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Exposure of EMS Personnel to Violence in Urban Cities of the Midwest

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Abstract

Exposure of EMS Personnel to Violence in Urban Cities of the Midwest

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BA, Drake University, 2013

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Emergency medical service (EMS) personnel experience both physical and verbal assaults towards them by patients, family members, and/or bystanders at the incident scenes. The mostly quantitative literature is limited in recognizing how this violence may affect the way that EMS personnel complete their jobs. Through in-depth, semistructured interviews with nine EMS personnel from the Midwest, this phenomenological study was used to understand EMS personnel's lived experiences and perceptions of violence towards them by patients or bystanders at the response scene. How this violence towards EMS personnel affected the way they approach incident scenes and interact with patients and/or bystanders at the scene was also examined. The constructivist self-development theory was used to illustrate how EMS personnel's past experiences of trauma and violence shapes their current experiences of being victimized. Data were analyzed via descriptive and pattern coding, which allowed for identification of themes and cross-interview analysis. Seven themes related to the research questions emerged: (a) physical assaults, (b) verbal assaults, (c) staging, (d) situational awareness, (e) the use of ballistic vests during high-risk situations, (f) requesting the presence of police officers while on incident scenes, and (g) the use of de-escalation techniques. One theme, the lack of de-escalation training, emerged unexpectedly and was not related to the research question. Fourteen subthemes emerged from these main themes. Recommendations include conducting more specific trainings on de-escalation techniques to help prevent violence towards EMS personnel. The findings could contribute to social change by improving awareness of violence towards EMS personal and the need for more training on de-escalation techniques.

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Chapter 1: Introduction to the Study

Emergency medical service (EMS) personnel are exposed to violence and trauma daily due to the vast number of citizens they work with including people with different backgrounds, different cultures, and different socioeconomic statuses (Maguire & O'Neill, 2017). EMS personnel in the United States are assaulted twice as much as the national average for other occupations (Maguire & O'Neill, 2017) but there is not much literature based on EMS personnel's own experiences to this type of violence. Most of the literature is quantitative and does not consider how this violence affects them physically, emotionally, or psychologically. The literature is also limited in recognizing how this violence may affect the way that EMS personnel complete their jobs. This current study on violence towards EMS personnel and how it affects them adds to the literature by identifying how EMS personnel may respond to incident scenes differently based on their prior experiences with violence. Further, the research study also adds to the literature by identifying how violence towards EMS personnel may affect the way they treat their patients and/or bystanders at the incident scenes.

In Chapter 1, I review some related literature on violence towards EMS personnel. I then identify the research problem and the purpose of the study which will go into depth about the focus of the study. Next, the research question and subquestions are stated along with the theoretical framework and how this framework relates to the research question and study. Following this section, the nature of the study is addressed to identify the type of methodology that was used for the study. The next sections cover definitions that are needed, assumptions, scope and delimitations, limitations, and significance of the

study. Finally, this chapter ends with an overview of the chapter and what to expect in the literature review.

Background

EMS personnel work in many different types of environments that include both rural and urban settings, day and nighttime shifts, and the many different socioeconomic areas in their community that they serve (Maguire & O'Neill, 2017). Risk of violent assaults are heightened because EMS personnel work in isolated and uncontrolled environments, are in contact with the public and people in distress, and are associated with possessing valuable or desirable items such as drugs, syringes/needles, and expensive equipment (Maguire, O'Neill et al., 2018). According to studies, professionals experience more workplace violence if they work in economically depressed areas, in urban areas, in public spaces, on their own, during the evening or at night, or, more often, in contact with citizens who are unknown to the professional (Reemst, 2016).

EMS personnel from all over the world are subjected to different forms of violence from their patients and/or bystanders or family members at the incident scene (Reemst, 2016). Reemst and Fischer (2019) concluded that EMS personnel and first responders have a high risk of being confronted with violence at work in many different countries. The researchers look at different variables such as gender, education level, frequency of contact with the public, working evening or night shifts, supervisory duties, years of service, and how many hours they work in a week. Approximately 38% and first responders and 72% EMS personnel experience physical and psychological violence.

Reemst (2016) studied workplace violence experienced by EMS personnel and concluded that there are five types of violence that EMS personnel most often receive. These types of violence include verbal aggression, physical aggression, threats and intimidation, sexual intimidation, and discrimination. Verbal assaults and threats and intimidation are the most common forms of workplace violence. Due to verbal threats and intimidation, many EMS personnel struggle with feeling like they can provide their patients with the appropriate care due to the psychological impacts that verbal threats and violence can have on them. Even though physical assaults can be traumatic, some studies show that verbal threats and intimidation towards EMS personnel have a larger impact on them which can cause frustration, stress, fear, and anxiety (Brophy et al., 2018).

Due to the increased fear of assault, some EMS personnel have changed their attitudes toward patients and families and have noted that patient care can be affected if they fear for their personal safety (Furin et al., 2015). More research on violence towards EMS personnel is necessary due to the growing concern of how violence affects EMS personnel and how it affects the way they provide medical care for their patients. More research can also provide the administration with different findings that can help protect their employees and provide proper trainings and follow-up services if they have been subjected to any workplace violence.

Problem Statement

Violence against EMS personnel is not a new concept. Maguire and O'Neill (2017) found that assault rates amongst EMTs and paramedics in the United States were twice as high as the national average for all other occupations. The U.S. Department of

Labor, Bureau of Labor Statistics (BLS, 2014) reported that the overall injury rate for EMTs and paramedics was 333 injuries per 10,000 workers, which is three times higher than the average rate of 107 out of 10,000 for all other occupational groups in the United States (Maguire & O'Neill, 2017). The U.S. Occupational Safety and Health Administration (OSHA) identified that there are a number of reasons for exposure to violence causing a higher risk to health workers to be victimized that include, "increased prevalence of handguns in the general population, chronically ill mental patients, gang activity, poor communication, and limited back-up support" (Maguire, O'Neill et al., 2018, pp. 1258-1259).

Some research studies have identified that threats and acts of violence usually come from the patients, relatives, or others on the arrival point of the ambulance and EMS personnel (Suserud et al., 2016). Often times, EMS personnel are the first on scene and have lapses in time before police officers can assist them, which in turn leaves them vulnerable to patient-bystander violence (Taylor et al., 2016). EMS personnel have reported that they were often verbally threatened, physically assaulted, threatened with weapons, and/or psychologically threatened by the patients and bystanders (Seserud et al., 2002). Enrich (2017) shared that EMS personnel have reported they are being put into difficult situations where they would not have been in the past. Enrich concluded that this is due to police officers being busy with other calls and are unavailable to respond when needed. There is a gap in the literature due to the limited amount of research that focuses on the specific experiences of EMS personnel. Specifically, there is a gap on how these

experiences of violence affect the way EMS personnel approach the incident scene and how they interact with patients and bystanders when they reach the scene.

Purpose of the Study

The purpose of this qualitative phenomenological study was to understand EMS personnel's lived experiences and perceptions of violence towards them by patients or bystanders at the response scene and how they characterized their experience of violence. I explored how these experiences affected the way EMS personnel approached these scenes and how they interacted with the patients and bystanders at these scenes. An interpretative phenomenological analysis (IPA), which is a detailed examination of a person's lived experiences (see Smith & Osborn, 2015) was conducted for this study. Interviews were conducted with nine EMS personnel after saturation was met. EMS personnel in the following states: Iowa, Minnesota, Nebraska, and Wisconsin. I conducted the interviews to explore how experiences of violence affected the way EMS personnel respond to the incident scene and how it affected the way they treat the patients and bystanders at these scenes. The research topic is unique and adds to the literature by identifying the lived experiences of EMS personnel who are subjected to violence within the Midwest and how this affects the way they approach scenes and treat patients and bystanders.

Research Question

RQ 1: What are the experiences of EMS personnel who are victimized by violence from patients and bystanders?

Subquestion 1: How do experiences of patient and bystander violence affect the way EMS personnel approach the incident scene?

Subquestion 2: How do these experiences of violence affect the way EMS personnel interact with the patients and bystanders on scene?

Theoretical Framework

The theoretical base for this study was the constructivist self-development theory. This theory looks at the perceptions and experience of individuals that have been through a trauma (McCann & Pearlman, 2015). It looks at the experience of victims of traumatic events and identifies that victims are "colored by their salient, preexisting schemas" (McCann & Pearlman, 2015, p. 292). Common responses of a person who was exposed to a violent crime tend to feel a sense of "violation to their self, feelings of inequity, perception of oneself as deviant, and a loss of a sense of safety and responsibility" (McCann & Pearlman, 2005, p.292). This theory looks at a person's previous trauma history and how their past experiences shape their current experiences of being victimized. This theory is described in more detail in Chapter 2. The constructivist self-development theory was relevant to the study because it guided my research in understanding the experiences of the EMS personnel who are victimized by others. Specifically, this theory helped to guide my research in understanding how this affected the way EMS personnel respond to incident scenes and how they treated bystanders and patients.

Nature of the Study

The nature of this study was a qualitative approach. Qualitative research is consistent with understanding the lived experiences of EMS personnel who are victimized by violence. IPA was used for the research. IPA aims to provide an account of lived experience in its own terms rather than one that has been suggested by pre-existing theoretical presumptions and it "recognizes that this is an interpretative endeavor as humans are sense-making organisms" (Smith & Osborn, 2015, p. 41). Interviews of EMS personnel who had experienced violence while on duty helped identify and measure the phenomenon of my study, which was the lived experiences of EMS personnel and how these experiences affect the way they respond to the incident scene and how they treat the patients and bystanders at these scenes. The targeted number of interviews with EMS personnel was initially 10-12, but saturation was reached after nine interviews.

Definitions

EMS personnel: Include first responders, paramedics, prehospital medical employees, such as field nurses, and emergency medical technicians (EMT) (Reemst, 2016).

Socioeconomic status: The social standing or class of an individual or group. It is often measured as a combination of education, income, and occupation (American Psychological Association, 2020a).

Trauma: Any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting

negative effect on a person's attitudes, behavior, and other aspects of functioning (American Psychological Association, 2020b).

Violence: The World Health Organization (2020) defined violence as "intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (p. 1).

Assumptions

I recruited participants through their chiefs or captains by having them send out an email that I wrote to their employees. In this email, my contact information was given for these participants to contact me directly. I asked participants to self-report their own experiences of violence towards them to determine eligibility to participate in the study. My primary assumption was that all participants answered my interview questions as honestly as possible. I also assumed that the study would add to the existing literature on this topic and would be of value to interested parties and agencies.

Scope and Delimitations

The purpose of this study was to understand EMS personnel's lived perceptions and experiences of violence towards them by patients or bystanders at the response scene and how this violence affected their attitude and relationship toward their patients. Participants must have experienced some form of violence towards them, (i.e., physical, verbal, psychological) and must work in cities in the Midwest United States. I chose this specific topic to better understand the experiences of EMS personnel who have been victimized and how this experience contributed to the way they treat their patients. I used

an interpretative qualitative approach because a quantitative approach would not allow for a thorough understanding and explanation of participant's live experiences.

Due to the focus of my study being about violence towards EMS personnel in Midwest urban cities, participant inclusion was based on those that work in the geographical area of the Midwest and participants that have experienced some form of violence towards them while on a call. If they were outside of the Midwest cities or were working in Midwest cities but had never experienced violence towards them, then they were excluded from the study. Only licensed EMS personnel were used which excluded any interns or ride-along students due to them not being actual employees of the ambulance service. Both men and women were included in this study as both genders may experience violence towards them while on shift. However, only male EMS personnel reached out to participate.

I used the constructivist self-development theory as the theoretical foundation in this study after considering the lifestyle exposure theory and the grounded theory. Lifestyle exposure theory suggests that a person or persons with certain demographic profiles are more likely to experience victimization because their lifestyles can put them in a risky situation (Madero-Hernandez, 2019). This theory describes how one's lifestyle poses a risk for victimization, but it excludes to identify individuals that work in certain environments as well as the individual's perceptions and experiences of being subjected to violence while at work. I would have only used grounded theory if I would have immersed myself in the daily lives and routines of the participants to collect data and themes. The constructivist self-development theory was chosen due to the theory being

used as looking at the perceptions and experiences of individuals that have been through a trauma (see McCann & Pearlman, 2015).

The transferability of the qualitative research findings can be limited. The findings may only be relevant for the specific populations in the study including the geographical area that the participants work in. Even when other EMS personnel with similar characteristics are chosen for a similar study, EMS personnel living in different locations or urban/rural settings may offer different responses to the research questions being asked. However, the findings of this study may be useful for future research in this topic to potentially identify the different themes and experiences EMS personnel have in different settings and how this affects the way they interact with their patients. The findings of this study may not be relevant to EMS personnel that work in rural environments as their exposure to certain populations may be limited.

Limitations

Different challenges and/or barriers that could have come up during this research study could have been a limited access to research participants. I was in touch with different chiefs and captains that expressed willingness to help me identify EMS personnel that have been exposed to violence. However, nine participants reached out to participate in the study which was sufficient for the research topic. Another limitation of a qualitative study is how time consuming the interview and coding process may be. Since I completed interviews with EMS personnel from different states in the Midwest; this could have caused a problem with getting the interviews done in a timely manner.

However, I was able to set up interviews well in advanced and only two of the participants needed to reschedule but they were all ultimately done in a timely manner.

Significance

The research study contributes to the literature by identifying how EMS personnel respond to incident scenes based on their prior experiences with violence during their work as EMS professionals. Further, the research study also identified how this violence affected the way they treat bystanders and patients at the incident scene. Much of the literature on violence towards EMS personnel is quantitative and does not consider how being exposed to violence affects the way they do their job. For example, Maguire and O'Neill (2017) found that assault rates amongst EMTs and paramedics in the United States were twice as high as the national average for all other occupations. The BLS has also reported that the overall injury rate for EMTs and paramedics was three times higher than the average rate for all other occupational groups in the United States (Maguire & O'Neill, 2017). These statistics can help identify that EMS personnel are experiencing violence in the workplace, but these statistics cannot show how this affects them when responding to calls.

The results of this study could provide much needed insights into the lived experiences of EMS personnel who have experienced prior exposure to violence towards them by bystanders and patients. There is a lack of knowledge and skill on how to prevent violent attacks on EMS personnel (Taylor et. al, 2016). Some countries, such as Canada and the United Kingdom, have placed signs in the back of their ambulances to state that it is a felony to assault a peace officer (Taylor et. al, 2016). Some cities in

Texas flag certain dispatch scenes to alert EMS personnel if the incident scene is the location of a previous patient-initiated violent injury (Taylor et. al, 2016). The study results could help state and local governments develop different policies within their jurisdictions by identifying EMS personnel's experiences of violence towards them and how this may affect the way they conduct themselves at response scenes. Within the EMS system, the EMS director could benefit from this research by implementing different safety protocols, such as bullet-proof vests, signs in their ambulances, and/or overall education on how to manage violent situations.

Summary

In Chapter 1, a background of the study and the problem and purpose statements were addressed. I outlined the study's theoretical foundation, nature, research questions, assumptions, scope and delimitations, limitations, and significance to ensure a basic understanding of the research topic. I also provided definitions of special terms to help specify how these terms relate to the study. Chapter 2 contains a review of the existing literature that is related to my study. This literature review shows the need for further research that provides a better understanding of the perceptions and experiences of EMS personnel who have been victimized by patients and/or bystanders and how this affects patient care.

Chapter 2: Literature Review

EMS personnel are subjected to violence and trauma every day. Some of this violence comes from the patients that they work with or the bystanders and family members at the scene of the incident. Much of the research and literature on violence towards EMS personnel is quantitative and does not consider how being exposed to violence affects the way that they do their jobs. The problem addressed in this study is that EMS personnel in the United States are assaulted twice as often as the national average for all other occupations (Maguire & O'Neill, 2017). OSHA, identified that there are many reasons as to why health workers are at a higher risk of being victimized, which include mentally ill patients, poor communication, limited back-up support, gang activity, and increased prevalence of handguns in the community (Maguire, O'Neill et al., 2018). The purpose of this study was to understand EMS personnel's lived perceptions and experiences of violence towards them by patients or bystanders at the response scene and how this affects the way EMS personnel approach these scenes and how they interact with their patients and bystanders at these scenes. The research topic is unique and adds to the literature by identifying the lived experiences of EMS personnel who are subjected to violence within the Midwest and how this affects the way they approach scenes and treat patients and bystanders.

In Chapter 2, I review literature that helped create the foundation of this study, including information relevant to the topic, population, theory, and phenomenon. It begins with an overview of the literature search strategy, including databases searched and key terms and topics that were used to help direct the search. I review peer reviewed

journal articles, scholarly works, books, and online resources that have helped develop this study. Next, I discuss the theoretical framework and a definition of the constructivist self-development theory and how this concept was applied in previous studies as well as how it relates to the current study. I discuss the literature review which includes sections based on common themes and current and past studies on the topic. Chapter 2 concludes with a synthesis of the reviewed literature, how it is relevant to my current study, and how the findings from this current study would address the gap in the literature.

Literature Search Strategy

Literature searches were conducted using Boolean indicators. The following search terms were used: *body armor, constructivist self-development theory, emotional and verbal abuse, EMS personnel, gang violence, injury, incident scenes, IPA, physical violence, population, prehospital violence, urban community, victimology, violent bystanders, violent patients,* and *workplace violence and aggression.* I used relevant literature, such as books and peer-reviewed journals, that were published between 2012-2022 from several disciplines including psychology, criminology, and healthcare. One of the articles was published in 2002 but was used to help discuss access to body armor and protection from 2002 to present. I also reviewed doctoral dissertations. The primary databases used were EBSCOhost, PsychARTICLES, PscyINFO, SAGE journals, Thoreau Multi-Database Search, and Google Scholar.

Theoretical Foundation

The constructivist self-development theory (CSDT) suggests that individuals construct their own personal realities based on their interactions with their environment

(Lee, 2017). In other words, this theory looks at a person's previous trauma history and how their past experiences shape their current experiences of being victimized. CSDT focuses on three major psychological systems: (a) the self (knowing one's self and engaging in capacities to regulate self-esteem and one's ego to help engage in relationships with others), (b) Psychological needs (which motivates behaviors), and (c) cognitive schemas (which helps a person interpret their experiences; McCann & Pearlman, 2015). When a person is presented with new information from their environment that cannot assimilate into existing schemas, the individual's cognitive schemas are modified to help accommodate the new reality (McCann & Pearlman, 2015). CSDT can be used to explain why some people experience traumatic events differently than others. For example, if a first responder is physically assaulted by a patient, their reality of what happened may be interpreted different than their partners who had to witness this traumatic event on their partner.

CSDT not only looks at the person who is the primary target of the trauma but also individuals that are involved in this traumatic event second hand (Lee, 2017). For example, first responders may be traumatized by their patient's stories and injuries. The first responders may start to develop their own understandings of the behaviors presented to them which can in return cause them to express emotional responses of anger, bitterness, numbness, fear, and decreased empathy for others both in their personal and professional aspects of their lives (Lee, 2017). I used CSDT to guide my understanding of the experiences of the EMS personnel who are victimized by others. Specifically, this

theory helped me to understand how this affects the way EMS personnel respond to incident scenes and how they treat bystanders and patients.

Literature Review Related to Key Variables and Concepts

The literature review was structured around six key variables and themes that were relevant for this study. These themes were physical assaults, verbal assaults, patient assaults, bystander/family member assaults, psychological impacts, and approaching scenes and patients. The section on patient assaults and bystander/family member assaults is about the main perpetrator of assaults on EMS personnel and how these assaults affect EMS personnel's interaction with their patients. Within the physical and verbal assault sections, different studies and statistics are reviewed to identify the types of assaults EMS personnel are subjected to and how this may have impacted them, especially when they are approaching the incident scenes. The section on psychological impacts is about how previous experiences of violence or witnessing violence affects EMS personnel on a more psychological level and how this affects their interaction with patients and how they approach incident scenes.

Physical Assaults

The World Health Organization (year) defined physical violence as "physical violence refers to the use of physical force against another person or group, that results in physical, sexual, or psychological harm. It can include beating, kicking, slapping, stabbing, shooting, pushing, biting and/or pinching, among others" (Maguire et. al, 2018, p. 1260). Further, OSHA defined workplace violence as "violent acts (including physical assaults and threats of assaults) directed towards persons at work or on duty" (Reemst &

Fischer, 2019, p. 1865). Reemst (2016), in a study about variations in workplace violence experienced by EMS, identified five types of workplace violence, specifically for EMS personnel, which included verbal aggression (name calling and yelling), physical aggression, threats and intimidation, sexual intimidation, and discrimination (including negative comments on skin color, age, or sexual preference). For the purpose of this section, physical assaults will be described, as verbal and psychological assaults will be reviewed further in the review.

Furin et al. (2015) completed a cross-sectional work safety survey of EMS personnel in a two-tiered, urban EMS system in New England, which responds to over 100,000 calls a year. In total, there were 196 respondents who completed the survey. Furin et al. sought to identify the types of physical and verbal assaults on EMS personnel and if they reported these assaults to the police or had to seek medical attention. Physical assaults represented 21% of violent acts and overall, 80% of the participants reported that they have been assaulted while at work. Forty percent reported that they went to the hospital because of these assaults and 49% stated that they reported the assault to the police (Furin et. al, 2015). Furin et. al found that more than two-thirds of EMS professionals in an urban system have feared for their safety at work, and more than three-quarters of providers have been assaulted while at work.

Brophy et al.'s (2018) research also supports the previous study by stating that roughly 26% of the participants in their survey have been subjected to physical assaults. A survey of 56 paramedics in Ontario and Nova Scotia found that 75% have experienced some form of workplace violence where 26% was physical assaults (Brophy et. al, 2018).

Further, Maguire and O'Neill (2017) supported that both fatal and nonfatal injuries are results of an assault on EMS personnel. Maguire and O'Neill analyzed 1630 violence-related injury cases on EMS personnel. The results indicated that 70 of the violence cases resulted in fractures, 20 were dislocations, more than a third resulted in sprains, strains, or tears, and 13% resulted in surface wounds and bruises (Maguire & O'Neill, 2017). In 33% of the cases, the EMS personnel stated the violence towards them was unintentional, such as an individual assaulting them while having an epileptic seizure, and in 35% of the cases, EMS personnel described their injuries as being intentional, such as an individual robbing EMS personnel for their drugs or money (Maguire & O'Neill, 2017).

Maguire, O'Neill et. al (2018) conducted a study with 1,778 EMS personnel from 13 different countries. Out of the 395 respondents who indicated that they received a violence-related injury during the previous 12 months, almost 80% received bruises and contusions (Maguire, O'Neill et. al, 2018). Of the remaining respondents, some received fractures, stab/puncture wounds, and an amputation. Kang et al. (2021) conducted a study of 141 paramedics in emergency departments. 28% of their participants reported experiencing some form of physical violence, such as being punched, hit with a thrown object, and grabbed by a patient. Respondents in another study conducted by Suserud et al. (2002) identified that 80.3% of their 66 respondents have been exposed to violence. The participants of the study described different examples of physical violence that has been done to them included being dragged by the hair, kicked on the legs, pinched on the arms, being hit with a fist, slapped on the face, kicked, hit on the upper part of the body, and being grabbed by the throat (Suserud et al., 2002).

Erich (2017) described multiple examples of extreme physical and fatal violence in his study on vested interests and if EMS agencies should invest in body armor. In January 2016, an EMS personnel responded to a call about a possible overdose. The patient was startled awake by this EMS personnel and fired multiple gun shots at the paramedic, who later died at a local hospital. During an incident in San Diego in 2015, two EMS personnel were stabbed multiple times by a bystander who was becoming agitated that the scene. In 2004, a female paramedic in Kansas City was shot twice in the chest while responding to a house fire. EMS personnel in Detroit were cut by a knife on both their hands and face whereas a Dallas paramedic was shot in the arm and leg and nearly died due to a nicked artery (Erich, 2017). Due to these increased concerns, many agencies and EMS personnel are purchasing body armor for their protection. Forty-four percent of responding EMS agencies have verified that they have either purchased body armor for their personnel or were planning on buying it (Erich, 2017). Different cities, like Cleveland and Orlando, mandate the use of body armor at all times due to different active shooter and violent situations that they frequently encounter (Erich, 2017). However, body armor does not always protect against certain situations, like slashing, kicking, hitting, or biting, and it must be practical for EMS personnel to effectively do their jobs.

Verbal Assaults

Verbal assaults or threats are the most common forms of workplace violence (Kang et. al, 2021). While verbal abuse may be considered as less severe than physical violence, researchers have identified that this isn’t always the case. Oliver and Levine

(2015) surveyed 1,900 EMS personnel who worked in different geographically areas. Sixty-seven percent of the respondents reported that they have been cursed at or threatened by a patient or family member/bystander. They also discovered that male EMS personnel and those who worked in an urban environment were more likely to be threatened or verbally assaulted from their patients or bystanders (Oliver & Levine, 2015). The researchers concluded in their study on workplace violence that individuals who have experienced verbal abuse were more likely to report poor general and mental health.

Suserud et al. (2002) conducted a study where 53 EMS personnel completed a questionnaire on workplace violence. The aim of the study was to describe how EMS personnel perceive how they are subjected to and are influences by threats and violence in their day-to-day work environment. Seventy-eight percent of the respondents identified that the most common form of threats and violence was the use of "threatening invectives including verbal threats such as threats of violence, threats of reporting, and threats of reprisals against close relatives" (Seserud et al., 2002, p. 130). Comments made to EMS personnel revolved around threatening to beat them up and threatening to come after them and making them watch while they would kill their family.

Tay et al. (2021) surveyed 246 paramedics who were both verbally and physically assaulted while on duty. The researchers of the study discussed how paramedics reported that most of the people who verbally abused them did so due to being in physical pain or under the use of substances. The types of verbal violence included the use of offensive

language and yelling or screaming by the patient and family members on the scene (Tay et. al, 2021). These scenarios will also be evident throughout Chapter 4 of my study.

Patient Assaults

For EMS personnel and healthcare workers, external workplace violence occurs more frequently by people outside the organization, such as patients, intruders, and citizens in general (Reemst, 2016). EMS personnel have a relatively high risk of experiencing violence at work because of the frequent contact with citizens, the negative emotions an emergency may cause to the citizens or patients involved, and the variety of citizens they deal with, including citizens who are more likely to be offenders such as those under the influence of drugs or alcohol and mentally ill patients (Reemst, 2016). Patient assaults are more prominent than both bystander and family assaults on EMS personnel. Maguire and O'Neill (2017) conducted a study based on the BLS findings on violence-related injury of EMS personnel between 2011 and 2015. There were roughly 1,900 EMS personnel that had a violence-related injury. In 77% of these cases, the source of the injury was identified as the patient themselves (Maquire & O'Neill, 2017). Maguire and O'Neill also identified the nature of the injuries and the event that was taking place during the injury.

Brophy et al. (2018) conducted a descriptive qualitative research approach to explore the phenomenon of violence against healthcare staff in Ontario and Nova Scotia. Similarly, to Maguire and O'Neill's (2017) study, Brophy et. al concluded that most violence-related assaults on healthcare workers were due to their patients. They identified different risk factors such as people being under the influence of drugs or alcohol, being

in severe pain, having a history of violence, suffering cognitive impairment, or having certain psychiatric diagnoses (Brophy et. al, 2018). Maguire, O'Neill et al. (2018) supported the findings by Brophy et. al by identifying that a lot of the violence-related injuries on EMS personnel are caused by patients with alcohol or drug addictions and/or mental health issues. Maguire, O'Neill et. al surveyed 1,778 EMS personnel using a previous survey developed by the World Health Organization. This allowed for the researchers to conduct surveys with EMS personnel from 13 different countries. The EMS personnel in the study also identified that being in "bad" parts of town was another reason they were being assaulted by their patients. They identified a variety of weapons that patients have used to attack EMS personnel which range from firearms to household items such as kitchen knives (Brophy et. al, 2018).

Another study conducted by Oliver and Levine (2015) further supports that violence related injuries occur due to the patients that EMS personnel treat, such as addicts, criminals, cognitively impaired, and mental health issues. Data used for this research study was obtained from the 2,000 LEADS study which was a 10-year project that began in 1998. Sixty-Seven percent of the 1,900 respondents claimed that themselves or their "partners had, at one time or another, been subjected to threats and/or physical violence from patients" (Oliver & Levine, 2015, p. 7). Patients with weapons is becoming a more common problem for EMS personnel and 62% of the EMS personnel who routinely searched their patients had found weapons on them (Oliver & Levine, 2015). A study by Suserud, Blomquist, and Johansson (2002) conducted an empirical descriptive study to use to describe how EMS personnel perceive, how they are subjected to, and are

influenced by, threats and violence in their daily schedules at work. The study was based on 13 questions in a questionnaire. They had 66 respondents to this study and the researchers identified that 80.3% of EMS personnel were subjected to threats and/or violence from their patients. Seventeen percent of the respondents identified being threatened with some form of a weapon (Suserud et. al, 2002). Even though this study is older, it shows that violence-related injuries due to patient assaults continues to be a major problem for EMS personnel over the years.

Studies completed by Furin et. al, (2014) and Taylor et. al, (2016) continue to support the findings of the previous studies mentioned. Furin et. al (2014) identifies that EMS personnel are often outnumbered by patients and bystanders/family members on the scene which can increase the likelihood that they may be assaulted by either a patient or family member. Taylor et. al (2016) found that a majority of EMS personnel who experience violence-related injuries are due to their patients. They identified underlying factors such as violent patients, patients with mental health issues, and patients with particular conditions such as dementia or seizures (Taylor et. al, 2016).

It is important to note that not all patient assaults are intentional, which is why most of the studies identify different underlying factors that may cause a patient to become assaultive. Patients who are mentally ill, have an addiction problem, have dementia, or who may be having a seizure may act out violently during these incidents. These types of assaults are important to discuss as they create unsafe situations for EMS personnel treating these patients. For example, paramedics were called to assist with a person who swallowed pills in an attempt to commit suicide. The person was not

susceptible to any contact when they arrived at the scene, but the patient suddenly gains consciousness and pulls out a gun and aims it at the paramedics (Suserud, 2002). Emergency calls that initially do not appear to involve violence may escalate at any moment which is why EMS personnel need to be prepared for all types of situations and patients.

Bystander/Family Member Assaults

Even though patient assaults are more prominent than bystander or family member assaults; EMS personnel are still threatened or assaulted by these individuals as well (Taylor et. al, 2016). During one incident in 2015, firefighters and EMS personnel responded to a scene in San Diego, CA for an intoxicated man down. Initially the scene was calm, until a bystander became agitated and pulled a hunting knife on the EMS personnel. This bystander stabbed the EMS personnel twice in the back and when his partner tried to help him the bystander stabbed him three times (Erich, 2017). Maguire, O'Neill et. al, (2018) conducted a study to identify the risks and factors associated with violence against EMS personnel internationally. 1,778 EMS personnel from 13 different countries participated in this survey, however, most of the respondents were from the United States. When the participants were asked about the type of person that was violent, only 31 (5%) of the 631 participants who answered this question were bystanders or family members. There are also different studies completed by researchers that confirm that bystander/family violence is less likely to occur than patient violence. Researchers such as Grange (2002) and Gerberich (2004), both support this finding by

identifying that only 10% and 3% of their cases have identified violence by bystanders or family members respectively (Maguire, O'Neill et. al, 2018).

However, countries that are less developed or have higher crime rates seem to have more bystander and family member assaults than patient assaults. For example, Hosseinikia et. al, (2018), conducted a survey with 206 EMS professionals in different providences of Iran. Violence against the EMS personnel at the scene were caused by patient's relatives (48%) and other people at the scene (47%) (Hossinikia et.al, 2018). The researchers concluded in this study that assaults by bystanders or family members may be higher in these regions due to cultural differences between the EMS personnel and the bystanders on scene. However, this study is similar to studies conducted by Wolfberg and Wirth (2015) and Maguire, O'Neill et. al, (2018). Wolfberg and Wirth and Maguire, Browne et. al, all support that violence towards EMS personnel are heightened when they enter certain neighborhoods. Neighborhoods with high crime rates, lower income, and gang involvement increase their chances of being assaulted, including higher chances of being assaulted by bystanders and/or family members (Maguire, Browne et. al, 2018).

As stated in the previous section on patient assaults; Brophy et. al (2018), conducted a descriptive qualitative research approach to explore the phenomenon of violence against healthcare staff in Ontario and Nova Scotia. The authors of this study did not just look at patient assaults, but they also reviewed bystander and family member assaults on EMS personnel. Brophy et. al (2018) stated that because members of the public are unpredictable, patients, their families, or visitors are potential sources of

violence. During one incident, a patient's family member came up to them with a wooden club because he didn't feel like the patient was getting enough care (Brophy et. al, 2018). Another example from this article is when a patient was being transported to the hospital and the patient's husband became combative and began to push and hit the paramedic (Brophy et. al, 2018).

Suserud et. al (2002) completed an empirical descriptive study where the aim of the study was to identify how EMS personnel experience threats and violence while they are at work. Of the 66 respondents of this study, 80% identified that violence from relatives or other persons present at the response scene, affected the patient/paramedic relationship. These EMS personnel have identified that it is difficult to concentrate on or care for a patient if they have people beside them threatening to harm them. During these situations, the paramedic tends to pay more attention to their surroundings instead of what is going on with the patient (Suserud et. al, 2002).

Psychological Impacts

After reviewing both verbal and physical assaults, along with whom is responsible for committing these assaults, a review of the psychological impacts is necessary. Due to verbal threats and assaults, many EMS personnel struggle with feeling like they are able to provide their patients with the appropriate care due to the psychological impacts that verbal threats and violence can have on them. Violence towards EMS personnel does not always have to be physical, but it can lead to psychological trauma as well. Even though physical assaults can be traumatic, research has shown that EMS personnel and hospital employees need more ongoing support for nonphysical assaults, which can cause

"frustration, anger, stress, fear, and anxiety" (Brophy, Keith, & Hurley, 2018, p. 584). Brophy et. al (2018) conducted a study on fifty-four healthcare workers in Ontario, Canada. The researchers focused on the healthcare workers experiences and ideas that they had on violence towards prehospital and hospital workers. The researchers concluded that witnessing a violent crime or incident can have extensive long-term effects on EMS personnel and other medical employees. Some of the participants described how their lives have changed due to having PTSD from the incident and how this not only affected them but their families. The participants described cumulative stress, negative impacts on family, feeling violated, being fearful, never feelings safe, and feeling helpless (Brophy et. al, 2018). Many healthcare workers also take their stress and fear home with them which can result in poor familial relationships.

Taylor et. al (2016) compiled research on patient-initiated violence towards EMS personnel. They used a convergent parallel mixed method design to use multiple databases and semi-structured interviews to identify potential EMS personnel who have experienced some form of violence while they were on duty. They identified that many of the participants spoke about feeling defensive, anxious, and detached after witnessing or being involved with a violent encounter. This claim supports Brophy et. al's (2015) claim on the types of emotions one may feel after experiencing a traumatic or violent encounter. EMS personnel may continue to be fearful which could overall impact the way that they do their jobs. Taylor et. al (2016) identified that many EMS personnel may not report the violent or traumatic event due to not wanting to look vulnerable and not wanting to relive the event.

Reemst (2016) used theoretical frameworks to help her study variations in workplace violence experienced by emergency responders. She used different criminal opportunity theories, external workplace victimization theories, and victim blaming theories. Reemst also supports the claims in previous studies in this literature review, stating that experiencing workplace violence may result in feelings of "distress, emotional exhaustion and burnout symptoms, insecurity, sickness, turnover intentions, and injuries or even death of professionals" (Reemst, 2016, p. 135).

The frequency and exposure to abusive and violent situations were among the top three stressors identified by EMS personnel highlights the need for prehospital providers to have access to counseling and psychological services for their stress and support (Oliver & Levine, 2015). As stated previously, Kang et. al (2021) mentioned in their study that the burnout rate of paramedics in emergency rooms was very high due to the psychological impact of being both physically and verbally abused has on the workers. Copeland and Henry (2017) completed 147 surveys on healthcare staff in a Level 1 Shock Trauma center. A majority of these participants (53%, n=78) identified that they didn't report any of the violent situations that they encountered where only 3% (n=5) of the participants stated that they reported all incidents. Some of the responses as to why they did not report the traumatic or violent experience were; it is part of the job, no follow-up on reports, nobody else reports incidents, reporting is not supported by management or administration, fear of retaliation from management, and being perceived as weak by their peers (Copeland & Henry, 2017). Brophy et. al (2018) supports that filing a report on violent attacks not only have serious physical implications but

psychological repercussions as well. Many participants consider trauma and violence as part of their jobs and some report that they get questioned by management on what they did wrong to get assaulted. Being blamed by management or your peers can evolve into self-blame and self-doubt which can have a significant psychological impact on EMS personnel as well.

Approaching Scenes and Patients

The final key variable and concept of this literature review is identifying how verbal, physical, and psychological violence by the patients or family/bystanders impacts the way that EMS personnel approach incident scenes and their patients. The public calls upon EMS personnel to respond to a variety of emergency situations in many different environments. Because EMS personnel are often sent to the front line, this group of professionals has specific risks of experiences trauma while performing their duties (Reemst, 2016). Due to the increased sense of fear of assault, some EMS personnel have changed their attitudes toward patients and families, and they are sometimes hesitant to intervene in certain circumstances (Furin et. al, 2015). At times, EMS personnel have reported that patient care can be affected if providers become impaired by their lack of sense of personal safety (Furin et. al, 2015). If EMS personnel are concerned about their own safety while on an incident scene, then they are unable to focus on their patient.

In the research study conducted by Suserud et. al (2002), 52 out of the 53 EMS personnel identified that threats and violence affects the patient relationship and 51 of the participants identified that threats and violence from bystanders and family also affects the patient relationship. One participant stated “yes, it does of course affect the situation

if someone is in a threatening state, you sort of keep your distance, and you absolutely don't do any uncalled-for examinations on the patient" (Suserud et. al, 2002, p. 131). However, many of the participants identified that some of these patients are in shock or are mentally unwell which is why they tend to overlook the violence towards them by these patients. They concluded that the easiest group to tolerate threats from was senile-dementia persons and stated that this didn't affect the patient/provider relationship as much as other patient or family/bystander violence towards them did (Suserud et. al, 2002).

In Taylor et. al's (2016) study on violence towards EMS personnel, the researchers interviewed one female paramedic who described how her interactions with patients have changed after experiencing a violent encounter. She identified that she doesn't get close to patients that she feels can become combative. The female paramedic stated that she sits behind the patient with the monitor sideways, straps them in, and sits by the side door of the ambulance in case she needs to get out quickly. This change in approach can have implications for the quality of care that EMS personnel provides towards their patients. Another participant in the study identified that he is always thinking about the violent incident and how his perception towards patients and the way he does his job is different and more cautious.

Overall, EMS personnel have identified that due to working in uncontrolled and sometimes isolated work environment, being in contact with the public and people in distress and possessing valuable equipment such as drugs and needles causes them to be more hesitant when they approach incident scenes in different neighborhoods (Maguire,

O'Neill et. al, 2018). EMS personnel have identified that they don't go into certain neighborhoods without the support of the police. However, many EMS agencies identified that they cannot just stay out of a particular neighborhood due to past incidents of violence (Wolfberg & Wirth, 2015). EMS personnel still approach these incident scenes and patients but tend to be more hesitant or change their approach based on their previous experiences with violence and trauma.

Summary

The six key variables and themes in the literature review, physical and verbal assaults, patient and bystander/family assaults, psychological impacts, and approaching incident scenes and patients, all focused on the experiences and perceptions of EMS personnel from around the world that work in different areas. According to the research provided, verbal assaults are deemed to be more prominent than physical assaults, but both can leave a lasting psychological impression on EMS personnel. Throughout the literature review, different research articles were provided to help gain a general overall view of violence towards EMS personnel and how they perceived this violence. The literature review contributes to the study on violence towards EMS personnel by identifying the types of violence experienced and the types of individuals who commit these forms of violence.

However, there is limited research on EMS personnel and how they approach incident scenes and their patients different after being victimized or witnessing violence. There is also limited research done on this topic with EMS personnel from the Midwest United States. To help build upon the limited research, the constructivist self-

development theory (CSDT) was utilized to help guide the research topic in understanding how violence affected the way EMS personnel responded to incident scenes and how they treated their patients. Further, an interpretative phenomenological analysis was used to provide detailed examinations of EMS personnel's lived experiences. These methods and strategies helped provide a better understanding from the perspective of EMS personnel, on how violence affected them and the way they approached incident scenes and/or their patients.

Chapter 3: Research Method

The purpose of this qualitative phenomenological study was to understand EMS personnel's lived experiences and perceptions of violence towards them by patients or bystanders at the response scene and how they described their experience of violence. I also explored how these experiences and perceptions affected the way EMS personnel approached these scenes and how they interacted with the patient and bystanders at these scenes. The study participants were adult men who are EMS personnel in urban cities in the Midwest who have experienced some form (physical, verbal, or psychological) of violence towards them while on duty. In this chapter, I discuss the research design and rationale, my role as the researcher, the study of methodology, trustworthiness of the study, ethical concerns, and finally data collection and analysis procedures.

Research Design and Rationale

I used a qualitative interpretative phenomenological approach to fully explore the lived experiences and perceptions of EMS personnel who have experienced violence towards them while on duty and how this violence has affected the way they approach incident scenes and interact with their patients. One research question, including two subquestions, guided my study and were used as a foundation to help understand the phenomenon being studied.

RQ 1: What are the experiences of EMS personnel who are victimized by violence from patients and bystanders?

Subquestion 1: How do experiences of patient and bystander violence affect the way EMS personnel approach the incident scene?

Subquestion 2: How do these experiences of violence affect the way EMS personnel interact with the patients and bystanders on scene?

Phenomenology is a "collection and analysis of people's perceptions related to a specific, definable phenomenon" (Dawidowicz, 2016, p. 203). Traditionally there are two main types of phenomenology that are practiced: descriptive and interpretive. For the purpose of my study, an IPA style was used. IPA recognizes that the researcher is trying to make sense of the participant who is trying to make sense of what is happening to them (Smith & Osborn, 2015). IPA also aims to provide an account of lived experiences in its own terms rather than one that has been suggested by pre-existing theoretical presumptions (Smith & Osborn, 2015). Completing interviews with EMS personnel can give researchers a better understanding of the experiences and perceptions of violence towards them while on duty. The goal of IPA is not to reduce these experiences into patterns and themes, like in descriptive phenomenology, but to allow the researcher to look at the psychological and/or sociological factors that influenced the way that the participants responded to the phenomenon (Dawidowicz, 2016). Since the purpose of my study was to understand the experiences and perceptions of EMS personnel who have been victimized while on duty and how this affects the way they approach scenes and patients, an IPA was best suited for this study.

Role of Researcher

In phenomenology, the role of the researcher is to gather, organize, and analyze the experiences and perceptions of the participants that have experienced the phenomenon (Dawidowicz, 2016). I was the sole interviewer and data collector which

helped prevent any variation in the different interview styles and data collection techniques (see Ravitch & Carl, 2016). I also conducted individual interviews with each participant as phenomenological studies derive their themes and data from individual experiences (see Crawford & Knights, 2016). My role was to develop interview questions, interview each participant separately, and comprise and interpret the data in order to gain a better understanding of the participants' perceptions.

Researcher bias has the potential to alter the data that is being collected during interviews as well as during the interpretation and analysis phase (Dawidowicz, 2016). Participants could change their answers based on how they perceive the researcher is reacting or showing bias. To help prevent this, Dawidowicz (2016) recommended researchers limit facial expressions and gestures, avoid leading questions, allow participants to skip questions with which they are uncomfortable, and avoid sharing personal stories or stories about other participants. During data collection, I used bracketing prior and after each interview, so I could write down my own thoughts and impressions while recording and/or analyzing the data to recognize my own personal influences of the researcher and how this may alter my data (see Dawidowicz, 2016). Chenail (2011) identified that a researcher should acknowledge their own biases, use a researcher journal to record their own reflections, and have a colleague interview the researcher, which is called interviewing the investigator. Interviewing the investigator allows for the researcher to assume the role of the participant and to record this interview to see what type of information could be gathered from the questions asked. However,

even though this is one technique that can be used, for the purpose of my study, I did not use this method.

My spouse is a fireman and paramedic in Iowa which could have caused some researcher bias. To help limit this bias, I did not interview any EMS personnel from his department or any people that he or I knew. I maintained reflexivity, which is the constant assessment and awareness of personal positions, beliefs, and biases during the research process (see Ravitch & Carl, 2016), by preparing my questions with my dissertation chair to gain institutional review board (IRB) approval. I also wrote down my own perceptions before and after each interview to help prevent showing any of my potential biases during the interview process. I continued to discuss my interviews and data with my dissertation chair to prevent researcher bias as well.

Methodology

Participant Selection Logic

Participation in the study was offered to both men and women EMS personnel from different cities in the Midwest that included Iowa, Minnesota, Nebraska, and Wisconsin. However, even though women had the opportunity to participate in the study, only men responded. The study participants needed to have experienced some form of violence or witnessed violence towards them or their partners, while on duty to be able to participate in the interviews. I contacted the chiefs and/or captains of the fire stations to discuss participant selection and an email I wrote was sent by the chief and/or the captains to their employees to see if any employees would like to participate in the study.

The email had my personal information in it, so they did not have to break confidentiality by going through their chief or captains to get my information.

I used purposive sampling, which is the primary sampling method used in qualitative research and it is used because individuals are purposefully chosen to participate in a research study for specific reasons that relate to the research questions (see Ravitch & Carl, 2016). As stated above I reached out to the different captains and chiefs in these cities, specifically those that focused on health and wellness, to help send out an email constructed by myself to EMS personnel that were willing to participate. I provided an email and my phone number for the interested participants to get a hold of me. I sent potential participants a letter explaining the study (informed consent), which explained the criteria that was needed to be eligible to participate in the study. They responded back to the consent form by stating that they consented and understood the study. They were also offered time to discuss the consent form with myself before agreeing to the study.

Sample size was determined by how quickly saturation was reached during the data collection process. Data saturation is reached when there is enough information to replicate the study and when the ability to obtain additional new information has been attained (Fusch & Ness, 2015). Therefore, for the purpose of this study, interviews were conducted with nine EMS Personnel due to saturation being met. Further, two to three participants per location was optimal for this study to ensure equal amounts of data were obtained.

Instrumentation

My role was to develop semistructured interview questions (see Appendix A) that included potential follow-up and subquestions to help organize and guide the interview with the participants. These semistructured interview questions were developed based on a comprehensive review of the literature along with questions that tie into my research question. Ravitch and Carl (2016) identified that interviews are important in qualitative research because it develops a full detailed description of a person's experiences and perspectives, it helps describe processes and experiences in depth, and interviews help bridge intersubjectivity between the researcher and the participant. One interview was conducted with each participant and the interviews usually lasted between 30-60 minutes. I made sure the participant was fully aware of the time frame of these interviews to ensure they had enough time to participate in them. The interviews were held via video conference but an option for telephone calls was made. The video conferences were audio recorded so they could later be transcribed using a qualitative-based software program, MAXQDA. After the interviews were complete, I used the qualitative-based software program and my notes of the interview to help analyze and code the data to identify specific themes.

Other researchers have also used semistructured interviews to explore topics that are related to workplace violence in the healthcare system. Dadashzadeh et. al (2019) used semistructured interviews to interview 19 male nurses to determine how they experience workplace violence and what strategies they believe could be implemented to help decrease workplace violence. Morphet et. al (2019) conducted semistructured

interviews with health care managers to understand their perceptions of workplace violence and how they can better manage workplace violence against their staff. Forte et. al (2017) used semistructured interviews with healthcare employees, that are exposed to violence through psychiatric patients, to understand their experiences with workplace violence. Fernandes and Sá (2019) conducted semistructured interviews with firefighters to understand their experiences and perceptions of violence towards them from bystanders and patients while responding to crisis situations in the community. As stated previously, using this type of instrumentation allowed for a more thorough explanation of the lived experiences and perceptions of EMS personnel who were exposed to workplace violence.

Data Analysis Plan

Qualitative data can be obtained by completing many different strategies. These strategies may include interviews, focus groups, observations, and field notes (Rubin & Rubin, 2012). For the purpose of my study, single person semistructured interviews were used as this technique correlated the best with my research questions. I audio recorded these interviews and used a qualitative-based software program to help transcribe these interviews as well as took notes during the interviews. Once the interviews were transcribed, I began the coding process. The main analysis tool that was used is MAXQDA. This tool helped organize, code, and analyze the data, and provided visual representations of all the data together. Researchers use data coding to help capture the essence of the data (Saldaña, 2015). I conducted two rounds of coding by printing off the transcripts to help label and define the different codes, themes, and events (Rubin &

Rubin, 2012). MAXQDA was used as well to ensure all codes and data were represented. During the second round of coding, pattern coding can be completed to help look for certain patterns in the data which can further help identify more categories and themes (Saldaña, 2015). Once the coding process was done, cross-interview analysis happened to help identify common themes amongst different participants on their experiences of violence in the workplace. Data collection and analysis stopped once saturation was reached.

Issues of Trustworthiness

Credibility

According to Ravitch & Carl (2016), in qualitative studies, credibility also refers to internal validity. Internal validity is connected to the data and the instrumentation utilized in a qualitative study (Ravitch & Carl, 2016). Different forms of credibility techniques can be used such as triangulation, participant validation, member checks, reflexivity, peer review, and saturation. Reflexivity will be maintained throughout my study to help prevent researcher bias. I did this by writing down my potential biases before each interview and did not share any personal experiences or thoughts with the participant to ensure they did not feel like they needed to change their answers. Member checks or participation validation were used to ensure the participants understood the questions being asked and the data being recorded was accurate. I provided the participants a transcript of the data to ensure I did not miss or misinterpret the information they provided. Saturation will also be used to help stop data collection and coding when no new information is being reported or discovered (Saldaña, 2015).

Transferability

In qualitative studies, transferability refers to external validity. External validity refers to how the outcome of the study can be generalized and used across other types of situations and studies (See Ravitch & Carl, 2016). Different forms of transferability techniques that can be used are thick description and variation in participant selections. Thick description is utilized to ensure that the researcher is describing their data thoroughly, giving detailed descriptions of the research methods and data, and providing enough data about the participant's thoughts and experiences so that others can make their own interpretations of the data (Ravitch & Carl, 2016). Variation in participant selection can help ensure that a good cross section of the population is being represented (Ravitch & Carl, 2016). I conducted interviews with EMS Personnel to help provide a better understanding of violence towards them in different cities in the Midwest.

Dependability

Establishing dependability in qualitative research requires the researcher to provide a reasonable explanation for the method of data being collected and that the data collected is consistent with this explanation (Ravitch & Carl, 2016). One way to ensure dependability is to provide an "audit trail, which records the researcher's decisions throughout the conduct of the research and the analysis of the data" (Babbie, 2017, p. 327). This will allow for transparency of the research process to other researchers, so they are able to determine the trustworthiness of the methods used and the conclusions that were made (Ravitch & Carl, 2016). This can also be referred to as an external audit. An audit trail was used in this study to help show dependability of my findings and research.

Confirmability

Confirmability refers to the idea that the results of the study are based on the data obtained from the participants and not by researcher bias (Amankwaa, 2016). Researchers need to remain objective while they are completing their study and the researcher must try to avoid any personal biases that may alter the data. The researcher needs to reflect on their research constantly as well as discuss the results and findings with a person that is not biased towards the topic. Reflexivity and discussing this topic with my Chair were used to help provide confirmability throughout my research.

Ethical Procedures

The American Psychological Association (APA) has specific guidelines to ensure certain precautions are put in place to ensure no harm is done to the participant. Researchers need to minimize potential risks to the study participants as best they can. Some ways that researchers can do this is by providing confidentiality throughout the process, providing informed consent, debrief before and after the interview with the participant, and use accurate representation of the statements made by the participants (Stangor, 2011). An approval from the Walden University IRB was obtained before contacting any potential participants. This ensured that the research study was ethical and protected the participants of the study. Participants were recruited for the study by contacting department chiefs and/or health and wellness captains to reach out to their crew members by sending out an email that I constructed myself. Any individuals that were interested in participating were informed of the study, told that participation is completely voluntary, and there will be no adverse reaction from myself or their

department if they chose not to participate. Participants were informed that their responses would remain confidential.

Confidentiality

Participants were made aware of how their responses and names would remain confidential throughout the entire process. I explained the coding system process to ensure that they understand how I would protect their confidentiality (Babbie, 2017). For example, if the participant's name is Jane Doe and she was interviewed on July 25, 2020, her code would then be JD072520. I shared this process with each participant and made sure they had a full understanding of how their answers would remain confidential. Assuring participants that their answers will remain confidential allowed them to be more open and honest about their responses (Babbie, 2017). Any paper documentation was locked in a safe along with thumb drives that contained any audio files or written documents. Data that was electronically obtained during data collection was kept on a password protected computer.

Informed Consent

Before participants participated in the research study, they were provided with an informed consent form (See Appendix B). This form provided a statement about the research study, a description of any foreseeable risks to the participant, a description of any benefits, a statement describing the confidentiality of each participant's records, an explanation of whom they should contact if they have questions about the research and the participant's rights, and a statement that participation will be strictly voluntary and they can end the study at any time (Stangor, 2011). The informed consent form also gave

the researcher permission to audio record the interviews. The informed consent forms were sent through email, and I ensured that understanding of this document was verified over the video conference call. Participants sent a written verification through email that they understood the information provided before they could participate in the study. They also identified they knew that their participation was completely voluntary and could discontinue at any time.

Summary

The purpose of this qualitative study was to understand EMS personnel's lived perceptions and experiences of violence towards them by patients or bystanders at the response scene and how they characterize their experience of violence. Another purpose of the study was to add to the existing literature on violence towards EMS personnel while they are responding to calls. Chapter 3 identified the purpose and details related to the phenomenon being studied. I discussed my role as a researcher and how I was going to minimize researcher bias. A discussion of the methodology of the research study included details regarding participant selection, instrumentation, and data analysis methods. Next, issues of trustworthiness were discussed which included how the researcher will ensure credibility, transferability, dependability, and confirmability. Finally, any ethical considerations, including informed consent and confidentiality, were discussed.

In chapter 4, an analysis of all the data collected will be provided. Chapter 4 will also provide the setting, participant demographics and characteristics, data collection and

analysis, evidence of trustworthiness, and the results of the study. Chapter 4 will end with a summary of the research and the results of the study.

Chapter 4: Results

The purpose of this qualitative interpretative phenomenological study was to explore the lived experiences and perceptions of EMS personnel who have experienced violence towards them while on duty and how this violence has affected the way they approach incident scenes and interact with their patients. One research question, including two subquestions, were explored in this study:

RQ1: What are the experiences of EMS personnel who are victimized by violence from patients and bystanders?

Subquestion 1: How do experiences of patient and bystander violence affect the way EMS personnel approach the incident scene?

Subquestion 2: How do these experiences of violence affect the way EMS personnel interact with the patients and bystanders on scene?

In Chapter 4, I present the findings from the analysis of the interview responses from the participants. The research setting, participant demographics, and the data collection processes are also discussed. Finally, evidence of trustworthiness is discussed, including the methods I used to establish credibility, transferability, dependability, and confirmability.

Setting

I conducted video (Zoom) calls for the convenience of the participants. Each participant could decide whether they wanted to be on camera. This helped promote confidentiality and anonymity for them. All but one participant wanted to participate face-to-face through camera. Semistructured interviews were used and allowed for open

dialogue. Participants were forthcoming in their responses by giving responses to each question, which is evidence of their comfort in the setting used for the interview.

Demographics

Nine EMS Personnel, whom were all males, participated in this study. The time that they have been involved in EMS was between 5 to 40 years, with an average of 19.9 years. All the participants worked in cities in the Midwest. These cities were in Iowa, Minnesota, Nebraska, and Wisconsin. Four participants were from Iowa, one from Minnesota, one from Nebraska, and three from Wisconsin. The population of the cities that they served ranged from 6,191 to 1,572,245. All the EMS personnel had experiences with either verbal or physical violence from their patients or bystanders on the scene. These demographics are visually depicted in table 1 below.

Table 1

Participant Demographics

Participants	Gender	Years in EMS Service	State
Participant 1	Male	21 Years	Nebraska
Participant 2	Male	40 Years	Iowa
Participant 3	Male	11 Years	Wisconsin
Participant 4	Male	21 Years	Iowa
Participant 5	Male	26 Years	Wisconsin
Participant 6	Male	19 Years	Minnesota
Participant 7	Male	9.5 Years	Iowa
Participant 8	Male	5 Years	Iowa
Participant 9	Male	11 Years	Iowa

Data Collection

My initial goal was to interview 10-12 participants. However, saturation was reached prior to interviewing that number of participants and only nine participants were interviewed. I knew saturation was reached after nine interviews when common themes and responses were beginning to be repeated with no new information being reported. The nine interviews were conducted via Zoom meetings, which was the most convenient method for all parties involved. This also allowed for the participants to decide if they felt more comfortable with keeping the camera on or off during the interview.

IRB approval (04-30-21-0658404) for this study was obtained in April 2021. The participant selection process started immediately after approval. I contacted fire department and EMS chiefs about the study and asked for the chiefs to forward an email that I wrote to their employees. I reiterated to the chiefs that their departments nor would their employees be named. Ten potential participants contacted me about the study. Consent forms, which detailed the criteria for inclusion, the voluntary nature of the study, and the study's purpose, were emailed to the potential participants. All participants responded back with an "I consent" after reading the consent forms. I also talked with each participant before the interviews for them to ask any questions about the consent form or the study. All participants qualified for the study. Interviews were scheduled three different times with one participant, but I was unable to get ahold of him. However, this interview was no longer needed because saturation had been reached.

Interviews began on May 8, 2021, and they were completed on July 21, 2021. Interviews were scheduled in 60-minute blocks to ensure that we had enough time to discuss the topic. I asked semistructured questions, which allowed me to ask follow-up questions and participants to elaborate on their answers when necessary. All the interviews were audio recorded and stored on a secure thumb drive that is locked in a safe when not in use. Handwritten notes were also taken during each interview to help with any follow-ups that may be needed. Once I transcribed each interview, using MAXQDA software, I emailed the transcripts to each participant. During the member checking process, I reviewed these transcripts with each participant about the different topics they discussed to ensure that my understanding was correct. All participants had no further input after these meetings.

After the transcriptions were complete, I then coded each interview transcript using the MAXQDA software. This software allowed for cross-analysis between the different transcripts to help find common themes. The document folders consisting of this data was then saved on a password-protected thumb drive and then stored in a locked safe until it was needed.

The actual data collection method did not deviate from the method that was described in Chapter 3, and I did not encounter any unplanned events in the data collection process. Although a few of the interviews were rescheduled from their original scheduled times, all participants were actively engaged in the process, and the interviews were completed in a timely manner. All participants were eager to participate in the study

and were forthcoming with their stories on experiences with physical and/or verbal violence towards them by patients and/or bystanders.

Data Analysis

I reviewed the transcribed interviews along with my handwritten notes before beginning data analysis. Descriptive coding, and then pattern coding was used to analyze the data. Using this type of coding allowed for categories to emerge which allowed for identification of broad themes. The following terms were frequently used during interviews: *patients, bystanders, verbal threats, physical violence, situational awareness, police, regulars, mistrust, de-escalation, weapons, safety, bullet proof vests, uniforms, training, approach, attitude, substance abuse, mental health, fear,* and *experience*. I highlighted important terms and themes in different colors, utilizing the MAXQDA program, in order to visually group these concepts, which aided in developing the spreadsheet containing the data. This was then saved in the MAXQDA software program.

A master spreadsheet was made which allowed for grouping of related terms and concepts into broader categories. The themes related to the main research question that emerged during analysis were *physical assaults* and *verbal assaults and threats*. The themes related to subquestion 1 were *staging, situational awareness, the use of ballistic vests during high-risk situations,* and *requesting the presence of police officers while on incident scenes.* The theme related to sub-question 2 was the *use of de-escalation techniques*. One unexpected theme emerged from the data analysis which was *lack of de-escalation trainings.* These themes are described in further detail below.

Evidence of Trustworthiness

The accuracy of findings in qualitative studies can be determined by examining the evidence of trustworthiness. I discuss the four components to trustworthiness in qualitative research: credibility, transferability, dependability, and confirmability (see Ravitch & Carl, 2016) in the following section.

Credibility

In order to confirm the credibility of this research, I used saturation, member checking, reflexivity, and data triangulation. Saturation was reached before the completion of 10-12 interviews, which was the original number that I had targeted. Therefore, interviews were able to stop after the ninth one. At this point, participant responses had become redundant and common themes were emerging which allowed for the interviews to be stopped. Member checks were used to allow the participants to correct any misinterpretation of their statements I may have made and to elaborate on any of the topics that was discussed. Member checking helped to establish credibility of the data recorded. Member checking also allowed for me to use reflexivity beforehand to ensure that I had not inserted my bias into the collected data.

Transferability

The findings of this study are context specific, which means it is not meant to be generalized to other populations. Thick description was used to allow a thorough and detailed description of the research methods and data, so other readers can make their own interpretations of the data. Providing sufficient detail and description of these complex experiences allows for individuals, other than EMS personnel, to find meaning

in the study findings. I also used purposive participant sampling to get multiple participants that may have different viewpoints and experiences.

Dependability

Environment and data triangulation helped ensure the findings were dependable. Participants were interviewed at different locations/departments, they were interviewed on different days of the week, and participants were varied in their years as EMS personnel. This helped to ensure that the views and experiences expressed were accurate and consistent across participants. The challenges and experiences of EMS personnel expressed by the participants can be considered trustworthy since the themes were similar across various participants. Every participant had different experiences, but common themes emerged from these experiences. All records are securely stored that pertain to this study. This allows for an audit trail, which helps establish dependability and credibility (see Ravitch & Carl, 2016).

Confirmability

Due to being responsible for my own analysis and interpretation of the data, researcher bias may have impacted study outcomes. I helped alleviate possible bias by maintaining reflexivity throughout the process. This involved a constant assessment of my personal beliefs and biases as well as writing down these biases before each interview. This was done to avoid the assumption that the upcoming interview would correlate with the previous interview.

Results

When exploring the experiences of EMS personnel's perceptions and experiences of violence towards them by either patients and/or bystanders, nine major themes emerged. Relating to the research question (what are the experiences of EMS personnel who are victimized by violence from patients and bystanders?), the following themes emerged: *physical assaults* and *verbal assaults and threats.* The theme of physical assaults had two subthemes which were *being physically assaulted when working with or restraining combative patients* and *witnessing physical assaults towards EMS personnel.* The theme of verbal assaults and threats had five subthemes which were *patients and bystanders using profanity towards EMS personnel, patients and bystanders calling EMS personnel inappropriate names, patients and bystanders threatening to harm EMS personnel, patients and bystanders threatening to kill or harm EMS personnel with a weapon,* and *verbal abuse of reoccurring patients.*

These themes are listed and described in Tables 2, 3 and 4. One theme did emerge unexpectedly that was unrelated to my research question. This theme revolved around the *lack of de-escalation training provided to EMS personnel*. This theme will be discussed in more detail below.

Table 2

Study Themes and Descriptions Relating to RQ1

Themes	Descriptions
Physical and verbal violence towards EMS personnel	
Theme 1: Physical assaults	Includes any type of physical violence perceived by the participants. The types of physical violence included hitting, slapping, biting, punching, kicking, getting shot, and getting hit with various items.
Subtheme 1: Being physically assaulted when working with or restraining combative patients	This includes being hit, punched in the face, and getting kicked when attempting to work with or restrain patients that have become combative due to either substance abuse issues, mental health issues, or a physical injury.
Subtheme 2: Witnessing physical assaults towards EMS personnel	EMS personnel witnessing other EMS Personnel getting physically assaulted while on a call. This included punching, kicking, and one EMS personnel getting shot.
Theme 2: Verbal Assaults and threats	The types of verbal violence and threats experienced by the participants included name calling, derogatory statements, profanity, threatening to harm them or their families, and threatening to kill them with a weapon.
Subtheme 1: Patients and bystanders using profanity towards EMS Personnel	Patients and bystanders using profanity towards EMS Personnel as a form of verbal violence and threats.
Subtheme 2: Patients and bystanders calling EMS personnel inappropriate names	Patients and bystanders calling EMS personnel on the scene inappropriate and vulgar names as a form of verbal violence.
Subtheme 3: Patients and bystanders threatening to harm EMS personnel	Patients and bystanders threatening to harm EMS personnel by threatening to beat them up, rip them in half, etc. This is another form of verbal violence.
Subtheme 4: Patients and bystanders threatening to kill or harm EMS personnel with a weapon	Patients and bystanders threatening to kill or harm EMS personnel on scene with a weapon as another form of verbal violence.
Subtheme 5: Verbal abuse from reoccurring patients	Reoccurring patients who tend to become verbally aggressive towards EMS personnel which results in name-calling, the use of profanity, and threats.

Table 3

Study Theme and Descriptions Relating to SQ1

Themes	Descriptions
Approaching incident scenes	
Theme 3: Staging	Staying away from incident scenes, usually from a distance, and not rushing into certain places or situations until it is deemed safe
Theme 4: Situational awareness	Knowing what is happening around your surroundings. This includes what is happening at the incident scenes and with patients and/or bystanders.
Subtheme 1: Strategic positioning	Strategic positioning included always being close to an exit, knowing where their partner is at all times, and positioning themselves between the patient and any objects that could be used as weapons.
Subtheme 2: Situational awareness while on scene	Being more alert and aware of one's surroundings while on an incident scene.
Subtheme 3: Heightened sense of awareness when approaching low-income and high-crime areas	Understanding neighborhoods with high poverty rates and low-income families have resulted in more violence towards EMS Personnel due to shootings, gangs, increased risk of patients with mental health issues and drug abuse.
Theme 5: The use of ballistic vests during high-risk situations.	Using ballistic vests in situations that involve shootings, active shooters, domestic violence, stabbings, and overdoses.
Theme 6: Requesting the presence of police officers while on incident scenes	EMS Personnel requesting police officers to help provide safety when approaching incident scenes.

Table 4

Study Themes and Descriptions Relating to SQ2

Themes	Descriptions
Approaching patients and bystanders while on scene.	
Theme 7: The use of de-escalation techniques	This includes different techniques they are either taught or learned from experience to de-escalate certain people.
Subtheme 1: Having a positive attitude and showing respect towards patients and bystanders	The way EMS personnel approach people and how they talk to people on the scene helps them work with patients and bystanders.
Subtheme 2: Building rapport and trust with patients and bystanders	Building a positive rapport and trust with the patients and bystanders creates better relationships and helps prevent violence.
Subtheme 3: Developing patience while working with patients and bystanders	Maintaining patience while working with patients and bystanders can prevent bystanders and patients from becoming aggressive.
Subtheme 4: Building a diverse crew to help build relationships with patients and bystanders	Having a diverse crew with different genders and races can help build a better relationship with patients and bystanders

Theme 1: Physical Assaults

Throughout the course of my interviews, the participants described instances of physical assault, ranging from witnessing physical violence towards other crew members, and being physically assaulted themselves due to combative patients. Another subtheme that emerged was the physical location of the participants when they were assaulted. The types of physical assaults that EMS Personnel received due to combative patients were scratches or bruises, getting spit on, and being punched. One participant described witnessing one of his crew members getting shot during a training. Other participants described being in lower income neighborhoods with high crimes also impacted if they tended to have to worry about physical violence. Another participant described his place of work being shot at by gang members. The main theme of physical assaults is broken up into multiple different subthemes to reflect the types of physical assaults that they either witnessed or had towards themselves. All participants stated that they either witnessed or experienced some form of physical violence towards them by either patients and/or bystanders. Participant 1 stated that although physical violence wasn't as common it still happened. This comment reflects other participant's views that verbal violence tends to be more prominent than physical violence, but physical violence can lead to injuries and time off the job.

Subtheme 1: Being Physically Assaulted When Working With or Restraining Combative Patients

Many times, physical assaults towards EMS personnel came when they had to restrain combative patients. The participants described that the patients were usually

combative due to substance abuse, agitation, or being in an altered state of mind. Even though restraining combative patients does not always lead to physical assaults towards EMS personnel, multiple participants described that if they are not prepared for a combative patient or do not get the help they need to restrain this patient, they tend to get punched, kicked, spit on, or hit by these patients. Participant 5 shared an experience where he experienced violence towards himself and others. He stated

> So, we got called for a person that had a seizure. We got to the front door, me and my partner, he was agitated and laying against the door, so we opened it up a little bit and I squeezed through and then I moved him, and my partner came through and then we lifted him up off the ground and put him on the couch. And I literally, I went to grab the blood pressure cuff on our EMS equipment, I turned around, and he just stood up and slugged me. And he had cut me right on my right eye. He had a ring on. And the next thing you know, we're all just jumping on him trying to restrain him.

Participant 2 mentioned that patients have only gotten physical with him four times, and each time, substance abuse was an issue which resulted in the patients being combative. Participant 2 also shared that "we got the patient on the cot, we got him in the ambulance, we were gonna start transport, and then as I started an IV, he came too, and started punching me." He stated the patient got a couple of hits to Participant 2's face before he was able to sedate him.

As stated above, many clients that become combative or assaultive tend to be under the influences of substances or have an altered state of mind. Participants gave

examples of these types of patients as those who are chronic drug users, people with mental health disorders, and people with intellectual disabilities. Participant 7 stated that most patients that get physical are due to some type of injury or altered state of mind. He shared that he has had some patients that have "intellectual disabilities that throw things at us, shoes, cups, statue figurines, you know, anything in the house that they get their hands on."

Subtheme 2: Witnessing Physical Assaults Towards EMS Personnel

Some of the participants described that they were not physically assaulted themselves but witnessed physical assaults on their coworkers during certain calls. They described this as traumatizing and feeling helpless as they were unable to intervene quick enough. Participants 3, 6, 8, and 9 all identified that they have had to work with and help restrain combative patients but at times, their partners were the ones who got assaulted by these patients. One of the most severe cases of physical assault towards EMS personnel that was described by one of the participants was when one EMS professional got shot in the leg. Participant 5 shared an experience where him and his crew were completing training in a vacant building when two rival gang members started shooting at each other. He stated that one of his classmates ended up getting shot in the leg. This was the most severe case of physical assaults being reported by the participants, but they all mentioned knowing about other EMS Personnel who have been either severely injured or killed while working with patients.

Theme 2: Verbal Assaults and Threats

Verbal assaults or threats were the most common forms of violence described by the participants. Different types of verbal assaults and threats that the participants experienced were name-calling, profanity towards them, threatening to harm them, and threatening to kill them with a weapon. Many participants also described how "regulars" or reoccurring patients can also be a challenge due to many of these patients being verbally abusive towards them. All of these experiences are broken up into subthemes below. All participants shared experiences and examples of verbal violence and threats towards them from patients and/or bystanders.

Subtheme 1: Patients and Bystanders Using Profanity Towards EMS Personnel

Mostly all the participants described patients and bystanders using profanity towards them. They described that patients tend to use profanity due to being in pain, being upset that they are not working fast enough, and simply because they are just agitated. Participant 7 stated that they get a lot of people telling them that they don't know how to do their jobs. He stated "I've had patients that will verbally abuse you and cuss and swear at you. They say, 'you don't know how to do your fucking job, you're not doing a good job'." He gave another example of this by stating

> We can bring the ER to their home and we're not just ambulance drivers. So, there's a lot more we can do, a lot more we can provide, and some of that takes time. So, there's that part of it where the care we're going to provide takes some time and they don't understand that, so they get verbally aggressive with you, and say "you need to hurry up, you need to move faster."

Subtheme 2: Patients and Bystanders Calling EMS Personnel Inappropriate Names

Another form of verbal violence reported by the participants was patients and bystanders calling EMS personnel inappropriate names. Many participants shared that this usually does not faze them much as people tend to say inappropriate things during crisis situations. They shared that they tend to brush off these inappropriate names but at times, these situations do stick with them. Participant 2 shared that he was on a call with a woman who was being very combative. He asked the woman if she could help them by walking to the stretcher. The woman became upset and "she went on a verbal tirade and called me a fucking cunt, and wanted my name, and so I gave it to her, and she was like, threatening to call the city administrator." Participant 1 also shared similar experiences with the other participants, and he shared

> A lot of the violence is verbal. Um, I could probably say, you know, every five days. I can't say it was every day, you know, but maybe a couple of times every set, ugh we would get somebody just angry at us verbally, and that could be from either a bystander or a patient on the scene. Some of the times they, you know, focus on our race, and I have been called, um, white boy, cracker, and um, things like that. Usually, I just try to ignore it and focus on, um, what is going on.

Subtheme 3: Patients and Bystanders Threatening to Harm EMS Personnel

Another common form of verbal violence towards EMS personnel were patients and bystanders threatening to harm them. Many participants acknowledged that people have threatened to kill or hurt them on multiple different occasions. Participant 5 shared there have been a few times in his career that he thought he was going to die due to the

verbal threats and actions of others. On one occasion, he went on a call where a child was not breathing. They started doing CPR and the father of the child came out and said, “you better save our son or we’re gonna, you know, you won’t go home to see your kids tonight.” The father then called dispatch and was able to get the names and addresses of the EMS personnel on scene. The crew ended up needing police protection for a few days until the father was arrested as he was a wanted felon. Participant 5 also shared a time where a man was shot in the foot, and they ended up in a small apartment with a cop and several members of a gang. The situation started to escalate, and the gang members started pushing them and threatening to harm them. He stated, “yeah, I literally thought I was gonna die on that run.”

Participant 3 also shared that it was more common to experience verbal violence over physical violence. He shared

> I mean, it’s a lot easier for someone to say something than it is for them to do something, and the consequences aren’t as great if someone says something versus if they actually do something. So, I would certainly say it’s more common to get yelled at or someone talking stupid things to us to that sort of thing, threatening us, and this actually happens more than any physical violence.

He also shared an experience of being verbally threatened by a patient. He stated that this patient was a pretty large guy who was very intoxicated. He explained that the man said he was “gonna rip us in half and beat the shit out of us if he got off the stretcher.”

Subtheme 4: Patients and Bystanders Threatening to Kill or Harm EMS Personnel with a Weapon

A few participants discussed times where patients and bystanders threatened to kill or harm them with a weapon. They stated that this is pretty intimidating, and it is hard to complete their job when they know someone has a weapon. Participant 9 shared experiences of people calling him and his crew names and people telling him that he does not know what he is doing. He shared that while on a call, he was working on a bystander's mother who was no longer breathing. The son became agitated as it was clear they were not able to get the mother back. Participant 9 stated that "he just kind of backed up to the bedroom door and reached his hand behind him and pulled out a baseball bat and started telling all of us we need to get out of there, we could not be anywhere near his mom." Even though this subtheme is not as prevalent as the other subthemes in this section, it is still necessary to note to fully understand the different verbal assaults that EMS personnel may face.

Subtheme 5: Verbal Abuse of Reoccurring Patients

It is important to recognize how reoccurring patients can become verbally aggressive. Some participants described how these patients tend to use up a lot of their time and resources due to many of them being chronic drug users or due to having serious mental health problems. Participant 3 shared "some of my regulars now, their more verbally combative with us and just see us as their source of frustration for some reason, even though they called us to be there."

Many of the participants described how some reoccurring patients will call them names or use profanity towards them. Participant 6 shared that he has been called "a bitch, umm, asshole, fucking dickhead, yah, like all those things from our regular patients, yah know?" He shared that he has learned to just ignore these types of comments as it has become normalized when working with reoccurring patients for many of them to become verbally aggressive towards them.

The Experiences of Patient and Bystander Violence Towards EMS Personnel and How Prior Experiences of Violence Affects the way EMS Personnel Approach the Incident Scene

The first sub-question of RQ1 explored how previous experience of violence affects the way EMS Personnel approach the incident scenes. The following four themes emerged: *staging, situational awareness, the use of ballistic vests during high-risk situations, and requesting the presence of police officers while on incident scenes*. The following three sub-themes emerged from situational awareness (theme 4): *strategic positioning, situational awareness while on an incident scene, and heightened sense of awareness when approaching low-income and high-crime areas.*

Theme 3: Staging

Staging was one common theme that emerged in SQ1. Staging means staying away from incident scenes and not rushing into certain places or situations until it is deemed safe. Some participants described previous experiences of rushing into situations which resulted in them or their crew getting hurt. They shared that staging away from an incident until the scene was safe and knowing all they can about the incident and the

scene before arriving has prevented violence towards them by others on many different situations. Participant 4 stated that he keeps himself and his crew safe by staging away from the incident and letting the police do their job first. Participant 9 also talked about staging away from the incident scene on certain calls and he stated that when it comes down to it "my crew and my safety takes precedence over anything else." He shared that the way he does this is being smart and knowing what he can and cannot do. For example, he shared that they will "stage" when they come to a scene where violence is reported. He shared

> If we have any likely violence, we will stage. So, if we are going into a shooting, if we're going into a stabbing, if we're going into an active fight. When I first came on it was always, we park a block away. I've made a point to be maybe a touch further than that and around the corner…Well, if I don't know if guns are secure on scene, if I don't know it's safe, I don't want to put my crew in that situation. So, we will stay back a little bit further, a little bit longer, until we know that the scene is safe.

Participant 5 stated that he has learned that he does not need to rush into certain situations and to wait for the scene to be safe. Participant 2 stated that some people may think he is weak or a chicken, but he is not going to put his crew at risk over people making bad decisions. He stated that they will eventually treat the person that is needing medical attention, but they will hold back and let the area become secure before they enter a scene.

Theme 4: Situational Awareness

Situational awareness was a common theme amongst all participants Situational awareness includes being aware of one's surroundings, identifying warning signs such as an agitated patient or crowd, visible weapons, and/or visible drug paraphernalia, and staging away from areas until it is safe. Since situational awareness was a major topic of all participants, this theme was broken down into different subthemes to fully examine how EMS personnel approach incident scenes as a result of their experiences of violence towards them.

Subtheme 1: Strategic Positioning

Many participants identified strategic positioning of themselves and their crew as a way to remain situationally aware. Strategic positioning included always being close to an exit, knowing where their partner is at all times, and positioning themselves between the patient and any objects that could be used as weapons. Many participants identified that being situationally aware while on incident scenes have prevented them from being physically assaulted or being put in a situation that could get them hurt or even killed. For example, Participant 8 mentioned that he is aware of where all the exits are at, and he is not going to put the patient between himself or the door, so he always has a way out if necessary. Participant 6 also stated that he remains situationally aware when he is on scenes, and he does this by physically positioning himself and his partner in the most appropriate spots.

Some participants discussed how previous experiences of finding weapons on scenes and having people attempt to use these weapons on them have changed the way

they position themselves as well. Participant 5 shared that he has found multiple guns, knives, and machetes at incident scenes, so he is always making sure those are secure when he enters the property. Participant 2 also mentioned that he keeps an eye out for weapons or drug paraphernalia on the scenes to ensure the safety of his men. He stated that removing the weapons or making sure they are out of the reach of the people on scene will keep himself and his crew safe. Participant 3 shared that he has found weapons at scenes which included knives or guns, but he has learned that he just will position himself or throw the weapon to the side to prevent anyone getting hurt. He stated that for the most part he is not worried about someone using the weapon towards them, but they want to make the scene as safe as possible to prevent an incident from happening. He shared that due to his experiences of being threatened with weapons, he wants to make sure the area is safe for everyone present.

Subtheme 2: Situational Awareness while on Scene

Some participants identified that past experiences of violence towards them while on incident scenes have changed how they enter certain scenes and have created a heightened sense of awareness. Participant 4 shared that due to his experience from past situations, he believes that his instincts have gotten a lot better while on incident scenes. He shared that "you can walk in and feel the vibe of the room and kind of know what's happening more than I ever have…you have to go on enough calls to figure that out, I guess." Participant 3 also talked about situational awareness and stated the following

> I'm making sure we're evaluating who's all in the residence or not letting people get behind us in the exit. I think just overtime you build that up but like I said, I

> think I have a unique opportunity to have further experiences with that because of my other situations. But yeah, I, I would say we certainly do kind of take into account all those things, neighborhood, the house, the people around, ourselves, the nature of the call, and kind of keep our guard up a little bit like that.

One participant described how he learned from one of his experiences to be more situationally aware. He shared that after he experienced this situation, he was more aware and alert on incident scenes and when helping high-risk patients. He mentioned a situation when himself and the cops searched a patient for weapons but did not find anything. He shared that once this patient got to the hospital, they found a large revolver on the patient. He stated, "I was in the back with this guy, and he was combative, and I didn't restrain him, I just tried to like talk him down and I thought if he became combative, I'd be able to hold him down until my partner could help me out, but if I would have known he had a gun on him, it would have been a different story." Other participants identified certain experiences like this one, which helped change how they approach incident scenes today.

Subtheme 3: Heightened Sense of Awareness when Approaching Low-income and High Crime Areas

Another subtheme of situational awareness that emerged from the interviews was having a heightened sense of awareness when approaching low-income and high crime areas. Some participants stated that due to past experiences of verbal and physical assaults, they are more alert going into these areas. They identified that areas with low-income and high crime rates tend to have more people that are abusing substances, people

that are participating in gangs, and higher mental health issues. Participant 7 shared that he felt the lower socioeconomic areas, where drugs, alcohol, and lower living status is a problem, seemed to be more hostile than other parts of town. He also stated

> When we go to the certain, you know, neighborhood or to the apartment complexes that have the HUD housing, and certain areas of town that we've been to before or certain addresses we've been to before, we've had some hostile interactions, we definitely are more on edge and more cautious approaching these areas.

Other participants described similar reactions when going into lower-income and high crime areas. Participant 1 also mentioned being situationally aware while on scene and he shared that this developed over time due to having more experience. He also explained how he approaches incident scenes by being situationally aware. He shared

> As soon as you just step off the fire truck here, you need to realize your stepping off in a different zone of town and you need to be paying attention with what's going on around. It's really easy for the average person, you know, even an EMT or paramedic that have never been in the neighborhood like that or never been in an environment like that could just be completely oblivious to things. So, we are pretty tapped in down there, so yeah, so anyway, when we go downtown, we are really situationally aware, and our Captain on our engine is good at his job and always watches our backs.

Participant 9 stated that 2 of their 29 stations have changed their Bay doors so they have a thick metal door with bullet proof glass. He shared that they made these

changes due to these stations being in the inner city where bullets have come through their doors. He said other than that, this is all they have been provided for their safety when they are stationed in these neighborhoods. Participant 1 mentioned that he spends the majority of his shift “smack dab in the middle of the lower income, higher crime area of town.” He shared that they were stationed only about half of a mile away from one of the largest homeless shelters in the area and this also resulted in a lot of shootings and violence. Participants 4, 7, 8, and 9 all mentioned lower income areas and section 8 housing as higher crime areas that they work in. Due to their experiences of being in these low-income, high crime areas, the participants stated that these patients tend to get more verbally and physically aggressive towards them. Participant 9 shared that his city is very segregated, and he has noticed that the lower income areas tend to have more violence. He stated that himself and his crew tend to be more alert on these calls due to past experiences of violence with them.

All the participants that mentioned going into low-income and high crime areas stated that they tend to be more situationally aware and more alert on these calls. They explained that past experiences of being either physically or verbally assaulted in these areas of town have increased their sense of awareness and makes them more hesitant and cautious when approaching these areas. Because of this, they always have a plan of where they are going to position themselves when they arrive on scene as well as having a plan on an easy escape route if the situation at the scene becomes violent or gets out of hand.

Theme 5: The Use of Ballistic Vests during High-Risk Situations.

Along with having a more heightened sense of awareness when going into low-income and high crime areas, some participants described the importance of using ballistic vests, especially during high-risk calls such as shootings, active shooters, stabbings, domestic violence, and drug overdoses and intoxications. Some participants described that from their experiences, these calls can still be unsafe when they arrive so in response to these situations, some departments have purchased ballistic or bullet proof vests for their EMS Personnel.

Some participants described the benefits of these vests as they can provide protection while on a scene and they do not feel as stressed going into these situations as they feel like they have more protection against being shot or stabbed. Participant 2 stated that they are using expired body armor for their paramedics after the police are done with them. He shared that they require their medics to put on this armor when they are going into a scene, like a shooting, stabbing, domestic assault, or anything involving a weapon or substance abuse. He also shared "Now I don't know if it'll ever do any good, but I'd feel pretty damn bad if somebody could have body armor, like if somebody had a 9-millimeter, and shot at him, and they at least had some protection, I feel a little bit better." Participant 4 stated that their department recently received a grant from a company which allowed for their city to receive bullet proof vests. He said that they mainly wear these vests when they are on calls that involve active shooters or anything that involves some type of weapon.

Participant 8 shared that their department is provided with ballistic vests, ballistic helmets, along with active shooter packs. He shared that they wear these ballistic vests every shooting and stabbing that they have. He shared, “we don’t wear vests a lot, pretty much the only time that I put on my vest is if we’re going to an active shooter kind of situation, or where there’s multiple victims down, and we’re not sure where the shooter is type of deal.” He stated that the vests can get hot and are heavy, so they don’t always like to wear the vests on all the calls that they go on. However, he described that due to his previous experiences of being verbally threatened by one of his patients and a few bystanders during a high-risk situation, he is more apt to put on these vests to keep himself safe.

Theme 6: Requesting the Presence of Police Officers while on Incident Scenes

Besides being situationally aware when approaching incident scenes, the participants described requesting police officers as a safety tactic that they use. Having police officers on the incident scene was a major theme amongst participants, and they described how past experiences of both physical and verbal violence on calls has resulted in police presence. Some participants described police involvement as good and that it makes them feel a lot safer on scenes. Due to some participants not having access to ballistic vests, they shared that involving the police allows them to feel safer when approaching different scenes.

Participants shared that by requesting police officers on certain scenes, the police are providing protection while on scene and diffusing situations before they sometimes even arrive on the scene. Participant 9 shared that they have had to call the police on a lot

of their calls due to the patients or bystanders being violent. He said for the most part the police are there to help get the situation under control. Participant 8 stated that in other cities that he worked in, cops would be on every call to assist in any situation. He shared where he works now, the city is so big and the police are so busy, that they only get police assistance on high acuity calls, like shootings, stabbings, domestic violence, etc. He stated that in his experience, he is not as afraid to go on the high intensity calls because he knows there will be a lot of back-up on the scene.

Participant 1 stated that due to his past experiences of violence towards him, he has learned to utilize the police in different ways on the scene. He shared that the police can be a positive safety net when on different scenes, but he did state police presence can also cause tension when they are on the scene. He shared sometimes patients and bystanders become more upset and agitated when police are on scene, but at times this can work in their favor. He stated, “we can use this to our advantage as sometimes people don’t want to talk to the police, so we are able to get them to talk to us instead.” He stated that when the people tend to become more focused on not wanting to help the police, they are more likely to talk to them which creates a feeling of safety while on the scene.

Theme 7: The Use of De-escalation Techniques

The use of de-escalation techniques was the main topic that the participants discussed in regard to this subquestion. Participants discussed de-escalation techniques as a learned technique based off of their previous experiences of working with patients and bystanders that have resulted in verbal and/or physical violence towards them or their crew. They identified that they are sometimes taught different techniques to use but most

of these techniques come from experience. Different techniques that they described using was being patient, building connections, especially when working with reoccurring patients, and showing respect. The participants also shared that talking about different scenarios before going on calls helps with understanding how other crew members have helped de-escalate situations. Participant 6 stated that he felt "90% is experience and then 10% the training that I got right at the beginning of my career," when it comes to de-escalating patients and bystanders. Participant 8 shared that his captain takes time on his shifts to meet with the crew and talk about de-escalation. He identified that since his captain talks about de-escalation techniques so much, it is ingrained in their minds to also use these techniques on calls, which helps keep different situations calm.

> We talk about de-escalation a lot. We talk about, you know, how our words can have an effect, and different ways to phrase things to try to, to get our population that we're trying to serve to kind of work with us and not necessarily against us…We as a crew kind of do a little bit of that training and I think just overtime you kinda, you kinda get good at it, even if you haven't had formal training.

Participant 1 identified the importance of de-escalation training and he shared that since he has been working with his own crew on de-escalation, he noticed better results in their patient care. "People didn't change, you know, we change, and we saw that we have less issues with people because we got better at our jobs." This theme of de-escalation techniques has been broken into four different sub-themes.

Subtheme 1: Having a Positive Attitude and Showing Respect Towards Patients and Bystanders

Having a positive attitude and showing respect towards the patients and bystanders on scene was one specific de-escalation technique. The participants identified that the way they approach people with a positive attitude and how they talk to people on the scene helps them work with patients and bystanders. They shared that this normally comes with experience as it takes time to learn what works and what does not work for certain people. Participant 3 explained that in his experience, the best thing that helped people from becoming violent towards them was his attitude towards them. He shared that as long as he is able to talk to someone like a human being than it makes it a lot easier to go into someone's home and help them.

Participant 9 discussed a lot about being respectful and having a positive attitude when working with patients and bystanders. He stated that he teaches his crew on every shift about respect towards others. He stated that he tells his crew to be respectful at all times. "Respect starts in the Firehouse by how we talk to each other and how we talk to all of our patients, and we treat them with respect regardless if this is the first time we've seen them today or the 10th time we've seen them."

Participant 3 stated that a person can learn a lot from their patients. He stated that they had one guy who was a routine narcotic user who would overdose often. So, whenever they went on calls with him, they would know to bring extra crew and have a police presence as this guy would normally become combative and try to fight them. He also shared "some of my regulars now, their more verbally combative with us and just see

us as their source of frustration for some reason, even though they called us to be there. And just you come in with the same sense of respect but cautiousness in a sense so that you won't get yourself in a bad spot." He also shared that he tries to treat all of his patients with respect as his attitude can change the way someone is coming off to him.

Subtheme 2: Building Rapport and Trust with Patients and Bystanders

Another form of de-escalation techniques was building rapport and trust with patients and bystanders. They identified they build more rapport and trust with their "regular" patients they see a lot, but have learned to try to build rapport and trust with all bystanders and patients. Participant 6 discussed how he builds a rapport with some of his clients if he sees them over and over again. He stated, "you know, I remember my patients pretty well, and I can kind of walk in and talk to them as more of a friend because we know each other and we have spent time together on previous calls, which helps with my approach on calls." Participant 8 stated that he tries to build trust with people in the neighborhood that he works in by talking calmly, being respectful, and taking the time to acknowledge their concerns. He shared building this rapport with the patients and bystanders has helped prevent situations from escalating into something more violent.

Participant 9 also stated he tries to build rapport with the people on the scene as this can help build relationships and trust within the group. He stated,

> One of the things that I've tried to make a point to do is figure out, especially when you have a scene where you could have five, ten, fifteen bystanders; figuring out who is sort of in charge for the family and quite often it isn't going to

> be the person that people would expect…and figuring out who that is and trying to connect with them as early as possible…I try to figure out, okay, who is it that needs to be braced? Who is it that is going to have influence on everybody else in the room, and be able to calm all of them down to keep the scene at its most level?

Participant 7 shared that he also tries to build rapport and trust with patients and bystanders. He stated that he has learned from experience if individuals on the scene start to become upset, he has learned to assign them a task or a job to make them feel like they are a part of the situation and are helping out. He identified that this helps build rapport and trust with the bystanders as it shows that he is needing help and willing to trust those on scene to help him with patient care. He shared examples of asking them to hold a flashlight, an IV bag, help lift the person up, or have them collect the person's medications. He stated, "it seems to diffuse the situation and makes them feel like they have a role other than being hostile."

Subtheme 3: Developing Patience while working with Patients and Bystanders

Participants described that developing and maintaining their patience while working with patients and bystanders has helped with de-escalating certain situations. They stated that working with patients that are "regulars," violent patients or bystanders, or just in general patients and bystanders that are hard to work with, have caused them to become impatient with them. The participants identified they have learned developing patience can really affect the way people respond back to them and have learned that patience is an important de-escalation technique when working with others. The

participants stated that reoccurring patients often can test their patience but learning from their past experiences with these patients help them in the way they approach them in the future and similar patients like them. Participant 1 shared an example of how building patience with patients and bystanders can affect the situation. He shared,

> A couple of really large guys that had mental health issues are normally some of our regulars. As long as we were cool with them, we could always get them to cooperate and sometimes it took a little bit of time and patience, but we could always get them to cooperate in just kind of use verbiage, using stuff, and yeah, so we definitely, there's certain people we treat in certain ways and then we also, I mean, ultimately try to treat everybody like that, but it doesn't always work. I mean, we're human, and sometimes people get under our skin and even the best of us makes screw-ups and sometimes it happens.

Participant 7 also shared that he tries to be patient with all of his patients and bystanders no matter how many times he interacts with them. However, he said that this isn't always the easiest thing to do, especially with patients that call frequently. He shared,

> But I have seen, you know, first-hand where the, where the frequent flyers or the people we deal with, there's so many situations, that we get into or other EMS providers, you know, they're irritated or short with the person or you know, they do treat them a little different when you've been there 30 times in the last two months, you know?

Participant 7 shared that many times when him or his crew get short with these patients, this can lead to the situations becoming more hostile, so they have learned to be as patient as possible and learn from their past experiences on what helps keep these types of patients calm to prevent any more verbal or physical assaults.

Subtheme 4: Building a Diverse Crew to Help Build Relationships with Patients and Bystanders

Some participants also identified having a more diverse crew helps build relationships with certain people on scene. The participants described a diverse crew as having people with different genders and races on their crew. Participant 9 stated that from his experience, the more diverse his crew was, the better off they were when on certain calls and with certain patients. He shared a female crew member is good to have, especially when it involves a female patient. He stated that his senior firefighter is Hispanic and can speak Spanish which helps when they enter a household that only speaks Spanish. He also shared that,

> My last senior firefighter was a, you know, a very young black man, who despite not having a lot of experience, had a really affable personality. So, when we would go into situations, a lot of the time, I would let him do the talking because he could just vibe with the community, vibe with the people that were there. And you know, also in terms, you know, age, gender, race, I feel that the more diverse my crew is the better off I'm gonna be, because it increases the odds that one of us is going to relate to the people who are being most problematic on scene.

Other participants also described having female crew members also help build relationships with the female patients and bystanders, especially when a violent situation has happened with their patient. They described having female crew members, especially when a female patient was sexually assaulted, provided a positive relationship with this patient, and made them feel safe.

Lack of De-escalation Trainings

There was one theme that emerged unexpectedly during the interviews with each participant. All the participants besides one felt like there wasn't enough training to help them with de-escalating patients and/or bystanders at the incident scene. Many of the participants felt that if they received more training, this could help prevent violence towards them and their crew. The lack of de-escalation training was seen as a challenge that many felt that their department needed to overcome.

Participant 1 and participant 2 shared that most of the de-escalation techniques they know is from years of experience. Participant 1 stated that he was not aware of a single fire department or EMT or paramedic program that provides proper de-escalation trainings. He shared that,

> In EMT class they tell you, well you know, you need to develop a rapport, well how the hell do you do that? No one's ever taught you how to do it and, you know, if you don't feel safe, leave. Well, that's not always an option sometimes.

Participant 3 acknowledged that in their monthly meetings, they talk about de-escalation techniques but only in reference to people there were experiencing mental health emergencies. He stated that other than that, there is no formal training in their

department and “it’s definitely not something at the fore front of training.” Participant 4 also stated that they have done a few informal trainings on de-escalation, but it hasn’t happened in years. He shared the following about safety and de-escalation techniques,

> Because, we don’t have any training to do anything in that matter, and even like de-escalation training, which is kind of the minimum, which doesn’t seem like that hard to pull off, it’s just something we don’t have. We just have the experience on the job on how we talk to people and make things better. And sometimes we’re our own faults. A lot of times, the situation gets worse because we don’t want to be there, or we’re tire, and things just kind of escalate sometimes, not of anything that you intentionally did but it’s just what you brought into the situation.

Participants 6 and 7 both mentioned the small number of trainings they receive from their departments and while in EMT school. Participant 7 shared that he notices more with newer personnel, they struggle more with de-escalation since they don’t have the experience and trainings on how to help them. Participant 8 stated that he didn’t feel like other members of their department got that level of de-escalation training since his captain is the one that is passionate about it and teaches it just to their crew on shift. Participant 8 shared that he was unsure of any formal de-escalation training for their department but felt that this should be something that their department takes more seriously as it can help with keeping them safe. Participant 9 shared a lot of experiences he has had with de-escalation techniques but noted that he learned most of this from

experience. He shared that they get “minimal and generally inadequate de-escalation trainings

Participant 5 differed from the rest of the participants and shared that he felt they do a lot more de-escalation trainings. He shared this started about seven or eight years ago. He stated, “we do, like a, critical incident stress management, or peer support debriefings.” One thing to note is that three other members from his department did not state that they did any formal trainings and felt like trainings were inadequate.

Summary

Seven major themes, multiple subthemes, and one unexpected theme emerged from this study. For physical and verbal violence towards EMS personnel, themes included physical assaults and verbal assaults and threats. The subthemes under physical violence included being physically assaulted when working with or restraining combative patients and witnessing physical assaults towards EMS personnel. The subthemes under verbal assaults and threats included patients and bystanders using profanity towards EMS personnel, patients and bystanders calling EMS personnel inappropriate names, patients and bystanders threatening to harm EMS personnel, patients and bystanders threatening to kill or harm EMS personnel with a weapon, and verbal abuse from reoccurring patients. All themes and subthemes included in this section related to research question 1, which explored the lived experiences of EMS personnel who have been victimized by violence from patients and/or bystanders.

For approaching incident scenes, the main themes included staging, situational awareness, the use of ballistic vests during high-risk situations, and requesting the

presence of police officers while on incident scenes. The following subthemes emerged from the theme of situational awareness: strategic positioning, situational awareness while on scene, and heightened sense of awareness when approaching low income and high crime areas. All themes and subthemes included in this section related to sub-question 1, which explored if patient and bystander violence affected the way EMS personnel approached the incident scenes.

For interaction with patients and bystanders at the incident scene, the following theme emerged: the use of de-escalation techniques. Four subthemes emerged from this theme which included: having a positive attitude and showing respect towards patients and bystanders, building rapport and trust with patients and bystanders, developing patience while working with patients and bystanders, and building a diverse crew to help build relationships with patients and bystanders. All themes included in this section related to subquestion 2, which explored if EMS personnel's experience of violence towards them affected the way they interacted with the patients and bystanders while on the scene. The one unexpected theme revolved around the lack of de-escalation trainings, and many discussed this as a challenge going into certain situations as they never had any formal training.

In Chapter 5, the study findings will be discussed. Following the interpretation of the findings, limitations of the study, recommendations, and implications will also be discussed. Finally, chapter 5 will discuss the overall conclusion of chapter 5 and the findings.

Chapter 5: Discussion

The purpose of this qualitative phenomenological study was to understand EMS personnel's lived experiences and perceptions of violence towards them by patients or bystanders at the response scene and how they characterized their experience of violence. I also explored how these experiences affected the way EMS personnel approached these scenes and how they interacted with the patients and bystanders at the incident scenes. In this study, I used an IPA approach to explore the lived experiences of nine EMS personnel to gain an understanding of their experiences with violence towards them by patients or bystanders. I conducted semistructured interviews with the participants to address the following research question: What are the experiences of EMS personnel who are victimized by violence from patients and bystanders? The semistructured interviews with the participants also helped address the following two subquestions: How do experiences of patient and bystander violence affect the way EMS personnel approach the incident scene and how do these experiences of violence affect the way EMS personnel interact with the patients and bystanders on scene?

The results yielded seven themes: physical assaults, verbal assaults and threats, staging, situational awareness the use of ballistic vests during high-risk situations, requesting the presence of police officers while on incident scenes, and the use of de-escalation techniques. Fourteen subthemes developed from those themes: Being physically assaulted when working with or restraining combative patients, witnessing physical assaults towards EMS personnel, patients and bystanders using profanity towards EMS personnel, patients and bystanders calling EMS personnel inappropriate

names, patients and bystanders threatening to harm EMS personnel, patients and bystanders threatening to kill or harm EMS personnel with a weapon, verbal abuse of reoccurring patients, strategic positioning, situational awareness while on an incident scene, heightened sense of awareness when approaching low-income and high crime-areas, having a positive attitude and showing respect towards patients and bystanders, building rapport and trust with patients and bystanders, developing patience while working with patients and bystanders, and building a diverse crew to help build relationships with patients and bystanders. Finally, one unexpected theme emerged from the results of this study which was the lack of de-escalation techniques. In the following chapter, I will begin to interpret and apply the results toward future research and positive social change.

Interpretation of Findings: Experiences of EMS Personnel who are Victimized by Violence from Patients and Bystanders

The research question in this study focused on exploring the lived experiences of EMS personnel who are victimized by violence from patients and bystanders. Answering this question, participants discussed both physical and verbal violence by patients and bystanders and how these experiences impacted the way they approached incident scenes and their patients.

Theme 1: Physical Assaults

All nine participants in my study also identified that physical violence was less prominent than verbal violence but was still a common theme. Seven out of the nine participants of my study mentioned that they were physically assaulted at one point in

their career. They admitted that physical assaults happen rarely, and some have only had it happen once or twice to them. One participant mentioned that he has been physically assaulted a total of four times over his 15 years of being an EMS professional. Similarly, several studies have shown that although physical violence is less likely to happen than verbal violence, physical violence towards EMS personnel is still a prominent concern they have. Furin et al. (2015) identified 21% of their participants in their study reported violent physical assaults towards them. Brophy et al. (2018) also concluded that roughly 26% of their participants also experienced physical assaults. Kang et al. (2021) also described 28% of their participants also reported experiencing some form of physical violence towards them.

The different forms of physical violence reported by the participants in my study were punching, grabbing, shoving, and hitting. These types of physical violence were also common in other studies. Kang et. al (2021) reported physical assaults as being hit by a thrown object, grabbing, hitting, scratching, pushing, biting, and spitting. Suserud et al. (2002) discussed types of physical violence experienced by their participants as hair pulls, kicking, pinching, punched, and throat grabs. Similarly, Reemst and Fischer (2019) described physical assaults of their participants as being hit, punched, and grabbed.

Subtheme 1: Being Physically Assaulted When Working With or Restraining Combative Patients

Four of the participants in the study described how restraining combative patients can lead to being physically assaulted by patients. The types of patients that they normally must restrain are those who are under the influence of substances, are agitated,

or those that are in an altered state of mind. Similarly, Brophy et al. (2018) described combative patients as those that have an altered state of mind due to being under the influence of substances, severe pain, history of violence, dementia, and certain psychiatric disorders Similarly, Taylor et. al (2016), also mentioned that the common underlying factors for combative patients were patients with mental health issues and patients with particular health conditions like a seizure disorder or dementia.

Types of injuries that are sustained due to combative patients varies on the patient and the situation. For example, Participant 5 described an incident where he was working with a person that had a seizure and when that person woke up, he punched Participant 5 in the face. Participant 2 also shared a similar story of working with a person who was unresponsive when they got there and when that person woke up, they began punching Participant 2 in the face. The other participants in my study also discussed varies injuries such as getting kicked or slapped by combative patients. Other studies described similar injuries they have received from combative patients with an altered state of mind. Reemst and Fischer (2019), in a study on EMS personnel and violence towards them, revealed that many combative patients hit, punched, and grabbed the EMS personnel that were working on them. Other forms of physical assaults that have been reported were bruises and contusions (Maguire, Browne, et al, 2018), fractures, stab/puncture wounds (Enrich, 2017), being dragged by their hair, licked, pinched, hit, slapped, and punched in the face, and being grabbed by the throat (Suserud et al., 2002). Overall, the participants in my study shared similar experiences of other EMS personnel in different studies.

Subtheme 2: Witnessing Physical Assaults Towards EMS Personnel

Witnessing physical assaults towards EMS personnel was another theme that emerged from my study and is consistent with the findings of other studies as well. Three participants in my study verbalized that they felt helpless and were upset with themselves due to not being able to intervene fast enough to prevent their coworkers from becoming assaulted. Some physical assaults that they witnessed were seeing their partners being punched and hit by combative patients and a more severe case was witnessing an EMS personnel get shot in the leg. In a study completed by Brophy et. al (2018), one participant mentioned that he witnessed his partner getting choked and beaten, and when he tried to help intervene, the patient began assaulting him as well. Erich, (2017) described multiple incidents where crew members witnessed their coworkers being physically assaulted. One scenario was where EMS personnel were on a scene for a man using cocaine. The person came to and shot one of the paramedic's multiple times which resulted in this paramedic passing away. Another example was when a bystander became agitated at the scene, and they pulled a hunting knife out. The EMS personnel first witnessed his partner get stabbed three times and when he tried to intervene, he was stabbed twice.

Theme 2: Verbal Assaults and Threats

Verbal assaults and threats were the most common forms of violence described by all nine of the participants in my study and are generally the most common forms of violence reported in other studies as well. Oliver and Levine (2015) stated that 67% of their participants in their study on violence towards EMS personnel were victims of

verbal violence. Another study identified that 88% of their participants reported being verbally abused or threatened by patients and/or bystanders (Furin et. al, 2015). In the subthemes below, these types of verbal assaults are explored in more detail.

Subtheme 1: Patients and Bystanders Using Profanity Towards EMS Personnel

One common subtheme of verbal assaults was patients and bystanders using profanity towards EMS personnel. Five participants described that the patients would use profanity because they were in pain, being upset because they felt like the EMS personnel were not working fast enough, and simply because they were agitated or in a different frame of mind. In a study conducted by Tay et al. (2021), the authors discussed how paramedics reported that most of the people that verbally abused them did so due to physical pain or being under the influence of substances. This is like what the participants in my study stated as well. The participants in my study also described that people would mainly tell them that they did not know how to do their "fucking jobs" and that they were not doing a good job. Four of the participants described that these types of comments are "pretty annoying," but they tend to not let people using profanity towards them prevent them from doing their jobs.

Subtheme 2: Patients and Bystanders Calling EMS Personnel Inappropriate Names

Name calling was also another form of verbal violence that was described by my five participants as well as participants in other studies. In a study by Copeland and Henry (2017) with 147 EMS personnel, the authors found that 64.6% reported their patients called them inappropriate names and 21.8% of bystanders called them inappropriate names. Again, the participants in my study mentioned that name calling

does not faze them much as people tend to say inappropriate things during crisis situations. They shared that they try to brush off these inappropriate names, but at times, these names stick with them. One participant described being called a “cunt” by a female patient and another participant described being called a “White boy” and a “Cracker” on multiple occasions. Taylor et al. (2016) described how female paramedics would be called inappropriate names such as “baby, sweetheart, cunt, and bitch,” amongst many other names (p.4). Due to not having any female participants in my study, this was not noted by my participants. However, inappropriate name calling was a general problem throughout multiple studies.

Subtheme 3: Patients and Bystanders Threatening to Harm EMS Personnel

Another common form of verbal violence towards EMS personnel were patients and bystanders threatening to harm them. Eight participants acknowledged that people have threatened to kill or hurt them on multiple different occasions. This is consistent with Suserud et. al (2002) who showed that the most common form of threats and violence was the use of threatening invectives (78%) which included threats of violence, threats of reporting, and threats of harming their families.

In my study, participants described types of verbal threats as threatening to harm one’s family members, threatening to kill them, and threatening to “rip them in half and beat the shit out of them.” Participant 5 described verbal threats can be more traumatizing than name calling and profanity towards them as a lot of times, patients and bystanders that are threatening them tend to have a violent background. He shared that he tries to not take these personally, but it can take a toll on him and his crew. One similar example of a

verbal threat described by Suserud et al. (2002) was a patient threatening to bash a paramedic's head in. The paramedic described this threat as traumatizing, and he felt like he needed to keep his guard up.

Subtheme 4: Patients and Bystanders Threatening to Kill or Harm EMS Personnel with a Weapon

Another form of verbal violence reported by six of the participants was being threatened with a weapon by patients and/or bystanders. Participants described this as being intimidating and it makes it hard for them to complete their jobs effectively since they are worrying about a weapon the person on scene may have. Some participants in my study described being threatened with things like baseball bats and knives. Maguire, Browne et. al (2018) discussed a wide variety of weapons that have reportedly been used by patients to threaten EMS personnel, ranging from firearms to household items such as kitchen knives. This study is like what the participants in my study described as what they have found on their patients as well. Further, in a study completed by Oliver and Levin (2015), 62% of their participants in their study stated that they routinely check their patients for weapons, and find weapons on them a lot of the times. The main weapons they have reported finding on their patients was knives, guns, and various other sharp objects, such as needles.

Subtheme 5: Verbal Abuse from Reoccurring Patients

A common subtheme of verbal violence and abuse with my study was verbal abuse from reoccurring patients. All nine of the participants in my study described how reoccurring patients can become very verbally aggressive and take a lot of their

frustrations out on them. Some participants described different forms of verbal assaults by reoccurring patients are being called names such as “bitch, asshole, fucking dickhead” and reoccurring patients using profanity towards them. Unfortunately, there was a limited number of studies that discussed reoccurring patients and/or clients amongst EMS personnel or in public safety jobs. This is an important topic to discuss as the participants in my study mentioned that even though reoccurring patients can be hard to work with, the nice thing is that they know what they are getting into when they deal with them and can usually come up with a plan to help resolve any major conflicts. Therefore, further research needs to be conducted on this topic to better understand how verbal abuse from reoccurring patients can affect the patient/provider dynamic.

Interpretation of Findings: How Experiences of Patient and Bystander Violence Affect the Way EMS Personnel Approach the Incident Scene

The first subquestion in this study focused on how experiences of patient and bystander violence affects the way EMS personnel approach incident scenes. Answering this question, participants discussed staging, situational awareness, the use of ballistic vests during high-risk situations, and requesting the presence of police officers while on incident scenes. These themes will be discussed in more detail below.

Theme 3: Staging

Staging refers to staying away from an incident scene and not rushing into certain places or situations until it is deemed safe (Enrich, 2017). Six participants in my study acknowledged that they have learned from experience that they do not need to rush into certain situations as rushing into these situations can result in themselves or their crew

getting hurt. Wolfberg and Wirth's (2015) study mentioned that at times, EMS personnel will stage away from the area to ensure everything appears safe before they enter certain areas. This is like what the participants in my study mentioned. Further, the authors in the study shared that staging away from an incident until the scene was safe and knowing all they can about the incident and the scene before arriving has prevented violence towards them by others on many different situations.

The six participants in my study, as well as the study conducted by Wolfberg and Wirth (2015), acknowledged that if it is a high-risk situation, they wait for the police to clear the area before they go in. The authors noted that EMS personnel tend to not go into certain neighborhoods without the support of police, but they are aware that at times they must enter these environments without police presence. The six participants mentioned in my study that there are times they have to go into unsafe areas but tend to wait on further details from dispatch before they approach an incident scene without further knowledge of what they are entering.

Theme 4: Situational Awareness

For EMS personnel to maintain safety not only for themselves, but for their partners and patients, they must be situationally aware. To be situationally aware, EMS personnel "must be able to recognize a situation, correctly interpret it, and analyze that information in order to anticipate future events" (Hunter et al., 2021, p. 2). Situational awareness was broken down into three separate subthemes to encompass the different ways that the EMS personnel in my study attempted to stay safe while on scene. The three subthemes, strategic positioning, situational awareness while on scene, and

heightened sense of awareness when approaching low-income and high-crimes areas will be discussed below.

Subtheme 1: Strategic Positioning

Strategic positioning revolves around placing oneself in a specific area to maximize their safety (Copeland & Henry, 2017). For example, being close to an exit, knowing where their partner is at all times, and positioning themselves between the patient and any objects that could be used as weapons. Eight participants in my study mentioned strategic positioning as a way they have learned to approach incident scenes differently. Multiple studies have identified that strategic positioning while on scene can allow someone to be situationally aware and help prevent them from being assaulted. For example, Copeland and Henry (2017) stated that knowing what is in the environment, where the patient and bystanders are, and ensuring they know where the exits are, are ways EMS have kept themselves safe. Copeland and Henry's findings are like mine as many participants stated that they are always aware of the exits, aware of any weapons on the scene, or anything that could be used as a weapon, and place themselves by any bystanders that could cause problems at the scene. The participants in my study have credited strategic positioning as one way they have kept themselves and their partners safe.

Subtheme 2: Situational Awareness While on Scene

Not only is strategic positioning an important tool but being situationally aware while on incident scenes is also an important strategy in keeping EMS personnel safe. All nine of the participants in my study identified that being situationally aware comes with

time and lots of experience. One participant identified how he believes his insights have gotten better and he has been on enough calls where he feels like he can walk in a room and feel the vibe of it. He described that he was unable to do this as a new paramedic. Similarly, in Copeland and Henry's (2015) study, participants mentioned their own perceptions on how to remain safe at incident scenes. Multiple participants agreed that people needed to be reminded of "being aware of surroundings at all times" (p. 73).

Some studies have shown that once EMS personnel become complacent at the scene, is when they are more likely to be assaulted or injured by patients and/or bystanders. For example, Hunter et. al's (2021) study identified that brand new paramedics and paramedic students are not situationally aware. Many of the students failed to recognize certain high-risk events or interpret what those events meant, which resulted in them being placed in dangerous situations. Many of the participants in my study recommended further training on situational awareness to help teach new paramedics what to look for when they go on incident scenes.

Subtheme 3: Heightened Sense of Awareness when Approaching Low-Income and High-Crime Areas

Staying situationally aware and having a heighten sense of awareness when approaching low-income and high-crime areas was another way EMS personnel stated that they could remain safe on incident scenes. Six participants in my study identified that areas with low-income and high-crime rates tend to have people that are abusing substances, people that are participating in gangs, and higher mental health issues. The public calls upon EMS personnel to respond to a variety of emergency situations in many

different environments (Furin et. al, 2015). Due to the different types of environments that EMS personnel are called to, they need to have a heightened sense of awareness going into certain neighborhoods. The participants in my study as well as other studies have identified that due to previously being more physically or verbally assaulted in these areas of town, they have learned to increase their sense of awareness and be more cautious when approaching these areas. Some participants mentioned that even though having a heightened sense of awareness in these parts of town keeps them safe, it also makes them more hesitant to enter these areas of town which ultimately could affect patient care.

Theme 5: The Use of Ballistic Vests During High-Risk Situations

The use of ballistic vests was discussed by all the participants of my study. Six participants stated that they were not provided with ballistic vests from their department while only three reported that they received vests. Similarly, in a study completed by Erich (2017), the researcher described the lack of availability of ballistic vests for EMS personnel due to the costs of the body armor and the size of the departments. This is similar to the reasoning of the six participants that stated they did not receive ballistic vests from their departments. The six participants shared that many of their departments were either way too big to provide ballistic vests to everyone or their departments did not have the funding to provide these vests.

However, all nine of the participants in my study concluded that they would feel safer if they were provided ballistic vests as it would be beneficial during high-risk situations. Some of the participants stated that they feel they would feel safer when they

approached high-risk situations, especially situations that involved active shooters or domestic violence. The three that stated they had ballistic vests provided to them by their department utilizes these vests only during high-risk calls and it makes them feel more effective at their jobs since they are not worried about their safety as much and can focus more on the safety of the patient. Enrich's (2017) study coincided with the thoughts of my participants by mentioning that many EMS personnel have mentioned that they feel safer and more effective in high-risk situations when they have protective vests to keep themselves and their crew safe.

However, out of the three participants that have been provided with body armor, two of the participants stated that the use of ballistic vests can be uncomfortable, and they don't like to wear them on calls that are not high acuity calls. Similarly, the study by Enrich (2017) mentioned that body armor needs to be reasonable for the type of job being done. For example, EMS personnel would benefit more from a lighter fitting body armor however, this means that the body armor might not protect them against bullets, but only knife slashes and stabbings from knives. Either way, the six participants that were not given ballistic vests from their department, stated they would feel more comfortable with having an option to utilize ballistic vests if it were given to them.

Theme 6: Requesting the Presence of Police Officers while on Incident Scenes

Requesting the presence of police officers while on incident scenes was another important topic brought up by the participants in my study and in different research articles. All nine of the participants in my study agreed that requesting police presence at some incident scenes were important for their own and their crew's safety. Three of the

research articles that mentioned police presence at scenes discussed the positive effects of requesting the police during certain calls. For example, Maguire, Browne et. al (2018), mentioned that many EMS personnel will not go to certain areas of town without the presence of police officers to help keep them safe. This was similar to what four of the participants in my study stated. The participants mentioned that police officers are automatically called to certain areas of town, so they have the protection of the police while on these calls. All nine of the participants mentioned that they feel safer during most calls when the police are present as they know the police will have their backs and protect them. Similarly, a study completed by Furin et al (2015) mentioned that EMS personnel who are protected by police officers while on certain scenes, feel like they are more efficient at patient care since they are not constantly looking over their backs for protection. Three of the participants in my study mentioned that the police officers on the scene can help them restrain combative patients which helps them feel safer knowing someone that is professionally trained to handle combative people are there to keep them safe.

However, three of the participants also mentioned that there are certain times they try to not involve the police as it seems to escalate the situations even more. Many of the research articles on requesting police presence for EMS personnel agreed that police presence was necessary and none of them mentioned the negative effects of police presence like the three participants mentioned in my study. Even though these three participants agreed that police officers could be effective at certain times, they mentioned that police presence could also escalate situations. For example, one participant

mentioned that sometimes calling the police to help with crowd control, especially in bigger cities, would almost always escalate the situation, due to recent protests against the police due to police brutality. One participant mentioned that he feels the only time there is any hostility towards them is when the police are around them as people will then correlate EMS personnel with the police. Even though, these participants had differing opinions than some of the other participants and research articles, they still all agreed with police presence being beneficial during most situations.

Interpretation of Findings: How Experiences of Violence Affect the Way EMS Personnel Interact with Patients and Bystanders

The second sub-question in this study focused on how experiences of violence affect the way EMS personnel interact with patients and bystanders. Answering this question, participants discussed the use of de-escalation techniques and how utilizing different techniques can help de-escalate situations with their patients and bystanders. This theme will be discussed in more detail below.

Theme 7: The Use of De-escalation Techniques

The use of de-escalation techniques was a common theme that was talked about by all nine of the participants in my study. When it comes to de-escalation techniques, many of the participants described different de-escalation techniques such as having a positive attitude and showing respect towards others, building rapport and trust with their patients and bystanders, developing patience, and building a diverse crew to help build relationships. Even though de-escalation techniques were a common theme brought up by all nine of the participants, there is a limited amount of research done on de-escalation

techniques used by EMS personnel in the field. Due to the limited amount of research, some of the articles below will describe how similar public service sectors, such as police officers and nurses, use de-escalation techniques with their patients and clients, to help prevent verbal and physical violence. It is important to note there are limited studies done on specific de-escalation techniques utilized by these different agencies as well.

Subtheme 1: Having a Positive Attitude and Showing Respect Towards Patients and Bystanders

Due to acts of violence towards EMS personnel by patients and bystanders, there is an understanding that they may change their attitudes towards patients and families, or they may be more hesitant to intervene in certain circumstances (Furin et. al, 2015). Three of the participants in my study discussed how they try to approach every patient with a positive attitude and being respectful. They mentioned that just having a positive attitude and respecting those around them has resulted in some hostile scenes becoming less volatile. Similarly, a study by Baig et. al (2018), identified that there was a reduction of aggression and violence towards healthcare workers when de-escalation techniques, such as positive communication, were used to help calm a patient. The study also acknowledged that proper de-escalation training on maintaining a respectful and positive attitude towards their patients also had improved healthcare workers attitude and temperament towards aggression expressed by their patients and family members (Baig et. al, 2018). Overall, research studies, including my own, have shown a strong correlation between maintaining a positive attitude while working with patients has decreased the amount of verbal and physical violence towards them.

Subtheme 2: Building Rapport and Trust with Patients and Bystanders

Building trust and rapport with patients and bystanders was another common subtheme of de-escalation techniques. A study by Garner et. al (2022) used standardized simulated scenarios to see what de-escalation techniques worked best with violent encounters from patients. They determined that healthcare workers who took the time to build rapport and trust with their patients were less likely to be assaulted while working (Garner et. al, 2022). Similarly, four out of the nine participants in my study also identified that building rapport and trust with their patients and family members also help de-escalate situations and kept them safe. One participant described building a connection and finding those that were in "charge" of the family, helped alleviate any tension between EMS personnel and family members. Another participant discussed how seeing the same patients repeatedly, helped them build rapport and trust, which made it easier to talk to the patients calmly if things started to escalate. Another study by Goh et. al (2020), discussed how showing empathy and building relationships with their patients has shown to be a promising technique when de-escalating their patients in a hospital setting. Overall, multiple studies, including my own, have shown that building trust and rapport with patients and bystanders is an effective de-escalation technique when working with others.

Subtheme 3: Developing Patience While Working with Patients and Bystanders

Developing patience while working with patients and bystanders is also another important de-escalation technique to utilize to help keep situations calm. Three participants in my study identified that developing patience for their patients is important

because everyone deals with crisis situations differently. For example, one participant described using a monotone voice and developing a plan before going into situations help him remain patient. Another participant described having self-restraint, especially when people are yelling at you as another way to remain patient. Unfortunately, there were limited research articles on EMS personnel using patience to de-escalate situations. However, a study by Oliva et. al (2010) described how police officers use patience to help de-escalate crisis situations. Police officers have learned to use active listening skills when working in crisis situations. They do this by using "I" statements, restating statements, summarizing what is being said which is all built on being patient and understanding each individual in crisis (Oliva et. al, 2010). This article correlates with my research study by describing how developing patience when working in high crisis situations can help defuse situations and prevent others from becoming violent.

Subtheme 4: Building a Diverse Crew to help Build Relationships with Patients and Bystanders

Having a diverse crew to help build relationships with patients and bystanders was talked about by two of the participants in my study. Having a diverse crew means having people of different races, ages, and gender to help build a connection with patients and bystanders at the scene. One participant stated that he has learned that having a more diverse crew means that there is always someone that can closely relate to others on scene. Another participant stated that having a diverse crew is a good de-escalation technique because he knows that people tend to relate to one another based on certain traits that we have. He shared that he could relate to the older white male population a lot

better than a younger, more diverse population. Unfortunately, this theme is only limited to two participants opinions and there is no known research that discusses how having a diverse crew can lead to building better relationships with patients and bystanders. Therefore, this has potential to be a good de-escalation technique, however, it is recommended that further research be done on this topic as well.

Interpretation of Findings: Lack of De-escalation Training

The lack of de-escalation trainings was an unforeseen theme that came out of this study. All nine of the participants in my study mentioned that they felt they do not receive adequate training in de-escalation techniques. Seven of the participants mentioned that most of the de-escalation techniques they know are from years of experience and that you learn as you go. All nine of the participants mentioned that they wished there was more de-escalation training for their departments as they feel this could help prevent their new staff from being in violent situations. Similarly, there are many studies that discuss the important of including de-escalation trainings more frequently for people in public services. In a study completed by Copeland and Henry (2017), many participants of their study recommended that there needs to be more staff training on staff dealing with verbally abusive persons as well as better de-escalation trainings. One of the participants in my study mentioned that the only training on de-escalation he was given in EMT class was to build a rapport with the patient, but there was no training on how to actually build a rapport with anyone. He felt that better de-escalation training was necessary as well.

Another study that was conducted by Garner et. al (2021) used 270 EMS professionals and evaluated them based on simulated scenarios. They determined that 54% of the professionals made an adequate de-escalation attempt of the scenario whereas 20% failed to use any de-escalation techniques. The researchers determined that many of the EMS professionals that succeeded in making an attempt at de-escalation were those that have been on the job longer. This is similar to what the participants in my study suggested. All nine of the participants in my study mentioned that they learned de-escalation techniques based on their experience but would not have been able to verbally de-escalate their patients as brand-new EMS personnel. This shows that verbal de-escalation techniques can be learned and used effectively if they are given the proper training.

Limitations of the Study

This interpretative phenomenological study was meant to better understand the lived experiences and perceptions of violence towards EMS personnel by patients and/or bystanders at the response scene. Further it was meant to better understand how this violence affected the way they approached incident scenes and interacted with their patients. Due to the lack of qualitative research involving EMS personnel who are subjected to violence within the Midwest and how this affects the way they approach scenes and treat their patients; this study addressed this issue.

As with many qualitative studies, the sample size involved in the study was small. A total of nine participants was used based on how many participants it took to exhaustively collect all relevant information and reach saturation. The small sample size

used in this study could prevent the transferability of findings to other populations. However, as described in chapter 4, the methods implemented to ensure trustworthiness, were adhered to. Therefore, there were no known limitations to trustworthiness in this study.

Implications for Social Change

The implications for social change resulting from this study are significant because the findings contribute to the body of researched aimed at EMS personnel who have experienced violence while working with patients and bystanders. This study outlines EMS personnel's experience of violence and how this impacts the way they approach incident scenes and their patients. Specific recommendations are offered to help interested parties increase awareness of violence towards EMS personnel and the need for more training on de-escalation techniques in the following section.

The participants described their experiences with being victimized by both patients and bystanders and how these experiences changed the way they approached incident scenes and interacted with their patients. Their experiences of violence impacted their views of their patients but taught them first-hand how to de-escalate patients by having a more positive and respectful approach, building trust and rapport, and working with a more diverse crew to help lessen their changes of being both physically and verbally assaulted again. If the findings of this study result in change for the safety of EMS professionals, the potential outcome would be lowered acts of violence on EMS personnel by providing appropriate and continued de-escalation trainings for them. This could impact how they approach incident scenes and how they interact with their patients.

Recommendations

If we are going to utilize this research to help raise awareness of violence towards EMS personnel and how it impacts the way they approach incident scenes and patients, then we must conduct future research that continues to examine the specific needs of EMS personnel and their perceptions of the violence towards them. Within my study, all participants described the need for better de-escalation training, which was an unexpected theme that arised from the interviews. There is a lack of literature based on de-escalation techniques that EMS personnel have used and the participants of the study described they rarely, if ever, talk about de-escalation techniques with their crew. All nine of the participants described that they would like better training programs developed around de-escalation techniques as they feel this would better prepare them to approach incident scenes and work with combative patients.

Research examining the opinions and perceptions of EMS personnel and the techniques they use to help de-escalate their patients and bystanders is largely absent in research literature. However, the opinions and perceptions of EMS personnel are relevant. EMS personnel are the ones that are directly working with combative patients and unsafe incident scenes, so therefore, it is important to develop more research literature that supports EMS personnel and their experiences of working with these clients and incident scenes. Overall, it is recommended for further research to be conducted on how the experiences of violence towards EMS personnel by patients and bystanders affects the way they approach incident scenes and patients to help develop a

better understanding on what EMS personnel need to keep themselves and others around them safe and effective at their jobs.

Conclusion

This study was an interpretative phenomenological study examining the experiences of violence towards EMS personnel by their patients and bystanders. Further, it examined how these experiences of violence affected the way they approached incident scenes and their patients. There were nine participants in this study, and they have been involved in the EMS system between 5 to 40 years with an average of 19.9 years. All the participants worked in cities in the Midwest which included cities from Iowa, Minnesota, Nebraska, and Wisconsin.

Although they had different life experiences based on the type of violent encounters they had while working, they still described similar concepts of what they have changed based on these violent experiences. When it came to how they approached incident scenes differently, four themes emerged: staging situational awareness, the use of ballistic vests during high-risk situations, and requesting the presence of police officers while on incident scenes. When it came to how they interacted with their patients and bystanders differently, the following theme emerged: the use of de-escalation techniques. Finally, all nine of the participants mentioned that there is a lack of de-escalation trainings provided to EMS personnel and they all felt that more training was necessary to keep them safe and help them de-escalate situations that are getting violent.

If we understand the experiences of EMS personnel who are victims of violence by their patients and bystanders, we can start to offer better trainings and services to

either help them deal with being victimized as well as finding better ways to help them manage crisis situations that are becoming violent. Therefore, further research needs to be conducted on how experiences of violence affect the way EMS personnel approach incident scenes and how they interact with their patients and bystanders on scene. This can help identify the different types of training that may need to be put in place to help de-escalate crisis situations before they become violent.

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Appendix A: Interview Questions

Semi-Structured Interview Protocol

Research Question	**Subquestions**	**Follow-up Questions**
RQ1: What are the experiences of EMS Personnel who are victimized by violence from patients and bystanders?	Q1: (Rapport) How long have you worked in the EMS field?	
	Q2: (Rapport) Can you explain what shifts that you work?	
	Q3: What are your patient demographics?	
	Q4: Have you experienced violence towards you originating from patients and/or bystanders?	4a. Have you experienced physical violence towards you by either patients or bystanders? If so, please describe your experiences of physical violence towards you. 4b. Have you experienced verbal violence towards you by either patients or bystanders? If so, please describe your experiences of verbal violence towards you. 4c. Have you experienced psychological violence, (i.e. threats towards you or your family, towards you by either patients or

	bystanders? If so, please describe your experiences of psychological violence towards you.
Q5: How does your experiences of violence towards you shape the way you approach incident scenes?	5a. Do past experiences of violence affect the amount of time on a scene?
Q6: How does your experiences of violence towards you shape the way you interact with patients and bystanders?	6a. Do you find yourself maintaining a higher sense of situational awareness? If so, how does this affect your ability to concentrate on on-scene patient care?