Trading Cards and Common Ground:
Paramedic Story-telling and Narrative Purpose

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ABSTRACT

TRADING CARDS AND COMMON GROUND:
PARAMEDIC STORY-TELLING AND NARRATIVE PURPOSE

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Paramedics are storytellers. The profession lends itself to acts of narration, with every service call becoming woven into a tale about odds overcome, and laced with humorous rhetoric. In this thesis, I argue that paramedics’ stories do more than fill the air with conversation to pass the time. They serve a distinct purpose within the professional culture, allowing for its members to navigate the harshest realities of their work environment. By applying an ethnography of communication framework I examine the uses of paramedic narratives while also combating the insider bias of being a paramedic myself. In using a combination of participant observation and semi-structured interviews, I explore the diverse purposes of paramedic narratives, which include educating, building a sense of belonging, validating decisions, and compartmentalizing trauma.
“We are seeing efforts to map an intermediate space we can’t quite define yet, a borderland between passion and intellect, analysis and subjectivity, ethnography and autobiography, art and life” – Ruth Behar, 1996
DEDICATION
To the paramedics who shared their voices and to those who didn’t: May we all continue to grow together, supporting each other and get to 10-19 when this is all over.

And to Lorona. I may never have known you but I know you are watching and I hope you are proud.
ACKNOWLEDGMENT
First, I want to thank all of the paramedics who sat down to share their stories with me. You all were not only supportive of my work but also genuine in your responses. You reached into your past and spoke not only of the good times but also the bad. I am forever thankful for the time I was able to spend with each of you. You exposed yourselves and gave me a piece of your identity with every story you told.

Second, I would like to thank my supervisor, Beth Finnis, for her time and support. I don’t know how I would have gotten through the tough grind of writing if it wasn’t for you giving me the pointers I needed to stay on track. And to Tad McIlwraith, who was always around when I needed to run ideas past him or simply read through what I had written, guiding the direction of my research.

Finally, I want to thank my U of G family. Our fairy grad mother Shelagh for all of her help with forms, registration and answering questions that I am sure she hears all the time, with a wave of her wand. And my fellow Obeyeskere’s Angels: Loa and Natali. There is simply no way I would have been able to get through these two years without you two. We have shared in pints and debates, fought over theory and my tendency to get distracted, and laughed over mispronunciations, Halloween one-sies, and poor life choices. I love you both, never change.
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CHAPTER 1: Introduction

“Stories are amazing. They’re such a rich and powerful way to express what it means to be human. And we as paramedics like we really know what it is to be human because we see people in their most vulnerable states and we’re called to be present for other people who are in crisis. And that, I don’t know any other way to feel connected to the broader, bigger picture of humanity.” – Trevor

Paramedics are story-tellers. It is a part of the job that is often overlooked by the Hollywood dramatization of the profession, and yet it is something that occurs with every shift. It is a process of trading of tales, a swapping of ‘war stories’ of days in the trenches. In this thesis, I combined interviews and participant observation notes to create a rich ethnographic description of paramedic culture as is seen through their story-telling practices. Situated in the city of Toronto, I worked with Toronto Paramedic Services (TPS) paramedics to co-construct a vivid account of the ways stories can serve a multitude of purposes for individuals within the profession. Throughout my thesis, I argue that paramedics not only tell stories to fill time and entertain, but also to educate themselves and each other, cement community ties and compartmentalize tragedy.

I am a paramedic and I am also a story-teller. I spent my youth exploring worlds of imagination, making up plays and skits, and producing performances for my family with my living room as my stage. In high school I changed mediums, moving to film and capturing scripted tales behind an out of focus lens. University would see me again playing with film and swapping stories over pint glasses with fellow peers as we stressed about upcoming exams. My interest in and aptitude for telling stories followed me into my adult life. I still film from time to time and I engage actively in story-telling at work as a TPS paramedic. This helped contribute to my academic interest in the purpose of
story-telling and how in critically viewing these narratives I could help contribute to a fuller understanding of paramedic culture.

Research Goals and Objectives

Story-telling is something that paramedics do every day on the job, sometimes without much apparent thought to the process. Whether it is in the truck with your partner or at the hospital as you wait to transfer care of your patient, stories flow back and forth. It is an embedded part of the profession, one that is often overlooked, or understood as simply a way to pass the time. But even if paramedics appear to be trading stories as part of daily routine, it is important to ask what purposes these stories serve for paramedics. Communication scholars have demonstrated that stories are not only culturally appropriate but that they have the power to do work (Austin, 1962; Gumperz, 1982; Hymes, 1962). They have a use and are used by the particular culture that shares them. This is what I explored in my research with paramedics. The research questions shaping my thesis were:

1) What, if any, importance do stories serve in paramedic culture?

2) Is the organization of the stories culturally specific with set rules and codes of conduct?

3) How might the act of story-telling, and the information transmitted, influence the teller and the listener?

To begin to answer these questions, I used a combination of participant observation and semi-structured interviews that allowed for participants to fully engage in the story-telling process. Data was collected and analysed, with additional feedback from participants requested in order to clarify certain elements. Allowing for on-
going conversations with my participants meant creating a co-
constructed account, meeting my own personal research goals, and goals important to my
participants.

Being a member of the community I am studying brings with it a level
of potential bias. Throughout this thesis, I will address the importance of self-
reflection when it comes to conducting insider-based research. I will explore my
biases, and inform the reader of moments where my position gave me a point of view that
an outsider may never have experienced. While I acknowledge the potential for skewed
results, I believe in my research, in my data collection techniques, and my ability to
reflect on my position within the studied community. Undertaking this kind of qualitative
study of paramedic culture is crucial to understanding a profession that has tended to
be understudied in academia

*Paramedics in Ontario*

Before moving into the theory, methods, and analytical sections of my thesis, it is
useful to provide some context about paramedic work in Ontario and the way paramedic
services are structured in the City of Toronto. As defined by the province of Ontario’s
Ambulance Act (2017), a:

““paramedic” means a person employed by or a volunteer in an
ambulance service who meets the qualifications for an emergency
medical attendant as set out in the regulations, and who is authorized to
perform one or more controlled medical acts under the authority of a
base hospital medical director, but does not include a physician, nurse
or other health care provider who attends on a call for an ambulance.”

A paramedic within the province of Ontario must meet the following qualifications in
order to be employed by one of the 51 municipal services within the province:
• Have an F class license or equivalent which allows an operator to drive a bus with a maximum of 24 passengers and/or an ambulance
• Be a graduate of an accredited college paramedic program
• Have successfully completed the Advanced Emergency Medical Assistant or A-EMCA exam

Ministry of Health and Long Term Care approved paramedic college programs generally range from 18 to 24 months and are offered at colleges throughout the province with both private and public programs available. Upon completion of the program a student will be eligible to write the provincial A-EMCA exam and be certified as a primary care paramedic. Advanced and critical care paramedics require additional training through approved programs and are certified to do skills beyond the training of a primary care paramedic. Table one shows the skills that can be conducted by the three levels of paramedic. These skills are known as controlled acts as they are regulated by the province and overseen by the license of a base hospital physician.
Table #1: Controlled Acts Permitted by Paramedic Level

<table>
<thead>
<tr>
<th>Primary Care Paramedic</th>
<th>Advanced Care Paramedic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Administration of glucagon, oral glucose, nitro-glycerin, epinephrine, salbutamol</td>
<td>1. Administration of the drugs referred to in item 1 of Schedule 1, in addition to any other</td>
</tr>
<tr>
<td>and ASA (80 mg form)</td>
<td>drug approved by the Director on the recommendation of one or more medical directors of</td>
</tr>
<tr>
<td>2. Semi-automated external cardiac defibrillation</td>
<td>base hospital programs</td>
</tr>
<tr>
<td></td>
<td>2. Semi-automated external cardiac defibrillation</td>
</tr>
<tr>
<td></td>
<td>3. Peripheral intravenous therapy</td>
</tr>
<tr>
<td></td>
<td>4. Endotracheal intubation</td>
</tr>
<tr>
<td></td>
<td>5. Non-automated external cardiac defibrillation and monitoring</td>
</tr>
</tbody>
</table>

Critical Care Paramedic
1. Administration of any drug that an advanced care paramedic may administer under item 1 of Schedule 2, in addition to any other drug approved by the Director on the recommendation of one or more medical directors of base hospital programs
2. The controlled acts referred to in items 2 to 5 of Schedule 2
3. Non-automated external cardiac defibrillation, electrical cardioversion and pacing
4. Maintenance and monitoring of arterial and central venous catheters
5. Gastric intubation and suction
6. Ventilation (mechanical) and setting of ventilatory parameters
7. Lab blood value interpretation
8. Management of chest tubes and chest drainage systems
9. Chest x-ray interpretation
10. Urinary catheter insertion
11. Intravenous blood product administration
12. Doppler flow monitor use
13. Use of infusion pumps
14. Other advanced airway techniques, e.g. needle thoracostomy, cricothyroidotomy

(MOHLTC, 2003)

Paramedics within the province of Ontario work under the medical licence of a base hospital physician who certifies them to perform the above listed controlled acts. This means that paramedics can use clinical judgment acting in accordance with their protocols in order to administer care to patients without having to ask for a physician’s direct approval if the act falls within their care parameters. Paramedics are held accountable by the municipal service they are employed by, the base hospital director that maintains their certification and the Ministry of Health and Long-Term Care.
In Toronto, the municipality controls paramedic services. The service encompasses Etobicoke, North York, Scarborough, and the downtown core. Toronto has four separate classes of skill sets: 1, 2, 3, and critical care. Level One paramedics are considered primary care with a Level Three being equivalent to advanced care paramedics. Level Two paramedics have additional intravenous access skills that allow them to start IV lines and give additional drugs outside the scope of primary care paramedics. These Level Two paramedics are trained in-house by the base hospital director and differ from the provincial standard of three different levels of skills as previously laid out.

The city itself is broken into four quadrants that are used to designate work placement at the beginning of shift. The city is divided east/west by Yonge Street and north/south by Eglinton Avenue (See Figure 1.1.). All paramedics are assigned to a quadrant 1 through 4 based on seniority within the service, with personal preference also being taken into consideration. Paramedics without a permanent station are considered on “swing” and are required to call in two hours prior to the start of the shift to be assigned their station. Full-time swing paramedics are kept to their side of the city, east or west respectively, while part-time swing paramedics can be sent anywhere in the city. The service attempts to keep all paramedics within their assigned quadrants but due to operational demands a paramedic may start their shift out of their quadrant or be moved throughout the day.
Chapter Overview

In Chapter Two of this thesis, I present a review of the theoretical and methodological literature that my research is shaped by, intersects with, and builds on. Anthropological understandings of communication and social interactions, in particular the ethnography of communication, combine to allow for a richer understanding of paramedic culture and the purpose of story-telling. In addition to the discussion of the emic approaches afforded by the ethnography of communication, this
chapter also discusses how an etic understanding, in particular the application of a monomyth structure, works as an appropriate starting point for the analysis paramedic narratives. This chapter also discusses the existing literature on paramedic culture, noting that social science studies of paramedics are limited with the majority of research having been conducted over ten years ago (Donelon, 2014; Palmer, 1983, Palmer & Gonsoulin, 1990, Tangherlini, 2000). Chapter Two goes on to explore this gap in the literature and provides examples of studies being done with other first responders and health care professionals to illustrate the importance of additional research.

Chapter Three is an overview of my research design and methods. I discuss who my research participants are and how I came to recruit them. Potential biases in recruitment are examined and a description of interview locations is reviewed. I go over my inclusion and exclusion criteria for participants and give examples of the most important interview questions used during my research. The need for participant observation is explored, explaining why it was used as a technique to gather information in combination with interviews. Finally, I address the importance of self-reflection in doing insider researcher. I explain my process of dealing with any potential biases or conflicts of interest.

Chapters Four and Five are devoted to analysing my data and will present the main themes extracted during my research. I used a mix of transcript excerpts, observational field notes, and personal experiences to build a powerful argument surrounding the purpose of stories. Chapter Four first focuses on the theme of education and validation by reviewing a participant’s story in order to offer a familiar starting point for the reader. The latter half of the chapter looks at bonding and the ability of stories to
connect paramedics to their professional community. Chapter Five deals with the ability of stories to offer a sense of control in uncontrollable situations leading to coping and strategic stress management. The final section of this chapter touches on the importance of the impact of PTSD and discusses an outlier participant who has personal experience with this mental illness.

In the conclusion, I provide a summary and overview of my thesis findings. I reiterate how stories have the power to do something and that they serve a purpose. I also discuss the need for additional research in the field of paramedic cultural understanding. There is work that still needs to be done at the conclusion of this project. I have barely scratched the surface as to the importance of peer interactions and profession identity. I have interjected moments of self-reflection and story-telling on my part as a means to expose my biases and bring the reader into my own socially constructed world as a paramedic story-teller. This allows for the reader to be aware of my position within my community of study as well as feel the personal impact of stories as they read my own narratives connecting my voice to my participants. This thesis is an amalgamation of many voices speaking to the need for further understanding of a previously overlooked group.
CHAPTER 2: A Review of the Literature: A Mixing of Emic and Etic Approaches

In this chapter, I provide an overview of the relevant literature that supports and illustrates the ability of paramedic narratives to do work within the culturally constructed context of the profession. Expanding upon the frameworks raised in the introduction, I also provide a discussion of the literature and principles I applied during the analysis of my data. Drawing on anthropological, sociological and linguistic perspectives, I have used an ethnography of communication approach in order to produce a robust understanding of the complex purposes of paramedic narratives. Highlighting both the strengths and weakness of the applied principles, I address how this approach offers a fuller description of the paramedic story-teller without universalizing the elemental components of their narratives. I also address the limited social science research being on paramedic experiences, addressing gaps in the literature as I explore each approach I used. In addition, I critique previous works that have been done with paramedics, discussing their limited gaze, data collection techniques, and year of publication.

An Emic Approach: Humour, Ethnography of Communication and Sociolinguistic Interaction

Intra-professional communication can be seen as a ritual process of interactions weighted on place and situation with the smallest of behaviors eliciting meaning (Goffman, 1967). What is said in these moments between colleagues when the stressors of work have been momentarily set aside, are more than simply the linguistic elements or grammatical form; they include and convey socially and culturally appropriate meanings for the community in which they are being uttered (Farah, 1998). The ethnography of communication looks to these norms of narrative production and stresses the value of
language use within a particular society based on its ability to encompass both linguistic expression and social meanings (Hymes, 1986). While the ethnography of communication as a framework has been used in various cultures and has rooted applications in medical based paradigms including patient/professional interactions and narratives of illness (Kleinman, 1988; Ryan, Bissell & Morecroft, 2006), it has been used less frequently in intra-professional contexts (Mattingly, 1998; Watson, 2011) and has yet to be used within the paramedical sphere.

The ethnography of communication, also known as the ethnography of speaking, has paid particular attention to the language use of non-western or Indigenous cultures (Keenan, 1989; Scollon & Scollon 1979; Basso, 1979; Basso 1990). For example, Keenan illustrates how the particular use of language by villagers in Namoizmangra, a small hamlet in south central Madagascar, helps to establish not only their social role, but also the norms upon which these roles depend (Keenan, 1989). Language use is therefore tied directly to actions considered socially acceptable within the culture being analyzed. Basso explores ethnographically the language use practices of the Western Apache of Arizona. He aimed to, “interpret social and cultural systems through the manifold lenses afforded by language and speech” (Basso, 1990, p. xii). Basso worked to expand the lessons gained from working with the smaller parts of speech, such as morphemes, to broader aspects of Apache culture. For the Apache, the use of culturally-laden words and expressions work together to create a narrative experience for the Apache audiences. As Darnell explains in her examination of a traditional Cree performance by an older member of the community (Darnell, 1989), the audience at which the performance is aimed impacts the choice of narratives told or words used. This illustrates the power of
the ethnography of communication to take into account not only the importance of words, but also the combination of culturally specific environments and interactions.

There are also limited discussions of the relation of linguistic choices and norms within western micro-cultures (Abrahams, 1989), with children (Sacks, 1986) and adolescents (Duff, 2002). For example, Abrahams has illustrated how understanding the use of language and narratives within a particular African American community can illuminate the patterns of their unique culture, bringing a more solid definition to bear upon their identities expressed in their subgroup. Shrikant’s work (2014) has shown how word choice within personal narratives can establish identity and define cultural boundaries of gender within the LGBT micro-cultures located in North America.

For story-tellers, the purpose of narratives and the ability to tell a story are two-fold. First, narratives have the ability to define roles and establish norms within a community. They allow for individuals to voice what is important to them and in turn define themselves within their own culturally constructed world. In turn, the stories help story-tellers define and assert themselves within their own culturally constructed world. The second purpose, as noted by medical anthropologist Kaplan-Myrth (2007), is that the act of telling allows for the narrator to reflect on the experience moving it from something lived to something interpreted. The purpose of reflection and validating of experience is a focus of this thesis, as it helps us not only to understand the self-defined roles of paramedics and to learn how to interpret those roles and experiences.

The ethnography of speaking offers an emic or insider’s approach to understanding stories and their meanings within a community. To see how this works, it
is important to look first at the interaction between story-telling participants in terms of both speech acts and speech events. Philosophers Austin (1962) and Searle (1962; 1969) introduced the idea of speech acts to describe how words have the ability to do things. They indicate that words carry meanings that are integrated into the performance of the utterance of the words themselves. Speech acts, units of speech became identifiable elements of broader speech events. Speech acts could then be labeled and classified. Interpretation followed. Speech acts are then combined to form speech events such as those found during storytelling sessions. A story is a speech event, or a combination of culturally defined speech acts, that is delivered to an audience in order to serve a purpose.

The ethnography of speaking breaks speech acts into their components by using the descriptive mnemonic SPEAKING. SPEAKING stands for: settings, participants, ends, act sequences, keys, instrumentalities, norms and genres (Hymes, 1986). ‘Setting’ describes the time and place in which the speech act takes place. ‘Participants’ are those who are involved in the speech act either directly by being present in the location of the act or indirectly by being referenced to by other participants in the speech act. ‘Ends’ refers to the goals or purpose of the speech act. These are the desired outcomes of the speech act based on the needs of the participants. For example, the “Ends” could refer to winning an argument or giving directions. ‘Act sequences’ are the sequence of events in the story, the structure of the tale. This sequence also involves the order of the overall telling of the narrative such as the concluding applause of an audience, laughter at a punch line, or punctuated silence between events or audience interruptions. ‘Keys’ are cues that establish the acceptable tone, manner and overall feeling of the speech act.
‘Instrumentalities’ corresponds to the forms and styles of the speech used by the storyteller. ‘Norms’ refers to the social norms that overlay the speech act. These norms are a patterning of acceptable and non-acceptable actions during speech that are culturally defined and adhered to by the participants. ‘Genre’ is the type of story being told. For example, gallows humour, revenge narratives, and pedagogical accounts.

The ethnography of speaking frames narratives as culturally acceptable events that relate to norms and roles as determined by the community in which they are told. This emic perspective allows for the meaning and purpose of the stories to be understood as the participants intend them and understand them. Stories, then, are a combination of language choice, mannerisms, and content chosen by the teller and then validated by a culturally knowledgeable audience. Paramedic narrative performances are no different and serve to validate the teller’s place within the community. The idea that our stories are formed due to the cultural context in which we are situated is an important aspect of the ethnography of communication. Paramedic stories are a reflection of our culture, serving a purpose that is inherent to our beliefs and norms.

Dell Hymes (1962) breaks down narratives into their elements, exposing the culturally specific building blocks of stories in order to shed light on the norms of the society of study. These building blocks are not necessarily universal structures – they do not represent components that would be found in all cultures – but they are features of a particular text and language that are built from pre-existing relationships folded into a specific culture (Hymes, 2003). Relationships, between language choice and cultural norms, are the grounds from which story-tellers compose their narratives speech events. I have taken up the task of deciphering these relationships in paramedic narratives focusing
on their overall function and exposing the links between verbal utterance and cultural importance (Bauman & Sherzer, 1989). Understanding the competency of paramedics within their self-defined speech communities is imperative to understanding the larger cultural system of which they are a part. By exploring the rules and purposes of the particular speech acts associated with story-telling and how they link to this competency, I will be able to show how these narratives serve a variety of functions.

Hymes illustrates the importance of cultural elements that situate a narrative by his use of the SPEAKING mnemonic (1986). Hymes’ ‘Setting’, ‘Goals’ and ‘Norms’ are particularly important for my analysis of paramedic stories. These elements speak to the specific rules story-tellers adopt or deploy when telling a story. It is also important to understand that personal narratives are being told by a participant are influenced by, and are in part a response to, the presence of the researcher. Allowing for participants’ voices to be heard and combining them with my insider perspective, as will be discussed in my methodology chapter, has allowed for me bring together a fuller picture of narrative purpose.

The idea of breaking down a narrative into its components and attributing a broadly cultural structure has an appeal. Elemental analysis of a narrative helps to take an unfamiliar story and shape it in a culturally appropriate way so as to be understood by an audience of people who did not participate in the actual even recounted in the story. By extension, paramedics give titles to situations, labelling components so as to reflect the cultural understandings and expectations of other paramedics. As a researcher, I try to pick up on these components and remain true to the way in which paramedics use them. In doing so, I am able to compare narratives within paramedic circles and show how
these stories work to educate paramedics. In short, I have used the familiar structure of paramedic stories, and teachings that come from this structural familiarity, as a means to analyse the data I collected throughout my research. These familiar structures are used in paramedic narratives to educate themselves and others.

*Interactional Sociolinguistics in the Medical World*

John Gumperz, a linguistic anthropologist, focused his work on the communication competency of the individual and how this competency works to integrate them into their social world (Schiffrin, 1994). Members of a cultural group have their own socially defined codes of communication that are interpreted based on subconsciously defined norms, mannerism and inflections (Gumperz, 1982). This theory presents language as a constructed and symbolic system, one that reflects the local context in which it is created. Erving Goffman adds a layer to Gumperz’s work, applying a framework that aligns with his background in sociology. Goffman looks at language as a symbolic system similar to Gumperz but stresses the importance of the self and the face-to-face social interactions of the speaker (Goffman, 1967). An actor places him- or herself within social encounters on a daily basis that are, “[patterns] of verbal and nonverbal acts by which he expresses his view of the situation and through this his evaluation of the participants, especially himself” (Goffman, 1967, 5). The self becomes a construct of the social interactions of which it is an active participant. Goffman combines the abstract theory of speech acts with their ability to produce work and the idea of the creation of self as a culturally appropriate actor producing and comprehending the meaning of the speech acts themselves.
In the medical literature, sociolinguist interaction theory has addressed the interactions of patients and physicians (Roberts & Aruguete, 2000), teamwork practices in hospital wards (Lewin & Reeves, 2011), and the use of electronic patient reports in emergency departments (Swinglehurst, 2014). These studies emphasize face-to-face interactions and how the socially defined roles of the actors are maintained and comprehended, and defined.¹ In a dynamic environment such as that of pre-hospital care, the understanding of face-to-face interactions allows for a grounded frame of reference. As I will demonstrate later, paramedics interact with each other within a culturally appropriate space (Hymes 1962), but these interactions are ingrained in the profession, maintained subconsciously by language symbols that can be understood from a sociolinguistic interactional perspective. This means that not only are the mannerisms of the actors culturally specific, the little inflections of voice, choice of metaphor, and body language of the participant also plays a role in the overall interaction. These collective actions lead to a sense of community, validation, and promotion of understanding that will be further discussed in the analysis section.

An emic understanding is crucial to the ability for humour to play a role in cultural understanding. In order to ‘get the joke’ you must have a working understanding of the culture community in which the joke is being told. Burson-Toplin (1988), and Mallett and A’hern (1996) speak to the integration of humour into the rhetoric of the healthcare professional. Burson-Toplin discusses how word play amongst physicians aids in the formulation of their identity and extends this to the cohesion developed within the

¹ Swinglehurst looked at how electronic patient records are used to supplement information given to patients during face-to-face interactions. It was found that EPR had both face-saving and face-threatening abilities when used by medical professionals.
group of professionals (1988). While situated in a rigorous and formalized institution such as medicine, group dynamics are stabilized by the use of acceptable language patterns, particularly the use of humour. For example, Burson-Toplin discusses an interaction between fellow medical residence and their dislike of a neurology fellow (1988, p. 283-284). In the conversation, biological terminology that is generally reserved for tragic events is reinvented and used as a humorous way to describe the residence feelings towards the fellow. Beyond the interactions between professionals, the practice of integrating humour into dialogue has been shown to improve interactions between caregivers and patients, extending to the care environment where the administration of healthcare is delivered (Mallet & A’hern, 1996).

Humour works to serve a purpose within culturally specific situations and is an important aspect to paramedic narratives. It works as a counter measure to the powerlessness felt by paramedics in their battle to combat the inevitability of death and the tragic events endured on the job. In this light, humour is not seen as an inappropriate or unethical source of banter but rather a needed construct for a balanced mental outlook within the profession. I discuss this use of humour further in my analysis section of chapter 5.

Etic Approaches: Paramedical Stories and Careers as Monomyth

Anthropologists have long examined connection between stories and the larger social contexts in which they exist (e.g. Georges, 1969). A myth is one such story that, at its root, serves to explain a natural or social phenomenon that is culturally specific in nature. These stories follow particular patterns that can be viewed etically. In doing so, the categories and rules of narrative construction and content are revealed (Campbell,
1949; Georges, 1969). A hero quest is a particular myth structure that follows a distinctive pattern. This pattern can be applied to the understanding of paramedic narrative structures, allowing for a better understanding of their overall purpose.

A hero quest pattern was identified by Joseph Campbell and explained via his Monomyth structure. Campbell’s monomyth is broken into three stages (1949):

- Separation from steady state
- Initiation, liminal transition and confrontation of a problem
- Return to the steady state with transcendent knowledge

Campbell’s monomyth model provides a useful tool for analyzing the stories that paramedics tell. By extension, it also offers a model by which paramedical careers can be described. Let me explain.

A paramedic narrative often begins when a call comes into the station. The story starts with something like, “I was sleeping at the station when the call came in.” The paramedic at the call is situated in Campbell’s steady state. The story might continue: “Stirred from my slumber, I moved quickly, grabbed my bag, and headed for the ambulance.” Now the quest begins in earnest and our hero, the paramedic, encounters the first crisis of the shift. This is a separation and a break from the ordinary. Our hero next moves into the second stage, what Campbell called the initiation. For paramedics, initiation is not the best word. Rather, this is a liminal state in which new territories are encountered and lessons are learned. It is a frequently a time of confusion and uncomfortable feelings for the paramedic. Often but not always, this is the time when a crisis is confronted and a personal struggle ensues. This is also where the learning happens and the hero grows professionally with new skills learned and valuable insights.
gained. The best paramedic stories come from the events that take place during this phase of the quest and those stories are structured around how these crises are managed. Upon transferring care to the hospital or leaving the patient on scene, the paramedic is free to return to the steady state. The call has been concluded and at this time, the hero is poised for the next liminal moment. And now, the paramedic is in the perfect social and physical location to tell stories.

There’s more to say about the application of Campbell’s model to the experiences of paramedics. As will be discussed further in Chapter 4 the word ‘hero’ in paramedic contexts represents the mythical figure that works to overcome obstacles. It is not a reference to a feeling or attribute that a paramedic folds into his or her identity. None of my participants referred to themselves as heroes; rather these elements of their duties and job. I have chosen the word as it is a straightforward reference to the monomyth structure proposed by Campbell and allows for an audience to follow a central character. Further, not all calls result in new knowledge or, in Campbell’s terms, transcendence. Some situations encountered by paramedics are routine, with similar patterns developing time and again. In these situations the paramedic moves from a learning and dynamic hero overcoming new adversities, to a well-seasoned veteran, going through the motions. And, frankly, these routine calls do not always form the basis of paramedic stories. Finally, as a paramedic continues down the path of his or her career, he or she will experience differing situations to their colleagues, producing chapters of a personal story that influence the obstacles experienced during 'quests'. This means that certain stories, certain calls, do not represent the pure form of the hero quest. Rather, they are a combination of past experiences and can become mundane and neutral, causing no
growth in the paramedic and have little influence on future practice. Still, they represent a full career in which paramedics overcome personal challenges, challenges which are frequently the basis for educational narratives.

In medical literature, myths and story-telling have been used in various applications, as a means of understanding particular groups and facilitating care. For example, Atkinson and Hamilton (2005) looked at how the story-telling of elderly individuals in Ireland labelled as having intellectual disabilities promoted their categorization. Additionally, stories worked to give voice to their resistance and struggles against these categorizations and isolating labels. The labels placed upon these individuals forced them into an assigned and fixed category of lacking intellectual capabilities. The narratives of these individuals simultaneously promoted these perceptions and challenged this perceived lack and shifted the universality of their defined label. Atkinson and Hamilton used their research to foster a better understanding of this particular group, and to advance the need for narrative-based approaches when looking into the uses of long-term care facilities. By applying narrative based approaches, the authors were able to stress the important needs of the community, pushing for policy changes and reform.

Another example comes from Banks-Wallace, Barnes, Swanegan and Lewis (2007), who looked at how a combination of story-telling and interactive learning can help promote the self-care needed to reduce cardiovascular disease in African-American women. Their work used a professional story-teller of the same cultural background as those in need of care to help bridge understandings of their health and their current behaviour. This strategy worked to help the women in the study consider new strategies
for self-care that involved physical activity and healthy lifestyle choices. Additionally, Banks (2012) discusses how story-telling can build bridges between communities and researchers in order to better understand access to health care. Shared stories offer a way to break down power imbalances and build trust that could otherwise block the true needs of the community.

*Anthropology and the Paramedical Literature*

Medical anthropology has a long history of looking at the culture of health care professionals. Doctors, nurses and medical students have all been subject to the anthropological gaze. Physician-patient interactions have been viewed as micro examples of larger socio-political climates and expressions of cultural norms. Cooper (2015) explores how these interactions work to not only reinforce established socio-political norms but also work to restructure social relations, allowing for physicians to become integrated bodies of their care community in Santa Teresa, Venezuela. Cooper found that patients held doctors to a saint-like standard, as a result of the country's love for Jose Gregorio Hernandez, a doctor of renowned humanitarian acts who lived in the early 20th century (Cooper, 2015). Additionally, doctors who were perceived to be working for more than simply profit were integrated into the community of care more effortlessly and accepted by their patients.

Ruusuvuori’s (2001) research looks at physician-patient interactions at the consultation level. Rather than focusing on how physician-patient relationships are expressions of the larger picture of the community of care, she explains the importance of body language and facial expressions in the story-telling of the patient. In order to discuss the reason for seeking care, a patient needs to feel as though a physician is hearing
them. Ruusuvuori looks at individual speech acts between physicians and patients, highlighting what needs to be done in order to foster in the patient an improved sense of compassion and understanding.

Nurses and their roles in patients’ lives have been studied extensively by anthropologists (Byerly, 1970, 1977; Fitzgerald, 2008; Slajmer-Japelj, 1993). Byerly, a practicing nurse and an anthropologist, has applied, “anthropological concepts to nursing administration, education, and practice” (2001, p. 775). She has worked to incorporate anthropological thinking into the curriculum of nursing students in order to improve health care delivery and cultural competencies (Byerly, 1977). Fitzgerald focuses her research on the impact of doctor flight from rural areas and how this influences nurse led care (2008). Working in rural New Zealand, Fitzgerald draws from her previous experience in rural communities to discuss the self-defined role of the nurse, the impact of emotional labour and external pressures.

Classic works such as *Boys in White* (Becker, Hughes, Geer, & Strauss, 1976) were merely the starting point for future studies in medical education. In her work in Malawi, Claire Wendland (2010) looks at how doctors work their way through medical school, combating burnout and fatigue with joy and commitment. She discusses how students identify strongly with their profession, becoming deeply rooted in their new identity as they work through their years in medical school. Without access to the financial and medical technological resources that are common to medical students in North American, students in Malawi are forced to make do with the monies they have. This helps to instill in them a hard-won wisdom, an understanding of their patient’s needs.
and their own personal abilities to help them that is unique to the struggles of their education.

Limited ethnographic work has been conducted with paramedics, as the dynamic, non-fixed environment of pre-hospital care can be difficult to study not only in the field of anthropology but in any type of social science research (Roberts et al., 2013). The care environment of paramedics is not constant, with social actors more able to come and go than in some other health care realms. The profession is conducted in public spaces with no structure of clinical walls, with relationships that are short lived and dynamic. This can make consent a fluid concept that is difficult to maintain from an ethical standpoint. This has contributed to limited work being done with paramedics in scholarly arenas, in particular within the social sciences, since they do not necessarily rely on statistics to produce knowledge and understanding.

The social science literature, including anthropological work that examines pre-hospital care highlights the decision-making practices, professionalization and behaviours of paramedics (McCann et al, 2013; Palmer, 1983; Palmer & Gonsoulin, 1990). Palmer’s work, though dated, is in particular an insightful look at the behavioural development of paramedics and the roles that they define within their profession. These roles as defined by Palmer are: medical authority figure, lifesaver, information specialist, partner, and other (Palmer, 1983).² In any given work shift, a paramedic can take on one or all of these roles either separately or blended together. Palmer briefly touches on language use of

² Palmer discusses other roles of paramedics including: performing work duties such as restocking, maintenance and washing of the vehicle, lecturing for special interest groups and teaching, and acting as counselor, comforter and conversationalist for patients (Palmer, 1983).
paramedics in his work and how the terms they define for types of calls, daily events, and roles played come together to construct the behaviours they expressed as “trauma junkies” (Palmer, 1983). It becomes apparent from his work that the use of language and word choice is linked to constructed norms and personification of roles within the paramedic profession. What Palmer’s work lacks is a defining purpose as to why paramedics construct these norms with their language choices. He does not explain the purpose of defined roles or the need for narrative production.

The narratives of paramedics are discussed and briefly analysed in the sociological literature by Tangherlini (2000) in his work Heroes and Lies. Tangherlini discusses the uses of story-telling and humour in regards to combating unpredictable environments, producing roles and the overall use of narratives within the profession. Tangherlini focuses his work in the San Francisco Bay area in a case-study approach that applies sociological principles to produce a work that is focused more on the actions of the profession than the professionals themselves. Although his work navigates the importance of narratives within the micro-culture of paramedicine by passively observing the ritual act of story-telling, it does not address the implications of the audience as receptive agents of the narratives nor its overall purpose defined by the paramedics themselves.

In her 2014 dissertation in educational research, Becky Donelon discusses the learned experiences of paramedics, focusing on constructs of knowledge and narrative inquiry. Donelon conducted her research in Alberta with five participants who shared their own personal narratives of their paramedic education. Donelon highlights the power of stories in their ability to share lived experiences and be integrated into the
development of identity. Her in-depth interviews show how her participants journeyed through the complex world of paramedic education, eventually becoming practiced paramedics. Donelon concludes that there is room in paramedic education for the complex nature of stories and their ability to integrate knowledge into self-experiences. She also highlights other improvements that can be made in educational institutions such as moving beyond the simple memorization of procedures and improved integration of student personal histories.

As a paramedic herself, Donelon demonstrates her position as community member by providing examples of her own personal stories and using her voice as a guide to understanding the paramedic narratives she shares from her participants. This act of self-exposure and shared voice gives a stronger stance to her overall argument. Donelon looks at the importance of narratives as a voice of the educational pathways of paramedics, but she does not discuss their overall purpose to the profession as a whole. By applying principles similar to Donelon’s work, I have been able to look at the broader purpose of narratives and fill a gap in the research.

A discussion of paramedic culture cannot be completed without a working understanding of the impact of post-traumatic stress and the implications of this on mental health. Post-traumatic stress disorder (PTSD) is a prevalent and destructive mental health disability and can lead to suicidal ideations, with 16 reported suicides by paramedics occurring in 2017 alone (Tema, 2017). It is defined as, “re-experiencing symptoms, avoidance and numbing, symptoms of increased arousal and significant distress or impairment of functioning,” with a minimum duration of symptoms of one month (Varley, Isaranuwatchai, Coyte, 2012, p. 670). Rates among the general public in
Canada for PTSD are approximately 2.4% (Van Ameringen et al., 2008, p.175) with the rate among paramedics in Canada being approximately 25.5% (Regehr, Goldberg & Hughes, 2002, p. 508). One of my participants openly discussed their diagnosis of PTSD and their struggles with the disease. I will discuss the importance of their contribution to this study further in my final chapter.

A content review of *American Anthropologist*, the flagship journal of the American Anthropological Association, shows a rather large gap in the literature surrounding PTSD and first responders, including paramedics. The words paramedic, first responder and EMT (emergency medical technician) were searched from the years 1888 to 2016 producing a total of 116 results of which only three contained a reference to care and only one that was actually about health care delivery in emergency/non-emergency situations (Kedia, 2006). When PTSD was searched, 75 results were found with a handful pertaining to health concerns such as AIDS and mental disabilities. The remainder could be clumped into larger categories of war, violence, globalization and migration.

An additional content review of Anthropology Plus, an online database of anthropological literature, was conduct with the key words paramedic, first responder, EMT and PTSD searched separately and in various combinations. When the key word paramedic was searched no results were found. Expanding the search to include anything written on paramedic or EMS or emergency medical service or prehospital or pre-hospital or ambulance or emergency medical technician or EMT garnered 14 results. Only one of

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3 According to the Tema Conter Memorial Trust website rates of PTSD among other first responders are: Corrections 25.6%, Firefighters 17.30%, Military 8% and Police 7.6%
the results was in English and is a look at how telemedicine has changed the patient care delivered by ambulance services in Sweden (Samuelsson & Berner, 2013). The authors found that with the increase use of technology ambulance services have moved from rushing transport of a patient to definitive care to being more integrated in the overall chain of care required by the patient. While the article discusses tensions felt by ambulance workers as their role within patient care changes it does not discuss post-traumatic stress or stressors.

A key word search for post-traumatic stress disorder resulted in 164 results found. When combined with the key words first responder or paramedic or police or fire fighter there were no results listed. This highlights the gap in anthropological literature surrounding first responders and PTSD. Military personal act in similar way as first responders, acting to help others, sacrificing for their career in order to bring peace to the forefront of human suffering. A brief look at literature that studied the effects of PTSD on military personal garnered 6 results. Of these results one is a review of two larger ethnographies on the impact of mental health disorders upon service members after they return home (Wool, 2013). In this article Wool looks at the work of Finley (2011) and Kilshaw (2009) and discusses how the illness of PTSD becomes intertwined into the military personnel’s identity, anchoring them to the military machine that they were not only a part of but was also the cause of their sickness. Wool discusses each ethnography, noting Kilshaw’s emphasis on the identity and the body, a link that can manifest itself in illness and suffering whereas one’s identity, their feeling of social space, can directly impact their physical bodily health. Wool also looks at how Finley describes the on-going combat that veterans encounter upon returning home, with the
interactions between public family and clinician’s all serving to engage a veteran’s mental stamina. This conflict is a direct result of institutional cultures and the perceived norms that a veteran arrives home to following a tour of combat.

The remaining five articles varied in subject matter from looking at the combined work of NGOs and military organizations in combating PTSD in civilian populations (Kienzler & Pedersen, 2012), the use of narratives and qualitative analysis in determining the conflicting stance of individual identity and institutional rule (Moldavsky, 2008; Molendijk, Kramer, & Verweij, 2015), a look at the impact of vigilance and attention on identity after military service (Messinger, 2013) and finally an article by Kilshaw (2008) who discusses her work with Gulf War veterans after they return home. This article is a prelude to her book, which is discussed by Wool (2013) and highlights the stigmatization of psychiatric assistance and how military personal resist this need for help despite shifting boundaries and identity politics. In addition to the work done by the authors found during this content review, there has also been small-scale work conducted by Finley et al. in 2015 around the issue of veterans with PTSD. In using an anthropological lens, Finley et al. (2015) helped to establish treatment alternatives and cultural specific forms of outreach for military personnel. While this work with Veterans Affairs in the United States is a welcome change to the dominant science laced voices heard at the policy reform table, more must be done for the definitive voice of anthropologist to be heard in the health care arena (Closser & Finley, 2016).

This content review shows that there is a gap in the literature surrounding post-traumatic stress disorder, paramedics and the anthropological perspective. In order to address this gap, future studies should be conducted, that better consider the cultural
context that constructs the categories of suffering experienced by paramedics and other first responders. Although there is work being conducted on veterans' experiences in order to understand the implications of post-service mental health issues, this work has yet to contribute to our understanding of high stress organizations such as police, fire fighters and paramedics. My project would not be complete without a discussion of the importance and lasting impression of PTSD and is a small contribution to a needed conversation surrounding these issues.

Conclusion

Social norms are defined and rules established by language choices (Sacks, 1986). These choices then allow for cultural specific roles to be determined through the performance of oral narratives and agent interactions (Bauman, 1986). By using an ethnography of communication approach to understanding paramedic culture, my research works to address the gap in the literature that exists. Ethnography has the ability to situate the researcher within the frame of the actors of study allowing them to determine the significance of speaking patterns, role switching during narration, performance structure and meanings of speech (Hymes, 1986). In filling this gap, this project will allow for a greater comprehension of the roles of narratives and humour within the medical profession and give insight into the identities of paramedics. With this in my mind, I now turn to my methodology chapter, which explains how I recruited participants, provides information pertaining to locations of data collection and interviews, as well as contains the first of two personal reflections that have resulted from my own research path.
CHAPTER 3: Methods and Research Design

In this chapter, I present an overview of my research methods, data collection strategy, and participants. I also provide background information on my field site and my position within it. This provides context for my analysis of results in Chapters Four and Five. The end of this chapter includes a personal reflection that developed out of my interview process. I could not have foreseen how much this work would impact me personally and I believe that by addressing this, my final thesis will have a richer impact on the reader.

Prior to discussing how my project unfolded, it is important to note that I am an insider of this community. I am currently employed as a paramedic with the City of Toronto and have been in the position for two years as of the writing of this thesis. Although there are inherent biases within a study conducted by a community insider, there are also benefits. These include strengthening rapport between the researcher and participant, a more comprehensive data production process as a result of shared experiences, and enforced reflectivity upon the author (Smith, 2012, Toffoli & Rudge, 2006, Wilson, 2008, Taylor, 2011). Throughout this thesis I will take moments to reflect upon how my biases may have affected my work, and also on how the connections with my peers have impacted myself personally and as a researcher.

I have attempted to mitigate any potential bias by following the example put forth by Smith in her work with fellow teachers, in which she adhered to a strict framework of data analysis and reflected heavily upon her own feelings, attitudes and influences (Smith, 2012). She first addresses the issues of power relationships between herself as
the researcher and her participants, in particular those associated with positions of authority either through position or experience. By using an approach similar to Smith, I am able to use these relationships as a means to co-construct the narratives expressed by my participants. My interviews were directed but allowed spaces for participants to reflect on how their stories contributed to their own identities and those around them. At times it was difficult to extract myself fully from the interviewing process especially as themes began to emerge. I attempted to mitigate this by probing my participants to explain what they meant, rephrasing their statements and asking for clarification.

In addition to this structure and reflexivity I have folded my own personal narratives into this paper, allowing for my positionality to be clear to the reader, as I am not simply a researcher but also a paramedic story-teller (Wilson, 2008). By exposing my place within the field of study I have allowed for a certain amount of transparency to be expressed. Wilson uses a letter to his children to expose his position, giving the reader a look into the development of his own socially constructed world as well as explaining to his children the purpose of his work. I shall do the same by including narratives that share experiences with the reader as a means of reflection, maintaining the balancing act of insider research and expressing the personal growth experienced by partaking in this thesis.

As was noted in the introduction, this thesis is based on a study conducted in the Canadian city of Toronto with paramedics of varying years of experience and levels of skill. The project was conducted in two phases, which were combined to form a focused case study of the interactions of paramedics amongst their peer group within a large metropolitan area. The City of Toronto paramedical staff complement consists of
approximately 1,450, which includes paramedics, supervisors, and support staff who serve a population size of approximately 3.5 million people as of 2017 (Raftis & Sadana, 2017). Paramedics are required to work 12-hour shifts with no set boundaries within the city that they may be dispatched in order to perform their duties.

For Phase One of the project, individual paramedics were asked to participate in a semi-structured interview in a location of their choice. Paramedics were recruited using word of mouth and social media platforms. Most recruitment was achieved via Facebook through the use of the local work union’s webpage. A message was posted asking for volunteers and follow up interviews were conducted with those who fell within the inclusion criteria for this study. Inclusion criteria for participation was simply that the individual must be a paramedic working for the city of Toronto and they could not be assigned to the same work quadrant as the researcher. This was done in order to mitigate any potential conflicts in work place power relations between the researcher and the participant. Additional recruitment techniques included going through collegiate Facebook pages to speak with currently employed alumni that may wish to participate and by using word of mouth between partners and friends of those already recruited.

It is important to note that these recruitment techniques presented a convenience sample, in the sense that they promote volunteerism and excluded the ability to contact those who do not use social media as a means of a communication. I hoped that I could use the Paramedic Service’s in-house web server to reach out to potential participants, but the Service felt that did not distance them enough from the individual recruits. While those who were recruited represented a good variety of demographic of ages, genders, and years of service, it has to be noted that those who wished to share their
stories were the ones that volunteered. Potential voices may have been lost due to the mode of recruitment that I used.

Participants were asked a variety of questions surrounding the profession of being a paramedic. Subjects that were covered ranged from what an average day was like to what do you do in your down time. My key interview questions can be found in Table #2. Years of service was documented in order to determine if there was a difference in purpose of stories between the early years and later years of a paramedic’s career. Participants experience as paramedics ranged from just over a year to 16 years on the road with the average being 7 years of service. Table 3# shows a full breakdown of my participants by their pseudonym, gender, years of service, and level of care qualification.

**Table #2: Key Semi-structured Interview Questions:**

<table>
<thead>
<tr>
<th>Key Interview Questions</th>
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<tbody>
<tr>
<td>1. Do you think paramedics are story-tellers?</td>
</tr>
<tr>
<td>2. Why do you think paramedics tell stories?</td>
</tr>
<tr>
<td>3. Do you think it is important that paramedics tell stories?</td>
</tr>
<tr>
<td>4. How does telling a story make you feel? What about hearing a story?</td>
</tr>
</tbody>
</table>

The locations for interviews were determined by the research participants. It was hoped that by allowing participants to choose the location, an element of comfort could be established prior to the formal interview process began. Locations varied from chain coffee shops to local neighborhood cafes, pubs, and restaurants. One participant opted to have the interview conducted in their own home. All participants allowed for a tape-
recorder to be used and although, initially, I thought that I would be taking written notes during the interview process, no such material was collected. The act of looking down to scribble on a notepad broke the connection I had with the participant. When I was writing, I found that my participants lost their train of thought or attempted to look at what I was writing rather than continue with their story. During the transcription process additional notes were made as sections of the recording helped me to recall mannerisms and gestures made by the participants.

Most participants found it easy to speak on tape, making jokes directed to the microphone and relaxing into their chairs during the interview process. On occasion, speakers brought up their experiences with paramedic management, and in those cases, individuals requested that that the tape recorder be turned off or that this portion be left out of the transcript. One individual struggled to recall a story that did not in their mind violate PHIPA, Ontario’s Personal Health Information Protection Act. A story would come to mind and they would begin only to quickly stop themselves as they realized that a portion would be related to the actual person involved. Besides violations of personal health laws and the concern over managerial ears, participants struggled at times to recount a story on the spot when asked. Time was taken in choosing something appropriate that was not too gross, vulgar, or that was not relatable.

The purpose of conducting these interviews outside of the workplace was that it allowed for participants, in their own time, with their own voices, to recount lived experiences. During a dynamic shift while on duty it would be impossible to allow the uninterrupted fluid nature of story-telling to occur because at any moment a call could come in ending the session.
<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Gender</th>
<th>Years of Service</th>
<th>Level of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bill</td>
<td>Male</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Brian</td>
<td>Male</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Calvin</td>
<td>Male</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Christine</td>
<td>Female</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Jack</td>
<td>Male</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Jude</td>
<td>Female</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Kirk</td>
<td>Male</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Malcolm</td>
<td>Male</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Peter</td>
<td>Male</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Steven</td>
<td>Male</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Tracy</td>
<td>Female</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Trevor</td>
<td>Male</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

These interviews were important because they allowed for uninterrupted narration to occur, and also allowed me to ask about how telling stories made the participants feel. The semi-structured interview environment allowed me to probe into the reason for storytelling rather than simply scratching the surface of the action itself, as was seen in participant observations.

Phase Two of the project involved participant observation in the workplace. Twenty hours were spent observing paramedics during shift trades between day and night crews that occurred at approximately 07:00 or 19:00 hours. Most participant observation took place in the evenings between 18:00 hours and 21:00 hours as night crews came to relieve day crews. I found that the morning changeover was less animated, with crews simply leaving the station with sleep on their minds and with the day crews
quickly dispatched to post assignments for the day. During the evenings more stories were swapped and paramedics were livelier, making the participant observation richer and more meaningful.

During my observations, I had two distinct kinds of data collection in mind. Initially I simply observed those around me, making notes of where people were sitting and how they interacted with each other and their environment. I took detailed notes on everything attempting to draw out patterns from the interactions I was seeing. I wrote as I observed, jotting down information and in the future expanded upon these observations in typed field notes. On several occasions an individual who I knew more personally would enter the station and I would be drawn into a conversation. I would abandon my jotting and scribbling of notes in order to fully participate in these interactions. I would note the goings-on around me at the time of these conversations, what others were saying and listen in on stories being told but I did not write anything down in the moment. I would return home and attempt to remember not only what was being told, but how participating in these events made me feel.

Both approaches to participant observation are highlighted by Emerson, Fretz and Shaw (1995) as a way to form relationships with those being observed while also allowing for the researcher to document the culture being studied. I found that by writing in the moment I was able to capture focused instances of story-telling practices. I could pay close attention to the mannerisms of the teller and the audience as they took in the performance. When I set aside my field notes however, I was able to feel the story and become immersed into the importance of its purpose. Rather than being a fly on the wall
to a performance, I was actively listening and conversing with the community I was studying.

I opted to do two separate forms of data collection for a variety of reasons. The pre-hospital environment is highly dynamic with a shifting stage and actors that come and go. There is no pattern to calls or post assignments that can be determined beforehand and you can never be sure when there will be anyone in a station let alone people actively engaged in story-telling. It was for this reason that I opted to do semi-structured interviews that would allow participants to tell a story at their own pace without fear of interruption. It allowed not only for an individual to tell a story of their choosing, but also to reflect on the content, its purpose, and how it ultimately made them feel. I was able to ask questions surrounding the act of story-telling as an individual was engaging with the raw material they were using to formulate a narrative of self-experience. I could be part audience and part researcher. Without interviews, I would not have been able to ask why it is that paramedics tell stories. Rather, I would have had to hypothesize from observed data the reasons that may have not been openly expressed within the environment of observation.

Despite the depth of information that I was able to obtain via interviews, there are several layers to story-telling that would have been missed had I not actively observed participants. As Schegloff (1997) discusses, interviews remove the context of the original telling of the story and can obscure the motives of the individual, reframing the content. Interviews, no matter how informal, place a participant on a stage of their own, with a prepared motive for interaction. There is a structure, a give and take that may not be present in the daily interactions of the participant with their community. Most of the
participants had come to interviews with pre-planned notions of what story they would be
telling me. They had it prepared, trimmed of any spontaneity. Several admitted to
adjusting the way they would tell stories based on the audience, reshaping the structure
and changing the language used whether it be removing medical terms, using less
profanity, or keeping only to what they believed were the exciting parts. The stories had
changed, admittedly by those telling them, to serve the purpose of the interview. The
context of the original frame had been shifted. Without participant observation, the subtle
differences between the original telling of a tale and its reformatted interview version
would not have been clear. Both methods together combined to give a fuller picture of the
story-telling practices of paramedics.

In total, I completed twenty hours of participant observation and 12 interviews.
All interviews were transcribed and the transcriptions uploaded to Nvivo 10 for coding
and analysis. Field notes of my observations were typed up following individual sessions
and also uploaded to the software program. Analysis was conducted in a way to draw out
the purpose of story-telling, highlighting the reasons paramedic’s fashioned stories
of their lived experiences to share with each other. This analysis focused on the content
and structure of paramedic narratives allowing for me to gain access to the overall
purpose of story-telling events within the profession.

The guiding theory that I used during the course of my data analysis was
the ethnography of speaking, also known as the ethnography of communication. This
theory allowed for a bridged understanding of not only the culturally appropriate nature
of the narratives being told but also their ability to do something, to serve a purpose. As
applied by Bauman and Sherzer (1989:7), and as discussed in Chapter 2, the ethnography
of speaking was the framework I used to express how what my participants were saying was fashioned out of their place within their own culture. The charge of the ethnography of speaking is to establish the interplay and dynamics of language choice within a performance that is not only culturally specific but also appropriate. Speaking, sometimes the act of narration, can be seen as a system similar to that of religion in so far as it is culturally defined, embedded and organized in a particular way. Viewing paramedic narratives as a system allows for a broader understanding of not only the narrations themselves but also the culturally specific roles and norms of the performances of paramedic story-telling.

Before moving into a discussion of my results, the bulk of this project and its ultimate conclusion as to the purpose behind story-telling in paramedic culture, I have to discuss briefly the impact of this project on me. As previously noted, I am currently a member of this community, a paramedic on the road working with those I am writing about. I was aware that interviewing individuals and listening to their stories could have an impact on me whether in the form of empathetic support, or in terms of traumatic reliving of previous events in my own career. I was unprepared, however, for the impact one particular interview would have on me as a flood of emotions left me feeling shaken after its conclusion. I believe that this interview warrants special reflection for my own personal processing of it as well, as its potential impact on readers who may be struggling with the effects of post-traumatic stress.

Personal Narrative #1: The Weight of Responsibility

The interview started like any other, the awkward introduction between strangers meeting at a local restaurant. I surveyed the crowd of retirees as I walked in hoping that the individual sitting alone on their computer was the person I was meeting with. We shook hands, ordered some much-needed coffee. From the beginning I could feel that this wasn’t going to be a normal interview. He never said it initially, never uttered the
words, but I could sense that he wanted to talk to me for a reason other than to be nice and volunteer, he had a purpose to what he was saying. There was weight to it. He commented on how he hadn’t been on the road in a while and spoke as though he may never return.

After getting the consent form out of the way and setting up my recorder, we began the interview. I asked my general questions, the ones designed to build rapport, to get the conversation going. I let him lead the discussion, more so than with my other interviews. I didn’t want to change his direction or tract of thought. He explained what life was like on the road for him. He lit up at explaining how he enjoyed using his skills at work, the importance of working together and the struggles encountered with various coworkers.

Initially the stories were light, although some were laced with dark humor. You can only discuss brain matter on the concrete beside your foot with a laugh or else you will cry. I listened intently as he told me about his career, the path he had taken and what still excited him. It all felt light and easy. A simple conversation between to coworkers, one providing guidance, the other listening openly filing away tips for future reference. I had shut off my interview brain for a bit and became a young medic learning from someone who had been there, who had done it all. This was the importance of story-telling, I was living it rather than recording it. I actively engaged.

I had work to do however and needed to ask questions that began to tease out of him the importance of story-telling, the feelings involved and its purpose. As we began to talk about stories he would tense up, running his warm coffee mug over the soft space between his eyes. He spoke of needing to feel useful, that chasing calls made him feel useful, using his skills made him feel useful as though this career and his choices had been worth it. As he spoke, his voice would catch in his throat, his eyes glistening slightly. I could feel my stomach knot up and tighten. This was my future. He had even said that this is what happens. The new people on the road, you don’t see this. You don’t know what it will be like in fifteen years when you wake up in the middle of the night screaming. I was scared and stubborn. It can’t happen to me? Can it?

We talked on, me attempting to interject on his stories with my interview questions, him simply getting out what he felt was important to share. He explained what it was like to go to WSIB and fight for compensation for PTSD, what it was like to relive past experiences just for the right to be understood and paid fairly. He discussed how management says they do a lot for us, that they try but that it isn’t really enough. That he has had one supervisor ever ask what do you need right now. There are no guidelines for what we see and how we feel in the moment after a horrific event. You can’t follow a rulebook; everyone is different. He reminded me of that, that you can do what you need in those moments. Not what management wants you to do, or your friends or even your family. Only you can know what it is that you need.

We finished up the interview and walked out into the sunny morning air. No awkward handshake but rather a hug goodbye. We had bonded during our two hours together. He had shared intimate details of his personal experiences in a hope to educate others. As I walked towards my car he called out saying that I needed to use this. He had commented during the course of the interview that he knew I could tell he was getting worked up over things, that our discussion wasn’t easy for him. But he explained it was worth it but only if I used it. If I took what he had shared, the piece of himself that he had
laid bare and used it to create something. I suddenly felt responsible, obligated. Honoured?

I sat in my car for several minutes before pulling out of the driveway. My head was spinning and my stomach had made its way up to my throat. I felt as though I could cry. I was scared, scared that I wouldn’t be able to explain it. To put words to the way he had described his life and his career. I suddenly knew how important my project was and processing the fear of failure associated with that was going to be a challenge. I let the tears fall as I drove home not bothering if I got stuck in traffic, wrapped up in my own thoughts not knowing if I could ever do him justice.

I have shared this vignette for two reasons. First, I want to highlight why this project is important. Stories serve a purpose. This thesis will explain the work that paramedic stories do emphasizing their collective purpose within the profession. First responders are constantly exposed to the worst of life, and these can be traumatic events that shape those who are touched by them. These become part of a paramedic’s narrative and in turn weave their way into their identity. This thesis is a contribution to the work being done on understanding the impacts of working in highly dynamic and downright terrifying environments. If we do not open discussions surrounding the influences of events within paramedic’s careers we cannot have a truthful conversation surrounding PTSD. Stories can be a window into these experiences, a way to cast some transparency and hopefully offer the potential for reflective healing to occur.

Secondly, I want allow for the reader to be a part of my socially constructed world. I am just as much a paramedic story-teller as I am the researcher behind this thesis. I tell stories every day, just as my participants do, and they help shape who I am as a person. You cannot fully extract yourself from the story you are telling nor can you become completely objective. This process allows for greater reflectivity on my part as a researcher and lets the reader become aware of my position within the community. It serves as a reminder that I am as much a part of the people I am studying as they are part
of my research. This is a co-constructed work that emphasizes the purpose of story-telling and explores identity formation within the paramedic profession.
CHAPTER 4: An Analysis of Paramedic Stories: Snakes, Compartments and Bonds

Paramedics spend twelve hours on shift serving the people of their community. They work in pairs, spending days and nights together navigating a multitude of environments. They get to see behind the stage at some of the biggest concerts, be ice-side when the home team scores, and are welcomed into the homes of everyday citizens. They also see heartache that will never touch most people, deliver the news that no one ever wants to hear, and attempt to help people find the next steps in the dark when their lives seem shattered. All of these moments are what form paramedic narratives, bridging emotions with reality in order to serve a purpose. In this chapter I argue that paramedic story-telling works to:

• Educate about best practice
• Strengthen professional bonds
• Validate the choices paramedics make
• Compartmentalize tragic experiences
• Integrate humour as a viable coping strategy

As part of my analysis in this chapter, I draw on two narratives shared by my participants. Each narrative represents a particular theme addressed by my research, and emphasizes how paramedic narratives serve a variety of purposes. These narratives are unedited, transcribed as my participant told them to me. They reflect the themes of the importance of needing to be heard and the purpose of educational episodes. While the first narrative I discuss highlights the importance of an emic approach to analysis, discussing the need for insider knowledge in order to understand the importance of listening, the second narrative is an example of how an etic approach can be a helpful
starting point to understanding how paramedic stories work to educate. In structuring my argument around their voices and experiences, I privilege their words in showing the impact of stories. This allows for the reader to directly connect with participants in order to bridge cultural understandings. Following each narrative, I briefly discuss its connection to the themes addressed in the overall analysis of my data and its importance. Before I discuss reasons behind story-telling, I briefly discuss how rules are embedded in story-telling processes, and how this can play out in paramedic discussions.

**Rules of Paramedic Story-telling**

During the course of my interviews, I asked participants what the rules of story-telling in paramedic circles were. I was generally met with the answer that there were no rules. As Brian put it, “There’s not really lot of rules really for what we’re forced to go and do and forced to go and see you know it’s the story goes where it goes.” Peter also commented, “I wouldn't say that there's any like social norms or rules to telling stories in a circle like that and think it just kind of happens.”

I had to probe for answers, asking my participants to think back to when they had been involved in a story-telling session at work. Rules began to reveal themselves as my participants spoke, discussing how stories would unfold at work. There were the standard rules revolving around the legal side of the profession such as discussion of sensitive information in public spaces, using patient identifiers, and being aware of Ontario’s Personal Health Information Protection Act (PHIPA). All participants were very aware of this legislation, choosing stories that did not identify patients or particular places and speaking in volumes suitable for whichever interview environment we happened to be in.
This was in contrast to what I observed in the station. Stories were animated and voices were used to interject life into narratives. Hand gestures and body language were also important, allowing for stories to rise and fall with rounds of laughter in between. Groups of paramedics would come together to speak of their days without fear of being overheard by the public. Frequent flyers\(^4\) would be identified and stories shared as a means to both educate and entertain. Things felt less static in the station, but questions to the teller were limited, as though the story was framed only by them and people did not ask many questions; this was unlike my probing during interviews. Beyond legality, generally, paramedic stories began as an initial statement or circumstance either work related or not.

“Sometimes it’s a matter of people already starting the story-telling chain and somebody adds one that either is relevant in terms of acuity or relevant in terms of how ridiculous a situation might have sounded or how relevant in terms of how it affected them in a similar way to the previous story happened. Another way is that it just be relevant to something around you. Oh, that taxi got into a crash well one time I went to a crash where a taxi car hit an Uber. Isn’t that funny. Actually happened. Actually, the Uber hit the taxi sorry, I got it backwards. I know and the passenger is like can I just leave, I have a flight in half an hour. See, I’m doing it right now.” - Bill

Then a story chain will form with another story being added and so on. Whether there is a direct catalyst that starts the chain or it is simply an organic process depends on the situation. There were times when in station that a story would be added to a chain, one after the other until the theme at hand ran out. Other times stories would be a one off, organic experience with no chain; this was typically something that needed to be shared for specific purpose. During participant observation sessions, I noted that some story

\(^4\) A frequent flyer is considered someone who calls 911 for transport to the hospital on a regular basis; these are individuals who may or may not need care at a hospital but become regular acquaintances of paramedics and hospital staff.
chains would begin with a clear theme, a catalyst that started a snowball of grouped stories around a certain subject. Other times there was no catalyst, nothing that sparked a chain; instead, each story just flowed with no real relevance to the previous story. As a story chain would get stretched and the audience would be start to lose attention. People would begin to leave the discussion either looking into their phone screens, lying their heads down on the couch, or moving as to get a better view of the television. On occasion someone would continue speaking, unaware that the chain had broken, and you could feel the tension, or glimpse eyes rolling, as people began to get frustrated. A rule had been broken. When the chain was over, it was over. Story-telling time had concluded.

Two concrete rules that were brought up by my participants were the importance of listening and the avoidance of taboo subjects. Even as a fellow paramedic you may not know to what extent a story will affect a group of your peers and as such, people tend to refrain from discussing certain taboo subjects. Things such as the death of a child, sexual assault, and calls involving personal injury to a co-worker are not shared as freely amongst groups of paramedics. These subjects can affect an audience in a way that cannot always be anticipated by the teller. The rule comes from respecting each other and knowing that certain calls have a lasting impact. These rules are not something said aloud or taught in school, rather they are a professional courtesy for your friends and co-workers. It was a general consensus amongst my participants that, depending on the size of the group and your knowledge of the members, you withheld certain subjects as a sign of respect of other’s potential experiences.

“It tends to kind of reopen those wounds especially when you're in the process of healing through those traumatic experiences right. And yah. Whether or not you actually talk about those really traumatic stories is a different thing but I think the impulse is to always go back to those
stories of you know what really traumatized you or what were, was some very deeply disturbing things that you saw even just for a split second. I think it just reopens, it tends to reopen a lot of old wounds.” – Peter

“There’s a line I heard from a supervisor that I really respect that comes to me a lot which was oh my PTSD didn’t need to see that. Oh, like my PTSD didn’t need to hear that. There are certain stories that maybe you need to read your audience. Do I tell this to this person? No. Do I mention a story about a sick little kid to someone who has a little kid at home? Um, so things can fall flat like that sometimes.”- Steven

Listening to a story serves a multitude of purposes in paramedic narratives as will be discussed throughout the remainder of this chapter. Listening in and of itself is an important rule in conversations among paramedics. Bill remarked that, “I think the most important rule is that you always listen even if you don’t want to,” and,

“…that stories get old but you always listen ‘cause that’s the respect you give to everyone else. They listen to you, you listen to them because they are telling it to you for some reason whether they believe its relevant to a situation you’re in or they need to get it out to make themselves, release some pressure so to speak.”

Kirk echoed Bill’s statement:

“When you tell a story you wanna be heard, you want people to listen to what you’re saying. Maybe especially if it was something that was particularly eye opening or jarring or upsetting or hilarious for you as the medic doing that call, experiencing that call and you want people to kind of appreciate those same emotions um so when somebody is doing the same for you and telling that story that is obviously in some way uh important to them listening.”

The following narrative highlights the importance of listening and how much this simple act can impact the entirety of a paramedic’s career. Calvin, a sixteen-year veteran of paramedic practice, discusses how being listened to by a supervisor following a tough call was the exact thing that he and his partner needed in that moment to cope. This narrative illustrates the importance of being heard and is a good example of why the rules within paramedic story-telling are followed.
**Paramedic Narrative #1: Shut the fuck up and listen**

In 16 years, I’ve had one supervisor come to me after a call and that was after again I could have gotten in some trouble. We did a, we went to an unknown problem. Baby crying on phone. No idea what the call was about. Couldn’t get anything on ring back and I said send fire, send police we don’t know what we’re walking in to. We got on scene, police were not there yet, fire had just got there. We’re going up in the elevator, hadn’t made contact and when we walked in we walked in to an eighteen-month-old who had pulled a pot of tea from a counter and had second and first degree scald burns from the head down half way down the chest. Black little boy, skin sloughing off in front of us going which right in front of me and fire did a great job. Everybody other than us and fire were completely losing their minds. At the call to (partners name) I said, “Get a line I don’t give a fuck where it is, just get me something.” Stepped into the hallway to patch ‘cause I knew I wanted more than the typical pain management orders, got what I wanted, got the kid, got the line, thank god. I don’t know how he did it but he did it. He was great that way and we drove down CTAS 1 to sick kids on a code fifty. Gave him lots of morphine. Got him to a point where he’s no longer crying but still breathing.

Perfect, and we got the call done, bought coffee, went out back to the truck and my partner flipped the coffee upside down in the middle of the truck. I looked at him and I says “You’re not right,” and I said I wasn’t even thinking about myself at this point, I said “We’re not doing anything more.” I walked into the crew room at sick kiddies and picked the phone up and says, “You can put us out of service.” I said, “We’re not doing anything, we’re not doing paperwork, we’re not looking at the truck for at least the next thirty minutes to an hour.” Click. Didn’t even wait for a reply. Supervisor shows up, it was [name] from the southwest hub. We’re now at this point 45 minutes later he walks into the crew room, shuts the door. And when he first came to the southwest hub as an acting DOS I told him this story. “You remember the first time we met?” He says “Nope.” I told him about the call and I said, “Do you remember what you said?” He says “Nope.” He said, first words out of your mouth were: “How are you?” 16 years. And then he said, “What is it that you need?” And then he shut the fuck up and he listened. That’s what we need. (Sighs). That’s what (partner’s name) needed that night.

For Calvin, the actions of the supervisor that day stuck with him. Years later, when he met the supervisor again, who at this point had been promoted to a higher position within the service, he retold him this interaction and its importance. For the supervisor, he was simply following the rules of story-telling, but for Calvin and his partner it was exactly what they needed. Without the ability to be heard, this interaction with his supervisor would have been different for Calvin, resulting in a mismanagement of his coping needs. When coping needs are not met, mental fatigue and post-traumatic
stress can find their roots. This story is an illustration of not only the importance of following culturally appropriate rules and norms but also the need for an understanding of these norms in order to properly administer care to a community.

In sum, when paramedics tell stories, they follow specific rules that call attention to the importance of the content of those stories and create solidarity between paramedics. These rules include: the appearance of informality; telling stories in sequence in story-telling sessions; avoiding certain subjects like PTSD or identifiable patients; only talking for a certain length of time and listening regardless of level of interest. These rules are tied specifically to story-telling session in the station but they extend to conversations inside the ambulance while on calls.

**Going Beyond Rules: The Benefits and Outcomes of Story-telling**

With these rules of story-telling in mind, and my discussion of the need to be heard, I now turn to a discussion of some benefits of story-telling. These are education and validation, and the building of bonds of belonging. I argue that paramedics use stories in specific ways that allow for them to grow as a professional and integrate into their professional community. Stories become a way for paramedics to educate themselves and others, offering areas for self-criticism and reflection. They also serve to validate choices and actions made throughout the course of a career. In addition to the use of stories as an educational tool, paramedics use stories as a way to build community bonds, forming a common ground from which to participate in their roles as paramedics.

*Education and Validation, Myths and Medics*

“It provides examples, it provides an example. It’s almost like a parent or like an older sibling. They’re like this is what I struggled with and so you know for the future and it like makes me, it makes me more humble and it makes me I think a better paramedic.” -Trevor
In this section I highlight the educational purpose of story-telling in paramedical circles. I have chosen this as a starting place for the discussion of how stories do things, and how they serve a purpose beyond entertainment, because this is something most people can relate to. We have been told stories our whole lives, often with some moral, and some shred of educational value, some shared meaning. Whether it is bedtime stories of Cinderella showing the importance of kindness and hard work, to Christmastime tales of Scrooge warning against gluttony and greed, we encounter these teachings and tales, parables if you will, throughout our lives. Even modern tales of Harry Potter against the Dark Arts or Luke Skywalker against the Dark Side provide us with demonstrations of the significance of friendship, teamwork and the strength of being a good person.

In this sense, most paramedic stories are the same, they serve the purpose of educating and informing. As one of my participants put it, “You might learn something,” and that action in itself makes story-telling extremely important. This section will first deconstruct a paramedic story that one of my participants told me using the “monomyth” structure put forth by Campbell (1949), before moving on to a discussion of the importance of using stories to inform and validate choice within the profession. I will emphasize the actions of stories and how they serve their agents by producing tangible results, a complex integration of entertainment, warnings and future possibilities.

If we are to look at paramedic stories as though they are similar to other ‘hero quests’ we can begin to break down the narrative into its parts. Campbell’s monomyth structure of separation, initiation and return (1949) offers an intriguing line of analysis for paramedic narratives, in particular those, which look to educate. It is important to note
however that as with any story regardless of its origin, narratives are told with a particular set of rules designated by the culture for which the story is placed (Hymes, 1986; Schiffrin, 1994). If we begin to travel down the structuralist path – turning paramedic stories into monomyths, for example – and placing a universal box around all components of a narrative, we may begin to lose sight of these cultural contexts. We also overlook the influence that the audience, including the researcher, can have in the final interpretation of the stories (Polkinghorne, 1988).

While it is possible to extract what might look like a ‘universal’ form from a paramedic story, and thus compartmentalize the components as suggested by Levi-Stauss (1968), I argue that these components are, in fact, subject to the agency of the audience members who become narrative co-creators with the teller. If we are to look at a paramedic narrative as a sum of parts, then we must begin by looking at those parts. While these parts are universal to paramedic stories they are also a direct interpretation of their audience in the station, who bring cultural awareness to each story-telling session. These are the components that make up this particular type of story for this particular profession within this particular cultural frame. This being said, it is useful to follow a paramedic’s quest line, using the “monomyth” structure to illustrate the educational purpose of these narratives, I use this analysis as a tool identifying the learning experiences passed on by paramedics to their peers (Davis & Weeden, 2009). The monomyth becomes a platform of interpretation, allowing for an outside audience to follow the sequence that a paramedic takes as they partake in the actions of a call that make up a story. Paramedics in this sense are seen as the hero, the man or woman who has battled past their personal limitations to submit and overcome adversity as defined by
Campbell (1949). Working through the monomyth structure a paramedic story, places the paramedic as hero and their professional environment as the holder of adversity of which they must overcome.

*Our Hero’s Journey: An educational story*

A hero, the central figure to our quest, is a representation of a mythical figure who purposefully overcomes hardships to achieve a goal. For the purposes of my analysis the paramedic story-teller plays the hero role. This is not to say that paramedics see themselves as heroes, saving lives and overcoming obstacles. Rather it is a reference to this mythical figure, portrayed in the monomyth structure. The first stage or separation of the hero from their steady state – the relaxed state that a paramedic is in when they are awaiting a call while on shift - occurs when a paramedic receives a call. The tones go off in the station, a loud overhead buzzer with an automated voice that indicates the call severity and a brief description of what it entails. For example, the voice may say that the call involves an MVC (motor vehicle collision), a fall, or a patient displaying some psychiatric behaviour. If our hero happens to be in their truck when they receive a call, a loud “bing”, similar to the sound of an incoming text message, will sound and information will pop up on the computer screen mounted to the dash. As soon as a call is received, separation from the previous state occurs and the hero moves into the secondary phase of initiation or confrontation of a problem. The initiation stage is a liminal space where a paramedic is no longer relaxed but has not successfully delivered their patient to definitive care. It is within this space that a paramedic must move in order to return to their steady state.
For a paramedic, initiation or liminal stage can be the longest phase of the hero quest. It begins with reading of the call details and ends with transfer of care of a patient at a hospital or a cancellation of the call on scene. In Toronto, unlike other services in the province, call details come up on a mounted computer screen in the front of the truck rather than over the radio. This allows for the dispatchers to insert additional details that they do not wish to share over the air. This information sometimes allows for a smoother transition into the initiation phase, as paramedics may plan how they will tackle the potential crisis on scene as they drive to the designated address of the call.

The story that I have chosen to analyse via the monomyth structure is the first story ever told to me by one of my participants. It was the only story that a participant stated its purpose from the beginning, indicating that it was “a learning point,” and that it contained an important lesson about the value of clear communication on the job. The participant was eager to share this story, becoming more animated as I asked whether she had a story she told on more than one occasion. “Oh, it’s so good,” she exclaimed and proceeded to dive into the incident using hand gestures to emphasize actions and tonal changes in her voice for different characters.

*Paramedic Narrative #2: An Educational Monomyth*

Oh, it’s so good. So, this story was a good reflection for me and a learning point because I had a student at the time and one of my big things, my big priority on this job is communication skills. So that’s something that I very much value. So, it was a good lesson for me and for the student and my partner who is quite new as well. So, this call is for a woman in her fifties who’s, she’s fallen down somewhere in the house and had a cut on her head. So, this woman lives in a condo, she’s an alcoholic, drinks everyday. Her thirty-ish son comes every single day to check on her. Comes to her place after work. And apparently many times before has found her in various states, right, like lying on the floor with a cut on her head but today she’s sitting in her bed, she’s got blood matted all in her hair and she appears a bit intoxicated. Now her speech is a bit slurred but she’s carrying on a conversation. She adamantly refuses to go to the hospital, her son says the police come all the time, you know, and try to convince her to go. Sometimes she goes.
Sometimes she doesn’t. And basically, we try to negotiate, recommend that she go to the hospital. She’s adamantly saying “No I’m not going.” So, fine.

So, we can’t really see what’s going on her head because all the blood has dried up and matted her hair. So, I say “Ok fine. Let’s get your son to get you, get you in your bathtub in your clothes, we’ll wash your hair, we will see what we’re dealing with and make a decision.” And for me truthfully this was just more ammo really, more information to say “No you need stiches. You need to get stiches now. Just come get the stiches.” So she’s in the sho...in the...she’s in the ...her son is with her in the bathtub, she’s got her clothes on so he’s just soaking her down. My partner and my student and I are just in the living room just chatting. We wait a few minutes. I go in. The son is trying but he hasn’t put like any like shampoo or soap on her hair. So, nothing’s really happening. Ok fine. Fine. So, I get the shampoo. Start washing her hair. Uhhmm...and she’s like, “You’re pretty rough.” And like I don’t know I’ve never washed anybody’s hair and then so she’s going ...I’m gonna tell the story, ‘cause this is the part of the story what I think makes it really funny. So, I’m washing her hair, washing her hair she looks at me up and says “Are you a lesbian?” And I’m like, “Nooo.... What is it my hair?” And she goes “No you have that aura.” So, fine, keep washing the hair, washing the hair and (laughs). I have to rinse it. So, she’s got one of the little handled spray nozzle on the, on the uh shower but I... I’m kind of annoyed at her that she asked this question cause she seemed like the person, in the rest of the story you’ll see that she’s just a person who likes to get riled, people kind of riled up like for fun. So, I go to spray her head and I leave the water on cold. So, she’s like, “Ahhhh....” She’s fucking screaming. Like fine but I find this cut, we clean her head and like, “Oh, you have a deep cut, you need stiches.” Take a picture with my phone, show her and she’s like, “Yah.” So, I appeal to her reason.

My stories are usually pretty long but I’m trying to give you details. I really like this story. People get tired of my stories. I usually don’t tell a lot of stories at work ‘cause I don’t tell very efficient stories. I’m making this less efficient purposefully so anyways so now she needs to get dressed cause now her clothes are wet.

So, I send her back into her bedroom with her son. We wait outside. Few minutes later go into check. Nothing’s happening. She’s still like nothing on from the waist up. She just keeps trying to get out of bed, her son keeps pushing her back down. So, I get...I try...search through drawers trying to find some clothes. Get some things together. You know find a shirt. Find a bra. Hand the bra to the son. He kind of turns it around. Looks confused. Oh right...so like this probably isn’t appropriate for him to do ‘cause he doesn’t have you know it, it’s probably be the wrong thing to ask this poor guy to do. So, then of course I pick up the bra, walk towards her and she’s sitting on the bed. No shirt on. And then she puts her hands behind her back, puffs out her chest and gives me this smirk and ‘cause she’s like (motions with head up and down) and I’m like putting my hands up. I drop the bra and go, “Put your goddamn clothes on!” And I walked out of the room. And then she put her goddamn clothes on. And then she came to the hospital and she was quite pleasant.

So that’s, yah, so that’s my story. It’s my favourite story because it’s very unconventional. You probably shouldn’t swear at people. Especially say goddamn. Some people may not appreciate that. Uhhmm was it effective -- yes. Would I do it again? Probably. So, for me it’s a funny story but it was also a good learning point especially
since I had a student. It’s like yah so we had a good discussion about should you swear at people right and what should you do right? People like it, it was a risky situation just with like things related to consent right and the fact that she’s topless and things that could be construed as you know sexual harassment. So, it was, I don’t know, it was a fun call. I really enjoyed it. And that’s all. – Jude

Jude begins her story by discussing the details of the call, similar to what would be seen on the computer screen in the truck. These are the who, what, when, and how portion of the story that sets up the descriptive actions that occur during the initiation phase. Upon entering the scene of the call, in this case an apartment, the hero has completely separated from their previous state and is now in the second stage of the monomyth where the educational process can begin. Our hero, her partner and her student enter an apartment and are greeted by the son of the patient who explains what has happened, discussing previous similar episodes and their general outcomes. The patient, who is intoxicated, has hurt herself but is refusing to go to the hospital and now it is up to our hero, the centralized character of the monomyth, and her trusty companions to convince the patient otherwise. It is apparent from the outset that this patient needs stitches and should be seen by a doctor at a hospital, but as she is coherent and completely orientated it is within her rights to refuse transport.

As indicated earlier by the participant, this story’s purpose is to teach the importance of effective communication. The call proceeds through various trials as our hero attempts to convince the patient to go to the hospital to receive definitive care. As in any initiation stage, fluctuations occur in the way that our heroes are feeling and their reactions to the challenges they are facing (Davis & Weeden, 2009). Frustrations begin to set in as the patient continues to refuse transport despite the best efforts of our story-teller. First our story-teller attempts to reason with the patient stating that they need
stitches. When that does not work, our hero cleans the site of the injury and takes a photo to show the patient. This seems to do the trick but has resulted in our story-teller becoming frustrated, having been berated by the patient during the process of cleaning the wound.

The solution to the challenge faced by our heroes is almost at hand. The patient has agreed to go to the hospital and all appears to be going in the right direction. The patient needs to change into some clean cloths prior to being taken to the hospital, as they are wet from the cleaning of the wound. The patient is fully capable of changing herself but is refusing to do so, slowing down the process of leaving the apartment and further frustrating our story-teller. It is at this point that the initiation phase hits its climax, tipping over into a learning point that the participant wished to share with me.

This is a point of internal conflict for our story-teller. Should you swear at patients? Would she do it again? For this participant, these questions are the point of the story and its overall purpose in teaching by sharing. A moment of reflection has occurred and the hero begins to return to their previous steady state. This is the third stage of the monomyth, the return (Campbell, 1949). For paramedics, the return is rather a dynamic process and something that leads away from the basic monomyth structure. Not only do paramedics learn during their quest but they also learn during the retelling of and reflection on their journey as they are constantly given feedback from fellow paramedics. The monomyth is not a circle, nor is it a perfect double helix as is described by Davis and Weeden (2009), rather it is a feedback loop as each experience plays into future calls and future challenges.
The Feedback Loop

Upon the completion of the hero quest and the return to a steady state, the paramedic story-teller now has the ability to tell and retell the story of their journey. This is an additional layer to the monomyth not explored by Campbell (1949) and only briefly touched upon by Davis and Weeden (2009) when they speak of their double helix metaphor. Davis and Weeden argue that the hero, rather than simply returning to the start of the circle, changes and takes a step up on the helix, improving personally and professionally based on the lessons that they have learned. While paramedics improve their skills, learn lessons, and expand upon their textbook knowledge while moving through the initiation stage, there is also a process of feedback both positive and negative that occurs during the recanting of their experiences.

Stories are a means to inform audiences. A paramedic works through a learning process, a hero myth and then proceeds to retell that quest from their own perspective. This retelling helps to provide examples to others, fostering a learning environment. Not only do these stories allow for a communal step up the helix but also gives the story-teller feedback into their initiation phase. Feedback can be positive, creating a collaborative agreement that the right thing was done within the initiation stage to proceed forward as a successful hero, or it can be negative, where a learning process is layered upon an existing lesson. Rather than a perfect helix, this can be illustrated as a classic board game of snakes and ladders. Unlike the monomyth that does not take into consideration the impact of the audience or the ability for the hero to both succeed or to fail, the analogy that I put forth of a board game does. The monomyth is a structured example of how to interpret a story in order for an outside audience to understand its importance, following
allowing a designated path. I argue that this path is not a circular trajectory nor is it devoid of audience influence. By explaining the structure of paramedic narratives as a game of snakes and ladders I allow for an outside audience to visualize the path of the paramedic, giving them a source of familiar reference in order to interpret the events of a culturally specific story. The use of this analogy has allowed for me to employ both an emic and etic approach to the analysis of paramedic stories resulting in an interpretation that is a balance between insider and outsider perspectives rather than incorrectly applying a monomythic structure (Harris, 1999).

The board represents a paramedic’s career with no defined end point. It is not a perfect square, like you would unfold from the games box; rather it has a definable starting point and continues on until the paramedic retires. This means that the paramedic is never not playing the game. They stand on the board that represents their career, awaiting a roll of the dice to occur as the tones go off. Every call is a roll of the dice that results in movement around the board. Sometimes the paramedic will roll resulting in a call that lands on a free space, nothing happens and there is no learning point or validation needed. Certain calls become mundane and habitual; a process that starts to spread out the spaces on the board that result in landing on a snake or ladder. The game board has the ability to change, unlike the real-life version of the game, which is a fixed illustration. As a paramedic experiences new things, more free spaces – those without snakes or ladders – will open up as skills are learned, becoming habits and previous mistakes are not repeated.

As the player moves through the game there are opportunities to go up a level, learn a new skill and successfully navigate the initiation stage. When a paramedic
recounts a story of a call to their colleagues, their personal development grows when they are told they have done the right thing or that their peers would have done something similar, shifting their position on the board in a positive direction, climbing a ladder. This is the validation that comes from the feedback loop established through story-telling. A paramedic moves through a call, having rolled the dice, landing on a space that results in needing to express their experiences via a story. With peer validation expressed the paramedic is free to move up the ladder prior to their next roll of the dice. This is similar to what Campbell (1949) describes as the “crossing of the return threshold”, in which the hero of the monomyth returns to their steady state with their newfound knowledge and power, but must survive the impact of their return, validated by the belief of their community as to their accomplishments.

The opposite can also happen as the playing field is not stagnant, nor inevitably about growth in an upward trajectory. Within the monomyth the hero will return to the steady state with a newfound sense of power, having learned from the hardships endured during the overcoming of obstacles. Paramedics, at the completion of a call, similarly return to this steady state. Retelling a story opens up paramedics to criticism about mistakes and errors in judgment. A common theme throughout participant interviews was the idea that no one will judge you as harshly as your peers. When you tell a story, you are not only allowing for positive, supportive feedback, but also creating the potential for negative comments. This is a layer to the educational value of the narrative and one that slips beyond the bounds of the monomyth as a circular process. Just as there are celebrated ladders within the game of narratives there are also snakes that paramedics can slide down, taking a step back in order to learn something new or relearn something old.
As one of my participants (Brian) put it, “You are all my witness.” This entails holding a paramedic accountable to mistakes before an audience that will expect a promise to never do it again. This continuous feedback allows for paramedics to grow as professionals, improving skills, and plays into the growing of a community, which will be discussed further, in the next section of this chapter.

There is also a role beyond witness of the audience of these narratives. Listening to stories is an active process:

“You went through, you go through a tough call, you go through an interesting call… you hear peoples’ experiences what they went through and you kind of learn from it… there's definitely times when I've had calls I'd only heard of from other people and I learned from their experiences then I had a similar call and I'm like oh this is what they did so maybe I'll try that and I'll tweak it a little bit and then it works well for my call as well.” – Peter

Thus, paramedics use the act of telling stories to educate themselves and others, and they also use them as a way of informing, and hopefully improving, their own personal practice in addition to other purposes that will be discussed later in this thesis. To carry the metaphor, the tellers are actively engaged on the game’s board and so are the paramedic audience members. The purpose of the story is to show how the initiation phase was tackled, expressing this challenge so that others can use the same techniques.

But it is not always as clear-cut as is illustrated in the quote above from Peter; things are adjusted, as the audience is an active agent in their own growth. Sharing of stories strengthens the lessons learned from previous tales, both those experienced personally and those engaged with as an active audience member (Orr & Friesen, 1999).

*The Inevitable Game*

Paramedic narratives work to educate both paramedics actively engaged in storytelling and those listening as audience members. Stories themselves can become means of
looking for validation. They are expressions of choices made during the course of a call and raise the question of correctness. While these narratives follow a monomyth framework of separation, initiation and return, the overall purpose is defined by the inevitable game of snakes and ladders that the tellers find themselves playing. The purpose of using this game as a metaphor is not to minimize the importance of these learning experiences but rather to emphasize how these events can make paramedics feel in a relatable way to an outsider audience. The feeling of moving up the ladder on the board is joyous and comes with it a sense of pride. The sliding down of a snake has the opposite effect, with frustration and dread sinking. There is no simple circular process of telling a tale that illustrates an educational event; rather there is an interactive game that precedes the telling event witnessed by peers, who add layers of interaction of both praise and criticism.

Paramedics are not only the educators and the heroes of their own stories; they are also the educated using their stories to seek approval and advice. This is different than Orr’s work with aboriginal educators who use stories to inform from a position of wisdom and learned experiences (Orr & Friesen, 1999). Narratives are devices used to seek approval for past actions, to communicate new experiences in order to inform others and to garner new perspectives on familiar situations. Regardless of experience in terms of years in the job, there is always something that can be taken from someone else’s story. This is unique in a sense, making the educational purpose of story-telling rather fluid, an endless game of going up and down snakes and ladders.

The shared experience of rolling a dice and moving to a space on the board exposes choices made on a call and allows for others to either validate those decisions, or
open up discussions about mistakes made and lessons learned. The feedback loop is established and the game of snakes and ladders is played out with paramedics moving up and down the board. The nature of the call – the roll of the dice – is based on luck. A paramedic can never know what sort of call they will receive at any point in a shift. Upon leaving the steady state – receiving a call – and moving into a liminal experience a paramedic now can begin to make decisions, something that differs from the classic board game. These choices impact the movement of the paramedic and are not based on luck, as the game becomes a mixture of decisions and fate. The metaphoric game board is used to illustrate the feelings associated with the movement up and down, success and failure and the importance of luck as it relates to the dice roll of receiving a call. Upon the completion of the call, a story is created as a vehicle to express choices made during the liminal stage. This formed story is subject to feedback that impacts the paramedic’s movement on the game board, either up a ladder or down a snack. With feedback generally limited to peers, these episodes of story-telling can sometimes be the only source of validation that paramedics receive when it comes to their choices.

“I think it’s a way for people to number one maybe figure out if they’ve done the right thing ‘cause we don’t get a lot of feedback on what we do. So sometimes it’s hard to know if we’ve done the right thing. Sometimes you never know.” – Jude

“It’s really weird ‘cause it can be such a small thing and like it can be like such a small comment from one of your other medics but when you know that someone’s been in the same situation as you and you know that they have as much medical knowledge as you, they know all the stuff that you know and they’re still saying you know you did a good job on that call.” – Jack

Stories allow for closure. They allow for paramedics to receive input on their choices from people who have been there and lived through those experiences. Working
in closed-off environments, such as people’s homes and the back of an ambulance, means that calls take place within tiny bubbles of experiences. Paramedics only have themselves and their partners to reflect upon the occurrences within these spaces until the call is fashioned into a story, shared and exposed. Story-telling fosters acceptance and understanding by opening up these closed-off environments, allowing for paramedics to feel as though they have done the right thing. Exposure of choices also opens up a paramedic to self-criticism, reflection and personal development.

Validation of feelings is another purpose of story-telling within paramedic circles. My participants all touched on the importance of being understood emotionally and that by telling stories they felt as though they were not alone. Stories normalize feelings and allow for emotions to be articulated and validated by peers. For example, Kirk said,

“So if you’re sort of re-telling something that maybe kind of upset you in some way shape or form, maybe communicating that as well to give that person a better understanding of A) how the story really is and B) how it’s affected you and maybe how it would affect them or if they experienced the same thing, validating for them, like this person did, that call and they were upset as well and I did that call yesterday and it upset me so I don’t feel like that’s an inappropriate response.”

Story-telling not only serves the purpose of providing the glue that binds the paramedic community together something that will be discussed in the next section, but it also serves to validate the personal choices made by individuals to be a paramedic in the first place. With limited public knowledge about the realities of the profession, and with images skewed by highly dramatized television and movie lenses, paramedics look to themselves and their stories to support their decision to enter the field. When speaking about feedback from fellow paramedics Jack stated, “It kinda makes you feel like doing the job is actually worth, like you've actually made a good choice in doing the job. It validates like your career choice. It validates all the decisions you've made.”
The mask of story-telling only works in so far as the audience it is placed in front of can validate its meaning or telling (Goffman, 1959). All paramedics can tell a story regardless of experience. Your first call on your first day on the job is your first story to tell, the start of your collection of story ‘trading cards’. Validation is an expression of the audience of the story and this validation is what allows for the mask of the actor to be assimilated into their self. Stories can help a paramedic be understood as competent, and therefore a member of their community by their peers. This competency is then maintained, a responsibility of the paramedic whose identity is continuously constructed by the feedback loop (Goffman, 1967). Paramedic identity is based on the choices that are made on calls, choices that are then exposed during stories and validated by an audience of peers.

*Common Ground: Building bonds of belonging*

While education and validation are important aspects of paramedic story-telling, stories also serve to build relationships of group belonging among paramedics. Feeling as though you belong to your work community is important for most professionals; this can be particularly crucial when working in high-pressure settings. For paramedics, who work in teams of two, community bonding beyond their partnership is accomplished via the act of story-telling. While partnerships can stay constant for a period of time, it is not uncommon for a paramedic to work with a new colleague every shift. Permanent partners may go on vacation or fall ill, temporary partnerships may occur due to service needs or old partnerships may just fall apart due to people no longer getting along. This routine switching of partners is facilitated in part through story-telling, building a common ground for relationships to develop.
Community Building

“People need to just get out the things they want to say and that applies to story-telling in many aspects of life but in this particular instance story-telling people just want to tell things and relate to people and in the same way that sense of community and that sense of feeling people want to relate to each other and what better way to do that in a culture than in a way that everybody knows best. Is doing calls.” – Bill

“I think stories are just our way of like cementing our bond in this tiny community and it’s not always one-upmanship, just like these are things that happen to me you know and these are things that happen to you and this is ridiculous and it’s not normal.” – Tracy

Paramedics work in a highly dynamic, fluid environment where the only constants are your co-workers. The consistency of co-workers can be the key element to keeping a paramedic grounded. Sharing commonality expressed through the act of story-telling holds this relationship together and allows for paramedics to feel as though they belong despite the extraordinary events that they are privy to day in and day out.

Tangherlini found that exchanging stories allowed for paramedics to bridge differences in personalities between staff and to navigate the inherently hierarchical communicative aspect of the job (2000). He found that paramedics used stories to define their relationships with other first responders, with bystanders, and with management. My research found that story-telling amongst paramedics included these power relations with several stories being expressions of contempt for other agencies, certain ‘frequent flyer’ patients, and the lack of common sense found at times in the general public. Tangherlini (2000) focused on the ability of paramedics to use their stories as a means to establish their own position within the complicated world of pre-hospital care. I found that stories moved beyond this establishment of self and served to validate belonging within the paramedic community.
“You kind of feel like when you, if you're telling a story about a patient and you're engaging your colleague's you feel like you belong in something. Belong in the community, kind of like a, a unique community of people where, who understand you.” – Trevor

Paramedics in Toronto tell stories in a variety of locations both on and off duty.

Several times during my interviews, before the tape recorder would start and the formal process began, my participant and I would discuss how work was going, an open invitation to begin the exchange process. This simple action not only built rapport with my participant, it also brought us together in a shared community practice, a culture built on a foundation of similarities expressed via stories. Since I was positioned between peer and researcher, I could begin my interviews from this common space, allowing me to ultimately build a richer description of the community I was studying.

I found that stories reached out and formed bonds between medics of varying seniorities, life histories and demographics. Any paramedic has the ability to tell a story, regardless of their likeability as a story-teller or even as a colleague. The content, as long as it is relevant to the situation in which it arose can be shared amongst the group, bringing together those who may not even know each other’s names. Held together by stories and uniforms of varying shades of navy⁵, paramedics were able to relate to each other.

“It’s a very common thing that we have especially when we have people who come from such different age groups, experiences, ethnic, religious, academic backgrounds we all have these stories that come together right and you can't, and it’s very hard to say to dismiss someone's story because it’s so unique right so it’s something that I feel everyone can bring.” – Peter

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⁵ Uniforms in Toronto are contracted out to suppliers. This results in paramedics having uniforms that differ in colour of navy, reflective stripe placement and badging.
“Sometimes it’s nice when you see a group of people telling stories that you have one to fill as well and that makes you feel like you belong in a way… A community feeling. Sometimes it’s nice to feel like you fit in.” – Bill

As one of my participants put it, stories act as trading cards, swapped over coffee in the truck or paper work while on offload at the hospital. They become traded entities, told over and over again as they remain relevant and unique. Paramedics have stories that they tell from ten years ago of the extremes encountered on the job, something that may never be seen again and is still engrossing enough to entice an audience. It becomes a means to belong, a way to fit in. As Steven put it, “medics are the people who understand,” and he went on to explain that with fellow paramedics he no longer needed to try shutting off because there is a level of shared experiences and common ground:

“I guess to a certain extent it’s how you demonstrate common ground and shared experience. But also these are our battle scars. These are our tours of duty medals. These are showing I did this job. I was there. I went through a similar thing that you did and it’s how we build common ground.” – Steven

My participants ranged in years of experience on the job, from those who had barely been working for a year to those who had been at it for over a decade. Those with less experience expressed how story-telling allowed them to feel as though they could contribute to a conversation, that they belonged to the group. As Goffman (1959) argued, when an individual is new to an environment and self-doubt is high, a mask can be worn that hides their fears, shielding their inexperience. As the individual finds belief in their new role, the mask becomes a part of who they are as an actor, an added layer to their personal identity. Paramedic stories act as these masks for the new and inexperienced. They allow for new paramedics to feel as though they are part of the community as they work their way through moments of self-doubt and actualization of community roles.
Story-telling then serves not only the purpose of making paramedics feel as though they belong to their profession but also cementing the norms of the community, fostering growth amongst its members. This growth allows for paramedics to become who they are behind the mask, integrating their paramedic self into their identity combining their masked actor with the self in reality.

Moreover, participants all spoke to how not feeling alone in their thoughts and decisions was important to being able to perform on the job. Calls occur in isolation. They take place in peoples homes, the back of the ambulance or private events. The actions that occur in these spaces are the sequences that make up stories, allowing for paramedics to proceed through the liminal phase of their monomyth. Upon leaving the liminal phase a paramedic now has a story to share with the community to which they are returning. This community has similar experiences, allowing for stories to generate a sense of similarity and belonging.

“You don’t feel alone. You feel like you have a shared experience. You feel like you’re all building towards something. You know maybe not necessarily in the same direction but you’re all a part of something bigger. You get a sense of shared struggle like shared experience, shared struggle…people kind of, something that you’ve struggled with is maybe something other people struggled with so you don’t feel so alone. I think it’s a big importance of it.” – Steven

Story-telling creates a sense of belonging amongst paramedics and allows them to feel as though they are not alone in the day-to-day experiences of the profession. When your average day can include anything from picking up an elderly lady who had a fall while getting out of bed, to talking to a bi-polar fourteen-year-old who has just attempted to end their life, this having a sense of being bound to a community of others is crucial. All twelve of my participants spoke to the importance of stories providing a glue to hold the community together, allowing for paramedics to relate to both their profession and
feel as though there was a purpose behind what they were doing. They felt as though they were not alone, there were others, and that in confiding in each other they could validate their roles within their cultural community.

“I think that’s what story-telling is. It’s like a method of feeling connected and feeling like what you’re doing has purpose and meaning.” – Trevor

“I definitely find that when people are adding on to each other’s stories and are relating to each other’s stories that they’ve experienced themselves it definitely adds to everyone kind of feeling like you’re part of one group.” – Jack

Finally, it is important to note that the act of sharing stories (or not sharing stories) also works as a way to draw lines between those who are insiders and outsiders, or paramedics and non-paramedics. A good example of this is how my participants discussed the issues they have with lay people asking, “What’s the worst thing you’ve ever seen?” This question was raised by nine of my participants, all with a mocking air. As Brian put it:

“I say: “I don’t think you want to hear the worst thing I’ve seen.” I think you want to hear something gross so you want to hear something funny and I can tell you any one of those but, and this doesn’t bother me personally but a lot of medics and this is the part I will tell them as well take offense to that question because you’re asking them to relive the worst thing that they’ve ever seen which for a lot is a nightmare and I’ve been fortunate enough to have nothing even remotely similar to that but I’ll ask them to refine their question. Do you want to hear something gross or do you want to hear something like messy, do you want to hear something funny, weird, like what are you actually looking for because you saying the worst is broad and usually leads to a very dark place for a lot of people.”

Kirk, another participant, went as far as to say that it is simply a question paramedics do not ask each other. It’s an unspoken understanding between paramedics that is not observed by the outside world.
“As medics we would never ask each other those kind of questions because we know that if you do A) you’re a dick and B) you might dig up something that has essentially crippled this person and they are actively being treated for like PTSD or maybe you know they haven’t been treated for it and you’re gonna really upset them and you’re gonna have a bad shift and not only that you’ve dug up some dark memories for somebody and it’s kind of an inappropriate question.”

In this chapter I have discussed two ways in which paramedics use stories within their cultured community. First, paramedics use stories as a means to educate themselves and their colleagues. Stories form the foundations of a game of snakes and ladders, opening up a paramedic to criticism and validation. As medics move around the board of their career the roll of the dice, a call, can result in the formation of a story which when retold starts a feedback loop that allows for positive professional growth or a relearning of skills and improved decisions. Second, stories serve as the common ground that paramedics share, bringing together professionals and allowing for a sense of belonging. This is an important feature of story-telling as it allows for individual paramedics to not feel isolated and fosters improved coping strategies, which I will discuss further in Chapter Five.
CHAPTER 5: Compartments, Conversations and Humour: Stories as Means of Coping

“If you don’t get to really talk about it you’re kind of just left with it on your own and if it’s particularly troubling it might be career ending, it might be life ending, it could change a lot of things for you especially if it’s something um pretty awful.” – Kirk

Story-telling and social interactions have the ability to place the power of the action with the narrator, relieving stress (Fritz & Sonnentag, 2005). In this chapter, I address the role of story-telling in compartmentalizing traumatic events in order to reframe experience and cope. I discuss ways in which paramedics use stories to remember calls and how this can help compartmentalize tragic events. Stories work to reframe events within a paramedic's mind allowing for coping and post-traumatic growth. They also serve to aid in opening up therapeutic conversations among colleagues. These conversations help paramedics to work through issues that impact their mental health, rather than harbour them inside where they can do damage to personal wellbeing and mental health. I also look at the importance and use of humour within paramedic narratives. Humour acts as an additional layer to stories, working to further improve resiliency and post-traumatic growth. I conclude this chapter with a discussion of an outlier participant and how his personal battle with PTSD has influenced his story-telling. This section highlights the importance for future research in this area as well as serves as a reminder to us all of the effects of a career that’s purpose is save lives in the event of tragedy.

Compartmentalizing Trauma: Ways of Remembering

Paramedics are privy to the unexpected, the heart-warming, and, at times, the gut-wrenching. The job is a mix of events, some seemingly small and repetitive: nursing
home calls, slip and falls, drunk people on a Saturday night. Others are, horrendous moments of crisis: heart attacks, strokes and the sudden passing of a loved one. Stressors pile up, contributing towards a potential tipping point that could be brought on by a single action or one too many of those smaller, repeating annoyances. Like other first responders, paramedics suffer from not only the extremes of life and death situations, but also repetitive hassles that take their toll (Marmer, Weiss, Metzler, Delucci & Wentworth, 1999). Coping strategies, stress, and psychological wellbeing in first responders could easily be the subject of a thesis on its own (Larsson, Berglund & Ohlsson, 2016). Although it is not the purpose of my thesis to address these issues from all angles, it is important to examine what participants consider the most important aspects of story-telling as it relates to coping and resilience. In doing so, I demonstrate that narratives can be used to reframe trauma, promote spontaneous therapeutic conversations, and allow for pre-coping strategies to be developed.

In order to manage with the stressors of the profession, paramedics exercise a variety of techniques that fall into three distinct categories: Task, Emotion and Avoidance (Endler & Parker, 1994). Task and Avoidance strategies involve actions in direct response to stressful events. Task coping strategies result in the elimination of or physical avoidance of stressors. An example of this would be paramedics avoiding certain kinds calls or conflict-laden situations or quitting their jobs altogether. Although considered healthier than Avoidance coping strategies, Task mechanisms still result in an individual manipulating their place in the outside world in order to find comfort. The individual will pull away from their work, detaching from the source but not necessarily the root cause.
Avoidance strategies are far more problematic in that they require that the paramedic avoid the source and the cause. They speak to the emotional avoidance of stressors not just the physical avoidance associated with Task coping strategies noted above. Rather than confront the issue, tactics are used to displace the feelings, avoiding the stressors and hiding the causes. Examples of this are using drugs or alcohol to cope with the memories of bad calls, or using social distractions, such as group gatherings and family events to detach from the thoughts in their minds. Avoidance ignores the source, completely masks the cause, and tends to allow for a disillusioned state to occur where seeking support is not considered necessary (Endler & Parker, 1994).

Emotional coping involves a behavioral and cognitive response aimed at avoiding emotional issues (Endler & Parker, 1994). Some of these are negatively directed, causing individuals to become detached, grumpy, and often times explosive with family members or friends. There is, however, a more positive side to Emotional coping, one in which social supports became not a means of Avoidance but a way in which to work through the source of the trauma and find the cause. Social supports in these terms can be better understood by the means in which individuals tell their stories to each other (Regehr, Goldberg, Hughes, 2002). For example, as Christine said,

“Especially when it’s been like a traumatic kind of call. I think sharing stories is important in the healing process of getting past like what we saw, what we dealt with, like that’s not normal for people to have to deal with and as much as we try to prepare ourselves for it we are going to see some things that are unexpected or even if you know that paediatric death is something that we could run into in our career it’s still something that would be sad. And I think that being able to share, share it with co-workers and again it validates what we did and how we are feeling about it. Really it’s a step towards emotional healing.”
In addition, stories offer a way to restructure the place of a paramedic within their own culture, framing their experience.

“I think it’s our way of processing and compartmentalizing the abnormal things that we see because it’s not something you talk to you know with your non-medic friends or even all the time your spouse.” – Tracy

Stories serve the purpose of allowing the teller to reframe the events of their lives in their own terms, from their own perspective producing a narrative that is manipulated and fabricated for an audience (Goffman, 1967). Paramedics produce narratives that function to ease stress. The events of their days are emotionally filtered, becoming stories bound to narrative structures, rather than relived episodes. The stories that were shared with me during my interviews were all told from the perspective of the paramedic who was involved, resulting in descriptive tales constructed by their memories, influenced by the situational environment of the interview, and shaped by my presence as an audience and researcher. Stories are products of a process, a lived experience that is taken from its original form and reformatted to serve a purpose (Cruikshank, 1990). The ability of stories to structure events within the narrator’s mind allows for them to act as a socially acceptable form of coping. Paramedics participate in acts of story-telling as a means to work their way through troubling calls. This act allows for events to be bounded, labelled for a particular environment, and retold as the situation arises. The ability of stories to structure events within the narrator’s mind allows for them to act as a socially acceptable form of coping within the defined culture of the profession.

“When you do get those crazy calls, telling the story over and over kind of turns it from an event that you experienced into a story. It’s not as crazy to deal with because you’ve turned it into a story vs. kind of replaying it in your mind you tell it, tell it to twenty people ok I’m done
with this one today. I’ve said enough about it. I’ve talked enough about it and I think it is a bit easier to put it behind you, put it to bed.” - Brian

Stories, regardless of their purpose, are personal in their content. The narrator decides what they wish to tell, omitting certain details, adding embellishments to stress importance or to flatter their own participation. The patterned structure of the story is not personal in its construction as it follows a particular framework, illustrated by the monomyth, however; the content and the way it is told to an audience is influenced by personal choice. This ability to turn an event into a fabricated retelling works to compartmentalize traumatic events in paramedics’ minds, distancing them from the initial stressor. It also intersects with other story-telling goals, including education, and community bonding. Mistakes can be transformed into learning points, sadness can be lessened with a joke, and traumatic details can be worked through till they become descriptors used to push the narrative to its conclusion.

“The conversion of a stressful event into a story which to me makes it less of a stressful event. Once you think of it as a story rather than something that actually happened, it distances you from it in a way.” – Brian

Paramedics respond to personal tragedies, paying witness to dying breaths and becoming temporary caretakers of distraught family members. These events become ingrained into the social narratives of paramedics often re-told to colleagues. One of my participants discussed how the act of re-telling allows for them to re-remember the demanding situations. This quote is in reference to a difficult situation in which the participant was transporting a patient that died en route to the hospital:

“There’s no seizure, coma, death. She just slumped forward and it was over. And so like for me I would say that’s an example of re-remembering and re-categorizing an incident. And I think everyone does that and I think that’s a coping mechanism. And it’s a coping
mechanism to be able to handle what unfortunately are regular occurrences of awful things. Daily. Well not necessarily daily but often enough. More than your average person.” – Malcolm

Re-remembering situations as you tell them illustrates the importance of formulating stories. Paramedics are able to structure events, telling them in a way that they can process what happened on their own terms. This acts as a coping strategy implemented successfully during story-telling sessions. Re-remembering is not simply a way of re-living a situation, it is an editing process that allows paramedics to look back on a particular situation and remember it in a way that has been reformed in their sub-conscious. They are re-remembering something on their own terms in a way that allows for them to manage it.

Paramedics have to recall details of particular calls for various reasons including police reports, criminal trials, Ministry of Health and Long-Term Care investigations, and workers compensation tribunals. In these instances details are important and paramedics are forced to recall their own actions and those of people around them. These can be jarring and emotional experiences with the starkness of precision eclipsing personal choices of remembering. When a paramedic tells a story to a fellow colleague they are not forced to remember details they do not wish to, they can choose the conversational elements. As Malcolm noted, stories become a way of re-remembering. Story-telling is not simply remembering events, detail for detail in a perfect sequence. Rather stories are laid out and re-remembered as the teller wishes them to be. This brings focus to the elements of the call the teller wishes to remember than their strictest memories of the event.
By producing these themes, placing stories within set limits, paramedics are able to restrict the traumatic events, transforming them into coping acts of narrative expression. As themes emerge, new stories are added to the chain with a collective release of tension.

“There are the coping mechanisms stories just like the outright sad ones where you commiserated together and just processing the events by turning them into a story which whether it helps you grow as a professional. I don’t know if that’s what I’d say but it certainly helps you survive as a professional and enables you to come back and do it all over again ‘cause there are certainly calls where you go why, why do I do this to myself, why did I get myself into this?” – Brian

Whether in groups or between a pair of individuals, these communal social interactions allow for the practiced act of re-remembering to work as a coping strategy. Stories become categorized, placed within compartments rather than running rampant through a paramedic’s sub consciousness. As themes emerge during conversations, paramedics are able to find contributing stories, transforming traumatic events into topics of interest.

“I find that that is a positive result ‘cause then it will decrease the personal stress inside and minimize the amount of damage you do to yourself by being really harsh on yourself.” – Calvin

“They listen to you, you listen to them because they are telling it to you for some reason whether they believe it’s relevant to a situation you’re in, or they need to get it out to make themselves release some pressure so to speak.” – Bill

Therapeutic Conversations

In addition to compartmentalizing difficult events, stories are used to open up therapeutic conversations among paramedics. Social interactions while on the job can foster a sense of belonging and have the ability to release tensions. Social interactions while off-duty can optimize posttraumatic growth, offering a supportive space to recover
from professional burdens (Fritz & Sonnentag, 2005). Interactions on shift, but during downtime, can also contribute to the overall wellbeing of paramedics. In a twelve-hour shift there are multiple periods of downtime that allow for the responsibilities of the profession to be forgotten about until the tones for a call go off. In these spaces conversations can develop that lead to support, understanding, and release of stressful situations.

Paramedics work in a unique environment where the dynamics experienced on the job can be defined by personal choice. If one wishes to speak with their partner, they can. If someone wants to hide in the truck all day, conversing only when necessary, then that is also possible. The fluid nature of interactions that occur outside of the paramedic’s role in patient care can play into successful negotiations of traumatic events. If a paramedic needs time to process on their own terms after being confronted by stressors, then it is possible to find that time. If they need to discuss things, formatting a story based on choice and perspective, then they can find an active audience in their peers.

“I think that if you experience something, for me personally, if I experience something that was particularly disturbing for me, or maybe for my partner maybe even, not so much for me, that talking to somebody else about it is therapeutic. Talking to my partner about it might be therapeutic. Maybe that person that I’m talking to, not my partner, if I’m talking to somebody that I see at a hospital or I run into elsewhere at a station and you know I say oh we just did this call can I talk to you about this, it’s bothering me 99.9% of the time people will say yes and being able to share that experience is definitely a way of maybe rationalizing what you experienced and coming to terms with maybe what sort of lose or audacity that you were exposed to.” – Kirk

The understanding of story-teller choice is important. Not only are paramedics manipulating the essence of a story to serve the purpose that they wish it to, but they are also consciously choosing their audience, their story-telling environment, and the
time of their performance. Stories that act as coping mechanisms are an unloading process for the narrator. They are controlled, emotional retellings directed to an audience for the purpose of shedding burdens held by the narrator. The audience plays a role as active listeners, social sounding board and commentators. This process is highlighted by Jack’s perspective on story-telling.

“I feel like when you're telling stories you're unloading some of that. When you experience something you hold on to it and you let the anger or the sadness or whatever emotion you're feeling about it, you let it, like fester inside of you and I feel like when you tell it in a story even if you're not conscious of it, you subconsciously just kind of like, let go of a part of that. I'll find myself super fired up about something, like really mad and then I tell a story about it and a bunch of people comment and if I'm talking in a group chat on like my phone or I'm telling them in person, either way a bunch of people will like respond and then I'll continue to rant a bit and then you know a couple hours later or a day later I won't even remember the event that happened in an angry way. Like I'll remember that it happened but I’m not feeling angry about it anymore because I've just vented and I've like let it out.” – Jack

These social interactions are carried out with a respectful understanding developed by the norms of paramedic culture. My participants indicated the importance of respect from their audience as well as the contribution of their inherent understanding. It was common for a participant to discuss how telling a story outside of a work context was different. Friends and loved ones lacked understanding on a subconscious level. They required additional information from the teller to be let in, a process that required the story-teller to unload in a way that was constructed, framed for a layperson. Extra energy was needed in the interaction, and this contributed to difficulties in expression and the desire to perform. Certain details would be spared and burdens held back. When asked if he changed his story depending on his audience, Bill said,

“You simplify your terms because sometimes things are really bothering you or just really need to be told because it’s so interesting or
it could be so interesting you get it out there but it is definitely much easier to tell stories to people who understand all the words you want to say rather than the ones you kind of censor, and not even censor but just change. Not the ones that come to mind first… It absolutely gets frustrating. It makes you feel almost disingenuous not because you’re lying about the story at all but it’s almost as though the gravity of it, the emotions you’re trying to convey, the seriousness you are trying to convey almost gets filtered, diluted. You’re changing the words you want to use and their actually, their true meaning for ones who don’t quiet convey the same message as you originally wanted to.”

Brian had this to say:

“In that sense you know that person wants to, needs to tell the story. They want to make you laugh with it. They want to get it off their chest and you do kind of have a role as one of the select few people in the city who will actually understand the story and act appropriately to it.”

These adjustments are not needed when paramedics are speaking with each other, allowing for conversations to turn into spontaneous therapy sessions driven by story-telling acts. The energy required to perform becomes minimal allowing for more effort to be expended towards the act of expressing emotion, finding the pressure valve and opening it. The purpose of story-telling to act as a release of negative energy and tension is crucial to personal health and post-traumatic growth (Shakespeare-Finch, Gow & Smith, 2005). In order to prevent maladjustment or social instability due to the build up of stressors, paramedics participate as both active tellers and listeners of stories. Respect is built into the norms of these processes with a mutual understanding of the importance of the interaction.

“It’s giving respect to the person telling the story and also respecting how much it’s affecting them after the fact because story-telling is cathartic. It’s a way to get out things that are potentially bothering you in some ways other ways to tell the story.” – Bill

“For someone to be able to tell a story about, like, this awful thing just happened to me or happened to someone else I had to be responsible for, that when someone else can tell a story as well to tell them back,
like, I know that happened to you and this happened to me, it helps to normalize and it helps to understand, sort of wrap your head around things.” – Malcolm

Pre-trauma Cautions and Building Resilience

Not all acts of story-telling act as a means to cope from an already sustained trauma. Paramedics acting as active listeners can repurpose narratives told to them by others as a means to learn potential coping strategies. This shows how stories not only act as means of expression of trauma for those who are suffering, but also as examples of ways to handle similar situations for others.

“It’s, I think, it’s more along the lines of like how would I cope with that? If somebody tells me about a call that they did it’s like they seem ok, would I be ok? Would I be at work the next day? Would I take a week off? Would I take a month off? Would I quit? And it’s a matter of maybe mentally preparing yourself for that possibility, you know, you eventually might do that call, you know, somebody has done it and is it a sign of they’ve done it so if you’re struggling you can either talk to them ‘cause you know they’ve been through it, they’ve shared it with you or is it, you know, are they the source of support that you need to cope with it.” – Kirk

Learning how to cope with what is normalized in the profession is instrumental to the development of the paramedic self. Narratives work to form these illustrations of coping, providing examples of what to do, how to reach out. This demonstrates effective communication practices.

Story-telling serves a distinct purpose in the ability of paramedics to explore appropriate coping strategies. Discussion of difficult events between groups or individuals is a process determined by choices of the participants. Narrators fashion stories that are defined in their own terms, becoming fabricated tales produced to alleviate tensions. These productions are used at the discretion of the teller. Paramedics choose when to partake in story-telling, they choose how to describe the events of their
experiences, and the audiences choose how to use these interactions in furthering their own personal resiliency.

The Humour Layer

“It’s our black humour that we use for coping because it’s better than crying.” – Jude

“You have to find some way to find it, to find things humorous because if you don’t you’re going to melt down either during or after and no one wants to melt down in front of their colleagues.” – Calvin

All of my participants spoke to the contribution of humour in their stories and reflected on its need as a means to cope with daily events. Similar to my overview of the ability of story-telling to contribute to healthy coping mechanisms, the use of humour is broad. Here I discuss how my participants highlighted its significance to story-telling in the profession.

Paramedic story-tellers exhibit the use of gallows humour, a particular form of humour that works to draw providers together, while buffering the negative abuses of the burden of emotional work. “Gallows humour is humour that treats serious, frightening, or painful subject matter in a light or satirical way” (Watson, 2011, p. 38), and can be a means of easing this tension. As Jack said,

“A lot of people will make jokes. The dark sense of humour is a big, big example of how people will deal with actually being uncomfortable about a situation or being like freaked out about something or like stressed or having anxiety about something. Most people don’t have such a dark sense of humour and for us it comes so naturally and it’s definitely a coping mechanism to deal with like seeing such tragedy like all the time.”

Using humour provides the ability to reframe an event, contributing to the compartmentalizing of trauma. Events can be re-defined, their boundaries manipulated in order to salvage the humanity of the story-teller. By telling their perspective on an event,
a paramedic can shift their positioning, reflect and own the experience. There is no
suppression of the source and the cause becomes laced with humour; wit becomes an
analgesic to trauma. Emotions can be expressed in the tone of the narrative, captivating
an audience of peers and allowing for the story-teller’s inner demons to escape, their
destructive qualities blunted by sarcastic rhetoric. This is similar to the
way that humour was used by the physicians studied by Burson-Toplin (1988).
The residents allowed for their stressful interactions with co-workers to be reframed into
humours anecdotes via the usages of otherwise traumatic terminology. Humour is an
added layer, a transparent covering to a narrative that contributes to the purpose of the
overall story, while shifting the original experience from something traumatic to
something manageable. As Malcolm puts it,

“It’s like re-categorizing something awful in your mind by finding the
humour in it or by trying to normalize it. And by re-categorizing it you
don’t remember it as being something super awful and depressing.”

Humour is used to bridge the gap among peers, becoming a shared response to an
individual experience. It has been explored amongst medical professionals as a means of
coping with the structures that shape the delivery of care (Watson, 2011). There are
things that you cannot change as a medical professional, such as poverty, crime, and hate.
These are the elements that bring patients to you in need of assistance that you, as a
professional, have no control over. The structural violence that creates and perpetuates
these external elements generates a tension between the health care provider and their
patients’ circumstances (Farmer, 2004). This tension can lead to burnout, PTSD, and
other mental health disorders associated with traumatic triggers and the day-to-day
experiences of paramedics and other health care professionals. Brian pointed out that
humour is one of the limited tools that paramedics have to deal with the stresses of the job, saying,

“Cause what else are you gonna do with most of the stuff we deal with. I mean obviously there are some truly tragic ones that don’t turn into laughter. I mean like any murder of a child, no one laughs at that story. That’s like an oh shit are you ok, you wanna go home, you wanna go for a beer like what are we gonna do. But the majority of these ridiculous situations we find ourselves in if, if you couldn’t laugh at it you would probably end up internalizing so much that you couldn’t do this. I mean if I couldn’t see the humour in these ridiculous situations I find myself in I don’t think I could have done this for ten years. I’d have lost my mind three or four years ago.”

Humour is a viable coping strategy amongst first responders and can contribute to lower rates of emotional burnout (Sliter, Kale & Yuan, 2014). The cognitive processes associated with traumatic events are combated by the ability to use humour, allowing it to be an active agent of the purposeful narrative. It is an alleviating moment amongst peers when laughter can distract from sadness, or replace trauma. Story-telling sessions amongst paramedics can be seen as deliberate cognitive strategies used to cope with critical events (Regehr, Goldberg, Hughes, 2002). Stories offer a way to restructure the place of a paramedic within their own culture, with humour playing a critical role in this process. The deliberate contributions of humorous occurrences can reframe events as stories unfold, which makes it possible for paramedics to come to grips with often extremely emotionally crippling incidents.

“I mean we talk about funny stuff that we see. I mean it’s, you know, normally the stuff that we talk about quiet, often it’s the most horrific stuff. And it’s, at the time, it’s kind of like you’re trying to make peace with it in kind of a weird way.” – Calvin

“I think for a lot of people the act of telling stories is how we wrap our heads around things that have happened to us and process them for our own memory because every time you tell a story that’s how it gets cemented in your own memory. So I think it helps us process some of
the ridiculous things for the long term and avoid, you know, damage. And it helps to frame it a certain way. Frames it the way we want to frame it and if we can put like a lighter spin on it or find the bit of humour in it, I think that’s good for our long term mental health.” – Tracy

Placing a lighter spin on the recurring situations that form the career of a paramedic releases the tension that builds up interfering with post-traumatic growth. The process of applying humour, of layering it upon an existing narrative, changes both the response by the external audience and the internal cognitive adaptation of the teller. My participants understand that what they see over the course of their careers would not be considered normal by the general public, but they had the ability to normalize incidents by adapting their viewpoint of them. Humour is used as an element in story-telling to foster this ability to adapt, creating manipulated process that leads to better emotional coping.

“Stories are important ‘cause black humour is important. I mean we are emotionally affected by this job probably on an unconscious level and occasionally, for some, on an outwardly emotional level. Depending on what triggers you and where you are in your life. Depending on what’s going on in your life it’s important to laugh as well and those stories bring people together to just laugh and have a few minutes of like not worrying about anything else.” – Jude

**A Participant Outlier and the Personal Impact of PTSD**

Of my twelve participants one in particular offered a differing opinion on the importance of story-telling within the profession. Calvin, who has worked for almost seventeen years as a paramedic, was the only participant who disclosed that he is currently being treated for post-traumatic stress disorder (PTSD). Calvin is no longer working on the road as a paramedic as he struggles with the impact of his PTSD on a daily basis, working through differing forms of therapy in order to return to a healthier
place. It is important to discuss how PTSD can work away at someone's mental health, destroying their resilience to stressors and impacting their daily functioning. Calvin represents the extreme, the end battle with your demons that follow you from a life on the road.

Calvin, like all of my other participants, believed that the act of story-telling not only served a multitude of purposes within paramedicine but also that it was extremely important. He differed in his opinion of when and how it ought to be used, stressing that younger paramedics new to the profession, tend to tell more stories and that the longer you work the less you involve yourself with tales. He stated that younger paramedics were the ones that he found telling stories, looking for acceptance from the community through their exchanging of experiences. For Calvin, telling stories had the potential to re-traumatize and re-expose, bringing him bright back to the events that had worked to form his post traumatic stress. This understanding of the downside to story-telling, the potential re-living of horrific events, was not emphasized by my other participants who were using the act of telling as a means of compartmentalizing and re-remembering.

For Calvin, the importance of story-telling was in its ability to be used as a mentorship tool. Stories work to educate others, offering examples of how to do things correctly and highlighting possible mistakes that can occur due to inexperience. They serve to normalize lessons, framing them in an interactive way that brings members of the profession together. They also work as a way to decompress and work through critical situations. Although this decompression can border on reliving of unwanted experiences, it is needed in order to move on and let go.

“I’ll speak for myself, I’m very hard on myself um especially on critical calls and sometimes by speaking your trust out loud it reinforces you internally by
reemphasizing what you did and that it was ok. And if you get that positive response back from the individual that you respect and or trust, especially if you respect them then that reemphasizes it which is good. So I find that that is a positive result ’cause then it will decrease the personal stress inside and minimize the amount of damage you do to yourself by being really harsh on yourself. The negative side of it, the other side of the sword is that it uh it uh you’re rehashing it, you’re re, re-examining it. You’re not letting it go and sometimes you’re re-traumatizing yourself.” – Calvin

More research needs to be done with paramedics who suffer from PTSD and how they are using stories to process their illness. Calvin’s views on story-telling are important and represent a different voice than my other participants. I was thankful that he was willing to meet with me and discuss his opinions on story-telling and that I could capture his distinctive take on the purpose of narratives within the profession. Future research should look at these outliers, those who lived through the extremes and are now suffering. By opening up these conversations, prevention and new techniques to manage this illness can be developed.

Paramedics use stories in a variety of ways as tools of their profession. They contributed to healthy coping strategies and resiliency, acting as ways to remember events layered in humour and remorse. In my conclusion, I review the ways in which stories do work in the paramedic profession and discuss how further research can contribute to a better understanding of paramedic culture. In addition to discussing the need for future research in terms of the areas put forth by my research into story-telling practices, I highlight two additional areas in need of future study. I conclude with a brief personal reflection that summarizes the difficulties I faced personally while working through this project. It is my hope that this reflection will expose my connection to my work on this project as well as to my profession.
CHAPTER 6: Concluding Remarks

My analysis has focused on the work of paramedic narratives. I have argued that stories have the ability to serve distinct purposes within the community within which they are created. These purposes are defined by cultural understandings, and are used by the individuals within this particular profession to manage and cope with the environment of their occupations. They also function to strengthen acceptance and validate ongoing involvement within the community. The following discussion is a review of these purposeful constructs of paramedic narratives. I also look at the need for additional research surrounding story-telling practices, identity and post-traumatic stress.

Education and Validation Purposes

Paramedic stories have the ability to inform and educate those within the profession working to improve practices, communication skills and future coping strategies. Following a hero’s path as described by the monomyth structure, a paramedic will navigate a call – and talk about it - in a three-step process similar to the way a mythological character from a fable or fairytale will undergo their storied metamorphosis. When a call comes in, a paramedic will leave the steady state, becoming embedded in progressive tale that works towards an ultimate conclusion. During the second phase, which occurs after being removed from the steady state, a paramedic must process a call working through uncomfortable environments, using skills and adjusting practices.

Upon the completion of a call, a paramedic will return to their steady state and can begin to process the event. This processing occurs by means of a feedback loop
engineered by the act of story-telling. Paramedics will share stories with each other of previous calls highlighting skills and stressors with directed audience responses acting as educational tools. If a paramedic shares a story that an audience deems successful, feedback will be shared and a paramedic can feel satisfied that they have acted correctly in a given situation. This results in them 'climbing a ladder' upon the game board of metaphorical snakes and ladders. If an audience does not agree with the actions of the paramedic than they will 'slide down a snake', learning a lesson along the way that can be integrated into their next call. These feedback loops serve to validate and education paramedic actions emphasizing the importance of story-telling acts in doing work within the profession.

There is still a need for more research that examines how story-telling practices influence paramedic educations throughout the course of their careers. Donelon pointed out in her dissertation work that the arena of paramedic education is a viable place to begin to understand the identity formation of the individual through story-telling (2014). I agree with her call for a better understanding of paramedic education as a whole. While story-telling and its ability to foster a learning environment is pivotal to professional development, the understanding of how differing methodologies work to improve skilled learning and practical comprehension are needed. Additionally, a more thorough review of the transitional phase from student to working paramedic needs to be examined, in particular how narratives and story-telling work to mitigate this transition bridging the gap between the identity of student and paramedic.
Community and Bond Building Purpose

Shared stories have the ability to bring people together over common experiences and interests. They serve to bridge gaps in seniority and identity, and even the formality of introductions. They are simply part of something bigger, a chain that works to weave differing members of the same profession together. It was common during observations to witness paramedic story-telling circles develop and break off with a member later asking who had been sharing, what their name was. There is a sense of belonging felt by those who contribute to the chain. From their first day on the job and their first call, a paramedic starts to have narratives to share. The purpose of stories in breaking down barriers between members of the profession is evident by their ability to be traded, passed back and forth with laughter and understanding.

Specific groups of people, whether it be professionals, athletes, members of religious organizations, or even book club members have defined, socio-cultural roles within them and although these roles are fluid with people breaking the mold from time to time, they are generally maintained by rules. These rules must be followed to be a thriving member of the group. Narratives serve the purpose of bringing shared meaning to lived experiences. If a member of a book club discusses the novel of the week as it relates to their life, another member has the ability to continue the chain, linking them together. The same can be said of paramedic narratives that are shared amongst a group and understood by the culturally defined rules of the profession.

Additional research needs to be done in this area as a means to understand how paramedics navigate their professional communities and find value in their work. This will likely contribute to improved job satisfaction and lower incidents of burn out. Stories
are only one piece to the puzzle surrounding our understanding of value. Stressors can work away at professional and personal senses of a value. When this occurs burn out and job dissatisfaction can lead to issues surrounding mental health and suicide. In order to improve professional standards, more research must be done in this area.

Our understanding of paramedic culture is limited. The area of professional community development is a critical area to explore, as it is a direct reflection of cultural norms and practices. Studies need to be conducted in order to look at how paramedics interact with each other both within the bounds of their daily work experiences and during free time. A better understanding of the profession will only serve to help with both educational structures and factors contributing to poor mental health among first responders.

Compartmentalizing and Processing Purposes

Paramedics also use story-telling to transform lived experiences from traumatic events to situations that are no longer lived but rather re-remembered. In this sense, stories act to compartmentalize extremes, blurring the edges of trauma with humour and rhetoric. The purpose is to mute stressors that work to undo the mental stability of a paramedic and they serve to function in healthy post-traumatic growth. Rather than avoiding events all together, narrative re-remembering offers an outlet to open further discussions, blunts harmful memories and allows for paramedics to take ownership of their experiences.

The transformative nature of narratives also gives the narrator the choice of labeled compartments for which the story belongs. The creation of themes, particular decks of trading cards that work within differing story-telling chains, plays into the
ability of stories to work as viable coping mechanisms. A sad or difficult call can be
shared with those who are also suffering from a sad or difficult call, bonding paramedics
together in shared compassion and understanding. An audience that understands and can
mentally relate to your lived experiences contributes to professional solidarity taking
personal struggles from internalized traumas to communal forms of pressure release.

In terms of additional research this is the area that deserves the most attention.
Post-traumatic stress disorder (PTSD) and suicides are, unfortunately, a very common
occurrence amongst paramedics. According to the Tema Conter Memorial Trust website
which tracked reported suicides among Canadian paramedics in 2017, the rate was 47.76
per 10,000 (TEMA, 2017). This can be compared to the national average from the most
recent year in which data was collected, which indicates a rate of 11.5 per 100,000 or
1.15 per 10,000 people (Navaneelan, 2009). There simply is not enough being done to
understand the mechanisms that contribute to these events. Continuing research that looks
into the life histories of paramedics suffering from post-traumatic stress would work to
shed some light on the lived experiences of those impacted by this mental affliction.
Additionally, research into external factors that impact the decision to commit suicide
must be better understood. Things such as family support, community involvement,
financial standing and personal development can all influence the choices of those
suffering.

These mental health issues are a dark reality to the profession that is not talked
about enough. Whispers make their way into educational reforms and legislation, but
more needs to be done in order to understand PTSD, as it has the potential to strip a
paramedic to a barren shell. Why is it that even when reframed and re-remembered in a
narrative does trauma stick in memories in a way that happiness and joy may not?

Paramedics do not simply encounter the tragic and heartbreaking. They also bring lives into this world, cradling newborns whose mothers simply could not make it to the hospital in time. Why do these events become shadows in the minds of those who suffer?

If we do not work to understand the effects of continuous exposure to traumatic events, paramedics and other first responders will continue to take their own lives. It is crucial that further questions are asked and explored in order to prevent future suffering.

Other Areas for Future Research

I was fortunate to interview a variety of people for this study who all had differing lives outside of being paramedics. These experiences, external to the job, offered additional areas of potential future studies. In particular two of my participants made comments that sparked interest in areas that contribute to their professional identity: sexual orientation and having children. Tracy, a mother and paramedic, discussed how having children directly influenced how she participated in and reacted to experiences on the job.

“The job changes after you have kids as cliché as that is. It’s brutally cliché and you’re like no, no, no I’ve seen things, I can, I can, no. It really is. I’ve done very similar calls before and after having babies and like completely different reaction afterwards so yah I don’t know.” – Tracy

It would be interesting to explore this further. In what ways does having children change the ways calls are experienced, and how is this expressed in practice? Tracy links changes in her personal life to the way in which she participates in her professional life as a paramedic. For her having children impacts how she now views certain situations that occur on the job. As paramedics move through the life course, so how do their stories
change, connecting to where they are at in life? Personal and professional lives are intertwined, with each side being impacted by change. Exploring these changes can contribute to a better understanding of the life course of the paramedic.

Sexual orientation is an additional layer to a first responder’s identity that can contribute to the way in which they see themselves. It can also directly affect their ability to process trauma, integrate into the profession, and navigate interactions with colleagues. One of my participants, Steven, openly identified as a gay male and made a point of discussing how his sexual orientation influenced his work identity.

“I have a different, or deeper understanding of identity politics if only because I went through the process of coming out and I had to really grapple with a lot of who am I as a person, who am I as a gender, as a sexual orientation, as uh you know an athlete, as a student, as an employee, uh as a family member and I think that’s a lot of not all of those things are things that the average person grapples with because they don’t have to grapple with identity until their faced with something that is usually a crisis. My crisis happened earlier in my life so I gained an appreciation for it at an earlier age. I think that is part of, that, that probably links in with mental health and how we see a big push now for medics who are harming themselves because maybe they haven’t had to grapple with thoughts.” – Steven

His discussion of identity politics and the coming out process as it relates to being a paramedic in the face of professional crisis is an important topic that needs to be explored more.

“Boiling yourself down to I am this and struggling with the concept of intersectionality is very common in straight, white people because they are not use to there being different colors, and being different shades situations. There are thoughts like I’m a feminist but feminism isn’t just one thing, there’s also how, uh how people of color deal with it, there’s also ableism built into that. There’s also like ageism built into it. There’s, there’s all these different levels and I think that I am a paramedic therefore I am a paramedic, capital P identity can come from people who you know they’ve never had to think about race because they are white and that is the background, no one has made them think about it, they’ve never had to think about uh gender or gender
orientation, they’ve never had to think about age much um that, that’s maybe changing as they age um I think a lot of people struggle with that because they haven’t had to. Uh and I can appreciate people who do struggle with that because like whoa that’s a struggle, that’s work, you’re putting work in there and you should be applauded for that but like you shouldn’t not have to do the work.” – Steven

In particular the idea that being able to separate yourself from your career, not allowing it to define you, can contribute to healthier ways of managing post-traumatic stress. Research into identity and coping within the sub-group of queer first responders could open up possible ways of combating mental health issues and burn out among the population as a whole.

Final Thoughts and Narrative

Narratives are a layered process of understanding, both internally as the teller relives their experiences, and externally as they serve a purpose, performing works within their cultural community. I undertook this research with differing positions: first as researcher, second as paramedic, and third as an individual person living out my daily life. This combination of lived experiences created the foundation for this thesis, and the experiences of my participants constructed the final argument.

There were times during this project that I found myself relating too closely to the stories being told by my participants. I had times where a personal friend, who is no longer working as a paramedic, would call me and want to talk about flashbacks they were having while I was editing through a literature review on PTSD. Things would hit home in ways that I could not have predicted. The following is a narrative of my personal experience, of a call that happened to be during the course of conducting my research and analysing my data. I chose to include this narrative, as it is
an example of where I stand as a researcher and an active community member. It is a reminder of the hardships of the job and the need for a balanced approach to research.

Personal Narrative #2: Struggling with Death and Writing

Like any project this thesis has its ups and downs. I had days where writing would come easily and getting ready to defend seemed close at hand, rather than some far off dream. Then there were times when writer's block seemed to barricade every attempt I made at formulating a sentence. I couldn't find a word, running around in circles repeating similar phrases and clauses. I wasn't at a dead stop but my wheels were definitely spinning. I would take breaks, walk my dog, drift off into some fantasy storyline courtesy of my PS4, and then come back to work ready to start over. Sometimes it was a matter of reading through my sources again, or pulling open a book to a chapter I had read three times looking for a new spark.

But then there were the downs and not because I couldn't find the way to say something, the word dancing on the tip of my tongue; these were moments when I couldn't write, I didn't want to. It's funny how writing about paramedic narratives is influenced by my own paramedic narratives. If I had a good shift, a positive patient interaction, a good partner who I could enjoy some enlightening banter with, on these days I could write. I could come home after work or wake up after a night and sit with a coffee, letting my analysis flow. It was easy and I felt as though I was accomplishing something, adding a voice to the works of others, bringing life to the paramedic profession.

Then there were bad days. I've had a few over the course of this project. Writing didn't exist in these moments. I would think about returning to my computer screen only to have my stomach twist in anxiety, not wishing to think about stories and purpose. Not wanting to think about the job at all on my days off. I needed a day off, or a week. Patients die. It's a part of the job, a part of life. We can't help it most of the time despite our best interventions. Sometimes all you can do is give as much comfort as you can. Offering dignity, compassion, reflection. These moments come and go with the job, but for me they made writing impossible. Holding the hand of a dying woman and telling her it's going to be ok while you race to the hospital when you know it's not going to be ok, when you know she is dying, takes a lot out of you. You can't function after that. You can't think about other's stories. You're still processing your own. You're still placing it in a box in your mind to be viewed upon later.

For me, the writing process of this thesis was a struggle. I had days where I wasn't able to do anything. Weeks where writing about other's narratives was an internal fight. I needed time. I needed to process. This is the power of narratives in my own life. They could consume me, but eventually with time they would find their place. I could get to a place where the story was a part of me, but not a defining aspect and then I could write about others again. I grew from realizing this process. Sometimes I had to let go of the writing in order to comprehend my life outside these pages.

There is no way to fully embody the life of a paramedic in words. Some feelings are beyond description with no metaphor that can be constructed to make people relate
and understand. Stories become edited, expressed in a way that is tolerable by the narrator. They are a part of the narrator, something that they carry that influences their lives. For me this influence was felt most when working through this research. I found that retelling my stories, in particular the tough calls like the one I have shared here, allowed for me to move on and begin writing again. It serves as a reminder that researchers are human too and that removing yourself completely from your work is not always possible.

Paramedics are public figures. They are a moving cog of the health care system that steps outside of the hospital or the clinic and interacts with the public, forging strong community ties and becoming integrated within these dynamic landscapes. Within the field of anthropology, and in particular public issues anthropology, these ties offer an intriguing and important field of study. By furthering our understanding of paramedical practices and culture we can improve not only the profession but also the public they care for.

For the paramedics I worked with in Toronto, stories work to compartmentalize trauma, validate identity, promotes community acceptance, and educational improvement. At any moment during a shift paramedics can begin the story-telling chain, stimulated by an occurrence or a memory. These chains work to bring people together over shared experiences. Themes run through the chains, swapped trading cards and war stories that bond participants together. Decompression and understanding is achieved during these moments of commonality.

A shift on the road can encompass the extremes of urban life, from walking into a million-dollar penthouse apartment, to attending to a crisis in the back room of a
homeless shelter. You see it all, and in order to process these experiences, paramedics use stories as a means to re-remember and compartmentalize. This means placing labels on events, storing them in themes to be worn as badges of honour, and 'swapping' them as trading cards. This ability of stories to be used, to serve a purpose and perform work is their real importance within paramedic culture. They are not used simply as a way to pass time, or to entertain, but rather they are structured interactions that salvage dignity and provide moments of communal compassion.
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