Working on the Poor: Ambulance Labor in the Polarized City

By

Joshua D. Seim

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

Doctor of Philosophy

in

Sociology

in the

Graduate Division

of the

University of California, Berkeley

Committee in charge:

Professor Michael Burawoy, Chair
Professor David Harding
Professor Seth Holmes
Professor Armando Lara-Millán

Spring 2018
Working on the Poor: Ambulance Labor in the Polarized City

© 2018

by Joshua D. Seim
Abstract

Working on the Poor: Ambulance Labor in the Polarized City

by

Joshua D. Seim

Doctor of Philosophy in Sociology

University of California, Berkeley

Professor Michael Burawoy, Chair

What is the role of the 911 ambulance in the American city? The prevailing narrative provides a rather simple answer: to save and transport the critically ill and injured. This is not an incorrect description, but it is incomplete. The ambulance plays another role, one that is less known. Along with other frontline institutions like the prison and welfare office, I argue the ambulance is part of a poverty regulating regime that is focused less on the eradication of material suffering and more on the day-to-day management of its symptoms.

I draw on nearly two years of fieldwork (including 9 months working as a novice emergency medical technician) and over 100,000 medical records to reimagine the ambulance as an institution of poverty governance. Against somewhat common assumptions that this vehicle is absent or tardy in poor neighborhoods, my research demonstrates that the ambulance is actually a prevalent and busy institution in these areas. Not only are the poor more likely to experience life threatening crises, they are also more likely to summon the ambulance for so-called non-emergencies.

Whether by compressing lifeless chests on the streets or by transporting the publicly intoxicated into the hospital, ambulance crews daily transform the bodies and spaces of urban poverty. This work brings them in recurrent contact with the emergency department nurses and police officers who share their clientele. I show how these different workers often conflict over the management of subjects they generally see as burdensome. With “legit” ambulance calls being relatively rare, crews frequently struggle with police and nurses over “bullshit” work. These street-level relations, however, cannot be understood without considering the forces that control and coordinate labor from above. Neoliberal principles of organizational efficiency and flexibility have flooded poverty governing institutions throughout the American city, and the ambulance is no exception. The state often delegates paramedical operations to for-profit agencies that run on a fee-for-service model. This intensifies the exploitation of labor and exacerbates tense relations between crews and their clientele on the one hand and crews and their nurse and police counterparts on the other.

My research advances a new framework for understanding the management of marginality: the labor theory of poverty governance. This model insists that we cannot understand how the poor are governed without understanding the labor process that generates
and re-generates the poverty regulating state. This means accounting not only for the interactions between laborers and the subjects of their labor, but also the horizontal interactions amongst laborers and the vertical interactions between laborers and those who control and coordinate their work. This framework is novel in that it integrates three crucial dimensions of poverty regulation: the frontlines of governance, the horizontality of governance, and the verticality of governance.
# Table of Contents

Preface ii

Acknowledgements vi

Chapter 1: Introduction 1

**Part I. Bandaging the Poor: Inside the Ambulance** 18

Chapter 2: People Work 20

Chapter 3: Ditch Doctors and Taxi Drivers 32

Chapter 4: The Emotional Thread 43

**Part II. Sorting the Poor: The Ambulance Between Hospitals and Squad Cars** 52

Chapter 5: The Fix Up Workers 55

Chapter 6: The Cleanup Workers 62

Chapter 7: Burden Shuffling 69

**Part III. Hustling the Poor: The Ambulance Underneath Bureaucracy and Capital** 79

Chapter 8: The Barn 81

Chapter 9: Supervision 87

Chapter 10: Payback 95

Chapter 11: Conclusion 105

References 113

Appendix: Notes on Data and Method 128
Preface

That’s a picture of me driving an ambulance. I was somewhere in the dense flatlands of a place in California I call Moon County. At the time, I was working as one of the nation’s many emergency medical technicians (EMTs). My paramedic partner took this photo one hot afternoon in 2016, while we were between 911 calls.

The long and winding path that lead to this photograph began five years earlier in Oregon. I was in Portland, meeting with James. Like me, James is a white male. Unlike me, James has spent much of his adult life in and out of squad cars, court rooms, probation meetings, jails, prisons, and parole offices. I first met him inside a prison while I was conducting a different study (Seim 2016). However, on this particular occasion, we met on the streets, just a few blocks from the transitional housing facility that he moved into after his recent release from prison. James told me that he hated his current living situation. He said residents were frequently stealing from one another, people were often fighting, and the living conditions constantly tempted him with the narcotics he was once addicted to.

Providing me with further evidence of this facility’s horrors, James said the ambulance was always there. He told me that ambulance crews were rushing in and out of the building at least twice a week, responding to assaults and other crises. James also mentioned that an ambulance crew had recently discovered a parolee’s corpse in the building. Rumor suggested it was a heroin overdose. For James, the ambulance’s frequent presence seemed to offer some proof that mayhem defined his living conditions.

After this conversation, I started to notice ambulances a lot more. Not only did they stick out in traffic, they also stuck out in a number of the books I was reading in graduate school. Written in as a background prop and with its workers cast as extras in someone else’s drama, the ambulance appears in some of sociology’s most influential ethnographies of urban poverty. Careful readers can find it in Mitchell Duneier’s Sidewalk (1999: 18), Elijah Anderson’s Code of the Street (2000: 138), and Martin Sánchez-Jankowski’s Cracks in the Pavement (2008: 74). More recently, it can be found in Matthew Desmond’s Evicted (2016: 199-201) and Forest Stuart’s Down, Out, and Under Arrest (2016: 218). Not unlike James, most of these sociologists
seemed to mention the ambulance simply to highlight some disorder or death in their respective
field sites.

Suddenly a bit more curious about ambulances, I turned to the scholars who honed their
focus on this institution. I found a number of ethnographers who had entered the ambulance to
reveal its unique work culture and organizational dynamics (Douglas 1969; Mannon 1992; Metz
1981; Palmer 1983; Tangherlini 1998; see also: Corman 2017). However, these scholars had
done very little to detail the ambulance’s prevalence or function in poor neighborhoods. I also
found some statistical research, published mostly in the professional literature on emergency
medical services, that demonstrated a correlation between poverty and ambulance utilization
(Meisel et al. 2011; Ruger, Richter, and Lewis 2008; Squire, Tamayo, and Tamayo-Sarver 2010).
But, these studies offered minimal insight into the way ambulance crews were handling a mostly
poor clientele base on the ground. These ethnographic and statistical studies of the ambulance
were not unimportant. They just didn’t really help me understand the role that this institution was
playing in and near the social margins.

Fast-forward four years past my conversation with James. I was shadowing ambulance
crews at a firm I call Medical Response and Transport (MRT) and collecting data for the
dissertation at hand. MRT is a for-profit 911 ambulance provider that holds contracts throughout
the nation. I embedded myself in its Moon County operations. There, management generously
allowed a nosy sociology student to ride-along in ambulances and take notes. They even
permitted me to observe some managerial activities to get a “bird’s eye” view of the
organization. And, as an added bonus to this rare entry, I was able to secure over 100,000 de-
identified medical records completed by MRT crews.

My ride-along observations brought me seemingly everywhere from multistoried
mansions perched atop steep hills to homeless encampments planted beneath highway
overpasses. It nonetheless became very obvious to me after just a few days in the field that, while
the ambulance can pop up just about anywhere, it gravitates towards poverty. This wasn’t
surprising given my conversation with James and the cameo appearances that ambulance
workers were making in urban ethnographies.

What was surprising was the variety of problems that ambulance crews were responding
to. As you might imagine, the paramedics and EMTs I shadowed were definitely rushing
severely sick and broken bodies to the hospital, and they were disproportionately collecting these
patients from relatively poor neighborhoods. However, such “real emergencies” ultimately
accounted for a minority of the 911 calls I encountered. Ambulance crews were more typically
mitigating less urgent symptoms of the chronically ill, connecting drugless patients to
prescription-writing physicians, and scooping drunk people off the sidewalk.

This dissertation started to come into focus. I was going to break from the popular but
limited understanding of the ambulance as an institution for saving and transporting the critically
ill and injured. The point was not to abandon this narrative entirely, but instead to think of
another role that ambulances were also playing in the American city. I started to consider how
paramedic and EMT labor contributed to what sociologists were more or less synonymously
calling a “regulation,” “management,” or “governance” of urban poverty (Piven and Cloward
1971; Soss, Fording, and Schram 2011; Wacquant 2009). By focusing on the work of ambulance
crews, I was poised to also join a rich tradition of scholars who examine the frontline labor of the
institutions that handle a mostly poor clientele base, like the welfare office, the emergency
department, and the police squad car (Lara-Millán 2014; Lipsky 1980; Moskos 2008; Watkins-
Hayes 2009; see also: Brodkin 2011; Ellis, Davis, and Rummery 1999; Evans 2011; Hupe and Hill 2007; Prottas 1979).

This worker-oriented analysis proved fruitful for three reasons. First, in carefully documenting what crew labor involved, I was able to explicate social relations inside the ambulance. Beyond underlining the fact that it’s disproportionately the poor who ambulance crews are working on, an analysis of the ambulance as a worksite clarified a general outcome of ambulance work. It’s an institution that offers rapid, but generally superficial and very specific, aid to suffering bodies. Second, this focus on labor also helped me locate the ambulance between two other institutions that poor people frequent in urban America: the hospital emergency department and the police squad car. I quickly noted how crews regularly shared the subjects of their labor with other “frontline workers” like nurses and cops. These cross-institutional interactions between workers not only structured life inside the ambulance but also the manner in which poor people were distributed across these institutions. Third, my worker-centric analysis inspired me to consider the ways the ambulance was situated underneath a series of political and economic forces that controlled and coordinated crew labor. Said forces helped set the possibilities for the street-level relations between crews and clientele on the one hand and crews and other frontline workers on the other. MRT’s pursuit of profit rested on the efficiency and flexibility of crew labor and this helped explain why the people who most relied on ambulance services regularly encountered exhausted and frustrated providers.

In short, I found the key to this dissertation during my ride-along observations. I was going to rethink the ambulance as a frontline institution of so-called poverty governance and I was going to examine a labor process to do this. There was a clear novelty to this approach and I speculated it could help social scientists understand other poverty regulating institutions. A hunch to study the ambulance years earlier was finally paying off. The plan was so simple. Until it wasn’t. After nearly a year of doing fieldwork, my wife abruptly lost her job. Suddenly, the research fellowships that funded my fieldwork were not going to cut it. It was during this time that Grant, a field supervisor at MRT and one of my closest subjects, encouraged me to apply to MRT. He recommended I work as an EMT, which is the lower paid position on the standard paramedic-EMT crew. I’d be like a “caddie” to paramedics who would lead the administration of care while I would mostly drive them around in the ambulance and prep their equipment. Grant reasoned this would be a great way to make some extra money and learn about ambulances. I asked several workers and managers what they thought of this. The response was overwhelmingly positive. “Finally,” one paramedic said with a smirk, “You won’t be just standing around with your hands in your pockets.” Another noted that this would give me a taste of what ambulance work was really like.

So, I began an unanticipated transition from ride-along to EMT. It helped that I completed a six-week intensive EMT training after my conversation with James but before I ever stepped foot into an MRT ambulance. I initially did this training to introduce myself to ambulance work and to network with people in the industry. Though, to actually become employable, I had to clear a few more hurdles at MRT headquarters. These included a fitness and agility trial, a mannequin-based skills exam, and a 50-question multiple-choice test covering anatomy and physiology, prehospital emergency procedures, and other topics.

I was eventually hired at MRT for pennies above the area’s living wage. Following two additional months of company-based training, I was then seated behind the steering wheel of the ambulance to assist better-trained paramedics. Indeed, it’s the paramedics, not the EMTs, who
inject needles into veins to start IVs, slide tubes down throats to intubate, and administer effectively all medications in the ambulance. On rare occasion, I was tasked with leading the administration of care for low acuity calls with no medical interventions beyond some simple first aid and the construction of a written case for the receiving hospital.

That said, I found EMT work forced me to confront human suffering in a way far more challenging than what I had done in my previous fieldwork. As a ride-along, I was occasionally asked to assist crews when “shit hit the fan.” This usually meant manually stabilizing an injury or collecting information from a bystander. Otherwise, I stepped back and jotted notes. But, there was no stepping back as an EMT. I was thrown deeper than a ride-along, but not as deep as a paramedic, into the tangles of 911 ambulance encounters. This work was far more exhausting than observing crews.

Working as an EMT was in many ways more enlightening than just shadowing ambulance crews. The job forced me to put pen and paper down. It needed my hands to steer the ambulance and lift the gurney. This was more than a fair trade because I learned so much about ambulance work by actually working. Beyond deepening my knowledge of various work procedures, this experience revealed a number of taken-for-granted assumptions about the job. It unearthed seemingly trivial, but actually important, elements of ambulance operations. Still committed to understanding the role of the ambulance in poorer places and populations, this experience also helped me better understand the frustrations, joys, and indifferences crews have about working with a mostly poor clientele base and a caseload that involves the handling of a lot of “non-emergency” problems.

I focused on being the best EMT I could be. While that focus was easy to lose towards the ends of my 12-hour shifts or when the occasional “spitter” was trying to get me, I took my job seriously. Among other things, this meant that I couldn’t write detailed notes like I did as a ride-along. But, this didn’t mean that I forgot what initially brought me into the ambulance: a curiosity to understand this institution amidst urban marginality. I also never forgot what awaited me once my family’s finances were in order: a dissertation on the ambulance.

So, from home, I journaled every shift I worked. At first, I thought of this as a kind of “post-fieldwork” exercise that could help me clarify what I already learned inside the ambulance as a ride-along. Though, overtime, the particular lessons I learned as a rookie EMT clearly became too significant to ignore. Even if I hadn’t written my experiences down, my EMT job fundamentally influenced my understandings of the ambulance.

Whether or not my time as an ambulance worker constitutes “research” in the same way as my attempts to mimic a fly-on-the-wall observer is somewhat beside the point. This experience yielded empirical knowledge, a knowledge acquired through my direct engagement with the world. It just so happens that this knowledge concerns the very corner of the world that this dissertation sets out to describe and explain. Failure to integrate this insight into the analysis that follows would be reckless and, I argue, impossible.¹

I’m not so naïve as to assume that my nine-month stint as an EMT makes me the ultimate ambulance insider, nor do I think this experience should eclipse what I learned through the year of ride-along observations. But a simple fact remains. My unexpected time as an EMT roots a particular viewpoint that shapes every chapter that follows this preface.

¹ For reflections on a similar experience, see Sufrin’s (2015; 2017) study of jail-based healthcare as both an anthropologist and a physician.
Acknowledgements

I owe a lot of thanks to a lot of people. First and foremost, I am grateful to management and labor at the studied ambulance firm for letting me poke my head around and get my hands dirty. I can never truly repay the people that appear in the pages that follow but writing a dissertation that neither glorifies nor demonizes their world seems like a good start.

And then there’s the people backstage, the people who don’t appear much in the text but who were nevertheless consequential for its development. My dissertation advisor, Michael Burawoy, was a tireless coach. I can’t imagine where I might be without his years of intellectual and material support. From 4:00am email exchanges to one-on-one meetings over coffee, Michael always made himself accessible. However, accessibility can only go so far. He also offered a rich commentary on my work and he was never afraid to push me further and harder than I thought I could go. All the while, he remained genuinely committed to this dissertation and my scholarly growth.

The other members of my dissertation committee, Dave Harding, Seth Holmes, and Armando Lara-Millán, were also incredible mentors. In several ways, I assembled the perfect dissertation committee, one with many complementary interests and strengths. Michael, Dave, Seth, and Armando’s combined expertise in the scholarship on poverty, labor, and medicine – not to mention their collective mastery over multiple research methods – proved incredibly useful during the design and execution of this dissertation. I’m also thankful for this committee’s unyielding faith in a little case study of the ambulance.

Additionally, my comrades in Michael’s legendary dissertation group – Zachary Levenson, Benjamin Sheshtakovski, Emine Fidan Elcioglu, Andy Chang, Harbert Docena, Andrew Jaeger, Shannon Ikebe, Aya Fabros, Thomas Peng, and Shelly Steward – all offered extensive feedback on many of the arguments presented in this dissertation. Workshopping my writing with these brilliant people over dinner, drinks, and dessert in Michael’s condo will forever remain one of the highlights of my academic life.

I was also very lucky to receive feedback from other great people in the Sociology Department at Berkeley: Cybelle Fox, Margaret Weir, Martín Sánchez-Jankowski, Loïc Wacquant, Claude Fischer, Chris Herring, David Showalter, Lindsay Berkowitz, Alex Barnard, Zawadi Rucks-Ahidiana, Michaela Simons, Esther Cho, and Seth Leibson. Their insights were all added to the earlier training I received from Sandra Smith and others in the department.

I’m also grateful to several people I found outside of sociology but still inside Berkeley. Denise Herd, in the School of Public Health, and several anthropology graduate students commented on some early ideas for this dissertation. I also received technical consultation from people in Berkeley’s Department of Demography (e.g., Carl Mason) and D-Lab (e.g., Patty Frontiera).

I know I wouldn’t have been able to meet any of these incredible people if I never found myself in Berkeley. As such, I’m incredibly grateful to Marion Fourcade and the Berkeley Sociology PhD admissions committee of 2011. I imagine their decision to admit a GED recipient turned aspiring sociologist was a difficult one. I at least know that whatever promise they saw in my application was due to the investments of educators and mentors at Spokane Community College, Clark College (another community college in Washington), Gonzaga University, and Portland State University. My appreciation for people at Berkeley is thus tied to my appreciation for people at these other schools.
Many social scientists outside of Berkeley also offered helpful advice for the project at hand. In no particular order they include the following people: Bill Hayes (Gonzaga), Vikas Gumbhir (Gonzaga), Deborah Gordon (UC San Francisco), Adam Reich (Columbia), Peter Moskos (John Jay), and David Brady (UC Riverside). The reviewers and editors at *American Sociological Review* also provided invaluable feedback during a critical stage in this project’s development. Additionally, I received useful feedback from folks at the Pacific Sociological Association meetings in Portland, Oregon (2017) and Long Beach, California (2018). I was also given the opportunity to workshop parts of my dissertation with a small number of graduate students from across campuses and disciplines at the 2017 Blum Initiative in Riverside, California.

Though, more than anyone else, I am grateful to Brenna Seim. She’s my wife, best friend, and the single most important advisor I have. She read every page of this dissertation and provided excellent editing advise. But that’s just the tip of the iceberg. She’s my biggest advocate and has been so since I was a community college student who daydreamt about becoming a sociologist. There’s no way I can summarize the many ways Brenna has supported me throughout the years, but without her I simply wouldn’t be filing a dissertation. That much is clear to me.

Finally, I want to acknowledge the many fellowships and grants that funded my research and writing. The Graduate Division at Berkeley provided me with a number of financial packages: the University of California Dissertation-Year Fellowship, the Doctoral Completion Fellowship, the Mentored Research Award, and a couple summer research grants. The Graduate Division also awarded me a number of Parent Grants, a critical resource for students who are also mothers and fathers. Additionally, Berkeley’s Department of Sociology funded portions of this research through small research grants and the Leo Lowenthal Fellowship.
Sightseer

It’s a few minutes before 5:00am. I’m with Eric, one of Medical Response and Transport’s (MRT) field supervisors. We’re inside his “supervisor rig,” a company-issued SUV, and parked at the “barn” (i.e., MRT’s headquarters). Eric’s primary task for the next 12 hours is to monitor the largest segment of MRT’s 911 ambulance fleet, the portion servicing the urban core of what I call Moon County. He has, however, agreed to a second task: showing me the ropes. According to upper management, this shift is partly meant to introduce me to the firm’s operations before I actually start jotting notes from the backs of ambulances.

Eric is a stocky white man in his 40s with a somewhat intimidating appearance. A former Marine, his arms are thick and veiny and his hair is chopped high and tight. He looks a lot like a cop in his company uniform, which includes a shiny supervisor badge. Eric even admits that he looks especially cop-like when he wears a bulletproof vest under his uniform. He’s not wearing the vest now. It’s hot and bulky, but he promised his wife he’d wear it during night shifts. Eric tells me he’ll show me some of the reasons why he straps his vest on from time to time.

He drives me through some “ghettos” and “hoods.” I’ll later learn that these are terms MRT workers and supervisors casually and interchangeably use to identify poor neighborhoods, which are disproportionately occupied by the county’s black and Latino residents. Eric first takes me to the “killing fields,” a predominantly black neighborhood with a high homicide rate. From here, we cruise into some nearby “barrios” before we make our way to some “projects.”

Inside the supervisor rig, Eric provides a verbal commentary for the sights outside our window. “There’re usually prostitutes here, but not at this time.” It’s 8:00am. I find this to be an odd summary for an avenue that seems to be better defined by its “Cash for Gold” billboards, fast food restaurants, liquor stores, and pay-day loan centers, but I appreciate Eric’s spontaneous description of place. In addition to “hookers,” he tells me there are lots of “bangers” on these streets. But again, we won’t find such characters at this hour. I guess the wicked rest.

After driving up and down the streets of these neighborhoods, waving to the ambulance crews we see in the process, we eventually pause at a red light. An older black man in torn clothes lumbers across the street, passing the front of our vehicle. Eric lowers his voice, adding an extra assurance of privacy, “There’s a zombie.” I chuckle nervously and ask, “What’s that mean?” “He’s an alcoholic. You can see it in the yellowing of his eyes,” he says, describing some jaundice that could be associated with liver problems and apparently by extension to the problematic consumptions of this man who we will never actually speak to. I come to later learn that Eric’s zombies include people who use heroin and other “downers,” and are distinct from his “tweakers,” “crack heads” and “meth heads.”

The tour continues, and I ask Eric to tell me about the types of calls his crews run. He doesn’t know where to begin and, in retrospect, I don’t blame him. The hundreds of calls I’ll see over the next couple years will cover just about every inch and layer of the human body, from the head down to the toe and from the skin into the marrow. There are calls for stabbings, strokes, and seizures. There are also calls for poisonings, pregnancies, and pulmonary edema. And with no call being exactly the same, the possibilities are seemingly endless.

---

2 Pseudonyms are used for the studied firm and county, as well as for all people.
Eric grabs a protocol book he keeps in the supervisor rig and tosses it into my lap. I skim through it as he continues to drive somewhat aimlessly through the dense core of the county. The book is a thick manual, but it fits perfectly in the side pocket of an EMT or paramedic’s cargo pants. Almost biblical in its authority, this book is published by Moon County Emergency Medical Services (MCEMS), the public agency that oversees MRT’s contract with the county government. It outlines a number of protocols from how to manage grieving bystanders to how to work with law enforcement during an active shooter event, but it’s mostly made of treatment procedures for a variety of emergencies. Among other problems, these include: cardiac emergencies, overdoses, psychiatric crises, pregnancy complications, respiratory problems, strokes, seizures, and trauma (i.e., physical injury).

Of course, some calls are more severe than others. Eric explains to me how county dispatchers classify ambulance responses not only according to the type of emergency (e.g., chest pain, headache, and stab wound), but also by the presumed urgency of the problem. In reverse alphabetical order, and from the most severe to the least, there are five primary levels of severity determined by county dispatchers: “echo,” “delta,” “charlie,” “bravo,” and “alpha.” Echo and delta responses include things like cardiac arrests and gunshot wounds while alpha responses include things like flu-like symptoms and hemorrhoids. The main point of these classifications is to set guidelines for how fast an ambulance should arrive to the scene of a call. For example, crews are supposed to arrive within 8 minutes and 30 seconds to most echo responses while they usually have 30 minutes to show up to an alpha response.

Eric warns that these dispatcher-determined triage levels are usually “good guesses” but they can be misleading. For him and essentially everyone I’ll spend time with at MRT, there is a more informal, but more important, distinction in severity. It’s determined on 911 scenes and in the backs of ambulances by crews who can see, touch, and speak to patients directly.

There are “legit” calls and then there are “bullshit” calls. Legit calls are the so-called real emergencies that necessitate and justify the craft of paramedicine. These are typically the cases that have crews exercising the skills that they were taught: intubating breathless airways, compressing lifeless chests, plugging bleeding wounds, etc. Bullshit calls are the so-called non-emergencies that involve little more than a collection of vital signs, a transport to the hospital, and maybe some minor interventions like placing an icepack on a sore joint. Legit and bullshit are not really binary or mutually exclusive categories but are instead more like poles on a continuum. I’ll quickly learn that both legit and bullshit calls (and everything in between) concentrate toward the social margins.

Poorer people and people of color are simply more likely to experience what Eric and others would consider “legit” emergencies. This is true not only for things like gunshot wounds (Wintemute 2015; Zebib, Stoler, and Zakrison 2017), but also traffic accidents (Chakravarthy et al. 2010; Laflamme and Diderichsen 2000) and other “intentional” and “unintentional” injuries (Chong, Lee, and Victorino 2015; Cubbin and Smith 2002; Yuma-Guerrero 2017). It’s also true for heart attacks (Beckman et al. 2017; see also: Diez-Roux et al. 1995; Hawkins et al. 2012; Phillips and Klein 2010), strokes (Addo et al. 2012; Cox et al. 2006; Kerr et al. 2011), drug overdoses (Davidson et al. 2003; Marzuk et al. 1997; O’Driscoll et al. 2001; Visconti et al. 2015), seizures (Begley et al. 2011; Elliott et al. 2009), breathing difficulties (Akinbami et al. 2012; Gottlieb, Beiser, and O’Connor 1995; see also: Eisner et al. 2009), psychiatric crises (Kelly 2005; McNiel and Binder 2005), and essentially every emergency listed in Eric’s protocol book. For many health scholars, these patterns are indications of a society that concentrates
vulnerability of illness and injury toward the bottom of the class and racial order (Link and Phelan 1995; Marmot 2004; Wilkinson and Pickett 2009; see also: Bourgois et al. 2017). Though, for Eric and others at MRT, the risk of emergency in the so-called ghettos and hoods need not be so complicated. Apparently, people down here should bear some responsibility. They “choose” to engage in risky behaviors (e.g., dealing drugs) and pile on years of unhealthy decisions (e.g., eating high caloric foods). Or so I’m sometimes told.

People located toward the bottom of the polarized city are also more likely to call the ambulance for so-called bullshit. Barriers to primary care, coupled with a changing social safety net in an era of “work first” welfare provision, seem to have led many to turn to emergency medicine for an array of non-urgent problems (Dohan 2002; Gordon 1999; 2005; Gordon, Chudnofsky, and Hayward 2001; Hock et al. 2005; Malone 1998; Rodriguez 2009).

I’ll come to learn that Eric and others often acknowledge these structural circumstances, but they’re more likely to credit the high frequency of bullshit calls in poor neighborhoods with the personal failures of patients. Workers and supervisors at MRT often tell me that people who call for bullshit reasons are either “selfish” or “stupid.” The selfish supposedly call 911 because they need a quick painkiller fix, don’t want to sit in the emergency department waiting room, or they want some other convenience provided by the crew. Such people greedily take an ambulance away from a more deserving soul in the area, like a gunshot or heart attack victim. The stupid apparently call for different reasons. They’re not interested in executing some sinister plan for self-reward. Instead, they lack basic problem-solving skills. They call 911 because they don’t know any better. Or, again, so I’m sometimes told.

Eric’s tour includes his personal reflections on both the bullshit and the legit calls he’s encountered in the past. His favorite example of a bullshit call, which he will tell me at least two more times during my fieldwork, would infuriate him if it wasn’t so comical. A man called an ambulance because his gums were bleeding. “His gums!” Eric exclaims before giving the punchline: “He had just flossed his teeth!” I’ll soon learn though that bullshit calls are not usually funny. They’re generally frustrating, even though they’re often technically easier to labor. That’s because they mismatch the craft of paramedicine. Supervisors and crews alike are interested in “real ambulance work,” and bullshit cases explicitly deny this kind of activity. To make matters worse, most ambulance calls are closer to the bullshit end of the continuum.

Still, it’s not all bullshit. Eric also tells about some of the “good” and “interesting” calls he’s run. Like all MRT field supervisors, Eric is an experienced paramedic and he’s seen his fair share of legit calls. He tells stories of how he skillfully brought the dead back to life with a combination of CPR and cardiac drugs and how he cleverly identified cardiac abnormalities through an EKG. He also provides some gruesome accounts of salvaging flesh and bone nearly obliterated by gunfire, car accidents, and other brutalities.

Eric’s reflections of past calls eventually lead him to some “war stories.” In somber tone, he tells me about finding young bodies pumped with bullets, intestines spilled out of abdominal walls, and the maggot-infested corpses of suicide victims. He tells me heartbreaking stories of having to inform children that their parents are never waking up and of patients literally taking their final breaths under his care. After working in the county for over a decade, it seems like every few blocks reminds Eric of the real-life horror shows he was abruptly cast into during their climaxes. Yet, for all the dramatic stories Eric shares, he’s quick to note, “It’s not like the movies.” Ambulance operations are not always adrenaline-rushing and even when they are they
can mentally wound providers. Like many experienced ambulance workers and supervisors, Eric seems to traverse these streets with ghosts in tow.

Eric’s tour suddenly brings me to the scene of gun violence. As a supervisor, Eric is frequently summoned to high profile calls like this one for a 24 year-old black man who was shot in the gut. When we arrive to the scene, not much remains but some blood splattered on concrete and encircled in crime scene tape.3 We were left in the dust on this call, but it worked out for the tour. Eric had planned on driving me through this area of town anyway.

The blood splatter left on the sidewalk is located almost perfectly at the epicenter of what he calls “a little nexus of evil.” Along with a couple other locations in the county, this five or so block area is distinctive not only in its intense marginality and suffering, but also in its apparent offensiveness to Eric and many others at MRT.4 To the north of this blood splatter holds what MRT crews swear is an open-air drug market and to the south is usually a homeless encampment that’s exact position seems to move every few weeks.

While unbeknownst to me during the tour, I will frequent this “little nexus” a lot during the next several months. In addition to encountering people that would probably fit Eric’s caricatures – dealers, hookers, bangers, zombies, and tweakers – I will experience some memorable “firsts” here. In addition to my first gunshot scene, this area will include my first death, my first overdose, and the first time I will see bone cut through skin. At times, this place will seem like hell on earth and I will acquire my own war stories here.

Yet, for all the legit calls I will first witness and then work in this area, I will encounter more bullshit calls: people needing prescription refills, clinically stable people requesting or perhaps even “seeking” pain medication, and people looking to eat a meal and sleep in a bed at the hospital. Inside this nexus, I will frequently shadow crews who are more or less just “taxiing” people to the emergency department for so-called non-urgent reasons and later, when I work as an EMT, I will drive those who supposedly “misuse” the ambulance to the hospital myself.

In the future, I will think of what Eric told me. I will remember his voice nearly every time I step out of an ambulance in this area. “This place is a little nexus of evil.” I’ll start to think he’s sort of right. Maybe this place is evil in some way.

But real villainy probably comes from outside the nexus, from those nefarious human systems that pack suffering into areas like this. Eric and I witnessed the aftermath of an attempted murder here, but more importantly we may have also witnessed what Friedrich Engels ([1885] 1993) calls “social murder,” capitalism’s wasting of human life on the urban margins (see also: Chernomas and Hudson 2009; Farmer 2004; Holmes 2013). The market yields and necessitates exploited (e.g., workers), excluded (e.g., jobless), and precarious (e.g., temporary employed) populations who are exposed to an array of bodily risks (Benach et al. 2014; Muntaner et al. 2010; Yuill 2005). Systemic racism is also suspect, from the continued legacy of Moon County’s segregated neighborhoods to the casual “color-blind” biases that help maintain white supremacy across market, state, and civil society (Bonilla-Silva 1997; 2001; Feagin 2006; 2012).

---

3 The victim on this particular call, who Eric assumes must be a “dealer” if he got shot on this block, had friends drive him to the closest hospital. Unfortunately, the hospital they took him to is not a trauma center and so an ambulance crew has to aid him anyway. They need to rush him to a facility better equipped to handle the hemorrhaging in his belly.

4 This area seems to capture what Irwin (1985: 2) calls “rabble,” the “lowest class of people” who are not just destitute but also detached and disrepute. Consistent with Irwin’s prediction, police heavily patrol this area. However, so do ambulance crews, and instead of sweeping them into the jail these workers connect them to the hospital.
Massey and Denton 1993). Public health scholarship is pretty clear: the American racial hierarchy, which is distinct from, but snarled with, the U.S. class structure, concentrates the risk of illness and injury downward (Gee and Ford 2011; Jones 2002; Williams and Mohammed 2013).

Similar evil forces likely account for all the so-called bullshit that Eric’s crews are responding to. A post-1970s “neoliberal turn” hasn’t obliterated the welfare state and may not have significantly stunted its overall reach in many respects (Pierson 1994, see also: Levy 2010), but this historical shift toward market-centric policies has made traditional welfare programming more “disciplinary” and arguably more “stingy” for the poor at a time when their economic and social precarity has increased (Soss, Fording, and Schram 2011; Wacquant 2009). One of the effects of this historical transformation seems to have been a “medicalization” of public support for the poor, meaning people are turning to medical entitlements like social security insurance (SSI) and emergency care for more generalized assistance (Gordon 1999; Hansen, Bourgois, Drucker 2014). From this point of view, it’s not the selfishness and stupidity of those who dial 9-1-1 for non-urgent problems that are to blame; it’s the selfishness and stupidity of a social order that pressure legions of vulnerable people to turn to one of the few institutions that are promised to them, the ambulance.

Ultimately, an expansive library of sociological thought tells us there’s little reason to doubt that when I’m with Eric, and soon his ambulance crews, I’m very far “downstream” in a causal river that links social structure to personal suffering. It’s never very obvious where all these bodies floated down from, but float they do. My objective is not to follow the stream up, but to stay down here and make sense of the workers who are waist-deep in the water trying to pull people out. Such an objective, however, necessitates that we first break from some common assumptions of ambulance operations in the American city.

Rethinking the Ambulance

Thousands of local agencies and organizations form a complex web of 911 ambulance operations in America (Institute of Medicine 2007; Mears 2012). In the space between federal regulation and the ambulances that roll past you in traffic, state-level emergency medical service authorities (e.g., California Emergency Medical Services Authority) charge local bureaucracies – often divisions of county health or public safety departments (e.g., MCEMS) – with assuring ambulances to citizens. Some of these agencies deploy 911 ambulances directly, such as in Pittsburgh and New Orleans. However, it’s more common for them to delegate such activities in portion or in full to fire departments, such as in Dallas, or to private firms like in San Diego. In California specifically, it’s estimated that less than a quarter (22 percent) of ambulance providing agencies are private, yet over three fourths (76 percent) of 911 calls are responded to by crews working for private companies (Jacobs et al 2017).5

5 The fragmentation of ambulance operations makes it difficult to provide an exact number for the national distribution of private providers. A report published by the Federal Interagency Committee on EMS suggests 25 percent of agencies are privately run, but they include non-transporting agencies (e.g., first responder fire departments who are intended to stabilize patients on scene before an ambulance arrives), non-911 ambulances (e.g., agencies that simply perform hospital transfers), and they’re missing data for four states (California, Illinois, Virginia, and Washington) (Mears et al. 2012). The Journal of Emergency Medical Services, a popular publication in the industry, suggests that 40 percent of the largest 200 cities in America have a private company doing “primary transports” (likely meaning the 911 system to questionnaire respondents) (Ragone 2012). However, their survey of 455 “leaders of the first responder and transport agencies” across the 200 most populous cities in the U.S. only
Buried somewhere in this web, we find MRT. As previously noted, MRT is a large for-profit firm that provides 911 ambulance services in many locations across the United States. I focus on MRT’s operations in a place I call Moon County. There, the company employs a few hundred frontline workers and monopolizes ambulance operations through a contract with the local government. MRT primarily secures revenue from ambulance clientele and personal health insurance policies (overwhelmingly public ones like Medicare and Medicaid) under a fee-for-service model. In billing patients or their insurance policies, MRT is similar to essentially all 911 ambulance operations in the country, be they private or public (Institute of Medicine 2007; see also: Avsec 2016; Haslam 2015; Maruca 2015; Washko 2015).

My time at MRT taught me the ambulance is an institution that in many ways fulfills its formally articulated mission to provide timely and consequential care to “anyone.” Similar to the emergency department, the ambulance cannot deny services based on one’s ability to pay. As such, the provision of ambulances cuts across divisions in class, race, citizenship, age, and gender. By and large, people just need to ask for an ambulance or somehow imply that they need one (e.g., lying unconscious in the street).

In fact, if you’re reading this dissertation somewhere in the United States, you can have an ambulance right now if you want one. Just pick up a phone, dial 9-1-1, and tell the operator you need some medical aid. The state, at multiple levels, promises you an ambulance in a somewhat timely fashion. More times than not, it will deliver on this promise. I don’t intend to oversell the utopia of ambulance accessibility, but this is an important point to make.

Of course, there are some caveats. While you probably won’t get a busy signal when you call, you shouldn’t be totally surprised if you do (Biersdorfer 2017; Robinson 2004). A successful call might be the least of your concerns though. I’d bet it’s more likely you’d have to wait longer than expected for an ambulance because there are little to none currently available in your area (Cain 2018; Crum 2017; Rasmussen and Smith 2017; Zekman 2017). Yet, even this is exceptional. Perhaps there are some legal reasons that make you hesitant to dial 9-1-1. The police may very well show up along with ambulance crews, especially if you call for something like an assault, an overdose, or a psychiatric emergency (Gratton et al. 2010; Honberg 2015; Lopez 2017; Lucas 2016; Myers 2017). So, if you want to avoid law enforcement, you’ve been warned. Still, maybe it’s not so much the police that scares you from calling, but the invoice. You should be scared. Even if you have insurance, you may get stuck with a bill well over a thousand dollars in a few weeks (Bailey 2017; Hall et al. 2016; Rosenthal 2013; Zamosky 2013).

With these conditions in mind, concerns over ambulance accessibility for marginalized populations are certainly reasonable. Indeed, a number of researchers have pointed to help-

---

yielded a 21 percent response rate and they warn that their study is not peer-reviewed. A similar survey with an 86 percent response rate and conducted by researchers at Johns Hopkins, but limited to seven Mid-Atlantic states (Delaware, Maryland, New Jersey, North Carolina, Pennsylvania, Virginia, and West Virginia), suggest that 31 percent of the population covered in their studied geography are serviced by a private “primary transport” agency (MacKenzie and Carlini 2008).

Specifically, MRT holds 86 percent of the 911 ambulance market in Moon County in terms of population coverage and 97 percent in terms of square-mile coverage. The remainder of the market is claimed by a handful of municipal fire departments. Before MRT’s arrival a few years ago, Moon County’s 911 ambulances were provided by another large for-profit corporation. MRT undercut the competition with promises of cheaper and faster services – a promise they said they could accomplish with a more flexible labor force that would be “dynamically posted” to street intersections between 911 calls. This contrasted the more traditional “ambulance station” model of the previously contracted firm.
seeking reluctances and thinned emergency services toward the bottom of class and racial hierarchy in the American city (Desmond, Papachristos, and Kirk 2016; Latimore and Bergstein 2017; Mclean 2016; Sasson et al. 2015; Tobin, Davey, and Latkin 2005; see also: Bohnert et al. 2011). We must nevertheless be careful not to write the ambulance off as an institution that is absent in poor communities.

Paramedics and EMTs respond up and down the socially stratified city and there are people toward the bottom who choose to avoid it, but neither of these facts negate an important feature of the ambulance: it’s an institution that’s heavily utilized by the poor.

This isn’t a particularly new pattern either. From the horse-drawn buggies that were often run by hospitals of industrializing cities after the Civil War to the motorized vehicles that were often run by police departments, fire stations, funeral homes, and small firms after World War II, the ambulance has long gravitated toward the urban poor (Bell 2009: 67, 87-8, 154-5; Abel 2011). This pattern held during the national expansion and standardization of paramedicine during 1970s, the partial federal withdrawal in ambulance operations during the 1980s, and the rise of national ambulance corporations during the 1990s (Bell 2009: 326-7, 334-6; see also: Institute of Medicine 2007). Today, ambulance crews working for both public and private entities continue to disproportionately treat and transport the poor (Meisel et al. 2011; see also: Ruger et al. 2008; Squire, Tamayo, and Tamayo-Sarver 2010).

What does this look like for MRT specifically? Well, over half the firm’s invoices are billed to either uninsured or means-tested Medicaid patients. And, as Eric tells us, MRT’s crews are disproportionately dispatched into Moon County’s poorer neighborhoods. I was able to confirm this not only through my fieldwork, but also through my analysis of several thousand medical records.

Figure 1.1 summarizes the neighborhood-level (i.e., census tract-level) response rate for MRT in the year 2015, which I have age-adjusted and averaged across poverty concentration deciles. The pattern is clear: ambulances are rolling into poorer neighborhoods at a relatively high rate. Look at the bar furthest to the right, the one with the highest mean rate of MRT responses. It captures the 30 poorest neighborhoods in the company’s jurisdiction and includes the “killing fields,” “barrios,” “projects,” “little nexus of evil,” and other areas that I encountered during my sightseeing tour with Eric. While not evident in this simple figure, these neighborhoods account for less than a tenth (9%) of the people living within MRT’s market, but they yield nearly a fifth (19%) of the firm’s responses. Perhaps unsurprising to most readers, these neighborhoods also contain a high proportion of Moon County’s black and Latino residents (64 percent on average, versus 36 percent of MRT’s jurisdiction overall). The ambulance is not limited to poor or minority neighborhoods, but something seems to push or pull the ambulance toward the social margins.

---

7 Bell (2009: 67), author of the most comprehensive history of the ambulance, quotes an unnamed observer in New York from the late nineteenth-century as stating, “the ambulance subject is usually a person in poor circumstances. One rarely sees a well-dressed occupant being carried to the hospital by ambulance.” In his own words, Bell (2009: 63) notes that around this time, “there was enough disease in the poisonous slums to keep the ambulance horses in Derby-winning trim.” This link between paramedicine and poverty continues through his historical description leading up to the early twenty-first century.

8 Previous ethnographic studies of the ambulance from the 1960s onward also offer clues suggesting the ambulance has long been present in poor neighborhoods, but the details are generally thin (Douglas 1969; Mannon 1992; Metz 1983; Tangherlini 1998).
Not long after my introductory ride-along shift with Eric, I lead a research team that included a couple of emergency room physicians and a paramedic to further examine this association between neighborhood poverty and ambulance responses. Drawing on the same medical records used to construct Figure 1.1, we found evidence suggesting that a 10 percentage point increase in neighborhood poverty is associated with a 45 percent increase in ambulance responses (Seim, English, and Sporer 2017). We even controlled for geographic patterns in race, citizenship, gender, age, emergency department proximity, and population density. This pattern held for all the major call types listed in Eric’s protocol book and for what he would probably consider both legit and bullshit calls. In a subsequent study, we also found evidence suggesting that MRT ambulances were not relatively tardy in poor neighborhood (Seim et al. 2018).

---

9 We found that neighborhood poverty was positively associated with 12 major field diagnostic categories: abdominal, altered level of consciousness, cardiac, overdose/intoxication, non-traumatic pain, psychiatric/behavioral, respiratory, seizure, stroke, syncope/near syncope, trauma, and general weakness (Seim, English, and Sporer 2017). The records we examined obviously didn’t include explicit indicators for what Eric and others call “legit” and “bullshit,” but they do include details on the clinical interventions made by ambulance crews. Building on previous scholarship on critical and non-critical prehospital interventions (Sporer et al. 2010), we calculated neighborhood-level ambulance frequencies by “high,” “medium,” and “low” severity contacts (see Appendix for details). Regardless of severity-level, we found evidence that poverty was positively and significantly associated with the frequency of ambulance contacts at the neighborhood level.

10 Our ambulance response time findings (Seim et al. 2018) flew in the face of both journalistic and scholarly claims that ambulances are especially late to aid the poor (Dillon 2013; Govindarajan and Schull 2003; Huang et al. 2017; Kleindorfer et al. 2006; Love 2014). Unlike much of the previous examinations on neighborhood ambulance
None of this is to suggest that ambulances don’t ever “no show” or show up devastatingly late in poor neighborhoods. They absolutely do. For example, once a crew I shadowed didn’t arrive on scene until 30 or so minutes past the time a 911 call was placed. This wasn’t particularly unusual except that it was for a preschool aged girl who was shot during a drive by. We rolled up to a street corner to find a reasonably angry group of people. “You’re too fucking late!” one man yelled before somebody else explained to us that a cop took the girl to a hospital. I don’t intend to conceal or trivialize tragedies like this or similar ones published in the news (Bergin 2015; Dillon 2013; Gross 2018). But, just as we should be careful not to assume the ambulance is an institution that’s evenly spread across the polarized metropolis, we should be careful not to conclude that it’s absent or typically later in poor neighborhoods when the evidence suggesting so is thin at best.

In short, we know the ambulance is a present and busy institution in poor neighborhoods. Yet, how the poor are so regularly, and often rapidly, churned through the ambulance remains somewhat of a mystery. The professional literature on paramedicine offers simple explanations for the poor’s heavy use of paramedicine: high rates of morbidity and mortality, detachment from primary care, lack of transportation, and shared misconceptions of emergency (Bledsoe 2011; Brown and Sindelar 1993; Donovan 2009; Johnson 2011). However, this literature tends to ignore the structural conditions of paramedicine and says very little about how ambulance crews are dealing with a disproportionately poor clientele base. Meanwhile, the limited sociological research on the ambulance offers some rich insight into crew-patient interactions but they say effectively nothing of the ambulance as a potential manager of marginality (Corman 2017; Douglas 1969; Mannon 1992; Metz 1982; Palmer 1983; Tangherlini 1998).

To help solve such a mystery, this dissertation rethinks the ambulance as a case of poverty governance. For our purposes, “poverty governance” simply refers to how state or state-delegated institutions handle relatively poor populations, be it by protecting them, punishing them, or simply processing them into objects to know and direct. It’s visible in the way welfare offices distribute and withhold various forms of aid (Collins and Mayer 2010; Piven and Cloward 1971; Soss, Fording, and Schram 2011; Watkins-Hayes 2009). It can also be seen in the way criminal justice institutions collect mostly poor subjects (Beckett and Herbert 2011; Irwin 2004; Moskos 2008; Stuart 2016; Wacquant 2009). Moreover, the simple concept of poverty governance captures more indirect relations between state and poverty through delegated third parties like the non-profit and for-profit organizations that are contracted and subsidized by local states to deliver public goods and services (Evans, Richmond, and Shields 2005; Milward and Provan 2003; Marwell 2007; Morgan and Campbell 2011; Smith and Lipsky 1993). And, despite real concerns over access to care, medical institutions must also be included into a discussion of poverty governance. Often tasked explicitly by law or contract to aid indigent populations, emergency departments, community clinics, and related healthcare sites constitute a critical frontline of urban poverty management (Hansen, Bourgois, and Drucker 2013; see also: Dohan 2002; Gordon 1999; 2005; Gordon et al. 2001; Hock et al. 2005; Malone 1998; Rodriguez 2009).

response times, we didn’t limit our analysis to particular emergencies (e.g., cardiac arrest and stroke). We also didn’t operationalize neighborhood using zip code or zip code tabulation area. For a critique of using zip codes in health and health care studies, see Krieger et al. (2002) and Thomas et al. (2006).

11 As noted in the preface, poverty governance is generally synonymous with terms like “poverty management,” “poverty regulation,” and “poverty processing.”
Although its reach and consequences can at times seem endless, many sociologists agree that poverty governance is less concerned with eradicating poverty and is more concerned with managing its many symptoms. The reasonable assumption here is that relative poverty is an incurable condition in advanced capitalist societies like the United States. As such, we’re left with a fragmented, and often-contradictory, mess of state and state-delegated institutions for handling the poor but not for eliminating poverty. The ambulance is somewhere in this mess and probably has been for some time. Though, if we hope to find it, we must reconsider the mechanics of poverty governance more generally.

Rethinking Poverty Governance

There’s at least one major barrier to adequately rethinking the ambulance as an institution of poverty governance. The existing frameworks for understanding how the poor are governed are insufficient. Extant scholarship identifies three basic dimensions to poverty governance: its frontlines (i.e., the street-level labor of governance performed by social workers, correctional officers, and others), its horizontality (i.e., poverty as managed by a series of laterally intersecting and often contradictory institutions), and its verticality (i.e., influential forces beneath, but more importantly above, frontline operations, such as the downward pressures of bureaucratic authority). On the whole, the literature seems to emphasize the necessity of each of these dimensions, but we were lacking a framework to account for all three at once.

Forgetting the Workers

It’s hard to imagine a more ambitious attempt to make sense of contemporary poverty regulation in the United States than the one offered by Loïc Wacquant (2009). In an analysis accounting for prisons, welfare offices, and seemingly everything in between, he imagines poverty governance occurring through a bureaucratic field. His argument is complex and filled with intimidating concepts, but it essentially rests on a vertical and horizontal conception of state power. He briefly admits a somewhat obvious hierarchal division between “policymakers” from above and the “executants” of policy from below. However, he is perhaps best known for his analysis of a horizontal struggle between the “Left hand” of the state, which steers the welfare institutions that protect and extend life chances, and the “Right hand” of the state, which directs the penal institutions that impair them (see also: Peck 2010). Under neoliberalism, the state’s...
Left hand is weakening, shrinking, and losing autonomy. This helps explain why, among other things, welfare programs like cash assistance for poor parents are often becoming more temporary and parsimonious. Meanwhile, the operations of the state’s Right hand are strengthening, broadening, and encroaching on operations traditionally exercised by its Left hand. This is most evident in the United States, according to Wacquant, by a near simultaneous ascension in incarceration and in various welfare reforms that have made public assistance more disciplinary and punitive (e.g., requirements to work in order to receive benefits).

Although Wacquant offers a rich theorization of poverty governance as both a vertical and a horizontal process, he seems to neglect the structures and operations of poverty governance for what they basically are: forms of accumulated labor. He occasionally mentions, but never analyzes, the frontline workers, the so-called executants of policy. The result is a generally passive and overly macro theory of governance that risks fogging potentially critical activities at ground level. Indeed, the poor are not passively arrested, hospitalized, or fed through an expansive “field.” Other people actively arrest, hospitalize, and feed them. People on the frontlines do the actual labor of classifying, assisting, and disciplining the subjects of poverty governance. The actions of these state (or state delegated) laborers add up to make the foundation of poverty governance.

Ignoring the Sides

Luckily, there is a framework that can help us make sense of the frontlines: Michael Lipsky’s (1980) frequently applied model of street-level bureaucracy. If Wacquant’s theory accounts for the verticality and horizontality of governance, Lipsky’s accounts for the verticality and frontlines of governance. For him, policy is really “made” at ground-level, by so-called street-level bureaucrats who deliver or withhold public goods, services, and sanctions to a mostly poor clientele. These include welfare caseworkers, police officers, correctional offices, nurses, physicians, and other boots on the ground. According to Lipsky, it’s the labor of people on the frontlines that really add up to make this thing I’ve been calling governance. These street-level bureaucrats are not just cogs in a firmly ordered machine. However, they’re also not fully independent actors who have full discretion over how they execute policy. Instead, street-level bureaucrats exist somewhere between these extremes of subordination and independence. They are semi-discretionary actors situated in bidirectional relations with organizational authority from above and a mostly indigent clientele from below. Managers tell them what to do and their clientele make demands, but these frontline workers have a lot of choice at work. Such choices shape the delivery of governance in important ways (e.g., whether a police officer arrests someone or not). Through examining the frontlines of governance, Lipsky and other street-level bureaucracy scholars (Brodkin 2011; Ellis, Davis, and Rummery 1999; Evans 2011; Prottas

or rather position, state entities on the ground. For my purposes, the Left-Right separation proves useful since the ambulance is between two quintessential cases of each in the American city: the Left-handed emergency department and the Right-handed squad car.

15 A strict reading of Lipsky’s (1980: xi) definition of “street-level bureaucracy” might suggest that it is not a really a theory of poverty governance since it accounts for those worksites where frontline laborers “interact with and have wide discretion over the dispensation of benefits or the allocation of public sanctions.” But Lipsky (1980: 54-6) is clear: street-level bureaucracy clientele can be generally described as “nonvoluntary” because they need the resources provided by these agencies (e.g., welfare) or these agencies descend upon them without or with relatively little consent (e.g., policing). In his words, “The poorer the person, the more he or she is likely to be the nonvoluntary client of not one but several street-level bureaucracies” (Lipsky 1980: 54).
1979; Watkins-Hayes 2009) reveal poverty governance as both a “top-down” and a “bottom-up” process.

Nevertheless, the bulk of the scholarship on street-level bureaucracies underemphasizes the horizontal dimensions of poverty governance. While relatively autonomous, the institutions of poverty regulation often overlap. For example, parole agencies have long brokered and mandated felons to drug counseling, transitional housing, and related third-party programs (Irwin 1970; Seiter 2002). Different frontlines of poverty governance also operate in reference to each other. Community colleges, for example, often set curricula to assure that eligible students can receive welfare funds (Meléndez, Falcón, and Bivens 2003). Street-level governance can be “bottom-up as well as top-down, but also ‘sideways’” (Hupe and Hill 2007: 295). According to Megan Comfort and colleagues (2015: 115), a key feature of this horizontality is irrationality, namely in the “massive disconnect between institutions” that share clientele but are often oriented toward distinct missions that undermine one another. Ultimately, the poor are generally governed across a number of contradictory institutions simultaneously, and Lipsky and many of the social scientists who deploy his ideas don’t seriously examine this. Such porous conditions of poverty governance likely affect frontline labor by determining whom workers handle and what other actors they have to work with in the process. In other words, inter-institutional horizontality likely affects how frontlines workers “make” policy in important ways.

Neglecting the Top

Beyond the yolk of street-level bureaucracy scholarship, there are some innovative studies that account for the more “sideways” interactions between frontline workers. Consistent with Wacquant’s claim that the penal state (Right hand) is encroaching on activities traditionally held more autonomously by the welfare state (Left hand), Armando Lara-Millán (2014) analyzes the daily interactions between nurses and police inside the hospital. His ethnography of a public emergency department shows how the labor of triage shapes, and is shaped by, horizontal interactions between these two parties. Nurses justify the rushing of medical services to criminal arrestees and jail inmates as a form of professional courtesy to the police who accompany these patients. And officers detailed to the inundated emergency department assist nurses by thinning clientele demand (e.g., running occasional background checks on people in the waiting room). Likewise, Kathleen Nolan (2011) details the relationship between police and educators inside an urban public high school. She too focuses on moments that could be described as professional courtesy to make sense of how order is established at her studied site. However, she also clearly emphasizes moments of lateral conflict, as police and teachers struggle to determine who has ultimate authority over student discipline.

But, in focusing on the grounded interactions between different frontline workers, studies like these come with their own blind spots. In focusing on labor and horizontality, such research can sometimes sacrifice an analysis of verticality. To be fair, Lara-Millán and Nolan do not outright ignore hierarchical relations. Both write about the political and legal circumstances that have positioned law enforcement in their respective field sites. Additionally, Nolan accounts for deans and administrators in her ethnography and Lara-Millán discuses charge nurses in his. In a more recent piece, Lara-Millán (2017) even theorizes the vertical relation between “frontline workers” and “political leaders” as one where the latter consults the former on how to best classify subjects in or out of a given agency or department. Even so, the theoretical and empirical
specifics are pretty thin in comparison to the detailed street-level relations between institutions. Ultimately, these case studies don’t outright ignore verticality; they just tend to neglect it relative to horizontality. More concerning, though, is the absence of a generalized framework that can advance our understandings of poverty governance beyond the limits of bureaucratic field and street-level bureaucracy scholarship.

**Poverty Governance as a Labor Process**

I propose an easy solution for the shortcomings in extant theory: we should rethink poverty governance as a labor process. I claim this yields a more comprehensive framework for examining poverty governance. Key analyses of the labor process span a number of sites that include but are certainly not limited to: factories (Burawoy 1979), nursing homes (Lopez 2006), hotels (Sherman 2007), casinos (Sallaz 2009), fast food restaurants (Leidner 1993), department stores (Ikeler 2016), and semi-trucks (Viscelli 2016). The versatility of the concept comes from its simplicity. It merely refers to how the capacity to labor is translated into productive activity.

Let’s break it down. The labor process involves both a practical and a relational component. The practical component involves a transformation or regulation of the world by the hands and minds of workers utilizing the instruments of production (Burawoy 1979: 15). With respect to poverty governance, this can be seen in the sheltering of unhoused bodies, in the feeding of hungry people, and even in the beating of supposedly dangerous subjects. This can also be seen in the way frontline workers process people into, or preserve them as, “clients” (e.g., patients and inmates) so that other workers can monitor and adjust them. The results may be micro and momentary, but they are transformations and regulations nonetheless. The relational component of this same process concerns the multidirectional associations through which these transformations and regulations occur, namely the relations workers enter into “with one another and with management” (Burawoy 1979: 15). This can be seen in the horizontal relations between frontline workers and in the vertical relations between these workers and the actors who control

---

16 In the latter piece mentioned, Lara-Millán (2017) advances a vision of “states as a series of people exchanges.” Said exchanges essentially constitute sidewise processes (e.g., moving clientele from a correctional agency to a mental health agency through adjustments in screening and diagnosis). He considers verticality, but only to explain a more horizontal process (e.g., how political leaders rely on “frontline actors’ expertise” to engage in a more lateral struggle with other agencies over who will relinquish or obtain “responsibility for people”) (Lara-Millán 2017: 83, 96). Just as Wacquant mentions the executants of policy but favors the vertical and horizontal axes of governance and Lipsky assumes horizontality but focuses on verticality and labor, Lara-Millán points to vertical processes but he does so secondary to his analysis of frontline workers and the more horizontal exchange of governed subjects.

17 While they do not deploy the same language, Donald Metz’s *Running Hot* (1981), James Mannon’s *Emergency Encounters* (1992), and Michael Corman’s *Paramedics On and Off the Streets* (2017) can be easily read as studies of an ambulance labor process. Indeed, the dissertation at hand is often inspired by the earlier inquiries into paramedic and EMT work. The key difference is that I consider how ambulance labor generates operations of poverty governance whereas these previous ethnographers do not seriously confront the relationship between the ambulance and urban poverty. In other words, I study poverty governance as a labor process.

18 We can trace the concept of the labor process all the way back to Karl Marx. In more orthodox terminology, the capacity to work refers to “labour-power,” which a person (e.g., a capitalist) buys to use (Marx [1867] 1978: 344). As later articulated in clearer language by Harry Braverman ([1974] 1998: 37), the worker sells “not an agreed amount of labor, but the power to labor over an agreed period of time.” When labor power is then in use (i.e., activated) it is “labor itself” and this involves a transformation of the world into useful things or fragments of useful things that may (or may not) be sold for a profit (Marx [1867] 1978: 344). This process of activation and transformation is essentially what we understand as the “labor process.”
and coordinate their labor. This dual consideration of the practical and relational components of production is what allows us to respond to the shortcomings in the literature.

What I’ve previously titled the “labor theory of poverty governance” offers a promising and novel approach for examining the management of marginality (Seim 2017). This framework rests on three general claims. First, the poor are governed across three dimensions identified in extant scholarship: the verticality of governance, the horizontality of governance, and the frontlines of governance. In other words, poverty governance includes both a practical and a relational component. Second, these dimensions are intersectional and interdependent. This model insists that no single dimension of governance should be understood without reference to the other two. Thus, it runs in intentional friction with theories of bureaucratic fields (which tend to forget the frontlines), classical writings of street-level bureaucracies (which tend to ignore horizontality), and more cutting-edge scholarship on the cross-professional frontlines (which tends to neglect verticality).

Mapmaker

During my first weeks of working as an EMT, I struggled to navigate Moon County. The ambulance’s navigation system was pretty helpful, but also pretty distracting. Glancing at it before putting the ambulance in drive was one thing but looking at the monitor as I drove through traffic with my lights flashing and siren blaring was nerve-racking to say the least. My paramedic partners helped me out. They’d tell me things like, “Left on X street, then a right on Y street, and it’ll be a block south of Z street.” They would say these things in a you-should-know-what-I’m-talking-about tone. However, I often didn’t know, and I frequently made wrong turns before I got the usual scolding. “Wrong turn! Wrong turn! Wrong turn!” I was embarrassed. At this point, I had spent a year doing ride-along observations and had been to most of the areas I was driving into as an EMT. It wasn’t until I was behind the wheel that I started to realize how difficult navigation could be.

When Lance, one of my trainers, figured out I was struggling to find my way around, he recommended I draw a map of the county. It was around 3:30am and we were parked outside a hospital. He turned on the dome light inside the cab of the ambulance, gave me a pen and some scratch paper, and then asked me to sketch a simple map of Moon County. I outlined the county’s many highways and noted a few exits. Lance corrected my many errors and then helped me draw a grid for the busiest streets in the core of the map. He had me draw this map again the next night. This was such a simple exercise, but it really helped me distill the county’s geography to its essence, or at least to its essence according to a nervous and inexperienced EMT.

In a way, I do something similar in this dissertation. Relying on extant theories and a novel vision of poverty governance as a labor process, I draw an analytical map to pursue two goals.

My first goal is to convince you that the ambulance is an important and telling institution of poverty governance. The ambulance may never be the go-to example of poverty governance that scholars think of. I assume that spot is indefinitely reserved for the welfare office. Nevertheless, the ambulance is parked at a couple of really important intersections that can help us understand the mechanics of poverty governance more generally. On the one hand, the ambulance is frequently interacting with two larger institutions of poverty governance: the hospital emergency department and the police squad car. It offers a unique view into the space between two hands of poverty governance, the welfare state and the penal state. On the other
hand, those who control and coordinate ambulance fleets often meet at the intersection of bureaucracy and capital, where public and private distinctions are increasingly blurred by the delegation of governmental functions to third parties. As such, the ambulance is not just a suitable case of poverty governance, it’s also a strategic case. It leads to a proxy study of hospitals, police departments, county government, and a for-profit firm.

My second goal is to advance a more general framework for understanding how the poor are governed. This dissertation builds, applies, and clarifies a labor theory of poverty governance. It explicitly accounts for both the practical and the relational components of governance and in doing so it generates a promising model to be applied to other settings. This labor process framework offers, in my view, the best way to locate the ambulance between welfare and penalty on the one hand and policy and profit on the other. It also provides us with a simple framework that may be useful for locating and navigating other sites of poverty governance.

Figure 1.2 Mapping the Ambulance

Figure 1.2 is the outcome of pursuing both of these goals. It’s our map, and it summarizes a deeply complicated world of paramedicine. As in any clinical setting we find a basic hierarchy, with crews positioned above their patients, here called riders.19 We can think of this as ambulance crews working on their subjects. Riders can demand (and often refuse) services and some even resist paramedics and EMTs by kicking, punching, and spitting. Crews nonetheless coax and coerce mostly obedient subjects. At the same time, ambulance riders often slide between other transient statuses like hospital patient and police subject. This situates ambulance crews between nurses and police, who they interact with daily. Atop the ambulance we find a proximal trinity of forces: official protocols published by MCEMS, upper management at the

19 The vertical asymmetry between medical workers and their patients is an enduring theme in medical sociology and can be traced to Parsons’ (1951) theorization of “therapist” and “patients.” In no way do most medical encounters constitute moments of total domination, but whatever powers patients have (e.g., “patient rights”) are usually overshadowed by the social and cultural authority of care providers (see also: Starr 1982; Waitzkin 1991).
firm, and the company’s field supervisors like Eric. Further up, we find a particular relation between bureaucracy and capital, where the former delegates operations to the latter. The county government contracts ambulance operations to the firm and gives them the “right” to earn revenue through a fee-for-service model. However, instead of totally hollowing itself out, the state remains present and powerful by setting the conditions, surveilling the activities, and sanctioning the performances of capital.

I explicate this map across nine chapters that are evenly divided between three parts. Part I takes us inside the ambulance. Chapter 2 summarizes ambulance work as a process that involves two material regulations of a relatively impoverished world: a transformation of spaces in bodies (e.g., clinical interventions into flesh and bone) and a transformation of bodies in spaces (e.g., transportation of people from streets and homes into the emergency department). These physical adjustments, however, cannot be understood without accounting for the socially produced and realized categories these workers use to navigate their jobs. So, Chapter 3 details a central, but fuzzy, moral distinction workers make between “legit” and “bullshit” calls. I show that paramedics and EMTs hold a strong sense of duty and purpose when it comes to making critical and deep interventions into the “legitimately” suffering body (i.e., transforming spaces in bodies). However, much to their frustration, their work seems to involve little more than administering shallow treatments and giving people with “bullshit” problems rides to the hospital (i.e., transforming bodies in spaces). Chapter 4 extends, but also complicates, this analysis by accounting for the emotional aspects of ambulance work. Together, these chapters help demystify a key mechanism of poverty governance: bandaging the poor. Like many institutions of poverty governance, the ambulance provides superficial solutions for the deep wounds of urban poverty. But, this cannot be fully understood without accounting for the horizontal and vertical relations ambulance workers are caught up in.

Part II locates the ambulance between two larger regulators of urban poverty governance: the hospital emergency department and the police squad car. Chapter 5 details the “fix up” work ambulance crews share with nurses and Chapter 6 details the “cleanup” work they share with the police. These two chapters make it clear that ambulance crews often work with their police and nurse counterparts without conflict or tensions, but conflict and tension nevertheless occur. So, Chapter 7 details the modal source of tension, which I call “burden shuffling.” This refers to the strategies that workers deploy in an effort to push, or shuffle, undesirable tasks or cases onto other workers. Ultimately, Part II demystifies another key mechanism of poverty governance: sorting the poor. Examining the lateral relations between workers helps us better see how the poor are distributed across a landscape of often contradictory institutions.

Part III locates the ambulance underneath a nexus of bureaucratic and capitalistic forces. Chapter 8 takes us into MRT headquarters, “the barn.” There, I show how the firm’s relationship with MCEMS shapes the way upper management organizes the ambulance fleet. MRT is essentially forced to service a mostly unprofitable clientele base (i.e., the poor) and they respond to this problem by trying to deploy a lean workforce that can efficiently and flexibly churn through as many transports as possible. Chapter 9 details a key weapon management uses to assure efficiency and flexibility: the supervisor rig. We’ll return to Eric and other supervisors’ SUVs. However, instead of looking out their windshields to see the common places ambulances are responding to, we’ll see how management more directly negotiates a lean workforce. Chapter 10 brings us back into the ambulance to make sense of how crews are responding to pressures above them. In addition to further contextualizing the relations that influence a bandaging and
sorting of the poor, Part III demystifies another mechanism of poverty governance: *hustling the poor*. Workers hustle clientele along through hurried interventions and this complicates, but does not contradict, claims that the poor spend much of their time waiting for the frontlines to do something.

I end this wave of short chapters with a conclusion that looks beyond the ambulance. This final chapter includes a call to bring the labor theory of poverty governance into other sites like the welfare office and the prison. It also considers the applicability of those key mechanisms revealed through this case study: bandaging, sorting, and hustling the poor. At the very end, I consider some ways to make the ambulance better for both patients and workers.
Part I
Bandaging the Poor: Inside the Ambulance

This first set of chapters jumps into the ambulance to better understand how a mostly poor clientele base is processed through it. I cover the manual, mental, and emotional aspects of ambulance labor and detail some of the subtle and not-so-subtle distinctions ambulance crews use to make sense of their work. The point is not to simply demystify what happens within this mobile structure that frequents poorer territories. That’s one of my objectives, but I’m also interested in laying the foundation for the horizontal and vertical analyses that follow (Parts II and III respectively).

Life inside the ambulance can be first and foremost summarized as a site of “people work” where crews labor a mostly impoverished clientele base. This work involves a physical regulation of spaces in bodies (e.g., relatively deep clinical interventions) and bodies in spaces (e.g., moving people into the hospital). However, ambulance work cannot be reduced to just a manual execution of treatment and transport. This material engagement with the world is interlocked with symbolic transformations, like the basic assemblage of a medical case. Workers’ written and verbal articulations of vital signs, diagnostic categories, and other formal classifications are essential to understanding how crews process people into ambulance patients. Yet, there are more informal classifications at play too. Workers’ shared distinctions in different kinds of people (e.g., racialized and gendered subjects) shape, and are shaped by, the labor they perform.

Such biases are significant, but I argue that a stronger axis of preference is at play: the taken for granted distinction in “legit” and “bullshit” cases. More ideal types on a continuum than mutually exclusive categories, these folk terms map onto variability in spaces in bodies (more legit work) and bodies in spaces (more bullshit work). Understanding the fuzzy moral order in legit and bullshit cases requires an understanding of ambulance work as a vocation. While a number of workers, especially the more veteran ones, describe themselves as “jaded” and “burnt out,” the overwhelming majority of people I met at MRT articulate some generally strong commitments to the craft of paramedicine. They want to “truly help” people by doing what they are primarily trained and equipped to do: salvaging bodies in crisis through relatively deep and technical interventions into human flesh. However, to their frustration, much of their day-to-day labor involves not a regulation of spaces in bodies, but the inverse. They’re often moving forgettable cases from homes and streets into the hospital for “non-emergency problems” like chronic illness exacerbations and empty prescription bottles.

Among other things, this legit-bullshit continuum is intertwined with crews’ mechanisms for coping with the particular challenges of ambulance-based people work. I argue that two opposing sets of dispositions are especially important: “being a dick” (apathetic, hostile, and cold) and “having heart” (sympathetic, hospitable, and warm). There are plenty of factors that engender someone’s disposition at work, many of which probably extend well beyond the workplace. I don’t deny this or intend to suggest that some one-dimensional spectrum between being a dick and having heart captures the entirety of worker temperament. However, the emotional thread I detail helps clarify the pathways through which the immediate conditions of labor influence the interactions between crews and clientele. The lows of bullshit work tend to motivate a cold handling of patients and the highs of legit work tend to encourage a warm handling. I link crew-clientele struggle to the former and crew-clientele solidarity to the latter.
This layering of the physical, mental, and emotional aspects of people work inside the ambulance is no doubt complicated, but it’s important. It helps us piece together the practical component of a labor process. Recall that the practical component refers to a transformation of the world by the hands and minds of workers utilizing the instruments of production. While the adjustments are often micro and momentary, ambulance workers nevertheless change the world by helping to regulate it. They identify and correct abnormalities within people and move those deemed ill and injured into places they’re better fit.

We must not forget that these transformations are unevenly spread across the urban landscape. Neither legit nor bullshit calls are limited to poor or racially oppressed populations, but both call types – and essentially everything in the gray area between – concentrate downward. Morbidity and mortality risks are higher near the floor of the social hierarchy, and so too are the risks for being locked out of the yolks of medicine, housing, and social security more generally. Crises, from the “urgent” to the “non-urgent” and from the “medical” or “non-medical,” accumulate in poorer and less white territories. The men and women who labor the ambulance are some of the few people the state dispatches to handle crises and this means much of their work brings them toward the bottom of the polarized city.

In several respects, ambulance labor amounts to bandaging the poor. Crews generally offer superficial responses to many of the deep wounds of urban marginality. This can be seen not only in the application of gauze and pressure to a bloody gash but also in the movement of a body from the cold concrete into the relatively warm hospital bed. It can be seen in the fentanyl, albuterol, and other medications that crews throw at the chronically ill, just as it can be seen during the forced restraint and transport of drunk or otherwise disordered subjects. Ambulance crews ultimately constitute a reactionary force for stabilizing, but not fundamentally solving, many of the crises that disproportionately plague destitute, stigmatized, and isolated populations in the American metropolis. This fact isn’t lost on crews either. As many put it, much of their job means applying “bandage solutions” to complicated problems.

We can learn a lot about poverty governance by looking in the back of an ambulance. Representative of the state’s quick and temporary responses to crises, the ambulance is a suitable analogy for a number of interventions that mitigate social suffering but rarely target its root causes: emergency housing, short-term cash assistance, expedited food stamps, etc. We may live in an era of “retrrenched” or “disciplinary” welfare, but we also live an era of ambulance welfare. The fragmented programs and policies that the poor depend on are not just stingy, they’re superficial.

---

20 Here lies another tension between my analysis and Wacquant’s (2013). In a recent plenary address to the Australian Sociological Association, he tells his audience that in order to comprehend the “building of the neoliberal Leviathan,” we must abandon from the “ambulance conception” of the state, which portrays government “as a reactive outfit that tackles ‘social problems’ such as poverty after they have taken root” (Wacquant 2013: 8). The state, he reasons, is not constituted as much by its reactions as by its capacity to stratify and classify. In his own words, the state “sets the basic coordinates of social space and produces inequality and marginality upstream, before it manages them downstream.” The state may generate marginality by legitimating and imposing social categories, but it still takes a reactionary form. I contend that the ambulance is an excellent reference point for understanding how the state, from far downstream, manages the social problems associated with destitution, stigma, and social isolation. We shouldn’t abandon the ambulance conception of the state, but instead embrace it. Doing so does not necessitate an ignorance of the stratifying and classifying capacities of the state, as I’ll demonstrate throughout this first set of chapters (e.g., triage, diagnosis, and the imposition of informal categories like “legit” and “bullshit”).

21 For a more specific example of ambulance as metaphor, see McKee (2015: 3) who likens social housing provision to the ambulance. According to her, such housing in England is “now akin to an ‘ambulance service,’ which
Chapter 2
People Work

The ambulance is a worksite. Like most medical and social service jobs, ambulance work can be reasonably described as a form of “care work” or “service labor.” However, I think the activities of paramedics and EMTs are best summarized as people work. Erving Goffman (1961: 74-83) developed this concept to make sense of staff inside “total institutions” like asylums and prisons. The concept nevertheless works in any setting where the primary material of labor, that which is practically transformed through the social relations of production, are people.

I’m especially partial to Goffman’s concept because it forces a simultaneous consideration of both the material and the classificatory moments involved in production. Whether laboring living or dead bodies, there is a definite physicality to people work: surgeons cut into flesh, morticians dress corpses, and prison officials feed inmates. Still, people work cannot be reduced to manual labor alone. Such work also necessitates moments of classification. In addition to being trailed by informative receipts that sketch the labor performed (e.g., medical records), people are worked through an institutional-specific scheme that identifies and distinguishes human problems in a particular way (e.g., diagnostic categories) (Goffman 1961: 75, 84).

What does people work look like inside the ambulance? At its essence, it involves a dual transformation. On the one hand, ambulance crews regulate spaces in bodies. Much of their labor involves an assessment and transformation of people as independent structures divided into anatomical and physiological regions. Paramedics and EMTs are trained to link external symptoms to internal problems (e.g., pale and diaphoretic skin and chest pain as possible indications of cardiac compromise) and internal problems to targeted treatments (e.g., inserting a nitroglycerin tablet underneath a patient’s tongue to widen their blood vessels). On the other hand, crews also regulate bodies in spaces. They move people from homes, sidewalks, bars,
rehabilitation facilities, and other places to the hospital. Sometimes they do so against the expressed will of their subjects, but most clientele voluntarily summon ambulance services. Regardless, this regulation also necessitates a classificatory moment because bodies are moved according to particular classifications of human material (e.g., the severely injured go to trauma centers).

This chapter sets out to describe a few basic features of ambulance-based people work. I begin by briefly detailing some of the instruments that crews use to regulate people. I then offer a summary of how ambulance calls are generally run, and this provides us with some basic insights into how crews handle their clientele. Yet, as I’ll make clear, not all calls are run the same. This is at least partly so because the material to be labored is not uniform. Crews see different types of people (e.g., racialized and gendered subjects) and this shapes the productive process by forming their preferences for particular materials.

**Tools of the Trade**

Nicknamed “rigs,” “trucks,” and “busses,” ambulances can be reasonably described as mini hospital rooms on wheels. They’re loaded with instruments for examining, adjusting, moving, and documenting people. We don’t need to take a full inventory of what’s inside, but a quick glance at some of the rig’s equipment will give us a sense of what can happen inside the ambulance.

Let’s start in the back. At the center is a gurney, which is easily loaded and unloaded through the backdoors. A waterproof – or rather a blood, vomit, and fecal proof – mattress sits on top and is covered with a cloth blanket and a paper sheet. The sheet is disposed after each transport and the blanket helps crews drag their patient off the gurney and onto a hospital bed should such a maneuver be necessary. A portable oxygen tank is also placed above the head of the gurney in case a patient happens to require any low or high flow oxygen. Additionally, a few pouches are attached to the gurney and carry nasal cannulas, spit masks, and other items.

As a ride-along, I usually sat in the captain’s seat immediately next to the gurney’s head (Figure 2.2). This provided me with a head-to-toe view of patients while they laid on the gurney or, far more commonly, as they reclined in the semi-fowler’s position (i.e., around a 45 degree angle). This seat also offered me a great front-to-back view of the ambulance’s main interior (Figure 2.3).
Cabinets covering the wall to the right of the gurney contain various needles, tubes, masks, chemicals, gauze, and other tools. A “monitor” usually sits on a nearby shelf, but it’s frequently moved. When on scene, for example, crews often hook the monitor to the back of the gurney. This boom-box shaped device has defibrillation capabilities (“Clear!”). However, it also includes a number of instruments for “objectively” assessing the body. In addition to a blood-pressure cuff, it includes a pulse oximeter (an infrared finger probe for measuring blood oxygen saturation and heart rate) and cables for a 12-lead electrocardiogram or “EKG” for “taking a picture of the heart.” One of the side pockets of the monitor includes a glucometer and a set of lancets for checking blood sugar.
bench for easy access, like a small bin with some IV needles of various gages. Just north of the bench and east of the captain’s chair are some additional shelves. Among other things, they hold a “med bag,” which carries a majority of the rig’s medications like Benadryl (for allergic reactions), Zofran (for nausea), and Narcan (for opioid overdoses). Medications requiring more security, like fentanyl (for pain) and versed (for severe psychiatric emergencies), are locked in a safe above the shelving that holds the med bag.

A few cabinet doors can be found on the ambulance’s exterior. Among other things, these include more items for moving ill and injured bodies. For example, a stiff spinal board and some cervical collars are included for when a crew needs to immobilize a patient’s spine before moving them into the rig. For less sensitive maneuvers, these exterior cabinets also include a “tarp,” a heavy-duty plastic sheet with handles that crews can use to lift and drag people on scene.

For essentially every instrument that crews can wield in the back of the ambulance there is a digital echo of sorts inside the crew’s laptop (Figure 2.4). In addition to documenting patient demographics and billing information, crews must use these computers to record vital signs, medical histories, current medications, primary impressions (i.e., field diagnoses), and treatments performed. In addition to checking boxes and selecting entries from dropdown menus, they must also write short open-ended narratives summarizing key aspects of the labor performed.
And then there’s the front cab (Figure 2.5). In addition to a radio for communicating with dispatchers, the cab includes a series of switches and buttons for controlling the rig’s lights and sirens. A second computer, which is installed into the dash, has a touch-screen interface and runs another computer program. This program mainly runs a live map that shows crews where they are and where they should be going. A couple pairs of latex gloves are usually tossed somewhere on the dash, allowing crews to glove-up before they step out on to a 911 scene.

Ultimately, and unsurprisingly, the ambulance contains a variety of tools for treatment and transport. Some are used to examine and regulate *spaces in bodies*, such as by measuring electrical activity in the heart (EKG via the monitor), lifting low blood pressure (saline via intravenous access), and stimulating bronchodilation for more effective breathing (Albuterol via nebulizer). At the same time, we also find tools that are used for regulating *bodies in spaces*. These include things like the gurney, the tarp, and even the rig itself; all are used to move people away from a given area (e.g., home and sidewalk) and toward a hospital bed. However, these also include instruments for regulating the movements of particular body parts, like the limb restraints and spit masks.

Taking stock of some of these tools is important because they enable, but also constrain, the activities that can unfold inside the ambulance. Such objects are clues into what kinds of problems do, and do not, fall under the scope of paramedical operations.

However, rummaging through the ambulance can only tell us so much. Many of the instruments that can be found in the back of the ambulance lay unused for entire shifts, while others are used on nearly every call. Plus, as we’ll soon see, ambulance crews are in many ways ill-equipped to handle a number of the problems they’re frequently presented with. In moving toward a better understanding of the people work performed inside the ambulance, we need to look beyond the instruments that are available to crews and examine what they typically do.

**Running Calls**

While the social interactions that occur in and around rigs are certainly varied, there is a basic pattern and rhythm to most 911 responses. Before a call “drops,” the crew is often in the cab with the EMT in the driver seat and the paramedic in the passenger seat. If they’re not departing from a hospital on a previous transport, they’re usually “posted” (i.e., parked) at an assigned street intersection waiting for a 911 call or en route to a posting location.

Three-fourths of 911 ambulance dispatches require crews to respond with “lights and sirens.” As the EMT drives the loud and flashy ambulance through the usually dense city streets, running red lights and sometimes driving in the opposite direction of traffic in the process, the paramedic reads the computerized map and provides verbal directions for the EMT. He or she will also typically read the “call notes” that the dispatching office automatically sends to the rig’s computer, but these notes usually provide vague and often inaccurate details.

Per the year of MRT medical records I acquired, roughly 52 percent of ambulance contacts occur in residential space (including yards and porches), while 16 percent are located on streets or sidewalks and another 16 percent are in commercial or public buildings. Most of the remaining 16 percent brings crews into hospitals, skilled nursing facilities (or “sniffs”), rehabilitation centers, assisted living facilities, and similar settings.

Crews usually park their rigs on scenes already attended to by firefighters. Somewhere between 70 and 90 percent of 911 calls that firefighters respond to in large American cities do not involve actual fires or even fire alarms but are instead “medical emergencies” (Eng 2017;
Hseih 2014; Keisling 2015). In Moon County, as in many places with private paramedical operations, firefighters are supposed to arrive on scene first and stabilize patients for 911 transport. All firefighters in the studied county are licensed EMTs and most fire crews include a paramedic called a “fire medic.” When extra hands are needed on high priority calls, the fire medic will enter the ambulance and assist the MRT medic, who is sometimes called a “transport medic.” However, this is typically not necessary and most fire crews simply give the MRT crew a brief oral report and a set of initial vital signs before returning to their fire station.

With the exception of those who are pronounced dead on scene or refuse services, most of the people that ambulance crews respond to are then transported to the hospital. But, first they are typically moved onto the gurney and loaded into the rig. Some legit calls are time sensitive and require crews to “load and go.” The gurney is quickly locked into the back of the ambulance and the EMT jumps up front and drives to the hospital (sometimes with lights and sirens) while the paramedic attends to the patient in the back. However, this is not typically necessary and so most crews “stay and play” instead. When this happens, both the paramedic and the EMT will enter the back before heading toward the hospital. The paramedic sits on the bench and talks to the patient. The EMT sits in the captain’s seat and begins to construct a medical record on a laptop. An ethnographer occasionally stands to the side and helps the crew by grabbing and prepping equipment.

As the EMT types on the computer, the paramedic does a medical assessment. One of the first things he or she does is determine the consciousness and the degree to which the patient is “alert and oriented” or “A&O.” When in doubt, the crew calculates an A&O score by asking their patient some simple questions: “What’s your name?” “What city are you in?” “What day of the week is it?” “Do you remember how you got here?” If the patient answers each of these questions correctly, she or he is classified as “A&O times 4” (often written “A&Ox4”). This indicates that the patient is alert and oriented to person, place, time, and event. Patients with lower A&O scores are usually considered incapable of making their own medical decisions and protocol commands crews to treat and transport such people to the hospital without verbal consent under the justification of “implied consent.” The assumption here is that people who are not alert and oriented would consent to ambulance service if they were lucid.

Regardless, most patients are alert and oriented enough to at least articulate a “chief complaint.” For ambulance crews, a chief complaint really just means a medical complaint. Consistent with what Michel Foucault (1973: 190) calls a “medicine of the sick organs,” paramedics usually help their clientele make sense of their suffering in terms of physical problems that can be located in the body. The more specific the better. “Do you have any head, neck, chest, or abdominal pain?” “Any nausea or dizziness?”

As sociologist and physician Howard Waitzkin (1991) might argue, these interactions can depoliticize the root causes of suffering and misidentify an etiology of illness in the “physical realm.” External causes are certainly considered, but paramedics keep them proximate rather than distal. This often involves a commentary on lifestyle: “Smoking isn’t good for your emphysema,” “You shouldn’t drink so much,” and “You gotta find a better man (who doesn’t beat you).” Likewise, assessments for “trauma calls” (i.e., physical injury cases) typically involve the paramedic determining the most local mechanics of wounding: “What did you trip over?” “How fast was the other driver going?” “Did he hit you with an object or just his fists?” Often, the EMT will chime in to collect further information for the medical record, including details on the patient’s medical history and current medications.
The paramedic’s “subjective” assessment is coupled with an “objective” one and for patients unable or unwilling to articulate a chief complaint this is all the crew can rely on. In a way, the objective assessment begins the moment a crew first sees their patient. Is the person “ambulatory” (i.e., walking)? Is she or he speaking in full sentences (i.e., breathing appropriately)? Is their skin pink, warm, and dry (i.e., not pale, cool, or diaphoretic)? Objective assessments continue in the rig where patients are set up to the monitor reporting blood pressure, heart rate, and oxygen saturation. Paramedics and EMTs also touch patients during the objective assessment. They press their gloved hands onto the body to check for bone instability, abdominal distension, and to determine whether or not the patient guards from any pain. If the paramedic suspects a respiratory problem, she or he will often auscultate lung sounds with a stethoscope. His or her sense of smell is also important, as it can detect incontinence, alcohol consumption, infection, and even hyperglycemia (which may present as a “sweet” smelling breath). Indeed, the paramedic’s “medical gaze” is, as Foucault (1973: 164) originally described it, a “plurisensorial structure.”

The paramedic’s assessment leads to a “primary impression” and this, in turn, guides the crew’s intervention. More formalized and objective than chief complaints, primary impressions are essentially field diagnostic categories (e.g., myocardial infarction, tension pneumothorax, and non-traumatic body pain). A “secondary impression” is also possible for people presenting with multiple problems (e.g., a skin abrasion secondary to a fainting episode), but all cases must be assigned at least one major field diagnosis. Sometimes described as “checking a box,” this process means reducing a person’s problem to one of the medical problems listed in the menu of impressions recognized by MCEMS protocols. As noted in the previous chapter, the protocol book includes several step-by-step guides for paramedic intervention, and these are divided by primary impression categories. Perhaps more than anything else, imposing a primary impression is what transforms citizens into “clients” of the ambulance. According to Jeffery Prottas (1979: 3-4), all frontline workers must “simplify and standardize” their subjects in order to process them through their intuitions. A patient’s chief complaint, the set of assessment findings, and, most of all, the primary impression do precisely this.

Once the paramedic determines a primary impression and performs any immediately necessary interventions, he or she then typically discusses transport options with the patient and the EMT. There are over a dozen emergency departments in the county and protocols require crews to take patients to the “closest and most appropriate” hospital. For some calls, this tends to be an easy decision. Myocardial infarction cases (i.e., heart attacks) are taken to the closest cardiac center. Stroke patients are taken to the closest stroke center. The severely wounded are taken to the closest trauma center. However, most calls are not so severe, and this gives both crews and patients some ability to select an emergency department out of one of the three or so closest hospitals.

Once a transport decision is made, the EMT will usually drive and the paramedic will remain in the back with the patient. For most transports, this means the paramedic will continue filling out the medical record started by the EMT. Sometimes the roles will reverse and paramedics will drive after “turfing” a low priority case onto the EMT. This simply means transferring the responsibility of care down to the EMT. However, EMTs still do most of the driving because county protocols limit many forms of turfing. Additionally, for many paramedics, driving is often seen as more annoying than sitting in the back with a low priority patient after a stay and play.
According to the medical records, 94 percent of MRT rigs roll into hospital ambulance bays without lights and sirens. Together, the paramedic and EMT unload the patient from the back but keep her or him on the gurney. The Hollywood cliché of crews sprinting into the emergency department while pushing the gurney occurs, but it’s rare. The reality is not usually so exciting: crews walk just inside the rear entrance of an emergency department and stand in line behind other crews who are also transporting low priority cases. This time standing in line is often called “holding the wall” and is in stark contrast to those many movie and television scenes where crews rush critically ill or injured patients directly into a hospital room.

As a crew begins to interact with the triage nurse it becomes clear why paramedics are concerned with reducing their cases to specific medical problems. Nurses usually begin with a simple question, “What you got?” The paramedic’s response might include the patient’s name or some details on where she or he was picked up, but it always includes a primary impression, a summary of the medical assessment, and details on any interventions made. Crews must simplify and standardize their clientele as sick or injured subjects not only to complete their own paperwork, but also to successfully release them into the administrative machinery of the hospital. Nurses want to know the nature of the problem (e.g., dizziness), its urgency (typically coded in the objective scores for blood pressure, heart rate, respiratory rate, oxygen saturation, blood glucose, and an A&O score), and any interventions that were made to address the problem or correct any abnormalities in the vital signs (e.g., oxygen via nasal cannula at a rate of four liters per minute).

At some hospitals, the nurses send very low priority patients to the waiting room, but usually they triage them to a bed where the paramedic and EMT roll the gurney. After wishing the patient luck, the paramedic has the nurse sign the medical report using a touch screen on the crew’s laptop. This signature officially transfers care to the hospital.

The crew will then return to the rig in the ambulance bay where more work awaits. The EMT will clean the gurney and re-tuck it with a new paper sheet before replacing and prepping any equipment that may have been used up on the previous call. Meanwhile, the paramedic will complete his or her paperwork, which at this point usually means writing the short open-ended narrative I previously mentioned.

At this point, an informal break is typically squeezed in. MRT, like many paramedical providers, does not operate the ambulance stations of yore. The firm instead runs on a “dynamic posting” system, which means they assign crews particular street intersections to park and wait for their next call. Hospital ambulance bays, and the time crews spend in them after cleaning their rig and finishing their paperwork, are some of the few places workers can rest during their shift. By waiting an extra 10 or so minutes before officially returning to 911 service, workers are able to use the restroom uninterrupted and maybe run to the hospital cafeteria. Following this break and before driving out of the ambulance bay, the EMT will announce their availability to the dispatcher. The voice on the other end assigns them a post or immediately gives them a new 911 call, should one be pending. Either way, more people work awaits.

**Kinds of People**

People work is complicated by the fact that the subjects to be labored do not enter into the worksite as uniform material. Instead, people come in with a number of physical variations, many of which are technically irrelevant for the procedures outlined above. Yet, technical irrelevance does not equal practical irrelevance. People workers collectively render otherwise
clinically insignificant physical features as meaningful information. They see different kinds of people.

We encountered some of this during Eric’s tour in the first chapter. There, the paramedic-turned-supervisor told us about “zombies,” “bangers,” and other caricatures of urban poverty. Labels like these are not uncommon or unimportant, but there are some more general distinctions that inform ambulance-based people work. Select physical features of patients, like their size and color, shape how ambulance work is performed. Crews often subtly rely on their shared understandings of such characteristics when determining the intensity and authenticity of their patient’s suffering.

For example, the weight of patients is perhaps one of the most obvious physical features of clientele that shape crews’ opinions. While in the field, I quickly learned that “fat fucks” and “heavy hitters” are generally considered to be pains in the ass. From the standpoint of workers, such bodies often force them to put their careers on the line. It only takes one “bad lift” of these substantial bodies to permanently damage a worker’s back. Yet, raw weight in pounds doesn’t fully account for their distaste. I learned that a very tall and muscular 300-pound body is more forgivable than a short and lumpy one of the same weight. A language of deservingness mixes into workers’ discussion of obese patients. But, this isn’t so much about deservingness of care as it is about deservingness of suffering. These “fat assess” bring it on themselves through a gluttonous and lethargic lifestyle. Or, so I’m told. Worker pity seems to be a bit thinner when thicker people are involved.

A patient’s age is also an important feature. With reasons justified by paramedical textbooks and county protocols, crews understand vulnerability to be intensified toward the beginnings and ends of long lives. Ambulance workers tend to look at babies, toddlers, children, and elderly people with somewhat looser standards of “real emergency.” Such hypersensitivity for the very young and the very old yields a relative hyposensitivity for working age people. The baseline assumption here is that these kinds of people are more likely to be medically “stable.” What might be seen as a critical symptom for babies and the elderly (e.g., a fever) might seem trivial for those riding the top of a presumed bell curve of health during the life course. Added to this, workers tend to see non-elderly adults as being more lucid and thus more scheming. Crews seem quicker to assume that such people are “seeking” medication by faking or exaggerating their pain. And, when punches are thrown, crews are generally more forgiving of elderly patients. Their punches are generally softer and the minds behind them are presumably much more senile.

The cleanliness of people, detected through both sight and smell, shapes the perceptions and actions of workers as well. Crews are quick to tell me that street slumbers – or “bums” – have leathery skin that is often “caked in filth.” This presents some mild concerns with their ability to gain access into the flesh. Many instruments assume a sterile body. Electrodes from the EKG, for example, sometimes fail to stick to a sweaty and greasy chest. Though, much of this can be solved with a sanitary wipe and some gloved-handed fanning. Crews are more concerned about the stench and residue that can accompany extreme material suffering. Early into my employment as an EMT, my trainer, Lance, taught me how to “burrito” smelly people with soiled clothes. It’s a simple and common procedure, but it can’t be found in textbooks or protocol books: wrap a water-repellant sheet, which is intended to shield patients from raindrops

I also found that crews tended to be quicker to doubt the suffering of teenagers. Workers often generalize these kinds of people as “whiny” and “hormonal.”
outside the ambulance, around these people in an effort minimize cleanup. In addition to containing the odors that sometimes watered our eyes and had us gagging in the confined space of the ambulance, this method helped minimize any leakage of bodily fluid onto the gurney. Thus, crews often hope to minimize the exposure of dirty flesh.

The consequences can be tragic. On a night I wasn’t in the field, a crew picked up a man lying in a park. The patient was supposedly a “bum.” Like many people in the field, I heard this story secondhand. The responding crew apparently believed the man was in a drunken slumber. However, as physicians and nurses would later surmise, this man was probably assaulted and knocked unconscious. As one paramedic told me he heard, the crew didn’t “get their hands dirty” and they subsequently missed a large hematoma underneath the patient’s knotted hair. Protocols clearly state that when a subject is unconscious for unknown reasons, the crews must perform a head-to-toe trauma assessment. They should feel for injuries and abnormalities by running their gloved hands across the entire body. As the rumor went, the crew simply didn’t do this, or they did it carelessly. They transported him as just any “ordinary drunk” they tend to encounter on a daily basis. As such, the man laid in ambulance triage at the hospital for over 30 minutes as an assumed low priority intoxication case. He died. For weeks, his case became an awful example of what can go wrong when crews don’t properly assess and touch their Leper-like clients. Many of the workers I talked to about this expressed remorse and heartbreak even though they didn’t work this particular case. They feared this scenario could happen to them if they didn’t just “suck it up” and do a proper assessment.

People’s skin color also matters. Paramedics and EMTs, who are much whiter than their clientele base, are quick to tell me that racial categories don’t influence their care.23 Several insist it’s like they don’t even see skin color beyond what’s necessary for a medical assessment (e.g., identifying pale skin as an indication of sickness). Of course, they do see race. In hospital bays, they frequently talk to each other about their “homeboy,” “esé,” and “white trash” patients. And, while muddled by perceptions of class and citizenship, a particular vision of race matters. As a physical feature essentially made salient across all spheres of interaction, skin color shapes how crews see their patients.

Over time, I learned that crews generally looked upon darker-skinned patients more suspiciously. This suspiciousness comes in two general forms, and while neither are limited to black or Latino bodies they do intensify on them. First, there is often a suspicion that such people are 911 abusers and this includes pain medication “seekers.” Second, there is a suspicion that black and Latino people are evasive and are therefore criminals trying to hide something from crews (e.g., providing a fake narrative for their injury to avoid the police). Indeed, these are like

23 Determining the race demographics inside the ambulance proves difficult. The medical records do not provide demographic data for workers or valid race information for patients. Moreover, the 566 calls I encountered in the fieldwork provide limited insight for a couple of reasons. First, they do not constitute a probability sample. Generalizability is seriously threatened. Second, race demographics drawn from the fieldwork rely heavily on my vision of race. I noted my interpretation of clientele race in my field notes and it’s unclear how well this corresponds with people’s self-identification. I generally did this for workers too, except I did occasionally ask them what race they identified as. These flaws in data collection are serious, but such data likely still captures some general patterns in the racial distribution of ambulance encounters. My fieldwork suggests that nearly two-thirds (64 percent) of paramedics and EMTs are white while about a quarter of patients (26 percent) are. It suggests that nearly half (43 percent) of patients are black, compared to about a tenth (nine percent) of workers. The proportion of Latinos (19 percent among workers and 14 percent among clientele) and Asians (seven percent among workers and eight percent among patients) suggest a relative match in distributions of these groups across the positions of crew and clientele. I also coded nine percent of patients as “other” or “unknown” in my field notes.
ambulance versions of Ronald Reagan’s welfare queen (blackness linked to welfare abuse) and George H. Bush’s Willie Horton (blackness linked to criminality).

Like perceptions of bodily cleanliness, visions of race can seem to risk devastating outcomes. This became especially obvious to me once I started working as an EMT. Like many novice ambulance workers, I eventually became accustomed to the term, “Hispanic Panic.” Sometimes this is just called “HP.” The idea is that many Latino patients (especially older women who immigrated to the United States) exaggerate their suffering or get unnecessarily “carried away” with grief. I like to tell myself that I am above such language, but this is a lie. While I still don’t think I ever uttered the term at work, I nevertheless learned to hear this as code for insignificant suffering.

This became especially worrisome when paramedic Matt and I responded to a high school near some of the “barrios” that Eric drove me through months earlier. We found a teenage girl sprawled on the ground outside, surrounded by students, teachers, and firefighters. As I lowered the gurney, a firefighter whispered his suspicion into my ear. He figured this could be just a case of “HP.” In other words, this was probably not a real, let alone a severe, emergency. It wasn’t until we were in the ambulance, when I rubbed my knuckle into this girl’s sternum, that Matt and I realized something was wrong. She didn’t respond to my painful stimulus, which I was trained to use as an easy way to detect the level and authenticity of unconsciousness. I remember thinking to myself, “Why the fuck didn’t fire figure this out on scene?” It was only then, after double checking a test the firefighters should have done, that Matt and I started taking this girl’s problem seriously. We ended up rushing her to the hospital with lights and sirens, suspecting a brain bleed. It’s certainly possible that we would have assumed the girl was “faking it” if she was not Latina and if the firefighter didn’t tell us he suspected Hispanic Panic. However, more than any other call, this one taught me how racialized visions of clientele can be mixed with perceptions of authentic suffering.

The gender of clientele also matters independently of these other factors. Just as race relations in the ambulance are shaped by the fact that crews are disproportionately white in reference to their clientele, gender relations are shaped by the fact that crews are disproportionately male. As a kind of people to work on, women occasionally come with some uncomfortable material to labor according to many of my colleagues. A number of men told me they generally don’t like calls “involving the vagina” (e.g., pregnancy, miscarriage, sexual assault). To be clear, these workers don’t prefer penis calls either, but there’s something about female genitalia in a clinical space that they find especially distasteful. Additionally, many paramedics and EMTs tell me they find women’s breasts to be mildly uncomfortable material to work with, especially if they need to lift one in order to place an electrode for an EKG. It’s impossible to say for sure, but this could mean fewer EKG screenings for women who might otherwise benefit from such a procedure.

On the flipside, there are cases in which the adult female body is desired, especially if it’s young, clean, and thin. Some male workers candidly told me about their excitement in “stripping and flipping” attractive women (e.g., removing or cutting their clothes to check for trauma). However, there are some fine moral boundaries here. The strip and flip needs to be necessary and

---

24 Of the ambulance medical records I examined, 50 percent of the cases were classified as female. I found roughly the same distribution in my fieldwork. I don’t have representative demographic data on MRT crews. However, of those who I shadowed and worked with, 75 percent were male. This distribution seems to also hold across paramedics (75 percent male) and EMTs (74 percent male).
justified or else fellow ambulance workers, nurses, and even the patient may reasonably accuse the scissors-wielding ambulance worker of being a “creep.” But even beyond this specific procedure, my colleagues frequently exchanged stories of the beautiful women they worked on. Simply talking to such people seemed to bring them pleasure.

**Labor of Regulation**

Ambulance crews churn through an array of people that concentrate toward the bottom of the class and racial hierarchy in Moon County. All workers transform the world in some way and ambulance workers are no different. Their labor, however, focuses on transforming abnormality into normality. At its core, ambulance-based people work involves a labor of regulation.

On the one hand, crews identify and mitigate problems located inside the human body. Using a number of tools and techniques, they peer into people as anatomically and philologically divided structures. They look for abnormalities and then work to correct them with more tools and techniques. Among other things, these workers lift falling blood pressures, ventilate breathless airways, and alleviate pain. The point is to help restore some order to people who are disordered from within.

On the other hand, crews also labor to restore some order to disorder that exists outside individual structures of flesh and bone. They carry ill and injured bodies from streets, homes, and other places into the hospital. In this way, they temporarily cleanse certain sections of the world of certain abnormal bodies. Crews pipeline the sick from spaces they’re ill-fit for and into the clinical spaces that more or less welcome them.

Both of these regulations – of spaces in bodies and of bodies in spaces – can be dramatic, such as when a crew shoves tubing down a patient’s throat or when they drag an unconscious and bloody body off the sidewalk. However, these regulations need not be so extreme. This is obvious when crews simply give patients a Zofran pill for nausea relief or when they’re summoned to transport a “non-urgent” patient from home to the emergency department.

Regardless of its intensity, this labor of regulation is complicated by the very materials that crews must work with: people. As Goffman (1969) tells us, this material is peculiar for a number of reasons, including its many protections under mutable notions of “humane treatment” and its variable appeal to frontline empathy. I hold that people are also hard to labor because they’re differentiated by certain physical differences that workers collectively render as meaningful distinctions (e.g., fat, old, dirty, black, and female). In other words, people workers understand there to be different kinds of people and this can shape the labor they perform. My fieldwork convinces me that these distinctions, which are intermixed with broader social divisions that exist outside the worksite, can establish the possibilities for biases in examination and treatment. The next chapter, however, points to another axis of distinction that is more fundamental for understanding what’s happening inside the ambulance: the gradient between “legit” cases and “bullshit” cases.
Chapter 3
Ditch Doctors and Taxi Drivers

Ambulance crews work in ostensibly wild places. They step onto scenes made of dismembered flesh, broken glass, and hysterical bystanders. Even in less dramatic circumstances, they’re summoned to provide some order to disorder, such as when they’re called to temper someone’s rapid breathing or when they’re tasked with removing an intoxicated body off the sidewalk. Added to this, they’re frequently encountering people who verbalize multiple hardships interwoven into convoluted narratives of personal suffering.

A significant portion of ambulance work involves these men and women making sense of the world. They must decipher the wilderness if they hope to work in it. In addition to translating clientele problems into a primary impression category that is made legible to protocol (“checking a box”), crews mentally carve the world into informal classifications. These include shared understandings of categories like “ghetto” and “junkie” and even more particular labels like Eric’s “little nexus of evil” and “zombies” discussed in Chapter 1. These also include the “kinds of people” that crews distinguish by skin color, cleanliness, weight, and other physical features covered in the previous chapter.

However, I hold that there is another meaning-making scheme at play inside the ambulance. It concerns the informal distinction that workers make between “legit” and “bullshit” work. This distinction is not just a reflection of how crews see their labor but also how they see themselves. Both paramedics and EMTs generally understand ambulance work to be a craft, albeit a low-paid and under-recognized one. At the same time, they frequently highlight how this craft – what they “signed up for” – is frequently denied to them on the jobsite. What they want to do doesn’t typically match what they actually do. They want to be “ditch doctors” who handle legit medical emergencies by performing relatively deep, technical, and timely interventions into the human body. However, as many are quick to note, they are more typically cast to act like “taxi drivers” who do little more than transport bullshit cases to the hospital.

Legit and Bullshit

Before digging into some specific examples, allow me to clarify the legit-bullshit distinction that ambulance crews are regularly articulating at work. Legit calls are the so-called “real emergencies” that necessitate and justify the craft of paramedicine. These are the cases that call on crews to exercise relatively deep and timely clinical interventions in an effort to salvage living bodies. These are the calls that have crews compressing lifeless chests, splinting broken bones, and ventilating breathless airways. They can also include calls where crews are using narcotics to mitigate “real” pain. Legit calls can be contrasted with bullshit calls. The latter are the so-called “non-emergencies” and the cases that seem to be generally misplaced inside the ambulance. Unlike legit calls, bullshit calls don’t typically involve much of an intervention into the body. They are mundane at best and infuriatingly insulting at worst.

Together, these categories are best understood as ideals and as two poles on a continuum. Most cases fall somewhere between the purified versions of these classifications, but crews generally locate their cases closer to one end over the other. Instead of saying a call was “totally legit” or “totally bullshit,” I found that crews were more likely to say a call was “pretty legit” or “mostly bullshit” and sometimes they even say a call is in a “gray area” on this continuum.
Table 3.1 further distinguishes legit and bullshit calls in the abstract. Legit calls tend to correspond with a regulation of spaces in bodies. These are cases where crews locate a legitimate problem inside their patient’s body and then take efforts to correct that problem, such as when they administer albuterol to compensate respiratory distress or push antiarrhythmic drugs to fix an abnormal cardiac rhythm. Bullshit calls tend to correspond to the inverse regulation. These cases are defined less by an adjustment to spaces in bodies and more by an adjustment to bodies in spaces, like when they transport a clinically stable 911 caller to the hospital for a prescription refill or some other “misuse” of emergency services as primary care. While the correspondence is not perfect, ambulance crews generally associate good work and legitimacy with deep clinical interventions and bad work and bullshit with shallow clinical interventions. Again, they want to be “ditch doctors,” not “taxi drivers.”

<table>
<thead>
<tr>
<th>Table 3.1. Legit Calls and Bullshit Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legit Calls</td>
</tr>
<tr>
<td>Regulation</td>
</tr>
<tr>
<td>Vocation</td>
</tr>
<tr>
<td>Primary Skillset</td>
</tr>
<tr>
<td>Relation w/ Client</td>
</tr>
<tr>
<td>Relative Frequency</td>
</tr>
</tbody>
</table>

Another distinction is thus important. Legit calls and the laboring of spaces in bodies correspond to ambulance work as a vocation and bullshit calls and the laboring of bodies in spaces do not. The former is generally linked to ambulance work as a craft and the latter isn’t. While legit calls are more obviously associated with the skillset of paramedics (who lead clinical intervention) and bullshit calls are more obviously associated with the skillset of EMTs (who do most of the driving), it’s important to note that both paramedics and EMTs prefer legit calls.25

The “goodness” of legit calls can be detected not only in the enthusiastic summaries provided by workers but often also in the interaction between crews and their clientele. Such calls often lead to moments of organic solidarity, where clientele not only need crews (sometimes to live) but crews need clientele with legit complaints to realize a sense of honor and purpose at the worksite. Bullshit calls, on the other hand, often lead to moments of verbal struggle where crews blame their clientele for abusing ambulance services and clientele accuse crews of being assholes who don’t care about them, their problems, or their communities. The final variation highlight in the table concerns relative frequency. Most calls are toward the bullshit end of the continuum.

Evidence for this latter point can be demonstrated in the medical records (Figure 3.1). While crews obviously do not provide a legit/bullshit score, protocol mandates that they report in somewhat granular detail the clinical interventions made. Research on intervention severity can help us make sense of these records. Originating from a focus group study that asked paramedics

25 When Dorothy Douglas (1969: 68-9), arguably the first ethnographer of the ambulance, studied crews she noticed that the “driver” was like the “captain of the ship” and the “attendant” in the back was tasked with doing the less desirable people work. No longer. The paramedic (today’s “attendant”) now holds the more honorable position of regulating spaces in bodies while the EMT (today’s “driver”) handles the less respectable transformation of bodies in spaces. This inversion is likely due in large part to the professionalization of paramedicine, the increased technical scope of the vocation, and contemporary licensing guidelines that more clearly separate the roles of paramedics and EMTs. Regardless of the reason, one thing is for sure: crews today would be generally offended by Douglas’ description of ambulance work as “essentially a truck-driving operation” (Douglas 1969: 8).
to rank clinical interventions in terms of their severity, this scholarship offers a three-level ranking system that generally maps onto an ethnographically detected continuum in legit and bullshit calls (Sporer et al. 2010; see also: Seim, English, and Sporer 2017 and Seim et al. 2018). Under this framework, higher severity calls involve more depth into the patient’s body: intubation, bronchodilators, defibrillation, antiarrhythmic drugs, etc. Lower severity calls involve comparably shallow interventions and don’t involve much beyond some low-flow oxygen, an icepack, or a simple transport to the hospital. The middle category approximates a middle depth: pain medication, high flow oxygen, anti-nausea medication, etc. As evident in Figure 3.1, most calls involve shallow rather than deep interventions. Most are better characterized as bullshit than as legit.

![Figure 3.1. Intervention Severity](chart)

**Figure 3.1. Intervention Severity**

*Note: Observations = 107,089.*

*Source: MRT De-Identified Patient Care Reports, 2015*

Ethnographic analysis, however, tends to do a better job of revealing this continuum. Indeed, this chapter more or less emboldens a central theme in ambulance ethnography. Dorothy Douglas’ (1969: 10) groundbreaking study of the ambulance offers a distinction between a “good load” and a “bad load,” with the former capturing the so-called real emergency. Likewise, Donald Metz (1981: 116-124) draws a distinction between “good runs” and “shit calls,” before he cuts the latter into some more specific types: “walkers,” “regulars,” “fakers,” and “drunks.” Comparable distinctions can be found in the works by James Mannon (1993), Eddie Palmer (1983), and Michael Corman (2017). Ultimately, my contribution lies not in the revelation of

---

26 I confirmed the internal validity of this measurement though informal conversations with MRT paramedics and with a physician before imposing it onto the medical records.

27 James Mannon (1992: 101-45) might offer the most complexity by specifying certain forms of “good runs” (e.g., cases highlighted in the media, actual “saves,” and cases that involve highly technical intervention) and “bad runs” (e.g., “dirty work” and “illegitimate runs”). His concept of “dirty work” often captures what I will call “nightmare calls” and his concept of “illegitimate runs” is generally synonymous with what I call “bullshit calls.” There is an essential difference in observed frequency of “bullshit”/“illegitimate” calls when comparing my analysis with Mannon’s. Perhaps because Mannon was researching a less impoverished county at different period with a stronger overall safety net or because he imposed a stricter operationalization of his concept, he concludes that illegitimate calls “constitutes the smallest number of runs” (Mannon 1992: 125). I insist the opposite. In addition to drawing on over 100,000 medical records to suggest that most calls are “low severity,” my ethnographic data overwhelming suggest crews assume most calls are closer to the bullshit end of the continuum.
this already documented distinction that ambulance crews use to make sense of their work but in my efforts to reveal how this distinction informs our understanding of a labor process more generally. Over the next several chapters, I show how this taken-for-granted classification of clientele problems informs both the practical and the relational components of labor inside the ambulance. However, the chapter at hand is more focused on describing the differences between legit and bullshit calls.

**Catching a Legit Call**

During my year of shadowing ambulance crews, most shifts began with crews hoping I’d “catch something good.” Later, as an employee, I learned that this is a somewhat common thing to say to ride-alongs, like the EMT students and physician residents that occasionally accompany MRT crews. Paramedics and EMTs generally hope that their guests get to see the craft of paramedicine in action, maybe the plugging of a gunshot wound, maybe the administration of naloxone (the so-called miracle drug that can bring people overdosed on opioids back to life), or maybe – just maybe – a “code” (e.g., a cardiac arrest where a resuscitation effort is made through chest compression, airway intubation, and other deep interventions).

Many crews said they hoped, as we departed from headquarters for the day or night, that I wouldn’t be a “white cloud” or bring the “curse of the ride-along.” These clouds and curses might be the reason why I wouldn’t see a “legit” call. Crews would also speculate on what could lift our chances of catching legit calls. Some night crews told me that the moon would be a curious predictor: a full one can summon a bizarre brutality in the city. A bit more seriously, many workers told me that weather and welfare play a role. Apparently, when it’s hot outside people will be more likely shoot and stab each other. And some tell me that legit calls can peak on the first and 15th days of the month because everybody’s partying extra hard in the ghettos off their welfare checks. Benefits are supposedly distributed around that time. The “junkies” will get super high and Uncle Sam will cover the bill. Or so I’m told.

However, the real junkies might actually be the ambulance crews. Eddie Palmer (1983), another ambulance ethnographer, describes paramedics and EMTs as “trauma junkies.” Arguing that these workers realize “role validation” through “advanced lifesaving, rescue, and medical skills,” he notes that severe trauma calls in particular become like an “occupational drug” and can lead to a “psychological high” for crews. There seems to be a degree of truth to this assessment.

Consider a call involving two critically injured patients. Per witnesses and victims, a 20 or so year old Latino man named Saul got into an argument with a couple of “bad dudes” in the parking lot of his apartment complex in the general area Eric called “the killing fields.” It’s never clear why the men were fighting, but at some point the dudes struck Saul several times with a lead pipe. Saul’s father, Manuel, heard the beating from the second floor of the apartment building and ran downstairs to defend his son. In return, one of these men drew a pistol, but not before Manuel could lift Saul from the ground. The father-son duo ran back toward their apartment. As they retreated up the exterior stairs of the building, their gun-wielding enemy aimed high and squeezed the trigger. He sent a bullet upward, through the Manuel’s groin and into his guts. Saul and his dad crawled into their apartment and the other men fled the scene.

Shortly thereafter, two ambulance crews, a supervisor, and a notebook toting ethnographer show up. We enter the apartment shortly after police and firefighters to find a bloodied and dizzy Saul vomiting in the kitchen (a sign of severe head trauma). Manuel is on the
living room couch, soaking the cushions with blood. Both of these men are separately transported to a local trauma center, and Manuel is driven with lights and sirens. While a paramedic was able to plug the wound and prevent more blood from spilling outside of the gunshot victim’s body, he couldn’t control the blood that was spilling inside him. Luckily, the paramedic was able to “challenge” a corresponding drop in blood pressure by administering saline via IV therapy. After Saul and Manuel were dropped on hospital beds, the two crews, the supervisor, and I convened in the hospital’s ambulance bay. Despite the grim circumstances of the call, everyone is smiling and laughing. It seems like a strange celebration of urban violence. The crews share opinions on the event and tell other coworkers in the bay about the call. Spirits are high because the call was good.

Such severe trauma (i.e., physical injury) calls are not the only way crews can realize a sense of honor or purpose inside the ambulance. A good non-traumatic “medical call,” like a diabetic emergency, a stroke, or even a legitimate pain management call, are also often welcome. And they do not necessarily have to require such swift interventions. While riding around in ambulances and talking with crews, I quickly realized that legit calls simply mean events that necessitate ambulance response as a form of medical intervention, ideally beyond a simple transport to the hospital. A legit call does not necessarily mean a life-threatening emergency or a blood splattered scene. It also doesn’t mean the call needs to be very memorable. Ambulance crews simply desire patients with “real physical pathologies” that are made legible by the craft of paramedicine. They are primarily concerned with physiological emergencies and there is significant variation in both the intensity and type of ambulance call.

Calls closer to the legit end of the continuum also lead to moments of solidarity between crews and clientele. It’s a solidarity of interdependence, where each party essentially need one another. Patients not only need crews, in some cases to live, but crews in a way need patients with legit complaints to realize a sense honor and purpose at the worksite. Saul and his father were writhing in pain, but legit calls with more lucid patients often include moments of desperation and gratitude. Patients beg their crews to mitigate their suffering and in some cases to keep them living (“Don’t let me die! Don’t let me die!”). They often thank their crews, sometimes for “saving” them. Meanwhile, crews, often “hungry” for a legit call, tell me they “need something good.” As Palmer (1983) might put it, they need “their fix.” Legit cases allow crews to realize their craft. Unfortunately for them, legit calls are relatively rare.

Dealing with a Bullshit Call

On another shift, I shadow Mark and Danny. This veteran crew has been working together for well over a decade. Both are men in their 50s, but Mark is white and Danny is Latino. Mark, the paramedic, entered his current profession after years of “boring office work,” and Danny entered after leaving a truck driving gig. I don’t know it at the time, but in about three months Danny will teach me how to drive an ambulance.

28 I borrow the phrase of “real physical pathology” from Howard Becker (1993: 33). His ethnography of medical students taught him the difference between “crock’s” and otherwise legitimate medical cases. The difference here is that paramedics and EMTs are concerned not only with real physical pathologies but also emergencies that require timely interventions in the field. They often see patients with verified chronic problems but with stable symptoms as “bullshit” cases that are better placed in primary care settings rather than emergency medicine (let alone the ambulance). That said, their preferences cannot be reduced to “emergency” alone. They are interested in biomedical emergencies, and thus more emotional, social, and even “mental” crises are less desirable than problems more clearly identified within subjects as fleshy beings.
Mark and Danny are summoned to an apartment complex a few miles from where Saul’s father was shot. They both groan when they read the specific address they’re summoned to. “Oh fuck!” exclaims Danny, “Again?” They’re called to a person who summons the ambulance a lot, a “frequently flyer.” After he parks the ambulance at this location, Danny tells me they will not need the gurney. “She’s walking,” he says in a frustrated tone that makes it sound like he’s going to vengefully make her walk. They head up some exterior steps of an apartment complex. Danny points to one of the steps. “See that, Josh?” It’s an electrode sticker that matches what MRT crews use to run EKGs. Danny suspects it’s from the last time an ambulance crew was here responding to this “regular.” “That’s the kind of shit we gotta deal with,” says Danny, “But you know, though. You’ve seen shit like that before, huh? It’s ridiculous.”

When we get to the apartment door, we’re greeted by a woman who tells us that her sister is the one who requested an ambulance. “Oh yeah, we know,” says Danny through a sigh. The patient is Denise, a black woman in her early 50s. “What’s wrong?” Mark asks her. “I got this burning on my insides. It’s burning me inside and out.” Mark is unimpressed with this woman who stands in the doorway with her purse in hand. As he’ll later say to me, she was standing there “ready for a taxi ride.” Danny responds to the woman’s complaint of internal burning, “So you want to go to the hospital?” “Yeah, that’s where you go when you’re sick, right? You go to the hospital when you’re sick.” “Ok,” concedes Danny, “Let’s go.” Her sister pulls me to the side and tells me she thinks Denise is off her “psych meds,” and I tell her I’ll relay the information to the crew. When I whisper this to Mark on our way back to the rig, he simply shrugs.

Denise follows us to the ambulance. She steps inside and sits on the gurney. Where the crews on the call for Saul and his father did a “load and go,” Denise’ crew “stays and plays.” Mark does the usual assessment. All objective signs suggest there’s no emergency here and Danny will later explain to me that the woman couldn’t have been “in that much pain” given her behavior and speech pattern. Mark asks, “Do you think it’s heartburn?” “I don’t know what it is. It’s burning all over.” Eventually, Mark “objectively” determines this to be low enough priority call that he can turf it to Danny. He jumps out the back and drives us toward the hospital.

During the commute, Danny and Denise argue. Danny is frustrated that his patient refuses to score her pain on a scale of one to ten, which is required for the medical record. “Come on,” says Danny, “I know you’ve had to answer questions like this before. Why are you making it difficult?” Later Danny will tell me Denise is abusing 911, but he’s not sure why. A pain med seeker usually provides a ten out of ten or “higher” score (e.g., “a thousand out of ten!”). Frustration seems to flow in both directions though. Denise mumbles something I can’t hear, but Danny later tells me it was “the race card.” And if there’s one thing that’s almost guaranteed to annoy a paramedic or EMT, it’s that damn race card. He snaps back, “Don’t bring up race. You did this last time. This has nothing to do with race.” Danny seems to stop just before telling her what this probably has to deal with in his opinion: Denise is wasting his time with a bullshit call.

While holding the wall at the emergency department and waiting for triage, Mark turns to Denise. He gives her the lecture Danny seemed tempted to give. He says, “You know, I’m about the same age as you. Do you know how many time I’ve been to the ER (emergency room)?” Denise, who now lays on the ambulance gurney inside the hospital, doesn’t respond. “Twice,” he says, “That’s it. Twice.” “I didn’t make myself sick,” responds Denise. “Ok,” continues Mark, “But why don’t you take care of yourself?” She responds, “You don’t know what I’ve been through. You’d be shocked if you’ve seen the things I’ve seen.” Mark doesn’t like this answer
and responds, “You’d be more shocked if you’ve seen the things I’ve seen on a given day. Trust me.” I think Mark is implying he knows true suffering because he encounters it daily at work. “I’m a good person,” says Denise, “I don’t want to be sick anymore. What do you want me to do?” “Call your doctor,” says Mark, “Don’t call 911.” “But I hurt now.” “Call your doctor,” repeats Mark. “What am I supposed to do when I’m burning at home?” “Call. Your. Doctor.”

Once Denise is given a room, she complains to a nurse that Mark just wants her to die. Upon hearing this, Mark whispers in my ear as we leave the room, “She’d be doing us all a favor.” We step into the bay and I help Mark clean the rig while Danny completes his medical record. Mark tells me he hoped his conversation with Denise would be a “teachable moment.” “Do you think it worked?” I asked. “Nope. Not today.”

Crews often associate regulars like Denise with bullshit, but it’s important to note that people are not classified as bullshit or legit. Instead, cases are categorized as such. Indeed, there are some regulars that slide between the legit and bullshit poles, depending on how “truly” sick or injured they are during a given ambulance encounter. For example, a woman a few miles away from Denise’s apartment calls frequently for breathing problems. It’s usually bullshit, but it’s also well known among the fleet that on a couple of occasions crews needed to provide aggressive airway management to this woman and she was recently “tubed” (intubated) at the hospital.

But like legit calls, bullshit calls take many forms. Consider some other scenarios. A young man calls 911 for what the crew describes as a “papercut” after a knife fight. Someone calls for COPD exacerbation and feels better when sat up and given a bit of oxygen. A man misses his curfew at a transitional housing facility and then uses a payphone to dial 911: he decides then and there that he wants to go to the hospital for a leg injury he sustained weeks ago. A woman misses her regular dialysis appointment and calls to be taken to the emergency department so she can be dialized. A young girl seems to fake a seizure for “attention” while at school. A worried mother calls for her toddler’s moderate fever.

Crews may visualize some significant problem with many of these cases. For example, Mark tells me Denise does have a “real psych” issue. But these are problems that ambulance crews generally believe they cannot reasonably address. The corresponding solutions exist somewhere outside the ambulance. Some paramedics and EMTs tell me their clientele need housing, food, and cash. But many locate the root problem in the lifestyles and behaviors of their clientele. They need to find employment, stop drinking, and do a better job taking care of themselves. But, perhaps above all, they need to stop requesting the ambulance for problems this institution is not equipped to handle.

As with legit calls, bullshit calls concentrate in poorer neighborhoods. However, the wealthier hills and suburbs summon ambulances for “inappropriate” reasons as well. Crews tell me that there’s a higher ratio of bullshit calls in the ghettos and hoods. Whether this assumed ratio is true or not (I actually found little support for it the medical records I acquired), there are simply more bullshit calls than legit calls and all call types seem to gravitate toward urban poverty. Thus, the modal call for MRT crews seems to be a bullshit one involving a body collected near the bottom of the polarized city. Instead of approximating the caricature of the “ditch doctor” who aids an entire county during clinically relevant crises, crews are usually frustratingly closer to embodying the image of a “taxi driver” in poor neighborhoods.
Ambiguous Moments

There is little doubt that most crews would consider the case of Saul and his father to be legit and the case of Denise to be bullshit. However, there are some more obvious gray area cases and they too can help clarify this distinction in legit and bullshit calls. Consider a third example, one where the responding crew loosely considers legit even if the interventions are not very deep or time sensitive.

I’m riding with Paramedic Mason, a Latino man in his late 30s and EMT Rocky, also a Latino man around the same age. I’ll spend the night with these men awake in the ambulance, from 6:30pm Saturday to 6:30am Sunday. Our first call of the night brings us near, but not quite inside, Eric’s “little nexus of evil.” We enter an apartment to find Barry, a black man in his late 50s sitting on his couch speaking to firefighters. He’s wincing and seems unnecessarily sweaty given the temperature of the room. A fire medic tells us they just arrived to the apartment but he’s already done some of the work of classifying the event for Mason. “Looks like abdominal pain,” he says before he and the other firefighters in his unit depart the scene.

Mason and Rocky aid Barry inside the ambulance, which is still parked outside his apartment. Unlike the crews on the call for Saul and his father but like Denise’s crew, Barry’s paramedic and EMT “stay and play.” Meanwhile, his wife and her friend sit in a car and plan to follow us to the hospital. Situations like this typically frustrate crews as they tell me that friends and family should just drive the patient to the hospital themselves rather than waste 911 resources. However, Mason doesn’t express this sentiment for Barry’s call and will later tell me that Barry would have had to unnecessarily suffer in the hospital waiting room on a busy Saturday night if he didn’t go by ambulance. At the conclusion of the transport, Mason will tell me in the ambulance bay, “It’s a pain management call, straight up. It’s legitimate though. His wife could have drove him, but he gets medication quicker in the ambulance.”

Inside the parked rig, Rocky begins a medical record on the laptop and Mason asks Barry a series of questions while collecting vitals via the monitor. Barry explains he has a history of hernia pain. “Oh, that’s why your abdomen is so extended,” says Mason as he triangulates a subjective complaint with an objective observation. Barry, still wincing and clenching, explains in a pained voice that he also has a history of high blood pressure and cysts on his liver and kidneys. There’s a lot going on in there – inside Barry’s body – and Mason has no doubt that there is a real physical pathology to explain the man’s suffering. Mason’s assessment continues by asking Barry to rank the intensity of his pain on a scale of one to ten, to which Barry responds, “It was a ten at first, but it’s like a nine now.” He explains he was going to wait to see his primary care physician at an appointment in a couple of days but the pain has become too unbearable. Mason seems to genuinely sympathize with Barry as he tells the paramedic he had to “work through the pain” today while at his low-level job at a nursing facility.

Rocky drives us to the hospital and I sit in the back with Mason and his patient. His intervention into Barry’s body is mild, but for the paramedic it is justified and valuable. He pierces an 18-gauge needle into Barry’s arm to “access” a vein. In withdrawing the metal needle, Mason leaves a tiny catheter in the vein which he then attaches to a “saline lock,” essentially a couple inches of exterior tubing that he then tapes to Barry’s arm. Mason is skilled and is able to accomplish this delicate procedure in a moving ambulance on the first attempt. He then uses a syringe to push fentanyl, a pain medication, into a port on the saline lock. After a few minutes, Barry’s posture and face relaxes. “I can feel this pain med,” he says. “Yeah, it works good, huh?”
saying Mason as he continues to type the medical record Rocky started. “Thank you,” says a relieved Barry. “No problem, man.”

Calls like this one are not particularly exciting or the “most legit.” Using the intervention-based severity scheme I imposed on the medical records, this would be a “medium” call, in gray area between high/legit and low/bullshit. But Mason is clear: this call is legit, even if not very thrilling. It’s not one that you will find crews bragging to each other about in ambulance bays or the type of call they might hope their ride-alongs witness. Nonetheless, Mason sees Barry’s suffering as a legitimate crisis and one that he has the tools and skills to mitigate. It’s a “real” pain management call and one the paramedic seems to find some sense of duty in treating through a mild intervention into the blood stream. The crews I shadowed are not just “trauma junkies” as Palmer insists. The fleet is not made up of blood thirsty adrenaline fiends. These workers typically characterize themselves as emergency care professionals, as “ditch doctors,” who are broadly equipped to aid a variety of crises whether “traumatic” (injury) or “medical” (illness) in nature.

There’s also something to be said about the similarities between Denise’s internal burning and Barry’s abdominal pain. While they are different genders and picked up from opposite ends of town by unique crews, I suspect most paramedics and EMTs would classify Denise’ case as bullshit and Barry’s case as closer to legit or at least in a more obvious gray area. The latter is more clearly linked to a “real physical pathology” and is rendered more visible through Foucault’s “medical gaze.” But while The Birth of Clinic’s author is right to claim that the medical examination today asks patients to locate suffering in the body through a central question – “Where does it hurt?” – that question is not sufficient. In order to be best transformed into what Prottas (1979) calls a “client” inside the ambulance, alert and oriented patients need to provide some additional answers that Barry gave but Denise did not (e.g., pain score and relevant medical history). Perhaps more importantly, subjective pain should also correspond to some objective symptomology (e.g., Barry’s distention, sweating, and clenching versus Denise’s relatively “symptomless” presentation on scene and in the ambulance).

The words “legit” and “bullshit” are part of the lexicon, but as already noted these are ideals. When prompted, most workers had difficulty stating if a call was totally bullshit or fully legit. Phrases like “mostly bullshit” and “mostly legit” were common and accounted for some admitted doubt: a mostly bullshit case could have some latent legitimacy and some seemingly legitimate cases may secretly carry some inauthenticity.

There are also some more obvious moments of ambiguity. Many death cases are examples of this. Some deceased people are initially “worked up” with compression, intubation, injection and other interventions before they’re “called” (i.e., pronounced dead in the field). Despite a deep intervention into the body (likely the deepest of the month for a fulltime paramedic), crews do not consider such death cases desirable at the conclusion of the call given the grim outcome. Other deceased bodies are not even worked up because the crew identifies rigor mortis or other obvious signs of death when they first see the victim. Still, crews do not consider such cases to be bullshit because the case was recently linked to a legit bodily crisis that concluded with a violent, surprising, or “natural” passing.

29 James Mannon (1992: 132-7) discusses something similar: “futile runs.” These are “occasions when an all-out effort is expended on a patient whose medical condition is so hopeless that the paramedics have little or no chance for success” (Mannon 1992: 131-2). See also: Donald Metz’s (1981: 126-8) discussion of “the dead and the dying.”
Additionally, there are scenarios where a call is *too legit* but not necessarily fatal. These are “nightmare calls” that are so grotesque and haunting they cannot clearly be considered a “good call” according to crews. Paramedics and EMTs often noted how the mutilated and limp bodies of children and babies were especially chilling. Even if the outcome is desirable in terms of a “real save,” the dark circumstances of some legit calls, such as rapes, can overshadow the rewarding aspects of the case.

In short, there are no shortage of examples that can be used to complicate the legit-bullshit distinction that I insist is so important for understanding ambulance work. However, those cases that seem to fall in a gray area or somehow beyond the continuum (e.g., nightmare calls) are nevertheless generally interpreted with some distinctions in legit and bullshit in mind. Crews may shrug some calls off as “not quite bullshit but not quite legit” and recognize others as so legit that they become undesirable, but they nevertheless make sense of such ambiguity relative to a shared schema that heavily organizes their perceptions of good and bad work. The existence of ambiguity doesn’t threaten the validity of the proposed distinction; rather it simply helps clarify the boundaries.

**The Moral Order of Cases**

Ambulance work is as much mental as it is manual. In addition to physically transforming the world, ambulance crews, like all frontline workers, also symbolically transform it. They transform citizens into the status of clients and they do this in large part by simplifying clientele into categories that are recognizable to the administrative machinery of emergency medicine. But in addition to imposing formal classifications (e.g., determining primarily impression, logging vital signs, and documenting pertinent medical history), ambulance crews also impose informal classifications, like “bum” and “Hispanic Panic,” onto their clientele. These are shared categories that crews often use to make sense of their clientele from backstage.

The central informal classification, however, concerns a distinction between “legit” and “bullshit” calls. This moral distinction shapes, and is shaped by, crews’ material adjustments of the world, with legit calls usually involving a deep regulation of spaces in bodies and bullshit calls usually involving little more than a regulation of bodies in spaces. It’s not only a retrospective estimation of a call’s value, it’s also a triaging device for determining how to handle particular cases. This distinction is perhaps best understood as a form of vision, as a lens through which these workers see the very world they transform.

Although heavily conceptual and not very explanatory, this is a lynchpin chapter. Understanding the moral order that workers impose on their work will be essential for deciphering both the horizontal and vertical social relations through which ambulance operations occur. Perhaps the most important takeaway lessons from this chapter are best stated as a question and an answer. The question: why do ambulance crews generally prefer legit calls over bullshit calls if the former are physically, mentally, and emotionally more exhausting? Indeed, legit calls generally require more tiring movements (e.g., rapid extraction), include relatively stressful procedures (e.g., complicated paperwork), and come with an increased risk of emotional depletion (e.g., coping with a patient dying in the ambulance). The short answer: they’re committed to ambulance work as a craft. Legit calls provide an opportunity to realize paramedicine as a vocation, while bullshit calls typically offer a recurring reminder that the dream of “real ambulance work” is dead, dying, or never existed in the first place.
I end this chapter with a couple of reminders. First, as you read the remainder of this dissertation, remember that the legit-bullshit distinction are not labels imposed onto persons. Instead, they’re labels imposed onto problems. Put another way, this is a worker-made classification in kinds of cases, not kinds of people. As I already noted, individuals can slide across the legit-bullshit continuum.

Second, while I argue that this distinction in kinds of cases is more fundamental than the distinctions they make in kinds of people (e.g., race and gender), it’s important to remember that I don’t intend to suggest that the latter are unimportant. As I detailed in the previous chapter, there is little doubt that the socially significant physical features of clientele shape the labor process and, in a partial break from Goffman (1969), I suggest this is a key feature of so-called people work. Yet, the moral classification I detail in this chapter transcends the other divisions of human material in important ways. Crews generally prefer to work a legit fatty than a “better” shaped body with a bullshit problem. They’d rather aid a seriously ill working age adult than a “false alarm” geriatric patient. These workers would rather assist a dirty body with a legit problem than a clean one with a bullshit problem. Crews overwhelmingly prefer to treat a gunshot or cardiac arrest patient who is black than a white patient with a non-urgent complaint. And while the female body offers some complications – some push and pull in terms of desirability – the central distinction in desirability concerns whether or not the body, however it’s gendered, presents as a legit or bullshit case. The kinds of people matter by shaping perceptions of authentic suffering and other clues for “legitimacy,” but the kinds of cases sorted on a legit-bullshit continuum typically matter more.

The next chapter continues an effort to explicate life inside the ambulance by examining a dimension only briefly discussed so far: emotion. In an effort to better explain the previously noted link between legit calls and solidarity and bullshit calls and struggle, I’ll illustrate how legit calls and bullshit calls correspond to two interactional styles linked to the affectual experiences of labor: what I call “being a dick” and “having heart.” The former is an apathetic disposition while the latter is a sympathetic one. I argue that both orientations, which I learned firsthand as a novice EMT, are linked to experiences with legit and bullshit calls in complicated, but nevertheless patterned, ways. Ambulance patients are variably handled by both warm and cold hands and to understand this we must not only consider what crews see but also what they feel.
Chapter 4
The Emotional Thread

Maybe due to morbid curiosity or a general concern for my emotional wellbeing, my friends and family often asked me a question that paramedics and EMTs seem to universally hate, “What’s the worst thing you’ve seen?” With minimal details, I’d offer brief visual descriptions that only seemed to exacerbate their concern: slit throats, exposed muscle, and bloated corpses. This was usually enough to sour their expression before I’d add something like, “It’s not that bad overall, though. We get a lot of low priority calls.” As the previous chapter made clear, ambulance work is neither an endless horror show nor a preputial adrenaline rush. I found the job could in fact be somewhat boring at times. In addition to lots of driving around without lights and sirens and holding the walls of hospitals, most bullshit and even gray area calls were simply not very stimulating or memorable.

My vague and contradictory descriptions of ambulance work for friends and family outside the trade attempted to capture a complexity that’s important for understanding how crews handle their clientele. Ambulance work is indeed stressful and horrifying and those closest to me were right to worry. Even knowing what I know now, I too worry about my EMT and paramedic friends still in the field. Given their somewhat frequent exposure to death and danger, it’s not surprising that some limited research suggests ambulance crews suffer post-traumatic stress disorder at high rates they face relatively high chances of suicide and suicidal thoughts (Marmar et al. 2006; Newland et al. 2015; Stanley, Hom, and Joiner 2016). This matters for clientele too, as the grotesque and otherwise stressful aspects of the job can mentally exhaust workers, desensitize them to suffering, and generally chill their perceptions of patients (Grevin 1996; Regehr, Holdberg, and Hughes 2002; Collopy et al. 2012). While no doubt significant, the deep emotional wounding that many workers experience on the job is but part of the experience of doing people work inside the ambulance. Bullshit calls, while not as stressful, can bring their own emotional trials. Most crews churn through multiple bullshit cases a day and this frustrating denial of vocation, as I’ve already suggested, is often coupled with verbal struggles between crews and patients.

But the emotional aspects of the job are even more complicated because ambulance work is not defined by trauma and frustration alone. As an EMT, I found that there was a lot to enjoy about my job. Not only did I like spending time with my paramedic partners between calls, I learned to appreciate many of my interactions with ambulance riders. There was both a rush and a reward to doing the job. Legit calls often led to moments of solidarity between workers and patients and I was not immune to this. It generally felt good to be part of a consequential institution that mitigated suffering in the city. I was deployed far downstream to manage a plethora of problems and I did so mainly as an assistant to better trained paramedics. But, the alternative I also lived as an insulated graduate student stuck at a desk always felt less admirable. I may have embodied the stereotype of a white ivory tower descendent trying to rescue people in the urban margins, but I simply didn’t care when my partners and I were rushing to cardiac arrests, diabetic comas, and other legit calls. Moreover, the bullshit calls were not always frustrating. Many of my partners and I found that transporting people to the hospital for a prescription refill or just a bed to sleep on for the night to be rewarding in their own right. We were sort of like untrained and ill-equipped social workers, and when we thought of it that way we could often salvage some good vibes from these so-called misuses of the ambulance.
As an EMT, I learned that the emotional complexities of my job oriented, and were oriented by, my relations with clientele. My partners and I interacted with patients not as fully rational actors, but instead as temperamental creatures whose moods and opinions shifted in patterned ways. Sometimes we handled our patients with cold hands. Linked to our more apathetic visions of clientele, we treated and transported people bluntly, technically, and sometimes coercively. However, sometimes we handled them with warm hands. We treated and transported people in a caring manner that reified our more sympathetic visions of clientele. With the goal of better understanding the practical relations between ambulance crews and the subjects of their labor, this chapter maps my cold and warm handling of patients as an EMT. It does so by detailing the dispositions I adopted to cope with a central dilemma of ambulance work.

Coping Downstream

The mixed emotions of 911 ambulance work, and their implications for crews’ handling of clientele, are partially rooted in a central problem that crews confront daily. This was a problem that wasn’t very clear to me until I faced it with my paramedic partners as an EMT. How could I cope with the pressures of mitigating human suffering that was as seemingly endless as it was varied?

My colleagues taught me that I needed to have the right “attitudes,” “mindsets,” and “senses” to weather the infinite wave of 911 callers in the county. I soon cultivated not one, but two, general sets of dispositions and they loosely map onto a distinction in apathetic and sympathetic people work. On the one hand, I became a “dick.” I developed a somewhat cold and hostile style for interacting with clientele. However, I also learned to “have heart.” I developed a warm and friendly style for interacting with patients. These were patterned acquisitions linked to both the material circumstances of my job and the meanings my peers and I collectively attached to these circumstances. And, where being a dick corresponded with struggles with clientele, having heart corresponded with moments of solidarity.

Figure 4.1 theorizes the pathways between the classified material of labor to the subjective orientations of a single laborer. In reflecting on my experience as a novice EMT, I suggest that both legit and bullshit calls can motivate apathetic and sympathetic orientations. However, there are some general patterns I observed when making sense of my new job. Legit calls can certainly mean a realization of vocation, but they can also be haunting. I learned to tolerate the grim aspects of dealing with blood, guts, and broken bones. This helped maintain my commitment to the job, but it also developed my apathy toward clientele, who I began to see as “meat and bone.” And while bullshit calls can certainly be frustrating and counter-vocational – the basic pieces of a daily grind – some of my colleagues showed me ways to rearticulate the

---

30 Lipsky’s (1980: 82-3) discussion of “coping mechanisms” among street-level bureaucrats who all seem to face some version of this problem helped me make sense of my new job and the affect it had on my perception and conduct as well. As he would expect, I learned the taken-for-granted tips for limiting demand and maximizing available resources and I quickly figured out how to modify my conception of both the job and the clientele to level my expectations. But this was only part of the story. I had to also figure out a way to “stomach” the pain of my subjects.

31 I hold that my feelings of sympathy for clientele was authentic and not a foolish or automatic embrace of “emotional labor” (Hochschild 1983). Having heart does not mean having a so-called managed heart – a disposition attuned by and to the interests of those who controlled and coordinated my labor. Indeed, there were few “feeling rules” designated, let alone surveilled or enforced, by management at MRT.
vocation. Bullshit calls were never preferred, but they occasionally became opportunities to practice a type of ambulance-based social work and there were virtues to this. These calls could indeed involve and develop sympathy.

![Diagram](image)

**Figure 4.1. Being a Dick and Having Heart**

**Being a Dick**

As a rookie EMT I embodied a common strategy of thought, speech, and action to cope with the emotional hazard of my work. Against my previously held standards of proper and professional etiquette, I adopted cold and coercive sentiments to navigate the jobsite. For lack of a better word, I became a *dick*. There are likely many reasons why I often evoked a no-nonsense and apathetic temperament at work, but two forces seem especially suspect: legit calls that were “grim” and the regular “grind” of bullshit calls.

Along with police, firefighters, and coroners, ambulance crews are often dispatched to disturbing circumstances that can “fuck with” or “shake” a person. These are the nightmare calls I mentioned briefly in the previous chapter. Fatal car accidents, vicious crime scenes, suicide discoveries, miscarriages, and child abuse responses are standard examples used by crews, but each person seems to have their own triggers. I did not witness as many brutalities as many of my peers, but I saw terrible things I wish I had not: a young man dying from multiple gunshot wounds, more than one corpse gripped by rigor mortis, and a raped woman with severe facial trauma gasping for breath. This last call was so horrific I quit my EMT job three months earlier than expected. I gave my “two weeks” notice and called out sick for the remainder of my schedule. Certainly, I felt sick. I came to terms with the fact that I was probably emotionally weaker – a “bigger pussy” – than most of my peers in the ambulance. I tapped out before giving the job a chance to more permanently shake me.

When they weren’t motivating my exit from the field, calls like these dispirited me and drained much of my perhaps naïve faith in human decency. As one of my partners accurately predicted, this job would often have me seeing people as “meat and bone.” I came to understand this less as a technical gaze (e.g., a way to see the body as ill or injured) and more as a lens to dull the colors of human agony. The job significantly, and perhaps necessarily, desensitized me to bleeding, weeping, and choking bodies. And where the very thought of touching a dead person once nauseated me, I eventually found myself carelessly eating lunch minutes after I handled a corpse.

My newfound meat and bone vision of the world was an apathetic one in that it helped me imagine a rupture in person and flesh. It was a reductionist and essentially dehumanizing point of view that kept me from dwelling on the misery of leaking, disfigured, and expiring bodies. However, this new-found vision also narrowed my definition of suffering. Like Mark and
other workers who get frustrated with bullshit cases, I too often found myself downplaying the pain of many people relative to the “real emergency” cases I had witnessed. In knowing that “it could be a lot worse,” I often found myself justifying my general lack of sympathy for less urgent cases. “She’ll live,” I remember telling myself as a “stable” woman sobbed on my gurney.

I’m confident such a perception of the world, spawned and at least in part by a repeated exposure to the grim circumstances of ambulance work, fueled my cold interactions with clientele. In a tone that deliberately expressed my frustration, I frequently said things like “you’re ok,” and “oh, chill out” to discount the suffering of others. And, when people were more “truly” suffering, I could in some ways perceptually reduce them to meat and bone. I realize this may be read as a weak justification for my dickish behavior, but many of my colleagues nonetheless helped me make sense of the world this way. My newly harsh and bitter approach to the world, according to veteran workers, could be partially blamed on the grim aspects of ambulance labor.

However, my decreasing sympathy for clientele seemed to be more deeply rooted in the relatively mundane aspects of EMT work. It seemed like every shift my partners and I were getting our “asses kicked” as we ran between bullshit calls. While not as emotionally shocking as grim scenes, the daily grind of bullshit calls were nonetheless exhausting.

Consider a lesson I learned on the job, around 1:00am midway through my shift with Lance and Vince. Remember, Lance helped me draw a map in Chapter 1. He’s an EMT and he served as my “field training officer.” Vince is his paramedic partner. It was usually around this time, immediately following a hospital transport, that these two men liked to offer me grand but informal lessons on how to do my new job.

“You’re so green it’s cute,” said Vince, a white man in his late 30s, as he watched me clean the gurney just outside our ambulance. “You gotta be a dick sometimes.” We agreed that Penny, the 70-something year-old white woman we had just transported to the hospital from her trailer, was a “pain in the ass.” She called 911 for a fever and anxiety before she spent about 45 minutes yelling at us and hospital staff. Her main complaint was rather simple and potentially accurate: she believed no one was taking her suffering seriously. She chastised us for not believing she had a fever, yelled at nurses for not triaging her quickly, and scolded doctors for walking past her gurney without acknowledging her misery. Penny was, as Lance put it, “fucking annoying.” I nervously attempted to calm her down while holding the wall in triage. “I took your temperature twice, ma’am, you don’t have a fever… They’re (hospital staff) really busy right now, but they’ll get you a bed soon… A doctor will see you when you get a bed.” I failed. She continued to scream, convinced I was not adequately helping her.

Vince said, “You did your best trying to keep her quiet, talking all soft to her and shit, but it wasn’t really working, was it?” I shook my head and he continued, “I’m telling you, man, you gotta be a dick sometimes.” Before I could respond, Vince hedged a bit, “I mean don’t be a real dick, but don’t be extra nice either. Otherwise, people will walk all over you. Get what I’m saying?” I lied and said, “I think so.” “It will get easier,” he said, “You see, you still got your soul, but give it time and these people will suck the soul out of you. Me and Lance lost our souls a long time ago. You’ll lose yours soon enough.” He continued, “It’s the harsh truth, but with all the bullshit we run, what do you expect?”

Along with my trainers and our patient, I was caught in a double mismatch in aspiration and action. On the one hand, bullshit calls like the one just described and the ones Vince generally warned of, are formed by a mismatch in vocation and labor. Instead of performing
deep and timely interventions to “save lives” and “really help people,” my colleagues and I were more often just taxiing people into the emergency department. To our frustration, much of the day-to-day consequence of our work was the movement of bodies rather than the valorized labor of salvaging them. Penny was one such frustrating call. According to clinical record, we did little more than collect a set of vital signs and transport her without lights and sirens to the hospital.

On the other hand, calls like this were often made of a mismatch in clientele expectation and worker capabilities. I learned to accept that I was unable to treat many of the problems that I saw as structural and that many of my partners saw as moral: substance abuse, homelessness, interpersonal violence, and other ostensibly non-medical problems. I also accepted that many of the more clearly “medical” cases were likely misplaced in the ambulance as well. From chronic pain to mild nausea, a mostly “stable” clientele base would often summon the ambulance only to be transferred to an emergency department and maybe get some fentanyl for pain or some Zofran for nausea on the way. While many of our “frequent fliers” seemed to also accept our true potential, less common clientele would often become frustrated when my partners and I were unable to significantly treat their suffering. This seemed to be a common cause for patient “outbursts.” On a somewhat routine basis, patients shouted at my partners and I for “not giving a shit” and “not helping.” Their expectations usually seemed to greater than our capabilities.

I hold that these dual mismatches encouraged a rough and forbidding presentation of self. A generally denied vocation was frustrating on its own, but my irritation was usually compounded when clientele insisted that we were unwilling (rather than incapable) of aiding them. I soon learned that Vince was right. These bullshit cases seemed to suck my soul.

When soft speech failed to calm irked subjects, I became a dick. My female colleagues sometimes referred to this as “being a bitch.” In later shifts I would speak firmly and authoritatively to clients. Short of telling patients to “Shut the fuck up!” (which I often wanted to do), I became accustomed to shouting things like “Stop!” “That’s enough!” and “Be quiet!” In a way I had never done before in my life, I yelled commands at people throughout my shifts (“Hold still!”) and I occasionally issued threats (“If you keep acting up, we’re going to restrain you. Do you understand me?”).

I take responsibility for the cold and shameful ways I handled many people inside the ambulance. But this is neither a confession nor an excuse. It’s a self-analysis that seeks to offer some limited but useful insight into the subjective experiences of ambulance work. My short time as an EMT showed me just how emotionally challenging the job can be. As a ride-along, I found it easy to silently judge crews for being rude to clientele. My opinions changed once I started working at MRT. The ride-along shifts where emotionally exhausting in their own right, but actually doing the work intensified my exhaustion. Lifting a screaming and mutilated body off the ground is different than watching people do it. Likewise, getting scolded, kicked, and spit on by patients is different than witnessing these interactions from the sidelines. The job also clarified new frustrations that were difficult to comprehend as a more passive observer. I may not have “bled” ambulance work like some of my more hardcore colleagues, but I too got caught up in the vocation. I too got high off legit calls and this made the low experiences of mundane bullshit work even more irritating. I hated hearing the dispatcher drop a nearby gunshot or a cardiac arrest call on another crew while my partners and I were stuck dealing with somebody’s bullshit complaint. And, I too got pissed when patients were so seemingly quick to accuse me of “not giving a shit.” Still, I can understand why they thought this. On many occasions, I was simply a dick.
Having Heart

Thankfully for those around me, I wasn’t a dick all the time. I like to think I was mostly boring and forgettable. Indeed, it was my paramedic partners who interacted with patients the most. I was more or less assisting them by hooking up their patient to the monitor, preparing equipment, and constructing a medical record on the computer. For the most part, my partners weren’t dicks or bitches either. Indifference and monotony best defined our daily grind. We were yawning far more than we were yelling.

Still, flashes of passion occurred inside the ambulance. Scolding and threatening patients was just one extreme. I often genuinely sympathized with clientele, despite the somewhat jaded perceptions I adopted over the course of my fieldwork. In addition to learning how to be a dick from time to time, I developed another strategy of thought, speech, and action to cope with the pressures of mitigating endless and varied suffering inside the ambulance. I learned to “have heart.”

While being a dick and its synonyms were terms frequently used on the jobsite, having heart is a phrase I impose to make sense of my workplace dispositions that countered my apathetic orientations. Nevertheless, it refers to a shared conception of “truly caring,” “treating people with dignity,” and an authentically sympathetic stance toward clientele. Like being a dick, having heart is less a spontaneous emotional response as it is an organized and patterned style of interaction. Just as being a dick did not give me the liberty to hit patients, having heart did not give me the freedom to weep with them. But, that does not mean we should assume having heart was a bogus or even a carefully articulated presentation of self. As I felt it, having heart was as genuine as being a dick. It refers to an authentically hospitable and caring demeanor and it’s distinct from a so-called managed heart that steers an inauthentic presentation.

For sure, I learned the “feeling rules” of MRT (Hochschild 1983). I knew to interact with patients with a forced smile and “good bedside manner,” especially when supervisors were around. I also knew to act compassionate as a strategy to manage some of our clientele. Patients were less likely, I reasoned, to fight me if I killed them with kindness. I wasn’t alone in reasoning this either. On many occasions, my partners told me they feigned a caring presentation of self to help assure their patients didn’t “lose their shit” or “go over the edge.” Clientele were not always oblivious to this either and I was called out on a few occasions for “just pretending” to care.

I don’t deny that there were moments in which I offered up a phony kindness, but for the most part such an act didn’t seem necessary. Management rarely supervised my direct interactions with clientele and patients rarely complained about crew behavior to supervisors. Moreover, most patients are not “on the edge,” so faking or exaggerating sympathy to avoid a fight was generally rare.

Like being a dick, there are probably many reasons why I adopted an authentically warm and sympathetic temperament for handling clientele, but two conditions specific to the worksite seem likely: legit calls where my partners and I realized the vocation and bullshit calls where we rearticulated it.

More legitimate calls, by their very definition, are seen by crews as more valid forms of suffering. In labeling a call as “legit” we were thus always recognizing some significant degree of “real” hardship. I learned that people couldn’t, or at least shouldn’t, be totally reduced to meat and bone. This was because seeing and touching people in pain was always somewhat of a painful experience. The sting was never crippling, but it hurt to see mutilated flesh, to feel the
fevered skin of a septic patient, and to hear a stroke victim struggle to speak. Calls like these often swelled a lump in my throat. They sometimes led me into the hospital restroom, where I’d splash my face with cool water to regain focus.

These moments of sympathy weren’t always limited to private reflection. Following a legit call, my partners and I would often calibrate a sympathetic, even if fairly shallow, understanding of the patient. Shaking our winced faces as we departed the hospital, we’d sometimes say things like “poor dude” and “that lady was really hurting” before turning our attention to the next call.

While sympathetic moments during legit cases could understandably lead to depressing feelings, I found that they were mostly coupled with a sentiment of good will. They seemed to motivate a caring interactional style with patients. It genuinely felt good to comfort and aid the so-called truly suffering. As an EMT, I never administered fentanyl or any of the medications that somewhat obviously relieved people, but I iced sores, wiped blood, and held hands. I also “talked patients down” from their pain and coached people to slow their breathing as paramedics performed interventions some saw as frightening (e.g., starting an IV). These were generally rewarding experiences.

Establishing moments of solidarity with clientele came easy under these emotional circumstances. This was a solidarity of interdependence. As noted in the previous chapter, clientele with legit complaints often need crews to live and crews need such clientele to realize a sense of honor and purpose at the worksite. We certainly argued with legit patients, especially if they were making a decision we believed to threaten their wellbeing (e.g., refusing to go the hospital), and we sometimes physically wrestled with them (e.g., during “legitimate” psychiatric breaks). Though, in general, we struck peaceful and compassionate relations rooted in a sympathetic, even if a somewhat specific, vision of true suffering.

Just as being a dick is not limited to bullshit calls, having heart is not limited to legit calls. We didn’t always discount bullshit cases as obnoxious or infuriating. Even in classifying people’s problems as bullshit, and therefore a relatively wasteful use of time and ambulance resources, there’s room for sympathy. Penny didn’t get much, but a guy who thanked me profusely for taking him out of a prison-like board and care facility and into an emergency department for a night of relative peace did. Likewise, frequent fliers frustrated my partners and I for sure, but they too yielded our compassion from time to time. In many ways, I found it pretty easy to at least mildly sympathize with bullshit cases attached to docile, grateful, and familiar people.

Moreover, we weren’t totally chilled to the fact that patients with bullshit complaints face “real problems” like lack of access to primary care, precarious employment, housing insecurity, social isolation, and limited transportation options. We sometimes articulated our sympathy regarding these conditions with patients and with each other. For many of my colleagues and I, the response to this realization was to simply grind through the calls and submit to our specialization: we’re just paramedics and EMTs. What could we do?

Some paramedics, though, taught me there are some narrow opportunities to rearticulate the vocation as a kind of social work on wheels. From time to time, I consciously broadened my understanding of what the ambulance can, and perhaps should, do as an urban safety net institution. I learned to draw some emotional reward from taking bullshit cases to the hospital for a prescription refill, a bed to sleep on, and a meal to eat. I wasn’t alone either. A few of my colleagues liked to give out company blankets to people on the streets, against the explicit wishes
of management. And, on a couple of occasions, my partners and I checked the blood pressure and glucose levels of people who walked up to the ambulance and asked us to do so. We did this under the radar so the “walk up” wouldn’t get billed and we were generally happy to help these chronically ill people monitor their vital signs. Sometimes at the hospital we would go out of our way to request an actual social worker on behalf of our client, to help connect her or him to housing, substance abuse treatment programs, and other resources. While not as exhilarating as realizing the vocation traditionally through legit cases, accepting bullshit as an opportunity to do some amateur social work brought its own emotional rewards.

During my ride-along observations, paramedics and EMTs frequently told me they liked their job because it felt like they were “making a difference” and “giving back to society.” As a cynical observer, I found it hard not to roll my eyes when I heard such things. But as an EMT I began to understand what these workers meant. Beneath these corny mantras of benevolence was a kernel of truth I never quite understood until I did the work. The realized vocation, the moments in which workplace aspiration matched workplace action, simply felt good. I learned that running legit calls and “truly helping” people through assisting paramedics’ relatively deep interventions into the body was something to live for in and of itself. Yet, having heart was not totally limited to legit calls. While the very definition of bullshit calls suggests a relative lack of worker sympathy, I nevertheless learned to sympathize with such clientele from time to time. This was especially true when my partners and I could momentarily rearticulate the vocation and our capabilities in mitigating a varied and endless wave of human suffering.

Looking Inside

Goffman (1969: 76) reminds us the materials that people workers handle “are almost always considered to be ends in themselves.” For him, much of this is accounted for by the exogenous, but largely unspecified, forces that hold an institution accountable to some “broad moral principles.” This is where things like general standards for “humane treatment” enter the picture.

I don’t deny that such conditions are important or intend to belittle Goffman’s contribution. Still, as I’ve argued, workers see some people to be more ends in themselves than others. Crews overwhelmingly see those suffering from legit medical emergencies as ones worth their efforts, and in many ways they crave these cases. The same cannot be said about bullshit calls, which are typically seen as just part of a “job.” Yet, in order to understand this variation in a sort of taste for patient problems, we must account for an endogenous force that Goffman generally neglects: workers’ sense of vocation (i.e., their commitments to a craft).

In several respects, crews’ emotional highs and low are linked to the realization and denial of this sense. Thus, the manual, cognitive, and affectual dimensions of people work are intertwined in complex ways. I’m less concerned with trying to unravel this knot and locate its thickest strand and am more interested in demonstrating its existence and its pieces. My goal in writing this chapter in particular has been to locate those emotional threads of ambulance-based people work and to show how they’re bound up with both the manual and mental aspects of that same work.

To sum up, ambulance crews handle a mostly poor clientele base with both cold and warm hands. My personal experiences as a novice EMT have taught me that the practical component of ambulance work is not a purely calculated, let alone a fully lucid, engagement. Instead, this labor is heated and cooled by the emotional circumstances of people work and this
is significant for understanding how interactions between frontline workers and clientele develop into moments of struggle or solidarity. I have identified two opposing sets of dispositions: the apathetic orientation of “being a dick” and the sympathetic orientation of “having heart.” These are general styles of coping with the pressures of mitigating human suffering downstream and they further complicate the distinction in legit and bullshit cases. Having heart is linked firstly to a realized vocation through legit work and secondly to a rearticulated vocation through bullshit work, whereas being a dick is linked firstly to the grind of bullshit work and secondly to the grim aspects of legit work.

In wrapping up Part I, we see how ambulance-based people work essentially adds up to a bandaging of the poor. When we look inside the ambulance, we find crews providing generally superficial responses to suffering that concentrates toward the bottom of the urban hierarchy. This bandaging involves more than a manual application of field medicine or a quick transport to the hospital. It’s a process enabled and constrained by a series of mental tasks, from imposing official classifications required by protocol (e.g., primary impressions) to articulating informal distinctions linked to the craft of paramedicine (e.g., legit and bullshit calls). Bandaging the poor is also an activity that influences, and is influenced by, the emotional circumstances of people work. Both cold and warm hands wrap the poor in gauze and this variability shapes moments of struggle and solidarity between ambulance crews and the people they work on.

But, the analysis can’t stop here. In order to understand what’s happening inside the ambulance, we must consider some forces outside of it. On the flipside, we should consider how the internal dynamics detailed in Part I react to and affect those external forces. The ambulance cannot be reduced to the practical interaction between crews and their patients. We must consider the relational component of a labor process; we have to account for the social relations through which a bandaging of the poor is made possible.

Hence the remainder of this dissertation. Part II accounts for the horizontal relations between ambulance workers and workers of different institutions. Particular attention is given the relationships between crews and their nurse and police counterparts. We’ll locate the ambulance between the protective Left hand (i.e., welfare operations) and repressive Right hand (i.e., penal operations) of the state. Part III then accounts for the vertical relations between ambulance workers and those who attempt to control and coordinate their labor from above. For MRT crews, and other governance workers throughout the delegated state, this means positioning the ambulance underneath a nexus of bureaucratic and capitalistic forces. It will become clear, through both of these endeavors, why an internal analysis of the ambulance was necessary and why such an analysis came first.
Part II
Sorting the Poor: The Ambulance Between Hospitals and Squad Cars

While on the job, my partners and I often said that we “worked the streets.” This had different meanings beyond the obvious fact that we spent much of our time traversing asphalt. It meant we did work that was distinct from those stuck in an office, like company managers and county dispatchers. For paramedics, street work also meant practicing medicine beyond the walls of the relatively insulated and sanitized hospital. It meant performing CPR on sidewalks and starting IVs on moving ambulances. Saying that we worked the streets also invoked an image of doing work that was a bit exotic. Our work brought us into the streets, into the so-called ghettos and hoods that were otherwise invisible to most of us.

However, as a sociologist, I thought of working the streets a bit differently. Ambulance crews work with other urban frontline workers who also handle a disproportionate number of poor populations. They work alongside nurses, police officers, firefighters, skilled nursing facility staff, security guards, and others whose activities tend to concentrate toward the social margins. These relations with other workers shape, and are shaped by, the ways ambulance crews handle the subjects of their labor. If we hope to understand how ambulance crews are churning through a relatively poor clientele base, we must examine these “street-level” associations between crews and other frontline workers.

Part II does this by focusing on the relations between ambulance crews and their nurse and police counterparts. Firefighters, physicians, and others will pop in from time to time, but the daily interactions crews have with nurses and law enforcement are particularly revelatory. They help us locate the ambulance between two polar sites of urban poverty regulation, the protective emergency department and the repressive squad car. As discussed in the introduction, the poor are governed across a laterally fragmented and an often contradictory regime and this is most obvious at street-level where we see a series of institutions managing poor populations simultaneously and in intersection: schools, welfare offices, hospitals, courts, jails, prisons, etc. There are plenty of factors that separate and position these institutions on the ground, but a left-right, or a welfare-penality, axis à la Wacquant’s (2009) amendment to Bourdieu’s (1998) bureaucratic field proves useful. The next three chapters extend this line of inquiry by examining the lateral relations amongst frontline workers.

I begin by detailing the relationship between ambulance crews and emergency department nurses. Rather than frame these parties as insulated workers occupying distinct worksites, I connect them by the work that they share. Together, they fix up people with medication, rides, shelter, and other aid. This all hinges, however, on their ability to co-produce patients, a special category of people that follows a dual exercise of manual and mental labor. Still, we must be careful not to assume those who become patients are passive to this process. Most articulate medical problems in the form of “chief complaints.” They nominate themselves for an ambulance trip to the hospital. Being caught by the safety net of emergency medicine often depends on them doing so. It’s a safety net made of gauze and one that’s labored by ambulance crews, nurses, and other frontline workers in and out of the hospital (e.g., firefighters, physicians, and emergency room social workers).

Ambulance crews also frequently work with the police. While paramedics and EMTs do a kind of fix up work with nurses, they also do a kind of cleanup work with law enforcement. Crews and cops often converge on scenes that need to be temporarily cleansed of an out of place
body. For more legit cases, this usually means that paramedics and EMTs remove wounded bodies from the traumatic scenes that both parties share (e.g., car accidents, gunshot wounds, and multi-casualty incidents). However, for bullshit cases, which are more common during crew-cop interactions, this usually means cleansing public spaces of drunk, drugged, or otherwise disordered bodies. Many of these cases involve the police forcing ambulance crews to transport people by writing 72-hour involuntary psychiatric holds. Yet, similar to people shared by crews and nurses, those shared by crews and cops are not totally passive in this process. They’re more acquiescent overall, but some challenge the coercive powers of the police by articulating a medical chief complaint, subsequently redirecting their immediate trajectory (e.g., from jail to hospital). Together, crews and cops successfully labor a kind of public sanitation machine that sweeps the streets of select bodies deemed out of place.

Further analysis reveals that these relations between ambulance crews and their nurse and police counterparts are not always harmonious. Indeed, there’s a fair amount of tension between these parties. This seems to stem from the fact that life on the frontlines isn’t so peachy. For crews, nurses, and police, the hours are long and the cases endless. And, to top it off, most of the work is not vocationally fulfilling. Just as crews complain about a lack of legit calls, law enforcement officers complain about a lack of “real police work” and nurses gripe about their departments’ inundation with low priority cases. There seems to be a near universal frustration with bullshit.

As such, it’s perhaps not surprising that the tense interactions I observed most, and later participated in, concern what I call “burden shuffling.” The point of burden shuffling is to make one’s shift easier by strategically pushing an undesirable case or task onto another worker. Such a strategy is both hindered and enabled by protocols. Hence, the primary directions of shuffling detailed in this dissertation: cops typically shuffle burdensome cases onto crews due to state-level regulations for involuntary psychiatric holds and crews typically shuffle burdensome cases onto particular nurses due to federal regulations in emergency department accessibility. Many frontline workers are able to cunningly navigate a complicated terrain of rules to benefit themselves against the interests of their counterparts in different uniforms. This may motivate more behind-your-back shit talking than in-your-face confrontation, but the result for clientele is more or less the same: they’re frequently shuffled across the frontlines by self-interested workers.

Ultimately, Part II helps clarify the relational component of a labor process. More specifically, it details the social relations between workers of different organizations. I hold that we cannot understand what’s happening inside the ambulance without accounting for the labor its crews share with other frontline workers. Paramedics and EMTs doubly regulate spaces in bodies and bodies in spaces and they often do so through their interactions with nurses and cops. Much, but certainly not all, of these productive relations are defined by tension and conflict.

Regardless, the labor shared across the frontlines of emergency response help clarify another key mechanism of urban poverty governance: sorting the poor. Crews, nurses, and police work with and against one another to distribute the poor across a landscape of often contradictory institutions.

Labor power is an essential factor in the sorting of people across medical and penal institutions. Forces beyond the frontlines, like official definitions of sickness and criminality, are no doubt important but only so in their ability to guide the workers who process people in and out of particular sites. And, as noted throughout this dissertation, such workers are imperfectly
guided. They have significant discretionary power, and this influences the exact sorting observed in the field, from whether someone goes to jail or hospital to the specific emergency department a patient is transported to. There’s a lot that motivates discretionary action, but an interest to avoid vocationally unfulfilling tasks seems to be a prominent one. Workers across the board want to improve their shifts by reducing the amount of bullshit they have to deal with and this often means trying to strategically shuffle undesirable work onto others.

As with bandaging the poor, sorting the poor can often seem inconsequential. Workers distribute people across institutions that offer generally superficial responses to the deep structural wounds of poverty. Yet, there are some respective differences for the subjects being sorted. Relative to the emergency department, the jail severs life chances. And, relative to the jail, the emergency department protects and extends life chances. Few would argue that getting arrested, incarcerated, and fined is better than getting transported, hospitalized, and billed. The former comes with more stigma, disruption, and risk of injury. The specific hospitals that ambulance crews sort the poor into are not equal either. Some are closer to home, some have more social workers on the clock, and some have more private rooms to offer.

How the poor are sorted also clearly matters for workers. It can mean the difference in a relatively busier or slower shift. It can also mean the difference in ending a shift on time and having to work an extra hour or two. How a particular case is sorted across the frontlines can also mean the difference between avoiding or confronting a shouting and punching subject. Again, the differences can seem inconsequential from a distance, but on the frontlines they’re often seen as significant. Many at least see them as important enough to motivate their efforts to struggle with both clientele and fellow workers.
With few exceptions, such as when death is determined on scene or when someone calls 9-1-1 but then refuses transport, ambulance encounters conclude with crews transferring their patients to an emergency department. Ambulance personnel don’t typically see the hospital as a place that offers permanent solutions to clientele problems. Instead, they generally understand it to be a place for stabilizing legit cases and pacifying bullshit ones. It’s a place where surgery is performed but also where prescriptions are refilled (or rather rewritten). It’s a place where comatose bodies perish but also where intoxicated ones sober. It’s a place where nurses, physicians, and other clinicians fix up patients with not just bandages and drugs, but also with a few hours of shelter and a meal or two.

However, paramedics and EMTs don’t just dump raw materials on the doormats of hospitals. They don’t simply unload bodies that are ready to be fixed up by emergency department staff. Instead, ambulance crews must fix up these bodies a bit themselves. Sometimes this is referred to as “working up” the patient. Crews bring in bodies wrapped in gauze, gripped by cervical collars, and decorated with other clinical artifacts. Even if they don’t do much of a medical intervention beyond a hospital transport, paramedics and EMTs bring in clientele who are at least fixed up with a field assessment. They bring in a medicalized body, one reduced to a primary impression (i.e., a field diagnosis) and one that’s linked to a set of vital signs (e.g., blood pressure, blood oxygen saturation, respiratory rate) and other clinically-relevant data (e.g., narrative of problem, medical history, current prescriptions). They purposively fix up the subjects of their labor into cases that are made legible to, and therefore processable by, the administrative machinery of the hospital.

**Making Patients**

In order to release someone into the hospital, ambulance crews must make them into a patient. Such a transformation involves both a material and classificatory moment.

This process is most obvious during so-called legit calls. Consider what happens when ambulance crews transport a cardiac arrest victim – a *code* – to the hospital. Crews usually arrive on scene to discover a warm, yet pulseless and breathless, body. Usually working with firefighters, the crew compresses the chest, intubates the airway, and administers drugs like epinephrine via IV access, occasionally pausing to “shock” the patient with a defibrillator.
If they “get pulses back” – known more formerly as the “return of spontaneous circulation” – then the ambulance crew rushes the patient to the hospital. Typically, a firefighter paramedic will assist the MRT paramedic in the back while the EMT drives. The EMT contacts a nurse at the receiving hospital on the radio while she drives with lights and sirens. She provides a “ring down,” a brief summary of the patient’s condition, the interventions made, and the estimated time of arrival. The main function of the ring down during a cardiac arrest is to “activate” a team of nurses, physicians, and other workers to prepare for such a high severity case.

By the time the crew arrives, hospital staff have usually prepared a room where a team of clinicians wait. The crew rushes into the emergency department with a limp body partially encased and infused in clinical artifacts: tubes, drugs, etc. Nurses, physicians, and other hospital workers help the crew move the body from the gurney to the hospital bed. During this transfer, the paramedic offers a “turnover report” to the receiving team, an updated and more detailed version of the EMT’s ring down. As such, ambulance crews bring hospital staff a body that is already physically and symbolically fixed up into a medical case.

While more obvious and dramatic during legit cases like a cardiac arrest, fixing up bullshit cases for the hospital is also a mental and manual process. They too involve an imposition of a primary impression, a collection of vital signs, and an assembly of pertinent clinical information. These “less legitimate” cases also involve a verbal flow of information from ambulance to hospital through the labor of the ring down and the turnover report; they’re just not so detailed because there are fewer interventions and less remarkable vital signs to speak of. Moreover, even on cases with few interventions logged into the official record, crews use their hands a lot as they attach instruments to the body to collect vitals and they frequently touch their subjects as part of their examination (e.g., feeling the skin to detect a fever).

For many calls that crews see as bullshit, paramedics are often starting IVs as a courtesy to nurses. While they see such calls not as “real emergencies” and as general misuses of ambulance resources, they’ll start an IV and simply apply a saline lock and nothing more. In other words, they’ll go through the motions of piercing the skin with a needle and accessing the vein, but they won’t administer any fluids or drugs. They do it simply as a favor to nurses.

Legit or bullshit, every person brought into the hospital via ambulance is “fixed up” a bit first. Crews assign everyone they bring into the emergency department a primary impression, and this is limited to classifications specified in the county protocols and paperwork that crews must complete after each transport. As previously noted, these categories include, but are not limited to, problems like: shortness of breath, chest pain, sepsis, cardiac arrest, myocardial infarction (heart attack), tib-fib (lower leg fracture), radius-ulna (lower arm fracture), nausea, stroke, altered level of consciousness, GSW (gunshot wound), asthma exacerbation, seizure, abdominal pain, general weakness, ETOH (intoxication and the medical abbreviation for ethanol).

Triage nurses who deal with crews at the hospital expect their paramedic or EMT counterparts to not only offer a primary impression but also to justify the impression (e.g., noting vital signs consistent with the diagnosis) and the management of that impression (e.g., noting which interventions where performed). For example, if a crew is going to classify a patient as septic then the nurse is going to expect some evidence that at least two of the following three conditions are met: a) the body is either hyper- or hypo- thermic, b) the heart rate is greater than 90 beats per minute, and c) the patient is taking more than 20 breaths per minute. He or she is
also going to expect that the crew made the appropriate interventions (e.g., administering fluid via IV treatment, especially if systolic blood pressures was less than 90 mmHg).

This flow of information usually occurs at a standing desk in the triage bay where the nurse begins an emergency department record for the patient. Assuming the case is not so legit that it requires hospital treatment right away (like a cardiac arrest), patients must lay on the gurney and wait until a bed is available. As noted in Chapter 2, this moment is sometimes called “holding the wall.” When it’s his turn, the paramedic will usually then stand next to the nurse, open his laptop, and then rattle off information that he and his EMT partner have already documented on their end: primary impression, vital signs, interventions made, name, social security number, date of birth, and insurance status. Meanwhile, the EMT usually stands next to the patient, sometimes re-measuring their vital signs and casually conversing with them about a variety of topics from children and pets to movies and presidential politics. Sometimes this means the EMT must “babysit” the patient, covering them with a blanket if they’re cold and occasionally using a firm paternalistic voice to keep them from shouting out their frustrations or sobbing too loud. We saw a bit of this in Chapter 4 as I struggled to keep Penny, the elderly woman who lives in a trailer, from shouting. Eventually, the nurse assigns a bed where the crew drops the patient off before collecting a nurse’s signature for their paperwork and returning to the ambulance.

In short, when ambulance crews bring people into one of the many hospitals in the county, they must first make these people into “patients.” This involves more than just medicalization (i.e., the imposition of a medical definition). It also entails a corresponding manual labor in the form of examination and treatment. Nurses then continue the labor of fixing up. They too must classify and treat their subjects and they lean heavily on the assessments and interventions that crews performed in the field. As fix up workers, crews and triage nurses labor to push their subjects deeper into the emergency department where they will most likely spend a few hours before they’re fixed up a bit more and then discharged back onto the streets.

The Chief Complainers

The people that ambulance crews bring into the hospital are far from passive in this process. Indeed, a majority of ambulance contacts are “voluntary,” meaning that patients consent to treatment and transport and many summon ambulances themselves by dialing 9-1-1. Most request that ambulance crews transport them to the hospital.

In order for such a request to be successful, the 9-1-1 callers must articulate what official protocols recognize as a “chief complaint.” This is usually understood as the answer someone offers when crews greet them and ask, “What’s going on?” or “Why did you call 9-1-1?” It’s a subjective problem that is at least imagined to be medical. The answers can vary in specificity, from “I have a sharp pain in the stomach” to “I just don’t feel right.”

A person’s chief complaint shapes the interaction between crews and nurses by informing the ways in which crews fix them up for the emergency department. Seemingly obvious to most clientele, a person must articulate a medical problem in order to enter the hospital by way of ambulance. If a crew finds someone who is unconscious or is struggling to speak, then they infer such an articulation under the protocols of “implied consent.” However, most people who encounter the ambulance are relatively lucid and do in fact verbalize a chief complaint. Indeed, in a way they must self-medicalize their problems if they hope to get an ambulance ride.
One late night, Charles, an older black man, dialed 9-1-1 on a payphone and requested an ambulance. He was wheelchair-bound at the time and his leg was casted from a fracture he sustained weeks earlier. At first, Charles asked ambulance personnel to take him to his mother’s house. His request was met with laughter by both the ambulance crew and a field supervisor who happened to show up. “No way, man,” said the EMT before explaining that they can only transport people to an emergency department.

Charles then said he’d like to go the hospital because “it’s cold out” and he missed the curfew at his transitional housing facility. Grant, the supervisor who I am shadowing, was clearly unimpressed with this answer and asked, “But what’s the medical problem?” Charles then pointed to his cast and said, “my leg,” before insisting that someone at a hospital check it out. The ambulance crew conceded and loaded Charles into the ambulance before collecting his vitals and transporting him with a primary impression of “leg pain.”

On another night while I was working as an EMT, my paramedic partner, Austin, and I were summoned to a shopping center. We responded to Johnny, a Latino man in his late 20s. I don’t remember seeing this man before, but Austin told me he’s ran into this patient a couple of times. Apparently, the police regularly place this man on involuntary psych holds, but on this particular night he had summoned the ambulance himself.

Johnny greeted us in the parking lot outside a Target retail store and articulated a clear medical problem: he said he had difficulty breathing. However, Austin wasn’t buying it. Both he and I counted the “rise and fall” of Johnny’s chest and estimated a normal rate (around 16 breathes per minute) and his oxygen saturation was normal per our rig’s monitor. Austin later told me he thinks Johnny was seeking shelter and articulated a medical complaint to force us to take him to the hospital. Whether this was a correct assumption about Johnny’s intentions or not, Austin and I were obligated to make the man into a patient with at least a documented medical complaint and a collection of vital signs.

Crews cannot take people to the hospital who cannot be reasonably classified as either ill or injured. As noted in Part I, even their paperwork requires them to impose a medical classification. No hospital transport can be done without crews selecting at least one primary impression category on the computer, and “shelter” is simply not a category available. And once someone articulates a medical problem, such as when Charles says that his leg hurts or when Johnny says he’s struggling to breathe, it’s challenging to then negotiate a de-medicalization of the complaint. Leaving the scene without the person in question would be difficult because it would require the would-be patient to sign a form releasing the crew of liability. It’s easier, or at least legally less risky, to just take Charles and Johnny to the hospital at that point.

Emergency department nurses know that protocols force crews to take many so-called bullshit cases into the hospital (not unlike their own federal requirements to screen anybody who walks into the emergency department). They also know that protocols force crews to fix up all transported subjects into “patients.” Still, through informal exchange not captured in official records, crews will often tell nurses if they think the case is not very “medical” or “urgent” at its root.

For example, Vince and I once brought in an older white female named Martha to an emergency department. Martha is a “frequent flyer” who spends many of her nights on the streets. Like Johnny, she complained of shortness of breath but, also like Johnny, all “objective” evidence suggested otherwise. The triage nurse at the hospital, upon recognizing Martha, asked us in a frustrated tone, “What now?” Vince sarcastically said, “She’s cold,” implying she’s
looking for temporary shelter before he quickly self-corrected in a blatantly sarcastic tone, “I mean she has shortness of breath.” Martha, lying on the gurney in the triage bay heard this and yelled, “I can’t fucking breathe! I need help!” “Oh yeah, Martha, I told them,” said Vince.

**Greasing the Revolving Door**

While sitting in the ambulance bay at any one of the hospitals in Moon County, I seemed to witness about as many people exiting emergency departments as I saw entering them. This wasn’t just my imagination either. The Center for Disease Control estimates that about nine out of 10 people who enter the emergency department are discharged directly from that department (Rui and Kang 2014). Very few die there and only a minority of emergency department patients are transferred to another hospital or “admitted” deeper into the facility (e.g., into the intensive care unit). My partners and I would even notice people exiting the hospital who either we or one of our colleagues brought in just a few hours earlier. Indeed, most emergency department patients are fixed up a bit and then released.

Sometimes, those who are discharged from the hospital don’t make it very far before an ambulance crew encounters them. Crews frequently find people who have just been released from the hospital and they occasionally jot this in their paperwork. For example, one paramedic’s narrative reads, “Pt (patient) still wearing the ID wrist band (hospital identification) and tape marks from previous venous punctures (from IV).” Another record notes, “Pt has some dx (diagnostic) paperwork and discharge (paperwork) from (hospital).” Similarly, one MRT worker jotted the following sentence, “Pt states that he was discharged from (hospital) several hours ago…Pt stated that he just took the bus to his current location (sidewalk) and was too weak and uncomfortable to ambulate (walk) any further.” In my experience, cases like these are almost always brought back into an emergency department.

For example, Martha, the frequent flier Vince and I brought in officially for shortness of breath but unofficially for shelter had a hospital band on her wrist when we found her. She was discharged only a few hours before we met her outside a grocery store that was only two blocks from the hospital. We simply brought her back.

However, some recently discharged patients request a different hospital, usually because they’re unsatisfied with the facility they just left. On another call, paramedic Mark and EMT Danny picked up Rob, another person sporting a hospital band. They found Rob, a black man around 45 years of age, sleeping on the sidewalk a few blocks from the county’s flagship public hospital. Apparently, someone called 9-1-1 for a “man down.”

Surprised to encounter an ambulance crew, Rob nevertheless requested to go to a hospital. However, he didn’t want to go the emergency department he was recently discharged from, the facility that was only a short walk away. At first, Rob said he had a seizure, but upon further questioning from Mark and learning that this chief complaint would limit which hospital he could go to, he then said he did not have a seizure. Mark never told me how he classified the call, but he agreed to take Rob to a smaller hospital in a neighboring city of Moon County. As he later told me, this was at least partially a strategy to get Mark and Danny’s ambulance out of the busy ghetto where they found Rob.

In some respects, this particular transport was a win-win. Not only did this transport bring the crew to a somewhat slower area of the county they preferred to work, it also brought Rob to an emergency department he preferred. When Danny and Mark pulled Rob’s gurney from the rig and began to roll him toward the emergency department doors, Rob began to nod in approval.
“One thing’s for sure,” he said, “Your damn ass will get a bed here.” The last emergency department that discharged him is a “sorry ass place,” where getting a bed is less likely and the meals are of worse quality. At least that’s Rob’s opinion.

Ambulance crews seem to be greasing a revolving door of emergency medicine. They bring back a number of people who have already been processed and discharged by emergency department personnel. Sometimes they bring them back to the same facility but they’re also frequently taking them to different ones.

This isn’t just a pattern for so called frequent fliers or even those who crews find with hospital wrist bands, EKG stickers, and other emergency department materials still attached to their flesh. Ambulance crews are often bringing in people who have visited the emergency department in the past month or two. It’s not uncommon for crews to draw on the history of these previous encounters to make their patients. For example, they frequently use discharge paperwork and other documentation to help them fill out their own reports. EMTs often copy demographic information, insurance policy numbers, and active prescription lists printed on these forms when starting the paperwork for the case on their own computer.

While they certainly constitute a minority of calls, these revolving door cases are illustrative of a more general relation between the ambulance and the hospital. Crews do not typically encounter raw material untouched by medical labor. Instead, they more often collect bodies that have already been examined and classified in some significant way. For example, they often forge patients out of people who have already been diagnosed with an acute or chronic illness and thus often people who are already under some regimens (be it through prescribed drugs and/or lifestyle recommendations). Through their interviews with patients or with people familiar with patients, paramedics and EMTs collect details on pertinent medical histories and current medications. These data points structure their processing of clientele by honing their examinations (e.g., known diabetics get their blood sugar checked while others may not) narrowing their primary impressions (e.g., linking shortness of breath to COPD exacerbation), and focusing their turnover reports (e.g., emphasizing whether someone is “compliant with their meds”). Ambulance crews also bring in a number of people who “know their symptoms,” meaning people who convincingly link their chief complaints to clinical categories (e.g., people who make sense of their wheezing as an asthma attack). As such, they often bring in people who have been pre-processed for the emergency department in some significant way.

A Safety Net Made of Gauze

Ambulance crews are in recurrent contact with emergency department staff, and nurses in particular, throughout their shifts. They regularly bring people from homes and streets into one of the largest and most overwhelmed institutions of the American welfare state: the emergency department. Whether public or private, all emergency departments are required by law to assess and aid (or at least stabilize) anyone, regardless of their ability to pay.32

---

32 Hospital emergency departments, whether publicly or privately operated, constitute a major component of the contemporary American welfare state thanks in large part to the Emergency Medical Treatment and Labor Act (EMTALA). Enacted in 1986, this policy essentially requires an emergency department receiving Medicare payments to provide treatment and stabilization to anyone who seeks aid regardless of their ability to pay (Centers for Medicare and Medicaid 2012). The result of this policy, combined with the retrenchment of other medical safety nets like free health clinics, has been an inundation of vulnerable clientele seeking an array of both “medical” and “social” aid (Dohan 2002; Hock et al. 2005; Malone 1998).
A combination of federal, state, and county policies assure access and aid through the ambulance as well, and across the United States people are generally given the right to demand transport to the hospital by way of ambulance. Paramedics and EMTs are often forced by protocols to take people to the hospital and to fix them up into patients in the process. For the most part, people summon the ambulance with a relatively clear medical complaint, but it’s not uncommon for some to at least ostensibly request an ambulance trip to the hospital for other reasons (e.g., transportation, shelter, food).

Together, ambulance crews and nurses labor a safety net. While thin and worn, this net is strung across Moon County. It’s made of several hospitals, but it’s breadth is really made possible by the many more ambulances that can essentially be dispatched anywhere. Still, it’s not a net that will catch just anyone. It’s limited to those with medical problems, to those who can be fixed up as patients. This net is made of medical instruments and processes. It’s a net made of gauze.

Disproportionately dispatched to aid poor populations throughout the American metropolis, paramedics and EMTs are processing people into patients and carrying them leftward toward the hospital. However, as detailed next, crews are also in recurrent contact with law enforcement. The safety net of gauze is often knotted with the metal chains that lock people up. The ambulance frequently rubs against the Right hand of the state.
Chapter 6
The Cleanup Workers

While on the streets, MRT crews frequently interact with police officers from over a dozen law enforcement agencies. Ambulance crews are not interacting with cops as much as they’re interacting with nurses, but I estimate that roughly a fifth of MRT calls involve the police. Crews and cops often share a number of “scenes,” from those involving gunshot victims and traffic accidents to those involving sidewalk slumberers and drunk wanderers. Just as ambulance crews fix-up people for entry into the emergency department, the police frequently usher people off the streets and into the ambulance. Together, crews and cops share a common task: temporarily cleaning up public spaces of the wounded, the nuisance, and the belligerent.

Matter Out of Place

The relationship between paramedicine, policing, and poverty is complicated. Given what we know about the geography of ambulance responses and police surveillance, it’s perhaps surprising to many readers that I found little evidence that ambulance responses in poorer neighborhoods are more likely to involve law enforcement. Instead, when coupled with the ethnographic data, the medical records offer evidence that cops and crews frequently converge in areas where out-of-place bodies are identified for removal.

Consider what I found when examining the medical records in particular. I turned to these crew-produced documents to ask a simple question. What neighborhood-level features predict crew-cop interactions? Table 6.1 reports the results of three multivariate analyses. I regressed the percentage of ambulance records that mentioned law enforcement within a tract on poverty and other factors. The first model suggests a small geographic poverty effect. Net of

---

33 As detailed in the Appendix, my estimates of crew-cop interactions are drawn from my examination of the medical records. I used some simple automated textual coding procedures to flag records where paramedics and EMTs mentioned the presence of law enforcement in their open-ended narratives. This technique almost certainly underestimates the number of times crews and cops interact on the same scenes.

34 Replicating some of the procedures used in Chapter 1 and detailed in the Appendix, I eliminated records on highways and bridges and then limited my scope to the 300 tracts that MRT holds a 911 transport monopoly over. In other words, I took the same 88,027 records I used to estimate ambulance frequencies by tract. This time, however, I not only calculated an overall MRT frequency but also the frequency of records that indicate an interaction with the police. I divided the former by the latter for each tract and then multiplied the results by 100 (mean = 19.2, standard deviation = 6.8).
population size and density, this model predicts that a ten percentage point increase in tract-level poverty is associated with a 1.2 percent increase in the overall share of crew-cop interactions. Not only is this association weak, the second model suggests that it’s not statistically significant when adding in a variable for race (i.e., percentage black or Latino within a tract). It’s also noteworthy that the race variable does not yield a statistically significant coefficient in this model. Though, as evident in the third model, there are some other geographic factors that are associated with the percentage of crew-cop interactions. Net of the other factors just mentioned, both the presence of metro train stations and jails (including municipal police headquarters where detainment is possible) are positively associated with the percentage of crew-cop interactions.

Table 6.1. OLS Regression, Percentage of Records Mentioning Law Enforcement by Tract

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty (10%)</td>
<td>1.19**</td>
<td>0.82</td>
<td>-0.11</td>
</tr>
<tr>
<td>95% CI</td>
<td>0.34, 2.05</td>
<td>-0.28, 1.91</td>
<td>-1.04, 0.82</td>
</tr>
<tr>
<td>Black or Latino (10%)</td>
<td>0.25</td>
<td>0.49*</td>
<td></td>
</tr>
<tr>
<td>95% CI</td>
<td>-0.21, 0.72</td>
<td>0.10, 0.87</td>
<td></td>
</tr>
<tr>
<td>Metro Train Station</td>
<td></td>
<td></td>
<td>12.10***</td>
</tr>
<tr>
<td>95% CI</td>
<td></td>
<td></td>
<td>9.20, 15.00</td>
</tr>
<tr>
<td>Jail or Police HQ</td>
<td></td>
<td></td>
<td>14.54***</td>
</tr>
<tr>
<td>95% CI</td>
<td></td>
<td></td>
<td>11.00, 18.07</td>
</tr>
<tr>
<td>Density Per 1,000 pop</td>
<td>-0.06</td>
<td>-0.06</td>
<td>-0.02</td>
</tr>
<tr>
<td>95% CI</td>
<td>-0.18, 0.07</td>
<td>-0.19, 0.06</td>
<td>-0.12, 0.09</td>
</tr>
<tr>
<td>Population Size (1,000)</td>
<td>0.42</td>
<td>0.39</td>
<td>0.16</td>
</tr>
<tr>
<td>95% CI</td>
<td>-0.07, 0.90</td>
<td>-0.10, 0.88</td>
<td>-0.25, 0.56</td>
</tr>
<tr>
<td>Constant</td>
<td>16.41***</td>
<td>16.15***</td>
<td>15.92***</td>
</tr>
<tr>
<td>95% CI</td>
<td>13.65, 19.17</td>
<td>13.35, 18.95</td>
<td>13.60, 18.23</td>
</tr>
</tbody>
</table>

Notes: Observations = 300. CI, confidence interval. * p < .05, ** p < .01, *** p < .001 (two-tailed tests).
Source: MRT De-Identified Patient Care Reports, 2015; American Community Survey 2015 5-Year Estimates

Jails make sense. The police will sometimes request an ambulance crew to transport one of their arrestees/inmates to the hospital for medical evaluation. But why is the presence of a train station positively associated with the rate of crew-cop interactions at the neighborhood level?

I learned early in my fieldwork that train stations are relatively common areas that police officers struggle to clear of drunk or otherwise disorderly people who loiter, panhandle, or slumber in the area. In my experience, train station staff usually request the police to respond to a disorderly body and the police frequently determine these bodies to be too sick (e.g., “mentally ill” or “intoxicated”) to either jail or release. So, they summon an ambulance crew to take their subject to the hospital. It’s not just train stations either. Shopping centers, fast-food restaurants, hotel lobbies, and other commercial spaces platform similar interactions. Employees at these establishments frequently dial 9-1-1 to have the state remove somebody from the premises who is not appropriately using the area (e.g., not shopping or eating).
When we disaggregate these data from the neighborhood level back down to the record level, we find three notable patterns regarding crew-cop interactions. First, there is a lower proportion of crew-cop interactions inside homes than in public spaces like streets, businesses, and government buildings (e.g., jails and schools) (Figure 6.2). Second, there is a higher proportion of crew-cop interactions on calls involving low severity interventions (Figure 6.3). Legit cases like gunshot wounds, brutal traffic accidents, and severe overdoses can certainly draw crews and cops to the same scenes, but crew-cop interactions claim a higher share of bullshit calls. Third, ambulance cases involving the police are patterned by call type. Compared to less than a quarter of records that do not mention the police, over two-thirds of the records that do are classified in one of three primary impression categories: psychological/behavioral, overdose/intoxication, or trauma. Across these categories specifically, crew-cop interactions account for nearly nine-tenths of psychological/behavioral calls, over a third of overdoses/intoxication calls, and over a fifth of trauma calls (Figure 6.4). Ultimately, crews and cops are more likely to converge in public spaces where they often deal with bullshit problems that frequently involve drunk, drugged, or otherwise disordered people.

Figure 6.2. Proportion of Crew-Police Interactions by Select Types of Scene Location

*Note: Observations = 107,208. p < .05 (chi-squared)*

*Source: MRT De-Identified Patient Care Reports*

---

35 Streets include highways and sidewalks. In my experience, crews usually classify calls at or near train stations as on a street.

36 Note the sample size for intervention severity is lower than the overall sample size. Less than one percent of cases (n = 119) are excluded from the severity scoring. These are incidents where crews determined death on scene but did not perform a “high” or “medium” level intervention. Sometimes these are called “discovery calls,” referring the discovery of death but the lack of deep intervention. Multiple informal conversations with crews suggested I should count these cases as either low/bullshit or high/legit, because the interventions are absent but the crisis (death) is real. There are more of these events than the records suggest, but firefighters usually make the discovery first and agree to handle the paperwork.

37 My fieldwork suggests that crews and cops interact with many more drunk and high people than is suggested in Figure 10.4. Crews often understand their clientele to be intoxicated but they don’t always list that as the “primary impression” (i.e., the most significant medical problem).
Ultimately, ambulance crews and police frequently meet on cases that must be cleaned up. They cleanse spaces of seemingly dirty flesh, what anthropologist Mary Douglas ([1966] 2002: 2) might consider “matter out of place” and essential disorder that must be eliminated in a “positive effort to organize the environment.” During legit calls, this often means moving wounded bodies from scenes of gun violence, car collisions, and other spaces that crews and cops share. During bullshit calls, which are more common in general and far more common for cases involving the police, this usually means removing an intoxicated or otherwise disorderly body from out of public view. And, it’s usually the poor, the racially oppressed, and otherwise marginalized populations who are going to be seen as such matter of place.

**Green Sheeting**

Perhaps one of the most striking findings from the medical records is that nearly half of the those that indicated a crew-cop interaction are classified as psychological or behavioral emergencies. My fieldwork suggests that an overwhelming majority of the cases involve the
police placing people under 72-hour involuntary psychiatric holds known as “fifty-one fifties” (the hold’s numerical reference in the California Welfare and Institutions Code).

Cops, usually in their response to a “disruptive” person in a public space, will frequently place their subjects on 5150 holds by filling out a “green sheet.” The green sheet, which actually varies in color depending on which police department is issuing the hold, includes a closed-ended item that reads, “Based upon the above information, there is probable cause to believe that said person is, as a result of mental health disorder: [] A danger to himself/herself. [] A danger to others. [] Gravely disabled adult. [] Gravely disabled minor.” By checking one of these boxes, the officer essentially medicalizes the case and mandates an ambulance crew to transport the subject to a hospital for a mental health screening and treatment.

From the standpoint of ambulance crews, there are certainly “legit” 5150s. Crews tell me there are people who need to be placed on 5150s, often because they are violent or seem to be on the brink of violence. For example, early into my employment at MRT, my field training officer, Lance, and our paramedic partner, Megan, responded to one of our county’s metro train stations. We arrived to find a black man around 30 years old sitting on the ground just inside the station with his hands cuffed behind his back. Police told us they were placing him on a 5150 for yelling unspecified threats at people in the station. We greeted the man, but he refused to tell us his name or anything about his medical history.

Lance decided early on that we were going to restrain the man to the gurney using leather restraints. It’s a decision consistent with a lesson he taught me weeks before this call and one echoed by many veteran ambulance workers: “If cops, who have guns and mace, decide it’s a good idea to cuff someone, then we should restrain them.” As cops un-cuffed the man, Lance and I used leather restraints to tie his wrists and ankles to the gurney. It was during this transition from metal cuffs to leather restraints that this man became difficult. He pulled his wrist away from me and tried to bite my arm. “Watch out, Josh! Don’t get bit!” shouted Lance. At this point, Megan decided to “stick” the man with a chemical sedative. With police helping us hold the man in place and with at least one cellphone camera pointed in our direction, Megan injected versed into the man’s arm against his will. “I ain’t getting no fucking shot!” he shouted just before the needle pierced his arm. With the added muscle of law enforcement, Lance and I were finally able to tie the man down to the gurney and load him into the ambulance where the sedative eventually mellowed him during the transport.

So-called legit 5150s typically involve both some wrestling and some sedation. However, most 5150s don’t play out like this. The administration of versed via syringe and needle happens on a minority of cases. And, while physical restraints are sometimes placed on docile patients as a “precaution,” most 5150 calls do not involve a physical struggle.

Indeed, ambulance crews often see 5150s as quintessential bullshit. When I’d ask crews in the field to tell me about bullshit calls in general, the go-to answer along with the archetypal “911 abuser” was the 5150. Most believed that the green sheet was a very convenient tool for the police to medicalize undesirable subjects into the ambulance. On several occasions, the police used personal history of mental illness (e.g., “She says she’s bipolar” or “We’ve placed him on a 5150 before”) to warrant the hold even if the event seemed to weakly justify the checking of one of the four boxes on the sheet: “[] A danger to himself/herself. [] A danger to others. [] Gravely disabled adult. [] Gravely disabled minor.” For example, during one of my ride-along shifts, police placed a homeless and shoplifting man on a 5150 and justified it because the man had an unspecified history of mental illness and 5150 holds.
On another call I worked as an EMT, the police justified a 5150 hold because Miles, their 40-or-so year-old black male subject, was wandering his neighborhood with a knife. One of the cops on scene explained that Miles, who later told us that he had recently finished three 40oz bottles of beer, was somehow disrupting people in the area. Apparently, Miles could not simply return to his home which was in eyesight because he had just got into a verbal altercation with his mother.

Or something like that. Thoroughly confused, I asked the officer if he found Miles holding a knife. “No,” said the cop, “It was in his pocket. Says it was for his protection, but he’s threatened to kill himself before.” “Did he tonight?” I asked. The cop, seemingly irritated with my questioning said in a firm voice, “I’ve determined him to be a danger to himself given the circumstances tonight.” “It’s cool,” I said, “I got you. The nurse is just gonna ask me. I just wanna make sure I get the full story.” The officer seemed to cheer up a bit, “Oh yeah, I know how it is.” “He been cool with you guys?” I then asked. “Sort of,” said the officer, “He gave us a little trouble when we put him in the back (of the squad car).”

Austin, my paramedic partner, insisted that we tie Miles’ wrists to the gurney. “Those are the kind of guys that will get you.” I nodded, but I wasn’t entirely sure what he meant. After we restrained Miles to the gurney and loaded him into the ambulance, he pleaded with us to let him go. “We don’t write the 5150s,” I said, “You gotta go, man.” After explaining that Austin and I have no choice but to take him to the hospital, I said, “My hands are tied.” I realized, almost instantly, that this was a bit of a rude thing to say to someone whose hands were literally tied down.

When we eventually arrived at the hospital, the triage nurse called Miles’ case “bullshit” before she even asked me any questions about the event. She simply glanced at the green sheet I handed her. “For past suicide intentions?” she said, quoting the cop’s hand-written narrative. I responded, “Yeah, I pushed him (the cop) on it a bit, but he was set on it.” Clearly frustrated, the nurse shook her head, but she seemed more irritated with the green sheet’s author than with me.

**Incarceritis**

Just as the fix up work that crews share with nurses is made complicated by lucid subjects, so too is the cleanup work crews share with the police. With the exception of those who are unconscious, the subjects that crews and cops share are not entirely passive in how they are swept up. This is often true even for those who experience crews and cops in their most coercive and violent presentation. For example, the cuffed man at the train station who Lance, Megan, and I had to transport on a 5150 offered both verbal and physical resistance. He didn’t take the limb restraints without a fight and this shaped the way we and law enforcement handled him.

The power of cleaned-up subjects is perhaps best seen during what’s colloquially known as cases of “incarceritis.” This occurs when crews and cops assume that an arrestee or inmate feigns a medical symptom in an effort to evade or delay jail. This usually happens inside a squad car or a jail cell and common symptoms include difficulty breathing, chest pain, abdominal pain, unconsciousness, and suicidal thoughts.

Of course, these symptoms can be seen as legit. During one of my ride-along shifts, the crew I was shadowing responded to an unconscious and likely an overdosed man inside the county jail. He was unresponsive to not only verbal stimuli (the paramedic’s shouting) but also to painful stimuli (the paramedic’s pinch). As ambulance workers explained to me at the end of the call, this particular man was “real unconscious” (i.e., legit) and not “jail unconscious” (i.e.,
bullshit). Still, most people who provide a medical complaint from inside a squad car or jail cell are met with suspicion by both crews and cops.

For example, on a 5150 my partner and I ran on, the responding officer told us they caught Mia, a black woman in her mid 30s, shoplifting. Mia had a couple of outstanding warrants. The cop told me, in an exacerbated tone, “Once we told her she’s under arrest she started screaming that she was going to kill herself… I explained to her that this is just delaying the inevitable (jail) but she’s still screaming that she wants to kill herself.” It was assumed that Mia knew how to force the cop’s hand to place her on a 5150.

On another call I observed, police arrested a man they claimed was driving a stolen vehicle. According to law enforcement, after the man was cuffed and placed in the back of the squad car he immediately suggested he was having difficulties breathing. Sometimes the legitimacy of these complaints can be settled through the scrutiny of an objective assessment (e.g., an EKG, painful stimuli, and infrared measurement of oxygen saturation), but usually these are symptoms that are hard to disconfirm with examination (e.g., abdominal pain).

More so than for people who are not under lock and key, arrested and jailed subjects are looked upon with intense suspicion. Indeed, they have an obvious material goal in presenting themselves as sick. And, from the standpoint of both crews and cops, the ability to “pull incarceritis” gives their subjects significant power to shape the labor performed on them. More accurately, it affects how they are “cleaned up” from a given area by momentarily redirecting their trajectory from the jail to the hospital.

The Street-Sweepers

When teaching me about the complexities of ambulance work, the paramedics and EMTs I shadowed and worked with often spoke of analogous jobs. Earlier, I mentioned how these men and women described themselves as being like doctors, taxi drivers, and even social workers. Another common reference point was the sanitation worker.

Ambulance work often means cleaning public spaces of dirty bodies. In some ways, the ambulance is like a street-sweeper, barreling through the county and brushing up matter out of place. This can involve the removal of those limp and leaking bodies that are left by brutal car collisions, critical gunshots, and other “legitimate” emergencies. However, more often than not, this involves the removal of subjects with “bullshit” problems. Such cleanup work is frequently shared with law enforcement and is often directly shaped by police action (e.g., writing 5150 holds).

There are some important parallels between crew and cop labor with respect to coercion (e.g., limb restraint), but the shared task of street-sweeping is what most commonly links paramedicine and policing. The ambulance regularly touches – and is sometimes outright manipulated by – the Right hand of the state through the cleanup work that draws crews and cops together.
Chapter 7
Burden Shuffling

Paramedics and EMTs sometimes used a vocabulary of war to describe their work. They exchanged “war stories” with one another in ambulance bays. Many portrayed neighborhoods with lots of gunshot calls as “war zones” and some even described themselves as crucial, but unrecognized, actors in a seemingly endless “war on drugs.” Added to these phrasings, actual war was collectively understood to be the cradle of civilian paramedicine. Several treatment technologies for traumatic injury are historically rooted in military medicine (e.g., the “combat application tourniquet”) and textbooks frequently used in EMT and paramedic training programs point to the beneficial treatment lessons gained through combat medicine during American-involved conflicts like those in Korea, Vietnam, and Afghanistan.38 War, no matter how distant or sanitized, proved to be a salient reference point for the men and women I spent time with at MRT.

There are, however, more immediate battles. In addition to their daily struggles with clientele (already detailed in Part I) and management (to be detailed in Part III), crews often conflicted with other frontline workers like nurses and police. Ultimately, these horizontal battles are battles over work and they shape how shared subjects are processed. In my fieldwork, I identified three general forms of horizontal tension: jurisdictional struggle, finger pointing, and burden shuffling.

Jurisdictional struggle happened when one party accused the other of encroaching on their duties and it tended to only occur during more legitimate cases. For example, crews and cops sometimes elbowed one another on gunshot cases. Crews accused cops of “getting in the way” by asking the wounded too many investigative questions on scene and in the ambulance while cops accused crews of unnecessarily tampering with evidence. Likewise, nurses and paramedics sometimes struggled with one another over the appropriate medical intervention. Much of this seems to stem from the fact that nurses, while better trained, have less autonomy in some ways. Paramedics can “push” a number of medications in the field per standing orders while nurses generally need physician approval first. If frustrated with a paramedic’s decision to administer a certain intervention, a nurse will sometimes accuse the paramedic of too eagerly pushing medicine in the field instead of waiting for the hospital to do it. Ultimately, I found these lateral struggles over jurisdictional claim to be rare. More often than not, the cases these workers shared were generally seen as undesirable by all parties. There was often little motivation to push another worker out of the way to access a given case.

Finger pointing was also pretty rare. This happened when workers attempted to assign blame onto someone else after a serious error had occurred or, far more likely, after the perceived risk of such an error had increased. Crews sometimes accused the police of failing to sufficiently “secure” a shared scene and therefore exposing them and their patients to significant

---

38 In the opening pages of the textbook I was assigned during my EMT training, the authors write, “What happens to an injured person before he reaches a hospital is of critical importance. Wars helped to teach us this lesson. During the Korean and Vietnam conflicts, for example, it became obvious that injured soldiers benefit from emergency care in the field prior to transport… We continue to learn about trauma care from the wars in Iraq and Afghanistan and to implement changes in EMS practice based upon the outcomes of those patients.” (Mistovich and Karren 2010: 7) A popular trauma care textbook assigned to many paramedic students digs even further back to link paramedicine to Baron Dominick Jean Larrey, Napoleon’s chief military physician, who articulated some early principles for fast hospital transport by way of ambulance and care en route (Salomone and Pons 2011: 7).
risk of injury. Additionally, nurses sometimes accused crews of missing critical signs during their examinations and then inappropriately fixing their patients up. Like jurisdictional struggle, when finger pointing occurred it tended to happen on more legit calls.

By far the most common form of horizontal struggle I observed as a ride-along, and then was later thrown into as an EMT, concerns the third form: burden shuffling. These were primarily struggles over bullshit, over mostly undesirable cases. Indeed, for crews, police, and nurses, the bulk of potential or actual ambulance clientele involves work to be avoided. While protocols may designate which party is responsible for specific cases at specific times, they don’t over-determine who will inevitably work these cases. Discretion also plays a role and workers across the board know this. Nurses know that crews have some control over which hospital they transport many of their patients to and crews know that cops have some agency in summoning ambulances, writing 5150s, and making arrests. It’s these discretionary acts over the transferring of subjects across squad car, ambulance, and hospital that leads to the most frequent tensions between workers across these institutions. Sometimes these tensions playout as heated arguments, but usually they platform a colder war made of playful bickering and backstage “shit talking.”

Regardless, the accusation is usually the same: someone is strategically shuffling bullshit cases onto others. This is a “shuffle” in a double sense. First, it’s an evasive, and sometimes sly, attempt to shuffle out of one’s duty to manage an undesirable case. The point is to hand it to someone else by sneakily bowing out of the situation. Second, in doing the first, it entails a mixing up of clientele that’s kind of like shuffling up a deck of cards. Cases don’t disappear as a result of burden shuffling. They’re just reordered and then dealt to a different worker.

Shuffling Jose

While an EMT, I worked a number of day shifts with Kyle. Like me, Kyle is a white man around 30 years of age. Unlike me, Kyle is really into fitness and weightlifting. I imagine I gave him the same blank stare when he told me about his gym and diet routine as he gave me when I talked about graduate school. Still, Kyle was one of my favorite people to work with. We spent most of our shifts together laughing as we exchanged absurd stories of both paramedicine and parenthood.

On this particular shift, Kyle and I felt a little lucky. Earlier, the ambulance gods gave us a legit call: a vehicle rollover where we found a woman with collar bone, forearm, and ankle deformities. Later in the shift, they blessed us with a 30-minute lunch break. We didn’t get it until we were already 8 hours into our shift, but we were happy nonetheless.

But then the gods punished us. Our break was cut about 10 minutes short. All of sudden our in-rig computer flashed and a dispatcher’s voice came through our radio’s speakers, “Unit 2118, I need to pull you from your code seven (lunch) for a delta (second highest priority) unconscious male.” “Copy,” I say over radio while chewing my food.” I shoved the rest of my sandwich in my mouth, put the ambulance in a drive, and drove Kyle and I through busy traffic. I blared our sirens and occasionally pumped the air horn to pressure other drivers to the shoulder of the road. Kyle hoped this call would be another legit one. I too was hopeful. Unconscious? This dispatch category is so vague and so promising. Maybe this person got knocked out in a fight. Maybe he faded into darkness after a heroin overdose. Maybe the call was for a diabetic who slipped into hypoglycemic coma.
However, the person we were summoned to was none of these things. Instead, he was “just drunk.” After only a couple of minutes of driving, we arrived on scene to find cops standing around a bus stop bench where a Latino man around 35 years of age laid on top. Kyle noticed this man before he even got out the ambulance. It’s Jose. He’s a regular and on this particular day he was sporting one of those hospital wrist bands from a recent emergency department visit.

Jose was pretty out of it, rolling his head back and forth. Sunlight splashed his face and his eyes were squinted. His lips were curled into a smile, through which he mumbled some incomprehensible speech. The pitch of his voice shifted in a songlike fashion. I think he was humming, perhaps even singing, underneath those mumbles. Kyle quickly concurred with the cops that this was nothing more than intoxication. There was even a smoking gun of sorts: an empty liquor bottle laid next to Jose’s bench-turned-bed.

This was a bullshit call, but Kyle and I both knew there was no getting out of it. Jose was clearly too intoxicated for us to leave and he probably couldn’t sign a release form even if we gave it to him. Police officers, who are the ones who initially responded for the call and then activated the ambulance for “unconsciousness,” clearly had the upper hand here. They decided this bench needed to be cleaned up, but instead of doing the cleanup work themselves (e.g., through arrest for public intoxication) they summoned Kyle and I to do it. Jail wasn’t even mentioned on scene, but we knew what the cops’ likely defense would have been because we had both heard it several times before: “too drunk for jail.” Ultimately, the police shuffled the burden onto us and they had protocol on their side.

As we loaded Jose into the ambulance, one of the officers asked us in a serious tone, “Can’t you guys take him to a different hospital?” This cop correctly assumed we were just going to return Jose to the hospital listed on his wrist band. He didn’t want Jose to get quickly discharged from the hospital and return to his beat. He wanted this man out of the area for as long as possible. “We don’t know where we’re going yet,” said Kyle before citing protocol, “but we need to go to the ‘closest most appropriate facility.’” The officer, seemingly unsatisfied and unconvinced, simply walked away. Indeed, we could have taken Jose to a hospital in a neighboring city but there wasn’t anything for us to gain by doing so. Kyle generally liked the area of the county we were in. The next closest hospital was embedded in a far poorer and busier territory. Plus, neither of us were in the mood to simply help the guy out who inadvertently pulled us from our lunch break to clean up this bus stop.

Inside the ambulance, Kyle asked for my opinion. “Fuck him,” I said of the cop, before I argued that we should just return Jose to the hospital that recently discharged him. I noted that Jose clearly hangs out in this area if the cop knows him this well and wants him out of his beat. “I’m not trying to fuck up his (Jose’s) day that bad.” Kyle agreed and added that taking Jose to a different hospital would be more difficult to justify to the nurses who might very well question why we didn’t take him to facility he was just discharged from.

Even so, it’s not like we brought Jose to nurses with open arms ready to help him out. The triage nurse at the hospital sighed when she saw Kyle and I wheel Jose in. She asked why we brought him to this particular facility. Kyle noted it was the closest hospital. Maybe it was because I was tired, but this nurse’s response pissed me off: a slight shrug of the shoulders, a head shake, and glance at one of her colleagues. It was if she was asking her coworker with non-verbal cues, “Can you believe these guys?” I snapped back with some attempted wit in my voice, “He was 10 blocks away. Had your band on from yesterday. Figured we’d return to sender.”

Firefighters were also on scene, but Kyle dismissed them once they helped us load Jose onto the gurney.
Kyle chuckled and I smiled as the nurse stared me down in return. Feeling a little guilty for picking an argument, I then noted how one of the officers on scene wanted us to go to another hospital. “It was probably Officer Jones,” she said matter-of-factly, “He’s always looking out for us.” “Yeah,” I responded, “I don’t think this guy was looking out for you. He seemed more interested in getting (Jose) out of his beat.” The nurse didn’t reply but she did assign us a bed to drop Jose onto. We took the burden police shuffled onto us and shuffled it onto this team of nurses.

Jose’s case is telling. On this particular call, and apparently on other encounters with police, ambulance, and hospital, he was a workable subject to avoid. Police initially responded and determined that Jose had to go. Somewhere between fully discretionary actors and cogs in a machine, they summoned Kyle and I to take their subject away. They requested we transport Jose out of the area, but we chose to go to the closest hospital. We could have obliged but decided not to. With the burden shuffled onto us, we then shuffled it onto a hospital we believed would make our shift a bit easier. It would keep us out of the very busy areas of the county for a bit longer. As a bonus, our decision was consistent with protocol, easily justified under nurse scrutiny, and it matched Jose’s assumed interest to remain in this general area of the county.

**Jail or Hospital?**

As noted in the previous chapter, ambulance crews and law enforcement converge on scenes that need to be cleaned up. But, who is going to actually do the work? Are ambulance crews going to transport someone to the hospital, or are the police going to arrest someone and take them to jail?

For crews, the answer is usually predetermined. Either the subject in question wills it (e.g., through so-called incarceritis) or the police do. With a powerful toolkit of protocols at their disposal, law enforcement in the county can strategically “cut paperwork” that forces someone to undergo mental health evaluation or simply claim that someone is so drunk or high that they need medical attention. Jail may register as an option for many of these calls, but by the time crews arrive on scene the police have usually already decided that the ambulance will carry the body away. They don’t diagnose, but cops have a curious ability to successfully medicalize human problems, and they frequently do so to shuffle out of undesirable cases.

However, an ambulance ride is not always so predetermined. Sometimes the alternative of arrest is mentioned on scenes that crews share with cops. From time to time, the police articulate the jail as an explicit substitute for the hospital. They usually do so to verbally strong-arm a relatively lucid person into the ambulance. Put simply, the police will occasionally use the threat of incarceration as a strategy to shuffle bullshit into the ambulance.

The same situation seems to repeat itself with some minor details changed. A cop arrives on scene first and determines that someone needs to be cleaned up from the area, usually because they’re drunk or otherwise disordered. For whatever reason, the officer doesn’t want to arrest his subject and so he does his best to medicalize the event. He opts not to write a 5150 or perhaps doesn’t even consider it. Instead, he simply decides the person should just go the emergency department for some other medical problem, usually intoxication. He summons an ambulance crew to do the transport. Maybe he thinks it’s faster and easier than taking the subject himself.

The responding crew, however, doesn’t typically want the call. It’s bullshit. “Total bullshit.” Not only is it not legit, it is arguably not even “medical.” So, the paramedic de-medicalizes the event, generally rejecting the cop’s classification. She double confirms this with
the subject’s lack of a chief complaint and her own examination (e.g., collection of vital signs). Upon confirming that the would-be patient does not want to go to the hospital and that he or she is “alert and oriented” (and therefore capable of making their own medical decisions), the paramedic then tells the officer that she cannot transport. Sometimes she offers some version of this punchline: “We’re not in the business of kidnapping people against their will.”

One of my partners liked to call maneuvers like this “cop blocking.” The idea is simple. If the paramedic can de-medicalize the case, then the officer will be unable push his or her subject onto the ambulance crew. This is where it’s necessary that I distinguish between what I saw and what I heard. Multiple workers at MRT told that they’ve successfully blocked the police from shuffling drunks and otherwise undesirable cases into the ambulance. They told me the police simply dismissed the crew and handled the case some other way. One paramedic told me he thought the officer he successfully blocked ended up taking the person in question to the hospital himself. But I heard of outcomes like these far more than I actually saw them. On a few occasions, I saw crews successfully block the police from shuffling in a drunk person when the subject convinced law enforcement that they could leave the area safely under their own accord. Such outcomes were rare though. It was more common for the police, upon learning that their subject did not consent to ambulance transport, to offer an ultimatum: jail or hospital?

Consider a few excerpts from the medical records (italics and parenthetic notes added):

ATF (arrived to find) 53 y.o (year-old) male sitting upright on bus. Bus driver attempted to wake pt (patient) and had a hard time doing so. Pt is AOX4 (alert and oriented) with normal VS (vital signs) denying any and all medical complaints, reporting he has had a few beers today. Police advised pt he could either go to jail or the hospital. Pt chose the hospital.

On scene, find 25 y/o (year-old) male pt (patient) AOx4 (alert and oriented) sitting upright on the curb alongside (city police). Pt does not appear to be in any acute distress or show any signs of obvious trauma. Pt was found by PD (police) sleeping in a bush, incontinent of urine, and under the influence of ETOH (alcohol). Pt denies any pain or medical complaint and was given the option of jail or the hospital by PD. Pt moved to gurney and transported code 2 (without lights and sirens) to (hospital) without incident.

Patient is a 63 yo (year-old) homeless man that was sitting out front of 7-11 (convenience store) and staff called PD (police) to shoo him away and when the officer arrived on scene the officer asked the pt if he wanted to go to Jail or the Hospital and he said Hospital. PD then requested EMS (ambulance crew) and stated pt had a seizure. Upon arrival pt found sitting awake and in no obvious distress or discomfort being attended to by (fire medic) with officer standing by. Upon pt contact pt a&ox4 (alert and oriented) and states he did not have a seizure.

The threat of incarceration provides law enforcement with another way to shuffle undesirable cases into the ambulance, and the excerpts above help illustrate this point. There is, however, something important these narratives miss. Crews may want to avoid the bullshit cases
the police try to bully into the ambulance, but this doesn’t mean they’re advocating for arrest. In my experience, most would prefer that the police simply dismiss the cleanup altogether, leaving matter out of place. This is at least partially why we see crews attempt to de-medicalize the case rather than criminalize it.40

Ultimately, when they share undesirable tasks, cops usually have the tools to successfully pressure crews to do the cleanup work. In addition to the easily-written green sheet and the loosely justified argument that someone is too inebriated for jail, police can verbally pressure people into the ambulance with a jail-or-hospital ultimatum. But, while crews might feel generally powerless to cops that shuffle bullshit onto them, they have some power to determine how they shuffle bullshit onto nurses. I consider this next.

**Strategic Transports**

Where do ambulance crews transport their patients? There are over a dozen emergency departments in the county. Yet, on paper, ambulance crews don’t have much of a choice on where they can go. County protocols mandate that crews take their patients to the closest, most appropriate facility. Appropriateness usually refers to the hospital’s specializations relative to both the primary impression and the severity of the emergency. For example, critically injured patients should go to the closest trauma center and those suffering a heart attack should be taken to the closest hospital with a catheterization lab. Thus, appropriateness tends to only matter for more legit calls.

However, at the risk of sounding like a broken record, most calls are closer to the bullshit end of the continuum. The next consideration, per protocol, is “patient choice.” If the patient is not so critical that he or she must be taken to a specialty facility or even just to the closest emergency department, then the patient can usually choose an emergency department “within reason.” This usually meaning one out of the three or four closest hospitals.41

For sure, there are many ambulance riders who articulate particular preferences for where they go. Some hate or love a particular hospital given their past experiences or stereotypes. Whiter and wealthier patients sometimes command crews not to take them to a “ghetto hospital.” Many patients with chronic illnesses want to make sure they go to the same hospital every time to assure a continuity of care. Some patients seem to even deliberately exploit the patient choice protocol for transport to a particular area of the county.42 So long as these requests are within reason, they’re usually fulfilled.

---

40 On a couple of occasions, I saw crews parrot the threat of incarceration to convince clientele to go to the hospital. In both occasions, this was part of a “CYA” (cover your ass) strategy. The crews worried about being held liable for some potential injury that could occur if they just left the patient, so they used the threat of incarceration to pressure hospital transport. These were, however, exceptional occurrences.

41 Protocols don’t explicitly limit choice to the closest three or four hospitals. This is more an informal rule and one imposed by MRT management. Some patients request hospitals across county or even in one of the neighboring county, but these requests are rare and not usually guaranteed. The crew may very well want to do some of these longer transports because it can mean avoiding more bullshit, but management actively discourages these long-distance transports and actively monitors for them in real time (as discussed in Chapter 9).

42 For example, Benny, a middle-aged black man who bounced between transitional housing facilities, homeless shelters, and the streets, was known to call 9-1-1 from the central part of the county and mandate a transport to a hospital in the western part. After a given crew would take Benny to the parking lot of that hospital he’d abscond before entering the emergency department. He’d simply step off the gurney and walk out of the parking lot and down the street. When Benny wanted to return to the core of the county he’d frequently do the same thing: call 9-1-1 and demand a more central hospital. Crews would sometimes try to resist Benny’s demands by telling him they’d
Many notable exceptions withstanding, patient demand is not typically so particular. This is where worker discretion creeps into the picture. During a “stay and play,” crews often negotiate a particular transport destination with their clientele. Paramedics, and to a lesser extent EMTs, discuss some transport options with their patients and they frequently pressure them to go to a particular hospital. They emphasize a sometimes true, but sometimes false, benefit to the rider: shorter wait times, superior care, better sandwiches, etc.

However, there is often a hidden interest in these negotiations. Unbeknownst to patients, crews are usually more intentionally recommending hospitals they believe will improve their shift in some way or another. Sometimes this means recommending a hospital in an area the crew is more familiar with or a hospital they believe has faster triage times during that particular moment. However, these strategic transport recommendations are usually driven by one of three ends.

First, crews are often invested in these negotiations during the final call, or what they hope is the final call, of the shift. During the eleventh hour, crews frequently attempt to convince their patients to go to a hospital that will bring the them closer to the crew’s designated sign-out location. This is an attempt to manage the risk of shift overtime, which is almost universally despised. The idea is simple. If my partner and I are required to return the ambulance and clock-out at central headquarters, the “barn,” then we want our final transport to be to a hospital that is as close as possible to headquarters. That way, if we’re dismissed from duty at the conclusion of the transport then we only have a short drive to the barn. The further our final hospital is from our sign-out location then the longer our drive back to headquarters. This increases the likelihood that we will get “pulled back” into 911 service should the availability of ambulances suddenly and substantially decrease. This is the most common motivation for a strategic transport, but it’s not the only one.

Second, crews sometimes hope to transport their patients to a hospital that’s located in a less busy and therefore a less poor area of the county. They reason that by taking someone to a hospital that’s in a less busy territory the dispatchers will be more likely to post them near that hospital once they complete the call. They see this as a way to push the ambulance into an area that may slow their shift a bit. It will reduce their chances of getting another bullshit call right after they complete the current one. And, because most crews assume that there is a higher legit-to-bullshit ratio in wealthier areas of the county, many assume the work will be better in these areas. Indeed, this was Mark and Danny’s reasoning when they agreed to transport Rob to a hospital in a neighboring Moon County city (Chapter 5).

Third, crews occasionally wish to avoid the county’s primary psychiatric hospital because it’s often inconvenient (e.g., away from their sign-out location and in a relatively busy area). They do this by more or less fabricating a “medical clearance” transport for 5150 cases. In green sheeting someone, the police mandate that their subjects undergo a mental health evaluation at “a designated facility,” usually meaning the county’s primary psychiatric emergency department. However, should a 5150 patient present with a medical problem (as somehow distinct from a psychological/psychiatric problem), then the crew should transport to the closest, most appropriate emergency department. Medical clearance protocols provide crews with quite a bit of latitude to medicalize a number of 5150 subjects. For example, just as cops can decide that

only be willing to take him to the closest hospital and some even paid him off with cash or food to cancel the transport. These maneuvers were, however, risky violations of protocol and were far less common than just transporting Benny to where he wanted to go.
someone is too drunk for jail, crews can often decide that a 5150 subject is too drunk for the psychiatric facility. They can also lean on some “borderline” vital signs to encourage transport (e.g., a heart rate above 120 beats per minute). Sometimes they “fish” a medical chief complaint out of a 5150 subject even if it’s unrelated to the 911 event. This usually happens through a battery of questions: “Any chest pain?” “Any nausea?” “Any dizziness?” Some crews get pretty direct: “Tell me you have abdominal pain so you don’t have to go to (psych facility).” While occasionally mixed into a seemingly authentic concern for the patient (medical clearance can mean an early discharge if the green sheet is weakly justified), 5150 medical clearance transports are usually driven by a concern to benefit the crew. More often than not this means medicalizing a case so the crew can transport to a hospital that’s in a less busy territory than the psych facility.

Thus, while the methods are complicated and the intentions are subtle, ambulance workers find ways to shuffle bullshit cases onto particular hospitals. These strategies largely come with the assumption that the next call will be bullshit and that it should be avoided for as long as possible. They’re usually part of a larger attempt to slow the shift down or end the shift on time, but these strategies shouldn’t be equated with an attempt to avoid work altogether. Crews are generally eager to speed things up and even extend their shift past their off-duty time if the call is vocationally fulfilling. But, as gambling men and women, they usually bet the next call is not so legit and this is often a motivation and justification for shuffling bullshit cases onto particular hospitals.

Nurses are not ignorant of these strategies. Triage nurses are often skeptical of crews’ transport decisions. Those who work in smaller emergency departments just outside the central city are especially suspicious. They frequently interrogate crews in the triage bay by asking two questions, “Where’d you pick her up?” and “Why’d you bring her here?” If a crew names a pickup location that’s obviously closer to one or two different hospitals, their defense is usually the same: “patient request.” This is why it’s important that crews convince their patients that the recommended destination is in their best interest. Nurses are not always buying it though and they frequently suspect strategic transports that serve the interests of crews above patients.43

But what can nurses do? The short answer is not much. Protocol, and federal law in particular, prevents nurses from turning away the patients who crews fix up for them. However, many paramedics and EMTs are convinced that nurses have ways to slow or discourage this burden shuffling. Some believe that nurses underhandedly prolong triage for bullshit as a strategy to discourage future transport.44 More directly, some nurses contact MRT field supervisors to complain. This, however, is rare as it requires a bit of proof (e.g., patient testimonial) to be successful. Ultimately, nurses don’t have many tools to resist the burdensome cases that are strategically shuffled onto them by ambulance crews.

Choose Your Battles

Let’s summarize the chapter so far. In answering the question of who is going to do the work on undesirable clientele, the police frequently summon ambulance crews and crews

---

43 Strategic transports are not the only source of tension between crews and nurses over so-called bullshit cases. For example, nurses sometimes accuse crews of doing some lazy fix-up work (e.g., offering an incomplete assessment or not starting a courtesy IV). However, in my experience as both a ride-along and a worker, the crew-nurse tensions over bullshit cases usually concerns transport decisions.

44 On a couple of occasions, field supervisors questioned nurses about vindictively, or at least unreasonably, prolonging triage for low severity cases. Nurses denied intentional delaying in both cases, but crews noticed lower triage times in the minutes and hours following supervisor intervention.
frequently nominate nurses at particular hospitals. Knowing the rules and regulations is a necessary but insufficient condition for understanding this process of burden shuffling. The protocols for things like involuntary psych holds, patient consent, and medical clearance are useless without labor on the ground to interpret and implement them. Workers discretionarily navigate inter and intra agency structures to shuffle undesirable cases onto others. Most tensions between crews and their nurse and police counterparts can be linked to these discretionary decisions. The stratagem here is pretty simple: navigate the protocols to shuffle the burden in such a way that somehow makes your shift easier.

We should, however, be careful not to reduce the relations between crews and their police and nurse counterparts to pure calculated struggle. The horizontal relationship between crews and these other frontline workers are certainly better defined by concord than conflict. The relatively smooth handoffs we saw in the previous two chapters are more typical than the tensions just revealed.

This makes sense when you consider the general solidarity shared between workers on the streets. As fix up workers, crews and nurses see themselves more as partners than as enemies on the frontlines of emergency medicine. Both parties were generally quick to back the other if a patient seemed to be giving one of them any “trouble.” We would sometimes bring nurses coffee and nurses would usually give us the key codes to hospital staff breakrooms so we could get some free snacks. Likewise, there was more harmony than hostility between crews and cops. By and large, cops were quick to physically defend crews during their occasional scuffles with patients. Crews also liked to express their solidarity with law enforcement by covering their badges with a black bar to mourn the not-so-rare death of a cop.

This kind of inter-agency solidarity on the frontlines is probably one of the reasons why burden shuffling is not strategized on all bullshit cases. This at least seems to be the case for ambulance crews. I frequently saw them bite tongues and bullets, and then complain in private about how they got “stuck” with some bullshit because a nurse seemed to prolong triage or a cop seemed to write a bogus green sheet. They often justified their lack of a defense as an overall concern for “keeping the peace.” Picking an argument with a nurse or cop may be a bad idea for crews. Running into these workers later on can be awkward and there is often a perceived risk of revenge (e.g., longer triage in response to strategic transporting).

Lateral solidarity coupled with a general motivation to keep the peace between frontline workers were not the only factors that shaped burden shuffling and the conflicts that can come with it. Workers’ cold and warm interactions with clientele also seemed to play a role. The more sympathetic the crew, the less likely they were to strategically shuffle the burden in a calculated effort to improve their shift. For calls more in a “gray area” than “total bullshit,” crews were less likely to coach a transport to hospitals that would make their shift easier at the possible expense of the client’s convenience. The race, gender, and age of the subject also matters. White, female, and elderly clientele generally yielded more sympathy from crews and were less likely to be treated as passive pawns in a subtle game to improve the shift.

Nonetheless, solidarity across the frontlines and sympathy for clientele don’t prevent burden shuffling. They simply reduce the likelihood of such a strategy and its related tensions. As these factors reduce the motivations for burden shuffling, other factors are increasing these same motivations. For example, when crews enter the eleventh hour of their shift, they’re highly motivated to shuffle bullshit cases onto nurses at hospitals closer to their sign-out location. Likewise, a few cops admitted to my partners and I that they summoned ambulance services
because they didn’t want to get held up past their off-duty time at the jail. However, they admitted this in retrospect by confessing to doing so in the past.

As both fix up workers (regulators of spaces in bodies) and cleanup workers (regulators of bodies in spaces), ambulance crews are caught in productive but often tense interactions with nurses and police. These frontline workers frequently conflict over the shuffling of burdensome subjects who are overwhelmingly poor. Inundated with so much bullshit, ambulance crews routinely struggle over the management of such cases with their police and nurse counterparts.

This chapter concludes the second part of this dissertation. Where Part I illustrated how ambulance crews recognize and churn through a plethora of human problems that concentrate toward the bottom of the polarized city, Part II illustrates that they don’t do so in isolation. Crews instead process a mostly poor clientele base through their recurrent interactions with other frontline workers like nurses and cops. It is through these horizontal relations that the poor are not only bandaged, but also sorted.

We can’t stop here though. For as important as horizontality is, verticality is perhaps even more critical. Bureaucratic and capitalistic forces rain on, and reign over, the tops of ambulances. We’ve already encountered some of this in my ongoing discussions of protocols and the occasional references to management, but Part III will offer a deeper analysis and will do so by examining the vertical relations that ambulance crews enter into during the productive process. Doing so will not only clarify how the poor are governed by way of the ambulance but also help explain some of the interactions observed between frontline workers.
Part III
Hustling the Poor: The Ambulance Underneath Bureaucracy and Capital

If we hope to understand how ambulance crews are handling their subjects, then we must make sense of forces imposed on these frontline workers from outside and above the ambulance. So, unlike Part II, which had us stepping into the streets and hospitals just outside the rig, Part III has us explicating the ambulance underneath a nexus of capitalistic and bureaucratic pressures. Returning to the map sketched in the introduction, we’re going to start at the top and work our way down. We’ll begin inside a manager meeting at MRT’s headquarters before heading into the supervisor rig and then again into the ambulance.

Profit and policy will be key themes during our descent. MRT’s tireless pursuit of profit is important not only because it motivates high ambulance transport invoices that disproportionately land on the poor, but also because it shapes the manner and context in which crews handle their subjects. For somewhat obvious reasons, MRT managers constantly pressure crews to improve their performance and more specifically the number of transports completed. Among other things, these pressures contribute to crew exhaustion and exacerbate their already tense relations with clientele and other frontline workers like nurses and cops.

This vertical analysis, however, cannot be reduced to an account of profiteers over workers. We’ll see how the “naked self-interest” of capital is tightly swaddled by the public policy interests of the local bureaucracy that surveils this firm. Moon County Emergency Medical Services (MCEMS), often following federal, state, and county mandates, establishes many protocols that boots on the ground must execute and thus company management must generally assure. These include the clinical procedures listed in the thick protocol book that supervisor Eric tossed into by lap in the introduction. They also include policies that indirectly contradict the profit motives of MRT and shape management’s relationship to labor as a consequence.

This intermingling of capitalistic and bureaucratic forces from above the ambulance shape, but don’t over-determine, the internal and horizontal features detailed in Parts I and II. For example, there are probably many reasons why someone who calls 911 is met by a “dick” or “bitch” ambulance worker, but pressures from outside and above the rig are especially suspect. Long hours, low pay, heavy call volume, few breaks, close managerial supervision, and waves of vocationally unfulfilling tasks are but some of the exhausting and agitating forces that can wear crews into generally cold people workers. Added to this, ambulance crews are often interacting with patients, nurses, and police as part of a subtle struggle with management and protocol.

I realize that an analysis of managers and protocols can seem like odd stops on a strange detour. However, understanding the vertical relations that crews are embedded in is an essential part of rethinking the ambulance as an institution of poverty governance. Such relations provide some necessary context for making sense of how crew labor amounts to a bandaging of the poor. MCEMS protocols clarify workers’ scopes of practice, specify the tools needed inside the ambulance, and detail step-by-step procedures for treatment and transport. These bureaucratic-produced guidelines narrow crews’ possible interventions to superficial responses. They also force workers to respond to essentially anyone who requests their services, regardless of their opinions of medical necessity. Yet, while the policy interests of the county explain why crews must offer particular responses and why they have to work bullshit, the profit interests of the company better explain why any given crew has to work so hard. County protocols tell crews
that they have to wrap people in gauze, but company managers tell them to wrap as many people as possible.

These vertical relations don’t just matter for understanding what’s happening inside the ambulance. They also matter for making sense of the horizontal relations between ambulance crews and other frontline workers. Verticality structures a sorting of the poor as well. Protocols, as we saw in Part II, specify the conditions for transferring subjects from the squad car to the ambulance and from the ambulance to the hospital. Indeed, it’s impossible to discuss a sorting of clientele without considering how the official rules for things like involuntary psych holds and patient choice condition the interactions between crews and their nurse and police counterparts. The forces of lean production, pushed more by capital than by bureaucracy, are also important for making sense of crews’ horizontal relations. These are forces that intensify paramedics and EMTs’ interests in pacing the shift. What I’m calling “burden shuffling,” starts to make more sense when such verticality is considered. Strategically transporting a non-urgent patient to a hospital that crews believe will make their shift easier or trying to block the undesirable cases that cops are trying to push into their rigs can often be read as efforts to combat the forces of lean production. How the poor are going to be sorted can affect shift pacing, and in turn how workers attempt to adjust this pacing can affect how the poor are sorted.

The vertical relations of production also help clarify another mechanic of poverty governance: hustling the poor. People processed on the frontlines are not just bandaged and sorted. They’re also hustled. I’m not referring to how MRT’s contract with Moon County allows the firm to charge people and/or their insurance policies thousands of dollars for ambulance rides. The firm’s position in an extractive market is a hustle of sorts, but not one best revealed on the frontlines. I never collected payment as an EMT, and billing was rarely discussed inside the ambulance. My partners and I were instead engaged in a different hustle. Our hustle didn’t concern a swindling of money from the poor, but instead a swift processing of them. We hustled people along through hurried interventions. Pressures from above not only pressured us to wrap a lot of people in gauze, they also pressured us to do so quickly.

Indeed, there’s a rapidity to ambulance-based people work. Some variably “legitimate” crisis strikes. An ambulance crew responds. They treat, transport, and move on to the next case. Hustling people through points of intervention is normal and is directly promoted by both county protocols and company management. The forces of lean production in particular encourage a high transport-to-crew ratio and this usually translates into crews rushing through interventions.
Chapter 8
The Barn

Previous chapters mention MRT’s Moon County headquarters, or the “barn.” This chapter takes us inside this building and walks us upstairs. It’s here, during daily operations meetings between upper and middle management, that we best learn about the relationship between bureaucracy and capital and some of the consequences of this relationship for ambulance crews. As I’ll also make clear, understanding what’s happening in the barn is key to understanding how the poor are handled by workers on the ground. Not unlike the many paramedics and EMTs that enter and exit this building daily, our stop here will be brief.

Upstairs

MRT’s headquarters is located in a two-story building. As an EMT, I got to know the first floor pretty well. I’d enter through the garage where rigs were repaired and restocked, tuck my uniform shirt in, and clock in for work using a fingerprint scanner located toward the front of the garage. I’d then approach “the counter,” where a vehicle service technician would sign me out some keys, a computer, and a pair of radios.

From here, I’d head outside to my assigned ambulance and set it up. I’d log into the computer and double check that critical equipment was there and working. Depending on the preferences of my paramedic partner, I’d sometimes hang strips of medical tape off a ceiling bar in the back of the ambulance for easy access, assemble some saline locks, and complete some other preparations. Meanwhile, my partner would retrieve and lock the “narc box” into a safe in the back of the rig before I’d “go available” over the radio: “Good evening. Unit 2223 logging on.” The dispatcher would then assign us a street intersection to “post” at and wait for a 911 call or she would assign us a call directly if one happened to be pending. Either way, we weren’t staying at headquarters. I’d drive the ambulance off the premises and wouldn’t return for 12, 13, and sometimes 14 hours later to park the rig and clock out.

While working, I spent more time in Moon County’s busiest hospitals waiting for beds than I did at the barn. Headquarters was just a place I encountered during the very beginnings and very ends of my shifts. And, even then, I only regularly accessed the first level where rigs were parked and the equipment counter was located.

I’d rarely venture “upstairs.” The second floor of MRT’s headquarters constituted a somewhat mysterious space. For workers, it seemed to be occupied by villainous managers and a supporting cast of office caricatures: number crunchers, paper pushers, and other pseudo-workers. From below, it’s imagined as a kind of fake, boring, and cushy world, insulated from the real, exciting, and harsh one that paramedics and EMTs confront daily.

However, before I was an EMT, I went upstairs several times. I’d accompany daytime field supervisors like Eric as they were pulled from the streets to attend meetings with both middle and upper managers. These meetings, here called “Daily-Ops,” are held in a large conference room. Usually in attendance are the chief of MRT’s local operations, the contract manager, the personnel manager, the clinical director, daytime field supervisors, and other specialized managers. These were regular meetings to “check the pulse” of the firm. More than anything else, it was during my time upstairs and in these meetings that I learned to untie that knot of bureaucratic and capitalistic forces that direct ambulance crews from above.
**Time and Punishment**

Of the Daily-Ops participants, Karen speaks the most. She’s basically MRT’s contract manager and she tells me that much of her job is to monitor the firm’s “compliance” and to act as “go-between” between MRT and MCEMS. Karen is often the only woman in the room and, while definitely part of the managerial team, she seems to always be the one taking the meeting minutes.

Sitting at the center of the conference table, Karen guides our eyes to a large flat screen monitor mounted to the wall in front of her. She begins the meeting by telling the rest of us how many late calls the firm collected in the past 24 hours and the types of calls that were late. Her comments summarize an important vital sign and helps the rest of the managers gauge the firm’s health. However, like a patient’s blood pressure or respiratory rate, this sign – the number of late calls – only makes sense relative to some shared expectations of healthy performance. For management, the number of tardy calls really only matter relative to the contract they’ve entered into with Moon County.

The details are a bit complicated. The contract, part of what I am calling “official protocol,” specifies strict requirements for ambulance response times (i.e., the time a crew arrives on an emergency scene minus the time that call was initially dispatched to the MRT fleet by the county dispatcher). The required response times vary according to two factors, and Karen speaks as if everyone in the room knows this. First, the contract specifies three area types for ranking each square kilometer of Moon County by its call volume density. The corresponding expectation is intuitive: busier areas should receive faster ambulances. Second, the alpha-to-echo triage categories mentioned in the first chapter establish another intuitive ranking: the higher the triage, the shorter the expected response time. Whenever Karen mentions there’s been a late echo call the night before, a sigh or two can be heard in the room while the late charlie and bravo calls are less concerning. That’s because the consequences are more severe for higher priority late calls.

Through the authority granted to them by the County Board of Supervisors, MCEMS negatively incentivizes response time compliance by fining MRT for tardy ambulances. However, they don’t fine for individual late calls except when they’re “outliers” (i.e., greater than 150 percent of the allotted time). The bureaucracy instead fines the firm when more than 10 percent of the monthly call volume for a given triage category are late. MCEMS calculates this percentage across several hundred patches of MRT’s service area (i.e., every square kilometer). In other words, the bureaucracy will fine the firm if they are less than 90 percent compliant across each triage category within each of these square kilometer patches.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Required Response by Area</th>
<th>Monthly Incompliance Fines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Most Busy → Least Busy</td>
<td>89.5-89.9%</td>
</tr>
<tr>
<td>Echo</td>
<td>8:30 14:00 18:00</td>
<td>$25,000</td>
</tr>
<tr>
<td>Delta</td>
<td>10:30 16:00 22:00</td>
<td>$15,000</td>
</tr>
<tr>
<td>Charlie</td>
<td>15:00 25:00 28:00</td>
<td>$15,000</td>
</tr>
<tr>
<td>Bravo</td>
<td>15:00 25:00 28:00</td>
<td>$5,000</td>
</tr>
<tr>
<td>Alpha</td>
<td>30:00 40:00 40:00</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

The stakes are high. Table 8.1 summarizes the fine schedule by dispatcher-determined triage and area call volume. Again, the details are complicated. The major concern for management, however, is simple. Late ambulances can lead to hefty fines. For example,
MCEMS will fine MRT $50,000 should they have a monthly compliance rate below 90 percent for the highest priority triage level in any of the square kilometer patches. That means if they get a late echo call, they’ll need to respond to nine more echo calls on time within the same patch to avoid the fine. If that late call happens to be an “outlier” (i.e., greater than 12 minutes and 45 seconds, or 150 percent of the requirement), then the monthly fine will swell by $5,000. And that’s just for the late echo responses. The late delta, charlie, bravo, and alpha late calls can snowball into some much heftier fines. Without providing me with a month-by-month breakdown of fines paid, management tells me these fines can reach nearly $400,000 a month even though over nine-tenths of MRT’s overall responses are “on time.”

The contract between the county and the company certainly specifies much more than response time requirements. Among other things, it details how much the firm can charge per transport and the amount of money MRT has to pay annually to help finance the county dispatch center and related infrastructure. However, for Karen and her peers in the Daily-Ops meetings, the central item of concern are the response time requirements and the teeth behind them. As I show next, these requirements are an important part of an unspoken dilemma for management and it’s a dilemma that concerns the poor’s heavy use of the ambulance.

**Poverty as Unspoken Dilemma**

Attending the Daily-Ops meetings, reviewing the contract, and talking to managers helped me unearth an unspoken, but nevertheless central, dilemma that MRT management faces. *If the firm aids the poor, they will continuously waste resources on a mostly unprofitable clientele base. But, if the firm abandons the poor, the county bureaucracy will fine them for violating protocol.*

Let’s break it down. In the first chapter, I noted that over half of MRT invoices are billed to either uninsured or means-tested Medicaid patients. This isn’t all that surprising given what we know about the insurance status of ambulance riders nationally (Meisel et al. 2011). Well, per management, uninsured people often don’t pay their bills and Medicaid covers about ten percent of a $2,000 to $3,000 transport. As such, the thicker flow of revenue for MRT really comes down from the hills of Moon County and from the wealthier pockets of its suburbs where people are more likely to have private insurance. As an added bonus, residents in these areas seem more poised to call for reasons that insurance policies will recognize as a “medically necessary” and therefore cover in full or nearly in full. However, despite the relatively thinner revenue flow from the more destitute flatlands of the county, MRT cannot just abandon the poor. The response time fines just detailed negatively incentivize the firm to keep areas with the highest demand stocked with the most ambulances. And, as also demonstrated in the first chapter, the areas with the highest demand are typically the areas with the highest rates of concentrated poverty.

Management at MRT, like management at any organization, face a number of challenges. However, what I’m branding the poverty dilemma is a central one for the studied firm. To be clear, I never heard anyone say “poverty” or “poor” during the Daily-Ops meetings and the contract lacks this language as well. Daily-Ops participants occasionally mentioned the challenges of “frequent fliers” who didn’t pay, the high proportion of Medicaid patients, and the busy areas of the county – all of which are terms that generally map onto poverty – but I never heard anyone upstairs explicitly discuss Moon County’s poor residents and their heavy use of ambulance services. Nevertheless, by examining MRT’s economic and legal circumstances, it becomes clear that the dilemma exists. Aiding poor patients hurts the firm, but abandoning the
poor hurts more.

The pressing question is not whether the dilemma exists or how its articulated, but how management responds to it. How do they alleviate financial loss, amidst the bureaucratic pressure to serve a largely unprofitable clientele base?

MRT can’t talk their way out of the poverty dilemma, but they can try and negotiate some provisions that make it less painful. In the span of just a few years, MRT has been able to amend the service agreement with MC to incrementally jack up the baseline price of transport, from around $1,500 to $2,000 (plus additional charges for miles traveled and oxygen used). This doesn’t affect Medicaid reimbursements and it probably doesn’t do much to increase revenue from uninsured patients, but it almost certainly thickens the flow of revenue from privately insured clientele. MRT has also requested and received some relief from paying certain agreed-upon fees to the county and they’ve been able to advocate some relatively minor tweaks to the fine schedule. Additionally, Ralph, MRT’s chief of local operations, is known to lobby the state legislature with some of his peers in the industry. His goal is to pressure the state to increase Medicaid reimbursements for ambulance transports (see also: Elliott 2016). This has largely amounted to asking for relatively modest increases of a couple hundred dollars per transport, crumbs in the grand scheme of things.

The Lean Fleet

While negotiations with county and state governments aren’t insignificant, they don’t constitute MRT’s primary strategy in responding to the poverty dilemma or the pursuit of profit more generally. The firm’s go-to tactic is more quintessentially capitalist: intensify the exploitation of wage labor, or, in other words, increase the amount of surplus that management can appropriate from workers. Put even more simply, management aims to increase a transport-to-crew ratio. The more hospital trips a given crew can handle, the better. It’s a kind of plug-your-nose-and-do-it-quick philosophy. The obvious solution is to pressure crews to grind through a large number of transports. It doesn’t guarantee profit, but it should minimize loss. At least that seems to be the general sentiment upstairs.

Management tries to increase a transport-to-crew ratio by deploying what I call “the lean fleet.” I’m inspired by sociologist Alan Sears’ (1999) account of how contemporary welfare states at the turn of the millennium have absorbed principles of lean production – systematic effort to decrease waste by increasing the efficiency and the flexibility of labor. To be clear, managers’ concerted efforts to orient the frontlines of poverty governance into lean bodies of production shouldn’t be limited to outsourced for-profit service providers like MRT. Strategies to increase frontline efficiency and flexibility can be seen in police departments (Police Executive Research Forum 2011), non-profits (Alexander 2000; Hohl 1996), and welfare offices (Soss et al. 2011). The articulated end might be profit, but it doesn’t need to be. More opaque goals like “efficient performance” and “fiscal responsibility” may motivate organizational heads to pursue a lean workforce.45

In the case of MRT specifically, leanness can be understood as a kind of goldilocks status between thinness and fatness (Figure 8.1). Management wants to avoid a fleet that’s too thin, because although it would reduce labor costs it would also increase the risk of late calls. If there are too few ambulances on the streets, especially in some of the busier, and thus generally

45 For similar discussions, see the scholarship on “new public management” (e.g., Brodkin 2011; Hasenfeld and Garrow 2012; Suleiman 2003).
poorer, areas of the county than the firm risks late call penalties imposed by MCEMS. At the same time, management wants to also avoid a fleet that’s too fat, one that would reduce the risk of late calls but would in turn raise labor costs. If there are too many ambulances, more crews will be sitting around on post and completing relatively few transports. Understandably, management wants to hit that sweet spot between thin and fat.

This very concern is taken up during the Daily-Ops meetings. Following her summary of a late call from the past 24 hours, Karen gives the floor to Bruce. Where Karen’s specialty is the contract, Bruce’s specialty is personnel. He’s responsible for ensuring ambulances are stocked with workers, a somewhat difficult task given MRT’s high employee turnover and callout rates.

Figure 8.1. The Goldilocks Fleet

The firm maintains a kind of skeletal schedule of full-time regular employees, but it’s almost never enough to cover anticipated demand. Bruce’s task is to layer some meat onto the bones by publishing an auxiliary schedule every day or two. This is typically filled by a flexible army of part-time laborers or fulltime workers looking to collect some overtime pay. If he struggles to fill these additional shifts or he’s concerned that they won’t fill easily, Bruce will incentivize portions of the schedule.

Bruce has two carrots at his disposal, one more expensive than the other. The cheaper carrot is a promise to erase a portion of an employee’s callout or tardy records. These are simply referred to as “incentive shifts” and they aren’t always filled. The more expensive carrot, however, is almost guaranteed to work: a promise to pay double the wage. For reasons that will be discussed in Chapter 10, these are oxymoronically called “voluntary mandation shifts,” but they’re more colloquially known as just “mandation” or “mando” shifts. The rest of us in the Daily-Ops room stare silently at a calendar displayed on the monitor as Bruce tells us which shifts will be generated, which will be incentivized with tardy/absentee forgiveness credits, and which will be upgraded to double pay. By expanding and sweetening the schedule, he reduces the company’s chances of being fined by the county.

However, Bruce needs to be careful. While more crews on the street decreases the likelihood of late call fines, too many crews can mean “too much post-time” (i.e., the amount of paid time a crew spends parked at or near a designated street intersection waiting for a 911 call). There’s always a risk that Bruce will add too much meat to the skeletal schedule, making the fleet more fat than lean.

While important, the day-to-day pliability of the fleet size is but one aspect of the fleet’s leanness. The crews in the field need to also handle tasks in an efficient manner. They should take patients to the closest hospital if possible and take as little time as necessary at the emergency department before returning to the streets for another 911 call. Management closely
monitors crew “drop times” (i.e., time spent at hospitals) and regularly reminds the fleet of their surveillance. Monday through Friday, Bruce emails the fleet a spreadsheet with everyone’s drop time from the previous day. He highlights in red those crews with the longest times and consistently insists the overall fleet “can do better.”

At the same time, management at the barn imposes other measures to assure the fleet doesn’t act too hastily or carelessly. They randomly audit workers’ medical records to assure workers are administering appropriate care consistent with the contract. In accordance with the company’s insurance, MRT has also installed automated road safety surveillance into each ambulance. While crews are obviously pressured to respond to 911 calls quickly, they’re discouraged from driving too fast, braking too abruptly, and turning too sharply. Management does a lot to pressure workers to self-regulate and maintain their own leanness.

Still, deploying an efficient and flexible workforce from headquarters is easier said than done. There are two opposing forces that hinder leanness: official protocols and worker discretion. On the one hand, protocols curb workforce flexibility. The protocol book lays out many procedures that thwart discretion, such as a policy to treat “medically unnecessary” problems and the requirement to transport all green-sheeted cases (i.e., those the police place on a 5150 psych hold). Protocols do not reduce workers to cogs in a machine, but they limit labor flexibility in a significant way. On the other hand, labor discretion, although arguably a necessary condition of frontline labor flexibility, also threatens leaness. Miles away from the barn, workers can choose to extend their time at hospitals, pressure patients to go to emergency departments in less busy territories and commit other “wasteful” sins against the interests of management.

Fortunately for those who sit at the Daily-Ops conference table, there’s a mobile team of managers who regularly leave the barn to pressure a lean ambulance fleet: the field supervisors. There are four on duty at any given time. Two show up to these meetings. The other two call in because they’re tasked with supervising operations further from the barn. Night time field supervisors, who are probably sleeping during the 9:00am meetings, are asked to read the minutes that Karen will soon send to them by email. However, their absence doesn’t really seem to matter since the field supervisors that are in attendance don’t usually speak anyway. Rarely asked by those at the table to contribute anything, these middle managers instead sit on the periphery and listen. Sometimes an ethnographer sits next to them. When the Daily-Ops meeting adjourns around 9:30am, the two supervisors on the phone hang up and those at the barn head out to their supervisor rigs. Indeed, they’re meant for the streets. Upper management needs them on patrol.
We’ve been in the supervisor rig before. Eric drove me around in one in the first chapter and this introduced us to some of MRT’s busiest areas. It was in this rig that I peered out onto a “little nexus of evil” and listened to Eric talk about “hookers,” “bangers,” “zombies,” and other caricatures.

Before summarizing the tour, I noted that Eric had two general tasks that day. One was to show me the ropes, but the other was far more important: monitor the largest segment of MRT’s 911 ambulance fleet, the portion servicing the urban core of Moon County. Indeed, Eric’s generous tour occurred amidst his managerial tasks. It occurred between his visits to hospitals, his phone calls with crews, and his attendance at the Daily-Ops meeting.

I shadowed Eric and other supervisors several times in the year following that introductory shift. It didn’t take long for these middle managers to stop their courtesy tours and just do their jobs with me next to them. I sometimes even helped, although not in a very consequential way. From the passenger seat, I transcribed a couple of emails for supervisors and assisted their navigation of traffic. I sometimes helped keep their eyes on the road by reading out loud the dispatcher call notes that popped up on the computer. While on the high-profile scenes that supervisors are summoned to, I’d sometimes help them carry equipment and collect information from bystanders. Ultimately, though, I was just along for the ride. Maybe they were just being nice, but most supervisors said they appreciated the company and they often encouraged me to ride-along with them again. So, I did.

A Different Kind of Bullshit

Each of the eight supervisors I shadowed provided three simple justifications for their movement from paramedic to manager: money, ease, and vocation. First, as veteran paramedics turned middle managers, the pay is higher inside the supervisor rig. No one shared their exact salary with me. In fact, the couple that I asked about compensation directly skirted the question with vague answers. One thing’s for sure though, the baseline salary is more “comfortable” than working full-time on the ambulance. One supervisor tells me that if he worked as hard as a
paramedic who pulled a lot overtime shifts (150 percent wage) or mandation shifts (200 percent wage), he’d be able to make more than his current salary. However, this would require several more hours of work. In terms of the 40-hour a week average that supervisors work, compensation is clearly better.

Second, while middle management isn’t easy, it’s not as exhausting as working on the ambulance. Few supervisors seem to ever admit this to their crews, but they tell me that their current position is not as labor intensive as being a full-time paramedic. Indeed, supervisors enjoy many more down-time periods than crews. I regularly went out to eat with supervisors and I watched entire movies with one of them on a portable DVD player. On a few occasions, supervisors parked in abandoned parking lots so that we could nap. Don’t judge us though. When 3:00am hits and you’ve been patrolling the fleet since 5:00pm the previous day, let’s see how easy you can stay awake in a warm SUV. And, in the napping supervisor’s defense, he doesn’t fully check out but instead learns to “half sleep” with “one eye open.” This means dozing off while still being conscious of radio traffic in case he gets summoned to a call. Thus, while field supervision is not gravy, Eric and his colleagues nevertheless admit it’s easier than working on the ambulance.

Third, and most importantly according to the supervisors I shadowed, there’s vocational perk to their middle management position. You get to not only observe but also assist crews on many of the most legit calls. Per the contract with Moon County, MRT field Supervisors are dispatched to every echo call (i.e., cardiac and respiratory arrest), multi-casualty incident, and other high-profile events (e.g., all shootings and some other severe trauma calls). While some of these calls are false alarms (e.g., cardiac arrest dispatch for someone sleeping on the sidewalk), a good proportion of them are legit. They’re just not very frequent. It’s not uncommon for supervisors to catch just a couple of calls in a shift. When they do respond to these high severity emergencies, supervisors frequently help crews push medication, intubate, and do other deep clinical interventions into the body. These calls really belong to the paramedic, who will continue care inside the ambulance, but supervisors nonetheless play a consequential role on many of these responses. They get to watch and work some of the best calls in the system while avoiding the mundane bullshit that most crews have to deal with. In some way, field supervisors live a paramedic’s fantasy: exclusively responding to legit calls.

Figure 9.2. Supervisor on High Priority Scene
But, while the position of field supervisor may come with some desired perks, it also comes with some downsides. As Supervisor Grant once told me, the job comes with “a different kind of bullshit.” There’s much to be annoyed with, if not outright loathe. Supervisors are frequently replacing broken equipment in the field and writing lengthy incident reports for things like ambulance-involved wrecks and patient-on-crew assaults. They’re at times called to neutralize the conflicts between crews and other workers in and out of the organization. A bit more exciting, but far from doing the legit clinical work in the field, supervisors are often talking to fire captains, police sergeants, and charge nurses about ways to manage the frontlines at their intersections (e.g., decisions to place a busy hospital on a temporary ambulance bypass status). To top it off, field supervisors have to deal with some other generally mundane tasks at the barn, like attending Daily-Ops meetings. None of these tasks, however, really capture the main grind of field supervision: the interlocking tasks of “watching levels” and “clearing hospitals.”

Watching Levels

It’s been several months since Eric’s introductory tour, but I find myself back in his SUV. We’re parked outside a grocery store some weekday morning near the epicenter of his supervision zone. Just a few minutes ago, we were in yet another Daily-Ops meeting together. And, per usual, I now have some clarifying questions about what was said in the meeting. Between our bites of breakfast, the conversation quickly carries us into a discussion of management’s tactics more generally. Eric tells me about the ways those at the barn calculate crews’ hospital drop times, track their driving performance, and audit their paperwork. The topic of conversation then shifts a bit. Perhaps in an effort to signal his sympathy for (or similarity to) labor, he tells me, “You need to understand that upper management is micro managing us too.” People upstairs in the barn often look at the late calls, long hospital drop times, and other poor performance measures as potential indicators of weak field supervision. Upper managers like Ralph, Karen, and Bruce count on field supervisors to find ways to prevent, or at least reduce, these poor performances.

Of course, just as those at the barn know that crews can’t fully control a number of circumstances like a patient’s insurance status, they also know that supervisors can’t fully control fleet performance. For example, the posting locations for ambulance crews, while “dynamic” and frequently changing, are pre-approved by MCEMS and are managed by the county dispatchers who assign posts to crews directly. Supervisors also can’t control the fact that emergency departments are perpetually overwhelmed with patients and that cops can somewhat loosely justify 5150 psych holds.

However, within reason, upper management expects Eric and his peers do what they can to maintain “levels.” This is simply a term used throughout the industry that references the number of ambulances that are currently available to respond to a 911 call. Depending on the hour, there can be nearly 50 ambulances out in the field at any given time, but the level is often less than a dozen. Every supervisor I shadowed carefully monitored the levels. They regularly looked at their in-rig computers and counted the number of ambulances available (Figure 9.3).
Supervisors are alarmed by low levels for two major reasons. First, low levels mean a currently thin fleet and thus an increased likelihood the firm will catch a late call. While upper managers hate late calls because they can lead to fines from the county government, supervisors dread late calls because they can bring heat from the barn. Eric and other supervisors tell me about times that upper management seemed to imply that they were somehow at fault for the tardy responses that occurred on their watch.

Second, low levels can prevent crews from ending their shifts on time. Per the contract, the county dispatchers cannot dismiss ambulance crews from duty unless it’s level eight or greater. In other words, if you’re working on an ambulance, and you’ve completed 12 hours of your 12-hour shift, the dispatcher cannot relieve you and your partner until there are more than seven ambulances available to respond to new calls. You may be forced to work for up to 14 hours total. Upper management doesn’t like this because those additional two hours come with a 50 percent wage increase. Shift extensions don’t just come with some heat from above, but also with some from below. Even with the wage bonus, ambulance workers – including your author – almost universally hate being held past a dozen hours. Supervisor Steve tells me he feels bad for crews who get held over, but he also hates the “whining and bitching” he gets from crews when they’re forced to work past their off-duty time. Supervisors are in the business of working an easy shift and observing some legit calls. The less drama the better.

As such, supervisors prefer levels to be as high as possible. In this regard, their interests are more aligned with labor in the field than with management in the barn. Supervisors and crews overwhelming desire what is colloquially known as “fat” levels. Neither want the goldilocks fleet that upper management hopes for, the one that’s perfectly sized to avoid the fines that come with thinness and the wasted labor power that comes with fatness. When levels are relatively fat, crews go home on time and get longer “breaks” on post between calls. This reduces heat from below. It also strangely reduces heat from above. While upper management clearly despises fat levels because it threatens efficiency, supervisors are not expected, or at least not provided with the methods, to trim excess labor power. Thus, from the standpoint of both workers and supervisors, fat levels are operational bliss.

Unfortunately, levels are rarely fat. Bruce, from the barn, does what he can to keep them lean and this produces a challenge for supervisors. They can’t just passively watch levels and shrug their shoulders. Instead, they’re pressured by upper management to lift levels, especially when they dip into “level shit.” And when it strikes “level zero,” as seems to happen several times a week, supervisors need to scramble to fatten the number of available ambulances.
Clearing Hospitals

There are a few ways supervisors can try to increase levels. They can ask incoming crews to rush their rig setup at the barn and head out into the streets as soon as possible. They can encourage others to avoid long hospital transports and thus trim the time between the call and the return to 911 availability. If there’s an incident involving multiple patients, they can recommend that more than one patient go to the hospital in a single ambulance. Supervisors can even speak to patients with bullshit complaints directly and encourage them to reconsider a hospital transport via ambulance. While these strategies can be somewhat effective, they’re drops in the bucket and often depend on special circumstances. The go-to tactic is far more practical: get crews who are at the hospital back onto the streets as soon as possible. This is called “clearing hospitals.”

The problem to be solved is captured in Figure 9.4. Ambulances often get “clogged” in emergency department parking lots. This is a stressful, but not an uncommon, sight for field supervisors. Every ambulance in that photo is unable to respond to a new 911 call because the crews attached to them are technically in the process of completing the transport for their previously assigned response.

But how can field supervisors help get these ambulances back onto the streets? Like many things, “full house” emergency departments are often out of their control. They can’t affect the number of available beds at the hospital. Likewise, they can’t change the protocols that force crews to transport anyone who wants to go. Supervisors also recognize the challenges that emergency department staff face, such as a busy waiting room and federal law requiring they assess anyone who comes looking for aid. They know such challenges are a major reason for why ambulance crews often have to “hold the wall” (i.e., wait several minutes for a bed assignment). Related to this, supervisors know that crews cannot just drop a body off on a bed and return to service right away. Protocols command them to write and print a patient care report before they return to the streets. Crews also need to clean the ambulance and prep any equipment that may have been used on the previous call.

These are some strong impediments to fast “drop times,” but supervisors nevertheless find ways to help clear hospitals. One option is to talk with nursing staff, and charge nurses in particular. A phone call might do the trick, but most supervisors tell me that face-to-face interactions work best. Sometimes a simple question can do wonders. “Y’all short-staffed today or something?” Supervisor Lisa once asked a charge nurse. The nurse apologized and found Lisa’s wall-holding crews some beds “like magic.” Just as supervisors will help charge nurses
out by placing an exceptionally busy hospital on a two-hour ambulance bypass, nurses will sometimes help supervisors by bumping ambulance patients a few triage notches above their already privileged status in the queue.

There is, however, a more effective way to clear hospitals: pressure paramedics and EMTs to return to service sooner rather than later. The point is to discourage crews from “milking” their drop times. Again, a simple face-to-face question can do wonders. Every shift I spent with supervisors involved them driving to hospitals when levels were low and asking crews questions like “Can you clear (i.e., return to service) soon?” and “Have you printed yet (i.e., completed your paperwork)?” Such questions are often prefaced with some brief, yet ostensibly friendly, conversation about legit, comical, or bizarre calls. Sometimes these questions are put into a context that may or may not be an outright lie. These include claims that it’s level zero and calls are pending, that other crews are past the 12-hour mark and are trying to go home, and that upper management is more closely monitoring drop times on this particular day.

Regardless, the supervisors’ intentions are pretty obvious to crews. They typically come to the hospital to put some fire under asses and lift levels. And while supervisors frequently question ambulance crews, they don’t always have to. Their mere presence at the hospital is often enough to motivate crews to return to service. When a supervisor drives into an ambulance bay, it’s not uncommon to hear crews suddenly announce their availability for a new 911 call over the radio. “They scatter like cockroaches,” supervisor Grant once told me as we heard a couple of crews clear over the radio shortly after he parked in a hospital ambulance bay.

Supervisors don’t just randomly select hospitals to clear. They use the same in-rig computer program that tells them where their crews are and what level it is. This program tells supervisors how many ambulances are at each hospital and how long each crew has been there. Supervisors’ computers also tell them whether or not crews at the hospital have printed their patient care report and are therefore (probably) technically ready to return to service. When supervisors feel the urge to clear a hospital, they will usually select ones that have four or more crews or ones where a single crew has been at the hospital for over 50 minutes. Supervisors will sometimes get a call from management at the barn requesting them go clear a particular hospital. Again, the point is to discourage crews from “milking” their drop times. The assumption here is that crews are deliberately extending the amount of time they’re spending at the hospital in an effort to avoid work. There’s a significant degree of truth to this assumption and it became very obvious to me once I started working as an EMT. For example, when it was my turn to write the paperwork at the hospital, my coworkers taught me to complete the paperwork but wait 10 to 15 minutes before actually printing the report. This would help keep management from knowing we were actually ready to return to service and hopefully give us a few minutes to take a break. Drop time milking certainly exists and it happens on far more transports than not. This is not a secret to anyone at MRT.

It’s also no secret that supervisors are generally tolerant of crews doing some milking throughout the shift. As previously noted, crews do not return to ambulance stations between calls. They’re instead “posted” at particular street intersections and these posting assignments can change on a minute-to-minute basis. This means crews are running a 12-hour cycle that basically repeats this chain: post-call-hospital-post. But, it’s actually worse than this because posting assignments change so often. Crews are frequently driving between posts when they’re not running calls. So, the chain tends to actually look more like this: post-post-call-hospital-post-call-hospital-post-post-post-call. The post-post links are “post moves” and occur when
dispatchers command crews to cover another area of the county. This produces incredible flexibility but also incredible exhaustion. The chain only ends when the shift does, the ambulance breaks down, or a worker falls ill.

Every supervisor I shadowed accepted the fact that hospital ambulance bays function as a sort of improvised breakroom for paramedics and EMTs working under this regime of dynamic posting. With levels typically being lean or low, crews rarely get scheduled meal breaks and so they often use their time at the hospital to eat. Additionally, emergency departments are in many ways the only places that workers can depend on for accessible restrooms that don’t come with a high probability of interruption. This is significant. Try working on an ambulance and taking a shit at the Starbucks near your assigned post. The ambulance gods almost guarantee that you will catch a 911 call as soon as you sit on the toilet. Beyond meal and restroom breaks, the hospital also provides a place for crews to “catch their breath” before heading back into the streets.

Supervisors understand that crews want to take a few minutes to “recharge” before returning to service. However, they expect this to be limited to around 10 minutes every couple or so calls. They also hope crews will be flexible and forgiving. More specifically, they hope crews will be willing to postpone or forgo such informal breaks for the benefit of “the system” when it’s level shit. But, expectations and hopes only go so far. Supervisors often feel compelled to hound and harass crews over the amount of time they spend at the hospital. For good reason, they’re suspicious that crews are doing what they can to push their transport times to the max. They’re suspicious that many, if not most, are a bunch of slackers.

The Lazy Fleet

It’s nearly midnight during one of my EMT field training shifts with Lance and Vince and we’re at a particularly busy hospital. After holding the wall in triage for over 30 minutes, we eventually moved our patient from the gurney to the hospital bed. Since then, Vince has completed the paperwork for this call and I’ve cleaned the ambulance for the next. It’s been six hours since we left the barn for the night and we haven’t received any official meal breaks. Experience tells me that we probably won’t get one during the next six hours either. So, I use this time to drink coffee and eat food. Lance sits with me in the back of our open-door ambulance as Vince reenters the hospitals to take a piss.

Suddenly, supervisor Jim drives into the bay, parks his rig, and walks directly toward Lance and me. While we’ve been at this hospital for about an hour, we’ve only been sitting for a few minutes. In addition to the long triage, we had a messy cleanup. Nevertheless, we know the drill. Jim has come to clear this hospital. Because we’ve been there the longest out of any of the other crews in the bay, Jim’s going to focus on us first.

He greets us and claims “calls are dropping” (i.e., it’s busy). Lance then tells the supervisor what he apparently wants to hear, “We’re about to clear, and not just cause you showed up.” “I appreciate that,” responds Jim. I continue to chew my food and swig my coffee. Lance then asks with a smile if someone at the barn called Jim and sent him to this particular ambulance bay. Jim admits this is the case. Attempting to keep the conversation light, Lance continues, “They always got you guys out here doing that, huh?” Jim seems unimpressed with this question. Speaking of the particular woman who called him from the barn, he says, “She’s

46 In a way, crews have limited access to something that resembles a break room. The barn includes a room with vending machines, a television, and occasionally even some fresh donuts. However, workers rarely enter it and when they do it’s usually at the beginning and ends of their shifts (before and after they clock out).
just doing her job. I’m just doing my job. And my job is to make sure you guys do your job. If we all do our jobs then everything will work out.” Lance and I nod but say nothing in return. Maybe Jim thinks he just dropped the mic or something. He abruptly walks away and approaches another crew. I guess they’re his next prey.

Looking back on this exchange, Jim said something to Lance that I mostly heard supervisors say privately to me when I rode along with them. It’s this idea that if crews do their jobs and do them well (i.e., efficiently), then life will be easier for management.

As supervisor Steve once told me beyond the earshot of labor, “I’m cool with crews as long they don’t make me work.” He clarified that this didn’t mean the legit clinical work that he was generally happy to assist crews with on scene, but rather what Grant was calling a “different kind of bullshit.” Echoing the sentiments of his peers, Steve tells me he doesn’t want to be a “babysitter.”

Supervisors generally don’t want to watch levels and clear hospitals. The latter in particular can require a lot of tedious driving and awkward conversations. For people still committed to the craft of paramedicine, these foreman-like tasks are simply not very rewarding. And, when supervisors aren’t responding to high priority calls, they would rather be eating out, watching movies, taking naps, and killing time in other leisurely ways. Some seem to think that they deserve this as a reward for working the streets for so long. Whether or not this is a reasonable opinion, people don’t always get what they deserve. Such supervisor ease depends on a number of factors like the volume of 911 calls, the availability of hospital beds, and the number of shifts that Bruce has added to the schedule.

Yet, the most frustrating threat to a gravy supervisor shift exists right beneath them: a fleet of ostensibly lazy employees. While supervisors verbalize sympathy for the hardships of a busy workforce, they also see crews as generally shiftless and opportunistic in their efforts to avoid work. Because crews like to push their hospital drop times, supervisors have to drive between hospitals and “get on them.” The comedy here is somewhat blatant to an ethnographer who drifts between the worlds of management and labor: supervisors suspect and despise a “lazy fleet” because it hinders their own leisure. An apparent laziness from below forces the middle to work more of that bullshit of a different kind. No one’s laughing with me though, especially not the supervisors.

---

47 I’ve heard supervisors call crews a lot of names behind their backs: dumbasses, retards, losers, etc. I’ve also heard crews, in the relatively private space of the ambulance, tag supervisors with many of the same insults. However, the go-to insult from both directions was “lazy.”
Chapter 10
Payback

In this chapter, we now step out of the supervisor rig and continue our descent downward. If we hope to understand how the vertical forces detailed in the previous two chapters shape poverty governance by way of the ambulance, then we must understand how said forces are first filtered through the practices of crews. In other words, we must account for workers’ responses to those forces as they trickle down from the barn.

Bloodlust

For labor, the most typical response to bureaucratic and capitalistic forces from above is obedience. In selling their capacity to work by the hour, crews embrace some significant degree of subservience to capital and bureaucracy. They generally adhere to the explicit commands of protocol and management.

The evidence in support of this obedience is somewhat obvious. They respond to every call the dispatchers give them and most note the “tight leash” that county dispatchers have over their movements throughout the county. Moreover, because protocol commands it, and because punishment for disobedience is too high to ignore, crews frequently transport a mass of bodies they’d prefer to leave behind. Inside the ambulance, they frequently execute the protocol-determined interventions for each medical problem they identify. And, despite a caseload of vocationally unfulfilling activities, crews work hard in response to the close surveillance of upper managers and field supervisors.

Still, as I’ve argued throughout this dissertation, ambulance workers are not cogs in a machine. In fact, neither protocol nor management expect them to be. The protocol book published by MCEMS is written for critical thinkers and emphasizes things like “provider judgment.” Likewise, management at the firm encourages a flexible workforce that’s adaptable to an array of clinical and operational uncertainties (e.g., shifting levels). Forces from above encourage, and in many ways produce, discretionary workers inside the ambulance.

Worker discretion is, however, a double-edged sword. It can help trim labor into a lean body by making it more flexible, but it can also slice into management’s bottom-line. Crews can use moments of discretion to pursue their own interests against the interests of management. We saw a bit of this in the last chapter as crews attempted to extend their hospital drop times at the expense of lean levels and frustrated supervisors. Thus, while labor’s obedience may be likely, it’s never fully guaranteed.

Workers frequently counter the interests of management through both individual and collective action. The crews’ labor union, as an upward force that confronts (even if it often concedes to) capital, is itself an important actor. A few months into my employment at MRT, my “brothers and sisters” negotiated a nearly two-dollar wage increase for myself and other rookie EMTs. And, when I accidently backed my ambulance into a pole at the hospital and significantly damaged the rear bumper, my partner told me not to sweat it because the union would have my

48 Further evidence of labor’s obedience can be seen as crews respond to certain stimuli from above. When protocols change (e.g., certain drug dosage requirements) or when management makes specific requests (e.g., to clear the hospital), crews generally adapt to obey. Whether done deliberately or habitually, crews are generally executing the will of those above them.
back. But, for as consequential as the union is, labor’s daily struggle with management occurs in a less formalized fashion.

More so as an EMT than as a ride-along, I learned how crews attenuate their own suffering as frontline workers charged with executing the will of MRT managers and Moon County bureaucrats. I learned to bend the rules and hurt management. My coworkers taught me some “little tricks” on how to *pace the shift* (i.e., slow production) and *swell the check* (i.e., increase earnings) (Table 10.1).

### Table 10.1. Payback Tricks

<table>
<thead>
<tr>
<th>Shift Pacing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Transporting</strong></td>
</tr>
<tr>
<td>Coaching “patient choice” for a particular hospital in an effort to make one’s shift easier (e.g. recommend hospital in less busy area of the county).</td>
</tr>
<tr>
<td><strong>Post Delaying</strong></td>
</tr>
<tr>
<td>Wait a moment to drive toward a new post assignment, often in hopes that the dispatcher will assign a more desirable post in a less busy area of the county.</td>
</tr>
<tr>
<td><strong>Drop Time Extending</strong></td>
</tr>
<tr>
<td>Postponing a return to 911 service after transferring patient care to a nurse, completing rig cleanup, and finishing necessary paperwork.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Check Swelling</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overtime/Holiday/Night Pick Ups</strong></td>
</tr>
<tr>
<td>Picking up shifts that pay 150% base wage and/or include a few more dollars per hour for night work.</td>
</tr>
<tr>
<td><strong>Clock Running</strong></td>
</tr>
<tr>
<td>Clocking in to work a few minutes earlier or a few minutes later than necessary.</td>
</tr>
<tr>
<td><strong>Lunch Dodging</strong></td>
</tr>
<tr>
<td>Evading official meal breaks (often by drop time extending) in an effort to secure a monetary compensation for missing such breaks.</td>
</tr>
<tr>
<td><strong>Mando</strong></td>
</tr>
<tr>
<td>Bid and secure “voluntary mandation” shifts, which pay 200% base wage.</td>
</tr>
</tbody>
</table>

The material benefits of a paced and pricy shift are significant, but there’s another reward for pulling the tricks defined in the table above: feelings of vengeance. Like many of my colleagues, I found something simply thrilling about “working the system” for my own benefit. The little tricks for what I’m calling shift pacing and wage swelling constitute a kind of upward violence, or at least many workers like to think they do. It’s a way to scratch and slash the underbelly of that beastly array of capitalistic and bureaucratic interests that attempt to control and coordinate labor. As one senior paramedic once put it to me as he summarized some of the tricks I detail in the chapter, “I’m here to bleed these motherfuckers dry.”

**Shift Pacing**

My partners and I often began work hoping we’d limit how much we got our asses kicked with calls. It’s not that we didn’t want to work or work hard. As noted in Chapter 3, crews overwhelmingly desire legit calls, which are usually more physically, mentally, and emotionally
exhausting than the usual bullshit. However, we couldn’t choose which calls we respond to and what we were assigned was usually much closer to the bullshit end of the continuum than the legit end. So, while we hoped for some hard work that was vocationally fulfilling, we also wanted to pace our handling of the more typical cases.

Yet, besides praying to the ambulance gods, what could we do? Many of the factors that determine shift pacing, like the call volume and our posting assignments, were simply out of our control. Luckily, we had a few tricks up our selves, some of which I’ve already touched on a bit in previous chapters.

As discussed in Chapter 7, there are strategic transports. By guiding “patient choice” during so-called bullshit cases, crews can help steer the direction of the ambulance. They frequently do so by recommending that their patients go to hospitals that they believe will somehow improve their shift. I previously noted three basic ends of strategic transports: 1) to go to a hospital that’s relatively close to the barn during the eleventh hour, 2) to go to a hospital in a typically less busy area of the county, or 3) to avoid the county’s primary psychiatric facility. These are important ways that crews horizontally shuffle undesirable cases onto nurses at particular hospitals, but they’re arguably better understood as part and parcel of a vertical struggle.

Strategic transports are often used in a larger effort to pace the shift. The first end reduces the likelihood that a crew will catch a “holdover call.” It does this by reducing the time spent travelling between the final transport and the crew’s designated sign-out location, and it’s a simple tactic for avoiding forced overtime. The second end, in directing the ambulance toward relatively less busy areas, is an even more explicit attempt to pace the shift. Crews hope that after such transports they’ll be assigned a less busy post nearby, thus extending their post time. Long post times between calls are rare, but when they happen they are doubly satisfying: you get a much-needed break and MRT has to pay you to sit in a parked ambulance. The third end, which involves avoiding the county’s primary psychiatric facility in favor of a closer emergency department, is often similarly motivated. As noted in Chapter 7, crews occasionally “fish” for a medical complaint when handling cases where the police force a 72-hour psychiatric hold. Paramedics and EMTs usually do this because they want to remain in a relatively less busy area of the county.

Another shift pacing trick involves what I call “post delaying.” Of the dozen or so posts regularly issued during my tenure at MRT, crews generally despised three that were in the heart of Moon County’s poorest areas. I too learned to dislike these posts. While we knew that legit calls concentrated near these intersections, we also knew that more often than not we’d get a bullshit call while in those areas. And we’d most likely get it quick and with less time to rest than if we were posted elsewhere.

Our frustrations with these post assignments often motivated us to subtly stall or slow our travels toward them. My partners and I would sometimes take slower routes to these posts (e.g., city streets rather than highways) in hopes of being reassigned a more desirable post en route. More commonly, though, we did something we called “the five minute rule.” When a county

---

49 Levels permitting, dispatchers dismiss crews from duty over the radio. However, crews can still be “pulled back” into service so long as the paramedic has his or her “narc box.” Thus, when dismissed from duty, crews want to reach the barn and return the narc box as soon as possible in order to avoid being pulled back should levels suddenly dip or a high priority call happen to drop nearby. Strategic transports during the eleventh hour almost always aim to reduce the distance between hospital and barn and thus (hopefully) the time travelled between these two locations.
dispatcher assigned us an undesirable post, we would acknowledge the assignment over the radio but wait five minutes until we actually started driving toward that intersection (e.g., from a hospital ambulance bay or a different post). This was usually just enough time to dodge any scrutiny from dispatchers or supervisors. If we were lucky, the five minute rule would lead to a closer post assignment as other crews became available for service following the completion of their hospital transports (thus changing the geography of available ambulances and possibly the post assignments).

Perhaps the most obvious method for pacing the shift was discussed in the previous chapter: extending the hospital drop time. Indeed, the supervisors are right. Crews are taking more time than needed at the hospital. After handing patient care off to nurses, completing paperwork, and cleaning the ambulance, crews often take a few minutes to eat, use the restroom, and otherwise relax. They do this in a busy 911 system that has them running a ton of bullshit and does not have them returning to an ambulance station between calls. Because it’s well known that most supervisors’ will start to question crews once they’ve been at the hospital for over 50 minutes, many push their drop time to just around this time (unless it’s the eleventh hour and they want to rush back to the barn to end the shift on time).

Drop time extending seems to frustrate upper management far more than strategic transporting and post-delaying. Largely oblivious to the day-to-day specifics of triage and other factors that occupy the majority of time spent at the hospital (e.g., messy cleanups and complicated paperwork), upper management seems to only see numbers. Still, they don’t like what they see: a daily average drop time of about 50 minutes for the entire fleet. Combined with crews’ time spent driving to the call, responding on scene, and then driving to the hospital, this means that each case will likely account for over 90 minutes of a crew’s shift. More time per case means a lower transport-to-crew ratio, that very thing they want to avoid with a lean fleet.

In addition to pressuring the supervisors to watch levels and clear hospitals, upper management encourages crews to trim their drop times directly. Their most aggressive attempt to do so during my fieldwork came early into my employment at MRT. Management struck a deal with the union that incentivized shorter drop times. They added two carrots. First, the firm agreed to pay us a three percent quarterly earnings bonus if the fleet’s average drop time for that quarter was less than 40 minutes. The monetary drop time bonus would increase to four percent if the fleet’s average drop time lowered to 30 minutes. It would even rise to five percent if drop times fell to 25 minutes. For essentially every worker I talked to about this, the 30 and 25 minute drop times were laughable given triage times at the hospitals. The 40 minute goal,

---

50 Because 50 minutes is a loose, but well known, tolerance threshold for most supervisors, crews are especially interested in hospitals with shorter triage times. If for some reason a crew happens to “hold the wall” (i.e., wait in triage with their patient) for 20 minutes rather than 30 minutes, then they’ll usually enjoy 10 additional minutes of down time in the ambulance bay before returning to service. Unless they’re at the hospital too, supervisors don’t know how long crews wait in triage (i.e., time ambulance patient lays in hospital bed minus the time of hospital arrival). Their in-rig computer simply tells them current drop times (i.e., present time in bay minus the time of hospital arrival).

51 As noted in Chapter 8, Bruce emails the fleet every morning to announce the average drop time from the previous day. He attaches a spreadsheet that names every crew and each of their drop times. Bruce highlights each crews’ longest drop time in these spreadsheets, which most people seem to delete or ignore without ever opening. While these emails sometimes include a brief note on how fleet performance is subpar, they usually include nothing but these data points and their averages. I’m not sure why Bruce sends these emails, but most of the workers I talked to about this insist it was a kind of intimidation. It seems to be Bruce’s way of saying, “I see you.”

52 The monetary drop time bonus would increase to four percent if the fleet’s average drop time lowered to 30 minutes. It would even rise to five percent if drop times fell to 25 minutes. For essentially every worker I talked to about this, the 30 and 25 minute drop times were laughable given triage times at the hospitals. The 40 minute goal,
the ambulance bays. If one crew was taking too long it would drop the fleet average and hurt everyone’s chances at getting the bonus. To facilitate this coworker-policing, management even allowed crews to access a limited “supervisor view” on their computers so that they could monitor their peer’s drop times. Second, management agreed to reward individual workers with exceptionally low drop times by permitting them to wear a company-approved “t-shirt” during the following month. This reward is relatively small, but it’s not insignificant to many workers. It means temporarily ditching a thick and itchy uniform button-up.

Management’s efforts to tempt labor out of the ambulance bays with cash and comfort largely failed. “Fuck those greedy motherfuckers, I’m not changing shit,” said one of my partners a few days after the new incentivizes were put in place. This seemed to capture the modal opinion of labor, at least as I encountered it inside rigs and ambulance bays. Many doubted the possibility of lowering a collective drop time average below 40 minutes and figured we’d just work hard to return to the streets quickly but not actually get rewarded (e.g., lower the average drop time to 41 minutes). Workers also reasoned that a three percent quarterly bonus, which would be taxed higher than our regular earnings, might not be worth “killing ourselves” over. You could just pace the shift as usual and then pick up a few additional shifts to make some more money. Workers also generally hated the idea of policing each other and figured any serious attempts to reach the 40-minute goal would raise tensions with nurses over triage times. Nevertheless, a minority of workers were apparently motivated by the t-shirt incentive and about one to two dozen employees were allowed to leave their button-ups at home every month. These eager crews were exceptional though. For the most part, the workers I talked to saw the t-shirts as something not worth sacrificing a paced shift over. They’d rather preserve their energy against the explicit wishes of management.

**Check Swelling**

Pacing the shift against management’s interests is one way crews can get some payback. Indeed, a slower paced shift means fewer transports and thus less revenue. We can think of this as hurting management by making the fleet a bit costlier. But, while shift pacing may increase the relative price of labor, workers don’t see a monetary benefit in doing things like strategic transporting, post-delaying, and drop time extending. Shift pacing simply helps protect them from exhaustion.

However, workers also have at their disposal another set of tricks I brand “check swelling.” These tricks don’t necessarily protect workers from exhaustion, but, like shift pacing, they help make the fleet more expensive. The benefit to workers is obvious: more pay per shift.

For example, thanks in large part to the union and California labor law, workers can often pick up shifts that pay higher than their base wage. One obvious way to do this is by picking up overtime shifts, which pay 150 percent the hourly wage. Holiday shifts also come with this benefit. Another option is to pick up night shifts over day shifts because the former come with a few more dollars per hour. Sometimes there’s even the option of combining these increases (e.g., an overtime-holiday-nightshift cocktail).

__________

however, was not so ridiculous. Following the introduction of the policy, labor actively discussed this option in hospital ambulance bays and on a private message board invisible to management.

53 Several paramedics also voiced concern over the legal risks involved rushing drop times: the pressure to rush back to service could encourage faster, and thus sloppier, paperwork. Should a paramedic get called into court as a witness or a defendant, this paperwork is closely scrutinized.
There are some more subtle ways to swell the check too. One option is to “run the clock.” Some workers intentionally punch the clock a few minutes earlier or later than necessary. To the annoyance of management, several employees come into the barn and clock in before they’re appropriately dressed (e.g., without uniform shirt on). Moreover, should they return to the barn a few minutes before their shift is scheduled to end, some will hang around the barn a bit before clocking out. Because crews cannot punch the clock more than 18 minutes early or late without offering a written explanation, this strategy can at best only yield about an extra half-hour of pay per shift (i.e., 18 minutes early plus 18 minutes late). While this is a somewhat petty effort, if done enough in a bi-weekly pay period it can noticeably increase a person’s paycheck.

An even sneakier trick involves what I call “lunch dodging.” While workers frequently complain that they don’t get the two 30-minute meal breaks they’re promised, they have a material interest in not receiving these breaks. The firm pays workers an extra hour of pay for each break missed. The actual strategies of lunch dodging are mixed into the strategies of drop time extending. Longer drop times not only provide some time and space for meal consumption, they also reduce the likelihood of getting a meal break since these cannot be issued to a crew when they’re technically in the process of completing a transport. Indeed, when management incentivized shorter drop times, a number of workers expressed concern that this could actually hurt worker pay by increasing the likelihood of missing out on the compensations for missing meal breaks. Not all crews want to dodge lunches, but a good number of them certainly do.

The most obvious way to swell the check concerns the so-called mando shifts that I briefly mentioned in Chapter 8. Recall that every so often Bruce will post these in an effort to thicken up an otherwise thin fleet. The particular conditions of these special shifts emerged from struggles between labor and management well before my entry into the field. According to some of the more senior workers I shadowed and worked with, management has long reserved the “right” to force mandate employees into work under the argument that ambulances, like squad cars and fire engines, are essential public infrastructure. Meanwhile, organized labor has long argued that forced mandation is a management-produced problem; it marks the company’s failure to hire enough people and schedule enough shifts ahead of time. At some point, capital offered a concession that softened mando: double pay (plus an additional overtime bonus if applicable). Added to this, labor convinced management to make mandation “voluntary” before forcing it. Now, Bruce must publish mando shifts for voluntary pick up before he can force mandate anyone. Perhaps as an effect of more experienced workers running the union, labor caught another crumb: senior employees (and thus the highest paid workers) get first dibs on these double pay shifts.

Because I was a rookie EMT at the bottom of the seniority list, I could only occasionally participate in the oxymoronic “voluntary mandation” program. In order for me to snag these shifts, mando needed to be “deep,” meaning that the number of voluntary mandation shifts outnumbered the more senior employees interested in these shifts. Lucky for me, mando was frequently deep right after I was hired. I was able to catch these shifts from time to time and my

---

54 Levels permitting and workers willing, management will sometimes request the dispatchers to dismiss crews a half-hour early if that crew missed a meal break. When this happens, the crew clocks out early but they’re paid for the entire shift as scheduled.

55 Most of the struggles over mandation shifts occurred before I started my fieldwork. In fact, per a few employees, some of these struggles predate MRT’s arrival to Moon County. When the previous ambulance provider left the county and MRT took over, the contract required MRT to honor the collective bargaining agreement the previous firm struck with labor.
coworkers taught me how to do so effectively. When I heard rumors that mando was deep, I would pick up few or no straight pay shifts and instead wait for management to publish the double pay shifts for me to bid on (sometimes they did this on the day of the shift or a day or two earlier). This strategy came with some risks though. Mando might not be deep enough for me to win a bid and by the time I would realize this there might be no straight pay shifts available for me to secure on that particular day. My efforts to hold out for a mandation shift sometimes left me with no work.

MRT continued an EMT hiring wave a couple months into my employment and this provided management with more bodies to put in rigs. Mando didn’t disappear, but it suddenly dried up for rookies like me. Still, while it lasted, mandation felt great. Like many of my peers on mando, I’d show up to work with a little pep in my step, bragging to my coworkers about the mando shift I got. The shift came not only with extra pay but also with a dose of vengeance. As one of my paramedic partners on mando said one shift, “That’s what they (management) get.” Our mandation shifts were like sanctions we imposed from below. They were fines not for late calls, but for the firm’s failure to retain staff. We relished the opportunity to collect on these penalties.

The Defiant Fleet

Ambulance crews are not entirely passive to the downward pressures of management and bureaucracy. They may be exploited and generally obedient, but they find some innovative, albeit slight, ways to undermine those who control and coordinate their labor. From this point of view, labor doesn’t constitute much of a lean or a lazy fleet. Instead, they’re a defiant fleet, or at least that’s how many workers like to see themselves. Several of my colleagues proudly described themselves and the fleet in general as “rebellious,” “punk,” and “anti-corporate,” and a “fuck management” maxim seemed to always accompany their justifications for shift pacing and check swelling.

These efforts certainly frustrated people above labor, but they never seriously threatened capital or bureaucracy. In fact, the argument could be made that the strategies detailed in this chapter actually help facilitate exploitation by making it more tolerable overall; they’re labor’s attempts to direct harm upward and away without fundamentally challenging those above them. Still, these defiant strategies constitute mild and momentary breaks from obedience and understanding them is important for three interconnected reasons.

First, the little tricks summarized in this chapter help clarify the suffering of crews by showcasing their efforts to mitigate it. For some readers, it might seem outright ridiculous that I discuss such a thing amidst the hardships we’ve already encountered beneath these workers’ boots. I sympathize with this critique. But, while crews are generally whiter, richer, and healthier than those they serve, they’re not immune to some of the same basic forces that social scientists

56 During negotiations with the union, management won something that helped them squash the mando strategy I played. Another hierarchy in mandation availability was applied: full-time workers get dibs before part-time workers. Management admitted that they requested this change to prevent part-time workers from picking up few or no straight pay shifts in hopes of filling up their calendar with mando.

57 During collective bargaining, management and labor agreed to not only give more senior employees first dibs on mando but also give full-time employees a chance to secure these shifts before part-time employees. Management wanted to combat a handful of very senior employees who voluntarily dropped from full-time status to part-time status just so they could “game” mando (i.e., open their schedule up so they could work more mando shifts, which they were entitled early dibs on).
insist are hurting people toward the bottom of the American social hierarchy. The encroachment of the market into essentially all arenas of society, the intensification of social insecurity, and the polarization of life chances may leave a few groups unharmed, but ambulance crews are not such a group. In many ways, shift pacing and check swelling mark crews’ daily efforts to ameliorate their particular experiences in an advanced capitalist society.

More to the point, these are tricks for alleviating the pains of low wages and long hours. Many workers see the strategies I’ve detailed in this chapter as essential to their survival. Several depend on things like overtime and mandation pay to cover their living expenses. Some even tell me that catching too many meal breaks (and thus missing out on the corresponding compensation) can seriously threaten their ability to pay their bills. Several with dependents to support feel a strong pressure to work 60 hours a week. Others are driven to “pull doubles,” which usually means they work a 12 hour shift, sleep in their car in the barn parking lot for a couple hours, and then return for another dozen hours of work. A few even have second jobs at other ambulance firms and at organizations unrelated to paramedicine.

Considering circumstances like these, the defiant strategies I’ve outlined can mean a lot to workers and not just because they can come with some refreshing feelings of vengeance. Swelling the check, even if by a little, can mean paying one’s bills on time or having a bit more spending cash in one of the most expensive states to live in. The motivations for shift pacing also start to seem more reasonable. For labor, pacing the shift is not just a way to lift a middle finger at management, it’s also a way to catch their breath in a system that has them running from call to call for multiple hours a day, several days a week. Extending their hospital drop times and doing related tricks help keep them from running into the ground.

Second, these strategies help illustrate that crews are neither tools nor total victims of the downward forces of capital and bureaucracy. They don’t just struggle with pain in the ass clientele beneath them, but also with those who kick their ass with difficult shifts. My job seemed to have me wrestling drunk and disorderly patients every couple of shifts, but my partners and I were more consistently grappling with forces above us. We pushed our knees into spines, tied wrists to the gurney, and forced masks over spitting heads, but we more frequently struggled to pace our shift and swell our checks. Enacting some payback on the firm, and to a lesser extent the county bureaucracy, held much of our focus while at work. In some respects, it was easy to lose sight of the patients beneath us as we concentrated on ways to survive and screw those above us.

Thus, a third reason why it’s important to understand the defiant strategies of crews. Ambulance riders may experience some collateral effects of crews’ upward struggles with management and protocol. In workers’ efforts to swell their checks, they are quick to become exhausted and this seems to increase their dickish interactions with clientele. Worker frustration, and the cold and apathetic hands that often comes with it, cannot be totally explained by the mismatch in vocation and labor I detailed in Chapter 4. Yes, most of the paramedics and EMTs I met are generally vexed by bullshit cases, but such distress is magnified when they’re tired. It’s really easy to lose sympathy for clientele when you’re on the 60th hour of work this week and you’ve managed to dodge a lot of meal breaks. Even mando, which has you working for double the pay, probably has you working more hours than you initially anticipated.

58 See Jacobs et al. (2017) for a more detailed report on the low wages and long hours, as well as the high risk of turnover and injury, for EMTs and paramedics.
But it’s not just check swelling and the exhaustion that tends to accompany it that matters for ambulance riders. Shift pacing seems to come with its own collateral effects. In doing things like drop time extension, crews are affecting ambulance coverage. It seemed like every shift I worked, my partners and I would find ourselves resting in a hospital ambulance bay as calls dropped near our current location. If the calls seemed legit, like those for cardiac arrests or gunshot wounds, we’d sometimes quickly return to service and try to snag it. But, this was rare. We mostly remained idle until we felt compelled to return to the streets after an informal break or until a supervisor came to clear the hospital. Likewise, post-delaying can come at the cost of thinning ambulance coverage in the busier and thus the poorer areas of Moon County. While such geographic holes in coverage may be temporary and not frequent enough to adjust an overall pattern of timeliness observed in poor neighborhoods, the risk for tardy ambulances can be at least be partially pinned on the defiant strategies of ambulance crews.

Finally, strategic transporting – that careful coaching of patient choice that helps pace the shift – tends to bring riders to hospitals that may not be ideal for them. Many of the so-called bullshit cases that more or less get duped into selecting a hospital in a less busy territory get transported to a hospital further away from the areas they dwell. This can mean a longer and more challenging return back home or to the streets following hospital discharge. And, because strategic transporting typically involves a transport away from the two busiest emergency departments, crews are often subsequently taking riders away from the two hospitals with the more robust auxiliary social service programming (e.g., on-site social workers, psychiatric care, and taxi-vouchers). Collateral effects like these can seem inconsequential at a worksite that’s officially and vocationally oriented toward “saving lives,” but they can chip away at the already low life chances of the county’s most vulnerable residents.

To sum up, if managers in the barn hope the fleet is something lean and those in the supervisor rig suspect the fleet is something lazy, then the fleet knows itself as something defiant. Even I, someone with probably more sympathy for management than the average worker because of my unique standing as an ethnographer-turned-employee, got caught up in the little tricks for payback. I too wanted to pace the shift and swell the check and I too found such minor acts of vengeance to be emotionally and materially rewarding. As such, I too must take some responsibility for the collateral effects.

This chapter concludes Part III. The vertical relations detailed in these three chapters not only contextualize a bandaging and a sorting of the poor; they also help detail a hustling of the poor. Due to particular constellation of bureaucratic and capitalistic forces, ambulance crews hastily process their clientele.

To be clear, this doesn’t mean that people aren’t waiting or that they aren’t waiting long. Suggesting that people are generally rushed through an intervention is not the same as saying that people are generally rushed toward an intervention. Ambulance patients in fact experience a lot of waiting (e.g., for the crew to arrive on scene, for the nurse to assign them a

---

59 The sociologies of poverty and state sometimes meet at the sociology of time (Auyero 2012; Comfort 2003). I don’t deny that the poor are often waiting for resources and services. My goal is to layer another temporal experience, that of labor. While the poor are often waiting, frontline workers are often pressured by forces from above to rush through multiple cases and complete interventions in a timely fashion. Thus, while queues may be long, once a person hits the top of the queue they’re often rushed through the next stage by the quick hands of tired workers. This often means the poor are hustled from one waiting period to the next.
bed, and for a physician to eventually see them). But, these periods of limbo are separated by flashpoints of intervention (e.g., rapid exams, quick triage decisions, and fast treatments).

Understanding this hustling of clientele necessitates an understanding of the vertical relations of production. Protocols designate quick treatments to stabilize crises, and management encourages an acceleration of people processing to increase the fleet’s productivity. Additionally, workers are generally motivated to churn through cases quickly so that they can free up some time for informal breaks.

If bandaging the poor helps account for the depth of intervention and sorting the poor helps account for the breadth of intervention, then hustling the poor helps account for the speed of intervention. An examination of an ambulance labor process illustrates how state responses to the sufferings that concentrate toward the bottom of the polarized city are not just shallow and diffused, but also hurried. Outside the ambulance, we can see this in temporary housing, one-time cash assistance, and other short-lived interventions that frontline workers hustle people through. Yet, the ambulance might be the best example. The flashing lights and loud sirens that allow its crews to rush superficial treatments to people are emblematic of a state that’s made not just of reactionary, but also rapid, interventions.
Quitting my EMT job was a bitter-sweet feeling. The bitterness came from saying goodbye to friends, sliding back into the seemingly less consequential world of the academy, and departing from a profession that I learned to love. The sweetness came from ditching an unpleasant mixture of long hours and low pay, freeing up more time to write, and abandoning a career that hardened my sentiment.

As mentioned in Chapter 4, I finally had enough of the ambulance after running a call for a woman who was raped and left for dead on the outskirts of Moon County. I was going to quit anyway, but this particular case was so nauseating that I decided to walk away sooner than expected. In many ways, this is the moment that separates me from many of my colleagues at MRT. When things got difficult, I had the privilege of running away from the pains of ambulance work. I tolerated many horrors for sure, but that was always easier to do when I was more energized, curious, and dependent on an ambulance paycheck. Things were different by the time my partner and I were sent to treat and transport the last person I saw writhing in pain in the back of an ambulance. I was more exhausted than ever, the intellectual wonder that lead me into the ambulance as a ride-along had mostly been resolved, and the economic troubles that ushered me into this vehicle as an employee had been fixed. The time to leave was inching closer and witnessing the aftermath of this woman’s assault was the final straw for me.

After sending an official notice of resignation to management, I posted the following note on the union’s private message board (parenthetical text in original, bracketed text added for clarity and confidentiality),

I have resigned after a short tenure at [MRT] to focus on what will (ideally) be my final three semesters in the sociology PhD program at Cal.

For those that don’t know, I’m writing my doctoral dissertation on EMS [emergency medical services]. I’ve been thinking about the ambulance as a social safety net for the urban poor. I am especially interested in the different types of labor you all perform. In addition to the obvious clinical tasks, this job forces you to do a type of “bandage social work” (e.g., taxiing homeless people across town and transporting folks for prescription refills). Much of this work also involves an augmentation to policing (e.g., 5150s and transporting arrestees for medical clearance). On top of this, I’ve become increasingly interested in (and frustrated by) the ways management exploits labor. These are banal points for people in EMS, but they are part of a sociologist’s wet dream.

As part of this project, I spent a year doing ride-alongs with crews and field supervisors and I continue to analyze nearly 100,000 PCRs [ambulance medical records] for 2015. Someone here told me that I couldn’t really understand EMS by watching people work or by crunching PCR data on my computer. This person encouraged me to apply as an EMT. I agreed, not realizing how difficult this job is. After 9 months, I am still far from knowing what this profession is about, but I think I’m a lot closer than where I was a year ago.
I owe many thanks to those who tolerated me during the ride-alongs and to those who stomached my mediocre-at-best performance at work. You were all kind when I asked a lot of stupid questions and everyone was unnecessarily forgiving of my countless mistakes.

Now at the literal conclusion of the dissertation, I see some ways I could have improved this summary. But hindsight is 20/20. The main point was to say goodbye and express my gratitude. The farewell messages I then received from a number of my colleagues made my departure even more difficult. However, more than anything, these messages assured me that my pivot from ride-along to EMT was worthwhile.

Consider a few of these responses,

It’s admirable that you had the humility to hop out of your ivory tower and join us plebes in the trenches. Always remember you will have a family in (Moon County).

It was nice to see you grow into your own in your short time here… I appreciate the fact that you got your hands dirty when most won’t.

Had the pleasure of working a few shifts with you and not to mention the countless times you did a make shift interview… It was genuinely uplifting to see someone who was willing to work in the field to get a better understanding. You caught on quick bro and it was good working with you!

I’m not sure this dissertation meets the high expectations of my former coworkers, but I hope it comes close. In this final chapter, I revisit the goals of the project and consider its implications for both scholarship and policy.

**Two Goals**

I wrote this dissertation with two goals in mind. The first was to rethink the ambulance. Sociologists don’t tend to write about this institution, but when they do they rarely ponder its frequent interactions with the poor. I was motivated before, during, and after my fieldwork to understand the relationship between paramedicine and poverty.

Much of this meant breaking from some competing framings of the ambulance in the American city. The primary framing is essentially the public relations image propagated by emergency medical service bureaucracies, ambulance provider agencies, and paramedic and EMT labor unions. It’s this notion that the ambulance is an institution that aids anyone and everyone in medical crisis, regardless of their physical or social location. Yet, there’s an alternative framing of the ambulance that rubs against this one and it’s propagated by a significant number of academics, journalists, and some whistle-blowing ambulance workers. It’s this idea that the ambulance is frequently absent and tardy in poor neighborhoods because of people’s reluctances to dial 9-1-1 and/or some structural biases in ambulance dispatch.
These framings aren’t totally wrong, but they’re misleading. Paramedics and EMTs respond up and down the stratified metropolis and there’s ample evidence that lower income populations and people of color choose to avoid ambulances due to concerns over billing, timing, and surveillance. Yet, both of these framings ignore one of the most important features of the ambulance: it’s an institution that is heavily utilized by the poor. Regardless of severity (i.e., high, medium, or low) or type of emergency (e.g., cardiac, traumatic, behavioral), neighborhood-level poverty is positively and strongly associated with ambulance responses (Seim, English, and Sporer 2017). Moreover, there’s strong evidence that that majority of the individuals who encounter ambulance crews are either uninsured or covered by Medicaid. There’s also evidence that people in poorer sectors of the studied county are not receiving ambulances slower than their counterparts in wealthier areas (Seim et al. 2018). The ambulance is perhaps best framed as a prevalent and busy institution in the lives of the urban poor. It’s a state, and often a state-delegated, institution that handles a plethora of problems that concentrate toward the bottom of the polarized city.

I don’t think the ambulance should only be understood as an institution for responding to the poor, nor do I think we should consider it the premier example of the state’s interactions with poverty. I nevertheless see it as both a suitable and a strategic case for studying urban poverty governance. The ambulance is parked at a few critical intersections identified in this literature (e.g., between welfare and penalty and between policy and profit) and studying it as such can have implications far beyond its walls and scenes.

If the first goal of this dissertation was born out of curiosity, the second was born out of frustration. I set out to rethink poverty governance more generally. Extant frameworks for making sense of how the poor are governed, like those detailing “bureaucratic fields” and “street-level bureaucracies,” were enlightening but also blinding. If they weren’t forgetting to examine the frontline labor of governance, then they were ignoring the horizontality or neglecting the verticality of poverty management.

So, I made a new map. This didn’t mean a total abandonment of existing theory (i.e., the trap of empiricism), nor did it simply mean a pure synthesis of previous models and concepts (i.e., the trap of theoreticism). Instead, it meant piecing together extant theory into something new that could help me navigate the case at hand. And, it meant linking existing themes in scholarship by embracing the special and surprising lessons learned from my unique case.

I’ve argued that the best way to make a new map for my case has been to rethink poverty governance as a labor process. Doing so forces us to account for the frontline laborers of governance, their lateral intersections, and the vertical relations they’re embedded in. This reimagining is simple. Start by considering what frontline workers are changing or maintaining. All labor processes involve a transformation or regulation of the world by the hands and minds of workers utilizing the instruments of production. This is true whether we’re talking about physical manufacturing, knowledge production, service labor, or so-called people work. With respect to poverty governance, labor-produced transformations and regulations can be seen in the sheltering of unhoused bodies, in the feeding of hungry people, and even in the beating of supposedly dangerous subjects. Sometimes the labor of governance can simply mean the processing of people into “clients” (e.g., patients and inmates) so that other workers can monitor and adjust them. The results may be micro and momentary, but they are transformations and regulations nonetheless. Regardless, these efforts are only made possible through the social relations of production. Productive activity is enabled and constrained by the relations workers
enter into with fellow laborers (i.e., horizontal relations) and those who attempt to control and coordinate their labor from above (i.e., vertical relations).

I pursued these two goals – rethinking the ambulance specifically and rethinking poverty governance generally – across multiple chapters. I first sketched a world of people work where crews were bandaging the poor by providing a number of stabilizing and superficial responses to the deep wounds of poverty. I then stepped out of the ambulance and onto the streets to find crews, nurses, and police collectively sorting the poor across medical and penal sites. Finally, I made my way into ambulance headquarters, down to the field supervisor rig, and back into the ambulance to see how the downward pressures of the delegated state motivate a hustling of the poor along through rapid points of intervention. Ultimately, these chapters mark the marriage of my goals. I was able to rethink the ambulance as an institution of poverty governance by rethinking poverty governance as a labor process, and vice versa.

**Working on the Poor**

The labor process framework I’ve used throughout my analysis – what might be called the labor theory of poverty governance – can be distilled to three propositions (Seim 2017). First, the poor are governed across these dimensions already identified in the broad scholarship on poverty management: the frontlines of governance (i.e., ground-level policy implementation), the horizontality of governance (i.e., poverty as managed by a series of laterally intersecting institutions), and the verticality of governance (i.e., influential forces beneath, but more importantly above, frontline operations). This can be rephrased as the poor are governed across both the practical and the relational components of a labor process.

Second, these dimensions are intersectional and interdependent. In order to best comprehend any one dimension, we must also examine the other two. For example, this is why we can’t make sense of burden shuffling, a horizontal process, without accounting for crew’s practical engagements with, and varied preferences for, the subjects of their labor. We must understand their frustration with bullshit. But this isn’t enough either. We must also account for the vertical forces that exhaust crews and force them to work so many vocationally unfulfilling tasks. Paramedic and EMT strategies of burden shuffling are intermixed with strategies for mitigating their exploitation as wage laborers.

Third, it is through these intersections that the poor’s life chances are extended or severed. For the case study at hand, I’ve attempted to demonstrate this through the three mechanics of bandaging, sorting, and hustling the poor. However, it’s perhaps most obvious through the second. Workers, doubly caught in vertical and horizontal relations of production, funnel people from the streets to hospitals or jails. Relative to one another, the first destination protects and extends life chances while the latter severs them. Additionally, the specific hospitals that ambulance crews take patients to can also come with some collateral effects for the poor, as some have more social services and are closer to a patient’s residence. Understanding how people are sorted across these spaces requires a simultaneous examination of policy execution and the work conditions that influence this execution. Frontline laborers, as both calculating and emotional actors, often sort their subjects in a way that benefits themselves against the interests of management and other workers.

In the end, I hope this little case study in a single California county inspires others to not only to see the ambulance as an institution of poverty governance but also see poverty governance as a labor process. The specific concepts used throughout the previous chapters (e.g.,
people work, burden shuffling, and the lean fleet) may be applicable to other cases. However, in my opinion, what’s far more applicable is the general view that the poor are governed by frontline workers embedded in horizontal and vertical relations of production. Consider, for example, the relevance this framework might have for two massive institutions of poverty governance in the United States: the welfare office and the prison.

More folk term than official title, the welfare office usually exists as a branch of a local human services bureaucracy. Caseworkers transform the world by admitting clientele into benefits programs (e.g., food stamps and temporary cash assistance) and brokering them into other street-level agencies for poverty management (e.g., job training programs and community health centers). They also work to inspirit responsible, entrepreneurial, and self-governing subjectivities amongst their clientele (Korteweg 2003; see also: Pulkinson, Fuller, and Kershaw 2010). The framework established in this dissertation suggests the lateral relations between overwhelmed frontline workers constitute a crucial dimension of poverty governance. Caseworkers, for example, may engage in something like burden shuffling with the Left-handed agencies they refer clientele to and the Right-handed agencies that share their jurisdiction (e.g., for subjects who receive public assistance but are also under parole supervision). Net of the specifics, a labor process examination of the welfare office would necessitate an examination of the horizontal relations of production, and this would almost certainly mean observing how frontline workers interact across institutions. When applied to the welfare office, this approach would also call for an examination of bureaucratic authority (e.g., the use of strict performance standards for caseworker labor) and capitalistic influence (e.g., delegating specific operations like Medicaid administration to capital and the absorption of market principles into bureaucratic operations through strategies akin to lean production).

What I call the labor theory of poverty governance may also demystify the prison. Despite claims that the American penitentiary is like a “warehouse,” the laborers of the prison do more than keep people locked up. For sure, prison guards work to keep inmates in cells, rotating them daily through the spaces of the cafeteria and the yard and discretionarily punishing them for incompliance (Lombardo 1989; see also: Liebling, Price, and Shefer 2010; Crawley 2013). However, the prison is also a place for regulating subjects from the inside out. Nurses (Weiskopf 2005), counselors (Fry 1990), and life skills instructors focused on transforming prisoner mindsets (Seim 2016) compose a consequential, albeit an understudied, part of the correctional labor force. The framework proposed in this dissertation suggests that we cannot understand the practical component of carceral labor without also analyzing the horizontal and vertical relations through which punitive poverty governance occurs. In addition to importing subjects from courts and jails and later exporting the bulk of these people into parole offices, the penitentiary is likely internally structured by the intramural relations between guards, counselors, educators, nurses, and other laborers that make and maintain prison operations. Of course, in thinking about prison operations as labor process, such a study would also need to examine the vertical relations of production. And while the hierarchical relations between inmates and staff that sociologists have long focused on are important (Clemmer 1940; Sykes 1958), the framework proposed here is equally concerned with relations between staff and those who control and coordinate their labor from above.

Whatever its capacity to inform other cases, it’s important to distinguish this particular framework from its parental models: street-level bureaucracy and a theory of (bureaucratic) fields. I’m no doubt indebted to Lipsky (1980) and other street-level bureaucracy scholars, but
I’m not convinced they demand a deep enough analysis of production. We should move beyond that once innovative, but increasingly banal, claim that policy is “made” by frontline workers. It’s not enough to say policy is made. We must consider what exactly is transformed and regulated by that labor. This has implications for social relations established between workers, clientele, and management. Among other things, a deeper analysis of production motivates a horizontal vision of governance where frontline workers struggle over tasks across locations and professions. Since the beginning, street-level bureaucracy scholars have claimed that multiple frontlines are managing the poor, but only a few highlight the sideways interactions between workers of distinct vocations (Lara-Millán 2014; Nolan 2011). In examining the everyday productions of a splintered and ostensibly hollow state, the labor theory of poverty governance assumes its people-processing sites are variably porous. This theory insists that lateral struggles between workers affect the life chances of the poor in ways inexplicable to models narrowly focused on the vertical conditions of governance labor.

The framework used in this study also moves beyond theories of bureaucratic fields, and arguably of fields more generally. There are certainly some similarities. Consistent with Wacquant’s (2009) framing, the model I propose thinks in terms of multi-dimensional relations and assumes state power is embedded in, and exercised through, vertical and horizontal struggle. However, the labor theory of poverty governance emphasizes an analysis of production over an analysis of “position.” Rather, it examines social positioning through an analysis of production. This framework breaks with field theory à la Bourdieu and its various iterations across organizational, economic, and political sociology (see Kluttz and Fligstein 2016). The definitive social relation for a labor theory of poverty governance is not an endless struggle over the different “species of capital” (e.g., economic, social, and cultural) that supposedly structure a field from top to bottom and side to side. Instead, the definitive struggle is over labor – its pace, its division, and its connections to capital more traditionally understood. This motivates the construction of analytical maps that are both familiar and foreign to field theory.

This dissertation is surely influenced by theories of street-level bureaucracies and bureaucratic fields. However, the labor theory of poverty governance that emerges from this little case study offers something new, and it’s more than just the combination of these previous models.

**Down the Unit**

I’m going to end this dissertation in a way similar to how I ended a few shifts at MRT: by “downing the unit.” At work, this meant pulling the ambulance out of service, usually for mechanical reasons. Assuming I didn’t need a tow, I’d drive the ambulance back to the barn for repairs or for a different ambulance if one was available (it often wasn’t). I’d sometimes wait out the remaining hours of my shift in the barn. Other times, the fleet mechanics would resolve the problem before I returned to the streets to finish out the 12-hour shift. For example, I once downed the unit because my rig kept overheating. My partner and I returned to the barn and waited a couple hours for the mechanics to repair the unit before we returned to service. I’m not exactly sure how the mechanics repaired our rig.

I’m also not exactly sure how the ambulance can be fixed to better serve the populations that depend on them most, be it for those who turn to this rig for assistance or for those who count on it for a paycheck. The analysis offered in the previous chapters can nevertheless point us to some general repairs and reforms.
As such, I’m less interested in ending this dissertation with specific policy recommendations. I’m no more a policy writer than a fleet mechanic. I’m simply motivated to down the unit and point to a couple possibilities for change. The “check engine” light is on and I’m bringing the rig into the garage. I can only hope that a coalition of elected officials, local civil society groups, labor unions, and other stakeholders will actually put in the work to fix what’s broken and modify what needs improvement. I’m just dropping this vehicle off with three recommended directions of change: decommodify the ambulance, transform its vocation, and strengthen a safety net beyond the rig.

Let’s start with decommodification. Those tasked with repairing and reforming the ambulance should consider pulling it away from “the market” and making it less capitalist in its orientation. Others suggest that de-privatization could lead to some better working conditions for crews and less expensive services for clientele (Calams 2017; Jacobs et al. 2017; Ludwig 2010). This may be true, but it’s not enough. So-called public operations, like those run by fire departments, usually depend on fee-for-service operations. They too are pressured to run an efficient and flexible workforce in navigating a “transport market.” The pursuit of profit may not be the name of the game for public ambulance providers, but the pursuit of “fiscal responsibility” may have similar effects anyway if money is primarily earned through clientele fees and primarily spent on labor power. I encourage more serious inquiries into the promises of entitlement-based ambulance provision, where fee revenue is eclipsed by tax revenue and private insurance is replaced by public insurance. This should be coupled with an effort to reduce caseloads for crews by fattening the fleet. Public investments can be made to add more ambulances (and ambulance stations) to the streets, irrespective of their profitability. A project of decommodifying the ambulance should also mean increasing compensation, benefits, and protections for its crews. They’d remain dependent on selling their labor power for a wage, but perhaps not so dependent that they have to work overtime and second jobs to make ends meet. The analytical model developed in this dissertation suggests this could reduce worker frustrations and increase their sympathy for suffering clientele. Ultimately, what I’m calling ambulance decommodification has the potential to doubly improve working conditions and quality of care.

But, we shouldn’t just ask for more of the same. My analysis also encourages a transformation of vocation. Throughout the United States, local EMS bureaucracies are experimenting with “community paramedicine” programs that deliberately integrate non-emergency medical services into the ambulance (e.g., having crews run post discharge follow up appointments) (Kizer, Shore, and Moulin 2013; Krumperman 2010; Iezzoni, Dorner, and Ajayi 2016). While much of this seems to be motivated by efforts to increase operational efficiency by reducing “unnecessary” transports in the long run, my fieldwork suggests such programming could benefit riders who depend on the ambulance for things like symptom management for chronic illness. However, I encourage an even larger scope, one that integrates not only a vision of “primary care” but also of “social work.” Future research should consider how crews could be given tools for linking clientele to housing, food, and other “non-medical” resources. I suspect that this would require not only a reconfiguration of tools but also of training. Integrating the “structural competency” pedagogies that are increasingly used in other healthcare professions into paramedic and EMT training programs is one option (Hansen and Metzl 2016; Metzl and Hansen 2014; Neff et al. 2016). This would have aspiring ambulance workers learning about the more “upstream” conditions that they would ideally be better-equipped to address in the field. An even more radical change would have us replacing the lesser-trained position of the EMT
with that of a licensed social worker who is also trained in basic life support skills (see Campbell and Rasmussen [2012] for a similar discussion). Ultimately, the point would be to expand the scope of the ambulance to better match demand on the ground. Among other things, this might help reduce the frustrations of both crews and clientele.

We can’t, however, expect the ambulance to do everything. My analysis lastly encourages advocates of ambulance reform to join broader efforts to strengthen the welfare state. This could include a call for programming that’s been demonstrated to mitigate medical crises (e.g., widespread naloxone distribution and citizen CPR training) (Giglio, Li, and DiMaggio 2015; Keane, Egan, and Hawk 2018; Stiell et al. 2003; Swor et al. 2008). However, it could also include strategies for improving the life chances of marginalized populations more generally. The goals here don’t need to be too complicated or opaque: universal health care, secure housing, and a more generous welfare state overall (Lasser, Himmelstein, and Woolhandler 2006; Lundberg et al. 2008; Navarro et al. 2006; Padgett et al. 2011; Shaw 2004; Srebnik, Connor, and Sylla 2012; Wilper et al. 2009). The point is not to eliminate a bandaging of poor people’s suffering, but to promote efforts that reduce the risks of wounding. Likewise, we can’t expect to abandon some sorting of human problems across a division of governance labor, but we can make some important adjustments to the possibilities of sorting. For example, we can change policies that allow for the coercive hospitalization of vulnerable populations (e.g., loosely justified involuntary psychiatric holds and strong-arm ambulance trips) and encourage better-fit programming (e.g., mobile mental health crisis response teams and sobering centers) (Kisely et al. 2010; Ross, Schullek, and Homan 2013; Scott 2000; Smith-Bernardin and Schneidermann 2012; Steadman and Naples 2005). And, while conscious of the long waits people encounter on the frontlines, we can work to develop interventions that are not so hustled and fractured (e.g., long-term and integrated health care).

In the end, we can’t expect poverty governance to disappear. The relative wealth of a few depends on the relative poverty of many in an advanced capitalist society. Barring the emergence of some “classless society,” the state will continue to govern the poor in some way or another, be it by aiding, punishing, or neglecting them. The question is not will the poor be governed, but how they will be governed. If nothing else, I hope this dissertation demonstrates that an examination of the ambulance, and the ambulance labor process in particular, can help answer this question. The answers come with more than scholastic implications and they can help us reimagine the possibilities of poverty governance in and beyond the ambulance.
References


Appendix

Notes on Data and Method

I lie on the floor in a stuffy office building. My eyes are closed. A young woman tears off my shirt and pants. She’s an EMT student and I’m her pretend gunshot patient.

“I’m checking for B-P-DOC,” she announces as she presses her gloved hands against my bare sternum and begins to slide her palms across my abdomen. “No acronyms,” commands the clipboard-wielding proctor who sits in a chair and watches this aspiring EMT examine my body. “Sorry, um, I mean bleeding, pain, deformities, open wounds, and crepitus.”

The proctor speaks in the same monotone voice he’s been using with the dozen or so other EMT students who have examined my pretend injury, “Ok, you notice blood on the right anterior chest, it’s a sucking chest wound.” The student responds swiftly and confidently, “I’m going to treat using occlusive dressing, using tape on three sides to prevent a tension pneumothorax.”

This is where desperation has brought me. To the floor, half-naked, and pretending to be injured. At the time, I knew I wanted to study the ambulance. I just wasn’t yet sure how to do it. Spending time at this EMT school seemed like a good way to address this problem. The instructors and fellow volunteers were some of the few people I knew who worked on ambulances.

I met them a few months earlier when I was a student in the program. Indeed, I was once in the same position as the woman who examined me on the floor. I too was peeling back the eyelids of a stranger to check their pupils and flashing a small light in their ears to act like I was looking for blood. Though, almost certainly unlike her, my primary goal in completing the program was to inspire a convincing dissertation project.

I enrolled in the EMT program roughly two years after the conversation I had with James outside of his transitional housing facility in Portland. I reasoned an entry-level training like this would help demystify paramedical operations and introduce me to people in the industry. Entering the six-week program only cost me a $3,000 tuition bill and a perquisite CPR course. Once I was in, I spent eight hours a day for four days a week listening to introductory lectures on anatomy and physiology and learning how to treat simulated emergencies. When I graduated the program, I continued to show up to the school as a volunteer.

That’s how I eventually made my way on the carpet, pretending I was unconscious and shot. I figured volunteering at the school would give me a chance to talk to a few experienced paramedics and EMTs about how to design an ambulance ethnography. However, this was only partially the case. The people I met at the school offered great insight into the profession, but they couldn’t imagine a way for me to access the ambulance as a researcher. They encouraged me to speak with more “powerful” people in the world of emergency medicine.

So, that’s what I did, and luck eventually came my way. After meeting with a few emergency room physicians and briefly interning for a public health bureaucracy, I networked my way into a meeting with leading administrators at MCEMS. They, in turn, referred me to upper management MRT.

Field Observations

About a year after I completed my EMT training, I entered the firm’s headquarters. There, I met Jared, the company’s medical director, and Laura, the clinical director whose
responsibilities included managing the firm’s “ride-along” activities. During this meeting, I pitched an exploratory study that would involve me shadowing workers as a ride-along. I admitted a somewhat intentional lack of focus but noted my interest in the role that ambulances play in poor neighborhoods. Projecting my own Hollywood-based fantasies of ambulance work, I mentioned this could mean a focus on gunshot wounds and other high severity trauma calls.

Both Laura and Jared were encouraging. Laura, who claims sociology as one her favorite courses from college, volunteered to help with the logistics of scheduling my ride-along shifts. She even solicited some free framing advice. Presumably relying more on stereotypes than research, she insisted my dissertation would be “really interesting” if I could somehow answer why Latinos were prone to stabbing one another while Blacks were partial to shooting their foe. I politely nodded and agreed that could be interesting. Jared, a bit closer to my wavelength, encouraged me to think about the ways ambulance crews could “better communicate” with marginalized populations. Again, I nodded and expressed appreciation.

Ultimately, the three of us didn’t know exactly where my analysis would take me, but Jared and Laura were surprisingly open to letting a nosy sociology student poke his head around the organization. Following their behind-closed-doors confirmation with other upper managers, they even recommended that I shadow MRT field supervisors. They said this would give me more of a “birds eye” view of how the organization functioned. And, because the supervisors are dispatched to monitor and assist a number of high priority responses like those for gunshot wounds, they told me this would increase my chances of seeing calls like these.

I had struck gold and the next year was dedicated to conducting these ride-along observations. Laura allowed me to request any ambulance or supervisor shift so long as it wasn’t on a unit with an assigned intern or trainee. I selected days and nights, weekdays and weekends, and crews and supervisors. None of the eight supervisors, 25 paramedics, or 14 EMTs I asked to shadow denied my request and several encouraged me to ask to observe their shifts again (which I often did). Through shadowing these people, I conversed with many more crews and managers as well as other parties like clients, police, and nurses.

Crews and supervisors generally, although incompletely, welcomed me into the world of paramedicine. My EMT training provided me with a superficial knowledge of ambulance work and helped me examine clinical decision-making in the field. I did not work as an EMT during this first year, but I attempted to lightly assist crews and supervisors throughout their shifts. I often carried, cleaned, and prepped equipment for crews and I sometimes helped supervisors with simple paperwork duties. On a few occasions I directly assisted with emergency care when events became unusually hectic (e.g., manually stabilized a broken femur, maintained pressure on a stab wound, and helped hold down a fist-swinging person). However, the rapport I built with the men and women I shadowed might have more to do with our similar social profiles. Like many of the crews and supervisors at MRT, I am male, white, and come from a working class family far away from the neighborhoods the ambulance frequents most. On the other hand, my status as a ride-along separated me from those I shadowed: some teased me for being a naïve “college boy,” some were irritated by my “politically correct” stances on 911 “system abusers,” and some were frustrated when, as a doctoral candidate, I was unable to offer smart clinical advice.

I took detailed field notes as a ride-along. When with crews, I focused my notes on their interactions with patients, supervisors, nurses, and police. While with field supervisors, I focused my notes on their interactions with crews and upper management. I jotted many events and some
conversations as they occurred, but I typically put pen to paper during “downtime” as I sat in
hospital ambulance bays, ambulance-posting locations, and at headquarters. I also used
downtime to informally interview crews and supervisors. Management forbid me from using an
audio recorder, so all conversations were paraphrased in my notes. Following each shift or set of
consecutive shifts, I expanded my jottings into more detailed narratives. Like many
ethnographers, my techniques for notetaking were directly inspired by Emerson, Fretz, and Shaw
(2011).

At the beginning of my fieldwork I articulated general interests in the everyday
operations of urban paramedicine, but I also stressed an early fascination in “trauma work” (i.e.,
the management of physically injured patients). I assumed I would extend Palmer’s (1983)
narration of ambulance workers as “trauma junkies” who are vocationally driven
to aid wounded citizens. Early into my fieldwork, crews labeled me the “trauma guy” and a few
joked that I had “come for blood.”

I couldn’t help but think that people were laughing at me and my focus on trauma. They
had good reason to. It became readily apparent in the field that the high-profile trauma responses
that define the ambulance in mainstream fiction, local news media, and my EMT training
program were not very common. I certainly saw crews rushing punctured, crushed, and broken
bodies to the trauma center, and they were mostly collecting these patients from relatively poor
neighborhoods as expected. Such events, however, only accounted for a sliver of the calls I saw
crews responding to. Not only were most calls not so “severe,” even the severe one’s weren’t
typically “traumatic.” They were instead more “medical,” meaning they involved crises of illness
more than crises of injury.

I needed to abandon the cliché of ambulance work as trauma work. As one supervisor I
shadowed early on noted, “You don’t want your thesis to be like that show Trauma,” referencing
a cancelled NBC drama he liked to mock for its technical inaccuracies and its overall
sensationalization of ambulance work. To favor intense trauma responses over less severe events,
let alone other high severity contacts that were not injury-based (e.g., asthma attacks, strokes,
and diabetic comas), meant that I would probably reproduce Hollywood fantasies of the
ambulance.

It wasn’t long until I knew that this project would be less about “trauma work” in poor
neighborhoods and more about a broader “poverty work” that ambulance crews were
performing. This early lesson from the field inspired me to analyze ambulance work as a form of
poverty governance. I began to comb through my field notes seeking patterns that complemented
and challenged existing scholarship.

I utilized the “extended case method” to make these connections and breaks (Burawoy
2009). Beyond my extension into the everyday lives of ambulance crews and supervisors, I
aimed to link the microprocesses of ambulance operations to extralocal forces and this
necessitated an extension of theory. In other words, I needed a theoretical framework to help
make the connections between activities on the ground and the social forces outside and above
my field site. Ultimately, the mission of this ethnography was neither a misguided attempt to
restate “common-sense” folk categories nor a pointless surrender to scholastic traditions
(Bourdieu, Chamboredon, and Passeron 1968). Instead, I aimed to use theory to see and organize
data and use data to stress and evolve theory.
After twelve months of shadowing crews and paramedics, I observed 279 calls. However, I wasn’t done yet. For reasons detailed in the preface, I pivoted from a ride-along to a novice EMT.

When adding in these additional calls, I encountered 566 ambulance cases and shadowed or worked with 48 paramedics, 19 EMTs, and eight supervisors across 21 consecutive months. Combined with the time I spent training as an EMT, I logged over 1,600 hours in the field and compiled over 450 single-spaced pages of typed field notes.

I used ATLAS.ti (version 8.1.3), a software program for field note data management and analysis, to code my field notes using the key analytical themes deployed throughout this dissertation (e.g., legit calls). However, besides assembling some simple “code cooccurrence tables” (e.g., tabulating the simultaneous occurrence of legit codes and police codes on the same calls), I did not use the analytical tools in this program. Instead, I basically used this software to index my notes for easy reference while writing.

Table A.1. Field Observation Demographics (%)

<table>
<thead>
<tr>
<th></th>
<th>Supervisor (n = 8)</th>
<th>Paramedic (n = 48)</th>
<th>EMT (n = 19)</th>
<th>Client (n = 566)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>74.63</td>
<td>75.00</td>
<td>73.68</td>
<td>52.12</td>
</tr>
<tr>
<td>Female</td>
<td>25.37</td>
<td>25.00</td>
<td>26.32</td>
<td>45.94</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>1.94</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>100.00</td>
<td>72.92</td>
<td>42.11</td>
<td>26.33</td>
</tr>
<tr>
<td>Black</td>
<td>.00</td>
<td>8.33</td>
<td>10.53</td>
<td>42.58</td>
</tr>
<tr>
<td>Latino</td>
<td>.00</td>
<td>12.50</td>
<td>36.84</td>
<td>14.49</td>
</tr>
<tr>
<td>Asian</td>
<td>.00</td>
<td>6.25</td>
<td>10.53</td>
<td>7.95</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>8.66</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child/Teen</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>6.54</td>
</tr>
<tr>
<td>20-59</td>
<td>100.00</td>
<td>97.92</td>
<td>100.00</td>
<td>60.95</td>
</tr>
<tr>
<td>60+</td>
<td>.00</td>
<td>2.08</td>
<td>.00</td>
<td>30.21</td>
</tr>
<tr>
<td>Unknown</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>2.3</td>
</tr>
</tbody>
</table>

*Note: Non-probability sample. Not all clients are “patients,” becomes some refuse services on scene. Demographics largely dependent on author’s interpretation. For events involving more than one patient, demographics are collected for the primary (i.e., most severe) patient. Source: Author’s field notes*

Table A.1 summarizes some of the observed demographics of crews, clientele, and supervisors during this time. These data are not drawn from a probability sample, and most rely on my imperfect determination of people’s race, gender, and age. In the next section, I detail my transition into, and experiences as, a novice EMT.

**On Becoming an EMT**

My shift from ride-along to EMT involved a series of rituals. I only briefly covered these in the preface: a fitness and agility trial, a mannequin-based skills exam, and a 50-question multiple-choice test covering anatomy and physiology, prehospital emergency procedures, and other topics. As you might expect, the details are a bit more complicated.
The EMT training I completed was not a sufficient condition to becoming employable. I had to also pass a three-day refresher course, a physical exam, and a written ambulance driver’s certificate test at the DMV. Once I completed these relatively easy tasks, I submitted an application to MRT and listed three people at the firm as references: an EMT, a field supervisor, and someone in upper management.

The employee-run hiring committee then invited me to a panel interview and a mannequin-based skills test, both of which included evaluators who knew me from my fieldwork. In the interview I clarified my long-term goals of becoming a sociology professor and doing research in medical institutions. I talked about my dissertation and my desire to learn about what ambulance work is “really like.” I also confessed to feeling inconsequential in academia and wanting to do something “that mattered.” I ultimately stand by my presentation of self in this meeting, even though I couldn’t help but put on my “interview face.”

The interviewers then asked me to change into some exercise appropriate clothes for a skills test. I showed a couple paramedics how I could shove an airway adjunct into a mannequin’s mouth and ventilate using a bag-valve mask. I then showed them how I would control active bleeding with a tourniquet and told them why I would hypothetically apply a cervical collar to an unconscious person at the bottom of an imaginary stairway.

A few days later, someone from the hiring committee called to invite me to participate in MRT’s final pre-hire challenge: the physical agility test. Among other things, I was tasked with briskly carrying 40 or so pounds of equipment up multiple flights of stairs, co-lifting a 210-pound mannequin off the ground, and performing 10 consecutive minutes of compression-only CPR. I was left sore for days, but I was hired.

The company’s “New EMT Hire Academy” constituted my first two weeks of employment. With over a dozen other new hires (also mostly male, white, and without 911 work experience), I learned county protocols and company rules. As one of my peers put, much of this academy was “death by Power Point.” However, we also spent a significant amount of “hands-on” time with the firm’s equipment (e.g., gurney, monitor, and radio). The academy concluded with another written test and a final skills assessment (e.g., on splinting, spinal immobilization, and delivering a baby) before the instructors brought us to an empty parking lot to teach us how to drive an ambulance.

Once out of the classroom, I was trained for six weeks “in the field.” For the first week, I was assigned to Danny who I mentioned a few times in the main text. While Danny obviously knew me from my previous fieldwork, he promised to make my life “hell.” True to his word, he spent much of three 12-hour night shifts (from 6:00pm to 6:00am) scolding me for my sloppy driving.

Following a stressful, but effective, set of shifts with Danny and his partner Mark, I was transferred to Lance, who we also met a few times in the main text. As my FTO (field training officer), Lance taught me all the on-the-job skills beyond driving. As he put it, much of this involved “un-teaching” me much of what he considered to be stale and often impractical lessons from the academy. On our first shift, Lance said something along the lines of, “The academy teaches you all the stuff that keeps them (MRT) from getting sued, I’m going to teach you how to actually do the job.” He taught me how to best use equipment, efficiently fill out paperwork, and the other technical aspects of the job. But more importantly, along with his regularly assigned partner Vince, Lance taught me a number of taken-for-granted tricks of the trade, like how to handle difficult patients with a firm and dickish voice.
Similar to Danny, Lance knew me well from my previous fieldwork, but he struggled to teach me. Frustrated after our first week together, he said, “It’s weird, you’re probably the most educated person I’ve trained, but I keep having to remind you to do the dumbest shit.” Early into my training, Lance and Vince both criticized my shaky hands when I spiked IV bags and prepared other equipment. They were also especially irritated with my inability to remember where specific medications and devices were stored in the back of the ambulance. My mediocre knowledge of the county’s major streets and highways didn’t help either. As noted in the introduction, this led to me drawing and re-drawing maps of Moon County with the assistance of Lance.

Luckily, after three or four weeks on the job and many hours of unpaid studying at home, I improved dramatically. I struck an imperfect rhythm with the technical and interactional aspects of the job. Repetition was my savior. In the end, Lance complemented my fast learning and assured me I would be a “good enough” EMT.

As an intentionally funny conclusion to my field training, Lance bought me a can of chewing tobacco. Chewing is a somewhat accurate stereotype for male ambulance workers. He joked, “You’re not leaving my ambulance until you chew… Then you’ll be a real EMT.” I chewed and hated it. Vince was sure to video record my grimaces and awkward spits on his cellphone and share it with a number of our mutual friends. Whether or not this made me a real EMT, I completed my field training and was finally free to work without a trainer.

As a part-time employee, I was able to pick up empty shifts on the schedule and cover shifts for full-time EMTs. This gave me the flexibility to spread my work across days and nights and weekdays and weekends. As with my time in training, most of my paramedic partners knew me from the previous year of fieldwork but those that did not know me always learned of my status as a sociology researcher interested in ambulance operations.

My job as an EMT meant driving a lot while my paramedic partners did most of the clinical work. When I was not behind the wheel, I was often on emergency scenes or in the back of the ambulance assisting paramedics by collecting patient vitals, securing limbs to the gurney, and starting my partners’ paperwork. As Supervisor Grant predicted, I was basically an “assistant” or “caddie” to paramedics. While most of the EMTs I know find these descriptions demeaning and rightfully note that they oversimplify the complexity of EMT work, I found them to be relatively accurate. Even county protocols and company rules frame the EMT as a subordinate and supplemental agent to the paramedic. Still, as I noted in the preface, EMT work forced me to confront human suffering far more intensively than what I had to do as a ride-along.

Throughout my short 9-month tenure as an MRT employee, I maintained a field journal that documented my personal experiences as a novice EMT. Because I was first and foremost an EMT, I did not jot notes in the field as frequently as I did when I was shadowing workers. I nevertheless jotted notes in the field during downtime, either when my partners and I were “on post” waiting for a 911 call or when we took informal breaks at hospitals between calls. And, not unlike my time as a ride-along, I always translated these jottings into longer narratives at home following each shift or a set of consecutive shifts.

However, the content of my notes changed. More so than before, I turned the sociological gaze inward and noted my subjective reactions and acclimations to a world I had already spent a year watching. Among other things, this meant accounting for my own apathetic and sympathetic feelings toward clientele. It also meant contextualizing these personal experiences relative to the
themes already detected through earlier fieldwork and through my ongoing conversations with fellow workers.

My critics would be right to note that this method relies heavily on the experiences of one person – myself conflated as both an analyst and a subject of analysis – and is therefore seriously handicapped in its ability to generalize to the experiences of others. I don’t deny this limitation. However, I also don’t deny that my repositioning from ride-along to novice EMT was revelatory and significant for the overall analysis offered in this dissertation. Any effort to scrub this experience from the dissertation would be misleading at best and dishonest at worst. That is why I felt compelled to address this experience in the preface.

And, while an introspective account certainly focuses on a single person, I never analyzed my experiences in a vacuum. I instead made sense of my EMT work through the social relations I was embedded in. I frequently talked about what it was like to “become an EMT” with my colleagues, many of whom knew me first as a ride-along, and they in turn shared personal tips, stories, and opinions to help me make sense of my new location in social space. In other words, I made sense of myself in reference to others. To suggest that my reflections as a novice EMT come from “just a sample size of one” is a therefore a bit misleading.

**Reflections on a Fusion Ethnography**

This study has fused two styles of ethnographic inquiry: *participant observation* and *observant participation* (see also: Lande 2007; Mears 2013; Sufrin 2015; Wacquant 2015). All ethnographers are arguably both *participants in* and *observers of* the microcosms they study. Indeed, a one-dimensional spectrum that locates the “full participant” on one extreme (caricatured as the ethnographer who has “gone native”) and the “pure observer” on the other (caricatured as the ethnographer who mimics a “fly on the wall”) tends to collapse on itself with any serious reflection. As a general rule, all participants observe the worlds they partake in and all observers participate in the worlds they look upon. Still, there are important differences between participant observation and observant participation, and I have attempted to leverage the strengths of each.

Table A.2 outlines my reflections on some key distinctions in these two styles of ethnography. These are ideal types, but they are not antithetical categories. Features from one can usually be found in its counterpart. These styles are instead best distinguished by what they preference relative to the other. Three axes are especially important: field positioning (i.e., the location of the ethnographer amidst the people and processes she studies), analytic gaze (i.e., where the ethnographer hones her focus), and data assembly (i.e., how the ethnographer builds her dataset).

<table>
<thead>
<tr>
<th>Table A.2. Two Styles of Ethnographic Inquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Positioning</td>
</tr>
<tr>
<td>Analytic Gaze</td>
</tr>
<tr>
<td>Data Assembly</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Let’s first consider position. The obvious point of difference might be between relative “outsiders” (participant observation) and relative “insiders” (observant participation). However, I think a more important distinction concerns differences in movability. Participant observation preferences a mobile position over a fixed one, whereas observant participation preferences a
fixed position over a mobile one. During my first year of fieldwork (before I worked as an EMT), I was able to move about the field. In my view, this was the key benefit of this style of ethnography. I was able to attend management meetings, shadow field supervisors, and ride-along in ambulances. This mobility yielded incredible breadth that I missed out on as an observant participant. Yet, working as an EMT came with its own benefits in positioning. What I lost in breadth, I gained in depth. I implanted myself deeper into the world of paramedicine, but from the more static position of EMT. In terms of my relationships with people in the field, the mobility of participant observation allowed me to interact with more parties and learn more perspectives, but this came at the cost of relatively thinner insight. On the flipside, my more fixed positioning as an EMT solidified my understanding of one position, but in doing so it also severed me from many others.

These two ethnographic styles also come with different ways to see the world. Both allow the ethnographer to look outwards onto others and inwards onto the researcher himself. However, participant observation lends itself to an outwards gaze first and an inward gaze second and observant participation lends itself to the reverse order. As a ride-along, I focused mostly on other people: workers, patients, cops, nurses, firefighters, bystanders, supervisors, upper managers, etc. My mission was to make sense of their world. I bent the ethnographic gaze back onto myself from time to time, but such an effort was always secondary to my observations of people and processes seemingly beyond my person. This can be contrasted with the gaze of observant participation. This is not a self-absorbed research practice – I still looked at others – but it’s a method that is more explicitly concerned with the personal, yet socially relevant, experiences of the individual researcher. The ethnographer’s own body – in my case my exhaustion, shaky hands, heartache, and other psychosomatic experiences – are all relevant pieces of information for understanding my world. Observant participation more explicitly accepts the researcher as someone who helps construct and carry the studied field, and it assumes that a more inward gaze can reveal tacit insights that are invisible to the traditional lens of participant observation. Still, we should be careful not to assume that an inward-centric vision is superior to an outward-centric one. Instead, we should simply conclude that the former gaze is narrower but deeper and the latter is wider but shallower.

Differences in positioning and gaze translate into differences in data assembly. To be clear, both participant observation and observant participation involve heavy amounts of writing and serious attempts to translate the ethnographer’s empirical knowledge into text. However, in several respects, participant observation favors inscription over incarnation and observant participation favors incarnation of over inscription. The difference is subtle yet significant. Participant observation hangs on a researcher’s ability to jot notes in (or immediately outside) the field and then elaborate on those jottings during a time and in a space a bit further from the “action” (e.g., in one’s private residence). Observant participation does this too, but as I’ve already mentioned, field jottings are rarer when the people and processes being studied need the ethnographer’s hands and mind for something else (like driving an ambulance). Pen and paper are set aside, and the researcher’s body becomes a fleshy tablet for collecting information about the world it’s embedded in (for a similar discussion see Desmond [2006]). While both styles involve a kind of incarnation before inscription (i.e., experience before writing), observant participation is more concerned than participant observation with developing a process of incarnation. The tradeoff was clear in my experience. Participant observation came with more
detailed field jottings but a poorer insight, and observant participation came with less detailed field jottings but a richer insight.

In this study, participation observation preceded observant participation, and that particular sequencing matters for each of the three axes noted in Table A.2. With respect to field positioning, I pivoted from a mobile participant observer who spent a significant amount of time with labor and management to an observant participant dedicated to knowing the more fixed position of EMT. This came with some unique challenges. A couple of my peers inside the ambulance asked me to dish on what supervisors “really” do. However, out of respect for the supervisors who let me shadow them, I resisted the temptation to gossip and was quick to change conversation topics. In refusing to offer juicy insights into the milieu of management, I may have shut the door to stronger comradery with labor and this may have sacrificed a deeper positioning in the field. However, protecting the people I connected with as a participant observer was more important in my opinion. At the same time, my relations with management changed. As an employee, I could no longer ride-along with supervisors or attend Daily-Ops meetings and distance quickly grew between myself and management. Still, I remained amicable with people like Eric, Grant, and other supervisors. A few of my paramedic partners even commented on how they believed we could “get away” with longer drop times, post delays, and similar tricks because the supervisors liked me. In short, my initial positioning as a participant observer shaped my subsequent positioning as an observant participant.

The sequencing from participant observer to observant participant affected my analytical gaze too. I unavoidably brought in lessons learned in the first phase into the second phase. I was already familiar with bullshit/legit distinctions. I already knew about many of the defiant strategies of labor. I had already seen rigor mortis, severed limbs, and other horrors. The year of conversations I held with people in the field also influenced my interpretation of my EMT job. In many ways, I read my own experiences through the experiences I previously saw and heard in others. My inward gaze was first attuned by an outward gaze. I’m not sure the reverse sequencing would have been any better or worse, but the second gaze is certainly shaped by the first and this is noteworthy.

Doing participant observation first and observant participation second also influenced data assembly. After a year of jotting in my notepad and then expanding on these jotting in a lengthier field journal, I had reached a point of “data saturation” for many events and procedures. My notes were already becoming thinner toward the end of my first year of fieldwork because I didn’t need to note redundant information. For example, after just a few weeks of participant observation, I realized I didn’t need to note every use of a blood pressure cuff or try to write the “turnover report” verbatim when these details rarely shifted between similar events; I simply needed to note when such incidents were surprisingly absent or different. By the time I transitioned to an observant participant, a focus on incarnation over inscription came easy because the inscription process had already been streamlined. It also helped, of course, that by the time I started working as an EMT I had already settled on a general focus on the ambulance as an institution of poverty governance and poverty governance as a labor process.

In short, this study has fused participant observation with observant participation. The differences between these two styles of inquiry are important for understanding shifts in field positioning, analytic gaze, and data assembly. Sequence and the fact that I followed participant observation with observant participation are also significant.
Ambulance Medical Records

I supplemented the ethnographic data by collecting and analyzing 107,208 de-identified medical records. I secured every “patient care report” completed by an MRT crew in the year 2015. Access to these records developed during my efforts to enter MRT as a ride-along. Before referring me to MRT headquarters, administrators at MCEMS recommended I analyze these records and pointed me in the direction on how to do so.

Table A.3 summarize some descriptive statistics for the medical records. Data in these records include those compiled through a computer administrated dispatch system (which capture variables like latitude and longitude coordinates of response) and ambulance crews in the field (who log variables like primary impression). While these records provide weak demographic information (e.g., patient race is an optional field and billing status is often incomplete), they offer somewhat rich data with respect to location of events, medical interventions performed, and workers’ narratives.\(^\text{60}\) I used Stata/MP (version 13.1) to clean and analyze these data.

To measure the severity of calls, I relied not on dispatch triage data but on the intervention data logged directly by paramedics and EMTs. Previous scholarship on critical and non-critical prehospital interventions inspired my decision to calculate frequencies for high, medium, and low severity ambulance contacts (Sporer et al. 2010).

Table A.4 summarizes the distinctions in intervention severity. As noted in the main text, I dropped 119 cases (0.1 percent) where paramedics determined death in the field but neither high nor medium level interventions were performed. These are assumed to be calls where crews discover obviously deceased bodies and don’t “work them.”

As noted in Chapter 6, I also performed some automated coding in Stata to flag crew-cop interactions in the medical records. Table A.5 lists the words and phrases I used to identify these interactions in the open-ended narratives that paramedics and EMTs write into the records.\(^\text{61}\) In these narratives, crews are supposed to document what are called “pertinent scene details.” Such details should indicate whether or not a subject was found under the supervision or care of a third party, like the police. The keyword, though, is *should*. I’ve written a number of these records myself and watched dozens of paramedics and EMTs do so. Whether due to laziness, forgetfulness, or habit, ambulance workers sometimes fail to document an interaction with law enforcement in these records. Luckily, the ethnographic data suggest crews are usually documenting their interactions with law enforcement through open-ended narratives and the finding that 20 percent of the records involve law-enforcement is generally consistent with what I observed in the field.

\(^{60}\) Over 51 percent of the medical records have missing race data. Of those that include race responses, 50 percent were categories as “unknown” and five percent as other.

\(^{61}\) Crews are not provided a “police on scene” box to check when completing their patient care reports and the computer administrated dispatch system does not automatically populate these records with data indicating whether or not crews and police were sent to the same scene.
Table A.3. Descriptive Statistics on MRT Medical Records

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Min.</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>.50</td>
<td>.50</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Age&lt;sup&gt;a&lt;/sup&gt;</td>
<td>52.41</td>
<td>22.90</td>
<td>.00</td>
<td>109.00</td>
</tr>
<tr>
<td>Child/Teen</td>
<td>.08</td>
<td>.26</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>20-59</td>
<td>.53</td>
<td>.50</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>60+</td>
<td>.39</td>
<td>.49</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Dispatch Priority</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alpha (lowest)</td>
<td>.25</td>
<td>.44</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Bravo</td>
<td>.20</td>
<td>.40</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Charlie</td>
<td>.23</td>
<td>.42</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Delta</td>
<td>.28</td>
<td>.45</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Echo (highest)</td>
<td>.03</td>
<td>.17</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Select Primary Impression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.10</td>
<td>.30</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Altered Level of Consciousness</td>
<td>.06</td>
<td>.24</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Cardiac</td>
<td>.04</td>
<td>.20</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Overdose / Intoxication</td>
<td>.04</td>
<td>.19</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Body Pain&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.12</td>
<td>.32</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Psych/Behavioral</td>
<td>.11</td>
<td>.32</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Respiratory</td>
<td>.08</td>
<td>.27</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Seizure</td>
<td>.03</td>
<td>.18</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Stroke&lt;sup&gt;c&lt;/sup&gt;</td>
<td>.01</td>
<td>.11</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Syncope/Near Syncope</td>
<td>.04</td>
<td>.19</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Trauma</td>
<td>.17</td>
<td>.38</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Weakness</td>
<td>.06</td>
<td>.23</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Select Scene Locations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>.52</td>
<td>.50</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Street</td>
<td>.16</td>
<td>.36</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Business</td>
<td>.11</td>
<td>.31</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Government Building</td>
<td>.05</td>
<td>.21</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Clinic/Assisted Living Facility&lt;sup&gt;d&lt;/sup&gt;</td>
<td>.10</td>
<td>.30</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Intervention Severity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>.62</td>
<td>.48</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Medium</td>
<td>.23</td>
<td>.42</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>High</td>
<td>.15</td>
<td>.35</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Crew-Cop Interactions</td>
<td>.21</td>
<td>.41</td>
<td>.00</td>
<td>1.00</td>
</tr>
</tbody>
</table>

<sup>Note:</sup> Observations = 107,208.

<sup>a</sup> – including gastrointestinal bleed and nausea/vomiting.
<sup>b</sup> – non-traumatic, non-cardiac.
<sup>c</sup> – including transient ischemic attacks.
<sup>d</sup> – includes health care facilities, hospitals, and rehabilitation centers.

Source: MRT De-Identified Patient Care Reports, 2015.
Table A.3. Clinical Intervention Severity

High
Adenosine, Albuterol, Amiodarone, Atropine, Atovent, bag valve mask, bronchodilators, calcium chloride, cardioversion, chest seal, continuous positive airway pressure, cardiopulmonary resuscitation, defibrillation, dextrose, dopamine, endotracheal intubation, epinephrine, glucagon, intravenous infusion, King supraglottic airway, naloxone, nasopharyngeal airway, needle decompression, oropharyngeal airway, Pralidoxime (2-PAM), return of spontaneous circulation, sodium bicarbonate, sodium thiosulfate, ST-elevation myocardial infarction alert, stroke alert, suction, tourniquet, transcutaneous pacing, trauma activation, or Versed.

Medium
No high severity interventions, but at least one of the following: aspirin, Benadryl, bleeding control, fentanyl, fluid bolus, glucose paste, nitroglycerin, oxygen (high flow), sepsis alert, spinal motion restriction (collar-only or full), splinting (traction and non- traction), vagal maneuver, or Zofran.

Low
No high or medium severity interventions. May include: electrocardiogram, an intravenous lock, an icepack, or low-flow oxygen. But the most significant intervention is arguably the hospital transport.

Note: Inspired by Sporer et al. 2010 and consultations with paramedics and EMTs in the field. Excludes less than one percent of records where death was determined on scene but neither high nor medium interventions were performed. See also: Seim, English, and Sporer (2017) and Seim et al. (2018).

Table A.5. Crew-Cop Interactions, Terms and Phrases Used in Automated Coding

<table>
<thead>
<tr>
<th>POLICE</th>
<th>COP</th>
<th>COPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD</td>
<td>P.D.</td>
<td>LEO</td>
</tr>
<tr>
<td>L.E.O.</td>
<td>LAW ENF</td>
<td>OFFICER</td>
</tr>
<tr>
<td>SHERIFF (sic)</td>
<td>DEPUTY</td>
<td>ARRESTED</td>
</tr>
<tr>
<td>UNDER ARREST</td>
<td>IN CUSTODY</td>
<td>HANDCUFF</td>
</tr>
<tr>
<td>HAND CUFF</td>
<td>SQUAD CAR</td>
<td>PATROL CAR</td>
</tr>
<tr>
<td>14 “XPD” abbreviations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: All text set to capitalized letters. Partial strings (e.g., “LAW ENF”) used to capture long and abbreviated texts. Common spelling errors included (e.g., “HAND CUFF”). “ARREST” not used to avoid miscoding “cardiac arrest” and “respiratory arrest.” Spaces and periods must be added after “COP” to avoid miscoding of “copy.”

Beyond these individual efforts, I noted that I lead a team that included a couple of emergency room physicians and a paramedic to run some geographical analyses of the records (Seim, English and Sporer 2017; Seim et al. 2018). After eliminating MRT records that fell outside of the company’s primary jurisdiction (e.g., mutual aid calls), we used an open source geocoding software program (QGIS 2.14.6) to link over 90 percent of the remaining records with a U.S. Census tract shape file for the county. While imperfect, census tracts have moderate to high face validity for approximating neighborhood.62 Because we were interested in the

---

62 Usually designed to capture between 1,200 to 8,000 residents and delineated through advice from “local participants” in the U.S. Census Bureau’s Participant Statistical Area Program, tract boundaries generally adhere to
relationship between neighborhood conditions and ambulance contacts, we used automated coding procedures in Stata to identify and drop cases where the open-ended narratives included keywords suggesting the response occurred on a major highway or bridge. The intuition here is that such calls are more obviously detached from neighborhood conditions. We also layered the tract shape file with Google Maps to review each tract, before eliminating a few we deemed non-residential (e.g., a tract covering little more than an airport). Following these procedures, we were left with 88,027 records geocoded across 300 census tracts.\textsuperscript{63} We then merged the resulting tract-level file with demographic data from the American Community Survey (ACS) 5-Year estimates for 2015.\textsuperscript{64} After the research team dissolved, I manually coded tracts with metro train stations and tracts with jail or police headquarters.

Table A.6 summarizes some of the descriptive statistics for these tract-level data. I used this dataset to calculate age-adjusted MRT response rates and to run other neighborhood-level analyses mentioned in the main text (e.g., regressing the percentage of ambulance records within a tract on poverty and other factors).

| Table A.6. Descriptive Statistics on Tract-Level Data |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                                 | Mean             | Standard         | Min.             | Max.             |
|                                 | Deviation        | Deviation        | Deviation        | Deviation        |
| Ambulance Contact               | 293.42           | 222.70           | 29.00            | 1317.00          |
| Crew-Cop Interactions (%)       | 19.23            | 6.80             | 5.71             | 54.96            |
| Poverty (%)                     | 12.63            | 10.45            | .00              | 49.64            |
| Black or Latino (%)             | 36.78            | 23.43            | .65              | 95.57            |
| Metro Train Station             | .05              | .23              | .00              | 1.00             |
| Jail or Police HQ               | .03              | .18              | .00              | 1.00             |
| Density per 1,000 pop           | 10.18            | 7.19             | .03              | 41.87            |
| 1,000 Population               | 4.52             | 1.60             | .07              | 9.63             |

\textit{Note:} Observations = 300.

\textit{Source:} MRT De-Identified Patient Care Reports, 2015; American Community Survey 2015 5-Year Estimates.

For the purposes of this dissertation, the medical records ultimately functioned as a tool to augment the ethnographic data. They allowed me to underline and triangulate key patterns revealed in the field.

\textsuperscript{63} We dropped 473 (less than one percent) of the geocoded records for the response time analysis due to missing or illogical time data.

\textsuperscript{64} The ACS is an ongoing survey managed by the U.S. Census Bureau and it supplements data from the decennial census with more detailed and up-to-date socio-demographic information (United States Census Bureau 2018).