined by further investigation. That being said, for the current purposes, the most prominent constituent needs in each category are those that should be addressed and satisfied.

6.3 PRACTICAL APPLICATION (RECOMMENDATIONS)

If EMS companies wish their employees to engage in self-determined behaviour, it is recommended that they create an environment that makes provision for the fulfilment of their needs. With the right focus on the needs categories of autonomy, competence, and relatedness, the satisfaction of these needs could be accomplished, and the well-being and motivation of the EMWs enhanced.

In order to create this environment, it is recommended that management use these findings to inform their management practices and ultimately their approach to the EMWs. Therefore, the satisfaction of these needs must be expressed in practical terms and solutions that could be successfully implemented within the company. One solution is for management to adopt a leadership style in line with the principles of the self-determination theory.

In 1970 Vroom and Deci mentioned participative management and linked it with self-regulation, which today forms the basis of the self-determination theory described by Deci and Ryan (2000).

In 1985 Deci and Ryan related participative management with the self-determination theory when they stated that this approach to management involves all aspects important for the maintenance of intrinsic motivation (Deci & Ryan, 1985). Based on Deci and Ryan's (2000) work on the self-determination theory, these aspects are concluded to be the needs for autonomy, competence, and relatedness. In 2005, Gagné and Deci mentioned that the satisfaction of psychological needs is accomplished through participative approaches within the work environment (Gagné & Deci, 2005). A climate of self-determination fosters a sense of ownership of the organisation, which in turn improves organisational performance. Participative management contributes to such a climate (Wagner, Parker, & Christiansen, 2003). It is thus recommended that the company adapt participative processes into its management style.

Participative management is explained by Hofstede (2001) as a decision-making process that involves the participation of employees not part of the management structure. The decision on which consensus is reached should be implemented. If no consensus is reached, the manager makes the final decision. Vroom and Deci (1970) state that participative management means to integrate the planning and the doing, to reduce the use of authority and the deployment of work

groups as problem-solving and decision-making entities. Participative management is a broad approach that may be implemented to various degrees and on various levels. For instance, Hofstede's (2001) explanation involves a scenario where employees are directly involved in the decision-making process. Employees may participate in generating proposals to be discussed and taken into account during management's decision-making processes. In this case they would fulfil an advisory role. During participative management, subordinates may be consulted on either a one-on-one basis or in groups, or individuals could be assigned a challenge to resolve (Howell & Costley, 2001).

This management approach makes provision for the self-determination of behaviour, and it may satisfy the needs at the core of the self-determination theory. For example, it may satisfy the need for autonomy by creating a space for EMWs to provide input. It may satisfy the need for competence by providing events or challenges through which the EMWs could receive recognition for their efforts. It t may also satisfy the need for relatedness by involving the EMWs and opening up opportunities for them to be better understood by their colleagues and managers.

The fashion in which participative management is implemented should be negotiated within the company, as the company size, culture, climate, and so on may influence the effectiveness of the approach. Vroom and Deci (1970) refer to these as organisational conditions that influence the applicability of this management style.

It is therefore recommended that the company adhere to several aspects when negotiating the implementation of participative management. First, the company should become familiar with the findings of the current study, and further investigate the topic of participative management. This will form the basis for successful implementation of participative

management. During these steps, and those to follow, the employees could already be involved in the decision-making process.

Although the recommendations of the current study are primarily directed towards management, the EMWs also have responsibilities. They cannot be passive receivers of satisfiers. They have to be actively part of the process and take responsibility for their own well-being. The other steps in the negotiation process could therefore include brainstorming, planning, and training sessions, which should be steered by the Human Resources Manager, either alone or in conjunction with a subject specialist. When an action plan has been decided upon, implementation can start.

6.4 A REFLECTION ON MY JOURNEY

In chapter 1 under *'My journey'* I described how I became involved in the EMS as well as the events that led me to ask what the missing element in the picture was. You have joined me on my journey of discovering that element, identified as the various needs and that, within the EMS, participative management is a vehicle through which they may possibly be satisfied.

My own growth entailed the understanding and insight I developed concerning the needs of EMWs. Especially in thinking back to the findings of the pilot study and how strongly its findings overlap with those of the current study, I realise that these needs are universal among human beings. I also know that they manifest uniquely within the EMS and that the environment in which EMWs function shapes this manifestation. Thus, in each environment these needs lead to unique challenges.

I have not created a systematic solution, but rather a foundation for understanding EMWs and the creation of effective approaches towards challenges. In future, when dealing with both

EMS managers and EMWs, I can draw on this knowledge I have equipped myself with during my journey. It will now be easier to provide both parties with tools for dealing with their challenges. If they understand the foundation of these challenges, they can by themselves actively generate appropriate solutions for them.

I feel that I have made an important contribution to both psychology and the EMS. However, I have much to learn and much to contribute and thus my journey continues…

You can never change things by fighting the existing reality.

You must create something which makes the old model obsolete.

(Fuller cited in Mayne, 2006, p. 160)

6.5 SUMMARY

At the start of this investigation a question was asked: what are the needs of EMWs? Through the investigation the question was answered, and the need for freedom, the need for competence, the need for recognition, the need to be understood, and the need for a challenge were identified. These needs were linked with the self-determination theory and organised under the needs categories of autonomy, competence, and relatedness. In addition, recommendations were made to the EMS management that directed them towards a process of adopting a participative management style.

The study has its limitations. Those imposed by the methodology are discussed in chapter 3. Maybe the biggest practical limitation is the homogeneous group of EMWs who participated in the study. For future replication of this investigation, it would be wise to involve researchers from various languages and racial groups in an attempt to recruit a more diverse range of participants.

Many possibilities exist for research based on the study, and a broad overview as well as a number of suggestions follows in order to stimulate your thoughts.

The literature on the EMS reviewed in chapter 2 revolves around stress, stressors, reactions to stress, coping strategies, and support. As the current study made the assumption that *needs* was the missing link in the approach of managers and counsellors to EMWs, it is suggested that researchers revisit these aspects and study their relation to the needs, the satisfaction thereof, and the implementation of participative management within the EMS.

In more definite terms this could be achieved by linking specific needs with specific symptoms, and by studying the influence of need satisfaction, or need dissatisfaction, on the presentation of symptoms. Even the prevention of the development of severe symptoms could be investigated in relation to coping strategies informed by the needs and the self-determination theory. The efficiency of participative management within the EMS could be investigated, as well as various approaches to the implementation of participative management within the EMS.

User-focussed studies should be employed, and the research focusing on the EMS should investigate challenges EMWs face, with a view to working towards solutions that accentuate the positive amidst these challenges.

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APPENDIX A: TRANSLATIONS FROM CHAPTER 4

BAA 1

p. 74

In general people do not often talk about scenes, except for now and again when something interesting happened.

Afrikaans:

Oor die algemeen praat mense nie regtig oor tonele nie, behalwe as daar nou so nou en dan iets interessants gebeur het, wat snaaks is.

AEA 1

p. 71

Hospital A told Hospital B that the patient was P3 (instead of P1)*…when we arrived there* (at Hospital B), *they did not have ICU beds available*.

Afrikaans:

…maar Hospitaal A het vir Hospitaal B gesê dis ‘n P3 pasiënt…Toe ons daar uitkom het Hospitaal B nie ICU beddens nie.

AEA 2

p. 62

I definitely do not like the blood.

Afrikaans:

Ek hou definitief nie van die bloed nie.

p. 71

…*I become emotional.*

Afrikaans:

…dan raak ek emosioneel.

p. 74

… I think counselling is necessary, because … the methods other people use (to cope with), even myself, are not always the best methods.

Afrikaans:

… ek dink *counselling* is nodig want … die metodes wat ander mense gebruik, selfs ek, is nie altyd die beste metodes nie. As mens weet van alternatiewe metodes – dit sal beter wees.

AEA 4

p. 61

It is a hard, physical work, because when you work, you work.

Afrikaans:

Maar dis 'n harde, fisiese werk, want as jy werk, werk jy.

p. 69

You see horrible things and experience dreadful things … it comes back. You think you have put it behind you and got over it, but it comes back some time or the other.

Afrikaans:

Jy sien lelike dinge en jy ervaar lelike goeters… dit kom terug. Jy dink jy het dit weggebêre en daaroor gekom maar dit kom terug een of ander tyd.

p. 73

You must have someone you can talk to.

Afrikaans:

Jy moet iemand hê met wie jy kan praat.

AEA 6

p. 62

In the evening when my head touches the pillow…my last thought is: 'I meant something good to somebody today'.

Afrikaans:

…as ek die aand my kop op die kussing neersit…die laaste gedagte wat ek dink is: 'Ek het vir iemand iets goeds beteken vandag'.

p. 65

That person pays for that quarter of an hour and I owe him my full attention during that time … Whether he pays or does not pay, that is what I owe him.

Afrikaans:

Daai persoon betaal vir daai kwartier so ek is verskuldig daai tyd om my volle aandag aan hom te gee… Of hy betaal of nie betaal nie – dis wat ek hom verskuldig is.

p. 67

… *there's a gap between the guys on the ground and management.*

Afrikaans:

…daar is 'n gat tussen die ouens op die grond en dan die bestuur.

p. 70

You know what? Yes, the stress caught up with me.

Afrikaans:

Weet jy, ja, die stres vang my.

APPENDIX B: TRANSLATIONS FROM CHAPTER 5

BAA 1

p. 95

That the family can develop empathy and sympathy … that they can understand what it is about.

Afrikaans:

Dat die familie kan impatie en simpatie ontwikkel ten opsigte, as jy by die huis kom en jy is bedonderd - skuus vir die vloekwoorde - dat hulle kan verSTAAN waaroor dit gaan.

p. 100

Do they actually ask us, who work with the (vehicles) from morning to evening: 'Won't it be more practical to equip the vehicles like <u>that</u>, or to turn it like <u>that</u>?' What will be more comfortable for us over the longer run?

Afrikaans:

…maar word daar regtig vir ons gevra wat met die goed werk van die more tot die aand: 'Sal dit nie meer prakties wees om die voertuie miskein *so* uit te rus, of *so* te draai nie?'. Wat vir *ons* meer gemakllik gaan wees oor die lang duur?

AEA 1

p. 80

If I was in management? I would have listened more to my crews. Much more.

Afrikaans:

As ek in *management* was? Ek sou meer vir my *crews* luister. Baie meer.

p. 82

… and sometimes you have to fully get away from the work circumstances. Often I take a weekend off and leave my jump bag at home. On purpose … otherwise what are the chances I would drive past an MVA?

Afrikaans:

…en partykeer moet jy heeltemal wegkom van die hele werksomstandighede. Ek vat gereeld, vat ek ‘n naweek af en ek los my *jump* sak alles by die huis. Aspris. Sodat ek ‘n ongeluk kom, kan in ene geval niks doen nie…anderster wat is die kans dat jy gaan verby ‘n *MVA* ry as jy iewerster is?

p. 83

It helps if you have done victim support courses.

Afrikaans:

Dit help ook as jy nou al *victim support* kursusse gedoen het.

p. 81

We know what we need. We know what we have to do.

Afrikaans:

Ons weet wat ons nodig het. Ons weet wat ons moet doen.

p. 84

And these people (paediatricians) are supposed to be better than you are…and I have done everything I could, what more can I do?

Afrikaans:

En hierdie is veronderstel om mense wat beter as jy behoort te wees … en ek het alles gedoen wat ek kan, wat kan ek meer doen?

p. 85

…what is the outcome? When you leave hospital, what is your condition? Because if I start my treatment correctly, you will walk out. If I do my treatment well and correctly, you will heal quickly and soon walk out of hospital. If I do not do it correctly, you will stay longer in hospital or come out of hospital in a wheelchair. This is how I evaluate myself – what is your condition?

Afrikaans:

As ek reg my behandeling doen en goed, herstel jy vinnig en loop vinnig uit die hospitaal uit. As ek dit nie reg doen nie, bly jy langer of jy kom in 'n rolstoel uit of iets. En dis, dis hoe ek myself evalueer. Wat is die kondisie van my pasiënte wanneer hulle uitkom.

p. 94

Because your colleagues…they understand…they are in the same circumstances. They understand your frustration or what the circumstances are.

Afrikaans:

Want die met jou medewerkers – hulle verstaan … hulle is in dieselfde boot. Hulle verstaan hoe frustreerd jy is of wat die omstandighede is.

p. 98

My aim is to improve your condition, or to keep it the same.

Afrikaans:

My doel is om jou kondisie te verbeter, of dit dieselfde te hou.

AEA 2

p. 100

(Blood) is not something I look forward to seeing everyday. If I have to see it I have to see it. If I have to treat a person I have to treat a person. But if I have the chance not to see it, it's better.

Afrikaans:

…dis nie iets waarna ek uitsien elke dag om te sien nie. As ek dit moet sien moet ek dit sien. As ek 'n persoon moet behandel moet ek 'n persoon behandel. Maar as ek kans het om dit nie te sien nie is dit beter.

AEA 4

p. 79

It [an ambulance] *is maybe small or not correctly laid out.*

Afrikaans:

Hy is dalk te klein of nie reg ingerig nie.

p. 84

Then you think … why am I not a CCA? Then I can do it and finish it. Why should I be dependent upon others? That's very frustrating.

Afrikaans:

Dan is jy gefrustreer want dan dink jy … waarom is ek nie ‘n CCA nie? Dat ek dit kan doen en klaar kry nie? Want waarom moet ek van ander afhanklik wees? En dit frustreer my baie.

p. 98

This work is not easy … it is a hard, physical work, because when you work, you work.

Afrikaans:

Want hierdie is nie ‘n maklike werk nie. Almal dink: ek wil ‘n *paramedic* wees, ek wil mense help. Maar dis ‘n harde, fisiese werk, want as jy werk, werk jy.

AEA 6

p. 83

You get the guy at hospital, hand him over…then you walk out and forget about it. It’s a conscious decision – forget about it.

Afrikaans:

…jy kry daai outjie by die hospital, jy gee hom oor daar … dan loop jy uit en jy vergeet van dit. Dis ‘n doelbewuste besluit – vergeet van dit.

p. 86

…they are appointed above us, but they are not able to perform the task.

Afrikaans:

… hulle word bo ons aangestel, maar hulle is nie opgewasse om die taak te doen nie.

p. 95

I've spoken a lot with my wife about it. She understands. I use her a lot as a sounding board.

Afrikaans:

Ek het baie met my vrou gepraat daaroor. Sy verstaan. Ek gebruik haar baie as klankbord.

p. 98

I lost one, two, three patients in that week…Now you have to work with the family and explain to them how it worked…it takes a lot from you…it takes a lot from you.

Afrikaans:

Ek het een, twee, drie pasiente verloor in daardie week … Nou moet jy met die familie werk, en vir hulle verduidelik, maar dis hoe dit in mekaar steek … dit vat baie van jou … dit vat baie van jou.