‘It was a 1A,
so top priority, completely unresponsive. And I just remember hearing it going - you just stop, and you just go… normally I try not to swear at work, but this is one of those instances where I've just gone, you know…. That's my kid.’

‘The next time I saw the family members, unfortunately was at her funeral. So that was quite challenging, because I felt that people were looking at me as if… you know she's the paramedic, and she wasn’t able to save her life.’

‘I ran. I never run when I’m on the job… It was like this classic thing the way that I was bought up as an ambo was “you never run,” and I ran back to the house.’

Paramedics who attend their own families

‘Still the best damn job in the world.’

‘I was begging them in the resus bay just to continue ventilating him.’

‘Every day was like waking up in a nightmare…. I very rarely slept… Emotionally, it was taxing, it was like waking up in hell. Like it was a nightmare, I just couldn't believe it was happening.’

‘We are action people.
We arrive at something that is atrocious, but we take action. We move towards it.’

‘She just said your dad, your dad, there is blood everywhere.
And then she hung up on me.’

‘I was sitting there, and I'm typing away during my paperwork, and it just hit me. I completely broke down. What the fuck just happened? How is this even something that's just happened?’

‘Send everyone, it’s my son’ – Combined Glaserian grounded theory and thematic analysis of paramedics attending their own families

Background

It is widely accepted as ethically advisable that healthcare practitioners do not treat their own family members, to avoid any impact on their professional objectivity, patient autonomy, and informed consent. This is particularly problematic as while in other areas of healthcare it is often feasible to organise other practitioners to care for relative-patients, this is regularly not practical in paramedicine – the time-critical nature of the disease or injury and limited number of available practitioners often precludes seeking alternative treatment without risking significant patient harm.

Method

Glaserian grounded theory and thematic analysis methods were both undertaken using a realist perspective. Acquiescence, wording, and habituation heuristics were mitigated in the interview design. There were 44 responses (n=93 instances of treating family), with 21 participants (n=34) from three countries interviewed. Saturation was determined using both Guest et al.’s and Thorne’s criterion. Semantic and latent themes were generated inductively via a five-step process, with grounded theory generated simultaneously via a three-step Glaserian process. Cohen’s kappa ranged from 0.82 to 0.93.

Relationship	Pathology	Severity	Outcome
Parent	Stabbing to neck and chest	Severe	Survived
Aunt or Uncle	Cardiac arrest	Severe	Died
Partner	Anaphylaxis	Severe	Survived
Child	Anaphylaxis	Severe	Survived
Partner	Oesophageal spasm	Mild	Survived
Cousin	Back injury	Mild	Survived
Child	Hanging	Severe	Died
Grandparent	Pneumonia	Moderate	Survived
Partner	Motor vehicle accident	Severe	Survived
Parent	Chronic obstructive pulmonary disease	Moderate	Survived
Parent	Retrieval	Mild	Survived
Child	Foreign body airway obstruction	Moderate	Survived
Niece or Nephew	Cardiac arrest	Severe	Survived
Child	Traumatic brain injury	Severe	Survived
Partner	Cardiac arrest	Severe	Survived
Child	Overdose	Severe	Survived
Niece or Nephew	Upper respiratory tract infection	Mild	Survived
Parent	Sphincter of Oddi spasm	Mild	Survived
Child	Fall from height	Moderate	Survived
Sibling	Hanging	Severe	Died
Child	Fall from height	Moderate	Survived
Child	Dislocation	Mild	Survived
Child	Laceration	Mild	Survived
Parent	Cardiac arrest	Severe	Died
Child	Heavy machinery trauma	Severe	Survived
Child	Seizure	Severe	Survived
Child	Respiratory arrest	Severe	Survived
Partner	Anaphylaxis	Severe	Survived
Parent	Dysrhythmia	Moderate	Survived
Sibling	Traumatic brain injury	Moderate	Survived
Partner	Hanging	Severe	Survived
Partner	Motor vehicle accident	Mild	Survived
Parent	Cerebrovascular accident	Mild	Survived
Parent	Dementia	Mild	Survived

The first few moments: shock, suppression, focus

- An immediate sympathetic hyperarousal response
- Running towards the trauma: wanting to treat
- Pre-notification is essential to resilience
- Cut to the chase: an abridged clinical approach
- Low acuity equals high enjoyability

The duality of clinician and family member

- Dealing with family on scene: am I paramedic or relative?
- Dealing with long-term family ramifications
- Increased self-awareness on scene
- Confusion about roles at the hospital
- The shock of becoming a carer
- It’s a privilege to treat your own

Inconsistent organisational support

- Organisational indifference and unresponsiveness
- Everyone knows: dealing with gossip
- The critical role of the line manager in helping
- Navigating unknown processes and needing a guide
- Investigative apprehension: it needs to look good on paper

Acute personal effects: the short-term consequences

- Paramedics as unrecognised patients
- Emotional anarchy: dealing with an acute stress response
- Medical knowledge and being on the other side of the system

Chronic personal effects: the long-term fallout

- Post-traumatic stress
- Post-traumatic growth
- A different person: changes in personality
- An increased sense of responsibility
- Loss of identity

Results

Incidents were both traumatic (hangings, stabbings, traumatic arrests) and medical (paediatric arrests, cardiac arrests, overdoses). The core concept was ‘conflict between the roles of clinician and relative’. Paramedics reported a sympathetic hyperarousal response that they quickly suppressed, a rapid transition into ‘work mode’, and difficulty obtaining their normal state of flow, balancing dual roles as clinician and relative, transitioning out of work mode and into becoming a carer, and simultaneously processing the event. Organisational responses were frequently described as inadequate. Paramedics reported short-term experiences consistent with an acute stress response, and a large proportion suffered long-term, life-altering consequences. It is theorised that this phenomenon disrupts professional detachment, increases outcome self-expectations, interrupts routines, and promotes overmedicalisation.

Recommendations for practice

- Paramedics’ addresses pre-loaded into Computer Aided Dispatch.
- Low paramedic threshold for seeking clinical advice on scene.
- Maintaining confidentiality by all staff who are aware of the case.
- Organisational recognition of high risk for psychological harm.
- A mandatory hot debrief, followed by automatic stand-down for the shift.
- Automatic referral to mental health services. This should not be a ‘one-off’ but include long term follow up over a period of several months and should be integrated into investigations and return to work plans.
- Organisational presumption that leave is to be granted, with the paramedic able to waive this if they choose. The paramedic should not be pressured into making that decision at the time, as they may remain heightened.
- If the patient survives, information on carer support should be provided.

Published article

Griffith UNIVERSITY Queensland, Australia

THE UNIVERSITY OF MELBOURNE