RED AND WHITE IS ALWAYS RIGHT:
PERSPECTIVES FROM A GROUP OF AMBULANCE WORKERS

by

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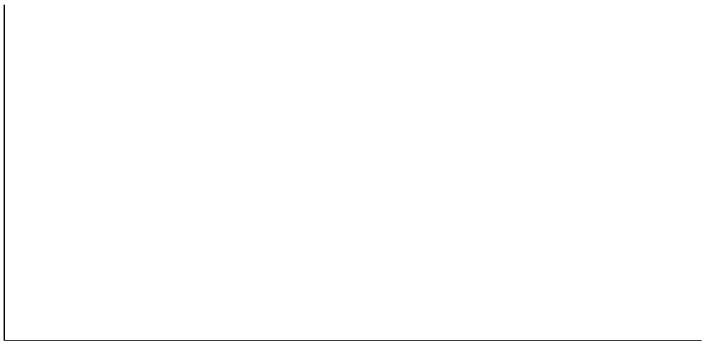

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ABSTRACT

From its European founders through to the "Chicago School" and up to the contemporary concerns of ethnomethodology, the study of work and occupations has been a central concern of sociological research. Based on data collected by participant observation and unstructured interviewing, this study presents an analytic portrayal of the work routines of Emergency Medical Assistants in Vancouver, BC. Topics discussed include work routines, local understandings of events, and interrelationships between emergency personnel, their colleagues, and others. A series of appendices provides details of specialized language, researcher access, and the researcher's personal relationship to the field.

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To all the Viking Warriors; may you win your next battle.

INTRODUCTION

> "Most people know shit about what we do--By 10pm they're tucked into their nice safe beds while we're out here covered in blood and sweat at 2am on Welfare Wednesday with 15 calls in the last 2 hours. You can't eat, piss, think, or even remember your last call--the street is hell."

Since sociology's beginnings, laboring has been a prominent concern for both theorist and researcher alike. For example, it can be seen as a thread that unites the work of the discipline's 19th Century European "founding fathers". Durkheim, in his classic, *The Division of Labour in Society* (1893), was concerned with the manner in which different styles of labour contributed to the integration of society. Marx agonized in *Wage, Labour and Capital* (1947) about the ways in which forms of laboring produced the alienation of workers. Weber's massive and influential *The Protestant Ethic and the Spirit of Capitalism* (1904-1905), can be read as an explication of the cultural and social sources of the motivation to labour in the first place.

A concern for laboring persisted as sociology moved from Europe to North America, and into the 20th Century. On this continent, the disciplinary sub field became known as the 'sociology of work and occupations'. For many years it has been a recognized specialty within the American Sociological Association. Judging by the number of articles contained in the index of that association's flagship journal, -- *The American Sociological Review,* it remains a popular area of sociological research. Further, since 1974 the topic has had an entire journal devoted to it: *The Sociology of Work and Occupations.*

In North America, the investigation of this topic was pioneered at the University of Chicago by Robert E. Park (1864-1944), and later reached full fruition in a series of post-World War II dissertations directed by Everett Cherrington Hughes, also of that university. Many of these have become sociological classics: Fred Davis' (1959) study of taxi drivers, Howard S. Becker's research on dance musicians (1963) and school

teachers (1968), and Raymond Gold's (1950) investigation of apartment house janitors' work routines are amongst these. Many other little known University of Chicago dissertations are lovingly documented in the footnotes of Erving Goffman's *The Presentation of Self in Everyday Life* (1959).

Early North American interest in laboring can be portrayed as differing from those of the European "founding fathers" in two significant ways. Firstly, while Durkheim, Weber, and Marx addressed the topic in a macro-sociological way, Park and Hughes urged their students to study laboring in a micro-sociological way. Basically, this meant a shift in emphasis from structural issues to human lived experience. The impetus for such a focus was largely anthropological; concern was with what Malinowski (1922) called "the imponderabilia of everyday life". Secondly, while the European "founding fathers" studied laboring through the use of archives, official statistics, and other secondary sources, Chicago School sociologists sought to understand it by using data obtained first hand through immersion in the culture and social circumstances of the laborers themselves. Rather than being "distant", sociologists operating within this tradition sought to get "close-up". In the editorial introduction to the journal, *Urban Life and Culture*, itself a phrase taken from one of Robert E. Park's lectures, John Lofland (1972) provides an unpacking of this somewhat ambiguous term;

> "The term close-up suggests that the researcher has sought through personal participation, observation or intensive interviewing intimately to acquaint him or her-self with a discrete circumstance of an urban society. Ideally, the researcher has been close in the physical sense of conducting for a significant period of time his or her life in face to face proximity to the persons and circumstances under study. Ideally, the researcher has also been close-up in the additional sense of attaining intimate access to the circumstances of concern and of giving searching attention to activities of everyday life. It then becomes possible for research reports to provide the kind of description and quotation that moves the reader "inside", as it were, the world under study.
> To be close-up is to attempt to portray the "tissue and fabric of social life," to use a leading practitioner's appropriate phrase. It is to convey the inner life and texture of urban societies' diverse public and personal

> circumstance, modes of life and social enclaves. This is in its nature a qualitative task, a task of showing the kinds of things that happen and the ways in which things happen." (1972: 4)

The present study is based on data obtained by getting physically and perspectivally "close" to a laboring community. The community of concern is that of Emergency Medical Assistants (EMA's). The techniques used to get close were participant observation and unstructured interviewing.

While there are no like projects in the literature from Canada, two studies from the U.S. are significant. Mannon (1981) did a participant observational study supplemented by formal and informal interviewing of a County Hospital service in the Midwestern U.S. in the late 1970's. The study focused primarily on the changes in responsibility and scope of workers over the previous ten years. Mannon suggested that the job description changed dramatically with new technologies, training availability and with the perception of the role of ambulance workers. For this reason, he argued, the vocation is emerging into a 'profession' and it is the perception of this emergent role that he investigates through immersion into the world of its workers.

Metz (1981) became an EMT (Emergency Medical Attendant)[1] for his participant observational study in the East. His research was primarily concerned with features of crew culture such as language, inappropriate jokes, storytelling, and used a Goffmanesque framework to look at the 'faces' of workers. He also examined preferences for types of patients and calls, on-duty theft of medical supplies, the socialization of an EMT from the point of view of a 'rookie', and other like topics.

Other studies on EMT's in the U.S. have utilized quantitative methods to examine satisfaction indices among paid vs. volunteer ambulance attendants (Allison et al, 1987), unsuccessful cardiopulmonary resuscitation efforts (Genest 1990), and "burnout" prediction (Masalach and Jackson 1981), (Mitchell 1984), (Leiter 1991). From a social-psychological perspective Palmer examined workers' strategies of coping with death and

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[1] EMT's and EMA's are essentially equivalent positions with different names.

dying (1983), occupational behavior of paramedics and ambulance attendants (1983), their 'performances' in relation to the public, other workers, and victims/family (1989), and the idea of their role as "playing doc" being a deviant one (1990). Finally, James (1988) investigated perceptions of stress in ambulance personnel, and Hughes (1980) analyzed the ambulance journey (to the hospital) as being important becasue of the power of evaluation by the attendant, and its subsequent impact on the treatment the patient receives once at the hospital.

This study is organized as follows. Chapter One presents a brief history of the British Columbia Ambulance Service, and the formal training of Emergency Medical Assistants. Following is a discussion of the techniques used to obtain the data that permit the portrayal presented in the subsequent chapter. The third chapter is a description of a typical shift. Chapter Four enters the interior world of ambulance workers and deals with some of the local concepts they use to organize their occupational routines. These include some characteristics of calls and clients. The fifth chapter deals with the informal working knowledge that Emergency Medical Assistants must come to learn and display in order to be seen as competent amongst their colleagues. Chapter Six discusses ambulance workers' interactions with other emergency services personnel, including firefighters, police officers, and hospital staff members. Some discussion is presented on their relationship with their peers, and those who dispatch their calls. Appendix One provides what Van Maanen (1988) has called "The Confessional Tale". Since Whyte's (1955) appendix to *Street Corner Society,* the confessional tale has become a qualitative research tradition; it permits the reader to place "the findings" of the research in the context, and provides information that assists in the assessment of its validity. A further series of appendices provides a glossary of terms and codes, and some sample 'official forms' utilized by EMA's.

CHAPTER ONE

> "Well, the outlying areas were mostly a family run operation. Sort of the one man show deal—you know, police, fire and ambulance all rolled into one. The city service was Metro back then—not very much training compared to now—we did all right though."

History of the British Columbia Ambulance Service

This chapter will briefly outline the history of the British Columbia Ambulance Service as it relates to the present day Emergency Medical Assistants and their roles. It concludes with the formal training that EMA's take in order to become certified at the various levels.

In 1972 the Provincial Government proposed and approved "The Emergency Health Act", which in part mandated the provincial government take over the ambulance offerings in Vancouver and its suburbs. This takeover was unique in that the government hired all the members of the previous regional services. The B.C. Ambulance Service became, overnight, the largest ambulance service in North America.

Vancouver had previously been serviced by 'Metro Ambulance Service', the members of which were retained by the new government service. Prior to this Act, the ambulance offerings were different in each city and township. Some municipalities ran the service out of fire halls and some contracted the service out to private companies. On the private side, some services were family businesses such as Allen Gordon in Whiterock, Doug Sager (who invented the Sager Splint) in Chilliwack, and Harvey Bull in Surrey. In small towns the ambulance service was often just part of some private company's offerings. For example, Milton Fernandez in Pemberton offered a tow truck service, responded to fire calls, was empowered by the police, and was responsible for the Emergency (disaster) program in that area. Many of these services were also incorporated into the new B.C. system. In fact, some of these men are currently Unit

Chiefs of various stations. Many of the members of Metro Ambulance Service that were retained are still with the Service as Unit Chiefs, dispatchers, and administrators.

With the Emergency Health Act came the concept of a *paramedic*, or Emergency Medical Assistants (EMA), which was an ambulance attendant certified to a level of training well beyond that ever required or provided in Canada before. The concept was loosely based on the U.S. model, which was already in place in large cities such as Seattle, Los Angeles, and Denver. In B.C. the training program was partially developed over time and through trial and error, and to this day each graduating class gets differing training. The first EMA III class was given in 1973-74, as a modular two-year training program. The Emergency Physicians at Royal Columbian Hospital basically invented the course, guessing at what types of things paramedics should be taught. In this first class were members of Metro service and others with street experience at the EMA II level. The first class learned everything from suturing to intubation, their contemporaries learn a streamlined content of those protocols found to be most relevant to paramedics working at the street level.

An interesting difference between American and B.C. paramedics is in their respective licensing. In the U.S., all actions undertaken by paramedics must first be approved by a doctor by telephone or in person, because they are licensed under those doctors who are thus ultimately responsible for the care provided by their paramedics. In B.C., the paramedics have a more autonomous license, similar to that of a medical doctor. B.C. paramedics have 'delayed orders', meaning that they are supposed to call the doctor at certain points in their issued protocols, but if the doctor is unavailable they are permitted to do "what they think is best", within their protocols. The U.S. model is obviously problematic in that the doctors have to give orders for a patient they have never seen, because the paramedics are not empowered to the same degree as their B.C. counterparts.

The B.C. system is considered by its own members to be "conservative" in its new protocols in comparison to the U.S.. As paramedics and other levels of ambulance attendants stateside are paid poorly on the whole, the staff turnover is high, and paramedics generally do not have as much field experience as those in B.C. In the U.S., someone who has been working for five years is considered senior, while in B.C. one would have to have five years part time experience *and* three to five years full time before they were no longer considered 'new'. For this reason, it was felt by the paramedics that I interviewed that B.C. 'backs up' its protocols with experience, while American paramedics get more 'radical' training, while lacking the experience base necessary in order to carry it off in the field.

The next section will discuss in detail the content and formal training of today's EMA, with a discussion of practical applications in Chapter Five.

Formal Training of Emergency Medical Assistants

Minimum Qualifications

To become employed by the ambulance service initially, an individual must have a Class 4 drivers license with a reasonable driving record, a successful criminal record search, and an Industrial First Aid (IFA)[2] ticket. Grade twelve is a 'desired' qualification, but is not mandatory. Currently there is no recognition given to higher education such as a university degree, nor is there any type of evaluative interview of candidates; centrally or otherwise. Once hired an individual would eventually be asked to take the Emergency Medical Assistant I (EMA I) course, as space in the course becomes available in the region of the station he or she was hired. To be eligible for the EMA I course, individuals must complete the "EMA I Entrance Booklet", which consists of reading and questions

[2] Industrial First Aid is a course endorsed by the Worker's Compensation Board of British Columbia for industrial work-sites. The course is approximately 80 hours of class time with practical and written exams at the end.

dealing with the understanding of operations of the ambulance service, particularly, who is responsible for which jobs while working 'on car', and the like. Below are the specifics of course content for the EMA program.

EMA I

The EMA I course itself is offered in a three weekend or 'block' format, usually one month apart. A block consists of the Friday night, all day Saturday and all day Sunday. The sessions cover a variety of topics and training modules, as outlined below.

Weekend #1

The first weekend begins with a small exam that reviews the written Industrial First Aid (IFA) content. Candidates then review 'hard collar' (a device that fits around the neck, supporting the chin, and thus immobilizes the neck) application for spinal immobilization, and 'Sager splints', a device used to apply traction to a broken femur. Next is how to complete "Form 2", the ambulance call record that is filled out for each patient attended. Other forms are also covered at this time, including forms involving; "Hepatitis B", "Cardiac Arrest", "Equipment loss", etc. Members cited view the amount of paperwork to be similar to that of the Army in its thoroughness. A comprehensive review of CPR (Cardio Pulmonary Resuscitation) is next, including skills for adults, children, and infants. CPR 'on the run' is also covered, as is the 'do not resuscitate' orders issued by doctors on behalf of the next of kin. The four conditions a crew member is permitted to cease resuscitation efforts are also covered. Safe lifting is next, then a series of mini simulations of illness and injuries that the crew members are evaluated on. Finally, the candidates' written exams are returned, and they are given an evaluation in written form on a document called the "Mastery checklist for EMA I Block 1". This document indicates how well the individual has 'mastered' the items covered in that block.

Weekend #2

The second block is thought to be the 'least pressured' block of the three by members interviewed. The mini-simulations are reviewed from the previous weekend, and many other evaluations are done. Members learn the application of the "SED" device (SAFECO Extrication device - a piece of equipment used to remove patients from automobiles) through lecture and practical work. They also learn the administration of Entinox, laughing gas, and review maintenance of IVs (intravenous). They then participate in a spinal immobilization review following the standards learned in IFA. Mini- simulations make up the remainder of the weekend, and constitute a large part of the block in general.

Weekend #3

The written final exam is administered this block, based on all relevant EMA I theory from the block. Formal testing is then conducted on Sager splint and hard collar application. After these have been completed, the groups splits in to two; one group does mini-simulation final 'testing', the other does the 'Driving Level 1' course. The groups then switch. The remainder of the weekend is used for licensing purposes, providing the candidate was successful. This process includes photo taking, paper work for license processing, and the like.

A final note is that some communities are equipped with automatic external defibrillators (AED) for re-starting the heart, and in these areas members would also get training on this equipment.

EMA II

To be eligible for EMA II, members must hold their EMA I license for at least one year, complete 25 calls as an EMA I, and must be an employee of the service for at

least one year. Members must apply for this training, and in so doing write an entrance exam and score 80% (This score has recently been increased to reflect the high competition among candidates). The content of this written exam is all the relevant book theory from the EMA I program knowledge and practical experience, as well as those items that are taken from IFA. After the score has been met, selection is dependent on space in the region and seniority with the service.

There are two course formats for EMA II, distance learning and a six week course at the Justice Institute (JI). With the distance learning format they have workshops every two months at a central location (assigned to a certain area). This format is preferable for outlying or sparse areas i.e.) Vancouver Island. The reason it is done this way is because of budget - it is cheaper to bring candidates down to Vancouver for 1 week rather than the alternative of six weeks.

The EMA II full format course is six weeks at the JI, and candidates are housed in a hotel. The course begins with a review of basic anatomy and physiology, pathophysiology (why things happen), and signs and symptomology that will aid the candidate in judgment. A course on over-embankment extrication and auto-extrication is next, and a two day driver training Level 2 course. Candidates also spend a day in emergency taking reports from crew members, admitting patients, assessing patients, monitoring vital signs - all under the supervision of an RN (Registered Nurse).

Next is a day in extended care where the candidate is 'buddied' with a nurse and completes all tasks he or she does in the course of his/her regular work day.. Duties covered are left to the nurse in question, candidates do whatever she or he see fit. The candidate also spends a day in the extended care ward, the purpose of which is to make the candidate more comfortable with geriatric settings so such scenes are not problematic when the time comes. A day in 'PAR' (post anesthetic recovery room) is next, which involves patient assessment, monitoring vital signs, and the member would intervene at any time if required. This designation is also under the supervision of an RN.

The bulk of the course matter in EMA II is patient assessment - from primary surveys and new protocols. The protocols learned include intravenous application, MAST pants (Military Anti-Shock Trousers), Entinox, medications to treat diabetic emergencies, allergic reactions, shortness of breath, and overdoses.

All practical testing is done with professional actors and is as real as possible. There are final exams at the end of the program, involving 80% achievement for both practical and written. There is no apprenticeship period for EMA II's after the completion of the module, they are back on car immediately to utilize their new skills.

EMA III

To be eligible to apply for EMA III one must have 3 years plus one day working as an EMA II in a high call area. There are exceptions such as a member who teaches in the Justice Institute as part of the time toward street time. The reason for such exceptions is that administration does not want to discourage good people from wanting to teach the upcoming members. Some members feel such an arrangement is problematic in that they do not have the same amount of experience with recognizing sick and injured patients. There is also a concern by some members that 5 years of street time are needed before going into EMA III training.

Applicants must be full time EMA II's, the eligibility does not apply to part time EMA's.. The acceptance into the program is geographically determined partially, that is,. if they need EMA's in Prince George they will fill two of the spots with applicants from that area. The EMA III locations include Prince George, Kelowna, Kamloops, Chilliwack, Surrey, New Westminister, Burnaby, VGH, Airevac, Richmond, and Lions Gate. There are also 5 stations on Vancouver Island.

Infant Transport team has the same requirements, these teams are all Vancouver based i.e., Children's or Royal Columbian. The program is essentially the same with a

different focus - kids up to 14 years of age. The primary focus is air transports of premature or unstable infants.

The EMA III course itself involves a pre-reading package, ideally given 3 months in advance, some pre-assignments, an entrance exam that determines where the person stands for course teaching purposes. There is a formula used by the service to determine 'who gets in' involving the variables of seniority, marks in the entrance exam, and personnel file content[3]. There is then an interview conducted with a panel including the local medical coordinator, a personnel department member, one or more physicians, and a ambulance supervisor. The interview panelists try to determine how the candidate would deal with different situations such as interaction with other services, for example fire Captains. They also want to determine how the individual would handle the authority vested in them at the scene, his or her skills of professionalism, people skills, and leadership. Some attention is also paid to his or her ability to manage a scene such as a riot involving triage of a large number of patients. Once a candidate has successfully completed these obstacles, he or she begins the first of the 3 blocks which make up, the EMA III course.

Block 1

Block 1 is cardiac arrest management, which includes practical work and a written exam. It is expected that students coming in for this block will know airway management, intubation, and bag and mask ventilation very well. They must also be right up to speed on drugs administration as per their protocol manuals. Potential problems with drugs and patients are part of this block. Candidates learn intubation in the hospital on a one week practice with an anesthesiologist as part of this block, and do

[3] This formula has changed with each class that goes through the program, and is a subject of much controversy from both management and candidate points of view. There are many grievances filed with the union with respect to 'who got in', indicated by members interviewed.

assessments in emergency on real patients. They get practically examined back at the JI, and do some case studies lastly, and the block ends with the candidate going on car again to experience at least 10 cardiac arrests. The candidate then gets assigned with two fully trained ALS members for a 6 week apprenticeship on car. In this setting, they participate in calls with the two fully trained members and learn the 'on the street' working rules.

Block 2

Block 2 is common cardiac and other medical emergencies, and has pre-reading which is expected to be completed while the candidate is on car for his or her six week apprenticeship. The focus of this module is on straight forward calls - those that are as they seem. Candidates spend two weeks at the JI where they do simulated ambulance calls using professional actors who simulate patients. The actors are given historical facts about the mock illness or injury, so the situations are very real to life. At the end of the two weeks candidates go into a hospital (St. Paul's, VGH, or Royal Columbian) emergency for two weeks where they do 'work-ups' on specific patients and consult with emergency physicians as to protocols where required. They basically get to observe and partially participate in what ever is going on at the time of their stay, and may be assigned small projects related to the patients they had seen. They have two days of written and practical exams as part of this block to measure their successful mastery of the skills and concepts. The candidates then go back on car for another six week apprenticeship.

Block 3

Block 3 is concerned primarily with respiratory emergencies such as anaphylactic shock, congestive heart failure and other complicated medical emergencies. Some pediatrics are also covered. Here patients have multiple problems, and the candidate must learn how to assess such a patient, which symptoms apply to which problem, and which is more important to treat. Candidates also learn sedation of conscious patients for

the purposes of intubation. This block consists of two to three weeks in the academy, and one month in the emergency department of one of the above hospitals. A great deal is expected of candidates at this level; they are required to develop a 'provisional diagnosis' and a working diagnosis, from which they develop a treatment plan of how they will manage the patient.

Also in this block candidates are required to do 12 assignments on case histories of patients presenting symptoms - this constitutes 20% of their marks. At the end of the block they go through two days of exams, some written and some practical, again using professional actors. For the practical they are given a senior ALS member as a partner, but he or she may only do as they are told. These situations are as real as possible, with such things as phones to call the emergency physicians at the hospitals on, as would be done in real life. The candidate then goes on car for another six week apprenticeship.

After the final apprenticeship the candidate writes and participates in final exams where he or she must score at least 80%. They then commence the final stage of becoming an EMA III, a brief 'internship' with one other ALS member where he or she drives and the candidate does all the attending. If the candidate is performing to standard the senior member can 'sign them off' which allows them to be full fledged ALS. In some cases it takes more than one internship with more than one ALS member in order to get 'signed off'.

. It was felt by paramedics interviewed that if a candidate made it to the end of the process, they were competent. It was not felt that people slipped through that should not, and in this sense the recruitment process was sound.

This chapter has traced features of the B.C. Ambulance Service up to the present day, including the level of training received by today's EMA's. Of note is the fact that the number of calls in B.C. has dramatically increased since the inception of the provincial service, yet there in that time there has only been a ten per cent increase in the number of ambulance personnel. As a result, the ambulance attendants have had to make many

adaptations in order to cope with the much greater call frequency. Clues as to strategies employed by attendants to cope with their work are evidenced herein, but they are not a focus in themselves. The next chapter will outline some of the problems I experienced while trying to get 'inside' this very technical organization, and my justifications for feeling that rapport was established.

CHAPTER TWO

> So he said, "Hey Nicole, we'll give you $5 to put your tongue in Tom's ear." I said, "No way!" Luckily they were all drunk, so they would move onto something else, and wouldn't think I was a poor sport.

This chapter describes the process of getting into "the field" and the problems associated with being there and gathering data. Although I am aware of the work of Golde (1970), Briggs (1970), Horowitz (1986), and others, I do not deal with the issue of working as a female researcher in a predominantly male setting in this chapter. Following William Foote Whyte (1943), I have discussed this in Appendix Two, and present the details of my research in a gender-neutral and technical way.

Research Plan

In order to observe the activities of ambulance personnel with the minimum of disruption of normal routine, I devised a research procedure involving my participation in the scene to be studied, following the tradition established by the Chicago school of urban ethnography. Research works consulted included that of Gold (1958), Douglas (1976), Lofland (1976), and Stoddart (1986).

Before I could begin the research proper, I needed to obtain some preliminary knowledge of the structure of the organization and the characteristics of the scene. This pre-knowledge was necessary in order to determine how activities could best be studied with minimum interference. To obtain this preliminary information, I carried out informal interviews with two ambulance attendants, each of whom was attached to different stations. I also 'rode along' for part of one shift with one of these interviewees and another unknown crew member in order to access the scene to be studied.

These preliminary interviews were very casual, even though I was 'up front' with the interviewees, that is, truthful as to the purpose and topics of the project, and the nature of the research. The attendants were then asked how access to the scene could be best

gained. Both respondents straightforwardly answered that "observers were permitted to ride on car" with the permission of the unit chief or a higher ambulance official, and both felt that riding as an observer was the best route to go. Both noted and denigrated other alternatives, such as my attempting to obtain employment in the service. They gave two reasons for dismissing this approach: one, it was very difficult to obtain a position at the time, and, two, even if I got hired, I would be assigned to an 'Outstation' like Sechelt, where there was low call volume and "it wasn't anything like the city service".

Additionally, they suggested that the time spent in between calls, whether at the station or other locale, was very important—one could "pick up a lot by listening on these occasions". On the shift that I 'rode third[4]', it became apparent that the latter was in fact the case, and that I must therefore observe not only the calls, but also the 'rest period'.

Through the experience of riding third I determined that it was possible to take notes at the station in between calls without being obtrusive. Members had sets of things they preferred to do in between calls, such as watching TV, writing letters and studying or reading. I also learned that it was 'normal' for researchers to be 'ride-alongs'. Social workers, nurses, medical students, journalists, and ambulance attendant 'wannabes', among others, had previously accompanied crews and taken notes. And even if in the field I found note taking to be problematic, the day's activities could be written up on returning after each shift.

On the basis of these preliminary interviews I decided to observe several different crews, with different levels of training, working out of different stations, rather than performing an in-depth study of just one crew. The attendants spoke of significant differences between the types of calls received and the clientele serviced in different parts of the city. This is not to say, however, that I thought I could get a 'representative sample' of all stations. Instead, I hoped I could draw a more richly detailed picture by observing some of these differences. However, this decision created a tactical problem: because I

[4] Riding third refers to there being a third person in the ambulance, where there are 'normally' only two.

would spend a relatively short time at each location, and my integration into the domain could be more difficult. This problem was addressed by selecting crews comprised of at least one member that I knew fairly well, either as a past co-worker or as a current friend, or both. In this way my presence could be 'approved' from the start by at least one member of the crew, which would improve the chances of the other doing the same.

Further, the interviews revealed that there were critical differences in the level of training that different crews had, which determined both the type of calls they got and the clientele they serviced. "ALS" (Advanced Life Support)[5] crews, who could administer approved drugs and do advanced procedures, typically went to calls such as street people who had overdosed on heroin, elderly people with heart conditions, and other life-threatening situations. In contrast, "BLS" (Basic Life Support) crews were typically dispatched to assaults, motor vehicle accidents, and public assists.

The attendants indicated that it would be important to observe both the day shifts and night shifts in order to see the whole picture. The attendants' shift pattern or "block" of two ten-hour days followed by two fourteen-hour nights was cited as being "relentless". I decided that full blocks of shifts would be appropriate for the time in the field. They would offer the opportunity of observing first-hand the conditions the attendants experienced.

Three stations with different crews were selected for observation:

#1 was a downtown station that covered 'the skids' of the east side of the downtown core as well as the West End and parts of the 'yuppie' area. This station was thought to get a 'nice mix' of calls. The crew was trained to the BLS level. The station was also known for its 'night life', that is, an abundance of calls after midnight. One of the crew members at this station was an acquaintance of mine for the past five years. He

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[5] Advanced Life Support is a specialty available to crew members as they take EMA III training; the alternative is Infant Transport Team.

had been my teacher and my coach in first aid competitions, and we served together as executive volunteers for a non-profit society.

Station #2 was on the South side of the city, which, in addition to its city duties, covered many of the "Airevacs", transports by small aircraft or helicopter in or out of the city to the interior or the islands. While it was not certain that I would be able to accompany the crews on flights, some information could be gathered about the flights through stories and mild questioning after the fact. If I was permitted to accompany the crew on flights, it would then be possible to experience some of the rural services of the province. Either way, I could ride with an ALS crew. The station was very busy at night, because it was responsible for ALS priority calls for the whole South side. The crew member that I knew at this station had been a co-worker for 8 years.

Station #3 was in the East side of the city, close to a low income neighborhood, Mt. Pleasant. The station covered a wide area, reaching as far as the border of the next city on one side, and into Kitsilano on the other side. The station also serviced. the downtown core, overlapping with station #1. Because of its coverage, station #3 was thought to have a 'good variety' of calls and clientele, as well as a high call volume. The crew member I was familiar with at this station was an acquaintance of ten years in the capacity of instructor, co-worker, co-volunteer, employee, and friend.

I was to function in the scene as an 'overt participant observer' (Adler and Adler 1987: 52-60), accompanying the crews on all calls, assisting at the scene where invited, and completing shifts with overtime where required. As the situation permitted, I would question crew members regarding activities and events observed in the course of the days work. I would also endeavor to be present for 'shop talk' or informal conversations between calls, and record the nature of such discussions when possible. The field of observation would consist, then, of any and all activities and events encountered in the course of tracking personnel following their routine work day.

Of note here is my difficulty in securing any shifts with a female attendant. A large percentage of the women working in the service were 'part timers', and therefore did not have set shifts that could be observed. As rapport (discussed below) was considered to be crucial, I thought it best to secure shifts with regular crews, and hope that some part time female attendants would be on shift.

It was hoped this strategy would allow me to observe activities in the setting from a structural perspective similar to that of the crew member, while at the same time avoiding any 'rookie' treatment reserved for new crew members. In this sense, I hoped to balance between seeing the world as the members do, and remaining objective enough to see it as an outside researcher. This position in the field would be beneficial as one could ask questions as a novice might, and receive any instructions as to the 'facts of life' about the job. However, I could also ask questions as an investigator, thus eliminating any queries as to why such a question would be asked in that context (Zimmerman 1966: 361).

In summary, this research strategy entailed my immersion into the field of ambulance work, on a full-time basis, at different stations with different crews. My prior knowledge of both the 'scene' and some of the crew members would assist in successful access and integration, and avoidance of some potential pitfalls.

Gaining Access to the Scene

Having developed the research strategy, the next problem I had was that of securing access to the service. To this end I approached the members of the Ambulance Service mentioned above to tell them about the project and ask if they would support me riding as a third for a block (4 shifts - 2 days and 2 nights) each. Together we came up with a timetable that would suit everyone's schedules and sorted out which days to ask for. Fortunately, all three members were on the same shift pattern or platoon, which made it simple to accommodate the shift to each station, and to work the same amount as

they did. It should be noted that crew members were surprised that I was interested in riding for a full block, as the shift pattern is regarded by them as quite 'brutal.' Consequently, many observers only ride for day shift or a part of nights, but these were regarded poorly by members, who felt that those observers were 'wimpy' for not wanting to stay out all night. The attendants thought that those observers got a partial and deficient experience of ambulance work. I would at least avoid that stigma.

The next obstacle was to get approval to do the shifts, and all members consulted said approval was obtained through the scheduler of thirds, if the request to ride was for full blocks. Unit Chiefs (Head of the stations) could approve an odd shift, but longer requests had to go through the administration office.

The first attempt to implement this step was met with little support or encouragement. I called the scheduler, and was told that the service was not letting anyone ride third, owing to the great number of requests. He said the only way to go about it was to write a letter to the Superintendent of the Ambulance Service, outlining what I wanted to do and for what reason. I then consulted a psychologist/sociologist acquaintance who had done research for the Ambulance Service in the past to discuss what topics he felt the service may be interested in. The discussion did not bring to light anything new, so a letter was drafted to the Superintendent.

In the end I was able to avoid the bureaucratic process of waiting for a response when I had the good fortune of a 'connection'[6] obtaining approval on my behalf A memo was sent to the scheduler by the Chief Superintendent of the service to 'extend her every courtesy' on the shifts requested. I then called the scheduler with my requests, as instructed, and settled the dates, times and stations. The only comments he made were that tardiness was not tolerated, and that I was to wear 'dark slacks and a white shirt. He also agreed to fax copies of the memos sent to the Unit Chiefs outlining the riding schedule as proof of access. The latter arrived a few days later.

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[6] For details of a further example of "its who you know" see Appendix 2 "Confessional Tale".

Field Observations: Occasions and Methods of Data Collection

The purpose of this section is to describe and briefly comment upon the variety of occasions upon which descriptive materials were collected during the course of fieldwork at the stations. I have presented excerpts from field notes to illustrate the nature and form of materials available on these occasions.

Calls

A primary source of data in the field was the actual 'doing of a call'. Such occasions were opportunities to observe attendants' behavior and interaction with others, usually without being observed myself. On some calls I was given tasks to do; on others I initiated activities myself, based on prior experience. In these instances I was more involved with the call itself, and thus more aware of minute details of the skills and procedures executed, statements made 'under the breath', and specific conversations with others at the scene. I believe that these two types of involvement offered a good balance of observation opportunities, and provided some rich detail[7].

Hospital 'hanging'

A second data source available in the field was the frequent instance of 'hanging out' at the hospital. These occasions usually presented themselves after a call was finished and the patient was delivered to his or her destination. On at least two occasions, hospitals were visited to 'see if anything was happening'. These instances were valuable as many crew members were often present, from various stations throughout the city. Typical conversation topics included calls done, both 'good and bad'; activities on days off; other attendants' personal lives; problems with management; and scheduling errors. Attendants were also observed to interact with nurses, doctors, and other hospital staff on

[7] For specific excerpts from calls, see Chapter 4.

these occasions, which provided valuable content to my field notes. Such occasions were sometimes casual and sometimes 'showlike'; attendants were observed to 'perform' in some cases when presented with the opportunity. For example, in the presence of some members that were not liked, the chat would be curt and uninteresting, as if to indicate that those individuals would not get the chance to be part of 'the gang'.

I also noticed that some previous-told stories were slightly embellished or changed in some way when being told to such a group. The alterations usually resulted in creating a more 'off the cuff' background for the story. For example, a longer version of a story involving heroic resuscitation efforts in minute detail may be condensed to the end result - "Code 4". This compacting gave the impression that the call was 'routine', and the attendant appeared to not remember the details.

Station 'waiting'

Sitting around at the station waiting for calls served a very valuable research purpose in that 'everyday activity' could be observed. The station was like an office or little home away from home, and attendants were observed to exhibit very casual behaviors. Differences between attendants were observed at the station. For example, those attendants who were full time often welcomed a quiet shift, and would retreat to various parts of the station to sleep, watch TV, or read. Part-timers would often make comments regarding the quiet nature of the shift, and complain in a testing sort of manner as to whether others agreed with them. Other full-time attendants, however, had spent 'too much time' at the station, and preferred to get out and, as outlined below, 'cruise'.

Cruising

Cruising was a popular activity among some attendants studied. It usually involved doing 'the square' or 'the loop', which meant driving the ambulance along Davie

to Denman to Robson and back again (past several Starbucks coffee houses), or driving past the hookers in one of the two main areas they work. Other shifts, weather and season permitting, allowed for a 'seawall cruise', or a 'beach crawl'. Cruising was viewed as 'stress release' by the attendants, although they may have said this to me by way of self-justification. Cruising was considered 'entertaining' as members could 'watch the sidewalks', see others, and be seen. Coffee was a large part of many attendants' days as well, and cruising gave them a vast selection of coffee bars to get a 'good brew'. During cruising, many comments about people or situations were overheard and relayed. The mood was usually very casual. Debates over 'hot topics', ranging from institutional scapegoating to haircuts were often a part of the 'cruise'. These instances were very valuable as I could write verbatim, without being seen (I was seated behind the attendants in an elevated chair). Many of the overheard stories and comments in this paper come from 'cruising' conversations.

Socializing after shift

The final opportunity I had for observing members was during social events after shift. Since attendants did two day and two night shifts, they had a 24 hour period in the middle of their block. This 'split' was a 'night out' for most members. This was traditionally a night to get very inebriated. The stated rationale was that it would allow them to sleep all day, which made the shift changeover easier. On split nights the group of participants gathered at a bar or restaurant for beers and snacks. If the night went well, they ended up 'going dancing' at another establishment, which is what happened on my first 'split'. That party went on long after I had left, and I don't know how they made it through the two subsequent nights.

On these social occasions I participated in conversation and generally tried to fit in. This was not too difficult as many of the members that showed up were acquaintances of mine. There was a great deal of show on these nights out: yelling, singing, chanting,

obnoxious banter with wait staff and other patrons. Those attendants that were full time seemed to be the ring-leaders of the group - the younger ones often paid attention to their 'commands or suggestions' in the hopes of living up to the past members' stories of the past nights out.

As these occasions were not official, that is, part of the work day, I can not infer too much about their behavior or activities in reference to their membership as ambulance attendants, but the observations were useful in other ways. The stories that got told were particularly interesting, for the differences from versions recounted earlier in the block, for their delivery, and for the reactions of other attendants. My observations of these occasions were written down after the events, unlike the typical procedure outlined below.

Writing in the field

I utilized a small spiral notebook to write down observations and thoughts while in the field. Initially, my writing occurred back at the station when our crew returned from a call. This technique worked for part of the time, but in busy times we often did not get the opportunity to return to the station until four or five calls had been done. This was obviously problematic as there was so much detail to remember, and the calls meshed into one another. The attendants themselves were not much help on this count as they often could not remember what type of a call they had just done. To offset this problem, I began taking the notebook along on the calls, and storing it in the clipboard pocket or on one of the shelves in the ambulance while on scene. This approach worked very well as I was able to take notes en route to the next call or while 'cruising' without being obtrusive. The seat where the 'third' rides was behind the line of view of the attendants in the front seat, and therefore was perfect for recording conversations virtually as they were occurring. Sometimes, when the crew would stay at the hospital for a prolonged period of time, I was also able to return to the vehicle to write, and in some

cases, take the notebook into the hospital to record the goings-on. At the end of each shift I would return home and transcribe my field notes onto the computer in an elaborated form. While my memory of the day was still fresh I would write down every observation, description and memory of the calls, the people, the comments, and the conversations. On a couple of occasions the field notes were blurred or too scribbled to read. In those cases I filled in the gaps as best as I could. In total, I made over three hundred pages of field notes, which represented one hundred and seventy-five hours in the field: scheduled shift time, overtime hours, and social time after shift.

For the most part, my note-taking was either not noticed or regarded as unimportant by members. While writing at the station or in the proximity of attendants, I adopted the stance of being very involved in my notes rather than appearing to be listening to the conversation at hand. In this manner I was able to record conversations almost verbatim without the attendants knowing. For example, if my name was brought up in conversation to 'check' to see if I was listening, I would pretend not to hear until the second comment, then look around with a 'huh?". When asked directly if I was recording the conversation I would usually make a joke or be sarcastic, "what exactly do you think you guys are saying that is important enough to write down?". The latter tactic worked every time it was used, and usually offset any other questions. When asked the subject of what was currently being written, I would usually reply "my impressions of yesterday". This response worked well to dissuade any further questions as the attendants seemed to be interested in what was going on today rather than what had been done yesterday. I always stopped writing when questioned and engaged conversations when addressed, in order to demonstrate to the attendants that what I had been writing really wasn't that important, and that I was more interested in the attendants themselves.

However, there were some instances where the taking of notes was specifically 'noticed'. At station #1 I met with a problematic member who was somewhat 'devalued' by his co-workers because he was a "real union man". This individual asked "Arnold" on

a number of occasions what his relationship to me was, and why I was there. In Arnold's estimation, this individual thought I was a 'management spy'. For the duration of field work this individual did not participate in any conversations in my presence. When I was at his station, he conspicuously spent most of his time reading in another room. Arnold thought this turn of events was great fun, and regaled many other attendants with stories of the situation. The tellings were always met with snickers of approval and heads shaking about the 'paranoia that exists'. So while I definitely disrupted the scene, at least for a few of the members, those very disruptions were smoothly re-integrated into the scene by most of the others. The very suspicions of a few were redirected so that the acceptance of the researcher was actually significantly increased. In other words, these disruptive events were accommodated by other members by means which maintained and even augmented my rapport with them.

The Problem of Maintaining Rapport

A persistent concern of overt participant observation is the establishment and maintenance of rapport with informants. To address this problem I did several things. Firstly, as mentioned above, I selected crew members with whom I had previously established rapport. These attendants would vouch for me. Secondly, I had some knowledge of "what to do" in the case of accident or illness, through my experience in first aid and CPR. Thirdly, I had some prior knowledge of the workings of the ambulance service studied through the above-mentioned 'ride along' and conversations with attendants—in a more general sense than the strictly medical one, I had a sense of what to do and what not to do. Finally, although I informed the attendants about my work, I was also able to use my previous background to seem just as interested in learning the work aspect of the job, which was the usual reason that people 'normally' rode third. I was able to switch back and forth between these two roles so the line between them became blurred.

A different contribution to rapport came about because the attendants saw me as an educated person who was a 'new ear' to listen to their opinions on the 'problems of the ambulance service and management' and other issues.

Several developments in the field also added to my successful development of rapport with the members. Firstly, Arnold, the first crew member I was to ride with, was assigned a very senior paramedic for the first day of my riding. This paramedic, Dylan, took an immediate interest in my project when briefed, and was fully supportive for the duration of the field stay. He would tell me stories that he thought would be of interest and related bits of history about the service, and gave me access to situations that I would have otherwise been excluded from. This reception by a central and distinguished member helped tremendously with the my acceptance by other members. For example, at the hospital, between calls, members would talk about past calls, issues of current interest, and general gossip. When embarking on the latter topic attendants would sometimes pause and look at me, at which point Dylan would intervene with a pointed, 'go ahead' or a simple nod and smile.

As with Dylan, a link to full-time, respected members of the scene helped with the other crew members' acceptance of me; just as Bill Whyte was brought in to the scene by Doc and therefore accepted, (Whyte 1920) and therefore was "O.K.". Further, this acceptance carried over to the scene of accidents and incidents with respect to other Emergency Services Personnel, such as police and firefighters.

An illustration of the rapport the researcher achieved was given by cases of 'devalued colleagues'. Beyond gossip, there were a number of members who crew members truly did not want to work with because of their personalities or lack of job skills. On several occasions I was brought into conversations about these individuals - before, during and after a shift with them. In these situations I was issued warnings and advice about dealings with certain individuals:

"Stay away from this guy Nikki, he has so many complaints against him with the women's committee, it's not even funny." (Luke)

"This guy's a real jerk." (Dylan)

"This guy's an MO."[8] (Arnold)

I was also asked opinion questions about an aspect of their performance or personality:

"How were the nights with the MO?" (Lewis)

"So how was Freddie's call?" (Tom)

And I was included as a possible solution to the problem:

"I'm attending, she's driving." (Arnold)

"We'll use her notes to get him." (Lewis)

A final note on rapport is the observation that many of the attendants worked with seemed to like having me around. As has been the case with many other researchers, Stoddart (1993), Zimmerman (1966: 386), members came to regard me as 'their sociologist' and quite enjoyed the attention the study offered. A small validation of this was the sincere invitations to return to the field 'at any time' and the offer that I would always be welcome.

Another similar instance was the *talk of* peoples' reactions to me. On several occasions the crew members seemed to enjoy having me as an observer, as I was something of an anomaly. Police, fire, hospital staff, other attendants and even patients all "wanted to know who the third is". A third was something of an attraction when s/he was not a 'rookie' it seemed, and some attendants seemed to revel in the possession of one. As mentioned above, some felt special to be the subjects of study, and they went out of their way to make comments about the research to others. For instance, Arnold was of the opinion that another attendant, Freddie, who was disparaged as an "MO", would be very paranoid about having me around. Arnold said that Freddie would be convinced that

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[8] "MO" was a derisory slang acronym for Mental Outpatient.

management had sent me to investigate his work performance, after receiving some complaints.

To illustrate Freddie's perceived paranoia, Arnold played tricks on him at the first opportunity he had. When some ambulance supervisors came to visit the station, Arnold went rushing out of the living area into the ambulance bay, as if something was up with the supervisors. Freddie looked around the room, then jumped up and quickly followed Arnold through the door, with enough lag time to miss Arnold re-entering the room through the other door. Freddie was then caught and engaged in conversation with the supervisors, something that he apparently dreaded. Arnold thought this was great fun and that it served as 'proof' that paranoia existed in Freddie.

My acceptance in the field was supported by members' actions towards me. There were several instances where my opinion was sought by attendants, which implied that they valued my opinion in some way, or at least saw me as an acceptable sounding board for rhetorical questions.

When riding third with an ALS crew, one of the attendants, Dylan, had been very supportive of my project. He often interjected with useful observations, stories, and comments. After a call I was assisting him to clean up the ambulance while we were waiting for his partner to return from the hospital. He told me that he was due to participate in a panel discussion on the topic of 'ambulance interaction with hospital staff' at the end of the month, and would appreciate any comments or observations I had. I took this conversation to, in a small way, support my successful integration.

The reflexive question that was often put to me, by Dylan and several others, was "How am I doing" or "How are we doing", while on a call. I would sometimes make a comment when appropriate, such as when I thought the patient needed another blanket, or needed further clean-up. These were always taken note of and I really felt as though I was part of a team.

Finally, the various warnings I received from some crew members about the sanity of two others led me to believe that I was accepted and trusted—and protected—by these crews.

As further 'proof' of my acceptance by members, there were several instances daily where my assistance was enlisted for tasks or provision of emergency aid. As in the research of Stoddart (1986) my role could be seen as fitting into the category of 'Disattending: erosion of visibility by display of symbolic attachment' (110-111). As in the case of Sudnow (1967) assisting the morgue attendant to transfer a dead patient in the hopes of reducing his feeling of 'being observed' (in Stoddart, *ibid.*), my participation in the scene can be argued as parallel. Mundane examples are when I assisted with the provision of medical oxygen, and in some cases, put it on the patient alone transferring the in-car oxygen to portable for transport, and back again once in the hospital.

Slightly more knowledgeable examples include my having assisted in 'doing chemstrips' on scene which involved taking a sample of the patients' blood and putting it on a litmus type paper to determine the blood sugar level, as per the scale listed on the box. I also started and stopped the heart monitor machine for the ALS crew, and ripped off read-outs at the appropriate time. I carried IV's at the right height, assisted with lifts and carries, gathered patients' belongings, assisted nurses with transfers on to beds and the changing of patients, and other related hospital duties.

More involved examples include one occasion at a Motor Vehicle Accident (MVA), when I was assigned my own patient until another crew could be freed up from a more serious patient. At another MVA an attendant told me I could 'take over' in splinting a broken ankle with a pillow splint. Further, when acting as second crew member on the Airevacs I participated in, I was enlisted to assist in the administration of narcotics, the suctioning of fluids from a patients' airway, and the ventilation of a patient through use of a 'bag and mask'. On these occasions I was also made responsible for obtaining the required equipment to accompany our crew on the helicopter or plane. I

was sent to get physician instructions, notify nurses of changes in conditions or requirements, and the like.

Finally, a note of 'proof' of acceptance at the scene was the periodic treatment of me as though I were a 'third' trying to learn the 'tricks of the trade'. For example, on a number of occasions an attendant would explain a piece of equipment or technique, using language that only those with training in the field would understand. Further, attendants would take the time to show me 'their way' of a completing a task such as taking a blood pressure, or another 'trick'. Finally, a number of members would 'quiz' me as to my knowledge during or after a call, asking me questions as to what I thought was wrong with the patient. This, I feel, was proof of my role as a novice in the field, and thus, successfully integrated.

In summary, I achieved some degree of success in gaining access to the everyday activities performed in the setting. This ethnography can be seen as 'adequate' in the sense outlined by Stoddart (1986) for the following reasons. Firstly, I was able to portray the scene of ambulance work with minimal interference by my presence as a researcher, evidenced by the situations depicted above in my role as 'Disattending: erosion of visibility by symbolic attachment'. Secondly, that every attempt was made to understand the domain from the point of view of the members, avoiding the problem of 'ethnocentrism'. Thirdly, the data on the domain was gathered unobtrusively, through overheard conversations, comments, and direct, informed observation, and are therefore was not in danger of 'methodogenesis'. Finally, the majority of detail herein was provided by 'valued' and informed members of the domain, thus avoiding the possibility of 'unentitled informants' tainting the information gathered.

CHAPTER THREE

> "So what's a typical day?"
>
> "A typical day? A bunch of transfers wasting the taxpayers' time and money and endangering lives. Probably a van full of immigrants with neck pain, hopefully something decent like an OD or a diabetic."

A Day in the Life . . .

Every participant in an occupation has a sense of what is "normal" or routine for a workday. This chapter describes Emergency Medical Assistants' sense of the ordinary shift. As will be seen, the extraordinary reinforces the notion of usual.

A typical shift in the Vancouver stations studied involved the following routine. Attendants arrived for 'early relief' half an hour prior to the time their shift was due to start, which allowed the previous crew to avoid that 'last call' that would take them into overtime, if they so chose[9]. Permanent crew members had lockers in the station where various pieces of their uniforms were kept, and they generally supplemented this supply with items returning from the cleaners. They changed into their issue uniforms, consisting of white shirts with patches on each arm stating "British Columbia Ambulance Service", blue pants with a lighter blue piping down the side, and boots. Some members purchased their own black boots or high topped black shoes, while others wore the issued pair. Uniform additions included navy blue vests, navy blue sweaters with the same patches on the sleeve, and various jackets. All attendants wore a 'supply belt' or 'fanny pack', which generally contained a small penlight or flashlight, a pair of 'super scissors', gloves, oral airways[10], and a pen. Stethoscopes were either hanging from the belt, worn

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[9] Generally competition for overtime was not a problem, crews worked it out between themselves without difficulty.

[10] An appliance used in unconscious patient to ensure they have an 'adequate airway', that is, the position of their airway was allowing oxygen exchange voluntarily, or assisted by the attendants.

around the neck. or stored in the shirt pocket. Some attendants also wore baseball style hats with the ambulance service logo on the front.

Once dressed, the crew members generally gathered in the living area of the station and chat with the outgoing or incoming crews about the calls done over the past while, media coverage, topics of interest concerning the job, etc. Some read a newspaper or a book; others watched TV. At some point early in the shift the car (ambulance) was examined and re-stocked with supplies. The amount of oxygen in the tank was measured, and some crew members rearranged the order of items throughout the car to their liking. If the crew was an Advanced Life Support (ALS) unit, the drug kit was be examined, restocked, and brought on car as well. Once this job was complete the crews either relaxed and waited for a call at the station, or went out 'cruising' in the ambulance.

The decision as to who drove, and who attended on that shift depended on a number of factors. For a Basic Life Support (BLS) car, if the crew working together were regular partners, they each usually did one day and one night shift. If a partner of a regular crew was off because of illness, holiday, or recertification, it was generally the regular attendant who made the decision. For ALS car, if the regular crew member was off the replacement may not be qualified to ALS level, and the regular attendant may be forced to attend. This arrangement was not mandatory, but on calls involving advanced protocol the ALS member was ultimately responsible for the scene, and therefore may wish more control by being the attendant.[11]

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[11] The circumstance of having only one ALS member on car, whether for holiday, recertification, or "to spread the ability around", referred to as "de-pairing", was regarded as problematic in at least two ways. Firstly, as EMA's have no formal evaluation of skills or protocols save 'recertification' every two years, they need another ALS member to help them evaluate how they are doing. The nature of the business is such that 'every case is different' as all human beings are different, and ALS members studied preferred to have the 'back-up' of another brain trained to the same level. Secondly, it necessitates the ALS member to be the 'attendant' at every scene requiring those skills, and does not allow the preferred alternation of driving and attending. "De-pairing" also leaves the ALS member 'in charge' at every scene, and ultimately responsible for everything that goes on while on car. Such one-sided responsibility was regarded as stressful by ALS members, and did not give them the opportunity to 'relax' as the driver. This issue is of serious concern for ALS members encountered while in the field.

The person who was attending generally was responsible for the set up or re-stocking of the car, or at least they had adopted this role to ensure supplies were adequate and in a suitable order within the car. The person who drove was responsible for radio or telephone communication with dispatch, and he or she was the one responsible for getting the crew to the address given.

Calls were received at the station via the 'hotline' (telephone reserved exclusively for the purpose of incoming call notification), or by radio either in the ambulance or on a hand held model. The procedure for receiving a call by telephone was to answer the telephone stating the number of the station called, then listening for the information on the call. Slips of paper were used to write the address of the call, or some attendants used a small book to record such detail. A typical telephone exchange is featured below, based on overheard conversations of both dispatch and crew members.

"Ring, ring."
"Station 42." (Crew)
"O.K." (Crew)
"Code 3[12] to 3917 Heather Street for a fall, response number is 123456." (Dispatch)
Crew member hung up last.

or

"Ring, ring."
"42." (Crew)
"Routine to Shaughnessy, 4th floor, ward E2 for a transfer to the helipad. Response number is 123457." (Dispatch)
"Helipad at Grace or the airport?" (Crew)
"Grace." (Dispatch)

Crew hung up last.

Information transfer on air by radio followed the standard procedures for radio communication. Dispatch initiated the call to the car in question, as follows below.

"42 Alpha." (dispatch)

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[12] All codes and uncommon terms are explained in the glossary and appendix.

"42 Alpha go ahead." (crew)
"42 Alpha Code 3 for a collapse to #201-1040 West Broadway, no ALS at this time. Your response number is 23456." (Dispatch)
"42 Alpha." (Crew)

Sometimes more communication was required at the scene, in which case the standard radio procedure was followed. Some cars were also equipped with cellular phones, which were used primarily to contact the emergency doctor on duty at the hospital the patient was being transported to, to let them know what was incoming, or in the case of a "Code 4"[13]. In all cases observed it was the attending member who spoke to the doctor on cellular, as they had the first hand information and knowledge.

Once a call has been dispatched, the crew then went about getting to the address. Sometimes a road map book was consulted to find the exact location of a street, or to confirm the best route to get there. As dispatched, calls were either "Code 2" (routine), meaning that the crew was to get there obeying all rules of the road including the speed limit, or "Code 3", meaning that both lights and sirens were used, the car was permitted to speed, to go through intersections following the approved procedures, and the like.

When en route in a Code 3 situation, the attendant helped the driver at intersections and tricky spots through the use of hand signals or verbal cues. Hand signals were important as the noise in the car was quite loud, and some attendants wore ear protection to combat it. Hand signals would be used in cases where the attendant had checked his or her side for oncoming traffic or motorist compliance, as an indicator that all was clear. The driver was responsible for sounding the horn when at intersections or when reminding a motorist to pull over, and did so very skillfully with the index finger while driving with two hands, or sometimes, one hand and a coffee.

An interesting phenomenon experienced was when the car got 'canceled' part way to a call going Code 3. This would happen if another car that was closer 'cleared'

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[13] A Code 4 is a 'suspected death' as it must be officially confirmed by a physician. Initial contact and request to stop resuscitation efforts was made by telephone, but the physician would verify the death in person once at the hospital.

(became available as the previous call was completed) its last call and was able to get there faster, or if the situation changed because of more information, etc. When a car was canceled the driver usually pulled over abruptly, shut off the lights and sirens, and attended to the dispatch call. It was generally the driver's job to speak to dispatch, but sometimes an attendant would speak on his or her behalf. Sometimes jokes were made about such a situation, sarcastic comments such as,

"Don't touch my radio."

or

"Hands off that radio."

When a cancellation occurred the car was usually re-assigned, as in the format below;

"44 Bravo 10-20?" (dispatch)
"44 Bravo Maple and 25th." (crew)
"44 Bravo cancel and *take instead* Code 3 to a collapse, 3421 Vine Street in Vancouver. Your response number is 34567." (dispatch)
"44 Bravo." (crew)

Crew members observed were consistently pleased with the cancellation of a call.

"44 Bravo, cancel." (dispatch
"44 Bravo." (crew)
"Excellent! A well timed mission." (Dylan)

and

"44 Bravo, routine to abdominal pain" (dispatch)
"Oh no, we're going to get it tonight!" (Dylan)
(A closer car cleared on the radio...)
"Come on, yes, yes!" (Jordan)
"42 Alpha, routine to abdominal pain." (dispatch)
"Some of your best work Mr. Smith, my favorite call, the one I don't have to go to!" (Dylan)

The exception to this enthusiastic response was for calls that "would have been good". For example, a MVA (motor vehicle accident) that many cars were being dispatched to

may have had the potential to be a 'good call'[14], and crew members were periodically observed to be disappointed if they did not get to attend such calls.

Upon arrival at dispatched calls, the driver parked the ambulance in such a position that the back doors would be accessible, and that the car was close to the destination. The attending crew got out and went to the scene immediately if it was a Code 3, and if it was more routine, paused to help carry equipment. The driver was responsible for getting the cot where required, and would get any other necessary equipment.

Once at the patient's side, the attending crew assessed the injury or illness, instructing the driver to get equipment readied, help with assessment, and the like. Depending on the patient, treatment of sorts may be given at the scene or the patient may be taken to the hospital more immediately. Central to a call was the completion of the "Form 2". This form was the official record of the call to a patient, and must be filled out in its entirety before the three copies were separated to protect the crew. Included on the form (see Appendix 4) were spots for personal information of the patient, the date, time and location of the call, the response number assigned by dispatch, the patient's age, past and present medical history , allergies and medications, his or her doctor's name and location, his or her current 'chief complaint'[15], the patient's respiratory rate and blood pressure reading, including pulse rate. The treatment provided was also recorded, which hospital (if any) the patient was transported to, and any additional information relevant to that particular call. For example, at the scene of an MVA the patient's license plate number was recorded, the type of car, and the responding police officer's badge number.

The completion of the form was not always done by the attending member, the other crew often filled it out along the way, or a 'third' such as myself may assist in some

[14] A 'good call' was cited by attendants in this study to include calls where the member was challenged, where the patient 'deserved' an ambulance, and where there was some excitement involved. See Chapter 4 for a more detailed examination of the subject.

[15] Crew members determined the 'chief complaint' by asking the question "What is bothering you the most right now?

areas of the form. Depending on the type of patient, the form may be almost complete by the time the crew and patient reach the hospital, or, if the patient was 'labour intensive' the form may be nearly blank. In busy areas paperwork was a concern to crew members as it was difficult to keep up with. In addition to Form 2, there were other documents to be filled out, depending on the type of patient. Some were formalities, for example, for a death, others were for current research, for example F.A.S.T. (). Doing paperwork soon after the call was important as members frequently could not remember what call they did last, let alone details of a call gone by several hours ago.

The destination for the patient was linked to the patient's medical history and doctor. Where possible, crews would transport the patient to the hospital where he or she had records or where his or her doctor worked, or both. If no records existed and the doctor was not local, the patient was usually asked which hospital he or she preferred to be taken to. Where the car was very close to a particular hospital, the patient would not always be given a choice. Once the hospital was decided dispatch was notified of the destination.

At the hospital, the attending crew presented the patient's case to the admitting desk, while the driver stood near the cot with the patient. Based on the type of patient, the admitting or 'triage'[16] nurse assigned a bed in emergency or sent the crew to the treatment room. In cases of a life-threatening nature, the crew would have radioed ahead to inform the hospital of the incoming, and the operating room may be readied for the impending arrival of the patient.

The crew then took the patient into the area assigned, and transferred him or her onto the hospital bed. The nursing staff usually assisted, but this was not found to be consistent across hospitals visited. The oxygen tank was then transferred from the portable unit from the ambulance to the wall unit, and the patient may be given an IV

[16] Triage refers to the prioritizing of patients requiring care. In hospitals studied there was generally one person assigned to this duty.

(intravenous) if he or she did not have one put in already (not all crews were certified to do this). The patient was also put into a hospital gown if he or she was in emergency. Some hospitals issued emergency bracelets for identification of the patient, others issued a plastic credit card.

When the patient was safely in the hospital bed, the crews' job was officially over. Once they completed any paperwork required, they were free to 'clear' (let it be known that they were free from the call) with dispatch, and be available for other calls. Crew members observed were often seen to prolong this step, and remain at the hospital for a number of reasons. The rationale given for this was that "they know where we are if they need us (dispatch)". Members were observed to remain at the hospital longer to "catch up on paperwork", to watch emergency staff at work to learn new information or skills, to socialize, and to avoid calls that they did not want to do.

In cases where the crew were loitering at the hospital it was shown that dispatch did indeed "know where to find them". Several times the crew was summoned by phone from the hospital "hotline" to return 'on air' (onto the radio inside the ambulance) to receive a call, or were given instructions to do a transfer[17] from a ward in that hospital.

"Doing calls" as illustrated above followed a routinized format across crews studied. Some shifts were, of course, busier or quieter than others, but the general format held. During night shift there were more attempts made to return to the station to attempt to sleep, but this generally did not become a concern until after 3 am or so, when the bar patrons had gone home and there would likely be "no more good calls" (as above).

Another important part of the crew's shift were their attempts to eat. Some crew members felt the attempts were followed by a 'Murphy's Law'; a crew could have no calls all shift but as soon as they wanted to eat they would get called away just as their number was about to be called at the deli. Such instances were often joked about, "Maybe we can

[17] A 'transfer' refers to the physical moving of a patient from one location to another. In the case of this ambulance service, the call generally meant the 'taxiing' of a stable patient from one hospital to another, from the hospital back home, or visa versa.

use our numbers when we get back". Other members were less understanding and commented as such, "Now this was what adds stress to our day, no time to get nourishment - back to back calls"[18]. Because of such time constraints, crews were observed to eat a great deal of 'fast food', that is, things that could be taken out quickly. Sit down restaurant meals were not attempted the entire time I was in the field, and rarely did I witness an attendant bring his or her own food in to the station. There were no guarantees that the crew would return to the station in proximity to meal time, so most elected to purchase food on the road.

At the station in between calls, crews were observed to do a number of things to occupy time. Activities observed were polishing boots, watching TV, reading, studying ambulance protocols, eating (often junk food from the 'pay as you pig[19]'), gossiping, telling jokes and stories, talking about calls, slamming management, to name a few. The time spent in the station was very informative as I overheard a variety of topics and opinions. Full-timers were always observed to be happy about a 'slow' day shift, and would jokingly reprimand the part-timers who said things like, "sure was slow today, I wonder when we will get a call?" It was a belief by full-timers that if one made mention of the slow day, a call would come in soon after.

On night shift the situation was a little different. In the busy downtown stations crews knew that they would be busy for a portion of the evening, usually the midnight to 3:30 am time slot. Because of this knowledge, crews 'stayed up' until this time slot was over, to save the irritating condition of being awoken by the phone. To stay up meant watching TV, reading, doing paper work for some, and 'cruising' the streets or seawall, sitting at a scenic location (e.g. Starbucks, Kits Beach) for others. The latter options of being out on the street seemed to be more popular on good weather nights,

[18] In the busy stations a crew's inability to obtain nourishment could be seen as detrimental as it was cited as adding stress to their day, 'making them feel rotten', and generally contributing to an already unhealthy lifestyle necessitated by shift work, fast food, and high stress work.

[19] Most stations had a 'candy store' arrangement that was on the honor system. It was commonly referred to as the "pay as you pig".

understandably. Further, this 'cruising' was regarded by some attendants as a possible way of getting a 'good call' - if they were in the vicinity of a busy area, something was likely to "go down", and they may be able to "horn in on the call".

In this chapter I have discussed a typical shift at the high call volume stations I participated in. Some aspects of 'crew culture' discussed have been similarly cited by Metz (1981) in his study of a U.S. ambulance service. Interesting parallels exist between this study and mine in the sense that some social aspects of ambulance work seem to be insensitive to locale-at least in North America. For example, story-telling at the station was viewed as serving the purpose of information transfer between crews with respect to obstacles (such as road construction) preventing crew from getting to a call (1981: 45). Metz also viewed stories as serving of entertainment or 'shock value', particularly for more senior members (*ibid.*). Likewise, derogatory comments and stories of management were also found to be popular amongst crews (*ibid.*). Finally, the universal habit of crews "stretching a run", that is, not 'clearing' with dispatch as soon as the crew is finished with the previous call was cited as 'routinely done'. Metz observed attendants as taking this extra time to obtain food most commonly, also a chief complaint of the attendants I studied.

Preferences for types of patients or calls is a subject that has been widely documented in the medical sociological literature, and was briefly alluded to here. The next chapter will address the topic in depth, bringing in some of the findings of other researchers in similar subject areas.

CHAPTER FOUR

> "A good call? One time I had one in this area where a guy had jumped in front of a train and had both his legs amputated--it was excellent. Way better than the usual shit--wanking MVA's and lower GI problems."

The sociological study of occupations has colored in a significant aspect of work that, despite its 'everyone knows that' nature, is useful for its comparative and generalizing properties. This feature is the perceived quality of duties associated with work, that is, the 'preferred' as opposed to the 'undesirable'. In the medical professions, such labeling is often reserved for the patients themselves, as they are the primary aspect that is beyond the actors' control (Jeffrey: 1979; Becker et al: 1961). However, actors employ strategies to exert control on outside influences toward an end that is 'preferable' in their estimation. Where such strategies cannot be employed or are not effective, it is nonetheless interesting to examine the dialogue around the subject, as will be discussed.

This research project is also concerned with how attendants regard patients, or rather, patients as part of the bigger 'call'. Found through participant observation and overheard conversations were the various categories treated below.

Characteristics of Calls

Ambulance attendants were frequently heard evaluating the calls that they received, talking about past calls, and wishing for future calls that would meet their criteria of being worthwhile. These discussions and comments are the essence of this chapter, that is, the social aspect of calls vs. the technical aspect of those same calls. Further, this treatment will include the evaluation of patients from this same 'social' point of view, and their resulting treatment. 'Regulars' encountered in the course of research will also be touched upon.

Good Calls

I was originally oriented to the attendant's definition of a 'good' and 'bad' call with the following excerpt from a conversation.

> "One you don't have to carry the person to the hospital and all that crap. A bad one is when you have to transport them and they are just whiners, like MVA's. A good scrap is O.K., you get to watch the fight and don't have to transport, it is bad if they get facial fractures, though. A good stab wound or gun shot where they aren't dead yet (is a good call)." (Luke)

Despite attendants' thirst for these 'good calls', they were aware that such 'cravings' would not be regarded as appropriate by all personnel. One night shift a group of paramedics from England were visiting with some ambulance supervisors. In conversation Arnold was asked what type of calls the station generally got, he responded,

> "Lots of heroin overdoses, AIDS related problems e.g. shortness of breath, etc., not too much pediatrics, some elderly falls, ped struck (pedestrian struck), elderly complaints, a *nice mix*." (Arnold)

When the English paramedic left I asked Arnold what a *real* nice mix was, he responded with the excerpt below,

> "Very little general weakness bullshit—lots of MI's (myocardial infarctions, heart attacks), stabs still alive, that's a good mix for me." (Arnold)

AIDS related problems, elderly complaints and falls are all 'general weakness bullshit' according to some attendants studied. Further, attendants were cited as liking pediatric calls because they got their skills and knowledge tested. At other times they claimed to hate calls involving children, which may indicate that it is seen as inappropriate to *like* such calls because they are treating children.

Further clues as to what constituted a 'good call' were available through stories told, comments made at the scene or following, and direct conversation.

> "Can't you guys (Police) find us something decent - give someone a throw-away knife or something." (Arnold)

"Well, we could shoot someone, but I wouldn't want to waste my bullets". (PC)

Good calls were identified by attendants as meeting certain criteria, as outlined below. Calls that were *challenging* in some way were regarded as good, that is that the attendants had their skills tested for a trauma call, or got to do 'protocols' (set procedures involving advanced equipment, drugs, or both). For example,

Wishing for good calls,

"These whiners are bullshit, I'm craving a good call." (Arnold)
"What would you like to get?" (me)
"Well, once in this area I got a good call, this guy jumped in front of a train and got both his legs amputated. It was great."

and

"41 Alpha, Code 3 for a fall #403 1121 West 40th" (Dispatch)
"Maybe she fell from suite 403 down to the first floor!" (Hugh)
"That would be excellent." (Junior)

and

"If that woman had pulled a couple more feet into the intersection that would have been a good call." (Arnold)
"Yeah, she would have been sitting in her son's lap." (Freddie)
"No, she would have been splattered all over the place and it would have been a great call!" (Arnold)

and

"52 Bravo, Main and Columbia for an OD" (Dispatch)
"Damn!" (Hugh on 41 Alpha)

Stories of good calls,

"Great block last at 46; 2 fatalities, delivered a kid, a stabbing and a shooting. That's a shit-hot block!" (Luke)

and

"Did you guys have any good calls yesterday?" (Hugh)
"Yeah, we got a suicide - full cardiac protocol[20]." (Bart)

and

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[20] Full cardiac protocol involved intubation of a patient, defibrulation, and drugs. Such a procedure took 45-60 minutes to complete, and involved the use of intravenous.

"Any good calls?" (Roy)
"Um, one MVA with triage." (me)
"Oh yeah! I heard about that one. How many fatalities?" (Roy)
"None at that one." (me)
"Oh." (looking disappointed) (Roy)

An extension of the above criteria without trauma would be a call that has *convenience* or *entertainment* value. For example,

"You get to watch the fight and don't have to transport." (Luke)

and

"44 Alpha, cancel." (Dispatch)
"Excellent, get to speed, then go to Starbucks." (Arnold)
"Now that was a well timed mission." (Dylan)

A call that got *canceled* was generally considered a 'good call' except when the call they were dispatched to was a good call. The latter rarely happened as such 'good calls' were observed to require more than one ambulance to attend. For example,

"May the word of the day be 'CANCEL'." (Tracey)

and

"My favorite kind of call, the one I don't have to go to." (Dylan)

Another phenomenon with respect to calls is that of the *'Code X'*. This code literally means 'do not transfer'. This was considered a favorable outcome by all crews observed, particularly in the case of a patient who was not seen to need an ambulance. Attendants were cited as liking to go to calls, do 'something', but not have to take the patient to the hospital.

"Fucking A, off to Starbucks we go, nice code X." (Arnold)

and

"Good call. Didn't have to pack him down the stairs, those are good calls. Get to do something, like diabetics[21], but you don't have to pack 'em down the stairs." (Bart)

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[21] Diabetic problems often involved a 'quick fix' solution of dextrose and fluids intravenously. Such a patient would be back to normal quickly, and may not need to go to the hospital.

A note about 'Code X' was that the terminology crept into their everyday vocabulary. I once overheard a phone conversation of Bart's where he was arranging to meet a friend at a bar. The conversation went as follows,

> "Let's go to Johnny B's then we'll *Code X* if there is nothing happening."

Similarly, a '*Code X dump*' is when a crew goes to a scene, and passes the transfer of the patient off to a more junior crew. For example,

> "Excellent! (in unison) Code X dump!" (Dylan and Jordan)

It should be noted that crews were in favor of transporting any patient who were seen to really need an ambulance (see below). For example, patients with heart problems, traumatic injuries, and those in respiratory failure were cited as requiring an ambulance, and crews were enthusiastic to see the call through to the hospital.

Another feature of a 'good call' was cited by attendants as being a call to someone who *really needed help.* Attendants were sympathetic to those who actually required emergency ambulatory service, as opposed to those who abused the system. For example,

> "That was a good call, he was a really unhealthy guy. I thought he was going to die right there when we sat him up." (Bart)

and

> "Good call, too bad we couldn't do anything for him. I thought we were going to be able to, he had an organized electrical impulse." (Dylan)

and

> "Did you hear that poor dear apologizing for bothering us? Yeah, that was a good call, he was having a heart attack while apologizing! (Hugh)

Calls may also achieve 'good call' status for their *story-telling* attributes. For example,

> "Have you heard the Black and Decker story? Well, this guy goes to visit his dad in his machine shop, and decides to kill himself by drilling himself through the head with a drill. The paramedics were able to keep him alive for an organ transplant - guess who got his liver? The Western Canada Sales Rep for Black and Decker." (Arnold)

and

> "Yeah we were bagging[22] this girl that jumped out of her 6th story apartment, she was so messed up that every time I did bagged her brain squirted out of her ears." (Hugh)

and

> "Went to this call, couple had been playing 'hide the soap' in the bath. She lost the soap in her 2001th body part". (Hugh)

and

> "Went to this mace call, I didn't want to transport because of the smell. Once I put a guy in a body bag and zipped it up so he wouldn't stink up the car...that didn't go over too well at the hospital." (Luke)

While call 'quality' was largely determined by chance and dispatch, attendants routinely employed strategies to help control the calls they do. One method was to go to an area where the potential for a good call was higher. For example,

> "Let's make our way speedily to Robson and Jervis, maybe we can horn in on a good call and if not, we can hit the Bread Garden for a hot chocolate." (Richard)

and

> "I think we'll cruise down toward the east side and see if we can pick up some of the action." (Arnold)

Another method was to drive slowly en route to a 'bad call' in the hopes that the crew would be canceled and re-dispatched to a Code 3 which had more potential. For example,

> "42 Alpha, routine for a lower GI problem." (dispatch) (the car noticeably slows down)
> "Let's go slow on this one, maybe we can catch a Code 3 out." (Hugh)

and

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[22] "Bagging someone" involves the use of a bag and mask apparatus which is used to ventilate a non-breathing patient.

"Let's back pedal on this one, I hate that place." (Richard)

and

"Throw out the anchor on this one, maybe we'll catch a Code 3." (Junior)

A final strategy referred to by attendants was the shifts worked. The time of day to get good calls was considered to be between 12 midnight and 3 am. These shifts were 'guaranteed' to host a good call or two, so one had to both work the shift and work with someone who was willing to stay for overtime if one was supposed to be off at midnight (Charlie shift). To this end, part-timers were cited as better partners as they needed the money associated with overtime. Full-timers were often more interested in being with their family when planned, etc.

> "Once the bars are closed, you might as well go home, no good calls." (Bart)

Bad Calls

I was oriented to the attendants' idea of a 'call that was not good' by their comments en route to a call, after a call, or in conversation. 'Bad' calls had a number of possible criteria that seemed to be universal across attendants studied. These criteria and names given by attendants to such calls will be outlined below.

The first feature of a bad call was a call involving a patient who was not seen to really need help by the ambulance. It was felt by attendants that many of such patients should be seeing their family doctor or going to a clinic for such problems. Attendants were seen to be irritated by such calls as they knew that if they were tied up with a 'bogus' patient, someone else in 'Code 3' condition may be having to wait, and possibly reducing their chances of survival. Such patients were referred to a 'whiners', 'wanks', or just 'bad calls'. For example,

> "This guy's a real *whiner*, he calls the ambulance regularly to check on his cast instead of going back to his doctor." (Tracey)

and

> "I'm getting sick of all this *wanking*, this lady needs home care daily, not an ambulance. If we go back my chat won't be as nice." (Arnold)

and

> "We had better get a decent call soon, I am sick of these sniveling MVA's who could drive to the doctor." (Lance)

Many patients of such calls were part of the category of 'regulars' to the ambulance service. Attendants often recognized the address given by dispatch because they had been there many times, or recognized the situation dispatched. For example,

> "42 Alpha routine to 900 Jervis for a hip problem" (dispatch) "Gabriella! The crazy German lady, Jesus Christ, I haven't seen her in a while, why don't we take this one?" (Arnold to Freddie)

and

> "42 Alpha, routine to a man-down in a wheelchair -public assist." (dispatch)
> "Fuck, I hate this prick." (Arnold)
> "Is this the old Indian guy that's all gibbled?" (Freddie)
> "Yeah, we're cheaper than a cab!" (Arnold)

A more obvious version of a call that should not be using the ambulance service was that of the following,

> "Yeah, Brutus the humanitarian did a big rescue the other day. This lady flagged down the ambulance because her dog was in respiratory failure. Brutus bagged the dog and gave it a shot of epi, what a waste." (Hugh)

Another type of call that was uniformly detested by ambulance personnel studied was the *transfer*. This call involved transporting a stable patient from hospital to hospital or hospital to home. Such calls were viewed as a waste of attendants' skills, and was a much debated subject in terms of a way to streamline the ambulance service (by contracting the service out) and save money[23]. It was perceived by attendants that dispatch 'picked' who was to do transfers for the day, based on some evaluative criteria of the crews' skills. For example,

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[23] This possible solution was cited as the $10 000 dollar question. It was the opinion of several attendants studied that patient's physicians could help save time by spending 2 minutes briefing the crew prior to the transfer to save them time on the form 2. Only once while I was in the field did I witness such a courtesy on a transfer in the lower mainland; the crew was most impressed by that physician.

> "If Tommy's (dispatch) on today hopefully Bravo can do all the transfers and we will do all the good calls." (Arnold)

Further, evidence of this is when crews teased one another about doing transfers, as if it were below them,

> "Look it's Alpha 42 doing a transfer!" (Junior) (Arnold turned around and gave our car a dark glare)
> "If looks could kill!" (Hugh)

Another feature of a bad call is one that involves *personal risk* to the attendants of some kind. Such situations could involve bugs or beasts,

> "I got a bad call one time, this guy was just crawling with lice. There was no way I was going to jeopardize myself or my ambulance, so I zipped him up in a body bag with just the O2 line hanging out. The emerg doctor wasn't impressed." (Luke)

and

> "Fuck, did you see the roaches in that place? I had to keep hopping around to keep 'em off me. I can handle bugs for about 20 minutes or so, but small rodents like mice, rats, etc., I'm out of there." (Junior)

Other situations would include risk to person in the way of injury,

> "Here's the nightmare call for you. I got called to the Convention Center once for back pain from a fall, it turned out to be the convention for Overeaters Anonymous of the U.S. Everyone in the room weighed over 300lbs and one of them had back pain and wanted to be lifted? What about me?!" (Arnold)

and

> "41 Alpha, Code 3 to Brandiz Hotel for shortness of breath."(Dispatch)
>
> "Fuck, I hate that place, the cot doesn't fit in the elevator so you end up packing them down the stairs. The last thing I need today with my back is to pack someone down the stairs." (John)

Finally, Arnold came out of the hospital from using the hotline to get a call,

> "This is not a good call. 17 year old girl seizing on Hastings, on LSD, puking all over the place. Probably some hooker with HIV. Everyone get your gloves on." (Arnold)

Another type of call that is considered undesirable by attendants observed is that of the unsuccessful SIDS (Sudden Infant Death Syndrome) case. Regular crews were generally at odds with any call involving children because they receive very little training on kids. There was a real contradiction in wishes with respect to calls with children, the same attendants were overheard saying that they "wish they could get some more experience with kids", and "I hate doing those calls, I never get enough to keep my skills up".

> "I wish I had more training, for fuck's sake...Larry had a SIDS on day shift, I hate those calls." (Luke)

From the story-telling side there were a few examples of 'calls from hell' overheard at the station or hospital after the fact. For example,

> "Here's a call from hell, 3 vans collide, one full of Ukrainians the other two are full of Chinese, none speak English." (Debbie)

and

> "We just did *the* call from hell. A psych patient who had slipped through the cracks for a couple of years, living in a house stacked to the rafters with shopping carts of garbage. The place was stacked so high we had to wade through it." (Lance)
> "What was medically wrong with him? (Me)
> "Well, when you've shit your pants for four days a better question is what isn't wrong with you."(Lance)
> "I hate calls like that, even though you are clean you feel like stuff is crawling all over you."(Tim)

A final example of 'bad' calls were those that were seen to take attendants away from their 'real' work, even if it was at no risk to the public. The most central example of this feature is the call where the attendants were seen as 'witness' to something, and would therefore be required to appear in court. Unlike the police, court time was not considered a bonus in terms of overtime, rather, it was considered to be 'inconvenient'. For example,

> "That guy was a ratbag, you can tell by his shoes. It doesn't matter one bit that he is a personal injury lawyer, he will be fighting with ICBC - that's what insurance companies are for."

"I guess we'll be getting a call for this one in court" (Freddie)
"Eh, we didn't see anything". (Arnold)

The above excerpt also brings to light a strategy employed by attendants to avoid such a call to duty in the statement 'we didn't see anything'. Another example of such a call is the 'union call'. On such calls the ambulance is called to verify the claim of the member of a union,

"42 Alpha, routine to the busloop for an assault" (dispatch)
"This is going to be a union call" - (mimicking) "I get the rest of the day off if I call an ambulance, don't I?" (Bart)
"Yeah, we'll be Code X'ing this one." (Arnold)

A Note on 'Regulars'

Attendants who had been working in a particular area for some time were aware of the category of patients referred to as 'regulars'. Regulars were those patients who used, and sometimes abused, the ambulance service on a regular basis. Such patients were recognizable by address, symptom, or situation, and were often referred to by name or other determining characteristic. These patients were treated differently when recognized, for their past history often pre-disposed their current condition. For example, one lady called the ambulance service on a regular basis to come and help her out of bed to go to the bathroom, or visa versa. She was considered hazardous to the rest of the general public as a crew was then 'tied up' and not able to respond to a sick or injured patient. This lady would be spoken to quite strictly regarding the proper use of an ambulance service (To go to the hospital), and such 'chats' would be passed on to other crews via radio so the 'ante' could be raised on visit number two or three.

Another example is that of a native male who drank ginseng regularly, and passed out on buses. He would be recognizable by his location and description, as the address is not relevant. Likewise, an elderly native male who uses a wheelchair was encountered by the service regularly as he often fell out of his chair from drinking. This call was

dispatched typically as a 'man down in a wheelchair', and was easily recognizable within the vicinity he was known to live. A further note on such a patient was the crew members' ability to remember what happened last time, and avoid unnecessary calls. Specifically, this patient was questioned as to whether he had his key to the elevator for his building, and was made to produce it for the member to see[24]. This check would ensure the service would not be receiving a call half an hour later for another 'public assist' call.

Another feature of knowledge of 'regulars' is in the diagnosing of the patient themselves. For example, one elderly German lady who was a regular of the service for falling down and hitting her head would be asked the question, "What year did you come to Canada in?". As the attendants knew the answer from previous calls her answer would speak to her level of consciousness and help them decide how valid her complaint was. Similarly, a 'regular' call from the same block would save time in history taking as they had done the same recently.

Other 'regulars' were not treated with such tolerance. There were several stories about street regulars that crews compared notes on and even refused 'to carry' (to the hospital). New members were oriented to such patients by these stories with comments such as, "There I was treating her like a human being and it was Christine". "What about that one with the Barbie dolls?", "I don't transport her - ever". "Ever? - Wow."

In this chapter I have discussed crews' preferences for call and patient type, the category of regulars, and have given some examples of the kind of situations encountered by attendants. Some topics herein are well documented in the sociological literature, and warrant some reference.

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[24] Crews were observed many times over to provide 'public assists' for people who did not have anything medically wrong with them. While such calls are an unfortunate use of an emergency medical service, it should be noted the 'social work' service provided by these crews. On a number of occasions crew members would 'lecture' regulars in a guiding way, for example, counseling the patient to check into a detox program, to remind pregnant females that 'booze and babies don't mix', and the like.

The topic of evaluation of patients parallels easily to the evaluation of calls with respect to ambulance attendants. The subject occupies a central place in the medical sociology literature, beginning with Martin's (1957) concern with preferences for types of patients among student physicians. In *Boys in White,* Becker, Hughes and Geer (1961) found through participant observation the evaluative category of "crock" patients, adding color to the previous bland survey research. Roth (1972; 1973) examined the 'moral evaluation' of clientele in the emergency room setting, as did Jeffrey (1979), who discovered the category of 'rubbish' to the literature. The "gomer phenomenon" was documented by Leiderman and Grisso (1985) in reference to frustrating patients in hospitals who were difficult to diagnose, were longer to return home, and the like.

Both Mannon (1981) and Metz (1981) did useful participant observation ambulance studies by going through the process of becoming an ambulance attendant. Their work outlined some of the perceptions of patients by ambulance attendants, framing this evaluation in terms of 'runs' made by the ambulance, and whether or not they were useful, or deserving. Palmer's (1983) work observing and interviewing ambulance attendants touched on this topic partially, but focused on the personality of the attendants themselves, and their obsession with 'trauma calls', labeling these workers 'trauma junkies'.

Another topic cited in the literature with parallels to my study was that of 'regulars'. Metz (1981) found the attendants he observed to find regulars "amusing because of their quirkiness" (1981: 120), as did some of the attendants I studied. However, both groups of attendants generally categorized such patients as "Shit Calls" in the case of Metz, and 'bad calls' in this project. The recognition of regulars by dispatchers and attendants due to address, situation, or symptom was also found to exist in each of the 1981 studies above.

How an attendant comes to understand the meanings of such terms as "good call", "bad call", "nightmare call", "union call", and later use them is an interesting topic in

itself. Such things are learned on the job by watching, listening, and learning from more senior attendants. The formal training an EMA receives in the classroom does not touch on such 'street knowledge', an attendant must learn through the informal 'apprenticeship'. The next chapter will outline other 'need to know' features of the business of working as an ambulance attendant, following this theme through.

CHAPTER FIVE

> "Those EMA II's from the interior can only dream about seeing the patients we get all the time down here. They are a liability for the first two years -- all they know is what they learned in the classroom. You don't know dick until you've worked downtown."

This chapter will examine activities observed in the field as displays of knowledge of the job of being an ambulance attendant, that is, the 'working rules' that one comes to know. Specifically, activities and actions will be examined in light of the category 'things I did not learn in EMA school.' Both the technical and the social aspects will be addressed.

An important preface to this treatment is the fact that the organization itself necessitates the transfer of the majority of these 'working rules.' When members are originally hired they have nothing more than an Industrial First Aid ticket, a drivers license, and perhaps some time 'riding third.' They are expected to perform calls based on experience they have not had, and training they have not yet received. Depending on call volume and who their partner is, the skill acquisition time period may be lengthy. It is not until these people have been working for some time[25] that they get the opportunity to attend an EMA I course, and even then much material is not covered.

The Basics

A newly hired attendant must quickly learn the basics of ambulance work. Understanding the schedule and shift patterns, finding the station, and knowing where to park are among the first challenges. Next is getting along with one's partner, and recognizing that all members are not perfect[26], ensuring the ambulance is stocked, noting where each piece of equipment goes in any given ambulance, and knowing the procedure

[25] The waiting period differs for each attendant depending on the region they have been hired in, their Unit Chief, their perceived skills, and the like. Attendants studied experienced a range of one weekend to a year and a half.

[26] For a complete treatment of this topic see Chapter 6 under 'devalued colleagues'.

for determining which member drives and which attends. Next would be the idiosyncrasies of the station itself - 'pay as you pig' (candy store on honor system), voluntary station fees ($0.50 per shift or $2.00 per block), entering and exiting the ambulance bay, phone line features (Call alert, multi-line phones, etc.), maintenance duties, in house research projects, and the geographical location of the station. The order in which a car takes a call also needs to be learned, as it may be different for each station or even each shift. Once an attendant has sorted out these basics, the actual 'doing of calls' can be attempted, and the working rules associated with them.

On Car

An interesting aspect of working 'on car' is being in the ambulance itself, and the freedom that affords. New attendants learn from others the various 'tricks' or methods to make the time between calls more advantageous, convenient, or less boring. Small things such as managing a coffee while driving Code 3 and honking the horn simultaneously are as much a result of practice as they are realizing that such activities are approved. An interesting example of 'tricks of the trade' would be the purchase of food. It is not possible for ambulance attendants to go to a sit-down restaurant and order a meal in the busy areas of town. Rather, they have to go for quick in and out food sources, and keep themselves available at all times by monitoring the portable radio and parking the ambulance in an accessible area. An accessible area is often an area where it is illegal to park, attendants justify this by the slogan "Red and white is always right". New members need to learn these justifications.

Another lesson to be learned is that of 'cruising.' Within the city stations researched, it was popular to spend some of the time in between calls in the car driving around the area they were responsible for, and in some cases, adjacent areas of interest. 'Cruising' past the hookers was recognized as 'mandatory' by crews studied when in that area, as was 'doing' 'The Square' or 'The Loop.' These two terms refer to a rectangular

route in the heart of the downtown core that included the popular Denman Street, Davie Street, and Robson Street. Visiting various Starbucks or other established coffee houses was also regarded as important by most crews studied, a new comer would have to be tolerant of such excursions. A similar activity that would need to be condoned by the new attendant would be 'doing the seawall.' This activity was done late on quiet nights and often took crews technically 'out of area', but was viewed as an entertaining and stress relieving 'thing to do.'

An important aspect of 'cruising' was knowing what to say when dispatch asked the car's '10-20' (location). One had to think quickly to answer with a suitable location that was both within the car's legitimate area and not too far away that a response time would appear off. Further to geographical locations was an in-depth knowledge of the area one is working in. The quickest routes possible must be identifiable quickly, as are possible obstacles the car may encounter, for example, road work, dead-end roads, and the like. Attendants had to be comfortable with street maps, and aware of their shortcomings. Maps were found to be incorrect or have confusing representations of streets while in the field, and the new attendant would need to be wary of that fact.

Doing Calls

The members' criteria of a 'good' and 'bad' call would also be important to a new attendant, as well as other call designations by members. For example, knowledge of the definition of a 'union call' or a call with U.S. citizens would be necessary, the former for a pre-warning for diagnosis, the latter to clue into the view by members that Americans are 'suit happy' and one should thus transport to hospital and treat for the worst even in the mildest cases. An additional important aspect of this knowledge would be the strategies employed to help control call assignment. (See chapter 3). Examples of the latter would include driving slowly to an undesired call in the hopes of 'catching a Code 3 out', taking

food to dispatch to ensure the crew is in good standing with them, and driving to an area of town with high likelihood of 'good call' volume.

Being on a call has a multitude of features that are required to be learned on scene by a new attendant. 'Street sense' is an important part of doing a call, advice such as how to approach a door safely, to trust no-one and believe everyone is trying to kill you, knowledge of which parts of the ambulance frame would stop bullets, and the like. Experience adds to this knowledge, stories are often passed down to new members of flying flower pots narrowly missing heads, knives running full speed out of an ajar apartment doors, etc. Learning to quickly survey a room for potential weapons or dangers is also prominent when working in 'bad' areas of town, as well as knowledge of how to dispose of any spotted weapons without escalating the situation. Similarly, attendants need to pick up on personal dangers such as bugs, either on the patient themselves, or in the room or site of the patient.

Another feature of the scene learned through 'apprenticeship' is preparing for the arrival of the ALS car. Crews may be required to delegate a fire department member to stand at the door to wait for the ALS crew, or may prop the door open by folding back the carpet. Where the elevator is required, attendants need to know how to 'lock it up' for the impending arrival of the other crew, and other such 'local' features of building and homes in their region.

The next aspect of doing a call with respect to learning the working rules would be the treatment of patients. New attendants would quickly be oriented to the fact that not all patients are treated equally, if they are treated at all. Here the stigma of social class is evident, those who live in the 'skids' are to be treated with a different set of 'working rules' than those residing in other areas of town. An alert for "knives, guns, bombs and bugs" were among the first concerns with such patients, falling into the category of "ensure no danger to oneself". However, it should be noted that all patients requiring emergency care were, of course, treated with the seriousness deserving of any

patient. Of note is the fact that many of a crew's 'serious calls' such as drug overdoses involved patients from bad areas of town. Regulars, that is, those individuals who routinely called the ambulance, were also treated differently than a 'stranger' patient. The 'regular's' past medical history influenced the way he or she will be currently treated, and new attendants would need to learn about such individuals where possible. The alternative could result in embarrassment to the 'rookie', some regular patients are capable of 'tricking' the unsuspecting attendant into a warm bed in emergency. Hospital staff and other crews would be quick to point out such an oversight, and rile the attendant in the future about the incident.

Another feature of the treatment of patients would be the 'handling' of patients that were obnoxious, mentally unstable, violent, under arrest, practitioners of illegal narcotics, or those who tried to sexually assault the attendant. While various attendants would handle such situations differently, the new recruit would be able to glean from observation and participation what types of strategies are employed, and thus accepted at some level. Bedside manner is another aspect of the treatment of patients that must be learned on the job - attendants learn what questions to ask from a medical point of view in EMA class, but nothing else. For example, the visual survey of a room may host all important clues as to the patients real medical problems. On one call a young man was thought to be a 'gentleman under strain' without any real problems because of the fact that he; 1)was unemployed; 2) had his own blood pressure cuff; and 3) had a number of books on Christianity around his room. The attendants guessed from these clues at the scene that there was probably nothing wrong with him other than his own sense of guilt at being unemployed[27]. Such skills of observation are again learned by experience on calls, and the observation of more experienced members.

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[27] In this case the patient was taken to hospital 'just to be safe', but the attendants perceptions were confirmed, there was nothing medically wrong with him at that time.

The phenomenon of the 'fatherly chat' is another feature of the work of ambulance attendants that is not taught in EMA school. A person who has just been revived from a heroin overdose, for example, may get a lecture from the attendants in private about the evils of the sellers of narcotics, the quality of the narcotic itself, or the deals they may have to make with God on the way to the hospital[28]. While such 'chats' are a very localized phenomenon, attendants working in that area of the city may be exposed to them and expected to perform similar tasks in the future. Another example of a recipient of a 'chat' would be an individual who abuses the services of the ambulance. This individual is not sick or injured, and does not need medical attention. They may be, however, lonely, making 'the chat' quite delicate. One must be firm yet offer alternatives to solve their problems such as homecare volunteers, a nursing home, or the family physician.

On the scene of a call there are a number of 'need to knows' that the new attendant must pick up. When obtaining a history about a patient, my field research showed it to be important not to fully trust fire fighters, family, homecare workers, or even nurses with the 'diagnosis' of the patient. On several occasions such individuals were found to impart incorrect and possibly detrimental information regarding the patient. Thus, the transfer of information must be taken 'with a grain of salt.'

Another aspect of doing a call that must be learned on the job is the enlistment of help from other emergency services personnel. For example, one must know how to recognize the Captain of a fire crew, and how to treat him[29] in order to facilitate the cooperation of his crew to complete tasks. Secondarily, an attendant must be aware that personnel such as fire may not always perform to standard, they need to be watched and corrected if necessary. On one call for an cardiac arrest, three different fire personnel

[28] As documented in Metz (1981), attendants were observed to 'harass' drunks or 'junkies' while attending them. Metz (119) cited observing attendants to 'confuse' drunks by pretending to arrive in an adjacent city, or by giving them such a rough ride they would be sick to their stomachs. In this study, attendants referred to 'making them repent to God for their sins' on the way to the hospital.

[29] At the time of this research, there were no female Fire Chiefs in British Columbia.

were observed to landmark[30] incorrectly for CPR. The attendants had to correct the placement.

On calls where a crew may be backing up the ALS car, a crew member must be familiar with the advanced crew's equipment and procedure, despite the fact that they are not taught it in the EMA I program, nor, often, are they supposed to perform such tasks. Examples would be setting up the 'leads' of the heart monitor, knowing the location and appearance of the 'pediatric kit' on the ALS vehicle, pressing the correct buttons for read outs to be produced on the monitoring equipment, and the like. One also needs to be aware of the practicalities of assisting ALS, for example, it was commonly held by some members that certain 'Airevac' flights required 'Gravol'[31] - the new attendant would need to be aware of this potential pitfall. The listed expected features of the scene are interesting as most cases involving ALS are time constrained, and there is virtually no time for instruction.[32]

To The Hospital

When preparing to transfer a patient to the hospital, once must also be aware of the family or friends present, how they are feeling and how they will get there. While the Ambulance Service does give general guidelines as to who may accompany the patient via ambulance and under what circumstances, it is sometimes necessary to bend the rules or at least investigate further. Crews were often heard telling friends and family to "'obey all laws and take your time getting there"', indicating that the crew was concerned about the mental state of these individuals, and their readiness to drive. Another situation that may arise is a case where the person that is injured or sick may be the only one in

[30] In cardio pulmonary resuscitation, a technique used to circulate oxygenated blood in a patient who is pulseless, the heel of the hand must be placed on the sternum two fingers above the zyphoid process (a piece of cartilage that could break off if compressed) to avoid further injury to the patient.

[31] A motion-sickness medication.

[32] Unstructured interviews with members revealed that at one time EMA 2 candidates received an "ALS Orientation" whereby a paramedic would go over the typical tasks that would be requested for performance, differences in equipment, and what not to do on the scene when aiding ALS. This practice has since been dropped, but would seem very valuable.

possession of a valid driver's license. In such a case, cabs need to be organized, friends called, and in some cases, the rules for transporting bent. Crews were also observed to ensure others did not have any underlying medical problems, such as heart conditions, that may manifest themselves because of the current strain of the situation. Such sensitivity must be learned from experience in the field.

Once at the hospital, there are several tasks that must be picked up if one is to "get along" with staff there and be regarded with respect. Firstly, the patient that the crew is delivering must be 'worthy' of the hospital, or the crew needs to have a very good explanation. Some hospitals refuse to admit patients unless they have a family physician based out of there, the new attendant must be aware of this potential obstacle. Further, some patients will not be admitted if their injury is not deemed an 'emergency' and the ward is very busy. The result of breaking these working rules was perceived by some attendants as the possibility that the nursing staff may not think twice about sending for a 'transfer', a most undesirable call from the ambulance members' point of view. Secondly, the crew must know how to assist the nursing staff, for such skills are not taught in the EMA program. Taking off patients' clothes and replacing them with a hospital gown, assisting with intravenous', and any other duties the hospital staff deem necessary are all 'need to knows.'

When finished a call at the hospital, the crew member must learn where to get equipment to clean up the ambulance, and the 'tricks' associated with that. One such example is the use of paper/plastic pillow cases as garbage bags. Such usage was observed universally with all crews studied, and yet it was not taught in an EMA course. Another feature of clean-up was the replacement of supplies. Seasoned attendants knew which hospitals one could get supplies such as linen, hard collars, triangular bandages and splints; and which ones one could not. This 'local' information was very important to the working relationship with the hospital staff, and the smooth efficient running of a shift on ambulance.

Other Features

In addition to the above 'need to knows' the new attendant must learn some skills and knowledge in the area of psychology. For example, in the event the patient dies on the scene, and the hospital is never reached, the attendant must be equipped to deal with the family or friends of the deceased. The EMA program does not touch upon the psychology of death, so attendants must learn this knowledge and skills from other attendants. Another example is that of a patient who has been sexually assaulted or raped. Attendants studied purported this to be 'the worst call a guy can get', and stated the benefits of having a female partner on such calls. The new male attendant would need to have the skills to deal with such a situation, given that a female attendant is not always on scene. A new female attendant would have to come to terms with the situation that may deeply affect her.

A final group of 'need to knows' for ambulance attendants is a variety of administrative and social features of the job of being an ambulance attendant. For example, one must know how to ask to have overtime paid out, know what percentage of pay one receives when off on sick time, and the like. One must also know how to fill out overtime forms, and under what circumstances they should be filled out. While this is clearly laid out in the union contract, the practical application of such 'rules' is often different. Further, one must be aware of the consequences of answers to research project questions that are active at each station. For example, if a question wants the attendant to state what the response time was to a call in an 'adequately staffed area', they may want to answer in such a way that it will appear that their area is understaffed.

Interaction with the media is another skill learned on the job. Often it is the Unit Chief who takes on the responsibility to train new attendants when the time comes, but this is most often reactionary. The wise recruit watches others on the news, paying close attention to the comments and reactions of more senior attendants. Finally, an attendant needs to get used to the "awful" shift patterns, complete with sleep deprivation, and the

strategies employed to offset this, such as the 'split night drinking fest.' The latter is reported to be a tradition within a busy platoon, to go out 'on a bender' so one is able to sleep the next day through, and ease better into the nights.

This chapter has outlined some of the skills and knowledge an ambulance attendant must quickly acquire in order to successfully complete the tasks associated with the job. While basic skills are taught to attendants through their formal training, the are part of an informal 'apprenticeship' period, and come about due to 'demand' rather than request examples. Many of these acquired skills are directly related to how one gets along with others at the scene, at the station, or while on car. The next chapter will elaborate on these relationships, and illustrate some of the 'street smarts' put into practice.

CHAPTER SIX

> "They're a fucking pain in the ass. If they did something that helped us out it would be OK like get the elevator, hold the door open, not park their fucking truck in front of the best access. All they do is slow us down."

It is generally held by lay persons that the three primary emergency service agencies, Police, Fire and Ambulance, work hand in hand to address any problem that may arise in the community, with a flair of teamwork, respect for each others' area of expertise, and with a similar commitment to helping others. Indeed, their dispatchers are centralized under the 911 umbrella, and they are often shown on scene by the media working together. However, the relationships between these agencies behind the scenes from the point of view of ambulance attendants is less than ideal in some cases, and in others - tenuous. The following chapter will elaborate on this theme from the side of ambulance personnel, based on "overheard" comments and stories, direct observations at accident/incident scenes, and informal interviewing and conversation. Of note is the 'local' nature of these comments and perceptions, they reflect only the areas covered by the ambulance crews in question, and may not be applied to the region more generally.

Firefighters

Throughout this field research, I came into contact with fire personnel at the scene 28 times. These encounters and later conversations make up the following information.

According to ambulance personnel, the provincial fire departments are funded based on the number of calls they do. With the decrease in fires because of building code improvements, and sprinkler and other preventative legislation, there are less fires to respond to and their role must change to adapt to the community needs.

> "The problem with the fire department is that they are a dying profession because of the improvements to building codes etc. They are trying to make a place for themselves in a society

that doesn't need them." (Dylan)

One direction they have taken is to be part of the "layered response" system of the Emergency Health Services in British Columbia, providing initial contact at the scene until the ambulance arrives. The proximity of fire personnel is usually better than that of ambulance, as there are many more fire stations than there are ambulance stations or ambulances. Because of these factors, their presence is justified, their statistics are sufficient for budget support, and they can help to serve the public. Despite the numerous calls responded to, the fire crews encountered in this research were, according to the ambulance personnel, not very well trained in first aid or resuscitation skills. Ambulance members attributed this to,

> "All their training is done in-house, they don't get the real critique they need." (Luke)

and

> "They (Vancouver Fire) refuse to take the First Responder course, so they rarely do correct CPR etc." (Richard)

And, at the station I commented post-call that two of the firemen's land marking for CPR was incorrect,

> "Yeah, that happens all the time. They teach each other bad habits."(Arnold)

Clues as to the ambulance perception of their relationship were evident in other comments made, fitting into categories listed below.

Ambulance personnel studied had the impression that the firemen (all were male in this study) were *in their way* and commented as such;

> "They are a fucking pain in the ass. If they did something that helped us it would be OK, like open the door, get the elevator ready, not park their fucking truck in front of the best access. All they do is slow us down." (Arnold)

"Of course the goddamn truck has to be blocking the alley." (Arnold)

"Bloody well in the way again, would be nice if we could get near the place."(Bart)

and

"If this truck would get out of my way maybe we could see an address." (Luke)

Firemen were also cited as *not doing the appropriate rescue measure* for the victim when the ambulance arrived on scene, one overheard discussion was in reference to the management proposal that fire personnel should get training in automatic defibrillation because they can get there faster;

"I kept track for three blocks straight. They backed us up 40 times, for ten of those they were there first on an AD (autodefib) situation, but six out of those ten times they had to be told to initiate CPR..."(Arnold)

Other comments overheard support the above perception by ambulance personnel;

"Can you re-landmark for CPR please?...No, like this." (Dylan)

"If that blonde Cylon[33] (fireman) gets into my ambulance one more time I am going to speak to his captain - that's 3 times this block." (Luke)

At the scene of an MVA a fireman asked me what training I had, when I told him he responded;

"Good, you take over, I don't know what I am doing."

Ambulance personnel studied also felt that firemen tried to *get out of helping* and 'slacked off' at the scene. For example, on one call for a cardiac patient in an older house with stairs that could not be negotiated with a cot the crew (ambulance) decided to do a

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[33] 'Cylons' are a robotic creature depicted in the popular science fiction movie *Battlestar Galactica.* The term was used to refer to fire fighters because of their 'mindless, robotic thoughts and actions'. This was not a positive light for fire fighters to be in.

chair lift out, and verbalized as such. The room had emptied of firemen, save the Captain. Arnold said;

> "Captain, could you get one of your guys back in here to help us get him out of here?"

Back in the ambulance Freddie said to Arnold,

> "Did you see the way those Cylons slunk out of there on the cue of 'lift'? That Captain is all right, but as if he should be doing the lift!" [34]

At the scene of a very bad motor vehicle accident a crew member was shouting instructions at bystanders and crews alike. He looked directly at a threesome of fire personnel and said,

> "Christ, don't all stand around at once! I need sandbags, the collar bag and a clamshell." (unknown crew member)

Further, at the scene of one cardiac arrest the CPR effort was stopped for a pulse check. The fireman who had been doing the compressions stood up and moved away. The paramedic looked around and said,

> "Resume CPR" (no-one returned to the chest)
> "RESUME CPR PLEASE!" (shouting toward the fireman) (Richard)

This failure to do resuscitation efforts seemed to be widely acknowledged by ambulance personnel, several times in conversation they would refer to what they have coined "*The Stare of Life*", whereby the fire personnel are seen to be staring at the victim instead of aiding them. This seemed to be a popular line of joking. For example, at the hospital

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[34] This statement opens up the whole issue of the treatment of 'rookies' and the hierarchy evidenced in the fire department, as is the case with many organizations. While interesting, I have purposely avoided this as a topic because of its magnitude.

between calls a patient in an emergency bed started thrashing around hysterically, his mother called out to the group of us who were talking, "will someone help instead of just staring!". Mark wheeled around away from her line of view and said to us,

> "We're giving him the 'stare of life' (doing a demonstration)."
>
> "No, (Lewis interjected) it is like this (does another)."
>
> "6 out of 10 times they had to be told to initiate CPR, they were doing the old 'stare of life' instead." (Arnold)

At the restaurant after shift, the table of ambulance personnel stood up and gave the fireman at the other table 'The Stare of Life', with one crew member standing on the table leading the effort.

Finally, as we were boarding the airevac helicopter, I commented on the name on the side, "Sound of Life". Dylan responded to me,

> "Yes, PR is everything these days, isn't it? Nothing like 'Stare of Life' I hope! (Laughs)

Firemen, their activities, equipment, and work ethic were frequently made fun of by ambulance personnel, at the station, at the hospital in between calls, and on social occasions after shift. This included name-calling, impersonations, and ideas of group mis-representation.

Fire fighters were often referred to as "Bucketheads" or "Squirters" for their ability to bring water to a scene, as well as "Cylons", as defined above. One comment made as we were driving on the seawall,

> "The Cylons can't make it around this corner, its excellent." (Freddie)

At the restaurant after a shift there was a recently hired fireman present at another table, the ambulance group chanted,

> "Cylon! Cylon! Cylon!; Buckethead! Buckethead! Buckethead!"

At the station stories were also told about 'Cylon mishaps',

> "Did you hear about the Surrey ambulance that crashed into the fire truck?" (laughter)
>
> "What about the brand new fire truck that got burned up because the fire overwhelmed it and it was parked too close?" (laughter)
>
> "In Kelowna, a volunteer buckethead drove right into a house on fire." (laughter)

At the hospital in between calls,

> "We're giving him the 'Stare of Life' instead."

The perception that fire personnel who worked night shift *did not like to be called out*, and thus were somewhat "wimpy" was also a common line of humor. This was in contrast to the ambulance members who thrived on the late night bar calls, and fast paced action of the streets after dark.

> "Cylons don't like to be woken up after they have tucked into bed at 10pm." (Bart)
>
> "They (fire crew) have been sleeping since 10pm (and therefore could not respond to a 'public assist' call)." (Freddie)

Dispatch assigned our car a call for a "walk-in man-down" at a fire hall, I asked how a man-down could be a walk-in,

> "Cylons get out of bed and are too disoriented to figure out how it could be a walk-in man-down." (Arnold)

At the scene of a suspected cardiac problem Luke joked to one of the fire personnel whose hair was standing on end,

> "Did we wake you up?"

Later, in the ambulance,

> "Did you see that Cylon hold the door open while sleeping?" (Luke)

Finally, in support of ambulance liking night shifts because of the "good calls";

> "I like night shift better, it is never boring and you get all the good calls".(Hugh)
>
> "Yeah, but once the bars are closed, you might as well go home, no good calls". (Arnold)

While 'cruising' Robson Street, Hugh and Junior discussed the upcoming "Viking Warrior Tour"[35] to Victoria (a group of ambulance personnel were going on a drinking trip to Victoria in between their day and night shifts) and suggested they get commemorative T-shirts made for the occasion,

> "We can get shirts with a Viking on the front with a beer, and Vancouver Fire Department on the back!" (Junior)
>
> "Yeah, that way when you end up puking in the bathroom like last time they will be horrified at the fire department, not ambulance." (Hugh)

At the restaurant, the waitress asked if the group was a stag, Martin replied,

> "No, we are just a bunch of firemen out for a beer after a hard days work."

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[35] Viking Warriors were a name the attendants used to refer to themselves in humor - it seemed to depict the heroic and street oriented aspect of their working personalities.

It seems that humor at the expense of the fire department was universal amongst crews studied, whether based on real-life examples or not. As humor was a big part of their day, this 'bashing' of the fire department seemed to serve a purpose in that it was enjoyed by all crews observed.

It should be noted here that in some instances the fire personnel worked hand in hand with the ambulance crews, particularly in the area of auto extrication, and stabilization of vehicles at the scene of a crash. Additionally, individuals and crews in some areas of the city were held in higher regard than the majority of 'local' crews.

> "Burnaby is excellent, they have taken the First Responder course - they gather the information we need when we immediately get to the scene." (Richard)

And , in reference to the fire department's Rescue Response Team,

> "They're all right. They have their IFA and are trained in auto extrication more than the ambulance guys, and they have rappelling training, etc." (Arnold)

As we pulled up to the scene of an MVA with fire already on scene,

> "Oh good, it's Foellmer. We'll get a history." (Hugh)

Captains were also regarded with more respect that his 'boys', and were seen as a vehicle to get 'the boys' doing what they should be.

> "Captain, could you get one of your guys back in here to help us get this guy out of here."

At the scene of a hanging the fire Captain had been upstairs with the wife of the victim talking to her while the resuscitation effort was going on downstairs. We met him on the way out after the victim had been declared "Code 4". The paramedics commented,

> "Good work Captain, that was a tough one, we could hear her screaming downstairs." (Francis)

Finally,

"The Captain is all right, but as if he should be doing the lift!"

As illustrated above, the behind-the-scenes regard for the fire department by the ambulance workers studied was not one of respect and admiration. On the contrary, fire personnel were implied to be lazy with respect to wanting to do calls at night, assisting with lifts at the scene, and the like. In a sense they were also implied to be uncaring or ignorant, as in the case of the 'stare of life' and neglect to begin early resuscitation efforts. While aspects of their experience were acknowledged as useful, for example auto extrication, the putting out of fires, and repelling; for the majority of calls they were regarded as "in the way", and not adding any quality of service to the scene. Further, this disdain has become a standardized scapegoat, offered up in the form of humor, name calling, and downright 'bashing'.

The relationship between the ambulance workers studied and the police, however, is much better than their 'squirter' counterparts, as evidenced by overheard comments and observations at the scene of interactions, and other references to the group.

Police

An overview of the relationship between police and ambulance can be characterized as appearing to be one of mutual respect on a professional level. Comments overheard would indicate that some ambulance workers thought that individual personalities of Police Constables (PC's) were questionable, but these opinions did not seem to mar their professional perception. Police/ambulance interaction was observed a total of 30 times. This section will elaborate the nature of those interactions.

Several comments overheard indicated that ambulance personnel felt PC's were "unstable". One observed situation was at the scene of a hanging, a female PC came on scene to gather the facts of the case. When told that the circumstances involved the wife of the victim coming home to find him 'swinging' she commented,

> "I don't know what I would do if I came home to find my husband like that - probably join him up there!"

At the hospital later that block a group of ambulance personnel were discussing the hanging, and commented about the female PC's comments being inappropriate,

> "There's nothing like a stable PC." (Luke)

Later still,

> "I still can't believe what that female PC said the other day." (shaking head)

Another situation involved several ambulance workers at a station telling a story about a co-worker who had gone to his ex-wife's home, she was a PC and evidently had a new boyfriend on the force. The estranged husband went into the house and into the bedroom and beat the boyfriend with a 'billyclub', which is a restricted weapon. At the completion of the story one paramedic commented,

> "That's PC's for you. Always getting in trouble between the sheets." (Martin)

This comment prompted other stories about PC's who were partners committing adultery with one another's wife, and the finding of badges between the sheets. One married ambulance worker shook his head saying,

"Those PC's are fucking warped, man." (Arnold)

Despite these comments and perceptions of Police, ambulance workers seemed to appreciate their presence at a scene, and therefore did not see the personality problems to get in the way of them doing their job. On scene, police were observed to do a variety of tasks such as traffic control, assessment of vehicles and the environment involved in MVA's, questioning of parties, arresting suspects, and the like. It would appear from the interactions observed and conversations overheard that these tasks were considered by ambulance personnel to be within the 'job description' of police and that they were relied on for that aspect of the call.

In contrast to the perception of fire personnel, police efforts on scene were appreciated and approved. Consider the following comment made after a drinking driving MVA,

"The guy was under arrest when we got there." (Arnold)

The above statement in context implied; 1) acknowledgment that the PC had done his job, i.e. made an arrest; 2) appreciation of the timeliness of the action by the PC, i.e. he was already under arrest in the short time it took the ambulance to arrive on scene Code 3; and, 3) approval that the driver in question deserved to be arrested for drinking and driving.

More evidence of this acceptance and appreciation was obvious in situations where the ambulance were instructed by dispatch to "wait for 5's"[36], in all cases the ambulance workers waited without complaint,

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[36] "5's" is the radio code for police, a command to 'wait for 5's' would advise the ambulance attendants to wait until the police arrive before entering the scene.

"If someone wants to take bullets instead of me, I'm all for it." (Junior)

"I'm for any measure that gets me home for dinner, if that includes waiting for the 5's, I'll wait."(Dylan)

The regard that the ambulance workers have for the PC's position (and their gun!) in terms of their own is evident in the above circumstances. Likewise, the police rely on the ambulance service to protect them with respect to injured suspects in custody. It is police protocol to have the ambulance see anyone in their custody that is bleeding or has another injury. However, on occasion the prisoner does not comply with the ambulance worker, and the police show their respect for ambulance by discontinuing this 'right' to medical attention. On one call, for example, Arnold was assessing a suspect's injuries out of the back of the 'paddy wagon' parked outside a local club. Freddie was chatting with the constables. The man started getting belligerent and verbally abusive to the attendant, the attendant said very loudly,

"Do you want me to treat your injury?" (Arnold)
"No, fuck off!" (patient)
"That's good enough for me." (Arnold)
"Patient refused." (PC)
"See you mates." (Arnold)

In the case above, the PC and the ambulance attendant reached consensus within the limits of their respective protocols, and both went away content with the situation.

Another example of cooperation is a case where the crew was called to the Salvation Army for a person who had been caught 'fixing' (using intravenous drugs). The police were called to address the law that had been broken, the ambulance to ensure the suspect would not die of an overdose in their custody. At this call, the suspect denied having 'fixed' today, claiming the last time was a few days ago. Arnold asked to see the man's arms, so the man halfheartedly pushed his sleeves up.

"All the way" (Arnold)

There was fresh blood and some track marks on the man's left arm, attempted to be concealed by his tattoos. Arnold sighed, looked at the PC, then at the patient and said,

> "Don't jerk me around. Do you have any chest pain?"
> "No" (patient)
> "So do you want an ambulance?" (Arnold)
> "No" (patient)
> (Loudly) "Those track marks are not from a few days ago. Code X folks, man refused." (Arnold)

The PC nodded in agreement and led the man to the squad car.

In the above case it was clear that the patient had done some sort of drug, but since he was denying any pain and refusing an ambulance the crew was able to "Code X". Again, the constable was able to agree because his line of protocol had been met - the form had been filled out by the ambulance.

The relationship between police and ambulance extends beyond the above 'protocol' instances, and further illustrates the understanding and 'courtesy' that exists between the two groups. For example, a routine call received for a man-down turned out to be a 'Band-Aid[37]' only, Bart got back in the car and said,

> "They just wanted alcohol foam and gloves - I restocked them, we can clear."

And, on the scene of an elderly man that was discovered dead in his apartment by friends (blue hands and decomposing body stench),

> "It would appear this man is dead" (Dylan)
> "Yeah, we thought he was dead, but we just wanted to make sure. Keeps it off our shoulders." (PC)

Further, late at night at the scene of a reported assault in progress the ambulance pulled up to the police car to locate the victim. The PC immediately said,

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[37] "Band-Aid" only was used to refer to a call that required nothing more than a band-aid.

"He's going to detox, then to jail. You guys see anyone else in your survey of the area?"(PC)
"No." (Freddie)
"See you , then." (PC)

This exchange is interesting because ambulances are not generally in the business of "surveying the area" and this occasion was no exception. However, in the name of speed, courtesy, or some unknown, Freddie was willing to back-up the PC's observation, and allow him to continue with his criminal to 'detox'.

Police were also observed to be aiding ambulance personnel to the end of 'less paperwork', or expediting a call. One call was to a bar for an assault. The assailant had left and the police were taking statements from the victim and witnesses. Arnold remarked to the PC that the injury would require stitches, the PC turned to the man's friend and suggested,

"You can run him up to St. Paul's, can't you?"

In this instance the PC was strongly suggesting that the man need not go by ambulance, and thus aiding the crew's favorite outcome, a Code X.

On the street, police and ambulance were constantly interacting as they both had the freedom to move about the area they cover, unlike the firemen who were more tied to their station until a call comes in. On one call to a Code 3 our car passed a paddy wagon, a patrol car, and 2 mountain bike patrol; all were waved at out the window. This was a common occurrence. It was also common for police to stop by various stations, particularly in the downtown core, to discuss the night's happenings, have coffee, and 'check in'. One nightshift, a patrol stopped by while everyone was sleeping, Arnold commented later,

"The cops came by for a visit while you guys were sleeping, I asked them about mace for you, Nicole. They said the best is called 'Cap Stun', and you can buy it at 3 Vets. You just have to register that you bought it for

> hiking in the alpine or whatever - no big deal - it isn't considered a restricted weapon unless you use it in an inappropriate fashion such as robbing a jewelry store."

The above 'advice' is interesting as it shows the police willingness to offer advice on such matters, but also how to get around the law, as it were.

Further, flexibility on the part of police and ambulance can be exemplified by the following two examples. After a call in the 'skids' (a highly trafficked area in the downtown core), the crew stayed to chat with the PC's involved. Mid conversation the PC's were dispatched to a call a few blocks away.

> "Will you guys back us up? Fight in progress." (PC)
> "You bet!" (Bart)

Bart then leapt into the ambulance and radioed to dispatch that our car was doing the call. This is outside of 'normal' ambulance protocol; dispatch is supposed to assign calls, not the other way around. Again, the crew were willing to go 'out on a limb' to back-up the police, whose work they saw as exciting and useful.

A more mundane example was at the scene of an MVA, when the patient requested to be taken to St. Paul's hospital. Sam asked me to inform the PC on scene of the destination, he groaned in response,

> "I don't want to go all the way down there, how about VGH?"

I went back to the ambulance and repeated his response, Hugh said,

> "VGH it is."

The above street interaction is another observed indicator of cooperation and appreciation. Further examples would include a case where our car was returning to quarters at the end of a shift. A patrol car came along side us to chat while in motion, the policeman asked what shift pattern we run, what calls we'd had during the night, and the like. When briefed on our shift pattern he responded,

> "That's not a shift, it's a tour of hell! You guys should get some sleep. Have a good one!"

Junior then said to Hugh,

> "What a great guy he is. He went to school in East Van so he knows all the scum bags personally, and they all hate him. He loves us!"

The above exchange shows the camaraderie on the street, as does the excerpt below;

> "Do you think you guys could come up with a decent patient? Maybe give someone a throw-away knife or something? (Bart)
> "Well, I could shoot someone, but I wouldn't want to waste any bullets. There might be a bad guy to shoot at later!" (PC)

Finally, at the scene of an MVA,

> "Hey Brad, we've been thanked twice this block for doing our job!" (Arnold)
> "Wow, they didn't want to beat you up?" (PC)
> "No! and...we did an excellent MVA yesterday and got to Code X." (Arnold)
> "Did you check out this one? So full of lust she ran a red light!" (Greta)
> "Such a job we have here. (PC)

Crews were also observed to do what would be considered 'police work', sometimes going outside their procedure as was the case with some crew members and domestic disputes,

> "You know, this force thing is really individual. What is right for me is to stay on the scene of a domestic until the police come, even if that is against procedure, so the woman doesn't continue getting whacked by her boyfriend. If I leave, she will...it would be wrong for me to leave, but that's not to say it is right for another guy." (Luke)

Another example of ambulance doing police work is in the assessment of patients at the scene of MVA's for the presence or absence of alcohol. While considered part of their primary assessment of a patient, ambulance crews were observed to pass this information on the PC's quickly so as to ensure further action could be taken. For example, at the

scene of an MVA Crew #1 came by to check on how I was doing with my patient. I commented that the man was drunk, Jordan responded,

> "Make sure the RC (RCMP) knows that soon - goddamn guy should be breathalized pronto."

A final example of police work done was in the case of a man who had a cardiac arrest and could not be revived. Procedure is that the police come to the scene to do the paperwork, wait for the body recovery service, and break the news to the family. In this situation, the RCMP had not arrived half an hour after resuscitation efforts had ceased, and the ambulance workers deemed this "too long to keep the family waiting". Luke volunteered to go to the home to speak to them instead of waiting any longer for the police.

This willingness to do police work further illustrates the working relationship between the two professions, especially the willingness of some ambulance crews to break protocol in support.

There were a few exceptions to the seemingly flawless teamwork illustrated above. The areas of the city that were covered by RCMP, as opposed to the city police, did not seem to have such a successful relationship. Attributed to less staffing per area and the line of authority in the ranks of RCMP, several instances were observed where the service from the RCMP was implied as being less than desirable. RCMP were cited as being too slow to get to a call, and un-empowered to make decisions. At the scene of a domestic assault, ambulance personnel elected to stay on scene to wait for the '5's' although it was outside their line of duty,

> "Here we are, stuck in a call for the 5's, and there is no cable (TV). Those goddamn RCMP" (Luke)

When the RCMP did show up 20 minutes later, Luke said to them briefly,

> "Husband (points to the chair), Wife (points to the bedroom). We're out of here".

This type of exchange is not very social nor particularly pleasant, and thus did not invite the type of camaraderie that existed in the city core. In another case the RCMP were very late getting to the scene of a man who had arrested and died. This necessitated the ambulance attendant to go and tell the family, as they had been kept waiting "too long". After the call Richard remarked,

> "We missed 2 Code 3's while you were talking to the wife, what's with these RC's?"

While turning around at the end of a street because of dispatch mis-guidance an RCMP patrol car flagged us down;

> "What are you guys doing?" (RCMP)
> "Just looking for Oxford." (Richard)

Richard rolled the window back up and Luke commented,

> "Fuck, they are all over you when you don't need 'em."

An investigation into the differences between the city police and the RCMP would serve to enhance the understanding of why one group is regarded more positively than the other; with each doing essentially the same job. However, this is not the task here, rather, the next section will explore the observed relationship between ambulance and hospital staff.

Ambulance interaction with hospital staff

Ambulance personnel interacted with various hospital staff on a regular basis throughout their day including admitting staff, nurses, and emergency room doctors. The character of these interactions will be elaborated below, prefaced by a discussion of the hospitals themselves.

There were several hospitals patronized during the course of research, two main 'city hospitals', a maternity hospital, a children's hospital, and several smaller hospitals, both public and private. Opinions varied as to which hospitals were 'good' and how the system worked; in fact, during the time of research there was a large controversy over a proposal to close one hospital down. Within the ambulance service there were supporters for both sides of the debate, indicating that agreement on even a 'health care issue' that affected them greatly was not necessarily possible. One side of the argument is summarized by the comments below,

> "The best thing they could do is put a nuclear device in the basement of that place." (Arnold)

> "It is ridiculous that public outcry should be able to overturn a decision based on fiscal facts." (Hugh)

Conversely, the other side of the argument had the following statements of support,

> "...as it is we have to wait 10-20 minutes for a bed, I sure wouldn't want to see Shaughnessy closed." (Luke)

and

> "Look at this place - it is stacked to the rafters and it is the critical care center for Trauma, Burns and psych for the Province of B.C. Imagine what it would be like if they nix 350 beds from Shaughnessy..." (Dylan)

Likewise, crews had opinions on which hospitals were 'good', and seemed to judge them by the staff that work there and the work they do with patients at that location. For example,

> "It's a good hospital despite the fact that it ends up with a lot of the 'skids'. (St. Paul's)

The statement above referred to less than desirable clientele that came to the hospital because of its proximity to 'skid-row'. Such patients were not well-liked by the crews in question (as treated in chapter 3) but in this case it was felt that there were enough other redeeming qualities to outweigh this portion of the clientele. Conversely,

> "I hate that place (Burnaby General), they won't admit a patient unless they have a doctor there. We end up jockeying around all over the place, not to mention how the patient feels." (Luke)

Above it is obvious that the crew member does not like the hospital because of the inconvenience for the crew, but also recognizes that the hospital is not very concerned with patient service. Another example of concern over the patient is,

> "VGH kills people on a regular basis because of their trauma center set-up. If they lived in Denver or L.A. they wouldn't be dead." (Arnold)

And,

> "Hospitals are not such bad places to have babies any more. They let you do what ever you want like get up and walk around, do it without drugs, watch TV, or whatever, they are really trying hard to make it better." (Dylan)

However, convenience was very important to crew members,

> "I really like this (Shaughnessy) hospital, I find it very comfy because of the close proximity of everything." (Jordan)

In this statement the attendant is referring to the availability of supplies for re-stocking the car, X-ray facilities, food services, and other 'one-stop' conveniences.

The main 'city hospitals' were more than just places to take patients needing emergency care, however. Hospitals were also seen as places to exchange job-related information, to check out the 'action' coming in for the shift, to learn new skills or information, to obtain supplies, and to gather for the purposes of socializing.

It was routinely observed that crews would gather in the ambulance bay area or in the hallway of the emergency ward and discuss patients they had had, problems with dispatch, union concerns, politics of the ambulance service, problematic members, and other job related information. These sessions served as learning opportunities for members, loosely falling into the category of "what I did not learn about in ambulance school".

The most common patient discussions were calls that did not fit the 'textbook' procedure or symptom. In these cases crews were observed to stay longer at the hospital to see what would happen, discuss the call, or learn a new procedure. For example, Sam went looking for Hugh in the ward and found him with another crew member in the trauma room watching as the doctors worked on a badly injured child. Sam asked,

> "What are you doing?"
> "Learning and socializing at once." (Hugh)

On another call I went into the ward to find our crew as it had been a very long time since we had delivered our patient. Two crews were standing in the ward discussing the patient.

> "What's up?" (I asked)
> "Apparently our patient is dying. It is a miracle he didn't crash in the ambulance." (Luke)

Further, Crew #2 came outside to the ambulance where I was helping to clean up and said,

> "You need to see this Nikki, the guys' X-rays are un-believable...no one can believe he can move his toes or legs, or feel anything below the waist." (Luke)

The above 'voluntary' examples of crews staying longer at the hospital were in contrast to situations were they were 'roped' in to staying. A common example was when the nurses asked the crew to assist in getting the patient out of their own clothes and into a hospital

gown. On one call, after a patient had been delivered to the emergency bed assigned, a nurse asked,

> "Could you help with her housecoat before you leave?"

Sam rolled his eyes at me and Hugh then went to assist the nurse. Later, in the ambulance, Sam mocked the nurse's request sarcastically and shook his head, implying that he did not appreciate being used in that capacity.

Crews were observed to monitor the hospitals' comings and goings by radio or 'drive-bys', for example, one quiet shift our ambulance stopped by the hospital to 'see who was in'. The number of the ambulance was looked at, then Arnold went inside to see where they were. He returned shortly to report that they "must be in ICU (Intensive Care Unit), they're not in emerg".

Crews also used the hospital as a place to gather and socialize, plan activities, and wait for calls. While in the field a 'road trip' to Victoria was being planned, and would often be discussed as the hospital. Similarly, the location of the 'split night drinking fest' would be organized and passed on at such gatherings in-between calls.

Finally, hospitals were places to replenish supplies, but crews were aware of the limitations and differences between hospitals on this count,

> "The staff at big hospitals are too busy to wine about us taking stuff, at the overstaffed hospitals they wine and snivel if we ever re-linen (make up the cot with their linen) or grab a hard collar, so we don't bother." (Arnold)

It was not clear in the course of research if ambulance attendants were officially 'supposed' to take supplies from the hospitals; it seemed to be an unwritten permitted activity. On more than one occasion a crew member seemed to be 'sneaking' into a storage cupboard to obtain a piece of equipment, that is, looking down the hall first to see if anyone was coming, shutting the door behind while in there, and exiting quickly to the

car with the desired item[38]. Other times, however, crews would openly request an item from the staff, and on one occasion at least, these staff would assist in getting the item.

> "David, we really need some triangular bandages, do you think you might find us a couple?" (Tom)
> "Oh, I don't know, I might be able to dig up one or two..." (David)

Other times the item was not available, and crews were forced to go elsewhere to find one. After doing a call for a child with a broken femur we went to St. Paul's' to find another 'sager splint' (a device used for creating traction on a broken bone). Jordan asked the nurse if there were any lying around, she replied,

> "No, sorry guys, you will have to go back and get the one you left at Children's when they are done with it."

Of note was the fact that the ambulance service itself does not own any flannel sheets, yet every car I rode in had several. Apparently the hospitals supply these on the 'Q and T'.

Hospital staff and their willingness to cooperate with ambulance attendants is part of a larger topic which will be treated next. Interactions and perceptions of nursing staff will be examined first, followed by a similar treatment of Medical Doctors.

Nursing Staff

There were two distinct types of nurses encountered in this research, the first were those working in the public hospitals, the second were those working in the private hospitals. Generally, the ambulance personnel studied had more respect for those nurses working in the public sector because their training, delivery of information, and evaluation of patients was regarded as more closely aligned with their own. Conversely, the private hospital and nursing home nurses were seen to be untrained, to have poor communication skills, and to care very little about the patients. For example on one call

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[38] In both Mannon (1981) and Metz' (1981) studies the "Five finger discount" was well documented and universal. While the intention of the attendants were identical between their studies and mine, to better help patients, the privatization of U.S. services makes their "borrowing" potentially more dangerous and morally questionable. The attendants in the U.S. were, in the strict sense, stealing.

to a private hospital an elderly woman had fallen in her room. When we arrived, no one at the front desk knew that an ambulance had been called or that there was an emergency. This was apparently a common occurrence in such establishments. After some calling around we were told to go to the 8th floor. A nurse pointed to the door of the room the woman was in, we found her lying on the floor with a pool of blood around her head. The nursing staff had just left her there alone. Dylan asked the nurse,

> "What sort of medical problems does Mrs. Trapp have?"
> "I not know, I only be here few years." (nurse)
> "What about heart conditions, can I see her chart?"

He looked at the chart and there was no indication as to any past or current heart problems. Interestingly enough, the electrocardiogram (ECG) indicated that not only had she had a heart attack at some point, but that she was currently on medications for that same problem. Such mistakes and miscommunication occurred frequently according to attendants studied,

> "Same old thing, the nurses have all been here for five years but know nothing. It's really sick seeing all these people living here without adequate care." (Luke)

And,

> "These pineapple princesses[39], they're all dumb, like a sack of shit." (Junior)

The observed interaction and overheard comments of ambulance attendants regarding the public hospital nursing staff can be generally grouped into; professional exchanges, humorous exchanges, and 'management'. Examples of these groupings will be elaborated on below.

Professional exchanges between nursing staff and ambulance were standardized because of the set-up of the hospital. Firstly, crews reported to the 'triage' desk where a

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[39] The name "Pineapple princess" was used in reference to the Philippino nurses found in private hospitals.

patient and symptomatic description were given. Based on this information the 'triage nurse' would decide the priority of the patient and assign a bed, send them to 'treatment', or ask them to wait in the lounge. The crew would then transport the patient to the assigned location, and give the same information to the nurses there. In the case of a 'Code 3' (urgent care required) patient, crews would most often call ahead to advise the hospital of the incoming patient, and the triage nurse would tell them a location as they came through the door. For example,

> "This is Marion. She has fallen and hit her head on a coffee table tonight, and was unconscious for a short time. She is on anti-depressives." (Junior)
> "Any heart problems?" (Nurse)
> "None known." (Junior)
> "O.K....bed number 8 is open." (Nurse)

Though the above interaction format is standardized, crews and nursing staff often added social or humorous content to the otherwise mundane procedure. Other information was exchanged at this time such as, niceties, complaints, changes in procedure, information regarding a difficult patient, and the like. An example of the latter follows,

> "This is Mr. -----. He is a jerk and he cut his hand in a bar brawl this afternoon. He doesn't know if he has had tetanus shots in the last 10 years, and he has a major attitude problem." (Arnold)
> "Right. Have him wait in the lounge." (Admitting nurse)

A notification of a change in procedure at the hospital led to a rather humorous exchange as we wheeled the patient down the hall into the emergency ward,

> "We have a new system for the forms around here." (Nurse)
> "Oh, is that right, do tell!" (Arnold)
> "Well, we will have a box for you guys to put your forms in." (N)
> "But we cannot break up our 3-part forms until they are complete - that won't work!" (Arnold)
> "Oh, I see (disappointed)." (Nurse)
> "Well, let's get back to this box, what kind of box is it? Will I fit into it? Is it like a coffin, does it have a door, will the light go on when you open the door?" (Arnold)

Further, a poorly communicated call for a Code 3 heart problem turned out to be a routine transfer for X-rays, the ALS crew member said to the nurse,

> "And what sort of medical problems does Mr. ----- have?" (Dylan)
> The nurse handed over a chart with 12 medical problems, Dylan responded, "Oh! We have 12 diagnoses, pick any 3 folks. Step right up and take a spin." (Dylan)

And, as we left another call Dylan joked to the nurse,

> "Oh my, (looking at a poster) when is the next carpet bowling session, or maybe a mystery drive! I'm coming!"

Finally, at the hospital Arnold and I help the nurse undress a young girl who had overdosed on a drug and had been throwing up and incontinent (she had feces all over her legs as we removed her jeans),

> "Now, is this the new grunge fashion? Am I missing out?" (Arnold)
> "(laughing)...this one is going to wake up in a diaper, I like them to wake up that way, it's humbling for them." (Nurse)

A final observation regarding nursing staff and ambulance interaction was attempts by ambulance crews to 'manage' the nursing staff, and visa versa. One interesting example was a dispatched call received at the station at 2:00 am for a transport to the home of a patient we had brought in earlier, Arnold seemed very irritated as we got into the ambulance and commented,

> "I think we need to have a chat with St. Paul's, we'll be Code X'ing this one." (Arnold)
> We arrived at the hospital and he told us to wait in the car, "I won't be long." He returned shortly saying it was a Code X. I asked him how he managed that? He replied,
>
> "Oh we had a chat, it's a TIA."
> "What's a TIA?"(me)
> "Trans-ischemic attack of the brain, Christine must have had one to think I would have fucking transported her (the patient)."
> "What do you say in a case like that?" (me)
> "Christine knows that if we transported Gabby I would have been up all night making it my personal business to bring in patients off the streets for

> her to take care of. We'll dig up old Roddy, he probably needs de-licing. 'Let's see, you have lice, you need de-licing, come with us to the nice warm hospital.' 'You are drunk, you need to be checked out for TIA's'. You have to do a round-up like that every 3 months to set them straight so they lose the transport ideas."

Hospital staff also tried to 'manage' ambulance workers to their advantage,

> "I heard that you are the head honcho around here, and I should talk to you if I want any supplies - I want some good scissors!" (David - nurse)
> "I'm working on it." (Roy)

Later,

> "David, we really need some triangular bandages - do you think you could find us a couple?" (Tom)
> "Oh, I don't know, I might be able to dig up one or two...what's happening with my good scissors?" (Nurse)

Further, much like ambulance staff tried to instill their way of thinking on the hospital staff with respect to 'transports' (above), nursing staff tried the same thing with respect to patients. For example,

> "This is Queenie, she is a diabetic, was unconscious and we revived her with dextrose. She didn't want to come here today." (Luke)
> "Well then, why didn't you listen to her then?" (Nurse, bitterly)
> "Well, she's 93, and we figured she has probably made enough decisions in her lifetime." (Luke)

And,

> "How are you today?" (Dylan)
> "I would be better if you guys didn't fill up all our beds with patients!" (Nurse, bitterly)
> "Well, this is Mrs. ----, she is experiencing a tachycardia..." (Dylan)

Overall, interactions with city hospital nursing staff were positive, with the exception of instances where the two groups goals were not aligned. Relations with the private hospital nurses were very strained and unproductive, and had negative effects on the patients in terms of service, and on the ambulance service in terms of lost or wasted person-power.

Doctors

Interactions with doctors were less frequent but still interesting. There were two types of doctors encountered in conversation and in the field; Emergency Room doctors and General Practitioners (GP's). Both groups were the subject of both positive and negative comments, however, generally the former group was held in higher esteem by ambulance attendants. The basis of these observations will be clarified below.

Attendants studied deemed a 'good' doctor to be one who assists them in completing their work i.e., who gives a history of the patients medical conditions, who treats them with respect, and who allows them to learn new procedures or skills. Conversely, a 'bad' doctor was one who made their job more difficult or lengthy by not providing a history or condition of the patient, who was disrespectful of them or their work by not listening to their comments or by speaking out against or questioning their actions, and who did not welcome them to observe for the purposes of learning. An example of the first instance of being a 'bad' doctor follows. One call turned out to be an older lady simply needing to be taken in for an X-ray. Junior commented,

> "Doctors don't think twice about calling an ambulance for anything, he was just here! He didn't even hang around to tell us what the history of the patient was, it would have taken him 2 minutes. The $10 000 question (how we could reduce expenses of the ambulance service drastically)."

Alternatively, 'good' doctors were those who passed on vital information resulting in an expedited call, and appreciative ambulance workers. For example, on one call we arrived at emergency with a patient and reported to the triage desk. The admitting nurse said,

> "Go right in to bed 11, his doctor called ahead with the information."
> "Wow, I'm impressed! Who was the doctor?" (Hugh)
> "Judy Kent." (Nurse)
> "Wow! I'm impressed." (Hugh)

Doctors who seemed disrespectful in some way were also not popular with attendants studied. For example, on a difficult call that should have been assigned to the

Infant Transport Team, our crew brought in a child that had been seizing. The doctor barely listened to Luke's history, and made comments such as,

> "Re-do those IV's." (Doctor)

The above statement implied that Luke had done substandard work with respect to putting some IV's into the child's arm. He had in fact done an excellent job, as was acknowledged by the nurse in his defense, "The IV is great!". A few minutes later the doctor looked around, sighed loudly and said,

> "Can we get the room cleared!"

Such a request denied the crew the opportunity to learn, and therefore pushed that doctor further into the realm of being 'bad'. Another example was a call with a 93 year old diabetic woman. The Crew had revived her in her home where she was found to be semi-conscious and non-verbal. Upon arrival at the hospital the emergency doctor on duty said that she wasn't diabetic at all, she was _____. Luke commented,

> "There's a conspiracy - I know it...that stupid doctor what's-his-name said she wasn't diabetic, yet she came around after getting dextrose - you explain that!" (Luke)

Later that shift,

> "I hope that jerk doctor is not on shift still." (Luke)

Finally, at the scene of a man who had hanged himself and was in cardiac arrest, the ALS crew member controlling the rescue effort called in to the emergency doctor on duty to request that the effort be stopped. The doctor on the phone asked what had been done for the patient, Dylan responded "protocol". She then asked what drugs had been given, Dylan seemed very irritated, frowning and told her. She agreed to stop the resuscitation effort, and Dylan thanked her, hung up the phone, shaking his head and still frowning. "Protocol' is a standard procedure involving standardized drugs - from the

members' point of view the doctor should not have needed to ask, and that paramedic found the question insulting.

In contrast were doctors that were appreciative of the crews' efforts, complementing them on the work they did, getting them to continue assisting once in the emergency ward, and the like. Such interactions were learning opportunities and positive re-enforcement for the crews, who get very little of the latter. An example was on a call for a 20 year old with a broken back, Luke had prepared blood samples, filled out the entire form, got two IV's in, and done two sets of vital signs. The doctor commented,

> "Excellent work! This helps us a lot. Do you want to help us get ready for X-ray?"

Further, when our crew brought in a transfer of a young girl from a MVA Dylan and I stayed in the Trauma Room and watched the rescue efforts. Periodically the doctor would ask Dylan questions about how the patient was found, and verbalize what he was doing. Whether this verbalization was intended as a learning opportunity for observers or to talk himself through the protocol, it was much appreciated and put the doctor in the category of 'good'.

A final example of what crews considered to be a 'good' doctor was in the case of agreement on the 'moral evaluation' of a patient. One story that was often told but that I did not observe directly was of a doctor that everyone liked at St. Vincent's Hospital. He apparently agreed with the attendants' view of MVA victims and their 'pseudo' neck injuries, he would routinely tell the patients to "get up, you are fine!". This story was met with great respect and approval whenever told.

The next section will deal with the peers of those studied, that is, other ambulance attendants. Treatment will include those with greater or lesser training or experience, those colleagues who were 'devalued' in some way, and general comments about their interactions.

Other ambulance attendants

Generally speaking, as with many other organizations, there were individuals that got along really well, others that didn't, and some that were just neutral. While these categories cannot be explicitly made with respect to criteria for each, it is useful to examine the conditions as they were presented by attendants and observed by the researcher.

Some attendants were friends, either through working together in the service, or from outside activities or interests. These people were entertaining to work with as they often joked back and forth more than others, making the mood very light. They also seemed to have a great deal of respect for one another, there weren't any comments made behind each other's back about quality of work, decisions made, or the like.

There were several reasons for attendants not liking another member gleaned from the scene. The first came about as a result of *the way they conducted themselves* at work. This category included members who were seen to have poor or dangerous skills, to be mentally unstable in some way, or to overstep their responsibilities. Examples of overheard comments regarding an individual's skills or abilities are as follows,

> "Watch out for 44 Bravo, I don't trust their driving." (Jordan)

and

> "Which of Lance and Tim are better trained?" (Me)
> "It's a toss up if either of them are, I wouldn't want to be one of their patients." (Luke)

and

> "Goddamn it Freddie, you know to bloody well get the Form ready with a patient like this - get out of my face next time!" (Dean)

and,

> "I hate working with 44 Bravo, those guys are just too intense at a scene." (Luke)

Another specific condition under which members were regarded as less than desirable to work with was the case of EMA's from the interior coming down to Vancouver to 'get calls'. These circumstances arose when an EMA II trainee had to

experience certain types of patients before he or she could proceed to the next block. It was felt by 'local' members that these individuals did not have the call volume experience, therefore making them less capable. Such individuals were also cited as 'taking too long' at the scene to 'get a history', load them into the ambulance, or other related features.

Examples of comments about patients who were thought to be 'unstable' in some way would include the following,

> "Freddie's an MO, the patients would be better off if you attend."(to me)

and,

> "Yeah, the car's a mess because this MO native guy that they can't get rid of was working last night. When I next see him we will have to have a little chat to see if I can get through to the remaining brain cells that you don't leave an ambulance in this condition." (Arnold)

and,

> "I refuse to work with her. She is an MO and has pulled a big scam by claiming sexual harassment by a member. Just avoid her like the plague." (Tom)

An example of overstepping ones' responsibilities at the scene is,

> "Did you see the way that little jerk argued with my oxygen request? And then he ran the IV all the way through! I think next time I see him we'll have to have the hands off and shut-up chat." (Luke)

The researcher directly observed members making *errors in the field*, both with patients and while driving. For example, "Freddie" was observed at least three times to go through a red light without doing the 'red light protocol'. Such errors can be highly dangerous obviously, both to the crew and to other motorists. Another example was when Sam repeated a 'primary and secondary survey' on a patient when his partner had already completed one and documented it. The error in this case was pointed out to him by a senior member. Another example with the same attendant was when he was attending a diabetic lady—he did not do a 'chemstrip' test for determining blood sugar level until his partner pulled the vial out of the jump kit and put it near the form he was filling out (this test would be a primary item to determine what was wrong with that type of patient). A final example was when he tried to put an oral airway into a conscious

patient. The patient was conscious but not talking, so Sam tried to insert an airway in her throat to make sure she was breathing (This would be very uncomfortable to a conscious patient).

The partners or co-workers on the same shift of the members in the situations above would sometimes make comments about the errors to me or to other attendants at the hospital or station. Other times they would just roll their eyes, make suggestions, or intervene completely. Behavior was never observed to be discussed or corrected in the above instances, they just went by.

Attendants also judged members by their *non-work related actions*. Overheard comments included,

> "The guy beat up his ex-wife's boyfriend with a restricted weapon, he definitely shouldn't be working." (Tracey)

and

> "Freddie is like 'Son of Sam'. He did a call with Steve and got into Karate stance after to go at him over some minor issue. The guy's a MO." (Sparky)

and

> "Bruce always wears a bullet proof vest. That really says something about a guy, you know - it says they are looking for trouble. I'll tell you, any signs of violence and I'm out of there. If Bruce is my partner we'll have to have a chat about limitations of responsibility." (Lewis)

A side note to this category was my experience of getting warned several times by different attendants not to let 'Sam' get near me as he was a problem around women,

> "The women's committee has so many complaints against him, it's not even funny." (Luke).

and

> "Stay away from that guy Nicole, he's a real asshole." (Dylan)

A final feature of 'devalued colleagues' is to do with 'part timers'. Part-timers in themselves are not devalued because of skill, attitude, or 'rookieness' necessarily, rather, it is the fact that they are filling in. The members that replace the regular attendants are referred to as *"Geek of the Week"*.

Dispatch

Dispatch for the B.C. Ambulance Service is centralized on the West side. Most staff working the switchboards are EMA's (Emergency Medical Attendant) and have worked 'on car' (on the street in an ambulance) in the past. Some dispatchers are full-time ambulance attendants who are able to work overtime shifts in dispatch when need be. All dispatch are trained in Emergency Telephone Instruction (ETI), which is used to instruct bystanders at the scene to initiate rescue attempts until the ambulance arrives. During the course of field research it became evident that some dispatch were liked more than others, based on a number of criteria. This theme of 'good' and 'bad' dispatch will be elaborated upon below, based on observations and overheard comments.

Dispatch in the Ambulance Service did not escape being the brunt of jokes, stories, and to serve as general release or 'bashing', as in the case of the firemen. In some cases the joking was not critical of the dispatchers' ability to dispatch, rather, their personal lives, personalities, and the like. In other cases it was a direct result of some aspect of their work, for example ambulance personnel were often heard telling stories about being 'burned by dispatch' so that other crew members would be wary.

One example of a frequently told story about a dispatch involving his personal life was the following. One dispatch was continually referred to as the "Mary Kay man" after the line of cosmetics. Evidently he was a homosexual who liked to wear make-up;

> "That's why they put him there (dispatch), so he can dress however he wants and not horrify the public." (Hugh)

Conversely, some stories involved things they did on the job, but were not seen as detrimental to their abilities necessarily;

> "This guy is hilarious. He is always telling us which way to go to a call, or asking specifically where we are. One time he said "hey, are you at McDonalds?", so we had to make fun of him - we said "we're in the south lane, facing the sun, I am in the passenger's seat, Science world can be seen, there is a blue car in front of us." (Sparky)

and

> "I once got a call from the guy (dispatch) for a "routine for a bleeding asshole". He doesn't give a shit, he's hilarious on air." (Arnold)

and

> "Yeah, I once got a call from him to go to Packard Street in Coquitlam. He said "that's Packard, like the car, of course you are too fucking wet behind the ears to know that", he's hilarious." (Junior)

Other stories had to do with some aspect of their work performance, for example two crews met at Burnaby General, one was coming in with a patient and remarked,

> "Routine for a short of breath!?" (rolled eyes at us) (Dana)

> "Yeah, we heard that when we were lost".[40] (Richard)

Another example was a story told at the station about a peer who had been involved in an MVA because of a Myocardial Infarction (MI - heart attack) at the wheel in the interior on a highway. Dispatch had refused to send an ALS car because there were already two BLS cars on scene,

> "They are going to hunt down that dispatcher - now the guys in ICU (intensive care unit) -couldn't have been a Vancouver dispatch. It sure is a drag when it is one of our own".(Luke)

A final example is a call received for a 'routine OD',

> "I've been burned too many times by this dispatch - you go there for a public assist routine, and its a full arrest and you have to whistle (drive Code 3) them into the hospital yelling at your partner down the stairs, "Get the defib!" (Hugh)

Dispatch was also overheard joking with crews on air or by telephone, sometimes at the expense of the crews. For example, one nightshift our crew wanted to go to the jail to visit a PC friend who was working. Hugh asked permission,

> "How do you feel about us going down to the jail to see someone?"
> "A relative?" (dispatch)
> "Ha, ha. No, a PC friend." (Hugh)

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[40] A short of breath call should be a Code 3 in all cases, and would require ALS back-up. To send a car "routine" to such a call would be unheard of.

Also, on day shift the power went out in the station one day, Hugh called dispatch to let them know what was happening. Dispatch replied,

"Go to A."(VGH, standby)
"OK." (Hugh)
"Just kidding." (dispatch)
"Oh." (Hugh)

Many statements by attendants on the job yielded clues as to which dispatch were 'good' and which were not. Generally, 'good' dispatch were those individuals who not only did was what was expected of them, i.e. ensured the safety of the crew, spoke clearly, made informed decisions, but also those who were humorous, dispatched 'good' calls to the crew in question, respected the crews' need to do other things i.e. eat, take 'mental health breaks', and go out of their area. Such individuals became well liked, indeed the crews often judged how their night will go depending on who was dispatching,

"Oh no, we're going to get it tonight!" (Jordan)

Crews appreciated those dispatchers who 'took care of them.' On one call to an assault we were instructed to 'wait for 5's' (police). Junior reported to dispatch that they were not on scene when we arrived, and said we would wait. The police then showed up and we proceeded inside to do the call without notifying dispatch again. A few minutes later the dispatch radioed on the portable to find out if we were all right;

"That's the best dispatch, he always keeps track of his crews." (Junior)

The above is in contrast to dispatchers that do not pay such close attention,

"41 Alpha 10-7 quarters." (Hugh announces we are at the station)
Pause
"41 Alpha 10-7 quarters." (Hugh repeats)
Pause
"That's the third time tonight he hasn't answered a quarters call[41]!" (Hugh)

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[41] A 'quarters call' is the transmission made to dispatch by the crew when they arrive back at the station. Dispatch is supposed to asknowledge that they received the transmission.

Further, some dispatch were well liked because of their humor on air;

> "Routine for a bleeding asshole. He doesn't give a shit, he's hilarious."

and

> "Meeting at the Bel Air tonight." [42](dispatch)
> "Ha! On air! this should be a good one." (Hugh)

and

> "Code 3 to UBC for a collapse." (dispatch)
> "52 Alpha cancel, Viking warriors retreat!"[43] (dispatch)
> "You village maiden." (Arnold)

The above examples are interesting as it is against radio protocol to use the system for anything other than work. Well-liked dispatchers often slipped a little something extra into their calls, as above. Further,

> "42 Alpha 10-7?" (dispatch)
> "42 Alpha Robson and Thurlow" (Dylan)
> "How's the Buck's?" (dispatch)
> "Yukon's very good today" (Dylan)

Arnold then remarked to Dylan,

> "If Tommy's on today hopefully Bravo can do all the transfers and we will do all the good calls."

Transfers were generally the most boring of calls and crews hoped to avoid them throughout their day. One advantage to having dispatch who also worked 'on car' was that they understood this factor of the job, and it seemed they favored those ambulance attendants who they knew or liked with the 'good calls', as implied above. This was in contrast to 'bad' dispatch,

> "Oh no, we'll be doing transfers all night and standing by all over the place." (Junior)
> "Yeah, he once had us stand by at Broadway and Cambie (about 4 blocks from their station), so we went 10-7 quarters on portable. It was hilarious, what an idiot." (Hugh)

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[42] The Bel Air Cafe is a restaurant near the downtown stations popular among attendants.

[43] The inside joke of Viking Warriors was carried throughout shifts in reference to power relationships. For example, "You small and weak junkie, me powerful drug lord", or "You village maiden, me Viking Warrior. It seemed to be a morale booster.

Another characteristic of a good dispatcher seemed to be one who recognized when a mistake was made,

> "41 Alpha, sorry about that call - that was the one with the language barrier - we didn't know what was going on.".
> "No problem." (Dylan)

In contrast were situations were mistakes were made but not reconciled,

> "44 Alpha routine to East 41st, collapse." (Dispatch)
> "44 Alpha cancel, take instead Code 3 to West 44th." (Dispatch)
> "44 Alpha cancel, take instead Code 3, East 41st." (Dispatch)
> "Fuck! Make up your mind, we're running out of gas!" (Jordan)

and

> "46 Alpha Code 3 for a cardiac $%#* Oxford."
> "46 Alpha, say again? (Richard)
> "46 Alpha 44*4 Oxford." (dispatch)
> "46 Alpha, say again? (Richard)
> "46 Alpha 4404 Oxford." (dispatch)

Our car drove around looking for the address for approximately eight minutes then Crew #1 said,

> "Fuck, I can't find it!"
> "46 Alpha, address please?" (Luke)
> "46 Alpha 2604 Oxford." (dispatch)
> "We're 4000!" (Luke)
> "Christ, I couldn't understand a thing from this guy." (Richard)

Dispatch who enabled the crews to 'get things done' i.e. get food, finish what they are doing, and the like were also popular, particularly when the call was 'routine' or the car was serving as back-up to another. For example,

> "41 Alpha 10-7." (dispatch)
> "41 Alpha Burrard and York." (Sam)
> "41 Alpha, routine when you are ready." (dispatch)

In the above instance the location given was the intersection closest to a popular deli and coffee shop. Dispatch knew where the crew was and what they were doing, and thus allowed them to proceed at their leisure. This is in contrast to the 'less considerate' ones,

"If it was just a transfer, they should have told us and we could have gotten lunch first." (Sam)

and

"44 Alpha/ 41 Bravo, Code 3 for a collapse." (dispatch)
"Doesn't that just frost you." (unknown crew)

Dispatch were also noted as unpopular for sending a crew other than the closest one to the call,

"Bravo is at least 25 blocks closer, what a jerk."(Junior)

And for questioning a crews' judgment at the scene,

"42 Alpha, man-down found in respiratory arrest, request ALS back-up and re-assignment of previous call." (Arnold)
"42 Alpha confirm respiratory arrest." (Dispatch)
"42 Alpha, I said he was (gruffly)." (Arnold)

And for dispatching the nature of the call 'unclearly',

"The way they dispatched that one I thought I was going to be looking at a fetus in a toilet bowl, damn it, she made me spill my coffee!"(Luke)

and

"A routine 'for a something' - are we supposed to guess?" (Jordan)
"Yeah, great (sarcastically)." (Dylan)

A final note related to dispatch is the crews' ability to 'manage' some dispatch, and their shift more generally. For example at the station on a quiet night Arnold was monitoring the portable radio to hear any action. Dispatch was heard to assigning a code 3 to another crew. Arnold quickly called in,

"42 Alpha, we're 10-7 quarters if you need us."
"Yes (pause), I was looking for you. Code 3 to the Salvation Army for an OD." (dispatch)
"Excellent!" (Arnold)

Another example is when the crew does not 'clear' (say they are free from the last call) until a 'bad' call has been firmly assigned to someone else. For example the crew

laughed when another crew was assigned a 'routine abdominal pain' at a nursing lodge on Kerr. The driver slowed the ambulance down to crawling speed, Richard laughed and said,

> "I'm with you, I hate that place. It's where they send Chinese people to die. You can smell it in the halls."

Similarly,

> "41 Alpha routine for a lower GI (gastrointestinal) problem." (dispatch)
> "Let's back pedal on this one, maybe we can catch a Code 3 on the way so we can get out of this call." (Junior) (the ambulance slowed down dramatically)

Further, in between calls at the hospital another crew member came outside and said,

> "Dispatch is looking for you."
> "So, we're busy. Jordan, find out what the call is and we will make a decision as to how quickly we want to get this cleaned up." (Dylan)

Finally, when driving outside of our area one night to see the hookers, dispatch asked our location (10-20), Junior said to Hugh,

> "Where should I say we are?"
> "I don't know, Pacific and Cambie?" (Hugh)
> "Sounds good."

The relationship between dispatch and ambulance workers on car was dependent on the above criteria set by the workers themselves. Humor, the assignment of 'good' calls and not of transfers, and leaving some leeway was important to the attendants.

As illustrated in the above chapter, the quality of relationships between emergency service personnel differed greatly, dependent on a number of factors. Roles at the scene, hierarchies, personal convictions, and peer pressure could all be seen as contributing factors to the resulting relationships.

CONCLUDING REMARKS

> "How much longer do you think you are going to be in this business?"
> "No more than 5 years, then I'll go back to school to re-train."
> "What will you do, Medical School?"
> "I haven't decided yet, but I'm thinking I might want to stay completely away from working with the sick and injured, 12 years is long enough."

This study has been based on a participant observational study of a group of Emergency Medical Assistants in Vancouver. It began with discussion of the history of the scene, that is, the history of the British Columbia Ambulance Service, as well as a discussion of the methodology in terms of technique and problems encountered in the field. Other topics examined include characteristics of a typical shift, crew preferences for types of calls and patients, informal transfer of 'working knowledge' to attendants through apprenticeship, and the relationship between attendants and other emergency services personnel.

As with most studies, there are always topics left un-treated or un-exposed. This study is no different. With a lengthier stay in the field I could have addressed types of patients more thoroughly and confidently, I could have spoken to the acquisition of 'street smarts' on a first hand basis through the process of 'becoming an ambulance attendant' myself, and could have experienced any 'rookie treatment'. I could have gone to rural stations and experienced what it would be like to get one call every two shifts, and the differences in crew culture in such a situation. Given enough time, I may also have had the experience with treating a member of the public who was also my friend, as commonly occurs in smaller towns. Further, I could have taken the formal training of EMA's with an eye to the differences in what is taught at the Justice Institute, and what is put into practice on the street. Finally, I could have tried to look at the things that plague EMA's such as stress, problems with management and scheduling, qualifications of Unit

Chiefs, the issue of "de-pairing ALS", inadequate "recruitment"[44], the absence of evaluation techniques, and the like. Perhaps I could have uncovered some interesting and helpful insights with an eye to improving their situation. Perhaps not.

This study is the first of its kind in Canada. Other examinations of this group of workers in this country have been from other academic points of view, and have primarily used survey techniques and personality profiles rather than going close-up as I have. Further research on EMA's in Canada will serve to increase understanding of the workers, their concerns, and ultimately have an influence on care of the sick and injured for future generations.

[44] There really is no recruitment technique in the service in the formal sense of other emergency services. There are no real interviews, there is no emphasis on education or work experience outside the field--it is all "who you know".

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APPENDIX ONE:

Confessional Tale

I grew up in various suburbs of a Vancouver as part of a small middle class family; my mother worked part-time when I was in grade school, and my father worked full time as a general manager of a middle-sized building supply firm. Since I can remember, they worked very hard at passing on to me a solid work ethic that they held to be central in any child's development. Work was regarded as a means to the end of independence, responsibility, experience, and later, university attendance. From this early talk of work and the occupations that people do I became interested in the topic, vis a vis a self-centered question of, "What will I be when I grow up?". I would quite often throw out ideas to my parents of vocations that seemed logical to me in terms of the skills I possessed. Each time one of them would very carefully take the time to explain some of the pros and cons of that vocation, usually coupled with illustrative situations. I soon became able to create these scenarios myself, and used the technique to enlighten my friends.

As a teen I obtained part-time work as a lifeguard and swimming instructor at a nearby country club, partially influenced by my father who had grown up with lifesaving in Australia, and partially because of my love for the water. This vocation provided a slightly older crowd of co-workers to interact with, as well as the financial independence that was much coveted by my peers. While lifeguards come from many facets of life, there are some similarities among staff groups generally. There always seems to be one or two 'technogeeks' at each facility I have worked at (over 20); and I use this term in only the most positive sense. These individuals are interested in such things as communications equipment (walkie talkies, VHF, pagers, cellular phones, etc.), rescue equipment which is 'gagetty' (motorized boats, oxygen tanks, spinal immobilization units), and personal rescue or first aid items that are interesting (pocket masks, fanny

packs to hold supplies, super scissors, etc.). Additionally, these individuals like being involved in situations where they get to use this equipment and their skills, particularly if it is out of the ordinary or 'news worthy'. Understandably it is these same individuals that often make their careers in the 'helping professions' as nurses, police, firefighters, ambulance attendants, and doctors. For this reason I came to be interested in the topic of ambulance work in particular, as many of my past co-workers chose it as a career path. The stories of 'calls' done, training undergone, and efforts to make light of what seemed to be difficult situations intrigued me, not in the sense that I wanted it as my own career, rather that it would be interesting for others to understand the job and the experiences those in it go through.

As an undergraduate I took a field methods course which inspired me to go on in sociology, and to put in to practice some of the methods and theory I had been told stories about.. Participant observation research seemed a bit like undercover detective work to me, regardless of whether the members of the domain knew the full purposes of the researcher being there. I always felt that few people really understood what the discipline of sociology was about, and that toting it as 'the study of patterns in society' cleverly disguised the more interesting aspect of its inquiry - the members of that society. In this sense, the 'cover' of field research seemed to me to be a unique opportunity to study work occupations. Job descriptions and first hand explanations never seemed to shed enough light on a vocation - I wanted to know what it would *feel* like to be in the job. To carefully investigate a dark alley on the hunt for a 'bad guy', to deliver a lecture to a group of 200 students, to defend a suspect of murder in a court of law, or to arrive at the scene of a bad car accident as a paramedic.

Once in graduate school I had an instructor who had the foresight to 'force' all the first year graduate students to write an M.A. thesis proposal as part of his course requirements. With my involvement in aquatics at the time and the ever-present 'technogeeks' turning to the ambulance service, I decided to focus on the latter. Like

many students my first attempt at such a project was naive and unrealistic, and while it met the course requirements it would not survive in the 'real world' of sociology. I went on to complete my graduate course work but continued to have trouble etching out a suitable research proposal. After several topic changes and a leave of absence, I produced a version of the original proposal that was approved for research 3 years later.

The accepted version of the proposal involved less fieldwork than I had originally envisioned, and seemed to me to be less 'honorable' than I had wanted. I really felt for these people who worked night and day under what I thought were strenuous conditions, dealing with sick and injured people exclusively - I really wanted to do a project that in some way would 'help them'. As I struggled with the literature around stress and the workplace and such topics, I realized that any centering on that topic would lead me out of sociological field research and into another area. In the end I decided that the bottom line was that the project had to get going, and that it was going to be as worthwhile as I made it. If nothing else it would involve a number of attendants and perhaps have them learn something about themselves or the job they do by looking at things differently.

With this new perspective on my previous naiveté in mind, I approached various members of the ambulance service that were friends and enlisted their help in etching out a plan of which stations to study, with whom, and the like. They also guided me to the right administrators to get permission to do the project. However, my first attempt to implement this new plan and list of requests was met with little support or hope. I called the scheduler of thirds, and was told that they were not letting anyone ride third as they were getting too many requests. He said the only way to go about it was to write a letter to the Superintendent of the ambulance service, outlining what I wanted to do and for what reason. As I drafted this letter I had a sinking feeling that the bureaucracy was going to tie up the project, and it may not ever get approved. I was aware that with my 'connections' in the service I could ride third 'under the table' for a few shifts here and there, but did not feel this would meet the requirements of ethnography. I then got an

ironically lucky break - my printer at home broke as I was trying to print the polished copy of the letter. I went to use a girlfriend's her office downtown, but her software was a different version than mine and therefore would not read the disk I had brought. She called down the hall to a co-worker to see if he would try the disc. His efforts to print from the disc were met with failure as well. As he peered at the screen to try and decipher the problem he suddenly exclaimed, the Superintendent of the Ambulance Service, I know him, why don't I just call him for you?". I looked at him in dubious disbelief and asked if he would mind. He said it was no problem, he knew him from a research project he had done on personality profiles of paramedics through the Justice Institute.

He called as we stood there in the office, and got the Superintendent's secretary, who said he was away at his cabin. The man was about to call the his residence in Sechelt when I interjected and said it could wait until Monday when he was back. He assured me that I had nothing to worry about in terms of approval for the project, he would see to it and let me know what the next step is. I left the office and thanked him and my friend, and went home. As I unlocked the front door the phone was ringing - I dashed in and answered it - the man was calling to say that he had contacted the Chief Superintendent instead, the project had been approved and he would send a memo to that effect to the scheduler, who I should call Monday to arrange the exact dates. I thanked him profusely and hung up. I just couldn't believe what a break I had received.

First thing Monday morning I called the scheduler back, he was away so I left my number and name. A day later he called back and left a message for me to call him back at the office or *at home*, and left both numbers. I returned his call and he said he had received a memo from the Chief Superintendent requesting that I be granted my request to ride third. He began to tell me which days he thought would be best to ride to 'see some action', and said that I would have to go home at midnight because sleeping accommodations in the stations were inadequate. I quickly explained that in order to

carry out my research it was necessary to observe for full blocks, and I was not concerned about sleeping arrangements. I also explained that I had spoken to members at the locations recommended to be the busiest, and they were happy to have me ride. We worked out the dates and times, he warned me that tardiness was not tolerated, that I was not to be involved in the treating of patients, told me what to wear, and wished me 'good luck'. He also said that he would fax me copies of the memos sent to the Unit Chiefs to show to my advisor. The latter arrived a few days later with the statement "please extend her all courtesies" on each. I was quite relieved and amazed that this had all come together when it seemed to be doomed.

As the time drew nearer I selected suitable clothes - dark pants, white shirt, obtained a small notebook to write in while on shift, and thought about what I knew about the service already. I also talked to members I knew as to what to expect, how the shifts worked, etc. One interesting thing I found out was that they all did 'early relief', that is, they came in for their shift half and hour early so that the earlier crew would not get a call in their last half hour. The scheduler had not known this and told me to arrive at the regular time, I was glad I had found out!

The first day I set out to find the station early, but could not find it. As the station was brand new that week, I was not given the exact address, only the cross streets. I searched the hundred block on both sides, and looked for a vehicle I recognized. As I was searching I was thinking to myself that being late was not going to make a very good impression. What if they get a call and leave me behind? I finally noticed some newly painted garage doors and peered inside the papered window-found it. I went around back and parked, very conscious about the possibility of the existence of a parking system of some sort, one that I have just thrown a major loop into. I tried the door, it was locked with a code-lock system. As I did not know the combination I had to knock. The station chief, Roy, answered and let me in, so I introduced myself and explained that I was supposed to be riding with Arnold for the block. He informed me that Arnold was

transferred late the night before to an ALS (Advanced Life Support) car, and would not be in that day. He then went back into his office. I went into the living area and sat down, thinking back to my methods courses trying to decide if it would be better to stay at one station and observe or to stick to one person. I choose the later, and then thought about a delicate way of approaching the Unit Chief with my problem, thinking - What a nuisance I am being and it is only 7:45 am! I approached Roy and he said he would call dispatch, find out where Arnold was, and get him to call in to the station. Shortly thereafter, the phone rang and Roy said that the other crew would come and pick me up, then bring me back at the end of the day. Perfect.

The ALS car that arrived with Arnold was interesting to be a third riding out of. The third seat was in the back, raised up about a foot and a half such that a person sitting there could not see out the front windshield without crouching over. This was a very unsettling way to travel, looking at a white wall or a strip of street going by, especially when traveling at Code 3 speed. The first Code 3 call we received I was rather taken aback at the sensation of not being able to see where we were going, especially since the small glimpse I had of the road was the yellow line going straight through the car! I realized at that point how much trust one had to have in one's partner. As we turned corners I felt the distinct possibility of a crash, particularly with the style of driving that seemed to be necessary to get people off the road so the ambulance could pass by.

Later in my field research on calls this concern doubled when the weather was wet, and on one occasion our car slid 3 lanes of traffic to the right as we banked a corner off of the Burrard Street bridge. Another time the car was going Code 3 through an intersection and narrowly missed another ambulance crossing the opposite way! (Such mishaps were considered to be the fault of dispatch). The attendants seemed relatively un-fazed on such occasions, save side-long glances at partners and a few white knuckles on the door handles. I was, however, quite fazed, and repeatedly asked the question to myself, "Why am I doing this! I could be doing document analysis!". I did get used to

the sensation and the driving as time went on, and felt a little silly at my initial reactions. After all, these people had taken driving courses and they did do it for a living.

Another fearful experience in the field was that of going to do Airevacs. I hate flying at the best of times, being one of those not appeased by statistics of 'planes are safer than cars', and the like. The thought of going in a small plane initially was horrifying, and later, a helicopter, seemed impossible. My naiveté pulled through for me though, I managed to convince myself that helicopters were much safer than planes (despite my later acquired knowledge that they have far more moving parts to go wrong), because they were more maneuverable. I did not get air sick, which I saw as a positive sign, but I did spend most take-offs and landings wondering 'why am I doing this? I could be on land!'. In the end I quite enjoyed the helicopter trips, and hope I can go in one again. My major rationalization through the ordeal was to keep thinking "These guys do this all the time, the pilots don't look suicidal either". I made it.

A situation arose while on car in my first block that was terribly embarrassing. I have a medical condition known as 'exercise induced asthma', which as of yet has never been produced by exercise. Nonetheless, on the first night shift I decided that I was not going to make it through the night without some sort of caffeine stimulant, and not being a coffee drinker the Starbucks runs were out of the question. I decided to brave an 'iced mocha' though, the chocolate content sounding very appealing. Half way through this concoction I began to wheeze, and thought I was coming down with a cold suddenly. This condition worsened until I felt it was recognizable as asthma. I, of course, did not have my inhaler with me as I rarely get the symptom, and decided to quietly suffer. Arnold eventually noticed me wheezing and asked me if I was OK. I said I was fine, being quite embarrassed about the whole thing. I really couldn't figure out what had brought this on.

Later in the evening as I felt worse Arnold insisted that I take a 'ventilin neb' which is a medication one breathes in with medical oxygen to relieve the symptoms of

asthma. I began to take this treatment sitting in the back of the ambulance, and we got a call. There I was, sitting in the back of an ambulance breathing into an oxygen mask, going Code 3 to a cardiac call thinking, "How embarrassing. Patient No. 1, could you please pass that O2 to the other patient?". The call ended quickly, thank goodness, and we went back to the station to sleep for a while. At some point Arnold asked me if I was itchy anywhere, I suddenly realized my collarbone and neck area were very itchy, and I had been scratching the area for the last hour. I looked at the area and discovered a bunch of hive-like bumps were there. Wow, I thought, what a joke I am, I couldn't even spot an allergic reaction on myself, how could I possibly think I was 'qualified' to be observing ambulance from this 'inside perspective'?

Arnold then gave me an antihistamine, I went to sleep for a while, and felt much better earlier in the morning. What an experience. Somehow I would prefer next time to be the anonymous patient rather than being surrounded by friends and co-workers. I also remember thinking about all the 'wanking' and 'wining' patients there were out there. I sure didn't want to join that category, I don't think I would ever call an ambulance for myself, I would sooner crawl to the hospital.

Another set of embarrassing memories of the time spent in the field is the feeling of being unsure as to what to do at the scene, and what not to do. As some of the members were familiar with my first aid skills, they tended to let me do things, or tell me to do things at the scene. There was no problem with the tasks given, but I often was not familiar with the terminology for equipment or the exact location of items within the ambulance. After I had trouble finding a simple item such as tape, I made sure that I spent some time at the beginning of each shift figuring out where the basics were in the ambulance (all were set up differently), and asking questions about items I could not identify. One time at the scene of a car accident an attendant yelled out to me "Nikki, measure up for a hard collar". This is a simple procedure for a person who had been trained in the administration of hard collars, but I was not licensed through Industrial

First Aid to do so. My strategy was to guess, and luckily for the patient, I guessed right. I suppose the attendant would have sent be back for a different one if I had been wrong, but I felt a bit guilty and embarrassed about that after, as if I shouldn't have been there to rely on if I could not perform for them.

On another call I was sent off the get the stretcher out of another ambulance. The stretcher was an 'old style' one, with more requirement for the attendant to lift, and I was not familiar with it. I had trouble getting it unlatched from the ambulance floor and remember having it seem like days had gone by from when I was asked to get it and when I returned. I had the impression that by the time I got the thing out of there the patient would be long gone to the hospital or something. The mind plays tricks.

A similar situation but not nearly as worrisome was one nightshift at 41, we had just come in. There were two other crews 'in' when we came on duty, and everyone was sitting around watching the news. A call came in and being the case that the 'first crew in was the first crew out', I didn't pay much attention to it. Suddenly I hear my name being called from the downstairs garage as the door was sliding up. Oops! You cannot take anything for granted around there. If an attendant feels like doing a call, I guess they go to it!

Another struggle I had in the field was wondering what to say and what not to say in conversation with attendants and hospital staff. I sensed a certain amount of defensiveness with some attendants encountered with respect to going to university, so I tried to avoid the topic. When people asked me what I was doing there I often just said 'riding third to see what ambulance work is like'. I didn't feel that was too deceptive as it was true, I just didn't announce that I was writing a paper on it. The crews I worked with directly were all eventually aware of my reason for being there, but I really only had trouble with one attendant

This man was the most despicable creature I had ever encountered; he was a racist, a chauvinist, a homophobic, was confrontational and unjustifiably opinionated - I

hated to be near him. I really did not know what to do around him as anything anyone did or said was immediately jumped on with a 'devil's advocate' position. The other attendants said nothing around him, so I took the cue to do the same. He was the only one in the course of my research that ever directly confronted me with his charming opinion about universities being a waste of time and the like. I tried to avoid getting in to any conversations with him after that, but really did not feel as though I had succeeded in winning him over. Despite these displays of hostility he commended me for my help at the scene a couple of times, and seemed to accept me on the level of an observer. Perhaps he just liked to have an ear to bend.

On the subject of embarrassing moments in the field were a couple of instances in which my gender seemed to come in to play. At the second station I visited I found myself chatting with one of the other crew members, he had gone to school in a similar area as I had, and we had mutual acquaintances. Later on in the day his partner had to go flying on an airevac so I asked what Lance would do while he was gone, wondering if they did a four hour call in to compensate. The answer I got took me by surprise and I really did not know what to say as it was in front of a few people,

> "What does Dave do while John was on the Airevac?"
> "He's doing it. Studying, sleeping, and chatting you up. Not necessarily in that order."

At the time I decided it was best to ignore the comment and continue the line of questioning on the subject of calling another partner in. Unfortunately this tactic did not work as the same sort of comment was made later at the bar to a larger group of attendants, I still didn't know what to do except adamantly deny that there was any interest there.

Another situation at the bar 'on the split' was embarrassing as well. A well-known 'womanizer', Tom, was getting friendly with me and I decided it best to put him in his place once and for all to stop his advances. This decision was met with grand approval of

all the attendants present, but created a problem in that they felt I 'was on their side' with respect to 'getting Tom'. At one point I was offered $5 if I would put my tongue in Tom's ear while he was chatting up another young woman, I declined which then put me back in the dubious position of perhaps being on Tom's side, or worse, being after him.

Generally speaking, the above instances of less than perfect situations in the field did not total disaster, but may be of use to future students who wish to undertake a similar excursion into the field. There are always, I believe, a number of other situations that one could include in such a confession, but perhaps seem too personal or may in some way jeopardize an informant. I, as many students have or will, had to struggle to achieve a balance that I (and my informants) could live with.

APPENDIX TWO

Glossary of Terms and Codes

Terms

Airevac	The transport of a patient, usually in critical condition, by air. Both helicopters and small planes are used for these missions.
ALS	Advanced Life Support.
BLS	Basic Life Support.
Bag and Mask	A device used to manually provide oxygen to a patient who requires it.
Bagging	The verb used to describe the action of using the bag and mask device.
Bay	The indoor garage space that the ambulance is kept between calls.
Block	Referring to the grouping of shifts which make up a full-time attendant's work week.
Buckethead	A term used to describe fire fighters because of their use of buckets, supposedly to carry water.
'Buck's'	A shortened version of the word 'Starbucks', used in reference to coffee itself or the establishment Starbucks.
Chemstrip	A litmus-type paper used to determine blood sugar level in patient suspected to have Diabetic problems.
CPR	Abbreviated form of Cardio Pulmonary Resuscitation, a manual technique used to maintain life (circulation of oxygenated blood) in a pulseless patient.
Cylon	A robotic life form encountered by the crew of the Battlestar Galactica, used to refer to fire fighters because of their apparent inability to think (as a robot cannot).
Defib	Short form of 'defibrillation,' referring to the electrical stimulation of a heart which is no longer beating on its own.
Detox	Short form of detoxification, referring to the sobering up of patients who are inebriated from alcohol.
Dextrose	Sugar, used to revive diabetics.

EMA	Emergency Medical Assistant.
Emerg.	Short for 'Emergency', referring to the emergency ward of a hospital.
Epi	Short for Epinephrine, a drug used on a patient who is having an allergic reaction to something (severe).
ETI	Emergency Telephone Instruction (certified), those who work in dispatch are currently required to be trained to this level.
Extrication	Removal of a patient, either from an automobile, 'autoex', or a steep embankment, 'over embankment ex'.
Fanny pack	A small pouch with a belt that goes around the wearers' waist to hold personal effects. Popularized in the early 1990's as both a fashion and function item.
FAST	"Full Arrest Survival Trial", a research project throughout the Service intended to assess the need for Fire Fighters to be trained in AED, Automatic External Defibrillator.
Fixing	A verb used to refer to a person who is in the process of utilizing intravenous drugs.
Form 2	The form used to record the crew's report of a patient when sent on a call. The form is a triplicate format with space to record each detail of the call.
GI	Abbreviation for gastro-intestinal tract.
Grunge	A current form of fashion started by Neil Young and popularized in the nearby city of Seattle by several 'grunge rock bands'. The style is essentially unclean looking, with oversized clothes in many layers. Plaids and denim garments are among the popular choices.
ICU	Short form of 'Intensive Care Unit'.
IFA	Industrial First Aid, a course endorsed by the Worker's Compensation Board of British Columbia for use on industrial work sites. The course is approximately 80 hours long with both written and practical exams at the end.
Incontinent	When a patient has lost control of his or her body waste functions.
Intubation	The insertion of a tube into a patients tracheal tube and down into their lungs in order to facilitate eased breathing. Used for non-breathing or pulseless patients as well as conscious patients who require less strain on their bodies due to heart attack, stoke, etc.

IV	Short form for 'intravenous'.
Landmarking	The process of locating the correct place on the sternum of the chest to do compressions in Cardio Pulmonary Resuscitation.
MI	Short form of 'Myocardial Infarction', referring to a total lack of oxygen to a central part of the heart, causing irreversible damage. Severe MI's can stop the heart from beating on its own.
MO	The short form or slang of "mental outpatient". Used in the technical sense as well as a colloquial one, for example, "Freddie is an MO." Generally a 'crazy' or 'unstable' person.
MVA	Motor Vehicle Accident.
OD	Short form for 'overdose', usually referring to a patient in respiratory arrest or cardiac arrest from taking too much of an illegal or prescribed (abused) narcotic.
On car	Working in the ambulance.
O2	Scientific form for oxygen.
Oral Airway	A plastic device used to maintain an 'adequate' airway in an unconscious patient.
Outstation	An ambulance station that is not located in the central lower mainland. Generally a place where new attendants begin their careers.
Paddy wagon	A vehicle operated by the police department for mass arrests and drunks. Generally takes occupants to detox and/or jail.
PC	Short form for "Police Constable".
Pineapple Princess	Referring to the immigrant nurses that where working in private care hospitals.
Platoon	Referring to the shift pattern an individual or group of individuals work on. For example, John works on 'B' platoon.
Psych	Slang for a psychiatric patient.
Quarters	The ambulance station the car is assigned to.
ratbag	a derogatory term used to describe someone who is underhanded or 'slimy' in their personality, dealings, etc.

Recert	Short form of 'recertification', meaning to renew an award or level of certification.
Rappelling	A vertical descent with rope aids. A rescue technique used to go down cliffs, buildings, etc.
Sager Splint	A device used to temporarily immobilize a fracture in a long bone such as a femur.
scrote	A derogatory term used to describe 'bums' that live on the street.
Scumbag	A derogatory term used to describe a person that is unclean or morally questionable.
SED	SAFECO Extrication Device. A device used to remove patients from wrecked cars.
Squirter	A term used to describe fire fighters because of their work activity of 'squirting water' on a fire.
Swinging	A common term used to refer to a person who has committed suicide via hanging.
Super scissors	Special sharp scissors designed to cut clothing, screen, thin metal, etc. Used at accident scenes.
Tachycardia	Rapid heart rate.
TIA	Trans-ischemic Attack. (of the brain) Used to refer to a person who has made a bad decision.
Triage	The prioritizing of patients in a multiple victim scenario.
Wank	A noun used to describe a person who is not behaving in the way the attendant feels they should.
Whistle	Referring to a Code 3 call where the car has to 'whistle' (go fast with lights and siren) into the hospital.

CODES

Code X	don't have to transport
Code 1	family member on board (unauthorized listener)
Code 2	routine mode of travel, no lights or sirens, obey all laws.
Code 3	emergency, lights and sirens while traveling
Code 4	reference to death
Code 5	police required
Code 6	fire member
Code 7	reference to dispatch
Code 9	reference to AIDS
Code 30	Crew is in danger, need police ASAP

10- Codes

10-4	understand, clear.
10-7	off the air or on the scene of ____.
10-8	on the air.
10-20	what is your location?

Hospital Codes

A	VGH
C	St. Paul's
Q	Grace
S	Royal Columbian
L	Shaughnessy
Y	Surrey Memorial

H	Burnaby General
M	St. Joseph's
K	St. Vincent's
U	U.B.C.
W	Lions Gate
O	St. Mary's

APPENDIX THREE

Official Forms

Province of British Columbia
Ministry of Health and Ministry Responsible for Seniors
EMERGENCY HEALTH SERVICES COMMISSION

CREW REPORT

HLTH 2402
REV. 8705

COMMISSION COPY

32. REG'N. STATION SHIFT | 33. DATE OF SERVICE DD MM YY: 131 | 34. VEHICLE #

1. PATIENT'S SURNAME | 2. PATIENT'S GIVEN NAME | INITIAL

3. POSTAL ADDRESS

4. CITY | 5. PROVINCE | 6. POSTAL CODE

7. PATIENT'S PHONE # | 8. BIRTHDATE DD MM YY | 9. AGE | 10. SEX (1) M (2) F

11. M.S.P. I.D. # | 12. S.I.N. #

13. PATIENT'S PHYSICIAN

14. BILL TO: (NAME IF NOT ALREADY INDICATED)

15. POSTAL ADDRESS

16. CITY | 17. PROVINCE | 18. POSTAL CODE

19. BILL TO / IDENTIFICATION

(01) Patient
(02) M.H.R.
(03) W.C.B.
(04) I.C.B.C.
(05) Non resident
(06) Employer
(07) Standby
(08) Parent
(09) D.I.A.
(10) D.N.D.
(11) A.G. Canada
(12) Coroner
(13) Sheriff
(14) A.G., B.C.
(15) Home Care
(16) Police
(17) I.H.T./T.R.
(18) M.H.A.
(19) R.C.M.P.
(20) Other
(21) M.H.A. Trans.
(22) Cont. Call
(23) Cancelled
(24) Pt. refused
(25) A.N.U.

TIME	KM:
20. CALL RECEIVED	
21. START	
22. CODE (2) (3)	
23. CODE (2) (3)	
24. AT SCENE	
25. TO DESTINATION	
26. CODE (2) (3)	
27. CODE (2) (3)	
28. AT DESTINATION	
29. CLEAR	
30. BASE	

31. AMBULANCE IN PAST 24 HRS. Y (1) N (2) Unknown (3)

35. SPECIAL CODE (1) (2) (3) (4) (5) (6) (7) (8)
36. PROV. RESPONSE # P-
37. RESPONSE #
38. AMBULANCE RESPONDED TO | PATIENT'S ADDRESS (1)
39. HOSP. CODE
40. PATIENT CARRIED TO
41. HOSP. CODE
42. DRIVER # | NAME
43. ATTENDANT # | NAME
44. ESCORT NAME

45. UNIT QUALIFICATION
(1) EMA (3) EMA I.V. (5) ALS I (7) ITT
(2) EMA II (4) EMA-D (6) ALS II

46. LAYERED RESPONSE
(1) EMA I / II (3) ALS (5) ALS not available
(2) EMA-D (4) F. Dept. Initials:

47. HOSPITAL CONTACTED
48. PHYSICIAN ORDERING
49. POLICE DEPT. / CONSTABLE #
50. VEH. LIC # IF M.V.A.

HISTORY

51. CHIEF COMPLAINT

52. MECHANISM OF INJURY / HISTORY OF ILLNESS

53. RELEVANT PAST HISTORY

54. MEDICATIONS

55. ALLERGIES

ASSESSMENT

56. VITAL SIGNS

TIME	B.P. SYS.	B.P. DIA.	PULSE	RESP. RATE	RESP. EFFORT (S) (N) (R)	CAP. REFILL (Ø) (N) (D)
					(S) (N) (R)	(Ø) (N) (D)

57. COMA SCORE

E	V	M	TOTAL

58. EXAM
State of consciousness
H & N
Chest
C.V.S.
Abd.
Back
Ext.
C.N.S.
Blood Loss

60. TS 1
61. TS 2

62. PUPILS
Equal (1)
React (2)
Dilat. (3)
Const. (4)
Rt. Lg. (5)
Lt. Lg. (6)
Other (7)

63. SKIN
Normal (1)
Cyanotic (2)
Pale (3)
Flushed (4)
Diaph. (5)

59. DIAGNOSTIC AND ADDITIONAL COMMENTS

64. DISPATCHED AS / DIAGNOSIS 1° / 2°

	AS	1°	2°
Airway Obstruction	01	32	63
Arrhythmia	02	33	64
Burns	03	34	65
Cardiac Arrest	04	35	66
Chest Pain - MI	05	36	67
Chest Pain - Other	06	37	68
Chronic Disorder	07	38	69
Collapse/Found Dn.	08	39	70
Coma	09	40	71
Congestive Failure	10	41	72
D.O.A.	11	42	73
Diabetes	12	43	74
Drowning	13	44	75
Drug/Alcohol OD	14	45	76
Fracture	15	46	77
GI/Abdom. Pain	16	47	78
Head Injury	17	48	79
Hemorrhage	18	49	80
Infectious Disease	19	50	81
Interpers. violence	20	51	82
M.V.A.	21	52	83
Neuro/C.V.A.	22	53	84
Obs./Maternity	23	54	85
Psych./Behaviour	24	55	86
Respiratory/SOB	25	56	87
Seizure	26	57	88
Spinal Trauma	27	58	89
TRANSFER	28	59	90
Trauma - Major	29	60	91
Trauma Minor/Cuts	30	61	92
Other (specify)	31	62	93

CARE AND TREATMENT

65. AIRWAY CONTROL
(1) Cleared
(2) Positioned
(3) Suctioned
(4) Ventilated
(5) Oral Airway # ____
(6) Intubated # ____

66. OXYGEN
(1) Cannula
(2) Mask
(3) Venturi
O_2 at ____ %
O_2 at ____ l pm

67. CARE GIVEN
(1) Control Bleed
(2) Dress wound
(3) Splint
(4) Traction
(5) Back Board
(6) Neck Immobil.
(7) Transport only

68. I.V.

ATTEND.	ATS.	SUCC.	DRIVER	ATTS.	SUCC.	TIME	SIZE	SOLUTION	TOTAL VOL. (ml.)	BLOOD DRAWN
(Y)	(1) (2) (3)	(1) (2) (Ø)	(Y)	(1) (2) (3)	(1) (2) (Ø)			(1) D5W (2) D10W (3) NS (4) R/L (5) Other		(Y)

69. PROTOCOL CODES
70. PATIENT FOUND
71. PATIENT POSITIONED
72. PATIENT TRANSPORT
73. HOSPITAL SELECTED

74. TIME	75. MEDICATIONS AND PROCEDURES	76. RESP. RATE	77. PULSE	78. B.P. SYS.	B.P. DIA.	79. CARDIAC RHYTHM	80. RESULT	INITIAL	CODE

81. ADDITIONAL REPORTS | 82. U/C - LMC INITIAL | 83. DRIVER'S SIGNATURE | ATTENDANT'S SIGNATURE | 84. M.D. | 85. RECEIVING PHYSICIAN'S SIGNATURE

Province of British Columbia
Ministry of Health

EMERGENCY HEALTH SERVICES COMMISSION

PROPERTY LOSS REPORT

THIS FORM IS TO BE USED IN ALL INSTANCES WHERE PROPERTY IS LOANED BY AN OPERATOR.

DATE: _____

STATION: _____ RESPONSE #: _____

OPER. #: _____ UNIT #: _____ PROV. RESPONSE #: _____

PATIENT TRANSFERRED TO: _____

AIRVAC ☐ HOSPITAL ☐ OTHER AMBULANCE ☐

OTHER ☐ , EXPLAIN: _____

_____

EQUIPMENT DETAILS:

QUANTITY	ITEM

DISPOSITION OF PROPERTY/EQUIPMENT:

DETAILS OF 1ST LOAN/BORROWER;

LOANED TO: OP.# _____ LOANED BY: OP.# _____

NAME: _____ NAME: _____

EMP. # _____ EMP. # _____

AT: _____ NOTE: PERSON RECEIVING EQUIPMENT WILL BE FULLY RESPONSIBLE FOR ITS RETURN TO THE ORIGINAL OPERATOR

DATE: _____

SHORT TITLE FORM (for the spine of the thesis)

Please put your surname and a suitable short title for your thesis in **50 characters or less** below. Leave two spaces after the author and a single space between words in the title. Do not use chemical or mathematical formulas. Please print very carefully or type the information.

Example:

M A C K E N Z I E _ _ M Y T H _ & _ R I T U A L _ I N _ T H E _ W I N T E R _ F E S T I V A L

Yours:

L I D D E L L _ _ R E D _ A N D _ W H I T E _ A R E _ A L W A Y S _ R I G H T

_____

For Office Use Only:

Bind Everything	Class A	No Trim	/	Trim Little	Date
	Pocket	Oversewn	/	Double Fan Glued	Colour:
	Folded Material	C.1	or	C.2	
		No Tape		Tape	

CR-11(3/93)

PROVINCE OF BRITISH COLUMBIA

MINISTRY OF HEALTH

EMERGENCY HEALTH SERVICES COMMISSION

RELEASE AND INDEMNITY

IN consideration of HER MAJESTY THE QUEEN in Right of the Province of British Columbia, as represented by the EMERGENCY HEALTH SERVICES COMMISSION, permitting me to travel in a vehicle used by it for the purpose of observing the operation therein, I, the undersigned, hereby release HER MAJESTY THE QUEEN in Right of the Province of British Columbia, the EMERGENCY HEALTH SERVICES COMMISSION, their servants, employees and agents, from all claims, actions, suits or demands whatsoever that I, my next-of-kin, heirs, administrators, executors or assigns may now or hereafter have, own, or possess arising out of or in any way related to my being a passenger in the said vehicle and whether caused by the negligence of HER MAJESTY THE QUEEN in Right of the Province of British Columbia, the EMERGENCY HEALTH SERVICES COMMISSION, their servants, employees, or agents or otherwise.

AND further, I hereby agree to indemnify and save harmless HER MAJESTY THE QUEEN in Right of the Province of British Columbia, the EMERGENCY HEALTH SERVICES COMMISSION, their servants, employees and agents, from all claims, suits, actions or demands whatsoever made against any or all of them and arising out of or in any way related to my being a passenger in the said vehicle.

AND further, I do declare that prior to seeking publication of any article or other material containing information of which I may become possessed through my observing the operations of the EMERGENCY HEALTH SERVICES COMMISSION, I will submit same for review by the Executive Director of the EMERGENCY HEALTH SERVICES COMMISSION or his designate.

AND further, I do declare that I will not disclose to anyone outside the EMERGENCY HEALTH SERVICES COMMISSION, any information of which I may become possessed through my observation of the operations of the EMERGENCY HEALTH SERVICES COMMISSION without authorization from the Executive Director of the EMERGENCY HEALTH SERVICES COMMISSION.

DATED at , British Columbia, this day

of , 19 .

(SEAL)

_____
Signature

_____
Name

_____
Address

_____
Occupation

HLTH 1042 - 02/81

Province of British Columbia
Ministry of Health and Ministry Responsible for Seniors

EMERGENCY HEALTH SERVICES
ADVANCED LIFE SUPPORT - CARE RECORD

RESUSCITATION FROM PRE-HOSPITAL CARDIAC ARREST

OFFICE USE ONLY
COORD. REVIEW

1. DATE D D M M Y Y	2. STATION Region	3. RESPONESE No.	80.
6. SURNAME		7. GIVEN NAME	
ADDRESS OF CALL ☐ Same as home address or:		HOME ADDRESS	

8. SEX ☐ M ☐ F	9. DATE OFBIRTH D D M M Y Y	FAMILY DOCTOR OR SPECIALIST

10. LOCATION OF CALL
☐ OWN HOME ☐ OTHER HOME ☐ PUBLIC PLACE ☐ WORK PLACE ☐ STREET ☐ NURSING HOME ☐ DOCTOR'S OFFICE ☐ OTHER:

54. RELEVANT RECENT MEDICAL HISTORY	55. PAST MEDICAL HISTORY	No. OF PREVIOUS MI's	MEDICATIONS

56. PRESUMED CAUSE OF ARREST
☐ Cardiac ☐ OD ☐ Trauma
☐ Other (specify):

57.
☐ FOUND IN ARREST
☐ Witnessed
☐ Unwitnessed
☐ ARRESTED during EMA3 attendance (Refer to SPC form)

61. INITIAL ARRHYTHMIA RATE
☐ Coarse VF
☐ Fine VF
☐ V tachycardia. . . . .
☐ 3rd degree block. . . . .
☐ Idioventricular. . . . .
☐ EMD. . . . .
☐ Asystole

58. CPR prior to arrival by:
☐ Bystander ☐ EMA 2
☐ Fire dept. ☐ Other:
☐ No CPR prior to arrival

59. Est. time in arrest prior to any CPR. . . . .

60. Est. duration CPR prior to EMA 3 arrival. . . . .

PROCEDURES PERFORMED
1IV ☐ D5W ☐ Saline Catheter size ________
62. No. of attempts to start . . . .
63. ☐ successful ☐ unable ☐ later went interstitial
64. Total vol. Infused . . . .

65. VENTILATION
☐ No assist required
☐ Ambubag ventilation
☐ ET intubation attempt
☐ successful
☐ unable to intubate
☐ Tube size . . . .

TIME	73-74. MED. OR PROCEDURE	ROUTE	RESULT RHYTHM	75. PALP PULSE OR BP

COMMUNICATION
66. Name of Hospital contacted Code

CONTACTED BY: ☐ telephone ☐ radio ☐ dispatcher
MESSAGE TO: ☐ ER staff ☐ MD
RADIO ORDERS: ☐ Not required ☐ Rec'd. from ER ☐ Rec'd. from MD at scene

67. Name of arrival hospital Code Time

Dr. ordering M.D.

68. CONDITION ON ARRIVAL AT HOSPITAL
☐ DOA ☐ Admitted to ER
☐ CPR being done on admission

VITAL SIGNS
69. Rhythm . . . .
70. Rate . . . . 71. BP . . . .
72. SPONTANEOUS RESPIRATIONS
☐ None ☐ Weak, needs assistance
☐ Spontaneous respirations ☐ with ET tube ☐ without ET tube

ADDITIONAL COMMENTS (RHYTHM STRIPS ON REVERSE)

76. ALS ATTENDANT	LIC. NO.	77. ALS ASSISTANT	LIC. NO.	RECEIVING PHYSICIAN M.D.