Management and the creation of occupational stressors in an Australian and a UK Ambulance Service

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Abstract

Qualitative methods were used to explore the aetiology of occupational stress experienced by on-road ambulance officers. The researcher found that the way in which a service is organised and its officers valued can create and reproduce workplace stressors that are as causative of occupational stress as the often acknowledged occupational specific stressors like night shifts, irregular work hours and witnessing human trauma and tragedy. These stressors thought to be intrinsic to the work of ambulance officers were found to have an organisational dimension.

Context of the research

A comparison of two very differently structured ambulance services – one a corporatised UK service, the other a paramilitary style bureaucracy in Australia - allowed the researcher to identify which structures and policies were the most stressful for officers. Though different stressors were identified in the two services the common denominator in both services was one of control.

The way an ambulance service is organised and its officers valued can create and reproduce workplace stressors which are as causative of occupational stress as the often acknowledged occupational specific stressors such as shift work and witnessing human trauma and tragedy. Though irregular working hours and being present at scenes which are distressing to any human being are unavoidable stressors which go with the territory of being an ambulance officer these seemingly intrinsic stressors of the vocation can also have an organisational dimension. That is, some party controls who does what work, when, how often, the pace and with what resources and support.

This paper addresses the findings of research in which a comparison of two very differently organised ambulance services was undertaken. Service Oz (a pseudonym for the Australian service studied) is structured along classic bureaucratic lines, having a paramilitary centralised line of command with many hierarchical levels. Industry-based collective bargaining, where the union bargains on the members' behalf, is still the method used to resolve industrial disputes and to negotiate pay and working conditions. The officers continue to receive penalty rates for irregular working hours and conditions, although this is coming under increasing scrutiny as publicly funded and operated health and welfare services come under increasing pressure to curtail their operating costs.

Like other governments in the western world, the Australian Government's response to the economic crises was to adopt neo-liberal economic and political policies and to roll back government spending on health and welfare services. Government bureaucracies, particularly in the social services, were accused of being inefficient and creating needs to justify their growth and existence, often referred to as 'bloated bureaucracies', wasteful of public funds (Gough 1979:145; Bryson 1992: 13). Consequently the number of public servants was reduced

and health and welfare services forced to operate with reduced budgets and staff. Some services were privatised in the belief that only competition can increase efficiency, quality, productivity, and be more responsive to user needs.

In the UK, the contraction of the Welfare State and the privatisation of hitherto public services is more advanced than in Australia. The Thatcherite ideology of individual pride in financial independence maintains that welfare agencies can even encourage a dependency in clients, thereby creating false needs and discouraging individuals from taking responsibility for themselves and their families. Subsequently, under the sway of the economic rationalism of the Thatcher Government, Service UK (a pseudonym for the UK service studied) was radically restructured along corporate lines in 1991.

Corporatisation is a market-oriented approach to the delivery of services by the Welfare State. Service UK was one of the first UK health services to adopt the status of a National Health Service (NHS) Trust. Trust status allowed services to operate as autonomous business units.

Government policy encouraged the purchaser/provider split system. This meant that publicly funded services were split into purchaser or provider sections and that providers were required to put in tenders to the purchasers. For example, in Service UK the patient transport arm of the service now has to tender and compete with other services - both publicly and privately funded - to provide all non-emergency patient transport at the local public hospital, which was previously their preserve. The National Health Service Management Executive (1992:4) suggested that purchasers should select from, ' a range of patient transport operators who can provide a flexible service to patients, for example the NHS ambulance services, private ambulance operators, vehicle hire, taxis and voluntary car services'.

Service UK, in stark contrast to Service Oz, has a flat management structure with only three Divisional Commanders between the on-road staff – the bulk of the organisation – and a handful of senior executives. The operation of Service UK is autonomous from the government bureaucracy in that they make all decisions on the expenditure of funds and the operation of their service. The service is also partially financially independent from government in that it generates 10% of its operating budget by income generating schemes. There is very little union involvement in Service UK, as each employee is required to sign an individual contract with the service. The contract includes a no-strike clause.

Defining occupational stress

Definitions of stress by psychologists have not changed significantly since Lazarus first presented his model of psychological stress in 1966. Stress is understood as an entire process from threat/stressor to conversion illness. Lazarus maintained that how individuals perceive threats and appraise their ability to control or adjust to stressors in their environment determines their response and the degree of distress experienced (Lazarus 1966; 1974; Lazarus & Folkman 1984).

Individual differences are important in the psychological model and the literature is replete with extensive research on what is a stressor for one personality type is not for another. There is compelling evidence of different degrees of responses to the same stressor (see for example Janisse 1988 and the extensive literature on stress and personality types). It is understandable that an individual's biography is relevant to how they perceive and respond to stressors and that past experiences can colour whether or not a person believes they can control their environment. Up to a point we all respond differently, though as Berger (1991) pointed out, as the stressors accumulate there must come a point when even the most hardy of individuals succumbs. Berger asked, 'what is the dose and who is administering it'?

There are organisational stressors that are out of the control of any worker, no matter how they perceive and appraise the situation or think of themselves as hardy, stress resistant, able to cope etc. In contemporary work organisations with the emphasis on the intensification of work, high workloads and long hours, employees have reached the zenith of their adjustment. The economic crises were out of the control of workers, just as the repercussions such as downsizing (a euphemism for mass sackings and redundancies) and unemployment or underemployment are out of an individual worker's control. It is useless taking a Pollyannaish attitude of turning a redundancy into a positive perception of a new window of opportunity for a life change as advocated by some clinical psychologists, when there is little or no job mobility and no opportunities for worker redeployment in some areas.

This was the situation in the particular geographic region of the UK in which I completed my research during 1998. Each evening on the local news I would hear that yet another company had collapsed or moved offshore with the resultant unemployment of thousands of people. The ambulance service was one of the more stable industries. Research participants in both the Australian and UK services reported that their jobs were secure and that job insecurity was not a source of stress. However, from the results of my research in the UK I would suggest that occupational stress was preferable to unemployment stress, because no matter how disgruntled, overworked or stressed they felt, employees of Service UK could not contemplate leaving the service as there were no other jobs to go to.

Definitions of stress which continue to make an individual responsible for their stress experience, effectively 'blame the victim' (a concept used by Quinlan 1988:189-90) and take the focus away from organisational stressors. The contemporary intensification of work prompted Christina Maslach (the North American guru on burnout and author of the *Maslach Burnout Inventory* – third edition 1996) to comment for the first time in her long career that employees have reached the limits of their adjustment. She argued that it is now time for employers to address the creation of stressors at the workplace (Australian Broadcasting Corporation 1999).

Hence, the working definition of occupational stress used in this research is as follows. Occupational stress is experienced when workplace stressors over which an employee has no control (it is not a matter of perception) accumulate to such an extent that a worker's mental and physical health can be impaired and he/she cannot function as usual.

The research method

I became interested in the work of ambulance personnel when as part of the professionalisation of the occupation, officers enrolled in university courses in pre-hospital care in the mid-1990s. I taught management subjects via correspondence and residential schools to officers from all over Australia and ambulance services in the UK and Canada. At the residential schools officers applied management theory to the practices at their service. This afforded me – an outsider – the rare opportunity to get 'backstage' (a method coined by Goffman 1959) and understand the day-to-day working life in the various services. The low morale and cynicism from some officers was palpable.

I was aware that the literature on occupational stress maintained that the work of emergency services personnel was considered stressful in relation to other occupations (Young & Cooper 1995; Mackay & Cooper 1987; James 1988; James & Wright 1991; Thompson & Suzuki 1991; Brown & Campbell 1994). However, stress and the causes of stress expressed by officers at the residential schools were not in keeping with the aetiology emphasised in the literature. The expressed stressors from one service, which has a relatively high turnover rate, were grouped together as "problems with management". They were not the stressors given precedent in the literature, such as highly responsible work in life and death situations, working all hours and the risk of experiencing that which is labelled Post Traumatic Stress Disorder (see for example Joseph et al 1997; Beaton & Murphy 1993; Everly & Lating 1995).

From my past research with other occupational groups and organisations I surmised that the expressed negativity at the residential school by some groups was more than an expected complaining about the bosses to counteract unequal power relations or an 'ambo culture of whingeing' as suggested by some Australian participants. It was from these participant observations (I kept notes in a journal) that I formulated my research questions, hypothesis and the objective to explore the multicausality of ambulance officers' stress. I also came to the realisation that qualitative methods would be more productive in 'finding out' than quantitative methods or standardised tests for this particular occupational community (see an earlier paper: Mahony 1996).

In the second stage of the research I arranged tape-recorded focus groups led by an insider: an ambulance officer. I made a research decision not to be present at the focus groups because I wanted the participants to 'open-up' to one of their own; not to be influenced by my ideas on occupational stress that I had gleaned from the literature and working with other occupational groups. I wanted the participants to raise their own issues in their own voice and not to be channelled into one direction by a pre-set questionnaire. The four focus groups which were held in Australia included men and women from the various ranks and rural and metropolitan stations.

Information from the focus groups provided the discussion areas for the third stage of the research, semi-structured, face-to-face interviews with ambulance officers, paramedics and patient transport officers held at the workplace. I wanted to interview a good cross-section of the on-road workers. I was not targeting 'stressed' officers.

Locating and interviewing a sample of officers drawn at random was a logistic impossibility due to shift work, road-work and long distances. The next best way to ensure some representativeness was to fill quotas drawn from the following three strata: rank, gender and metropolitan/rural (thirty officers from each service). Greater representativeness was achieved in Service Oz than Service UK because in the Australian service only the Station Officer knew that I would be arriving to approach officers for interview and it was a matter of chance who was available on the day to fill my quotas. Not in any way was it a selected sample, but unfortunately the same cannot be said of the Service UK sample. In the UK part of the sample (9/30) was selected for me by two of the Divisional Commanders who decided which officers would be "the more articulate" and "an ambassador for the service".

All the interviews were tape recorded, transcribed and all comments coded. Recurring comments and themes were deemed to have more validity than the odd anecdotal story. Body language, pauses, reluctance to talk about a subject and changing the subject were all noted, as was any emotive language or changes in volume.

Results

From my early participant observations at the residential schools I could not help but notice the on-road officers' antagonism towards management. This did not just apply to the two services in the present study but to all the services whose officers had a residential school. "Problems with management" at Service Oz were creating such stressors that it was reported at the residential schools to be the main reason experienced officers left the service. This was later supported by the interviews.

The fact that I observed this rift in all the services I had contact with, initially suggested that perhaps this was integral to the way ambulance services are structured. The literature is replete with many examples of the negative consequences of steep and distant bureaucracies where senior bureaucrats have lost touch with the workers at the coalface or roadface (Gouldner 1979:50; Robbins & Barnwell 1998:Ch 11; Morgan 1986:Ch 2). But the flat structure of Service UK did not initially support this theory.

Problems with management so dominated the research interviews that I have had to address this source of stress; it cannot be 'glossed over' in any of my reports. I will come to the specific problems identified later in this paper.

Nisbet's (1970:106) taxonomy of *gemeinschaft* is telling of the sorts of close-knit yet antagonistic groups formed in the ambulance services – the 'us versus them' phenomenon. As Nisbet explained the solidarity of such groups is formed and strengthened in response to animosity and defensiveness towards the opposing group. While there were constant jibes at management during the residential schools, when it came to conducting the interviews with the on-road staff in Service Oz, there were 'no holds barred'. They had no inhibitions in expressing their frustrations with management even though none of the questions specifically asked as much. It appeared that members of Service Oz took, or needed every opportunity to express their frustration with management. For example:

> *They [management] don't trust staff; therefore staff don't have respect for management – have no desire to help them.*

The group dynamics as explained by Nisbet are also illustrated in the following comments:

> *If I had problems I would speak to the blokes here–I would never expect anything from any management level at all.*
>
> *We repeatedly told x [a senior manager] that the ripped carpet was dangerous. In the end we had to report him to Workcover [government body that oversees occupational health and safety legislation]. He retaliated by insisting that everything go by the book and gave us a really hard time but we got back at him by making sure that we blew out his budget by using the most expensive pain-killers and things.*

In Service UK the research participants were a lot more reticent about saying anything negative about management. The CEO was constantly reiterating the need for company loyalty and a united front as part of his planned culture of excellence [service newsletters]. The officers in Service UK, apart from being told they were to act as ambassadors for the service in any dealings with outsiders, were cautious about saying anything that could jeopardise their jobs and incomes in a very limited job market.

What were the 'problems with management'? Recurring comments from the interviews included comments that Service Oz management was indecisive, had an endless rule book, actually reneged on recruitment and promotion decisions, gave no clear career path for officers who wanted to get ahead clinically or administratively and constantly changed their minds.

> *Just when you think you've worked it all out the goal posts move; you can't possibly know all the rules - to bung you they invent some more rules.*

I read official correspondence that supported the claim that management reneged on recruitment and promotion decisions.

In contrast the managers of Service UK were reported to be particularly organised, efficient and decisive. They would never need to renege on a decision or give false hopes at recruitment. But herein lay the problem. The managers at Service UK were so efficient that they had covered every possible contingency with military precision.

At each station there were four Station Officers. Though all four did on-road work and shift work they had different administrative responsibilities to complete. These responsibilities were more of the character of a checklist of administrative tasks than solving problems or making any real decisions. There was no need or room for participatory decision making, though this was advocated in many publications put out by the CEO who is committed to empowering staff by participatory management, if only in theory. A flat management structure would ordinarily indicate that decisions were being made locally but the flat management structure of Service UK is based on the sort of centralised control and authority indicative of a classic bureaucracy. An experienced Station Officer commented:

> *Empowerment is the latest buzz word; the old ways still trickle through; it is management by edict.*

'Problems with management' at both services related to control; staff believing that all management decisions, directives and moves were out of their sphere of influence; that they were mere pawns in the managers' much larger plans; powerless to change things.

Officers in Service Oz reported the added stressors of what is colloquially known as the 'mushroom effect' (kept in the dark and fed on manure). They reported that senior managers did not communicate their plans or decisions and that they were often subject to arbitrary power exercised by managers who created new rules to suit themselves. The lack of formal communication was reputedly the reason why the 'grapevine' – the informal information and gossip network – was so very active in Service Oz. When asked whether officers could influence those aspects of the job they found frustrating, they responded, "no way", "you live with it", "you live with it or you go under".

The occupational stress literature suggests that low discretion work, which entails little autonomy, is stressful (Karasek 1979; Landsbury & Spillane 1983; Fletcher 1988). Low discretion work does not allow workers to exercise their human capacities such as initiative, decision making or judgement. Such work relegates humans to alienated clock-watchers under the close supervision of a higher authority who decides how and when tasks are to be performed. The situation in terms of work autonomy in both services was quite paradoxical. Although all participants reported having a high level of clinical autonomy at the scene of an emergency, the way that their work was organised meant that they had little autonomy in deciding their workload, hours or recuperative periods after stressful assignments. Officers were expected to use their initiative and to make judgements concerning diagnosis and treatment in life or death situations yet management via Co-ordination (the centre where the emergency telephone calls are received and crews deployed) could send them anywhere at any time.

The Co-ordination staff and the on-road staff at Service UK were working to two different agendas. Co-ordination staff were under direction to send the nearest available ambulance, no matter whether it was close to a crew's 'knock off' time or whether a crew had just completed a "bad job", which is their expression for an horrific or tragic assignment. As quality is assessed using measures borrowed from the private sector, the only quantifiable indicia used, were response times. Although very important, in life or death situations, eighty percent of an ambulance officer's work is non-emergency (personal communication from one of the senior executives) and there are many important human skills of the occupation which cannot be reduced to numbers. Response times and the efficiency of the service were reported to be Co-ordination's only objectives, whilst doing the best for your patient was the officers' objective; an objective they felt that they could not meet if they were fatigued, rushed and forced to cut corners.

A comment that typified this theme was as follows.

> *Sometimes you're just taking your patient off the back on the stretcher and your radios going beep, beep, beep, beep – another job – you haven't got your patient off the stretcher yet. So you can't give them their proper handling because you have someone else who wants you – someone else who needs you. You're rushing in with that one, rushing back for equipment or a form. It takes its toll, doesn't it? You've got your back problems starting and people going on the sick. You think to yourself I've had enough of this – you haven't had your proper meal break, you haven't been relieved, you haven't had anything to eat all day – then four or five others go on the sick. The pressure goes higher, higher, higher – eventually it's all going to pop.*

Other officers (9/30) also referred to the high rate of absenteeism at the time of the interviews.

The majority (70%) of officers from Service Oz expressed extreme frustration at having to transport clients who were clearly not in need of hospital care. These cases tied-up fully equipped emergency vehicles and the time of skilled staff. When a real emergency came in it took officers longer to respond, especially in times of staff shortages due to sickness or staff cutbacks. For clients in receipt of welfare benefits the ambulance service is free in both services. It frustrated officers that some people often took advantage of the service.

> *They run out to meet the big red and white taxi waving their benefits card before them when it was something they could've seen their GP about next week [ambulance vehicles are painted red and white in Australia].*

In neither service were officers allowed to decide which patients are transported to an emergency department of a hospital and this results in many unnecessary and inappropriate transfers. The policy states that if a client requests to be taken to a hospital's accident and emergency department a crew must take them. Ostensibly the reason given for this policy is that "we are here to service the community", but when you consider the rationalisation of other health and welfare services the official reason does not fit with the espoused economic rationalist objectives of each service, particularly Service UK. Triage nurses decide which clients can have access to the emergency room. Is this an indication of the clinical regard ambulance officers and paramedics are held, that they cannot make these decisions?

On those rare occasions when a hospital's clinical operation attracts negative media attention or an official inquiry it is usually when a patient has been sent home from the emergency department and the patient becomes seriously ill or dies some hours later. This suggests that although it is costing the state and the services considerable funds in transporting inappropriate cases to an emergency department, that the main undiscussed reason for continuing this policy is fear of litigation if officers made an incorrect decision. I would also suggest that until such time as the services trust their experienced personnel to make such decisions they are holding back the professionalisation of the occupation, as autonomous decision making characterises the work of professionals (Probert, 1989:55-56).

"Clinical frustration" was a stressor mentioned many times by officers in Service Oz. All the Level 3 officers reported being "stuck on Level 3", their applications for clinical advancement repeatedly declined to the extent that officers with over six years experience described their position as a "dead end job" or "just a job – not a career". Only the ranks above Level 3 (Level 4 known as Advanced Life Support and Level 5, the Paramedics) could administer life saving drugs and carry out some specific procedures such as cannulation and intubation. In Service UK every crew includes a paramedic, however this was not the case in the Australian service. For the client it is a matter of chance – particularly in rural areas – whether or not the crew who arrives includes a paramedic to administer life saving drugs and procedures. Competition to gain entry into the elite paramedic course in Service Oz is intense, creating rivalry were there was once mateship. All Level 3 respondents commented that the process for entry was unclear, and that selection was unfair and smacked of favouritism and cronyism.

So few are trained as paramedics in Service Oz that competition has further split the service into two factions. From research into hyperskilling in other industries this could be expected because there are two sides to the coin, with downskilling the other face. Whilst upskilling adds to the professionalisation of the service, should provide more skills and autonomy for staff and is much better for the client, upskilling some members nearly always takes away some of the decision making and responsibility previously enjoyed by experienced staff. It does not have to be this way, but as Herdman (1998) noted of the implementation of nurse practitioner specialists, only the specialists were allowed to make decisions which were previously the preserve of the experienced nursing sisters.

For officers in Service Oz the experience of applying for clinical skills advancement was such a stressful and demoralising experience that three out of the ten Level 3s I spoke with reported that they would "never apply again", "never put myself through that again". One officer commented, "I withdrew from everyone and stayed at home watching escapist videos".

A radical restructure at Service UK in the early 1990s, from a local bureaucracy of the NHS to an autonomous business unit, has produced stressors for officers in all three tiers: paramedics, technicians and patient transport officers alike. Work intensification was nominated as the major stressor in the UK interviews. Though initially disappointed that I was not given permission to interview the city officers at their stations I soon realised that this would have been logistically impossible as the city officers were literally 'run off their feet'. They had no downtime (time on the station waiting for an assignment to be allocated) as they were constantly on the road.

Keeping accident and emergency crews continually on the road as mobile service units was the espoused objective of the CEO as he believed crews could be located and deployed more quickly. Gaps in the roster caused by sickness, pregnancy (pregnant officers had the right to take sick leave) or recreation leave had to be covered by other members of the team on a time-in-lieu basis, as paid overtime and penalty rates had been traded off for marginally better rates of pay in individually bargained enterprise agreements. All the accident and emergency officers I interviewed had accumulated many hours time-in-lieu, which they were unable to take because of the high absenteeism at the time.

It was reported to be not uncommon in Service UK for officers to be allocated a patient transfer half an hour before the end of a twelve-hour shift and not to complete an assignment and return to the station until many hours later. As one officer related:

> *The thing that really broke us up was Control passed us a job at the eleventh hour. We'd had a busy shift. A job can run 6, 7 hours over the end of shift. That was like the breaking point, you know. You've just done a 12 hour shift – it makes it a 19 hour all-nighter – you don't get back until 1, 2, 3,4 even 5 o'clock in the morning [end of shift was 7 PM]. It was hard going from there.*

In both services officers complained that management did not care about their staff. In Service Oz it was reported that senior managers were considered to be too distant to know what an officer's work entailed, to be able to care. In service UK the road staff felt that they were constantly pushed to achieve more with less resources and that management did not care about their welfare: "They're working us into the ground". Officers commented that "we are supposed to be a caring service but that does not extend to staff".

When officers complained to management about working long past the end of shift, they were told to, "get on with it you've got a three day break". One senior executive anxiously predicted that the officers would complain to me, during the interviews, that they were not getting their proper meal breaks: "when I was on the road, there must have been something wrong with you if you couldn't organise time to eat". I noted that this was before a satellite tracking system could locate vehicles putting an end to 'foreign orders'.

The stressor of having a founded or unfounded complaint made against you by a member of the public was a stressor which also came under the heading 'problems with management' due to the way senior managers dealt with such situations. The process was reported to be a major stressor by officers in both services. The stress of the complaints process caused officers to take sick leave, stress leave, consult mental health practitioners, be on medication and contemplate resigning from the service. In the non-select part of the sample in Service UK, I happened across two officers (2/21) who although the complaint was not upheld, experienced a very stressful period due to the way in which Head Office handled the complaint. One felt that his reputation had been ruined: "I'll always be under a cloud". He was still taking medication for his "nerves" twelve months after the incident.

In Service Oz I interviewed one officer, whose mental health had been affected by the way in which a complaint - which her Station Officer confirmed, was "a very trivial matter" - had been handled by senior management. Like the UK officer she was also on medication for her "nerves" and sought help from a counsellor. During the interview she was visibly distressed, contemplating alternative employment, examining her limited options. The most distressing aspect for this officer was the long drawn out process during which she was constantly interrogated and yet given no feedback or resolution. She was left 'in limbo' for nine months not knowing whether or not she had secure employment.

I need to note that both the respondents in the UK and Australia samples were quick to point out that they received the much needed understanding and support from their immediate colleagues and/or Station Officer. It was senior managers who were considered to be aloof and insensitive to what "we're going through", senior managers who "have the power to make or break you".

Though only one participant in the Australian sample reported the experience of occupational stress due to the complaints procedure, other cases were reported by the participants. They related how officers had taken stress leave because of the distress generated by the complaints procedure, or to be more precise, the lack of a communicated set procedure in Service OZ. All ambulance officers have to work and live in the knowledge that a member of the public may make an unfounded complaint against them no matter how conscientious or proficient they are. Emergency situations are known to be highly emotive and patients and relatives can project negative feelings onto the most immediate health worker who can often get the blame for a poor outcome. Rather than management recognising that all officers are at risk of unfounded complaints and alleviating these inherent fears by a policy of support and defence until proven guilty, the majority of participants in the study both Australian and British reported that "you are always presumed guilty until proven innocent". Perhaps it is the military culture that perpetuates such responses to complaints, and these kinds of responses can only add to an officer's distress.

The risk of having an unfounded complaint levelled against you appears to be an intrinsic stressor for all on-road staff, a potential stressor that is out of an individual's control no matter how competent they are. Though the risk may be intrinsic to the occupation management's response is not.

The purge of the middle managers in Service UK and designating Station Officers as 'productive' on-road shift workers as well as administrators created particular stressors for the middle-aged officers (6/30). When they joined the service it was an old style bureaucracy and they were led to believe that, after twenty to thirty years of night work and physical on-road work, they would be rewarded by promotion to a nine to five administrative, training or co-ordination position. There were positive aspects to the old seniority system, which is now condemned as time-serving; there were motivating rewards for years of loyal service. Now after many years of service there are no rewards or respite in sight, even if promoted to Station Officer. Early retirement is not an option because unlike the Police Service in the UK, which recognises the cumulative effects of stressful working conditions, their pension scheme requires more years of service before they can take out the full benefits.

As an experienced industrial researcher I was surprised to find so many middle-aged men who were talking as if they were approaching retirement age. The following quote typifies the accumulated affects of stressors in that it expresses how hard it was for these middle-aged officers to continue meeting the expectations of the new service. "The wife can see changes in me as it gets towards the end of my days off and I have to face coming to work again".

My findings on the aetiology of what has come to be known as Critical Incident Stress or Post Traumatic Stress Disorder supports that which is already known. The most traumatic incidents for officers are those involving child fatalities, multiple fatalities and people known to the officer (Thompson, Skilton & Scully 1996). Rural officers who live or who have grown up in the community in which they work, are at greater risk of treating someone they know.

Though witnessing trauma and tragedy are potential stressors intrinsic to the occupation, officers in both services felt that the Co-ordination Room staff could have been a lot more sensitive in regards to who they deployed and how often they deployed crews to critical incidents. In Service Oz, officers had coined the term "de-stress". That is, they felt that they were not allowed sufficient time between a traumatic assignment and the next case to take part in a debriefing and to recover - to "de-stress". For example, a rural officer explained how it was very difficult for her to maintain her composure and act in a professional manner with a patient she was sent to immediately after a particularly traumatic and tragic assignment. It was a child who had been bashed by a close relative the night before. The child died on the way to the hospital. The officer was not allowed the time to attend the debriefing at the hospital with the police and other health workers. When she arrived at the next assignment she was particularly embarrassed because the patient could tell that she was visibly upset.

Rural officers in the Australian sample reported similar stories and although it is recognised that it is sometimes difficult for Co-ordination to deploy an alternative crew in rural areas the problem is exacerbated by the tightening-up of the 'on-call' funds. Though rural Station Officers have been directed to be more judicious with the 'on-call' money it was the Co-ordination Room who decided not to call out for another officer.

The Australian officers reported that the other emergency services were better organised to deal with critical incident stress.

> At the house fire last week [multiple fatality] the Fire Brigade sent out a truck with food and drink for the officers, arranged a debriefing straight away and made sure that their officers were sent home free of duties, whereas we were sent to another job.

There was some acknowledgement that Co-ordination in Service Oz do try to keep track of who has been sent to what sort of an assignment. This was not the case in the UK because the closest crew was deployed no matter what the circumstances, as quality and efficiency were measured in response times. This is a quality measure that is difficult to ignore or criticise as it is well established that patient outcomes in emergency situations are relative to the time elapsed between an emergency and treatment. However, external quality awards such as given by the UK Enterprise Council were also important signifiers to Service UK in terms of having the competitive edge when tendering for contracts. Service UK was very aware that they needed additional proof of quality as they were still reeling over the lost of a contract two years earlier to provide non-emergency transport to the local hospital.

The last question I asked turned out to be very telling of work satisfaction and morale: "would you recommend your work to a friend or relative?" Initially I did not consider it a question, which would elicit much information because the standard answer given by the selected part of the UK sample was, "yes, if they were suitable". "Suitable" referred to "dedicated", "mature", "professional attitude" and "could cope with blood and gore". But when I came to interview the non-select part of the UK sample, particularly the older experienced officers (6/21) a different pattern emerged. There was a well-considered pause, followed by a resounding "no". On probing why, I received responses such as, "it's just too hard; there must be an easier way for my kids to make a living". They referred to the long indeterminate shifts, re-certification of their technical qualifications each year, the imposition of completing a university degree in their 'spare' time by correspondence and intensification in the pace of work. "But around here I'm lucky to have a job even if it is doing my head in".

None of the participants from Service Oz gave an unqualified 'no' to the above question but there were more reservations expressed by those experienced Level 3s who felt that they had no opportunities to advance in their career. Young inexperienced officers who believed that they had a career ahead of them were very positive.

Conclusion

From interviews with the on-road staff of two very differently organised ambulance services I was able to explore the multicausality of occupational stress. The comparison allowed an examination of which organisational factors were candidate stressors.

Economic rationalism has changed the nature of work in many organisations, including the two organisations studied. The increased rationing of government funds for health and welfare services has led to work intensification, longer hours and the challenge of maintaining standards with fewer resources. This has impacted on the stress levels in most service industries (Maslach & Leiter 1997). Workers have needed to constantly adapt to new stressors and yet as this research has demonstrated there comes a point when even the so-called hardy succumb and the workers in general reach the limits of adaptation. As Maslach and Leiter (1997) state, it is now timely for employers to take stock, and to take the responsibility for policies and methods which have the potential to create additional organisational stressors in an already 'stressed' work environment.

I found that there were stressors that you would find in other organisations, and stressors that were occupation-specific. Both sets of stressors can be minimised or maximised according to how the work is organised and the officers valued, even those stressors considered intrinsic to the work of ambulance personnel. Both sets of stressors can lead to occupational stress, absenteeism and staff turnover. Both sets of stressors need to be addressed.

The literature mostly addresses critical incident stress. However, my findings would suggest that the other stressors of the way the work is organised are those that accumulate to such an extent that even very experienced and highly skilled officers look for a 'way out' – alternative employment if it is available.

'Problems with management' dominated the Australian research. The interviewees painted a picture of a distant, many layered, unwieldy bureaucracy with communication problems. 'Problems with management' also

dominated the UK responses, but here the problems centred on the imposition of an economic rationalist agenda of increased productivity, heavy workloads and very long and uncompensated hours. Corporate objectives were clearly privileged over staff needs or health.

Though different problems, the basis to their 'problems with management' was the same. In both services the officers were trying to "live with it"; trying to find some personal strategy whereby they could continue working – continue making a living - in an organisation where they had no control over the constant stressors; stressors which accumulated to take a toll. On-road ambulance personnel felt powerless to change or influence the management of their working conditions.

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