**The impact of blame culture on paramedic practice**

**A qualitative study exploring English and Finnish paramedic perceptions**

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**Abstract**

**Purpose** – The purpose of this paper is to explore English and Finnish paramedic perceptions of the healthcare blame culture, its relationship to complaints, the use of defensive practice and if this impacts on paramedic practice and clinical care.

**Design/methodology/approach** – Participants were recruited from English and Finnish ambulance services that have similar organisational and professional scopes of practice. The aim was to gain insight into the similarities and differences between the countries regarding the existence of a blame culture in paramedic practice. Semi-structured focus groups and interviews involving 20 English and Finnish paramedics were undertaken. Qualitative perceptions concerning the reality of a blame culture in paramedic practice and its impact on professional roles were sought.

**Findings** – Three major themes that were identified in the thematic analysis included: blame culture and its influences; the impact of complaints against paramedics; and the use of defensive practice within their roles. These data themes were similar for both groups of participants. The majority of participants thought the healthcare blame culture to be widespread and believed that this was likely to directly influence paramedics’ working practices.

**Originality/value** – Whilst the impact of blame culture and complaints on the medical profession has previously been examined, this study makes an important contribution by exploring the factors that impact on paramedics’ lives and their practice, within two European countries. The inappropriate use of social media by some members of the public in both countries was a disturbing issue for many participants and was identified as an area for further research.

**Keywords** Blame, Litigation, Defensive practice, Emergency ambulance systems, Paramedic, Pre-hospital

**Paper type** Research paper

**Introduction**

A blame culture is characterised by an unwillingness to accept responsibility for mistakes due to a fear of criticism or prosecution (Walton, 2006; Harris and White, 2013). Indeed, Furedi and Bristow (2012, p. 14) found, “there are no such things as accidents, it has to be someone’s fault and someone has to pay”. Litigation claims against the National Health Service (NHS) in the UK have increased year on year over the past two decades (Dobbie and Cooke, 2008). Written complaints against ambulance services in England have also risen by 28.5 per cent in 2013/2014 compared to 2012/2013. As of March 2011, the NHS Litigation Authority (NHSLA) estimated its potential liabilities at £16.8 billion, of which £16.6 billion relate to clinical negligence claims (Furedi and Bristow, 2012). Despite annual increases over recent years the 2015/2016 NHSLA annual report revealed that clinical negligence claims had reduced by 4.6 per cent from the previous year. However, damages paid to patients continue to rise with a 23 per cent increase in 2015/2016 from the previous year...
(National Health Service Litigation Authority, 2016). Indeed, it is reported that there is now a significant “blame culture” in the UK with the public being far less tolerant of mistakes (Dobbie and Cooke, 2008). The general public are exposed to an over-abundance of companies promoting the common “no win no fee” mantra and encouraging members of the public to claim for an accident or even perceived medical negligence (Furedi and Brown, 1999). Waring (2005) identified that the rise in the culture of blame has had a major impact on the medical profession resulting in a significant fear of litigation amongst doctors, affecting their practice, making it defensive and resulting in an under-reporting of clinical incidents due to fear of reprisal. This is further highlighted by Marienisis (2013) who suggested that the fear of litigation in the emergency medical profession leads to defensive practice and possibly influences overcrowding in emergency departments in the USA, thus highlighting the fear of litigation as an international concern amongst the medical professions. This can be damaging to healthcare professionals; “[The fear of litigation] erodes professional autonomy, stifles innovation, leads to defensive practices, and encourages greater bureaucracy. ‘Best practice’ is now defined as having checked all the boxes in a quality assurance form rather than doing what is best for the patient” (Furedi and Bristow, 2012, p. 6). Catino (2009) suggested that this defensive practice approach may pose a risk to patients when interventions and treatments are undertaken without necessarily being required. This is further explored by Furedi and Bristow (2012) who claim that defensive practice whereby clinicians will treat a patient, not because it is the right specific treatment for them, but to avoid complaint and potential litigation is on the rise. Clinicians have reported incidences of “over-referral, over-investigation and over-treatment” to avoid complaints but which are not necessarily in the best interests of patient care or the most cost-effective method (Furedi and Bristow, 2012, p. 19).

The position in Finland is different. Whilst numbers of complaints in Finland have increased between 1993 and 2012, the comparable numbers of complaints to the overall number of annual healthcare patients receiving care are small (Mäkelä, 2015). Between 2010 and 2015, there was an average of 59 official complaints per year, with the years 2014 and 2015 receiving 90 and 83, respectively (National Supervisory Authority for Welfare and Health (Valvira), 2016). There is limited evidence of a “complaint culture” within Finland. Nevertheless, Mäkelä (2015) highlighted that similarly to the UK the number of patient complaints is increasing.

**Contextual background**

Historically UK paramedics were trained to assess and manage a range of medical and trauma conditions and transfer patients to the nearest emergency department (Brady, 2014). Education and training was delivered by individual NHS ambulance trusts and the paramedic qualification accredited by the Institute of Health and Care Development. Paramedics became a registered profession with the now Health and Care Professions Council (HCPC) in 2000. Education and training was traditionally focussed on managing acute life threatening conditions, however, pre-hospital care is now changing (Wankhade and Mackway-Jones, 2015). Over the last 16 years, the changes in health and social care in the UK have seen the evolution of the paramedic. The UK ambulance service now has a much wider role with paramedics managing a broader range of complex health needs (Association of Ambulance Chief Executives (AACE), 2011). Despite this, the ambulance service is still seen as the “gateway” to the NHS (Wankhade and Mackway-Jones, 2015).

Higher education for paramedics is now considered central to achieving a modernised UK ambulance workforce (Lovegrove and Davis, 2013) that is able to provide a greater range of mobile urgent care and clinical advice, as initially envisaged in the ambulance review “Taking Healthcare to the Patient” (Department of Health, 2005). The move to an all-graduate entry to the register for the paramedic profession in the UK has been gathering
momentum over a number of years, with the majority of the accredited universities now
delivering HCPC approved BSc (Hons) programmes, an approach being driven forward by
the professional body, the College of Paramedics (2015).

In Finland, the introduction of paramedic training occurred in 1998 and is undertaken in
higher education institutions (Jormakka and Saikko, 2015). This reflects the need for a more
specialised clinician in clinical practice. The degree-level training is similar to the UK,
however, it involves a four-year dual role programme, comprising both nursing and
paramedic education (Jormakka and Saikko, 2015). Nevertheless, the undergraduate course
content, structure, skill set and knowledge are all similar to the UK, with a focus on
assessment, treatment and referral as clinicians directly refer patients to operating theatres
and intensive care, bypassing the emergency department (Jormakka and Saikko, 2015).

There are different clinical roles within the ambulance service in Finland, with first
responders, basic and advanced-level paramedics, and in some areas a medical unit.
The first response unit is not an ambulance crew or a paramedic but some other unit of
medical services (e.g. volunteer fire brigade) (Castrén et al., 2012). Basic-level paramedics
are educated and trained to assist with basic levels of care. Advanced-level paramedics are
required to have a Bachelor-level degree and therefore have a greater depth of knowledge,
skill set and clinical expertise (Castrén et al., 2012).

Every hospital district in Finland has a team of field managers who provide 24-hour
support. Field managers work under the auspices of an emergency department medical
doctor who answers to the whole emergency medical service (Statute of Emergency Medical
Service of Ministry of Social Affairs and Health, 2011). Field managers are advanced-level
paramedics, which allow them to be an additional support to other paramedic units. Field
managers can help the Emergency Response Centre in periods of high demand by
prioritising and redirecting incidents to other units (Castrén et al., 2012). When the public
call for help (112), the Public-Safety Answering Point categorises and prioritises the calls
and dispatches the appropriate level of response (Määttä, 2015). Due to the geographic area,
many paramedics travel long distances with patients, or offer advice to patients to seek
self-care, or even advise patients to make their own way to hospital, following their clinical
assessment. Paramedics have the ability to consult with on call ambulance service doctors
for medical oversight.

In 2016, the Finnish Ministry of Social Affairs and Health published a report in which
they examined nationwide emergency medical services (Ilkka et al., 2016, p. 40). In 2014,
there were almost 900,000 medical emergency responses, of which 66.6 per cent were lower
risk or non-life threatening incidents (36.9 per cent category C and 29.7 per cent category D
incidents, respectively). In Finland, many patients are treated and left at home or at the
scene. When a patient is left at home/scene or they are transported by other means than
ambulance, they are categorised into X-codes (National Supervisory Authority for Welfare
and Health (Valvira), 2014). This categorisation is undertaken by healthcare professionals
following national and regional guidelines. Ilkka et al. (2016) highlighted that patients who
are categorised with X-codes have been gradually rising. Use of X-codes between 2010 and
2015 has risen almost 15 per cent. More importantly, the X-8 calls, where a patient is treated
at the scene and did not require to go into any medical facility after the call, have risen
almost 5 per cent. This is due to the enhancement and development in the home-based
services that paramedics provide after consultation with a doctor.

The literature reveals little evidence concerning paramedics’ fears and perceptions of
clinically related litigation, and none of these compare the situation in other countries.
One recent study by Van der Gaag et al. (2017) explored reasons behind the significantly
high proportion of complaints received about UK paramedics that highlighted
some fear of the regulatory body and pressures of the role, but not the overall fear of
receiving a complaint. In Finland, there is a growing demand on ambulance services
resulting in increased stress levels amongst personnel (Jormakka and Saikko, 2015). The unprecedented demand on paramedics in both the UK and Finland has seen many leaving the profession due to the resulting pressures. Indeed, it is widely reported that staff morale within UK ambulance services is not just low, but the lowest amongst all healthcare professionals (AACE, 2011).

There is a paucity of research into how paramedics feel about the ever increasing blame culture and its impact on their professional roles. This study aims to identify if such a fear exists, the comparisons with different cultures, health systems and socio-economic environments in other international services, and if this has an effect on clinical practice.

Aim
The background literature and the scarcity of studies in the subject area gave the impetus for a study which had the aim of exploring English and Finnish paramedic perceptions of the healthcare blame culture, its relationship to complaints, the use of defensive practice and if this impacts upon clinical care.

Methods
Theoretical framework
A qualitative study was undertaken that was influenced by the research traditions inherent in phenomenology and it focused on the subjective analysis of human experiences (Denzin and Lincoln, 2011).

Recruitment
Participants were recruited from both an English and Finnish service that had comparable structures, organisations and clinical scopes of emergency medical practice. Participants were chosen from England and Finland as the organisational design and scope of clinical practice are very similar, more so than between other European nations. Whilst there is a clear population difference between the two countries, the region chosen within the UK has a similar overall population to that of Finland. The data were collected between November 2015 and April 2016. Participants were recruited on a convenience sampling basis by responding to an advert posted within each service. The inclusion criteria required participants to be a paramedic of any grade, with a minimum six month’s operational experience. Participants were also required to have regular face-to-face or phone contact with patients.

Data collection
Data collection took place in the university settings of both countries. All the Finnish participants spoke fluent English, although a Finnish University lecturer was on hand to translate if needed. The focus groups and interviews were conducted by the first two authors, who are male university academics with expertise in paramedic practice and research. Both have undertaken focus group and interview training. Prior to each focus group and interview, the authors/researchers introduced themselves and gave an overview of the project, their interests and reasons for the study.

Four focus groups and three individual digitally recorded telephone interviews each lasting about one hour were undertaken. Three UK participants were unable to attend the focus groups when they were scheduled but agreed to be interviewed by telephone instead.

The interview schedule consisted of a series of open-ended questions and addressed topics such as the actuality of a blame culture in paramedic practice, the extent to which defensive medicine is practised and its effect on paramedics’ clinical practice. The researchers used a set of semi-structured questions to guide each focus group,
responding to and exploring concepts as identified by the participants. The focus groups and interviews were conducted until no new or different views were expressed. Interviews took place at Edge Hill University in the UK and at Saimaa University of Applied Sciences in Finland.

**Ethics**

Ethical approval for the study was obtained by Edge Hill University and the study approved by each participating ambulance service. No specific ethical approval was required in Finland as no patients were involved. Approval for staff access was given following UK ethical approval. The relevant NHS ethics committees in England were contacted and it was confirmed it was unnecessary to gain ethics approval as the study was deemed to be practice development. All usual ethical procedures were adhered to when undertaking the study including gaining written consent from the participants.

**Data analysis**

Each focus group and the one-to-one interviews were digitally recorded and transcribed verbatim. Field notes were recorded to aid later interpretation of data. An applied thematic analysis influenced by phenomenological traditions as described by Guest et al. (2012) was employed to analyse the data. The aim was to identify reoccurring patterns or themes in the data, which give a dimension and detail through assignment of data to distinct categories. The advantage of this type of analysis is described by Davies et al. (2014) as being a flexible approach that allows for the reduction of large data sets without loss of meaning. It is also ideal, as is the case in the present study when multiple researchers are involved in data analysis.

The initial processes of analysis began with all the interview recordings being transcribed verbatim which resulted in 93 A4 sheets of data being available for analysis. The analysis strategies involved reading and re-reading the data whilst listening to the interview recordings. Illuminative, relevant and recurring patterns of responses were then identified which led to organising the data into themes and categories. The last author who is a highly experienced qualitative researcher undertook the initial analysis. Data analysis checks were then made with all members of the research team undertaking cross-sampling and verifying each others’ analysis. Finally, exemplars from the transcriptions and survey responses were used to illustrate and provide contrary opinions within each data category.

A further aim of the analysis was to identify similarities and differences between the two data sets. That is, to examine if the experiences of the English and Finnish paramedics were comparable. To this end, the Finnish and English data sets were originally analysed separately. Major themes and categories were then compared to identify where the findings proved to be alike or dissimilar.

**Results**

**Participants**

In total, 20 participants took part in the study; 11 were based in England and 9 in Finland. The Finnish participants were slightly more experienced than the English participants. For example, two-thirds (n = 6) of the Finnish participants had been paramedics for over five years, whereas not quite half of the English participants had been practising for over five years (n = 6). In all, 11 of the participants were male and 9 were female.

**Data themes**

Analysis of the data revealed the same data themes for the two data sets which were “blame culture and influences”, “complaints” and “defensive practice”. The data
categories were the same and comprised of the universality of the complaint culture, not taking responsibility for one’s actions and the roles of legal firms, the mass and social media. Details of the content of each category are given in the following sections. There were also 14 data categories. An overview of the data themes and categories is given in Table I.

**Blame culture and influences**
All participants said that the blame culture seemed to be a universal feature of many developed nations they were familiar with. Some participants also said they thought it appeared to be interrelated with the public not taking responsibility for their own health. For example, one participant said:

There’s (sic) people who don’t want to take responsibility for their children, so if a child runs out in front of a car they don’t blame the child they blame the car driver. Then if something happens to the child they try and blame us. It all goes down to litigation and looking for some form of compensation (English:4.1*) (*Focus group and transcription codes).

However, a few of the Finnish participants did feel:

We don’t have a strong blame culture here in Finland because I think people are used to believing in what nurses and doctors say. But maybe it’s coming (Finnish:1.1).

Influences on society’s present-day blame culture included the mention of such things as the role of legal firms which was prominently alluded to by the English practitioners. Many participants, whether English or Finnish, referred to the influence of social and mass media. Some reported how unnerving they found it when bystanders recorded incidents which were later posted on social media sites. For example, one interviewee said:

I think it’s sort of scary. If you attend a job that’s in a public arena there’s (sic) often people standing around with their phones filming you. Later you would see it on Facebook. You should be focusing on the patient but you want to say, “Put that phone away”. Instantly you think I am doing everything right (Finnish:3.19).

Both the Finnish and English participants found the widespread use of social media unhelpful with an English participant saying they felt the public posting events on social media websites was:

Almost like a kangaroo court where we are judged as being guilty (of neglectful care) regardless (English:7.8).

<table>
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<tr>
<th>Data theme</th>
<th>Data category</th>
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<td>Blame culture and influences</td>
<td>Universality</td>
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<td>Not taking responsibility</td>
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<td>Role of legal firms, the mass and social media</td>
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<td>Complaints</td>
<td>Types of complainants</td>
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<td>Common reasons for complaints</td>
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<td>Being involved in a complaint</td>
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<td>Impact of a complaint</td>
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Table I. Data themes and categories
Complaints

The second data theme “complaints” held several similar data categories although akin to the first data theme there were nuanced differences between the comments of the Finnish and English participants. The topic areas covered included the types of people who frequently complain, common reasons for a complaint, the impact of being involved in a complaint, complaint procedures and organisational support and prevention strategies.

Both sets of participants discussed how many complaints emanated from those considered to be serial complainers, as well as patients who are aggressive and/or drunk and patients’ relatives. For example, one participant related:

I once had a demanding relative, the son of a patient. He was very aggressive. From the beginning he said he didn’t believe we knew what we were doing. He complained but nothing came of it (Finnish:1.7).

Colleagues and other healthcare workers were also seen as frequent fault finders. For example, one participant said:

Hospital doctors sometimes go past questioning your history (of a patient’s illness). They really question your judgement. There was no official complaint but I was told (by a doctor) explicitly once that what I had done was rubbish. This was in front of the entire A&E department. I was so glad afterwards that I found out what I had done was proved to be right (English:4.4).

Another participant commented:

Having a complaint makes you feel uncertain especially if you hear the complaint is from your co-worker. I think that’s maybe the worse thing. We are not supposed to look down on each other. We’re meant to support our colleagues (Finnish:2.7).

The types of complaints described by many of the participants centred upon care not meeting up with expectations and that not automatically taking every patient to hospital often generated ill-will. For example, one participant said:

I explain we are not just drivers. I explain it’s not because we don’t want to take you but we serve the whole of the area. If we take you with your broken wrist your neighbour, mother or daughter might have a massive heart attack and die because we are taking you to hospital with something very minor. It’s very difficult getting it across (Finnish:2.6).

Being involved in a complaint was described by several of the participants as having a major impact on their lives with one participant saying:

It was probably one of the worse points in my life. It (a complaint about my practice) had a huge impact. Not just of my career. It had a huge impact on me as a person (English:3.6).

Similarly, some participants cited how they had known colleagues who had left because they were unhappy with how the paramedic culture has changed. For example, an interviewee commented that:

We’ve had a lot of older paramedics leave, partly due to the amount of complaints coming in and partly because the way the job has changed (Finnish:6.5).

Both the English and Finnish participants described local procedures that were followed when a complaint had been registered. Understandably, these descriptions differed both between the two countries, but also between the various ambulance organisations of the two countries. Most referred to the role managers played when a complaint was initiated, with many saying that the organisational support was variable. Some described managers as being very supportive, whereas, others felt their organisation did not support staff and personnel were “guilty until proved innocent” (English:3.23). A seeming lack of organisational support was identified by both the English and Finnish participants.
Finally, many participants described some of the strategies they deployed to circumvent receiving a complaint. Some described how they tried to be compassionate and kind with one participant saying they had been told to remember:

Bad doctors get complaints and good doctors get complaints but nice doctors never do (Finnish:3.22).

Others said how it was important to be honest, with one participant identifying that:

We are only human. All humans make mistakes. (What makes the difference) is as long as you admit it. If you apologise and say you have made a mistake most people will understand (English:6.21).

**Defensive practice**
The last data theme of “defensive practice” included the topic areas of changing practice, covering your back, erring on the side of caution and experience and education.

Some participants relayed how they had changed their normal practice and “worked unnaturally” (English:5.3) to prevent a complaint. For example, one participant said:

I think I practise (defensively) all the time, whether I am leaving them at home or not. I think every time I write a patient report form. I kind of have this thing in the back of my head that thinks if somebody official like a coroner ends up reading this (English:3.3).

Similarly, several of the Finnish participants also referred to taking patients to hospital to “cover their backs” (Finnish:6.6) with one person saying:

So, I think in my head if it would only take 5 minutes to take them to hospital, it's easier and faster. But if it’s 80 kilometres away then, no I’ll just write a very good paper and explain very carefully to the patient. If I think they are going to complain I explain even more carefully (Finnish:2.4).

Erring on the side of caution was a further category of data identified with one participant describing how:

A c-spine is applied with full mobilisation when sometimes you know full well that the evidence doesn’t actually support it. It’s easing back a bit now. We are given more authority to make our own decisions but that’s a typical example (English:7.3).

However, several participants relayed how experience had impacted on their decision making, with one participant saying:

When I was newly graduated I was less brave. Some more experienced colleague would say “no, no, no there is no reason to take them to hospital”. I have learnt a lot since then (Finnish:1.9).

Finally, comments were also made in relation to the advanced training that meant paramedics, as a professional group, were now beginning to practise more autonomously “with practice less dictated by regulations and guidelines” (English:5.2).

**Discussion**
The main findings of this study revealed three major data themes “blame culture and influences” “complaints” and “defensive practice”. The definition given earlier that a blame culture is characterised by an unwillingness to take risks or accept responsibility for mistakes due to a fear of criticism or prosecution (Walton, 2006), epitomises many of the findings of this study. There were, however, some slight differences in the beliefs of the English and Finnish paramedics studied. These related mainly to the first data theme of “blame culture and influences” with the Finnish participants appearing to be more uncertain about the prevalence of a blame culture in Finland. However, the interconnections between the blame culture emanating from the readiness of many people to complain about their
treatment were comparable. Descriptions of the defensive practices deployed to avoid the possibility of litigation were very similar in both countries.

A noteworthy finding of the present study is the use of social media and its relationship with the blame culture. There are many positive uses of social media in healthcare, for example, the General Medical Council (2013) described how social media can be used to engage people in public health and policy discussions, or to help establish professional communication networks and facilitate the widespread dissemination of medical information. However, whilst social media has become an integral part of healthcare there remains problems associated with its use. Indeed, a recent study by Archer et al. (2014) surmises that complaints to the General Medical Council have been fuelled by the rise in use of social media. Similar to the findings of the present study, Bird (2014) described the use of social media to comment on and “rate” doctors’ performance and reported how negative reviews can be a source of much distress to those involved. Another recent study by Van der Gaag et al. (2017) further highlights that social media makes it much easier for the public to make complaints and spread bad news about their experiences with the health service.

Several studies have examined patient satisfaction with the ambulance service provision and have found largely positive patient attitudes and performance indicators both in the UK (Halter et al., 2006) and Finland (Lindström et al., 2011). Nevertheless, in the second data theme of “complaints” in the present study, there were many references to patient dissatisfaction. Some authors highlight that in many countries people are less tolerant of mistakes in healthcare provision and inadequate services (Risavi et al., 2013). Several authors report that litigation relating to healthcare provision is increasing. For example, Dobbie and Cooke (2008) undertook a descriptive review of litigation claims against the English ambulance services. Over ten years, there was a year on year increase in litigation cases, most of which concerned lack of assistance or care and a failure or delay in provision of care.

The traditional role of the paramedic was very much aligned to “treat and transfer”, with paramedics adhering to strict protocol-based care, and the emergency department to the default patient destination (O’Meara, 2009). This model was similar across the international field, not just within the UK. Following the professionalisation of the role over the past decade, paramedics are now required to make a range of complex clinical decisions, assessing, treating and transferring patients to the most appropriate care destination. Up to 30 per cent of patients who call 999 (112) in the UK are not transported to hospital (Porter et al., 2008), in contrast to Finland which has a high 60 per cent of patients not transported to hospital (Jormakka and Saikko, 2015). This change in the role and professionalisation in the UK challenges the legacy “uniform culture” whereby paramedics are now seen as autonomous practitioners who make decisions based on clinical practice guidelines and evidence-based practice, with the oversight of clinical governance and leadership structures within their employing organisation or ambulance authority (Wankhade and Mackway-Jones, 2015). The ever-expanding scope of practice is another factor challenging paramedic perceptions of their role (Lord et al., 2012), and this has brought about further pressures. Clinical governance is an umbrella term aimed at maintaining and improving high standards of patient care (Royal College of Nursing, 2017). The UK ambulance services adopted clinical performance indicators to ensure continuous improvement in patient care and safety based upon specific outcome measures (AACE, 2011). However, austerity measures with governments trying to do “more with less”, such as target-driven healthcare, increasing public expectations, managerial pressures and increasing volume of calls have all added extreme pressure onto paramedics and the traditional model of delivery (Wankhade and Mackway-Jones, 2015). There is a general feeling of lack of support from managers, creating an internalised
culture of fear, and perception that there is an historical disciplinary agenda from management (McCann et al., 2013; Van der Gaag et al., 2017). Low organisation trust, lack of support and value, and fear of repercussions add to the already heightened stresses and strains of the job (McCann et al., 2013).

In Finland, most of the official complaints are dealt with by the Regional State Administrative Agencies (AVI) (2013). The complaint will only be dealt with by the National Supervisory Authority for Welfare and Health (Valvira) if the possible malpractice has caused the death of the patient or the patient has become seriously disabled. Both supervisory agencies are governed by the Finnish Ministry of Social Affairs and Health (STM) (National Supervisory Authority for Welfare and Health (Valvira), 2017) Unofficial complaints are managed within employing organisations, all of which have different processes for dealing with complaints.

Paramedics in the UK are now being referred to the professional regulator (HCPC) for fitness to practise hearings more than any other profession, along with social work (Van der Gaag et al., 2017). There is an inherent fear of the regulatory body which is seen as “big brother” resulting in a cultural norm of fearful scaremoungering amongst staff (Van der Gaag et al., 2017). Colleagues, managers and unions are perceived as using a “big stick” approach to instil fear into staff if they do something wrong in practice (Van der Gaag et al., 2017). This culture of fear now appears significantly prevalent in UK practice. Paramedics have a fear of making errors and being “struck off” by their professional regulator if they do something wrong in practice, and many fear complaints and litigation related to their clinical practice (McCann et al., 2013; Kirk et al., 2017).

The third data theme concerned defensive practice. There were many examples given as to how the actions of several of the participants stemmed from the desire to prevent a complaint. Many of these related to the unnecessary use of the ambulance service with similar examples being given by both the English and Finnish participants. Examination of the literature gives many instances of similar concerns in other countries (Finn et al., 2013; Hjalte et al., 2007 and Kawakami et al., 2007). Several reasons were given as to why the paramedic participants acted in this way, which included that it was sometimes easier to accede to patient demands and avoid possible complaints. However, a further explanation given was that of the role that practice experience played in the decision making.

The concept of different levels of practice is described by authors such as Benner (1984) who conducted the seminal work about the progression of skills development from novice to expert and later work by authors such as Gallagher and Hoare (2016). A novice’s practice is rule governed with actions often being halting and rigid. Conversely, an expert’s performance is marked by an intuitive grasp of the situation. Reference to both these different levels of practice was identified in the data with many participants giving examples of when they began to practise as a paramedic and how they stringently adhered to policy guidelines, whereas, the more experienced the participants became the more fluid and flexible their practice. Comments made in the present study about the in-depth paramedic education programmes now undertaken, it is hoped will facilitate a more rapid transition from novice to expert proficiency.

Limitations of the study include those applicable to many qualitative studies, among which are the small sample size and the subjective nature of the findings. In the UK, there were limited participants who responded for the focus groups, so to capture the data semi-structured telephone interviews were used. This difficulty in recruitment could be due to the nature of the study, or paramedic concerns about the complaint culture and not wanting to speak up. In mitigation, the sample size attained did allow for the collection of a large amount of rich qualitative data, which at the same time remained manageable and in keeping with the resources available. Having multiple
researchers and cross-checking of their analyses also gives some reassurance to the legitimacy of the findings.

The overall topic of the study could have incurred bias, given that the researchers asked specifically about perceptions of a blame culture. However, questions were kept open initially to explore participant views and minimise potential bias. Other limitations include that there are clear geographical and population differences between the UK and Finland which could be argued do not provide a true comparison. However, the two ambulance services chosen are very similar in organisational design and set up, with a similar scope of practice for paramedics. Data obtained about Finnish complaints are scant, with the only statistics available in actual figures and not percentage differences. Whilst this can impact on the comparative nature of the study and not provide a true comparative picture, it does highlight the relative difference in numbers of complaints between the two countries.

Conclusions
This study gives several positive findings. However, it is disappointing to report that there is scant evidence of a move from a blame culture to a no blame culture in either of the countries studied. The paramedics interviewed rarely mentioned incidents of valid complaints and how they can be used as a source of service development, or what lessons institutionally had been learnt from past mistakes. It was also evident that accountability issues were of greater importance than those of improving quality and safety through adoption of a no blame culture. The influence of social media seems to be an evolving factor in paramedic practice which may lead paramedics to becoming more defensive. However, further studies on the influence of social media in paramedic practice need to be explored to determine the impact this is having on professional staff and patient care. Greater transparency from employers and the regulatory body is required so staff are more aware of the complaints process and know what happens during an investigation. Van der Gaag et al. (2017) identified that the regulatory body being seen as the “guiding uncle” as opposed to “big brother” whereby a more supportive culture occurs when complaints are made with greater emphasis on learning from an incident is required. The fear of the unknown and scaremongering within the paramedic culture appears rife and this only fuels unease and fear among paramedics. It is of paramount importance that paramedics lose this fear of management and the regulatory body. This will only come with greater transparency of the complaints procedure and supportive learning resulting from this process.

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Impact of blame culture on paramedic practice


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