

SPECIFICS OF PARAMEDIC–SERVICE MEMBER COMMUNICATIVE INTERACTION IN EMERGENCY MEDICAL CARE**Соломія Гнатишин***Тернопільський національний медичний університет імені І. Я. Горбачевського МОЗ України***СПЕЦИФІКА КОМУНІКАТИВНОЇ ВЗАЄМОДІЇ
ПАРАМЕДИКА З ВІЙСЬКОВОСЛУЖБОВЦЯМИ ПІД ЧАС НАДАННЯ
ЕКСТРЕНОЇ МЕДИЧНОЇ ДОПОМОГИ**

Abstract. This article details the specifics of paramedics' communicative activities under conditions of high stress, time deficits, and unpredictability during the pre-hospital stage and combat operations. Effective communication represents a critical element of the medical support system that directly impacts diagnostic accuracy, crew safety, and casualty survival rates. The study examines risk factors in emergency medicine, including the lack of prior contact with the patient, working on "unfamiliar territory", the presence of third parties, psychological reactions in critical conditions, and the threat of professional burnout among specialists. A classification of typical complex situations in the "paramedic – patient" system based on behavioral responses is proposed: aggressive-hostile, hysterical-demonstrative, anxious-phobic, apathetic-depressive, anosognosic, and intoxication-induced. Corresponding communication de-escalation algorithms are provided for each response type.

Significant attention is devoted to the algorithm for interacting with service members across evacuation stages, which includes safe contact establishment, verbal and non-verbal guidance during interventions, emotional stabilization, gathering a critical medical history (SAMPLE) while respecting ethical boundaries, and data handoff via standardized protocols (TCCC (Tactical Combat Casualty Care) Card, MIST). Particular consideration is given to communication characteristics with patients suffering from blast concussion, or post-traumatic stress disorder (PTSD).

To build resilient practical skills, a comprehensive training framework for paramedic students utilizing high-fidelity simulation and standardized patients is essential. Key communication barriers are identified, and practical algorithms for effective verbal and non-verbal contact are offered to enhance the quality of pre-hospital and emergency medical care.

Keywords: paramedic; emergency medical care; medical communication; service members; patient behavior; stress; tactical medicine; de-escalation; medical education; simulation training.

Анотація. У статті розкрито специфіку комунікативної діяльності парамедиків в умовах високого стресу, дефіциту часу та непередбачуваності на догоспітальному етапі та під час бойових дій. Ефективне спілкування є критичним елементом системи медичного забезпечення, який безпосередньо впливає на точність діагностики, безпеку бригади та рівень виживання поранених. Досліджено чинники ризику екстреної медицини, серед яких: відсутність попереднього контакту з пацієнтом, робота на «чужій території», присутність третіх осіб, психологічні реакції у критичному стані та загроза синдрому емоційного вигорання фахівців. Запропоновано класифікацію типових складних ситуацій у системі «парамедик – пацієнт» за поведінковими реакціями: агресивно-ворожа, істерично-демонстративна, тривожно-фобічна, апатично-депресивна, анозогностична та інтоксикаційна. Для кожного типу сформульовано відповідні алгоритми комунікативної деескалації.

Значну увагу приділено алгоритму взаємодії з військовослужбовцями на етапах евакуації, що включає: безпечне встановлення контакту, вербальний та невербальний супровід дій, емоційну стабілізацію, збір критичного анамнезу (алгоритм SAMPLE) із дотриманням етичних меж, а також передачу даних за протоколами (TCCC Card, MIST). Окремо розглянуто особливості спілкування з пацієнтами, які мають контузії чи ПТСР.

Для формування стійких практичних навичок важливою є комплексна система підготовки студентів-парамедиків за допомогою високоточної симуляції із залученням стандартизованих пацієнтів. З'ясовано основні комунікативні бар'єри та запропоновано практичні алгоритми ефективного вербального й невербального контакту для підвищення якості надання домедичної та екстреної медичної допомоги.

Ключові слова: парамедик; екстрена медична допомога; медична комунікація; військовослужбовці; поведінка пацієнта; стрес; тактична медицина; деескалація; медична освіта; симуляційне навчання.

Introduction. Paramedics operate in environments characterized by high stress, time constraints, and unpredictability. Effective communication is critical for establishing a diagnosis and delivering emergency medical care. The behavior of patients experiencing

acute distress is often atypical or destructive, giving rise to communication barriers, threatening crew safety, and compromising the quality of care.

A paramedic's communicative activity during combat operations represents a critical element of

the medical support system that directly influences wounded survival rates. Unlike civilian medicine, where communication prioritizes partnership and psychological comfort, tactical communication functions in an extreme external environment marked by acute time deficits and high levels of psychological trauma affecting both parties involved.

The aim of the article is to classify typical complex situations within the “paramedic – patient” system based on the patient’s behavioral responses and to develop effective response algorithms for medical personnel. Furthermore, it aims to substantiate and design a comprehensive training framework for paramedic students on the specifics of interacting with service members across various stages of evacuation.

Theoretical Framework. Providing emergency medical care to service members requires not only a high level of clinical skills and proficiency in protocols (TCCC/PHTLS (Prehospital Trauma Life Support)), but also specialized psychological competence. Under conditions of elevated adrenaline levels, combat exhaustion, painful shock, or psychotraumatizing factors, traditional “medic–patient” communication models often prove ineffective or even counterproductive (Zaw et al., 2026).

Service members experiencing acute stress or trauma operate in a specific mode of reality perception, where safety, chain of command, control, and trust serve as key criteria. An inappropriate tone, contradictory instructions, or a loss of control by the paramedic can trigger aggression, treatment sabotage, or disorientation in the wounded individual (Shulhai et al., 2025).

Theoretical and Methodological Foundations of Communication in Emergency Medicine. In

describing the theoretical and methodological foundations of communication in emergency medicine, primary attention must be given to the following key factors: 1) The Specifics of the Prehospital Stage: The lack of prior contact with the patient, operating on “unfamiliar territory” (e.g., the patient’s home or the street), and the presence of third parties (relatives or bystanders) create additional risk factors. 2) Patient Psychology in Critical Conditions: The impact of pain, fear of death, hypoxia, or intoxication on cognitive function and the capacity for cooperation, often leading to hyper-fixation on internal somatic sensations. 3) Paramedic Burnout Syndrome: The role of chronic stress among medical personnel in altering the perception of “difficult” patients and triggering iatrogenic conflicts.

For each identified response type, a tailored communicative response strategy (de-escalation techniques) is developed: for aggression (the “psychological aikido” technique (acknowledging the emotion without accepting the accusation), maintaining a safe physical distance, and using a calm, low-pitched voice); for panic (short, clear instructions, establishing eye contact, and employing “grounding” and controlled breathing techniques together with the patient); for denial (anosognosia) – appealing to objective facts (e.g., blood pressure or ECG readings), involving authoritative family members, and explaining potential consequences without resorting to intimidation.

If a patient’s behavior directly threatens the safety of the medical crew (e.g., acute psychosis, presence of weapons), the paramedic has the right to retreat to a safe location and request police assistance, as personal safety remains Priority № 1 (Banerjee et al., 2017).

Table 1

Classification of Complex Situations Based on Patient Behavioral Responses

Patient Behavioral Response Type	Behavioral Description	Primary Risk to Interaction
Aggressive-hostile	Verbal and physical aggression, threats, accusing medical staff of incompetence	Threat to paramedic safety, refusal of examination, physical resistance to medical procedures
Hysterical-demonstrative	Hyperbolization of symptoms, screaming, crying, demanding “exclusive” attention, theatrical behavior	Distortion of the clinical presentation, wasted time on calming the patient, distraction from life-threatening conditions
Anxious-phobic	Panic attacks, obsessive fear of death/disability, constant repetitive questions, distrust	Psychosomatic worsening of vital signs (tachycardia, tachypnea), inability to follow instructions
Apathetic-depressive	Complete indifference to their state, refusal to answer questions, suicidal ideation or hints	Concealment of critical symptoms, refusal of hospitalization (treatment sabotage)
Anosognosic (denial)	Categorical denial of illness (“I’m healthy, leave me alone”) despite overt signs of myocardial infarction or stroke	Loss of the “golden hour” for medical intervention, legal issues surrounding refusal of care
Intoxicated	Behavior under the influence of alcohol/drugs: erratic behavior, euphoria, sudden mood swings	Unpredictability, inability to take medical history, high risk of occult trauma

It should be noted that the communication algorithm between a paramedic and a service member is built on clarity, predictability, and respect for personal boundaries under stress.

Step 1. Safe Establishment of Contact.

- Visual Contact: Approach within the casualty's line of sight, avoiding sudden movements from behind.

- Self-Introduction: Briefly and confidently state your name, role, and intent: "I am medic/paramedic [Name]. I am here to help you".

- Orientation Assessment: Ask for the patient's call sign or name to establish rapport and evaluate mental status: "How should I address you?"

Step 2. Verbal Accompaniment of Actions (Prior Warning).

- Announcing Manipulations: Explain every action before performing it, particularly when removing gear or cutting clothing: "I am going to cut your sleeve now to inspect your arm. It will feel cold/painful".

- Obtaining Consent: Whenever possible, request permission before examining sensitive areas: "I need to examine the area below your pelvis. Starting examination now".

- Feedback: Clearly acknowledge reactions: "I see that it hurts, try to hang in there, I am doing only what is necessary".

Step 3. Emotional Stabilization and De-escalation.

- Tone of Voice: Speak in a calm, steady, and confident tone. Avoid shouting, panicked expressions, or raised pitch.

- Directive and Concise Phrasing: Use simple sentences without ambiguity: "Look at me. Breathe through your nose. You are safe, we are moving to the vehicle".

- Grounding: Apply basic grounding techniques in the presence of panic: "Feel the ground beneath your feet. Squeeze my hand".

Step 4. Critical History Taking.

- Clear Questions: Ask exclusively about relevant medical facts (using the SAMPLE protocol): "Where exactly does it hurt?", "Is anything else bothering you?", "Do you have any drug allergies?", "When did you last eat or drink?"

- Prohibited Topics: It is strictly forbidden to ask about the course of the battle, casualties among comrades, locations, or to critique command decisions (Butler et al., 2007).

Step 5. Information Transfer and Evacuation.

- Data Documentation: Record all findings regarding condition, administered medications, and applied tourniquets on the Casualty Care Card (TCCC Card).

- Briefing Before Transport: Inform the patient of the immediate next steps: "We are loading you into the vehicle now. The drive will take 10 minutes, and a medical team is waiting there" (Hnatyshyn, 2025).

Particular attention is drawn to non-verbal communication. First, this concerns eye contact. Establishing and maintaining "eye-to-eye" contact helps to ground the patient and bring them back to reality. Second, physical contact plays a significant role. A firm yet gentle touch on the shoulder or arm (provided there are no injuries in that area) signals control and support. Third, attention should be paid to the handling of weapons and equipment. Psychologists advise against disarming a service member abruptly or without prior notice. If it becomes necessary to disarm the wounded individual for safety reasons, this should be done calmly with a clear explanation: "I am taking your weapon and handing it over to your commander / safely storing it in the vehicle".

High-fidelity simulation utilizing standardized patients (actors or veterans with combat experience) demonstrates the highest efficacy in skill acquisition.

To enhance and master communication skills, we propose a structured model for simulation-based training: briefing (Familiarization with the tactical situation, time constraints, and communication equipment. Building readiness to operate under conditions of unpredictability); active Simulation (Scenario execution (e.g., evacuation from a combat zone). Practicing verbal commands and applying protocols under high-noise conditions); debriefing (video analysis, discussion of the emotional state of both the patient and the student using standardized formats [Hnatyshyn et al., 2026]. Error analysis and self-reflection on verbal behavior); performance Indicators and Assessment Methods (OSCE) (to evaluate skill acquisition, incorporating a dedicated checklist station, "Tactical Communication and Casualty Handoff", into the Objective Structured Clinical Examination (OSCE) framework is proposed).

Example Assessment Criteria (OSCE Checklist): Initial Contact Establishment (0–2 points): Clear self-introduction, command voice, establishing visual and physical contact; Assessment of Consciousness and Psychogenic State (0–2 points): Determining condition via the AVPU scale, rapid orientation in cases of combat shock or aggression; Application of Grounding Techniques (0–2 points): Short imperative phrasing without negative constraints (e.g., using "Look at me, breathe" instead of "Don't panic"); Reporting via the MIST Protocol (0–4 points): Sequential, concise, and accurate handoff of data during casualty transfer, without omitting critical details such as tourniquet application times.

Post-traumatic stress disorder (PTSD) is a chronic mental health condition that can develop following a traumatic event. Approximately 8 % of men and 20 % of women who have experienced traumatic events suffer from PTSD. Left unaddressed, it can

lead to the breakdown of relationships, employment, physical health, or even result in the loss of life. However, PTSD can be overcome or effectively managed (Banerjee et al., 2017).

Many service members suffer from acute acoustic trauma (blast injuries) or PTSD. Medical personnel must account for hearing impairments and cognitive deficits: speak clearly, loudly enough (without shouting), and at a measured pace. If the patient asks for repetition or loses focus, calmly repeat the information. Visualize information: because stress or concussion can impair attention span, duplicate critical instructions in writing (e.g., medication schedules, follow-up appointment times) using clear handwriting or printed text. Response to triggers or flashbacks: if a patient suddenly freezes, begins breathing heavily, or panics in response to a sound or word, reduce the intensity of interaction, offer water, and assist them in returning to reality (Fedchyshyn et al., 2025).

Conclusions. A paramedic's operational effectiveness depends not only on clinical skills but also on their level of communicative competence and stress resilience. A patient's behavioral response to illness or injury is dynamic and can shift under the influence of medications or psychological support. Regular simulation-based training in communication skills – focusing on conflict de-escalation and

managing acute stress – must be implemented for both paramedic students and practicing emergency medical teams.

Paramedic communication with service members during combat operations constitutes a specialized psychophysiological methodology. Successful interaction is achieved by combining strict adherence to international protocols with proficiency in short directive suggestion and psychological de-escalation techniques. Training in tactical communication elements should be a mandatory component of medical personnel preparation for operations in armed conflict environments.

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