“Danger Lies Everywhere and Waits for Us.”
Cape Town Metro EMS Ambulance Personnel’s Experiences of Risk, Danger and Fear.

by
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Dissertation Presented for the Degree of Master of Philosophy (Criminology, Law and Society) in the Faculty of Law at the University of Cape Town.

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February 2022

Declaration

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Signed by candidate

Minette Beukes

February 2022

Acknowledgements

- To my supervisor, Professor Kelley Moult, thank you for your tireless efforts to keep me on track. Thank you for your honest advice, guidance and jokes throughout these two years, I would not have been able to do it without you.
- To Annie Kok, a colleague who became a friend, thank you for answering all of my questions, I appreciate your friendliness and patience.
- To Dr Shaheem de Vries, thank you for assisting me throughout the entire research process. I appreciate it.
- To all the Western Cape Government staff, thank you for your friendly service and help.

Dedication

This study is wholeheartedly dedicated to the Lord. He has carried me throughout the course of my entire student career, giving me strength and hope. He has taught me the meaning of reckless grace. I will forever be grateful and humbled by His love for me. All the glory to Him.

To my parents and grandparents – you were my pillars of strength. Thank you for guiding me and for granting me the opportunity to further my education. I would not have come this far without your love and support.

To all of my friends and family, I am truly grateful for all of you. The support, jokes, love and memories that you have provided me throughout the years are priceless. Thank you, I am truly blessed with people like you in my life.

To Harry, you came into my life during the busiest time, but you have been one of my greatest sources of encouragement, support, safety and love. I appreciate all of your listening, advice and reminders of where our Strength truly comes from. I am so grateful that I met you.

To all of my participants, I dedicate this study to you. Your bravery, faith and passion truly astound me, and I am honoured to have been a part of your lives. You, the angles in green, are an inspiration to me and I hope that we can continue making a difference in each other's lives. May you be saved while saving.

Abstract

Introduction: Emergency medical services (EMS) ambulance personnel have increasingly become victims of violence while providing lifesaving medical services. This is not only a problem experienced globally, but in South Africa as well – particularly by the Metro (public) EMS ambulance personnel in Cape Town. This phenomenon has not yet been formally investigated in South Africa; thus, this study aims address this gap by exploring Cape Town Metro EMS ambulance personnel's experiences of risk, danger and fear associated with crime while performing service calls, and how these experiences shape the delivery of prehospital services.

Methods: This study utilised a qualitative research approach to explore Cape Town Metro EMS ambulance personnel's experiences of risk, danger and fear associated with crime while performing service calls. Semi-structured interviews were conducted with a sample of twelve permanently employed and qualified Metro EMS ambulance workers in the city. The study used thematic analysis to identify six main themes within the data set, including: experiences of risk; experiences of danger; experiences of fear; education, training and experience; occupational challenges; and safety interventions and recommendations.

Results: This study determined that most Metro EMS ambulance personnel that experience risk on the job, and that they do not feel that their training adequately prepares them for the realities of their occupation, especially in terms of crime. In terms of the experience of danger, respondents noted that certain ambulance divisions work in particularly dangerous areas or 'red zones', and that these red zones impact negatively on EMS protocol and subsequent service delivery. The most common dangers they experienced included: shootings and getting caught in crossfire; hijackings or attempted hijackings; stoning; robbery or attempted robbery; and being held at gun and knifepoint. Additionally, most respondents felt that the night shift is more dangerous, and that rural areas – and the infrastructural challenges they pose – are seen a danger. Metro EMS ambulance personnel reported that they experienced verbal, physical and sexual abuse from different types of offenders. How Metro EMS ambulance personnel experienced fear differed: 8 participants stated that they get scared while on duty; 2 stated that they do not experience fear; and 2 had mixed feelings about being scared. Some participants indicated that fear does not influence their ability to perform their medical duties optimally, while others were of the opinion that it does, especially in cases where they have been previously victimised. This study also found that participants experienced occupational challenges in terms of their mental health. Participants were generally of the opinion that traumatic calls and victimisation had negative effects on their mental wellbeing, and stated that

the counselling services provided to them did not aid in their recovery. The results of this study show that EMS personnel did not feel that the presence of police escorts reduces their experiences or risk, danger and fear. Respondents thus made safety recommendations based on their experiences of risk, danger and fear.

Conclusion: The narratives provided by respondents gave an exhaustive overview of their experiences of risk, danger and fear associated with crime – this included whether or not they experience these elements while performing service calls prehospital environment, as well as how they experience it. The majority of Metro EMS ambulance personnel experienced risk, danger and fear associated with crime while performing service calls, and most of the participants believed that these experiences negatively influence service delivery.

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Chapter 1

Introduction

"I greet my family as if I am going to war" says an emergency medical services (EMS) ambulance worker starring in a documentary titled *'Red Zone Paramedics'* directed by Leanne Brady (Red Zone Paramedics, 2017). The film addressed and promoted the safety of EMS ambulance personnel in South Africa, focusing particularly on Cape Town (Hendricks, 2018). EMS ambulance personnel are rapidly becoming targets of various forms of violence, especially while performing service calls (Furin et al., 2015: 460).

Crime is a serious problem, globally and in South Africa, and has a myriad of negative consequences on countries, residents, the economy and infrastructure (United Nations Office on Drugs and Crime, 2009). The high crime rate is driven by factors such extreme poverty, high levels of unemployment and income inequality, making it a difficult and devastating problem faced by the residents of South Africa (Vincent-Lambert & Westwood, 2019: 12). The criminal climate is violent and the most frequent forms of crime include gender-based violence (rape, domestic violence and murder); murder; corruption; and motor vehicle hijackings (Gifford, 2021).

The victimisation of medical first responders is a serious problem. For instance, in the United States, an above average amount of fatalities and injuries against these individuals are reported in the country, - around 250-560 serious, non-fatal attacks per year (Maguire et al., 2018: 526-527). In England, approximately 3,569 attacks on EMS personnel were reported during 2020 (Marsh, 2021). In South Africa, attacks on medical first responders have increased enormously, with most of the attacks occurring in Gauteng, KwaZulu-Natal and the Western Cape (Vincent-Lambert & Westwood, 2019: 12). According to Brady et al. (2019: 1), attacks on EMS personnel are especially rife in Cape Town. During 2018, 64 incidents of violence against paramedics were reported in the city, with approximately one attack happening each week (Brady et al., 2019: 1). Although both the private and public ambulance crews are targets of violence in South Africa (Alfreds, 2020; Isaacs, 2020), the public service providers are subjected to higher risks and dangers in their occupational environments (Brady et al., 2019: 1).

Ambulance personnel play an integral role in providing efficient and lifesaving pre-hospital services, whilst working in challenging environments (Kotzé, 1990: 320-321). The provision of emergency medical care involves the immediate and urgent stabilisation of patients,

especially those who have potentially fatal injuries or diseases (Razzak & Kellerman, 2002: 900). EMS ambulance personnel must be able to make prompt medical decisions to prevent unnecessary loss of life or disabilities (Razzak & Kellerman, 2002: 901). As these service providers are the first responders at emergency scenes, they are in personal contact with patients, family members or residents of the community, with no infrastructural support from healthcare facilities and only occasionally protected by law enforcement (Grange & Corbett, 2002: 189). They are thus frequently seen as "easy targets", making them vulnerable to continuously become victims of violence within their occupational environment (Grange & Corbett, 2002: 189). The consequences of attacks on EMS ambulance personnel are serious, and it includes poor service delivery to patients; fear of crime; depression and anxiety; post-traumatic stress disorder (PTSD); and frays the bond between the community and ambulance crews (Vincent-Lambert & Westwood, 2019: 14)

Although the literature superficially speaks to the risk, danger and fear associated with crime against EMS ambulance personnel, their experiences of providing services amidst these threats has not been adequately addressed. Furthermore, there is a limited amount of South African academic research on the victimisation of EMS ambulance personnel in the prehospital environment, particularly in the public health sector. Moreover, neither international, nor South African literature addresses key aspects of the multifaceted problem, such as 'risk', 'danger' and 'fear', and it does not (a) comprehensively define these concepts, and (b) operationalise these concepts through attempting to understand how they are experienced by EMS ambulance workers while performing service calls.

To fill the knowledge gap(s) in South African literature, this study focuses on Metro (public) EMS ambulance personnel in Cape Town, and aims to understand how they experience risk, danger and fear associated with crime while performing service calls and if (how) this shapes the prehospital services they provide. The study provides evidence that the majority of Metro EMS ambulance personnel in Cape Town experienced risk, danger and fear associated with crime while attending to emergencies, and most of the participants were of the opinion that these experiences negatively influence effective medical service delivery to communities.

Structure of the Dissertation

This study consists of six chapters. Chapter 1 presents an introductory overview of the study, as well as the structure of the dissertation.

Chapter 2 provides an in-depth literature review of the topic, and it consists of both international and South African literature with the goal to facilitate a detailed understanding of the phenomenon.

Chapter 3 outlines the research methodology, and provides a thorough overview of the research design and research methods utilised in the study. The research methods include the sampling and recruitment process followed; the data collection and analysis process utilised; the ethical considerations and limitations of the study.

In Chapter 4, the narratives of the participant's interviews are presented through the use of thematic analysis. The key themes discussed are: the experiences of risk; experiences of danger; and experiences of fear; education, training and experience; occupational challenges; and safety interventions and recommendations. This chapter thus constitutes as a representation of the study's results. A summary of the findings is also presented in this chapter.

Chapter 5 serves as a conclusion for the study. The conclusion outlines the researcher's interpretation of the results of the study. The interpretation is be based on the analytical understanding of the data, revealing how it contributes to existing knowledge; how it answers the research question; and what unique contribution it makes to the development of knowledge. Moreover, this chapter outlines the recommendations for future (and further) research.

Chapter 2

Literature Review

EMS, more commonly known as ambulance or paramedic services, are essential medical services established to provide urgent medical care within the prehospital environment (Mehmood et al., 2018: 1). This includes the evaluation, treatment, and transportation of patients with life threatening diseases or injuries (Razzak & Kellerman, 2002: 900). EMS ambulance personnel are usually the first medical personnel at the scene of an emergency (Razzak & Kellerman, 2002: 900), and upon arrival, the 'golden hour' of treatment is essential. This refers to the critical period to save a patient(s) life, during which a patient is asseses, treated and stabilised on the scene before they are transported to the nearest and most suitable hospital and attended to by physicians (Kotzé, 1990: 321). Despite providing emergency treatment to patients, EMS personnel also respond to and manage disasters (both manmade and natural) or mass casualty incidents in a well-resourced and skilled manner (Mehmood et al., 2018: 1).

EMS personnel operate in unsafe, unpredictable and high-risk occupational environments, and experience a high frequency of violence committed against them (Holgate, 2015). This study aims to understand what EMS ambulance personnel's experiences of risk, danger and fear associated with crime while on duty are. Therefore, to comprehend why and how they are victimised; this literature review focuses on the international and South African literature pertaining to the problem and is shaped against the backdrop of risk, danger and fear. These concepts are made contextually relevant to address the research question of the study. The review is structured according to the history and development of EMS; the public healthcare system in South Africa; and the public EMS system in the Western Cape and Cape Town.

The History and Development of EMS

The history of the EMS system can be traced back to Biblical times, as highlighted by the story of the Good Samaritan who was travelling between Jerusalem and Jericho when he found, treated and transported a wounded man (Chung, 2001: 85). During 1023 AD, Christian monks began to treat pilgrims who travelled to Jerusalem, and thus the Order of St. John was established (Von Güttner-Sporzyński, 2013: 205-207). This was a significant contribution to the EMS, as it enabled the establishment of two essential foundations, namely the Ambulance and the Ophthalmic Hospital in Jerusalem (Chung, 2001: 85). During 1796, ambulances were used for the first time to transport wounded soldiers from battlefields to hospital stations

(Barron, 2014). In 1854, Florence Nightingale organised care for wounded soldiers during the Crimean War, and during the American Civil War, ambulance trains of horse-drawn wagons were used as an urgent mode of transportation for injured soldiers (Barron, 2014). It was during this time that an American nurse, Clarissa Harlowe Barton, made the important suggestion of "treat them where they lie", which ultimately underlines the emergence of EMS (Barron, 2014). In 1935, the foundation of Europe's EMS system was established by Professor Martin Kirchner, a German surgeon, who recommended that "casualty should not be brought to the physician, but the physician should be brought to the casualty" (Sefrin & Weidringer, 1991: 246-247). Both the Korean War (1950-1953) and the Vietnam War (1964-1967) lead to the establishment of the 'paramedic concept', as well as of medical helicopters for casualty evacuation (Trunkey, 1991: 1261). Medical advances in the 1960's, such as the administration of cardiopulmonary resuscitation (CPR), defibrillation, and medication to treat out-of-hospital cardiac arrest, contributed to notable changes in the functioning of ambulances (Kouwenhoven et al., 1960: 1064). Since the 1970's, improvements in the prehospital environment are seen as significant contributions to the effective functioning of health care systems by the World Health Organisation (WHO) (Al-Shaqsi, 2010: 320). Current EMS systems have rapidly developed into advanced medical care in which personnel can administer medications such as morphine and epinephrine; perform invasive procedures; make complex medical and clinical decisions; and declare death (Al-Shaqsi, 2010: 320). The global EMS system functions based on two models; the French-German model, provides emergency care through enabling doctors to work on ambulances or response cars with the goal to bring the doctor to the patient. In this model, paramedics or EMS personnel only assist doctors and are constantly supervised (Arnold, 1999: 98). The Anglo-Saxon model, which is used in South Africa, is paramedic based, therefore the prehospital setting is dominated by care provided by EMS personnel, without the involvement of doctors (Arnold, 1999: 98).

In South Africa, Major Peter Shepherd and Colonel Francis Duncan initiated the teaching of First Aid to untrained individuals within the domain of the St John Ambulance association in 1877 (Pearn, 1994: 1718). Therefore, the first ambulance to exist in South Africa was known as the St John's Ambulance Brigade (Van Huyssteen, 2017). Patients who needed emergency care were only provided with basic first aid care – a technique called 'scoop and shoot' – and were rapidly evacuated by mbulance to a hospital (Sobuwa & Christopher, 2019: 2). The concept of 'the paramedic' was established in South Africa in the 1970's, as the Emergency Medical Assistance (EMA) Course was developed, covering advanced first aid training, as well

as intravenous fluid administration (Kotzé, 1990: 320). A Cape Town doctor, named Alan MacMahon, introduced ambulance services as a completely independent health service in the country (Kotzé, 1990: 320; Barron, 2014). The Health Act of 1977 led to ambulance services becoming the responsibility of the Health Departments of each Provincial Administration (Dalbock, 1996: 119). In 1992, the Professional Board for Emergency Care Personnel (currently known as the Professional Board for Emergency Care [PBEC]) was established under the auspice of the South African Medical and Dental Council (currently known as the Health Professionals Council of South Africa [HPCSA]) (Sobuwa & Christopher, 2019: 2). The Minister of Health and Population Development established the Professional Board for Emergency Care Personnel [PBEC] in January 1992 (Dalbock, 1996: 119). Since 1994, all EMS personnel had to register with the PBEC and abide by its regulations and ethical protocols (Dalbock, 1996: 119-120).

The Public Healthcare System in South Africa and EMS

In 1994, the apartheid era ended and the African National Congress (ANC) became the new democratic government of South Africa, led by President Nelson Mandela (Pruitt, 2010: 119). The new democratic dispensation experienced reform and changes were made to the institutions, legislation and policies of the country (Pruitt, 2010: 119). The new Constitution informed significant structural changes to the healthcare system, and all South African residents were ensured the right to receive health care in the country (Constitution of the Republic of South Africa, 1996). The current health system is divided into the National Health System, the Provincial Health System and the District Health System, and is further divided into public and private services which functions independently from each other (Coovadia et al., 2009: 818-825). The private health sector serves approximately 16% of South African residents (Bresick et al., 2019: 109), which include individuals who are either able to pay for the services, or those who are comprehensively covered by a medical aid (Mahlathi & Dlamini, 2015: 3). Private ambulance services in South Africa are either self-governed or dependent on a particular hospital (Van Huyssteen, 2017). The public health sector is divided into three sectors, namely primary, secondary and tertiary facilities (Mahlathi & Dlamini, 2015: 3), serving approximately 84% of South African residents with minimal resources (Bresick et al., 2019: 109). Each provincial Department of Health controls all the medical services provided in its geographical area, including emergency care, which is managed by each respective executive committee of the EMS (Wallis et al., 2008: 70). Emergency medical care in South Africa is thus available to all residents, in the form of either a land ambulance or an aero-

medical helicopter, and is free to anyone who has an income below a certain level (MacFarlane et al., 2005: 146).

Currently, the National Emergency Care Education and Training Policy exists against the backdrop of a three-tiered emergency system that functions with the purpose to educate and train individuals. This system is aligned with the South African National Qualifications Sub-Framework (Sobuwa & Christopher, 2019: 3). As a result, three different levels of EMS exist in South Africa. The most basic level is known as the Basic Ambulance Assistant (BAA), who is qualified with a Basic Life Support (BLS) certification (MacFarlane et al., 2005: 146). They receive one month of formal training on the use ambulance equipment; conducting CPR; and using automated external defibrillators (AED's) (MacFarlane et al., 2005: 146). The second level of EMS is known as an AEA, who hold an Intermediate Life Support (ILS) certification (MacFarlane et al., 2005: 146). ILS certified EMS personnel have at least three to four months of EMS ambulance experience and, in addition to the BAA responsibilities, are qualified to provide nebulisation; to administer certain intravenous and oral medications; and to manually defibrillate patients (MacFarlane et al., 2005: 146). The third level of EMS is achieved after a year of completing a full-time training course, after which the individual will be certified as an Advanced Life Support (ALS) paramedic, also known as a Critical Care Assistant (CCA) (MacFarlane et al., 2005: 146). Paramedics have extensive emergency medical knowledge and their training incorporates various protocols based on paediatric advanced life support (PALS); advanced cardiovascular life support (ACLS); and advanced trauma life support (ATLS) in order to provide excellent patient care (MacFarlane et al., 2005: 146). EMS ambulance personnel can also extend their training by completing a three-year full-time qualification at designated South African colleges to become either an Emergency Care Practitioner (ECP), or complete a four-year Bachelor of Technology degree to become an Emergency Care Technician (ECT) (MacFarlane et al., 2005: 147). In 2019, a higher certificate in emergency medical care was developed for individuals to register as Emergency Care Assistants (ECA) (Health Professionals Council of South Africa, 2019). All formally qualified EMS personnel should be registered under the auspices of the PBEC and the HPSCA (Health Professionals Council of South Africa, 2021).

The Public EMS System in the Western Cape and Cape Town

The public EMS system of the Western Cape is divided into four core components, consisting of HealthNet (Health Non-Emergency Transport), rescue, ambulance operations, and emergency communications (Western Cape Government, 2021). HealthNet transports non-

emergency patients across the province, either between their homes and health facilities, or between health facilities (Western Cape Government, 2021). Rescue, which "consists of highly qualified, advanced rescue technicians" provides both technical and medical care on the scene of a rescue operation (Western Cape Government, 2021). Approximately 250 ambulances operate across the province, and each ambulance is equipped with medical equipment, medication and two skilled EMS ambulance personnel (Western Cape Government, 2021). Ambulance care includes specialised services such as SPRINTT (Specialised Paediatric Retrieval including Neonatal Transfer Team); ART (Adult ICU Retrieval Team – which is manned by ALS teams); and Inter Facility Transfers (Western Cape Government, 2021). All of these vehicles are located at specific holding points as they await to be dispatched to an incident (Stein et al., 2015: 28). The City of Cape Town is divided into four divisions, each with their respective ambulance bases. These divisions include Northern (Tygerberg Hospital base), Southern (Mitchells Plain Hospital), Eastern (Khayelitsha Hospital) and Western (Pinelands base) (Kotzé, 1990: 320). According to the Western Cape Government (2021), there are six emergency communication centres (ECC's) in the region, and employees are trained to correctly prioritise each call and to dispatch the closest ambulance to the emergency scene. After being dispatched, the ideal response time for priority 1 (P1) medical emergencies is within 15 minutes or less. For non-life-threatening emergencies, categorised as priority 2 (P2) calls, individuals will have to wait longer for ambulance personnel to arrive (Western Cape Government, 2021). However, the response times of South African EMS may vary based on if the emergency is located in an urban or rural area, with the latter sometimes experiencing delayed response times of up to 40 minutes (MacFarlane et al.., 2005: 147).

Ambulance personnel operate in an extremely challenging environment, as they deliver lifesaving services in the prehospital setting (Kotzé, 1990: 320-321), and it is unfortunate that they are especially vulnerable to become victims of workplace violence based on the nature of their occupation (Furin et al., 2015: 460). After attacks against Cape Town Metro EMS ambulance personnel started to escalate in 2015, the Western Cape Government became concerned about the safety of personnel, as well as the influence that these incidents had on service delivery (Gleby, 2018: 7). To address the problem, dangerous areas with high crime rates, gangsterism and poor infrastructure were designated as 'red zones'. These red zone designations can be temporary, permanent, a hot zone or a no-go zone (Gleby, 2018: 7). A cooperation protocol was established with Metro EMS and the South African Police Service (SAPS) to provide services in red zones and no-go zones. A red zone should be responded to

from a predetermined safe zone (a police station), and Metro EMS should be escorted to the emergency scene with either SAPS or Metro Police present (Gleby, 2018: 8). The red zone protocol also requires ambulance crews to limit their time spent at emergency and to leave the area escorted as well. Vehicles may only enter no-go zones for short amounts of time, as it is extremely dangerous (Gleby, 2018: 8). Unfortunately, the SAPS is under-resourced and understaffed, which means that they cannot always escort Metro EMS ambulance crews immediately, delaying the prehospital teams' effective and timely service delivery (Gleby, 2018: 8).

Defining Risk, Danger and Fear[1]

Risk

Risk is ever-present and even more pervasive in the current state of the world; humans face both natural and unnatural disasters, economic crises, pandemics, and terrorist threats (Battistelli & Galantino, 2018: 2). Although risk is difficult define precisely, Lexico (2021) describes it as a situation which exposes an individual to potential danger. Luhmann (1993) suggested that the conceptualisation of risk should be accompanied by the distinction between risk and danger. Although both risk and danger include the notion that there is uncertainty about future harm, Luhmann (1993) argues that harm, which is produced from decisions made within social systems, is seen as risk. In contrast, harm produced from outside social systems is seen as danger. "Only in the case of risk does decision making (that is to say contingency) play a role. One is *exposed* to danger" (Luhmann, 1993). It is thus important to acknowledge that individuals make decisions which may (or may not) produce risky (and even harmful) consequences for themselves and others (Luhmann, 1993). Risk is related to a situation in which the future outcome of an event is uncertain, and is therefore a product of probability that may result in a potentially harmful event (Battistelli & Galantino, 2018: 3, 5). Certain occupations are inherently regarded as risky, for example, being a police officer – these individuals face risk constantly, everyday (Perkins, 2018). The occupation of being an EMS worker is also regarded as risky - these service providers are usually the first responders at dangerous and unpredictable emergency scenes, with no infrastructural support from healthcare facilities and only occasionally protected by law enforcement (Grange & Corbett, 2002: 189). Ambulances are often regarded as vulnerable and easy targets by offenders, as they

[1] The terms risk and danger are sometimes used interchangeably, as they are closely related to each other.

have to enter difficult areas, drive slowly and stop to attend to patients (Grange & Corbett, 2002: 189).

Danger

Danger is seen as external harm, which cannot be controlled by individuals and it occurs independently from their decisions (Battistelli & Galantino, 2018: 4). Danger does not involve intentionality and thus responsibility cannot be attributed to an individual's decision(s) (Battistelli & Galantino, 2018: 4). Perkins (2018) suggest that danger includes the possibility of and the exposure to vulnerability and possibly injury or death. In terms of crime, danger is often interpreted as certain situations, individuals, or activities that may lead an individual to become harmed and/or a victim of crime (Andrews & Gatersleben, 2010: 473). The notion of danger includes the prevalence of a specific type of crime (or the overall crime rate), which in turn increases the risk of a crime taking place, ultimately contributing to the perception or experience of danger (Drakulich, 2013: 611). An individual's perception of danger is influenced by factors such as perceptions of disorder, confidence in both formal and informal social control, and the context in which their neighbourhood is situated (Drakulich, 2013: 613). The literature below depicts that EMS personnel are routinely exposed to dangers (situations, groups or activities) associated with crime within the prehospital environment – causing them to become victims of workplace violence (Bigham et al., 2014: 494).

Fear

"'Fear' is the combination of defensive responses—physiological, behavioural and (perhaps in the case of humans) the conscious experience and interpretations of these responses—that are stimulated by specific stimuli. Such fear-inducing cues result in active defensive responses that gradually subside when the stimulus is no longer present." (Mobbs et al., 2006: 4-5). Fear thus arises when an individual experiences something physically, emotionally or psychologically threatening (Brett, 2021). This fear can be either real or imagined, and it serves the purpose of keeping individuals safe, as it enables them to cope with the danger(s) faced (Brett, 2021). If an individual is unable to deal with or escape from the dangerous situation, it may cause them to feel helpless, numb, or passive, which may intensify their fearfulness (Brett, 2021). In relation to crime and victimisation, fear of crime exists. Garofalo (1981: 840) defined fear of crime as: "An emotional reaction characterized by a sense of danger and anxiety…the fear must be elicited by perceived cues in the environment that relate to some aspect of crime for the person." The fear of crime is the subjective belief that an individual might be at risk of becoming a victim of crime – and the anticipation of what the consequences of victimisation

might be (Howitt, 2015). Examples include "I am scared of walking alone at night in my neighbourhood, because I might end up being robbed and hurt" (Howitt, 2015). The public's perception of crime is influenced by their knowledge of the crime rate (usually prompted by the media); previously personally experiencing victimisation; and hearing about or witnessing family, friends or colleagues experiencing victimisation (Howitt, 2015). Interestingly, some individuals fear crime more than others, for instance, professionals are less worried about crime than unemployed individuals, and women are more afraid of being burgled than men (Howitt, 2015). Nevertheless, Howitt (2015) argues that the public addresses their fear of crime in a variety of ways, especially focusing on increased security – such as moving to gated communities, or installing closed-circuit television cameras (CCTV) (Howitt, 2015). As mentioned above, EMS ambulance personnel experience risk and danger daily within their occupation – therefore it can be argued that they experience fear as well. Their fear of crime is a negative consequence of being personally victimised – or being subjected to the stories of their colleagues who were victimised (Bigham et al., 2014: 494).

International Literature

To understand the victimisation of EMS ambulance personnel, this study aims to view their experiences against the backdrop of risk, danger and fear. These individuals are exposed to occupational risks that influence their health and safety daily (Senol et al., 2018: 40). In an international study, 1778 emergency medical personnel from 13 countries completed a survey, and 65% of the respondents reported that they were physically assaulted while on duty (Maguire et al., 2018: 526). EMS personnel in Australia has the highest injury or fatality rate than any other occupational group in the country (Maguire et al., 2002: 625), with the United States' EMS system experiencing a workplace violence rate that is about 22-times higher than the average for all groups of workers in the country (Maguire et al., 2014: 477). In Albuquerque, New Mexico, 80% of Emergency Medical Technicians Basic (EMT-B's) stated their safety was at risk due to the high levels of occupational violence (Pozzi, 1998: 321). The frequency of violence against EMS ambulance personnel indicates the broad scope of the issue faced globally (Knor et al., 2020: 464), making it a pertinent issue to be examined and addressed.

Risks and Dangers

The risks and dangers that EMS personnel experience has been interchangeably addressed in international literature – the occupation itself is often regarded as risky, and the exposure to certain high-risk situations is regarded as dangerous (Senol et al., 2018: 44). This correlates

with the above definition of risk: “a situation which exposes an individual to potential danger” (Lexico, 2021). Thus, the experience of danger is a consequence of the exposure to certain situations, and the phenomenon is often interpreted against the backdrop of the safety of the environment and prevalence of crime (Knor et al., 2020: 465). Certain causal factors – which will be discussed in more detail below – provide a comprehensive overview of how and why emergency personnel are victimised.

The types of violence experienced by EMS ambulance personnel is addressed by various scholars, together with the perpetrators of these crimes. The types of violence include: verbal abuse (offensive language, harassment and threats), which is most often perpetrated by patients or their families (Bigham et al., 2014: 493). Intimidation – which includes verbal threats and throwing objects – are usually committed by colleagues, managers, police officers or physicians (Bigham et al., 2014: 493-494). Physical assault includes, for example, kicking, punching, hitting and biting, and is mostly committed by patients (Bigham et al., 2014: 494). For instance, in 1630 of physical violence cases reported by EMS personnel in the United States from 2012-2015, 77% were committed by patients – these patients are usually scared, intoxicated or mentally ill (Maguire & O’Neill, 2017: 1770). Bystanders are also involved in the verbal or physical abuse of personnel; however, they are often part of high-risk groups such as substance abusers, gang members or criminals (Gormley et al., 2016: 440). In contrast, Knor et al. (2020: 466) found that violent bystanders may be ordinary individuals who are under extreme stress. Sexual harassment (indecent gestures, offensive slurs and jokes) and sexual abuse (groping, fondling and rape) are also prevalently experienced by personnel – both of which are most often perpetrated by patients, usually in the back of the ambulance (Bigham et al., 2014: 494).

The literature revealed that several conditions may lead to EMS personnel becoming victims of crime while on duty. Knor et al. (2020: 465) found that event shock – which refers to the patient or family member experiencing extreme trauma, agitation or anxiety based on the unexpected emergency event – may result in unpredictable aggression or violence towards EMS personnel. Patients (or their relatives) may feel helpless in these situations, which may cause them to exert their frustrations or anger towards personnel (Petzäll et al., 2011: 9). EMS personnel respond to a lot of calls daily, which may delay prompt arrival times at emergency scenes (Maguire & O’Neill, 2017: 1770). Delayed response time has led to either the patient(s), their family members or the community to react aggressively towards ambulance personnel as soon as they arrive (Knor et al., 2020: 465). Petzäll et al. (2011: 10) found that 27% of

ambulance personnel experienced verbal threats – which included harsh comments related to their delayed arrival at the scene of the emergency. Both event shock and delayed response time highlights the high-risk nature of EMS as an occupation, exposing them to dangerous situations when arriving at emergency scenes. It can thus be argued that victimisation occurring due to event shock is precipitated by patients, whereas attacks caused by delayed response time is precipitated by the nature of the occupation. Nevertheless, the reasons for attacks against personnel should only be seen as explanations, not justifications.

Contextual conditions, such as the time of the day that emergency personnel respond to calls was identified by various scholars[2] as a danger for prehospital workers. At night, when visibility is poor and residents are more relaxed – neighbourhood crime rates tend to escalate, causing the environment to become more dangerous (Grange & Corbett, 2002: 189). Knor et al. (2020: 466) found that 90% of EMS personnel experienced violence while they were on night shift duty in Prague (2-6 AM). In the United States, 50% of violent episodes were recorded between 4 PM and midnight, 39% occurred between 8 AM and 4 PM, and 11% took place between midnight and 8 AM (Maguire & O'Neill, 2017: 1772). Additionally, violence is more prevalent in disadvantaged, rural areas with greater social malaise. These areas are rife with violence and poor infrastructure, which may place EMS personnel who operate here at greater risk (Knor et al., 2020: 465). Related studies found that emergency personnel felt that the attacks against them were financially motivated, especially in impoverished areas (Pozzi, 1998: 322). Moreover, victimisation in these areas may be perpetrated by gang members attacking ambulance crews as part of their initiation (Nordberg, 1992: 25). The public (patients, family members or bystanders) may lack knowledge about the precise duties of ambulance personnel, causing them to express violence toward these first responders (Knor et al., 2020: 465). In contrast, EMS personnel who ineffectively deal with patients during medical emergencies, or not sufficiently trained to manage certain situations, may be victimised by patients or relatives (Knor et al., 2020: 465). The incompetence of personnel may therefore cause them to precipitate their own victimisation. Cooperation with other organisations, such as attending to emergency scenes with the police, may escalate violence – for instance, one of the participants in the study said:

[2] Grange and Corbett (2002: 189); Knor et al. (2020: 466); and Maguire and O'Neill (2017: 1772).

> *"We wanted the help of the police, yes. But the policemen started to humiliate our patient and one of them wanted to hit him. The presence of police sometimes contributes to more violence from patients"* (Knor et al., 2020: 465).

Although dispatch centres play an integral role in providing accurate information to ambulance crews, poor communication between control rooms and personnel may expose personnel to dangerous situations (Taylor et al., 2016: 156). In their study, paramedics and EMT's shared that they often felt disconnected when contacting dispatchers for backup, causing delays – and ultimately leaving them vulnerable to possible patient-initiated violence (Taylor et al., 2016: 157). Petzäll et al. (2011: 9) determined that language barriers – hindering the patient and the EMS worker to understand each other – may increase the risk of victimisation. These contextual conditions underline the risks and dangers faced by EMS personnel in the prehospital environment which influences the services they deliver to patients.

Individual risk factors may also increase the probability of ambulance personnel to be subjected to dangerous situations. These factors include demographic characteristics, such as education and training, experience, gender and age (Hogh & Viitasara, 2005: 292). Bigham et al. (2014: 493) showed that female paramedics were more likely to be subjected to victimisation in the prehospital environment in comparison to their male co-workers. Older paramedics were also less likely to be victims of violence, whereas personnel qualified as paramedics were more likely to be victimised than EMT's (Bigham et al., 2014: 493). Moreover, volunteer personnel experienced less violence than permanently employed medical first responders or student paramedics (Gormley et al., 2016: 443; Koritsas et al., 2008: 420). Interestingly, paramedics who spend more time in direct contact with patients have a greater probability to experience violence exhibited from the patient (Koritsas et al., 2008: 420), which supports the argument that the occupation in itself is a risk for personnel.

Fear

As mentioned above, fear arises when an individual experiences something physically, emotionally or psychologically threatening (Brett, 2021). On the other hand, the fear of crime is the subjective belief that an individual might be at risk of becoming a victim of crime – and the anticipation of what the consequences of victimisation might be (Howitt, 2015). Fear is a negative effect that EMS ambulance personnel experience after being either personally exposed to, or witnessing violence in the prehospital setting (Lanctôt & Guay, 2014: 499). Paramedics regularly experience fear when responding to calls which occurred under the same conditions of previous violent episodes, usually requesting police back-up more often (Bigham et al.,

2014: 492). In New England, 68% of EMS personnel experienced fear in terms of their personal safety while on duty, with females being more afraid (76%) than men (68%) (Furin et al., 2015: 462). Fernandes et al. (1999: 1247) found that 73% of emergency healthcare workers in Canada are afraid of patients, with 35% stating that they fear patients have "the potential for being violent". The exposure to and/or fear of exposure to workplace violence negatively affects personnel's medical abilities; it causes them to distrust patients; it leads to the development of burnout syndrome; and it deteriorates their mental well-being (Deniz et al., 2016: 296-299). Moreover, fear developed after the experience of victimisation may cause personnel to lose interest, make career changes, or "get off the road" in an attempt to seek physical and phycological safety (Bigham et al., 2014: 493). The literature thus illustrates that EMS workers experience fear of crime in their occupation, which affects their ability to provide efficient medical services to the community.

South African Literature

Risks and Dangers

Ambulance personnel in South Africa are increasingly becoming targets and victims of violence while on duty (Vincent-Lambert & Westwood, 2019: 12). Although very little scholarly literature on the problem in South Africa exists, various news reports provide a snapshot of the province-specific statistics regarding attacks against EMS personnel. A study from 2015 found that 56% of South African EMS participants had been assaulted while on duty. The majority of victims were male (66%), and participants experienced both verbal abuse (20%) and physical violence (45.5%) (Holgate, 2015). In most cases, the offender was the patient (67.3%), although in a minority of cases these were bystanders (18.2%), or a colleague (9.1%) (Holgate, 2015). In South Africa's criminal climate, EMS personnel are frequently required to respond to calls at scenes where patients were victims of crime and violence (Vincent-Lambert & Westwood, 2019: 12). These situations may place personnel at risk, as they may arrive at a hostile scene without police present, increasing the probability that they may be victimised (Vincent-Lambert & Westwood, 2019: 12). Reinecke (2017) found that South African EMS ambulance personnel are more likely to be caught in crossfire when they respond to calls within high-risk neighbourhoods, characterised by high crime rates and gang activities. One of the most recent attacks occurred on the 4th of October 2021 when a 40-year-old female paramedic was shot and killed while delivering pre-hospital services in Estcourt, KwaZulu-Natal (Nxumalo, 2021). The victim and her partner were responding to an emergency when they came into crossfire with a shooting that was already underway. Moreover, EMS

crews are frequently seen as soft and valuable targets, as they are unarmed, and they travel with medical equipment, drugs, cell phones and tablets (Vincent-Lambert & Westwood, 2019: 12). Ambulance crews have been robbed (sometimes at gunpoint) and equipment stolen from the vehicles (Seleka, 2021). For example, in Gauteng, two paramedics were shot and robbed at an emergency scene in the Dukathole informal settlement in Germiston earlier in 2021 (Seleka, 2021).

As mentioned earlier, each division in Cape Town has known red (dangerous) zones, which are identified based on either frequent violence or an isolated violent episode against ambulance crews (Gleby, 2018: 7-8). For instance, Hanover Park (a residential area in Cape Town) has been a permanent 'red zone' since 2016. Attacks on Cape Town Metro EMS has escalated drastically since 2015 (Gleby, 2018: 7-8). A Cape Town EMS staff member interviewed by EWN (2020):

> *"So, this red zone vehicle is designated to actually treat and assist and transport the people of the red zone area of Mitchells Plain – that would be Beacon Valley, Tafelsig and Eastridge. What goes through my mind is mostly safety, because we're working during the nightshifts, for example, and we're going to a red zone area, [where] visibility is on the low, so safety is a major concern. Although the police are with us, that hasn't stopped the negative aspect of the red zone from being what they are, putting us in danger."* (EWN, 2020).

Some of these individuals work in urban areas, and others are employed to respond to emergencies in rural areas. Service delivery in South Africa's rural areas can be challenging, because residents may live in informal settlements with poor road construction, making it difficult for the ambulance personnel to attend to patients (Allgaier et al., 2017: 2). In addition, ambulance crews may sometimes be obligated to enter unknown residential areas without the support of law enforcement, which contributes to the unsafe prehospital environment in which these individuals work (Van Huyssteen, 2017). A paramedic, who has been an EMS worker for 12 years, stated that the threat of being attacked while on duty is a daily reality for EMS personnel (Adams, 2020). During 2019, his crew was attacked while responding to a call in Khayelitsha, in Cape Town, fortunately, they were not harmed, but the tablet in the ambulance was stolen (Adams, 2020). The victim said that when EMS personnel respond to calls in certain high-risk areas, it may sometimes be difficult to drive straight to the house where the emergency happened, so it is easier to drive to a nearby church or school to park there (Adams, 2020). In the densely populated neighbourhoods of Cape Town, the use of landmarks is often

the safest way for EMS personnel to reach patients in the case of an emergency. In identified red zones, paramedics are escorted by the SAPS or Metro law enforcement, and the red zone protocol demands that all stakeholders (SAPS, Department of Correctional Services [DoCS], EMS, and neighbourhood watch) work together to ensure the safety of personnel and community members (Adams, 2020). Although these escorts work, a Mayco member of Safety and Security, said that they take up time and resources, and that they slow down EMS' response times. In Reinecke's (2017) study, one of the Metro EMS ambulance personnel said that: "… you get dispatched to a call and you arrive although you've just been given a call the community goes and attacks you because you're you're late and it's like but I just got this call it took me six minutes to get to you they don't care…".

One of the greatest dangers faced by South African EMS ambulance personnel while on duty, is being hijacked (Lambert & Westwood, 2019: 14). In Vincent-Lambert and Westwood's (2019: 14) study, 83.19% of EMS students revealed that "they consider themselves to be at higher risk of vehicle hijacking…" Motor vehicle hijackings is also a significant problem faced by Metro EMS ambulance personnel in Cape Town, especially when attending to or leaving emergency scenes (Mlamla, 2020). For instance, an ambulance crew was stopped on a highway in Cape Town (while transporting an eight-year-old patient) and hijacked at gunpoint. The hijacking interrupted the treatment and transportation of the patient, and he passed away on the scene (Collins & Davids, 2017). During 2017, an ambulance crew transporting a child was hijacked and robbed near Borcherds Quarry, delaying the treatment of the child, who thus unfortunately passed away (De Kock, 2017). The general secretary of the Health and Other Services Personnel Trade Union of South Africa (Hospersa) said that: "We strongly condemn the increasing level of EMS attacks. While it is our members' duty to respond to calls, it should not be at the expense of their lives. It is deplorable that there are still individuals who make false emergency phone calls with the intention to lure EMS personnel in order to rob them." (Singh, 2021). According to Cruywagen (2019), these 'fake' or 'hoax' calls are made to the EMS dispatch centres, but as soon as ambulance crews arrive at the scene, there is no real emergency to attend to, and they may end up being hijacked or attacked. It is EMS' protocol that each call has to be presumed as an emergency, which contributes to the unsafe environment in which they have to function (Van Huyssteen, 2017).

In Durban, KwaZulu-Natal, paramedics working for private ambulance group, KZN VIP Medical, were attacked while 'en route' to attend to an emergency in Verulam (Govender,

2021). The crew was driving on the R102 when their vehicle was stoned in the midst of a dangerous protesting action in the area, and they were unable to attend to the critically ill patient (Govender, 2021). In another incident in Lion's River, two ambulances of the St Michael's Ambulance Service were stoned while delivering prehospital services (Nair, 2020). In KwaMashu township, EMS ambulance personnel were held at gunpoint and all of their personal belongings were stolen (SAPeople Contributor, 2021). The South African Emergency Personnel's Union (SAEPU) condemned the attack and stated that: "The community itself is also suffering. In Wednesday's attack, the crew had to abandon the call for the sake of their safety; and the family members of the patient had to make their own arrangement to transport their loved one to the hospital" (SAPeople Contributor, 2021). The abovementioned literature highlights the variety of risks and dangers faced by South African EMS ambulance personnel, and it indicates how these experiences influence medical service delivery to communities.

Fear

In South Africa, the crime rate is extremely high (Vincent-Lambert & Westwood, 2019: 12). The Victims of Crime Survey (2016/2017) showed that approximately 32% of South Africans feared crime to the extent of inability to conduct daily tasks, with 79% feeling unsafe in their own homes at night (Faull, 2018). Fear of crime is prompted by personal victimisation, or the victimisation of friends, relatives or colleagues (Howitt, 2015). Previous attacks on South African paramedics led them to continuously experience fear while performing prehospital services (Etheridge, 2016). Vincent-Lambert and Westwood (2019: 13) found that 92.04% EMC students from 4 South African universities felt unsafe while working. In Cape Town, EMS ambulance personnel frequently experience fear, especially when they have to enter dangerous rural neighbourhoods (EWN, 2016). For instance, a paramedic shared: "The fear never goes away. You come to a point where you don't want to come to work anymore. At the end of the day, we are putting our own lives at risk for somebody that we don't even know." (EWN, 2016).

Impact of Victimisation on EMS Ambulance Personnel

The effects of victimisation may be physical. Injuries (ranging from mild to serious) resulting from physical and sexual assault experienced by ambulance personnel are common (Maguire & O'Neill, 2017: 1772). Petzäll et al. (2011) found that 21% of personnel sought medical attention after being physically attacked. Reported cases included haematoma with swelling and minor bleeding; concussions; fractures; and dislocations (Petzäll et al., 2011: 9). High medical expenses and the cost of the time lost from work are also consequences experienced

by personnel after victimisation (Mechem et al., 2002: 399). Victimisation also has major effects on the well-being of emergency workers and the services they render to the community (Maguire & O'Neill, 2017: 1770). After the experience of being victimised, it is common for paramedics to behave differently within their immediate work environment, as they act cautiously (and with distrust) around patients (Petzäll et al., 2011: 9). Taylor et al. (2016: 158) found that paramedics often feel anxious and detached after being physically attacked by patients. Lanctôt and Guay (2014: 499) argued that the exposure of paramedics to violence while attending to emergencies may have a negative impact on their psychological well-being, and they may develop conditions such as depression or PTSD. Moreover, prehospital victimisation can cause ambulance personnel to lose interest in their line of work, make career changes or "get off the road" in an attempt to seek physical and phycological safety (Bigham et al., 2014: 493).

Underreporting

It is unfortunate that EMS ambulance personnel underreport victimisation against them. Taylor et al. (2016: 156) determined that female paramedics were more likely to report victimisation than their male counterparts, and that males indicated that they do not want to appear "weak" for reporting incidents. Grange and Corbett (2002: 186) added by stating that EMS ambulance personnel may deliberately underreport incidents of violence, as they feared that doing so may imply that they are either unable to manage such situations, or that it may reflect negatively on their service records. In addition to this, several participants normalised violence, stating that patient-initiated injury becomes an expected part of the job (Taylor et al., 2016: 156). Pozzi (2002: 322) found that mechanisms for reporting violence in New Mexico did not exist, which substantiates the perception that "violence is a part of the job" or "normal". Formal reporting mechanisms and policies are extremely important, as their absence discourages reporting; causes a lack of acknowledgement of abuse; and worsens prehospital conditions (Pozzi, 2002: 322). In an attempt to quantify the frequency of violence, clear definitions of verbal, physical and sexual abuse should be provided to personnel and employers (Pozzi, 2008: 322). Unfortunately, personnel may feel that verbal assault and intimidation is not as 'serious' as physical assault, which may lead to underreporting (Bigham et al., 2014: 493).

Interventions to Address the Problem

Various scholars have addressed the interventions (proactive and reactive) to prevent and protect EMS ambulance workers. The use of restraint can be a useful measure to implement to protect both the ambulance crew and the patient him/herself (Brice et al., 2003: 50). EMS

personnel can choose between either physical or chemical restraint. Physical restraint includes practices such as tying or handcuffing the patient, whereas chemical restraint includes the practice of administering sedatives to calm patients (Brice et al., 2003: 50). It is advisable, though, that prehospital personnel only utilise restraint as the last option, and rather try to less-forcefully verbally de-escalate the violence through attempting to calmly communicate with the patient (Richmond et al., 2011: 18).

As EMS personnel often "stage" at a safe location near the emergency scene until the original scene is cleared by police, this may protect them from possible harmful situations (Holroyd & Nabors, 1993: 597). In addition to this, crews should aim to remain aware of their surroundings, and be aware of weapons or objects that can be harmful (Holroyd & Nabors, 1993: 597). It is important that crews clearly identify themselves to the patients as EMS personnel, and it is recommended that their uniforms clearly distinguish them from law enforcement or military personnel (Corbett et al., 1998: 130). Although the provision of readily available bulletproof vests is a necessary measure to protect personnel in dangerous situations, and have proven to save many lives of prehospital providers, it is unfortunately not useful to avoid a violent situation (Corbett et al., 1998: 130). Although arming EMS personnel seems like a logical option for protection, most of them have stated that they do not feel comfortable being armed, as it may endanger both their own and the life of the patient (Corbett et al., 1998: 130). Furthermore, police should be dispatched to all dangerous areas, including to certain situations (suicide, murder, domestic violence, intoxication, and mental illness) to ensure the safety of all parties involved (Corbett et al., 1998: 130). EMS providers should identify a safe exit route from all dangerous areas and remove the patient from that area as soon as possible, even if it means treating the patient in a different (safer) environment (Holroyd & Nabors, 1993: 597).

Programmes such as Hostile Environment Awareness Training (HEAT) assists emergency personnel to develop the ability to assess dangerous situations and risk factors with the aim to avoid victimisation as far as possible (Vincent-Lambert & Westwood, 2019: 15). In South Africa, the private ambulance service, ER24, ER24 offers a HEAT course called Emergency Medical Support in Hostile Environments (EMSHE) (Vincent-Lambert & Westwood, 2019: 15). South African EMC students indicated that they would benefit from HEAT training, with 89.38% arguing that it should be included in their curriculum with the goal to prepare them for the (hostile) work environment (Vincent-Lambert & Westwood, 2019: 15)

Based on the psychological effects of victimisation on EMS personnel, Holroyd and Nabors (1993: 597) stressed the importance of providing personnel with post-event counselling and psychological debriefing. Employers must thus be able to recognise the symptoms of burnout, PTSD, anxiety, and depression (Holroyd & Nabors, 1993: 597). The following should be included in the training curricula of EMS personnel: stress management; the impact (physical and psychological) of trauma; how to intervene in crises; how to cope with difficult patients; how to assist and calm upset family members; how to communicate effectively and how to resolve conflict; and how to successfully debrief a situation (Reinecke, 2017).

Conclusion

Guided by the research question of this study, the literature review provided an overview of the risks, dangers and fears faced by EMS ambulance personnel in the prehospital environment. The risks and dangers faced by personnel are interrelated – their occupation is already seen as a high-risk, which inevitably exposes them to dangers. The exposure to these dangers ultimately prompts feelings of fear. The literature has also revealed what the impact(s) of victimisation on EMS personnel are. Current interventions and efforts undertaken to reduce and ultimately combat the victimisation of EMS personnel is extensively addressed in the literature.

Chapter 3

Research Methodology

This chapter serves as a thorough overview of the research design and the research methods utilised in this study. It includes the sampling procedure; the ethical considerations; the recruitment process; the data collection and analysis process; and the limitations of the study. Both of these sections will provide comprehensive explanations for why and how these research methods were the most suitable to answer the research question(s) of the study.

Research Methods

Sampling & Recruitment

For the purpose of this study, a qualitative research design was used. In order to explore the objective of this intended project, a qualitative design was the most suitable to provide a rich description of the experiences of Cape Town Metro EMS ambulance personnel. Moreover, this study was exploratory in nature. Exploratory research enabled the researcher to understand how Metro EMS ambulance personnel experience risk, danger and fear in terms of prehospital victimisation. As very little academic literature in South Africa exists with regard to this specific topic, exploratory research was used to address the qualitative knowledge gap.

Purposive, criterion sampling was used for this study as it enabled the researcher to identify participants who have had similar occupational experiences, but who differed in terms of personal characteristics. Although private ambulance companies also deliver prehospital services in Cape Town, the literature has indicated that the ambulance personnel employed by the Metro (public) EMS in the city are more frequently subjected to violence (Brady et al., 2019: 1). Consequently, the sample population identified for this study, was Metro EMS ambulance personnel in Cape Town. The ideal sample size for this study was twelve Metro EMS ambulance personnel, with the goal to represent all four divisions in the city. As this is a Master's dissertation, and although the sample size is limited, saturation was nonetheless achieved in the data as no new information was received by the 12th interview. Participation in this study was voluntary and participants were able to self-select. Those who were willing to participate had to meet the requirements of the following strict inclusion criteria:

- May include volunteer Metro EMS ambulance personnel working in Cape Town;
- May include permanently employed EMS ambulance personnel in Cape Town who are currently registered with the PBEC under the HPCSA;
- May be qualified as any of the following: BAA; AEA; ECA; paramedic; ECT; or ECP;

- Should have responded to calls within at least one of the relevant divisions of Cape Town (Northern, Southern, Eastern or Western division) throughout employment; and
- Should include male and female Metro EMS ambulance personnel.

After the study was ethically cleared, the researcher contacted the head of the EMS in the Western Cape, Dr Shaheem de Vries, to arrange the recruitment of participants. In addition to this, the managers of each division were also thoroughly informed about the objectives and the purpose of the study, and they were provided with a video created by the researcher to ensure that they have received all of the necessary information. As part of the recruitment process, the researcher distributed 500 informative flyers to all public EMS personnel (permanent employees and volunteers) in Cape Town. The flyers were attached to their payslips and were sent out on the 15th of October 2021. Unfortunately, the researcher was informed that the distribution of flyers was not be the most suitable method to recruit participants, and was thus advised to visit each of the four ambulance bases in-person. Thus, in-person recruitment began on the 16th of October 2021 and lasted until the 3rd of December 2021. The researcher visited Khayelitsha Hospital (Eastern division), Mitchells Plain Hospital (Southern division), Pinelands ambulance base (Western division), and Tygerberg Hospital (Northern division), and ensured that the shift manager knew that she was (ethically) on the premises. In addition to this, the researcher aimed to arrive at each base before either the day shift or the night shift started without interfering with the duties of the ambulance crews. The researcher randomly spoke to Cape Town Metro EMS ambulance personnel while they were getting ready for the shift, explaining the objectives of the study, the inclusion criteria, and stated that participation is voluntary and anonymous.

At the end of the in-person recruitment process, 12 participants were recruited. The researcher thus recruited 5 participants from the Western division; 1 from the Southern division; 3 from the Eastern division; and 3 from the Northern division. Out of the 12 participants, 7 were male and 5 were female.

Data Collection

Participants were interviewed at a time convenient to them, and they were allowed to opt to be interviewed in any official South African language (with the assistance of an interpreter). All participants chose either English or Afrikaans, and interpretation services were therefore not necessary. Due to the global Covid-19 pandemic, using an online platform ensured that both the interviewer and the interviewee remained safe and healthy during the data collection process. Participants were given the following options to choose from: Zoom Video Call;

WhatsApp Voice/Video Call; or Microsoft Teams. Only one participant could not meet online, and one in-person meeting was scheduled. All of the necessary Covid-19 protocols were strictly implemented by both parties.

Semi-structured interviews were used as the method of data collection. Semi-structured interviews consist of certain set questions and open-ended questions, which allows for additional probing during the interview (Maree, 2016). As both pre-determined and follow-up questions were be asked, the researcher was able to probe further into the context of the answer for elaboration and clarification purposes. The interview questions (see appendix D and E) aimed to elicit each participant's unique response (as comprehensively as possible). Twelve semi-structured interviews were conducted, each lasting about one hour. Participants were informed that they would receive a transcription feedback letter (see appendix H), as well as the entire interview transcript to review and return with any comments, changes, or additional information to enhance the credibility of the data. All the participants agreed to having the interviews audio recorded, and each recording was saved according to the anonymous identifier linked to the interview. The data was transferred to an anonymous file on a computer storage device. The recordings were played back and transcribed word-for-word, as accurately as possible. Where it was not possible to adequately hear what the participant was saying on the recording, the researcher contacted the participant to either confirm or correct the information. This enhanced the credibility of the interview data collected.

Data Analysis

Thematic analysis was used because it allowed the researcher to explore the different perspectives of participants, in order to identify similar and different patterns situated within the data. The analysis process followed by the researcher started with printing out all the interview transcripts, opting to conduct the thematic analysis by hand. Based on the research question of this study, a combination of deductive and inductive thematic analysis approaches was used. Three predetermined themes were identified based on existing literature before the coding process started, and these included: experiences of risk; experiences of danger; and experiences of fear. The researcher then read through each of the transcripts, carefully exploring the information. Thus, similarities, differences in opinions, interesting information, and factual information were identified, and coded. Each transcript was re-read four times to ensure that all relevant information was coded. Hereafter, the researcher listed all of the codes as they appeared on the transcripts, and indicated in which (and how many) transcript(s) they appear. At the end of the coding process, 126 codes were identified. The codes were

systematically categorised, and three additional themes emerged from the data. These three themes included: education, training and experience; occupational challenges; and safety interventions and recommendations.

Thus, six main themes emerged from the data, and became the structure upon which chapter 4 was written. Each of the themes were addressed separately, and the researcher ensured that all of the important information provided by participants pertaining to that specific theme was added into the depiction of the results. Each of the transcripts were re-read after the initial analysis process was completed to compare the information presented in the results chapter with the information in the transcripts, ensuring its adequacy. The researcher kept a strict record of each step taken during the analysis process, aiming to increase the credibility, transferability, dependability and confirmability of the study.

Ethical Considerations

The study was cleared through the University of Cape Town's (UCT) Law Faculty Human Research Ethics Committee (HREC); the Health Science Faculty HREC at the UCT; the relevant Medical Director of the Western Cape Government Health EMS (site approval); and the National Health Research Database (NHRD) (facility approval). Approval letters are attached as appendices A, B and C.

The ethical considerations of this study were based on the Belmont principles, which includes respect for persons, beneficence and justice (Gyure et al., 2014: 2). Respect for persons requires the researcher to respect the autonomy of each participant, thereby providing them with the freedom to make their own decisions regarding participation (Jahn, 2011: 225). In this study, after Cape Town Metro EMS ambulance personnel were thoroughly informed about the nature and objectives of the research through the provision of a detailed information sheet (see appendix F), they had the freedom of choosing whether or not they were interested in participating. If they did agree to participate, they also had the freedom of withdrawing from the study at any point during the research process.

The second principle, beneficence, requires the researcher to protect the participants from harm, and to ensure that their well-being is prioritised (Vanclay et al., 2013: 245). The researcher thus provided each participant with a detailed consent form (see appendix G), in which they had to indicate either 'yes' or 'no' to important participatory-related statements. This included that they agree or disagree to participate, and whether or not they agree to having the interview voice recorded. Each consent form was completed and signed by the participant and the researcher. The researcher also ensured that the anonymity of each participant was

protected by using ‘P1’, ‘P2’, ‘P3’, together with the division that he or she was employed in, for example ‘Southern; P15’. These pseudonyms were neutral, and thus cannot be traced back to the participants. None of the files containing: the list of participants (and their relevant information); the consent forms; the voice recordings; the interview transcripts; the draft thesis; and the final thesis, contains the name of the participant (or any other name that they mentioned during the interview). Although participants had to use their names to sign-up during the recruitment phase of the study, the researcher immediately changed the names of participants to their respective pseudonyms, and the document was destroyed thereafter. Each file containing the abovementioned information was thus named according to each of the participant’s respective pseudonyms, and all of these files are stored under a secure cloud folder on Dropbox, as well on an external hard-drive. Only the researcher has access to this information and if any third party wants to access the data, special permission will have to be given. The audio recordings will be kept for a year from the day it has been recorded. The transcripts are anonymously archived and kept at the Centre for Criminology at the University of Cape Town. All of these measures thus protect the anonymity of each participant (and all relevant parties).

As the researcher planned to ask participants questions about how they experience risk, danger and fear while performing service calls, it was expected that certain feelings of psychological distress may be evoked. Consequently, the researcher ensured that the participants were made aware of the Employee Health and Wellness Programme (EHWP), which is offered free to all of the Western Cape Department of Health’s permanent employees (Western Cape Government, 2020). A copy of the EHWP booklet was thus attached to the information sheet. In addition to this, the researcher was prepared to manage any psychological distress that may have been evoked through the use of an interview distress protocol. Fortunately, the use of the distress protocol was not necessary, as the participants did not indicate any signs of psychological distress.

The third principle, justice, states that the researcher should distribute the costs and benefits of the study in just manner. Consequently, the researcher made sure that each participant was treated equally and fairly; each participant was asked the same pre-determined questions; and that each participant was informed about the counselling services available to him or her. Additionally, the researcher ensured that all participants were asked if they wanted to be provided with 2 Gigabyte (GB) data bundles.

Limitations

The researcher utilised a sample size of twelve Metro EMS ambulance personnel working in Cape Town. The researcher conducted twelve interviews and thematic saturation was reached, thus the number of interviews was deemed as acceptable. However, it is feasible that a larger sample size may provide an ever-richer thematic analysis and description of the phenomenon.

One limitation of the study is that it only focuses on Cape Town and thus the experiences of Metro EMS ambulance personnel in the city cannot be generalized to the entire South Africa. In addition to this, it only takes into account the experiences of public EMS ambulance personnel, and not those of (if any) private ambulance services.

Although the purpose of qualitative thematic analysis is to provide descriptions of individual experiential realities, these experiences should be read and understood with caution when making generalised assumptions. It should be noted that the responses contained in these narratives represent subjective experiences and views.

Chapter 4

Findings

As depicted in Chapter 3, thematic analysis was used to identify six main themes from the interview transcripts. The six themes are: experiences of risk; experiences of danger; experiences of fear; education, training and experience; occupational challenges; and safety interventions and recommendations. This chapter thus constitutes as a representation of the study's results, and each theme is addressed individually through the use of short descriptions and quotes.

The Characteristics of the EMS Participants

Twelve Metro EMS ambulance personnel took part in the study. The general demeanour of the participants was friendly, considerate and professional. The participants ranged between 27 and 63 years of age. Five participants were female and seven were male. All of the participants were permanently employed with Cape Town Metro EMS, and three participants were volunteers before being permanently employed. The years of experience of participants ranged between 4 and 40 years. Their qualifications differed between paramedic (6); Intermediate Advanced Emergency Assistant (1); ECP (2); Emergency Care Officer (1); ECA (1); and BAA (1). Some worked operationally, focusing on house calls and accidents, while others conducted inter-hospital transfers and worked in the critical care unit.

Experiences of Risk

During the interviews, participants were asked if they experience risk associated with crime while on duty, and if so, how this experience influences their crew's decision making. The majority of participants, 11 out of 12, explicitly stated that they experience risk in the prehospital environment. Four participants were of the opinion that:

> *"The biggest risk is that at some point, you might not come back home alive."* [Eastern; P4].
>
> *"Look, uhm, I feel like getting onto an ambulance nowadays is actually a risk…because no matter where you go, a red zone, wherever, the ambulance service has become a target for all the robberies."* [Southern; P6].
>
> *"Yes, we do. EMS as a whole – our lives are at risk."* [Western; P8].
>
> *"I mean, we face risk every day, you know? [laughs]*. [Western; P12].

The participants generally felt that the threat of risk is everywhere – and that it is unfamiliar and unpredictable, for example, *"…every time I go to a call, you don't know what's going to*

happen, you don't know, the circumstances, you don't know the environment that you're getting into." [Western; P11]. One participant especially noted that: *"So, one of the risks is that if someone only speaks Afrikaans or English in Khayelitsha, the language barrier can be a risk, because you may not understand what they are saying they will do to you while you are there."* [Eastern; P9].

Moreover, they shared that that they face a myriad of risks while performing service calls, such as entering unfamiliar rural areas, and dealing with hostile patients and relatives. For instance, one paramedic stated:

> *"I mean, we can go into an affluent area and experience sort of aggression from patient or family, which has happened."* [Western; P11].

Participants stated that certain dangerous areas may create on-the-job risks, which highlighted the importance of risk management, and being *"observant"* [Southern; P6] and *"street smart"* [Western; P8]. They also stated that they manage risk through avoiding unnecessary exposure, and utilising 'load and go' tactics to get out of the area. For example:

> *"We will usually go into an area and if we see a lot of people standing around or if we see that things look a bit dodgy, we will turn around and leave. We will not expose ourselves."* [Northern; P1].
>
> *"So, sometimes the police will take us to a scene, and they may sometimes get a call that is more important than that and then they leave us. So, what we do is, we would load the patient into the ambulance and try to do as much as we can while the vehicle is moving…"* [Eastern; P9].

The interviewees also associated risk management with a good working relationship with their partner, which enables them to make decisions together in dangerous situations. As depicted by a male participant with 18 years of experience working for Metro:

> *"We had another understanding that we need to watch one other's backs. When we respond to calls, the driver should be observant, but his partner should be double observant. We worked together, being on the same page, it helps tremendously."* [Southern; P6]. Another participant added:
>
> *"And if we are going into like high-risk areas…if we are going without a police escort, I will brief my partner, and we will, if something doesn't look right, let the other one know in advance so that we can make plans accordingly."* [Western; P11].

In terms of the involvement of the community, a dichotomy between risk involvement and risk management emerged. One of the participants felt that the community is involved in the creation of risk in the prehospital environment:

So, the risk is always, you always think in terms of if I don't do a, b and c, 'What will they do to me?'…like the one guy said: "If my father does not make it, I will kill you." [Eastern; P9]. In contrast, some stated that:

"If we get there and we actually get out of the ambulance, we show people that we want to be there, we want to help, and most of the time people leave us alone." [Northern; P1]. And,

"So, you start to trust the people and they start to trust you, and in 70% of the cases the community is there and some of the guys come out and they tell you: "Don't worry, we are here". [Northern; P2].

Experiences of Danger

This theme prominently emerged from the data, and it included: the participants opinions of the dangerous areas in the four different divisions of the city (Northern, Southern, Eastern and Western); the influence of these dangerous areas and/or red zones on EMS protocol and service delivery; and the opinions of personnel on what they regard as 'dangers' within their occupation.

Dangerous Areas

The experience of danger was explored through asking all participants about the dangerous areas in their respective divisions. Participants from each of the divisions named these 'dangerous' areas. Although some participants mentioned that green zones exist, in which personnel do not need a police escort, some isolated areas were identified that are regarded as more dangerous to enter. Moreover, most of them argued that the general service area in Cape Town is experienced as dangerous, especially when taking certain factors such as the time of the day; infrastructure; and the criminal climate of the area into account. Participants shared that the extreme level of danger in these areas caused them to act cautiously (and with fear), and influenced community members to resort to alternative ways of reaching the hospital.

One out of the three participants recruited in the Northern division (Tygerberg hospital) stated that:

"*Uhm, yes in the Northern suburbs you do have your hotspots. Uitsig, Ravensmead, Kalksteenfontein, Valhalla, die hele Valhallapark, Leonsdale, Kalkfontein in Kuilsrivier, Bloekombos, Phisantekraal, Dunoon, it is a lot. Eliesrivier. Yes, it is quite a lot."* [Northern; P2].

From the Southern division (Mitchells Plain), one participant said:

"Uhm, if you look at the Southern division, about 80% of the division is made out of red zones. I believe Mitchells Plain is not THE red zone of our division, uhm, Gugulethu, Nyanga, Philippi – that is the most dangerous parts of the Southern division. There is quite a lot of violence" [Southern; P6].

Three participants were recruited from the Eastern division (Khayelitsha), and all of them identified Site C as one of the most dangerous areas. For instance, the following two participants mentioned:

"Okay, Site C is one of them and there's an area called Mandela Park in Khayelitsha as well. And there's a section called J section. They are all in Khayelitsha. I would say 80% of Khayelitsha is a red zone area…" [Eastern; P4].

"The whole of Khayelitsha, actually, but it depends on the time of the day." [Eastern; P7].

From the Western division (Pinelands), participant stated:

"…the dangerous areas would be Hanover Park, which is obviously a red zone for EMS. Lavender Hill…uh, Sea Winds, Houtbay - a township there, Imizamo Yethu, is dangerous. Then, a township above the harbour, I think it's called Hangberg and Masiphumelele can get dangerous if they protest there, so it's not always a dangerous area, but it can get volatile." [Western; P11].

"Yes, so we do have our standard red zones, but most of our secondary facilities are in green zones, where it's much safer to go, you don't need a police escort." [Western; P12].

EMS Protocol and Service Delivery

Throughout the interviews, the protocol of the EMS and the development of red zones and the protocols were addressed by five participants. Respondents stated that as soon as an area is identified as a red zone, they are not allowed to enter those areas without a police escort:

"So, red zones are areas that you're not allowed to enter without police after six o'clock in the evening and before six o'clock in the morning." [Western; P12].

"…if there is a high incidence of shootings in an area for a short period of time, then Metro may declare that a temporary red zone for 24 to 48 hours." [Western; P11].

The consequence of waiting for a police escort before entering the red zone, was identified by nine of the participants as a major reason for poor service delivery. Although most of the participants understood that the police are overworked and understaffed, for instance, "*It takes long, because they have to do their job as well…"* [Eastern; P4], they still felt that the influence of waiting time on service delivery is tremendous. Interviewees stated that it leads to delayed

response times, which causes violence from family members and patients; causes the patient(s) to need to be moved; or causes the patient to resort to alternative forms of transport. The majority of interviewees were of the opinion that the red zone protocol influences response time, as they have to wait long periods of time before a police escort is available to assist them: *"So, in a red zone, you have to wait for the police to escort you and if they are not available, you sometimes wait thirty to forty minutes for the police, then you have not even reached the patient yet…they sometimes die while waiting for us."* [Northern; P1]. The participants further shared that delayed waiting times caused patients and family members to become aggressive towards them: "*The people wanna kill us, if we are late – by the time we get there and the person is dead already?! And they phoned since the morning, they tried to get three ambulances maybe in there, when I'm the last one, I'm the target now, because now they're gonna 'doner' [hit] me, but it wasn't my fault in the beginning."* [Western; P3]. Consequently, the red zone protocol causes both the Metro EMS and the community to manage the dangerous environment in an attempt to either provide or receive medical service delivery. As illustrated by one male participant:

> *"We need to report to the to the control room, which is the one who dispatches us, we have to explain to them, we have to alert them, and then they will tell us to go to the place of safety, then they'll communicate with the member of the family who called that they must try and get the patient to a safer place that we can reach."* [Eastern; P4].

In contrast, the community manages the dangerous environment through private transport and alternative locations:

> *"So, the people who live in red zones struggle and they already know that if they phone an ambulance, it will take a lot of time for the crew to get there. Sometimes they come out of the red zones to the police station, because they know it will be safer and that we will be there. Or, sometimes they arrange with private transport, but that is not always possible."* [Northern; P1].

Some participants addressed the involvement of the community in the protection of ambulance personnel in dangerous areas, which enabled them to deliver medical services more effectively. Personnel indicated that it involves building trust with community members and showing them that EMS care about helping them. Participants were of the opinion that:

> *"The members of the family, the whole members of the family, they won't interfere with that. They'll try and help out."* [Eastern; P4].
>
> *"Recently, in one of the areas we entered, a man said to someone 'leave them alone', and we later found out that he was one of the patients we treated before. If it is at night*

and it is getting late, we will phone the control room and ask them to let the people know that we are on our way. Just for someone in the street to wave at us, because the houses are not always marked with numbers – so it becomes interesting and difficult. And then four or five people will usually stand outside the house and they will say, 'We will be on the lookout', and that helps." [Northern; P1].

Dangers Experienced

One of the participants stated: *"Danger lies everywhere and waits for us."* [Western; P5]. Moreover, participants were asked what the dangers are that they experience while performing service calls, to which all participants indicated that a myriad of different dangers are experienced. The most common dangers experienced by participants were: shootings and getting caught in crossfire; hijackings, attempted hijackings, and stoning; different types of abuse (verbal, physical and sexual) from different types of offenders (patients, family members, community members, gangsters and substance abusers); robbery, attempted robbery, and being held at gun- and knifepoint; time of the day; and the challenges of entering rural areas. These experiences will be addressed below:

Robbery or Attempted Robbery

Some of the participants stated that a lot of crime committed against them are opportunistic. Three of the respondents personally experienced stoning. Some answered:

"But sometimes opportunistic stuff happens, like last night, we were on our way out of Leonsdale when someone threw something at the ambulance. On the side of the ambulance, I saw a fist-sized hole in the vehicle." [Northern; P1].

"Uhm, I've been held hostage in my ambulance by someone who tried to stone me with bricks. Uhm, this was an unhappy community member. And he just kept throwing bricks towards the ambulance, and he kept telling me to come out like he wants to kill me." [Western; P12].

Three participants mentioned being robbed of equipment and personal belongings, and were of the opinion that their equipment places them at risk to become victimised. It has been determined that four of interviewees personally experienced being robbed or attempted robbery. Some were of the opinion that:

"Firstly, I would say my equipment, if they must know what's inside, they'll target me every day. Uhm, but the tablets is a danger for me, because they think it's a phone, and the other thing is, uhm, they think the ambulance people's got a lot money, so they like to target them in the different areas." [Western; P3].

"…a lot of crime is opportunistic at the moment. They see the ambulance is there, so they know we all have cell phones and therefore rob us." [Northern; P1].

"In 2019 or 2020, yeah 2020, uhm someone tried to steal an MDT (mobile data terminal) and then I jumped up from the seat…and then I tore the whole ligament of my right ankle." [Eastern; P9].

The danger of being robbed, held at gun point or knifepoint while performing service calls was noted by a few participants as a threatening danger in their occupation. Five participants personally experienced being held at gun point (5) or knifepoint (1). Interviewees shared their opinions of this danger:

"In Cape Town, guns and knives. They are not scared, even though you are treating them, to pull a knife on you and rob you and get out of the vehicle. They pretend to be injured to get into the vehicle." [Western; P8].

"…it's multi multifactorial…I mean, that I think the biggest dangers are that you are worried that you're going to get held up at gunpoint or, or at knifepoint…robbed. But…the robbing is not so much the issue, it's more the, you know, are you actually going to survive?" [Western; P12].

"At the day hospital, it was about I think past 03:00 in the morning. In 2019. We were dispatched on a call at site B, Day Hospital. So, we waited in the ambulance, me and my partner. While we waited in the ambulance, I heard my partner screaming, and I asked her 'what is going on?', and she whispered and said 'it's a thug, a thug next to my window'. As my eyes got used to the dark, I saw a young boy, he was aiming a pistol right in the window on my side." [Eastern; P4].

"We had a call in Uitsig. I was the main one, because I drove that night, who was gun pointed." [Northern; P10].

"We were trying to treat the patient…you could see the people were the main gangsters, you'd know if you saw them, got out of the vehicle and they approached the ambulance and one of them actually pulled his gun out. I thought I was going to die that night." [Western; P12].

'Fake Emergency Calls', Hijackings and Attempted Hijackings

Hijackings and attempted hijackings were noted as a big hazard faced by the interviewees. One participant stated that some of the attacks against them are planned, where perpetrators call an ambulance, wait for the crew and then rob (or attempt to) them:

"… it has happened before in Samora Machel, a very bad area, someone phoned the ambulance on behalf of an asthmatic patient. When the crew arrived…the 'tannie' or

patient stood next to the road. As soon as the patient was loaded into the ambulance, she told the crew that she does not really want to go the hospital, she only phoned, because people paid her to do so." [Northern; P1].

With regard to hijackings and attempted hijackings, some participants mentioned:

"When I started in the service in 2007, I all on the corner of Jakes Gervel and, I came through Philippi, from Mannenberg to Philippi. They attempted to hijack me with a quantum." [Western; P8].

Shootings and Getting Caught in Crossfire

Some participants stated that experiencing shootings in the area or getting caught in crossfire are two of the biggest dangers they face in the prehospital environment. Six of the interviewees mentioned that they personally experienced shootings (3) or getting caught in crossfire (3). Most of the participants stated that this happened in either in the presence of police; in gang-ridden area; or where substance abusers were present. Participants answered:

"I worked in Mitchell's Plain for a little while, and we were at a house one night…when we got to the fourth floor, they began shooting. So, the police came in with us, and when they started shooting, the police started shooting back…so, I said well, okay, we will stay here until the situation is calmer…" [Northern; P1].

"But there are areas which are rife with gang violence, then it is difficult. You arrive and you hear gunshots, or the bulletin comes on the radio to say that it is a gunshot. Or sometimes, dayshift tells nightshift what is going on or the nightshift tells the dayshift: 'Shootings took place in that area", and then you have to enter that area. You have to go and help.' [Western; P5].

"That is why it is the way it is today and it is mostly because of the drug lords and drugs, that is mainly what it is about: drugs. They have areas in which they operate and the one wants to eliminate the other and then we, uhm, we get caught in the crossfire." [Northern; P10].

Time of the Day and Rural Areas

Most of the participants indicated that the time of the day had an influence on if they would get victimised or not, most of them stating that it was most dangerous at night – although responses were mixed. Four stated that it is always dangerous, and some were of the opinion that it depends on the area they enter. When asked about when the most dangerous time was, participants responded:

"It's so unpredictable, man. It's so unpredictable. You can't say, at this time it won't happen or that time it won't happen. But I know for a fact, nightshift is the most time that anything can happen at any time. Really, there is no specific time…" [Eastern; P4].

"During the day, I would actually say, it's quite fine. It's all about into what areas you go. But I think at night, mostly, that is the time that it's rife." [Southern; P6].

"No, my darling no. Always dangerous. Being it during the day, broad daylight, being at midnight, being it wherever whenever – if they want to do it, they will." [Western; P8].

"…I would say yes, on weekends, especially like Saturdays and Sundays, which are the times when the communities have a lot more to drink, and there's a lot of sport going on." [Western; P12].

Furthermore, a lot of participants noted that rural areas are dangerous due to various reasons:

"The threat you experience when going into an area without knowing that you will be able to come out, is a danger." [Western; P5].

"I think the biggest dangers is being on an isolated road or being in a dark space and being robbed. Mitchell's Plain is very congested, some areas don't have lights, so that's where the perpetrators get the opportunities to do their thing. [Southern; P6].

"…although you have a GPS system, it does not always take you on the fastest route, do you understand? Sometimes there are reroutes, there are detours, there are roads that are blocked, some of the roads are not named, some of the houses are not numbered. Or the person who phoned us, phoned on behalf of someone else, but they already moved away from that point…" [Western; P5].

Types of Abuse

Participants, throughout answering the questions on either risk, danger or fear, identified the types of abuse that they (or their colleagues) experience while performing service calls in Cape Town. These types included verbal, physical and sexual abuse. Some experienced isolated types of abuse, while others experienced a combination. The number of participants that personally experienced these types of abuses were 6 (verbal); 6 (physical); and 1 (sexual). Respondents also identified different types of perpetrators, which included patients, family members, community members, and gangsters.

Verbal Abuse

Respondents had different opinions and experiences of verbal abuse while on duty, some experienced it from patients and family members, while others shared that they were threatened

by community members or gangsters. The reasons for the abuse included delayed response times and treatment of gang members in certain areas. The respondents shared:

> *"Uhm, and I mean, also, sometimes, aggression from the patients or the, the patient's family themselves, you know, you can get threatened, uhm, by the patient, or the family, or a like a gang member."* [Western; P11].
>
> *"…we used to work in the Retreat and Kraaifontein, there were times that we were attending to somebody and the gang that was rivals with this guy would say, 'leave him, let him die, otherwise you are going to die' or 'you better help our friend or else you are going to die'"* [Southern; P6]. One respondent, a male ECP with 19 years of experience with Metro, stated that the family or community may become aggressive when the response time of the EMS is delayed:
>
> *"In some cases, they get aggressive, verbally and physically. I have not been physically attacked yet, but I was a victim of verbal abuse a lot of times."* [Western; P5]. Another participant added:
>
> *"Uhm, I've been held hostage in my ambulance by someone who tried to stone me with bricks. Uhm, this was an unhappy community member…and he kept telling me to come out like he wants to kill me."* [Western; P12].

Physical Abuse

Interviewees stated that they have been physically abused, especially by patients. Most of them were of opinion that they understood why some patients became volatile, for instance that patients were unaware of their behaviour. Answers included:

> *"Oh, yeah. Yeah. More than once. I was kicked by a young boy, 15-year-old, he had constant convulsions…my partner leaned over the patient to hand me the oxygen mask. So, the patient felt threatened at that time and he lifted himself up and he kick me in the abdomen. But that wasn't a robbery or anything. The patient was just scared."* [Western; P8.]
>
> *"Multiple times, yes…the patient bit me, because he did not want to restrained. Like the minor attacks, like when a patient smacks you or hits you on your chest, if the patient is not in the right state of mind, I give the attack off as he doesn't know what he is doing, so then it's okay. I don't feel that it is a threat."* [Eastern; P9].

Sexual Abuse

Sexual abuse was only experienced by one participant, while another respondent shared a story of the attempted sexual abuse of her previous partner. Both of the participants mentioned that it occurred at the back of the ambulance and mentioned the dangerous influence of the Perspex

divider (installed due to Covid-19) in the ambulance. The participant who personally experienced sexual abuse stated:

> *"In 2017, I was almost raped in the back of the ambulance…his hand was in my panties and he was touching my privates, that was my most uncomfortable one. Thank God we didn't have Perspex, I was still very small, so I could climb through to the front, start the vehicle and drive. All he said to me was: 'I am going to kill your partner and we will all rape you', and they were about seven men on the scene."* [Eastern; P9]. The other respondent told the following story:
>
> *"There is a plastic Perspex divider between the front and the back of the ambulance and her male partner was driving the ambulance. She was at the back with the patient and the patient pushed her against the back of the ambulance and wanted to rape her. Her partner could not hear her, because the Perspex is sound proof."* [Northern; P1].

Experiences of Fear

Participants were asked if they experience fear associated with crime while on duty or when called to an emergency, and whether they do, if it influences their ability to perform their medical duties optimally. The responses received were mixed, with 8 participants stating that they get scared while on duty; 2 stating that they do not experience fear; and 2 had mixed feelings about being scared. For instance:

> *"[Laughs]. So, uhm, I mean, it depends on which emergency but yes, I would say so. When you're going into more dangerous areas than others, I mean, we are always worried that something is going to happen. So, yes."* [Western; P12].
>
> *"Look, if you are not scared or if your heart does not skip a beat, then you really are stupid. Do you understand? To enter these areas without a police escort, without being scared. Yes, there is a sense of being scared or fearful, but you hope for the best."* [Northern; P2].
>
> *"To be honest with you, I do not. Because I grew up in a hard area where you know, you had to look out for yourself. And I think I am one of the very few that do not get scared anymore. You know I take it as it come."* [Eastern; P7].
>
> *"On the, on the response car I work alone, I was scared because of the weather… But never in the area. Someone asked me, "why do you like to work alone?", but I really don't have a problem…– you must not show them you are scared, if you gonna show them you are scared, they are going to attack you."* [Western; P3].

Participants who experienced more fear were previously victimised while on duty, and stated that either re-entering the area where they experienced violence, or hearing of colleagues who were attacked, prompted increased feelings of fearfulness:

> *"Yeah, you know now, after the recent one, I'm experiencing a lot of fear. Sleeping, I don't sleep well at night, I have become restless, I have become scared, listening as if there's people who are probably coming to my house."* [Eastern; P4].
>
> *"Yes, I do. So, when I get called to Site B, Site C or Macassar I am already on edge. So, all the areas where I have been attacked, I will forever be on higher alert than I would have been. Initially I was very scared to go back to work. Even now still, in certain areas I get very scared, and I am forever checking if the police are on the scene."* [Eastern; P9]. A female paramedic, who was previously victimised while on duty, stated that:
>
> *"So, what I've noticed is that the other ambulance attacks that happens around me, uhm, they influence me and give me so much anxiety that it actually prohibits me from doing my job. And then, yes, definitely going back into the areas…even now when I get a call to go there or to the other area where I was specifically gun pointed and held hostage, I can feel myself become anxious." [Western; P12].*

Two participants, an ECP and a paramedic, stated that colleagues who are attacked increase their fear:

> *"So many cases that some of our colleagues, they were just shot in the ambulance…so, you already get scared, thinking: what if?"* [Eastern; P4].
>
> *"The things that happen around me influence me a lot, because it brings back lots of my own trauma, and then obviously the fear of losing my colleagues, which in our service becomes like family…it becomes a significant fear for their loss of life."* [Western; P12].

When the participants were asked if the experience of fear influences their ability to perform their medical duties optimally, the opinions of participants differed. Two stated that it does not influence their ability to do their jobs, as they focus on what they have to do and strive to provide the best care to patients:

> *"No, it does not, since I'm passionate about this job! One thing I will do, I'll just try and focus on my job."* [Eastern; P4].
>
> "*But I have never been so scared that I could not do my job. I believe in God; He is greater than all of this stuff. So, I do not know if I really am the right person to talk to*

about fear." [Northern; P1]. Two of the respondents were of the opinion that the experience of fear does influence medical service delivery:

"I would say, to a degree, especially in cases where you have to spend time with a patient, but you don't have time to do everything. So, to only grab him…it does influence service delivery." [Northern; P2].

"And then, yes, definitely going back into the areas, I can feel myself become anxious. That's when I say I can't mentally prepare myself for the patient that I am about to treat and to give my entire self to them and be on top of my game…" [Western; P12].

Education, Training and Experience

Participants were asked if they felt that their education and training adequately prepared them for the realities of their occupation, and the majority of participants felt that they were not sufficiently prepared for their work, especially in terms of crime. One of the participants were of opinion that:

"No, no, no, no, no, no. In terms of the crime and the attacks on EMS, when I was a student, there was no such thing. When I qualified there was nothing like that, so to me, it was never really part of my job. So, I was unprepared for that." [Eastern; P9].

Another participant stated that:

"Negative. The only thing that one person told us: if you are hijacked, never make eye contact with a hijacker. Let it be. Your safety comes first." [Western; P8].

In terms of emotional preparedness for the realities of dealing with death, debriefing families and counselling, one of the participants mentioned that:

"…when I was very new, I didn't know how to tell a person's family they passed on. That was very difficult for me. Now I do it with straight face and I don't even have a feeling…." [Western; P3].

A lot of the participants highlighted practical experience as an important factor in being prepared for the prehospital environment, stating that most of today's newly qualified EMS personnel are not exposed to enough practical training during the period of their education. For instance:

"Yes, I think in today's EMS, or the people who finish College, they lack practical experience. I think theory is necessary in this line of work, but they spend way too little time on the road." [Northern; P2].

"…what is happening currently is that people leave school and then study for four years at university …They are not adequately prepared for what really waits for them." [Western; P5].

A few participants were of the opinion that their training and experience differs a lot from the current reality of the occupation, especially in terms of working with and being respected by the community. The following participant shared:

"People used to applaud us, even the gangsters. We used to work in Elsiesriver, you know Elsiesriver how dangerous it is? But then, the gangsters will let us in and allow us to pick up the injured one. They protected us until we left, then they started their thing afterwards." [Eastern; P4].

Occupational Challenges

Participants were asked about their mental health after experiencing a traumatic call or victimisation, and if they went for counselling. Seven participants experienced mental health challenges due to their occupational duties. Only one participant, an ECP with 14 years of experience working for Metro, indicated that he went for counselling and that it helped him to cope:

"Yes, I've stopped working for a while ma'am. I went for counselling. "It did, in a way it did help me, yes. I mean, I've managed to work afterwards. I've coped." [Eastern; P4].

Another male participant stated that mental health problems arose from dealing with death and trauma:

"I think, also, during all these years, declaring people when you get to scenes where people have died…you have to assess, you have to calm the people. So, some people have difficulty in dealing with that. I have been to counselling. It's not for the faint hearted…." [Southern; P6].

Most of the participants were generally of the opinion that they suffered from mental health problems after being victimised; raised the issue with the statement "it's just part of the job"; and stated that counselling did not work for them:

"The guy that almost raped me… changed me a lot. I had PTSD, depression, severe anxiety after that. So, the counselling didn't work, then I went to see a psychologist and then a psychiatrist." [Eastern; P9]. The same participant later stated:

"The one thing that should change, is when it comes to an injury on duty, if it's a mental situation, they cannot put a time limit on that. Because every time now, when I have to

go pick up a rape case, my mental health is so messed up, but I continue. To them, they are saying a part of the job – yes -, but it was not part of my job to almost get raped. They think it's part of the job – that's forever the line I hear. It is part of your job." [Eastern; P9]. Another participant, who had 34 years of experience working for Metro, was a victim of an attempted hijacking and being gun pointed, and when he was asked if he sought counselling after the incident he responded:

"No, uhm, nothing, nothing, nothing. That is one of the things that is also, uhm, absent when things like that happen to us. Perhaps we have become used to it, us older guys in the service, we are already saying 'it is part of the service we deliver to the community.' It happens now and again, tomorrow it is over." [Northern; P10]. A female paramedic (32 years of age), who was a victim of crime while on duty multiple times, explained that her victimisation experience had a serious effect on her mental wellbeing:

"So, I never got the treatment of, of being debriefed or, to know, you know, you have just looked down the barrel of a gun, but it's fine [laughs], you have to go back to work the next shift. So, I was then off work for an entire year for PTSD, I ended up in a mental health clinic, uhm, and on loads of medication, I lost 40kgs in six months, uhm, yes, I was severely ill. So, a year later, I was able to work again, well, not even as an, in an operational capacity, I was able to come and do admin work…" [Western; P12]. When asked if she got any benefit from the counselling services at the moment, she stated that:

"Uhm, well, the counselling services that helped me at the end of the day came from my own pocket. Uhm, the only service that was available, was ICAS. Unfortunately, there is no way that you can speak with someone over the phone and they can know exactly how you are feeling or what you are going through. So, no, I never found any benefit with the services that they provided…when many of us needed medical help…– just talking about it, doesn't help, it doesn't help." [Western; P12].

Safety Interventions and Recommendations

All participants were asked what they think should be or could be done by the South African Government and the Western Cape Government to reduce or eliminate their experiences of risk, danger and fear in the prehospital environment. A lot of suggestions have been made by respondents, and the most common included: additional escorts, which included personal opinions on the effectiveness of current police escorts in red zones; safety adjustments on

ambulances and panic buttons; personal protective equipment; prioritising human resources; prioritising mental health; and engagement with the community.

Deploying Additional Escorts

Interviewees were specifically asked if they felt that police escorts lowered their experiences of risk, danger and fear in dangerous areas. The responses and opinions of participants were mixed – five participants stated that they did not feel police escorts were sufficient protection when responding to calls in dangerous areas. One participant argued that police escorts cause EMS and the community to be more relaxed, and the other five participants had both 'yes' and 'no' answers. With regard to the effectiveness of the police, participants argued:

> *"I am going to say something completely radical now. I do not believe that the police escorts are useful. The gang members know that when an ambulance enters a certain area, they will be escorted by police. And the police are usually armed, so if the gangs want weapons, they hijack the police."* [Northern; P1].
>
> *"There is a balance. It reassures us to an extent, in contrast to going in without any physical protection. The police also serve as a deterrent for those who wants to take a chance to rob us, or to physically or verbally abuse us. But then you get the determined person who will take the chance despite the presence of the police."* [Western; P5].
>
> *"In my case, yes. But there is, look, you are a bit more relaxed when the police are around, because then you can spend more time with the patient and on the level of care you give. And half of the community may know the specific policeman, then they are also relaxed."* [Northern; P2].

Seven participants thus recommended that additional escorts should be deployed to enter with EMS into dangerous areas or red zones. These escorts included the army and private security companies. One participant noted that two vehicles should escort one ambulance, at the back and at the front, for better protection. For example:

> *"I would love them to put more money aside to assign vans for every vehicle. Make use of the army or security companies."* [Western; P8].

Safety Adjustments on Ambulances and Personal Protective Equipment

Participants recommended adjustments to ambulances, such as installing cameras on the dashboard and at the back of the ambulance. Moreover, the participants stated that helmets and knife proof vests would serve as protection. Nevertheless, three participants were of the opinion that arming EMS personnel and providing them with bulletproof vests would not be a suitable solution. With regard to adjustments to ambulances and panic buttons, four respondents noted:

"So, the new ambulance, I love it, because when you press the safety button, the moment someone moves around the vehicle it makes a noise. And then it has spotlights, so when you switch that on, it is so bright that whoever is in the vicinity of the ambulance, it will scare them away. Also, they should not put normal wheels on the ambulance, they can put run flats on, if they get punctured, we can still move with them." [Western; P9].

"…I feel that we should have, uhm, personal panic buttons. So, I don't think it makes sense the way they have panic buttons on our tablets in the ambulances at the moment…something that is attached to your key, or to your person, or in your pocket. So, the cameras at the back of the vehicles, the reverse assist, it at least gives you a view at the back as well. And then, dash cams are so important." [Western; P12].

Opinions regarding personal protective equipment included:

"Like to give us better personal protective equipment, maybe at least just give us the availability of knife proof vests. Even helmets would be good." [Western; P12].

"Our safety committee thought that we all should wear bullet proof vests, because that will keep us safe. If someone is gun pointed, the gun gets pushed against their heads. You do not have a bullet proof vest on your head." [Northern; P1].

"Previous years we were allowed to carry weapons, but that defeats the purpose, because we are there to help people." [Eastern; P7].

Human Resources

Four respondents argued that EMS are understaffed and that more (skilled) personnel have to be appointed. Two participants also addressed the control room, and recommended that appropriate individuals are appointed to operate these facilities. Participants thus recommended:

"If we had more personnel, we could have attended to calls quicker, which would have reduced the risk. If the police had more staff, we could have attended to calls quicker." [Western; P5].

"I thought of having a little control room and you have all the role players (ambulance, fire, traffic, police) in the control room in the Southern Division. The same for all the other divisions. But, another thing, a dispatcher sitting in Tygerberg, he dispatches in Southern Division, they don't know how this division works. I told the director, why don't we take the control room operators into these areas, show them around." [Southern; P6].

Community Involvement and Education

Three participants provided useful recommendation for involving and educating the community as a way to minimize the risks, dangers and fears they experience. These recommendations included education on ambulances and their function; providing first aid treatment; and regaining respect. Respondents were of the opinion that:

> *"…going out to the community, bring yourself to their level – be kind and be hard where you have to be hard. There should be a committee formed that will go out and empower the people outside, and go and advocate for us outside – what we are here for, why you phone an ambulance. So, with this Tafelsig Project Vehicle, we had to reawaken this and to try and build a new connection. I think there should be more awareness in the townships about EMS."* [Southern; P6].
>
> *"I actually I'm involved, uhm, in Metro, we do a community outreach thing where we teach first aid, we give emergency first aid courses for free. We do it because we recognize the value of how important it is that, a lot of people are trained, because we know that our response times are so poor. It's called the EFAR program."* [Western; P11].

Mental Health Policy

In terms of mental health and wellness, a lot of participants stated that they are not satisfied with only receiving counselling or talk therapy when they have to debrief a call or work through the experience of victimisation. They recommended that the government teach them how to deal with such experiences; provide them with psychological and psychiatric help; provide medical personnel on standby; and develop an occupational health clinic. Responses included:

> *"My point is, nobody teaches that to our people. Absolutely. Teach the people the techniques to deal with this kind of stuff. If I had a choice, as a part of self-defence, how do I keep my brain and my emotions safe? Teach me coping skills. If I could get my wish, then government should give more attention to teach us to look after ourselves."* [Northern; P1].
>
> *"Then I think that we should have medical personnel on standby, an occupational health care clinic that serves all of us from the EMS…that would be available 24 hours a day, that would have qualified psychiatrists and psychologists."* [Western; P12].

Summary of Findings

Experiences of Risk

During the interviews, participants were asked if they experience risk when performing service calls and, if so, how it influences the crew's decision making in terms of handling the situation. It was noted that 11 out of 12 participants indicated that they do experience risk, however, the situations in which they experienced risk, differed. The participants were generally of opinion that their job in itself is regarded as a risk, and that they thus face risk every day, everywhere. The risks they identified were entering unfamiliar areas, and dealing with hostile crowds and family members. The data showed that dangerous areas create on-the-job risks, and participants thus regarded risk management, being observant and street smart, and establishing a good working relationship with their partners as important. Participants were of the opinion that the community plays both a role in risk involvement and risk management. The study revealed that that the community is often involved in the creation of risk in the prehospital environment, through aggressive behaviour towards personnel. In contrast, personnel also believed that if they show the community that they care, and if they gain the community's trust, the community helps and protects them at emergency scenes.

Experiences of Danger

Participants from each of the divisions were asked if certain areas were more dangerous to enter in their respective division, and then asked to name each of the areas. In the Northern division, Kalksteenfontein was regarded as the most dangerous area, and Site C in the Eastern division. Moreover, the participant from the Southern division stated that Gugulethu, Nyanga and Phillipi are regarded as the most dangerous areas. In the Western division, Hanover Park and Lavender Hill was seen as a dangerous area to participants. Some participants mentioned that green zones exist, nevertheless, most of them argued that the general service area in Cape Town is experienced as dangerous, especially when taking certain factors such as the time of the day; infrastructure; and the criminal climate of the area into account.

The consequence of waiting for a police escort before entering the red zone, was identified by nine of the participants as a major reason for poor service delivery. Although most of the participants understood that the police are overworked and understaffed, they still felt that the influence of waiting time on service delivery is tremendous. Interviewees stated that it leads to delayed response times, which causes violence from family members and patients; causes the patient(s) to need to be moved; or causes the patient to resort to alternative forms of transport. The red zone protocol causes both the Metro EMS and the community to manage the dangerous

environment in an attempt to either provide or receive medical service delivery. Some participants stated that the community is involved in the protection of ambulance personnel in dangerous areas. Personnel indicated that building trust with community members and showing them that EMS care about helping them causes the community to protect them in dangerous areas.

Personnel were specifically asked what they regarded as 'dangers' in the prehospital environment, to which a myriad of different types were identified. These dangers included: being held hostage; shootings and getting caught in crossfire; hijackings or attempted hijackings; stoning; robbery or attempted robbery; and being held at gun and knifepoint. Moreover, the time of the day; and the challenges of entering rural areas was also noted by the majority of participants. In addition to these dangers, the different types of abuse (verbal, physical and sexual) from different types of offenders (patients, family members, community members, gangsters and substance abusers) was also experienced by respondents. Being robbed and gun pointed was mentioned and experienced by a lot of participants, and they regarded these two crimes major dangers. The main reason for robbery included the expensive equipment and personal valuables in ambulances, and interviewees particularly mentioned that being held at gun point was a traumatic experience for them. A lot of participants were of the opinion that they experienced verbal abuse and death threats from either family members, patients or gangsters. Respondents indicated that they were physically abused by patients, however most of the victims did not regard abuse from patients as dangerous. Although sexual assault was only experienced by one participant, and mentioned by another, both of these respondents mentioned that the Perspex divider installed in ambulances during the Covid-19 pandemic was regarded as a danger to them. Furthermore, the majority of interviewees mentioned that rural areas are difficult to enter due to poor infrastructure and unmarked streets and houses, causing service delivery in these areas to be seen as a danger. The majority of participants regarded night time as the most dangerous time for them to attend to emergency calls.

Experiences of Fear

Metro EMS ambulance personnel were asked if they experience fear while performing service calls and, if so, whether or not this influences their ability to perform their medical duties optimally. This study found that 8 participants stated that they get scared while on duty; 2 stating that they do not experience fear; and 2 had mixed feelings about being scared. Interestingly, participants who were previously victimised while on duty, who had to re-enter

the area where they experienced violence, or who heard of colleagues that who had been attacked, experienced increased feelings of fear. The answers with regard to the influence of fear on service delivery differed. Some participants indicated that fear does not influence their ability to perform optimally, because they are passionate their jobs and helping patients. Other participants indicated that it does influence their medical abilities, especially in cases where they have been previously victimised.

Education, Training and Experience

During the interviews, participants were asked if they felt that their education and training adequately prepared them for the realities of their occupation, especially with regard to crime. The study determined that most participants felt that their education and training did not sufficiently prepare them for the current crime-ridden realities of the occupation. Most also believed that practical experience is an important factor when preparing for the prehospital environment, and that it should be implemented as part of their education and training.

Occupational Challenges

One of the participants in this study stated that she was not adequately prepared to deal with death, debriefing and how to cope with the psychological consequences of handling emergency calls. The participants were asked about their mental health after experiencing a traumatic call or victimisation, and if they went for counselling. Seven participants experienced mental health challenges due to their occupational duties and victimisation. Participants felt that they would benefit from psychological and psychiatric services be made available to them, and that they want to be taught coping strategies and skills as a measure to protect their overall wellbeing.

Safety Interventions and Recommendations

Interviewees were asked what they think can be done by the South African and Western Cape Government to minimize or reduce their experiences of risk, danger and fear associated with crime while performing service calls. Participants made a series of suggestions based on their occupational experiences. Respondents were asked if they believed that the presence of police escorts reduced their experiences of risk, danger and fear, and the majority were of the opinion that it does not. Based thereon, participants recommended that additional escorts should be personally available to Metro EMS escorts. Furthermore, they requested personal protective equipment, however some were against arming personnel and equipping them with bulletproof vests. As mentioned above, a lot of respondents recommended that the mental health policies should be amended. Interviewees were also generally of the opinion that both the police and

EMS are understaffed, and thus more (skilled) personnel should be appointed to improve service delivery. It was suggested by a few participants that engaging with and educating communities would play a tremendous role in safeguarding EMS personnel.

Chapter 5

Conclusion and Recommendations

Conclusion

These findings add to the growing body of literature that violence against EMS ambulance personnel is a serious public health problem globally, and in South Africa. The study determined that the majority of Cape Town Metro EMS ambulance personnel experience risk associated with crime while performing service calls. Although scholars such as Senol et al. (2018) and Maguire and O'Neill (2017) specifically address risk associated with EMS personnel, these studies mostly focus on individual risk factors (gender, age or qualification), without investigating *how* risk is experienced and managed, or *what* the impact of risk within the prehospital environment might be. The researcher found it concerning that participants regarded their job in itself as a risk. If they believe that their lives are at risk every day; if they feel that risk is everywhere; or if "*getting onto an ambulance nowadays is actually a risk"* [Southern; P6] – should risk not be regarded as a serious problem within the public EMS system?

Risk management emerged as an important theme from the data, with most participants agreeing that it involves being observant and street smart, and establishing a good (communicative) relationship with their partners. This finding makes a unique contribution to the literature on risk, especially in terms of how it is experienced by EMS personnel, and how it is managed within the South African public health environment. Personnel indicated that risk is managed through decision making that either exposes them of protects them from risk, which highlights a critical paradox in the data. If personnel decide to face risk and enter dangerous areas, they put their own lives at risk to save that of the patient, however, if they avoid risk by not attending to a (risky) emergency scene, they may save their own life, but put that of the patient in danger. Should risk management within the prehospital environment involve the juggling of such important (lifesaving) decisions?

Participants believed that the community is involved in the creation of risk in the prehospital environment, through aggressive behaviour towards personnel. Perkins (2018) found that South African police felt most at risk when the bond between them and the community is frayed, indicating the importance of a good relationship between community members and public services. In terms of danger, participants were of the opinion that the establishment of red zones lead to delayed response times, which caused patients and family members to exert aggression towards them. This study found that although the red zone protocol safeguards

personnel (to an extent), it has a critical influence on service delivery, and is viewed by the researcher as a counterproductive measure. This is supported by the literature[3] and the findings of this study in which the majority of interviewees were of the opinion that police escorts do not necessarily reduce the risks, dangers and fears that they face while on duty. In fact, it was determined that SAPS are also targets of violence while escorting Metro EMS ambulance personnel, which should be investigated by future research. Most of the personnel thus recommended that additional (private) escorts should be employed. In line with South African literature (SAPeople Contributor, 2021), an additional consequence of red zones emerged from the data. Participants shared that residents residing in red zones often managed dangerous situations through arranging private transport or moving the patient to safer areas themselves, indicating the extent to which not only service delivery is affected, but also how dangerous (inaccessible) these areas are to enter. In stark contrast, personnel shared that the community helped them to manage risk in dangerous areas, as they protected them at emergency scenes. Personnel felt that the establishment of trust was pertinent in the process of receiving help. This was an interesting finding that has not been noted in either international literature. It can thus be argued that additional community-based initiatives should be endorsed as a measure to reduce the risks, dangers and fears faced by personnel in Cape Town.

All of the participants in this study stated that they do experience danger associated with crime while performing service calls. From each of the divisions, interviewees shared the dangerous areas and highlighted that the general service area is regarded as dangerous. The consequence of being immersed in danger daily is immense. The types of abuse (physical, verbal and sexual) are addressed in both international[4] and South African literature[5]. Nevertheless, the researcher found that the South African literature and the findings of this study provides a more in-depth presentation of the types of dangers experienced by South African EMS personnel. The data revealed that Cape Town Metro EMS ambulance personnel experience a wide variety of dangers within the prehospital environment, which can be attributed to the criminal climate of South Africa; the cultural diversity; extreme poverty and inequality; and poor infrastructure and economic climate. Moreover, international literature[4] mostly identified the perpetrators of violence against EMS as patients, relatives or bystanders – rarely focusing on the community or gangs. In contrast, this study revealed that a lot of crime committed against Cape Town

[3] Gleby (2018); and Reinecke (2017).
[4] Bigham et al. (2017); Maguire and O'Neill (2017); and Knor et al. (2020).
[5] Vincent-Lambert and Westwood (2019); and Holgate (2015).

Metro EMS ambulance personnel involved random community members (especially in the cases of hijacking or stoning) or gang members. The normalisation of violence, as addressed by Taylor et al. (2016), was noted in this study, as participants who were physically abused by patients stated that: *"…he doesn't know what he is doing, then it is okay."* [Eastern; P9]. This type of compassion shown by EMS personnel towards abusive patients has indicated that they always prioritise patient care, underlining their passion for the job. It can be argued, however, that if EMS personnel normalise violence from patients, they may not report these instances of abuse, contributing to the problem of underreporting[6] faced in the system. Two important factors that were identified as dangers by personnel (and in the literature[7]), was night shift duty and entering rural areas with poor infrastructure. This indicates that environmental conditions, outside of EMS workers' physical control, contributes to the victimisation they experience. This is thus something that needs to be addressed by the government – highlighting the importance of improving the infrastructure in these areas.

This study determined that the majority of Metro EMS ambulance personnel experienced fear while performing service calls. Some indicated that they do not, while others had mixed feelings of being scared. Participants who were previously victimised while on duty, who had to re-enter the area where they experienced violence, or who heard of colleagues that who had been attacked, experienced increased feelings of fear. This finding is supported by studies conducted by various scholars[8]. The answers provided by participants thus suggest that their fearfulness is a consequence of experiencing risks and dangers associated with crime within the prehospital environment. The fear of crime often causes individuals to resort to increase measures of security (Howitt, 2015), which could explain why red zones and police escort protocols were established – as an attempt to lower the fear of crime of EMS personnel. The experience of fear may have also prompted participants' recommendations for safety and policy interventions. Interviewees were also asked that if they do experience fear, does this influence their ability to perform their medical duties optimally. Their answers differed. Some participants indicated that fear does not influence their ability to perform optimally, because they are passionate their jobs and helping patients. Other participants indicated that it does influence their medical abilities, especially in cases where they have been previously

[6] Pozzi (2002).
[7] Grange and Corbett (2002); Knor et al. (2020); and Maguire and O'Neill (2017).
[8] Bigham et al. (2014); Furin et al. (2015); and Fernandes (1999).

victimised. It was enlightening for the researcher to find that religion played an important role in ambulance personnel's regulation of fearfulness while on duty.

Interviewees were asked to provide recommendations that can be implemented by the South African and Western Cape Government to reduce the risks, dangers and fears associated with crime they experience while on duty. Most of the participants were generally of the opinion that they suffered from mental health problems after being victimised, and stated that counselling did not work for them. The researcher was surprised by the willingness of interviewees to discuss the psychological impact of their victimisation. Nevertheless, it was alarming to note that a lot of them felt that the counselling services provided by the government was not adequate, and this was further substantiated by personnel's recommendations that changes should be made to the existing mental health policies of EMS. Additionally, it can be argued that personnel may underreport cases of victimisation, as these experiences are seen as "part of the job." The study's findings, correlates with existing literature[9] and suggest that victimisation have a severe physical, financial and psychological impacts on EMS personnel, which ultimately hinders them to effectively deliver medical services to communities. Poor service delivery is unfair in a democratic country where everyone has the right to free, adequate emergency care. Thus, these recommendations should urgently be taken into account and addressed by the South African and the Western Cape Government. Additionally, participants made excellent practical recommendations that can easily be executed, in policy and practice. The myriad of recommendations made, however, highlights how unsafe they feel while on duty. Both international and South African literature address safety interventions for EMS personnel quite extensively[10], causing the researcher to wonder if this has been implemented (or even researched) by the Western Cape government.

The findings thus illustrate that Cape Town Metro EMS ambulance personnel do experience risk, danger and fear associated with crime while performing service calls. This study has found that risk and danger are often used as interchangeable terms, as the occupation of EMS is itself experienced as a risk – exposing personnel to danger while on duty. As a contribution to the literature on risk and danger, this study has determined that although these two concepts can be used interchangeably, risk is sometimes seen as a constant variable, whereas danger takes on the form of an independent variable. Moreover, the risks and dangers experienced by the

[9] Maguire and O'Neill (2017); Mechem et al. (2002); and Petzäll et al. (2011).
[10] Brice et al. (2003); Holroyd and Nabors (1993); Corbett et al. (1998); Vincent-Lambert and Westwood (2019); and Reinecke (2017).

sample population in this study differs from that found in international literature. Overall, the findings of the study correlate with the literature pertaining to the problem. The data revealed that personnel experienced fear associated with crime, and this fear was caused by the experience of on-the-job risks and dangers. In addition, previous victimisation and the victimisation of colleagues also prompted feelings of fear. The experiences of risk, danger and fear ultimately caused either poor or delayed service delivery to communities in Cape Town. Although international literature provides an adequate, quantitative representation of violence against EMS personnel, Dr Paul Farmer argued: "Statistics or graphs are not optimal to understand the experience of suffering." (Goodreads, 2022). Thus, this study addressed the qualitative knowledge gap in the literature, by providing an in-depth account of Cape Town Metro EMS' experiences of risk, danger and fear while performing service calls. This study therefore proofed that the extensive risks, dangers and dears faced by personnel are serious problems that should not only be investigated, but addressed as well. Crime against first responders is unacceptable and their lives should not be at risk when saving that of others. They should be safe while saving.

Recommendations

As this study was qualitative in nature, it was difficult to determine the exact amount of (and types) victimisation that Metro EMS ambulance personnel experienced. It can thus be recommended that a quantitative study is conducted in South Africa to provide statistically accurate representation of the personnel's experiences of risk, danger and fear associated with crime.

It can be recommended that a psychological study should be conducted with the aim to understand how ambulance personnel's experiences of victimisation affects their psychological wellbeing, and what measures would be helpful to minimize these effects.

As the SAPS are also victims of crime while escorting Metro EMS ambulance personnel into red zones, it can be recommended that a study on their experiences (if any) of risk, dangers and fears while either escorting EMS personnel, or while performing their own duties can be conducted.

Moreover, based on the excellent interventions and suggestions made by Metro EMS ambulance personnel to reduce the experiences of risk, danger and fear while performing service calls in Cape Town, it is recommended that these suggestions serve as the foundations for a policy paper. These policy interventions should be formally presented and recommended to the South African and Western Cape government in an attempt to facilitate safety and mental health policy changes with regard to EMS personnel.

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Appendix A: Ethical Clearance Letter from the University of Cape Town's Research Ethics Committee (REC)

Faculty of Law: Research Ethics Committee

Private Bag X3 ▪ Rondebosch ▪ 7701 ▪ South Africa
Room 6.29 ▪ Kramer Building ▪ Middle Campus
Tel: +27 021 650 3080 Fax: +27 021 650 5560
E-mail: lamize.viljoen@uct.ac.za Internet: www.law.uct.ac.za

Certificate of Approval for Ethical Clearance

PRINCIPAL INVESTIGATOR/SUPERVISOR: K MOULT STUDENT: MINETTE BEUKES- **[BKSMIN001]** FACULTY: LAW DEPARTMENT: PUBLIC LAW	**ETHICS REFERENCE NUMBER: L0170-2021** ORIGINAL APPROVAL DATE: 16-APRIL-2021 APPROVAL EXPIRY DATE: 15-APRIL-2022

PROJECT TITLE: Cape Town Metro EMS and Crime: Exploring the Experiences of Risk, Danger and Fear While Performing Service Calls.

PURPOSE OF RESEARCH: To explore Metro EMS ambulance personnel's experiences of risk, danger and fear while performing service calls.

CONDITIONS OF APPROVAL

This Certificate of Approval is valid for the above term provided there is no change in the protocol.

Modifications
To make any changes to the approved research procedures in your study, please submit a formal "Request for a Modification" to the REC Administrative Office. You must receive ethics approval before proceeding with your modified protocol.

Renewals
Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You are responsible for submitting this by at least 2 months prior to the expiry date of clearance date issued.

Project Closures
When you have completed all data collection activities and will have no further contact with participants, please formally notify the REC: Law as well as your supervisor where applicable.

Certification

This certifies that the University of Cape Town Law Faculty's Research Ethics Committee has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Cape Town Research Regulations Involving Human Participants.

MS M CARELSE
REC: LEAD REVIEWER

Certificate Issued On: 19/04/2021

Appendix B: Ethical Clearance Letter from the University of Cape Town's Faculty of Health Sciences Human Research Ethics Committee (HREC)

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room G50 -6 Floor
Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 650 3260
Email: hrec-enq-...@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/h...manethics/forms

02 August 2021

HREC REF: 474/2021

A/Prof Kelley Moult
Department of Public Law
Centre of Criminology
Room 6.36.5, Kramer Law Faculty
Middle Campus
University of Cape Town
Email: Kelly.moult@uct.ac.za
Student: BKSMIN001@myuct.ac.za

Dear A/Prof Moult

PROJECT TITLE CAPE TOWN METRO EMS AMBULANCE PERSONNEL AND CRIME: EXPLORING THE EXPERIENCES OF RISK, DANGER AND FEAR WHILE PERFORMING SERVICE CALLS. (MPHIL DEGREE – MS MINETTE BEUKES)

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 August 2022.

This approval is subject to strict adherence to the HREC recommendations regarding research involving human participants during COVID-19, dated 17 March 2020,06 July 2020 and 1st July 2021.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

The HREC notes that the following Staff member will be involved in the study: Miss Minette Beukes

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Please also note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC REF number 474/2021 in all your correspondence.

HREC REF 474/2021 SC

Appendix C: **Ethical Clearance Letter from the Western Cape Government Health (Emergency Medical Services) and Facility Approval**

Western Cape Government
Health

DIRECTORATE: **EMERGENCY MEDICAL SERVICES**
ENQUIRIES: **Dr Shaheem de Vries**
shaheem.devries@pgwc.gov.za
: +27 21 508 4523

ATTENTION: MS MINETTE BEUKES

RESEARCH PROJECT: CAPE TOWN METRO EMS AMBULANCE PERSONNEL AND CRIME: EXPLORING THE RISKS, DANGERS AND FEARS EXPERIENCED WHILE PERFORMING SERVICE CALLS.

Dear Ms Beukes

Your request on the above matter refers.

Thank you for the request to conduct research within the Western Cape Government Emergency Medical Services. Your proposal has been evaluated and has been recommended for approval by this office.

I am therefore pleased to inform you that such approval is hereby granted.

I wish you well in your endeavor and trust that you will keep this office and its department informed of your findings when these become available. I look forward to the insights that your research will afford us.

Yours sincerely

Dr Shaheem de Vries
Medical Director: Emergency Medical Services
Western Cape Government Health

Date: 30 August 2021

WCG Health: EMS – Office of Medical Director, 11 Alexandra Road, Pinelands, 7405
Private Bag X24; Belville (+27) 21 508 4523 (+27) 21 931 8490

Appendix D: Interview Questions (English)

Questionnaire

1. How old are you?
2. How long have you been employed in the Cape Town Metro EMS?
3. What qualifications do you have and what is your subsequent role?
4. What motivated you to become an ambulance worker and do you enjoy your line of work?
5. In which of the four divisions (Northern, Southern, Eastern or Western) of Cape Town do you work?
6. Have you always been employed to operate within the (name specific) division or have you worked in some of the others as well?
7. Would you say your studies and training prepared you adequately for the realities of the occupation?
8. Are there areas in your division which are seen as more dangerous to enter than others?
9. Do you experience any risk associated with crime as a Metro EMS ambulance worker in Cape Town? If so, how do you experience risk and how does this shape the decision making of your team?
10. What are the dangers associated with crime that you experience as an ambulance worker in Cape Town?
11. Are there specific times during the day that are seen as more dangerous to perform service calls? If so, does this affect the service delivery of the EMS? If so, please describe how the service delivery is affected.
12. Do you experience any fear associated with crime when you are called to an emergency? If so, what is the reason(s) for the prompting of these fear(s)?
13. Do these fear(s) inhibit you to perform your medical duties optimally?
14. Do you receive any support or protection from the South African Police Service? If so, in what circumstances is this be provided?
15. Do you think that the support and protection provided by the South African Police Service reduces the risks, dangers and fears (if any) that you and your colleagues have?
16. What motivates you to continue being an ambulance worker despite the experience (if any) of risk, danger and fear associated with crime?
17. What do you think can be done to effectively minimize the risks, dangers and fears (associated with crime) of the occupation in South Africa?

Appendix E: Onderhoudsvrae in Afrikaans

Vraelys

1. Hoe oud is jy?
2. Hoe lank is jy al in diens van die stad Kaapstad se nooddiensste?
3. Oor watter kwalifikasies beskik jy en wat is jou rol?
4. Wat het jou gemotiveer om `n ambulanswerker te word en geniet jy jou beroep?
5. In watter van die vier afdelings (Noordelike, Suidelike, Oostelike of Westelike) in Kaapstad werk jy?
6. Werk jy nog altyd in die (noem spesifieke afdeling) afdeling of het jy al in van die ander ook gewerk?
7. Sou jy sê jou studies en opleiding het jou voldoende voorberei vir die realiteit van jou werk?
8. Is daar areas in jou afdeling wat gesien word as meer gevaarlik om binne te gaan as van die ander?
9. Ervaar jy enige risiko(s) in verband met misdaad as `n ambulanswerker in Kaapstad? Indien wel, hoe ervaar jy die risiko(s) en hoe beïnvloed dit die besluitneming van jou span?
10. Wat is die gevare in verband met misdaad wat jy ervaar as `n ambulanswerker in Kaapstad?
11. Is daar spesifieke tye gedurende die dag wat gesien word as meer gevaarlik om noodienste te verskaf? Indien wel, het dit enige invloed op dienslewering? Indien wel, beskryf asseblief hierdie invloed.
12. Ervaar jy enige vrees/vrese in verband met misdaad wanneer julle uitgeroep word na `n noodgeval? Indien wel, wat is die rede(s) vir die onstaan van hierdie vrees/vrese?
13. Belemmer hierdie vrees/vrese jou om jou mediese verantwoordelikheid as `n ambulanswerker optimaal na te kom?
14. Verskaf die Suid-Afrikaanse Polisiediens enige ondersteuning of beskerming aan julle? Indien wel, onder watter omstandighede word hierdie dienste verskaf?
15. Dink jy dat die ondersteuning en beskerming deur die Suid-Afrikaanse Polisiediens die risiko's, vrese en gevare wat jy ervaar, verminder?
16. Wat motiveer jou om `n ambulanswerker te bly ten spyte van die risiko's, gevare en vrese wat jy ervaar in verband met misdaad?
17. Wat dink jy kan gedoen word om die risiko's, gevare en vrese van die beroep (in verband met misdaad) in Suid-Afrika te verminder?

Appendix F: Information Sheet

INFORMATION SHEET: EMS AMBULANCE PERSONNEL.

Cape Town Metro EMS Ambulance Personnel and Crime: Exploring the Risks, Dangers and Fears Experienced while Performing Service Calls.

Hello, I am Minette Beukes, a student at the Centre of Criminology at the University of Cape Town, and I am doing my MPhil degree in Criminology, Law and Society. I am conducting research on the Metro EMS ambulance personnel in Cape Town towards the completion of my degree under the supervision of Professor Kelley Moult.

The purpose of the research is to explore the Metro EMS ambulance personnel's experiences of risk, danger and fear associated with crime while performing service calls. The proposed study will be conducted in Cape Town, and semi-structured interviews will be conducted with ambulance workers to explore these above-mentioned experiences (if any). Therefore, I would like to invite you to take part in this research project.

Before you make a decision to participate, I urge you to read the following information carefully. Please feel free to ask questions if anything you read is unclear or if you would like more information. Please note that participation is completely voluntary and that you will be subjected to no negative consequences if you choose not to participate. Additionally, if you do choose to participate, but wish to withdraw during any phase of the study, you are free to do so without any negative consequences. I would appreciate, however, your assistance by allowing me to conduct an interview with you.

This study is qualitative in nature; therefore, one interview will be conducted in either English or Afrikaans (or in any language you are most comfortable with) via either an online platform of your choosing, or in person. Thus, in order to participate, you should have access to a device (smart phone/laptop/tablet). If you do not have access to such a device, please contact me (contact details provided below) to make an alternative arrangement. The alternative arrangements will include either a phone call interview or an in-person interview (based on strict Covid-19 protocols). You will be provided with a data bundle if need be, which should suffice for the duration of the interview, as well as for the downloading of the relevant application. Each interview will last for about an hour (it may be longer depending on connectivity issues or conversational information) and should not be scheduled, if possible, while you are on duty. The purpose of the interviews will be to provide you with the opportunity

to share your experiences (if any) of the risks, dangers and fears associated with crime while performing service calls in Cape Town. Your permission to voice record the interview will be requested in the consent form. Please note that you are allowed to refuse the voice recording, however, you can be assured that the information you provide will be protected throughout the research process. The recording of the interview will solely be used to accurately transcribe the information during the data processing phase of the study.

You will be granted the opportunity to read through your transcribed interview so as to confirm the accuracy of the interview record. You will be provided with a specific code, for example 'P1', in order to ensure that your anonymity and confidentiality is guaranteed. Therefore, each file (containing the consent form, voice recording, interview transcript, analysed data, the draft theses or final thesis) will be named according to the division that you are employed in, as well as the code you were given, for example 'Northern; P1'. None of the relevant documents will contain your own name, only the code you have been given. Additionally, each protected file will be stored (and backed-up) on a secure external hard drive and Dropbox. The audio recordings will be (anonymously) stored for a year starting from the day it has been recorded. After the submission of the dissertation, the audio recordings will be destroyed.

This study does not provide for any direct benefit to you as the participant. Nevertheless, it may enhance both your and the researcher's knowledge on the subject. Moreover, the research may provide you with the opportunity to share your personal experiences and stories, which have not been possible in a formal South African qualitative research setting before. Your input will enable the researcher to present the findings to your employing organization, which will be pertinent to the training and support services provided to ambulance workers.

You should understand that there are some risks involved by participating in this study. as you will be asked questions about your experiences of risk, danger and fear associated with crime while performing service calls, it may be possible that you experience psychological distress during the interview. Therefore, please note that each *permanently* employed EMS worker has access to the Employee Health and Wellness Programme (EHWP) offered free by the Western Cape Department of Health. The EWHP programme offers confidential services such as counselling (face to face or telephone) and medical services provided by trained health professionals. Permanent Metro EMS employees can access this service through the use of the following toll-free number: 0800 611 093. A EWHP informative booklet is attached to this information sheet. All public Emergency Care volunteers are able to access group debriefing

sessions offered by the Western Cape Government Department of Health. This can be arranged if need be.

The data gathered from each of the interviews will be thematically analysed and a thesis will be completed for the requirements of the degree MPhil in Criminology Law and Society. Sections of the research might be published in a reputable academic journal.

'If you have concerns about the research, its risks and benefits or about your rights as a research participant in this study, you may contact the Law Faculty Research Ethics Committee Administrator, Ms Lamize Viljoen, at 021 650 3080 or at lamize.viljoen@uct.ac.za. Alternatively, you may write to the Law Faculty Research Ethics Committee Administrator, Room 6.29, Kramer Law Building, Law Faculty, UCT, Private Bag, Rondebosch 7701.'

Researcher (Minette Beukes) contact details: 071 104 8746 or beukesminette@gmail.com

_____ _____

Signature of Researcher Information Sheet Dated

Appendix G: Informed Consent Form

CONSENT FORM: CAPE TOWN METRO EMS AMBULANCE PERSONNEL.

Cape Town Metro Ems Ambulance Personnel and Crime: Exploring the Risks, Dangers and Fears Experienced while Performing Service Calls.

Dear Participant,

Please read through the following information and **tick either YES or NO**:

	YES	**NO**
I hereby confirm that I have read and understood the information about the research project provided to me in the information sheet		
I hereby confirm that I have been given the opportunity to ask questions and that these questions were answered to my satisfaction		
I understand that my participation is completely voluntary and that I am free to withdraw from this project at any time, without any negative consequences		
I hereby confirm that I have been made aware of and provided with information pertaining to support services that will be available to me in the case of distress		
I hereby agree to having the online interview voice recorded		
I hereby agree to participate in this research project		
I have received a copy of this consent form		

Please note: By signing this form, you consent to participate in this research project.

Signature of Interviewee

_____ _____

Signature of Participant **Date**

Signature of Interviewer

_____ _____

Signature of Researcher **Date**

Appendix H: Transcription Feedback Letter

INTERVIEW TRANSCRIPTION: OPPORTUNITY FOR COMMENT/FEEDBACK

Dear Participant,

You kindly consented to participate in my research project entitled *'Cape Town EMS Ambulance Personnel and Crime: Exploring the Experiences of Risk, Danger and Fear while Performing Service Calls'*, conducted under the supervision of Professor Kelley Moult from the Department of Criminology, Law and Society at the University of Cape Town.

The interview was conducted on [**add date and platform here**].

The informed consent form that you signed on [add date here] stated that "You will be granted with the opportunity to read through your transcribed interview so as to confirm the accuracy of the interview record". I would therefore like to give you the opportunity to do so at this time.

Please send any comments or feedback you might have before or on [**add date here**] to the following email address: beukesminette@gmail.com

If you do not have access to email, please feel free to contact (via SMS, phone call or WhatsApp) me at the following number for us to make alternative arrangements: 071 104 8746.

I would once again like to assure you that your anonymity and confidentiality will be protected throughout the research process.

I want to thank you again for granting me with the opportunity to conduct an interview with you. I appreciate that you shared your experiences with me. It was an honour to be a part of the reality of your world for a brief moment.

Kind regards,
Minette Beukes
071 104 8746