INTO THE BRINE:
THE SOCIAL CONSTRUCTS OF PARAMEDIC BURNOUT

By

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This is a transdisciplinary critical discourse analysis of the ways in which educational, organizational, hidden and lived paramedic curricula intersect with ubiquitous social constructs to contribute to paramedic burnout in Canada. Cartesian dualism; nature vs. nurture; emotional labour; stigmatization of mental illness and the transmission of trauma are considered using queer theory, disability theory, feminist theory, neurophysiology, sociology psychology and educational theory. Transdisciplinary curricula reform is proposed to reduce the incidence and impact of paramedic burnout.
Introduction

Recent headlines (Gollom, Sept 29, 2014; Leung, Oct 8, 2014) have drawn national attention to the impact of post-traumatic stress disorder (PTSD), suicide and operational stress injury (OSI) on paramedics in Canada, and the Tema Conter Memorial Trust reports twenty-seven known first responder suicides in Canada in the last seven months. These harbingers in mainstream media echo the intent of several papers published in the summer of 2014 by the Paramedic Association of Canada that are lobbying for support of paramedic mental health. On July 28, 2014 a Paramedic Association of Canada strategic planning report championed by the Paramedic Chiefs of Canada named paramedic mental health as a top priority for standards work (Paramedic Association of Canada, p. 5), and on September 29, 2014 the Paramedic Association of Canada initiated a Canada-wide survey on mental health among paramedics. Change is coming from the managerial ranks by way of research and policy reform, and in Ontario for example there is legislative momentum building by way of Bill 129 tabled to improve support to emergency services workers who are experiencing PTSD (Legislative Assembly of Ontario, 2014). There will be curriculum reform originating at a national
level as our National Occupational Competency Profile (NOCP) is evolving to reflect the prioritization of paramedic mental health (Paramedic Association of Canada July 28, 2014). Leaders in the field of paramedicine have taken up the charge to begin building a work environment that recognizes and provides support for paramedic operational stress injury.

These management-driven advances are warmly welcomed. To date, the absence of a comprehensive approach to supporting paramedic health has allowed a culture of burnout to take hold, and the woefully inadequate, threadbare façade of bravado barely veils a paramedic workforce that is a-fester with fluctuating degrees of burnout. It’s a perpetual machination, burnout: a reciprocal causality in which symptomatic behaviours and cognitions contribute to a toxic workplace that further nurtures burnout in self and others.

Compassion fatigue, burnout, depression/anxiety, attachment disorder, PTSD and suicidal ideation and/or action occur to varying degrees over the span of every career in paramedicine as every working medic knows. Within these sequelae burnout is the most pervasive, consistent toxin. Medics can readily recite its common definition as a “state of physical, mental, or emotional exhaustion combined with doubts about [one’s] competence and the value of [one’s] work” (mayoclinic.org) as burnout is very well understood within the ranks of paramedicine from both theoretical study and lived curriculum. This superficial definition misses the deeper experience of burnout affecting medics’ personal lives. Internalized negativity, alterations in intimate and social relationships, physical illness and soldiering on through intense pressure with varying degrees of success are all part of burnout. Cieslak (2013) provides a more relatable
definition of burnout as a response to job stressors that involves exhaustion (physical, emotional, mental), with disengagement and depletion of coping mechanisms, measured in a domain-specific context.

In the literature antecedents to burnout are usually grouped under three categories: organizational, occupational, and individual characteristics (Swider & Zimmerman 2010, p. 487) and these are the fields in which the Paramedic Association of Canada and Paramedic Chiefs of Canada are spearheading research. It will be productive to compare this emerging evidence to age-old anecdotal accounts of paramedic burnout being fueled by panopticon oversight by numerous agencies; the paramilitary structure of paramedic organizations; the lack of critical incident stress management; non-recognition and support of PTSD; wildly irregular daily occurrences within ever-changing circadian shifts; and pre-existing personal characteristics such as resiliency and personal history.

Research addressing organizational, occupational and individual causes will contribute to partial amelioration of the culture of burnout however a much more robust approach includes consideration of the social constructs and cultural phenomena that are contributing to paramedic burnout. That is to say, wherein the organization is lid, the occupation is the jar and the medic is the hardened, crunchy pickle (not without its certain charms), one must also consider the potent brine in which the very best pickles and fresh rookie cucumbers are swimming, and the great wide world outside the jar: a grocery store full of endless choices of healthy sustenance and/or self-destruction. In deconstructing the complex culture of paramedic burnout one thing is for sure: ye shall not blame the pickle!
So within this jar of paramedicine there are ingredients that have to be there: the vinegar, the dill, the garlic and the salt. Some potential influences are necessary evils. For example, emotional labour is a required skill for medics—but too much can spoil the batch. Titratable flavours include the social constructs of a false nature/nurture divide, the stigmatization of mental illness, and the effects of trauma. It is this list of ingredients, the very brine in which medics season and thrive, that will be considered in detail below.

The intent of this consideration of the social constructs and phenomena that are negatively influencing paramedics is to support curricula reform and therein contribute to the dismantling of the culture of burnout. For the purpose of this exploration, “curricula” will refer equally to the curriculum offered within paramedic training programs at community colleges; training offered to working medics by their employers; and most importantly to the sometimes overt, sometimes hidden and always lived curriculum that infuses into the good people who are swimming in the general brine of life as a paramedic.

**Approach and Scope**

Medics are naturally transdisciplinary thinkers. At a motor vehicle collision for example, the medic is constantly reassessing the most current knowledge (evident and/or hidden injuries and emerging patient needs) while considering priorities in terms of the patient’s present state (comfort and immediate threats to life/limb), history (patient’s underlying medical, psychological and social needs), and future (patient’s likely clinical outcome, long term prognosis and the implications of these potential changes). Medics consider all of these factors while simultaneously formulating and enacting a plan of
action (treatment and transport), collaborating with allied disciplines (police, fire, dispatch, receiving facility staff) often while contending with potential threats (ongoing weather and/or traffic dangers) and incredible social pressures (patient and/or bystander reactions to traumatic events) with the endgame of ensuring the best possible outcome for a patient (medically, socially and psychologically) all while considering impact to the wider society (traffic shut down and implications). This fluid, multi-space/time continuum, multi-disciplined thinking with attention to both evidence-based and lived knowledge with informed action on behalf of a “good life” (Angus 2008, p. 15) is an example of transdisciplinary thinking.

Nicolescu (2007) defines transdisciplinarity as “the understanding of the present world”, and as entailing “both a new vision and a lived experience. It is a way of self-transformation oriented towards knowledge of the self, the unity of knowledge and the creation of a new art of living in the society” (p. 3). Using a transdisciplinary approach to considering burnout in paramedicine takes us beyond the limits of organizational, occupational and individual causes of burnout. Nicolescu transforms his theory into a call to action, a call for a new state of education hinged on a reunification between scientific and artistic cultures, and a “new intelligence” founded on equilibrium of analytic intelligence, feeling and body. He describes four pillars of a new style of education in which learners develop themselves equally in the realms of science, creativity, cultural competency and self-awareness (p. 6-7). Most medics have not had this balanced approach in education, at least not at the hands of official paramedic programs or service instructors.
Our curricula would benefit greatly from an infusion of creativity, cultural competence and self-awareness into the foundational medical education with which medics are provided. Not just as add-on objectives but throughout the curriculum delivery. For example, instead of dropping a frame-less factoid such as black Canadians are at higher risk for heart disease than white Canadians (which was taught for years by Heart and Stroke Foundation and parroted in paramedic classes and stations as being likely due to a genetic predisposition), this issue could be better presented within the socio-historical context that black Canadians have a higher risk of heart disease because of the accumulative stress of ongoing racialization (Williams, 2013), and by inviting consideration of medics’ personal awareness and experiences around the intersection of racism and healthcare.

While transdisciplinarity challenges consideration of all possible factors, there is tempering theory that guides exploration into more manageable approach. Szostak (2012) lobbies for consideration of issues using both Apollonian (ordered, scientific) and Dionysian (free, creative) study of issues and Angus (2008) pushes for inclusion of knowledge that exists completely outside of the academic disciplines (p.48-50). Medics are educated and practice within the confines of the medical discipline and as such are innately familiar with the medical model in which an axis of power/knowledge exists between the health care practitioner (the more empowered provider) and the patient (the less empowered recipient). While the medical model and some physiology will be addressed below more attention will be paid to the humanities and non-academic knowledge as these sources have been given far less airtime in paramedic curricula.
Code (2012) agrees with overturning the academic applecart, and eschews the practice of using a top-down approach to knowledge production by encouraging a less hegemonic rule of academy and market place and lives (p. 193). She lobbies for “situated knowledge” that takes into account the subjectivity, cognitive agency, and geographical-mathematical-historical-cultural location of the knowledge (p. 194). To this end I will situate myself as a medic with twenty years experience working on land, air, in hospital and teaching mostly in Southern Ontario. For the non-medic reader, that means transport of over twenty thousand patients; exposure to all manner of personal violence from the ubiquitous micro-aggressions of verbal abuse to sexual harassment to the less common life threats of having suicidal patients point loaded rifles at my partner and me; exposure to children newly slaughtered on the highways, women intentionally burned almost-to-death by spouses, innumerable devastated seniors coping with the loss of their spouses of fifty plus years, vulnerable members of marginalized communities who have experienced racialized or homophobic or ableist or gendered (and/or any combination thereof) violence; and so on ad nauseam. Medics reading this list will have been humming and reaching for another coffee, as they should. This is merely the daily brine of transdisciplinary medics.

In the face of this transdisciplinary pressure to consider absolutely everything Sarewitz (2010) ensures humility by noting, “the only truly holistic representation of a system would be the system itself” and that every other approximation is wrought with incompleteness and researcher-influenced choice regarding what incomplete part of the whole will be considered (p. 8). In addition to the actual incomprehensibility of any complex system he observes, “the inability of local actors to understand the cumulative
and emergent consequences of their actions is revealed as a central cause of the complex problems to begin with” (p. 6). Indeed. In the case of burnout not only is the culture complex, but the actors within it are potentially neurologically altered by burnout itself and therefore their interpretations may be altered accordingly. A generous helping of humility is imperative. Even from within our own ranks we are duly cautioned as our Paramedic Association of Canada requires us to, “Identify risks associated with over confidence” and, “Adjust behaviour to exhibit an appropriate level of confidence” (National Occupational Competency Profile 2.4.d. sub-competencies). So there is no actual expectation to understand every nuance of burnout here and, as we are so mired in the briney sauce of it, our ability to do so will always be somewhat limited. So with a spirit of curiosity and an acknowledgement of the inherent incompleteness of any transdisciplinary exploration of paramedic burnout we shall proceed into the estuary of paramedic burnout and intricately inter-related social constructs in an attempt to supplement paramedic curricula.

Deconstructing social constructs

Social constructs are generally held beliefs that exist because a bunch of people said so and keep saying so. “The world is flat” was a good example until poor Galileo tried to say otherwise and the church promptly imprisoned him for life. It can be this way with social constructs as well. People and organizations hold on dearly to what they believe to be true because letting go of fundamentally held beliefs would shake the foundations of how one exists in the world. Letting go of constructs would undermine authority and the sweet smugness of conviction and who wants that? With the benefit of
hindsight it seems like old Galileo had something there. Let’s keep that in mind as we consider some current social constructs upon which our understanding of medic life is built.

Cartesian dualism

For centuries we have been reproducing a construct named for 17th century philosopher René Descartes. Cartesian dualism, a.k.a. the Cartesian divide, is the ostensible division between the mind and body. It’s an important concept because much of our trouble as medics can be traced back to this fictional divide wherein the body—made of tangible matter that can be studied, quantified and controlled—exists separately from extracorporeal, indefinable consciousness. By western standards this seems impossible as the mind is considered to be to be housed in the brain. And yet the construct of the mind-body divide persists in such classics as the nature/nurture debate, emotional regulation, hegemony of all sorts, gender role expectations and the stigmatization of mental illness and trauma.

Nature vs. nurture

The nature vs. nurture debate is well established with genetic predisposition opposing socialization as two distinct forces. Drawing on queer theory, however, we can blend this theoretical Cartesian division into a single intertwined process for example in gender programming. Butler (1988), Nicholson (1994), Hood-Williams (1996) each illustrate the ways in which gender is socially constructed—that is to say physically embodied—through social programming. Physical comportment is taught—for example
crossing one’s legs at the knees has been considered polite, “womanly” behaviour but will eventually leave a physical legacy in the form of hip pain. The interplay of nature and nurture is seen again in the example of learning to throw a ball. There are physical changes occurring in the body: muscle building and muscle memory; neurological processing in hand-eye coordination and short- and long-term memory building; and gross and fine motor skills orchestrated by proprioceptive hardware in the ears and body. The development of these physical changes can be moderated by and verily incorporate socializing influences provided by way of coaching and positive external rewards like family and team adulation. The social influences create physical learning, physical knowledge and physical changes (Young, 1980).

So this co-evolution of physical and social learning happens with burnout, too. Neurological, endocrine, immune and other physical adaptations occur as a result of the stressors of paramedic work. The neurological changes that occur do not exist in isolation of the psychological changes—they are one in the same. Like pathways in the forest—the more travelled a neural pathway the more established it becomes. That is exactly why learners practice throwing the ball. Butler (1988) speaks in similar terms of gender development, stating “the body becomes its gender through a series of acts which are renewed, revised, and consolidated through time…one might try to reconceive the gendered body as the legacy of sedimented acts rather than a pre-determined or foreclosed structure, essence or fact, whether natural, cultural, or linguistic” (p. 523).

This layering of experiences upon the body and the resulting display of altered behaviour is a useful way to consider burnout. Ironically the experience of being burned out can actually lend itself to being an effective paramedic.
Emotional labour

The ability to portray a particular emotion while experiencing another is a learned and necessary skill in paramedicine. Health care workers often must portray a sense of calmness and confidence even when they are feeling sadness, disgust, fear or horror. Hochschild (1983) defined the term emotional labour as “the management of feeling to create a publicly observable facial and bodily display” (p. 9). It’s akin to feigning sleep in the middle of a tumultuous sneezing fit. Emotional labour is hard work but made somewhat easier when one’s emotions are blunted by burnout. Being able to manage one’s emotions on a scene is a necessary skill, but there is a vestigial, old school expectation that medics ought to be impervious to the continuous emotional challenges of their work. In other words, medics simply should not experience sadness, fear, disgust or horror in response to their work. The oft sung refrain “If it bothers you then you shouldn’t be doing the job” has caused many a medic to clench their emotional sphincters, much to the detriment of their own health and that of their loved ones and patients. Tears and requests for even an hour off after a difficult call have been met with derisive, bullying comments from colleagues—it is not enough to manage one’s emotions on scene, one must also refrain from indulging in any emotional experience after calls. A good entry point for deconstructing these harmful, socially sanctioned messages about emotional regulation is gender theory.

Canadians and medics in particular have been socialized along binary gender lines regarding emotional regulation. The display of emotions is seen as negative, as a loss of
control, as a sign of weakness, frivolousness and femininity. Conversely the control of emotion is seen positively as a sign of strength, dependability and masculinity. It’s worth noting here that paramedicine was a male-dominated field until recently, but all medics are socialized to regulate their emotions according to the masculine ideal. This gender-based social construct is rubbish, of course. Humans evolved with emotions occurring as physiological phenomena no different than sneezes and coughs, but we have assigned judgment to this particular set of physiological events. The gendered meaning assigned to emotions is distinctly patriarchal and the reproduction of this construct is inadvertently contributing to gender inequality both on the job and in our wider society.

Not only are gendered messages about emotions reproducing harmful stereotypes, but controlling emotions outside of the necessary times (on calls) requires a great deal of energy mind-body wise. Damasio (2000) states, “the essence of emotion [is] the collection of changes in body state that are induced in myriad organs by nerve cell terminals, under the control of a dedicated brain system, which is responding to the content of thoughts relative to a particular entity or event” (p. 139). For example the experience we call anger activates the sympathetic nervous system and causes physiological changes throughout the body including increased heart and respiratory rates, increased blood pressure, dilation of the pupils, increased blood flow to muscles and decreased blood flow to the gastrointestinal tract. Anger is not the only emotion that can be mapped throughout the body, it’s just the one with which medics are most familiar as it is the same system that is activated when patients are in shock. Other emotions are just as much physiological events—i.e. there is no divide between the mind and body.
when it comes to emotions—but we just don’t have the Google map version of all the other emotions yet.

Blunted emotional response is both a cause and a sign of burnout. Like the proverbial chicken and egg: we blunt therefore we burnout therefore we blunt. There are other physiological symptoms of burnout including depressed immune response, diminished cognitive ability and attachment disorder—which is merely healthy distancing from patients that unhealthily creeps into personal relationships. Regarding neurological changes associated with burnout MacEwen (2007) notes the “hippocampus, amygdala, and prefrontal cortex undergo stress-induced structural remodeling, which alters behavioral and physiological responses” (p. 873). The behavioural changes associated with burnout include projection of downward comparisons and generalized negativity. Ironically these outlooks themselves perpetuate another social construct that fuels burnout.

*Stigmatization of mental illness*

“Mental illness” is a phrase laden with Cartesian dualism. The implication of the phrase is that the illness is all in the mind, or more to the point that the illness is a fabrication of the mind. “Psychological illness” is better, though it still carries with it a significant stigmatization. To trace the roots of this stigmatization it is helpful to consult disability theory in which “normalcy” is problematized and disability is reframed as a disruption of social norms. Titchkovsky (2006) notes that both medicine and sociology have labeled disability as a “problem” (p. 135) to be solved. Medicine has offered precisely measured marginalization with its categorization of individuals by disability,
and sociology has inadvertently reinforced the “exacerbation of social structures, stereotyping and processes of interaction” (p. 136) that reproduce the “problem” of disability. Foucault (1990) notes the historical norm of the patriarchic scientific community in categorizing and exposing people as defective (p. 43), and it is his opinion that science reflects social norms (p. 53).

Certainly medics are products of scientific training and as such are programmed to categorize people by their “defect”—illness or injury. When further fueled by the altered neurological experience and negative affect of burnout, medics experience a confusing coexistence of the stigmatization of and self-identification with mental illness. The burned out medic is in the unenviable position of having to declare oneself “mentally ill” in order to access much-needed care. In addition to the usual wariness of stigmatization that anyone would have, the medic has an innate understanding of both the underlying stigmatization by health care workers and the predilection for emotionally-regulated responses from the person to whom s/he discloses. Medics disclosing mental illness give up their positions of power in the health care and paramilitary axes, and may experience a shift in their class if they are deemed unfit to work and/or are bereft of benefits. Add to these considerations any intersectional coordinates and the full picture begins to emerge. Nestel (2012) notes that racialized minorities may have higher burnout rates based on lifetime of racialization, and this pattern of marginalization affecting health might be extrapolated to the queer community also. There is risk to one’s gender identity in identifying as mentally ill. Women who require care instead of providing it and men who are unable to hold gainful employment are “failed” women and men according to social doctrine (Wendell, 1986). Medics who identify with one or more
synergistic coordinates on these axes of oppression will have a more difficult time disclosing mental illness.

Given the vociferous stigmatization of mental illness within health care ranks it is understandable that those medics who are experiencing burnout are highly reticent to self-identify, and prefer instead to “pass” as non-disabled in the workplace. The insidious nature of burnout is that its very symptoms reproduce it. Burnout shuts people down and in forgoing disclosures one perpetuates burnout. Porter and Johnson (2008) note that medics fear social reprisal, feel isolating self is unhelpful but 80% of medics do it anyway, and use emotional repression resulting in psychological and physical stress symptoms. This maladaptive behaviour aligns mentally ill medics further with the disabled community. Charlton (1998) writes generally about the disabled community and the altered self-perception is reminiscent of that which can accompany burnout,

[Psychological internalization] creates a (false) consciousness and alienation that divides people and isolates individuals. Most people with disabilities actually come to believe they are less normal, less capable than others. Self-pity, self-hate, shame, and other manifestations of this process are devastating for they prevent people with disabilities from knowing their real selves, their real needs, and their real capabilities and from recognizing the options they in fact have (p. 220).

So burnout can cause individuals to isolate themselves from colleagues, friends, family and intimate partners (King, 2014). But isn’t this internalization protecting loved ones from the traumas of paramedic work?
Transmission of trauma

Trauma is an unavoidable element in paramedicine. Most often medics are exposed to secondary trauma in which they witness the intimacies of a patient’s physical, psychological and/or sexual trauma, and through conversations about other calls. This secondary trauma can manifest in a unified body-mind way as a contributing factor to compassion fatigue or burnout. Symptoms mirror those experienced by the victim of primary trauma and can include intrusive re-experiencing of traumatic material, avoidance of trauma triggers and emotions, and increased physical arousal (Bride et al, 2004).

Critical trauma theory offers two explanations regarding intergenerational (or inter-professional or inter-familial) transmission of trauma. Firstly a traumatized individual may employ isolation, violence or other unhelpful strategies to cope with trauma and in doing so creates a mind-body learning experience for those around her/him. Secondly a traumatized individual may not use helpful strategies to cope and therefore does not provide a healthy example of how to cope with trauma. In both these ways medics are transmitting and reproducing a burnout culture.

In addition to secondary trauma medics may be exposed to personal trauma and/or the threat of personal trauma. There are many factors influencing the development of PTSD and unfortunately a robust exploration of these factors is outside of the scope of this discussion. PTSD is a flashpoint for invoking the social constructs of the Cartesian divide, gendered emotional regulation, the stigmatization of mental illness and the very experience of neuro-trauma itself. Lovrod & Ross (2011) question a medicalized approach to PTSD, noting that responding to trauma with an individualized treatment
misses the opportunity to evoke social change. “Individuated treatments are too
dependent on existing hierarchies to promote widespread gender equity and social justice.
As therapeutic interventions increase, so do tendencies to frame social problems as
emotional ones, reinforcing heteronormative gender schemas already predisposed to view
women as “emotional” (p. 40). Following this logic, men who are diagnosed with PTSD
risk alteration of their gender-status due to their inability to “control” their “emotional
experience”.

Highly traumatic experiences may eliminate a medic from the workforce
temporarily or permanently, and/or they may just contribute to burnout. The degree to
which a medic is affected by traumatic experiences is not necessarily associated with
reluctance to seek assistance. The fear of disclosure is rooted in several of the constructs
already discussed. Medics’ indoctrination within the patriarchal paramilitary
organization and the hierarchical medical field predispose them to read their environment
using vertical comparisons, i.e. to judge others by rank, qualifications, position or if no
relevant rank presents itself, perhaps by coordinates of intersectionality. Lovrod & Ross
(ibid) note the maintenance of the status quo through the use of yet another
power/knowledge model—that of diagnosis and individualized treatment plan—rather
than directing efforts to mitigate the cause of trauma which in many circumstances is a
prevailing zeitgeist of dominance/knowledge (p. 43).

Brown (2006) provides an attractive option to receiving care in which a medic
would be supported by a therapist employing a feminist approach—that is one that is not
based on vertical comparisons but rather on an interdisciplinary, client-centered
approach. “Feminist critique demands a complex analysis and synthesis of the emerging
data about the biology of various forms of distress, on the one hand calling into question assumptions about the hard-wired, evolutionarily immutable nature of some phenomena, and on the other calling attention to the profound changes made to neuroanatomy by exposure to traumatic stress” (p. 18).

PTSD and trauma are much in the news these days as members of the Canadian military are speaking out about the support they are, or ought to be receiving from the government. The way in which their stories are framed and unfolding will be instructive to medics who are interested in providing workplaces that are supportive to coworkers.

Discussion

Dismantling the culture of paramedic burnout is a complex task. Managerial, legislative and educational reforms are commendable steps forward, however the culture of paramedic burnout is so deeply entrenched in our working ranks that we cannot rely exclusively on outside forces, we must dislodge ourselves from familiar constructs in order to create workplaces free from the reproduction of burnout.

While burnout is usually defined in terms of individual experience it would be helpful to consider the degree to which burnout itself is a social construct. To what degree are medics reproducing burnout in one another through language and action, through transmission of trauma, through stigmatizing one another and by laying these lessons down repeatedly in the neurological embodiment of coworkers? The destructive culture of burnout does not have to dominate paramedicine any longer. The intentional dismantling of social constructs and the creation of transdisciplinary curricula to balance
medics’ experiences of science, creativity, cultural competence and self-awareness will dilute the dangerously toxic brine of paramedic burnout.

References


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