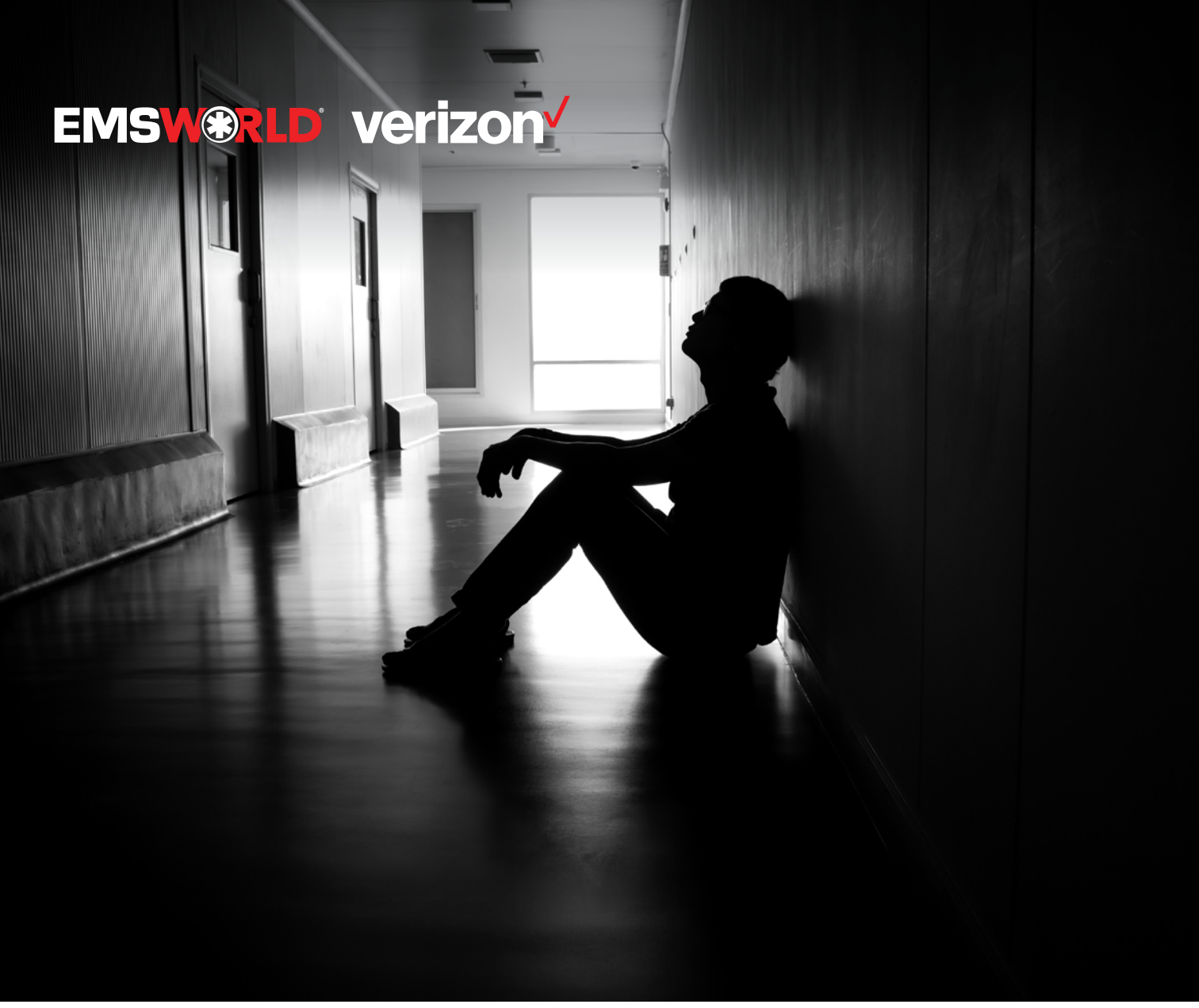
EMSWORLD verizon



EMS WORKPLACE STRESS

RETHINKING RESILIENCE AND EXAMINING THE ROLE OF MORAL INJURY

PROTECTING YOUR MOST VALUABLE ASSET

Many who work in EMS roles are suffering from significant mental health conditions, or are just plain burnt out. Under-resourced, taken for granted, and expected to be impervious to severe workplace stress—it seems unsustainable.

Is it time to rethink responder "resiliency" and examine the obligations of organizational leadership to protect the mental health of their most valuable asset? The articles and research in this supplement were authored by Mark Layson, a first responder and PhD researcher at Charles Sturt University in Australia who has worked in police and firefighter roles as well as an ambulance chaplain in Sydney, Australia.

Note: The author is thankful for the support of the NSW Centre for Work Health and Safety for helping fund the research. Any inquiries can be made to the author at mlayson@csu.edu.au

CONTENTS

Photo: Derek O. Hanley/DOHP

MORAL INJURY AND THE EFFECTS OF TRAUMA

Researching causes of workplace distress

Photo: Derek O. Hanley/DOHP

It's been a long shift. Nothing that has taxed us clinically; in fact just lots of routine caseload with clinically minor jobs that didn't push our clinical skills. But there were plenty of frustrations! There was one of our "frequent flyers" who consumed a good hour of our time. Then we waited for 3 hours in "bed block" (ambulance ramping) with a patient whose condition really warranted a visit to their local doctor, whom ultimately we were required to transport anyway.

There was the overdosed mother in the risky part of town where there is poor radio coverage; control did not know where we were for 45 minutes and we couldn't call for help if we needed it, which thankfully we didn't (this time). The good thing was we kept out of the way of the boss, until he found us and berated us for long response times last month. Funny how he cares more about KPIs than lack of radio cover.

We are now 8 hours into the shift, and still no meal break. Good thing I grabbed a snack from the vending machine while clearing to go to the next job. The toll our workload is taking on my partner and me is exhausting. Under-resourced, taken for granted and no breaks—this is unsustainable.

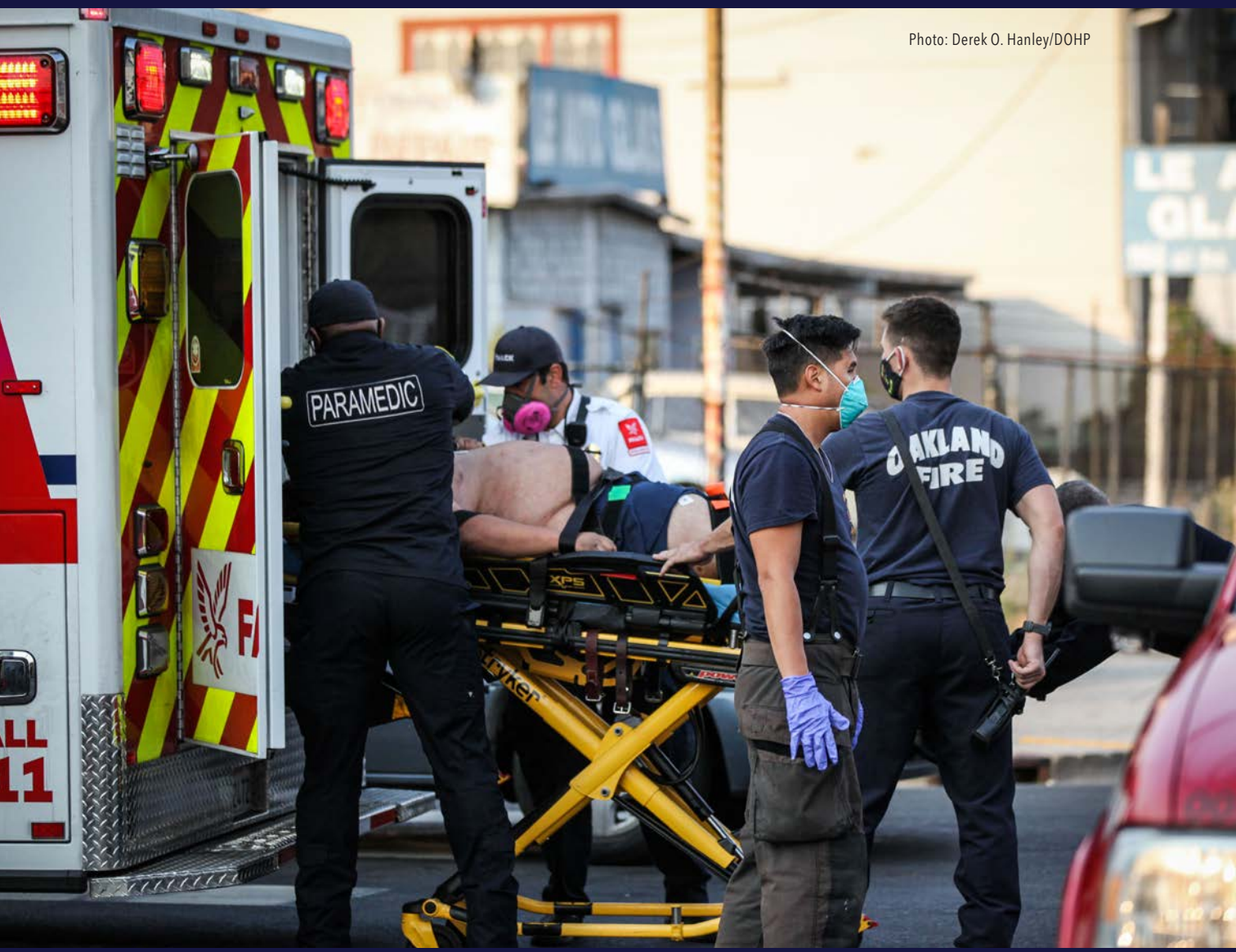


Photo: Derek O. Hanley/DOHP

Working in EMS can be one of the most rewarding jobs in the world because it does genuine good for vulnerable people in our community. Some of the most profound, tenacious, and caring people are emergency medical service providers. When the public is polled on the most trusted profession, the top of list is usually filled by paramedics, doctors, nurses and firefighters.

The great irony is that for such an important role trusted by most people, so many who work in EMS roles are suffering from significant mental health conditions, or just plain burnt out.

Statistics on the mental health of first responders have become increasingly alarming. Pre-COVID research reported that out of over 21,000 participants in Australia, 23% of former first responders and 10% of current employees had probable PTSD, compared to only 4.4% in the general population. In addition, 3% of current employees and 10% of former employees had severe PTSD.[1] Something is not right.

Early Research

The traditional wisdom regarding EMS and first responder distress is that it is caused by excessive exposure to trauma, which then manifests itself as post-traumatic stress disorder (PTSD) and other comorbid conditions. While there are impacts on well-being from trauma exposure, research increasingly reports other stressors playing a greater role in the cause of distress. Some call them organizational stressors.

While the opening scenario on this article is not a true story, it is an amalgam of many different stories the author has encountered over the last 30 years from first responders about elements of organizational stress. But it goes much deeper than just being frustrated. Stressors run deep and long in EMS organizations that have a history of poor workplace cultures and practices that attack the identity of those who work for them. And this is being increasingly reflected in research. It is worth going back a few years to understand the current state of play in EMS distress.

In the mid-1990s, Jonathan Shay, a psychiatrist with the Department of Veterans Affairs, noticed something important about the veterans he was serving. In his book *Achilles in Vietnam,* Shay wrote, "Veterans can usually recover from horror, fear, and grief once they return to civilian life, so long as "what's right" has not also been violated."[2]

Shay went on to coin the phrase "moral injury" to describe another way of understanding the causes of distress arising in the context of traumatic situations. Shay described moral injury then as something arising from the "betrayal of what is right, by someone in legitimate authority, in a high-stakes situation."[3] Trauma may not cause distress, but it certainly makes a situation "high-stakes." Soldiers were incurring "dents on their soul" from unhelpful organizational and leadership cultures and practices. But it is not just others who can betray a soldier (or EMS)—we can cross our own lines too.

Defining 'Moral Injury'

In perhaps the most influential research paper on moral injury, it was described as "the lasting psychological, biological, spiritual, behavioral and social impact of perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs

Although trauma exposure cannot be removed from EMS work, the trauma that results from organizational frustration can be addressed.

Photo: Carlos Pena, Capii Media

and expectations."[4] This highlights another facet of moral injury—at times we can do things ourselves that we know to be wrong, or we can make errors that haunt us, or we can witness time and again scenes that cause us to question our beliefs about the world and destroy our social trust. Therefore, moral injury can be either "other-focused," resulting from a sense of betrayal, or "self-focused," resulting from our own acts or omissions. So while PTSD comes from exposure to trauma and locks in the fear response, moral injury comes from a breach of our moral expectations and locks in guilt, shame, or moral outrage. These emotions are destructive to our sense of identity, our social relations, and our chances of successful clinical treatment of physical and psychological injuries.

Moral injury, and other terms such as moral distress, have come to prominence and are increasingly the subject of research that is reporting on their impacts. To date, most of the research has been conducted in military populations. However, in a doctoral research study, this author is examining whether and how moral injury and moral distress are present in first responders.

From a group of nearly 300 Australian first responders, all groups (police, fire, ambulance and ED nurses and doctors) reported considerably higher levels of moral injury than military populations. Paramedics had high levels of moral distress, and over 33% reported they felt they had been betrayed by a manager, colleague, or systems in their organization more than 50 times. What was also clear was that other-focused moral injury was substantially higher than self-focused moral injury. These findings are supported by other research in this field. Australian research on first responder distress during COVID in 2020 reported that workload, insufficient support, and lack of management connection, along with ambiguous, conflicting, and redundant communication from organizations and the rapidly changing environment to be the five largest associations with poor mental health for first responders.[5] While distressing, the trauma of high death tolls and life-threatening illness was not the main cause of distress. It was the sense that staff felt let down, even betrayed, by their organizations and leaders.

Research in other nations is beginning to emerge as well. Research findings in England, Canada and the United States indicate that non-traumatic stressors must be addressed to alleviate and even prevent first responder distress.[6-11] The key takeaway is that our systems, cultures, and many management styles are creating or aggravating distress in workers.

Changing the Culture

Despite the increasing research knowledge, there is still an overwhelming focus by organizations on trauma exposure as the main, if not the only, cause of distress in first responders. There is an urgent need for EMS organizations to reconsider what is ailing their staff, and then take appropriate action.

This has the potential to be good news for all first responders. While trauma exposure is a core part of their job description, betrayal is not. For organizations there is good news too, as there are low-cost options to reduce distress, absenteeism, and poor organizational citizenship behaviours. While being low cost, it will require senior leaders to exhibit the humility to listen to their workers and change some of their practices and cultures.

Additionally, there is almost no primary prevention strategy for PTSD,[12] but moral stressors can be prevented before they start. In the next article on moral suffering some of these primary prevention strategies will be outlined. They will be presented in hope that the frustration and anger from too many long shifts do not turn into long-term mental health problems.

REFERENCES

1. Beyond Blue Ltd. (2018). *Answering the call national survey: National mental health and wellbeing study of police and emergency services–Final report.* Beyond Blue.
2. Shay, J. (1994). *Achilles in Vietnam: Combat trauma and the undoing of character*. Scribner.
3. Shay, J. (2014). Moral injury. *Psychoanalytic Psychology*, *31*(2), 182-191.
4. Litz, B. T., Stein, N., Delaney, E., et al. (2009). Moral Injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review*, *29*, 695-706.
5. Roberts, R., Dwivedi, A., Bamberry, L., et al. (2021). *The mental health, wellbeing and work impacts of COVID-19 on first responders and frontline workers in Australia.* Charles Sturt University.
6. Greenberg, N. (2021). *Potentially morally injurious events (PMIEs) and healthcare workers (HCWs).* Australasian Conference on Traumatic Stress, Australia.
7. Murray, E., Krahé, C., & Goodsman, D. (2018). Are medical students in prehospital care at risk of moral injury? *Emergency Medicine Journal*, *35*(10), 590-594.
8. Carleton, R. N., Afifi, T., Taillieu, T., Turner, S., et al. (2020). Assessing the relative impact of diverse stressors among public safety personnel. *International Journal of Environmental Research and Public Health*, *17*, 1234.
9. Smith-MacDonald, L., Lentz, L., Malloy, D., et al.(2021). Meat in a seat: A grounded theory study exploring moral injury in Canadian public safety communicators, firefighters, and paramedics. *International Journal of Environmental Research and Public Health*, 18(22), 12145.
10. Bayani, B. A. (2021). *Exploring the relationship between moral injury, supervisor leadership style, and suicidal behavior in Texas paramedics.* [Doctor of Philosophy, Dallas Baptist University.]
11. Gaitens, J., Condon, M., Fernandes, E., & McDiarmid, M. (2021). COVID-19 and essential workers: A narrative review of health outcomes and moral injury. *International Journal of Environmental Research and Public Health*, *18*(4), 1446.
12. Skeffington, P. M., Rees, C. S., & Kane, R. (2013). The primary prevention of PTSD: A systematic review. *Journal of Trauma & Dissociation*, *14*(4), 404.

RETHINKING RESILIENCE AND THE ROLE OF 'JUST CULTURE'

Preventing moral suffering in EMS

On a lot of days, I think that my decision to work in EMS all those years ago was the most important and best decision I ever made. Then on other days, I wonder why I do this. Five years ago, and after ten years of service, I gained a promotion to be a frontline manager. I don't know who was prouder—my partner or me. I felt the opportunity was there to contribute not just to the patients, but also to help the staff. Helping was the plan, but I barely get enough time to fill in the reporting requirements of the role, let alone care for the staff. Some days, if I am really honest, I don't want to care for them either. I have had to make decisions that were hard, and I knew would not be popular, but I did not expect so many of the people I'd counted as friends to turn on me after making the decisions. I feel torn up inside on so many days because I feel a tension between what I am required to do as a manager, and what I want to do as a leader of people. I know I am clinically competent—that's a big part of why I was promoted, and I thought I was good with people, but now I am not so sure. The organization is asking one thing and the staff often want another, and I was just not trained to balance these competing needs and how to really care for staff. On more and more days I feel I am drowning in this role, but I push on and hope for the best.

Research into moral injury and moral distress has been conducted largely among military populations, but research on moral suffering in first responders is starting to take off. The causes of mental health problems in EMS workers have as much, if not more, to do with organizational stressors than with trauma exposure, and these stressors can be perceived as betrayal by workers.

Although trauma exposure cannot be removed from EMS work, the good news was that the sense of betrayal and organizational frustration can be addressed, and relatively cheaply.

The Paradigm Shift

While addressing these issues may come at a minimal financial cost, it requires a paradigm shift in the way we prevent distress in workers. The overarching mind shift required by organizations entails a shift

Photos: Derek O. Hanley/DOHP


Photo: Derek O. Hanley/DOHP

away from an emphasis on the *content* of the work, namely trauma exposure, to also addressing the *context* in which trauma is experienced.[1]

While it is intuitively logical that trauma causes distress and therefore the attention of well-being programs, an excessive focus on trauma exposure in programs can overlook the effect of organizational and moral stressors. A large review of well-being programs in Canada, Australia, New Zealand, Ireland, and the UK reported that they contain an overly restrictive focus on PTSD.[2] The organizational, moral and even spiritual context in which trauma exposure occurs, from recruitment to retirement, needs to be seriously considered alongside trauma exposure.

Interestingly, the "good" (in the moral sense, as opposed to competent sense) work that EMS organizations do may even contribute to distress. Humans are morally attuned, meaning-making beings, and emergency work is a moral good for society.

Organizations tend to trade on the opportunity to do good in their recruitment tactics, asking people to do things like "join the most trusted profession," or "do something worthwhile" while showing pictures of high-profile exciting aspects of the job.

Moral humans are enticed to join a moral organization and do moral good. This brings with it the reasonable expectation that the organization will be good to them.

Emerging moral injury research is suggesting that this expectation constitutes a "psychological contract" between workers and their organizations that tacitly supplements their legal written contract.[3] If and when this silent contract is breached by workplace systems, it results in negative psychological impacts. Organizations that understand these psychological contracts and better negotiate expectations while living up to workers' reasonable expectations will do better in relation to worker well-being.

Rethinking 'Resilience'

To implement these changes will involve complementing individual well-being interventions, and in some cases replacing them, with organizational and leadership interventions. Many EMS organizations have developed a dazzling array of resilience programs that target individuals. Well-being workshops, yoga sessions, mindfulness programs and the like have been multiplying at a great rate.

While these programs may have some benefit, they assume the problem


Photo: Carlos Pena, Capii Media

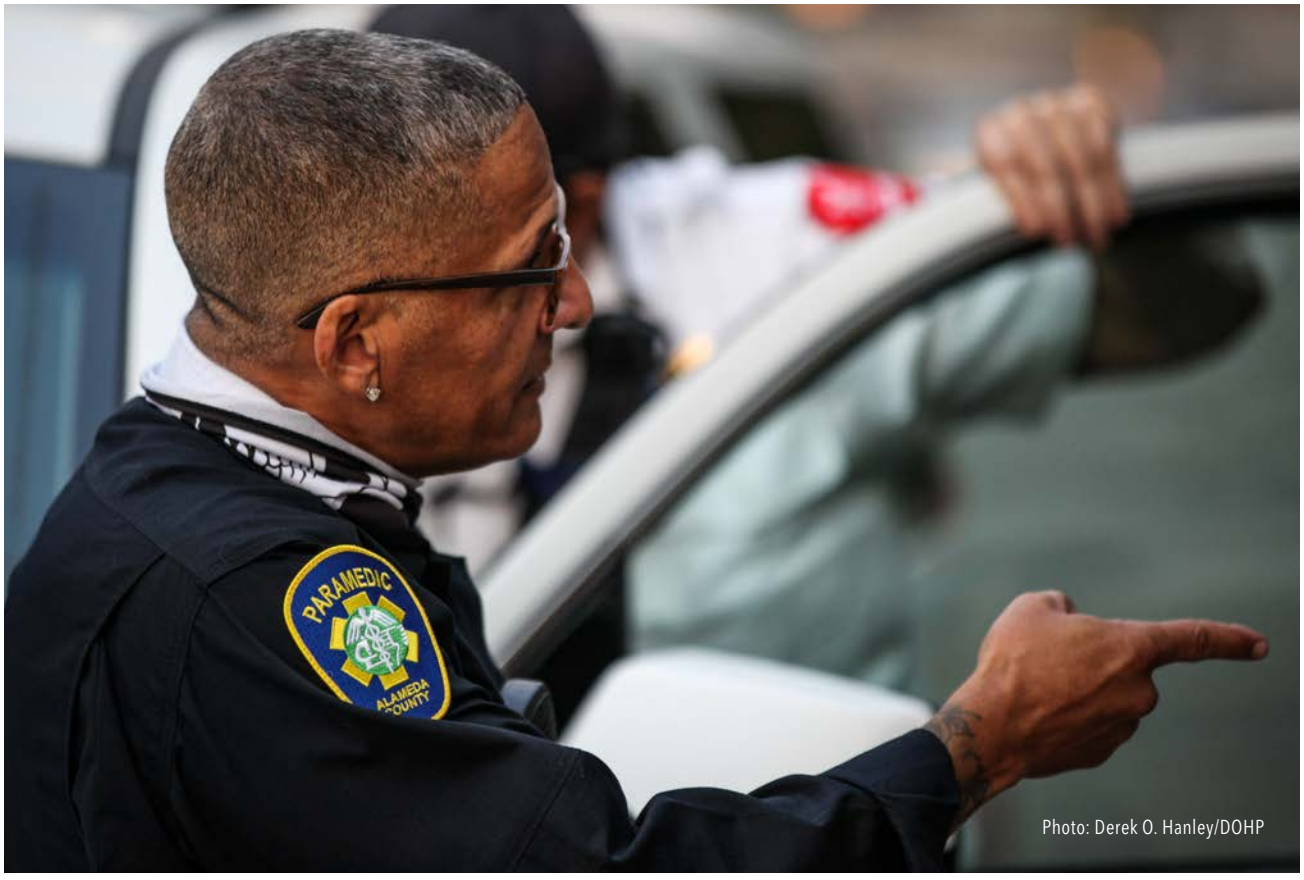


Photo: Derek O. Hanley/DOHP

with workers' distress is the workers themselves, and that if only they were more resilient, there would be less distress. This is possibly and partially true. However, there remains much scope to develop interventions that target harmful organizational culture and practices, and most importantly leadership interventions. In fact, they must develop these interventions.

At a regulatory level, organizations are increasingly being required to address organizational stressors under "psychosocial safety" frameworks. In 2021 the International Organization for Standardization produced ISO 45003 that requires workplaces to mitigate psychological risks in a manner similar to physical hazards.[4] Issues such as overwork, poor procedural justice, bullying, inadequate reward and recognition, and similar components must be addressed.[5]

A surprising finding in this author's research was that many of the morally distressing events experienced by first responder participants were also psychosocial categories according to such frameworks. A moral injury lens deepens the spiritual and existential weight of psychosocial risk categories and illuminates the importance of unwritten psychological contracts. EMS organizations will increasingly become legally liable for the moral injuries that are inflicted on their workers by their systems and poor leadership practices.

Role of 'Just Culture'

The foundational issue for organizations to address is the development of an organization-wide "just culture." Just cultures directly address the risk of poor procedural justice and have the power to prevent moral injury arising from a sense of betrayal by the organization or leaders.

For example, an unjust culture takes a punitive and adversarial stance when it comes to worker error, by seeking to find who is to blame and then blaming them. This is a "backward-looking accountability" that fails to prioritize learning from mistakes, but does well at punishing workers.[6] Dekker reports that a just culture develops "forward-looking accountability" that is safer as it aims to prevent future error by seeking to understand how systems allowed for the worker to make an error as a priority over punishing that worker for making the mistake.

In EMS errors can be fatal. The moral beings who joined the organization to do good will often feel a sense of self-directed moral injury, as they have done something against their own good goals. In reality workers become what Dekker in other publications calls a "second victim."[7] A second victim is a worker who did not have malicious intent and is often as distressed as the first victim (those harmed by the error) and suffer significant psychological distress.

When organizations seek to maximize individual blame while minimizing the role of systemic factors that led to the error, a second "other-directed" betrayal type moral injury is highly likely in the person

EMS EMPLOYEE WELLNESS HAS PASSED THE TIPPING POINT

By Russell Myers, D.Min., BCC

Critical incident stress debriefing, psychological first aid and other post-incident support models have been around for decades. Yet it seems that only in recent years has the benefit of intentional, proactive emotional/spiritual support for front-line public safety personnel moved from the margins toward the center of our consciousness.

The first 20 years of this century brought a gradual increase in awareness of and concern for the emotional weight borne by EMTs, paramedics and dispatchers. Individual leaders in communities around the globe began to ask what could be done to better support their people. As they connected with each other, information was shared.

Researchers have uncovered a phenomenon called informational cascades that helps to illuminate what happened next.[1] "The starting point is that people rationally attend to the informational signals given by the statements and actions of others; we amplify the volume of the very signals by which we have been influenced. Social movements of various kinds...can be understood as a product of cascade effects."[2]

An article here, a workshop presentation there, a webinar or consultation by someone recognized as an authority or thought leader—all fed this cascade of information. Support for the well-being of EMS staff grew from an isolated practice to one that is more commonly considered. People paid attention to the social signals, and the reputation of employee wellness grew. Even the skeptics took note, because others in their professional networks were.

Attention to employee wellness as a business practice also benefits from network effects: it is "taken as something of which people think they should be aware."[2] Apart from the intrinsic merits of investing in the self-care and well-being of employees, it's good to know about it, so you can talk to others about it.[2]

The tipping point came in mid-2020. All of the slow but steady acceptance and growth of employee wellness initiatives got a shot of steroids when the COVID-19 pandemic hit. No longer an option, staff support became a matter of survival. Recruitment and retention of skilled EMTs, paramedics and dispatchers depend on it.

Now the conversation has changed. Instead of asking "do we want to implement wellness programs?" the question is "what kind of support mechanisms are the best fit for our organization?" Choices for where to put your energy include developing a peer support team, hiring a clinically trained, professional chaplain, contracting with a psychologist or social worker, getting a therapy dog, additional training for operations leaders, and other proactive employee support measures.

Perhaps this is one positive thing to come out of the pandemic, and it's a win-win. Employees benefit, the organization benefits, the patients and communities we serve also benefit. Creating and nurturing an organizational culture of support is not only a good idea. It's the right thing to do.

REFERENCES

1. Salganik, Matthew J., Dodds, Peter Sheridan and Duncan J. Watts (2006) Experimental Study of Inequality and Unpredictability in an Artificial Cultural Market, *Science 311*: 854–856, 10.1126/science.1121066
2. Sunstein, Cass R.: *Beatlemania*, 2022 https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4018431

RESOURCE

'Head of Team Anywhere,' and Other Job Titles for an Uncertain Time. *New York Times*. https://www.nytimes.com/2022/08/04/business/job-titles-remote-work.html?referringSource=articleShare

Russ Myers is chaplain for Allina Health EMS, based in St. Paul and the author of Because We Care: A Handbook for Chaplaincy in Emergency Medical Services. He can be contacted at russell.myers@allina.com

making the error and their colleagues. Procedural justice considers contextual factors, before seeking to apportion blame to the individual who made the error. Just cultures proactively give space for the worker to give their own account and, through appropriate reparation, to be restored as a valued worker.

An area of EMS that often serves as an example of good practice in just cultures is aeromedical units, who synthesize both medical and aeronautical safety cultures. Aeromedical units often proactively debrief difficult cases in weekly meetings that prioritize learning over blame.[8]

There will be times for formal investigations; however, just cultures buttress the investigative process with the engagement of well-being professionals to provide supportive care for those they investigate. A just culture produces collaboration between investigators, work health and safety experts, mental health

professionals, and spiritual care providers in a process that aims to prevent the error from happening again and to protect the worker from destructive levels of distress.

Obligation of Organizational Leadership

The crucially important level of intervention is with frontline leaders. The anecdote at the start of this article is fictitious, but it is an amalgam of experiences of many leaders encountered by the author. Leaders become the "meat in the sandwich" between the moral organization and the moral worker.

Leaders may not know it, but they mediate the unwritten psychological contract between the moral individual worker and the morally-laden work of the organization. It is easy to blame bad leaders for distress, but there are seldom good support networks or a framework to support them. If organizations spent as much money training and providing ongoing support to frontline leaders as they do on individual resilience programs, we might expect much better staff well-being and organizational savings. A case in point is research conducted with firefighters in Australia. A brief course in mental health awareness with managers produced a 10:1 return on investment from reduced absenteeism.[9]

Training is only one element to support leaders, who can be better supported in at least two ways. First is to give leaders ongoing pastoral care and a mentor to help them navigate the moral complexities of this work. In the modern era, chaplains have served as character and moral guides for leaders and soldiers in the military since the Korean war.[10]

Regardless of who plays this role, the existence of a mentor-type role is important to support leaders. Secondly, research by the author led to the development of a "servant" leadership framework based on a shepherding model. Shepherds used to lead from the front, with the herd following them because they were confident the leader would take them to safe pasture.

Space does not permit a detailed explanation of this model, but nine key behaviors for leaders include: leading (not just managing or ceding leadership), service, presence, provision, protection, communication, gratitude, restoration, and their own need to follow others. Such innovations are the future of EMS well-being.

An EMS leader once mused that had we known about PTSD 40 years ago we would have done so many things differently. Now, he wondered, what will we know in 40 years' time that will make us look back at what we do now and wish we had done differently?

Moral suffering is one of the things that will be common knowledge in 40 years, and now is a good time to start responding to the research on its effects.

REFERENCES

1. Cox, T., Griffiths, A., Barlowe, C., Randall, R., Thomson, L., & Rial-Gonzalez, E. (2000). Organisational interventions for work stress A risk management approach (1368-6828). *Health & Safety Executive, Issue*. https://www.hse.gov.uk/research/crr_pdf/2000/crr00286a.pdf
2. McCreary, D. R. (2019). *Veteran and first responder mental ill health and suicide prevention: A scoping review of prevention and early intervention programs used in Canada, Australia, New Zealand, Ireland, and the United Kingdom*. Donald McCreary Scientific Consulting.
3. O'neill-George, J. (2022). *Betrayal-by-systems: Psychological contract violation and moral injury in Australian Army Veterans.* Society for Mental Health Research: Breaking down the silos, Hobart, Tasmania.
4. International Organization for Standardization. (2021). *Occupational health and safety management—Psychological health and safety at work—Guidelines for managing psychosocial risks* [Online browsing platform] (ISO 45003:2021). https://www.iso.org/obp/ui/#iso:std:iso:45003:ed-1:v1:en
5. SafeWork NSW. (2021). *Code of practice: Managing psychosocial hazards at work*. New South Wales Government. https://www.safework.nsw.gov.au/__data/assets/pdf_file/0004/983353/Code-of-Practice_Managing-psycho-social-hazards.pdf
6. Dekker, S. (2018). *Just culture: Restoring trust and accountability in your organisation (3 ed.)*. CRC Press.
7. Dekker, S. (2013). *Second victim: Error, guilt, trauma, and resilience*. (Ebscohost, Ed.). CRC Press.
8. Goodsman, D., & Wong, T. L. E. (2021). Death and disability meetings at London's Air Ambulance: Working in a just culture. In E. Murray & J. Brown (Eds.), *The Mental Health and Wellbeing of Healthcare Practitioners: Research and Practice* (pp. 146-157). John Wiley & Sons Ltd.
9. Milligan-Saville, J. S., Tan, L., Gayed, A., Barnes, C., Madan, I., Dobson, M., Bryant, R. A., Christensen, H., Mykletun, A., & Harvey, S. B. (2017). Workplace mental health training for managers and its effect on sick leave in employees: a cluster randomised controlled trial. *The Lancet Psychiatry*, *4*(11), 850-858. https://doi.org/10.1016/s2215-0366(17)30372-3
10. Sabel, E. T. (1981). A history of character guidance in the Australian Army. *Defence Force Journal*, *28*.

Verizon Frontline

The advanced network for first responders on the front lines

When lives are at stake, those on the front lines rely on our network and technology to make a real difference. Because every detail is critical and every second counts.

The #1 network choice in public safety.
Verizon is the leading network for public safety, relied on by first responders for decades.

America's most reliable 5G network.
We built our network for 5G to keep first responders connected when lives are on the line.

Making first responders the true priority.
Our intelligent platform scrutinizes network users to prioritize mission-critical first responders.

verizon.com/frontline

verizon

5G Ultra Wideband available in select areas. 5G Nationwide available in 2,700+ cities. Most reliable 5G: based on most first place rankings in RootMetrics® 1H 2022 assessments of 125 metros. Experiences vary. Not an endorsement. Priority and Preemption services are available on 5G Nationwide, but not on 5G Ultra Wideband (5G UW). In the unlikely event the 5G UW network is congested, eligible users' communications fall back to 4G LTE for Priority and Preemption. Based on quarterly third-party wireless voice market share data, Q1 2022.