"Violence, in fact, is not part of the job"

A Qualitative Study of Paramedic Experiences with Workplace Violence

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October 12th, 2019

Peel Regional PARAMEDIC Services

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Author Information

Commissioned By

This report was commissioned by the *Culture and Engagement* Department of Peel Regional Paramedic Services as part of the External Violence Against Paramedics (EVAP) Working Group.

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To Cite this Document

Mausz, J. & Johnston, M. (2019). *"Violence, in fact, is not part of the job" A qualitative study of paramedic experiences with workplace violence.* Brampton, Ontario: Peel Regional Paramedic Services.

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To the Reader

Some of this report will be difficult to read. The paramedics who completed our survey provided detailed accounts of experiencing verbal abuse, threats, and – not infrequently – physical and sexual assault. In sharing their stories, the paramedics occasionally use strong language, and we have not redacted or edited their words in an effort to represent their experiences faithfully and communicate the vitriol that they describe. All of this is to say that their stories may be triggering if you have personal or professional experience with violence.

Our analysis also touches on issues of organizational culture, and the participants often shared a perception of feeling unsupported by management, and unsafe in the workplace. These comments, too, can be difficult to read, particularly if you are in an administrative, management, or other leadership role in our community. In reading this report, however, I ask that you remember that what we are sharing with you are *lived experiences*, and our goal – you in reading this report, and Mandy and I in writing it – should be in coming together to understand these experiences to create positive change.

The culture of an organization is made up of the tapestry of people with whom we work – no *one* person is responsible for the good or the bad in our culture, but we all have the power to change it. What we are sharing with you are several ways in which we can change our culture to hear, to support, and – most importantly – to empower each other in *rejecting* violence as a normal part of our work.

This can be an uncomfortable process, but in organizing the External Violence Against Paramedics working group, in empowering those members of our community to study an important and difficult subject, and in reading this report, *you* are an integral part of the solution.

Thank you for having the courage to ask difficult questions and the wisdom to listen to (sometimes) difficult answers.

Yours very sincerely,

Justin “Dewey” Mausz & Mandy Johnston

Abstract

Introduction

Paramedic exposure to violence is a well-documented, and growing problem. However, our understanding of the consequences of violent attacks, as well as the circumstances surrounding abuse and the context in which it occurs is lacking. Our objective was to broadly explore paramedic experiences with violence.

Methods

We distributed a survey to a single, large, urban paramedic service in Ontario, Canada with the goals of (1) estimating the prevalence of exposure to violence; and (2) qualitatively unpacking the experience. The survey consisted of a combination of forced-response (i.e., yes/no, multiple choice) and free-text questions, and was distributed electronically and made available for a 30-day period. Quantitative data were analyzed using summary and descriptive statistics. The qualitative analysis followed the principles of inductive thematic analysis, borrowing the coding techniques of grounded theory, with the goal of describing the experience of workplace violence among paramedics.

Results

A total of 196 paramedics completed the survey, for a response rate of 33.3%. Of the participants, 48.2% identified as men, 50.2% women, and 1% as gender diverse people. The majority (46.4%) of participants reported having 11 or more years of experience, with the remainder evenly split between 0-5 (27%) and 6-10 (26.5%) years of experience. With respect to exposure to violence, 97.9% reported exposure to verbal abuse, 86.1% intimidation, 80% physical assault, 61.5% sexual harassment, and 13.8% sexual assault. Our qualitative analysis indicated the participants are regularly exposed to a wide variety of different forms of abuse, spanning the spectrum of severity to include threats and assaults with weapons, including firearms. This exposure to violence resulted in sometimes long-term physical, psychological, and emotional harm, and occurred in the context of a tacit institutional acceptance of violence as a normal – even expected – part of paramedic work.

Conclusion

Among our survey participants, exposure to violence was common, with potentially-serious and long-term physical, psychological, and emotional harm. We highlight several opportunities to enhance operational safety, while at the same time addressing an organizational culture that normalizes workplace violence.

Introduction

"Overall, I have been luckier than others, and I'm thankful for that."

The nature of pre-hospital emergency care means that paramedics often find themselves interacting with patients and members of the public who are in crisis, or under the influence of alcohol or drugs – often in the context of stressful and unpredictable situations, creating the not insignificant potential for violence.

Unfortunately, violence against paramedics is a well-documented and growing problem. For example, research from Australia indicated that 87.5% of paramedics surveyed were exposed to workplace violence over the course of their careers [1]. Similarly, a series of studies from Europe revealed that more than 80% of paramedics were the victims of threats or violence over a one-year period, with more than a third of paramedics reporting some form of violence every three months [2]. In North America, a study of paramedics in the United States found that fully 90% had been assaulted during their career [3]. In Canada, a comprehensive survey of paramedics in Ontario and Nova Scotia discovered that 75% of survey participants had experienced violence within the past year [4]. Across studies, the most commonly reported types of violence include verbal abuse, followed by threats, physical assault, sexual harassment and sexual assault [2-6]. Perhaps most concerningly, several recent investigations have found that violent attacks against paramedics are on the rise, with 1-year increases of up to being 23% reported in the media [6, 7].

Exposure to workplace violence has important and potentially far-reaching consequences. For example, in a US study, of the 61% of respondents who had been the victim of a violent attack, 25% had sustained a physical injury [3]. This can result in a substantial cost to the paramedic service, with research conducted by Safe Work Australia indicating that when paramedics were injured as a result of an attack, the median lost time from work was nearly two and a half weeks [6]. This amounted to a total cost of $250,000 in compensation claims [6]. Beyond physical injuries, the emotional impact of these events is also an important consideration, but has been more difficult to quantify. What limited research exists suggests that changes in mood, fear for personal safety, and decreases in job satisfaction occur [2, 6, 8, 9]. Finally, patient care may ultimately be affected as well, with a study by Suserud and colleagues finding that of the 98% of paramedics who had experienced violence, 80% felt that the care they provided to patients suffered as a result, pointing to potentially significant downstream consequences for the public [2]. Collectively, however, the ultimate effects of violence against paramedics remain understudied.

Part of what makes studying this problem difficult is that many of the incidents likely go unreported. For example, Bigham and colleagues found that 61% of participants did not report violent incidents to a supervisor, with 81% not documenting the incident at all [4]. In the free-text comments, many participants indicated that exposure to violence is just 'part of the job' as a paramedic [4]. This tacit cultural acceptance of violence may be an important contributing factor in the trend of underreporting.

Taken together, the extant research illustrates that violence against paramedics is on the rise, but tracking and understanding the impacts of these incidents may be hampered by contextual and cultural factors that limit reporting. Much of the existing research has focused on prevalence, and a

more complete understanding of the consequences of violence against paramedics is urgently needed. Such questions are much more amenable to qualitative methods, but their use in understanding this problem has been limited. Our objective was therefore to qualitatively explore paramedic experiences with workplace violence.

Methods

Overview

We undertook a web-based survey distributed to a single paramedic service with the goal of (1) estimating the prevalence of exposure to violence; and (2) qualitatively exploring the experience of exposure to violence and its resulting impact on paramedic wellbeing. The survey consisted of a combination of forced-response and open-ended questions, was distributed via workplace email and made available for a 30-day period.

Setting

Our study was situated in a single paramedic service in Ontario, Canada. Peel Regional Paramedic Services (PRPS) is the sole provider of land ambulance and paramedic services to the Regional Municipality of Peel, encompassing the municipalities of Mississauga, Brampton, and Caledon. At the time of the survey, PRPS employed 632 paramedics and responded to an average of 130,000 emergency calls per year across a mixed suburban and rural geography of 1,200km^2.

Survey Instrument

The survey was created and distributed using the web-based platform *SurveyMonkey* and was circulated via workplace email to all employees maintaining certification to practice as a paramedic (n = 632). The survey was available for the 30-day period between February 14th to March 14th, 2019 with emails sent at 2-week intervals encouraging participation. Survey questions consisted of demographic information including years of experience and gender, as well as a combination of forced-response (i.e., yes/no, multiple choice) and free-text questions designed to explore paramedic experiences with exposure to violence. For our definition of workplace violence, we drew on the definitions used by Bigham et al. in their 2014 study. Survey items were generated through consensus at a working group composed of front-line paramedics, management, and service administration, with a draft of the survey sent to a regional information analysis team for external consultation and feedback. The final version of the survey (Table 1) was approved by the service's senior administration prior to distribution.

Data Analysis

Quantitative data were analyzed using summary and descriptive statistics to report on the proportion of paramedics reporting exposure to violence in the workplace, the types of violence encountered, and the actions taken (i.e., reporting). Qualitative data in the form of free-text narrative comments were assembled in Microsoft Word (Microsoft Inc) and imported into NVivo for Mac Version 11 (QSR International) for analysis. The analysis followed the principles of inductive thematic analysis [10, 11], borrowing the coding methods of grounded theory [12]. Inductive

thematic analysis is an iterative technique of deriving cogent, explanatory themes that remain analytically 'close' to the data while still allowing for interpretive flexibility [13]. Grounded theory coding emphasizes identifying and making explicit social processes and relationships in the data. The analysis began with open coding, assigning short labels to segments of text using gerunds (-'ing' statements) to identify social actions [12]. Subsequent rounds of focused coding deleted, collapsed, and expanded the original open codes as appropriate, organizing the codes by conceptual similarity [14]. A final round of coding clarified the relationships between conceptual themes and organized the codes into a coherent explanatory framework. We used in-vivo annotations and memos [15] to document analytical decisions during the coding process and met regularly to discuss in-progress work.

Results

A total of 196 paramedics completed the survey out of a total pool of 588 eligible (i.e., not on leave) participants for a response rate of 33.3%. The demographic characteristics of our participants and a summary of the quantitative findings are reported in Table 2. With respect to exposure to violence during their careers, 191 participants (97.5%) reported experiencing verbal abuse, 168 (86.1%) intimidation, 156 (80%) physical assault, 120 (61.5%) sexual harassment, and 27 (13.8%) sexual assault. Only a minority of participants (40%) reported the incident to PRPS management, or to the police (21.3%).

Qualitative Analysis

The free text responses yielded 63 single-spaced pages of comments for a total of 30,602 words for analysis. Through successive rounds of coding, we developed a total of 5 major themes and a number of sub-themes describing the participants' experience with workplace violence and the context in which it occurs.

Trigger Alert

It is important to note that the participant accounts describe situations involving physical and sexual violence, often using strong language. In attempting to faithfully represent our participants' lived experiences, we have not edited or redacted potentially offensive language, and their comments **may be triggering** to readers who have personal or professional experience with violence.

Types of Abuse

"I have been yelled at, cornered, slapped, bit, punched in the throat, told I would be raped, told my family would be raped and killed…"

The range of abuse that the participants described was shocking. Often the participants would simply provide a long, bullet-point list of the various kinds of abuses to which they had been subjected over the course of their careers, including name-calling and racial slurs, threatening behaviour, physical attacks (sometimes with weapons), sexual harassment, and sexual assault. The

overarching commonality was in the diversity of the abuse described, and the frequency with which it was encountered: nearly every participant reported experiencing all of the various types of abuse, often more than once. This litany of abuse ranged from relatively benign incidents – such as being yelled at, called offensive names, or being subjected to racial slurs – to more serious incidents, including being threatened with death or rape, or being physically or sexually assaulted.

These more serious incidents are particularly concerning, with several participants reporting receiving threats not only directed at them, but also at their spouses and family members. In several instances, the participants described being threatened with weapons, including situations in which knives and guns were produced and pointed at them:

> "At the extreme end, I have been threatened with knives twice (i.e., the weapons were presented and held against me)" "I've entered a residence and found someone pointing a gun at me"

Of course, incidents of physical attacks were also troubling. Spitting was particularly common, but physical abuse also included striking (such as punching, kicking, slapping, or hitting), grabbing, or pinning the paramedics. The participants also described being assaulted with weapons: "*I have been chased out of a house while having objects (including knives) being thrown at me*"

Particularly concerning was how many participants described experiencing various forms of sexual harassment and assault. The incidents included sexist remarks – often directed at women – and misogynistic comments, not just from patients or members of the public, but also from allied services personnel such as police officers and firefighters:

> "Wouldn't you rather go in the ambulance and spend time with these lovely *ladies* than be brought-in in the back of a police car?" (emphasis added)

More serious incidents involved sexual solicitations, inappropriate comments, lude gestures, and threats of rape, with several participants reporting numerous incidents in which patients exposed themselves and masturbated in their presence:

> "An intoxicated man told me that if I sucked him off, he would guarantee that he would be fine while completing sign-off paperwork" (referring to refusal of service)

> "On more than one occasion, I've been witness to both male and female patients attempting to masturbate"

Finally, the participants described several incidents of inappropriate touching, stroking, or groping, amounting to outright sexual assault:

> "As a woman, having men think it is their right to comment on a female's look, or put their hand up a medic's thigh, or 'accidentally' grab a breast, all regardless of the paramedic's verbal warnings"

While women reported many of the instances of sexual harassment and assault, some men disclosed experiencing sexual harassment as well, but described feeling an added layer of stigma in reporting these incidents to management or the police:

> "As a man, I am frequently sexually harassed and have been groped numerous times. It does not feel safe to address this in anything but a comedic manner with coworkers and management"

Circumstances and Sources of Abuse

Where the participants described abuse from patients, in the majority of cases, the patients had an altered mental status, with alcohol or drug intoxication, and hypoglycemia being the most frequently reported. Alcohol intoxication was particularly problematic, with some of the most serious cases of physical assault perpetrated by patients who had been drinking:

> "I was 10 weeks pregnant and was transporting a drunk male patient who woke up and attempted to leave. I tried to talk him down and have him stay on the stretcher, but he attacked me, ripping my shirt and pants, scratching my face, and kicking me in the abdomen."

Service policies and provincial standards of care advise paramedics to request police presence in the case of violent or aggressive patients and – if necessary – wait for their arrival before initiating care. However, in the majority of the situations described by the participants, the police were on scene, and the perpetrators were often already in police custody:

> "I was spit at and verbally abused by a patient who was (intoxicated) in custody of police, telling me to go kill myself, calling me a fucking bitch"

In situations involving physical abuse, many of the incidents occurred in the back of the ambulance, often when the vehicle was in motion, and often when the treating paramedic was alone with the patient. This included intoxicated patients becoming aggressive or violent in an attempt to exit the vehicle, underscoring the transportation phase as particularly high-risk.

While physical abuse was commonly perpetrated by patients, instances of verbal abuse were often described as coming from the family of the patient, and other individuals (such as bystanders) present at emergency scenes.

> "He (the patient's son) became furious, started yelling at us, starting with 'stop asking such ignorant questions and *do your fucking job'*. (emphasis added) He proceeded to videotape us while we cared for his mom saying things like 'look at how horrible they are treating my mother', 'I will have you fired' (and) 'you are fucking useless'"

The above example is illustrative of a trend where disagreements over patient care created tension that sometimes escalated into abusive language. Emergency scenes are stressful, and the instances of abuse from family were underpinned by conflicts around what hospital to take the patient to, whether family could accompany the patient in the ambulance, or how best to care for the patient.

> "I have been on the road for greater than 30 years. Most times were verbal or physical threats by family due to the stress of having a sick loved one"

In response to instances of violence, the participants described a number of strategies they use to stay safe. For example, participants spoke of attempting to distract an agitated patient to de-escalate a tense situation, expediting on-scene care to leave a hostile scene, or disengaging from the patient by sitting out of sight during the drive to hospital. In some cases, the participants reported having to physically defend themselves from patients who had become violent.

The Consequences of Abuse

"I was terrified. I was assessed in the ER and received an ultrasound the following day to assess my pregnancy."

The participant in this example was 10-weeks pregnant, and had been kicked in the abdomen by an intoxicated patient attempting to flee the ambulance while it was being driven to hospital. The consequences of abuse are wide ranging and significant, including physical, psychological, and emotional harm. A number of participants described sustaining injuries that required them to take time off work after being attacked by patients:

> "I had a woman physically attack me on a call. She came at me punching me in the chest and grabbing at me, when I tried to stop her, she got a hold of my fingers and twisted my wrist. I finished the call and was seen in the ER (emergency room) by a doctor I was off with a wrist injury for 3 months."

Indeed, the incidents the participants described were understandably upsetting and the participants reported experiencing a wide variety of uncomfortable emotional reactions to the events. The participants spoke of feeling angry, anxious, unappreciated by the public and stressed about coming to work, driven primarily out of an overarching perception of feeling *unsafe* in the workplace.

> "There isn't a day that I don't worry about my personal safety, and even times that I worry about the safety of my family (some threats sound and feel more real than others)"

> "I try not to let it affect me; however, I have knowledge of coworkers being physically injured because of an attack. It certainly causes some anxiety that regardless of how careful I try to be, I may be attacked while on a call"

The effects of the abuse persisted long after the incidents themselves, leading to a number of important consequences for the working lives of the participants. For example, many participants spoke of feeling more on edge, or alert on calls, and having an increased awareness of potential safety risks. While in some cases this was framed positively, in many instances, the participants described this as leaving them feeling "*hardened*", with less empathy and compassion for their patients, noting that violence "*changes how you think about patients and family members.*" This erosion of trust can ultimately have downstream consequences for the quality of patient care:

> "(Violence) definitely makes me frustrated, upset, and angry. It makes it very hard to move on and be compassionate and professional for the next patient"

Unfortunately, many participants spoke of feeling unsupported by their supervisors and the service management, describing situations in which they reported abuse only for the incidents to be dismissed as minor, or worse, to be reprimanded for not following procedure. For example, several participants spoke of being admonished by supervisors for not wearing face shields after having patients spit in their face: *"(The) supervisor told me I needed to review my PPE (personal protective equipment) application, and if I had been wearing a face shield, the angry drunk would not been able to spit in my face."* A handful of participants reported being mocked by supervisors after disclosing that they were having trouble coping with a violent attack:

> "The two (supervisors) on that night found me hiding in the ambulance crying. In a nutshell, I was told I'm probably not cut out for this job and should start looking for a new career. 'Look at yourself, you're a mess'"

Ultimately, the experience was intensely traumatizing for some, and comments like these were felt to perpetuate an institutionalized view that tolerating abuse is an expected part of paramedic work, with paramedics who 'can't take it' viewed as – or made to feel – unsuitable for the profession.

This perception of feeling unsupported also extended to the police as well, often because incidents of abuse or violent attacks occurred when the police were present, or where the perpetrator was already in police custody. The participants described what they perceived as apathy on the part of the police, driven – in part – by the view that because the perpetrators were intoxicated or in an otherwise altered mental status that perusing charges would be futile. This left the paramedics feeling unsupported by a historically close and trusted ally.

> "Having my ass slapped by a patient twice while police are standing there and doing absolutely nothing about it is extremely degrading."

> "I have been swung at and punched at by drunk patients, (and the) police appear to have no eagerness to pursue any charges. I feel that these cases are likely easily dismissed as the patients are deemed to be 'just going under a medical issue' and charges would likely not stick."

Collectively, the experience of violence in the workplace had tangible effects on work life for many of the participants. While some of this was positive, such as being more alert or cautious on calls and taking proactive steps to ensure personal safety, more often the effects were negative. The participants reported that being subjected to violence in the workplace diminished their enjoyment of their work, leaving them with less compassion for their patients – and, importantly, feeling alone and unsupported in the face of chronic abuse.

> "She (the patient) began calling me names and verbally abusing me, all while my partner, social workers, police officers stood beside me silent. *I was surrounded by people yet felt completely alone*." (emphasis added)

The Context and Culture

We identified a complex interplay of contextual factors that describe a workplace culture in which violence in the workplace is implicitly tolerated. Previous research, for example, has found that paramedics often report that exposure to violence is just an accepted 'part of the job', and we found this in the current study as well, with an overwhelming number of participants echoing this sentiment.

> "It is part of the job, and although unfortunate, you learn to deal with it or the job becomes unbearable."

Exactly why workplace violence is so widely tolerated appears to be the result of several important factors. First, exposure to violence is so common for paramedics that the problem is described as chronic. When asked about specific violent incidents, the participants would often describe encountering "*too many to count*", listing a litany of abuses ranging from the benign to the extreme. Chronic exposure over a long period of time appeared to normalize the issue. Second, because so many of the incidents involving (in particular) physical abuse were perpetrated by patients under the influence of alcohol, or drugs, or as the result of a mental health crisis, the police were reluctant to pursue charges, often indicating that the prospect of conviction was unlikely.

> "From my experience, these incidents were beyond the control of the patients (because they were intoxicated or mentally ill), so it's easier to disregard them as not having a sound mind than to pursue any legal ramifications"

This led many participants to conclude that much of the abuse is *unpreventable*, noting that the paramedic service, or even the police, cannot prevent people from behaving inappropriately.

> "I think a lot of the violence is just inherent in the job and cannot be curbed. When we are dealing with patients with mental health problems, or alcohol and drug intoxication, or medical issues, they either have no control over, or don't care to control their behaviour"

Consequently, the participants often explained that reporting violent incidents was not worth the hassle, noting that the perpetrators often cannot or will not be held accountable for their actions. As a result, many participants downplayed the significance of violent incidents, passing off situations in which they were not seriously harmed as minor. Taken one step further, this normalization of violence on an individual level appeared to translate into an expectation of *tolerance* on an organizational level. Paramedics provide an important public service, and the participants spoke of the implicit expectation to prioritize their service to patients at the expense of their personal safety, often in service of professionalism: "*Customer service dictates that the (patient) is always right*." This meant that the participants were reluctant to address inappropriate behaviour, and were concerned about being disciplined if they acted to set boundaries, refuse service, or defend themselves from a violent attack.

> "When it comes down to it, sometimes it feels as though upper management would rather discipline paramedics for negative outcomes and patient complaints than stand up for their employees against workplace harassment and violence"

This perception of powerlessness compounds the emotional effects of an already stressful situation. In addition to the potential for physical injuries and (sometimes long-term) psychological and emotional harm, the institutional acceptance of violence as a normal part of their work left the participants with a profound sense of injustice:

> "(The abuse) makes me feel worthless. It shows society that they can get away with this behavior toward paramedics because there are no consequences."

What Paramedics Want

"I think people just want to be heard"

Not just heard, but empowered. Because there are often no consequences for the perpetrators, the participants articulated a very strong sense of injustice, compounded by an organizational culture that normalizes abuse. When asked what solutions might exist, the participants offered a number of suggestions that center on feeling empowered, with being heard as a necessary first step.

Many of the participants described feeling unsupported by management, often relating accounts of reporting abuse to unsympathetic supervisors. What the participants wanted was for their concerns to be taken seriously, and to feel that their immediate supervisors and the broader management team valued their wellbeing. Beyond this initial validation, the participants described that they wanted supervisors to 'stand up' for them, making it clear to perpetrators that abusing paramedics is unacceptable, and that they will contact the police to report offenses.

> "SUPPORT! (emphasis retained) We are pretty much left to defend ourselves, not only from the initial incident, but also if we want to push the incident forward. Many incidents do not get reported as there is a strong feeling of 'what's the point, nothing is going to happen'"

The participants explained that this would involve adopting a 'zero tolerance' policy toward abuse – and communicating this policy explicitly through media campaigns, social media advertising, and signage in the patient compartments of the ambulances. The participants also described the need for an improved and streamlined reporting system. But importantly, support from management was also felt to reflect an acknowledgement that being the victim of abuse can be a stressful, and sometimes traumatic experience – an experience that should prompt the availability of resources *"to deal with the fallout for those that experience these situations*."

The desire for empowerment also included the desire for more training in how to deal with violent or abusive patients. The participants suggested training in situational awareness, crisis intervention, and de-escalation training, but many participants spoke of the necessity of providing hands-on self-defence training, noting that de-escalation may not always be effective. Indeed, some of the more serious incidents the participants described occurred in situations where the paramedic was alone with an intoxicated patient in a resource-limited, high-risk environment (such as the back of a moving ambulance), creating the potential for catastrophic injuries if the paramedic is unable to safely control a violent patient.

> "Training staff to be able to subdue an attacker enough to get away to a place of safety and to call for help. You cannot reason with unreasonable people."

Finally, the participants articulated a very strong desire for meaningful consequences for perpetrators. Although many recognized the difficulty in pursuing systemic changes in the justice system, the participants suggested changes in legislation that would impose harsher penalties for people who assault paramedics, similar to existing provisions in the Canadian Criminal Code for assaulting a peace officer. More pragmatically, the participants spoke about wanting the police to take the issue of violence against paramedics more seriously. Collectively, the participants often described that perpetrators are able to 'get away' with abusing paramedics because they are intoxicated or mentally ill – contributing to the perception of injustice discussed earlier. What the participants wanted was to correct the injustice and acknowledge that such behaviour is unacceptable:

> "If I go to a restaurant and yell at the staff I get kicked out, rightfully so. But, if I call 911 and attempt to physically or verbally assault the paramedics then it is just "part of what they signed up for". It is complete bullshit."

Discussion

Our goal was to explore paramedic experiences with violence in the workplace, qualitatively unpacking their experiences to understand the circumstances and contexts in which violence occurs. Nearly every participant reported encountering verbal abuse, and more than 80% had been the victim of a physical attack over the course of their careers. Of particular concern was the large proportion of participants who had been subjected to sexual harassment (61%) or assault (14%).

Our qualitative analysis of the free-text comments paralleled the quantitative findings, revealing that paramedics are subjected to a wide range of abuses on a regular basis. Verbal abuse, intimidation, threats, physical assaults – including assaults with weapons - and sexual violence were all discussed with disturbing frequency. The circumstances surrounding these incidents suggest some common themes: first, almost all of the physical abuse the participants described was perpetrated by patients who were intoxicated by alcohol or drugs, or in the midst of a mental health crisis, underscoring these subsets of calls as high-risk. Despite existing procedures that emphasize requesting – and occasionally, waiting for – police assistance, the police were often on scene and the perpetrator already in custody when the attacks occurred, suggesting an opportunity to revisit service policies and strengthen collaboration with police. However, we also identified a not insignificant pattern of attacks occurring during the drive to hospital, often when the paramedic was alone with an intoxicated patient. The consequences of a physical attack in the confined space of an ambulance travelling at highway speeds are potentially catastrophic, if for example, the perpetrator is able to incapacitate the treating paramedic, distract the driver, gain control of the vehicle, or even open one of the vehicle doors while it is in motion. Thankfully in the situations described by the participants, the attacks were usually quickly controlled. There are, however, lasting consequences stemming from what the participants described as a chronic exposure to workplace violence. First, physical attacks occasionally resulted in injuries, some of them serious

and resulting in substantial lost-time from work. Second, even when a paramedic is physically unharmed, there are tangible emotional and psychological effects that arise from being the victim of a violent attack. The participants spoke of decreased job satisfaction, changes in mood, and symptoms consistent with post-traumatic stress disorder, to name a few. Looking downstream, the participants talked about long-term changes in their ability to provide compassionate and empathetic care, noting that it's difficult to establish a rapport with a patient when they feel unsafe. Although not discussed in detail specifically, this raises the possibility that patient care may ultimately suffer as a result.

Finally, the participants provided a number of comments that illuminated the larger context and organizational culture within which workplace violence occurs, helping to explain, at least in part, the phenomenon of under-reporting described in the literature [4]. Because the exposure is so frequent, and perpetrators of violence are often intoxicated or mentally ill, we found a distinct perception that violence is *unpreventable* and *un-prosecutable* – sentiments that left the participants with a profound sense of injustice. This translated into a perception of a tacit, institutionalized acceptance of violence, going so far as to suggest that paramedics are simply expected to tolerate the abuse in service of maintaining a 'professional' image. The participants made it clear that such sentiments are unacceptable ("It is complete bullshit"). What the participants want is to feel supported and empowered in taking the view that violence against paramedics will not be tolerated, and to explicitly communicate a policy of 'zero tolerance' to patients. Similar campaigns have been implemented in the United Kingdom and Australia amid a growing awareness of violence against paramedics. Such a policy not only has effect of potentially preventing some instances of abuse, but also legitimizing the concerns of the paramedics in such a way that if an attack does occur, the subsequent emotional harm may be mitigated by a supportive and empathetic management team.

Our findings highlight several opportunities to better understand and address the problem. First, we recommend the establishment of a streamlined reporting process with consistent definitions for various forms of abuse, ideally drawn from a literature review or environmental scan. This will allow for better tracking, and afford a more complete understanding of the problem, particularly for identifying trends such as seasonal variation. Second – and in a related sentiment – we recommend a mechanism to identify and monitor the economic burden of abuse, particularly where incidents cause physical or psychological harms that result in lost-time from work. Third, we recommend a comprehensive review of operational policies, with particular attention to strengthening interagency collaboration with police. Given that so many of the situations the participants described involved perpetrators who were already in police custody, there are likely opportunities to establish safety procedures to further mitigate the risk. Collaboration with police should also include processes to support the reporting and charging of perpetrators. Fourth, we recommend the implementation of safety equipment, such as commercially-designed soft restraints and 'spit-hoods', consistent with existing recommendations in the literature [5]. In the current system, physical restraints must be improvised or police officers must handcuff patients to the stretcher. Both have potentially significant safety concerns. Improvised restraints may harm the patient or fail to adequately contain them. Handcuffs, meanwhile, cannot be released quickly in the event of an emergency and may not adequately restrain a particularly violent patient. Coinciding with safety equipment, we additionally recommend the service consider specialized training, ideally in partnership with the police as part of a coordinated inter-agency plan. Training might include, for example, situational awareness, conflict resolution, crisis intervention, and de-escalation training, but should also include hands-on physical self-defence training to deal with immediate, high-

consequence threats, such as a violent patient in the back of a moving ambulance where retreat is not possible. Finally, and most importantly, we recommend taking proactive steps to change the culture from (what is perceived as) institutional acceptance of violence to explicit rejection. Recognizing that abuse may not always be *preventable*, it is important that it never become *tolerable*. Communicating to the public and to the paramedics that violence against paramedics is never acceptable would go a long way in creating the sense of support and empowerment the participants seek.

Limitations

Our findings should be interpreted within the context of certain limitations. First, our methods preclude direct comparisons with existing research on the prevalence of workplace violence. This makes it difficult to say whether the incidence of violence our participants describe is higher or lower than other estimates in similar settings. Second, the response rate for our survey was 33.3% and the reader must exercise caution in generalizing our findings to the entire service. Finally, the qualitative analysis of survey comments carries with it well-recognized limitations [16]. Although nearly 200 paramedics completed our survey, it is nevertheless a *passive* form of qualitative data collection that limits our ability to gain deep insight into the topic (as compared with in-depth interviews, for example).

Conclusion

In our study, exposure to workplace violence was common, with the participants describing a wide variety of verbal, physical, and sexual violence. Acts of physical violence were commonly perpetrated by intoxicated patients, or patients experiencing a mental health crisis, often with police already in attendance; however, we identified that the transportation phase of patient care was also high-risk. The consequences of chronic exposure to workplace violence are potentially significant, including long-term physical, psychological, and emotional harm. Because the problem is so pervasive and is often perpetrated by people for whom criminal prosecution is unlikely, there is a perception of tacit institutional acceptance of violence as a normal, unpreventable part of paramedic work. Our findings have important implications for service administrators, and we identified several opportunities to enhance service policy, staff training, and organizational culture by adopting a ‘zero tolerance’ position on workplace violence.

Acknowledgements

We would like to acknowledge and express our gratitude to the members of the External Violence Against Paramedics working group – Monica Misra-Lui, Alexis Silverman and Willie Wong – as well as Faith Bisram and Daniel Paterson for their support and assistance in completing this study. Finally, we would like to thank the survey participants for taking the time to share their (often difficult and deeply personal) experiences with us, and for the important work that they do in our communities.

References

1. Boyle, M., et al., *A pilot study of workplace violence towards paramedics.* Emerg Med J, 2007. **24**(11): p. 760-3.
2. Suserud, B.O., M. Blomquist, and I. Johansson, *Experiences of threats and violence in the Swedish ambulance service.* Accident and Emergency Nursing, 2002. **10**(3): p. 127-135.
3. Corbett, S.W., J.T. Grange, and T.T. Thomas, *Exposure of prehospital care providers to violence.* Prehosp Emerg Care, 1998. **2**: p. 127-131.
4. Bigham, B., et al., *Paramedic self-reported exposure to violence in the emergency medical services (EMS) workplace: A mixed-methods cross sectional survey.* Prehosp Emerg Care, 2014. **18**: p. 489-494.
5. Maguire, B.J., et al., *Preventing EMS workplace violence: A mixed-methods analysis of insights from assaulted medics.* Injury, 2018.
6. Maguire, B.J., *Violence against ambulance personnel: a retrospective cohort study of national data from Safe Work Australia.* Public Health Res Pract, 2018. **28**(1).
7. *Ambulance staff face rise in physical and verbal sexual assaults*, in *The Guardian*. 2018.
8. Pourshaikhian, M., et al., *A Systematic Literature Review: Workplace Violence Against Emergency Medical Services Personnel.* Arch Trauma Res, 2016. **5**(1): p. e28734.
9. Wongtongkam, N., *An exploration of violence against paramedics, burnout and post-traumatic symptoms in two Australian ambulance services.* International Journal of Emergency Services, 2017. **6**(2).
10. Vaismoradi, M., H. Turunen, and T. Bondas, *Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study.* Nursing and Health Sciences, 2013. **15**: p. 398-405.
11. Braun, V. and V. Clarke, *Using thematic analysis in psychology.* Qualitative Research in Psychology, 2006. **3**(2): p. 77-101.
12. Charmaz, K., *The logic of grounded theory coding practices and initial coding*, in *Constructing Grounded Theory*, J. Seaman, Editor. 2014, Sage Publications: London. p. 109-137.
13. Braun, V. and V. Clarke, *What can "thematic analysis" offer health and wellbeing researchers?* Int J Qual Stud Health Well-being, 2014. **9**: p. 26152.
14. Charmaz, K., *Focused coding and beyond*, in *Constructing Grounded Theory*, J. Seaman, Editor. 2014, Sage Publications: London. p. 138-161.
15. Charmaz, K., *Memo-writing*, in *Constructing Grounded Theory*, J. Seaman, Editor. 2014, Sage Publications: London. p. 162-191.
16. LaDonna, K.A., T. Taylor, and L. Lingard, *Why Open-Ended Survey Questions Are Unlikely to Support Rigorous Qualitative Insights.* Acad Med, 2018. **93**(3): p. 347-349.

Tables

#	Survey Question
1	How many years of service do you have as a paramedic? (0-5, 6-10, 11+)
2	What is your gender? (Man, Woman, Other Gender)
3	Have you experienced any of the following by a patient, a patient's family member, or a bystander? (Check all that apply)
4	Did you report the incident to your supervisor?
5	If you did, what were the results?
6	If you did not, can you let us know why?
7	Did you report the incident to the police?
8	If you did, what were the results?
9	If you did not, can you let us know why?
10	How do these experiences affect your work life?
11	Can you describe your experiences?
12	What does a solution to public violence against paramedics look like to you?

Table 1: Survey questions developed through consensus at the External Violence Against Paramedics working group meetings and sent to a regional survey team for external consultation. Options for Question 3 included verbal assault, intimidation, physical assault, sexual harassment, and sexual assault

Demographics	N	(%)	Types of Abuse	N	%
Experience			Verbal Assault	191	97.9
0-5 Years	53	27	Intimidation	168	86.1
6-10 Years	52	26.5	Physical Assault	156	80
≥11 Years	91	46.4	Sexual Harassment	120	61.5
Gender			Sexual Assault	27	13.8
Man	94	48.2	*Reporting*		
Woman	98	50.2	Reported to PRPS Supervisor	78	40
Gender Diverse	2	1%	Reported to Peel Police	41	21.1

Table 2: Demographic characteristics of sample and summary of quantitative findings.