

RIDING THIRD:
EXPLORING THE ROLE OF SOCIAL WORK
IN AMBULANCE WORK

by

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Abstract

The research explains whether the creation of a new social work role would benefit situations in ambulance work, what this role would look like, and provides recommendations for the education of this position. An ethnographic study included semi-structured interviews, observations, and a collection of vignettes, with data collected over 300 hours while riding on ambulances in various locations. Data collected suggests that a social work role would provide needed psychosocial care during ambulance calls and would possess unique qualities and challenges from other traditional social work roles.

Preface

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1 Introduction

The inspiration for my thesis came through my work as an emergency department social worker. During my time in a specific hospital, I felt I needed to experience a paramedic ride along in order to gain a further understanding of their role in the hospitalization process. As the designated first responders, paramedics are normally the initial step to a patient's hospital visit. As such, they are privy to information that hospital staff are not. During my ride along, I frequently encountered situations where the paramedics would comment that social work would be a benefit to their patients. As an observer, I was not allowed to practice social work, but I also noted situations that would benefit from social work.

When I left my position to pursue my graduate degree, a number of paramedics wished me well, and one made the statement that I should come back and study them. I kept this comment in the back of my mind and when the opportunity presented itself to investigate a partnership between social work and paramedics, my research topic was set.

In this thesis I outline my research findings regarding whether the social work role should be included in the ambulance service. My research contends that service gaps may be present in the British Columbia Ambulance System and could be addressed through a partnership with social work. I used an ethnographic approach in my research, which consisted of observations of actual ambulance work and interviews with relevant personnel.

I begin by contextualizing the role of social work in general terms and then examine the specific role and historical roots of medical social work, followed by a detailed observation of emergency room social work. As the role of social work on ambulances would most closely resemble emergency room social work, I examine the application of two major theories utilized in emergency social work. Since an exploration of this role has never been attempted, it is important to draw on a theoretical background that in my opinion closely resemble the proposed ambulance social work role.

My research explores a partnership between paramedics and social workers. I therefore examine the role of the paramedic and their interactions with patients. I consider a theoretical examination of interdisciplinary collaboration, since the role I propose would require social workers and paramedics to work closely together during patient care.

1.1 The Role of the Social Worker

Many people understand the role of social work primarily in terms of the traditional role of child protection. In my experience, people commonly perceive this profession in terms of the traditional role of social work: child protection. However, social work has assumed a multitude of roles in different specializations in society, in the community and in healthcare settings. Specializations include administration, many forms of clinical practice, policy development and implementation, community and economic development, referral and care planning, corrections and parole, non-profit work, trauma, discharge planning, case managing, as well as child protection. Social work practice, in a broad sense, “is a playing field between two goal posts – one of human development and the other of social policy development” (Rehr, Rosenberg, & Blumenfield, 1998, p. 30). Regardless of the specialization, or the population served, social work is a constant balancing act between working with clients, working with families and communities and working in society-at-large (macro practice roles).

In this project, I am primarily concerned with investigating social work roles in health care delivery. Medical social work officially began in the early 1900s at Massachusetts General Hospital under the direction of Dr. Richard Cabot, who is credited with professionalizing social work in hospitals to assist patients in keeping up medical treatment in combination with their social issues (Bloom, 2000; Rehr & Rosenberg, 2006; Stuart, 2004). The population targeted by social work in early medicine was mostly the poor, immigrants, the mentally ill, and other vulnerable people mostly likely to contract communicable diseases and require medical attention due to their social situations (Stuart, 2004). Social work became necessary to educate this vulnerable population and assist them in preventing the spread of disease and improving their quality of life, in order to prevent hospital usage.

Eventually, due to social reforms throughout the last century, early medical social work split into social-policy/community work and clinical work, the latter remaining within the hospital (Rehr & Rosenberg, 2006). The social worker’s clinical function became one of attending to a patient’s specific needs within a large medical facility and of representing the patient’s social situation to the medical staff (Stuart, 2004). Social workers “worked alongside these physicians, learning diagnoses and trying to impact their assessments of patients and their needs” (Rehr & Rosenberg, 2006, p. 25). Since physicians initiated medical social work,

collaboration between disciplines increased so that the medical community now perceives clinical social work as a necessary part of the hospital setting.

As well as representing the social and psychological needs of the client within the hospital, early medical social workers, “unlike physicians...could go outside of the hospital or clinic, into the patient’s environment, to gather information or...directly intervene with the patient in his or her environment” (Stuart, 2004, p. 10). Slowly, as hospitals were identified as helping to contain disease, provide treatment, and conduct research, institutional medicine became the norm for rich and poor alike (Stuart, 2004). In response, social workers “helped foster multiprofessional care for patients...introduced a biopsychosocial context...and individualized care within the growing social-health medium” (Rehr & Rosenberg, 2006, p. 31).

Medical social work eventually divided into community based social work and hospital social work. Community based social work appears in ambulatory clinics, community resource centers, and community case management. Specific roles include preparing discharge plans, managing support for individuals in the community, and linking people to further resources specific to their needs. This type of social work “might be best described as a return to the early history of social work in health as it responds to the needs of culturally diverse and vulnerable individuals, groups, and populations of consumers” (Egan & Kadushin, 2007, p. 102). Unfortunately, hospital social workers seldom enter the client environment, and community social workers seldom enter the hospital. A social worker who could access both patient environment and hospital setting would possess more clinical tools and community information which would better serve patients.

The role of the social worker in the hospital, while at times difficult to define, can be summarized as coordinating care and addressing patients’ psychosocial needs (Lord & Pockett, 1998). These needs vary depending on the patient, and the social worker must discover those needs and utilize clinical skills to develop care plans, perform interventions and conduct appropriate therapies within their mandate. A social worker also acts to “bridge the gap facilitating improved care. Social workers [also] bring the family’s voice to the team” (Kitchen & Brook, p. 15, 2005).

Research indicates that the involvement of social workers with patients leads to positive outcomes and better treatment. Kitchen and Brook find that “physicians stated they had more and better social information about the patient and family than they previously had, and that this

new information was helpful to them in treatment planning” (2005, p. 10). Lechman and Duder conclude from their research that a positive correlation exists between the length of stay and the severity of a patient’s psychosocial problems, indicating that social work intervention may assist in decreasing lengths of stay and potentially lead to more satisfactory psychosocial outcomes for patients (2009). Finally, McLeod and Olsson conclude from their research in the United Kingdom and Sweden that social work involvement in emergency departments “emerged as important in underwriting well-being in the longer term” (2006, p. 150). Their findings indicate that social work involvement early on led to better patient care and outcomes in the long term. Clearly, social work is an important factor during medical stays. By addressing psychosocial issues early on, better and more appropriate treatment and care plans can be developed for patients.

While the specific practice of a social worker depends heavily on the particular area of the hospital to which the social worker is assigned, in general “social workers in health settings integrate a person/family-orientated biopsychosocial model of care, into their practice as they strive to identify the needs of sick patients and their families” (Rehr et al., 1998, p. 22). Regardless of the area of practice, social workers generally employ a biopsychosocial model, in collaboration with the medical model, in order to provide a more holistic approach to patients’ needs. These needs include discharge planning needs, community referrals, financial concerns, and medical support (Corwin, 2002).

The biopsychosocial model allows social workers to assess and intervene in all systems affecting patients’ lives: social workers are able to provide support for the biological, psychological, and social components that comprise patients’ system (Corwin, 2002). In its most basic form, the biopsychosocial model assumes that health is intricately tied to an individual’s overall well being, and incorporates a holistic approach to health. As research continues, it indicate that an individual’s health is related to “the functions of emotions, cognitive outlook, social supports, and even religious beliefs,” social workers are beginning to adapt their practice to address these findings (Zittel, Lawrence, & Wodarski, 2002, p. 24). Biopsychosocial models incorporate prevention into a health model, and include recovery related not simply to symptoms, but to the individual’s life as a whole. One of the demands of the biopsychosocial model is the need for specific training in its application, which social workers often lack, as well as the need for specifically tailored care plans (Zittel, Lawrence, & Wodarski, 2002, p. 24).

Social workers often shoulder the responsibility of knowing non-medical aspects of patient care, combining psychological, social and economic components.

1.2 Emergency Social Work

While emergency social work falls under the umbrella of medical social work, it is distinct from other types of medical social work. The skill set required is specific to the unit. The emergency department is the foremost point of contact for all patients when they enter the hospital and is the place where a patient will be admitted to a unit or discharged. As a result, the emergency social worker will see a range of patients and problems, from infant to elderly, mental health to physical trauma, during the patient's initial presentation at the hospital. Rehr, Rosenberg, and Blumenfield state that performing social work in health care occurs in three areas (1998). The first is in crisis, which includes both situational crises, the result of a specific circumstance, and transitional crisis, creating change for the client. The second includes short term and episodic treatment. The third area is long-term therapy, which entails multiple sessions over an extended period of time. This area may include therapy, counseling, or case management. Emergency social work falls mostly within the first two areas and, due to the time constraints and the process of the emergency room, long-term therapy is not utilized frequently. In emergency rooms, the priority is the medical condition of the patient. This priority results in minimal amounts of time between social worker and patient. Moreover, if patients are relocated to more specific hospital units, this relocation limits the emergency social workers therapeutic relationship with family and patients.

Research specific to the role of the emergency department social worker indicates that the involvement of social work early on during hospital visits leads to greater patient satisfaction and better patient outcomes (McLeod & Olsson, 2006). The results of patient surveys indicate that emergency department social work "contribute(s) to the quality of care while they...(are) in the emergency department" (McLeod & Olsson, 2006, p. 145). In this study, McLeod and Olsson find that the social workers assist patients with advocacy on their behalf, communication of important details to the team, and psychosocial support during bereavement (2006). The beneficial nature of early emergency social work to clients further supports the need to investigate whether social work involvement prior to hospital involvement would be equally as beneficial to for patients.

1.3 Medical Social Work

Social work is a dynamic discipline. Medical social work is evolving in order to best serve patients and clients who need support. For example, medical social workers are shifting their knowledge and practice skills into the community to provide continuity of support to patients after they leave an acute care setting (Corwin, 2002; Rehr et al., 1998). An increase in care provided in the community can be seen among the communities where my research took place.

Traditionally, the primary role for hospital based social work has revolved around discharge planning and how to best support patients when they return to the community. As noted by Zimmerman and Dabelko, “assisting with the transition from hospital to community is a unique skill of social workers” (2007, p. 40). As our community needs change, however, it is becoming more important for the traditional role of social work to evolve to best support patients. Zimmerman and Dabelko argue that “standard-setting organizations are encouraging increased patient and family involvement within healthcare environments” (2007, p. 45) and that social workers should “further advocate with executive administrative leaders for collaborative models of patient care” (2007, p. 45). It could be argued that if discharge planning leads to better patient care, if early involvement of social workers in the emergency department leads to positive patient outcome, and if collaborative patient care produces positive care plans, that, potentially, early social work involvement planning for a hospital admission is also needed. This research attempts to explore this possibility. As Zimmerman and Dabelko state so clearly “increasing evidence supports the need for healthcare providers to transition from a traditional medical model...to one that supports patient and family involvement in all aspects of healthcare planning and service delivery” (2007, p. 46). Social workers are also the ideal profession to take on the responsibility of increasing patient and family involvement in care.

Social work responsibilities in hospital seem to no longer be exclusive to social work. One theory suggests this is occurring because the social work values of advocacy, empowerment, and treating the client in their environment actually are in conflict with the hospital’s mandate of quick discharges and turnarounds (Auerbach, Mason, & LaPorte, 2007). Social workers though, are specifically trained in their professional skill set, which is why, for example, nurses and social workers have distinct training programs.

One of the greatest skill sets that social workers possess and makes them best suited to addressing the psychosocial needs of a patient is their ability to navigate both complex community systems, and complex patient systems (Kitchen & Brook, 2005). Psychosocial issues rarely find themselves straightforward or clear, as they often intersect and shift between multiple areas of an individual's life. A medical problem will often have consequences in the areas of work, family, health, mobility, self-care, or finances, requiring attention and understanding of many different areas. While nursing may be able to address medical concerns, social workers possess a theoretical background in systems theory and ecological perspective, giving them a holistic understanding of an individual in their real world social and economic environments (Kitchen & Brook, 2005).

Social workers are also trained in a skill set including “brief, solution focused, and case management models” that have proven effective in patient treatment - skills that medical professionals lack (Kitchen & Brook, 2005, p. 3). As single session social work practice becomes the norm due to time constraints, heavier caseloads, and budget concerns, the need for skilled social workers able to practice this type of intervention increases. Gibbons and Plath found single session social work to be effective (2005). For our purposes, this research also indicates that not only would social work on ambulances potentially be effective, but it would also require a certain skill set in order to provide positive results. Brief therapy theory will be discussed further in detail, but I will explore why social work specifically is needed for these brief sessions.

In order for a single social work intervention to be effective, several components have to take place, often in a short period of time. These components include: managing the situation, explanation of protocols and boundaries, assessment, realistic goal setting, advocacy and negotiation, and practical assistance (Gibbons & Plath, 2005). Consequently, single session social work practice is not something that can be done without training, practice, and education because of the complex nature and logistical concerns around the time frame. It comes as no surprise, then, that “single contacts potentially encapsulate social work at its highest skill level. Social workers, within the framework of their professional values and in a short period of time, are using all their skills, knowledge and practice wisdom” (Gibbons & Plath, 2005, p. 31). While this does not indicate that single session contacts are ineffective, it does highlight that not only are only experienced and highly educated social workers most effective in this type of practice,

but also that other medical professions attempting to fill this role may not be as successful in terms of good patient outcomes. Addressing psychosocial issues as early as on ambulances, then, could be a role best designed for social workers due to their specific skill set.

As single session intervention in hospitals becomes increasingly the norm, social workers have to adapt their case management and clinical skills to match this short time frame (Corwin, 2002). Crisis theory is relevant to emergency social workers as it directly addresses a traumatic event, such as sudden death or illness, while brief therapy allows the social worker to address past issues that are relevant to the present in a time sensitive manner (Rehr et al., 1998). In both approaches a “client-centered, problem-focused approach, in conjunction with the use of rapport-building techniques such as attentiveness, concern, respect, and genuineness, aid in the rapid establishment of a positive working relationship” (Corwin, 2002, p. 187). Building the relational component of a therapeutic alliance first ensures, potentially at least, that both brief therapy and crisis theory could be effective once taken out of the standard emergency room. In order for emergency social work to be extended and to be effective in the community, both crisis theory and brief therapy should, in my opinion, remain as primary theoretical frameworks for practice. Combining brief therapy and crisis intervention ensures that a therapist is engaging the client’s coping strategies and establishing that the crisis is an opportunity to expand the client’s normal coping skill set, all within time sensitive constraints (Corwin, 2002). Not only is the situation being treated, but also the psychological response as well as the social situation can then be addressed once the crisis has been worked with. An individual is less likely to respond to a holistic care plan when they are in a crisis situation.

Below I explore the use of crisis theory and brief therapy as they might apply to social work in ambulance work. I will also explore the role of the paramedics and how collaboration between paramedics and social work might be achieved in light of potential partnerships. The role of social work during ambulance work will be quite comprehensive and require a broad range of skills and knowledge.

1.4 Crisis Theory

Cope and Wolfson define crisis in a tripartite way (1994, p. 70). They state that a crisis is a situation with no clear guidelines, rules or frames of reference for the individual to use, which is extremely stressful with no clear end in sight, and, to which normal coping mechanisms are frequently useless. Using this definition, a crisis may encompass a variety of incidents, ranging

from stereotypical medical crises, to events in the past that continue to influence present day behaviour. Often traumatic events, which occurred in the past, are not properly processed or worked through. By understanding what factors create crises, useful interventions can be developed and implemented

According to Cavaiola and Colford (2006) a crisis embodies five characteristics:

1. It begins with a spontaneous event;
2. The state of crisis is time limited;
3. A state of instability and ineffectiveness is produced for the individual;
4. The reaction of the individual to the crisis is determined by his/her cognitive interpretation;
5. As a result of the above, a collapse in the individual's capacity to cope will occur;

When an individual experiences a crisis, a crisis social worker must “bring order out of the chaos of real life crisis using only their training, ingenuity, and clear-headedness” (Cavaiola & Colford, 2006, p. 20). A few of these skills include making sense of the crisis for the patient, anticipating the client's needs, making rapid assessments, quick and non-traditional problem solving, and thoroughly understanding the available resources. Often times the luxury of an office, booked time, or even privacy are unavailable when working within emergency departments among scenes of trauma, which can be both psychological and physical. Unlike psychotherapy, crisis intervention requires a more active approach (Greenstone, 2008). Crisis workers use techniques that “are not therapy, although they are therapeutic; they are short in duration and are designed to bring victims to a state of semi-equilibrium” (Cavaiola & Colford, 2006, p. 20). Examples of these techniques include directing the patient through the next steps of the process, such as phoning family or preparing for extended stays in the hospital, encouraging the individual to eat or sleep, and advising both patients and families what to expect in the following days. Crisis work requires the social worker to be able to assist patients with decision-making and identify needs, act as a liaison between different groups, and provide counseling (Corwin, 2002). These skills all stem from the individual, group, community, and clinical training that social workers undertake in their education.

It should be noted that emergency crises that require social work services include more than medical emergencies, which result in emotional upheaval for patients and families. Individuals access emergency services in other ways; for example, they may call an ambulance but may not be transported to hospital. Further, domestic violence, addiction, and pregnancy loss are considered traumatic by the definitions above. What one individual may perceive as an inconsequential event may be perceived by another individual as a traumatic incident, demonstrating that social workers could be called upon to intervene in a broad spectrum of incidents that can be considered crises. Regardless of the severity of the traumatic event, Brown argues that the initial contact between therapist and patient shapes how the individual normalizes the event in the future as well as their responses to the immediate crisis (2006). Without social work intervention, clinical outcomes would be dramatically different and quite possibly negative. Thus, social work is a necessary element of an appropriate response in crisis intervention.

1.5 Brief Therapy

Once a therapist makes contact with an individual in crisis, the therapist uses specific therapeutic action to provide support. Not all therapeutic models can be used in a crisis or emergency situation due to time constraints and other uncontrollable factors. Brief therapy is one model that social workers and other clinical therapists use in non-traditional situations, such as emergency rooms. Since the goal of therapy in hospitals is typically to help patients with the recovery process, their adaptation to a new disease, or their life post treatment, health care settings provide ideal situations for brief therapy because the setting in which social worker is practices limits patient contact (Corwin, 2002).

One of the fundamental principles of brief therapy is the notion that “what clients know, think, feel, and want has far more relevance to problem resolution than the favored academic conceptualizations” (Bannink, 2008, p. 216). As brief therapy has grown and evolved, it has become “more strength orientated, collaborative, and accessible than earlier models of strategic therapy, and such emphases are clearly more compatible with the traditions of mainstream social work practice” (Stalker, Levene, & Coady, 1999, p. 473). Through further client involvement in therapy and encouragement of client direct input in the goals of therapy, client participation could be expected to increase, thereby increasing the number of positive results. As social work

centers on the idea that clients are the experts in their own lives, brief therapy supports their participation and desired outcomes, to a certain extent.

Emergency social work frequently limits client contact to a short, single meeting before the hospital discharges or moves the client. As such, social workers must use their time with clients effectively in order to result in beneficial outcomes for clients. The question then becomes whether or not a therapeutic relationship that lasts for a single session is effective. This question is directly relevant to the notion of practicing this type of social work on ambulances. Research conducted in a clinic in Calgary, Alberta offered clients single walk-in sessions without registration processes, wait lists or formal assessments (Slive, McElheran, & Lawson, 2008). The therapists used a combination of techniques in order to maximize benefits, including immediate commencement of the therapeutic alliance, focused questions, and closure to remove the need for follow-ups. Results indicate that participants felt that this model of therapy delivery was helpful and effective, and therapists felt that the accessibility of the therapy provided a much-needed service (Slive et al., 2008). As these single sessions resulted in clients and therapists speaking about beneficial outcomes, it is possible to conclude that single sessions with social workers, when used properly, may benefit clients who ambulance experience does not result in a trip to the emergency room.

1.6 The Role of the Paramedic

While paramedic positions vary slightly from province to province and country to country their role in British Columbia can be summed up as pre-hospital care. This care includes medical emergencies that require transport to hospital, inter-facility transfers, and responses to 911 calls that are not transported to hospital. Paramedic training consists of several levels. Primary Care Paramedics take a qualifying course, while Advanced Life Support Paramedics receive 18 extra months training for further pre-hospital care (personal communication, April 28th, 2010). British Columbia Ambulance System does not cover training for ambulance paramedics.

When on shift, paramedics work in teams of two, with one driver and one attending paramedic. These roles switch between partners regularly, as the attending paramedic is the primary paramedic for the shift and performs the majority of patient care. This role includes the majority of verbal contact with the patient or family, assessment of the situation, explanation of

treatment, and decisions about patient care. In consultation with the attending paramedic, the driving paramedic supports the attending by securing equipment, taking pulse and blood pressures, filling out paperwork, and providing a second opinion to their partner.

Paramedics are not trained to refer to community agencies and this task is not included in their job description. It would be virtually impossible for paramedics to distribute resources for psychosocial concerns while simultaneously attending to medical issues; it would simply be too much to address, especially when dealing with more pressing medical concerns. Psychosocial support is beyond their level of training and outside their scope of training. Social workers in emergency departments are able to pick up where paramedics have identified psychosocial concerns; however, there is no follow-up unless the patients are transported to hospital.

As their role is pre-hospital care, paramedics frequently lack the time to treat patients beyond their immediate biomedical needs. Psychosocial needs are not a priority, leaving these needs unaddressed or untreated. If a patient is transported to hospital, paramedics can refer him or her to a social worker on duty, but after hours or when the medical needs of the patient are too great, there is no guarantee that a referral will be made for further follow-up. Thus, the issues of identifying the psychosocial needs of a patient and following up for social work and community referral are often overlooked and unaddressed in paramedic work.

Abuse and domestic violence are two scenarios in which, despite their involvement, paramedics are unable to refer patients to community resources. Abuse can range from child abuse to elder abuse. Not only physical, abuse can include neglect, isolation, and emotional, sexual, and financial abuse. Since abuse is “more predictive of medical contact than age, ethnicity, self-reported symptoms, and injurious health behaviors” (Pelucio, 2001, p. 567), I argue that it would benefit the health care and ambulance systems for social workers to have the capacity to make community referrals in these situations. The positive results for the client in terms of psychological well-being and quality of life, as well as savings to the health care system from repeated visits, ambulance calls, and activation of emergency services, could be significant. Unfortunately, domestic violence continues to be undetected by ambulance workers due to lack of recognition, as well as victims’ lack of follow-up, making community outreach more important for victims (Davis, Parks, Kaups, Bennink, & Bilello, 2003; Greenstone, 2008). Social work is utilized in domestic violence situations to make referrals for resources and provide support to victims, but if victims are not brought to the hospital or knowledge of resources is not

available from the professional, victims will go unsupported. Social work outside of emergency rooms would provide follow-up and referrals that could eventually stop the abuse. Further social work intervention at this stage could take strain off the ambulance system due to repeat calls. I will explore this issue more fully later in the thesis.

Paramedics are charged with responding to medical emergencies; however, knowledge of emotional first aid is just as important as physical first aid (Greenstone, 2008). As Greenstone states, “if we do a good job providing crisis intervention, the need for therapy may be greatly reduced” (2008, p. 97). Not only do patients need medical intervention, they need therapeutic intervention in times of crisis in order to minimize the lasting effects of abuse, such as family breakdown, emotional problems, post traumatic stress disorder, and anxiety. Feelings of guilt and blame may also surface during a crisis, and if left untreated may manifest into long lasting issues for individuals and patients.

Paramedics are exposed to situations that affect not only the current and future mental well being of the patient, but also the mental well being of paramedics themselves. As stated by Regehr and Bober “paramedics, as a result of the nature of their work, report significantly higher rates of exposure to death of patients, multiple casualties, deaths of children, and violence against others, with 80% reporting exposure to each of these events” (2005, p. 13). These situations involve paramedics not only navigating medical issues, but also working with patients, families, and bystanders of crises. The high prevalence of these situations leads to the conclusion that, if not trained properly on how to manage the psychological component of crisis, paramedics may be adversely affected in their own lives with anxiety, depression, PTSD and traumatic situations (Regehr & Bober, 2005).

Social work in these situations would provide immediate services not only to patients, but to paramedics as well. A trained individual who has witnessed the scene or understands the type of work that a paramedic does may be better able to provide emotional support than another paramedic. Ethical issues may also prevent colleagues from helping colleagues. Further, many people may be embarrassed to ask for help or think that they are coping well, when they are not coping well at all. Direct access to support could provide immediate debriefing or brief therapy, thus eliminating much of the perceived stigma that primary care paramedics, PCP’s, may associate with calling an outside agency, which stems from an assumption among themselves and their peers, that they cannot handle the job.

Moreover, the management of crises scenes may can be just as overwhelming as the crisis itself. Paramedics encounter people of all ages, cultures, ethnicities, classes and lifestyles: parents, children, immigrants, teenagers, spouses, and babies (Steen, Naess, & Steen, 1997). Unfortunately, this multitude of people means that paramedics have to control the situation, work with family or bystanders, ensure their safety, and communicate with dispatch, all while trying to provide medical care, which can become challenging. In one study, “responders described situations where parents were screaming and beating on the backs of firefighters and paramedics as they were attempting to assist an injured child or baby” (Regehr & Bober, 2005, p. 16). In this situation, neither the family nor the paramedics get the support that they need, either to process their child’s condition or do their job. Social workers present at the scene may be able to provide crisis intervention with the family, make appropriate community referrals, and support paramedical workers after the event has finished. While paramedics may be aware of psychosocial aspects, they may not have the time or tools to properly break traumatic news to family members (Steen et al., 1997). Importantly, “this (ability) is critical, as the first contact will have significant impact on the grief process and bad news conveyed in an appropriate, incomplete or uncaring manner may have long-lasting effects on the family” (Steen et al., 1997). Paramedics are frequently patients and families first or only professional contact, receive medical, not psychosocial training and it may be challenging to expect their job to include the larger elements of identification of potential psychosocial issues, psychosocial support and community referral.

This thesis argues that these gaps in service could be addressed through a partnership between social work and paramedics. Interprofessional collaboration between these two disciplines would address both medical and psychosocial needs without overburdening paramedics with more responsibilities outside of their area of expertise.

1.7 Interprofessional Collaboration

Interprofessional working can be complex as it involves collaboration between individuals from different professions with different mandates and different ideas of what interprofessional collaboration means (Salhani & Coulter, 2009). Interprofessional, interdisciplinary, multidisciplinary, and cross -disciplinary and transdisciplinary are only a few of the terms used to describe different forms of interprofessional working. Interprofessional work in health care, regardless of the specific form, can be defined as “the process whereby

members of different professions and/or agencies work together to provide integrated health and/or social care for the benefit of service users” (Pollard, Sellman, & Senior, 2005, p. 10).

Interdisciplinary teams conduct a specific form of interprofessional working. One of the central reasons for integrating such teams is to ensure that comprehensive standards of care, even within large organizations, are maintained for the benefit of clients (Chan & Rubino, 2010). Collaboration between disciplines is utilized to assist individuals who are frequent users of multiple agencies, providing more holistic care for numerous complex needs, which may also prove cost effective (Finlay & Ballinger, 2007; Forst, 1997). Specific advantages to interdisciplinary work for professionals also include a larger range of expertise, the sharing difficult situations and cases, the better division of tasks, and the support of team members (Aronoff & Bailey, 2003).

However, interdisciplinary practice is not without its difficulties, especially among professions with different training, viewpoints, and mandates (Salhani & Coutler, 2009). Common difficulties include status differentials among team members, different professional languages and values, the desire to protect one’s own profession, and a lack of understanding concerning different roles among team members (Whittington, 2003). Regardless of the challenges and difficulties, “agencies, their social workers, other professional staff, and managers are engaged in more planned and formalized arrangement: that is joint projects, multi-agency teams, and integrated services” (Whittington, 2003, p. 54). If organizations continue to integrate services to improve patient care, providing social work on ambulances is a logical choice not only to benefit patients, but also to decrease non-emergent visits to emergency departments by providing community resources to patients. I will revisit this hypothesis later in Part Five.

While social workers and paramedics have not worked as a unit outside of emergency rooms, social workers collaborate with police to provide psychosocial support during their emergencies, such as house fires, assaults, sudden deaths, next of kin notification, and most often in child welfare cases. Most police departments throughout Canada employ combinations of volunteers and paid victim service (Royal Canadian Mounted Police, 2009). I conducted my research in an area where the Royal Canadian Mounted Police and Vancouver Police Department detachment services the same areas as the ambulance stations. In one area, the RCMP employ two fulltime victim service workers and a number of auxiliary staff to be on call

at all times support in situations such as motor vehicle accidents, suicides, next of kin notifications, sexual assaults, sudden deaths, and fires (Royal Canadian Mounted Police, 2009).

As previously noted, social workers are skilled at providing knowledge and therapeutic and other skills to emergency services, and this ability also extends to medical social work. Social work has long had a role in the medical community for psychosocial support. The collaboration of social work, psychiatry and general medical practitioners allows “social work practitioners to intervene in human problems that must be understood to their full complexity if they are to be successfully treated” (Proctor & Rosen, 2003, p. 102).

Paramedics also engage in interprofessional collaboration in their work. In a pilot project in the United Kingdom, a nurse was dispatched with a paramedic for low priority ambulance calls (Machen, Dickinson, Williams, Widiatmoko, & Kendall, 2007). Upon completion of the project, “paramedics and nurses believed that the interprofessional working had improved quality of care and prevented unnecessary transfer to hospital” (Machen et al, 2007, p. 190). Additionally, paramedics and nurses learned new skills, which increased patient care, and both professions thought that the improved teamwork benefited patients (Machen et al., 2007).

Further collaboration between paramedics and nurses was studied in Sweden, where nurses were paired with emergency dispatchers (Forslund, Kihlgren, & Sorlie, 2006). While the collaboration began uneasily, with both professions feeling uncomfortable, eventually both dispatchers and nurses agreed that the pairing worked to instill higher confidence in both professions, provide better patient care, and eventually resulted in complementation between the two professions (Forslund et al., 2006).

Collaboration between social work and paramedics has yet to be seriously considered, however, and the studied collaborations between police and social work partnerships, such as victim services, paramedics and nurses, leads to the conclusion that there are situations where social work and paramedical should intersect (Forslund et al., 2006; Machen et al., 2007; Royal Canadian Mounted Police, 2009). Just as the police have psychosocial support for the emergency situations that they encounter and follow-up for needed referrals, paramedics could eventually benefit from such collaborations considering the similar situations that they encounter on a regular basis.

1.8 Developing Social Work Roles

The involvement of social workers in health care began in the 1900s in support of Cabot's holistic model of health care (Rosenberg, Blumenfield, & Rehr, 1998). Such a model acknowledges that "an integral relationship exists between people's health and their environment, to the extent that although confronting the actual infective and causative agents of disease is critical, it is secondary to changing the social and physical environmental conditions that permit disease" (Rehr, Rosenberg, Walter, Showers, & Young, 1998, p. 133).

Social work in health care developed out of a call to address non-medical client needs, in order to improve the overall health of the person. "The domain in which social workers practice is being continuously re-drawn" (McDonald, 2006, p. 98), requiring the position to change and evolve in response. The changing health care needs of the population - influenced mainly by increasing life spans and developing technologies - have been the driving force behind medical social works' evolution into hospital, clinical, and community healthcare roles (Egan & Kadushin, 2007; Rehr & Rosenberg, 2006). Originally playing a combined hospital/community role, social work's influence then retreated solely to hospital. In the present day, the changing needs of the population have resulted in a differentiation between hospital and community roles. The population's needs continuously evolve, and these needs may be unmet by the current division of hospital and community services. A social work role that integrates both areas would fill a gap in service, echoing past developments in medical social work that arose during times of population transition. This thesis explores one such possible role for social workers.

If a social work position were to integrate both community and clinical medical roles, one would anticipate the skill set and knowledge required to be an amalgamation of both areas. Understanding and developing community resources, key players, and referral systems might be just a few of the necessary areas of expertise for a social worker in this new role. Combined with skills in brief therapy and crisis intervention, this role may require a social worker well versed in multiple areas. This position would likely require more than a general knowledge of community and clinical medical social work, as such, an expert or specialized knowledge level may be required in order to perform the job skills necessary.

In order to develop a new role social work, theory and practice guidelines must be set out to guide and define the nature and scope of the role. Practice guidelines are "a set of systematically compiled and organized statements of empirically tested knowledge and

procedures to help practitioners select and implement interventions that are most effective and appropriate for attaining desired outcomes” (Proctor & Rosen, 2003, p. 84). The first step in the development process is to explore the possibility that a partnership between social work and ambulances might be beneficial.

As noted by Aronoff and Bailey, “in *practice*, interprofessionalism means designing and implementing a contextually based, comprehensive, and collaborative approach to assessment, intervention, and evaluation” (2003, p. 261). Not only would practice guidelines be needed for a new social work role on ambulances, but the working relations between paramedics and social work would need to be investigated in order to understand what this collaborative working relationship would look like in practice. The only way to systematically develop practice principles as well as a collaborative working relationship is through research. According to Aronoff and Bailey, “in an applied field, good research serves practice, helping us better understand and respond to social issues through evolution of best practices and relevant knowledge base” (2003, p. 265). My research explores how social work might approach collaboration with paramedics, and how current collaboration between emergency services is conducted. I will examine the issue of interprofessional collaboration with between social workers and paramedics later in the thesis.

Medical social work is an area of practice that has evolved to meet current population and client needs, and ambulance work may be one area that is in need of development. This project is based on a hypothesis that there is a gap in the ambulance system that could be addressed by an inter-professional collaboration between social workers and ambulance paramedics. Although my ethnographic research project used the British Columbia ambulance system as a field of research, I will provide qualitative evidence:

1. That a demonstrable need exists in the ambulance system that could be addressed in a partnering role between social work and ambulances;
2. That it describes the parameters of this new role, and how it would function within current social work practice;

Without research to support the notion that medical social work can be extended beyond the emergency room and re-establish itself in the community, a new social work role cannot be developed. It is through my research that I investigate the creation of a new social work role.

2 Research Methods

2.1 Background

The inspiration for this research project stemmed from personal experience during paramedic rides along. During these ride along sessions, I wanted to observe if a gap in service existed for patients and families of emergency service calls. Statistics from 2008/2009 show a total of 212,871 calls were placed in the Vancouver area to 911, with 82,266 of those calls requiring transfer for further treatment (British Columbia Ambulance Service, 2008/2009). That means that 61.35% of calls were not transferred to hospital, and consequently, 61.35% of calls did not connect with members of the interdisciplinary team in the hospital.

For those patients who were transferred to hospital, I noticed that support for their families was limited to the paramedic team, who were often rightly pre-occupied with the medical condition of the patient. From my initial observations, the idea of researching the possibility of creating a social work-paramedic partnership surfaced. While some literature exists on this topic, only a few researchers have studied this topic. This combination of factors led me to develop an ethnographic study to explore the feasibility of a social work role on ambulances, explore what this role might look like and determine how this role could be implemented.

I employed qualitative research methods in this social work project. Qualitative methods can be used when “one wishes to explore a topic or phenomenon of which little is actually known” (Padgett, 2008, p. 345). The nature of the research design, the need to present a detailed view of the setting, and its exploratory quality, indicated that qualitative research would suit my purposes (Creswell, 1998). As the “purpose of qualitative research can also be to explore phenomenon such as test ideas, assumptions, or variables or assess/evaluate something” (Thyer, 2010, p. 343), qualitative research methods were a natural choice for an exploratory study due to the current lack of research in this area. As there was little to predict where the direction of the project would go or how to frame the progress of the project, a quantitative design would have been impractical. Qualitative methodology allows the direction of the project to progress at the same pace as the investigation (Padgett, 2008).

The purpose of qualitative social work research is to produce an accurate description and rich text by documenting the words or observable actions of individuals, groups and social

relations (Thyer, 2010). Ethnography, as a method of qualitative research, “helps to discover human needs. And therefore it helps to find ways for meeting those needs” (Rice & Ezzy, 2000, p. 154). Moreover, upon examination of both social work and ethnography, “the use of self, awareness of biases, exploration of context, the native’s or client’s perspective, acknowledgement of different cultural realities and patterns, non-judgmental attitude, reflection, and the process of self-monitoring” are seen to be common to both areas (Thyer, 2010, p. 435).

Applying ethnographic research to a health discipline, for example, by observing and recording ambulance services, is a relevant and applicable methodology. As Rice and Ezzy argue,

ethnographic research is not only concerned with understanding the world of people under study, but with applying its findings to bring about change. This is particularly valuable in the health area, where information gathered from ethnographic research can be applied in order to change health practices (2000, p. 169).

This research explores the possibility that the health practice of providing social work support in emergency rooms could be extended beyond what is traditionally viewed as a social work area. This expansion would drastically change the practice of health delivery and the standards of care afforded to patients serviced by ambulances.

Ethnography can be viewed from two different perspectives: conventional ethnography and critical ethnography. Thomas defines critical ethnography as posing the question of what could be, as opposed to conventional ethnography describing what is through the viewpoint of a theoretical standpoint (1993). Similarly, a critical ethnographer attempts to create some type of change around what the conventional ethnographer describes (Thomas, 1993). Critical ethnography then attempts to view traditional ethnography as a vehicle for public awareness and social change built around a framework of academic theory (Foley & Valenzuela, 2005; Madison, 2005; Thomas, 1993).

This thesis not only investigates the possibility of social work on ambulances, but examines whether the population served by paramedics would benefit from professional social work prior to, during, or in absence of their hospital transfer. By looking at the opportunity to expand the traditional emergency social work role, this research project not only attempts to describe a service gap, but also suggests changes to overcome that gap. Simply suggesting change is not actually implementing change. However, critical ethnography is a method of

calling into question certain ways of doing things, and while this method may not be enough to change these ways, it is an essential beginning (Kincheloe & McLaren, 1994).

Critical ethnographers have evolved in their topic choices and are “focusing more on dramatic public issues, and they are finding ways to reach wider audiences” (Foley & Valenzuela, 2005, p. 220).

The difference between critical and conventional ethnographic topic choices begins with a passion to investigate an injustice (e.g. racism); social control (language, norms, or cultural rules); power; stratification; or allocation of cultural rewards and resources to illustrate how cultural meanings constrain existence (Thomas, 1993, p. 36)

This research project examines service delivery to patients served by the ambulance crews. Many calls were not transferred to hospital during my initial ride along due to a lack of access to hospital resources. This lack of resources means that clients’ psychosocial issues continue to be cyclical, thus maintaining the status quo in their lives due to lack of resolution. The use of critical ethnography allows me to view the research from the lens of social change and examine the implications that result from the data collected. Coupled with the past use of critical ethnography to promote professional and social change this method was a natural choice for this research project.

Exploring the creation of a social work role in this setting has been minimally investigated by researchers. After extensively viewing the available literature with the assistance of an expert who specializes in searching bodies of knowledge, I was unable to find any research regarding the specific role that I propose in the ambulance environment, thus leaving me uncertain as to what conclusions the research would lead to until I had collected data, which was a process of discovery. Critical ethnography allows for this flexible direction, and maintained the purpose of changing social work roles throughout the project.

2.2 Methods

The ride along research took place primarily out of a station in Vancouver, with several ride along sessions being done in other communities at the invitation of paramedics. For confidentiality purposes, I am unable to disclose the exact stations and crews with whom I had the privilege of riding. The British Columbia Ambulance Service designates this area, which

consists of 131, 810 people as metropolitan (British Columbia Ambulance Service, 2008/2009). The ambulance service for this area consists of three 24-hour ambulances, with an additional ambulance during daytime hours (personal communication, April 20th, 2010).

Because “ethnographers typically use an informal strategy to begin fieldwork, such as starting wherever they can slip a foot in the door” (Fetterman, 1998, p. 33), I chose a specific station as the primary site for this fieldwork because of my previous experience with its ambulance crews. Building on this relationship and requesting access to do formal fieldwork became a matter of paperwork and formalities, rather than introductions and building trust. I completed 300 hours of fieldwork and rode with the crews collecting data, which included observations, a field diary, and formal interviews with paramedics. Once further relationships were built, access to stations in other areas, were established and I was invited to expand my research.

The process of setting up fieldwork began six months before the commencement of the research itself. During November 2009, I made an informal request to station crews to determine if they would be willing to take on a researcher for 25 shifts at 12 hours each, beginning in April 2010. Following this verbal agreement, I made a formal request (February 2010) to the Acting Chief of the Station, which he forwarded to the appropriate British Columbia Ambulance System Area Manager. I supplied a formal package containing the approved thesis proposal, the UBC Okanagan Ethics Application, and the Informed Consent forms to the Area Services Manager for review and approval. I received a letter outlining the formal approval of BCAS and was able to commence research in April 2010 after receiving the final approval and certificate from the UBC Okanagan Ethics Board.

The approval process, while straightforward and necessary, came on the heels of a BCAS strike, as well as during the 2010 Winter Olympics in Vancouver. At the time of setting up fieldwork, BCAS had been in the process of on/off negotiation with the provincial government for a year in order to secure contracts for BC paramedics. This conflict was well publicized in various media and tensions between both sides were evident. Securing fieldwork in the midst of this controversy required added time and patience in order to respect the boundaries and positions of the frontline paramedics.

During the months of February and March, Vancouver welcomed the 2010 Olympics and Paralympics Winter games. This event significantly increased the number of people and area

covered by paramedic crews. Combined with an increase in service, major road closures, and additional required overtime and planning, paramedic crews were extremely busy during this time. While they were eventually able to negotiate the setting up of my fieldwork, it did take longer than originally anticipated due to the extraordinary circumstances.

The paramedics were a varied group. I rode with men and women, paramedics with years of experience and those new to the profession, regular crews, and those covering vacations. Their ages ranged from those in their early 20s to close to retirement. Some had found the profession by accident decades ago, while the newer paramedics had taken specific steps and training for their position. A few had additional schooling, such as bachelor or graduate degrees, but preferred paramedic work. It would be hard to pinpoint a specific demographic that I rode with as the crews were varied in their education, background, age, experience, and motivations for being in the field.

Once fieldwork commenced, I used a variety of methods in order to ensure adequate findings. The most significant method of data collection was participant observation. Participant observation can be described

as a three-stage process in which the researcher somehow, first, gains access to a particular community, second, lives and/or works among the people under study in order to grasp their world views and ways of life, and third, travels back to the academy to make sense of this (Crang & Cook, 2007, p. 37).

My fieldwork involved actively participating in the work environment of the paramedics in order to collect data in support of my research goals. The calls took me from ambulances to various major hospitals in the area, through peoples' houses, and at various paramedic stations where I rode. Observing paramedics during their work resulted in doing night shifts, working in adverse weather conditions, taking breaks when they took breaks, and being exposed to the same situations as they were. Participant observation resulted in data collection from people, calls, group dynamics, and observations from which meaning of the situation to the research subjects could be determined through conversations with paramedics and observations made on shifts (Thomas, 1993). Formal interviews were conducted with paramedics, and informal conversations with firemen and police. Data collected during calls included the details of the situations, what types of interactions occurred between rescue workers, and the outcome of the

situation. General observations not related to a specific were made in order to record context, daily routines, and paramedic procedures. I recorded these details in notebooks I kept with me throughout research.

Performing participant observation required more than simply taking notes of what occurred during the ride alongs; I searched for deeper meanings, patterns and exceptions to behaviour, and an understanding of practices related to the paramedic situation (Barbour, 2008; Fetterman, 1998; Fife, 2005; Thomas, 1993). Participant observation of the paramedics spanned a variety of shifts, calls, and situations, which allowed me to study a process, such as responding to a 911 call, and to record in depth observations (Thyer, 2010). I viewed a specific behaviour over a variety of settings, performed by a variety of people, and made further interpretations and conclusions regarding this situation. Three hundred hours of participant observation fieldwork provided sufficient time, for an adequate assessment of the role of paramedics. Due to the number of hours set up in the initial agreement, long-term participant observation could take place for deeper investigation of behaviours encountered in the first phases of fieldwork and that were of greater interest as the research progressed. Behaviours could have been missed at the initial phases of the research, but long-term observation allowed further opportunity to observe and record these situations. Because anomalies are pieces of observation that lead to further investigation and produce relevant data (Thomas, 1993), long term participant observation is important in the field in order to be able to identify these anomalies.

Ethnographic research requires multiple methods for data collection in order to produce a holistic and comprehensive depiction of the population studied (Fetterman, 1998). Interviewing participants is crucial to investigation of “the interrelationships among the various systems and subsystems in a community under study” (Fetterman, 1998, p. 19). My interviews during this research project were a combination of semi-structured and open format. During the initial phases of fieldwork, open-ended questions were used primarily in the discovery phase to determine which points were important to respondents and required further pursuit (Fetterman, 1998). An open format allowed the participants to interpret the question and choose the direction of the interview (Fetterman, 1998; Fife, 2005;). In this method, “the interviewee is given the opportunity to shape his or her own responses or even to change the direction of the interview altogether” (Fife, 2005, p. 95). An open interview also gives the participant the “right” to assume the meaning of the question, instead of being led by the researcher (Fife, 2005). I found this type

of interview to be important for my research, as it was imperative that I gained insights that the paramedics felt I should know for my research, rather than limit their responses. As the role I propose would work directly within their organization, paramedics have some expertise concerning what might be the most beneficial activities for this role and how these activities might function effectively.

Throughout the process of gathering fieldwork data, I also conducted semi-structured interviews in the form of guided interviews with specific research objectives, but without explicit questions (Fetterman, 1998). This process took the form of open-ended questions and allowed flexibility to ask further questions based on participants responses. I had several set questions to ask each paramedic, but allowed participants to deviate and offer information they felt was necessary. Those interviews were conducted once time had been spent doing participant observation because they are “most valuable when the fieldworker comprehends the fundamentals of a community from the ‘insider’s perspective’” (Fetterman, 1998, p. 38). A total of five semi-structured interviews were conducted over the course of fieldwork with a variety of paramedics, including Advanced Life Support and Primary Care crews. Cabbage Tree Solutions transcribed them and the transcriber signed a UBC Okanagan confidentiality statement.

Field notes were the foundation of data collection throughout the fieldwork. Different types of notes were taken in order to provide a thorough description and understanding of the situation. As stated by Rice and Ezzy, “fieldnotes contain not only descriptions of what the ethnographer has seen and experienced, but also her perceptions and interpretations of the events” (2000, p. 163). Detailed fieldnotes were taken during every ride along and included observations regarding every aspect of 911 calls, from the dispatch to the hospital transfer. Details were written in short hand when time did not permit note taking and later transcribed during free moments or after a shift was completed. This process was done on a daily basis to ensure accurate details and descriptions.

Note taking during the semi-structured and open interviews, while incorporating similar strategies from field notes, also included information and descriptions concerning the context of the environment. Contextual details about the interviews were included, ensuring that features regarding the setting, general atmosphere, and events that occurred before and after the interview were recorded (Barbour, 2008). These details were included to ensure that they were available for future analysis, if needed.

The last type of note taking was the creation a field diary. While commonly confused with field notes, a field diary is a separate entity entirely (Crang & Cook, 2007; Fetterman, 1998). The purpose of a field diary is to record what is learned on a daily basis and make sense of understandings and misunderstandings (Crang & Cook, 2007). A field diary can also act as a coping method for the researcher throughout the fieldwork experience (Fetterman, 1998). Thus a field diary can be a space to write about biases, feelings and reactions to events, and personal thoughts that may affect the data. Looking back over a field diary also provides material to reflect upon during the process of fieldwork.

Using a variety of procedures, I collected of data from multiple sources for analysis. In conformity with research ethical protocols, all notes and other materials were kept in a confidential field office and locked in a secure file cabinet while the research was in progress. Computer sources were password protected to ensure confidentiality. All identifying information was kept out of all sources of data and participants were identified solely through codes to ensure confidentiality. Only my thesis committee and I were privy to identifying knowledge. Upon completion of the research project, the field notes will be kept in a secure and locked location until they are destroyed.

Validity and reliability are two components of any research project that must be maintained in order to produce credible results. As well as validity and reliability, trustworthiness and credibility were also considered when establishing my methodology. As stated by Thyer, “to achieve internal validity using narrative data, researchers must demonstrate that the data collection was conducted in such a manner as to ensure that the subject under study was accurately identified and described” (2010, p. 363). Validity can be considered the level to which data are considered justifiable and logical. Several strategies were used throughout this project to ensure as much validity as possible. The first strategy involved ensuring that the fieldwork was a prolonged engagement, allowing enough time to observe behaviour and the culture (Thyer, 2010).

Purposeful sampling was the second strategy employed during this research project and involved choosing participants for ride alongs and interviews that were able to contribute to the project (Thyer, 2010). The participants I chose were determined by their willingness to participate, the area of the community they covered, and the shifts they were scheduled to work, such as a weekend versus a weekday. Once I determined that I would like to gather information

pertaining to a certain area or time, I approached the paramedic team and asked if they would be willing to be part of my research and allow me to accompany them.

The third strategy for ensuring validity was characterized by the method of triangulation, which always improves the data quality and accuracy of findings (Fetterman, 1998). Triangulation “is at the heart of ethnographic validity – testing one source of information against another to strip away explanations and prove a hypothesis” (Fetterman, 1998, p. 93). This method was arduous, as it included using multiple methods of data collection, and ensuring that I was the only individual performing interviews and analysis (Thyer, 2010). Throughout the research project, I collected data using different methods of observations and interviews performed by only myself, in an attempt to ensure, to the highest level possible, an acceptable level of qualitative validity. The final strategies that increased the validity of the project were the support of the committee through debriefing and supervision, the documentation of the personal biases and feelings in the field journal, and the periodic checking of that the data that I collected for accuracy with the participants of the study (Thyer, 2010). Through the maintenance of the above practices, my data are authentic and justifiable.

Furthermore, reliability is the level of accuracy in a study and requires different methods in order to ensure high levels. Reliability is increased detailed note taking during the period when behaviour is displayed or immediately afterwards. In addition to keeping detailed notes, I expanded any shorthand versions or cueing words immediately after a shift at the end of each day, or soon thereafter, in order to record the most accurate details. In addition to ensuring validity, keeping a field journal increases the reliability of the project because it is another source of description and detail. Finally, I improved reliability through an organizational system for all notes, descriptions, data, and information (Thyer, 2010). I collected data in the same notebook, and separated it according to general observations and observations specific to a call. I also kept the same format for information recorded pertaining to calls was kept. I kept interviews separate from the observations. I analyzed the data on new print outs each time I entered the data into the computer, in order to view the progressions, and organized the information according to its stage in the analysis. This procedure allowed me to sort and classify information for future use.

Following fieldwork, I sorted the data were sorted into different types. Data collected included data pertaining directly to specific 911 calls, such as call time, weather, progression of the intervention, comments made by the patient and rescue teams, and the final disposition

(hospital versus no transfer). I also collected data regarding the general culture and process of paramedics. This data included role responsibilities, procedures, shift patterns, seniority systems, and job descriptions. The data came in the form of observations, interviews, and informal conversations.

I analyzed the material through coding. The coding process outlined by Crang and Cook (2007) involves four steps done by hand:

1. Open Coding: Involved coding by examining the intent of the statement or content before looking for specific themes;
2. Similarity Coding: Involved a second examination of the data looking for similar events, subjects, and acts, and grouping them together into categories;
3. Sorting: Involved arranging the data, including deleting repeating codes and themes and combining similar themes;
4. Organizing: Involved organizing codes according to their classification;

Once I completed the process, I was able to understand the data and use it to make inferences regarding the original research questions.

My coding strategy followed the basic premise outlined by Crang and Cooke, but included modifications in order to address the specific purpose of the research and the nature of the data. For example, once I realized that I had collected an assortment of vignettes from the 911 calls, this collection became the backbone of my analysis, as I was anticipated that the vignettes could demonstrate the most need for the proposed social work role. To create the vignettes, I extracted and expanded into narratives, including as much detail as possible.

I then examined the narratives for specific themes and key points related to social work. I looked for themes that presented the potential need for the role of social work, and detailed a series of points for each vignette that spoke to the role of social work with ambulances.

Next, I assembled these points, or codes, and expanded on each one to include the implications for social work. During this step, I also put duplicates together and cross-referenced codes for similarity and relatedness. This step involved looking beyond what the code about the role of social work, to how the code would affect the social work role, what challenges exist in social work as a result of this code, and how the role would differ from traditional social work. I also included recommendations for the delivery of social work throughout the implications.

Once I expanded the codes to include implications, I analyzed data from the observations and interviews in the same manner, beginning with identifying the codes and then expanding on the implications. I also marked specific quotes from interviews and casual conversations and kept them with specific codes in order to present further evidence. At the end of this portion of the analysis, I had three sets of codes and implications, one each for the vignettes, interviews, and observations.

My next step involved a global analysis of the three data sets and application to the original thesis questions. As previously realized, much of the data that I collected was in excess, so I undertook the process of sorting relevant data. I mined each set of codes and implications for information and evidence that directly related back to one of my three original questions. I organized the data under the appropriate questions, sometimes in duplicate, in order to gain a global view of what the evidence suggested in terms of the proposed social work role. I then wrote up a summary of the evidence to complement the full version that included all of the raw data.

3 Results

3.1 Case Studies

In this section I present data collected during my research in the form of case studies. These case studies are a compilation of observations and field journal notes. Together they present the data as a comprehensive narrative that allow conclusions and implications to be formulated, analyzed, and applied to the original research questions.

These case studies are the backbone from which I examine how social work could fit into ambulance work. The case studies were taken from different areas, over a variety of shifts and examine ambulance work within a large spectrum. I believe they allow readers to gain a better understanding of the calls, circumstances, and reality of paramedic work. These case studies provide a valuable glimpse into the research and are a form of data that allow for a greater understanding of the research. They are included in the results section to supplement and enhance the data as a whole.

Case One

The call comes from dispatch at 6:05pm on a Friday. We pile into the ambulance and the lights and sirens go on, since the call has come through as a code 3, a high priority. We are headed out to the Seymour Demonstration Forest in North Vancouver. All we know is that a skateboarder has been injured. We arrive at the scene after 20 minutes of travel time, and are escorted through the forest by a park ranger. We see a teenage boy on his hands and knees beside a fence on a bridge crossing. There are about five or six youth standing around looking concerned.

This call has a discouraging feel to it immediately. Paramedics work twelve-hour shifts, from 6:30am to 6:30pm. Unfortunately, paramedics cannot refuse last minute calls and leave them for the next day. If a call comes in at 6:15pm, they are automatically on overtime, whether they like it or not. Their families wait, their commute home gets longer, and their kids are picked up late. After years on the job, I get the sense that the overtime they are paid is just not enough. Legally we can only go 10 km over the speed limit, but we are still flying through traffic; the drive is more dangerous. I am thankful that it is not raining.

When we arrive on scene the paramedics begin their assessment without touching the boy. They ask questions about how fast he was going, where he fell, if he hit anything, and if he lost consciousness. While they do this, they also assess his breathing and heart rate. They determine that he came around a corner on his long-board, and was going too fast to stop. He was wearing a helmet. He ran into the wooden fence post of the bridge. Since he fell, he crawled around on his hands and knees, but was in too much pain to get up and walk.

The paramedics determine his injuries are not life threatening, though they are serious and get him on a stretcher. The boy screams and yells in pain; his hip causes him the most pain. The paramedics eventually load him into the ambulance. We head back to the hospital, proceeding without lights and sirens. As we sit in the back for the long ride to the hospital, the paramedic begins the standard questions. The boy is 14, he is not from North Vancouver, and his parents are not with him. When he offers his mother's phone number for the paramedic to call her, the paramedic states: "You can give her a call yourself when you get there." The boy's friends ultimately call his mother, but have little information to tell her other than that her son is on his way to the hospital.

When we arrive past shift end the boy's mother and her friend meet us there. They talk to the boy, but the paramedics must still check the boy in and prepare the ambulance for the next shift. They do, after all, want to get home to their families.

Case Two

For this shift I ride with the ALS, or Advanced Life Support crew. The call comes in at 1:35pm and is reported as a 57-year-old male with cardiac issues. The call takes us to Deep Cove on the North Shore; we ride out code 3 with lights and sirens. PCP and fire are already on scene and have the patient stabilized and on oxygen. There are 3 family members present, the patient's wife, his teenage son, and his elderly mother. Once the emergency workers establish that the patient requires transport to hospital via PCP ambulance, they take him out to the ambulance via stretcher.

ALS paramedics operate at a level above basic life support and deal with the more critically ill patients, such as those suffering from cardiac issues. They are able to give different drugs, and perform different procedures than a PCP. The crew today consists of one ALS paramedic, paired with a PCP paramedic with extra training, as the regular ALS partner is on

holidays. The information that dispatch gives them is frequently wrong or exaggerated. I have been told that many dispatchers are not paramedics or have never worked on car, meaning that, through no fault of their own, they take the caller's information at face value as they do not have the experience to probe deeper with questions not on the dispatcher script.

When we arrive, fire and the PCP car are already on scene. Due to the larger number of fire trucks present in the cities, they normally arrive first on scene and regularly take care of the tasks of finding the patient, securing the scene, and providing immediate treatment, such as oxygen. Any call that requires ALS normally also requires PCP in case a complicated transfer to hospital is needed, or in case the patient does not require ALS transport, freeing it up the ambulance for other calls. On the whole of the North Shore, there are 3 PCP cars at night, 4 in the day, and only 1 ALS car.

The patient and family appear to be East Indian, as the elderly wife wears traditional clothing. The patient's wife is calm and collected, answering questions in detail and giving information to the paramedics. Her story reveals that the patient has had previous cardiac issues and has been hospitalized in the past. The ALS paramedic takes time to gather information from the patient and wife, and I sense no feeling of panic or stress.

While the ALS paramedic allows the family to provide information, his partner performs tasks related to patient care, such as gathering cardiac information, taking vital signs, and filling out paperwork. There is no conversation with the family members besides his wife regarding the current situation, as the paramedics remain focused on providing patient care.

However, the patient's mother begins to have a panic attack. She was visibly shaken and upset throughout the ordeal, but now seems to have broken down. The ALS paramedic shifts his focus to her and attempts to explain to her that her son will be fine. This reassurance does not appear to help, so the paramedic takes her blood pressure. The woman is given some anxiety medication from the family and the paramedics decide that the elderly mother is suffering from anxiety due to the situation with her son. The paramedics do not transport her to hospital, instead leaving her in the care of her family.

As we walk to the ambulance, the paramedic partner states: "Well what do you think? Not much social work going there." As we sit in the car and head back to the station, the ALS paramedic is very open to any questions I have regarding this situation. He makes the comment that appearances of grief and reaction to trauma can depend on the culture of the family, such as

stoicism or over emotionality. I get the feeling that this comment does not result from prejudice, but from a factual, job specific point of view. It should be noted that not only do paramedics work on the patient, but they must also negotiate the family and the environment of the call. Without training or skill in this area, the call can be more difficult.

Case Three

At 11pm dispatch puts through a call concerning an internal defibrillator going off within a male patient's chest. Both ALS and PCP cars are sent to this call in North Vancouver. When we arrive at the scene, the patient is on the floor in a bathroom directly left of the front door. The patient's pacemaker fires every 20 seconds, sending a large jolt of electricity to his heart. Quickly the situation progresses to a fast transport to hospital to fix the pacemaker. Two ALS paramedics ride in the back of the ambulance, with the two PCP paramedics driving the two ambulances to the hospital. A peripheral intravenous line, an IV, is put in en route to save time at the hospital and allow direct access for the administration of drugs. When we arrive at the hospital, both paramedic teams help to transport the patient directly into the trauma room and hand care over to the doctors and hospital staff.

It is a Thursday night shift in North Vancouver. The crew I am riding with is very supportive and willing to have me ride with them over numerous shifts. They are a chatty crew and supportive of my research for school. I feel as if I have become easily absorbed into their car and am welcome to ride without being a burden. The night progresses well enough, with a few calls.

The fire department is on scene when we arrive, and they have found the patient and direct the paramedics to the scene. The firemen and paramedics chat amicably as they walk to the scene, and greet each other by name. All teams that are on tonight appear to be senior employees who have been working for a long time, leading to the conclusion that they have probably been working in the same community together for many years.

The scene is extremely crowded, with six rescue workers, the patient and his wife. The patient appears to be in his late fifties. He is a heavyset man, and is on the floor naked. The patient's wife stands in the background completely nude as well. She is also heavyset and in her fifties, and does not interact or engage with the rescue team.

The jolts send him writhing and screaming in pain every 20 seconds. The atmosphere in the crowded front hall of the apartment slowly escalates as the paramedics try to help the patient. It is not the calm, slow pace that I am used to, but rather a pace characterized by quick and deliberate actions. Conversation revolves solely around the patient, with ALS directing the scene and what steps are to be taken.

Once the decision is made to transport the patient to the hospital, firemen and paramedics work together quickly as a team to get the patient onto a stretcher and into an ambulance amidst his screaming. As we rush out the door, one of the paramedics turns back to the wife and states: “He is going to be fine.” I run to catch up with them.

A report from the fire department reveals that when the wife answered the lobby door of the apartment building, she greeted the firemen naked. She remained naked for the duration of the call and did not ask any questions regarding the situation with her husband. As a result of the two paramedics riding in the back with her husband, she could not have accompanied him. However, when we brought a patient in later that night, the nurses reported that she had not come to hospital at all. Both teams of paramedics agreed that this call was one of the stranger calls that they have been on in terms of family members present at the scene.

Case Four

The call comes through dispatch as a code 3 for an 89-year-old female with a head injury. The patient, a small and frail woman, sits on the floor propped up against her bed with a large bloody gash on her head. When we arrive there is no fire present, only our PCP car. According to the building manager, the patient lives alone, and had fallen four times in the past, all resulting in head injuries. The paramedics apply gauze to the head wound, which has stopped bleeding, and clean her face. We make our way back to the hospital without lights and sirens because the patient is stable.

On the same night as case three, it’s now 3am. We are in West Vancouver doing cover for the West Vancouver ambulance that is already on a call. As the call came in, I was woken by the ring of the emergency line, a jolting experience due to the shrill sound of the line. I had been asleep for what felt like two minutes when the call came through and was in disbelief. On this particular night I had a combined 40 minutes of sleep and without that small amount I would not have been functional.

When we arrive at the building, the building manager is woken up to facilitate entry into the building and the apartment, as the patient lives alone. In such a situation, if the building is unavailable, it is not uncommon for paramedics to buzz other apartments in order to get into the building.

My first thought when I enter the bedroom is the amount of blood; there is blood everywhere, which is consistent with a head injury, as even minor head wounds bleed heavily. The paramedics learn that she got up in the middle of the night and fell, hitting her head on the sharp corner of her nightstand. Luckily, she had a lifeline button around her neck and was able to press for help.

There is evidence in the living room of walking and mobility aids; however, there are no such aids in the bedroom for when she needs to get up in the middle of the night. The patient does not have any type of home support or daily help. Her son lives in North Vancouver and the building manager gives us his number.

The paramedics are gentle and sympathetic towards the patient, something that surprises me after being woken up at 3am. Even I am cranky. The paramedics help the patient change into a clean nightgown because they know she will be at the hospital for a while. As one paramedic treats the patient, the other paramedic makes a point of taking a used package of bubble packed medications out of the garbage for hospital information. He also looks inside her fridge to assess her ability to care for herself.

For the patient's part, she answers questions appropriately. I cannot say if she is cognitively intact, but her conversation is normal. She appears embarrassed at her fall, which the paramedics pick up on, so they try to reassure her. Both paramedics comment that this patient requires social work follow-up due to her history of falls; unfortunately, there are no social workers at the hospital at this hour and it becomes the responsibility of the nursing staff to make that referral in the morning. However, the nursing staff lacks insight into the patient's environment, insight that the paramedics have as they see the scene. Paramedics give the details to the nursing staff, but are not able to convey the lack of mobility, the type of food in the fridge, or the patient's ability to cope with her situation, as the nurses ask only about her current medical status.

Case Five

At 9:00 am the PCP crew that I am working with gets a call concerning the cocaine overdose of a 30-year-old female. It is a code 3 call, but the patient's location is five minute from the hospital in a residential neighborhood. The location is not the patient's her home address, which is unusual. She can walk and talk, and states she took five grams of cocaine over the last 36 hours. By the time the paramedics finish their medical assessment, we arrive at the hospital and she must be checked in, leaving many unanswered psychosocial questions.

Today is Monday. I get to the station and while I sit and wait for a call, the ALS paramedics finish their shift. ALS paramedics work later than their PCP counterparts when on a night shift. There is a female ALS student who patiently waits for the night to end so that she can go home. We talk about my research and she is really receptive. She tells me about a case that occurred the previous night: an extremely intoxicated man called the ambulance, and the student reported that "he couldn't tell me anything or answer any questions really because he was so drunk". She noted that he slept in a hospital bed and had no help, and that there were bottles everywhere.

When we arrive at our patient's location, she stands outside a house waiting for us. She does not explain why she left her house and requested a pick up somewhere else. Visibly upset, she states that she has increased her weekly dose of cocaine recently from three grams without explaining why. The patient states that she does not know why she called and that "it was probably stupid". The paramedics reassure her that it was not stupid, but are unable to delve into her cocaine increase because of the short hospital trip.

As we remake the cot in the ambulance, both paramedics speak about how hard it is to get into detox without the help of somebody already working in the system. Both agree that without detox availability, there are few resources for addicts to access, and the ambulance is the main resource.

Later on, while we bring in other patients to emergency, we see the same female patient on her second or third visit. It is unknown whether she was seen by a social worker on her previous visits, but she came in every time by ambulance for cocaine related problems.

Case Six

The next call, which comes in at 12:15 pm for a scalded infant, is designated as code 3. Both ALS and PCP crews are dispatched for this call. When we arrive on scene, fire is already present, ALS heads into the house and PCP grabs the equipment and gear. Emergency workers fill the scene and a fireman holds the crying baby on the couch. The infant grabbed a cup of hot tea and spilled it over herself, resulting in second-degree burns over a large portion of her body. The ALS team instructs the PCP team and fire crew to soak towels in cold water and place them over the burn sites. ALS calls up ITT, the Infant Transport Team, from BC Children's Hospital, but they must make their way through traffic to North Vancouver. One fireman and two paramedics ride in the back of the ambulance while the mother sits upfront, and we head over to the local hospital to meet the ITT team.

At noon before the call, we attempted to eat some lunch. Two rules I have learned from my short time on the ambulance is to eat and use the bathroom when you can, even if you do not need to, as you never know when you will get another chance. As one veteran paramedic told me, "the thing about this job is you gotta take care of yourself because nobody will do it for you. Then you can't take care of anybody else". When hungry or after passing up a bathroom break, these are wise words. I shove my sandwich into my mouth as we head for the ambulance because this call will not be short.

The family is an immigrant family living in a basement suite. As the paramedics and firemen treat the infant, the mother stands in the background visibly upset. No one addresses her, and there are too many people for her to get close to her infant. When the decision is made to transport the infant to the local hospital and have the ITT team meet us there, the mother attempts to leave the house without shoes on, packs diapers, and generally is at a loss as to what she should do.

The infant's father meets us at the hospital and is clearly very angry. He begins to argue with his wife even before the infant is inside the hospital. The paramedics say later on that they were worried about the mother's safety given the level of anger.

Inside, the trauma room is abuzz with doctors, nurses, paramedics, and the ITT team who have just arrived. One of the nurses allows the mother to sit on the trauma bed with the infant in her arms, but the father hovers beside her and still very angry. The doctor does not attempt to

reassure either parent of the condition of the child, simply stating, “she’ll be ok” before leaving the room.

Next the RCMP arrives in the emergency waiting room because they think that the father is an individual they have dealt with before and are currently investigating for abuse. It is unclear throughout the whole ordeal if this is the correct man or not. Our team leaves the hospital in the midst of a discussion between whether or not the ALS crew wanted ITT to meet them at the hospital, or whether the infant would stay and not be transferred to BCCH. This is one of the cases that involved the most amounts of emergency response personnel that I have seen so far.

Case Seven

At 11:45pm a call comes through for an assault on a bus. It is upgraded to a code 3 while we are en route. When we arrive, the bus is stopped, and all passengers have been loaded onto another bus. The patient is a male in his mid twenties whose face was beaten up by a homeless person who had fled the scene. Police are present and Coast Mountain Bus Company has sent their on duty supervisor. We transport the patient to hospital after discussing his medical needs.

It is a Wednesday and we are on a night shift. Even though it is not yet midnight, we are all tired. The more I work these shifts, the more I wonder how somebody could do this for the rest of their life. While people keep telling me that you get used to it, that has not happened yet and I continually feel exhausted.

The patient appears to be upset, and he is moved to the back of the ambulance for assessment. When the paramedics recommend that he should go to the hospital for stitches, he is reluctant because of the \$80 ambulance fee. When it is explained that he will be charged \$50 for just having them show up, he is still resistant to the extra \$30. The patient does not know that there is a public fund set up through the government that compensates victims of crime for any cost incurred to them, including ambulance fees, missed time at work, physiotherapy, and counseling.

However, the patient agrees to hospital care once he understands that he can be compensated. The RCMP will meet the patient at the hospital in order to take a more complete statement from him.

Case Eight

As we are pulling away from a scene, we get a call for a cardiac arrest for a male in a single room occupancy apartment, termed an SRO. It takes us about five minutes to drive there with lights and sirens. When we arrive on scene it is clear that the patient is already deceased, but the paramedic checks for a pulse just to ensure it. As we stand and wait for the police to arrive, his girlfriend comes out of her apartment next door and fills in knowledge gaps and explains the history of the patient.

It is sunny today, something that makes working outside with equipment much easier. I am on the Downtown Eastside working a day shift. It is been busy so far today, with a steady stream of calls.

The deceased is lying on his bed in a tiny room, which has a window, a little bar fridge, and a small closet. There is a radiator beside the bed and an old TV. The bathroom is down the dark hallway. The room is littered with juice boxes, take out containers, and bottles, but no drugs. For this space he pays about \$400 a month in rent. I am told not to go into the room but to stand at the door and look.

Between recollections of the girlfriend and the acting building manager we piece together a story. The patient was not seen since last night by his girlfriend. She is very upset and the paramedic tries to give her words of comfort. The paramedic says to me “this is a situation where you could use your skills”.

When three police officers arrive, they begin their line of questions, but are sympathetic when they learn of the deceased’s girlfriend. While we stand and wait for the coroner, the paramedics and police engage in a discussion about how paramedics should receive more respect for their job and more money, alluding to the recent labour dispute. The conversation then turns to family and next of kin (NOK) and how the police make every attempt to do a proper NOK notification, preferably in person with the family. They state that NOK notification can take place across countries and jurisdiction in order to provide service to families, and note that it is important to do a proper NOK even with individuals from the DTES. The paramedic tells me that the deceased’s situation is not unusual and that many times people die without family and are left undiscovered for some time.

As we gather our equipment to leave, it is revealed that the deceased is only 35 years old and had suffered a head injury a month ago. I am shocked at his true age because he looks closer to the age of 55 that we were originally given.

Case Nine

I am working a day shift on a Saturday and the call comes in around lunchtime. I have not written down the exact time because we had just cleared another call when we get this call from dispatch for an arrest in progress. The patient is a 65-year-old male in full arrest. We are escorted up to his apartment and walk in to see the firemen actively performing CPR. Support workers, who called 911, found the patient unconscious in his bed. He now lies completely nude on the floor with CPR being performed. The ALS arrives and immediately hook up the patient to their heart monitor. They assess the rate, rhythm and strength of his vital signs before pronouncing him at the scene as deceased.

Today I am riding on the DTES with a crew that has worked there for years. One of the firemen has commented that it is “the same planet, but a different world”. The calls have a different feel then the North Shore, as there is a different population, different needs, and shorter distances to the hospital.

I rarely see paramedics move with a sense of urgency, it seems that they take everything in stride, but when an arrest takes place as we speak, they move. We arrive at a BC Housing building and it looks somewhat out of place. It is new and modern, contrasting with the run down environment of the street.

Two staff members are on scene throughout the whole ordeal, watching as the rescue teams attempt to resuscitate him. The workers cry and are visibly upset as this process happens. The paramedics and firemen work easily together, as the firemen continue CPR and the paramedics insert IV's and get the relevant history. We wait for the ALS team to arrive, but apparently they are coming from a further distance.

The ALS and fire team leaves and we are left to wait for the police and speak words of comfort to the workers. One of the workers states, “I have never seen anybody die in their apartment”. The team does their best to empathize, with the workers by covering the deceased with a sheet and acknowledging their grief.

When the police arrive, they offer victim services, but the workers refuse; the workers state they are alright, which seems contradictory to their appearance. The workers are required to give information to the police regarding the patient including any NOK information, family contacts, or if they know of anyone who would take the cat before they contact the SPCA. While this information exchange takes place, the paramedic team cleans up the mess that was made in the room, including needle and IV wrappers, wires, and oxygen masks.

As we leave, there is a somber mood over us. This mood is surprising since both paramedics have worked for decades in the business, but it is encouraging that even a death on the DTES still affects veteran paramedics. After that it is business as usual as we go back in the ambulance and ready for another call.

Case Ten

Our first call comes in at 6:50pm for nausea and vomiting. We go code 3 to East Vancouver, and I am confused as to why we are driving with lights and sirens. The assessment starts with paramedics taking vital signs and asking a detailed history. The paramedics do not take the patient to hospital, but prescribe Gravol for her upset stomach and water.

Today is a Wednesday night shift. I keep thinking that on weeknights nothing will happen, or it will be slower, but that is never the case. It is rarely slow, no matter what night it is. I am on the DTES again hoping to see some interesting cases.

We are given instructions to enter the residence through the backdoor and we make our way over a broken cement path and under some low hanging structures to the back door. We enter and are greeted by about 5 people, family members, in a tiny kitchen of a basement suite.

The patient is in a bedroom that holds a dresser, a closet and a set of bunk beds. The patient is a female in her 20's and an immigrant. She appears to have a language barrier, as the father wants to stay in the room and translate, but I observe pictures of a university graduation on the dresser. The father is asked to leave the room while we assess and examine the patient. He seems to be confused as to why he is being asked to leave. The father would like to translate for his daughter, but he is asked to leave the room while paramedics do their assessment, since there are confidential questions to be asked. This situation can be tricky, as the patient is an adult, but culture could dictate different privacy terms.

The senior paramedic gets down to of the patient's level and makes good eye contact with her as he talks to her. The paramedics run into some translation issues about what questions they need to ask. Eventually it is worked out, but takes some effort. The paramedics also ask personal questions and the patient appears to become embarrassed, as the paramedics are male. There do seem to be barriers in terms of cultural competence, as the younger paramedic may be unaware that it is culturally significant to have a single female being questioned alone in the presence of two males. The father also seems uncomfortable when we re-enter the kitchen; the whole family looks at us, most likely wondering how their family member is doing.

Case Eleven

We get called to a man who was hit in the hand by a bunch of youth who threw a street sign like a Frisbee. The paramedic describes the sign as “ten foot tall and bulletproof, that's alcohol.” As the paramedics clean the patient's hand in the back of the ambulance I see a scuffle up the street. I point it out to the officer who attended our call, and he assesses the situation. Then, he runs up the street toward the fight. We finish our call and wait to see what happens. Sure enough, a few minutes later, we are called back to provide care for the victim of the beating. When we arrive, we see that the victim is a 30-year-old male with a cut to the forehead who is badly shaken up. The police indicate to us that they are investigating whether or not the attack was a gay bashing, which would result in a more serious assault charge. The patient does not need to go to the hospital, and we clear the scene following his treatment.

On this Wednesday evening, the night continues on the DTES. As darkness starts to fall, the playoff hockey game finishes, unleashing people into the downtown core from the pubs and bars. As we drive by, we see the police have apprehended one of the assailants in the beating. “There's shit rat number one”, the paramedic comments as we drive by.

Again, the paramedics put the patient in the back of the ambulance for his privacy. The back of the ambulance is a great place for privacy and treatment, like a mobile hospital. As the patient sits the back, he tells us that he was walking home minding his own business when these punks jumped him, even though he gave them a wide berth and space. He tears up as he says this and his voice cracks.

The senior paramedic who treats him is very sympathetic, and tells him that there is no shame in trying to avoid a fight, and he states “I have no problem crossing the street if there are a

bunch of shitheads.” The patient is unaware of the victim services program that compensates victims of crime if they incur ambulance costs or need counseling, a service that the individual would benefit from.

The paramedics and the police do not work closely on this case; the police take the suspect into custody and gather statements, while the paramedics treat the victim. We leave the victim shaken up and upset, but we must get back to be available for other emergencies, as this night is shaping up to be a busy one. While this call was a short one and required minimal medical attention, it was beneficial for the victim to have somebody to talk to and empathize with.

Case Twelve

It’s 3:45am and we receive a routine call involving a 37-year-old sleepwalker. A paramedic immediately recognizes the individual as a repeat system abuser. The person in question is also banned from one of the hospitals for wasting time and resources. The paramedic forcefully asks him why he called the ambulance. The patient replies in a meek voice, “well I was sleepwalking and I trashed my place”. The paramedic yells back “and for this you needed to call the ambulance and take it away from people that are dying or having heart attacks?! Unbelievable! Absolutely unbelievable! Well if you want to go to the hospital, get in the ambulance!”

The man replies, “well maybe I don’t want to go then”, as if this statement would hurt our feelings. The paramedic then replies, “fine then, we’re leaving!!”, and the other paramedic and I scramble into the ambulance.

We finally make it back to the station on the same Wednesday night, which is now early Thursday morning. I feel awful, and yet again I am told I will get used to it, but really I am not. The 3am hour is the least favorite hour of the night, it just feels so unnatural to be up and roaming the streets. In the daylight, there is hope, but at 3am the world is an in between place that neither the night nor the day claim, like a forgotten hour that nobody wants.

The shrill sound of the hotline jolts me awake. I feel nauseated, drunk, and hung over at the same time, all while trying to find my shoes because I know that the call is ours. “This had better be good”, is my comment as we walk out the door.

The building is our first indicator that this call will not proceed according to plan. The senior paramedic immediately recognizes it and exclaims that he knows a guy that lives here. The paramedic reports that the man is a notoriously bad abuser of the system because “the ambulance on this side of town is the poor man’s taxi.”

The second indicator that this call may go sideways is a woman sitting outside the front door. She smokes and informs us that our intended destination is the apartment of her and her boyfriend. She tells us that he kicked her out of the apartment and she went to take a walk. I think who takes a walk at 3am in the DTES? Her boyfriend, the patient appears in the lobby of the apartment. And the paramedic is fed up...

“That’s how you get bitter paramedics”, the paramedic vents in the car. I don’t know if it’s the fact that it’s 3am, or that I am extremely fatigued, or maybe that somebody finally stood up to a person who abuses the system so blatantly, but I cannot stop laughing in the back of the car.

Case Thirteen

Our first call of the night comes pretty early at 6:40pm for a man walking aimlessly down a hallway. It’s a code 3. We arrive at an SRO and are met by the building manger. The patient has taken his regular methadone treatment, and then his regular heroin, effectively doubling his dose. The patient is 42 years old, but like other addicts, looks much older. The manager waits outside the apartment until we leave. The patient refuses transportation to hospital, even though the paramedics try to convince him that it would be a good idea. Even with the high rate of abuse of the system, they still encourage him to call back later if he changes his mind and wants medical attention. We leave the patient with the advice not to walk around too much or do any more drugs tonight, even though there are clearly drugs present in the room. I notice on the patient’s door is a note stating “call your mother.”

I ride with the alpha car today, the night car again on the DTES. I am always amazed at how different calls are from the dispatch we get; sometimes they are completely inaccurate.

The manager tells us that he is the one who called the ambulance as we squeeze into the smallest and smelliest elevator I have ever been in. He tells us that the patient is living in an SRO, “there are no bed bugs in this suite”, and that he thinks he may have overdosed on methadone.

When we get there the patient sits on a futon in one of the smallest rooms I have ever seen. He does have his own bathroom off to the side, but the two paramedics and I barely fit into this room with our equipment. The first thing the primary paramedic does is cap open needles to ensure safety. They do not make any judgments about the drugs, but take a harm reduction approach. “That’s a lot of shit on board, man”, reacts the paramedic when the patient states he doubled his dose.

Throughout the assessment, the paramedic is very respectful of the patient and his drug habit. He displays no condescending attitude nor gives a lecture about the patient’s drug use. He gets down to the patient’s level and takes time to build trust. In return, the patient cooperates and appears to appreciate the service. At one point, he apologizes for the paramedics having to come and the paramedic replies, “I’d much rather come now and check you out then come back when you’re unconscious”.

As we leave the building, taking care not to touch door handles or elevator buttons with our bare hands, a resident pokes their head outside their door and the paramedic jokes, “did you order a pizza? No? Oh, must be the wrong suite”, which elicits a smile from the resident.

The paramedics tell me that “the mental health system down here fails people miserably”, as we walk back to the ambulance and get ready for the next call of the night.

Case Fourteen

At midnight we get a call to the Vancouver Police Department, VPD, cells. The call is routine, involving a female with a head laceration. We are briefed on the patient and her history. She was apprehended under section 95 of the *Mental Health Act* and can be extremely aggressive and mentally unstable. She is well known to police and has a history with them. She is known to be a spitter when restrained. She is also a transgendered individual who has undergone the transition from a man to a woman and takes huge offense to being called “he”. Unfortunately the patient has not taken her hormone pills recently and has re-developed strong male features. The patient developed a cut to her forehead by repeatedly hitting her head against the glass portion of her cell door.

We travel back to the hospital with one police officer in the ambulance and another traveling behind in the police vehicle. We encounter no problems from the patient, who is very chatty with everybody. Once we arrive at the hospital, the doctor takes a quick look at the mild

laceration to her forehead and clears her medically. Once this happens, the patient threatens to commit suicide by jumping off a bridge, forcing the hospital to certify her until the *Mental Health Act* and keep her in hospital. We leave the patient in the custody of the hospital and continue on with our night, waiting for more calls.

I had never been to the VPD cells and was interested to see what it would be like at midnight. We arrive at the cells and park the ambulance in the secure garage. As we make our way into the cells area, I am surprised at the chaos of the environment. There seem to be a number of people in custody tonight for various reasons, and some are extremely vocal and loud through their doors. They are each kept in separate cells, and escorted to different areas as needed for (photos, fingerprints etc). Staff separate from the police run the jail and employ a nurse on staff.

Police and paramedics consult on the best way to transfer this patient. They decide that they will restrain all of her limbs for the transport because if she becomes aggressive, they have staff to subdue and control the situation, as opposed to as the hospital. The paramedics return to the ambulance to prepare the stretcher, as well as remove any sharp objects from around their tool belts, including pens.

When the time comes to get the patient on the stretcher, a team of people assemble in case things go sideways. Fortunately, the patient is extremely cooperative. The police explain the procedure to the patient, as well as why they will use restraints, something the patient agrees with and accepts. Throughout the whole ordeal, the gender identity of the patient is a non issue and everyone refers to her as female. Instead, the larger concern seems to be the safety of the workers. The paramedics and police work well throughout this process and maintain their professionalism.

Case Fifteen

We get a call towards the end of our shift for a 50-year-old male having chest pain. We arrive at his apartment at the same time as fire and the ALS team, so there are lots of rescue people on scene. Since everybody arrived at the same time, ALS take over treatment of the patient, while PCP support by setting up equipment and taking information. The firemen wait for any instructions, and eventually go back to the ambulance to get a chair cot to transport the patient to the ambulance.

The patient tells us that he has felt pressure in his chest for the past three hours, but only called 911 at his niece's insistence. He states that the pain did increase and is currently radiating down his arm. The ALS crew does a heart scan and the paramedic leans over the patient, looks him in the eye, and says, "I'm going to be honest with you, you're having a heart attack." He then explains that they need to get him to the hospital as soon as possible, and that they will be calling ahead to inform the doctor, as well as sending his heart information electronically to the hospital. Once the emergency responders load the patient into the ambulance, one ALS rides in the back of the car with the PCP paramedic in order to get IV lines and medications to the patient. We go back to the hospital with lights and sirens and he is brought directly to the trauma room without delay.

It is a beautiful day in Vancouver and I am riding at the Kitsilano station with a PCP crew. When we enter the apartment and the first thing I notice is how small it feels, especially with six large men in it. The apartment contains some exercise equipment, a portable sauna, and a very old computer. The patient lies on his back with his legs up on the coffee table in his boxer shorts. He is extremely tanned and hairless all over his body. His niece is present, and states that she found him to call the ambulance after they returned from church with the rest of the family. The niece has a baby with her as well.

Once the paramedics establish the heart problem, the focus shifts to getting the patient to the hospital as fast as possible. The rescue team communicates and works together to get the patient onto the chair cot and into the elevator. Meanwhile, his niece stands there a bit stunned, lacking information regarding who she should call, whether she should she go to the hospital, should she bring anything, and what will happen in the following hours. She is told which hospital they will be going to, but otherwise, they focus on the patient and getting him to hospital.

3.2 Theme One: "I'm here to provide advanced pre-hospital medicine"

One of the strongest themes that occurred during my research period was the role of a paramedic. This theme includes how paramedics view their own role, and the grey areas that have developed as a result of paramedics taking on tasks outside their area of their original training, such as psychosocial support. Paramedics had strong feelings regarding what their role

is, what they are now being expected to take on, and how this impacts their ability to do their job.

Primary Role of Paramedics

Data gathered through interviews indicates that the primary role of the paramedic is to provide medical treatment and transport for patients. As one paramedic stated, “my role as a paramedic is to provide pre-hospital medicine and care to the citizens of British Columbia” (Paramedic #2). One of the paramedics described his role as “making medical decisions; some critical, some basic and standard. Taking control of the scene. Taking control of family members. Keeping people calm. Yeah, that’s basically you do everything. You don’t just do medical. You console the family when someone’s been injured or killed. You too could become a shoulder to cry on too” (Paramedic #1). Paramedics also did some psychosocial work with patients. Psychosocial support included attempts to connect patients with further resources or address non-medical concerns, which I saw minimally.

One paramedic described the role of paramedic as,

a lot of (...) social work, counseling, you know. There’s lots of times when you go meet someone who’s been drinking and he’s calling an ambulance. ‘Well, you’re drunk. Why are you calling an ambulance?’ Well, if you just sit and talk to him for a while, he’s a 40-year-old guy who’s alone. His wife left him, and you know, took the kids and, you know, life didn’t turn out the way he thought it was going to turn out. He just wants someone to talk to. And when you get talking to him, then you start to realize that yes, he’s been to counseling. Yes, he’s had rehab. And now he’s bounced and he’s just looking for a cry for help” (Paramedic #1)

Psychosocial Work in Paramedic Work

Paramedics stated that their work includes addressing both medical and non-medical issues. “I do believe that social work is an integral part of our job. And I think there should be maybe more to address that”, stated Paramedic #5. While researching, I observed calls that involved psychosocial issues as well as medical complaints. Situations included a cocaine addiction resulting in anxiety, decreased mobility in an elderly patient resulting in a fall and a head injury, and an assault based on sexual orientation. I also observed situations that required more than only medical support. These situations included psychosocial support during an

accidental infant scalding, family contact and notification regarding the condition of a minor injured long boarding, and an arrest in progress witnessed by community workers.

I also observed addiction pamphlets in ambulances to give to addicts. One situation involving a patient addicted to cocaine which prompted a conversation with me regarding how difficult it is to get an individual into detox and how paramedics are unaware of what to do. The patient was found the next day in the emergency room with the same complaint, having again used the ambulance system as a result of her drug addiction. I observed paramedics having conversations with patients concerning their psychosocial issues, including addiction, living alone at risk, and self-care in an effort to provide some type of support beyond simply medical assistance.

Paramedics stated that it was not their desire when they entered the profession to do both paramedic and social work and that these skills sets are too diverse to be done well simultaneously. Instead, one paramedic noted that, "I'd rather see, you know, a paramedic that was awesome with all his medicine and had absolutely no social work skills whatsoever than a, you know, social worker come in who had all those skills than, you know, somebody that was an okay paramedic and an okay social worker. I'd much rather see a distinction, and to be honest, I'm here to provide advanced pre-hospital medicine. I'm not here to provide social work" (Paramedic #2).

Informal conversations occurred where paramedics stated that they would not like to work with the non-medical aspects of a patient, that they find the work difficult and/or depressing, and that they enjoy the paramedic work more. In one occurrence, paramedics commented to me that they did not envy the work that social workers do with family members during trauma scenarios in emergency rooms.

One paramedic expressed his views on training paramedics in more in depth psychosocial skills follows: "We're already understaffed, overworked, and you want to throw something else on our table? Are you nuts? And, you know, you want me to do social work on top of paramedics? No. When we go in, we stabilize the transport. Emotionally, psychologically, and personalities to suit that job. It takes a certain type of person to be a paramedic. The same thing with social workers. I'm sure that the psychological makeup of the social worker is nothing in paramedics. And I think it would be ludicrous. It will be like, you know, trying to teach a baseball player to be a swimmer" (Paramedic #4).

Taking the Psychosocial Out of Paramedic Work

The sentiment among paramedics that I interviewed is that their service is already overworked and understaffed, and the expectation that they will address concerns above and beyond their mandate is not something that would lead to better patient care. They argued that it would dilute the service they currently provide. As noted by one paramedic, the inclusion of a social work role on ambulance “could be (enhance) our service and taking a load off of us. I don’t think people would be threatened by them. Well just say I was thinking it would be another resource to help us so... rather than putting more weight on our shoulders. Hey, they know more about this than we do” (Paramedic #1).

One paramedic stated that “to get anything you could do to take that off our plate would be huge. And we’re not equipped to deal with these people” (Paramedic #4). “I mean what it basically boils down to a lot of times is well, sorry I don’t know who to call, but we’ll take you to the hospital, and they could hook you up with someone who can”, commented Paramedic #1.

“I can spend more time trying to sort that out, but in fact, that’s tying up an ambulance, which is a resource to do other things that are maybe a little more pressing”, summed up Paramedic #5. The paramedic system is a finite resource that has a limit on how many services it can provide to its patients, as indicated in the vignettes. I observed a variety of cases, including non-urgent calls and non-medical calls that tied up the service, added pressure and increased the workload of the remaining ambulances. Those demands made paramedics busy and force them to sacrifice their breaks and self care in order to provide service to the public.

While perform my data collection, I regularly experienced shifts where paramedics were not given meal breaks due to high volume calls, where we were dispatched to calls outside of our area because all other ambulances were tied up, or where there was a backlog of calls. One particular night, we left the station at 7pm and did not return or get a meal break until we returned at 7:30am, having to eat in sporadic periods. These deficiencies took place in different areas during both night and day shifts.

One paramedic concluded paramedic and social work are both distinct roles, stating: “Oh, I think it would absolutely be great because traditionally, our service training is always done half assed, and there’s no way you can expect somebody to maintain a mind full of medical knowledge and a mind full of social work knowledge, and I think it’s to convoluted that when

you start expecting somebody to specialize or have the skills in a broad variety of areas, you kind of water down on what they can deliver in the end” (Paramedic #2).

3.3 Theme Two: “The world doesn’t shut down at 10 o’clock at night”

Throughout my research, it became apparent to me how important shifts, timing, and schedules were to paramedics. Call volume, types of calls, and even when a person gets to eat is dictated by what shift a person is working, what time of the month it happens to fall in, and even what calls they happen to be dispatched to. Time plays an important role, almost like a third partner, in the workload of paramedics and other shift workers.

Service Takes Place Around The Clock

Most social work roles occur during regular business hours; however, calls during the research period that were candidates for social work occurred at both day and night. Many calls occurred on nights and weekends, at times when alcohol consumption was increased, when people were not at work, or when children were not in school. Paramedic #1 summarized this reality by saying, “so yeah, it does have its benefits, and you know, basically, what it boils down to is the world doesn’t shut down at 10 o’clock at night.” Paramedics also talked about the 24-hour need for social work during the course of the research.

Data collection took place over all paramedic shifts. Paramedic shifts are 12 hours in length, typically running from 6:30am to 6:30pm, and paramedics operate on weekends and holidays. As a result, calls are unpredictable in nature and can fall anytime during the day or night.

Shift Volume Can Vary Greatly Between Shifts

Attempting to describe a typical call day would be similar to predicting hockey scores; a guess can be made based on the area and population, but anything can happen. Paramedics may take two to three calls on days that are slow, which allows for paperwork and ambulance maintenance to be done. However, on other days, they will not return to the station until well after their shift has ended. Paramedics reinforced the practice of eating and using the washroom when the opportunity arose, the need to always be prepared for the busiest shift, and the high need for self care outside of the job. This reinforcement was evident in a conversation that took

place between myself and Paramedic #6, who stated “the thing about this job, is you gotta take care of yourself because nobody will do it for you. Then you can’t take care of anybody else.”

Since I worked the same shifts as paramedics, I took my break when they got theirs’, and I ate when they ate. Over the course of the research, there were numerous instances where I ate quickly before or after a call or did not eat at all. One notable shift I did not use the bathroom at an opportune time and was dispatched to call after call without passing by a washroom, as we did not end up at the hospital or the station. During one overnight shift, I left my dinner in the station and was able to retrieve it during the only minute we spent at the station, after which we did not return to the station until dawn. Throughout all situations, paramedics were as sleep-deprived, hungry and tired as I was, but had to continue to provide care to patients.

Calls Are Not Always What They Seem

During ambulance calls, the situations can change quickly or become something different entirely, as noted in the situations reported below. I recorded several situations where paramedics were heading to a call and were either called off, re-directed, or told to change their approach to the situation, such as arriving lights and sirens for a call where a patient originally felt unwell and then reported chest pains, requiring more support teams. These changes occurred for a variety of reasons, including higher priority calls, the obtainment and relaying of further information to paramedics, or cancellation of call due to a change in status or more accurate information.

Data collected also recorded situations where the call was drastically different from what was originally relayed by dispatch. One paramedic told of a situation where he was called for a post-operative infection and the situation turned out to be a kidnapping involving an individual held against their will for several days. I also observed situations called in as cardiac concerns that were not in fact cardiac related, or a head injury, which was actually an assault requiring wound treatment.

3.4 Theme Three: Family and Friends - Not Thought of in the Big Picture

My research indicates that family and bystanders on scene for ambulance calls also need support. Paramedics are frequently busy with medical care, leaving the family’s psychosocial

needs unattended during the course of the call, or were working within situations that were outside their scope of practice.

Psychosocial Needs Unattended

Paramedics identified a variety of psychosocial issues that would benefit from further psychosocial support. These issues can be differentiated between those that require immediate social work on scene, and those that require follow-up in the long-term.

During data collection, situations regularly arose where paramedics took a patient to hospital and were unable to provide direction or details to the family due to the paramedics' preoccupation with providing medical care. Examples of these situations include a person who was left wondering what to do next when their family member suffered a cardiac arrest and was taken to hospital; a person who witnessed the body of their deceased partner; and community workers who witnessed an attempt to revive their client from cardiac arrest. As mentioned previously, the workers were visibly upset, even though they verbalized that they were fine. They stated that they had never seen a situation like this before and were unable to make decisions about what they should do next. Their body language was closed off and they paced the scene. I observed that family and witnesses needed support, including information regarding what to pack for the patient if transported to hospital: who to call from the patient's family; what information the hospital would require, such as care card; what the next steps would be if the patient died; and what to expect in all situations in the following days.

Another situation involved a person finding their partner deceased overnight. The person had been the last to talk to the deceased and when they went to talk to their partner the next morning, he was found deceased in their bed, apparently from a head injury. This situation was clearly upsetting to the person, who described feelings of guilt and sadness to paramedics. A final situation included the mother of an adult son who had an anxiety attack when her son was taken to hospital. Even though the situation had occurred before in their household, the mother became short of breath, displayed visible distress and had to be looked after by her grandchildren. I observed during these calls that paramedics were sometimes at a loss to produce the appropriate words and actions during crisis situations and were either unaware or too busy to provide support to patients' families during times of stress.

Throughout the data collection process paramedics frequently spoke, both formally and informally, about what situations would warrant psychosocial support beyond what they are able to offer. As stated by one paramedic, “you know, I notify the family that their loved one has died, and then I leave, and the aftercare, and you know, the social point of view I’ve never really thought about that afterwards, but on any given shift, there’s probably 10 cardiac arrests in the lower Mainland that I think every one of those families would benefit greatly if they had the option to talk to a social worker or some sort afterwards” (Paramedic #2).

Another paramedic stated, “oh no, I think it would be a real big help especially like... You know, a lot of people have never seen people who are dead. So it’s very traumatic to them when we told them that this person was deceased. They started crying. You know, it’s not something I’d say and leave them right away... so they may be able to have maybe social work or somebody to deal with them whether it’s friends or family at the scene that maybe get kind of always pushed aside and they are not thought of in the big picture” (Paramedic #3).

Paramedics Responding to Non-Medical Calls

Data collected indicates that there are certain types of calls that regularly take up resources that could be better used elsewhere, demonstrating that another type of service or resource is needed to address these calls. Examples of these calls include repeat addiction calls, elderly patients living at risk with no support, and mental health clients who could be better served by an alternative to the ambulance, as previously indicated in the vignettes.

These calls mainly involved substance abuse and mental health concerns that did not require immediate medical attention, but for which there was no alternative to sending out an ambulance. Conversations with paramedics concerning these calls led to the revelation that inappropriate calls and abuses of the system lead paramedics to burnout and feelings of frustration due to the lack of resources and professional referrals. One such call concerned an individual who called the ambulance for sleepwalking and had a history of using the ambulance to get a ride to another part of town. The paramedic angrily stated that this was the type of call that made paramedics frustrated with their work and their protocols.

3.5 Theme Four: Across Ages, Culture, and Illness

Paramedics encounter a wide variety of patient populations and are not simply limited to medical situations or certain populations. Their work forces them to cross cultural boundaries, have skills that can be used on any age, and are able to competently work with cases beyond medical care.

Cultural Conflicts

Situations that required translation of or cultural awareness to patients' values and beliefs regularly arose. One particular situation included the need to examine an adult girl and the confusion her father felt when he was asked to leave the room. Paramedics were required to follow their protocol; however, it was clear that the family did not understand the protocol. Other situations involving cultural roles included paramedics who treated immigrants, who did not speak English as their first language or had values in conflict with North American practices. I recorded situations where paramedic protocol was in conflict with cultural values and traditions, and paramedics were not given the tools to navigate cultural conflicts; instead, they learned them on the job. Another situation involved the infant of an immigrant who was accidentally scalded. The father arrived at hospital clearly upset and angry at this wife, which made the situation uncomfortable, as paramedics stated that he should be concerned for his child, not angry at his wife.

Unpredictable Populations

Evidence suggests that there is very little predictability about the age of patients, as each station received calls for patients ranging from infants to the elderly. Unless the paramedic team had a specialty, such as the Infant Transport Team, paramedics agreed with the data that no specific demographic or population was served.

The wide variety of patients that I observed through my research provided data for the range of patients that a social worker would encounter in this role. I observed calls for scalded infants, injured teenagers, university students experiencing sickness, children with stomach pains, middle aged men having heart attacks, elderly women who fell, young men assaulted, middle aged women with flu symptoms, and addiction spanning all ages. There was no consistency or predictability for the age of callers, although complaints were somewhat more

expected, such as calls for elderly people in areas with high elderly populations, or immigrant calls in areas with minorities.

Paramedics regularly work with the elderly population. As one paramedics noted, “you look at this woman who’s 80 years old, 100 pounds, soaking wet. You’re looking at the fridge just empty, you know. She’s got a bowl of soup on her table that looks like it’s been there for a few days, but it’s not even touched. And we don’t do anything for that. All I do is write on my form she’s alone. It looks like she’s failing to thrive. And I’ll mention that to the Triage nurse where... I don’t know if it would be beneficial for social work to show up to the house and have a look for themselves...” (Paramedic #1).

When paramedics interacted with seniors, they referred to patients by their last name, and used “sir” or “ma’am”, and the patients responded positively. I also observed situations where paramedics used the term “bud” or “pal”, which did not help the patient to drop their boundaries or appreciate the care being provided. Social work should take notice of this and use language and greetings that are appropriate, which promotes a respectful relationship.

Pain

Situations where ambulance attendants were needed typically involved an individual in pain or some type of distress. Situations recorded included patients experiencing chest pain or breathing difficulties, suffering from tissue and bone injuries, and undergoing burns, mental health issues or drug reactions, or childbirth. When a patient was in pain, such as during childbirth, paramedics were intensely focused on the patient and thus unable to provide support to family or bystanders. During all calls paramedics used medical terminology, took patient vital signs, and made conclusions based on this evidence. This procedure took place for every call, regardless of the complaint and dictated the outcome, whether that outcome was hospital transfer or follow-up with a family doctor.

I observed multiple situations where medical terminology was a barrier to families and patients, requiring translation from paramedics as to what exactly was happening. Heart attacks were the most common of these situations, as most families not familiar with terms such as “A-Fib”, “V-Tach”, or “arrhythmia”. High levels of pain also increased the severity of the situation and heightened the anxiety felt by those witnessing the incident. Pain was also recorded to vary greatly between patients, even if they had the same complaint.

Mental Health and Addiction Populations

Addiction was a central theme in many calls that were responded to during the research period. It came up regardless of the neighborhood we rode in, although it did manifest itself in different forms. This nature of the addiction encountered depended heavily on socioeconomic status.

During my research, I worked in a variety of areas, including both affluent and incredibly disadvantaged communities. Even though the paramedics may not have been a part of those communities, they were able to use language, respect, and body language to attend to clients needs. One notable call included paramedics who attended to an individual in an underprivileged area of the city who had taken too much heroin. The paramedics got down on the individuals level, used his terminology (referring to heroin as “down”), and verbally expressed their concern. This patient did not become violent or aggressive, and appreciated the care of the paramedics. Paramedics also did not lecture the patient on his drug use, but asked the patient what they wanted to see happen for them.

One call involved a patient who overdosed on cocaine and used the ambulance system twice in two days. Because follow-up is not done in the ambulance system, it is not known whether the patient was seen by social work or simply discharged. A second call involved responding to a patient who overdosed on his methadone treatment by taking heroin, effectively doubling his normal intake. He refused transport to hospital and it was his neighbor who called 911, not the patient. A number of calls involved alcohol abuse which led to injuries or crack cocaine which interacted with respiratory conditions. One such call involved patients discharging themselves from hospital in order to smoke crack cocaine again, leading to a very serious breathing issue.

Informal conversations with paramedics deal with how the mental health system did not seem aid with substance abusers, such as the detox system which requires addicts to call in everyday to maintain their waitlist spot, when many addicts do not have access to a phone. Paramedics spoke about how they did not feel that they had resources beyond transport to hospital for those suffering with addiction. Moreover, certain patients did not want support for their habit and this reality requires a harm reduction approach. One paramedic commented that “the mental health system has failed people down here,” in reference to the DTES.

3.6 Theme Five: “We’re just expected to deal with everything that we see and experience on our own”

Helping the Helpers

Situations occurred during the course of data collection that were traumatic or crisis orientated. These situations were regularly followed by calls, leaving little time for support, re-grouping, or a break. Paramedics were able to take time if they had to clean their ambulance or re-stock equipment, but time was not made if they required support as a result of the trauma.

Previous evidence suggested that paramedics become frustrated working within their system, as they are exposed to a wide variety of traumas on a regular basis. One paramedic related that, “I think it’s as paramedics, we’re just expected to deal with everything that we see and experience on our own. In a lot of ways, it’s probably expected that it’s part of the job description. And as we all know, you can only be able to so much as scratch in so much traumatic events before you start to break down” (Paramedic #1).

Evidence suggests that accessible counseling and support is minimal and not immediate, often requiring paramedics to complete shifts after experiencing trauma. Discussing the available support, one paramedic noted that, “there’s a healthcare peer counselor that’s, you know, inaccessible during the day. It’s kind of, if you need to seek peer counseling, it’s something that’s expected to be done on your own time, not while you’re on-duty. And if you deal with that call and you can’t finish your shift, you’re not financially compensated if you book off after say dealing with a cardiac arrest on a shift” (Paramedic #2).

“I think if we had access to social worker during shift, you know, it would allow us to talk and possibly identify some emotional breakdowns earlier than later if they can give us somebody to talk to other than our partners, somebody that’s actually legitimately trained with counseling people versus our peer counselors who take up a one-day course,” states Paramedic #2.

Expanding the Paramedic Team

Paramedics provided feedback, both formally during interviews and informally during casual conversation, regarding how they would incorporate some type of psychosocial support

within their working environment. One quality of the role that they felt would be necessary is the ability to move independently between scenes without relying on ambulance transport.

Paramedic #1 stated, “So then, we can either sit and wait if we feel appropriate, or we can maybe even say, ‘You know what? We’re going to leave you here. We’ll have these people come over, and they’re going to talk to you, and they’re going to give you their numbers and they’ll tell you who the contact, or someone’s going to come see you in the morning, or whatever. And you guys can handle it from there. Do I think one is needed like in every corner of the Lower Mainland? No. But 2 or 3 maybe.”

One paramedic gave a detailed account of how they would like to see social work working within the paramedic environment. The paramedic stated that, “I think the best way to utilize it would be see if you have a social worker or two social workers in a mobile vehicle that we have the option to call, you know, and we had a number, and we could call them, and they could show up where we are, and you know, we can discuss what’s happening, and then they can bring in their additional resources. That being said, I think you would have to have, we know a group stationed in Tri-Cities area, and one for the downtown Vancouver area, and one for the North Shore area, you know, logistically, and numbers wise, I’m not sure how many we’d need, but I think just to have one covering the whole lower Mainland would be a little overtaxing” (Paramedic #2)

They also felt that social work would be able to cover a larger area and be responsible for several ambulance stations. Data outlining how paramedics would design the role is important; their first hand experience is relevant as there are no other professionals working in partnership with the paramedics. Their input is also significant because they would potentially work directly with the social workers filling the proposed role. One paramedic proposed, “so maybe they have an on call social worker, whether it’s through the hospital or through the health authority, or whatever, you know...So, we could actually... We could contact social work through our dispatch for them to assist this person that otherwise, because they don’t show up at the hospital, they don’t get a social work there with them” (Paramedic #3).

Navigating the Professional Boundaries

I recorded data that includes how current rescue professionals performed their duties in relation to members of other professions working in the same area. Situations that involve

multiple teams of rescue workers regularly occurred during my research. When a call came in for a dangerous patient needing assistance, police were dispatched to secure the scene, fire arrived because the scene was in public and the paramedics might need their support, and paramedics were there for medical concerns. Moreover, multiple teams were dispatched to deal with a scalded baby. In that case, fire was dispatched and arrived first to treat injuries. Basic Life Support arrived to provide higher medical care, and Advanced Life Support arrived because it was a severely injured infant. The Infant Transport Team was called and met us at the hospital. A total of 11 rescue team members were dispatched for one patient, creating a situation that required navigation between teams with different mandates and protocols.

Typically, police or firemen also attended calls on a regular basis for various reasons. Police would show up in order to maintain a safe scene for paramedics to provide care, and firemen would arrive to assist with patient stabilization. Paramedics often worked within the procedures of other disciplines or vice versa. For example, paramedics called the police when a patient was deceased in order to facilitate NOK notification and during potentially violent situations, and called firemen to secure scenes of motor vehicle accidents.

4 Discussion

4.1 Theme One: “I’m here to provide advanced pre-hospital medicine”

The definition of a paramedic should influence how the role of social work within ambulances would function and how the two professions would partner together. If social work is to fill a gap within the ambulance service, understanding the limitations and boundaries of paramedics is necessary in order for social work to compliment the current procedures and processes. As paramedics work in diverse and changing environments, social workers would also have to be flexible and ready to adapt their traditional practice to fit within the rescue services world. Since social workers would heavily rely on paramedics as their co-workers on scene, it would be imperative to have a good working relationship, which begins with the understanding of roles.

Paramedics already perform some type of social work during calls, and many of them have developed good assessment and psychosocial skills. A social worker new to the job or area would benefit hugely from the knowledge base of an individual who has worked in that community for a long time. By understanding the training of paramedics, social workers would more readily complement the work of the paramedic colleagues. Flexibility is required during calls, and some paramedics will be competent to perform certain social work skills, while others may not be, requiring assessment of the situation and interventions accordingly. Social work may also allow paramedics to focus more on their role, rather than force them to provide social work care in addition to their medical responsibilities.

Paramedics can be called to several calls one after another. When this happens, paramedics are unable to spend extra time on non-medical issues. They also should not have to respond to calls that use their service inappropriately or needlessly. Unfortunately, there are few alternatives. In this context, social workers would be available for referral non-medical calls, or could remain on scene longer than the paramedics with patients that require extra assistance. Social work would also be preventative, using interventions to prevent abuse of the system. Social workers would complement the medical component of emergency care, providing holistic care. The biopsychosocial model would be helpful to understand the larger picture.

An understanding of the biopsychosocial model and holistic care plans would be essential to social work in paramedic work. Medical issues may be the cause of the emergency call;

however, psychosocial issues frequently contribute to the health of the person. Social work could intervene on both a preventative and reactionary basis to assist in decreasing ambulance calls. An extensive understanding of how different areas of a person's life affect their health and interconnected would be essential to care planning. Being able to communicate and facilitate the individual to speak about different areas of their life would require interview and listening skills.

The reason that social workers and paramedics should not be cross trained would be more related to the defined expectations of their respective roles. Social workers would not be expected to perform medical procedures while doing psychosocial interventions, and vice versa for paramedics. This would create a better working relationship, as each profession would be allowed to practice in their respective areas, while not having to learn new skills or be responsible for another area of expertise. Paramedics would not be expected to deal with psychosocial issues and could focus on medical concerns.

Importantly, better patient care would arise from a social worker's ability to adequately address areas of a patient's life and lift this responsibility away from paramedics, such as in the cases indicated above. Essentially, there is a need among paramedics for social work to address psychosocial issues and other social work related issues that are not properly addressed with the current system of emergency care.

4.2 Theme Two: "The world doesn't shut down at 10 o'clock at night"

Social work which could happen at all hours invariably means shift work. Shift work affects how social workers feel about their job, whether they like shift work or not, and their level of energy and attitude. These elements translate directly into their practice. Shift work also influences what resources a social worker can call on and refer to, and who is available for consult questions. For example, resources are plentiful on a weekday, but at night, social work would have to become much more independent and autonomous, similar to the paramedic style of work.

Social work during ambulance calls may not always happen in controlled environment of an office or hospital. This reality would require social workers to be equipped with appropriate clothing for the weather (rain jackets, boots), safety gear (neon vests for car incidents, proper shoes), and personal protective gear (gloves, hand sanitizer). This role would require social workers to have access to ambulance for transport or their own mode of transportation. Social

work outside of the office would also require the individual to carry their own resources (computer, handouts) and be able to telecommunicate if they need further consults. Patient privacy would be dealt with as best as possible (using the ambulance, for example), but social work interventions might occur on scene without the luxury of a controlled environment.

Without an office and access to required devices, such as computers or telephones, work would be difficult. A social worker would require access to the Internet and a computer, whether in the form of a Blackberry or an iPhone, and a cellular phone. Because they travel to different locations, GPS would be a benefit and save time as well. As most resources, such as the Red Book, are electronic, it would make even more sense to have a mobile computer or smart phone. Resources such as clinical debriefing or consulting, supervision, and inter-disciplinary consults would have to be pre-planned or become telephone based.

Social work in paramedic work means no scheduled breaks, no convenient bathrooms, interrupted sleep, dirty apartments, smelly situations, blood, vomit, feces, rain, mud, and missed meals. Paramedics work through all such situations and are expected to perform, and this expectation would fall on social work as well; it would require social workers to leave personal problems and complaints behind and use clinical skills in awkward or non-ideal situations. A higher level of personal safety is required in paramedic work, including physical safety, emotional safety, and protective gear. Self-awareness would have to be high to understand triggers. Self-care would become extremely important in order to avoid fast burnout.

The role of a social worker revolves around the types of patients that they see and the patients' psychosocial needs. The population and situations that social workers encounter influence the parameters of the role and the practice. During ambulance calls, the situations can change quickly or become something different entirely. As a result, social workers in this role would have to be flexible in what their scope of practice includes in order to provide best practice for patients and fully support paramedics. Flexibility extends to the ability to change practice approaches as the situation evolves or provide logistical support to paramedics. Calls may be unclear in nature, requiring a social worker to assess situations quickly without background knowledge.

Due to the nature of ambulance work, each situation is different. A social worker must be able to have skills to deal with the range of human emotions, multiple populations, and be able to address culture, age, gender, and responses. Patients, families, and friends can become violent,

uncooperative, or simply inappropriate. A variety of clinical skills, theoretical approaches, and resources must be available to for social worker in any given situation. Social workers must be able to walk patients or family through a variety of situations, including grief, trauma, crisis, happiness, and pain. Understanding the needs of patients and being able to address them is the fundamental nature of social work.

Crisis intervention requires assessment skills. Brief therapy is helpful in order to maximize time during the situation. Support may also include follow-up with patients or families following the emergency call, which could include home visits, office appointments, telephone calls, or informal meetings. Understanding how a crisis can affect individuals in the long-term would help for assessment and informational purposes. Follow-up could be initiated by the social worker after an event, by the family or patients at their request, or upon the referral of a paramedic. Follow-up would not be long term, as social work in ambulances would be focused on current situations; however, ensuring referral to further services could decrease the usage of inappropriate ambulance calls.

4.3 Theme Three: Family and Friends - Not Thought of in the Big Picture

Paramedics get calls for psychosocial issues because there are no other alternatives or resources. Social workers would be able to take over non-medical calls, allowing paramedics to leave the scene. Social workers would have to be trained in dealing with a variety of issues and populations. Paramedics recognize that they are stretched and want resources to refer patients to or hand off to. Prevention does not exist in the paramedic profession, and social work could be the beginning of practicing prevention with patients.

Working with such diverse situations requires social workers to have a diverse skill set. Since they have skills that would be needed on scene, social workers would have to arrive promptly on scene, either with paramedics or with their own transportation, quickly assess a scene and begin interventions. Social work would involve navigating complex situations that would frequently be intertwined with medical issues. Assessment skills would be necessary in order to prioritize urgent situations or modify intervention plans as situations change. Social workers would require a large knowledge foundation in order to be competent in a wide range of areas.

Social workers would benefit from being able to stay on scene to address further needs if paramedics are no longer required. Social workers in this scenario would need to be trained on safety, since they would be alone with patients and/or family. They would need transportation to enable them to come and go from the scene, as well as communication devices between themselves and dispatch, such as radios. Social workers would also be able to do further follow-up if needed at a later time, which could decrease inappropriate use of paramedics' time.

Acting as a liaison with family members includes acting in person while on scene, but also with family members not present. Communication is essential and social workers must be able to handle all types of reactions from family members, whether those reactions are anger, placing blame, crying or nothing at all. Communication tools, such as cell phones and email, are also important in order for the family to get a hold of the social worker, or vice versa, for example, to relay updates on a child injured outside of their parents care. The information provided to the family would have to be deduced from the paramedics, sometimes without having a conversation, so a working knowledge of medical conditions is important. I found that as my research progressed, I was better able to determine how sick a patient was based on talk between partners, vitals that were taken, or which medication was given. These details are potentially useful information for social workers to use when communicating with family members. Understanding and anticipating the needs of family, including hospital information, food, or privacy needs, or support, and being able to access resources would be essential when acting as a liaison.

The role of a social worker must include being able to recognize when follow-up is needed during crisis situations. Assessment skills would be needed in order to determine when situations are in crisis and if patient' and families' reactions are normal or require further intervention. Mental health skills would be necessary, as crisis reactions can include anxiety, posttraumatic stress disorder, and depression in the long term. Recognizing which situations require support beyond social work follow-up would also be necessary for the role of social work in ambulance work. Social workers would also partner with paramedics to determine which patients require follow-up, instead of relying solely on themselves to determine psychosocial interventions.

4.4 Theme Four: Across Ages, Culture, and Illness

Paramedics are governed by policies and procedures in order to ensure the best Western standard of care for patients. Unfortunately, these guidelines do not take into account cultural values, beliefs, or customs from other cultures. While medical practices are based on their own set of cultural values and beliefs, because they are part of their own historical context, these issues are beyond the scope of this research and I refer to the conventional distinction between medical practices and tradition, values, and beliefs.

Social work practice with patients and families would include an explanation of why certain procedures must take place and possibly involve modifying procedure in order to facilitate patient care. Education concerning cultural issues could help paramedics understand why there is resistance to certain attempts at medical care. Acting as a liaison between the family, patient and paramedics could result in a smoother delivery of medical care. Social work could also include translation (through access to telephone translation), acting as a bridge with information, and providing an understanding of gender roles in different cultural contexts. Furthermore, it could also help develop more culturally sensitive and appropriate models for the delivery of medical care in these strenuous circumstances.

Paramedic work involves treatment of a wide variety of populations, from infants to elderly. As social workers attend the scene, they would be required to have clinical skills that match each possible age group. Not only are clinical skills important, but an understanding of the legal issues that apply to the situation (child abuse, elder neglect, age of consent etc.) would be necessary. Assessment skills would be key in order to work with parents, family, or the patient. Resources for each age group would be necessary, as would be contacts in certain key organizations. Social workers would have to shift their attitude if they work with and favor a particular population because they would no longer be working with just that one population. Specialized areas of knowledge required for different types of social work (geriatrics, pediatrics etc.) would thus be required for all social workers in this role.

Working with elder populations requires knowledge about specific legal issues, including abuse and neglect, power of attorney, and adult guardianship. Understanding competency and its testing (MOCA, mini-mental) would be essential, as would understanding the rights of seniors living at risk. Functional assessment skills, including mobility, cognition, and transferring would allow social workers to assess patients more effectively. Social workers with seniors would also

require an in-depth knowledge of senior resources, government benefits, home support, and community case managers. Communication skills would be essential when speaking with family members and long-term follow-up would be probable.

Pain requires social workers to have a working knowledge of the causes of the pain and/or the symptoms being experienced. This reality requires a basic medical knowledge and physiological understanding of the human body. An understanding of drugs and their effects on pain management would allow social workers to gauge the severity of a situation. However, patients in pain are a medical priority and present an ethical dilemma. Essentially, providing social work at the expense of paramedics' medical attention would be negative patient care. Instead, achieving a balance would provide a positive experience for the patient. Communication would be needed between social workers and paramedics in order to allow them to do their job and provide them with support, rather than get in the way of their care.

Social workers encounter populations that abuse drugs and alcohol. Building trusting relationships would be key to working with individuals with substance abuse problems. Ethical issues concerning substance abuse could involve legal issues (i.e. possession of illegal substances), child safety concerns, or confidentiality and disclosure. An in-depth knowledge of resources, treatment options, and referrals would be essential. Theoretical approaches could include harm reduction if it works for the patient. Referrals for drug and alcohol support would lighten the load of paramedic work when the call is inappropriate for paramedics. Follow-up for substance abuse would be useful in order to connect patients with further treatment options. Safety regarding how work with active substance users, including needle safety, hygiene, and transmission, would be necessary.

Social workers frequently advocate for the autonomy of the client and attempt to begin where the client is currently. This practice would not change for social work in emergency services, but could take different shapes and forms from the familiar. Thankfully, paramedic protocol also values the autonomy of the client and would not make it difficult for social work to continue this practice. Beginning where the client is could challenge social workers by presenting them with situations to which they are not familiar with and requiring them to emphasize and advocate for the client.

4.5 Theme Five: **“We’re Just Expected to Deal With Everything That We See and Experience On Our Own”**

Emergency work among rescue teams requires respect and the ability to work within other professions policies and guidelines. When outlining parameters for social work in ambulance work, it is imperative to discuss social work and the need for the profession to work within the pre-existing policies and procedures of the other organizations involved in emergency response work.

While the goal of partnering social work with ambulances would be to increase patient care, one of the side benefits would be increased support for paramedics themselves. Paramedics may receive traumatic calls and be expected to continue out their shift without any crisis debriefing. Social workers would be available on their schedule (between calls, on a ride to another call, or while getting a meal), enabling them to seek immediate support. While this service would not take the place for longer-term follow-up, it would be a short-term solution in that moment. Social workers would also be an informal support for those who do not wish to seek out formal support, as the social workers would be at the situations, and would understand the community and see the work first hand. As a result, social work would require training regarding employee debriefing, crisis intervention, and support following disturbing instances.

Gathering feedback from paramedics about how they would like to see the role created could shape the role directly. As this role has not existed within the British Columbia Ambulance System in the past, feedback from those who would work directly with social workers would be a major source of information. Their insight impact what types of calls social workers are dispatched to, the boundaries and protocols of the role, and how the role would incorporate the procedures currently in place. I argue that feedback is also important to create good working relationships with paramedics, as paramedics would have to work directly with social workers and should have input into what that looks like.

Social workers in paramedic work would step outside of their traditional environment and into the working cultures of organizations that have been there for long periods of time. In order to create professional respect, legitimacy, and relationships, social workers would have to understand the policies and procedures of other organizations and work those frameworks. Communication at times of crisis would be essential, but perhaps more important would be the training and knowledge built up prior to taking the position. Without a solid knowledge base of

professional boundaries and procedures, social work might inadvertently create bigger problems and add to the workload of other organizations, rather than decrease it.

5 Conclusion

The purpose of this research was to investigate whether social workers could address psychosocial issues during ambulance work and what this role would look like. Evidence collected throughout the course of the study suggests that the following conclusions can be drawn regarding the original thesis questions. Social work would be an asset to the British Columbia Ambulance System and would help to address the psychosocial and cross-cultural needs of patients. This role would contain many elements of traditional social work roles, but would also include significant differences and unique challenges. These differences include access to resources, hours of operation, greater flexibility and scope of practice, and a greater need for extended knowledge of variety of populations including: individuals across gender and age ranges, individuals with substance abuse and mental health disorders, immigrant populations, LGBT individuals, and other vulnerable people.

By definition, paramedics do not provide for psychosocial needs or provide follow-up care. Identified issues in this regard include high numbers of calls with psychosocial needs, overworked paramedics, large numbers of non-medical calls, and a general lack of resources for patients with non-medical needs. The skills of social workers are needed by both patients and families for immediate issues and follow-up calls. The nature of calls are varied and social workers would be able to assist in holistic treatment plans, perhaps decreasing reliance on the system. Social workers would also fill a need for immediate and instant support to paramedics themselves.

The role of social work would be varied, taking place around the clock and on weekends. Social workers would be required to be flexible in their approach and their contribution to the paramedic team. Their work would take place outside of normal working conditions, and would need access to mobile resources and technology. Social workers would require the ability to transport themselves to and from scenes, as well as provide transportation for patients and families if needed. Social workers would be required to work within other organizations' procedures and understand those procedures well. Understanding the community that social work would take place in would be paramount for social work and building relationships. This work would require the social worker to be able to function in less than ideal situations and be

extremely self aware of their triggers and reactions. Relationship building, team playing, and flexibility concerning the traditional role of social work would be necessary in order to function with the rescue teams. Social work would also require education for both paramedics and community members concerning the role of social work and what needs it would fill. Building relationships with community organizations would be necessary for follow-up cases, resource referral, and care planning. In order to best create a plan for care, high assessment skills would be needed due to the short time that social workers may be involved with patients and families.

5.1 Implications for Social Work

Implications for the profession of social work include the creation of a new role and the expansion of social work into a new field of work. Evidence demonstrated that medical issues have psychosocial aspects that are linked to health, which further strengthens the need for the holistic care model and social work in general. This research strengthens the argument that psychosocial interventions should be applied earlier than when a patient reaches hospital, which increases the need for preventative interventions. Education for social work would be necessary in order to adequately prepare social workers for successful patient care.

While the partnering between social work and paramedics has not been tried in the past, this research leads to some conclusions regarding the proposed interdisciplinary practice. For this partnership to be successful, it would be necessary for the role of social work to be clearly outlined, including worker expectations, and a job description. Having a common language between both professions would also be important for social workers and paramedics to work together in a positive manner, making the medical knowledge an important thing for social workers to learn. As this research has demonstrated, medical knowledge is important to communicate with and support paramedics in their roles, but also to establish a common language between social workers and paramedics.

Evidence collected in this study also echoed what the literature suggested about paramedic collaborations: while they may start off somewhat rocky or experience growing pains, eventually the relationship evolves into a positive association that benefits patients. Fire, police, and paramedics currently collaborate when needed to ensure patient care, and with some specific and important measures, like proper training, social work could contribute significantly to this team.

This research also demonstrates that social work is not an independent profession and that partnering with other disciplines could be a necessary process in administering holistic care. As such, interdisciplinary teams would have to be considered when developing best practice guidelines and investigating future health care teams that function outside the hospital.

The final implication for social work is the necessity to continuously seek out and develop new roles for social work. As medical developments are made and research introduces new practice methods, social work should also progress and grow to match the needs of the community and population.

5.2 Limitations and Further Research

Research limitations included the small-scale nature of the study, which resulted in a small sample. A larger sample might have revealed other suggestions or implications during interviews. The research also took place over a two-month period, and thus was not exposed to other seasons, major events taking place in the city, or different months. Situations and calls would change depending on the climate and time of year. A larger study would be able to examine the difference in calls and the difference in social work needs as a result.

Further research could include performing social work on a pilot basis and examining the outcomes. As this research demonstrated a need for psychosocial and cross-cultural support during ambulance work, and that social work could be the profession to fill it, further research could consist of social workers providing active social work interventions and support, as well as measuring whether these measures made a positive difference in the care of the patient. Finally, patient input and feedback should be a component in further research.

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Appendices

Appendix A: Letter of Confirmation

Attached is the Letter of Confirmation from Michael Sanderson, British Columbia Ambulance Service.

Dear Ms. Campbell:

This letter will serve as confirmation of approval by British Columbia Ambulance Service (BCAS) for your requested observer activities in support of your thesis work in partial fulfilment of the requirements for Master's of Social Work degree at the University of British Columbia Okanagan (UBCO).

Please ensure that your activities and participation is in strict compliance with the methodology outlined in your outline provided in your request to Superintendent Black who will remain as your designated BCAS contact on this matter.


Prior to commencement of any third party observer role you will be required to attend a safety lecture, be fit tested with an appropriate N95 mask, and sign a third party liability waiver. You are encouraged to consult with your personal physician regarding any immunizations he or she may believe appropriate for your exposure to patients in the pre-hospital setting.

I wish you the best of luck in your endeavours.

Appendix B: Confidentiality Statement

Attached is the confidentiality statement signed by the transcriber of the interviews.

THE UNIVERSITY OF BRITISH COLUMBIA


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**UBC Okanagan
Confidentiality Statement**

Confidentiality Statement

I, Prakash Patodia, being a transcriber in the research done by Hilary Campbell at the University of British Columbia Okanagan understand the following:

- I understand that the nature of the data is confidential and will not share its contents beyond transcription purposes.
- I will destroy all records of the data once the researcher has deemed the transcripts appropriate.

Signature: *Prakash Patodia*

Date: 6/12/2010
