Autoethnographic analysis of the self through an occupational story of a paramedic

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Abstract

This article discusses the role that storytelling plays in understanding both the personal and professional self from the perspective of a paramedic. The practice of paramedicine provides individuals with a strong platform upon which storytelling can be built, with narration of work-related stories presenting opportunities for reflection on the interplay between organisational culture and self-identity. Using elements of narrative inquiry, autoethnography and critical reflection, a paramedic story is deconstructed and examined from a number of perspectives. From this narrative exploration, three distinct themes emerged and are subsequently discussed: assumptions and preconceptions, fears and insecurities, and distancing and control. The findings illustrate the benefits of exploring paramedic stories in order to recognise, transform or eliminate unhelpful assumptions relating to paramedic practice, and discover unexplored aspects of the self through analysis of story.

Key words

● Paramedic ● Storytelling ● Self-identity ● Narrative ● Critical reflection

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In this empirical paper, I argue that storytelling is integral to the field of paramedicine. The stories told by paramedics can serve as powerful tools to facilitate meaning-making and identity within the profession, both of which may lead to a greater understanding of the discipline of paramedicine as a whole. I draw from a range of literature and from my own experiences as a paramedic to support this premise. I have also chosen to relate one particular story to demonstrate the richness of meaning that can be drawn from stories through exploration of the experiential dimensions of paramedic work. The nature of paramedicine provides fruitful ground for the emergence of stories that can serve to inspire individuals and allow for an exploration of self – both personal and professional.

Propelled into the chaos and tragedies they respond to in order to fulfil their role, paramedics serve as sudden and unexpected characters in the lives of others. They often encounter people who are at their worst, when the usual social conventions and constructions are torn down by pain, confusion, disempowerment or sorrow, and a different set of understandings and behaviours take their place. Significantly meaningful stories are born out of this involvement in the rawness of life and its realities. Working within an environment replete with atmosphere, tension and emotion, it comes as no surprise that "paramedics are immersed in narrative" (Tangherlini, 2003: 348), particularly given their exposure to events that abruptly and significantly alter the life stories of the individuals they are called to.

It has been my experience that paramedics engage in storytelling as they move between roles and activities, including during downtime between call-outs, while re-stocking vehicles, or while liaising with other emergency and health care workers including nursing staff and police. I have told stories on an almost daily basis throughout my career, and for me, storytelling is an inherent aspect of paramedicine that helps me make sense of what it is I do and see, both as a paramedic and as a human being. Paramedic storytelling serves as a lens through which I can explore the complex interplay between my self-identity and the organisational culture I work within, and the differences between my experiences outside of work and while performing my role as a paramedic. I am not alone in this practice; it has been stated

that "among ambulance personnel storytelling stands as one of the most developed aspects of the occupational culture" (Tangherlini, 2000).

Paramedic storytelling can facilitate a kind of organisational dance with a narrative beat, a do-si-do wherein participants move from the individual to the collective and back again. Yet rather than physical actions, a different kind of movement takes place, one in which "initial understandings shift in response to the story and the storyteller" (Frank, 2012). This process of shifting understandings allows for comprehension of work phenomena and can be used as an exploration of the way in which individuals live through events and ultimately interpret and give them meaning. (Laverty, 2003; Connelly, 2010). Storytelling is often a shared process, an intricate and artistic dance, with activities allowing participants to understand and form identity and meaning through both co-creation and self-reflection (Black, 2008). The accrual of both individual and shared oral narratives is said to not only contribute to, but to form what anthropologists define as a tradition, a history, or a culture (Bruner, 1991). Organisational culture can be both informed and constructed by story (Boyce, 1996; Denning, 2005; Küpers, 2005; Marra and Holmes, 2005).

Stories have also been credited with facilitating the development of both our personal and professional identities (Marra and Holmes, 2005; Black, 2008; Salzer, 1998), and the creation of an avenue through which we can produce an understanding of who we are in relation to others. 'Through narratives we make sense of the world, of our relationship to that world, and of the relationship between ourselves and other selves... it is through such stories that we produce identities' (Tracy et al, 2006).

In order to demonstrate the power of stories to gain an understanding of self in both a professional and personal context, I have transcribed a story that I have previously told verbally, into written narrative. The narrated story was selected after searching through my memories and 'repertoire' of stories until I came to a case I had relayed to others on a number of occasions. I have modified some of the minor details of the story to allow for anonymity of those involved. The narration of this story will be followed by analysis and subsequent categorisation into themes to demonstrate the value of using stories to more deeply engage with what effective paramedic practice might be. A critical reflective process will be used whereby I actively deconstruct my stories and search for underlying values and assumptions (Morley, 2014). Critical reflection allows me to move beyond familiar ways of thinking to identify my own assumptions, thoughts and perceptions, and to ultimately work towards the transformation and development of more positive or helpful perspectives (Mezirow, 2000; Morley, 2014).

I had a feeling that the job would be a challenging one given it involved a child. I glanced at the two-way radio and silently hoped; cancel us and we can go back to the mess room and work our way through the quiz in the local paper. I want the action, the complexity, the chance to make a difference to the lives of others, but sometimes I long for simple quiz questions. There is safety in boredom, and when I get the answer wrong, nobody suffers.

The child wore shorts splattered with mud from the river, the pockets stuffed with lolly wrappers and a plastic frog. He should have been laughing and playing in the water, squealing at its coldness as it flowed over his skinny legs. Instead he was lying on the bank, silent and still. A word came into my mind: fragile. He was pale, and lifeless, and fragile, his skin milky white and almost luminescent in the fading light. I wanted to yell at him to go back to being a boy, to go back to looking real and being alive, to not become another one of the many memories that disturbed me when I least expected it. But I already knew I would not be able to see a child playing in the river again without thinking of him. I knelt at his head and reached for the equipment bag. My partner and I concentrated on organising, analysing, thinking and acting, but not reacting, at least not emotionally. Right then the clinical overtook the emotional, as it so often did, and I was glad. I was relieved that I could stuff the feelings down and get on with what I had to do. For one brief but startling moment I thought to myself – am I pushing down my feelings, or have I lost them altogether? What had I become? What has the job done to my ability to respond as a normal human being to such a tragedy? I should be upset, and yet, I don't feel much at all.

The parents stood to one side and watched, all the while clutching at each other, mouths gaping as though drowning in the moment. Drowning – just like their son. I knew what they were thinking; 'paramedics save lives, and they will save our boy'. But this was not like in the movies, where the patient is pulled from the brink of death and saved. We knew it, but did the parents?

I wanted to tell the parents right then, to get it over with, but instead I flicked open the blade on the laryngoscope, made sure the globe was bright, and prepared to insert a plastic tube into the throat of the small boy. But I knew, and so did my partner. I'd known when I first arrived, but I have no idea from where that knowing came, and I knew after 40 minutes when I put down the equipment and stood to tell the parents. They shook their heads, grasping at each other and at the straws still floating in their minds. The words I spoke could not be taken back. They would embed themselves like poisonous arrows designed to provoke a grief-filled life. And I tried, but I couldn't seem to soften their impact. The boy's heart stopped, as did time, both for the parents and for the treating paramedics.

Methods

I engaged in the process of narrative inquiry as a means of exploring the above story. Narrative inquiry can take a number of different forms and methods (Clandinin et al, 2007; Denzin and Lincoln, 2011). One such method is the process of focusing on the meaning ascribed to the experiences of individuals through analysis of their tales (Riley and Hawe, 2005). As the story I analyse is a personal one, I also engage in the practice of autoethnography. This is the blending of ethnography – the process of studying behaviour within a culture or social group – with personal story (Patton, 2002). The use of these social constructionist methods of inquiry allow for a rich and meaningful examination of the self and the relationship between self and other.

Autoethnographic approaches encourage the exploration and ownership of one's own voice. The process of writing an autoethnographic piece is concurrently a process of writing identities and engaging in meaning-making (Berger, 2001); and 'because life comes to us in the form of stories, the analysis of narratives becomes a way of analysing experience' (Gubrium and Holstein, 2008: 246). Autoethnographic stories offer a chance to explore the narrative from a number of different vantage points; as analyst, writer and protagonist.

In 2011, United States paramedic John De La Garza completed an autoethnographic dissertation that centred on his stories as a paramedic, and his journey to meaning making through engagement with narrative. He used Arthur Frank's illness typology to create an autoethnography of chaos and quest in his search for meaning for the events he had lived, and to 'make it count for something' (De La Garza, 2011). In his thesis he reflects that both discussions and storytelling with former colleagues served to validate his own 'physical, psychological, and spiritual struggles' (De La Garza, 2011) and to inspire his colleagues to do their own exploration for meaning. Among his concluding thoughts within his thesis is this statement: 'My autoethnography is not a singular story. There is more than ample evidence throughout the narrative that there are others who played a significant role in it. They, too, have their stories to tell" (De La Garza, 2011).

The benefit of analysing stories told in paramedicine is two-fold. The reflexive stance taken when engaging in narrative inquiry not only leads to focusing in on the self and the emergence of a clearer understanding of social and individual identity, but it can also be a powerful tool in understanding organisations that the stories are situated within, as 'we can only understand an organisation if we know the stories that are told about that organization' (Gill, 2001: 336). While there are several ways in which reflexivity can be understood (Etherington, 2004), being reflexive means acknowledging that the way I interpret experiences is shaped by a combination of my own assumptions, values, morals and biases. To be truly reflexive is to continually remain attentive not just to these, but to the social, political, ideological and cultural surroundings that my research is situated within (Patton, 2002; Morley, 2014).

The above story was read and re-read, with a reflexive stance taken during the search for meaning and social significance. I engaged in the process described by Clandinin and Connelly as the 'search for patterns, narrative threads, tensions, and themes', a process both complex and iterative (Clandinin and Connelly, 2000). During the analysis of the story, three distinct themes emerged; assumptions and preconceptions, fears and insecurities, and distancing and control. The next section of this paper will briefly explore these themes, with the associated components of the narrated story expressed in italics.

Results

Assumptions and preconceptions

Prior to commencing analysis of my story, I was anecdotally aware that this type of story was not unusual in the field of paramedicine, and that I (and no doubt others) made various assumptions and held preconceptions in regard to my practice as a paramedic. What I didn't realise was how I had become conditioned to think in a certain way about issues that could not be given the title of 'clinical management', and how that thinking could be detrimental to my sense of wellbeing.

What had I become? What has the job done to my ability to respond as a normal human being to such a tragedy? I should be upset, and yet, I don't feel much at all.

I make the assumption that I should feel a certain way about the cases I attend, and when I don't, I assume that there is something wrong with me. I believe I have been conditioned to view certain jobs I attend to as 'abnormal'. This is compounded by the statement used by paramedics that 'you are having a normal reaction to an abnormal event'. Yet such events should be deemed fairly standard for a paramedic or for those involved in similar lines of work. Distressing sights and situations are not abnormal for paramedics, and yet, I assumed I should have reacted with emotion, as if not doing so made me less human.

I wanted to yell at him to go back to being a boy, to go back to looking real and being alive, to not become another one of the many memories that disturbed me when I least expected it. But I already knew I would not be able to see a child playing in the river again without thinking of him.

I had very quickly relegated this child to my memory bank of disturbing cases, the memory of which would recur and affect other aspects of my life. I made an assumption that this would be the case – a judgement based on previous events in my career as a paramedic. Yet I now wonder if such preconceptions are healthy. Perhaps if I chose not to make this assumption, the outcome may have been different, and the event may not be assigned so easily to my memory bank.

The parents stood to one side and watched, all the while clutching at each other, mouths gaping as though drowning in the moment. Drowning – just like their son. I knew what they were thinking; 'paramedics save lives, and they will save our boy'… They shook their heads, grasping at each other and at the straws still floating in their minds.

I cannot know what others are thinking or how they feel emotionally. I can merely make assumptions. In retrospect, I feel that I have disempowered the parents of the child when I did this. They may not be as helpless as I perceive, but this perception helps me to separate them from myself; I know what is happening, they do not. I am in control, they are not. As long as this is the case, I am somehow separated from their pain, their distress, and their reality. If I see these parents as being just like me, I may find myself on the precipice with them, and I fear that I cannot help unless I am at least a few steps back from the edge of the cliff to remove the possibility of plummeting beside them. This fear is but one of many that lie buried under the surface of my practice as a paramedic. Feeling somewhat like an archaeologist on a newly discovered dig, I use narrative inquiry to uncover elements such as fears and insecurities, and examine them in a new light.

Fears and insecurities

In my experience as a paramedic, I don't think I recall hearing many of my colleagues talk about their fears, unless they formed part of an amusing story. More frequently, I have found that fears and insecurities are expressed in ways other than verbal. It may be via their actions or facial expressions, their reluctance to undertake assessment or training, or the avoidance of conversations or situations. Prior to engaging in this process of critical reflection, and while in the act of writing my story, I did not realise my own fears and insecurities were so prevalent, and so subtly embedded in my narratives.

I had a feeling that the job would be a challenging one given it involved a child. I glanced at the two-way radio and silently hoped; cancel us and we can go back to the mess room and work our way through the quiz in the local paper.

I believe there is a preconceived idea in paramedicine that cases involving children will inherently be difficult or challenging. While there are a number of reasons for this notion, of particular significance to me are my own fears relating to the emotive side of managing an innocent child, particularly if the family is also present. I do not verbalise this fear to others however, but 'silently hope'. Upon reflection, I realise I do a lot of silent hoping, pleading, considering and worrying. This is perhaps for the fear that my voice won't matter to anyone else and therefore, should remain an internal monologue; for fear that I am not like the other paramedics who may not have the same emotions. I have a need to fit into the culture of paramedicine, to think like the rest of the cohort, and to be among the accepted. I fear that other paramedics may not share my fears and hopes, and that I may be ostracised as a result. Stories, such as the one I have narrated here, provide me with a way to subtly raise uncertainties and emotional issues without drawing excessive attention to them. The emotional is interspersed in the body of the story, buffered by the storyline itself. I feel safest discussing my insecurities

and emotions in this way, particularly in the field of paramedicine, where I am a female in a profession where shadows of a male hegemonic past still linger.

For one brief but startling moment I thought to myself – am I pushing down my feelings, or have I lost them altogether? What had I become? What has the job done to my ability to respond as a normal human being to such a tragedy? I should be upset, and yet, I don't feel much at all.

The above extract can be seen to represent my struggle as a narrator to understand my own emotions, and gives a voice to the doubt arising from the personal side of ambulance work. It shows the emotional dichotomy that exists; a paramedic hoping not to feel, while at the same time, wishing they could. The question 'what has the job done to my ability to respond?' is symbolic of who I believe may be to blame for my emotional 'loss'. It is the profession that wears people down. When I blame something outside myself, I become the innocent victim and something or someone else can take responsibility for my feelings or the lack thereof. I fear not being normal, and of not responding in ways that others perceive as normal.

I wanted to tell the parents right then, to get it over with…I knew, and so did my partner. I'd known when I first arrived, but I have no idea from where that knowing came, and I knew after 40 minutes when I put down the equipment and stood to tell the parents.

This section of my story exemplifies the sensitive ethical and moral decision-making incumbent upon paramedics as they carry out day to day activities: When to tell the parents that their child has died? When to stop resuscitation efforts? It hints at the occupational pressures involved, but also at the intuition that paramedics may have. A sense of knowing that may not necessarily have evolved from clinical experience. This unsubstantiated knowing is often ignored in place of waiting for the development of a more concrete information platform upon which to logically rationalise patient management. Yet there is an unsatisfying aspect to this, a disregard for what may be a strong feeling or belief for fear that it is incorrect.

Distancing and control

Paramedics frequently work in unpredictable environments. The dynamic nature of paramedicine is such that paramedics are sometimes called upon to navigate chaotic circumstances and bring a sense of order to the situations in which they find themselves. In some circumstances, paramedics have been seen to become '…focused on the patient or practical procedure in hand, which serves to emotionally distance the paramedic from the patient and their relatives; thereby forming a psychological barrier…' (Mildenhall, 2012). Upon analysis, I realise that I have employed this same method of psychological self-protection. Components of my story also highlight my desire to gain overall control of circumstances, both overtly and through the act of distancing myself from both situations and my own emotions.

He was pale, and lifeless, and fragile, his skin milky white and almost luminescent in the fading light. I wanted to yell at him to go back to being a boy, to go back to looking real and being alive.

I refer to the child as though he has somehow changed from being a boy to being something else simply because of this event. If he is no longer a boy, what is he? If he becomes non-human, it will be easier for me to deal with from an emotional and psychological perspective; his loss becomes manageable for me. I have distanced myself from this job even before I commence resuscitation. I allow myself a moment of recognising the tragedy, the unnaturalness of the situation and of the boy's body, before I regain control of my thoughts and emotions, and commence clinical management.

The words I spoke could not be taken back. They would embed themselves like poisonous arrows designed to provoke a grief filled life. And I tried, but I couldn't seem to soften their impact.

Here I express the mistaken belief that I am the one responsible for inflicting the wound. I tell the parents their son has died, and to me, it feels as though my words are arrows that damage flesh and blood, and penetrate the soul. It seems that it is not the circumstance I am called to that causes the pain, but rather the words I speak. Upon reflection I know that this is an unrealistic view. I did not cause the situation, and can do nothing to alter the outcome, yet a part of me grapples with such thoughts. This, like many situations encountered by paramedics, is one in which no one really has control of the final outcome; not the patient, neither the parents, nor the paramedics. By placing so much emphasis on my

Figure 1. Paramedics routinely face emotionally and physically strenuous situations that consequently give rise to storytelling and reflective practice

own actions, I try to gain some control over the situation and the way the case evolves, however unpleasant the task. There is safety in control and a bearing of responsibility for others, however irrational.

Discussion

It is through telling and re-telling my stories that I can move to a point of knowing who I am in relation to my experiences, both painful and otherwise. The reflective stance I take has led me to value my own stories and those of others for their ability to act as both directional and moral narrative compasses. For me, paramedic stories are directional compasses in that they serve to illustrate where I have been in terms of my perspectives, and where I am going in terms of resilience and development of the self. Paramedic stories also act as moral compasses, facilitating a review of the decisions and assumptions I have made in both my professional and personal life. The paramedic stories I hear allow me to share in the lived experience of others, and they prompt me to continually think: who am I in relation to that, and who do I want to be? Yet this reflective process is not without challenges and sometimes pain. The moral and ethical implications of a paramedic's actions plant themselves as incendiary devices on our occupational landscapes. The challenge for the reflective paramedic is to pick their way carefully through the minefield, walking mindfully, avoiding acts of self-destruction and criticism, and stepping slowly lest they stumble and hurt themselves in the process.

Storytelling by paramedics may serve a more extensive intention than one of self-reflection and personal meaning-making, and that is to construct and inform the purpose and meaning of an organisation as a whole. The use of storytelling has been deemed to have succeeded in performing this function within both health and non-health related workplaces (Boyce, 1995; Orr, 1996; Gill, 2001; Humphreys and Brown, 2002). This does not mean however, that all employees within one organisation merge perspectives and agree on the resulting social construction. In fact, Humphreys and Brown (2002) suggest that stories within organisations are as contested as they are shared. While having similar work experiences, individuals present with a myriad of perspectives based on personal social histories and self-conceptions. Resultant stories may possess values and worldviews that differ from those of others within the organisation, but rather than encouraging disparity, individual stories can be seen as an invitation to engage in perspective-taking and deliberation (Black, 2008).

The practice of telling and analysing stories relating to paramedicine could be used as a way of reducing the inherent mental burden experienced by individuals in the field (Tangherlini, 1998), and could provide

valuable ethnographic information regarding the complexity of the profession (Orr, 1996). The authors suggest that storytelling be recognised for the many benefits it may offer to not just qualified paramedics, but novice practitioners finding their way in such a challenging profession. Narrative practices should be embedded into undergraduate curriculum, clinical induction processes, and lifelong professional practice.

Conclusion

The process of deconstructing and reconstructing stories and critical reflection can lead to an understanding of self and the development of personal resilience. Stories can also be helpful in recognising, transforming or eliminating unhelpful assumptions in relation to paramedic practice, and can lead to a new way of perceiving the role of a paramedic. Storytelling analysis can also be implemented as a way of challenging and reshaping unsupportive aspects of paramedic culture. I invite others to search between the lines, to uncover hidden meanings, and to explore alternate possibilities through analysis of their own, and others' stories. Exploration of these and other uses and benefits of storytelling will form the basis of my future study involving storytelling among operational paramedics.

Key points

- Storytelling is ubiquitous to paramedicine and it plays a part in both the personal and professional self from the perspective of a paramedic
- Paramedicine provides fertile ground for the emergence of stories
- Storytelling can be used as a platform for personal and professional reflection in paramedicine
- The practice of narrating stories can lead to meaning making and organisational identity

References

Berger L (2001) Inside out: Narrative autoethnography as a path toward rapport. *Qualitative inquiry* **7**: 504–18.

Black L (2008) Deliberation, storytelling, and dialogic moments. *Communication Theory* **18**: 93–116.

Boyce M (1996) Organizational story and storytelling: a critical review. *Journal of Organizational Change Management* **9**: 5–26

Clandinin DJ and Connelly FM (2000) Narrative Inquiry: Experience and story in qualitative research: San Francisco: Jossey-Bass.

Clandinin DJ, Pushor D and Orr AM (2007) Navigating sites for narrative inquiry. *Journal of Teacher Education* **58**: 21–35

Denning S (2005) Transformational innovation: A journey by narrative. *Strategy & Leadership* **33**: 11–16

Denzin NK and Lincoln YS (2011) The sage handbook of qualitative research. 4 ed. Thousand Oaks: Sage Publications, 766.

Etherington K (2004) Becoming a Reflexive Researcher. London: Jessica Kingsley Publishers

Gill PB (2001) Narrative inquiry: designing the processes, pathways and patterns of changes. *Systems Research and Behavioral Science* **18**: 335–344

Gubrium JF and Holstein JA (2008) Narrative ethnography. In: Hesse-Biber S and Leavy P (eds) Handbook of emergent methods. The Guildford Press, 241–264

Küpers W (2005) Phenomenology of embodied implicit and narrative knowing. *Journal of Knowledge Management* **9**: 114–33

Marra M and Holmes J (2005) Constructing ethnicity and leadership through storytelling at work. Available at: http://hdl.handle.net/123456789/237 (Accessed 25 October 2016)

Mezirow J (2000) Learning as Transformation: Critical perspectives on a theory in progress. The Jossey-Bass Higher and Adult Education Series: ERIC.

Mildenhall J (2012) Occupational stress, paramedic informal coping strategies: a review of the literature. *Journal of Paramedic Practice* **4**: 318–28

Morley C (2014) Practising critical reflection to develop emancipatory change, Surrey: Ashgate Publishing Limited

Orr JE (1996) Talking about machines: An ethnography of a modern job: Cornell University Press

Patton MC (2002) Qualitative research and evaluation methods. Thousand Oaks: Sage

Riley T and Hawe P (2005) Researching practice: The methodological case for narrative inquiry. *Health Education Research* **20**: 226–36.

Salzer MS (1998) Narrative approach to assessing interactions between society, community, and person. *Journal of Community Psychology* **26**: 569–80

Tangherlini T (1998) Talking trauma: Paramedics and their stories: University Press of Mississippi Jackson

Tangherlini T (2000) Heroes and lies: Storytelling tactics among paramedics. *Folklore* **111**: 43–66

Tangherlini T (2003) And all anyone heard: Crystallization in paramedic storytelling. Dynamics of tradition: perspectives on oral poetry and folk belief 13

Tracy SJ, Myers KK and Scott CW (2006) Cracking jokes and crafting selves: Sensemaking and identity management among human service workers. *Communication Monographs* **73**: 283–308