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“SAVING LIVES; LIVING THE DREAM”: GENDER AND EMOTIONAL LABOR AMONG AMBULANCE-BASED 911 PARAMEDICS

A dissertation submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

SOCIOLOGY

by

Megan B. McNamara

June 2016

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ABSTRACT: “SAVING LIVES; LIVING THE DREAM”: EMOTIONAL LABOR AND GENDER PERFORMANCE AMONG AMBULANCE-BASED 911 PARAMEDICS

by Megan B. McNamara

This project examines intersections of work, gender, and emotional labor among paramedics in Emergency Medical Services (EMS). Ethnographic research on gender and work analyzes labor through pre-gendered lenses: occupations are either masculinized or feminized, and the people who work those jobs are either in gender-matched occupations, or they are crossing over into occupations that have not traditionally been associated with their gender. EMS is a unique case in which workers are required to perform both masculinized and feminized labor in the context of the same job. Furthermore, EMS is relatively gender-integrated, which allows us to see how women and men engage emergency work/masculinity and care work/femininity in a single occupational setting.

I investigate paramedics’ emotional labor and gender performance on the job using interviews, participant observation, and auto-ethnography conducted over eighteen months that I spent working as a paramedic on a 911 ambulance. Where labor process workplace ethnographies focus on workers’ experiences on the shop
floor, I argue that we must move into paramedics’ break room time and off-duty time when analyzing their social reproduction and commitment to EMS. I identify key challenges relating to their dignity and posit specific forms of emotional labor that neutralize those challenges while shoring up paramedics’ identities as “heroic.”

I begin “on the shop floor” – on 911 calls – and expand my focus outward to encompass increasingly wider units of analysis. First, I set the context with a comprehensive survey of EMS and ambulance-based paramedics’ working conditions within the industry. Next, I explore the emotion work that paramedics deploy to protect their patients from stressful information. I then interpret the ways in which break room conversations allow medics to process emotionally challenging calls, vent anger over being “abused” by the public, and engage in intimacy-building practices that prepare them to work cooperatively in high-stress emergency situations. In the final section, I explore the retroactive emotion work that paramedics perform on themselves to return to work each day with their dignity intact. The conclusion includes a refashioned understanding of heroism incorporating both physical and emotional risk-taking.
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To Steve McKay: I am a different scholar, worker, writer, teacher, and activist for having spent the last 8 years learning from you. I count myself exceptionally lucky to have benefited from your mentorship. Thank you for pushing me to think harder, for being patient when I did not produce anything for long periods of time, and for always continuing to believe that I could. Your confidence in me was the bridge I needed to grow my own.

CHAPTER 1: INTRODUCTION

One thing that fucks me up more than anything else, like with a sudden traumatic code or an accident or something, is when we get called in the middle of lunch, and I think, like, when I ordered this sandwich, that person was driving down the road listening to their music and everything was fine. Now it’s ten minutes later and I’m trying to cram this sandwich into my mouth on the way to the call, but they’re dead. And I know they’re dead, but their dog doesn’t even know that they’re not coming home tonight. It trips me out... just knowing how fast life can disappear. It’s amazing.

- Sean, 35

Sean is a typical paramedic. He loves some parts of his job and resents other parts. He takes pride in his work, despite being poorly paid compared to his colleagues on the fire department and in hospital emergency departments. He has worked on an ambulance medic for thirteen years – longer than most medics will stay “on the bus,” but far short of the two or three decades that a small percentage of his older colleagues have clocked. Unlike the characters in television depictions of Emergency Medical Services workers, Sean does not spend his workdays responding to calls as dramatic – and traumatic – as the one he describes in the quote above. He spends a lot of time doing paperwork, running non-emergent calls, trading friendly insults with his co-workers, and taking advantage of the occasional opportunity to nap before a busy
night. Sean puts his physical and mental health at risk every day that he comes to work, yet he feels that he enjoys less social prestige than firefighters who run far fewer calls but benefit from higher pay and a full public retirement. Sean’s wages in EMS support his feeling that he is not paid as much as comparable jobs in emergency services: the national wage median for paramedics was $780/week in 2012 (as compared to firefighting at $1068/week or nursing at $1097/week). Despite his desire for better pay and more respect, though, Sean isn’t planning to leave the industry. He sees himself as an emergency worker, and is proud of what he does.

Sean’s understanding of his work mirrors that of his coworkers. Like most paramedics, he tends to place more emphasis on the “emergency” part of the job than on the “caring” part. Many other jobs fall into straightforward occupational categories: nursing is “care” work, for example, while firefighting is “emergency” work. We understand those categories as natural binaries. But what happens when we look at an occupation whose categorization is more ambiguous? EMS workers perform both care work and emergency work. What are we to make of paramedics like Sean who face a paradox in that they perform different kinds of work in the
course of doing a single job? Exploring this tension can help us tell a more nuanced story about gender and work.

In this project, I use Emergency Medical Services (EMS) work as a means of understanding how work is gendered. My first puzzle addresses the question of what happens when we move beyond gender binaries in the study of gender and work. The Sociology of Work and the Sociology of Gender tend to set up both work and gender as binaries. Jobs are either “men’s work” or “women’s work;” the labor they entail is thus “feminized” or masculinized.” This is fine for jobs that are defined by extreme gender segregation, but it is less useful for jobs that have both feminine and masculine characteristics, or that fall somewhere on a spectrum. Instead of looking at women’s and men’s jobs, then, we need to look at gender more generally. How do people do gender at work when their work mixes traditionally feminine and masculine kinds of work, and when the workforce is more gender-integrated? How do paramedics, who seem to do both care work and emergency work, help us understand the masculine and feminine gendering of work more generally? EMS complicates notions of both gender and work because it cannot be categorized in accordance with familiar binaries. An analysis of gender – rather than femininity/masculinity – can
give us insights into other areas of Sociology where gender binaries place limits on our analysis.

My second puzzle involves emotions, gender, and work. Emotion work (or “emotional labor”) is the work that a worker performs on her own emotions for the purpose of managing the customer’s or client’s emotions (Hochschild 2003). Emotion work falls victim to the gender binary when we fail to talk about the emotional labor that results from the gendering of jobs. Here, too, EMS work provides a useful case study because it has masculine and feminine qualities, each of which requires specific kinds of emotional labor. EMS thus complicates the question of emotional labor by showing how gendered subjects perform a range of tasks that are gendered in markedly different ways within a single occupation.

My third puzzle is the question of how social reproduction, commitment, and emotional labor intersect. In Sociology, “social reproduction” refers to the social conditions that make it possible for workers to return to work each day (Marx 1978; Vogel 2014; Federici 2008). Social reproduction is the process through which a worker’s basic needs are met: in order to show up for work each day, workers must ensure that they and their dependents are fed, clothed, and housed. However, social
reproduction is not limited to the domestic labor that reproduces a worker’s physical capacity for labor. Social reproduction also includes less tangible exigencies like “commitment.” When we analyze workers’ commitment, we are asking why they keep coming back to work (Hodson and Sullivan 2002; Lincoln and Kalleberg 1990; Becker 1960). Hence, the question of social reproduction asks what enables workers to come to work each day, while the question of commitment asks what motivates workers to return to work each day. Conversations in different fields of Sociology do not always happen in the same “room,” so to speak. The Sociology of Work looks at commitment and gender, but not always connected to emotions; the Sociology of Emotions looks at gender, but not always connected to work. Emotional labor helps solve the puzzle around commitment and gendered work; and since EMS is a case where some of the emotional labor of social reproduction takes place away the factory floor, EMS helps solve the puzzle brought about by the juxtaposition of commitment, gender, and work.

The aim of my project is to create a more nuanced analysis of emotional labor by intersecting two frameworks: (1) emotional labor in an occupation where women and men workers simultaneously negotiate and perform the interplay of masculinities
(emergency work) and femininities (care work) and (2) social reproduction in an occupation where a significant component of workers’ off-the-shop-floor reproduction is explicitly emotional. Drawing on my empirical findings as evidence, I will argue that (1) women and men actually navigate EMS work in surprisingly similar ways, which suggests that the overall emotional culture of EMS has successfully integrated both “feminized” and “masculinized” forms of labor into a tense yet stable occupational hybrid of gender performance; (2) the social reproduction of EMS workers requires specific, ongoing emotional practices that take place on – and beyond – the shop floor, and (3) the idea of heroism as a specifically physical practice highlights some of the mechanisms through which work performed by women is afforded less social prestige than the same work performed by men. I will conclude by proposing a new framework for understanding heroism and suggest some ways that it can help us evaluate care work, reconsider what we mean when we talk about “feminized” labor, and serve as linguistic tool in the larger struggle for gender equality.
EMS: A UNIQUE CASE STUDY FOR GENDER AND WORK

EMS offers unique opportunities to scholars of gender and work because it allows us to control for the confounding factors that typically make a cross-gender occupational analysis difficult. For example, gender-based inequalities in pay are virtually non-existent in unionized EMS. 37% of paramedics work in union shops, and women – who account for approximately 27% of licensed paramedics in the United States – enjoy significant pay raises and promotional protections in an industry that is gender-integrated to a much greater extent than many other historically “men’s” occupations such as construction and trial law (Chapman et al. 2008; Pierce 1995; Paap 2006). Advancement in unionized ambulance-based EMS is also highly regimented; salary increases are based on years of service, and aside from promotions into field supervision and management (neither of which hold appeal to many field medics), there isn’t any kind of occupational “destination” that extends beyond the ambulance itself. Ambulance delivery of emergency medical care is essentially a dead-end position. With labor contracts preventing unequal compensation, unionized ambulance-based EMS is progressive in terms of pay for a mixed-gender workplace. Emergency Medical Services is also a profession uniquely suited to the task of
dealing with subtleties because it involves parallel extremes: women doing “men’s” work (rescue/emergency work) and men doing “women’s” work (care work; emotional work). Even more usefully, it incorporates them on the same job in a ready-made intersection.

Expanding the lens to include emotion work, EMS is also a useful case because of the occupation’s unique emotional culture. There are aspects of EMS work that are rewarding and other aspects that are thankless – even demoralizing. Highlighting these contradictions and the tension they engender can help us understand medics’ commitment to their job. Paramedics risk both their physical and emotional safety in the course of doing their work, and their emotional culture determines how they interpret that risk. In her ethnography of mountain search and rescue teams, Jennifer Lois notes, “Small groups…may construct emotional cultures by developing norms and vocabularies to express and reinforce their beliefs about particular emotions” (Lois 2003: 11-12). Paramedics, like search and rescue teams, also share a set of specific meanings related to the expression and interpretation of emotions in high-stress situations: they share an emotional culture. Unlike Lois’s subjects, however, paramedics are usually not volunteers (Chapman et al. 2008). The
fact that EMS work is a job means that we must intersect any analysis of its emotional culture with an examination of the labor process in paid professions; indeed, its emotional culture both builds and reflects on workers’ commitment to the occupation – a topic to which I will return at several points in this project.

The emotional culture of paid paramedicine is gendered in different ways from the emotional culture of volunteers because it is mediated through the wage form. It is also distinct from the emotional culture of paid emergency work such as law enforcement and firefighting because it entails a combination of emergency work and care work. Emergency work is gendered as “masculine” (Desmond 2007) while care work is devalued on the basis of its association with femininity (Glenn 2010). Emergency work is culturally defined as heroic; an act is heroic when it goes “above and beyond the call of duty” (Goode 1978; Edelstein 1996). The literature consistently identifies heroism as an exclusively physical feat. EMS holds care work and emergency work in a state of constant tension. The contradiction refashions broader definitions of gendered labor like heroism and emotional vulnerability, and the visibility of this tension contributes to EMS’s usefulness as a way to understand work and gender.
REVIEW OF LITERATURE

Labor Process Theories In Pre- And Post-Industrial Capitalism

Work has been at the center of sociological inquiry for nearly the entirety of sociology’s existence as a discipline. Karl Marx (1978), Emile Durkheim (1985), and Max Weber (1920) analyzed work extensively in their analysis of early modernist political economies. Marx framed class as the source of all social conflict, and structures of work as generative of class distinctions (Marx 1978). Marx distinguished between two classes: workers/working class (the proletariat) and capitalists/owning class (those who owned the means of production). Their conflicting interests are the source of a continual cycle of antagonism and crisis; in Marx’s view, the nature of the owner-worker binary is inextricably linked to the wage form, to exploitation, and to estrangement from the process and product of labor, oneself, and one’s species being. Marx’s formulation of history privileges economics as the basic fact of material life under capitalism, and though the nature of the human labor was transformed in the course of the transition from feudalism to capitalism, the necessity of performing work was not. In Marxist assessments, employment cannot be profitable for the worker without also being exploitative; the wage form simply invisiblizes the
exploitation such that it appears natural or inevitable rather than the outcome of social relations.

Marx was chiefly concerned with the social relations of the factory. This accounts, in part, for the continued focus on industrial sociology in some of the best-known sociological studies of the labor process in the 20th Century (Braverman’s *Labor and Monopoly Capital* (1972); Burawoy’s *Manufacturing Consent* (1979); Tilly and Tilly’s *Work Under Capitalism* (1998). Sociology’s dominant thread through at least the mid-1970’s was manufacturing and industry (see Cockburn 1983; Burawoy 1979; Willis 1977; Braverman 1974). In 1977, Rosabeth Moss Kanter published the now-classic *Men and Women of the Corporation*, which inspired subsequent work on work and gender, organizational theory, and white-collar work. In essence, the prominence of Kanter’s offering seemed to open new spaces for conversations about something other than factory work.

The fact that such a substantial proportion of the sociological literature on work trained its eye on manufacturing is a reflection of the central position that manufacturing occupied in the U.S. economy through the middle of the 20th Century. Men’s overrepresentation in manufacturing jobs is a likely reason for their
predominance as the subjects of social research about work and employment, as was mainstream academia’s tendency to ignore women as legitimate participants in the social world. Women’s employment in manufacturing, domestic service, and the informal sector were rarely the topic of analysis, nor was their unpaid home labor. Manufacturing accounted for 1 in 2 U.S. jobs in the mid 20th Century; by the end of the same, it accounted for a mere 10% (Sweet and Meiksins 2012: 25). It is helpful to understand the basic tenets of labor process theory as it applies to manufacturing jobs, but traditional labor process theory falls far short of explaining the organizational dynamics of work that does not result in the production of a physical product. Later analyses of the labor process in the service sector (Buchanan 2002; Leidner 1993) focus on service low-intensity, low-stakes service interactions in which the service being provided is bounded by the generation of profit. As EMS involves the provision of a service, industrial labor process theory does not suffice as a theoretical framework for understanding the labor process on the ambulance. Furthermore, since EMS work is performed in a unique situation in which the paramedic’s customer service does not directly generate profit for the employer, the context of the service labor they perform is quite different from the labor process literature on service work.
Commitment

The literature on workers’ commitment to their jobs approaches the idea of commitment primarily from an organizational standpoint; it is the worker’s commitment to a specific job/employer, and managements’ attempts to control workers’ labor and behavior that drive the analysis (Diefendorff and Gosserand 2003; Lincoln and Kalleberg 1990; Hodson and Sullivan 2002). This narrow focus on organizational commitment does not account for occupational commitment, however. A worker can be committed to her job (a specific employer), but she can also be committed to her occupation more generally (Tilly and Tilly 1998). When commitment is to the job, the salient questions resolve around incentives: negative incentives do not produce quality work, but positive incentives only go so far in terms of motivating workers (McKay 2004). In production enterprises that are profit-driven, such as the manufacturing concerns that McKay describes in the Philippines, workers respond to employers’ varying levels of incentives to work by displaying increased or decreased commitment to the job more so than to the occupation. In profit-driven service jobs, such as retail sales, employers make a direct
connection between emotional labor and workers’ generation of profit (Hodson and Sullivan 2002).

When a worker is committed to her occupation rather than to a specific job, Sociology asks different questions, e.g., why would people invest in their professions? What keeps someone working in an occupation, even if they aren’t attached to a specific job? (Tilly and Tilly 1998). McKay (2004) distinguishes between three kinds of worker commitment: effort (why people work hard), loyalty (why people work even when they are not being compensated properly), and attachment to the job (workers’ positive or negative incentives for keeping the job).

Rodriguez (2014) posits workers’ performance of emotional labor as a means of neutralizing the stigma attached to low prestige care work or “dirty” work, noting that the satisfaction that workers derive from the caring part of their labor can function as a form of non-financial compensation that motivates workers to stay in their jobs despite having little day-to-day autonomy. Although McKay’s research subjects were manufacturing workers, an extension of his distinctions would be useful for understanding occupational commitment, since workers attached to an occupation (rather than a job) are also motivated to work hard, to work in spite of inadequate
compensation, and to develop and nurture an attachment to the occupation;

Rodriguez’s work explains how emotions how care workers find dignity, but not how these boundary-making practices work on a job that encompasses higher-prestige work alongside care work. I will argue that the case of EMS workers is a platform from which to make such a theoretical contribution.

*Gender And The Labor Process In The “New” Economy*

Given the unprecedented rise in the proportion of U.S. workers employed in the service sector, labor scholars have devoted considerable energy over the last two decades toward understanding the gender wage gap and the organization of service sector work (see Waldinger and Lichter 2003 and Appelbaum et al. 2003). However, workplace gender inequalities cannot be understood outside larger theories of societal gender inequalities, especially Raewyn Connell’s theory of hegemonic masculinity. Connell (2005) uses Antonio Gramsci’s concept of hegemony to describe gender regimes – of labor market, state, family, etc. – into which power and patriarchal domination are organized. She defines hegemonic masculinity as “the configuration of gender practice which embodies the currently accepted answer to the problem of
the legitimacy of patriarchy, which guarantees...the dominant position of men and the subordination of women” (Connell 2005: 77). This configuration of gender practice includes both hegemony over women and hegemony over subordinated masculinities (such as gay men’s masculinity, which is subordinate because gay sexual desire threatens patriarchy) (Connell 2005; Demetriou 2001).

Connell’s (2005) hegemonic masculinity is not restricted to men’s quotidian masculinities; rather, it is deployed culturally through personages like film stars, athletes, media personalities, and public “heroes” such as firefighters. Hegemonic masculinity, according to Connell, defines itself in opposition to what it seeks to avoid: that is to say, femininity. Hegemonic masculinity operates not just in opposition to femininities produced by women, however; it also reacts against “subordinate” masculinities such as the masculinities performed by gay men – which are eschewed as feminine - and by men with little access to economic power (Connell 2005; 1987). In Connell’s view, hegemonic masculinity involves a successful claim to authority that is historically mobile, shifting flexibly over time in accordance with changing social structures. Connell also makes the controversial claim that most men do not conform completely to the strictures of hegemonic masculinity, but instead
benefit from the institution’s subordination of women through complicit acceptance of what Connell terms “patriarchal dividends” (Connell 2005).

One example of a patriarchal dividend is the gender wage gap. As women moved back into the workforce in the late 19th and early 20th Centuries, their salaries were far from commensurate with men's, even when they were doing the same job. Not until the Equal Rights Act was passed in 1964 in the United States – Title VII guaranteed women equal pay – followed by its British equivalent, the Equal Pay Act of 1970 – did women have a legal foundation on which to make their case for “same-job” equal compensation. “Between-job discrimination,” however, was not (and is not) illegal (England 2010), and women-concentrated jobs remain underpaid. The jobs in which women are most highly concentrated are generally those with the lowest pay and the poorest working conditions (Reskin and Roos 1990; Padavic and Reskin 2002).

The devaluation of “women’s” work results in two major forms of work-related inequality: the wage gap and occupational gender segregation. Gender segregation refers to the heavy concentration of women in some jobs and the domination of men in others. Gender segregation is measured by the percentage of
women and men workers who would have to transfer into an occupation wherein their
gender is underrepresented in order for gender integration to occur. When
desegregation does occur, it is women who are likely to be moving into men-
dominated occupations, rather than men moving into female-concentrated
occupations, which are underpaid (due to employer discrimination) and socially
devalued (Reskin and Roos 1990). This has often resulted in lower pay for men in
newly integrated occupations. Gender segregation tends to culminate in men's
decreased desire to work in feminized occupations due to an expected loss of social
status, pay, and authority; one of the biggest predictors of the social status and
compensation conferred by an occupation is whether it has been gender-typed as
"women's work" or "men's work" (Sweet and Meiksins 2012).

The interaction between masculinity and femininity in gender-typed jobs is
made especially visible by “crossover” literature. I define “crossover” as research on
women in “men’s” jobs and men in “women’s” jobs. In collecting the experiences of
a group of workers that constitutes a minority in an occupation, crossover studies
reveal social facts about the workers at the center - facts that would otherwise remain
unspoken or unacknowledged. Crossover studies emerged following a period in
history when issues of gender inequality in the workplace became, in many senses, more possible than they had previously been: several notable pieces of U.S. legislation – including the Civil Rights Act of 1964, Executive Order 11375, and Title IX – codified women’s right to equal employment opportunities and harassment-free workplaces. As with the contemporaneous de jure eradication of race-based discrimination, however, the net effect on gender discrimination was messy: more often than not, it became harder to see but did not actually disappear – a topic I will discuss in more depth in my literature review. Compounding the ambiguities were specific changes to work brought about by a service-based economy (Sweet and Meiksins 2012; Korczynski and Macdonald 2009). Crossover studies can illuminate some of the subtleties of gender and work in the post-industrial age.

The scholarship on women’s participation in occupations historically dominated by men is particularly robust. The difficulties that women face trying to get co-workers to take them seriously in professional occupations like law (Pierce 1995, Martin and Jurik 1996) and engineering (Robinson and McIlwee 1991) are underscored by ongoing struggles with sexual harassment, hazing, and tokenism (Kanter 1977). Despite differences in the occupations themselves, the experiences of
these predominantly white-collar women bear more than a passing similarity to the challenges that women face as workers in both blue-collar industries and protection occupations like construction (Paap 2006), firefighting (Chetkovich 1997), and law enforcement (Martin and Jurik 1996). While women enter occupations dominated by men for many of the same reasons – financial stability, flexible schedule, etc. - that men do (Padavic 1992), they tend to experience the highest levels of gender segregation in those occupations that have the fewest resources available, due in large part to their marginalized status as second-class workers and consequently, to their lower priority access to “good” jobs (Wharton 1986).

The crossover literature of men in women-concentrated occupations paints a different picture. Hochschild (2003) observed that men in women-concentrated occupations tend to benefit, both substantively and emotionally, from their token status. This has since been reinforced by Christine Williams’s work demonstrating the “glass escalator” effect, wherein men working in women-concentrated occupations profit from cultural expectations leading to their disproportionate representation in managerial and promotion-tracked positions (Williams 1993). Pierce (1995) notes similar findings among men paralegals in two large urban law firms, where men are
more easily able than women to refuse what they consider to be degrading job assignments (and therefore to mitigate any negative effect on their perception of themselves as masculine).

More recent qualitative work seems to parallel the increased significance of service work and the false “crisis” of masculinity. Lupton (2006) points to the tendency of men workers in women-concentrated occupations to reclassify their work as masculine or to use descriptors of their job titles that hide their actual duties. Lupton’s findings echo those of Cross and Bagilhole (2002) and Simpson (2004), whose studies of men librarians, school teachers, flight attendants, and nurses showed that men exploit remarkably creative tactics in order to reaffirm their sense of their own masculinity to women co-workers and to other men: they over-emphasize pride or career orientation in their work; they express satisfaction with the benefits afforded a token man; they refuse to “do deference,” (a finding corroborated by Henson and Rogers 2001 and Williams 1993); they explicitly identify “female” traits like caring or empathy as integral parts of their personalities, renaming or reframing their work to de-emphasize the “feminine” aspects of the job; and they lie outright about their occupations when they are sufficiently concerned about others’ perceptions of them.
Many of the (mostly heterosexual) men interviewed for these articles reference their repeated exposure to questions of sexual practice, and see the tactics listed above as a means to reassert their participation in a home or work environment of compulsory heterosexuality.

Women have made few inroads into more highly paid blue-collar occupations such as the manual trades despite women’s overall workforce participation rate of 70% (England 2010). Sociologists studying women working in occupations dominated by men – such as construction – have found that women workers in those jobs tend to either conform to rigid “masculine” behavioral practices or participate in the objectification of women’s bodies (in this case, of their own bodies by tolerating harassment or engaging in sexual banter and physical horseplay). Women workers also tend to be compensated at a lower rate, to have a harder time securing regular employment in union hall distribution, to be blocked in their attempts to advance/promote, and to be prevented from breaking into the men-dominated industries in the first place (Paap 2006; Moccio 2010).

Like labor process theory, crossover literature describes a specific gender setting in which men in women-concentrated occupations and women in men-
dominated occupations report very different experiences of their jobs based on their respective gender identities. While it does explain some aspects of gender performance in EMS, it does not address the more complicated situation that arises when both men and women do a job whose characteristics are both stereotypically masculine and stereotypically feminine at the same time. Here, too, I intend to make an intervention that will help bridge a gap in the theory of occupational crossover experiences.

Care Work

At the most basic level, sociologists divide care work along the lines of work that is paid and work that is not paid. Continuing along the Marxist vein, care work falls squarely into the category of reproductive labor, i.e., labor whose product serves capitalism by feeding, producing, cleaning, and re-dispatching its workers to their jobs each day. Reproductive labor in the home is disproportionately performed by women (Dodson and Zincavage 2007; Glazer 1990), whose unpaid labor subsidizes the capitalist enterprise, and who are then left with less time outside the home than men to pursue higher-status paid employment (Glenn 1992). Home-based
reproductive labor is typically outsourced by middle- and upper-middle-class white women to women of color (Duffy 2007).

Paid reproductive labor is also dynamic. As Glenn (1992) notes, the social manifestation of reproductive labor in any particular moment is the outcome of historical forces that dictate both who does the work and to what extent it is valued by society. Glenn does not conflate social prestige with the actual value of the work; one need do nothing more, she argues, than imagine what would happen if that reproductive labor didn’t get done to understand how critical it is. As reproductive labor, care work enjoys little occupational prestige, and stands on some of the worst real estate in the spectrum of service work. Unskilled care workers are poorly paid, of course, but their disposability also makes them particularly vulnerable to exploitation by employers (Glenn 2010 and 1992; Ehrenreich and Hochschild 1996; Romero 1992) and to physical and verbal abuse by customers/clients (Dodson and Zincavage 2007; Akerstrom 2002). Workers must go to extraordinary lengths to achieve any sense of dignity for themselves in such conditions: they may convince themselves that a non-reciprocal relationship with client is an emotional “family-like” relationship (Dodson and Zincavage 2007; Rodriguez 2014; Ehrenreich and Hochshild 1996);
they may alter their boundaries around violence in order to reinterpret a patient’s slap or pinch as acceptable (Akerstrom 2002); or they may perform an ideological reframing of their job in resistance to its stigma as “dirty” work (Ashforth and Kreiner 1999). Davies (1995) distinguishes between “caregiving work” (informal care provided without pay by family/friends), “care work” (unskilled caring work that takes place in the community) and “caring work” performed under professional licensure, which tends to confer higher social status and pay on the worker.

Sociological conceptions of care work as face-to-face service work (England and Folbre 1999) and as work with intrinsic, non-monetary motivations (Himmelweit 1999) provide a useful framework for viewing medical occupations of all kinds. Himmelweit and Jones (2001) see the care relationship as an exchange; in the sense that it constitutes a formal work relationship with the employers, it is a form of labor – like any job - from which the worker expects a reward. Unlike non-caring paid work, however, workers accept that at least some of the compensation will be non-monetary, perhaps taking the form of personal satisfaction and/or the development of a personal relationship with the recipient of care. In the case of medical jobs with higher levels of compensation – physicians and nurses, for example - a health care
worker’s dedication to “helping people” is part and parcel of popular conceptions of medicine, irrespective of extrinsic financial motivators.

Himmelweit and Jones reflect Hochschild (2003) in observing that alienation secondary to emotion management is more common in low intensity, non-relational (cashier, flight attendant) care jobs than in high intensity (nurse, elder care) ones in which the caregiver develops a personal interest in the care recipient. EMS can be categorized as high intensity care work because the care interaction tends to be extreme in both its short duration and its emotional and physical levels of intensity. EMS workers have comparatively little time to build relationships (20-60 minutes) but deal with situations whose highest emotional intensity levels could not reasonably be sustained throughout the workday. Conversely, physical duties run the gambit from heavy lifting to fine motor skills (IV starts, medication administration) to “unpleasant’ tasks such as cleaning incontinent patients.

Women accounted for some 90% of registered nurses in 20111, which makes men’s eagerness to perform caring work that includes duties similar to those of nursing (an occupation ostensibly rejected by most men) all the more confounding.

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1 www.bls.gov/cps/cpsaat39.pdf
Clearly, the care component is not such an overarching aspect of paramedicine that the men who enter the profession see it as feminine. Indeed, while men may be discriminated against for performing care work in the world outside EMS, they do not suffer the same denigration in EMS. And unlike men who enjoy higher pay and higher likelihood of promotion as token workers in women-concentrated occupations like nursing (Williams 1992), women in EMS can expect no such special treatment. Thus, the literature on care work does not explain how men who perform care work within the larger context of a so-called “masculine” occupation negotiate their gendered identities in the process of performing that work.

*Emotional Labor*

The compulsory production and management of workers’ emotions to effect particular emotional responses in the customers or clients is the defining characteristic of service sector jobs that are performed in view of the public (and even some that aren’t) (Goodwyn 2006). Emotional labor requires acting. Acting may be surface level or deep (Korczynski 2009). Deep acting is associated with occupational performances in which the service rendered is explicitly emotional (Bernstein 2007;
Lois 2003). Hochschild (2003) shows how flight attendants engage in surface acting to give passengers the impression of friendly graciousness and a deeper sense of safety, while debt collectors work to repress their own feelings of empathy in order to avoid unpleasant cognitive dissonance when pressuring debtors to make a payment; in both cases, the result is significant alienation from the worker’s species being (Marx, in Tucker 1978). Himmelweit (1999) and Jones (2001) point to Hochschild (2003) in observing that alienation secondary to emotion management is far more prominent in low intensity, non-relational (cashier, flight attendant) care jobs than in high intensity (nurse, elder care) ones in which the caregiver develops a personal interest in the care recipient (Rodriguez 2014; Glenn 2010). The labor of EMS workers, whose care work is of short duration yet high intensity, will complicate these divisions.

Emotion work is an integral part of the performance of care work. Sociological conceptions of care work as face-to-face service work (England and Folbre 1999) and as work with intrinsic, non-monetary motivations (Himmelweit 1999) are a useful framework through which to view caring occupations. Himmelweit (1999) and Jones (2001) frame the care relationship as an exchange. It is a form of
labor from which one expects a reward of some sort. Unlike non-care paid work, however, workers accept that at least some of the compensation will be non-monetary, perhaps taking the form of personal satisfaction and/or the development of a personal relationship with the recipient of care. This enables continued exploitation, particularly in the case of low-wage care work. In the case of medical jobs with higher levels of compensation - physicians, for example - a health care worker’s dedication to “helping people” is part and parcel of popular conceptions of medicine, irrespective of extrinsic financial motivators; the assumption of similar levels of personal reward seem to justify poor compensation and contingent labor markets.

The high intensity nature of EMS work requires deep acting on a semi-regular basis. However, the literature on emotional labor is too simplistic to explain EMS work. It explains emotions chiefly in the “factory floor” setting, with insufficient attention to the emotional work required for social reproduction on jobs where workers perform intense emotional labor on themselves while not on the clock. My project will redress this hole by examining emotional labor of off-duty social reproduction as well as the emotional labor that paramedics perform for their own and their coworkers’ benefit in the break room.
Emergency Work And Heroism

Rescue occupations like fire protection and EMS are notable for workers’ interventions in time-sensitive, often volatile situations, and for their element of personal risk (Desmond 2007; Lois 2003; Chetkovich 1997). Heroic labor tends to be perceived as “masculine” and therefore, as higher prestige (Glick et al. 1995). The sociological literature distinguishes between altruism and heroism. While altruism requires only that the person who is aiding someone else be acting without expectation of reward or compensation, “heroism” requires the assumption of substantial, uncompensated risk to one’s own safety for the benefit of another (see Goode 1978, Berkowitz 1987, and Oliner 1999). The designation of an act as “heroic” is also context-dependent: labeling someone a “hero” must be done by someone other than the heroic deed-doer (Edelstein 1996). In short, nothing about an action is intrinsically heroic until social context defines it as such.

Despite its misconceptions about the relative everyday safety of fire protection and the “low” physical risk undertaken by EMS workers, the public still seems to understand the “saving lives” component of EMS work as forming the basis for some sort of heroism. I share the experience of a number of my respondents that a common
reaction to identifying oneself as a paramedic in conversation is a strong assertion on the other person’s part that “I could never do that!” The content of paramedic heroism is clearly contained in the undefined “that”; the person speaking presumably perceives “that” to be something out of the ordinary in terms of their expectations of average human capacity.

Heroism theory is not a perfect fit for EMS. Unlike firefighting, EMS work does not enjoy public perception of regular risk to workers’ physical safety. The fire service’s “hero” image is built in part on the assumption that firefighters regularly enter situations that are immediately dangerous to life and health. It is worth noting the irony that, per capita, EMS workers assume an even higher risk to their physical persons than do fire personnel; the fatality rate for EMS workers between 2003 and 2007 was 7.0 per 100,000 FTE (Full Time Equivalents), as compared with workers as a whole (4.0 per 100,000 FTE) and firefighters (6.1 per 100,000 FTE) (Reichard, Marsh, and Moore 2011). The primary cause of death in most EMS line of duty deaths is traffic accidents (fatal ground ambulance and air ambulance crashes; being struck by vehicles in the roadway). If the heroism implied here is not of the “risk of life and limb without expectation of compensation” variety, what exactly is it? This
contradiction in occupational status – high danger in the presence of low prestige – needs to be explored through a nuanced analysis of gender and work as I outline in my puzzles at the beginning this chapter.

Furthermore, heroism is defined in the literature as a risk to physical safety (Chetkovich 1997; Edelstein 1996; Goode 1978). As Goode notes, “We honor more those who risk their lives for others because the contribution may be crucial, and thus demand high; and because the supply of willing self-sacrificers is low” (1978: 344). “…”True’ heroes,” writes Lois, “perform acts that are independent of material rewards; thus, people who undertake risk as part of their everyday occupational duties would not be considered heroes” (2003: 14). I contend that such a definition is insufficient to explain EMS workers’ risk-taking, and that defining risk-taking as physical merely reproduces the notion that only masculine activities can be labeled heroic, and that emotional labor (associated with femininity) is not “real” work. Jennifer Lois notes that while conventional definitions of heroism in sociology typically exclude acts performed in the course of a paid occupation, exceptions may be made for going “above and beyond the call of duty” on the job. Indeed, she specifically cites the paucity of sociological research into the occupational heroism
exhibited by “professional fire fighters, military personnel, police officers, and ambulance workers (who) often perform above and beyond the call of duty…” (2003: 14). Her assumption of occupational similarity in a diverse group of workers is problematic but unsurprising given the representations of them in popular culture. Nonetheless, I take this as an invitation to engage just such a question. I also assert that an expanded definition of heroism could help to account sociologically for other forms of occupational sacrifice in which workers assume personal risk to their emotional or psychological health, or offer their time and energy on behalf of another person, in the absence of any obligation to do so. Such occupations include therapists, social workers, teachers, suicide hotline workers, and workers in other emotional “helping” professions that are gendered as “feminine” because of their association with emotions. I found no evidence that heroism has ever been defined sociologically in a way that troubles its specific relationship to masculinity and physical risk. The character of heroism as an act is fundamentally masculine. It is my aim in this project to open up spaces in the heroism literature for inclusive conceptions of heroism that reject gendered binaries.
RESEARCH METHODS

My decision to explore the emotional culture of paramedics through ethnography and autoethnography was inspired by anthropologist Clifford Geertz’s notion of thick description (Geertz 1973). Since my aim was to examine gender performance and emotion work in a very insular culture, I immediately ruled out quantitative methods; I suspected that the superficial data elicited by surveys would be insufficient to get at the questions I wanted to explore. I also knew that I would fail to discover much of import if I could not find a way to contextualize what EMS workers say with regard to their thoughts and feelings about their work within their actual behavior at work.

It’s not that I hadn’t had ample opportunity to observe EMS workers on the job; I am a paramedic myself with over 16 years of experience. At the time that I started my formal research, I had already spent somewhere in the neighborhood of 30,000 hours participating in EMS work – which meant that I had also spent 30,000 hours watching other EMS workers do their jobs. My pre-research observations were not without value, but they were filtered through my own interpretive lens and uncorroborated by interview data. In short, my understanding of my co-workers was deeply biased by my anecdotal, unsystematic analysis of my personal experiences on the job. My
theories about EMS work were in no way scientific or “grounded” (Glaser and Strauss 1967; Strauss and Corbin 1990). Nonetheless, I was convinced that the puzzle was worth exploring, which meant that my best approach would necessarily involve the intersection of several qualitative methods (Schutt 2009).

There is no shortage of ethnographic work on cultures of all shapes and sizes. Culture is what ethnographers do. As a subgenre, though, workplace ethnographies generally focus on the shop floor and the labor process (from Burawoy 1979 and Kanter 1977 through Parreñas 2011 and Sallaz 2009). The experiences that I have had as paramedic left me convinced that EMS cannot not be understood by looking solely at the shop floor. For one thing, EMS work entails considerable downtime: depending on the volume of 911 calls, anywhere from 5% - 100% of EMS workers’ time in a given shift of 12, 24, or even 48 hours may be unoccupied. This unoccupied time can best be understood as time in a metaphorical “break room.” Furthermore, EMS workers are regularly exposed to troubling parts of the human experience that non-EMS workers encounter rarely or never (such as sudden, unexpected death, serious physical trauma and illness, violent outbursts, and others’ grief). It does not make sense to assume that paramedics’ on duty time simply ends when they collapse into
their cars at the end of their shift. They are not performing the sort of work from which a worker can easily create emotional distance, such as making lattes or signing payroll checks (Laurier 2013; Sallaz 2009). Paramedics’ work comes home with them, mentally and emotionally. The nature of emergency work also limits what they can do in terms of emotional processing while on the shop floor (i.e., on the scene of emergency calls). They have to keep their wits about them until the call is over, i.e. until they leave the shop floor. Thus, their commitment to their work is brought about in part by the ways that they come to terms with and make sense of their shop floor experiences after they are no longer there. I locate these two sites of social reproduction in the “break room” (when paramedics are on duty but not on an emergency call) and in their off duty time (when they are not at work at all, but still dealing with their occupation mentally and/or emotionally).

Ethnographic methodologies have long been a mainstay of grounded theory (Glaser and Strauss 1967). My theoretical approach to ethnography as a research method is modeled on Michael Burawoy’s notion of the Extended Case Method. In his work on the topic, Burawoy (2011) delineates four principles of extension: first, the extension of the observer into the community being observed (my years on the job
provides ample time with the EMS community, both during the formal research period and in my years on the job leading up to the research); second, the extension of observations over time and space (my project requires ethnography in my workplace over time); third, the extension from micro to macro processes (I ultimately used this case study as a way to understand larger forces of transition in the world of work); and finally, the extension of theory (updating labor process theory such that it becomes relevant to occupations that do not clearly belong to larger occupational categories, with the understanding that such hard-to-categorize jobs are likely to increase in number in the coming decades). Of particular importance is the second extension (time and space), since I argue that we gain a richer and arguably more accurate understanding of paramedics’ emotional culture only when we look at how emotions off the shop floor inflect what happens on the shop floor. This may have important theoretical implications for other jobs by allowing sociologists of work to consider what we might be missing in workplace ethnographies by restricting our analysis to the shop floor.

I approached different angles of my research question through two distinct research methods: (1) ethnographic interviews with approximately thirty paramedics,
and (2) fieldwork in the form of participant observation that I conducted on the job over a period of about 18 months. By engaging this variety of research modalities, I hoped to establish a model for understanding major categories of identity formation among paramedics, and to identify the conditions under which various types of emotional labor were performed.

*Ethnographic Interviews*

To identify both their reasons for entering the profession and their on-the-job work strategies once they have established themselves in EMS, I conducted approximately 30 one-on-one interviews with paramedics. These interviews took place in an open-ended format designed to open up further, unpredictable topics of conversation. This “unpredictability” was critical to the design and outcome of the research. While it should be clear from this introduction that I am particularly motivated by a personal and scholarly interest in the intersection of labor and gender, using inductive methods helped me minimize the change that my personal bias would obscure aspects of paramedics’ identity that were more salient to them than gender. This turned out to be a valuable failsafe, particularly since many of the topics that my subjects brought up
in their interviews as explicitly not related to gender ended up being a critical part of my analysis of gender.

My interviews were fairly long by design – between 60-120 minutes each – in order to allow each worker ample time to explore her experiences both prior to undergoing paramedic training and in the course of her career. I typically spent anywhere from 30-60 minutes before turning on my recording device establishing rapport by engaging in shop talk and “bullshitting.” Oddly enough, this ended up being especially important for those interviews in which I had already worked with the subject; both they and I seemed to need some time to transition from our usual relationship (co-workers) to a more formalized researcher-subject relationship. I prefaced each interview with an explanation of my research purpose, and made it clear that each participant was welcome to stop the interview at any time or skip questions that for any reason he did not wish to answer. I recorded the interviews and transcribed them at a later date. Due to the potentially sensitive nature of the subject matter – not to mention the legal constraints of the Health Insurance Privacy and Portability Act (HIPPA) - I chose a pseudonym for each participant. I have identified my participants using pseudonyms and their ages.
My questions were loosely organized to guide the conversation, but also deliberately broad and inductive (Schutt 2009). The first section consisted of questions about each paramedic’s life prior to entering EMS and the circumstances that led to the choice of EMS as a career path. The second section examined my subjects’ experiences on the job. What did participants like and dislike about their work? What sorts of conflicts had they encountered with co-workers and allied agencies\(^2\), and how did they deal with them? How did participants feel they have changed over the course of their careers? What work experiences shaped them? How did they feel about various aspects of their job? What were the calls that they found most rewarding? Which were most challenging? I tried to be particularly attentive to the silences that occurred in order to identify common themes or experiences that I did not consider asking about when I first formulated my interview questions. Again, while my initial interest in this research question came out of my personal experiences with gender on the job, I wanted to leave ample space to discover the

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2 Fire departments, police departments, hospital staff, and other public service workers with whom a paramedic can expect to interact in the course of a day’s work.
parts of other paramedics’ stories that were at the forefront of their own self-analyses.

As other themes emerged, I altered my approach accordingly.

*Participant Observation; Insider Status; Auto-Ethnography*

Because I began this project with insider status, I did not have to contend with gatekeepers (Whyte 1955). I also needed no elongated period of relationship building before I was accepted as a full participant in the community. Indeed, as I have already argued, such an expectation simply is not realistic. As Vietnam veteran Tim O’Brien writes of his spiritual disconnect from his platoon-mates after an injury takes him out of combat: “They were still my buddies, at least on one level, but once you leave the boonies, the whole comrade business gets turned around. You become a civilian. You forfeit membership in the family, the blood fraternity, and no matter how hard you try, you can’t pretend to be part of it” (O’Brien 1990: 133). EMS is very much like this, although the ebb and flow of belonging goes beyond mere employment status: even if you’re currently employed and run into your co-workers off duty while out and about, if you’re not on the clock, you are (at that moment, anyway) not fully one of them. If you are not an EMS worker, you are *never* one of them.
In the only two full-length ethnographies of EMS that I found (Tangherlini 1998; Metz 1983), both researchers write at length of the sense that they have of not being privy to medics’ uncensored stories because of their subject position as occupational outsiders. Tangherlini’s account is anthropological (he’s a folklorist); Metz worked on an ambulance as an EMT (Emergency Medical Technician), but positioned himself as a sociologist to his co-workers; i.e., not a “real” EMT. The material that Tangherlini includes in his anthropological ethnography of paramedics’ “war stories” is restricted to ex post facto accounts of the shop floor. This is useful for understanding how paramedics represent themselves when they are being asked to reflect on the highlights of their work experiences, but it does not give us insight into the parts of the job that happen around the highlights (which actually account for much of the job). We miss the rich data that come out of the break room, and we also miss the participant observation data from the shop floor itself. These missing data provide the empirical foundation for the gendered analysis that is the focus of my paper. It’s not that my data contradict these earlier works so much as that Tangherlini’s and Metz’s research methods do not extend far enough outside their
specific contexts to make any arguments about gender, emotions, or social reproduction. They are simply different projects with different aims.

The question of how people talk about themselves is also quite distinct from how they interact with one another at the level of emotional culture. Given how important it is to examine EMS workers in multiple contexts, it is reasonable to expect that a single-method approach to studying EMS workers would leave some holes in the data. For example, I found that medics’ interactions with one another in the “break room” were critical to their social reproduction and occupational commitment. In the absence of a Burawoyian extension beyond the shop floor, we would miss the opportunity to look at (for example) the role that intimacy-building practices play in paramedics’ ability to run emergency calls smoothly. Without asking paramedics about the “non-highlights” of the job, we would miss the opportunity to learn how they make sense of their professional identities. If we don’t follow them into the back of the ambulance, we never see their active frustration with hunger, fatigue, or non-emergency calls.

A final area where insider status was helpful was in my ability to blend in with other people and to interpret behavior, jargon, and linguistic subtleties
accurately. This came in handy during interviews with people I did not know; we already spoke the same professional “language,” so building rapport was not especially challenging. I also benefited from insider status because paramedics are on their best behavior in the presence of outsiders, much as we would expect that any worker being observed in her professional capacity would err on the side of trying to impress. My insider status allowed me to observe my coworkers unobtrusively, since they thought of me (quite accurately) as one of them and did not alter their behavior in my presence. In short, I am not claiming that this project could only be done by me in particular, but practically speaking, there is little crossover between career paramedics and academic sociologists. In the end, my ability to collect different kinds of data from both my interviews and participant observation was enhanced by my insider status (Ellis and Bochner 2000).

For the participant observation portion of my research, I analyzed experiences that I had while at work as a paramedic. The data from this portion includes informal conversations with my work partners about their interpretations of incidents that occurred in the course of them and me performing our work together. In such conversations, I solicited my partners’ opinions about why something might have
happened as it did, or why someone could have behaved in a particular way. An example of such a conversation might include something like asking my partner if she or he thought that an intoxicated patient who was being verbally abusive would have made the same sorts of comments if the attending paramedic had been had not been a woman (or a man), or asking my partner how he felt about an interaction with a patient’s family member, a member of the fire crew, or hospital staff.

I also made notes of my own observations – those not discussed with others – about significant events that happened during each shift. I collected data from the participant observation portion of my research via field notes, which I scribbled down as soon as possible after each incident and then wrote up in greater detail once I was off duty. I took these notes for approximately 18 months during my regular shifts (1-3 times per week for 12-hour shifts). In addition to my field research, I have also included in this project a small number of memorable work incidents that have taken place at various points during my 16-year career.

I assigned pseudonyms to each of the co-workers whom I interacted with during the participant observation portion of my research. In order to comply with my IRB restrictions – since I did not secure consent from these partners to include their
identities – I approximated their ages and length of time in the field in order to protect their identities (Stein 2010; Barton 2011). I also assigned pseudonyms for each of the ambulance companies that I or my respondents worked for, as well as for any management personnel, co-workers, and allied agency colleagues (including, but not limited to, fire, law enforcement, and hospital personnel) to whom my participants or I referred.

Population Selection And Sampling Strategy

A central question of my research is how paramedics complete necessary tasks, and how they either take or cede control of an emergency scene. Since I was intrigued in part by how gender affects workers’ relationships with one another, I stood to gain the most insight from situations in which those workers are minimally beholden to preexisting occupation-based cultural contexts (e.g., the military “chain of command”) that might otherwise pervade their interactions with one another. Furthermore, by selecting a unionized workforce, I was also able to minimize some of the confounding factors (inequalities in pay, promotions, etc.) that could have compromised the results of my research. By centering my research on ambulance-
based paramedics, I was able to advantage of both my insider status on the job, and of the structural simplicity of a unionized, ambulance-based EMS workforce.

My subjects are ambulance-based paramedics who work for several different private corporations. Most of them are based on the West Coast of the United States. I recruited them through my personal work social networks (consisting of co-workers and fellow bargaining unit union members) with direct written and/or verbal requests. I also used word-of-mouth to recruit other participants via snowball sampling. In general, my respondents seemed eager to participate in the project. I experienced no direct refusals to participate.

**Potential Methodological Weaknesses**

Before starting my research, I identified three potential weaknesses in my methodology. I attempted to remain as attentive to them as possible throughout the research and subsequent analysis. First, my interviews were limited in their capacity to obtain relevant, in-depth information. These limits took the form of both my participants’ individual willingness to share awkward or sensitive information, and by each person’s capacity and motivation for introspection and self-assessment. The
most effective strategies I had for dealing with this shortcoming was ensuring that the questions I asked were effective in getting to the heart of the issues without alienating the participants, and by taking pains to establish rapport with each participant over the course of the interview process. I added some questions and removed others after the first few interviews, when I discovered holes in my questioning or lines of questioning that did not seem to make sense to my participants.

Second, I encountered some inconsistencies with the participant observation. As a worker, I had to deal with the daily unpredictability of the job. There were days when we were too busy running calls to eat, resulting in irritable moods and a marked disinclination to engage in unnecessary conversation. On the flip side, there were also shifts when the volume of 911 calls was so low that the day produced little in the way of data. After critical 911 calls, I was sometimes too occupied with job duties and paperwork to be able to jot down the details of the call until several hours later. In those cases, I attempted to recreate the memory of what happened as faithfully as possible. Human memory is flawed, and it is probable that I misremembered some details. It is my sincere hope that these minor variations will not have changed the overall picture of the event in my mind.
As with virtually all forms of participant observation, there were methodological issues inherent to my presence - most notably the potential for it to cause alterations in what people around me said or did. I assumed that some of this effect was mitigated by my work experience: as an experienced paramedic, I can meld relatively seamlessly with other paramedics in conversation: I know the rules of interpersonal engagement in paramedic culture. My learned unobtrusiveness proved an asset in participant observation. I believe that it helped to mitigate the impossibility of approaching my field research with no preexisting ideas about what I would find there.

Finally, it goes without saying that my personal biases and perspectives came into play at various points during this research. You can’t spend sixteen years doing a job without developing a sense of how it “should” be done. It should therefore come as no surprise that my initial impetus for doing this project stemmed from a curiosity about my own experiences at work, and a desire to understand the ways that I, as a woman paramedic, have been shaped by participation in an industry historically dominated by men. I had to remain rigorously attentive to the frameworks through which I observed and analyzed my data. While I tried to approach my fieldwork with
what Buddhists have called “beginner’s mind,” I caught myself lapsing, on occasion, into long-nursed preconceived notions about what was significant and not significant on the job. Certain things came to my attention that I had not previously considered to be important; other things that I had originally believed important came to feel largely insignificant. In the moments where I became consciously aware of my preconceptions, I tried to deconstruct them. I hope that my personal investment in the topic has allowed for a final product that is as engaging and provocative as any participant observation.

ORGANIZATION OF CHAPTERS

This project is laid out geographically, beginning at the center with the shop floor and moving outward. Chapter 2 is a prequel: an overview of the industry in which I acquaint the reader with the history of Emergency Medical Services and describe the working conditions of a typical paramedic. In this section, I explain common terminology and provide a “day in the life” tour of an ambulance shift. Chapter 3 moves onto the shop floor. In this chapter, I consider the different modalities of emotional labor that paramedics engage when they are running emergency calls, with
attention to how they manage distinct categories of emotional suppression such as
disgust, mirth, and fear. Chapter 4 relocates from the shop floor to the break room; I
define “break room” liberally, then delineate several different types of emotional
labor performed in the break room. I explain the intended audience of each and its
overt and covert functions. In Chapter 5, I transition out of the workplace and into
paramedics’ off duty lives, examining the ways that they analyze their at-work
experiences while they are off duty, and demonstrating how this introspection helps
them negotiate and maintain their professional identities despite persistent challenges
to those identities. I close the project in Chapter 6 with a review of my findings about
social reproduction in EMS, followed by a discussion of their theoretical implications
for sociological theories of gender and work, the labor process beyond the shop floor,
and gendered representations of heroism.
CHAPTER 2: OVERVIEW OF THE INDUSTRY

We don’t get paid nearly enough for the shit we have to put up with in this job. I was running a call at the jail recently and the patient was super combative. She tried to kick me in the face and none of the guards was jumping on her or trying to restrain her or anything. I yelled at her, like, “Don’t fucking fuck with my FACE!” Sometimes they really just hang us out to dry.

- Wendy, 39

When civilians imagine Emergency Medical Services work, they do not imagine the sorts of scenes that Wendy describes above. This makes sense, since EMS work happens behind closed doors, behind police lines, on the side of the road, and in a variety of other non-public spaces. The fact that civilians rarely get close to emergencies creates extraordinary misunderstandings about the nature and character of EMS work. The delivery of Emergency Medical Services (EMS) has undergone substantial changes over the five decades since the first state-sponsored systems emerged in the mid 1960s. The original, simplistic approach emphasized rapid transport with few interventions; over time, however, the paramedic scope of practice – i.e., the medical interventions that paramedics are allowed to perform in the course
of doing their jobs – has expanded such that its current form would be unimaginable to the pioneering medics of the some of the first well organized EMS systems in Seattle, Miami and Baltimore in the late 1960s and early 1970s. In first short section of this chapter, I will outline a basic history of how emergency medical services have been provided in the United States over time, followed by an overview of the current workforce. I will spend the remainder of the chapter giving a detailed ethnographic account of the day-to-day experience of life on the job for an ambulance-based paramedic.

A BRIEF HISTORY OF EMS IN THE UNITED STATES

EMS today is such an entrenched part of U.S. society that even EMS workers themselves are generally unaware of how new it is. Cultural representations about EMS specifically, and public safety/first responders in general, abound in the entertainment media. Pioneering television programs like Emergency! (1971), which introduced the concept of out-of-hospital emergency medical care to a nation in which such systems were largely nascent and disorganized, have been replaced by a lineup of films (famous examples of which include Mother, Jugs, and Speed (1976)
and *Bringing Out the Dead* (1999) and long running television shows like *Third Watch* (1999), and more recently, reality shows like *Paramedics* (1998). The prevalence of these cultural products suggests that the public now takes the existence of EMS for granted; these shows are voyeuristic rather than explanatory in their approach to describing EMS. That said, modern EMS is a relatively recent addition to the health services infrastructure of the United States. In this section, I will highlight some of the historical events and political trends that led to early attempts to organize and systematize the provision of Emergency Medical Services nationwide.

*Early Adventures in Triage, Rapid Transport, and Trauma Care*

Wars are high-casualty affairs, so it’s no surprise that some of the most significant advances in triage, rapid medical transport, and trauma care came about during armed conflicts of various stripes. Historians of medicine and EMS trace emergency transport back to Napoleon, whose personal physician designed a system for the rapid removal of injured soldiers from the battlefield (Shah 2006; Eisenberg 1997). Military leadership on both sides of the Civil War employed similar strategies. Subsequent conflicts brought improvements to preexisting systems; by the time World War II
finished, the U.S. military had whittled fatality rates down to 4.5% for any soldier who was still alive by the time he reached definitive medical care in the form of a field hospital. By the time Vietnam was over, the fatality rate had fallen to 2% (Heston 1966).

These extraordinary improvements did not trickle down into civil society because civil society lacked the infrastructure to implement them. More significantly, though, civil society had also not yet identified the need for emergency medical services. One of the primary reasons for this was that the need was only just starting to arise in a visible way. The 1960s were a moment during which political attention was focused on social programs designed to combat poverty, educational inequalities, and childhood. Presidents Johnson and Kennedy both addressed the emerging epidemics of stroke, heart attack, and traffic accidents, prompting a political discussion at the national level around how to address public health priorities (Strickland 2000). All three of these problems were somewhat new in scope as the 1950s gave way to the 1960s. In the case of trauma, automobile ownership among the general public had been vanishingly rare just 50 years earlier, so injury and death secondary to traffic accidents was a phenomenon that expanded alongside car sales in
the post-war era. Rates of heart attack and stroke as the top causes for early death also increased over the course of the first half of the 20th Century: changes to work, transportation, and urban planning led to increased sedentarism in the U.S. population; meanwhile, the expansion of industrialized and fast food radically changed Americans’ diets, and with them, the prevalence of heretofore rare diseases of affluence such as heart disease and diabetes (Guyer et al. 2000). Thus, a confluence in changes to lifestyle and eating habits prompted concerns over the resultant public health “crises:” traumatic injury, stroke and heart attack, and cancer.

At the dawn of public discussions about EMS in 1960, only six states had any kind of regulated medical transportation service. Those systems that did exist were staffed by people who, more often than not, had no medical training at all. Among the more infamous were undertakers, from whom the term “meat wagon” came about. (To be clear, the undertakers didn’t kill people, but their presence at the scenes of fatal accidents or medical emergencies certainly streamlined the transportation of bodies to the appropriate destination). The paltry transportation structures that did exist were, at best, inconsistent in quality and in services offered (Boyd 1982).
In 1964, President Johnson, on the advice of a task force convened to advise him on public health, instituted a plan of Regional Medical Programs (RMPs) that were charged with distributing medical care as a matter of public health. The RMPs were to integrate with university-based research programs to enhance the public’s access to specialty care like trauma centers and children’s hospitals. The infrastructure required to deliver this care necessarily included medical transportation. Two years later, the National Highway Safety Act of 1966 required states to implement regulated EMS systems, although the funding for those systems came from grants rather than a steady flow of federal funding; the decentralization perpetuated inter-regional inconsistencies and problems creating national standards and practices that persist to this day. The National Highway Safety Act placed oversight for EMS with the Department of Transportation, revealing that it saw EMS primarily as a system of medical transport, rather than medical care (Strickland 2000; Eisenberg et al. 1979).

The 1960s were a moment of extraordinary leaps forward in prehospital care, however, and passionate advocates - from recently returned Vietnam medics to forward-thinking physicians to public safety officials - saw the potential for
technological and medical progress to be applied to the civilian population in the prehospital setting. The first mobile intensive care unit carrying a defibrillator, staffed by a pioneering physician in Ireland, had shown the life-saving potential of early defibrillation in the care of cardiac arrest. In the U.S. and in Europe, developments in cardiopulmonary resuscitation (CPR) techniques gave cardiac arrest victims a few extra minutes of time for a defibrillator to arrive - if only the infrastructure to ensure a rapid response could be built. The likelihood that defibrillation will return the heart to a viable cardiac rhythm drops with each passing minute. CPR does not “restart” the heart, as many people erroneously believe; rather, it attempts to maintain enough blood flow to keep the heart muscle alive until a defibrillator arrives. Early proponents for EMS saw the potential for prehospital care to be applied to situations beyond getting stroke, heart attack, and trauma victims to the nearest hospital, since it was clear that transport alone did not always save lives (and, in the case of cardiac arrest, never saved lives) (Eisenberg 1979 et al. 1979).

By 1973, little progress had been made. The passage of the EMS Systems Development Act that year charged the federal government with taking a more active enforcement role in states’ EMS systems. The EMS Systems Development Act
specifically promoted emerging medical, communications, and transportation
technologies. The increased accountability afforded by the Act led to enhanced
systematization at the state level. EMS training and focus gradually began to expand
beyond its original focus on trauma, stroke, and heart attack; complex transportation
systems including networks of specialty centers connected by ground and air
ambulances did indeed transform Americans’ access to expert medical care.

EMS Today

Today’s Emergency Medical Services systems still vary widely from place
(Chapman et al. 2008). About 40% of them are administered by fire departments,
while the remaining 60% are administered by government agencies or the private
sector (note that administrating a system does not mean that an entity also staffs a
system; they may contract the work out to public or private providers). 74% of low-
volume rural services are staffed by volunteer EMS providers, although voluntarism
is not a feature of high-volume metropolitan systems (Chapman et al. 2008).

The focus of EMS has, by now, morphed from an exclusive focus on trauma,
cardiac, and stroke care. Public perception has changed as well; rather than the scarce
resources that they used to be, ambulances are now a standard part of any healthcare system. People do still call ambulances for true medical and traumatic emergencies, but they also call ambulances for psychological problems, anxiety, fainting, intoxication, weakness, nausea, simple lacerations, to get “checked out” after a minor fender-bender, for respiratory distress, to get a sandwich and a bed for a few hours, for abdominal pain, for urinary tract infections, for low back pain, and for a myriad of other reasons that the designers of early EMS systems might have found surprising.

For better or for worse, however, ambulance transport is now an indelible, taken-for-granted part of the U.S. medical infrastructure.

OVERVIEW OF THE EMS WORKFORCE IN THE UNITED STATES

The difficulty in describing the EMS workforce in the United States is actually the product of the regional inconsistencies described in the previous section; since states and local agencies do not track the same demographic data, nor accredit paramedics and EMTs in the same ways, quantifying the workforce is, at best, a project of approximation. One problem is that some EMS workers are volunteers, some work in more than one occupation (for example, full time firefighter-paramedics who also
work part-time on the ambulance), and some maintain a license but do not work in
EMS at all. Since my project deals specifically with paramedics who work for pay on
ambulances, the data that I present in this section are drawn from sources that
measure the characteristics of EMS workers who are employed for pay and who work
on ambulances rather than fire engines (including the Bureau of Labor Statistics and
some parts of the extremely comprehensive 2008 EMS Workforce Report undertaken
by UCSF and the University of Washington in conjunction with the Office of
Emergency Medical Services of the National Highway Traffic Safety
Administration). Because the data do not make distinctions between EMTs and
paramedics, I have no way of doing so on my own; however, since many people work
as EMTs prior to being certified as a paramedic, these figures are likely an accurate
representation of both the EMT and paramedic workforces.  

Except where otherwise specified, all quantitative demographic data in this section was acquired
from the 2008 EMS Workforce Report, which itself draws on over a half dozen secondary data sets
from, among other organizations, the BLS, the NREMT (National Registry of Emergency Medical
Technicians), and LEADS (the Longitudinal EMT Attributes and Demographics Study).
The EMS workforce can be loosely characterized as young, white, male, short-term, and moderately dissatisfied with EMS work. Some basic workforce statistics follow:

- The average age of an EMS worker is 35 (as compared with Registered Nurses at 44, firefighters at 38, and law enforcement at 39).
- 22% of licensed paramedics are women (as compared with 93% of Registered Nurses, 4% of firefighters, and 14% of law enforcement personnel). The number is slightly higher for EMT-Basics (29%), although EMT-Basic is a position with substantially less decision-making power.
- 81% of licensed paramedics are white. By contrast, whites represent 72% of law enforcement, 78% of nurses, and 76% of firefighters.
- BLS data for 2014 estimates the paid workforce at 235,760 (again, this includes both EMTs and paramedics since the BLS does not distinguish between the two in tabulating its statistics).
- BLS data for 2014 measures the median wage for EMS workers at $15.24/hr. (Note that this median is calculated from a sizeable range of $9.95 at the low end to $26.29 at the high end.) By way of comparison, BLS data for the same year show a median wage of for $32.04/hr for nurses, $22.10 for firefighters, and $27.31 for law enforcement.
- Approximately 37% of paramedics are unionized. Union EMS workers enjoy higher pay and access to better benefits such as health care, dental coverage, and 401(k) retirement plans.

On-the-job injuries

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4 http://www.bls.gov/oes/current/oes292041.htm#ind
5 http://www.bls.gov/oes/current/oes291141.htm
6 http://www.bls.gov/oes/current/oes332011.htm
7 http://www.bls.gov/oes/current/oes333051.htm
As an industry, EMS is relatively dangerous environment for workers. Paramedics can land in some very precarious positions in the course of their workdays: they carry and sling gear weighing up to 35 lbs., carry patients weighing many hundreds of pounds (sometimes up steep embankments with precarious footing), drive up to several hundred miles per day, risk exposure to transmissible disease, and encounter combative patients bent on injuring them. EMS workers’ overall injury rate is 36.4 per 100 full time workers; their relative risk of injury resulting in lost workdays is seven times the national average for all workers. 55% of their injuries can be classified as sprains, strains or tears (most commonly of the back), and women are at higher risk of injury than men (31.5 of injuries per 100 full time workers as compared with 38.3 injuries per 100 full time workers). The cause of injuries includes overexertion/lifting injuries, assaults (mostly by patients), falls, and transportation accidents. This injury rate far exceeds that of other emergency and health care workers. EMS workers are 1.5 times more likely to suffer injuries than firefighters, 5.8 times more likely than health care personnel in general, and 7 times more likely to be injured on the job than the national average for all workers (Maguire et al. 2005).
Given the physical nature of the job, it goes without saying that a serious injury can be career-ending.

More ominous than EMS workers’ injury rate is their on-the-job fatality rate. At 12.7 fatalities per 100,000 workers, EMS is only marginally less risky than other emergency response occupations such as firefighting (16.5 per 100,000) and law enforcement (14.2 per 100,000), and substantially higher than the national average for all private-industry workers (8.1 per 100,000). The most common cause of death is vehicle accidents. EMS workers may be killed in crashes, or struck by vehicles at the roadside while on emergency scenes. Paramedics spend most of their transport time unrestrained in the back of the ambulance. Even low speed accidents can result in medics being thrown across the patient compartment; high-speed accidents and rollovers magnify this trauma exponentially. The second most common cause of death is heart attacks and strokes on the job. Lifestyle and heredity are obviously components in risk for these deaths, but the constant physiological and psychological stress of the job cannot be underestimated. Homicide brings up the rear; as with women police officers, women EMS workers suffer from a homicide risk three times the rate of men workers (Maguire et al. 2002).
One other serious EMS health risk – raised by leading EMS injury epidemiologists Brian Maguire, Katherine Hunting, Gordon Smith, and Nadine Levick (2002), and supported by my ethnographic data and personal experience – is suicide. No statistics are available on suicide among EMS workers, since suicide is not counted as a job-related death. However, the number of times that my subjects brought up losing coworkers to suicide, combined with our personal understanding of the cumulative effect of psychological trauma on the job, suggest that suicide in EMS is as underappreciated a job-related risk as was suicide in active-duty and returned military personnel a few short years ago.

_Morale and Advancement: EMS as a Stepping-Stone_

That the average age of an EMS worker (35) is so much younger than that of firefighters and paramedics reflects the current trend for workers to use EMS as a stepping-stone to move into more lucrative, stable, or prestigious jobs (most commonly nursing and firefighting). Where twenty years ago, people who went to paramedic school saw paramedicine as a career, people who are pursuing a paramedic license today are often doing so in order to enhance their chances of getting picked up
by a fire department (since many departments no longer hire non-paramedics) or parlaying it into a transition to nursing school or a physician assistant training program. Indeed, one of the major stumbling blocks with EMS work is that there is little meaningful opportunity for advancement. EMTs may become paramedics, but paramedics – unless they pursue one of comparatively few careers in EMS management – have nowhere else to go unless they leave the industry. There are no other positions to promote to (as firefighters can do by moving up the chain of command) or new fields to explore (as nurses can do by moving into a different specialty or pursuing advanced degrees like Nurse Practitioner). The more short-term EMS workers flee the ambulance for greener grass, the more the morale of long-term EMS workers suffers.

This built-in dead end is just as well for private employers. Since they are not providing pensions or promotions, they have little financial incentive to invest in the longevity or satisfaction of their workers. The largest single employer type in EMS work is private ambulance at 40% (Chapman et al. 2008); both my interview data and my experiences as a shop steward during multiple year-long contract bargaining processes support EMS workers’ widely-held assumption that private ambulance
companies’ approach to cost-cutting is to keep their workforce as new, young, and non-union as possible. Experienced paramedics may provide qualitatively better care than new paramedics, but the companies they work for often seek, overtly or covertly, to push them out. Certainly, there are individual members of local management teams who attempt to mitigate or shield employees from the anti-employee attitudes pervasive at the upper levels of ambulance corporations, but neither can I disregard the words of one manager who told me frankly that the policy of the last company he had worked for – one of the largest providers in the U.S. – had been to encourage its managers to “find” opportunities to terminate long-time, high-cost employees.

THE STRUCTURE OF THE LABOR PROCESS IN EMS

This project is partly about paramedics’ emotional labor. It would be impossible to understand the implications of emotional labor without having a clear understanding of what being a paramedic looks like on a day-to-day basis. The irony, of course, is that a paramedic never has the same day twice. In this section, I attempt to outline those things about the job that are predictable, and to explain the range of possible variations on each theme.
Scheduling

One of the aspects of the job that appeals to EMS workers is the hours. Depending on the system, ambulances are typically deployed in shifts of either 12 or 24 hours. Medics refer to these shifts colloquially as “twelves” or “twenty-fours,” and as “units” or “cars” (e.g., “I worked a 24-hour car for several years”). While there are a limited number of extremely busy urban systems that use a ten-hour, four days per week schedule – as well as a limited number of slower systems that may utilize longer shifts of 48 or even 72 hours – the vast majority of U.S. systems operate as twelves or twenty-fours. For full-time employees, twelves and twenty-hours bring some degree of predictability: twelves usually run on the same days and hours each week, while twenty-fours run on a variable schedule such as the nine-day cyclical Kelley Schedule (one shift on, one shift off, one shift on, one shift off, one shift on, four days off). Some twelves run four shifts every week; others are four shifts one week and three shifts the next week, for a weekly average of 42 hours. The Kelley schedule (or similar variations) results in an average weekly hour count of 56 hours: 48 hours the first week followed by 72 hours the second week.
The long hours raise important questions. Pay is, of course, an obvious concern when schedules are formatted such that they regularly exceed the 40-hour federally mandated workweek. The pay scales are designed with built-in overtime. Although some contracts provide for daily overtime (after 8 hours of work), most provide for weekly overtime only. The weekly overtime works out well for full-time workers who regularly benefit from the pre-factored overtime, they do not benefit part-time workers who work less than 40 hours per week. Another working condition related to long shifts is the issue of meal breaks and rest breaks. Legal loopholes allow public safety employers to skirt the standard requirements for rest breaks (10 minutes of paid break for every four hours worked) and meal breaks (30 minutes of unpaid time for shifts of five hours or longer). These loopholes were created to account for the emergent nature of public safety work; it is reasonable to assume that there will be times when a meal break is not feasible if workers must prioritize an emergency response. The problem is that “emergency” is a constant state of affairs in EMS, so it lets employers off the hook for finding workarounds (such as staffing more ambulances). While some EMS labor contracts have attempted to enshrine meal
break protocols into contract language, EMS workers who get regular meal breaks are the exception.

A third issue related to scheduling is sleep. As with all shift work, night shift workers are expected to sleep during the day and come to work rested. In practice, many workers are unsuccessful at this. On 12-hour units, one must make a point of going home immediately following the shift and prioritizing sleep if one wishes to get a solid 7-8 hours. This doesn’t allow much wiggle room for spending time with loved ones or hitting the gym. For workers with families, or for workers who are unable to adjust their circadian rhythms effectively, working the night shift means chronic sleep deprivation. It can be quite difficult to unwind after a busy shift, rendering the process of recovery even more challenging. Chronic sleep deprivation leads to severe physical consequences and poor mental functioning – arguably an undesirable condition for a worker who must perform under acute stress and at a moment’s notice. The oft-repeated industry mythology about average burnout rate – time on the job before an EMS worker leaves the industry - is five years. Sleep deprivation, along with a punishing work pace - is a central component to eventual burnout. The worker who
does not develop chronic sleep dysfunction in the form of insomnia, hormonal
dysregulation, and stress-related illness is rare indeed among her colleagues.

Workers on 24-hour shifts often suffer even more. If their unit is a
consistently busy one, they may find themselves awake for 24 hours straight. Any
sleep that can be obtained during downtime is of markedly poor quality. My own
experience on twenty-fours for four years echoed my co-workers’ conviction that the
sleep one gets at work is not the same as the sleep one gets at home. Even if a crew is
lucky enough to get four hours of uninterrupted sleep, the sleep they do get is fitful
and restless since the possibility of being awakened keeps the mind too aroused to
achieve deep, restorative sleep. Many 24-hour shift workers have families,
schoolwork, and other accountabilities; even those without competing priorities often
find themselves unable to fully recover from a bad night when they get home in the
morning. Because they have to be back to start a new shift the next day, and because
they repeat that cycle a third or even fourth time before getting several days off in a
row, the cumulative lack of sleep has devastating consequences on functioning,
personality, and physical and mental well-being. In my experience, the change
apparent in someone who has been off work on vacation or injury for several weeks,
and who then comes back having slept every night for that period of time, is striking.

A rested EMS worker is more alert, less prone to anger and irritation, and more positive in her outlook on life.

An obvious question is why, if twenty-fours are so detrimental to health and well being, they persist as a work model. The answer is complicated. Before the spread of unionization in the EMS workforce, twenty-fours allowed ambulance companies to save money because they paid workers their full wage only while they were on emergency calls, and not for their downtime. Labor organizing mostly changed that (although there are still some smaller, non-unionized transport companies that still operate in that way). In terms of cost, twenty-fours are still far cheaper to run than twelves, because the employer can provide twenty-four hours of coverage over a week with six workers, versus the eight workers (and associated benefits costs) that are needed to a unit providing the same coverage through twelves.

In EMS systems where twenty-fours have been replaced by twelves due to increased workload, the change has sometimes been initiated by the employer (citing safety concerns) and sometimes by the union (also citing safety concerns). Clearly, there is a level of business at which employers cannot expect workers to perform to minimal
standards without rest. This is particularly the case in urban areas with high population density.

Somewhat surprisingly, it is the workers themselves who sometimes resist attempts to change their schedules. EMS workers – like firefighters, who work shifts varying in length between 24 and 48 hours – place high value on their off-duty time, and see their shift schedules as enabling of more off-duty time. Having to work “only” ten days each month sounds like a boon – except that each of those days requires a full day or more for recovery (which, as I explained earlier, often does not happen). Again, the cumulative effect of chronic sleep deprivation is far greater than the loss of a single night’s sleep. Nonetheless, some workers fight hard to keep their twenty-fours, even as they complain about the punishing pace of work and increased call volume. Of the two EMS systems in which I have worked, one system is comprised of a combination of twelves and twenty-fours, and the other system is entirely made up of twenty-fours with the exception of one 12-hour unit. In the latter system, complaints by employees to management about increased call volume led to offers by management to split twelves into twenty-fours. Management allowed workers to put the matter to a vote of the workforce on multiple occasions over a

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period of years; every time, twenty-fours won handily. Despite the effects on their
health and relationships, and despite the negative effects of sleep deprivation that
workers freely admitted to, no one was willing to give up the 24-hour schedule. On
the contrary, there is always a small handful of workers who regularly work more
than 24 hours at a stretch, pulling 48 or even 72 hours at a time for overtime pay.

It is not difficult to make a case for why it is inadvisable to allow someone
who has not slept for 48 hours to operate a large vehicle under emergency conditions
or to perform emergency medical interventions; this argument was the foundation for
the movement to restrict the work hours and on-call duty time of medical residents.
Healthy, rested people make more competent decisions and react to stressors with
greater flexibility and dexterity. Brain-compromised individuals are not equipped to
respond as well to stress. As I will show in the chapters that follow, an EMS worker’s
ability to perform emotional labor is a key skill, and one on which her job depends.
Any factor that compromises physical well being also compromises emotional well-
being, and thus, job performance.
Who Makes up an Ambulance Crew

The composition of an ambulance crew varies from system to system, and even from unit to unit. In the United States, most 911 systems now run on a “one-and-one” model, in which an ambulance is staffed by one paramedic (EMT-P, or Emergency Medical Technician – Paramedic) and one EMT (Emergency Medical Technician – Basic). EMT and Paramedic training requirements vary from state to state. In the California, where this research was conducted, EMT certification involves approximately one semester of coursework (120-150 hours), after which the EMT student must sit for and pass the nationwide standard exam managed by the National Registry of Emergency Medical Technicians (NREMT). Paramedics, on the other hand, complete up to 1500 hours of training, which can take anywhere from one to three years, depending on the design of the program. Some states even require that paramedics complete a two-year community college degree in EMS. Paramedics can do everything that EMTs can do (and a whole lot more), while EMTs are constrained by their more limited scope of practice.

An easy way to think about the difference between EMTs and paramedics is that paramedics can break skin (or, as we sometimes like to say, “paramedics can kill
people”). EMTs are authorized to perform basic lifesaving interventions such as CPR and automatic external defibrillation (AED), to administer simple medications like oral glucose and oxygen, and to assist in packaging trauma patients for transport. The scope of practice for paramedics is far broader. While it varies from state to state, and is often most liberal in rural areas with extremely long transport times (in which the delay of a critical intervention could result in disability or death), the paramedic scope of practice typically includes the ability to start IV (intravenous) fluids; to administer several dozen medications including cardiotropic medications (drugs that affect the functioning of the cardiovascular system) and narcotic pain medications; to place endotracheal tubes into the tracheas of patients who are not breathing effectively; and to perform transcutaneous pacing and cardioversion with defibrillators (using electrical charges to resolve or compensate for serious heart arrhythmias). The potential for an improperly administered medication or intervention to kill someone are actually quite real.

The division of labor on a one-and-one ambulance varies according to local practice. In some systems, the EMT’s role is to assist the paramedic on the scene of calls, drive the paramedic and patient to the hospital, and to perform most (if not all)
of the driving that happens between calls. Other systems allow the EMT to attend to
the patient (colloquially known as “teching” a call) if the patient’s medical complaint
falls within the EMT scope of practice. There are few systems left that are comprised
entirely of dual-medic crews because dual-medic crews are more costly. Where dual
medic crews do exist, they generally work 24-hour units, or units where the uneven
workload of a one-and-one unit would be impossible to maintain. While the two crew
members are technically considered to be partners, the paramedic is ultimately
responsible for the medical care that takes place on scene; even if the care is provided
by the EMT, the medic is on the hook if something goes awry. The same is not true of
the EMT; hence, the paramedic is always the highest medical authority on the unit.

The actual nature of EMS partnership is an interesting topic in itself. To some
degree, being an experienced EMS worker means being able to meld more or less
seamlessly with any partner to whom you are assigned for a shift, even if you have
never met that person before. Roles on an ambulance are predetermined by job
description; beyond the work itself, how the shift goes is the result of negotiation
between partners (Where shall we eat? Do you mind if we go downtown so can run
an errand? Do you think we should take this guy to the trauma center?). I have been
consistently shocked over the years by the intimacy – false and temporary though it may be – that can arise between complete strangers in the course of a single shift.

Being stuck with one person in the front of a vehicle, navigating boredom and stress by turn, seems also to enable the forging of bonds that might take weeks, months, or even years in a workplace where workers only ever interact with one another in passing. I have been repeatedly surprised by the personal topics that people I don’t know have chosen to discuss with me, and me with them. Needless to say, smooth relations between partners can make a shift pass with pleasurable speed; relations characterized by friction can leave a medic feeling trapped as the clock moves with agonizing slowness. Serious conflict between partners is sufficiently discomfiting that EMS workers may “down” their unit after a serious conflict, or call in sick if they find out that they have been scheduled with a partner who they do not trust, or with whom they have clashed. Because the stressful nature of the work requires partners to trust one another implicitly – including trusting unknown partners until such time that they prove themselves not to be reliable – working with a “bad” partner or a lazy partner is a much higher-stakes endeavor than lacking that sort of rapport in, say, movie theater concessions.
For part-time medics, partners may change daily. Full timers are another story.

Some full-time partners work together for months or years, sometimes spending more cumulative time with one another than with their romantic partners and spouses.

Extremely close relationships can develop, although closeness at work does not necessarily translate to closeness off work, i.e., good work partners may or may not actually pursue their friendship outside of work. The benefits of a strong work partnership are many: good long-term partners know and tolerate one another’s daily habits and routine; they know one another’s style on scene, and can predict each other’s needs before any need must be verbalized. They can provide valuable sounding boards for work-related issues (such as talking through calls after they are over) and home-life struggles (such as issues with marriage or children). Partnerships between both single people and already-partnered people occasionally result in short-term or long-term romantic connections, marriage, and families. The intimacy that EMS life forces upon its workers speeds up the “getting to know you process” in unquantifiable but dramatic ways.
Power Dynamics on Scene: Relations Between ALS Fire and Non-Fire EMS

The power dynamics of a scene are complicated by the presence of fire departments that provide ALS (Advanced Life Support) services, and who staff their engines with paramedics. During the 1980s and 1990s, there was a mass movement in U.S. fire departments to shift some of their focus to EMS. This was largely the result of fire prevention technologies having grown too effective. With fewer actual fires to fight and questions about their large budgets mounting, the fire service saw EMS as a way to use pre-existing emergency response infrastructure to justify their public spending, labor costs, and pension fund spending (much like the military, firefighting is one of only a handful of public-sector jobs remaining that does not require a college degree and whose wages allow for a solidly middle-class lifestyle with a lifetime pension and medical benefits after retirement). Getting into the EMS business initially meant that the fire department simply ran as first response and extra support on emergency scenes with ambulances. Some of their firefighters trained up as EMTs, while others did not. Over time, however, fire departments initiated paramedic programs of their own (a move known in the industry as “going ALS”). With multiple paramedics on a single scene – the first arriving medics on the fire engine, and second arrivals on the
The division of labor on calls shifted to fire-based EMTs assisting to fire-based paramedics initiating treatment and then handing off care to the ambulance medics for transport. After some years of hiccups as both groups of workers adjusted to the new reality, the two systems are now relatively well integrated in most places where they exist concurrently. This is not to say that calls always run smoothly - there are plenty of power struggles and on-scene conflicts between two people with equal training who both believe themselves to be in the right or in charge – but the growing pains of the 1980s and 1990s have settled somewhat.

The main effect of fire-based EMS on the ambulance based EMS workforce is not necessarily positive. Ambulance-based paramedics who have been on the job for years – some of whom are old enough to remember the days before fire “went ALS” – have not benefitted from the changes. The working conditions, social prestige of firefighting, and attractive benefits package offered by the fire department has resulted in a wholesale transition of ambulance paramedicine from career path to stepping stone. While EMTs who undertook paramedic training in the 1960s, 1970s, and 1980s generally did so as a permanent career move, most people who attend paramedic school today are doing so as “in order to” eventually get another, better job
beyond the ambulance. There are few remaining fire departments who will even hire candidates who do not have a paramedic license. Because of the fire departments’ sudden intense demand for trained paramedics, California state regulations changed from requiring two years of on-the-job EMT experience before one could even apply to paramedic school (pre-1999), to only six months of experience (1999-2001), to no work experience at all (2001). The creation of “dime a dozen” paramedics had a net effect of lowering the social value of ambulance-based paramedicine while increasing the social prestige of the fire department – a process that was greatly aided by the public glorification of the fire service that took place in the days and months following 9/11. Now, high turnover rates on the ambulance have changed ambulance-based paramedicine from a career that took several years of investment just to enter, to a stepping stone process requiring only a high school diploma. Those left behind are robbed of their pride not only by the public obsession with firefighting, but by the same work speedups, downsizing, anti-union efforts, and cost-cutting measures that affect workers across so many sectors in modern industrial capitalism. No wonder, then, that paramedics bristle so fiercely when a member of the public refers to their number as “ambulance drivers.” The scope of this project does not allow for a more
comprehensive treatment of the effect of fire-based EMS services on ambulance-based EMS workers; suffice it to say that in systems where fire runs ALS engines, ambulance medics struggle with decreased morale and public acknowledgement while still performing the same emotional and physical labor. Public acknowledgement is a key form of non-monetary compensation on the job, and its diminution is no small thing.

A DAY IN THE LIFE ON THE AMBULANCE

Getting On Shift

Regardless of what kind of schedule an EMS worker labors under, and despite the inherent unpredictability of an individual day on the job, certain aspects of daily work are predictable and consistent. At the beginning of the shift, EMS workers report for duty either at a central deployment location (for 12-hours shifts) or at a 24-hour station. They may receive their “rig,” “truck,” or “bus” (regionally variant terms for “ambulance”) from an off-going crew, or they may be assigned to a vehicle by deployment staff. If they receive equipment from an off-going crew, they will take a report on the equipment (what’s missing or broken, what needs to be restocked, etc.),
and chat about how busy the crew’s shift was, whether they had any good calls, or what they’re going to be up to on their day off. These conversations are more than utilitarian; in addition to being a vehicle to communicate critical information about equipment, they allow the off-going crew to blow off steam about calls that went awry and supervisors or workers in other agencies with whom they may have had conflict (e.g., firefighters, police, or hospital staff), and to mentally shake off the day’s emotional detritus before heading home to loved ones. If the two crews aren’t particularly friendly, this conversation may be short and businesslike; between friends, it may be long and therapeutic.

Once the handoff has occurred, or an oncoming crew has received its equipment from deployment staff, the next step is checking out the rig. This involves surveying the physical equipment (cardiac monitors, drug boxes, etc.) and inventorying smaller items like medications and IV catheters to ensure that the ambulance is appropriately stocked for a full shift. New medics may take some time to accomplish this task; more experienced medics can get through it in a matter of minutes because they have seen the back of the ambulance so many times that they know immediately when something is missing. The check-out step is sometimes
skipped, but doing so is risky: the crew on duty is responsible for the condition of the ambulance, and should they find themselves without a critical piece of equipment at an awkward moment, the excuse “the last crew didn’t restock it” doesn’t fly. So, while the standard handoff assurance is “the rig should be good to go,” a paramedic is expected to assure himself that the rig not only should be good to go, but actually is good to go.

Once both crew members have checked out the ambulance, the crew must advise its dispatch center via phone or radio that the unit is in service, or log themselves into the CAD (Computer Aided Dispatch) system. At this point, they become available for calls (although if they are on a 24-hour unit, they were available for calls during checkout at well; 24-hour cars have no designated downtime for pre-duty activities).

*Post Moves/Move-ups*

This is the point during the shift at which the predictability of the day is mostly over. Depending on the system, a unit may initially be dedicated to a particular geographic region. When the unit is posted to its designated region, it is considered to be “at
post” or “in zone.” However, EMS systems are inherently dynamic. Most systems prescribe a more or less complex series of post moves designed to provide maximum coverage across the entire system when emergency calls go out. So, for example, if a large urban area normally staffs 30 units during the daytime hours, and several calls are dispatched at the same end of the county, a domino-like system of post moves (also called “move-ups” or “bumps”) juggle the remaining resources such that they are spread more evenly across the resulting holes in coverage.

The main rationale behind post moves is compliance with county-specific regulations about response times. For decades, the industry standard has been eight minutes for urban areas. This means that ambulances must arrive on scene within eight minutes of dispatch 90% of the time. The eight-minute requirement reflects the focus of early EMS on traumatic and cardiac arrest emergencies (in the case of the latter, early defibrillation is often the difference between survival and lethal outcomes), and is the reason for which ambulances travel Code 3 (with red lights and sirens) to the majority of calls (Shah 2006). Because the number of calls for which minutes really do matter is so slim, there is considerable debate these days (see Blackwell and Kaufmann 2002; Shah et al. 2005) about whether the benefit to the
very few outweighs the risks to the many: Code 3 responses actually cause plenty of traffic accidents, not only between ambulances and other vehicles, but between vehicles attempting to clear the road for ambulances. Response time standards persist, however, so post moves are designed to help mitigate the risk of long and frequent Code 3 responses.

Post moves can represent a draining part of a day’s work on the ambulance. For one thing, they rarely entail short distances. Some move-ups require drive times between anywhere from ten minutes to nearly an hour or more if traffic patterns are heavy. Time behind the wheel causes involves both physical and emotional labor, particularly in systems where the EMT does the vast majority of driving. In large, geographically dispersed systems, post moves may add up to 200-300 miles of driving per day, a not-insignificant burden on the body given that time between move-ups is spent running EMS calls. If the home unit runs and clears its call before one arrives at a post move, or shortly after, there is nothing to do but turn around and drive home. At night, this effect is compounded by fatigue: if a post move doesn’t result in a call, the absence of physical stress response (i.e., an adrenaline dump that allows night shift workers to access increased levels of alertness to perform their
duties) results in even more dangerous driving conditions. Doing a “there-and-back”
without running a call on a long post move amounts to rousing oneself at 2 a.m.,
driving a few miles (or a few dozen miles) with no emergent destination to promote
wakefulness, and then turning around and driving back. The extraordinary potential
for accidents should not be underappreciated.

While EMS workers understand post moves to be necessary for outlying
areas, they are less sympathetic to short-range post moves, which feel less utilitarian
and more like wasted effort since EMS workers themselves are most keenly aware of
the false imperative for a time-sensitive response on most 911 calls. This effect has
been heightened by the advent of ALS fire, since the fire department paramedic
ingines – of which there are several times more available than ambulances – do not
perform the same sorts of post moves (or at least, not until their ranks are
substantially more depleted), and are therefore nearly always well positioned to
perform what few time-sensitive interventions the system requires. Those calls in
which the defining lifesaving treatment is transport to a hospital rather than a critical
intervention that a paramedic can perform on scene are exceedingly rare. One word
about frequent short-range move-ups that has surfaced repeatedly among my
colleagues during my time in the industry is “demoralizing.” This is particularly the case with nighttime move-ups, which are perceived by workers as especially useless because nighttime road travel is substantially quicker that traveling during peak traffic hours. In my experience as a chief union steward and as a volunteer member of local pre-hospital care stakeholders’ committees, I noted that some members of ambulance management, as well as public officials responsible for EMS management, either did not consider move-up time to be “work time,” or did not comprehend the degree to which move-ups left EMS workers feeling physically drained and intellectually underutilized. Indeed, the squishiness around how move-ups are conceptualized – as “work,” or as “not work” – remains a major bone of contention between management and the field.

What Happens Between Calls and Post Moves

What happens during those periods of time in which a crew is neither checking out the rig, nor on a post move, nor on a call, nor completing post-call duties? Quite a wide variety of things, as it turns out. Time spend on shift between job-related duties is technically a medic’s own, provided that the crew stays within its designated
posting area. Crews may perform any number of personal tasks between calls, including running errands, visiting/meeting up with friends or family, shopping, doing banking, trying to nap, making appointments, catching up on phone calls, double-parking the ambulance on a street corner and chatting together, meeting other ambulance crews for social time, visiting other agencies (such as the fire department) for social time, surfing the Internet, playing video games, watching television in the station, preparing and eating food, buying food out, exercising at the station, doing homework or studying for personal educational pursuits, going to children’s back-to-school nights or sporting events, cruising areas with good people-watching opportunities or a scenic view (my co-workers in one of the areas that I worked were fond of going to look at the ocean “just to make sure it’s still there”), and even cleaning and organizing one’s car.

It goes without saying that all of these pursuits are subject to interruption at any time. This is both lovely and problematic: the feeling of accomplishing personal chores (or enjoying some bonding time with colleagues) while on the clock is a source of pleasure and satisfaction, since time that one might otherwise have had to spend on those tasks on an off day is now freed up. Boredom at work can allow EMS
workers to cross a surprising number of long-procrastinated chores of the list, since an EMS worker in her down time is truly a captive audience. (Although I have learned never to count on the time in advance, I have found that an unexpected windfall of free time on the ambulance has been a source of a large handful of uniquely productive writing days while in graduate school; certainly, I have rarely managed to write for eight hours straight while at home, except under the tightest of deadlines.)

On the other hand, downtime at work has a “borrowed time” quality, since it can be (and often is) interrupted unceremoniously at inopportune moments. Little is more frustrating for a medic than getting a call or move-up shortly after putting in a food order at a restaurant, or while standing in line at the grocery store with a full basket, or while leaving a Thanksgiving table filled with loved ones. Downtime, in others words, is a crap shoot: you win some, you lose some. It is also not even an occasional reality for all EMS workers, especially those who work in consistently busy systems. Certainly the social and commercial options are much more limited at night, leaving night shift workers posting, sometimes for hours, in the front cab of their ambulance. Population density is also a factor. EMS workers who are employed
in the busiest urban systems (on tens or twelves) typically run non-stop for the entirety of their shifts, and are lucky if they manage to get even a single uninterrupted meal break. In those systems, errands and personal chores simply don’t happen.

Conversely, in extremely slow rural systems or on slow units, a crew might run just one or two calls a day, or have no calls at all during a shift (a “shutout”), leaving them with, if anything, too much time on their hands. Feeling underutilized can be as demoralizing as being exploited. I have worked in both kinds of systems, and on a variety of cars – very busy and less so – and have found that the most tolerable and satisfying days are those in which we work at a steady pace (perhaps six calls in 12 hours) but still have enough downtime to put our feet up for a bit, eat when hungry, and enjoy some social time with co-workers which, as I will explore in more detail later, is a critical emotional survival strategy.

THE ARC OF A 911 CALL

Dispatch and Response

A call officially begins when a unit is dispatched. Dispatch centers are either private (run by the ambulance company) or public (run by a local governmental agency).
When an emergency call comes in to the primary dispatch center, a 911 dispatcher determines the nature of the complaint and (in some places) runs the call through a decision-making algorithm called Emergency Medical Dispatch (EMD). EMD helps the dispatcher decide what kinds of resources to send and at what speed to send them. For example, a call for a vehicle accident involving several cars and a stopped highway would prompt a more comprehensive response – with fire, law enforcement, and ambulance – than would a cardiac arrest at a residence. The cardiac arrest, in turn, would prompt a faster (Code 3; lights and sirens) response than a sprained ankle (Code 2; no lights, normal flow of traffic). The primary dispatch center then transfers the information about the call to the ambulance dispatch center. If the primary dispatch center is the one that manages ambulance dispatch, the call-taker will transfer the information about the call to the EMS dispatcher.

Dispatch occurs by pager (alpha-numeric, voice, or both). EMS workers refer to a dispatch as “getting a call,” “bagging a call,” or “getting a job” (jargon varies by region). Once the call is dispatched, the crew has a preset amount of time to acknowledge the dispatch and to “go en route” to the call. A common time limit is one minute during the day and two minutes at night, although this can vary from
location to location. The information that is included in a dispatch can also vary from place to place; crews may get anywhere from a standard short-form dispatch (such as “Medic 84, respond Code 3 to a report of a trauma at 224 Main St.…224 Main St.…time out, 1534”) to a much longer form (such as “Medic 84, respond Code 3 with Engine 4 to an auto versus pedestrian at 224 Main St…224 Main St., corner of 1st St.…reporting party states that patient was hit by an SUV and thrown about 20 feet and is on the ground and not moving. I can hear bystanders yelling in the background. Law has been started. Time out, 1534”). This is more a matter of local practice. In either case, the paramedic must assess the dispatch information for clues that she will need more resources than what she knows is already on the way. For example, if it is standard practice in her system to “send fire” on every call, she doesn’t need to request fire if she knows that she will need extra hands for extrication. On the other hand, if she works in a system where the standard practice is to transport major trauma victims to out-of-area trauma centers by air ambulance, having advance dispatch information enables her to request those resources even before she arrives at the scene. Starting additional resources early is prudent, since you don’t want to have
to wait for them if you arrive on scene and discover an immediate need for them; you can easily cancel them if you find that you end up not needing them.

On occasion, an ambulance crew may “jump” a call or “buy a call” off another crew if they believe that they are substantially closer to the call. System design and zone assignments may change as system administrators attempt to cover an area more efficiently, or cover it with more or fewer ambulances, changing the crews’ perception of which calls “belong” to which units. Buying calls is a less common practice in extremely busy systems where crews do not monitor radio traffic and cannot mentally keep track of where each unit in the system is due to the system’s size. In these systems, crews have little awareness of what other ambulances are doing; their work assignments come down through the pager and they run the calls to which they are dispatched without trying to help manage the system more efficiently or divide up the workload more evenly from the field (a practice that is feasible in smaller systems).

There is a remarkable amount of grumbling and complaining that occurs when a crew believes that another unit was closer to a call, that another unit should have jumped the call, or that a unit was “dodging” (avoiding being dispatched) a call in
“their” zone. This may be one of the most pervasive forms of negative talk on the ambulance. A reputation as a habitual “call dodger” is hard to shake once acquired, and may or may not be based in reality. In my experience, the types of call dodging incidents that EMS workers complain about are the same incidents that they themselves perpetrate, given the opportunity.

Call dodging and jumping have contradictory effects on morale. On the one hand, it can be exhausting to monitor all radio traffic and try to remember where everyone else is. In the extremely busy urban system that I worked in for three years, I recall feeling a giddy sense of ignorance when I realized that I wasn’t expected to keep track of where other units were or to jump their calls. I had no sense of whether I was working much harder (or less hard) than a nearby unit, so I could neither come to the aid of crews who were getting “hammered,” nor could I feel upset by a perceived workload imbalance. On the other hand, call jumping – when it works well between crews who work together regularly and make a communal effort to “protect” each other and to try as best they can to prevent other units from having to run calls in “their” zone – has the effect of promoting a strong sense of solidarity and communion between crews. This morale-enhancing practice counters the morale-killing practice
of call dodging (or complaining about perceived call dodging). The complaining, of course, is always at its worst when the call volume is higher for some units than for others; on days where everyone is getting hammered, the sense that “we’re all in this hand basket together” creates enhanced solidarity based in shared suffering.

On the way to the call, the paramedic or EMT driving the ambulance responds to the traffic conditions and may use any of a range of techniques for getting around traffic. Unsurprisingly, Code 3 driving reveals much about the personality, experience, and hunger/fatigue levels of the person behind the wheel. Newer, inexperienced EMS workers have to be taught – quite explicitly – that Code 3 driving does not mean driving as fast as you can at all times. On the contrary; the purpose of Code 3 driving is merely to get to the call expediently while avoiding major traffic obstacles such as stopped or heavily congested traffic, long waits at intersections, and lengthy routes around one-way streets. New drivers take unnecessary risks, putting the public in danger on the misguided assumptions that seconds count (second mostly don’t count, and neither do the minutes) and that they are doing something wrong if they don’t try to get everywhere as fast as possible. While I now see this misconception as profoundly naïve, I recall holding it myself. I have a very clear
memory of when an experienced 20-year medic schooled me on the actual logic of Code 3 driving: “It’s not your emergency,” she told me bluntly. “Don’t create another one on top of it.” Prudent driving, then, means operating with what the Vehicle Code refers to as “due regard” for public safety. This sometimes means “shutting down” (turning off lights and sirens) while on a free-flowing highway or while traveling a road on which exceeding the speed limit would be dangerous.

Driving Code 3 is a source of frustration and exhilaration. There is a quiet thrill in being able to be legally “naughty” via speeding, going through red lights (only after a full stop!), traveling the wrong way down a street, driving over medians, or driving on the shoulder. We aren’t allowed to do those things in our cars, so being able to do them without getting in trouble with the law is fun. Younger and less experienced workers also thrill from fast driving, until they learn to avoid it. But Code 3 driving can also be stressful when other drivers fail to yield, or when they pull to the left rather than the legally-prescribed right, or when they panic and squeal to a stop right in front of your 10,000 pound ambulance. With traffic accidents the primary cause of on-the-job death for EMS workers, Code 3 driving carries real risks. In most cases, these risks do not outweigh the benefits of a slightly quicker response;
the problem, of course, is that there are very rare exceptions. For this reason, all 911 responses are assumed to be worst-case scenario until proven otherwise.

Aside from driving, there is another serious consideration that must be factored into a crew’s thought process prior to arrival on scene. This is the question of scene safety. “Scene safety” is a general phrase that encapsulates a wide range of possibilities for danger on a 911 call. Some dangers are inherent to the type of call that a crew is responding to. For example, a motor vehicle accident (MVA) on a highway presents an obvious risk of getting hit by other cars on the highway. This risk increases at night, when visibility is poor and when intoxicated drivers are likely to be confused by flashing red lights (driving into, rather than away from them). The best way to prevent these sorts of accidents is by parking the ambulance in such a way that it (and ideally, the scene) is blocked by larger vehicles such as fire engines.

Other considerations on MVAs include the presence of fire (actual objects on fire, not the fire department, as I mean when I write “fire” in the rest of this project), the presence of hazardous materials such as gasoline, or, in the case of accidents involving industrial vehicles, chemicals or other dangerous cargo. Provided that the crew is aware in advance of these threats to safety, they can “stage” (park a safe
distance away from the scene) until such time that the fire department or other appropriate first responder advises them that it is safe to enter the scene. In the case of hazardous materials, the crew may not be able to enter the scene or make patient contact at all until the fire department has gone through decontamination procedures. This can mean driving Code 3 to a scene and then waiting up to several hours before any medical work is done.

Other pre-arrival concerns for safety surround the behaviors, actions, or potential actions of either the patient or other people on scene. When dispatch is able to identify a safety issue during the call-taking process, the dispatcher advises the crew to stage in the area until law enforcement (or less frequently, fire), arrives on scene. Calls that might prompt a staging order include physical and verbal altercations, domestic violence, suicide attempts in which there is a known weapon or the absence of a weapon cannot be confidently verified, calls in which the patient or caller has indicated that someone on scene is violent, calls in which background noise like screaming has alerted the dispatcher to an unusual situation, and anything the patient says that leaves the dispatcher uncertain if she is sending the crew into harm’s
way. “Staging in the area” typically means parking a block or two away from the call, depending on the reason.

Even in the absence of an order to stage, crews can choose to stage of their own accord, and are usually not castigated for doing so because of the sheer number of calls where staging turns out unexpectedly to be necessary. An example of what happens when the right information doesn’t get communicated was painfully clear in the case of one of my interview subjects, a 12-year medic. He and his partner were dispatched to an unknown medical (the standard parlance for a call whose details are unclear but for which the dispatcher suspects the possibility of medical need). He and his partner ended up on a live shooter scene, ducking behind the ambulance in order to avoid getting struck by stray bullets. The scene itself was chaotic, and the police on that scene were not aware that it involved a live shooter until it was too late to report the situation, but the paramedics involved were nonetheless quite shaken by the experience. Another one of my interview subjects recalled a scene from early in his career where, during a standard MVA, the other side of the multi-lane freeway where his accident scene was located suddenly exploded in a proliferation of speeding police vehicles chasing a lone car down the highway. That call, which I recount and analyze
comprehensively in Chapter 5, ended with a fatal shootout between the police and the
chase suspect just yards from my subject’s accident scene, illustrating the fact that an
EMS worker can never put safety out of her mind, even if the scene initially appears
to be predictable and stable.

Scene safety also means considering the possibility that the patient or
bystanders may not want the ambulance at all. In poor urban neighborhoods of major
metropolitan areas, bulletproof vests are either standard issue or optional uniform
pieces that some EMS workers choose to wear either because they have experienced
gunfire on scene or because they have heard stories about other EMS workers
experiencing gunfire on scene. Although I was unable to find any official reports of
such calls, there is certainly no shortage of urban legends and stories passed from
crew to crew about a medic or EMT who got attacked by the person who tried to kill
(or successfully) killed her patient, and then stuck around to make sure that the victim
actually stayed dead by preventing medical aid from reaching him.
Arriving On Scene of the Call

Once the crew arrives on scene, they begin a complex series of decision-making processes. The first decision is what equipment to bring in to the call. Each ambulance is equipped with a standard set of “carry-ons,” bags filled with emergency medical equipment that might be needed to stabilize or treat the patient on scene before moving him to the ambulance. Carry-ons include a portable oxygen tank with necessary administration devices, airway equipment such as endotracheal intubation kits and bag valve masks for providing assisted ventilation, basic trauma care supplies, a medical box or bag with IV (intravenous) supplies and IV medications, a bag with pediatric equipment, and a cardiac monitor and defibrillator containing blood pressure cuff, stethoscope, and blood glucose measurement supplies. While the expectation is that a crew will bring all carry-ons in to a call – something that newer medics are more inclined to do since they have not yet developed the ability to guess/predict what they may need based on dispatch information – many experienced medics bring, in practice, only the equipment that they think they may actually need. This is especially true if ALS fire has arrived on scene first, since having redundant carry-ons takes up space and occupies the hands and attention that will likely be
needed to carry the patient. All bets are off if the patient location is far from the
ambulance, however. If the patient’s room is located up flights of stairs or in the
recesses of an apartment building, or if the scene is located down a steep embankment
or miles up a trail – anywhere too far to return to the ambulance if the patient turns
out to need more equipment than the crew predicted – everything comes along.
Nothing is more awkward than realizing your patient is far sicker than she sounded
and that you’ve left a critical piece of equipment behind in the rig.

If there is no fire crew on scene – if it is a Code 2 call with no fire response, or
if the ambulance has arrived before the fire crew – EMS workers take greater care to
establish scene safety. The presence of fire or law suggests that someone else has
already handled this question, so an ambulance crew’s vigilance goes down if they
are preceded by other agencies. The “sketchiest” scenes (the scenes most liable to
contain surprises) are those where dispatch information is unclear or insufficient.
Often called “man down” or “unknown medical” calls, these are dispatches prompted
by ambiguous reports or “cell phone Samaritans” – people who see someone that they
think might need medical help and simply call 911 as they drive by or walk away,
rather than investigating to see if the person actually needs or wants help. Many “man
“down” calls end up being a person sleeping in the bushes (perhaps intoxicated or homeless). Others, however, are people genuinely in need of medical aid, but unaware that EMS has been summoned. If their need is the result of recreational drug use and they are concerned about being arrested, the presence of official-looking EMS workers dressed in the same navy blue as law enforcement may not be welcome. If the scene feels unsafe or a patient in need of medical care refuses to cooperate with care during the first few moments of a call, the crew may back out of the scene, request law enforcement, and wait for their arrival before proceeding with the call.

Establishing or Obtaining Scene Control

Once scene safety is established, the paramedic’s next move is determined by the presence or absence of ALS fire. If ALS fire is not present, she will conclude that she, as the first arriving paramedic, is in control of the scene and begin to run the call. If ALS fire is present, she will make her crew’s presence known to the fire paramedic and/or the captain, and may either jump in to assist if there is obvious assistance
needed, say something like “let me know if you need anything” or ask, “can I get you (a piece of equipment) or do (a medical procedure or intervention) for you?”

The question of scene control and the associated interplay of power and social dynamics are quite extraordinary in their subtleties. If ALS fire arrives first, the fire crew technically holds medical control of the scene until such time that the fire medic turns the call over to the transporting medic on the ambulance. While there are systems in which local policy dictates that control be relinquished to the transporting unit upon its arrival to the scene, they are in the minority. What happens next depends on the relationships between fire and ambulance in the system in general, and the relationship between the fire medic/crew and ambulance medic in particular.

In the early days of ALS fire – a story repeated by some of my older and more experienced interview subjects, and something that I, too, noted in the first few years of my career – relationships ranged from strained to hostile as fire and ambulance personnel attempted to assert or reinforce their authority on scene. In the large urban system from which several of my interviewees came, the first couple of years after the transition to ALS fire (in an “old-school,” men-dominated, highly regimented big-city department) were extremely difficult; my subjects recalled times when they were
met at the door of a patient’s home by a firefighter who blocked their entry and
spouted some version of “you guys can wait outside until we call you in” It was not,
suffice it to say, a particularly cooperative relationship in the beginning.

On the other hand, none of my newer subjects reported this type of overt
hostility. I personally began my career just a couple of years after the wave of
transitions from BLS to ALS fire began. I have also found over time that the contests
for power control have largely settled down. People seemed to become more
comfortable in their roles and less competitive, resulting in a generally cooperative
relationship between fire and ambulance. I am not denying the persistence of
occasional conflicts over treatment, extrication, and transport decisions, but where
they used to be dealt with in the moment that they arose, the more common approach
now is to either let the issue lie (if it doesn’t affect patient care one way or the other),
to address it as diplomatically as possible on scene (if it does affect patient care), to
take action to correct it without mentioning it directly, or to let it go in the moment
and then sort it out verbally after the call by making contact with the fire crew on the
phone or in person.
Of these options, “addressing the issue as diplomatically as possible on scene” and “taking action to correct the issue without mentioning it directly” may be the most interactionally rich from a power relations standpoint. In my field notes, I detailed two different interactions that I had with one fire medic who I experienced as insufficiently aggressive with his medical treatment. I used each of these techniques in turn on two separate calls that I ran with him. The patient on the first call was a teenage girl who had fractured her humerus (the bone in the upper arm) into two pieces when she ran into a wall. She was in severe pain and screamed whenever anyone tried to touch her. The fire medic was a field training officer for his department and was in the company of a new hire firefighter that day. On a previous call that day, he had pulled me aside to ask that I let his “new guy” run all the calls that day so that he could get the patient contacts he needed to complete his training. I readily agreed. However, on scene of this call, I noticed that the trainee was not stating his intention to start an IV in order to administer morphine before trying to move the patient. Since medicating for pain is something that we can do easily, and since the patient was right next to the ambulance, I asked pointedly if I could grab the morphine for him; asking another medic if you can do something for him is an
effective way to initiate a treatment that you feel strongly about while allowing the other medic to save face; rather than calling attention to his gaffe, you can remind him of what he “should” be doing in the guise of trying to be helpful.

In this case, however, the inexperienced trainee lacked the knowledge to take part of the bait. He responded, “I guess we could do five milligrams of IM morphine.” At this point, I glanced at his training officer, who said nothing, despite the fact that this was the wrong dose and the wrong route for the medication; morphine takes 15-20 minutes to work when administered via intramuscular (IM) injection, and requires twice the amount for the same effect of morphine administered intravenously (IV). I knew from experience that 5mg of morphine was unlikely to put even a tiny dent in the patient’s pain. So, despite the training officer’s request that I not intervene, I offered, “Look, she’s got great veins! We could have a line (IV line) in her in less than a minute, and then we could give her IV morphine instead. She looks super uncomfortable. Want me to flood you a line (get an IV set-up ready)?” “No,” he said, “I think we can just do it IM.” The training officer pulled me aside and said, “I asked you to let him run the call. I’m not going to interrupt him unless he’s doing something wrong.” “But,” I persisted, “he is doing something wrong. Five milligrams isn’t going
to touch her, and even if he was giving the right dose, it’s going to take a long time to
hit her if we give it IM. Look at her – she’s really hurting.” Fundamentally, this was a
conflict about the “right” thing to do. The training officer’s perspective was that his
need to see his trainee run the call uninterrupted took precedence over other
considerations; my perspective was that the need to medicate the patient appropriately
took precedence over watching the trainee.

I couldn’t prevent the trainee from administering what I considered to be an
inappropriate dose, but I could (and did) take another form of action. While the
trainee drew up his medication, I walked over to the ambulance, pulled out an IV set-
up, walked back to the patient, and had an IV started on her within a minute. I looked
pointedly at the training officer but said nothing. Once she was loaded in the back of
the ambulance – still sobbing – I drew up my own medication and administered it
immediately. Within a couple of minutes, she was calm and more comfortable.

This didn’t turn into a major altercation, but it is illustrative of the differences
in approach to paramedicine that exist between the fire department and ambulance
paramedics. Because the fire department is organized along traditional paramilitaristic
lines with clear chains of command, firefighters have less room to negotiate outside
of standard operating procedures. It goes without saying that some people who are attracted to firefighting may already be indoctrinated into this culture (many firefighters come from firefighting families), but certainly the culture of the fire department forces constraints on fire medics as well. At any rate, they are prone to what seasoned ambulance paramedics refer to as “cookbook medicine;” i.e., paramedicine that does not deviate at all from protocol. Calling someone a “cookbook medic” is a sort of subtle insult, implying that he knows his protocols but can’t think outside the box.

The other means of dealing with conflict on scene – “taking action to correct the issue without addressing it directly” – is a more aggressive version of allowing someone to save face by offering to help them. I used this tactic with the same fire medic on a separate occasion when I walked into scene with a chest pain patient. He gave me the basic history on the patient, a man in his 60s with classic symptoms of a heart attack. He verbalized his intention to administer a nitroglycerin tablet, a standard medication given for chest pain to dilate the coronary arteries and increase blood flow to the heart. The tablets last only a few minutes and must be regularly readministered. I prefer to use nitro paste, which can be placed on a patient’s skin for
a constant small dose that need not be thought about further once placed; I don’t like to have to keep dealing with the tablets while trying to attend to other tasks.

Technically, as I had just arrived and the medic had not turned the call over to me, I was not yet the attending medic and should have complied with the medic’s request. Instead, he said “I think I’ll give a nitro tab,” and I turned to my partner and said, “Could you pass me the nitro paste, please?” At that point, he would have had to contradict me – thereby compromising my face – to get the tab that he had asked for. Since he didn’t, the call continued to run smoothly. If he had, I would have backed down and handed him the bottle of tablets without a word. What makes this interaction interesting is that it was very specific to the time, the place, and the people involved. If the fire medic had been someone with considerably more experience than me, rather than considerably less, I would probably not have attempted to circumvent him out of respect for his time on the job. If he had been someone of whom I had formed the impression of “sensitive” or “fragile ego,” I might also have just waited until I was alone in the back of the ambulance to place the nitro paste and discontinue the tabs. The interaction happened as it did because of who he was, and because of who I was.
These sorts of “pissing contests,” as several of my subjects referred to on-scene conflicts, seem to be more a function of personality and experience than of gender. This surprised me, as I expected gender to play a more substantive role in how and when conflict arises and is settled, especially in a men-dominated workplace with a strong paramilitaristic ethos. As I will discuss in other chapters, though, gender is sometimes very significant, and sometimes surprisingly less so. This was an area where it was surprisingly less so. One of my subjects shared the following story where she felt that gender had been significant:

There was an instance where I had this pregnant woman. She was in SVT\(^8\)…she was taching\(^9\) around 220, but she was fine. Fire was already on scene and the fire medic who was there was all jacked up. He knew that I had had experience with moms and births, but he really never let me handle the call. He was like, I think we’re gonna push adenosine to get her heart to slow down. But she was doing fine, totally stable. We had her on the monitor and the fire medic rode in with me…he felt like it was his patient, and he’s drawing up the adenosine and he wanted to push it. I was like, “Whoa, wait, what are you doing?” And he was like, “Well, her heart rate hasn’t changed,” and I said, “I know, but she’s stable, her blood pressure is good, she’s not feeling exhausted, and we’re three minutes away from the hospital. I don’t really want to give

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\(^8\) SVT, or supraventricular tachycardia, is an arrhythmia in which the heart beats 2-4 times faster than what is considered to be a “normal” rate (60-100 beats per minute). The drug used to treat it, adenosine, stops the heart completely for a couple of seconds, with the idea that the heart’s internal pacemaker will resume beating again at the normal rate. Because it puts the patient into a temporary cardiac arrest, it is not without inherent risks.

\(^9\) Her heart was beating rapidly (“taching” = experiencing tachycardia, i.e., rapid heart rate.)
her that because it could affect the baby in ways that we don’t have the
capacity to take care of in the back of an ambulance.” So we kind of
had a little conversation about it. I wouldn’t say it was a huge conflict
but it was like, what are you doing? I was like, let’s just wait until
we’re in a controlled environment and they can do an ultrasound and
everything else. What he was looking at was the monitor, not the
patient. He wanted to get that heart rate down. I followed up on it later
and they ended up giving her adenosine but that was maybe an hour or
two later, in a controlled environment. And they tried literally
everything else first.

- Laura, 55

Another woman medic in her 20s but with about the same amount of work
experience, explained that she had no problem “getting in the face” of a firefighter
who had been on scene for fifteen minutes before the ambulance arrived, but who still
hadn’t managed to take a set of vital signs. However, the same respondent also
lamented about the difficulty of working on a two-woman crew. Recalling a time
when a fire captain addressed her as “sweetheart” and didn’t understand why she was
offended, she countered, “Would you call one of your guys “sweetheart?” “That shit,”
she insisted, “does not happen when I am working with a male partner.”
Determining the Reason for the 911 Call

Whether scene control is obtained immediately by the transporting paramedic, or whether it is transferred (or wrested) from the fire medic at a point within the call, the ambulance medic’s first step is to figure out why she has been called to the scene. In the presence of a patient or bystander who communicates the chief complaint clearly – a “good historian,” as EMS workers are apt to call such a person – the process of establishing the reason for the call is generally straightforward. Statements like “I’m having chest pain,” “Every time I sit up, I feel like the room in spinning,” and “I haven’t had a bowel movement in three days” require no decoding.

In the absence of a good historian, the medic must use visual and aural cues as well as complex verbal assessment algorithms to establish the reason for the call. Although it is sometimes very obvious (wrecked cars; blood on the patient or floor; a mangled or deformed limb; a patient who is purple and not breathing), it’s often surprisingly tricky to sort out what is going on. If the patient called for himself, he may or may not be able to give a clear explanation of what is troubling him; if a bystander or family member called, that person may also struggle to give an accurate depiction of the problem at hand. Asking a very general question like “Why did you
call 911 today?” can sometimes shed light on the issue at hand, but not always. The attending medic may be treated to a lengthy story in which no clear medical complaint seems to emerge if the reporting party simply does not know what resources he actually needs. An example: someone calls 911 because they are unable to get rid of an intoxicated or drug-addled acquaintance who has been staying with them, or a family member calls for a loved one who is on hospice and feels unable to cope with the physical dying process on their own. In these cases, the medic must separate medical need from social need and sift through each problem in turn.

Another difficulty in establishing the reason for the call is the patient or family member’s emotional response to the situation. Patients may feel embarrassed or awkward about the reason for the call. It turns out that patients feel embarrassed or ashamed for experiencing any number of physical complaints, from weakness to nausea to pain. Individual patients’ subjective experience, cultural and ethnic background, and personal histories seem to be the primary source of these emotions; they are in no way uniform, but they are to some degree predictable; for example, I can recall countless older male patients who admitted that they had experienced chest pain for several days leading up to their 911 call, while minimization and covering up
of pain and discomfort – often referred to in EMS as “being a cowboy” – is not a behavior that my colleagues and I associate at all with elderly female patients.

People also call 911 for nefarious reasons, or reasons that EMS workers do not consider to be legitimate. This includes things like faking a medical complaint to get a ride to the hospital in order to be driven to the hospital, whereupon the “patient” takes off, having benefitted from the ambulance ride as a free taxi to another side of town; alternatively, people use ambulances to get a ride to the hospital so they can have a bed to sleep in for a few hours and so that they can get the meal that the hospital offers to patients after they have been in the ED (Emergency Department) for a while. This use of ambulances comes as a shock to the public, but is a regular occurrence in urban systems; medics are, with rare exceptions, not allowed to refuse transport to anyone requesting a ride to the hospital. Even when the patient and EMS workers are both well aware that the patient has no legitimate medical complaint, EMS workers still cannot refuse transport. This results in the phenomenon of “frequent flyers”: patients who repeatedly call 911 for transport to the hospital but who do not have a true medical emergency. Frequent flyers may call anywhere from a
few times each week to more than once each day. Medics who encounter them repeatedly are soon on a first-name basis with them.

Frequent flyers are a source of deep frustration. In their more sociologically enlightened moments, medics may take the long view, as Karen (38) did when she noted, “We go into people’s most vulnerable times of their life, or their most frightening times, or their most painful times. We go in and we’re expected to show compassion and actually sort out what’s going on as well as being compassionate enough to this person in their most vulnerable state.” More often, though, medics consider frequent flyers to be illegitimate, undeserving drains on the system. In the course of one interview, a longtime co-worker reminded me of a frequent flyer – several years dead – whose habit it had been to call an ambulance nearly every day, claiming that he was going into withdrawals from lack of alcohol. Since that patient was always intoxicated when he called, his claims of “withdrawal” symptoms were physiologically impossible, so he was lumped into the “undeserving” category. In general, frequent flyers come in phases; one will appear as another leaves the area or dies. Mostly, they are people with serious mental illness and/or substance abuse issues who have fallen through the cracks of social safety nets. Their resources are
limited and the EMS system becomes a way for them to meet their immediate needs for food, shelter, and human interaction. Sociologically speaking, frequent flyers are a predictable phenomenon in any society with pervasive wealth inequality and insufficient social safety nets for its most vulnerable populations.

Other examples of dubious reasons for 911 calls include financial motivations or the desire to avoid undesirable situations in which a caller might find himself. One of my subjects, Kendra (29), recalled a vehicle accident with no injuries: “I walked up to the patient and I was like, if you’re not injured, why are we going to the hospital? The guy looked right at me – no shame or anything – and he was like, ‘It’ll look better for the insurance.’ He was literally taking an ambulance to the hospital so he could stick it to the other guy’s insurance.” Avoiding undesirable situations could include calls where a person is getting stopped or arrested by police and tells law enforcement that he is having a medical emergency in order to avoid getting arrested. Even when law enforcement and EMS are uniformly clear that the person is not experiencing a medical emergency, the rules governing both agencies require all responses to be taken seriously. While this can be profoundly frustrating – “It drives me crazy,” the medic in the previous quote complained, “that we can’t just call
bullshit on people like that,” removing the opportunity for making judgment calls does occasional deaths that occur while arrestees are in police custody. The frequent misuse of ambulances does contribute much to paramedic psychological burnout; on the other hand, paramedic burnout contributes to an increase risk of assuming that all iterations of certain kinds of calls are “bullshit.” EMS is full of urban legends about medics who got “bit on the ass” when their failure to take a seemingly non-emergent complaint seriously resulted in a poor outcome for the patient. It’s something that more experienced medics are even more vulnerable to, since their years on the job lead them to believe that their well developed sense of “sick” vs. “not sick” will protect them from making medical errors.

*History and Physical Assessment*

Once the reason for the call has been established, the paramedic must perform a history and physical exam. This occurs in two phases. During the primary exam, the medic assesses airway, breathing, and circulation – the stuff that can kill you quickly. The medic quickly sizes up the patient’s breathing effort by simply observing him breathe for a moment (labored breathing or no breathing = bad; unlabored breathing
She can easily assess circulation — that is, whether enough oxygenated blood is being circulated to the body and the brain — by observing skin signs (rosy, warm, and dry = good; pale, sweaty, cool = bad) and whether the patient is conscious, alert, and oriented to his surroundings (good) or not (bad). Other pieces of information like behavior (is the patient writing, groaning, or screaming?) and the patient’s general appearance (kempt or unkempt?) The primary assessment happens almost instantly and without much conscious thought for all but the most inexperienced medics. This is typically the moment when a medic determines for herself whether the patient is “sick” or “not sick.” The sick/not sick distinction is not one of “any problem at all” versus “no medical problem at all.” Rather, sick/not sick is a binary related to a medic’s sense of medical emergency. A sick patient is one who has a time-sensitive medical emergency; a not-sick patient is one for whom, regardless of the possibly dramatic visual impact of their medical complaint, time is not of the essence. An example of a sick patient would be a patient with poor skin signs, difficulty breathing, and severe lethargy, while a an example of a not-sick patient might be a person with a fracture of the lower leg that, while painful, will also not get substantially worse if not treated in the next hour.
Before starting this project, I had a long-standing rubric for breaking down the severity of EMS calls. If you had questioned me about it, I might have answered something like this: “70% of our calls don’t need an ambulance at all and probably don’t even need to be seen by a doctor; 20% of our calls aren’t emergencies but it just makes more sense to take them by ambulance; and 10% really can’t get to the hospital any other way or are true medical emergencies.” In my interviews, I thought it would be interesting to compare my own anecdotal breakdown with my colleagues’ equally unscientific assessments. Responses fell ranged from “50% bullshit” to “90%” bullshit, but the consistent eye-rolling and cynicism did provide a useful illustration of the enormous chasm between what paramedics believe they will spend most of their time doing on the job when they enter paramedic school and what how they understand their jobs once they have been in the field for a couple of years. Needless to say, the vast majority of our calls fall in the “not sick” category, making the minority of truly emergent calls all the more memorable. Daily life on the job, as described by Phillip (28), is “a whole lot of ‘boring,’ punctuated by some exciting stuff a few times a month if you’re lucky.”
Establishing sick/not sick immediately alters the trajectory of the call. For not-sick patients, the second phase of visual and physical assessment (the secondary assessment) continues at an unhurried pace. Sick patients inspire a different level of activity; while all rescuers on scene make an effort to keep the patient and family’s anxiety down by speaking calmly to them and to one another, more things begin to happen at once. Equipment is brought out, vital signs taken, treatments initiated, and plans for extrication and transport discussed. Much of this happens without explicit conversation, particularly among experienced crews who are so accustomed to working together or working within a particular EMS workplace culture that they can easily anticipate one another’s needs. Each person on scene knows her or his role, and can operate competently within the well-oiled machine of the call. When one rescuer isn’t going with the program, or isn’t experienced enough to know the program, the system breaks down and the crews on scene have to use verbal conflict resolution techniques to try and get on the same page. The ultimate goal for sick patients is to perform only what stabilizing interventions are absolutely necessary on scene as quickly as possible, and then to initiate transport. Anything that can wait until the crew is en route to the hospital or helicopter landing zone must wait. The standard of
care for sick trauma patients is ten minutes or less on scene; for medical patients, similar standards apply. Actual on scene times, of course, depend on the intricacies of the scene; if a patient requires lengthy extrication from a cliff face, or requires special transport equipment like a bariatric unit (unit built for patients with severe morbid obesity), it can take much longer – sometimes hours - to get on the road.

For not-sick patients, medics might spend significantly more time on scene. Part of this time is spent assessing the patient: taking one or more sets of vital signs, getting a thorough history from the patient or bystanders, recording the patient’s medications, and speaking by phone with family members who are not present in order to fill in details of the story that may be missing. Paramedics begin medical treatment as indicated, and begin to think about packaging (preparing a patient for transport on a gurney or backboard), extrication (getting the patient from the location we find them to the ambulance), and transport (to a hospital or medical helicopter landing zone). Depending on the complexity of the necessary treatment, all personnel on scene may be involved, or only some; in rare cases, e.g., with extremely heavy patients, more resources may be called to the scene to assist.
Most treatment that occurs on scene (as opposed to in the ambulance, en route to the hospital) is treatment designed to either make the patient more comfortable or to minimize damage from an acute problem that threatens organs like the heart or brain. Comfort measures could include administering pain medications before attempting to move a patient, or anti-nausea medications to someone who is vomiting. Medications to prevent damage due to acute problems could include the administration of dextrose (sugar) in order to prevent brain damage to a diabetic patient with very low blood sugar, or nitroglycerin to enhance blood flow to coronary arteries whose circulation is compromised by a myocardial infarction (heart attack).

Prophylactic treatment – for example, starting an IV that the hospital will probably use, but that the ambulance crew probably will not use – is something that would happen en route to the hospital rather than while sitting on scene. Standards and local practices for on-scene times vary; some local work cultures favor short on-scene times as a way to run the system more efficiently; other work cultures take a more contentious approach. The contentious approach is partly a form of resistance to management-induced work speedups (for-profit ambulance companies’ profit is maximized when they run their systems using as few resources as possible, but
speeding up on-scene times means providing less care for the patient on scene and more care en route). During my field research, I observed that a call’s close proximity to the hospital seemed to increase my partners’ self-imposed pressure to remain on scene (even if that meant performing care in the back of the ambulance while sitting in front of the scene) so as not to get grief from hospital staff about why they hadn’t gotten an IV or obtained a 12-lead electrocardiogram (ECG or EKG) prior to arrival at the hospital.

Medical scenes themselves can be more or less challenging to manage, depending on their idiosyncrasies of location, time, and people involved. Medical emergencies can and do happen everywhere. By way of demonstrating the sheer variety of locations we respond to, I offer the following brainstorm spanning my career, jotted down during a 3-hour period of time when my partner and I were staged in a remote area, waiting for the fire department to locate and extricate our patient from the scene of a mountain bike crash:

In houses: in every possible room in a house, in the garage, out in the backyard, on the roof, in the bathtub (way too many of those), wedged between the toilet and the wall (too many of those, too), on the toilet, in the closet (hangings, blech), in the hot tub or pool; in motels and hotels, IFO calls (“in front of” calls, in which we’re dispatched to “in front of” a particular location); highways and city streets; busses and cars pulled over on the side of the road;
beaches and forests and horse trails miles from anything; boats in the middle of the ocean, construction sites; factories and warehouses; malls, shops, small businesses of all kinds, schools, fields, tanning booths, and/in the ocean, rivers, swimming pools, bouncy houses, amusement parks, and trampolines; airplanes, courthouses, office buildings, restaurants, and hospitals; the parking lot of the emergency room, the lobby of the emergency room (really!); an endless stream of assisted living facilities, nursing homes, urgent care clinics, and doctors’ offices; soup kitchens, homeless encampments, homeless shelters; sidewalks, bushes, state parks, public restrooms, alleyways, jails and prisons; fire stations, ambulance stations, and gas stations. Basically everywhere human beings can get themselves to, we have to come get them from.

As the reader will no doubt surmise from this list, there are many considerations to weigh. Is there a crowd to wade through? Is the patient a serious hoarder whose house is virtually impassible? How we safely extricate the patient from a small space without putting the patient or ourselves at risk? Can the patient walk? Do we need to cover the patient to preserve his modesty or to prevent contamination of our clothing and equipment by a patient who is covered in feces, urine, maggots, or body lice? How can we access the patient at the bottom of the 100-foot embankment with all of our equipment and without getting poison oak? Techniques for dealing with all of these possibilities are learned on the job, rather than in paramedic school. They require an extraordinary level of creativity and strategy, and are the result of having to both think for oneself and having watched many other more experienced rescuers
think their way through thousands or tens of thousands of unique extrication situations.

Once the medic has a clear idea what is going on – whether or not she considers the complaint to be medically valid or to warrant an ambulance – she must next ascertain what the patient wants to do. With serious medical conditions, the question of transport almost never comes up; a sick patient is assumed to be going to the hospital, and non-transport is not something that is even on offer for sick patients. Not-sick patients are less cut and dry. While one might assume that everyone who calls 911 for an ambulance actually wants to go to the hospital – and the vast majority of patients do agree to transport without hesitation – acquiescence is not the case with everyone. Some people call 911 “just to get checked out” and then refuse transport. Other people, for whom 911 was called by a third party such as a family member, refuse transport on the grounds that they did not want an ambulance in the first place. Still others could probably benefit from an ambulance ride but are concerned about the expense or feel embarrassed to be the center of such a production.

The question of whether to go to the hospital by ambulance, for the few patients who are not already committed to ambulance transport, can be a source of
contention between ambulance medics and fire medics. Transport is rarely a foregone conclusion except when the patient is alone and unable to make her own decision, or when she is in the custody of law enforcement or has otherwise been temporarily deprived of her rights to make her own decisions. Legally, EMS personnel must have the patient’s consent in order to take him to the hospital. Consent is most clearly obtained by asking explicit questions like “Would you like to go to the hospital by ambulance?” In general, fire personnel tend to push much harder for non-emergent patients to go to the hospital in an ambulance than ambulance medics do. Each group has a different set of motivations and incentives. For ambulance personnel, there is a strong disincentive to transporting non-emergent patients, since every transport requires the completion of a PCR (patient care record), a more or less onerous task depending on the user-friendliness of the system’s medical charting software. For the fire department, the paperwork is less cumbersome when the ambulance transports the patient than when the fire department completes a release of liability known as an AMA (“Against Medical Advice”).

The subtle battle of wills that can ensue contains subtleties that only the rescuers on scene even notice. This sort of battle is a near-daily occurrence, but I took
detailed field notes for several such incidences in order to understand the pieces more clearly:

On scene with fire for 22 y.o. female who rolled her ankle while hiking with friends. Didn’t need to go to the hospital at all in my opinion. The ankle wasn’t even swollen and she could bear weight with just a slight limp. Fire medic said, “Well, the ambulance is here, and they’re happy to take you over to the hospital. You’ll get in faster that way, through the back door.” I said, “It looks like you might have sprained it, but we’re not really doing to do anything for you other than drive you. I’m happy to take you buy ambulance if you want to do that, but I’m also comfortable with you going to see a doctor on your own.” The patient said, “I’ll take the ambulance. I have insurance” even though she had not just one, but two friends on scene who could have driven her.

Three components stick out at me as common features of this sort of conflict. The first is fire’s use of the phrase “The ambulance is here,” as though the mere presence of an ambulance justifies the subsequent use of that ambulance. The second is the (usually false) statement that going through the back door of the ER means bypassing the line in front. The third is my own lie, “We’re happy to take you by ambulance.” I was not at all happy to take her by ambulance – at least in the sense that I didn’t consider her injury to warrant the use of an emergency resource – but honest assessments like this are among a long laundry list of things that paramedics are not allowed to say. (And of course, things we are not allowed to say constitute a large
portion of the interactions that I analyze in this paper, as later chapters will reveal).

“It seems,” my notes conclude this incident, “that a whole lot of what we do on the ambulance is hope that people can read between the lines of all the stuff we’re saying to pick up on the stuff that we’re not allowed to say because of liability.”

After the transport-or-not decision has been made, the patient is either left on scene (in the case of a non-transport), or loaded into the ambulance for transport. Transport destination is based on a combination of factors such as proximity to each local hospital, the patient’s medical complaint (some, like major traumas, strokes, and myocardial infarctions require transport to specialty centers), and the patient’s preference in EMS systems where patients are permitted to express a preference. Paramedics occupy transport time with medical treatment, reassessment, and clarification of the history of the present medical problem. Treatment may continue if indicated, or may cease if the appropriate protocol has been completed.

Paramedics operate under a doctor’s license. They practice medicine in accordance with “standing orders,” otherwise known as “protocols.” Protocols are algorithms for care that allow paramedics to perform interventions and administer medications based on their findings rather than on the order of a doctor, as a nurse in
a hospital would be obligated to do. While medics’ scope of practice is limited to emergencies, some of the standing-order interventions they perform are substantially more invasive and risky than those permitted to registered nurses. In the hospital setting, for example, endotracheal intubation and cardiac pacing are strictly the purview of physicians. But in the field – out in the world – paramedics are the designated medical decision-makers. Indeed, as previously discussed in this chapter, paramedicine came about in no small part because it was not cost-effective to staff ambulances with physicians. The role of the paramedic as it was originally conceived was to take the place of the physician when critical interventions could make a potentially life-saving difference.

What happens with patients when needed care has been delivered or no care is needed (as in the example of my 22-year-old sprained ankle patient from a few pages back)? Transport time can be filled in a variety of ways. If the attending paramedic is a friendly type, transport time can be filled with amiable conversation. If the patient is in emotional distress, the paramedic’s conversation may be of a reassuring nature. If the medic is disinclined toward small talk or emotional comfort, the ensuing conversation may be filled with awkward silences, stern lectures about how alcohol
or drugs “are gonna kill you,” or admonishments to quit abusing the EMS system.

This last sort of conversation is directed at frequent flyers, with whom paramedics are more apt to let their frustration out verbally since many are too intoxicated to remember the conversation later and are not likely to complain to management (or to be believed if they do). One of my subjects, Sam (26) confessed,

> Sometimes I think I’m kind of a shithead to people who call all the time. Not like they don’t have it coming…I mean, they are abusing the system, and they shouldn’t be, but I also know they probably got the short end of the stick in life. I mean, no one would be all like, ‘Hey, I could go to college and get a job and not be a drain on society but I think I’ll just be an alcoholic dirtbag instead.’ So I know I should at least just be civil but sometimes I can’t help being antagonistic and trying to provoke them.

Other activities that may occur during transport are paperwork (getting ahead means less to do after the call), talking about the patient’s interests, or talking about current events.

Transport time for patients in need of medical care – which, again, is not a category that all patients fall into – is filled by treatment and reassessment. Treatment that takes place in the back of an ambulance can be stressful and sketchy. Paramedics must contend with occasional patient doubts about whether procedures requiring fine motor skills (like IVs) should be attempted in a moving vehicle. While paramedics
do, on occasion, request that their partner pull over or stop temporarily for a
particularly challenging IV stick, most patients do not require such measures. Far
from being nervous, paramedics take particular pride in being able to perform tasks
that other medical professionals (not to mention patients) consider risky or
impossible, and take offense at the suggestion that they will fail. Over the years, I
have noted co-workers responding to these doubts with everything from mild sarcasm
(“Well, this is my first time ever doing this, so hold still!” to defensive pride (“I’ve
been doing this for _______ years, so I guess I’ve gotten pretty good at it by now”) to
outright defiance at the expense of non-paramedics (“Who would you rather have
start your IV? The person who’s good enough to do it all the time in a moving
vehicle, or the nurse in the hospital who never has to get as good at this as I am?”).

For more critical interventions such an endotracheal intubation, needle thoracostomy
(inserting a large bore needle into a patient’s lung to relieve the pressure of a
collapsed lung), or CPR, the need to initiate the transport process as timely as
possible means that a medic’s options are limited; she has little choice but to make it
work in the back of the ambulance. Under the best of conditions, a medic has a
workspace of perhaps twenty square feet, including the space where the patient is
lying. Under the worst of circumstances, when fire medics are riding in to lend extra
sets of hands on a critical patient, medics have almost no room to move around. In the
event that an IV proves impossible on the closest arm, a medic with sufficient
mobility may find herself assuming some creative perches across the patient’s body in
order to gain access to the other arm. Intubation may take place from a tiny seat
behind the patient’s head, while swapping rescuers every two minutes during CPR
means having to crawl or climb over other medics. Quarters, suffice it to say, can get
cramped.

Most “sick” patients are transported Code 3, which requires the concentration
of both the driver (to ensure safe driving and as smooth a ride as possible) and the
paramedic. With the exception of those patients for whom definitive care in a hospital
is time-sensitive, all other patients are transported Code 2, or with the normal flow of
traffic. Ambulances may be dispatched Code 3 a majority of the time (assuming the
call is critical until proven otherwise), but they turn around and transport Code 2 with
all but the very sickest patients. Code 3 transports happen only when the potential
benefit to the patient outweighs the risks to the public. Some time-sensitive transports
include major trauma, heart attacks, and strokes. In the case of the latter two, the
credos “time equals brain cells” and “time equals heart muscle” neatly encapsulate the imperative to minimize the time that the patient’s brain or heart is deprived of oxygenated blood (which, at its most basic level, is problem that needs to be solved for both of those emergencies). Other time-sensitive issues include major uncontrolled bleeding, uncontrolled airway or breathing issues, and newborn resuscitations: situations in which the patient either cannot be stabilized in the field, or has the potential for rapid decompensation (getting worse really quickly).

At the Hospital

Arrival at the hospital prompts another series of decisions, starting with what equipment to bring in. A stable patient may be brought in with no equipment at all, whereas a patient with a cardiac issue or who is being treated for acute breathing problems may require a cardiac monitor in addition to oxygen equipment, IV drips, etc. Patients on whom CPR is being performed continue to get CPR on the way in to the hospital, with the rescuer on CPR standing on the side of the gurney as her colleagues push her and the patient through the ER doors. For the most part, though, little equipment is required. Hospitals that are less busy can bed ambulance patients
immediately, although busy urban hospitals may not actually have available beds, in which case the medics must stand around, maintaining patient care for as long as the hospital takes to get them a bed. The amount of time this takes can be shocking. In one of the busier systems where I worked, I once stood in a hallway with a patient on my gurney for 90 minutes. The two obvious problems with that are that the patient doesn’t see a doctor (which is only a problem if the patient actually needs a doctor quickly), and the ambulance cannot be in service to run more calls. More extreme ends of hospital wait times at impacted facilities extend up to several hours.

After the patient moves (or is moved) to the Emergency Department gurney, and any equipment transferred over, the paramedic gives report to hospital staff. For most patients, especially low acuity patients, giving report is no more complicated than explaining the patient’s reason for calling 911, the paramedic’s findings on physical exam, the patient’s medical history, and what treatments were or were not completed in the field. If there are any mitigating circumstances – information that the medic does not wish for the patient to overhear – she may ask the nurse to step out of the room for a moment. This is an important technique for communicating information that the patient may be denying (for example, that he told his girlfriend
that he was going to commit suicide, but is now claiming not to have said that) or painful information that helps the hospital staff get a better sense of what is going on (for example, that a patient having an anxiety attack lost his wife in an accident the week before). Hand-off reports sometimes go well, and sometimes do not go well. Nurses have their own ideas about what should or should not have been done for a patient in the field. Some are do not hesitate to second-guess field treatment (“Why did you do X? Why didn’t you do Y?”) or to dress down the medic for a perceived hole in the medic’s assessment. Sometimes the questions are entirely valid; as with any job, there are more thorough and less thorough workers. Medics with reputations as thorough and intelligent practitioners do not get questioned as often as those who have demonstrated sloppy patient care in the past. And predictably, some problematic paramedic-nurse interactions are the result of personality conflicts. Not everyone can be expected to like everyone else, and when tensions run high as they do in emergency medicine, minor conflicts can take on a life of their own. For the most part, though, basic hand-offs occur without difficulty.

In larger teaching hospitals or trauma centers, giving report as a paramedic can be a nerve-wracking experience. One must speak loudly, clearly, concisely, and
with confidence in a room filled to capacity with up to a dozen physicians and nurses.

As with any situation where people with different skill and experience levels are trying to impress each other with their knowledge, considerable posturing takes place in report situations like these. Regardless of their years on the job, paramedics are at the bottom of this particular food chain and are not always treated with as much respect as their field experience might warrant.

There are two tasks that remain once the patient has been dropped off. The first of these is cleaning up. Most calls don’t involve complicated or distasteful cleaning jobs. The messy ones, though, are superbly labor-intensive. EMS workers try their best to contain fluids to prevent messes (my motto is “An ounce of containment is worth a pound of decontamination”), but it simply isn’t always possible. Patients may experience projectile vomiting with no warning and if they are immobilized to a backboard when it happens, they must immediately be turned on their side to prevent aspiration, moving the target of the vomiting to our equipment-filled wall cabinets. Intoxicated patients may empty the entire contents of their bladders (sometimes by accident and sometimes very much on purpose). Trauma victims may bleed out (lose most of their blood volume) en route to the hospital if
EMS cannot get severe bleeding under control. Patients who were already covered with body fluids on scene and who have altered mental status may be too disoriented to realize what they are doing, and may reach out and touch the walls and gurney with contaminated hands.

Cleaning up from a call involving spilled body fluids (urine, feces, blood, vomit, phlegm) and detritus (insects, mud, sand, dust) can take a while, particularly if the body fluids were high volume. The floor of an ambulance is a closed system, much like the floor of a shower stall. Once everything is removed, it can quite literally be hosed out should such measures be necessary. The problem is that the floor of the ambulance is also the home for all of the carry-on equipment. In rare cases, the bottoms of the carry-on bags are contaminated to the point where the equipment within must be discarded and the bags themselves laundered. Every surface on the inside of the ambulance may need to be wiped down with disinfectant spray; the gurney may need to be taken apart and wiped down, straps removed and replaced, and blood removed from the cracks that hold the plexiglass cabinet doors. The longest cleanup jobs can take several hours. Fortunately, those are infrequent occurrences.
The other major cleanups occur as the result of taking out or using many different pieces of equipment on a single call (most frequently on a code/cardiac arrest, or on a trauma call with multiple victims). On a standard medical or trauma call, experienced medics generally try to clean up as they go along, sometimes even before they have arrived at the hospital. It does take a solid year or two of experience to time the workload of a call in order to get the hang of this, but it is a skill that virtually all medics acquire. All bets are off on complicated and/or critical calls, however. When it becomes clear that keeping up with cleanup isn’t going to be possible, or when the patient’s condition warrants complete disregard for anything other than his emergent needs, EMS workers talk about the resulting chaos in back as “my ambulance exploded” or “a bomb went off back there.” Restocking after a critical call means inventorying and interviewing: what equipment is missing? Who used what size of which equipment from which cabinet or bag? Did fire plunder the ambulance to restock their bags after the call? Are we forgetting to replace some really important, infrequently-used piece of equipment whose absence no one will notice until it’s needed months or years from now, and isn’t there?
Whether short or long, the completion of the hand-off report and cleanup indicate that it is time to clear and go back in service. The crew may delay clearing the call if they have been “getting hammered” and want to create a de facto break to grab drinks, sit down for a moment, hit the bathroom, flirt or engage in friendly conversation with hospital staff, check up on patients brought in earlier, or connect with co-workers. Of all these activities, connecting with co-workers seems to be among the most important. As discussed earlier in this chapter, friendly conversation with co-workers is a central focus of coming on duty each day. For those medics and EMTs who work 24s out of remote stations, and who are not deployed out of the central operations, out-at-hospital time (time when one is out of service at the hospital after a call) is one of a tiny handful of consistent opportunities for building relationships with co-workers. Back door conversations are ideal moments to blow off steam, hear the details of calls that sound bad or interesting (and that one was not on), “shoot the shit” about everything from work to personal relationships, engage in sexualized banter and flirtation, and trade information about moody fire captains, cranky supervisors, or gripes about call-dodging co-workers. Back door conversations also serve to build solidarity among the workforce, either by reinforcing alliances or
by positioning oneself as more competent or intelligent in opposition to others.

Tactics often involve liberal use of “shit-talking;” i.e., deploying playful insults for the purpose of expressing affection for others. I will discuss these social interactions in further detail in Chapter 4.

**Paperwork**

Everyone hates paperwork. I don’t mean this as an abstract statement: in neither my interviews, my field observations, nor my career have I encountered a medic who didn’t hate paperwork. Medics mostly discuss paperwork in abjectly binaristic terms: “This would be a great job if we didn’t have to do paperwork” or “I wouldn’t mind running calls nonstop all day if we didn’t have to do paperwork.” Up until the early 2000s, many systems still used paper charts. Writing a PCR (patient care record) means documenting a laundry list of information about the call, from dispatch times to patient demographics to chief complaint and physical findings to multiple sets of vital signs, treatment and response, and a narrative explanation of the call. Various web-based systems now exist for logging PCRs. Until new medics become familiar with their charting system, PCRs may take up to an hour per call. Practiced medics
can sometimes complete their charts in 15-20 minutes, depending on how onerous
and redundancy-filled the charting system is. The requirement that medical personnel
document their interactions with patients is not unique to EMS; indeed, a paperwork-
driven work speedup is one cause of complaints across the medical industry that
practitioners do not spend enough time with their patients because they are too busy
writing their charts. This claim is not an exaggeration.

In busier systems, medics are supposed to have a dedicated period of time for
paperwork after they clear each call. Paperwork time doesn’t exist everywhere,
however, and in those places that lack paperwork time, medics must do paperwork
during their “down” time. Downtime is not calculated by ambulance companies as
work time, which means that the actual labor of paperwork is minimalized and
invisibilized by the employer. Even in systems with dedicated paperwork time, the
time is shortened or temporarily suspended when county ambulance levels are low. In
busy counties, of course, low levels are par for the course on a daily basis. Paperwork
gets done in the in-between times: on the way to calls, while eating, while riding to
the hospital with a low-acuity patient, and even done on one patient while riding to
the hospital with a different patient. Paperwork is a source of anxiety for some, since
it is the primary method of “CYA” (cover your ass) available to EMS workers. The cultural approach to paperwork can be approximated as “If it was documented, it happened; if it wasn’t documented, it never happened.” Some paramedics are detail-oriented in their paperwork, while others deliberately keep their narratives brief and vague. In both cases, the idea is to prevent oneself from “getting burned” if the call gets reviewed, if it comes up in court because the call resulted from a crime, or if an unhappy doctor or nurse takes issue with a medic’s care and decides to run the call “up the flagpole.”

Paperwork is one of many aspects of EMS that makes it difficult to distinguish between work time and downtime. Along with the inability to fall deeply asleep, to eat, to let go of constant vigilance, and to filter out some noises as irrelevant, the constant treadmill of paperwork reinforces the fact that a medic is only off-duty when she is off the clock and away from work. And even then, as I will demonstrate in the remaining chapters, EMS is not a job that is easy to put aside – mentally, emotionally, or physically – when a paramedic goes home at the end of a shift.
CONCLUSION

In this chapter, I have reviewed the history of modern EMS in the United States, provided an overview of the current workforce, and sketched an outline of paramedicine as an occupation. It should be clear by now the nature of EMS makes any description of a “typical day on the ambulance” a project richly deserving of suspicion. In the chapters that follow, I examine gender, labor, and emotions in the context of the shop floor (running calls), the break room (time between calls), and off duty.
**CHAPTER 3 - THE LABOR PROCESS ON SCENE: RELATIONSHIPS BETWEEN EMS WORKERS AND THEIR PATIENTS**

*My stepdad died in our house. The ambulance came and picked him up and coded him in the house. I was 12 or 13 and I remember it all, everybody’s tone and facial expression. I remember it all. It’s a trip. Being aware of how we deal with people in that kind of scenario…I know it sticks with (the families of our patients), too. For us, it’s four in the morning and we’re on the twenty-first hour of a 24-hour shift and we’re wanting to go home. They’re like, “Is my husband gonna make it?”*

- Jeremy. 36 years old

In Braverman’s account of the labor process (1974), the primary site of inquiry is the factory floor. This chapter is my attempt to follow his lead, using the emergency scene (being “on scene”) as the parallel locus. There are certainly some key distinctions between an emergency scene and the sorts of industrial production environments that Braverman so famously described in *Labor and Monopoly Capital*. The most obvious is that emergency medical care is an industry that falls most appropriately under the rubric of service work. The EMS worker is providing several distinct services: she is performing emotional labor for the benefit of patients and their loved ones; she is performing skilled labor in the form of medical interventions such as gaining intravenous access, administering medications, intubating, and stabilizing traumatic injuries; she is performing manual semi-skilled labor in the form
of extricating patients’ physical bodies from their place of origin to the emergency transport vehicle; and she is providing transportation to the hospital via ambulance (another semi-skill).

In writing about “emotion work” on scene, I am referring to Hochschild’s classic definition of “labor that requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others” (Hochschild 2003: 7). However, the emotional labor performed by paramedics is complicated by requirement that they perform both care work and emergency work, each of which is gendered in specific ways. In the case of emergency work, the relevant emotional labor is actively acknowledged by the EMS worker and is evidence of skill and experience. In the case of the care work, the emotion work is often (although not always) unacknowledged to self, others, or both. Emotion work performed by the EMS worker on himself should be understood as a coping mechanism aimed at career longevity, even though the end result is not always aligned with the intent, nor does the suppression of emotions necessarily create a psychological and social health for EMS workers. On the contrary, EMS workers
self-report suicidal ideation and suicide attempts at approximately ten times the rate of the general population (Newland et. al 2015).

This chapter concerns the labor process in the EMS equivalent to Braverman’s factory floor: the 911 scene or emergency scene (henceforth referred to as being “on scene” or “on a call” in accordance with industry jargon). Since EMS is fundamentally a service industry, my analysis centers around the provision of different kinds of services: skilled and semi-skilled, emotional and physical. There are important distinctions to be made in the delineation of various kinds of emotion work in EMS, some of which happen in the course of performing the job, and some of which take place during downtime or off-duty time. This chapter will address neither the emotional labor nor the workplace culture of the backstage aspects of EMS work; that is a topic to which I return in a subsequent chapter. It will also not include the deeply private emotion work that medics do in service of their own social reproduction (also the subject of a later chapter).

That said, the prospect of framing different kinds of emotional labor in EMS – even if we restrict it to types of labor performed in the process of delivering emergency medical care – leaves us with a bewildering selection of contexts and
combinations. We imagine the factory floor as involving relations between laborer
and labor process, between laborer and fellow laborers (and manager), and between
laborer and product (Marx 1978; Tilly and Tilly 1998; Burawoy 1979). These
relationships exist in facsimile on 911 scenes: there is the EMS worker’s relationship
with the service work she is performing on scene; there is the worker’s relationship
with himself and his co-workers (and supervisors); and there is a relationship between
the laborer and the recipient of her service. “Service work,” write Korcynski and
Macdonald, is “work that involves working on people. The presence of the service-
recipient within the labor process is the central definitional element of service work”
(2009: 3). The service-recipient is the person to whom the service is rendered: in
EMS, the patient. These relationships are not much different to parallel relations in,
say, the branch office of a large tax preparation corporation. What distinguishes EMS
is the complexity of the relations involved, services rendered, and recipients of the
labor (both explicit and implicit). In the hypothetical tax preparation company, the
recipient of the service is the client whose taxes are being prepared, not an anxious
parent of the client. The service is the completed filing, it is more or less impersonal,
and the worker does not require the cooperation and agreement of four or five other
people to get each tax return filed. While the service interaction in EMS is short-lived and defined by the boundaries of time, EMS workers do not seem to fit in the category of “emotional proletariats” who have “perform face-to-face…service work, but who have no control over the feeling rules that guide their emotional labor, and who are in a subservient position vis à vis the customer” (MacDonald and Merrill 2009: 115). On the contrary, they are performing a service in which they are expected to manage their and the client’s emotions, but there, EMS work diverges from the classic definitions of service work that I recounted above. EMS workers do not necessarily occupy a subservient position vis à vis the client; what’s more, the emotional labor involved in their service extends beyond the client in ways that they can (to an extent unusual in service work) exert agency in choosing both how and what types of extracurricular emotional labor they want to perform.

EMS, unlike accounting, is a team sport—at least on the surface. A medic cannot successfully run a scene without the buy-in of everyone on that scene: patient, family, allied agencies such as fire and law, and her own partner. It also isn’t accurate, as with the tax client, to consider the sick or injured person to be the only recipient of the service. In the starkest instances of this contradiction, wherein a
patient is clearly and irreversibly dead, the intended recipient of labor performed on scene may not be the patient at all, but rather, his family or other bystanders. I will address bystander and family relations in a later chapter; for the remainder of this one, I will examine the various relationships that EMS workers cultivate and negotiate with their patients on emergency scenes, with a focus on the emotional labor that each type of relationship requires. I will consider how relationships are influenced by factors such as the seriousness of the patient’s medical complaint (or lack of seriousness, as the case may be), by the patient’s physical and mental condition, by her social identities, and by her emotional state.

NON-EMERGENCIES: “BULLSHIT” CALLS AND FREQUENT FLIERS

In medic school, all they ever train you for is really crazy stuff. Like, they drill you on all these real serious medical calls, and train you to think about these crazy hypotheticals like where you’re going to land a helicopter given the proximity of the train tracks…but then you get out there, and you’re just driving drunks around, day after day.

- Rob, 29

While it might seem strange to the reader that I have chosen to begin a chapter on the emotional labor of paramedics with a discussion of non-emergencies, be assured that
there are compelling reasons to do so. Indeed, the great majority of a paramedic’s workload consists of non-emergent calls. The sentiment expressed in what Rob says above exhibits a level of disenchantment that would doubtless surprise a layperson whose understanding of EMS was limited to television shows and Hollywood films. Every single one of my interviewees had something to say about the chasm between their expectations of the job prior to entering the profession, and what the job actually consisted of. Medics speak with indignation, disappointment, occasional sympathy, and sometimes, frank anger about the “bullshit” calls that make up a substantial proportion of their workload, perhaps because EMS workers themselves tend to share the public’s misconception of what EMS work entails before they enter the industry.

A “bullshit” call is any call that does not meet a medic’s definition of “emergency.” The *Oxford English Dictionary* defines emergency as “a serious, unexpected, and often dangerous situation requiring immediate action,” yet the majority—arguably the greater majority—of EMS calls fall considerably short of meeting the constraints of that definition. Considering the preponderance of non-emergent calls in medics’ daily lives, it is no surprise that they describe these calls with such vehemence. Rob reflects an attitude common to EMS workers, which might
be summed up as “This isn’t what I went to school for.” Disappointment with being
misused or underused was a common theme running through my conversations about
the aspects of the job that my subjects least enjoyed. Consider the patient load model
that Sarah, 33, advances as her notion of the distribution of calls in her system:

    In paramedic school, all of the scenarios that we did were actual medical
    complaints. But we were never trained about how to deal with bullshit calls,
    even though I feel like bullshit calls make up sixty or seventy percent of our
    call volume. And that’s a skill. You have to learn how to do that. There’s an art
to it. But it’s something you can only learn on the job. These brand new people
coming out of medic school right now…they just have no idea. The drunks run
them around in circles.

Bearing in mind that there are very few EMS systems that allow medics to refuse
service to someone who requests transport by ambulance, “bullshit” calls can be
considered both a feature and a bug of EMS work. EMS workers do not reserve the
right to refuse service to anyone, even a person who openly states that he is not
experiencing a medical problem but wants to go to the hospital regardless. Fear of
litigation drives the transport requirement, since refusing to transport a patient who
later suffers a poor outcome constitutes patient abandonment and medical negligence.

Patients who use the 911 system regularly on a non-emergent basis are referred to by
paramedics as “frequent fliers.” Frequent fliers are a source of profound frustration to
medics who perceive them as being manipulative, as wasting EMS’s time and resources, or as refusing to take responsibility for their problems:

I don’t like feeling abused. I feel like shit rolls downhill and there’s only so many places it can go. It can go to jail or it can go to the emergency room. Sometimes I categorize patients as worthy patients or unworthy patients, and I get frustrated when I go into the ER and it’s filled with drunk homeless people and then we bring in a 35-year-old mother with this stroke or something and there’s no bed because all the drunks are taking up the beds. It just drives me up the wall.

- Jen, 28

I was talking to my mom the other week and she was like, “God, you sound jaded. You’re making comments about bums and dirty people.” And I was like, “No, I care…you just become so desensitized to it.” You don’t want to run that call at the homeless shelter…you see so many people, and although they’re maybe not intentionally abusing things, you have that inkling to be like, “You’re full of shit. You’re just abusing the system.”

- Benjamin, 34

You get your bums that you get irritated with, and you get mad at them…the frequent fliers that shouldn’t be calling.

- Michael, 46

Frequent fliers are often (although not always) linked with perceived or actual substance abuse. Medics vary in their understanding of the social inequalities from which these calls arise. Some express an interpretation of frequent fliers’ behavior (and their own response to it) that is firmly rooted in a Sociological Imagination:

Our largest majority of patients in the different places I’ve worked is the “somewhere in the transient-to-poverty” patient...most people that call 911
either don’t know any better, or actually believe something’s going wrong. Most of the time, they interpret that to be a really bad day for them. It’s about what the person interprets. I think our patience ebbs and flows with the day. Sometimes we’re much more patient, and sometimes we’re not…like at 3am. Sometimes you get patients that you’ve done it with too many times, and you’re just over it. Sometimes, you’re like, fuck, all these fucking bums!…and the reality is, most of them are in some sort of survival mode and you can’t blame them although you still get frustrated with it. It’s so hard to describe that to non-EMS people without sound like an asshole.

- Don, 50

After I got my license, I spent my first few years in the inner city and I’d get so pissed at how people treated the ambulance there. There were people who would take ambulance rides to the hospital and then walk away at the back door, like, “Thanks for the taxi ride to the other side of town.” When I was little, I always thought that 911 was a sacred thing, that you NEVER called except in a very serious emergency. But that’s not what people think everywhere, and I don’t know, maybe there’s a reason for that. Maybe they had stuff happen in their life that made it seem like a reasonable thing to do.
Anyway, that’s what I would tell myself to try to stop getting so mad about it.

- Sandra, 52

Sandra’s efforts to assume a more charitable outlook toward her “system abusers” required considerable effort on her part. But, as she noted later in her interview, “I think it helped me not get as jaded as some of my co-workers.” Unlike flight attendants who invoke a variety of tactics to prevent themselves from expressing anger directly toward abusive customers, Sandra is not performing this emotional labor for the benefit of the customer (Hochschild 2003: 113). Rather, the purpose
of Sandra’s emotional labor in this instance is less about providing physical or
emotional comfort to people that she perceives as legitimately in need of such
comfort, and more about finding the means to avoid expressing her anger toward
people who do not require medical care at all: people who she does not perceive to
be customers in the first place. This can be an emotional struggle when medics are
confronted with a patient who calls for an ambulance every single day, or even
multiple times per day, as in this incident from my field notes:

We got dispatched to K.S.’s house again today. My partner just about hit the
roof. (K.S. is a middle-aged guy who is pretty much in a constant state of panic
attack. He spends most of his time convinced that he is about to die, and he has
been calling 911 daily for years. We always end up canceling on him, but he
calls all the time anyway). My partner told me that K.S. called the ambulance
three times on his last night shift…every hour on the hour between about
midnight and 3 a.m. “Fuck that guy! If it weren’t for his stupid bullshit, we
would have gotten four solid hours of sleep that night,” he said. Fortunately, we
got canceled by fire when we pulled up on scene, because my partner was
aggravated by the mere thought of having to talk politely to K.S.

Several of my interviewees represented their relationships to local frequent fliers
with a depth of caring that surprised me in light of the pessimistic shop talk that
pervades an EMS workplace (put simply, eye-rolling and verbal complaining about
frequent fliers are more common than expressions of concern for the patient’s
social situation or general well being). Claire, 34, volunteered:
I have a really hard time with people who get out there, and they’re just dicks to people because they don’t try to remember that these are individuals, too. They’re like, “Oh, you’re calling again.” I get attached to our frequent fliers! I don’t like all of them, but we have hobos, and you know, I try to get to know their story and then I get sad when they eventually die, which they all do. There are mean ones too, but that’s somebody’s dad, brother, son…their asshole uncle. It’s still somebody, you know?

Medics have a keener understanding than civilians of the societal cost of substance abuse. Illegal recreational drugs vary in prominence by geography—one system’s drug-related transports may be dominated by methamphetamines, another by heroin—but alcohol is a significant problem everywhere. As Laura, 55, quipped sardonically when I asked her what practical skills she had developed over the course of her career, “Well, I can spot a drunk person from a mile away…that’s always useful!” My field notes record a conversation that I shared with a co-worker about alcohol-related calls: “R. was on Medic 652 the other day…she said they had thirteen calls in a 12-hour shift, and TWELVE of them were alcohol-related.” One particularly lively comment contrasted the extent of alcohol as a social problem with ambulance calls in which marijuana created a medical emergency:

It’s crazy that we have so many alcohol-related calls, but how often do we transport a pot-related call? Once a year? And it’s usually because they ate, like, ten brownies. Pot’s not the problem if you’re looking at what is costing us
a lot of money, and what is making so much work for us, and what’s causing all the car crashes… I mean, it’s not pot.

- Sarah, 33

The amount of time and energy that medics expended each day in service of non-emergent calls was the only consistent genesis of work-related despair that I noted in my research. In terms of emotional labor, what is most striking about this commonality is that it seems to revolve around medics’ collective knowledge that they are being underutilized (or at the very least, that the medical skills for which they trained so hard to learn are being underutilized). Paramedics do not derive primary occupational dignity from their work with frequent fliers, nor do they measure their professional worth by how they perform on “bullshit” or frequent flier calls. Instead, their emotional labor consists of mitigating the embarrassment and annoyance that these calls cause while focusing on those aspects of the job that bring they perceive as bringing greater social reward in the eyes of others: the labor involved in taking care of emergencies.
SUPPRESSING AND GENERATING EMOTION ON MEDICAL CALLS

Paramedics define “emergency” somewhat less narrowly than the *OED*. An emergency *may* be a true matter of life and death (or life and limb), but it may also be a situation requiring an intervention beyond the aid expected of an ordinary person. The interaction between paramedic and patient depends on the condition of the patient. For example, a conscious and alert patient requires direct emotional labor in the form of conversation, reassurance, explanation, and exhibitions of interest, while an unconscious patient requires only physical interventions (which is not to say that no medic speaks to an unconscious patient, only that medics vary in their belief that doing so makes any kind of difference).

It goes without saying that the range of emotions that a paramedic might experience in the course of her job is multifarious. However, job-related emotional labor is a more limiting concept. My interviews and field research highlighted different varieties of emotional labor, which I would loosely categorize along two main themes, in a breakdown that parallels Hochschild’s understanding of emotional labor as labor that produces an emotional response or state of mind in another person (Hochschild 2003). The category includes those emotions –
typically unseemly – that workers actually feel, but that they must suppress. The second are emotions – unrelated to a medic’s actual relationship with the patient – that workers do not actually feel, but are expected to perform in the course of doing their jobs. (I will sometimes refer to this type of performance as “generating” emotion, since the performance process sometimes leaves the medic feeling actual emotion.) The first category includes emotions like disgust, shock/surprise, disapproval, anger, fear, amusement (at the patient’s expense), disdain, horror, fascination, hesitation, anxiety, worry, uncertainty, helplessness, boredom, insecurity, contempt, hostility, and irritation. The second category encompasses emotions like compassion, comfort, amusement (at patient’s attempts at humor), concern, and confidence. Let’s look in some detail at a few examples.

Disgust

Disgust looms large in medics’ stories of their most memorable experiences on the job. We regularly see things that elicit a disgust response, and often must also touch and physically manipulate those things. We are obligated to bodily carry people who are covered in human waste or vomit, who are harboring infestations
of insects, or who have infected wounds. We also interact regularly with people who are homeless and who do not have regular access to showers or laundry facilities, and whose clothing and physical bodies may smell strongly or be impregnated with urine, feces, sweat, or blood. (Interestingly, EMS workers do not generally place fresh blood in the category of patient presentations that elicit disgust; on the contrary, excessive blood is more often a source of fascination and keen curiosity.) Medics often report that they struggle more with one particular substance than with others; for example, “I hate when people cough and want to show you what they coughed up. Snot’s my thing” (Claire, 34); or, “The most disgusting thing is suctioning. I hate trachs. The thought of it makes me want to vomit. I absolutely can’t stand it. I want to gag when someone coughs out of their trach” (Don, 40); or, “It totally embarrasses me, but I can’t stand puke. I’m a sympathetic puker. If someone starts puking in the back of the ambulance, it takes a lot of concentration for me not to puke, too” (Alicia, 27). One subject, Robert (30), recounted an incident when he caught a patient who was stumbling toward him and realized with horror that that patient was actively defecating on his boot. “Obviously, I threw them away. There’s no saving shitty boots.”
While everyone seems to have their “thing,” which shows up in their working life more or less regularly and must be regulated through a concerted effort not to let disgust either show in face, voice, or behavior, disgust also figures prominently in medics’ stories about the “craziest” things they’ve seen on the job.

Two common sources of disgust are insects and decomposed bodies or parts of bodies:

We had this guy when I was an intern, and he was unconscious and unresponsive…looked like a heroin overdose so we gave him Narcan and cut off his clothes. I don’t know if he did overdose or pass out or what, but he was lying on an anthill. There were ants coming out of his rectum. They were coming out everywhere. They never stopped. We cut off all his clothes and just took him, but we still had ants all over the gurney because they were coming out of him.

- David, 43

We had a call to a sick guy on the levee. It’s disgusting down there, lots of homeless people living down there in trench camps. There’s feces everywhere…we tromp down there, which I hate…to this couch, and there’s this guy sitting on the couch, and I look at him, and he does look sick. He really does look sick. His friends are like, he’s been sick for days and he’s been sitting there for days. And I grabbed him and stood him up, and when I stood him up, all this white shit just fell off of him. And I look, and right then, this light bulb goes off in my head…maggots! And literally his entire abdomen was just crawling with maggots. We unzipped his clothes, and he was covered with maggots. These huge open sores. We just stripped him on scene and poured water all over him and got as many off as we could, and then we burrito-wrapped him and got him to the hospital, put him right into
the shower. And we went in there with him, because we were totally disgusting ourselves by that point. I mean, he had maggots coming out of his rectum. He had maggots inside him. And to this day, all I have to say is “Maggot Man” to my partner and she would punch me.

- Steve, 50

The foot. That was gross. We could smell the decomposition from four apartments away…He had literally just died, okay? He wasn’t decomposing; his foot had been decomposing for like, six months…he was a fresh code, but his goddamned foot had been decomposing for easily six months and you could smell that shit. WE smelled like it. It clung to our clothes for the whole day. The dude lived with his mom. So my partner’s like, “So what kind of health problems did he have?” And his mom was like, “He doesn’t have any!” My partner’s like, “No, no…he does.” My partner’s like, “Don’t you smell that? That’s his foot!” Things with smells. Those are the worst calls.

- Monica, 36

Another source of uncommon, unexpected disgust seems to be related to calls that stand out as freak injuries, such as the description that Claire (34) offered of a burn victim: “I remember her nipples…the skin on her nipples was coming off, and I was just so grossed out by this. And then I went to grab her arm to start an IV…there was a Vietnam movie where (the actor) grabbed a guy and pulled like this (gestures) and the guy’s skin came off…that’s what happened to her hand when I picked it up.”

The main commonality with incidents such as these – in other words, incidents that elicit internal disgust – is that medics cannot express their authentic
emotions in the moment that they experience them. Since disgust is a powerful emotion, its suppression requires deep acting (Wharton 2009). Ideals of compassionate medical care require that patients not be made to feel bad, or guilty, or burdensome when they request help. But the suppression of disgust certainly does not mean the absence of disgust. If anything, calls that stand out as uniquely disgusting become fodder for dramatic post mortems when the call is over. Like anything unusual that occurs on the job, the back door of the hospital and the ready room at the deployment center play host to de facto group therapy, where medics can vent their pent-up disgust for the delighted, vicariously disgusted ears of sympathetic co-workers who invariably have “been there before.” Such debriefing plays a significant role in predictable places – after tragic and dramatic calls, as might be expected – but is also an important form of regrouping after exposure to a disgust trigger. Indeed, medics’ ability to respond professionally to calls, and to treat patients with respect even in the presence of profound disgust, relies on their ability to temporarily withhold the disgust for processing when the call is over and equipment and personnel have been decontaminated. While sadness and grief may get suppressed – much to the medic’s emotional detriment down the road – disgust does not seem to
suffer from the same tendency to go underground. Discharging the disgust later, preferably through dramatic storytelling in a group setting, allows for safe dissipation of the emotion and the socio-emotional reproduction of the worker.

One form of disgust that bears special mention is EMS workers’ disgust for obese patients. General disgust surrounding obesity and overweight in the United States is culturally bound, so it is unsurprising that medics share some of that cultural animosity toward overweight. However, their vitriol often has a more personal edge. Where a non-medic might look on a morbidly obese person with a criticism laced with moralistic undertones (“That obese person is too lazy to lose weight”), the medic’s animosity reflects her feeling that the obese person “did it to himself” and therefore, his special transport and medical needs are framed as an imposition rather than a normal part of medics’ jobs. “I ran on C.P. the other day,” Miguel (39) told me at work one day last year. “He was walking in front of me and he was naked from the waist down. He weighs like 600 pounds now. I was looking at his balls hanging down to his knees and his pannices all covered with pus and hanging off the side of his body…he’s fucking disgusting.” My own field notes recount a medical call for an anxiety attack in a 40-year-old woman who is bedbound and weighs 500 lbs: “I got so
incredibly MAD at her,” I reflected. “I’m not sure if it’s because I don’t really think of anxiety attacks as valid medical complaints in the first place, but then on top of that, she was refusing to take even three steps to get to the gurney. She wanted us to carry her! I knew that she’d been back and forth to the bathroom multiple times, so I was pissed. I’m supposed to risk injuring my back because you’re too anxious to walk?” In some cases, anti-fat animosity is exhibited in the form of frank dehumanization, as when a man partner of mine in his mid-thirties commented after we had completed transport of a 700-lb. frequent flier: “If she codes and we have to work her up, she’ll probably get pulses back just to be a pain in our ass. We should just not do a good job coding her…maybe she’ll stay dead!” Similarly negative sentiments often accompany expressions of frustration about frequent fliers in general (“Why can’t she just die already?”) and obese frequent fliers in particular. Both frequent fliers and morbidly obese patients are more likely to be classified as “undeserving” patients.

The suppression of disgust may be easier for the medic when the patient acknowledges that the situation is disgusting, or even apologizes for the medic’s experience. Because medics are keenly sensitive to the dichotomy of either being
appreciated or being unappreciated, a patient’s acknowledgement of the medic’s labor in disgust-provoking situations can make the emotional labor of those situations far less onerous. As James, 25, reflected, “It’s easier for me to deal with that guy who’s covered in shit if he’s like, ‘Hey, dude, sorry I’m covered in shit.’ I don’t know why, it just makes it better. I can’t stand it when someone’s like, ‘You have to pick me up and also bring along my piss-soaked wheelchair because it’s your JOB!’”

Boredom

In Chapter 2, I outline certain aspects of EMS work that are intensely boring, such as sitting around waiting for calls, driving to move ups and posting away from the station, and doing paperwork. Medical calls may also be boring, even when they are somewhat emergent, such as for patients requiring ambulance transport who are stable and/or whose complaint has been managed to the best of EMS’s ability (e.g., a minor fracture who is comfortable after being medicated for pain, or an older patient with general body weakness but no acute complaint). Long transport times in heavy traffic or to outlying destinations leave both medic and patient with considerable unstructured time on their hands. For some medics, this scenario becomes an
opportunity. Claire, 34, enthused, “I like the variety… I like talking to people a lot…. I like interrogating them and getting their life stories about stuff, and I just like conversing with strangers.” Some medics reflect this level of active interest in their patients and do, in my observation, go out of their way to make conversation, as if each person who landed on their gurney were an opportunity to play conversational roulette. We do indeed meet an extraordinary variety of people; some of our elderly patients are keen storytellers, and generous with their opinions on how to live a long life, how to succeed in marriage, or how to understand the aging process. This last point is particularly interesting, as many patients in their seventies, eighties, and nineties use the phrase “it’s the pits” to describe aging.

There are three primary ways that medics seem to react to periods of inactivity and boredom during transport. The first, of course, is to deliberately engage the patient in friendly conversation, as described by Claire a few pages back. This works well when both patient and medic are interested in participating. The conversations are not deeply intimate, and they can resemble the awkwardness of a first date: two people thrown together temporarily in a situation from which neither can politely escape. They can sometimes be downright fascinating. I have thoroughly enjoyed
hundreds of conversations with people I would never otherwise have met, and
overheard countless partners engaging in a similar fashion. Certainly making
conversation – however awkward – can be less awkward than sitting together in the
same space, not talking at all.

Unlike the less personal situations described by Goffman in his notion of civil
inattention (Goffman 1967), the back of an ambulance contains two people who have
an explicit, if temporary relationship. Simply ignoring the patient isn’t a viable option
(although the patient can choose to ignore the paramedic). When patient or medic
lacks the motivation to converse about topics unrelated to the present situation, the
medic may work to fill the empty space by asking questions that appear to be relevant
to the medical call, but in fact serve as space filler (such as asking physical
assessment or detailed medical history questions whose answer the medic has use for
and are unrelated to the present complaint). The medic may also perform “busy work”
in the form of cleanup tasks, paperwork, or not-strictly-necessary blood pressures. In
those cases where conversation simply isn’t flowing, or where the transport time is
sufficiently long that topics of superficial conversation are exhausted, a medic
attending a stable patient may move to the “jump seat” behind the patient’s head –
often with the excuse “I’m going to move to this seat so I can buckle up” – to avoid the discomfort of having to sharing visual space with someone that he is not talking to.

*Surprise/Shock/Amusement (Mirth)*

Although they might seem to be strange bedfellows, I lump mirthful surprise, shock, and amusement together because they are all to some degree emotions that arise when medics encounter the sorts of calls, patients, or situations that led Wendy, 39, to exclaim, “I’m a total rubbernecker. If there’s an accident, I want to see it….people pique my interest. The things that people will tell you just because you’re a health care professional…it’s like reading a juicy novel or something! You get the inside scoop that nobody else gets.” These forms of amusement or interest often occur at the patient’s expense, or when the patient has found herself in a situation that she finds embarrassing or shameful. For this reason, the emotional labor called for in these situations is the suppression of amusement *when it might offend the patient*, i.e., at the patient’s expense. (There are times when humor is a useful tool for the reduction of
pain or emotional discomfort, but I will discuss those later in this chapter.) Emotional suppressing allows the patient to save face (Goffman 1967).

The desire to be on the inside, or to get to be part of things that civilians do not get to witness, was perhaps the single most common response to my interview ice-breaker, “What do you like about the job?” A great many responses clustered around two themes: first, “I hate offices and I’d rather be out and about,” and second, “People are really interesting and we see some crazy shit on the ambulance!” These views on what makes the job pleasurable run rampant, but they also illustrate the importance of emotion management in maintaining professionalism on scene: we do indeed see things that non-medics rarely or never see, but we also must stay “in face” (Goffman 1967) by feigning disinterest, masking any surprise/shock, and keeping a decidedly serious demeanor. This can be challenging. David, 43, recounts the following story with some glee:

So the call went out for abdominal pain and we get there, and this guy is sitting in a chair and he’s like, yeah, my stomach hurts. And so I go through my abdominal pain assessment…like, what were you doing when this started? His responses are really cagey and weird. “I…I was sitting there.” So I say, “What does it feel like? Is it sharp? Dull?” And he’s like, “Dull.” Totally flat affect, just like that. So I ask, “Does it radiate anywhere?” And he’s like…”No, I don’t know!” “How long have you had it?” Now he’s getting super agitated, like, “I don’t know,
thirty minutes? Can we just go to the hospital?” And I’m like, “Yeah, yeah, we can go to the hospital, I just need a little more information. How bad is it on a scale from 1 to 10?” Now he’s really irritable, like, “Eight! I don’t know, let’s just go to the hospital!” So I say, “What were you doing when it started?” And he’s like….“All right. FUCK! I’ve got a flashlight up my ass, are you happy?” He’s totally fed up with the questions, and he’s like, “Fine, I don’t have abdominal pain, I’ve got ASS pain, can we go to the hospital now?” They took an X-ray, and this was no small flashlight. It was a Maglite with the 4 DD batteries!

Every medic has some version of this call: from a patient who called 911 because a “tree is growing out of my vagina” (the tree turns out to be a potato, inserted and forgotten about weeks ago, that had since sprouted) to the young woman who believe that she has “lost” her vibrator (“Don’t they teach them that in college, that you can’t LOSE something in your vagina?” exclaimed a co-worker when she told that story to me during our downtime one day), people do seem to get themselves into situations that they would rather no one know about, but cannot avoid seeking help for. In such situations, the medic’s emotional labor consists of acting as though he sees that sort of thing every day, and that is nothing to be ashamed of. Indeed, collaborating with patients to save face in embarrassing situations (or, as previously discussed, in situations that arouse disgust) is a central feature of emotional labor on calls.
Certainly, not all incidents that are a source of amusement to the medic go blithely unmentioned. One interesting form of emotional labor that helps medics to deal with the sheer absurdity of what we see on the job is engaging in mild pranks at the patient’s expense, and without the patient’s knowledge. This pranking allows the formation of a kind of camaraderie between rescuers, and acts as a form of alliance building that mitigates frustration or helps medics to cover their surprise.

We had a woman who was lying totally naked on a mattress, just screaming and screaming. And we were like, “Ma’am, can you talk to us? Can you tell us what’s wrong?” And she stopped screaming and said, “Can you see them? They’re all around me!” And we were like, “What? What’s all around you?” And then she stops, totally calm, and says, “Horse penises. They’re thrusting in my pelvis right now!” And there’s a picture on the wall of a horse running on a beach in a beautiful sunset. My partner looks over at the picture and points to it and says to her, all serious, “Is this the one?”

- Sam, 27

Like the disgust venting described earlier, pranks such as these provide an outlet for emotions whose unabashed expression could be interpreted as taking advantage of a patient’s vulnerabilities (in this woman’s case, mental illness). However, this story is not an outlier; I have watched medics prank patients while keeping a straight face (more or less successfully) more times than I can remember. A skilled prankster will
attempt to cause his partner or fire personnel to lose control of their own face while
never breaking character in view of the patient. Such pranking bonds rescuers
together by reinforcing the absurdity of the situations that we encounter on the job,
perhaps in a “there but for the grace of God go I” spirit. The line between comedy and
tragedy is a fine one.

*Hostility, Contempt, And Irritation*

Among the more difficult emotions to manage on scene are the emotions aroused in
the context of attending patients for whom a medic feels hostility, contempt, or
irritation. These emotions emerge as a result of a patient’s behavior or their speech or
their membership in a social category, rather than the patient’s physical body. As
such, these triggers are medic-specific and somewhat less universal in their effects.
Without exception, medics do not appreciate being unappreciated. Civilians who
perceive medics to be public servants – and who treat them with the respect that
public service entails – may be surprised to learn of the verbal haranguing to which
medics are regularly subjected by belligerent, intoxicated, high, and/or mentally ill
patients who are unable to care for themselves. Many of these patients are under
arrest, and see paramedics as part of a continuum of people in authority who are preventing them from going their way. Here are some selections taken from my 18 months of on-the-job field notes: (1) “Drunk man in his fifties yelling at my (man) partner, “Fuck you! Fuck you, motherfucker! Get your fucking hands off me, you pussy-ass bitch!” and to a (woman) partner, (2) “You’re an ugly slut. I bet no one will fuck you because you’re so ugly.” A former partner of mine reminded me of an experience we had shared a couple of years earlier:

We were on that call together, remember? And that guy called us both a gutter slut. He said that we were gutter sluts and that we sit on dicks!
We walked in to the ER with him, and he was yelling it, and we were like, “Be quiet! There’s children in here, and there’s sick people in here. And he’s like, “You’re a whore that sits on dicks!,” and we’re like, my GOD! I just remember we were laughing hysterically, and I think about new medics who are all upset about how people are so mean…but you’ll find humor in it. I think that’s why we have such a sick sense of humor, because it’s our coping mechanism. We learn to find it funny. Because the first few times, you’re offended, but if you don’t find it funny, you go home pissed off.

- Wendy, 39

Fortunately, such scenes are not everyday occurrences, but neither are they uncommon. Both women and men medics seem equally prone to verbal abuse, although the nature of abuse leveled at women medics is often crudely sexual in nature, versus abuse to men that might simply be a barrage of cursing and name-
calling. Employers and law enforcement typically support medics who firmly instruct the patient in proper decorum by saying things like “It’s not okay to talk to me that way,” or “I’m speaking respectfully to you, man, so you need to respect me, too,” or “I’m trying to help you, so please stop swearing at me.” Physical violence is not condoned by employers except in cases of serious, immediate need for self-defense (rare patients will physically attack rescuers). Verbal violence is also not condoned. However, both physical and verbal retribution occur in small ways when a patient is harassing a medic and there are no witnesses. A medic may deliberately rile up an agitated patient by saying things aimed at angering the patient, or may engage in methods of “punitive medicine” such as starting larger-bore IVs than strictly medically necessary, or using more roughness than is actually required to restrain an uncooperative patient. A restrained patient who is continuing to verbally abuse a medic may receive a fairly unrestrained dose of his own medicine. “We don’t hurt people and we don’t talk shit to people who aren’t talking shit to us,” said Carl, 27, “but let’s just say that what happens in the back of the ambulance stays in the back of the ambulance.”
Other subjects of contempt include patients who have previously behaved in morally contemptible ways, such as murderers, perpetrator of sexual assaults, and the drunk drivers responsible for auto accidents who have not died (“The drunk person never dies,” noted Kendra, 29, when I asked her what makes her angry at work; this anecdotal belief is held by many medics). Medics may be asked to transport convicted felons from county jails or state prisons to local hospitals for treatment; some are considered dangerous enough to require the presence in the ambulance of two armed law enforcement officers, in addition to the patient being shackled to a waist chain. These patients must be treated with civility, although a drunk driver who has hurt or killed other people at the accident scene from which the ambulance just departed may be verbally reprimanded in the form of a speech that “stays in the back of the ambulance.”

_Concern For Patient’s Condition; Discomfort With Patient’s Distress_

The emotional labor that I have described thus far has been relatively low stakes in terms of what happens if a medic fails to perform the labor (i.e., expresses disgust or anger), or does not help a compromised patient to save face. “High stakes
emotional labor” is that labor which can have a profound impact on the patient’s condition or outcome. Given that only a small number of calls are true emergencies, medics actually are not called on to perform high-stakes emotional labor very often; perhaps once or twice per shift in a busy system, or once per week in a less busy system. When the situation is emergent, however, the medic must hide her own concern for the patient’s condition, even when his condition is unstable or critical. The reason for this is only partly emotional: certainly the job of an EMS worker is to provide reassurance and comfort, but it is also to prevent further harm from coming to the patient. A patient who is in the throes of a major heart attack is not a great candidate for an honest assessment like “This is a major heart attack, and you’re probably going to die.” Such news could provoke a level of anxiety that could worsen their already-fragile condition. Medics’ approach with such patients is to offer calming, non-specific platitudes such as “This does seem like it could be serious, but we are going to do everything we can for you.”

Another form of emotional suppression arises when a medic experiences empathetic distress in response to her patient’s pain or discomfort. Like concern for the seriousness of the patient’s condition, these emotions generally do not serve
the patient, beyond a general expression of sympathy such as “I can see that you are in pain, and I am going to do my best to get you feeling better.” My field notes reflect a grand diversity in how medics deal with patients who are actively suffering. For example, I mused at one point: “Worked with Marco today and he wanted to just transport this hip fracture with no pain meds. I would never do that! This poor lady is just screaming and screaming every time we move her…why would you not try to make her feel better when we have the tools to do it?” Having worked with Marco many times before, my notes observed, it seemed like he just had this attitude that people should “tough out” their pain. “I definitely do NOT,” I continued, “have the stomach for watching people be uncomfortable if there’s something I can do to make it better.” The tough love approach shows up frequently on panic attack calls, where verbal intervention can range from patiently coaching an anxiety sufferer to slow his breathing to telling a patient to “Get a grip – you’re a grown-ass man, so start acting like it!” (Field notes).

Frequently, my notes document instances where medics use comforting tactics to suppress their own discomfort at the sight of a patient’s distress. It is far beyond the scope of this research to speculate on the more psychological question
of why a person might experience more or less empathy for a stranger’s pain – it seems that some people are able to maintain clearer boundaries between their patients’ emotions and their own – but certainly, those among my colleagues who demonstrated a greater sensitivity to the patient’s distress also deployed some remarkably creative strategies to make their patients feel better. I recorded one such call as follows:

Worked with Potter today (34-year-old man). We ran on this guy who was around our age. He locked himself out of his car and he slashed both his wrists to ribbons trying to break into the car through the sunroof. The sunroof glass broke all at once and he fell through, arms and head first. He was cut up bad enough that we had to use QuikClot (clotting gauze used by the military in combat situations) because he was bleeding out in front of us. He looked terrified and he was obviously hurting a lot. I noticed that I was reacting pretty strongly to his pain. I wanted it to stop.

Potter and I have the same sense of humor – dry and sarcastic. We started giving each other a bunch of shit (which is pretty much what we do all day long whenever we work together) and the patient actually started laughing…so we turned it on him, started teasing him about how he got into this mess, and pretty soon this guy is just cracking up. He’s still bleeding out and sheet white and in a lot of pain, but he’s also noticeably less miserable.

Since an inability to be distracted (from moaning, crying, writhing, etc.) is one way that we assess the significance of a patient’s pain, this patient’s laughter actually
provided us with evidence that our attempts at humor provided actual relief for him – and relief for us as well. Other strategies include verbal comfort (“We’re going to do the best we can to get you feeling better soon”) and emotional coaching (“Try to focus on your breathing”) both of which tactics, when successful, provide relief to both patient and paramedic. Verbal coaching and distraction are sometimes effective for patients whose primary source of distress is emotional (e.g., panic attacks). I observed that both parent and non-parent medics, regardless of their attitudes toward adults in pain, worked harder to soothe crying children and babies than to soothe adults.

**Fear Of Failure**

Confidence in one’s own medical skills is another underappreciated form of emotional expertise demanded by emergency work. Medics sometimes find themselves – especially at the beginning of their careers, before they have built up an arsenal of personal experiences – filled with terror about the prospect of running a particular kind of call. The anxiety provoked by a dispatch for “baby not breathing” can be sudden and paralyzing. A medic may wish to run away, or for
dispatch to send someone else, “anyone but me.” This sudden concern about one’s ability to perform is often referred to by workers in EMS as the colloquial “pucker factor,” implying that the pressure of having to be the one to deal with such a critical call will induce the fearful medic to squeeze (“pucker”) his anal sphincter. The “pucker factor” disappears for most medics on most calls with the passage of time and increased job experience. Some of those for whom it does not disappear end up having to leave the industry if their anxiety becomes debilitating; even for experienced medics, though, certain kinds of calls can provoke a desire to escape in order to not have to deal with the situation. And yet, EMS culture reinforces the notion that a medic must be willing and ready to walk onto the scene of literally any medical emergency and render aid. Since running away is not an option, the suppression of self-doubt (visible and/or internal) in critical calls is part of a medic’s emotional labor on scene.

*Horror, Sadness, And Shock (Not Mirthful)*

In contrast with my previous discussion on emotional responses to shock/surprise – in which paramedics suppress their authentic emotional response in order to
preserve the patient’s dignity, or to help him save face – there are emergency situations in which a medic engages in suppressive emotional labor simply because to do otherwise would prevent them from responding appropriately to the emergency. This is the sort of emotional labor that looms large in the public imagination as “heroic,” or otherwise exceeding the expectations of what a civilian could be expected to cope with. I categorize these calls as either emergent (in the sense that the patient’s condition is critical, the situation unexpected or accidental, and her survival and/or full recovery is uncertain) or tragic, in which death or debilitating injury has already occurred and its consequences are a foregone conclusion. Both situations create emotional stressors, and in both cases, medics’ ability to competently complete the associated tasks depends on their ability to maintain a cool head. In essence, they suppress their emotional response because to do otherwise would render them useless on the emergency scene. As Kendra, 29, remarked, “The one thing that I told myself right off the bat when I started this job was, “Whatever you do, don’t lose your shit on scene. Save it for later; you have a job to do. Sometimes it’s hard, but I’ve gotten a lot better since back when I was new. I just shove it down now. Sometimes I feel it later; sometimes I don’t.”
Kendra’s last comment – “Sometimes I feel it later; sometimes I don’t” – is noteworthy in its explicit discussion of the idea that one can “revisit” suppressed emotions at a later time. While the culture of the industry is changing – albeit slowly – the idea that a medic should be strong enough to not let things to him is firmly ensconced in the EMS ethos, as it is in other public safety and paramilitaristic professions (law enforcement, firefighting, military, hospital-based emergency medicine, etc.). Indeed, it would be a mistake to assume that the burnout and suicides in EMS are unrelated to the things that EMS workers see and experience, many times over, and do not have the resources or desire to process. Increased awareness of the physical and psychological effects of traumatic events and experiences has led to the institution of mandated, therapist-mediated group debriefings by forward-thinking agencies, in which emergency responders are required to participate after working a “critical incident.” Mandatory participation is not yet a norm across the private sector, leaving EMS workers mostly up to their own devices about how or when to seek treatment for post-traumatic stress disorder. Peer support sometimes exists in the form of Critical Incident Stress Management teams, but EMS workers sometimes do not seek this sort of formal
peer debriefing of their own accord. As a result, repeated exposure to traumatic events often results in a cumulative injury affecting a paramedic’s home and work life.

I was surprised over the course of my research to discover that my subjects were far more expressive with me in our interviews about the ways that traumatic experiences impact them than I was accustomed to hearing in casual banter while on duty. Consider the following story:

I was on a shooting of a police officer that I knew. That one was traumatizing for so many reasons. Not just seeing someone shot. I’ve seen that before. But realizing who it was adds a little emotion. And then while we were on scene, more gunfire opened up out of nowhere. That one took it out of me. Like most bad calls, when you can close your eyes and think about it and picture it and all that good stuff. 

(MM: Any therapy after that one?) No. Just the debriefing. We talked about it. I can still see it, but I guess it doesn’t bother me too much. But there’s a lot of calls that I can still see and smell and taste, and that’s just the way it is. That’s part of you now. You just go with it. It was funny, when we were doing the debriefing with the psychiatrist, she looked over at me and she was like, you’ve been through a lot of trauma, and I’m not just talking about work. And I was like, yes, it’s not good that you can see that, though. I’ve seen a lot.

- Aaron, 36

I made multiple efforts to engage my partners during my field work in informal, front-of-the-cab conversations about what sorts of calls bother them the most, and
how well they think they deal with their feelings after these calls are over. While my partners tended not to say anything as dismissive (and preposterous) as “Nothing bothers me,” neither were their responses particularly rich in detail. Non-specific responses are the norm: “I hate pedi codes” (cardiac arrest in children) or “I don’t love hangings.” Common strategy is to avoid thinking thoughts about the details of the call and about one’s emotional state during the call as much as possible. Journaling in after work one night, I mused:

I probably should not find anyone’s reticence surprising. I do basically the same thing. I mean, I’ll talk about some terrible call, but mostly from a distance. I won’t actually say how I felt…which is strange, because I love talking about emotions, but I guess I don’t want to be perceived as weak-minded by my co-workers. I don’t want them to worry about whether I’m going to fall apart on the next critical call and be useless. We all have professional reputations to uphold. Crying is okay, but only once, and only when the call is over. Next shift, you have to leave it at home.

In thinking about the ways that paramedics “keep on keeping on” on the job, I thought repeatedly about a call that I was on some years ago, involving the double drowning of 2 ½-year-old twin girls who had gotten into the family swimming pool enclosure. This was an emergent call in which the patients were considered potentially viable, and therefore everything was done to attempt to restore their circulation. On scene, I went through the motions of my job, even though it was
clear to me that the toddlers had been under the water too long to survive the accident with brain function intact. I remember a sense that I had two separate brains. One of them was processing my actual emotions like a computer program running in the background (“THIS IS FUCKING AWFUL! THESE BABIES ARE DEAD, AND THEY’RE GOING TO STAY DEAD, AND THEY’RE JUST BABIES, AND THEIR INATTENTIVE PARENTS KILLED THEM!”).

Meanwhile, another compartment of my thought process – the dominant one, by necessity – prompted me to calmly ask a nearby firefighter if he wouldn’t mind taking over CPR so I could set up the intubation equipment.

I will be returning to the various ways that medics cope with the cumulative effects of the job in their off-duty lives in a later chapter, but let’s turn now to the emotional labor required on “tragic” emergency scenes that involve a patient whose survival seems likely (but whose life will clearly never be the same due to a debilitating injury), or a patient who is in beyond help. The patient’s survival in these cases is not in question, but medics often reflect on how difficult it is to maintain face when they are able to see themselves or their family members as similar to the patient. Sean, 35 and an avid outdoorsman, recalled:
I rolled up on this guy who had crashed his road bike. He was covered with blood but he was awake. I walked over to him and I was like, “Hey, man, how are you doing? Anything hurt?” He was like, “Naw, just my pride.” But he was in this weird position, like those body outlines you see on *Law and Order*. Something didn’t look right to me. I tapped his leg and I asked him, “Can you feel that?” And he’s like, “Feel what?” And I had this sinking feeling, like, *shit*, this guy is totally paralyzed. I tried a couple more limbs. He couldn’t feel anything. And then he started asking me, “Wait, am I paralyzed?” I think he was just too much in shock from the crash to even realize to that point that he couldn’t feel anything. And what am I supposed to say to him? “Yeah, dude, you’re totally paralyzed! Sorry!” I knew it wasn’t good, but I still felt like I had to say something euphemistic like “Sometimes, it’s just temporary and you get feeling back after the swelling to your spinal cord goes down.” But it was bullshit and we both knew it. It flipped me out, because that totally could have been me.

Michael, 45, is a highly experienced twenty-year medic who admitted that he worries more then ever these days about how he will keep his head on a pediatric fatality: now, unlike at the beginning of his career, he has children of his own:

I was on a car accident a couple months ago. The car was upside down. There were some car seats in the back but I couldn’t find the kids. The dad was dead and the grandpa was critical, but he told us the kids were at home. The father of the two kids is dead. His neck’s broke, and he’s submerged in a pool of blood up to his eyes. And I said to my partner, “Can you imagine if the kids were there? They would have been flat. There was no room to survive that.” I told my partner, “I’m not going to do so good on a kid call. I think I’m gonna break down.” It’s only a matter of time. I’m pretty good at putting stuff aside and doing my job, even at home. I can turn off that “daddy” thing and be the medic for a few seconds, not let my emotions get the best of me. Just sift through
what’s going on. I’m afraid of the kid call, though. I really am. I don’t want to end my career having a kid call that’s just too close to home. I know it’s going to happen, though. Just a matter of time.

Michael’s reference to “ending my career” is not a comment on the kind of call he doesn’t want to have on his last scheduled day of work before retirement. On the contrary, the idea of a “career-ending” call is one in which a single, catastrophic call ends a paramedic’s career before she expected to leave the job. Proper lifting technique prevents a career-ending back injury; proper psychic distance prevents a career-ending pediatric death. As previous in this chapter during my discussion of confidence on the job, being able to do EMS work well requires the paramedic to perform a delicate balancing act between caring labor and emotional distance.

**PARAMEDICS, PATIENTS, AND RACE/CLASS**

Poverty is really bad for your health. I feel like that’s where our resources need to go. That kind of includes everybody: homeless, migrant workers, single mothers with no money, and a lot of elderly people on fixed incomes. There’s something I love about the idea that, no matter what your problem is, no matter what your background, if you’re a drug addict, this is 911 and this is the ER and you can come in here for anytime for whatever your problem is, and you will be seen. You might have to wait, but you will be seen. There’s something I like about that, and there’s something that drives me up the wall about that.

- Melanie, 34
The question of how paramedics interact with patients based on their membership in core social categories such as race, class, and gender is surprisingly hard to assess through inductive research methods. No doubt the genesis of this difficulty insofar as race is concerned lies in the cultural dominance of color-blind racism as an ideology. Color-blind racism “explains contemporary racial inequality as the outcome of non-racial dynamics” (Bonilla Silva 2014). We can observe parallel phenomena in class-based inequalities, where the working poor are held personally responsible for their poverty (Grusky 2016). Meanwhile, gendered inequalities are attributed to fundamental “differences” between female and male people in a manner reminiscent of classic functionalist thought that may be out of fashion in sociological circles but still enjoys plenty of credibility in mainstream society (Wade 2013). Where conflicts arise is in the spaces between paramedics’ actual thoughts, feelings, and opinions about their patients and the way that they actual treat their patients. Emotional labor in this area of paramedic practice is inconsistent. A medic might withhold judgment and treat her patient with authentic kindness and empathy; or, she might feel intolerant but hide it from the patient; or, she might feel intolerant and treat the patient poorly without attempting to hide her emotions. The expectation for
all healthcare providers is that they treat their patients with kindness and empathy – but of course, expectation and reality rarely line up perfectly. In this final section, I will examine a small selection of incidents – reported in interviews and witnessed in my observation on the job – to give the reader a sense of how paramedics respond to racial and class differences in their patient populations.

Before I move on, two disclaimers are in order. First: the race and class characteristics of patient populations vary dramatically between geographical locations. I refer not merely to individual EMS systems, but to units as small as neighborhoods. Consider the example of an EMS system in a large county such as Los Angeles (not a place in which any of my interviewees works): one finds wealthy, largely white communities like Beverly Hills and Santa Monica; one also finds poverty and violence in spades in poor communities of color. Despite their geographical proximity, these communities are obviously worlds apart. The same dichotomy exists in any large EMS system, and because paramedics can be deployed anywhere within the system in which they work, they see both the poles and everything along the spectrum. Second, the compounding effect of multiple layers of oppression is powerful in much of the EMS patient population. Countless are poor
and they are undocumented immigrants; they are poor and they are suffering from mental illness. Their lived experiences are illustrative of Patricia Hill Collins’s useful notions of intersectionality and the matrix of domination (Collins 1993). That their social locations are complex is an understatement.

The paramedics that I interviewed, and all but a handful of the several hundred that I personally have known over the years, come mostly from middle class backgrounds, with a small but present percentage coming from lower middle class/working class backgrounds. Most of them are white. The national prevalence of white workers in EMS is 81% (Chapman et al. 2008) although there is considerable variation in more racially diverse metropolitan areas such as those in which I did my research. Some paramedics (especially those whose goal in pursuing paramedicine is to advance a future career in the fire service) come from families where their parents – mostly fathers – or even grandparents worked in public safety. The second-generation medics who have grown up in public safety culture are thoroughly indoctrinated by their parents’ attitudes about the patient population before they ever hit the streets, but even the “new to EMS” crowd has rarely spent any meaningful time in or around poor communities. As I will demonstrate, their attitudes toward
poor people and racial and ethnic minorities range from verbal expressions of pity and compassion to intolerance, paternalism, and hostility. Paramedics do not, as a whole, exhibit a pronounced inclination toward sociologically motivated analyses of social problems; yet they do express some understanding of their privilege vis-à-vis these patients, often in the same sentence that they express frustration or anger.

*Paramedics And Class: “Deserving” vs. “Undeserving Poor”*

One confounding factor in trying to draw medics out on the subject of class is that poverty almost invariably intersects with other hot-button sources of anger and/or annoyance. For example, nearly all of the patients that paramedics would classify as “frequent fliers” are desperately poor. Many are homeless. Knowing by the dispatch information which frequent flier a paramedic is about to run on is generally a matter of recognizing them by age and complaint rather than by a specific address. Virtually any medic would be able to tell you the first name, last name, life story, and medication list of half a dozen “frequent fliers” in her system whose daily calls – and sometimes, twice- or thrice-daily calls, elicit expressions of rage among peers, especially in the middle of the night.
There is much crossover between the transient population, the population of psychologically and socially fragile patients, and the population of patients with substance abuse issues (predominantly alcohol, with variation among recreational drugs like meth, cocaine, crack, and heroin varying somewhat between communities). Most of these patients have several different issues going on medically; mostly they are sub-acute (meaning the Emergency Department is not the appropriate place for them to be cared for), but the cumulative effect of their severe living conditions makes them far more vulnerable to rapid deterioration. A person with unstable housing and alcoholism is vulnerable to traumatic injury, to complications from pneumonia and skin infections, to malnourishment, and to death by hypothermia, even in temperate geographical regions. It’s extremely easy to underappreciate their physical condition or underlying complaint simply because one is annoyed by the 911 call or by the patient’s foul clothing or hygiene. An inexperienced paramedic who cuts corners in his assessments, or does not take a blood pressure because an indigent patient “looks fine” and is wearing 5 layers of jackets and sweaters may find himself being warned by a more experienced medic with several call stories about times that she blew someone off as “just drunk,” and
that patient ended up being seriously ill or injured. In the industry, this is often
verbalized with colorful, self-deprecating language, e.g., “I had this patient one time
who totally bit me on the ass…”

It would be facile to claim that some paramedics are judgmental, while others
are compassionate and empathetic; more accurately, the same paramedic is
sometimes judgmental and short-tempered, while other times, she is patient and
eager to provide what comfort she can. This spectrum of responses depends on who
the patient is (including previous experiences with the same patient), but also the
paramedic’s mood, time since the start of shift, fatigue, and business of the shift. As
such, my attempts to delineate clear descriptions of which patients a medic
categorized as “the deserving poor” versus “the undeserving poor” were quite
slippery. Often, the same situation might be assessed differently for seemingly
arbitrary reasons. In the following quote, Jeremy, 36, demonstrates a common
manifestation of quasi-schizophrenic attitudes toward the homeless:

The homeless can be a very manipulative population when it comes
to being in an ambulance. They know what to say, how to get what
they want, they’ll run circles around somebody new. But if you had a
little bit of insight about mental health, it might make paramedicine a
little more efficient. We all know it after we’ve been in the field, but
how come we’re not teaching it to (paramedic students) in the classroom?

Here, Jeremy is simultaneously expressing significant irritation and attributing patients’ behavior to deliberate, even flagrant abuse of EMS – including the conscious of new medics who are too naïve to understand what is happening. In the next sentence, though, he suggests that their behavior is more accurately attributed to mental health issues, and laments the paucity of our mental health education. Mizuki, a 25-year-old woman who has only been working on the ambulance for a year, complained, “We have plenty of those people (adopts a whining tone)...‘I’m cold and I want a blanket, I’m cold and I want a sandwich, I’m tired of being on the street and I want to go lay in a bed, so I’m going to say I have shortness of breath, but I really don’t have shortness of breath.” Because paramedics in most systems are not legally allowed to refuse transport to anyone who requests it – for any reason – Mizuki’s resentment at her patient’s perceived lie reflects paramedics’ larger anger (discussed elsewhere in this project) at evidence they are being unappreciated or taken advantage of.

Contradictory though they might appear, both observations have some validity. There is indeed minimal education about mental health in paramedic school,
and paramedics are largely aware that their poorest patients have not had easy lives. As often as they make offhanded comments of individual attribution (“Why are my tax dollars paying for this guy to go the hospital every day? I’m out here working…why can’t she work?”), neither are they unaware that our homeless patients struggle on a daily basis with life circumstances that they would never actually choose as a reasonable alternative to working. That the “individual attribution/” belief can co-exist so pervasively and unproblematically with the “it’s not their fault that they’re homeless/crazy/drug-addicted” belief is a testament to how challenging this particular strain of emotional labor actually is. Jen, 28, expresses the “choice” discourse in rather binaristic terms: “I do think that a lot of our calls have to do with poor choices. Alcohol involvement; mental illness that’s not being treated; homelessness; drug addiction; alcohol addiction…not that, like, all our patients brought it on themselves, but sometimes there’s things going on that could have been prevented.” This is not an especially sociological – nor even biological or psychological – view of mental health and addictive processes, but neither is it uncommon. Performing the emotional labor of blame produces the effect of enhancing the job-related dignity of the paramedic, while reducing the cognitive
dissonance caused by the distance between, on the one hand, the heroism of emergency work as EMS workers wish to be perceived, and on the other hand, the day-to-day reality of medics’ more cynical representations of their work: “I just drive drunks around;” “We’re the big red, white, and blue taxi,” and “You call; we haul.”

Feeling anger and resentment toward someone that a paramedic is expected, by nature of her line of work, to treat with compassion and civility, is a tough balance to strike. Some medics regularly fail (intentionally or not) to uphold this standard; this is yet another instance where “what happens in the back of the ambulance” comes into play. I have witnessed many “educational moments,” wherein a medic either lectures the patient on the proper use of 911, berates him for calling again, or asks him when he is going to pull himself together, such as this the following example:

I like to try to take those moments to talk to those people about other services. A lot of the homeless people that I talk to that aren’t necessary the frequent flyers, but they choose to go in the ambulance when they’re hurting, it’s because they don’t like to be treated like a sub-citizen or a piece of dirt when they go to the county clinic. But asking me for a ride for the hospital because you need a prescription medication filled is not a reason to use the ambulance when we’re down to one or two ambulances in the whole county!
I asked Laura if she thought that educational “interventions” like this made any difference. “Not really,” she admitted, “but it makes me feel better in the moment. I guess I just don’t want them to keep thinking they’re nothing wrong with what they’re doing. I think I’m really just venting at them, though.”

In short, paramedics are sufficiently aware of how much of a struggle life is as a person who is homeless, possibly mentally ill, traumatized, and medically fragile that they stop short of wanting to trade places, despite their resentment of the patient’s use/misuse of services. Some medics spoke about more active efforts to maintain prevent themselves from becoming jaded to human suffering. A story I noted down earlier in my career illustrates my own struggle with this process:

We got a call today for a homeless guy from downtown. I’d never seen him before. He seemed pretty cool and we got to talking. I was setting up to get an IV on him since his blood pressure was kind of low, and he said, “You’re never going to get an IV on me.” I bristled like I do every time someone says that, because man, this is my JOB, and I’m pretty good at IVs. He was like, “No, I’m serious. I’ve been shooting heroin for 40 years. I really just don’t have any veins left to hit. Don’t even bother trying.” Yeah, right. So I ended up getting one in his foot, which I felt very proud of, but when I was writing down his information, I stopped cold when he told me how old he was. Fifty. He’s fifty, and he’s been shooting heroin for forty years? What the hell? So I ask him, and he says, like it’s no big deal, “Well, my mom started shooting me up when I was ten.” I swear my jaw fell on
the floor, because this guy is a total miracle. Heroin addicts usually do not live to use heroin for forty years; they either kick it or they overdose and die. But this man is alive! I’ve never thought about privilege in terms of the absence of something. I’ve always thought of it like, “I’m lucky I had parents who could pay for me to take music classes.” But how about, “I’m lucky I had a mother who didn’t inject heroin into my veins when I was ten.” How’s THAT for lucky!? This man didn’t stand a chance, and yet here he is, alive if not entirely well. I wanted to shake his hand for not dying.

Leticia, 32, approaches the difficulties with a frankness that reflects considerable experience – nearly ten years, in her case - with the emotional intersection of empathy and frustration:

I don’t like working with people who don’t have empathy for the people who call 911, and people who are so hardened that they kind of forget what the heart of what we do is. No one wants to be a hobo living on the street, but these people are. Who knows why they are? But they are, and it’s a shitty situation. They’re cold, they’re wet…yeah, do I wanna be running on them and smelling them? No, I don’t. But they’re a human being, and there’s a story behind them. Don’t get so hardened that you forget that these are all people. They all have a story, so don’t brush that aside just because you’re pissed off because your burrito’s paid for, waiting three hours ago somewhere else, you know?

Of the poor and working poor who are not homeless, attitudes tend toward greater tolerance, but only when the medic perceives the medical complaint as a valid emergency, or understands that the patient lacks resources to resolve the issue elsewhere. For example, a patient with a suturable laceration who does not own a car
and cannot seek care at a clinic for lack of private insurance is certainly non-emergent, but does need treatment within a few hours and has limited or no options for medical transport other than the ambulance. There are also patients who get classified as “deserving poor,” particularly if they are subject to life circumstances beyond their control, such as congenital physical disability, serious illness or loss of their partner, etc. Where the undeserving poor are an inconvenience, the deserving poor are more apt to get the benefit of the doubt, as Jen (28) admits:

> This sounds so bad to say this, but I think working poor people just kind of deserve more compassion. I grew up with a mom who was a working poor person. We never had insurance and I lived in an apartment and my mom was on food stamps. I shared a room with my mom, and she was busting her ass, but she had married a dirtbag and she was a housewife. And then one day, she was divorced and didn’t have life skills and didn’t have much. She worked 40 hours a week and didn’t make much money and she had two kids to raise. She couldn’t just go back to school. So I feel for those people, and I feel like sometimes those are the last people who ask for help.

While the majority of paramedics’ class consciousness is focused on the poor, the wealthy are not exempt from class-based ire. The source of medics’ irritation is not dissimilar: wealthy callers who do not have emergent medical problems, but who act “entitled” to ambulance transport – “The insurance will pay for it, so it doesn’t matter” – are the subject of particular derision, again highlighting
EMS workers’ profound sensitivity to their physical and emotional labor being wasted. Wealthy patients are liable to be treated with more overt respect, as one would expect in a society that castigates the poor, but they are not immune to behind-the-scenes invectives, as Leticia, 32, complained, after naming a wealthy community in her EMS system: “I hate it when people just think everything is our job. Like, “I scraped my knee but it’s your job to take me (to the ER) because I just had a chardonnay.”” And Claire (34), griped, “I hate going to those huge houses where they want you to take your boots off when you walk in. Rich-people houses in L---- and B------. When I was on a 24-hour unit in L----, that happened all the time. ‘Can you take your boots off?’ ‘Um, no, I can’t!’ Is this an emergency or not?”

The middle class, interestingly, did not come up in any of my interviews as a specific category of patients in the similar ways to poor and wealthy people. The middle class, it appears, operates much as whiteness does with regard to race in a white supremacist society: it is an unmarked category. Middle class people are certainly seen as misusing ambulance services, but their misuse is attributed to ignorance rather than to entitlement or personal failure.
As I noted at the beginning of this section, the ideology of color-blind racism figures prominently in EMS. As with color-blind racism on a societal level, medics are cognizant that they are expected to treat all patients and family members with respect, regardless of class, race, religion, etc. My on-the-job experience shows that their behavior toward non-white patients lines up more or less with the dictums of color-blind racism, or “have a nice day” racism, in which face-to-face interactions proceed smoothly with no overt hostilities toward people of color. Instead, hostilities show up in how medics talk about their patients once they are out of earshot, or in the form of microaggressions (during treatment) that the patient may or may not pick up on, but certainly would not constitute evident of overt discrimination.

I should begin by reaffirming my belief in the ubiquity of unconscious bias and my conviction, supported by countless scholars of race relations, that people living in white supremacist societies cannot mentally “opt out” of the system by “choosing” to not be biased (Wise 2010; Bonilla Silva 2014; Desmond and Emirbayer 2015). That said, my interviews and field notes revealed a spectrum of attitudes toward patients of color that suggests considerable underlying hostility that
is notable not so much because its pervasiveness mirrors racial discourse in
American society, but rather for the manner in which comments about race came up
invariably in relationship to comments about class. I do not use the term “invariably”
without forethought, nor to overstate my claim; it is simply the case that not one of
my interviewees failed to explicitly link class and race together at some point in our
interviews.

Bearing in mind that a significant proportion of ambulance patients seek our
help because they do not have alternative avenues for health care, and that people of
color in the United States are statistically far more likely than white people to be
struggling with poverty (Bonilla Silva 2014; Golash-Boza 2016; Healey and O’Brien
2015), paramedics’ focus on the relationship between those two forms of
disadvantage is not surprising. Some comments that I overheard made this
connection with a marked absence of self-consciousness: for example, when
canceling off a false alarm in a city inhabited predominantly by people of color, my
partner, a 55-year-old woman, commented on the patient’s car: "How does she
afford to drive an Escalade?" The woman (who had refused ambulance transport)
was Latina but lived in a middle-class apartment complex. I pushed my partner to explain what she meant, but she brushed me off and changed the subject.

How paramedics talk about patients of color depends somewhat on the characteristics of the populations of color in their work areas. For example, several of the paramedics I interviewed work in an agricultural area that has a sizeable community of migrant farm workers, some of whom are undocumented, and many of whom speak limited English or no English. Karen, a 38-year-old medic who had spent her entire career in that system, observed:

I feel bad sometimes, when I work in _______ , that I don’t speak Spanish. I think that’s frustrating because I have to do more veterinary care with these people. It’s good in a way because it trains you to just look at the person. Because you can’t talk to them, really. They can’t tell you their history or what’s going on with them and so you have to treat them by exactly how they look and what the monitor says. When you work in _________, if you don’t speak Spanish it’s a problem.

Aaron, 36, makes a similar comment:

The Spanish population…how do I deal with that? Veterinary medicine! I do the best I can, to the best of my ability…Sometimes, some of these places we see in our county…it’s like a different world. I forget that there’s people really close to me in my life that will never see some of the better and even worse sides of this town. They just have no concept of how impoverished some people live, and what it’s really like to be in that environment, smelling the smells and feeling the heat. A lot of the times, dealing with people that live like that…I’m trying to understand, trying to see it, because no rational human being
will live a certain way if they have a choice. So going into some of these areas where I’m not super comfortable but I’m there for work, I try to take it in as a learning experience, just observing.

The use of the term “veterinary medicine” is common, not just in EMS but in emergency medicine in general. It refers to the type of non-verbal medicine to which one is limited when the health care provider and the patient cannot communicate because of a language barrier. A veterinarian must rely entirely on a physical exam and diagnostic testing to care for a sick animal, and veterinary medicine on non-English speaking human beings makes this relationship quite explicit. The end result is that non-English-speaking patients get dehumanized by language (Healey and O’Brien 2015). The dehumanization process is a form emotional labor in that it decreases any guilt that a paramedic might feel about treating the non-English-speaking patient with less warmth than one with whom she can converse. In other words, a paramedic may want to engage more emotionally with his patients, feel helpless when he is unable to do so, and subsequently mitigate that helplessness (since helplessness is not part of the socially reinforced skill set of emergency work) by temporarily reframing the emotional skills that his job entails. Referring to his ability to communicate with Spanish-speaking patients, Ben (30), affirmed, “Here’s
the three things you need to know: *respiro profundo por favor* (take a deep breath, please), *escribe tu nombre aquí, por favor* (sign your name here, please), and your basic “*dolor aquí?*” (pointing to a body part while asking if the patient has pain there).” Wendy, 39, reinforced the idea that non-English speaking patients also lack basic knowledge about the body when she remarked, “The migrant farmworkers who don’t have good access to healthcare…they’re wary of the system a little bit. There’s a lot of patient teaching and educational needs that need to happen. Tylenol, for instance…your baby has a fever! Why don’t you give it Tylenol?” Notable is the fact that the term “veterinary medicine” is not used for patients with physical or developmental disabilities that make verbal communication impossible, nor for patients who are unconscious – both situations that require a diagnosis based purely on physical assessment and objective diagnostics. The fact that “veterinary medicine” is invoked for non-English-speaking patients shows that race is indeed a salient factor in paramedics’ rubrics for deciding how to classify and interact with their patients.

Another curious site where race pops up regularly is when paramedics treat patients who are suffering from anxiety or panic attacks. Some paramedics do not
actually believe that panic attacks are a legitimate medical issue; their response to such patients can only be understood in the context of a denigration of any emotional response that the medic determines could be controlled by the patient “if he just chose to control it.” A panic attack or an episode of hyperventilation may be accompanied by alarming-looking physical symptoms such as carpal-pedal spasms, where low carbon dioxide levels in the blood cause the patient’s hands and feet to stiffen and bend in awkwardly at the ankles and wrists (this resolves within minutes of resuming normal breathing and is not a cause for medical concern). Two things complicate how paramedics treat non-white patients with anxiety attacks: first, medics’ belief (or at least, their suspicion) that hyperventilation and anxiety attacks are largely preventable means that they label these sorts of calls as non-emergent “bullshit” calls, or calls that do not enhance their perception of themselves as performing important emergency work. Assessment questions include thinly veiled accusations of poor coping skills, such as “Did something upsetting happen to you today?” and “Have you been under a lot of stress lately?”, both of which subtly communicate the paramedic’s belief that the problem is emotional and psychological, rather than physical. (To be clear, it may indeed be emotional or
psychological; notwithstanding, the sufferer believes that he is experiencing a medical emergency, and is sometimes convinced that he is going to die). The intervention provided to patients of any race who activate 911 with this complaint typically does not extent any further than verbal coaching to “slow your breathing down,” sometimes accompanied by statements of mild condescension (“get ahold of yourself,” etc.).

What complicates these calls is the cultural ethnocentrism of dominant whiteness. The Protestant Ethic described by Weber (1920) extends in its “spirit” far beyond capitalism; culturally dominant forms of whiteness also seem to determine appropriate responses to emotionally upsetting events, mostly along the lines of “stiff upper lip” behaviors. Medics may be annoyed and frustrated with white patients who call for anxiety attacks, but they do not express their irritation in racial terms. They speak with flippant derision, on the other hand, about non-white patients who call with identical complaints. This derision is explicitly racial in content: depending on the demographic of the area, a call might be labeled as “H.P.” (shorthand for “Hispanic Panic”), “Mexican Meltdown,” “Curry Worry” (for South Asian patients), and “Asian Anxiety.” There’s even a politically correct, non-
racially-specific euphemism: “Ethnic Emotional Event.” The astounding variety of different populations to which these “inappropriate” responses are attributed – not to mention, the creativity employed in the invention of slurs, and their ubiquity in far-flung EMS systems – suggests that paramedics experience significant discomfort when confronted with emotional displays that do not conform to culturally dominant, white notions of emotional appropriateness. These calls simultaneously challenge their occupational identity as workers who “deal with emergencies only” and their identity as people who can provide comfort and care in times of emotional distress.

Regardless of whether hyperventilation is learned by observation – as most medics will argue, and as is possible, in much the same way that displaying a “stiff upper lip” is socially learned – paramedics’ overwhelming tendency to interpret this as a personal weakness on the part of the patient and her entire ethnic group or community is a critical point. Long before I took my first Sociology class, I found the term “H.P.” offensive enough to formulate a theory about why we seem to react so strongly and in such an explicitly racialized manner to hyperventilation patients. In years of experimentally pushing my co-workers to examine their cultural assumptions, what I mostly got was a lot of resistance; they seemed to be truly
attached to the racial analysis. Cultural relativism was not on their screens, much less the idea that the open expression of powerful emotions might actually serve a purpose (such as promoting faster emotional healing after a traumatic event).

This section (up to this point) has painted a rather pessimistic picture of paramedics and race. However, I do want to include some of the voices of those who, despite their participation in ethnocentric Othering of non-white patients, expressed sentiments of genuine curiosity about or enjoyment of the variety of people with whom they come into contact:

We don’t have a lot of people of color where I work except for Latino folks. I think most of them are Mexican immigrants. But where I used to work, in _____, we had a lot of Asian immigrants, South Asian immigrants. It was a whole different challenge to work over there. There were all these elderly Chinese people who’d been here for a long time but never assimilated at all. They spoke zero English and they were all like ninety years old, and their way of dealing with being uncomfortable being in a medical situation was stare at the wall and refuse to answer questions. I didn’t even know if they understood them. They wouldn’t even flinch when you started an IV. It was like, do whatever you want. I remember learning something when I was little about how shame is a big deal in Chinese culture, so they will just try to pretend that they’re not there in order to not feel the shame. I was really startled by it the first few times, but it also made me curious to learn more about those people. Of course, I couldn’t talk to them, though.

-Alicia, 35
The *barrio* is my favorite place to go! They got little dogs that are trying to attack me…they got amazing smelling food…there’s a lot of sign language that’s going on because nobody can communicate with each other.

- Claire, 34

Claire’s tone of voice when she made this statement, as I noted while transcribing our interview, was “enthusiastic and excited;” she clearly considered her forays into “ethnic” neighborhoods to be adventures. Like other medics, though, she employs the typical slate of racialized terms when she talks about anxiety calls in the those neighborhoods, and refers affectionately to her favorite homeless “frequent fliers” as “hobos” (another term that could easily be interpreted as pejorative out of context).

Claire, however, expressed similar forms of affection for many different kinds of patients. She is not alone in these ostensible incongruities; indeed, this sort of schizophrenic approach to understanding difference, inequality, and humanity is endemic to EMS culture. Its prevalence suggests that, as a form of emotional labor, it, too, is crucial to the social reproduction of paramedics. Like the other forms of emotional labor discussed in this chapter, and the contexts to which I will move in the chapters that follow, it turns out that nurturing the ability to hold contradictory
ideas – by minimizing any cognitive dissonance associated with them – is among the most indispensible emotional survival skills in EMS.

CONCLUSION

In this chapter, I have explored the shop floor – 911 calls – and the various types of emotional labor that paramedics perform on themselves and on their patients. This emotional labor benefits both them and their patients. In the next chapter, I move off the shop floor and into the break room to examine paramedics’ emotional labor between calls.
CHAPTER 4: THE LABOR PROCESS IN THE BREAK ROOM: 
PARAMEDICS’ RELATIONSHIPS WITH ONE ANOTHER

It can be hard to be a female on this job. It’s a total sausage fest. It’s like you have to fight just to be recognized as a member of the team. I always think of it as being “Cool Girl” from that book Gone Girl. Cool Girl is a learned thing on this job. You come in and you’re not sure where you fit in. I remember when I was in my twenties, and I was flirting with another medic, and then he was really coming on to me, and I had a boyfriend, and all of a sudden, I was super uncomfortable. I feel like that taught me a lesson not to be overly flirty, because they’re like, “Hey, we’re sleeping in quarters together; maybe we can just hook up and nobody would know…AND we’re getting paid for it!” So I started being more abrasive and not taking any shit. And then I kind of found a balance as I got older. I can take a joke, but I also know my limits.

- Wendy, 39

It’s funny…when I think about what I like most about this job, some of the stuff I like the most isn’t running calls or saving lives or any of the heroic shit. I mean, that’s the job, right? Anybody could do that if they went to medic school and learned the skills. I’m not saying I don’t get satisfaction from that, but I think when I quit the ambulance, what I’m really going to miss is the little things. Like, you know what I really love? When a bunch of us are clearing the hospital at the same time. When there’s like, four or five ambulances just sitting at the back door of the ER, and we’re all just standing around with our rigs cleaned up, shooting the shit and screwing around. I always laugh so hard and it makes me feel like we’re a family. Maybe I was super pissed at one of those guys an hour ago because of some call that he dodged…but man, when we’re all there together, we laugh our asses off. I love those times.

- Derrick, 30
In Chapter 3, I discuss the dynamics of the labor process on the factory floor – in other words, the emotional labor that paramedics undertake in the process of providing emergency medical care to patients. I dedicate considerable space to the factory floor because this project is, at its core, a work ethnography, and work ethnographies traditionally focus on the factory floor. There’s a good reason for this: it’s hard to argue that the labor process for most jobs takes place away from the (literal or metaphorical) production line (Thompson and Newsom 2004; Burawoy 1979). Regardless of whether “production” entails the manufacture of goods, the delivery of services, or the application of specialized technical knowledge, it is the case that most manufacturing and service jobs are structured around workers performing productive work (more or less) during most of the time that they spend on the clock. There are designated breaks if the employer is abiding by laws that require them, but breaks account for only small proportion of the workers’ time in a given day.

At the center of this project, however, is my argument that an exposition of the factory floor does not come close to telling the whole story of emotional labor in Emergency Medical Services. On the contrary, I have made the claim that it is
impossible to understand the social reproduction of paramedics without looking at the other arenas in which they deploy highly specific forms of emotional labor. In this chapter, I will examine the emotional labor of the break room. “Break room” should be understood as a metaphor: a place-holder for the unstructured time during which paramedics are neither dedicated to emergency calls nor engaged in other call-related labor such as writing Pre-hospital Care Reports (PCRs) or restocking the ambulance with missing medical equipment.

The amount of unstructured time, as I discuss in Chapter 2, can vary significantly from system to system. In the EMS system in which one of my interviewees worked, for example, there was a car that was scheduled in 48-hour shifts and often ran only one or two calls in that time period. That works out to perhaps 4 hours of time on call, with 44 hours of downtime. This would be akin to a barista spending only 45 minutes of her 8-hour shift behind the espresso machine (Laurier 2013). On the other hand, I also interviewed medics who were always paged to their first call within minutes of logging on, and who then proceeded to run 10-14 calls before logging off, exhausted, at the end of their 12-hour shift. In practice, call volume varies even within semi-consistent shift schedules. Whether one can regularly
anticipate a few hours of downtime, or whether it comes as a pleasant surprise, it is as significant a part of the EMS experience as running calls. Emotional labor gets done calls (on the factory floor), and emotional labor also gets done between calls (away from the factory floor) (Desmond 2007).

In a typical job, the break room is a specific space to which employees retire for respite. It is physically distinct from the factory floor in both location and purpose. Hence, another reason that I encourage the reader to understand the EMS break room as a metaphor is because downtime for EMS workers occurs in infinitely many locations, the boundaries between which may be fuzzy. Among the most common is the front cab of the ambulance; especially in EMS systems that involve heavy move-ups (or “bumps”), a medic and his partner may spend the better part of their shift sitting in the rig (either running calls, driving to calls, or moving to cover an empty zone). The front of the rig is a sacred space; ill-kempt “biohazard” passengers (such as friends or family members of patients) are refused courtesy transport on the grounds that the front cab is essentially our living room. The seat covers are plush, not vinyl, and are not easily divested of dirt, body fluids, or insect infestations.

Ambulances are kept in service until 250K miles, and sometimes upwards of 350K or
400K miles, depending on the system. We guard our living rooms carefully. Other sites of break room activities include public spaces such as parks, stores and businesses; scenic overlooks; city street corners; banks; medics’ own homes; schools; restaurants and fast food spots; coffee shops; spouses’ workplaces; the DMV or the bank; the back door of a hospital emergency room; and an ambulance station (a residential space with beds, TVs and living spaces, food preparation facilities, and a bathroom that is made available in to crews who work 24-hour shifts).

With the exception of the back door of the hospital and the station, the list of potential break rooms obviously includes places where one would expect to see any worker on her day off, i.e., running the sorts of errands that everyday workers must attend to in order to allow them to return to work each day, as described in theories of social reproduction under capitalism (Marx 1978; Vogel 2014; Federici 2008). Katz’s explanation of social reproduction in its several manifestations is worth quoting at some length because it highlights the strangeness of performing tasks of social reproduction while the worker is ostensibly at work (and the impossibility of doing so on the factory floor): “Social reproduction is the fleshy, messy, and indeterminate stuff of everyday life…At its most basic, it hinges upon the biological reproduction of
the labor force…through the acquisition and the distribution of the means of
existence….it also encompasses the reproduction of the labor force at a certain…level
of differentiation and expertise (Katz 2001: 711). What makes paramedics’ downtime
such a point of interest is that its value exceeds its capacity to (sometimes) give EMS
workers the chance to complete those “means of existence” tasks that they would
otherwise be obligated to do on their days off. Indeed, downtime serves an emotional
purpose that is every bit as compulsory to the social reproduction of paramedics as
shopping for groceries and finishing the laundry. Downtime turns out to be a crucial
opportunity for paramedics to discharge complex emotions related to 911 calls, as
well as to forge, expand, and maintain the interpersonal dynamics with coworkers that
facilitate smooth partner relationships on scene, not unlike the relational activities that
Hochschild highlights in flight attendants’ pre-flight “emotional tone road show”
(Hochschild 2003: 115).

Downtime conversations can be loosely divided into two categories:

conversations that are explicitly about calls or work, and conversations that are not
about calls or work. Each of these two larger categories can be subdivided into
smaller subunits of analysis. Within the realm of conversations about calls, I will
explore the emotional functionality of venting (chiefly of anger and frustration),
processing (of self-critique, sorrow, or the aftereffects of seeing – as one partner of
mine put it – “a lot of freaky shit”). With regard to the utility of conversation that is
not specifically about work or calls, I will detail the ways in which paramedics
interact with one another to build alliances, hold one another to account, forge bonds
of trust (sometimes explicitly temporary ones) and negotiate social and power
relations in the workplace, using multifarious devices such as sarcasm, ribbing and
teasing, and sexually explicit discourse (both heteronormative and
homophilic/homophobic). Within this second category, I will also examine the
specificities of relationships between women medics and men medics, a site that
illustrates to great advantage the persistent degree to which EMS has not yet reached
a point of easy comfort about the presence of women in the industry, and where the
tension that I describe in Chapter 1 - between masculinity and femininity as
performed at different moments by men and women medics - becomes easier to see.

The data for this chapter consists in larger part of my field observations than
did the data in the previous chapter. This point is worth mentioning because the
absence of interview data about the break room is itself revealing. One question that I

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asked of each of my interviewees was “What do you like about being a paramedic?”

As I expected, my interviewees interpreted this question mostly in the context of patient care, i.e., what they enjoy about practicing medicine, caring for people, performing a “heroic” job,” etc. Only a small handful of my subjects mentioned downtime at all, even though some of our workdays consist overwhelmingly of time spent in a variety of break room settings. Of those who did comment on aspects of the job that are not related to emergency care, most made mention of the general pleasure and/or value that they derived from relationships with their partners and coworkers, but without advancing any specific theory of how those relationships function as a form of self-care, emotional discharge, or bonding for the purpose of better performing their factory floor jobs. Some examples:

I like the people I work with…their medicine, their personalities…you get a lot of goofy people in this world, and you can kind of talk to anybody in this field about anything, because we’ve basically heard it all already. You have to pick and choose who you talk to because there are people who will just go and tell all your secrets to everyone else, but we’ve heard it all. People complain to us about literally everything. We’re like, “Oh yeah? Whaddya got?” Nothing can really shock us.

- Aaron, 36

When I used to be full time and have a regular partner, it was fun to work with that person. We were together for too long. I got totally tired of her shit! Thankfully she hurt herself and had to go out on a hernia for
six months or something… I was like, thank god! But she’s hilarious.
We’d laugh a lot.

- Monica, 36

I really like the camaraderie that you have, knowing that you’re doing something that is odd, and that you’re surrounded by other odd people, It takes odd people to do what we do. We have a very strange sense of humor. We’re all pretty crude; we’re all pretty to the point. It’s like a big family because you just all lean on each other.

- Leticia, 32

All three of these subjects are more experienced medics (Leticia and Aaron have about twelve years each, while Monica has been licensed for fourteen years). This is also significant, since it suggests that that experience as a medic decreases the importance of the emergency work portion of the job, while increasing awareness of the social relationships that make time spent at work more rewarding.

Notwithstanding these medics’ valuation of partner and coworker relationships, however, most of my subjects did not address any aspect of their at-work downtime in our interviews. As I explain in Chapter 1, this is a mixed-methods project consisting of both interviews and field notes. My interviews were performed over the 18-month period during which I conducted the formal participant-observation research for this project. However, my observations about the industry are understandably more robust for the inclusion of my memories, impressions, and
sociological analyses born of sixteen years working in EMS. It would be impossible
(and intellectually limiting) to consider my field note data outside the context of my
entire career; hence, in this chapter, I draw on interview data (when possible), field
note data, and my own experiences on the ambulance.

TALKING ABOUT CALLS AND/OR WORK

In Chapter 3, I explore the many kinds of emotional labor that paramedics undertake
in order to successfully complete their basic job function of running emergency calls.
The emotional residue of 911 calls – whether it’s frustration over the perception that a
patient has wasted the medic’s time, or the challenge of maintaining emotional
distance while treating a patient who reminds the medic of her child or wife – does
not magically disappear after the patient is handed off to hospital staff. On the
contrary, the relinquishment of patient care delineates the moment in the progression
of the call where the medic is no longer responsible for the patient, and therefore is no
longer required to engage in emotional suppression or generation – at least, once she
is out of earshot and out of view of the patient. This is the moment when the medic
can begin accounting for her experience of the call. In the section that follows, I will
examine three varietals of downtime conversations about work: venting, rubbernecking, and processing.

Venting

Bearing in mind that frustration is a constant for EMS workers, venting is an important means of releasing the emotional tension surrounding a 911 call. There are two primary sources of tension: either the patient herself is at the root of the paramedic’s emotion, or the emotion is directed at someone/something that was present at the scene and negatively impacted the direction of the call. Situations that generate tension as a result of the emergency call include “ungrateful” or abusive patients; abrasive family members; situations that generate disgust (such as patients covered in body fluids or who live in hoarder houses); uncooperative law enforcement, medical personnel, or fire department personnel; and conflict with one’s partner. Venting may take place at the back door of the hospital or in the sanctity of the front cab, depending on the need for privacy or a medic’s readiness/reticence to discuss the issue. With regard to on scene conflicts with other public safety personnel, the venting process allows the paramedic to discharge her anger, disgust, frustration,
or irritation in a way that does not compromise her ability to work cooperatively in the future with person with whom she had a conflict. Consider how Jerry, 50, reflects with emotional distance on his problematic interactions with fire department paramedics:

I stay calm, and I try not to argue on scene. And if it’s something that’s not going to harm the (patient), I just kind of let it go, and then I go into the back of the ambulance and fix whatever they did.

If it’s something that shouldn’t be done – like the wrong drug - I just kind of pose it as a question to fire…”So, guys, we have a slow heart rate…do we really want to give something that would slow the heart rate down more?” Sometimes people want to do things, and they’re just reacting, not thinking. I do that all the time. Sometimes our reactions are wrong, though. So I pose it to them in a way to try to get them to stop and think.

Other medics practice similar conflict avoidance techniques, citing the need to keep things running smoothly on the next call: “I avoid conflicts whenever possible,” Jerry added later. “It’s not worth it. Your vocal cords hurt from yelling.” Jen, 28, is also circumspect: “I think that there’s a million ways to skin a cat. I feel like, okay, you want to do it that way? Fine. If it’s really wrong, I’ll say something in a nice way. Otherwise, I just don’t say anything.” Ben (34), elaborated,

I think personality conflicts are the most common that you run into. Partners, agencies, nurses, doctors…it all depends. If it’s somebody that I’m not likely to have many interactions with, then it’s not really
worth bringing to light that there’s a conflict. But if it’s somebody that you’re likely to have ongoing stuff with, the fire departments that you’re likely to run into all the time and all over the place…then yes. I’ve learned to handle that on scene without putting somebody on the spot, but kind of making suggestions about, “Hey…we don’t have to agree, but we’re here to do a job and sometimes that can be a fun job and sometimes it sucks.”

These medics are not making a claim that they manage conflict on scene by playing nice, and that therefore, they cease to be bothered by the event. On the contrary, most of them suppress their annoyance long enough to run the call. When it’s over, a medic may spend many animated minutes describing the altercation to her partner or other crews using details designed to gather consensus for her version of events. This type of venting can be quite dramatic, with the venting medic imitating or caricaturing the offending member of the fire crew, accentuating his apparent stupidity while downplaying any errors or poor communication choices that the ambulance medic may have made. This is similar to observations made by Tangherlini about the narrative purpose of paramedics’ storytelling: “Although the medics may not be able to exact any real vengeance on their tormenters, they can exact narrative revenge” (emphasis mine) (1998: 213).
The minimization of one’s own role in a call that “goes sideways” is an important way that a paramedic attempts to save face when he has made an error (Goffman 1967). This preserves not only his dignity – a feature of emotional social reproduction that entices him to return to work each day – but also his confidence, without which he cannot function as a paramedic. The admonishment to “fake it ‘til you make it” is no joke on the ambulance, as a crisis of confidence from which he does not recover can destroy a medic’s career. From my field notes:

I ran a call today with T. He’s newish, maybe six months on the rig. He still doesn’t have a lot of confidence and I think it scares him. He seriously blew it on reading a patient’s 12-lead (ECG). He interpreted the ECG as SVT (a serious cardiac arrhythmia caused by a problem with the heart itself), but it was Sinus Tachycardia; the patient’s heart rate was just too fast because she was super sick with a raging pneumonia. She was hemodynamically unstable, barely holding on, and the medication he wanted to give her would probably have killed her. It was the wrong medication, period. K., the fire medic, called him on it. K’s been around maybe ten years longer than even me. He’s humble and he will always be the first to admit when he doesn’t know something, but he’s a strong medic and he was totally the right saying something to T. when he did (if he hadn’t, I would have). T. played it off like he didn’t care, but after we cleared the hospital, he would not let it go. He went on for about five minutes about how K. was wrong, and he should have at least given a trial dose of the adenosine (the med that he wanted to give). I let him talk for a while, but I realized that he was interpreting my silence as agreement. I finally just had to say, “K. was right. You made the wrong call. It’s okay, though; everyone makes that mistake in the beginning.” He totally switched gears, almost as if
me saying, “It’s okay to screw up” gave him permission to stop being so intransigently defensive. We talked through the diagnostics and then we dropped it. He didn’t bring it up again. When we ran again with K.’s crew a few hours later, he was perfectly friendly with him. He even went out of his way to solicit K.’s opinion on his treatment plan!

Because crew conflicts severely hamper all rescuers’ ability to complete tasks in an emergency, this kind of behind-the-scenes venting allows the medic to feel justified in his complaints, to make them known to others, and then to work civilly alongside the person with whom he had the conflict on subsequent calls. So effective is venting as a coping strategy that even an angry medic whose partner does not agree with his reasons for being angry may allow him to vent because the partner sympathizes (not necessarily consciously) with the face-saving function of venting. My interview data backed up my field observation that paramedics are generally conflict avoidant. Those who are not rapidly develop reputations as troublesome, which is not a desirable trait to bring onto the scene of high-stress EMS calls.

Strong emotions toward the patient are another common reason for initiating post-call venting sessions. “Bullshit” calls often elicit complaints – although interestingly, medics’ griping about frequent fliers is mostly mild in nature, perhaps because dedicating too much emotional energy on a situation that you are likely to
encounter dozens (perhaps even hundreds) of times in the future with the same person. It seems an imprudent expenditure. Rather, it is the more unusual “bullshit” calls – stories that are fodder for games of “bullshit-call-one-upmanship” – that end up being woven into fantastic yarns. One way of off-gassing the frustration of being called for something that is emphatically not an emergency is to tell the story in a way that highlights the absurdity of the things we see on the job while employing storytelling devices like sarcasm and exaggeration (corroborated in accounts of emergency work storytelling by Desmond (2007), Lois (2003), and Tangherlini (1998)).

The same techniques come into play for patients who may have a semi-valid reason for ambulance transport (such as being too intoxicated to walk safely), but who are verbally abusive to the EMS crew. For example, in Chapter 3, Wendy (39) reminds me of an encounter in which she and I were subjected to explicit verbal harassment by a patient. She recalls our reaction after the call was over as a moment in which we were “laughing hysterically.” In another instance, I transported a patient who repeatedly screamed at my partner and I that we were “doing everything wrong,” and went on to inform us at top volume that we “shouldn’t be paramedics if you can’t do your job!” (She was angry that we would not administer morphine prior to moving
her; at that time, however, we did not have a protocol that allowed us to give morphine for back pain). The patient’s diatribe – deliberately personal despite our attempts to calm her and explain that the situation was beyond our control – continued unabated for the duration of the 20-minute transport. When we finally transferred her to the bed in the Emergency Department and walked back out to the ambulance bay, my partner looked at me and exploded, “I HATED HER!” Her expression of solidarity with my experience (she was driving the ambulance, but had had no trouble hearing the stream of insults coming from the patient care compartment) sent me into convulsive laughter. On an emotional level, it felt very much like taking a shower.

Since the experience of feeling unappreciated is a point of contention common to all of the medics I interviewed, the emotional energy required to suppress the anger that arises in response to a patient’s verbal abuse is considerable. We do not have access to the physical anger-management tools that Hochschild’s flight attendants have, like “chew(ing) on ice…or flushing the toilet repeatedly” (Hochschild 2003: 133), but we find ways to suppress until discharge is appropriate. It’s not that medics necessarily take things personally; we understand intellectually
that the people who are lobbing sexually explicit, homophobic, sexist, or racist comments at us are mentally unwell. A medic has three possible responses to verbal abuse: he can either ignore the abuse, tell the patient that her words are inappropriate/unwanted, or deliberately provoke the patient further with revenge practices such as those described in Chapter 3 (“What happens in the back of the ambulance stays in the back of the ambulance”). While we are skilled at building emotional boundary lines, years of practice still do not make such conversations pleasant. We may come to find them amusing in their sheer absurdity, but they are still exhausting.

Finally, medics use venting as a strategy to brush off residual disgust. This disgust is either generated by the patient’s body (fluids, weight, general physical condition) or by the location where the patient was found. Disgust can be oddly “sticky,” in the sense that the event stimulating the disgust may linger for some time in a medic’s mind. A venting story told not long after the call has taken place is, while the memories are sharp, rich with evocative detail. The following call was relayed by one of my interviewees only a day after it occurred:

Oh my god…yesterday! I had a homeless man that had the worst case of scabies, head lice, and bed bugs I’ve ever seen in my life…all at the
same time. We got called for a guy who was “itching” underneath the highway overpass. As we walked up to him, he’s all, “Watch out, I’ve got bugs!” So we all stopped and said, “Thanks for telling us!” I’ve never seen bugs jump off of somebody. That was the bedbugs. His scabies were so bad, it looked like he had plaque psoriasis. It wasn’t just in the creases and all the normal spots. It was everywhere. His lice looked like little lice condos. The nits were so gnarly on his head! He took his had oft and we were like, “Put that back on!! Contain that shit!” That was the grossest. He called because he was so itchy. He was like, “I can’t eat; I can’t sleep; I can’t do anything.” I was all, “Dude, I don’t blame you!” We had him stripped down. We made a poncho out of a yellow blanket and we made him take his clothes off. He was like, I don’t have any other clothes! And I was like, “We’ll get you new ones, buddy. That shit needs to be burned.” We put a poncho on him and then we just wrapped him in a bunch of sheets. The whole day, I was just convinced that I had bugs. I’m still itching! Is it my excema? Is it scabies?

- Claire, 34

Venting disgust to others garners sympathy for the ordeal while enhancing a sense of shared suffering. Each time a medic finds himself in a disgusting situation, he knows that he is not bearing a disproportionate burden of disgusting calls; he’s heard a lot of stories, and he knows that they happen to everyone.

Rubbernecking

One of my interviewees, Jen (28), told me flat out that she thinks of paramedics as “the ultimate rubbernecker.” I asked her to clarify, and she replied, “We’re nosy. We
want to be in the middle of everything. This job lets us be nosy without getting in
trouble.” I couldn’t disagree. We get to tromp behind the yellow tape of police lines.
We scramble down embankments after wrecked cars that leave traffic backed up for
miles in lines of frustrated bystanders. We enjoy ample opportunity to rubberneck
under professional cover. It’s a sweet deal, and we “share the wealth,” so to speak, by
swapping stories with other crews during our downtime.

Most EMS systems are dispatched through one central location. EMS workers
listen casually to the radio throughout the waking hours of their shift. They listen
closely when their own unit is paged out (for obvious reasons), but they also listen for
dramatic-sounding dispatches that go out to other units. Calls that might make the
entire system’s ears perk up include potentially tragic calls (“baby not breathing:”
“male found hanging in the garage”); unique or serious mechanisms of injury (“kite
surfer slammed into the cliff”); absurd calls (“female reports that a tree is growing out
of her vagina”); or calls involving many potential patients (multiple-fatality car
crashes, colloquially known as “cluster fucks”). For the remainder of the day, the
crew attached to that call can expect to be battered with questions from every other
crew they run into at the hospital, at the deployment center, or at the station. Indeed,
they may not have to wait; medics whose curiosity gets the better of them will simply call or text their coworkers to get the story: “So, dude, what happened on that call?”

While medics are prohibited by federal privacy laws from discussing patient identities with people who are not directly involved with the call, they do not typically hold back from each other. It would be bad form to refuse to tell a story on request, and poor form as well to restrain oneself in terms of detail. These stories are meant to be dramatic, and so they are recounted with verbal and physical flourishes to underscore their best points.

The question of why paramedics seek other medics’ stories and share their own is answerable, but not as simplistically as we might expect. One of my subjects, Patrick, 44, brought up some subtler features of break room rubbernecking in his interview:

I might be kind of old school, but I really pay attention to what my coworkers say about a call, especially if it’s a kind of off-the-wall one that I haven’t seen before. I mean, yeah, of course I’m interested in hearing about the crazy shit. Who isn’t? But I also want to hear about the really unique medical stuff. I’ve seen a lot, but I haven’t seen everything, so if I can hear about how another medic handled some call that I’ve never had before, and maybe I won’t see it except for once or twice ever in my whole career…well, it’s probably a good idea for me to listen up.
Patrick is a career medic with nearly 20 years in EMS. Since he is not planning to leave EMS for another job, his level of investment in medicine is on the high side among my research participants. Nonetheless, he points to a valuable aspect of rubbernecking: the human body can survive any number of creative injuries, and is vulnerable to an extraordinary range of disease processes. There is never a point in medicine where there is nothing left to learn.

**Processing**

After venting and rubbernecking, the third type of conversation about work that takes place in the break room is *processing*. Processing refers to the time that a medic spends performing an emotional post-mortem a call – her emotions about the patient or the situation, or her assessment of how well (or how poorly) she acted in her capacity as a paramedic. Processing is a bi-directional activity; the audience for the medic doing the processing may be herself be rubbernecking, even as she is performing the emotional labor of active listening. Professional post-mortems function as an emotional reckoning. For the medic who has run a call and is not satisfied with the work she did on the call, processing with a coworker is one way to
come to terms with not having succeeded in forestalling death, preventing a patient’s condition from deteriorating, or simply missing (overlooking) an injury or medical condition that could have been treated in the field. For the medic who has experienced a call whose circumstances troubled her – the death of a child, for example, or someone who reminded her of a loved one – processing is a critical safety valve for the expression of emotions whose buildup could compromise her ability to function both at work and at home (Timmermans 1998).

An oft-repeated maxim in EMS is “It’s not our emergency.” This phrase encapsulates two key values in the practice of paramedicine. The first is that EMS workers are expected not to lose their heads under any circumstance. This fact, obvious though it might seem, dictates the emotional culture of the entire occupation and other public safety occupations where levelheaded action is one’s primary job duty. It goes without saying that a medic who fails to keep his calm, regardless of the gravity of the situation, is of no use to anyone. It would not be overstating the centrality of this feature of EMS culture to claim that it is the foundation on which all of the emotional labor that I describe throughout this project is overlaid. A good
medic keeps calm and gets the job done, repressing any desire he may have to laugh, panic, run away, weep, or berate.

The other side of “It’s not our emergency,” is the notion that we should avoid feeling bad or taking personal responsibility for patients who die or suffer permanent disability despite our best efforts at helping them. This, of course, is where things can get complicated. In my participation in thousands of informal processing sessions over the years, I have observed that paramedics hold themselves as individuals to a higher standard than they hold their coworkers. A number of them operate (at least some of the time) as if “It’s not our emergency” applies to other medics but not to them. Processing, then, is also a means through which a paramedic can reach out to another medic for comfort and reassurance without having to make herself vulnerable by requesting it explicitly.

In EMS culture, an admission of emotional distress may be interpreted as a sign of weakness or as an inability to emotionally handle the job. No one wants to be thought of as a medic who cannot be depended upon to perform in an emergency situation. As a result, medics tend to manage their emotions such that they do not openly admit their distress – to others or to themselves. Curiously, this is an older and
comparatively intransigent form of emotion management in EMS. It is not encouraged by employers or by industry leaders. On the contrary, industry publications such as *JEMS* (the *Journal of Emergency Medical Services*) regularly disseminate research about the importance of practices like group Critical Incident Stress Debriefings (CISD) after traumatic or emotionally challenging calls. Medics no longer openly espouse the repressive ideals of the past. Public and private sector employers pay plenty of lip service to mental health, encouraging workers to seek counseling if they need it and providing them with resources such as employer-mandated CISD sessions and 24-hour Employee Assistance Program lines that they can call to get referrals to psychotherapists.

The availability of these resources does not always translate to widespread use, however. Both within public safety and in the deployment of hegemonic masculinities of the United States, the ideology of the stiff upper lip is being dismantled. More than at any previous historical moment in the development of advanced capitalism, hegemonic masculinity seems to be decoupling from compulsory emotional restraint: Pascoe and Bridges note the utility of “dislocating” theories of masculinity to “consider masculinity discursively, not just in terms of
male bodies or categories of men (Pascoe and Bridges 2014:328). Like traditional racism, though, being out of fashion simply means that emotional repression has shape-shifted into something more palatable. Bearing in mind that EMS shares cultural roots with militaristic subcultures and power hierarchies, it turns out that paramedics are generally less enthusiastic about “feeling their feelings” in a public way than employers and mental health professionals have encouraged them to be. This reticence plays out on their bodies – when they consume alcohol or other substances to relieve their distress – and on their mental health, when their work-related emotional trauma bleeds over into their relations with themselves and their loved ones.

The emotional-social reproduction of paramedics happens in the presence of a means by which they can process their distress over the difficult scenes they witness in the course of their work. As has become increasingly evident with the return of tens of thousands of profoundly traumatized U.S. soldiers from Iraq and Afghanistan (not to mention the traumatized civilians with whom they interacted in violent ways during their deployment), the human mind does not appear to cope well with repeated exposure to sights that human minds aren’t well equipped to cope with (Van der Kolk
The exigencies of battle, like the exigencies of EMS, create a situation in which participants are forced to choose between breaking down and “feeling the fuck out of my feelings” (as one of my partners commented after we worked without success to resuscitate a hanging victim) – thereby risking censure and the crisis of confidence of their coworkers – and convincing themselves (with or without success) that they really just don’t care. Either outcome has negative repercussions: the first, on our ability to work effectively as a member of our team, and the second, on our long-term mental health.

The practice of processing in the break room is a form of emotional labor best thought of as a compromise. It allows the medic to save face (vis à vis himself and to his coworkers) through a kind of ritual self-flagellation. In repeating the call aloud in detail – his doubts about his performance, the things that “tripped him out” – he gives his coworkers an opening to intercede with words of comfort disguised as offhanded comments. Some of this involves self-deprecation (“Man, I can’t believe I missed that head bleed”). Other expressions attempt to convey a medic’s difficulty coming to terms with the patient’s identity or the situational aspects of the call (“I can’t believe all those kids in that car. They were all my son’s age!”). The
reassurance elicited by a self-deprecating comment is suitably vague, and aimed at restoring the distressed medic’s alignment with “It’s not our emergency.” From my field notes:

We had an electrocution code save today! It was the first time I’ve ever seen someone survive such a major electrocution. The patient was a guy in his mid-thirties who was using a pole saw to trim some branches and knocked it into a power line. It put him into cardiac arrest. His buddy flagged down a passer-by to call 911, and that guy actually stopped and performed bystander CPR, which is the only reason the patient survived. It must have been some damned good CPR; the fire medics got pulses back with the first shock. By the time we got him to the helicopter landing pad (our protocol required us to transfer him to a trauma center), he was awake and talking. Coherently! (When does THAT ever happen? Never.) Anyway, the helicopter flight nurse called me with follow-up a few hours later. I had told her on scene that we only found burns on his hands, so we thought the electricity had entered one hand and exited the other. Turns out he had a substantial exit burn on the bottom of his foot. I never took his shoe off, and I should have. It was a dumb move. I was a little amped because we had gotten him back, and I just didn’t think about taking his shoes off. I called the fire medic (we’ve been working together for years) and he had the same reaction. So there we are on the phone, beating ourselves up about not taking this guy’s shoes off, and then we’re tripping over each other to say, “No, that could have happened to anyone! Don’t lose any sleep over that…it doesn’t matter; it wouldn’t have changed what we did for him.” After we had both lamented to each for a while about what shitty medics we were, and then reassured each other that our failure to remove the patient’s shoes didn’t actually mean that we were terrible medics, we hung up. I felt like my pride was intact because someone else who does my job told me it was okay that I fucked it up a little bit. That’s kind of all I needed to hear to
move on. It didn’t really bother me after that. I think it did the same thing for him.

Another interviewee, Alicia, 27, shared the following story with me:

This one time…I remember I had gotten in a fight with my boyfriend, and I was irritable that whole day to begin with. My and my partner got an asthma patient. She was bad. I knew she was sick but my head wasn’t in the game because I was thinking about that fight. So anyways, I get this lady on a breathing treatment but she just wasn’t getting any better. She ended up coding at the hospital, maybe five or ten minutes after we got there. I totally knew I blew it when we were transferring her over. I mean, she’s barely breathing! But instead of putting her on CPAP or giving her epi or intubating her – which she probably could have handled; she was basically unconscious – what do I do for her? Fuck all, that’s what. A breathing treatment. I saw how the nurses and the doc were looking at me and I kind of realized how I screwed up. Like, if I’d been a little more aggressive, I could have turned her around before she coded. I went back out to the rig and closed the door and made out like I was doing my paperwork, but I starting crying and I couldn’t stop. I just felt so bad, like I killed that lady. My partner eventually found me and asked what was up, but I wasn’t about to tell her that. You know what I mean. Like, what’s your partner going to say? “It’s not your fault. Don’t worry about it.” But it was my fault, at least in my mind, and I didn’t want her to think I was losing my shit over that, so I told her I got another text from my boyfriend and she left me alone.

Incidents like this can severely undermine a medic’s confidence. Alicia’s hesitation in expressing her doubts about herself to her partner stem from her fears that her partner will respond negatively not so much to her self-doubt (in fact, this could be a great moment for the processing ritual of self-deprecation and reintegration), but rather, to
her “inappropriate” emotional expression of her self doubt. Alicia’s story also demonstrates the way in which downtime processing happens in accordance with a script. Any departure from the script invites rebuke and invalidation.

A final function of downtime processing is as a release valve for emotions that a “normal” person might think – and with good reason – of bringing to a professional therapist. Calls that get “burned into your brain” (Jeff, 30) have an additive quality to them. They don’t go just go away, even if their emotional immediacy decreases over time. While all of my interviewees readily responded to my questions about calls that were particularly memorable, they tended to tell stories of calls in which they felt like they had made a significant difference or calls in which the situation stood out for its drama or absurdity. When stories about traumatic calls did come up, none of the medics telling them reported seeking therapy. On the contrary, their coping mechanism simply involved telling and retelling the story to coworkers. Downtime storytelling functions as a stand-in for talk therapy (and, it should be said, a surprisingly decent substitute, based on its prevalence in on-duty conversations).

The longevity of my career (sixteen years) as compared with the average length of an ambulance career (five years) has left me keenly interested in what
enables some people to stick around longer than others. Some medics – known as “short-timers” - leave quickly on purpose because their primary intent in getting an ambulance job was to create a stepping-stone into the fire service. Others, though, leave because they struggle with constructing emotional barriers to protect themselves from the pain, grief, and stress associated with the job. In my field notes, I paid close attention to the downtime processing practices of younger medics after they ran particularly stressful or tragic calls. I observed that they showed little or no interest in CISD sessions provided by the employer, even when such activities were encouraged. CISD, for all its potential benefit, is underutilized. EMS workers sit in group sessions when required to do so, but they rehash the clinical and operational events of the call rather than their emotions about the call.

Medics are less apt to bring their distress home to share with intimates or friends who they perceive as being ill equipped to handle their stories, either because they do not want to burden non-medics with their baggage, or because they believe that a non-medic truly could not understand. When rubbernecking coworkers actively solicit their stories, however, distressed medics enjoy repeated opportunities to process the “what happened” of the story. Maintaining the ability to talk about it
translates to sharing the burden with others. Indeed, severe trauma is characterized by a marked inability to speak about the traumatic events either at all, or without experiencing debilitating physical and/or emotional symptoms (Van Der Kolk 2015).

One trauma treatment modality, EMDR (Eye Movement Desensitization and Reprocessing) attempts to put the traumatized person’s brain into a REM (Rapid Eye Movement) state in order to facilitate the talk therapy that the person cannot otherwise accomplish because she finds herself unable to verbalize the traumatic event. The therapy proceeds with the practitioner asking the patient to tell and retell the story of the event as many times as is necessary to reduce physiological arousal.

This sort of therapy is valuable – even imperative – in cases where a traumatized person is unable to speak about what happened (a necessary prerequisite for psychotherapy). However, between the countless processing scenes I witnessed on the job and the rehashing of difficult calls that occurred during my interviews, I concluded that downtime processing seems to be many medics’ primary form of therapy (with the exception of medics who are married/partnered either with other medics or with other kinds of emergency first responders).
As a young medic in my first year or two on the street, I went out of my way to look at as many dead bodies and dramatic injuries as possible. In retrospect, I would characterize this behavior as emanating from morbid curiosity – i.e., classic rubbernecking. During my first year on the job, I saw several dead children in car wreck sites. During my second year, I spent 45 minutes in the back of the ambulance holding the corpse of a 7-month-old baby who had been riding in a car that had been crushed to half its original length when it was shoved under a flatbed tow truck by a tractor trailer whose brakes failed. I did not realize (consciously or unconsciously) the importance of talking through calls at that point in my career, and my silence landed me in trauma therapy a few weeks later as my personal relationships and sense of reality started to unravel in spectacular fashion.

I began to make different decisions over time when I realized that my curiosity was damaging my peace of mind. Rather than seeking out opportunities to view things that I had not seen before, I learned to actively avoid them. My personal credo – which I now share liberally with new medics whether they ask for it or not – is: “If someone else has called the patient dead, I don’t need to call them dead again.”

The role of the medic on the scene of a traumatic or medical death in which the
patient is not a candidate for field resuscitation is to determine the patient dead through the application of physiologic criteria. In certain cases of very obvious death such as decapitation, decomposition, and separation of trunk from body, the determination of death can be made by a first responder with a lower level of training. Once a patient has been determined dead, there is nothing else from a medical standpoint that needs to be done. Therefore, if one rescuer has called the patient dead already, then no one else needs to go repeat the process. As someone who has been around for a while, I go out of my way to advise newer medics to avoid seeing anything they do not have to see. Not to worry, I reassure them: there will be plenty of stuff that you have to see. No need to add to your psychic burden by looking unnecessarily at sights that you cannot un-see.

Through both my interviews and many informal discussions with partners of various career lengths, I concluded that the tendency to not look becomes more common as medics gain experience. When an exposure is unavoidable, medics are apt to utilize their coworkers as therapists, sounding boards, processing partners, and receptacles for their emotions. They are not necessarily expressing their emotions in direct terms (e.g., “I feel sad,” or “I’m worried that this will happen to my kid
someday”) but they are doing the processing labor that forms the basis for trauma therapy. In this way, they use one another to stave off the effects of repeat traumatic events. As Michael, 45, observed, rituals between long-term partners can be deeply rewarding. Speaking of the EMT that he worked with for over a decade, he recalled:

My partner and I had this thing: if we had a shitty call, we’d buy ice cream for each other afterward. We’d stop at 7-11 and buy a Haagen Daaz bar. I’d be writing a chart and he’d be cleaning the rig for two hours, and it was just our little way of making ourselves feel a little better.

Yes, it’s ice cream. But it’s also more than ice cream: it’s emotional social reproduction.

TALKING (BUT NOT ABOUT WORK)

Much of the content of downtime conversations consists of shoptalk, but the proportion depends on the day, how busy the system is, which partner a medic is working with, the presence (or absence) of management personnel, and the unique dynamic of a given group of people. The salience of gender (and to a lesser extent, the race) to group relations is rarely far from view. Non-work talk is culturally specific to EMS in both content and delivery. I argued in the first part of this chapter
that downtime conversations about work serve as an outlet for work-related distress, irritation, and trauma such that paramedics ensured the continuity of their emotional social reproduction over time. In this section, I will review some dominant aspects of non-work social relations between on-duty medics. In this section, I will argue that non-work-focused downtime provides medics with opportunities to test each other, engage in boundary play, and forge the trust – at least on a professional level – that facilitates smooth operations between rescuers on emergency calls.

*Intimacy (False And True)*

I like the camaraderie. I feel like when we’ve been driving around all day long, you become fast friends with whoever you’re working with. It’s crazy, but it happens even with people you’ve never met before. In my county, I’m constantly working with people that I don’t even know who they are. Turnover is really high here. But you’re dealing with stressful stuff and you hear what’s going on in their lives, with their families, their relationships. I feel like there’s bonding that wouldn’t happen in an office situation. You get to know people a little deeper sometimes. I’ve had moments where I start talking to someone, telling them intimate details, but then I feel like I’m emotionally cheating (on my husband), like, “Why did I tell them that? I shouldn’t have told them that!” There’s a bonding thing sometimes. Other people, I didn’t click with and I took a long time warming up to them, and then I kind of warmed up to them, and then by the end, we’ll be kind of talking. But it doesn’t last.

- Claire, 34
Downtime conversations about non-work occur in the context of relationship-building practices. What Claire is describing in the quote above is a phenomenon that I have named “false intimacy.” False intimacy is situational, and occurs when two people who do not know each other well (or have never met) are partnered for the day and must find a way to build a strong enough sense of relatedness that they can function as partners. To some degree, the job trains EMS workers in their roles to the point where experienced personnel can predict with relative accuracy the probable behavior of a partner with whom they have never before worked. One knows, for example, that the medic’s role is to assess the patient, determine the course of treatment, and decide on a transportation destination; the EMT or medic partner’s role is to set up the equipment requested by the medic, assist with patient care in accordance with her scope, and navigate the ambulance safely to the hospital. Experienced workers do not perform all of this communication verbally; participating on thousands (or tens of thousands) of calls obviates the need for explicit instruction. However, medics use non-work conversation as a means of getting a sense of an unfamiliar partner’s personality.
Since a crew may be sitting in the cab of the ambulance for a 12-hour shift (or moving between the ambulance and the station for a 24-hour shift), it is not a stretch to say that conventional rules around self-disclosure in the workplace don’t apply here. Among the non-work topics that EMS workers may discuss with near-strangers: romantic and sexual relationships, body image issues, workout and diet regimens, career plans and tips, and their children. With rare exceptions, they are also fond of exchanging gossip about coworkers and colleagues on the fire department. What distinguishes these conversations between relative strangers is their temporary depth, followed by an absence of follow-up. As Claire pointed out, an EMS worker can have what feels like a very intimate conversation with someone and then walk away at the end of the day with no plan for a follow-up interaction. By the time he sees that person again, he may literally not even remember that they have ever met, despite having shared 12 hours of purported verbal intimacy.

This is not to suggest that all EMS workers operate in such a way. Certainly there are medics who are not in the habit of self-disclosure, and who remain polite but aloof with strangers. Yet, the prevalence of false intimacy suggests significant utility in the practice. False intimacy provides a frail but nonetheless serviceable foundation
for depending on one’s partner in an emotionally, physically, or intellectually rigorous emergency situation: “If I’m going to lose my shit on a call,” one medic said to me during an interview, “I goddamn well better get some backup from my partner. I’m not saying that’s going to happen, but if it did…you know, if I had to run on my own family or something…I’d want to know that my partner had my back.” (Brandon, 36)

True intimacy – at least, contextual intimacy – is far more common between long-term partners. In some cases, EMS workers enjoy “work marriages” that outlast (or predate) their actual marriages. One medic colleague who is very dear to me (but whom I did not formally interview) is 43 years old and has been working with his EMT partner for over twenty years. They are not best friends, and they do not socialize outside of work, but they function very well as partners and know with absolute certainty what the other will do or say in virtually any situation. Michael, 45, (the medic who shares ritual ice cream bars with his partner after bad calls) described his relationship with his partner in the following terms:

I’ve been with my partner for 9 years. Long time. He got me into fishing. He taught me everything I know about fishing. I’ve actually known him since before I got married, and I’ve been married for thirteen years. People tease us sometimes, because we’ll be in town
when we’re off duty, running errands together, or going to base station
meetings together and having lunch after. One day we were shopping
for beds for the station. One of the fire captains we work with a lot
came up to us in the furniture store and he was like, “Are you guys
gay?” And we looked at him like, “Why do you say that?” And he was
like, “Well, every time I see you guys, you’re together. You guys work
together, and you’re looking for beds together.” And I was all, “It’s for
the station.” And he’s like, “Oh…so you’re not gay.” And my partner is
like, “Stop telling him that; we’re totally gay!” (laughs) We’re married,
for sure.

Leticia, 32, has not been “work-married” to her partner for as long a period, but still
frames their relationship using affectionate language:

I feel like, the kind of people that come to this job, they have this
strange sense of humor…being crude in order to deal with the stresses
of the job. I think that kind of opens up a lot of different kinds of
humor or conversations that happen. My normal partner now is a male,
and we have lots of very interesting conversations that I don’t think that
I would have with any other guy. We talk about his Tinder and his
Match.com and all his dates. I think there’s an intimacy that comes into
it when you have a normal consistent partner. I think I talk to him about
things that maybe I wouldn’t talk with other people about, even my
close friends. He and I have some very strange conversations that I
would not have with anyone else. If you take a step back and look at
those conversations…well, my grandmother would be offended that I
was having these conversations.

Not all (or even most) partner relationships include either the length or depth of a
decade or more; yet intimacy, affection, and affinity do matter. The positive
experience of a productive partner relationship leads partners to re-choose each other
repeatedly during shift bids (which usually occur in seniority order at regular intervals such as every six months). A medic’s desire to work with her preferred partner may take even prevail over her preference for a particular shift schedule: “Basically, nothing matters more to me when it comes to being happy day-to-day than my partner,” Sean, 35, told me. “We work great together and she’s a good listener. I trust her with my bullshit. I hate Wednesdays, because she’s off that day and I have this other guy who’s super boring and a terrible EMT. It makes the day drag on forever. I just don’t have fun with him.”

Intimacy (true or false) is beneficial in the extreme. Mistrust or animosity between partners can have serious consequences. Low stakes antipathy results in misery or discomfort during downtime. Extended awkwardness in cramped quarters makes the opportunity presented by downtime…well, less fun. Poor relationships have more serious consequences in high stakes situations such as critical calls, when clear and cooperative communication between partners is essential to their effective management of the emergency. Personal conflicts between partners (as well as between ambulance medics and fire medics) can and do negatively impact patient care when they delay the provision of interventions to relieve pain, or when silent
battles of will make rescuers less attentive to the patient’s comfort or medical condition. Such conflicts are comparatively uncommon, and would not be evident to an outside observer in any but the most extreme situations. EMS workers are more prone to express animosity on scene in the form of passive aggression, such as waiting for the attending medic to make specific requests before rendering aid that one knows will be needed, or making comments/asking questions that sound relevant and valid but are aimed instead at needling the offending medic. Note that these “read between the lines” tactics are not dissimilar from those that pass between partners when they are ridiculing a patient during “pranking” incidents (as I explicate in Chapter 3); however, in this case, the target of the pranking is the partner rather than the patient, and the target is usually very much aware of and discomfited by the pranking. In short: a sense of trust between partners is imperative to getting the job done; intimacy (true and false) is the basis for trust between partners (regular or temporary); and intimacy is built and enhanced during downtime.

**Gender Play, Part 1: Gender Policing And Ritualized Sexual Banter**

There’s different kinds of girls. There’s girls who come in all slutty and they flirt with everybody and kind of sleep around. And then there’s the
girls who are kind of butch, and kind of like... rougher. They’re just butch and they’re attracted to this job. Then there’s the girl who’s, like, feminine but does her job and isn’t sleeping around... she shoots the shit, she can take the jokes, and she can handle the sense of humor without being like, “Oh my god, I can’t believe you said that! That’s sexual harassment!” You know, you can kind of roll with it. You can hang out with the boys; maybe you had brothers or whatever. But it’s a learned skill.

- Jen, 28

We’re either a lesbian or a bitch or we’re sluts. The three categories that we normally get put into, right? Obviously, you can prove that you’re not a lesbian by being a slut... or you can just be a bitchy slut.

- Leticia, 32

The social interactions that occur during ambulance downtime are often aimed at reinforcing hierarchies and cultural norms in EMS. These verbal matches provide a socially acceptable channel for men medics to express their hostility toward, affection for, and objectification of women. Downtime conversations are also a way for men (and women) to distance themselves from the threat of the feminization in a men-dominated industry, a boundary-making practice also observed by Desmond (2007) and Chetkovich (1998) in their ethnographies of firefighters, and by Appier (1998) on women police officers. Since men tend to flee occupations as they desegregate along gender lines, both men and women stand to lose access to the patriarchal dividend.
that is currently – albeit tenuously – available to EMS workers as members of an occupation that is (a) still demographically dominated by men and (b) gendered by paramedics (despite the contradictions that I have outlined in this paper) as predominantly masculine work (Reskin and Roos 1990; Connell 1995). Women medics may not personally enjoy the gender-based oppression and harassment that they experience in their workplaces, but as I witnessed during my participant observation, neither do they frequently resist it. On the contrary, women medics can play just an active role a role as men in perpetuating misogynistic, sexist, and androcentric practices. I read this in part as an attempt to allay men coworkers’ concerns about the presence of women in EMS. Women medics police the gender doings of other women, castigating those who do not strike an appropriate balance between emphasized femininity and emphatic sameness (Wade and Ferree 2015):

We have this girl who just started here. She’s new here but she’s not new to EMS. She’s been on the ambulance for a couple of years, I think. But I got tripped out the other day when we were in quarters and she was flirting like crazy with my partner. I was working with Anderson, and that fucker flirts like crazy with anyone with a vagina who will pay attention to him and laugh at his jokes. But she doesn’t know him, so she doesn’t know his reputation or that people don’t appreciate him a lot of the time. Anyway, I felt kind of embarrassed for her so I just bailed. I walked out of quarters at the same time as her partner, who happens to be a good friend of mine. And we just stood out in the parking lot and talked for an hour because it was so uncomfortable to be
around them. Actually, I thought, “Did I ever do that?” I hope I didn’t. I would be embarrassed for myself, too.

- Sarah, 33

Unsurprisingly, Sarah expresses irritation with her partner Anderson’s flirting, but she does not parlay her criticism into a question of whether his behavior is or is not masculine; as annoying as she finds it, she still interprets the flirting as an appropriate expression of masculinity. Her critique of her woman coworker, however, calls that woman to account (West and Zimmerman 1987) for her failure to do femininity appropriately.

Women also police themselves, as this quote from Wendy (39) illustrates:

This is my workplace, and I’m not going to sleep around and hear rumors about myself. It took me a couple years to find that balance. I think you can get exhausted trying to fit in. Male partners will kind of feel you out. They’ll say something, and then you’ll laugh. You’ll be driving around together in the rig, and they’ll be like, “Oh my god, check that girl out, she must have big boobs!” And you’re like, “Ha ha ha,” because you want to be the kind of girl who can roll with that. We can scope chicks together. And you laugh point to another chick on the street and say, “Well yeah, but look at her. So you learn to be that way, but then you’re expected to be that way. Or maybe you just put up with it.

Wendy’s comments allude to the downtime practice of girl watching (Quinn 2002), which men medics readily involve women coworkers in once they have given their consent. Consent is implicit: women in EMS do not come out and inform their men
coworkers, “It’s okay for you to objectify women in my presence.” Rather, they may contribute a comment themselves, or simply not inform their partner that the objectification is upsetting to them. Given women medics’ status as minorities in a “skewed group” (Kanter 1977), speaking up means risking reprisal or teasing; on the other hand, women’s socialization into a sex/gender system in which “a woman’s value is heavily dependent on their attractiveness” (Wade and Ferree 2015). Women who are bothered by such behavior may speak up, but at the cost of compromising their access to the patriarchal dividend of EMS work. Women medics who refuse to participate in the objectification of other women, either by remaining silent or by making a specific request that the behavior be stopped, *may* keep the professional respect of their coworkers, but at a cost: they risk acquiring the stigmatized “bitch” label – applied to those women who refuse to uphold their end of the patriarchal bargain by tolerating men’s sexist behavior.

Although I spent the vast majority of my own career utilizing strategies of gender equivocation – taking shit and dishing it back while underscoring my femininity through physical presentation and occasional flirting – I did experiment with gender rebellion on several occasions. In one instance, I engaged a coworker at
length in a conversation about sexism that he actually initiated (surprising because sexism is not typically a topic of analytic interest in EMS downtime chats). My experience of Phillip (29) over the two years that we had worked together suggested that he was unusually thoughtful and intellectual for an EMS worker. (I say “unusually intellectual” because EMS culture, with its white ethnic immigrant working class roots, is markedly anti-intellectual to the point where EMS workers sometimes deliberately hide their educational attainment or aspirations to avoid ridicule from their peers.) One day in the station after the other crew left to run a call following a particularly athletic exchange of sexually explicit barbs, Phillip remarked, “All that shit that those guys talk all day long…all those ‘That’s what SHE saids’ that they’re always throwing down…that must get really old for you guys.” “No man coworker in all my time here,” I confirmed, “has ever even acknowledged out loud to me that we might be bothered by that.”

In another informal experiment, I used humor and gentle ribbing to confront a John, a 26-year-old man coworker who was telling me about his and his partner’s most recent patient. His partner, Julie (24) was in the next room. “You should have seen this guy, Megan,” John began. “He had this totally nothing little laceration, but
he was being the biggest vagina!” I interjected, “Could we just drop the ‘vagina’ thing? I’m seriously over the way everyone’s using female body parts when they’re trying to insult someone.” John and I had a couple of years of rapport building under our collective belts and I had ten years more seniority, so he heard my complaint without ridiculing me.

“Whoa, Meg, I’m totally sorry. I didn’t mean anything about women. I mean, it’s just a phrase but I definitely didn’t mean it that way. You know I don’t have anything against girls.”

“It’s all good, man. I’m not mad at you. It’s just that every time you call someone a ‘vagina,’ you’re kind of comparing vaginas to something bad. Then people think of anything associated with women as bad. It’s like when people say, “That’s so gay” to talk about something that isn’t cool. They don’t think they’re really saying that anything is actually gay – not in real life – but they’re reinforcing the idea that being gay isn’t cool. It’s still homophobic.”

“Yeah, okay. I can get that. I’ll try to work on that…so now can I tell you the rest of the story? Anyway, this guy is just screaming like a baby, and – “
At that moment, Julie walked back into the room. “Hey,” she exclaimed, “are you telling her about our last patient? Oh my God, that guy was such a fucking PUSSY!”

John, eyebrows raised, just looked at me and shrugged: See what I’m up against?

Gender Play, Part 2: The Culture Of Shit Talk

When I was brand new on the ambulance…I was twenty-three, twenty-four…I got a lot of shit from people. I always thought it was because I was a girl. It really hurt my feelings, you know? I didn’t get it; I didn’t understand how EMS people are. Someone would be teasing me and every time, I’d let it get to me. I thought it was real, like they really thought I was dumb or whatever it was they were giving me shit about. Usually it was something I did on a call or something I said in quarters. It must have been obvious that I was bummed, because eventually this guy Ted who used to work here, he pulled me aside and had a come-to-Jesus talk with me. He basically told me to sack up. He was like, “Look, when we tease you, it means we like you. If we didn’t like you, we’d just ignore you.” That totally blew my mind. I mean, my friends in high school and college…we were always super supportive and encouraging. We always tried to be nice to each other…we wanted to be the opposite of the girls in Mean Girls. It seriously never occurred to me that anyone would be mean to me on purpose, but not really mean it, you know? But after Ted explained it, I started to notice how everybody did it. Everybody. So yeah, I wasn’t a sarcastic motherfucker when I started this job, but I definitely am now. I even
have to be careful when I’m off duty that I don’t attack someone who
doesn’t know how to defend themselves.

- Kendra, 29

In his book *On the Fireline* (2007), Matthew Desmond describes a culture of “shit talk” among wildland firefighters. Shit talk functions as a means of reinforcing masculinity and expressing affection for coworkers without compromising one’s claims on a hegemonic masculine identity. Shit talk consists of razzing and joking that is personal in nature, but without the intent of causing real harm. It is typically quite explicit (insults about the target’s body, attractiveness, sexual prowess, gender expression, or intellectual acumen). Shit talk serves two purposes: it provides a channel for the communication of non-sexual homophilic affect (between multiple men medics, multiple women medics, and mixed-gender groups); it also allows users to assess their targets’ understanding of and conformity to EMS culture. As Desmond (2007), Lois (2003), and Goode (1978) have argued, dangerous and physically taxing work is closely associated with high-status forms of masculinity. EMS shares the tendency of such occupational cultures to eschew behaviors and affects associated with femininity (such as emotional vulnerability) as a means of reinforcing occupational boundaries against gender interlopers (feminine women and gay men)
whose presence might compromise straight men’s status as “real” men. Shit talk
provides men and women alike with the ammunition they need to bolster their claims
on their identities as people who do not fall apart when things get rough, who do not
run away in the face of risk, and who can operate effectively in situations that they
and civilians discourse as “heroic.”

Desmond’s account delimits three possible responses to the relentless
onslaught of teasing and insults: *engagement* (trying to beat the opponent by
outwitting him); *escalation* (responding with physical opposition if engagement is
unlikely to be successful); and *inaction* (ignoring the insults and waiting for them to
stop) (Desmond 2007: 94-99). My observations of EMS culture confirmed that a
similar process occurs on the ambulance, with some contextual modifications. One
significant *difference* is that the proportion of women in EMS is much higher than the
proportion of women on the wildland fire crews that Desmond worked with.
Consequently, the tradition of ambulance-based shit talk is less a matter of blanket
opposition to an opponent’s jests than it is a skillful aikido-style redirecting of them,
even when the content of the razzing is meant to call the target’s masculinity into
question. As the prevalence of hybrid masculinities expands (Bridges and Pascoe
2014), so do the options available to men (and women) for doing masculinities. But that does not imply an increased valuation of femininity. On the contrary, ribbing in EMS performs the same sort of distancing and differentiation from femininities that characterize the “fag discourse” described by Pascoe among high school boys (2005). This occurs even when such boundary work is performed by women medics. Consider the following interaction from my fieldwork: a man coworker, Andrew, approached me and a woman coworker, Trina, with whom I was conversing at the hospital after completing a call. Andrew greeted us, “Whoa…I hope I don’t get run over by the high estrogen levels here.” Trina — without missing a beat — “Yeah, especially since you just walked up.” Trina’s response is juvenile, yet very much in line with the rules of engagement. Interestingly, Trina does not problematize Andrew’s implication that estrogen is something from which one should distance oneself, nor does she take offense to the comment on the basis of her membership in the category “woman.” She simply rolls with the punches, dishing back a healthy serving of Andrew’s own medicine. Her response at once gives Andrew to understand that she hasn’t taken personal offense, that she is not one of those “sensitive” women, and that she shares his general derogation of the feminine. Moreover, her cooperation demonstrates that
she understands the rules of the game and is not contesting the inherent social value of shit talk.

The same analysis applies to another incident in which a favorite man coworker, Brian – someone with whom my relationship was so overwhelmingly sarcastic that we failed to take one another seriously on the rare occasions that we actually meant the words we spoke. I recorded an incident in which he referred to me with obvious affection as a “fucking whore” to two men coworkers. In retaliation, I complained vociferously about their collectively inability to put the toilet seat down after using the restroom. These reproductions of domestic gender relations in intimate relationships hint at men medics’ persistent discomfort with the instability of their status and prestige as EMS workers, who perform both emergency work (read as masculine) and care work (read as feminine) without the benefit of public sector compensation or retirement.

*Gender Play, Part 3: Sexualized Shit Talk*

In their ethnography of women veterinarians, Irvine and Vermilya (2010) found that women working in veterinary medicine – a historically men-dominated occupation
that has undergone rapid feminization over the last decade – employ discursive practices that maintain the hegemonic masculine status quo. They argue that women veterinarians and veterinary students do this in an effort to distance themselves from femininity and, by extension, the decreased social power associated with feminized occupations. The women medics that I observed and interviewed participated in a strikingly similar patriarchal bargain, largely through strategies of gender equivocation in their relations with men and their gender policing of other women.

As the quotes in the previous sections illustrate, women medics can be unrelenting in their critiques of women coworkers. They are reminded continuously of men’s expectations of them through the practices of shit talk described in the previous section, particularly when it takes the form (as it often does) of ritualized sexual banter. Indeed, the primary difference between shit talk directed at men and shit talk directed at women is that the content of insults. Comments directed at a man cast aspersions on his masculinity, which he must defend in order to distance himself from femininity. Comments directed toward women are more likely to include a sexual objectification of the woman herself: either an assertion of suspected
promiscuity or an accusation that she is unfairly denying men access to her body (to which they are implicitly entitled).

Women medics who are socializing during their downtime in mixed-gender groupings may appear to participate just as readily as men in ritualized sexual banter directed at other women coworkers (although they are often more enthusiastic in their excoriation of other men). However, they are less apt to continue objectifying one another when they are no longer in the presence of men colleagues, suggesting that the real audience for that banter is actually men. My interview data did not include specific comments from women medics about the differences between how they interact with their women partners when they are not in the company of men coworkers. When gender came up, it was usually in the context of how the gender composition of the ambulance crew affected the way the crew was treated by fire department personnel on 911 calls (something I do not cover in detail in this paper, although I discuss the importance of further research into that topic in Chapter 6). In my own time on the ambulance, however, I have witnessed and participated in sexually charged shit talk that targeted women coworkers, and consented to or participated in my own objectification. Although I cannot attest to conversations
between women coworkers that I have not been privy to, neither has it been my experience that women habitually drag those conversations out when they no longer have an audience that includes men.

Returning for a moment to Desmond’s rejoinders to shit talk (Desmond 2007: 96), a woman medic can respond to men coworkers’ objectification and harassment of her in several different ways that are somewhat akin to the responses available to any medic confronted by a non-sexually-explicit shit talk situation: she can engage it by returning the volley in hopes of outwitting or out-insulting her opponent, or she can ignore it by walking away or simply not responding. (Ignoring the shot will end the interaction more quickly, but will not enhance her status as a “cool girl”). Interestingly, one of the strategies that Desmond identified, *escalation*, is not a response that I witnessed during my field research. In fact, I noticed more physical contact between men (mostly in the form of horseplay and mild roughhousing) than I did between men and women. Men and women hugged one another affectionately – mostly with one arm around each other rather than two – but they did not generally wrestle, put each other into headlocks, or bump chests. Confrontations played out mostly in words.
The Implications Of Gendered Play In EMS

Verbal jousting and gender policing are arguably problematic in their reproduction of the patriarchal status quo. The sociological tradition of revealing, critiquing, and intervening on social inequalities would posit this as an appropriate moment to for a comment on the “tragedy” of women medics acceding to (and even participating in) their own subjugation and harassment on the basis of sex and gender. Tradition notwithstanding, I do not think that this is theoretically valid as a move to describe the unique situation in which women medics find themselves. Shit talk is a substantially messier phenomenon than can be explained through facile claims like “Men paramedics are sexist” or “Men paramedics don’t want to work with women.”

Yes, it sometimes occurs at women’s expense, and on the basis of gender. It is nonetheless profoundly utilitarian. Because it plays a key role in the social reproduction of people who work as paramedics, it would be a mistake to proffer a blanket critique of “sexual harassment in EMS.” Instead, I conclude that women’s disinclination to resist their own sexual objectification (and sometimes, their active encouragement of it) bolster my claim that its real purpose extends far beyond “keeping women in their place.”
Shit talk is, above all, a performative act with cultural and professional implications in EMS. During downtime, the confrontation is playful even as it reinforces the gender status quo (recall the words of Kendra’s coworker: “If we didn’t like you, we’d just ignore you.”). Men medics’ sexual objectification of women can be interpreted an expression of generalized societal hostility toward femininities and the threat that they pose to patriarchal dominance in a feminizing workplace, but it generally did not appear to me to be an expression of malice toward any individual women. Gendered verbal play varies in content depending on the roster of participants in a given exchange. Women medics are subjected to a more explicitly sexual style of razzing than men, but its overarching purpose for both genders is consistent. Trading insults is a proving ground for assessing a medic’s ability – regardless of gender identity – to keep maintain control over his emotions in stressful situations. Shit talk teaches medics to construct psychic barriers against assaults that come across as personal in the break room – even as it braces them to distance themselves emotionally from their patients’ pain and suffering, from the unremitting verbal abuse to which they are subjected on some calls, and from the feelings of
helplessness that arise when a medic fails to adhere to the tenets of “it’s not my emergency.”
CHAPTER 5 – SOCIAL REPRODUCTION AND PARAMEDICS’ EMOTIONAL LABOR OFF DUTY

You know what’s glamorous? It’s when you’re young and cute and you have this little uniform and you go around and say, “Yeah, I help people. I save lives.” But really it’s a pretty thankless job sometimes. When I started school, I thought I was going to be dealing with a lot of little kids and people in their time of need...and you do have some of those, but they’re very few and far between. Getting a thank you or a ‘thank you’ card or actually saving a life...it’s like, rare. It’s notable when it happens.

-Melanie, 34

Melanie is under no illusions: she finds parts of her job very fulfilling, but perhaps she would not stay in EMS if the fulfilling parts were not there to balance out the “thankless” parts. Where is the boundary? Why does she keep coming back to work?

In the last two chapters, I discussed first emotional labor as social reproduction on the factory floor, and then the emotional labor as a form of social reproduction in the break room. In those cases, the emotional labor either (a) gets the job done in the first place, or (b) keeps the paramedic at the ready to abandon her downtime activity in order to run a 911 call. What came to the fore during both my interviews and my participant observation was the contrast between the aspects of paramedicine that motivated paramedics to come to work, and those aspects that they came to work in
spite of. Stories of motivation came up in seemingly innocuous contexts, such as in response to superficial questions such as, “What do you like about your job?” and “What do you dislike about your job?” Although I meant those questions to simply build rapport and enhance emotional comfort during the interview process – admittedly a different context than the one in which I normally conversed with those among my subjects who were also my coworkers – I found that those straightforward questions delivered an unexpected variety of answers. Since the questioning took place outside of work, I assumed that the things they told me in our interviews were an edited version of their ongoing internal dialogue: the sort of emotional labor they performed on themselves when they thought about work in their off-duty time.

The literature on workers’ commitment to their jobs tends to explain commitment in terms of a worker’s commitment to a specific job/employer and managements’ attempts to control workers’ labor and behavior. (Lincoln and Kalleberg 1990; Hodson and Sullivan 2002). Organizational commitment does not account for occupational commitment, which arises from a worker’s commitment to a profession rather than to a specific employer (Tilly and Tilly 1998). When a worker is committed to a job, incentives for working become the analytical focus.
Negative incentives produce low-quality work, but positive incentives have limited capacity to motivate workers to work hard (McKay 2003). In capitalist enterprises that produce goods, such as the manufacturing concerns that McKay describes in the Philippines (2003), workers respond to incentives by exhibiting increased or decreased commitment to the job more so than to the occupation. In profit-driven service jobs, employers also make a direct connection between emotional labor and workers’ generation of profit (Salas 2009; Hodson and Sullivan 2002).

When a worker is committed to her occupation rather than to a specific job, employer incentives do not adequately explain commitment. In this case, the worker is investing in a profession. What motivates workers to do this? McKay (2004) elucidates three kinds of worker commitment: effort, loyalty, and attachment to the job. McKay’s distinctions are useful as a theoretical extension for understanding occupational commitment as well as job commitment, since workers attached to an occupation are also motivated to put in effort, to stay loyal to the occupation despite feeling that they are being paid less than they are worth, and to foster an attachment to the occupation. In his study of nursing homes, Rodriguez
(2014) observes that emotional labor serves to enhance the dignity of nursing home workers when the organizational and managerial constraints of the job would otherwise rob them of it: “…workers drew from a reservoir of memorable moments and experiences of doing care, which seemed to them outside the scope of the reimbursement and regulatory systems, to construct a sense of meaning and dignity at work” (2014: 115). The idea that reimbursement can come from non-financial reserves – reimbursement “from the heart,” as one of his subjects put it – underscores workers’ efforts to “find a source of meaning in care that transcends monetary concerns” (2014: 121). Taken together, McKay and Rodriguez offer a theoretical foundation that begins to account for what motivates paramedics to come to work, despite spending much of their day in situations that compromise rather than shore up their occupational dignity.

In this chapter, I will use this model of commitment as I examine some of the themes that featured in my subjects’ off-duty accounts of their identification with and commitment to their ambulance work. I begin with a discussion of some of the nuances of compensation and dignity in ambulance-based EMS. I approach the question of occupational commitment in EMS with the underlying assumption shared
by theories of both commitment and social reproduction: that people who work have reasons for returning to their jobs each day (at a minimum, financial compensation), and other reasons *not* to return to their jobs each day, and that effective social reproduction requires workers to accentuate the former while minimizing the latter. In the second section, I expand on the question of dignity by looking at how paramedics reflect on their feelings of pride and accomplishment on the job. I conclude the chapter with a proposal for a new understanding of heroism.

*Compensation and Dignity*

The social reproduction of paramedics involves the usual array of self-care that all paid labor entails in industrial capitalism: one must prepare food, shower, have clean clothes, look after family members, etc. (Katz 2001). However, the complex emotion management required in EMS means that workers also spend much time off duty thinking about their time *on* duty. Jobs that workers do not perceive as intrinsically satisfying require less thought off duty in terms of social reproduction. One goes to work, does the job, goes home, and leaves the job at work. The motivation to return to work at an unsatisfying job is largely financial, or indirectly financial if the money
earned provides social status outside of work: “Commitment,” as McKay observes, “while shaped by employers, is ultimately controlled by workers’ own decisions…Their jobs, under a panoptic work system, were not particularly gratifying and often unrelenting. Yet working and earning a living in a high status industry did provide some autonomy and control over their lives, which workers prized quite highly” (McKay 2004:402). This dilemma can be framed in terms of “It’s not a great job, but I need the money and it’s better than (no job/another worse job).”

EMS work must be considered more expansively than production work because the motivation to go to work each day involves components beyond money, autonomy, or status. The parts of the job that inspire workers on their own merits are not opportunities easily found elsewhere (such as “saving lives,” as Melanie notes above). Whether or not they report being deeply attached to these opportunities, my subjects never reflected on them as dissatisfying. On the other hand, the uninspiring parts of the job (such as situations that elicit disgust, or contending with “bullshit” calls) predominate, and often leave paramedics in the same position as workers in any other industry: trying to convince themselves that it’s worth the money, or at least
that they could not expect to make the same money working elsewhere under less repellant or objectionable conditions (Rodriguez 2014).

One way to think about how medics understand their dignity on the job is to consider how misaligned they perceive their compensation to be compared to the value of the work they are performing. In the conversations I witnessed during my participant observation, paramedics expressed feeling undervalued and underpaid, irrespective of their absolute wage. Most of my subjects were residents of a fairly affluent metro region, which positions their pay rate among the highest ambulance-based EMS wages in the U.S. (although they also struggle under a cost of living commensurate with the high price of rents and real estate in that area). In considering their compensation, however, my subjects did not compare themselves to other ambulance-based paramedics. Instead, they perceived their wages as low vis à vis the firefighter-paramedics alongside whom they regularly worked, or (less commonly) vis à vis the registered nurses and physicians assistants with whom they interacted at the Emergency Department. Medics perceived firefighters’ base wages as being only somewhat higher than ambulance paramedics’ wages; however, they also saw firefighters’ shifts as less physical grueling overall in terms of sleep deprivation,
move ups, and call volume. They were also aware that firefighters look forward to full public retirement with lifetime medical benefits after 25 years of service, whereas ambulance medics must fend for themselves through individual contributions to 401(k) funds and Social Security.

Both my interviews and my participant observation reflected the paradox under which so many paramedics seem to labor when they are not career ambulance medics; i.e., when they have not resigned themselves to spending the preponderance of their adult working lives on the ambulance. It is worth noting that only three of my interviewees did not plan to pursue other career avenues at some point. Unlike the days before the explosion of Advanced Life Support (ALS) fire departments, paramedicine is no longer the sole purview of ambulance-based medics. Ambulance paramedics who see themselves as destined for greener pastures speak with an eye toward the future, although not necessarily a coherent or consistent one, as Aaron, 36, demonstrates in this frankly contradictory statement:

I’m looking to move into construction. I’m not “over” medicine, exactly. I’m just over the hours. I’m exhausted all the time, and I was a lot happier when I was part time because I could pick my hours. Even though I was still working the equivalent of full time at the time, I just liked being able to choose what I’m doing and when I’m doing
it. I’ll always (work on the ambulance) because it pays well. You can work one extra day and can get a pretty good amount of money.

Aaron recognizes that the money is good if you pull extra hours, even as he complains about the negative impact the hours and fatigue have on his quality of life.

Indeed, “having lots of free time because of our schedule” was a benefit that the paramedics I talked to seem to consider a sort of non-financial compensation for both the worse benefits and pay (compared to fire and registered nursing) on the ambulance and the necessity of performing the less inherently appealing aspects of the job.

Beyond my interviews, I found this schizophrenic attitude to be a common ingredient in break room “gripping” sessions related to hours of work. For example, when one of my workplaces underwent a drastic overhaul several years ago in how it staffs the system – changing many 24-hour hour units to 12-hour units – an outcry went up from medics who claimed that having to go to work “four days per week” (as opposed to “ten days per month”) would devastate their quality of life by forcing them to be at work more. When I pointed out that their weekly average number of hours spent at work would actually decrease by eight hours, and that they would be much less fatigued if they kept a regular day or night sleeping schedule, they
backpedaled. They downplayed the negative impact of their current 24-hour schedule on their quality of life, insisting that it was really “not so bad,” sometimes they slept okay, isn’t it great to only have to work ten days per month, etc. I didn’t generally push the issue, but it was hard not to notice that the people who spoke up the loudest against the transition from 24-hour shifts to 12-hour shifts were, often as not, the medics who also complained most vociferously about fatigue when new crews would arrive in the morning to relieve them at the tail end of a brutal 24-hour shift.

I was intrigued by the way paramedics repeatedly brought up non-financial forms of compensation – such as work schedules – to diminish their sense of decreased value in comparison to their fire and nursing colleagues. I identified the effect of feelings of inferiority compared to fire department medics through my subjects’ critiques of fire medics’ paramedic practices, medical work ethic, and critical thinking skills. These were the attributes of fire medics that they could comfortably criticize while maintaining their superiority as ambulance medics, but without demeaning the idea of EMS as a whole. This tendency was not as omnipresent among medics who were actively pursuing jobs, or pursuing schooling that would prepare them for jobs beyond the ambulance. Those who were on their
way out were less inclined to justify their presence on the ambulance by pointing to all of the logistical “benefits” of remaining. They had less need to reduce their cognitive dissonance because they were actively pursuing an escape plan. Since their escape plan involved moving into an industry that ambulance medics sometimes criticized relentlessly, they reduced their dissonance by refraining from participating in the critiques.

Non-financial benefits do emotional work for ambulance paramedics by justifying their ostensibly voluntary tolerance of perceived low wages and high physical stress (including fatigue). A distinct and indispensible form of non-financial compensation has to do with personal dignity. Organizational sociologist Randy Hodson identified the primary role that dignity plays in workers’ expression of satisfaction with their jobs (Hodson 2001). His argument certainly holds true of paramedics. When it came to their professional dignity, my interview subjects and the medics who I observed during my field research expressed a contentious view of the fire department, much more so that for other colleagues like nurses and law enforcement. Indeed, fire personnel figured the as villains in the overwhelming majority of responses to my question, “How do you deal with conflict on the job?”
is hard to avoid making an inductive conclusion that fire personnel loom large in medics’ evaluation of EMS conflicts.

As they relate to social reproduction, my interviewees’ constant references to fire personnel are deeply relevant to their sense of dignity at work, since it is the fire department medics with whom ambulance medics see themselves as being in direct competition for “hero” status in the public eye. Looking back at the points I made in Chapter 1 – about how part of being a paramedic is accepting (and embracing) civilians’ perception that paramedics perform acts that go “above and beyond,” and might therefore classified as heroic – the contest for “hero” status is ethnographically very significant. Fire medics benefit to a greater extent than ambulance medics from prestige and hero status conferred upon them simply by virtue of their job title.

“Firefighting” implies the potential to risk one’s own life and safety – a classic expression of specifically masculine heroism – whereas the emergency labor in EMS work is sullied by its concomitant association with care work.

Resentment is also stirred up by civilians’ continuous misidentification of ambulance paramedics as “not” paramedics. Some members of the public erroneously believe that paramedics only work on fire engines, and that ambulance-based EMS
workers are merely “ambulance drivers.” As one career medic commented wryly, “If I had a nickel for every time a patient asked me if I was with the fire department when I introduced myself as a paramedic, I could have retired in my twenties.” (Jerry, 48)

Needless to say, paramedics’ self-comparison to their colleagues in the fire service leads to the emotional discomfort associated with cognitive dissonance. Ambulance medics cannot simultaneously hold the belief that “working on the ambulance is much better than working for the fire department” while holding the contrasting belief that “given the choice, I would prefer to make more money, have a guaranteed public retirement, work better hours, run fewer calls, and enjoy more social status in the public eye.” To reduce the discomfort, some medics participate in the strategies that I have outlined above, i.e., critiquing the fire department or rejecting the ambulance as inferior employment and actively seeking to be hired with a fire department (a process that can take years). This sort of emotional distancing allows them to continue coming to work with their dignity largely intact. Other medics withdraw emotionally from the job: workers whose dignity is threatened or destroyed (for reasons related and unrelated to the fire department) and who cannot or
do not seek alternative employment become the “burnout” medics of whom others speak with disdain or pity. Burnout medics may also use the strategy of discoursing fire medics as clinically inferior or lazy, reinforcing their “choice” to stay on the ambulance with its lower wages and higher workload as a reflection of their higher standards for paramedicine. Finally, medics may derive dignity from their pride in various aspects of their work. It is to this source of dignity that I turn for the remainder of this chapter.

PARAMEDICS’ RELATIONSHIP WITH PROFESSIONAL PRIDE

A Note On Method

In the tradition of ethnographic reflexivity, I want to begin this section with a short commentary on the research process. The portions of my interviews during which my subjects expressed pride in their work and talked about what they loved about our job were a source of real pleasure for me. Since I returned to graduate school for my first Masters just one year after starting work on the ambulance, I have (metaphorically, at least) had one foot out the door for the entire duration of my career as a paramedic. After my first round of grad school, I spent three years doing science prerequisites in
order to apply for Physician Assistant school. One of those prerequisites was

Introduction to Sociology; I ended up applying to P.A. school and, on a whim, to a
doctoral program in Sociology. I chose the longer path of doctoral education over
P.A. school, which resulted in a commensurately longer career on the ambulance.

Very few of my coworkers spend quite that much time waffling around between jobs.
The upshot of so many years with one foot out the door is that I came to see myself as
a sort of interloper, or temporary visitor in a world that I did not really feel I belonged
in. My attitude was less “I hate doing this job and I can’t wait to get out of here,” than
it was “I’m proficient (but not brilliant) at some parts of this job, and really good at
other parts, but it just isn’t a good fit for me.” The holding pattern sometimes felt
interminable, but the knowledge that I would eventually be able to move on allowed
me to simultaneously feel pride in my work and an attenuated sort of contempt for the
occupation as a whole.

The emotions that the interviews brought up for me came as a surprise. At
first, I noticed that I felt a “high” after concluding each one. I’d consistently leave the
interview location in a good mood, regardless of whether my subject was someone I
had worked with for years, or barely knew. A typical interview visit lasted for 2 ½ - 3
hours. The actual interviews averaged 70-100 minutes, but the visits were nearly always padded by “shooting the shit” time, during which I built on preexisting rapport or swapped stories with unfamiliar subjects to establish common ground. It sounds silly now to think of this as transformative, and yet, the rapport brought me pleasure. I would approach each interview feeling ever so slightly nervous – would the person like me? Would conversation flow? Would it feel weird to talk outside of work? By the end, I would find my mood light, my confidence soaring, and my pride in my work as a paramedic stronger than ever. Ironically, although consent forms for interviews typically include admonitions to the participant that she can expect to receive no personal benefit from her participation, I (as the researcher, not the participant) did in fact receive a benefit. I had fun. I felt proud. Journaling in my field notebook after an interview, I wrote:

I think I spend so much time trying to convince myself that I’m “not like a career paramedic” just because I associate it with blue-collar work and I’m as classist as the next middle-class person and I feel embarrassed that I have a job that you don’t even need to have a college degree for. But listening to other people talk about it makes me realize that what we do really is not ordinary at all. It isn’t something that “just anybody” could do. I lose sight of that a lot, worrying about being judged for my working-class job by people whose opinion I probably should not invest quite so much emotional energy in.
In the remainder of this section, I will evaluate medics’ assessments of their professional pride as derived from two distinct sources: the physical and intellectual work they do on patients’ bodies and the labor they perform in caring for the emotions of patients and/or non-patient bystanders.

“SAVING LIVES; LIVING THE DREAM”: REFLECTING ON HEROIC MASCULINITIES

The phrase “Saving lives; living the dream” has been a cultural staple in my workplace for as long as I can remember. It’s a tongue-in-cheek response to a casual “How’s it going?” posed by one paramedic to another. It is meant to be sarcastic (since most of what we do does not involve saving lives), but the “living the dream” piece reinforces the heroic ideal of paramedicine, as if to say “I got into this job to save lives. I don’t get to do that very often, but when I do, it is very satisfying.”

Paramedic culture is driven by compulsory displays of public humility. A common snippet of occupational wisdom is: “If you have to tell people that you’re a good medic, you’re not a good medic.” Because of this, you cannot ask a paramedic to tell you about the time he was a hero and saved a life, because he’s likely to insist
(whether or not it’s true) that any other medic would have done the same thing, it’s just monkey skills, etc. Getting at the hidden kernels of paramedics’ professional pride requires specific questions. Non-specific questions elicit non-specific responses that abide by the code of compulsory humility. Consider the following bland responses to the question “What do you like about your job?”:

I like helping people. I like the calls where it actually feels like I’m making a difference.

Scott, 26

I like the fact that I’m not inside a building. We’re able to travel around the city, and we don’t have to stay in one location. Also you know, of course, helping people is why we do the job.

Noreen, 28

I love being able to care for take care of patients, help them in time of need.

- Alicia, 35

I dislike when bad things happen to good people, but when that does happen, I like to be nearby so that I can respond to it. It’s gratifying, being able to bend your mind to the task and utilize the techniques you’ve been trained in.

- Patrick, 44

I love helping people and I like being able to go out and see different things…being outdoors.

- Jeff, 30
I like interacting with multiple individuals and helping them on a short-term basis. Being a problem-solver, delivery of medical care. I like the excitement. I like the challenges that the job actually provides.

- Brandon, 36

If there is anything that stands out about these answers, it’s the high density of clichés, all of which can be summed up as, “I enjoy helping people.” Not coincidentally, this is also a standard answer to the question “Why do you want to be a paramedic?” when it shows up on job interviews. It is universally palatable, it sounds plausible, and taking satisfaction from helping people seems like a logical prerequisite for entering into a “helping” profession. What it avoids is any mention of how being a paramedic contributes to one’s identity in a direct way. Claiming to get pleasure or esteem from helping others is radically different from a statement like “I feel proud of my physical assessment skills when I can identity the root cause of an infection, but nobody else caught it.” Medics’ claim of deriving pleasure from helping others also downplays the powerful draw of hegemonic masculinity. In other words, acceptable forms of pride are pride in the job in general, as opposed to pride in one’s individual skill or ability compared to other medical personnel. It is not irrelevant that “I like helping people” is not reason enough to keep coming to work each day in spite of disincentives such as feeling chronically abused and unappreciated (discussed in
more detail in Chapter 3). “I like helping people” applies to virtually all so-called helping professions, from medicine to social work. It doesn’t seem plausible to say that the joy of helping people is compelling (or specific) enough to explain the social reproduction of paramedics over a period of years or decades. My belief that paramedics sculpted this claim largely for the purpose of public consumption bore out as the interviews progressed.

Different stories emerged when I asked paramedics about their sources of personal pride. “What are you proud of?” requires an answer related to skills that “not everybody” can claim to have. Granted, it’s a tricky business asking such a question in compulsorily humble paramedic culture, which is overlaid in the wider U.S. cultural decree against self-aggrandizement. The stories of proud moments, though, were a study in contrasts next to the “I like helping people” responses. Consider the detail in the following two accounts:

This call popped out at Spa Fitness for a man down on the treadmill and we got there and it ended up being a full arrest. The guy was like, 35. We were, like, on it. Immediately. We got pulses back and he started to breath a little bit against the tube in the ER. And he ended up walking out of the ICU a couple days later with a heart attack. And he was young. He was a marathon runner. He had some cholesterol factor or something where he wasn’t breaking down cholesterol at all – a genetic thing that had nothing do with his physical fitness. At the EMS
awards ceremony that year, he ended up showing up and giving me a huge hug. That one tears me up just now, because that’s a person who wouldn’t have been alive, maybe, if I wasn’t there… it’s nice to see somebody that looks so different when they were in cardiac arrest and then they pop up and give you a hug. And it’s like, my god, you’re living your life and you have kids and whatever! That doesn’t happen a lot, though.

- Jen, 28

When no one else knows what to do, you get to be that person who brings calm to chaos and gets things back in order. I feel like there’s some kind of pride in that. You don’t have the ability to be like, “I don’t want to deal with that.” We’ve all gone on calls where we’re like, oh my God, that sounds bad!” But we can’t not go. We can’t be like, “Medic 73 isn’t responding to that. We don’t want to deal with that.” Like with soldiers in the military. They don’t have a choice about what they do and don’t do.

- Wendy, 39

Jen’s pride comes from her knowledge that someone was alive because of something she did, while Wendy derives esteem from her ability to confront situations that she believes most people would find “unconfrontable”: a role that she compares to that of “soldiers in the military,” another highly masculinized opportunity for actions that are later deemed by others to be heroic.

Another story, recounted by Emilio, 39, exhibits both pride in the job that he specifically did, but is tempered with considerable anger about recognition that he felt he was denied by other agencies and medical personnel:
Here’s the story of my best call ever. We got no credit for it, though, so it ruined me. I got pissed. We got called for a little girl. I think she was eight. She got her hand amputated. She was riding in the back of a car, swinging a jump rope. And the rope got caught under the wheel of the car and somehow it was wrapped around her wrist. It tightened and pulled her hand off. Getting your hand pulled off is way different from getting it chopped off!

We pulled up and fire was there. Her hand nub was wrapped so we couldn’t see it. And they just handed me her hand. It was wrapped up in a trauma dressing with ice packs on it, and I was like, “Really, guys? That’s a hand”! And the jump rope was still attached! I was like, “Are you kidding me?” So we brought her into the hospital, and once again, we did not get recognition because we drove two towns over to the trauma center. I was stoked, because between getting the call and getting to the trauma center, it was maybe 25 minutes. Super quick.

And you know what they said? They said, “Why did you bring her here? We don’t deal with this kind of thing. You should have gone to University Hospital.” And I was like, “It’s rush hour, and you guys are the closest trauma center. I came here; deal with it!” So, no recognition there either. No “Good job, you guys…you brought this girl’s hand…strong work out there.” Just, “Why are you here?”

They eventually transferred her up to University Hospital. University attached her hand and she got full movement back. So then later, they had a dinner for the EMS responders, to go and to thank them, but only the fire crew was invited. Once again, no recognition.

To me, that was a great call because everything turned out good. This poor 8-year-old who could have gone without one hand the rest of her life…well, now she able to do everything with it, and I know I had a part in that. But I lost part of that “Oh, that was awesome!” experience because there was no recognition at all, from the beginning to the
end...which isn’t why we do this job, but that one was kind of extra special.

Emilio’s story is actually two stories: the story of how something that he did made a very positive impact in a patient’s life, and the story of how his contribution was disregarded by literally everyone who was on the call, even down to his being left off the list of invitees to the award dinner. His anger and betrayal on this call is vivid evidence that a major part of the reward for “helping people” is related to the honor and prestige that accompanies public acknowledgement of it. Like Jen’s heart attack victim (above), Emilio is pleased by his role in improving a patient’s quality of life; but also (again, like Jen), being recognized for his quick actions would have enhanced his experience of himself as heroic, since heroism requires both a hero (actor) and an audience (an external agent who determines that his action qualifies as heroism) (Lois 2003).

The following story is by far the longest one that I have included in this project, but I do so because it is dramatically illustrative of a variety of different kinds of public recognition that the paramedics I interviewed seemed to bask in. This story comes from a 17-year paramedic (David, 43), who was enthusiastic about recounting
his most rewarding call. “This one was freaking amazing,” he gushed. “This was
years ago, and it’s not like I haven’t had thousands of rewarding experiences on the
rig since then, but everything just came together perfectly on this call!” David was
physically and emotionally expressive, with performative aspects to his storytelling
that included wide-flung hand gestures and a caricatured delivery of other people’s
lines:

So this was back when I was a brand-new paramedic and I thought I
was hot shit. It was around the time when O.J. Simpson happened. I
was hanging out with my EMT partner and we got toned out to a car
accident on Highway 64, on the way out of town. At the time, it was
barren dirt between both sides of the freeway. There’s three lanes in
each direction with no center divider. Just dirt. This SUV loses control
– it’s one of those big Escalades – so it crosses the dirt in the center and
hits a small Mazda Miata convertible on the other side with a guy
that’s, like, in his seventies driving the convertible.

Somehow, most of the vehicle wreckage ended up in the center divide
and the southbound lanes of traffic heading out of town. We’re working
this scene, and of course, as you would imagine, the 70-year-old guy in
the tiny little car has pretty major injuries. Abdominal injuries; bad
injuries. The lady in the SUV, she’s got nothing wrong with her
because she was in a big old SUV! So I’m looking at the freeway
congestion, because everybody’s rubbernecking and it’s blocking all
the lanes in both directions. And I’m this brand new medic, so of
course I’m like, “I’m gonna land a helicopter on the freeway!! I’ve
always wanted to do that!” And you know, Highway Patrol hates it
when you shut down their freeway…but I’m a paramedic now, and I
just got my patch, and I’m all excited that I can actually do this!
They tell you that distance is the main consideration when you’re thinking about whether you should call a helicopter…like, how long it will take to get them to a trauma center if they need one. My justification – well, I really wasn’t that far from a trauma center in town – but I said, you know, the freeway’s all backed up and it would be really hard for me to maneuver around ALL THIS TRAFFIC…but honestly, I really just wanted to land a helicopter on the freeway.

So I call in the air ambulance and it’s on its way. And we’re packaging up this old guy, and I’ve got the driver of the SUV just watching, standing nearby. She looks fine. My plan was, when I got the guy out of the Miata and into the air ambulance, I’d finish checking out the SUV lady. So I’m doing my stuff, but then, the next thing that happens is…I’m with the Miata guy, and this cop runs up to me. He’s actually tugging on my sleeve. He’s like, “I hear you’re the guy in charge!” And I’m all serious with him, like, “Yes. This is my scene. Can I help you?” And he looks super nervous. And he’s like, almost stuttering, “We’ve got a car chase coming from Lawton!” And I’m thinking to myself, okay, so it’s coming from Lawton. That’s to the south. That means they’re approaching in the northbound lane. We’re on the other side of the freeway; what does that have to do with me?

So I turn to him and I’m like, ”SO WHAT?” But then I look over his shoulder and I can see off into the distance…the longest line of police cars and lights flashing, a super long train. And by the way, this is the only connection to O.J. Simpson in the whole story…but it IS a white Bronco, the exact same car that O.J. Simpson was running in! And that’s why I still remember, because this was about the same time, and I’m seeing this same model car in a car chase. There was a line of probably 50 police cars chasing him. So I’m wrapped up in the situation, and I’m all, “LOOK, it’s a white SUV! Check that out!” Of course it wasn’t OJ, but still…but anyway, I’m still not worried about this, because it’s on the other side of the freeway. I’ll admit it. I’m a
little entertained at the moment, but I’m supposed to be taking care of my patient and I can hear the helicopter coming overhead and dispatch is telling me that my air ambulance is circling to land.

And so I’m like, okay, so I’ve got to focus back on what I’m doing. So we start to do that when something you would never expect to happen, happens…the white Bronco realizes that there’s so many rubbernecksers slowing down to watch my scene and the helicopter that’s about to land, that there’s no place for him to go now! Traffic is now on HIS side of the freeway! But I’ve shut down the freeway on MY side, because I’m about to land a helicopter! So, everything past where the helicopter’s gonna land…well, there’s no traffic! So he decides to do a U-turn across the center divider, and go back towards Lawton. He’s just gonna flip around, right in the middle of my scene! And maybe that would be smart, if he wasn’t going a hundred miles an hour! So what was supposed to be a U-turn crosses, like, maybe 60 feet away from my scene, and he can’t correct it, so he ends up just making an L-turn and going over the embankment. He just flies over the embankment and goes down, like, 50 feet. And he’s just down there, wrecked. He launches it!

So all these cops and sirens and everything are coming onto my scene! And I’m like, are you kidding? Now I’ve got a cluster! Now I’ve got all these cops who are driving down the embankment, coming around to where this SUV landed. There wasn’t even really time to think about it: next thing that happens, I hear gunshots! Like, must have been a hundred, like POP POP POP POP. And I’m like, what the HELL? And then these guys, these two Ricky Rescues who just stopped to watch me load the Miata guy onto an air ambulance, they start running to see what’s going on. These idiots are running TOWARDS the gunfire! I don’t know what they thought they were going to do. Help the cops? That were shooting? And I’m like, “WHAT ARE YOU DOING? THEY’RE SHOOTING!”
And then the lady that was the driver of the SUV, she didn’t actually realize that that sound that she was hearing was gunfire. And when I said, “They’re shooting!,” she totally passes out! Right next to me! Just faints dead away! And I’m like, I don’t even know how many patients I have now! I’m hearing all this gunfire! I was just supposed to take care of this old guy and fly him in the helicopter, and now I’ve got this lady passed out, there’s somebody getting shot over there, and I STILL got the old guy! And then my radio goes off, and they’re like “Medic 30?” And I pick up the radio and I go, “Medic 30.” And they say, “Your air ambulance is canceling because there’s gunfire on your scene.” And I’m like, “WHAT?” And then the helicopter just flies off!

So I’m now the only ambulance and I don’t even know what I have right now. I’m just staring at my radio, like, shit, what’s going ON? And then I feel my sleeve getting tugged again. Like, literally; someone is tugging on my actual sleeve. And it’s the same cop, and he’s like, “We...we...we...we got an officer, and he’s hurt...the...the...car lurched forward and pinned him! And...and...and...we SHOT a guy!” And I’m like, “Okay. So...is the officer hurt badly?” And he’s like, “No. No, he’s just got a bruise.” And of course, I’m pretty sure that they guy they all shot is dead.

So I look at the officer, and I say, “You know what? You’re just going to have to take a number!” I actually told this cop to take a number! Because I’ve got nothing! I’m it! I’m the only ambulance for miles. So he just goes walking off with his tail between his legs to tell his sergeant that he’s going to have to wait. I get on the radio and yell to dispatch, like, “I don’t know, just send me, like...FIVE MORE AMBULANCES!” I know I’m gonna need a lot! So I just picked a number.

The first rig in to the scene declared the white Bronco guy dead. Me and my partner, we gave all our equipment on our ambulance to other ambulances who came in. The other units...they transported the cop;
they transported the lady that passed out; they transported the old guy.

At the end, my ambulance was stripped of equipment. There was nothing left. And when the dust had kind of settled and everything was calm, my partner looked at me, and just yelled at the top of her lungs, “THAT WAS THE BEST CALL. EVER!” Because there were ambulances and car chases and shooting and a helicopter…and we never even transported anyone! I had called one too many ambulances!

In this story, David gets to experience himself as heroic on at least five distinct levels:

his ability to accurately assess a critically injured patient for life threats; his authority to request an air ambulance with the understanding that his order would be obeyed without resistance (in classic Weberian style); his role as “owner” of the scene, even in the eyes of the police who normally “own” a medical scene that involves a crime; his authority to request more ambulances from dispatch; his authority to stop bystanders from rushing toward the gunshots; and finally, what seems to be his favorite moment: telling the frightened police officer to “take a number.” None of these instances are evidence of medical heroism per se. The heroism demonstrated by David in this situation is particularly masculine, and he deploys it in such a way that his authority to make major decisions (like shutting down a highway) is not questioned by anyone, including the law enforcement agency that has jurisdiction over that highway. David makes a point of noting how young he was at the time of
this incident – “too young to drink” – and yet, the power to give orders to which people respond is clearly one that he enjoys for its social prestige. The fact that he and his partner take such sheer delight in ending up without a patient to transport at the end of the debacle illustrates that patient care is not necessarily (or even always) the source of heroism for EMS workers; rather, it is the social situations that patient care emergencies allow them to access. The same might be said of firefighters, for whom heroism constitutes entering a burning building (risking life and limb), but not so much just spraying water on it from the outside.

In a very real sense, David’s patient – the elderly man with major injuries who was driving the Miata – is actually the least interesting character in the story. Miata Man does not himself provide David with heroic opportunities in terms of medical interventions. Instead, his injury provides David with the opportunities to throw his weight around. David, as a young and new medic, seems chiefly enamored of the role he plays in shutting down the highway, order police officers around, and telling bystanders what to do. He does not reflect overmuch on his intellectual skill when it comes to assessing the one medical patient on the scene. His identity is reinforced by the very things that support his display of hegemonic masculinity, suggesting that
some – if not many – medics’ associations between heroism and work performance are not as focused on the delivery of emergency medical care as they are on the prestige-generating logistical tasks related to emergency situations.

EMOTIONAL CARE WORK: TOWARD A RECONFIGURATION OF “HEROISM”

One form of emotional labor that I left out of my discussion about the factory floor is the emotional labor that paramedics undertake in the course of running what I term “social work” calls and “counseling” calls. These calls turn out to be an important form of non-financial compensation that contributes to some paramedics’ sense of dignity on the job, particularly those paramedics for whom hegemonic masculine forms of “rescue” heroism are less appealing (or, as is the case for women medics, less accessible). I excluded them from the factory floor intentionally because they are not, strictly speaking, related to the provision of medical care. Nonetheless, they are part of the backbone of professional dignity – the all-important non-financial compensation – in the social reproduction of ambulance paramedics.

The first category of calls I will address is “social work” calls. Social workers are problem solvers: experts who assess a client’s needs and then connect the client to
the appropriate public or private resources. Social workers learn their trade in of
Masters-level coursework – something to which paramedics are obviously not
exposed during their training. Social work calls are those in which the primary issue
really isn’t the patient’s medical condition, but rather, a need for connection to a
specific kind of service, education, or problem solving. Some examples of social
work calls:

• An elderly woman on hospice whose family has called 911 because her
  breathing has become erratic and they aren’t sure what the process of death
  actually looks like.
• An elderly man who is unable to care for himself, but refuses to leave his
  house.
• A moderately intoxicated man who has no medical complaint, but would like
to detox from alcohol and cannot get a bed at the detox facility until the next
day.
• A patient visiting from out of the area who is having a problem with his
  portable oxygen tank.
• A mother whose 16-year-old daughter will not stop crying after a minor
  parking-lot fender bender, and who does not know what to do.

These calls do not require emergency medical intervention, but they do require
problem-solving skills that take in to account both the patient’s needs and the
patient’s safety. Ambulance medics are quick to disdain fire medics for their tendency
to offer blanket ambulance-transport advice to anyone who calls 911, even in the
absence of a medical complaint: “The safest thing is for you just to go to the hospital

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in the ambulance to get checked out.” Sound advice, unless you consider the
needlessness of transport in the vast majority of cases, and the cost incurred for even
a short ambulance ride and a low-intervention visit to the Emergency Department (the
combination of which would run the patient five thousand dollars at minimum, even
if no treatment at all were rendered).

Solving social work calls means finding creative solutions to help people
avoid unnecessary trips to the hospital: “unnecessary” in the sense that the hospital
simply isn’t the right place for them, does not have the resources they need, or will be
an expensive means of solving a problem that could have been handled with a trip to
the drugstore. For example, the family of a patient on hospice can be educated about
what death “looks” like as it progresses; the moderately intoxicated man can be
educated about the dangers of unsupervised withdrawal and encouraged to maintain a
minimum threshold of alcohol consumption until his detox bed opens up; the mother
of the crying teenager can be reassured that “all crying stops eventually” and
encouraged to take her uninjured daughter to a cheaper and faster urgent care clinic,
should she wish to get a prescription for a sedative. Social work calls can involve
contacting a patient’s physician to consult with her, or contacting a neighbor to
arrange for regular visits for the next couple of days, or even contacting the appropriate county agency for someone who is in need of more formalized follow-up.

The paramedic’s role in these sorts of calls is general problem solver. A creative resolution can be rewarding for an individual medic if she is able to use specific knowledge that “not just anyone” would have, as Monica (36) shares in this story:

I saved somebody from an ER visit once. They were tired. New parents. Just came home from the hospital 20 hours ago. The lady was trying to breastfeed and her baby had the world’s worst latch. I actually worked with this lady, like a lactation consultant. I taught this lady how to breastfeed. And then the baby was suckling away, and the lady was like, “Wow, that doesn’t hurt!” And I was like, do you still think you need to go to the hospital? And she was like, “You know, I don’t so!” And I was like, FUCK YEAH!! Saved those people a trip! Mobile consulting. Because if that had been two dudes on that call, forget it. She would have gone to the hospital literally for not being able to breast feed.

This call qualifies as a “bullshit” call since it most emphatically does not involve a medical emergency. Far from being put out, though, Monica takes pride in having found a way around an unnecessary ambulance transport that also allowed her to provide a genuinely useful (albeit non-medical) service to someone. By specifically remarking that a crew of men would not have been as well equipped to handle the call
– that they would, in fact, have had no idea what to do – she is also experiencing herself as uniquely capable of handling the situation in the way that she did. This call is not about “monkey skills” learned in paramedic school; rather, it’s about her having the opportunity to pull in her own life experience as a parent to help other parents navigate the early days of their newborn’s life.

Another subject, Sean (35), told me about a time that he had been called out for a domestic violence incident:

I got called out for this lady once. Her husband had shoved her a couple of time and then he drove off with their toddler in the car. She wasn’t injured at all, just upset and freaked out and worried about the baby. We happened to be right around the corner but the cops were about 20 minutes out so I had a good long while to talk with her since I couldn’t leave before the cops got there. I told her it wasn’t her fault and nobody deserves to be hit…you know, all that stuff you’re supposed to say to a battered woman. Sounds like this guy was a real douche. Anyway, she just was not coping well. She kept saying how she brought it on herself, which of course is complete horseshit. We all know that. Anyway, I got this great idea. I was really proud of it, actually. I took this piece of paper and I made her write, “It was not my fault and I do not deserve to be hit.” Then I took a picture of it with her cellphone and told her to look at the picture anytime she started talking that way again. I don’t know if she ever looked at it. For all I know, she got back together with that asshole. But at least I tried to do something. Maybe it made a little bit of a difference. Who knows?
In the end, solving non-medical problems requires different knowledge, but not necessarily a different skill set as taking care of medical emergencies or strategizing a complex extrication. In both cases, (a) there’s a problem, (b) we are the ones who have been called out to solve it, and (c) we can’t leave until it’s handled. We get creative and handle it. This “seat of your pants” creativity is a source of pride for paramedics.

Another way that paramedics enhance their dignity on the job is through “counseling” calls. Counselors are compassionate listeners and advisors who validate a client’s emotions and offer suggestions for how the client might interpret, tolerate, or transform difficult emotions. Frequently, situations arise in EMS that require social work and counseling-type interventions. They cannot be classified as medical care. The recipient of the emotional labor is often not even the patient, and there is certainly no part of paramedic training that educates EMS workers about how to handle these exceedingly delicate situations. In truth, this is quite extraordinary: young people with little formal education beyond high school (or perhaps college), and who sometimes have very little life experience, find themselves in situations where they must contend not only with the death of the patient, but with a range of
powerful emotional responses from bystanders or family members. This is the sort of intervention for which licensed therapists may train for years and for which chaplains may have spend considerable time in a religious seminary. Paramedics, when they find themselves pressed into service on calls requiring counseling, are winging it. They’re flying by the seat of their pants and hoping for the best. Many of them become very skilled over time.

This is not to suggest that all paramedics embrace this part of the job with joy. In my years on the ambulance, I saw some medics approach these situations with ease, comfort, and remarkable compassion, while others – especially younger, inexperienced personnel – beat it out of the room as quickly as possible, perhaps with a hastily mumbled, “I’m sorry for your loss” to the grieving father or widow or friend. I chose this chapter as a place to discuss these calls, however, because they came up again and again in my interviews as sources of hidden pride for my subjects. Inasmuch as they considered these emotional interventions to be something that “not just anybody can do” (and indeed, that most people want to actively avoid, much like body fluids that evoke disgust or a particularly grisly injury), my subjects expressed pride in their ability to tolerate other people’s emotions, solve complicated problems,
and provide psychological comfort. Counseling calls don’t meet the theoretical
definition of heroism that requires the hero to go above and beyond the call of duty,
risking life and limb. But they do require that the medic risk her own emotions on
behalf of another person. Risking one’s own emotions – making oneself emotionally
vulnerable – is not an action that we typically correlate with heroism. Because
heroism has hitherto been culturally defined by physical risk, and physical risk is
associated with hegemonic masculinity, non-physical risk is disregarded as feminine,
and therefore, not heroic. In fact, by this definition, emotional risk-taking is decidedly
unmasculine, so emotional risk-taking could be regarded as a questionable
undertaking if it could compromise one’s masculine/heroic identity.

What intrigued me about my interview findings was the prevalence of medics’
stories of emotional risk-taking. While they varied in degree of risk, I found that
paramedics were almost universally aware of and proud of the emotional risk-taking
and problem-solving behaviors that they understood to be part of their work. They
understood these behaviors as true risks (having some element of real danger), in the
sense that getting too personally wrapped up in a stranger’s emotions compromised
the integrity of their own emotional well being. Nonetheless, they spoke of these
incidents with pride. The first story comes from Michael, 45, who has spent his 22-year career working in a popular ocean-side vacation destination:

Jamie and I had the worst call on record. Nine people from this family were out on the rocks, taking a family portrait. They turned their back on the ocean because it looked nice and calm. They’re all up on the rocks, and all of a sudden this monster set (of waves) comes in. It breaks, and everyone goes running. Two women get swept into the ocean. The husband of one of the women jumps in after them. He gets pushed back up on the rocks. Just destroys his knees and cuts up his lower legs, but he’s alive. The other two women are panicking. They’re still stuck in the water. The thing is, if you get sucked out, just swim out. If you try to swim back in, you can get stuck under a ledge or get torn to shreds. They panicked so bad that they both drowned right in front of the whole family.

The lifeguards go out in the jet ski and pick up both the women and bring them back to the beach...by the time they got back to the beach, it was 40 minutes after the call came through. No way we could work them up after that long. Too far gone. We brought to monitor and two body bags and walked the ten-minute walk to where the lifeguards were on the beach. Lifeguard looks up at me. He’s just panicking. I walked up to the first one and she’s purple. Just asystolic. Sea foam pulmonary edema coming out of her mouth. The next one…I walked over…they were sister-in-laws. She was way beyond help, too. It was the worst feeling. I was like, in front of all these people, I’m just going to have to call (the code)?

We call the doctor at the hospital. I say, “Look, doc, we gotta have closure for these people. They gotta be able to see their family, no matter how bad they look.” We’re not allowed to transport dead bodies, but I got permission to take the bodies up from the beach to the fire station. And we took them out and laid them down on the ground,
opened up the bags, made their faces presentable, wiped away all the sand and foam. We did the best we could do.

Then the family showed up. The one daughter came in. She was thirteen or fourteen. There were two or three kids. They all just bawled their eyes out, hugged their mom. I stayed because I needed to be there. I can’t leave. I need to be there and watch this. Jamie started crying. It was too much for him. It was so preventable. I asked the husband and the daughters if they wanted the jewelry and they did, so I took everything off and gave it to them. We took our ambulance and went home. I thought, what are these people going to do? They’re stuck now. They’re here on a family vacation, and they’re going to have to take home two dead daughters.

Michael and Jamie’s medical obligation to the two drowned women ended when Michael determined that the victims had been “down” too long for resuscitative efforts to have any chance of working. His only duty to act at that point was declare them dead, wait for law enforcement to show up and take control of the bodies, and leave. What he chose to do instead, however, was undertake a profound emotional risk for himself and his partner by advocating with medical control (the physician at his local base hospital) to break the rule against transporting dead bodies. He also spent time that he was not obligated to spend making the women’s bodies look as presentable as possible so as to minimize distress to their families. Essentially, he bluffe...
the course of doing so, he exposed himself to the family’s grief and to his own reactions from spending time with the dead women’s bodies.

He did this not for the patients (who were dead) but for the survivors. Michael told me that vacation drownings and near-drownings are common where he works, and that he his heart breaks for these people who have come to spend quality time with their family, but leave with fewer family members than they arrived with. Thus, he sees his job as a paramedic as extending beyond the life and limb of his patients. He also wants to do the very best he can by the survivors of these incidents, who he perceives as being “emotional patients”: their pain and grief is just beginning. This is the reason that he goes above and beyond in his advocacy. In doing so, it’s important to realize that he is also voluntarily incurring emotional risk to himself, as evidenced by the fact that this call still lives vividly in his mind. His partner broke down on scene; Michael himself processed it over time, but the experience never left him. In his desire to provide closure for a family whose position he could empathize with, but whom he did not know, he went “above and beyond,” incurring an emotional burden that he had no obligation to bear, and into which we can imagine a non-medic would not have rushed headlong (nor even had the opportunity to do so). The first rule of
paramedicine is “never lose your head”; in this situation, Michael kept his head in ways that enabled the worst day of one family’s life to be fractionally less horrifying.

He, like other medics who allow themselves to be vulnerable to others’ pain, can expect no direct compensation for taking on this emotional burden. The compensation for his voluntary effort is his own dignity as a medic – knowing that he did something that he did not have to do, that was beyond the expectations for his position, and that could cause him harm, and yet had benefited someone else in a way that he understood as making an important difference.

Not all paramedics are as apt to run toward such opportunities. During my formal participant observation period, I ran two calls – related to one another – that reinforced to me the degree to which emotional deep dives are an optional part of the job. These calls occurred about four hours apart on the same day:

Call #1: Motorcycle fatality on North Mountain Rd. The guy who died was riding with five or six of his riding buddies, all best friends who knew each other since they were little. He was trying to pass a car on the left, over the double yellows around a blind curve. A woman was stopped beyond the curve, waiting to turn left into a driveway. He went head first into her rear wheel well and got sucked around the rear tire. He was obviously dead. The accident snapped his neck, and he was so badly stuck up there that it took fire about 2 hours to cut his body out. That’s not an image I’m going to forget anytime soon.
I spent an hour on scene. First, I did some mental health first aid on the riding buddies. I told them that it’s normal for them to feel really complicated feelings about the accident. I talked to them about PTSD, and what the symptoms are, and how to find a therapist if they need help. They looked as shell-shocked as motorcycle-fatality-riding-buddies usually do, in that “there but for the grace of God go I” kind of way. They’re going to take this hard for sure, but at least I could let them know that there’s nothing wrong with them if it affects them badly enough to need help moving on.

Next, I spent about half an hour with the woman whose car the guy got sucked up into. She was a complete basket case, sobbing uncontrollably, blaming herself, etc. I read her a similar riot act, except I spent a lot longer with her because she just wasn’t coping. I explained PTSD symptoms to her boyfriend, and pretty much extracted a promise from him that he would get her into therapy immediately. Not “if” she developed symptoms, just immediately. I’ve talked to people who have killed someone through absolutely no fault of their own (kid running out in the middle of the road, for example), and it fucks them up for the rest of their lives. This lady was obviously going to be fucked up, so I wanted make sure there was someone following a plan to minimize the damage.

Call #2: About three hours later, Brent and I got dispatched for someone who had passed out. The address was about 15 miles away. Normally, it wouldn’t be our call, but the system was at low levels so we ended up being the closest unit. We got en route, but I kept feeling like I knew the address. Then I remembered: it was the address of the dead rider. I’d written down his info for my report so it was fresh in my mind. I told Brent it must be the guy’s family, and he said, “Whatever we do, we can’t tell them we were there with that guy when he died!” He’s not the most touchy-feely guy in the world, but it still seemed like a bizarre response. I asked him what the problem was. “They’ll blame us. They’ll say we didn’t do enough. They’ll put
it all on us. Man, I do not want to go on this call. Maybe we can get someone else to jump it for us.”

This floored me. Why would they blame that guy’s death on us? I said, “I totally disagree. I think we’re the perfect unit to go on the call. We’re the only ones who can say anything comforting to them, like “Your son didn’t suffer.’” That was when I realized that I had literally no idea what he’d been doing the whole time we were on the motorcycle scene. I’m sure he wasn’t sitting in the rig, but I bet he was just hanging around watching fire or something, because he sure wasn’t with me, and there was nothing medically to do on that call at all.

We got to the house and I told him I’d run the call, even though it was his turn to attend. The Sheriff’s officer met us on the sidewalk. Turns out he had just gotten there a few minutes ago to do the death notification. The dead guy’s mom was in her sixties and in fragile health. She had almost passed out when they told her, so they called us (which is totally normal). We went inside and there were about 15 family members in the house at the time. Everyone was just sobbing or wailing or shocked. It was a wall of emotion, dense and overwhelming. Most of the people there did not speak English, but the motorcyclist’s sister did, and I spent a while with her, explaining what had happened, that we were there, that there was nothing we could do, and most importantly, that he did not suffer even for a second. I got her to repeat it back so I knew she understood it all. Then I asked her to please make sure that she passed that information to her mom when her mom was ready. This girl’s world had just fallen apart half an hour before, but she was doing an amazing job of trying to listen despite her obvious distress. Brent just took the mom’s blood pressure and kind of hung back.

We ended up not transporting the mom. She wasn’t sick; she was just devastated. Brent and I talked about the call on the way back to our
“Why do you get mixed up in that kind of stuff,” he asked? He wasn’t off base; I do get “mixed up in that kind of stuff” all the time, on purpose. I think it’s because I hate major trauma and I hate critical calls. I feel like I suck at them, and I know that I shouldn’t. But I work too part time to keep my skills sharp. I rely a lot on other people to get me through those calls. I don’t lose my head in a visible way, but I still know that I could be a lot stronger medically. Emotions, though…that’s one area that I actually can rely on myself completely. I know I can dig in better than a lot of people, so I make it my specialty. It helps me keep my self-respect when I feel like a mediocre medic in other areas.

What struck me about this incident after Brent confronted me about it is that I had never, until then, thought in such a deliberate way about my fear that I had grown to “suck” at certain kinds of calls. But even though a good medic doesn’t have to tell everyone that she’s a good medic, the paramedic ethos demands a baseline level of either confidence or bravado. For me, the deep emotion work served as evidence to myself (and on which I could base my claim of “confidence” in my medic skills) that I could perform feats that were not in everybody’s repertoire. They were one way that I knew I could always go “above and beyond.”

Since I did not interview Brent, my partner on the motorcycle call, I can only speculate about the primary source of his occupational dignity (although I suspect that it may have had more to do with media representations of the industry, since he has
frequently parlayed the status conferred by his uniform into opportunities to flirt with attractive women while on duty). But comments like the following one appeared somewhere in virtually every interview, often when I asked where my subjects derived their greatest sense of pride on the job:

You asked me what I find most rewarding, and you know what it is? When you’ve lost the patient, you’ve lost that person’s family member, but you’re there and you’re genuinely comforting someone. I’ve had codes where I was genuinely bummed, where I was like, that’s fucked up; that person was young and they died kind of out of nowhere. Then you give the family member a hug, and they’re like, “Thank you,” even though their family member died and you didn’t do anything for them but listen and communicate like a human being. And you probably took that instance in their life and made it not as bad as it could have been. But we don’t prepare people for that in paramedic school. We say, “Here’s how to focus on your cardiac arrest protocol.” But what about the crying spouse behind us? They’re going to remember everything we do and say forever. It seems like we all just figure it out eventually. I was bad at it when I was a new medic. I guess I’m still bad at it with kid calls. I mean, what can you possibly say to that parent? When the parent of a dead kid wails like they always do, it’s hard to handle. It makes my skin crawl, it sounds so terrible. But I really try to remember that what we say and do in that moment matters a whole lot. I think time slows down for people when they lose their person. They’re just never going to forget who was there and what they said and what happened. So I think the least we can do is talk to them about their loss, even if you’d rather just clear the call and get your lunch.

- Rob, 29
Rob’s words echo the sentiments of my many other interviewees who reflected the same sense of pleasure from being of comfort to someone other than the patient. Most of them also pointed out that comforting someone can come at some degree of personal cost, if only having to tolerate the profundity of someone’s grief (and Rob was one of many people who specifically mentioned the grief surrounding pediatric deaths as especially challenging to navigate). While one could certainly argue that the medical care of an individual patient has an emotional component, the job description of paramedic does not, strictly speaking, include emotional comfort of people other than the patient. The fact that so many medics spoke of their emotional labor on behalf of family members and bystanders with pride, however, suggests that their pride in this area must constitute a critical piece of that non-financial compensation package that neutralizes the negative effects to their occupational dignity of things like being paid less vis à vis workers in similar occupations, feeling unappreciated and abused by patients, running “bullshit” calls, and putting miles on their bodies as they wrack up miles on their ambulances. In Rodriguez’s words, “These emotional and rhetorical strategies…(give) their work positive meaning in a social context that is fraught with things to feel bad about” (2014: 116).
My data suggest that we need to account for forms of heroism that go further than the notions of “above and beyond” physical risk-taking associated with hegemonic masculinity. Indeed, we need configurations of “above and beyond” that posit emotional vulnerability and the caretaking of other people’s dangerous emotions as a form of heroism in itself: an undertaking that I term emotional heroism. In the final chapter of this dissertation, I will examine the ways that the concept of emotional heroism could be utilized to better understand gender, work, and emotional labor.
CHAPTER 6 – FINDINGS AND FUTURE DIRECTIONS

As corny as it may seem, I really do feel blessed, grateful that I do what I get to do here, where I live. Aside from the frustrations I told you about, it’s the job itself and when I have patient contact in the back of the ambulance, or I’m in someone’s house or wherever, and I’m taking care of the patient, and I tell myself, “That’s why you’re here. You’re not here because you’re getting along with your partner or they think you’re just as awesome as they are.” So this is why I’m here. I’m here because I’m taking care of someone in my community the best way I know how. I’m advocating for them if I need to. I’m trying to make their experience as painless and calm as possible. And when that happens and I feel like I’ve helped that person or at least made them feel secure enough to continue their journey in whatever illness or tragedy that they’re in, that’s why I’m there. That to me, keeps me going on those days that I’m feeling frustrated about other things. The little things keep me going, knowing why I’m here.

- Laura, 55

Throughout this project, I have explored various aspects of paramedics’ emotional labor and social reproduction efforts. I have used the empirical data gathered during my research to make claims about how paramedics do their work, how they process their feelings about their work with their coworkers, and how they come to understand their experiences emotionally such that they keep coming back to their jobs each day. In this final section, I will revisit the puzzles that I set out to solve, the conclusions that I made about each of those puzzles, the theoretical implications of
my conclusions, and their implications for EMS workers. I will also reference some
of the topics that I was not able to cover in this project, especially in those cases
where I felt that additional material would have allowed me to make more nuanced
claims. These brief discussions of how each topic could be expanded constitute my
recommendations for further research.

FIRST PUZZLE: MOVING BEYOND GENDER BINARIES

I began this project by laying out a very general puzzle: what do paramedics’
reflections on their experiences at work tell us about the nature of jobs comprised of
both historically “masculine” work and historically “feminine” work? How does
“masculine” emotional labor expand our understanding of emotional labor as a whole,
and which aspects of gender and work become visible only when we consider the
simultaneous interplay of masculinities and femininities in the same setting? I argued
that previous research into crossover occupations (Williams 1995; Paap 2006; Lupton
2006) was limited because it studied occupations that were highly segregated along
gender lines. These were also jobs that workers perceived as “feminine” and
“masculine” (Reskin and Roos 1990; Cross and Bagilhole 2002). The workers who
are doing the “crossing over” are small in number and noteworthy for their presence in occupations whose workers are mostly not men (in the case of men’s crossover into women’s occupations) or mostly not women (in the case of women’s crossover into men’s occupations). Some scholars have attempted to show how other social identities can make complicate the ways that subjects benefit from or do not benefit from their token status (Wingfield 2009), but by and large, crossover research seems to support the claim that Rosabeth Moss Kanter made in one of the earliest examples of crossover ethnography about women tokens, *Men and Women of the Corporation* (1977), and that Christine Williams made fifteen years later about men tokens in “The Glass Escalator” (1992): namely, that women do not benefit from their status as tokens in the workplace, while men do benefit from their token status.

Crossover literature’s focus on deeply segregated occupations has meant that the research sites that have benefitted from its explicitly gendered analysis tend to be those that already carry a gender label, e.g. “men’s work” or “women’s work.” I posited that EMS is unique because it has occupational elements that are read as feminine – care work – and elements that are read as masculine – emergency work. This dichotomy means that EMS workers have to negotiate spaces in which they can
do femininity or masculinity (West and Zimmerman 1987) while performing both kinds of work, since they cannot opt out of either one. I also argued that EMS is unique because it is actually less gender-segregated than many so-called feminized or masculinized occupations; while it is still men-dominated at 78% of the total U.S. workforce (Chapman et al. 2008), these numbers represent higher levels of integration than comparable “masculine” jobs like firefighting (where women make up 4.5% of the men-dominated workforce\textsuperscript{10}) and nursing (where men make up only 10.6% of the women-concentrated workforce\textsuperscript{11}).

Ethnographies dealing with care work or emergency work do not look at jobs that mix the two (Glenn 2010; Desmond 2007; Chetkovich 1998). They look at care work or emergency work. Typically, those occupational cultures are masculinized or feminized, and people do the job in relatively similar ways, regardless of whether they are men or women. I found that EMS’s culture is different, although this was not evident until I applied the notion of emotional culture to my analysis, because medics themselves don’t seem to think in terms of the “feeling rules” for EMS culture

\textsuperscript{10} http://www.bls.gov/iif/oshwc/cfoi/osar0017.htm
\textsuperscript{11} http://www.bls.gov/cps/cpsaat11.htm
(Hochschild 1983). The most surprising finding was that the one piece of EMS that always seems to be inextricably linked with masculinity – “heroism” – turned out to be more complex than traditional renderings of heroism as a physical act would have us believe (Goode 1978; Edelstein 1996). Such a discovery would not have been possible in an occupation where crossover workers only ever reach token status in terms of gender integration, nor would it be possible in a job where the gender of the workers is more integrated, while the work itself remains highly feminized or masculinized. As a site that allows us to see multiple layers of gender performance at once, EMS facilitates this gendered analysis.

Finally, our preconceived notions about what kind of work a job entails ultimately drive what we choose to focus on when we analyze gender on a job. When the job involves kinds of work that we weren’t actually looking for, we may miss important details that would help us to better understand that job in the context of work and gender. This absence is problematic, and reinforces the potential of insider ethnography when it comes to complex and culturally insular workplaces (or, for that matter, any culturally complex ethnographic research site). My experiences working on this project reinforce methodological approaches supportive of insider
ethnography and authoethnography: partly because of what subjects may withhold from outsiders, and partly because of the potential for outsiders to misinterpret subjects’ comments and behavior. As with any culture, if you don’t speak the language, you may lose things in translation.

My research site does not uncover all of the ways that gender can manifest in an occupational culture, nor even within EMS. For example, my focus on ambulance paramedics could lead some readers to assume that paramedics are always people who work on ambulances. This is not true. Some paramedics are firefighter-paramedics who work as first-response medics on fire engines, but who do not transport patients to the hospital. Firefighting, as I have made clear at multiple points, shares some cultural overlay with ambulance-based EMS when it comes to the provision of emergency medical care, but it is also very much its own beast, especially at the level of gender. Some paramedics also work doing ALS (Advanced Life Support) inter-facility medical transport. These paramedics have the same training as 911 paramedics, but work for private companies who either do not contract with municipalities to provide 911 services to the public, or who maintain separate inter-facility transport divisions if they are 911 contractors. ALS transport
medics do not perform the heroic work – physical or emotional – that 911 medics perform. Having never been a medic in such a workplace, I can’t speculate on its emotional culture beyond to say that on the intermittent occasions wherein my employer has picked up local inter-facility transport jobs and assigned them to 911 units, these transports have elicited intense complaining. I personally derive little professional pride from those jobs, since they are 100% care work and 0% emergency work. It seems probable that full-time inter-facility transport paramedics socially reproduce themselves – and do gender – in ways that are markedly different from 911 paramedics. Finally, some paramedics work for fire departments, but transport patients by ambulance in fire department ambulances; their emotional culture may be an amalgam of ambulance and fire cultures, making them a potential site for understanding to what degree my findings about the gender performance of ambulance medics are can be extended to fire department personnel who work in a less gender-integrated environment.
SECOND PUZZLE: EMOTIONS, GENDER, AND WORK

The second puzzle that I hoped to solve was the question of what happens when we consider emotions, gender, and work together. The way that I answered this question was through the lens of emotional culture, both on and off the shop floor. My data show that the emotional labor that buttresses identity and keeps medics returning to work each day takes place not just during calls, but also before and after calls. Unlike jobs where the job is incidental to workers’ lives, and where break room conversations revolve around topics unrelated to work, medics talk quite a lot about their work while they are at work. They also engage in very specific conversational practices that enhance their social reproduction by bolstering claims to intimacy, partnership, and trust. I found that medics talk about work by engaging in three distinct behaviors: venting (complaining about their employer, coworkers, allied agency colleagues, non-emergent calls, equipment, or fatigue); rubbernecking (actively seeking out dramatic call stories from other medics in order to learn from them and to experience the vicarious professional thrill that comes when we are reminded of the wide range of disturbing, traumatic, and “trippy” things we see on the job); and processing (talking through memorable, difficult, or mishandled calls with...
coworkers in order to process challenging emotions without losing face or seeming to abandon masculine expectations for emotional suppression). These “talking about work” behaviors often take up hours in any given shift, and must figure prominently in an analysis of paramedics’ emotional culture.

The other break room talk that I laid out in my findings was the relationship-building practices that facilitated medics’ effective team performance during emergency calls. My findings echo those of Desmond (2007) and Lois (2003): namely, that emergency workers must rely on one another in highly charged, dangerous, and critical situations. Medics can only do their jobs during crunch time when they know that their partner has their back; if they aren’t well acquainted with their partner, they lose the edge that predictability provides. In order to forge temporary bonds, medics utilize strategies of social bonding that (a) are culturally specific and (b) are exactly the opposite of what they appear to be on the surface. Medics’ gender policing of each other in accordance with standards of hegemonic masculinity (Connell 1995) reinforces norms of masculine behavior, thereby shoring up medics’ self-identification as heroic, capable, and worthy of professional respect.

Social bonding includes homophobic and sardonically homophilic gender play,
especially between men and men, and between women and men. Men medics’ policing of women medics’ on-the-job gender performance does two different kinds of work: either it distances men from characteristics they associate with femininity (and by extension, the non-heroic), or it posits women as “honorary men,” thereby removing the threat to the heroism and masculinity of EMS work that the presence of women and femininity represent.

Medics’ deployment of shit-talk as a strategy for social bonding also creates intimacy, albeit via an indirect approach that may or may not make the transition from “false” intimacy (temporary affinity for an unknown partner that enables both to do their jobs on a one-day basis) to “true” intimacy (a relationship, even restricted to work, that two medics build over time, and which allows for predictability and trust on a professional level, a personal level, or both). Desmond writes of shit-talk:

What does a joke do? Most of my crew-members view shit-talk as a form of entertainment, a jovial ritual, and nothing more; hence they believe that if repartee serves a function, it is to build solidarity and friendship ties in a twisted system that fosters alliance through animosity…To my crewmembers, shit talk does not create divisions; on the contrary, it ensures fraternal closeness…The more taboo the insult, the rationale goes, the more resilient the friendship.

(Desmond 2007: 99)
This quote illustrates the ways that my coworkers use shit talk to create relationships with people they do not know and on whom they must depend in critical situations. Like Desmond, I also found that shit talk operates as a cultural literacy test. Medics who can’t roll with it – or either dish it but can’t take it back, or who can’t take it or dish it – fail the test and become suspect. Similarly, medics who dish it too early when arriving on the scene as a new hire may fail the “humility” test that is also a reflection of masculine heroism and a concomitant eschewal of femininity.

Shit talk and the construction of false and authentic intimacy are emotional labor. This labor may take place during downtime (although it also takes place on calls, especially as a tactic to distract a patient from pain or embarrassment), but it does not make sense to relegate it to a pile of social behaviors that is unrelated workers’ job performance, as one might do when talking about the break room social interactions of low-wage service workers. I am not suggesting that break room joking is not a valuable form of interaction for movie theater employees or retail clerks, but the stakes are clearly very different. Break room time is also quite limited in most hourly work, so even if social joking behind the scenes enables workers to have more fun (or simply to be less miserable) while working, it clearly does not have the same
implications that verbal jousting has in occupations like emergency work, in which workers’ assessment of their colleagues’ character determines to what extent they will trust them and cooperate with them to get the job done. Joking, then, is not “just” joking; it is also emotional labor. Knowing how to interpret it, respond to it, and return the volley is evidence of a medic’s literacy in the emotional culture of EMS.

By using the emotional culture approach, we can better understand how both men and women paramedics can “do” masculinity and “do” femininity without compromising their overall identity as emergency workers. Medics’ commitment to their occupation, in other words, shows up in their emotional culture and keeps them coming back to work.

The theoretical implications for my findings should be encouraging for work ethnographers who have leaned more toward investigating workplace practices than toward investigating workplace emotional cultures. It is probably unrealistic to expect to find emotional cultures of this depth in workplaces characterized by low commitment, little emotional or physical risk, and little break time during which to forge a culture. EMS emotional culture exists in service to getting EMS work done. On the other hand, it is likely that an emotional culture approach could give us greater
insight into answering the question that I pose in Puzzle #3: Why is it that people keep coming back to work each day? Whether our interest is organizational (i.e., understanding workers’ motivations in order to lower worker turnover or aid workers in organizing efforts) or whether it emanates from a curiosity about emotions, emotional labor, or conversation analysis, the emotional culture lens allows us to see ostensibly unremarkable encounters between workers as potentially fraught with meaning. Ethnography is fundamentally about the interpretation of culture (Schutt 2009), so having more culture to pick through should lead to more fruitful ethnography.

There were several very key aspects of paramedics’ emotional culture and gender that I was bereft at having to leave untouched. Unlike the absences I alluded to in the previous section, these missing pieces are less the result of data left ungathered, and more the unfortunate castaways of restrictions on dissertation length. In short, they could be an entire project all by themselves. I can loosely categorize them into three main classifications: (a) sexual harassment, sexual objectification, and differential treatment of women medics by men medics on the basis of gender; (b) on-scene conflict and resolution between paramedics and fire crews, hospital staff, and
law enforcement, and the different experiences that men and women report in their interactions with fire crews based on their own, their partner’s, and/or the crew’s gender identity; and (c) inter-agency emergency-worker emotional cultures (i.e., the collective emotional culture shared by ambulance medics, firefighters, cops, and hospital-based emergency workers). These themes are woven together by the thread of power relations, and this is the question that most leaps out at me as worth answering. When people from different emotional cultures and different occupations have to work together to produce the same result, how exactly do they negotiate power? Given how frequently this topic came up in my interviews – a frequency that correlated strongly with incidents I witnessed, incidents that I listened to medics vent about during my participant observation, and incidents that I have experienced myself literally thousands of times – the question of how power operates on emergency scenes is well worth exploring for the insight that it could provide about women’s strategies for dealing with prejudice and sexism on the job. Women medics – unless they leave the industry – are remarkable for their resilience in the face of challenges to their femininity, their masculinity, their physical ability, and their capacity to be successful in the field. Crossover researchers studying women tokens could learn
much from these medics’ approach to both conforming to and resisting an
occupational environment that, while steadily improving, is still hostile toward them.

THIRD PUZZLE: THE INTERSECTION OF SOCIAL REPRODUCTION, COMMITMENT, AND EMOTIONAL LABOR

The third puzzle that interested me related to paramedics’ dignity and occupational
commitment. That puzzle arose in part from my pre-research, career-long anecdotal
impression that paramedics spend a lot of time complaining. They complain about
feeling unappreciated. They gripe about “bullshit” calls, venting their frustrations
about fire or hospital personnel with whom they have had interpersonal or
professional conflicts, and lamenting their low pay, long hours and fatigue, or poor
treatment by the companies that they work for (at least relative to the pay and
working conditions of their firefighter and registered nurse colleagues). Some of these
complaints are well founded, at least in the sense that paramedics are trained to deal
with emergencies – indeed, are led to believe in their professional training that most
of what they encounter on the job will be true emergencies – and then get a rude
awakening when they discover that most of what we do is anything but emergent.
The question of why a worker keeps coming to work is what sociologists mean when we talk about “social reproduction,” Marx’s term for the labor involved in reproducing the worker under capitalism such that she is able to return to her job day after day. The sociological literature on commitment is also helpful in analyzing why workers stay at their jobs. The work itself may bring a worker dignity, or the worker may be able to create dignity for herself by organizing her coworkers for change, despite working in conditions that do not actively promote it (Hodson 2001; Rodriguez 2014; McKay 2004). The case of ambulance paramedics’ commitment is unusual in that their commitment turns out to be directed at the occupation rather than the employer – a point that was made and remade over the course of my many interviews and the informal conversations that I documented in the workplace.

Ambulance medics often do not have a choice of employers, since many municipalities do business under an Exclusive Operating Contract, which designates them as the sole provider of emergency transport in the area. When an employer loses a local contract, employees seek employment with the new provider. They are attached to the occupation and to the geographical location much more than they are attached to the company.
As helpful as it is, the commitment literature is best equipped to explain organizational commitment, but less well equipped to explain occupational commitment. What does better explain occupational commitment is the notion of emotional culture: the interpretive frameworks through which workers come to understand their own and others’ emotions and behaviors on the job (Lois 2003). In Chapter 3, I laid out a map of the ways that paramedics perform emotional labor on 911 calls. My findings related to suppressive emotion management, in which medics suppress or manage their authentic emotions such that the patient remains unaware of them. The suppressed emotions included disgust (over body fluids, body size, or a patient’s physical surroundings); boredom; mirth (inappropriate surprise or shock coupled with amusement); hostility/contempt; concern/worry about the patient’s condition; discomfort with the patient’s pain or fear; fear of professional failure; and horror/sadness. The purpose of suppressing these emotions is to keep in line with professional expectations about how a medic “should” treat patients, and to elicit specific emotional responses in the patient. Some of the suppression allows patients to save face when they find themselves in a potentially humiliating situation. Other variations of suppression allow the medic to save face if she finds herself
experiencing a crisis of confidence in her abilities. Still another category allows the medic to hide from the patient the true seriousness of his condition if the medic believes that such knowledge could negatively affect the patient’s condition.

This emotional labor reinforces paramedics’ commitment to paramedicine as an occupation rather than a job. My subjects did not reflect on their performance at work as something they did to benefit the company, or to produce profits. Rather, their performance at work reflected on their self-characterization as a “good” medic or a “bad” medic. In service jobs such as EMS, the connection between emotional labor and financial profit for the company is much murkier than it is in manufacturing jobs. If a company’s paramedics habitually provide poor customer service, it could theoretically lose a contract, but the loss of a contract, when it does occur, is generally related to the company’s failure to serve its governmental customer (the municipality) by meeting its minimum response times or keeping its fees to an acceptable base rate for local residents. The municipality has more control over the company’s ability to do business than does any individual patient.

This separation of profit from emotional labor means that we cannot understand paramedics’ emotional labor as an expression of their commitment to their
employer. The intended recipients of their emotional labor are their patients and, equally as important, themselves. When they perform emotional labor for their patients, they are simultaneously constructing a mental scaffolding to buttress their own identity as 911 paramedics. They are not attaching themselves to a specific company; their dignity comes from their loyalty to their occupation. When they feel that their services are being abused, the “hero” part of their identity is compromised. This puts them in the position of having to choose between several options. First, they can continue to perform the emotional labor of taking the patient’s complaint seriously, as one would in an emergency. This requires a temporary reformulation of identity (e.g., “My job is to help anyone in need”), which saves their occupational pride by downplaying the compromise to the “paramedic” identity that is caused by non-emergency calls. Their second option is to adopt neutral civility, in which they do not take the patient’s complain seriously, but also do not instigate conflict or provoke the patient. Their third option is pranking, in which they deliberately provoke the patient or ridicule the patient without her being aware, so as to reinforce that this is “not an emergency” and hence does not require the emotional labor dictated by a true emergency.
All three of these options – albeit in markedly different ways – serve to distance the misused medic from the loss of prestige that he experiences when he is not performing emergency work. It is important to recall that, even though this project is also about care work, and all of my subjects derived some degree of personal pride from their performance of care work, the masculine/heroic/rescue part of the job is what attracts people to the occupation. Recall the prevalence of “I want to help people” as a justification for entering the field. No one said, “I went to paramedic school so I could drive drunks around” or “I wanted to be a paramedic because I liked the idea of driving people to the hospital who could have unlocked the car in their driveway and driven themselves to a clinic.” Paramedics’ professional identity revolves around their ability to intercede during the worst moments of people’s lives. Their emotional labor, accordingly, is aimed at either supporting that identity (during a true emergency, in which the paramedic is concerned for his patient’s feelings and physical condition), or neutralizing the assault on that identity represented by “bullshit calls.”
METHODOLOGY: MOVING ETHNOGRAPHY BEYOND THE SHOP FLOOR

In the introduction to this dissertation, I asserted that contemporary labor process theory (LPT) leaves sizable holes when it comes to the social reproduction of workers. Thirty years ago, one might have critiqued the entire body of literature for its narrow focus on manufacturing, as evidenced by the robust literature on factory production in that genre (Braverman 1972; Burawoy 1979; Edwards 1979; Cockburn 1983). Its theoretical concern is managerial control in the workplace. As Thompson and Newsome write in a review of the theory, “The (LPT) framework…focuses primarily on the workplace level, while seeking to extend up to the causal powers manifest in mechanisms of capitalist social and market relations (2004:136). The analysis of the labor process has been extended out to non-manufacturing concerns as global economic changes have led to an unprecedented rise in service work with a concomitant loss of manufacturing jobs, but even labor process analyses of service jobs seem to focus on the shop floor (even when that shop floor has moved to a restaurant or an office building) (Kanter 1977; Leidner 1993; Buchanan 2002). When emotion, rather than the production of stuff or services,
does come up as a topic of interest, it is still in the context of managerial control over workers (Diefendorff and Gosserand 2003; Hochschild 2003).

Labor Process Theory does not tell the whole story when it comes to the social reproduction of workers who are attached to an occupation more than they are attached to a specific job, because the social reproduction of such workers – not to mention, their negotiation with management for control – takes place in multiple locations. Their identity is “I am a _____” rather than “I work for X Company.” That is not a phenomenon particular to paramedics; surely there are many jobs in which we can imagine loyalty occurring at the occupational level rather than at the job level. What makes paramedicine distinct that such a large chunk of on-duty time takes place away from the shop floor (in the metaphorical or literal break room). As I state in Chapter 3, the time a medic spends in the break room sometimes exceeds the time she spends running calls by a wide margin. This means that trying to understand paramedics using only the shop floor excludes some of the most important features of their emotional culture. How they talk together about what they do when they run calls is a curious mélange of interview and participant observation: sometimes they are performing and narrating a context for their performance at the same time.
Social reproduction, as originally theorizes by Marx, encompassed those activities that needed to be performed in order to get the worker back to work each day: cleaning clothes, preparing food, maintaining the home, and caring for children.

Social reproduction was performed not only by the worker, but also the worker’s spouse and other family members. Social reproduction consisted of discrete tasks that could be performed. Like all workers, paramedics must perform those discrete tasks to get themselves back to work each day, but they also have to perform extra maintenance on their professional identities. This happens in two ways: first through the venting/processing cycle that I described earlier, and second, in the emotion work they do on themselves while they are off duty.

The methodological implications for taking work ethnographies beyond the shop floor are tremendous. Such an exploration could be potentially useful to explaining workers’ behavior on the job – as in the tradition of labor process theory – but it could also add wonderful nuance to research into workers’ social reproduction. Sometimes extreme cases are useful because they make things social phenomena obvious that might otherwise escape our notice as ethnographers. Paramedics are an extreme case because they have so much time off the shop floor. If medics based their
professional identity off a calculation of what kinds of calls they spend most of their

time running, they would come up very short on occupational pride. Most of what

ey they do, as I demonstrate throughout this paper, is not deal with emergencies; yet

much of their pride comes from performing those aspects of the job that “not just

anybody” could do. Things that “not just anybody” could do fall into two categories:

medical emergencies and non-medical emotional labor that they believe makes a
difference to their patients and to patients’ family members or bystanders. Paramedics

reframe emotional labor that is not technically part of the job in order to bolster their

claim to making a difference by going “above and beyond” their job description. As I

describe in Chapter 5, “above and beyond” means accepting some degree of risk to

the self that one is not obligated to take. In the case of paramedics, the risk involves

opening themselves up to emotional injury by performing emotional labor on behalf

of a person to whom they have no specific obligation.

It is not surprising that medics do not see these kinds of interventions as

heroic, despite the very real danger that they entail. The medics in my study are the

product of a society that understands heroism strictly in terms of physical (and

therefore masculine) acts of risk-taking. Beyond their basic gender enculturation, too,
my subjects are also part of a general occupational sub-culture of emergency workers who privilege masculine risk-taking as the only authentic means through which to be designated a hero by others; indeed, the potential for being labeled a hero is one of the things that attracts emergency workers to the job. Since paramedics have much to neutralize in terms of negative identity formations – “we run bullshit calls;” “we don’t get paid as well as firefighters;” “we are just glorified taxi drivers” – their reliance on traditional masculine notions of heroism is not especially surprising. What is surprising, as I wrote in my discussion of social reproduction off duty – is how much pride they express in the emotional labor that they perform on behalf of strangers. It doesn’t “count” to them as heroism, and yet it forms a huge part of the foundation on which they construct their professional and personal respect for themselves. Their occupational identity is part of what keeps them coming to work everyday, despite the fact that they may be spending a disproportionate amount of each shift being misused and unappreciated and dealing with working conditions that feel anything but heroic. Given the extraordinary risks that they assume to their own peace of mind, the only conclusion I can come to is that their failure to interpret their risk-taking as heroic is the result of the same cultural sexism that is responsible for
the low social value of many kinds of emotional labor. It is for this reason that I propose a new definition of heroism as going “above and beyond” in any way that risks the integrity of a person’s well-being: physical or emotional. This understanding of heroism could help us reframe our analysis of many so-called “helping” progressions in which workers make sacrifices that negatively impact their physical or emotional health (such as therapists, social workers, suicide hotline volunteers, and teachers), but wherein their work is persistently devalued because of its association with femininity or emotions. Although I call this *emotional heroism*, it is also important to recognize that the irony that the need to modify “heroism” with “emotional” only reifies the notion that heroism is inherently not emotional. As with many socio-linguistic transitions, sometimes it is necessary to use language as a bridge to carry us from the old ways of thinking to the new. I sincerely hope that this will be one of those times.

**IMPLICATIONS OF FINDINGS FOR EMS WORKERS**

As I discussed in Chapter 2, paramedics struggle with a very high occupational burnout rate. This is problematic. First, the effort required to become a paramedic is
substantial; now more than ever, it often includes a sizeable financial investment as
more paramedic training programs are relegated to the purview of private vocational
schools that charge up to $25,000 for training. We cannot expect that people will
continue to seek out medic training if they cannot expect to recoup the cost. Second,
it takes several years before new medics report feeling comfortable with their skills.
That is a very sharp learning curve indeed – on top of which, medics have to be able
to deal with infinitely many situations that they have never encountered before and
will probably never see again, so the more hours, months, and years a paramedic has
under her belt, the more qualified she is to run calls. Losing experienced medics used
to be the main issue facing ambulance employers; now, new hires sometimes quit
before they’ve spent even a month or two in the field. Mostly, they are leaving for fire
departments where they know they will get better pay, more respect, and a solid
retirement. However, they will also benefit from lower call volume and no patient
transports, which means that their skills will remain comparatively weak for the
remainder of their careers. At the end of the day, high turnover hurts employers for
the loss of institutional knowledge; it hurts the public (because fewer medics really
know what they’re doing); and it hurts medics who remain behind on the ambulance
(it’s hard to hold yourself in high esteem when everyone around you is plotting their escape to greener pastures).

My findings in this project also suggest that private industry providers of Emergency Medical Services need to take seriously both EMS workers’ emotional health and their desire to be respected in their work. Private employers are not solely responsible for EMS workers’ emotional well-being, and in defense of employers, they do actively promote their subcontracted Employee Assistance Programs as resources for employees who are struggling. However, the existence of these programs does not translate to the programs actually being used by workers. The upper corporate echelons of private EMS are run by businesspeople, not EMS workers. What ends up “trickling down” is corporate culture, and corporate culture is decidedly out of touch with EMS culture. As a result, the people in the conference room do not see eye to eye with the people in the field, and their attempts to reach out to them are mostly not successful. Local management, who are more likely to be former EMS field workers, can mitigate this to some extent by filtering what gets through from corporate to the field. But local management has no control over unionized workforces’ pay and benefits, and compensation disparities remain a key
ingredient in private industry medics’ persistent view of themselves as less respected
and less valuable than the firefighters who share their “paramedic” job title. The
disappearance of private-sector jobs that provide adequate retirement is hardly
specific to EMS, but EMS workers are definitely more aware of the inequalities
because they work daily alongside people who do “their” job but who can retire after
25 – instead of 40 – years of service. Those firefighters then enjoy a paycheck
comparable to what they made during their working years instead of struggling to get
by on Social Security if they (like many Americans employed in the private sector)
have not reaped the promised benefit of a fully stocked 401(k) account.

I would like to conclude on a personal note. My research subjects were
friends, coworkers, and strangers who I had never met but with whom I enjoyed a
strong bond based on a shared identity. I came out of this project with a renewed
appreciation for them and for the job that we all do. I was moved by their stories and
saddened by the ways in which they verbally diminished the deeply human
contributions that they have made to many people’s lives. I hope to see EMS workers
learn to understand their value as extending beyond the traditional masculinity
associated with emergency work. I hope that they – and I – will come to embrace the
idea that our emotional labor is powerful, valuable, and worthy of the designation "heroic."
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