Standard of Care: The Professionalization of Emergency Medical Services

Ming Ray Xu
Swarthmore College Department of Sociology & Anthropology
Class of 2020
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Advised by Professor Shani Evans

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ABSTRACT

Emergency medical services (EMS) is a relatively new and ubiquitous public service in American communities. Widespread EMS has only existed in the US for about 50 years, a recent outgrowth of a much longer history of volunteer firefighting that is still in the process of rapid social and organizational change. Though predominantly volunteer-based, EMS also has a substantial career contingent closely tied to the growth of the healthcare sector, making the American EMS system a unique combination of paid and unpaid care providers. While the sociological literature surrounding occupations and volunteering is extensive, there is very little research on the coexistence of these two models of work in the same setting, making EMS a compelling environment to explore the development of professionalization and its interaction with other forces such as an existing tradition of volunteering. In this study I find that, in reality, occupational and volunteer models of EMS are highly intermingled among providers and even within the same provider, precluding an easy separation of EMS workers into an occupational side and a volunteer side.

Keywords: professionalization, volunteering, Emergency Medical Services (EMS), occupations

INTRODUCTION

Emergency medical services were originally developed in volunteer fire departments, institutions with great significance in 20\textsuperscript{th} century America as hubs of community life driven by widespread volunteerism, but in more recent years there have been reports that levels of firefighting and EMS volunteerism are declining. While volunteerism remains an integral part of the emergency services, recent decades have seen the new development of a career or paid firefighting and EMS system. The growth of the healthcare industry in the US has been a further influence on this
development, bringing new models and ideals of employment and professionalization. As such, EMS is practiced both as a hobby and as an occupation, an oddity in the sociological study of work and leisure.

More attention to the organization and practice of EMS, and to the contrasting approaches to EMS as a volunteer activity and an occupation, is thus sorely needed. This study draws on the relatively divergent strands of sociological research to date on occupations and volunteering for its analysis, and particularly on the idea of professionalization (the elevation of particular occupations to a special status as a profession) as a model for examining EMS. I particularly focus on a neo-Weberian theory of professionalization focused on the idea of social closure in an occupation and state legitimation of occupational standards as essential elements of professionalization. These frameworks will be useful for examining what social forces are at play in a volunteer activity or an occupation and whether they could go together, e.g. whether a volunteer field can be professionalized, and I review them in Chapter 1.

In this study, I endeavor to understand the nature of the volunteer-career coexistence in EMS, with the prevailing research question of how do EMS workers practice and reconcile the competing roles of volunteer and professional at work? I begin in Chapter 2 with a review on the history and structure of EMS as it relates to these two roles. As detailed in Chapter 3, through an approach of semi-structured interviews and participant observation of EMS workers, I then observe their day-to-day practices and uncover insights on how they identify themselves, their thoughts on each other and their work, and their opinions and predictions of the present and future state of EMS.

Through this exploration, I observe that the negotiation of career and volunteer roles at work, and the specter of professionalization, is complex to the point that it is difficult to separate volunteers and career staff as distinct and closed groups. This coexistence is likely to continue long
into the future with the importance of both groups to fulfilling specific needs for communities and local governments. In Chapter 4, I show evidence of factors that have reduced the capacity of volunteers in the studied areas to contribute hours toward working in EMS as well as some points concerning the continued relevance and importance of volunteering for particular community settings despite evidence of decline. In Chapter 5, I connect the decline in volunteerism described in Chapter 4 to the growth of the paid EMS occupation and review the prospects of professionalization among paid EMS staff. I also explore the idea of conflict between volunteers and paid staff as described by providers on both sides and its relevance to the neo-Weberian model of professionalization as social closure. In Chapter 6, I pivot and demonstrate that despite this sense of competition, the entanglement of volunteer and career roles prevents easy delineation, and this coexistence of roles is likely to persist long into the future. Volunteers and career staff are deeply entangled on a personal and social level, including in their reasons for participating in EMS and the major features of their day-to-day work. They overlap in their membership of organizations and in their involvement in operations, providers commonly participate in both roles and/or move between them, and a single provider can hold the ideals and motivations of both paid professional and volunteer. Finally, I conclude by offering policy recommendations on managing this coexistence and intertwining of career and volunteer staff in EMS. It becomes clear that EMS, as a landscape of social contradiction and ongoing change, will continue to offer a challenge to organizational and occupational sociology well into the future.

Note on Terminology

Several key terms in this work have alternative meanings in general use versus in the specialized contexts of sociology and EMS. The terms “EMS worker” or “EMS provider” will be used for all people working in EMS, while “EMT” and “Paramedic” are terms that refer to two
distinct types of EMS providers with different levels of training (see Chapter 2). The terms “career staff” or “paid staff” will be used to distinguish the occupation of EMS, or working in EMS for pay, while “volunteer” refers to personnel who work in EMS without pay.

The uses of the terms “profession” and “professional” are highly varied in general use but have a particular and more defined meaning in occupational sociology and in this work. We will use the word “profession” to refer to a restricted set of jobs that meet defined criteria relating to autonomy, prestige, and self-regulation in American society as described in Chapter 2 and reserve the term “occupation” to refer more generally to all regular jobs done for pay. “Professionalism” refers to the idea or goal of developing an occupation into a profession in this work, and “professionalization” is the process. These usages are sensitive in EMS given the dual presence of volunteers and paid staff in EMS, the desire by some to see EMS developed into a profession, and the common use of “professional” to refer to a standard of quality and excellence at work regardless of whether the worker is in an academically-defined profession or not. These ambiguities are significant in our exploration of the different ways EMS workers wish to define and develop EMS. Speakers quoted in interviews in this work may be freer in their use of these terms than I am, given their socially negotiated use.
CHAPTER 1: LITERATURE REVIEW

The study of professional change in the emergency medical services (EMS) is at the intersection of two prominent lines of inquiry in sociology: the study of occupations and the study of volunteering and civic life. The tension between these two models of organized activity, coexisting in EMS, is at the crux of our examination of EMS in the United States. As such, we will survey the extant literature on these two models and examine their applicability to EMS today in the coming chapters.

Volunteerism

Volunteering is a mode of participation in an organized activity in which the individuals participating do so freely with no or only negligible monetary compensation. This has been the historical model for the organization of EMS in the United States, and a large body of sociological research is devoted to understanding the reasons behind volunteerism (the act of volunteering) and the impact of volunteering on communities. In the latter case, there has been much interest in the choice between volunteering in large, established community organizations (including organizations such as the Rotary Club, church groups, and the fire department) versus other forms of organization.

Factors Affecting Volunteer Participation

One topic that has fascinated sociologists is the question of why people volunteer at all. A range of theoretical lenses have been used to answer this question, including social exchange and behaviorist theories, social network theory, and attitudinal theories that are particularly prevalent in social psychology (Wilson 2000). Because volunteers comprise much of the EMS workforce, EMS is an emergency service with a unique set of risks for practitioners, and there have been reported
declines in volunteerism in recent years, understanding the factors that lead volunteers to participate or not participate in EMS is a significant concern for policymakers as well as sociologists. I present a variety of theories for why individuals volunteer and will apply them in the examination of interview data in later chapters.

The social exchange theory of volunteering focuses on the utilitarian idea that volunteers are self-interested and rational actors who weigh the costs of investing time and effort into a cause with potential gains when deciding to participate in a volunteer activity (Wilson 2000). In this theory, which is also used to analyze a variety of other social relationships, volunteering is described as an activity that combines a social relationship with a social transaction under certain rules of exchange (Jiang & Wang 2018), the result of which is increased utility for the individual. Sociologists using this theory assume “reciprocity, rationality, altruism, group gain, status consistency, and competition [between volunteer activities]” are key factors affecting the choice to volunteer in a particular activity (Hallman & Zehrer 2016). Social exchange theories may be especially helpful for explaining motivations to volunteer based on a desire to acquire professionally or personally useful skills (such as EMS volunteers planning to transition to a paid career in EMS) or seek community recognition and approval, overall stressing a view of an individual volunteer who is rational and self-interested in search of an optimally rewarding volunteer experience.

Social network theories, on the other hand, follow from research demonstrating that rich social networks increase the likelihood of volunteering and suggest that deep(er) social ties are both a motivation for and a result of volunteering (Wilson 2000). Family transmission of volunteering activities, when parents recruit their children to volunteer for the same activity, has been studied under this framework and may be seen as a strong example of the influence of social closeness on volunteering (Mustillo et al. 2004). Microstructural theories of volunteering have been reported that
are very similar to social network theories, emphasizing that attitudes toward volunteering are affected by social ties, both before and after recruitment into a volunteer organization (Sokolowski 1996). These theories suggest a motivation to volunteer in EMS initially because an individual knows other volunteers already in the fire department or seeks new friends, and a motivation to continue volunteering in the long term because of a desire to maintain and/or deepen social bonds with other volunteers.

In contrast, attitudinal theories posit that altruistic motives on the part of individuals and/or the positive feelings they receive from volunteering or philanthropy are the primary drivers of both activities (Sokolowski 1996). Much work has also been done in social psychology to identify the motives people consciously attribute to volunteering, especially stressing the values passed on by parents to children, though a link between these values and the observed rate of volunteering is not well demonstrated (Wilson 2000). This line of research may explain narratives of volunteering in EMS due to a tradition in the family or other strongly held beliefs, such as a feeling of civic duty.

These models are complementary to each other, as a volunteer may conceivably be motivated by multiple factors at once, although some studies argue that social ties are a more important factor in decisions to volunteer than attitudinal theories (Sokolowski 1996; Perkins 1987). Sokolowski arrived at this conclusion based on quantitative survey data showing that social ties had greater predictive value than self-reported personal values and attitudes, while Perkins made this argument on the basis of ethnographic data in a firehouse. It has also been argued that altruistic and individualistic motives for volunteering (such as gaining transferable skills for one’s career) may coexist, and that volunteers are constantly balancing these desires with external forces like family and work (Heffernan 2013:35). There is disagreement in the literature about the applicability and effectiveness of particular theories of volunteering (Sokolowski 1996), allowing a variety of pathways
to explain why EMS volunteers exist and serve for long periods. The data collected in this study may suggest some of these theories are more effective in understanding EMS than others.

An equally important consideration in the sociology of volunteering is the question of what factors predict an individual’s degree of participation and involvement in a volunteer organization after joining. Sokolowski argued that as an individual volunteers over time, their interest in volunteering increases, concluding that interpersonal contacts in volunteering cause a change in mindset, helping to cultivate a “philanthropic ethos” over an extended period (1996). Also, a study of voluntary social movement organizations has shown that many of the same factors that drive an individual to volunteer in the first place (ideology, various motives, and social network effects) also predict their level of involvement in a voluntary organization, with microstructural or social network effects being the strongest. In addition, organizations with local chapters or a local focus, organizations that have a high level of commitment to and effectiveness with respect to a cause, and organizations possessing leaders with an aura of legitimacy may also have some positive effect on member participation (Barkan et al. 1995). Another study on volunteer fire departments in particular suggested that having autonomy to act as they thought most appropriate was important for maximizing volunteer participation (Perkins 1987). Finally, perceived organizational support, or the perception that an organization values the contributions of its members and is concerned with their well-being has been suggested as an important part of engagement in work and thus holds a special position in an individual’s decision to keep volunteering in a social exchange theory framework (Jiang & Wang 2018). As volunteer firefighting and EMS operate out of firehouses where a regular and long-term commitment to training and working is expected, understanding why volunteers engage themselves deeply in the work of firefighting and EMS is as important as understanding their initial decision to join the organization. The degree of variability in involvement is also one of the significant contrasts between the volunteer and occupational models of EMS, as the latter demands
a higher and more-or-less uniform level of involvement from all paid staff members at the same level.

Volunteering and the Community

Volunteering has also been studied to a considerable degree in its connection to community life. It has been suggested that the extent and forms of volunteering in American society are changing in recent decades because of changes in the structure of American communities and overall declines in social connectedness (Marsden et al. 2020, Putnam 2000, Wuthnow 1998). For example, Wuthnow has suggested that volunteer initiatives in the suburbs of major metropolitan areas tend to be more informal and short-term than in small towns because people may live in suburbs more transiently and, for a variety of reasons, feel less attached to such communities and are more focused on their own interests (1998). He also argues that time pressures due to work and family and an eroding barrier between work and leisure time have helped shift volunteering from being centered in longstanding organizations like volunteer fire departments (VFDs) and service clubs like Rotary and Kiwanis to initiatives with looser interpersonal connections or more short-term involvement. The emerging form of volunteering, in his view, consists of informal causes discovered over the Internet that have a one-time involvement on a weekend, rather than a service organization meeting weekly and discovered by word-of-mouth. Finally, it has been suggested that a change in the cultural definition of “service” could be decreasing the absolute number of volunteers, as more people are now inclined to believe that having a career in a public-facing occupation like medicine or law is a sufficiently altruistic contribution to society for one person (Wuthnow 1998).

It has also been suggested that volunteering may not necessarily have net positive effects for society, and that some forms of it can worsen inequality. One study of middle-class volunteers at a homeless shelter showed that when volunteers were given redundant jobs focused on rule
enforcement but had little power to actually improve the lives of the people they served, they drew upon “cultural ideologies about the homeless to altercast [conceptualize]” those they worked with as ungrateful charges requiring their intervention. This was done to avoid cognitive dissonance for volunteers trying to justify a need for themselves and had the effect of perpetuating a harmful cultural ideology about the homeless (Holden 1997).

**Occupational Sociology**

As opposed to the sociology of volunteering, the study of work done for pay is the subject of occupational sociology. Labor for pay to acquire the basic necessities of life being a universal feature of modern industrialized societies, much effort has been put into understanding the social world of the workplace and of the development and organization of occupations. Special attention has been paid to why some jobs develop more prestige, more autonomy, and better working conditions than others, resulting in the concept of the profession. It has been suggested that occupations are in constant competition in each other to improve their standing and conditions in society, and that all occupations seek to achieve the status of a profession. The prototypical profession in American sociology has been medicine, which has achieved a high degree of prestige, scarcity, self-regulation, and renumeration in the US compared to other industrialized countries (Starr 2017). The physician has thus been suggested as a model for professionalization that other occupations measure themselves against, especially for other occupations in healthcare. The theory of professionalization as a goal for all occupations, with its particular relevance for healthcare occupations, makes it important to consider when examining emergency medical services.

**Professions and Professionalization**

The study of the subset of occupations considered professions, and the process by which occupations become professions, has been a central concern of occupational sociology. Sociologists
have commonly referred to occupations such as medicine, engineering, and law as professions, distinguished as operating with specialized and high-level bodies of knowledge as well as features like codes of ethics, a sense of prestige, restrictive credentials for entry, a high degree of autonomy in working conditions, and costs of services that are less subject to the vicissitudes of the open market (Saks 2012; Abbott 1988; Pavalko 1988:17-19; Larson 1979). Abbott, a particular authority on the subject, characterizes the profession as “an exclusive occupational group applying somewhat abstract knowledge to particular cases,” and leaves the definition deliberately vague to argue that it is a moving target for occupations (1988).

The conditions favoring professionalization, as posited by Larson (1979), are several. It is ideal for the service being professionalized to be salient and universal to the public, and for the clientele for the service to be as broad as possible. Occupations which are initially exposed to the most competition are also most favored to professionalize, especially when the work of the occupation is mostly independent from other capital or goods markets. Occupations are also most likely to succeed in professionalizing if their cause is compatible with the dominant ideology of the time. Ultimately, professions are “dependent on public willingness to accept and legitimize the superiority of their knowledge or skills,” and the “uneven distribution of knowledge protects and enhances” the power they gain from their status (48).

Many theoretical frameworks have been brought to bear for studying professionalization. Functionalists in sociology have explained professions as occupations of complex knowledge and great social need who are accordingly granted a high status by society as compensation. Sociologists taking the Marxist approach cast professions in ways ranging from agents assuring the power of a dominating class to occupations that will be inevitably subsumed into the proletariat by the forces of commodification, making them no different from any other occupation. Foucauldian theories see
professions as extensions of the state, itself an “ensemble of institutions, knowledges, and procedures,” in its quest to extend the extent and scope of its governance. For example, the legal profession is part of the state’s system of legitimized force through the justice system and medicine a manifestation of the state’s biopower in this analytical framework. Another perspective focuses on the idea of professionalism as a form of discourse about occupations.

Finally, a particularly popular theoretical framework for characterizing professions is the neo-Weberian lens, under which professions are characterized not by the expertise of the work being done, but by a form of “exclusionary social closure in the market sanctioned by the state” (Saks 2012). This approach characterizes occupations that manage to professionalize as social groups that have united to promote a collective advancement in the social hierarchy in competition with other occupations for professional standing. Boundary disputes between aspiring professions may even be key to determining the eventual scope of the profession (Abbott 1988). The reward for securing such standing is protection by the state from market competition (Abbott 1988:323-24) by regulations endorsing the ability of the profession to restrict entry by newcomers and dictate the prices for its services. The neo-Weberian approach suggests that social closure around occupations could be a major explanation for the origin of earnings inequality and occupational stratification, as occupations increase rewards for their members by creating artificial monopolies and extracting monopoly rents as well as building social prestige. Undesirable outsiders may be closed off from the rewards of the profession on the basis of race, social background, gender, or other factors, not just for a lack of competence. Five strategies for social closure have been suggested as particularly salient: licensing, credentialing, certification, unionization, and the use of professional associations (Weeden 2002:57-58).
An important development in the study of professions has been viewing professionalization as an ongoing project of occupations, not a fixed status, which exists independently of the actual skill, expertise, or ethical standards of the occupation (MacDonald 1995). In this view, just as occupations can become professions by adopting measures of unity and exclusivity like licensing and self-governance through professional associations, occupations can stall on the way to becoming professions. Sociologists have cited fields like nursing, teaching, and social work as semi-professions which have gained only partial autonomy and public recognition as distinct occupations with special expertise (Etzioni 1969; Ritzer 1977:45). Some fields, laboring in the shadow of more dominant professions while doing related or identical work, may face exceptional barriers to becoming professions in their own right, such as laboratory or medical technicians (Ritzer 1977:45). When one occupation is controlled by another, class, gender, and the privileged epistemological model of the occupation (e.g. science-based or experience-based) can affect which comes out on top (Kitto et al. 2011:28).

The concept of professionalization has been widely used to examine healthcare occupations, making it an attractive model for examining emergency medical services. While medicine has long been studied as a profession, attention has also been paid to the rise of allied health occupations, and the means by which they attain social and cultural acceptance has been described as a professionalizing process. The most prominently studied example is nursing, which has long existed as a subordinate occupation to physicians and was described as being in the process of professionalization in the late 20th century, driven by large nurses’ associations advocating for collective interests (Klaus & Brown 1982, Levi 1980, Zadorosnyj 1990) and perhaps spearheaded by the development of the nurse practitioner (Glynn 1989). A study of nursing has particularly shined a light on the intersection of gender, race and class as factors affecting the professionalization process and its relevance to inequality (Schneider 2016). Other established allied health occupations in the
US that have been described as professionalizing include optometrists (Begun 1979) and genetic counselors (Hinton 2006). While there is disagreement over the possibility of successful professionalization by allied health occupations, even detractors have conceded that these occupations actively seek greater autonomy and prestige, outwardly some of the most important markers of a profession (Lescoe-Long & Kronenfeld 1988). These studies suggest that professionalization is a commonly sought goal among the many occupations in American healthcare, taking after the model set by the physician. If practitioners of emergency medical services see themselves as healthcare workers, they may also consider professionalization to be a natural model for the development of their own occupation.

Occupations

Outside of the study of professions, occupations of all kinds have been analyzed as particular cultures or subcultures with unique belief systems, myths, stories, symbols, rituals, and taboos that offer a powerful source of identity for individuals. The assemblage of occupations as subcultures in a working environment arguably shape the overall culture of an organization. Like other cultures, occupations have been suggested to seek control over their work but are constantly in flux due to the reconstructive influences of external pressures, like bureaucracy and regulation (Trice 1993). In this sense, the line separating professional and non-professional occupations may be thinner than one might expect.

An important consideration of the neo-Weberian theory of social closure is that it is applicable to all occupations, not just those already considered professions. It is possible that, given the lack of security of having occupational standards set by the market, most or all occupations would seek to become professions if possible, and the stratification of occupations seen in the workforce today is a result of varying degrees of success among them in the competition for
professional status. The closure strategies of licensing and certification, for example, are widespread in the US among occupations of highly varied prestige and income level (Weeden 2002). Occupational licensing requirements alone were estimated to directly affect 18% of the US workforce, more than unionization or the minimum wage (Kleiner 2000:190). Unionization, a strategy particularly associated with working class occupations as opposed to the canonical professions, is similar to professionalization in terms of its seeking of a monopoly on labor and its reliance on the unity of the occupation to increase bargaining power (Kleiner 2000:193), and arguably proceeds from the same motivation of social closure. The lowest paid and most unskilled jobs may in fact have the most to gain from social closure and raising their prestige (Weeden 2002), escaping the Marxist alienation and lack of autonomy that may characterize their working conditions (Ritzer 1977:58).

The flexible applicability of neo-Weberian theory for non-professions makes it particularly attractive for the analysis of paid emergency medical services (EMS) compared to other models. EMS, for example, would not currently meet the canonical definition of a profession but employs licensing and certification of providers as a means of controlling who gets to practice. Because the demand for emergency medical services cannot be easily altered, those who aspire to professionalize EMS may have particular incentive to control the supply of EMS providers through these strategies. It is important to note that because neo-Weberian theory synthesizes so much of what has been previously theorized about how professionalization works and posits a continuity between the lowliest occupations and the most prestigious professions in terms of their desire for advancement to professional status, much of the previous research about professionalization will be applicable to EMS.
Studies of EMS

One of the reasons the study of EMS is an attractive prospect is because EMS and fire departments have been scarcely represented in the sociological literature. Here I review the few studies that could be found. One such study was done by Perkins (1987), showing that in his time volunteer fire departments (VFDs) were often key community institutions, and that fire departments existed on a continuum from the fully volunteer to the fully paid. He suggests that social relationships are the main incentive of joining a VFD and justify the extensive investment of leisure time required to maintain an active fire department, as well as the dangers of the job. These findings support the relevance of social-network theories of volunteering and the idea of the “philanthropic ethos” previously mentioned in this chapter. Perkins also notes that even in his study setting of a rural all-volunteer fire department, there existed a tension between two models of organization and understanding of the work of firefighting. First was the traditional notion of autonomy, that the department ought to be kept free from state regulation of record-keeping and training requirements with a focus on expertise built by experience; and second was a “professional” notion that firefighting was a skilled activity that justified state-mandated training requirements, extensive training for individual members, and greater coordination with neighboring departments and the local government as opposed to strict independence. The second model, which stresses greater state oversight and higher standards of training for firefighters, is consistent with themes described as crucial for professionalization—the development of a specialized body of knowledge that not everybody can practice and state legitimation of such standards. This disagreement in philosophy among department members in the Perkins study followed age lines, as the younger members tended to be more of the “professional” mindset. The notion of professionalism in unpaid EMS has also attracted attention in a single article (Gora 1985), which asserted that the framework of professions could be applied to volunteer EMS work.
However, an interest in studying EMTs has been slowly growing in recent years. The method of ethnography has been a particular mainstay for this process, being well-established as a means of studying healthcare providers within the hospital (Chambliss 1996; Finkler et al. 2008). Some existing studies of EMS in the field have covered the work strategies of paramedics in Canada (Corman 2017), the intersection of EMS with the governance of American poverty (Seim 2017), and their impact on the experience of migration at the US-Mexico border (Jusionyte 2018). A series of scholarly projects on how volunteer EMTs may be recruited and retained have also been conducted (Haug & Gaskins 2012; Heffernan 2013; Greene 2016; Henderson & Sowa 2018). However, there remains a need for a theoretical analysis of the coexistence of volunteer and career EMTs with the aid of neo-Weberian theory beyond merely the emphasis of recruitment and retention of volunteers, as this thesis proposes to do. We have seen that the literature of both occupations and volunteers offers models of understanding that can be applied to EMS.
CHAPTER 2: BACKGROUND ON EMS

History

Compared to police and firefighting, emergency medical services (EMS) is a relatively young emergency service in the US. Until 50 years ago, organizations providing emergency care to civilians in the field were isolated and uncoordinated, and mostly drew inspiration from military medical services caring for soldiers on the battlefield (Shah 2006). The birth of the modern American EMS system is often dated to 1966, when the National Academy of Sciences published a report titled Accidental Death and Disability: The Neglected Disease of Modern Society, commonly referred to in the field as “The White Paper” (National Academy of Sciences). At the time, the combination of cancer, cardiovascular disease, strokes, car accidents, and other cases of trauma became recognized a major public health issue (Shah 2006). The report shocked policy makers, declaring that “the human and financial loss from preventable accidental death constitute a public health problem second only to the ravages of ancient plagues or world wars.” It asserted that “[military] experts returning home from Korea and Vietnam judged that, if seriously wounded, their chances of survival would be better in the combat zone than on the average city street” (National Academy of Sciences 1966:12).

The White Paper called for sweeping changes to establish a consistent nationwide EMS system to replace the existing piecemeal, unevenly organized, and unevenly trained local systems run by hospitals, fire departments, volunteer groups, and even undertakers (Shah 2006). Proposed reforms in the White Paper included, among others, nationally standard references and courses for training first responders (police, firefighters, and ambulance crews), “exploring the feasibility of a nationwide telephone number to summon an ambulance,” and generally more expansive regulation of emergency services by state governments (1966:35-37). New federal laws provided resources and the impetus for these reforms to be implemented. The Highway Safety Act of 1966 compelled states
to fund emergency services along with other safety programs such as vehicle inspections, highway design standards, and accident investigation procedures. The Emergency Medical Services Systems Act of 1973 invested over $300 million ($1.8 billion in 2020 dollars) in the development of regional EMS systems. The National Registry of Emergency Medical Technicians (NREMT) released its first blueprint of a nationally standard EMS training system in 1993, and the National Highway Traffic Safety Administration (NHTSA) created the first regulated system of EMS training levels in 1996 (NREMT 2007:6-7).

The first nationally recognized EMS training standard, the Emergency Medical Technician-Ambulance (EMT-A), was published in 1969 (Edgerly 2013) and required 72 hours of training (Harrison et al. 1979). It was followed in the early 1970s by the first Paramedic programs (EMT-P), which required 400 hours of training and 100 hours of clinical rotations, launched by physicians who believed that advanced resuscitative techniques like intubation could be done in the field (Edgerly). The NREMT notes that its first EMT-P exam was given in 1978, followed by its first EMT-I exams in 1983 (“The History of the National Registry” 2018). By the 1980s, EMS had established itself across the country as an important part of public safety. EMS services are now seen as a routine fixture of public services in most American communities, there now exist nationwide organizations of EMS providers to set standards and advocate for EMS-related interests, and the scope of EMS training and operations has continued to expand ever since.

In the neo-Weberian model of professionalization, essential elements employed by groups hoping to professionalize an occupation include licensing, credentialing, certification, unionization, and professional associations. The establishment of a nationwide governmental mandate for EMS, national EMS advocacy organizations like the National Association of EMTs (NAEMT), and training standards for EMS providers from the 1960s onward arguably mark the birth of conditions
that could give rise to professionalization in EMS. EMS licensing and credentialing have become well-established for providers in the US through both the NREMT standard and the standards set by individual states. Unionization has occurred to a limited extent in EMS, as seen in organizations such as the International Association of Fire Fighters (IAFF) and EMS Workers United/AFSCME (EMS Workers United), which together represent over 300,000 firefighters and EMS providers. These measures, and the readiness of federal and state governments to implement them, suggest a willingness of the state to legitimate the social closure that defines professionalization in the neo-Weberian sense. Continued professionalization would require deepening these measures to achieve more complete social closure, such as higher training requirements. The IAFF has demonstrated a continuing interest in this process, as its membership requirements prohibit IAFF members from volunteering outside their paid employment in firefighting or EMS, a provision which has generated some controversy in the industry (Barnhardt 2002, Nash 2002, Roh 2010).

*Structure*

Today, EMS activities in the US are undertaken by thousands of private and public organizations, many of which operate at the county level or lower. These organizations include volunteer fire companies with ambulances and personnel cross-trained in firefighting and EMS, EMS-only volunteer rescue squads, municipal emergency services systems in large cities with mostly paid staff, private companies contracted to provide local EMS service or interfacility patient transport, and large hospital systems that directly employ EMS personnel to help ensure a supply of emergency patients from the area.

EMS is principally regulated at the state level, with each state’s Emergency Medical Services Office issuing its own guidelines on the scope of practice for various levels of EMS personnel. Although EMS workers are licensed on a state-by-state basis, their certifications usually
carry over from one state to another under the framework of the National Registry of Emergency Medical Technicians (NREMT), a credentialing organization formed under the auspices of the federal government, which issues a national standard of EMS training that most states recognize and incorporate into their state EMS standards. Those states then issue state licenses to those who have completed NREMT-standard or state-standard courses and passed written and practical exams (“National EMS Certification Process”). The federal National Highway Traffic Safety Administration (NHTSA) has a secondary role in national research, planning, and advising on EMS strategy (NHTSA 2018).

Levels of Certification

Four levels of personnel certification predominate in the US EMS system: Emergency Medical Responders (EMR), Emergency Medical Technicians (EMT), Advanced Emergency Medical Technicians (AEMT), and Paramedics. These are in ascending order of seniority, and each level comes with increasing length of education as well as a larger range of techniques that practitioners may perform (see Table 1 below). Additional abilities, such as driving an ambulance or other emergency vehicle, working aboard an airlift EMS unit, working in wilderness EMS, and working as an educator in EMS usually require additional training courses, certification, and state licensing. Within these four levels, the EMT certification is the backbone of the EMS system, alone accounting for more than half of all EMS certifications. EMTs and paramedics together account for more than three-quarters of the system, with AEMTs being increasingly phased out in favor of paramedics, and EMRs usually playing a secondary role as ambulance drivers or workers in businesses that benefit from having employees with some medical training, such as lifeguards.
<table>
<thead>
<tr>
<th>Preferred Name</th>
<th>Other Names</th>
<th>Training hours *</th>
<th>Example Competencies</th>
<th>Licensed **</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medical Responder (EMR)</td>
<td>First Responder</td>
<td>48-52</td>
<td>Basic airway support, oxygen, auto-injectors, CPR, AED use, manual stabilization of injuries</td>
<td>107,516 (11%)</td>
</tr>
<tr>
<td>Emergency Medical Technician (EMT)</td>
<td>EMT-Basic, EMT-B</td>
<td>150-200</td>
<td>Positive pressure ventilation devices, assisting patients with their own medications, oral glucose, aspirin, splints</td>
<td>547,693 (57%)</td>
</tr>
<tr>
<td>Advanced Emergency Medical Technician (AEMT)</td>
<td>EMT-Intermediate, EMT-I</td>
<td>150-250</td>
<td>Starting IV lines, nitroglycerin, epinephrine, glucagon/D50 for diabetes, nitrous oxide, opioid antagonists***</td>
<td>54,855 (6%)</td>
</tr>
<tr>
<td>Paramedic</td>
<td>EMT-Paramedic, EMT-P, Medic</td>
<td>1000-1200</td>
<td>Intubation, IV medications (including opioid painkillers), blood transfusion, manual defibrillation, EKG, sedation of combative patients</td>
<td>203,807 (21%)</td>
</tr>
</tbody>
</table>

*Other certification types

| TOTAL | 42,583 (4%) |

| TOTAL | 956,454 |

*PA Dept. of Health 2017

** NHTSA 2014:89-90

***This includes naloxone/Narcan, the recently popularized drug for reversing opioid overdoses. Note that while the NREMT lists this as an AEMT skill, in practice naloxone may be commonly carried and administered by personnel ranging from EMTs to police officers, firefighters, or even laypeople depending on the region.

Table 1: The names and selected competencies of American EMS personnel outlined by the NREMT. Each level is capable of all the competencies listed in its row and above it. The legally mandated minimum training time in Pennsylvania is also given for reference (PA Dept. of Health 2017), although in practice these prescriptions may often be exceeded.

**Demographics**

The *National EMS Assessment* estimated the total number of licensed EMS providers of EMT-Basic (EMT), EMT-Intermediate (AEMT), and EMT-Paramedic certifications at 826,111 people. When personnel with First Responder or Medical Responder (EMR) certifications are
included, this number climbs to nearly one million state licenses as of 2011 (NHTSA 2014). The total number of providers is likely smaller, as professional personnel who work in multiple states require certification in each state, and the number of active personnel who are currently working in EMS must be smaller still. On the other hand, the Bureau of Labor Statistics estimates that 251,860 Americans are employed as EMTs or Paramedics as of May 2017 (“Occupational Employment & Wages” 2017). Assuming the number of EMS providers has grown from 2010 to 2018, this implies that perhaps around 30% of EMS personnel are paid for their work. However, this figure has some uncertainty as 2015 survey data from LEADS, a longitudinal study of EMS providers run by the NREMT, show that 20% of EMS providers from a sample of 4,000 people newly certified in 2013 are mainly volunteer, suggesting that as many as 80% are paid for some part of their work. The same study reported that 67% of respondents volunteered in at least one of their EMS jobs, suggesting that it is common for paid EMS providers to also volunteer (NREMT 2015).

EMS personnel in the US are primarily White men, most of whom have graduated from high school, but not from college. LEADS data from 2014 revealed that EMTs and Paramedics in the US were 66% male with an average age of 32 years. 43% of the respondents reported a maximum educational attainment of “some college,” and 23% held a bachelor’s degree (NREMT 2014). The *National EMS Workforce Assessment* reported that in 2007, 75% of EMTs, AEMTs, and Paramedics were non-Hispanic whites (NREMT 2014:35).

**Operations**

In EMS operations, EMTs are usually the lowest level of practitioner that can manage a case independently, from when the patient is encountered at the incident scene to their transfer to a hospital for definitive care. They may be assisted by EMRs, but as previously noted EMRs are mostly trained to “hand off care to more experienced practitioners” when available and as such do
not typically staff ambulances except as a driver or attendant to a higher-certified crew member. More commonly, EMRs are employed by venues when it is expected that some form of rapid medical response will be necessary on-site for stabilizing a patient before the arrival of an ambulance, as is the case with lifeguards or private security guards.

Ambulances where the most capable provider aboard is an EMT are called Basic Life Support (BLS) units, while those with an AEMT or Paramedic aboard are called Advanced Life Support (ALS) units. In the typical “tiered-response model” of operations, BLS units handle the majority of calls, while ALS units are usually dispatched only to the most severe emergencies, as determined by the 911 dispatcher, due to the greater scarcity of paramedics and AEMTs. This may take the form of separate ambulances for BLS and ALS crews or BLS-crewed ambulances that can be supplemented by an ALS responder in a separate vehicle or “chase car” when needed. Calls that are initially dispatched as requiring an ALS response can be released to BLS units when the AEMT or Paramedic assesses the case and determines that their advanced capabilities are not necessary, allowing the ALS unit to return to service for other calls.

After a 911 call is placed and the dispatcher decides which emergency units are needed, EMS personnel are typically paged or hailed on the radio to respond. EMS personnel then arrive on-scene and provide patient care according to predefined protocols developed by the state EMS office and Medical Command, a physician authority that indirectly supervises EMS operations. After transporting them to the hospital, EMS personnel complete a patient care record for the call, to be added to the patient’s medical record and/or preserved as a source of evidence in case of medical litigation.

When multiple EMS units respond to the same event, the operator with the highest level of certification is in command. For most calls, this takes the form of a paramedic coordinating the
delivery of care and a team of EMTs that carry out his or her orders. Larger incidents often have a standalone unit present that serves as the EMS commander for the incident, who coordinates with fire and police command officials. While working, EMS personnel can also contact Medical Command, where a physician is on duty at all hours to give advice on complex cases and authorize serious interventions, such as using physical or chemical restraints on a combative patient. Mass-casualty incidents (MCIs) are one of the only exceptions to the absence of physicians on-scene in the American EMS system, as doctors and nurses may sometimes work in the field alongside the usual paramedics and EMTs in such situations.

The presence of multiple ranks and levels of EMS competence has been a large factor in the continued coexistence of volunteers and paid staff with different levels of interest and time available to work in EMS. As a result, providers with limited training are nonetheless able to contribute to the extent of their ability while practitioners with more advanced training can supervise them and be deployed wherever needed. The existence of a physician providing Medical Command and supervising all EMS providers in a particular jurisdiction is also arguably the legacy of professionalization among physicians, implying that EMS practitioners are extensions of the authority of a physician who delegates them permission to perform a limited set of interventions in the field in the absence of that physician. This is a similar situation to those of allied health providers such as nurses and physician assistants, occupations which were founded to take on some of the routine work of physicians and who remain formally subordinated to physician authority in most contexts. As we saw in Chapter 1, there have been numerous cases of occupations which are subordinated to the medical profession seeking to become professions themselves, and EMS may well follow a similar path of development.
Working Conditions

Despite the crucial role played by EMS providers in many communities, pay and conditions for EMS as an occupation leave much to be desired and may form a significant motivation for EMS professionalization efforts. The Bureau of Labor Statistics reports current median pay of $33,380 per year or $16.05 hourly for EMTs and paramedics combined (“Occupational Outlook Handbook” 2018). This level is only 27% above the 2020 federal poverty line of $26,200 for a family of four (HHS 2020). Salaries for paid EMS work climb with certification level. A 2016 survey of EMS provider salaries indicated the average salary for EMTs was $38,442, climbing to $40,102 for AEMTs and $48,877 for paramedics (Ragone & Washko 2017). The National EMS Assessment 2011 asked EMS directors from 47 states if they thought providers of various levels of certifications could earn a reasonable living from working full-time for one employer. Only four out of 47 state directors agreed with this statement for EMTs (8.5%), and 18 out of 47 for paramedics (38.3%), compared to 29 out of 47 (61.7%) for non-EMS firefighters and 36 out of 47 (76.6%) for police (187).

EMS pay is far below comparable occupations in healthcare according to the Bureau of Labor Statistics (BLS) Occupational Outlook Handbook in 2018. The pay for EMTs and paramedics, at an average of $16.05 per hour, is comparable to construction laborers and helpers (paid an average of $17.31 per hour) and general hand laborers and material movers ($13.80 per hour), who require only short-term on-the-job training. Official BLS statistics indicate that licensed practical nurses (LPNs), who hold a non-degree certification in nursing that requires about 1 year of education (compared to 1-2 years for a paramedic training program), make an average of $22.83 per hour or $47,480 per year. Respiratory therapists, who hold an associate’s degree earned in similar time as a paramedic certification or associate’s degree, make an average of $29.48 per hour or $61,330 per year. Huxley reports that EMS providers often extensively supplement their regular
hours with overtime and second jobs, with the potential for greater income at the cost of work-life balance (2018).

The aforementioned healthcare occupations which are similar to EMS are notably also in hospital settings as opposed to being in the field like EMTs and paramedics. EMS workers experience exceptionally difficult working conditions for healthcare workers. NREMT data from the longitudinal LEADS II survey indicated that 41% of respondents had worked 24-hour shifts in the previous year (NREMT 2015). Huxley indicated that the rate of work injuries for EMS personnel is also much higher than the average for the US workforce. One often-reported type is back injuries from lifting heavy objects and patients in cramped conditions, where ergonomically safer lifting strategies, such as using the legs to lift while keeping the back straight, are difficult or impossible. Other potential sources of injury include environmental hazards such as fire, broken glass, or chemicals; automotive accidents from ambulance operations; and assault from patients and bystanders--LEADS 2013 data show that 67.0% of EMS personnel surveyed had been verbally abused in the past 12 months, and 43.6% had been physically assaulted (Gormley et al. 2016:439-447). The psychological and emotional toll is also immense, from exposure to traumatic or disturbing cases, verbal abuse, sleep deprivation from difficult shift schedules, and sexual harassment. In spite of this, in 2011 only a single state (Pennsylvania) was known to track work-related injuries in EMS (National EMS Assessment 2011 186).

Understandably, just as volunteers can easily decide when to get involved or walk away, turnover rates for professional EMS are also high, ranging from 15.2% for full-time EMS employees, to 18.6% for volunteers, to 23.2% for part-time employees according to an employee survey by the Journal of Emergency Medical Services (Williams 2007). The most commonly reported reasons for leaving were higher pay elsewhere, a desire to leave the industry entirely, and to
go back to school (Williams 2007:42-56). Huxley reported that owing to the demanding nature of 
the work, many providers consider EMS a personally unsustainable job. According to him, by the 
age of 55 most EMS workers have long since changed their occupation or burned out (2018).

These working conditions, which are far from ideal, show that there is much to gain should 
paid EMS workers to organize and professionalize their occupation. The presence of both 
volunteers and paid staff in the same line of work may be a complicating factor for this process, as 
there may be downward pressure on wages and working conditions for paid EMS workers while 
there exists a significant population of EMS providers willing to do it for free.

EMS and the Medical System

EMS has a major role in feeding patients into hospitals and shuttling patients between 
different medical institutions. In emergency departments, ambulance transports accounted for 
between 11% and 16% of Emergency Department visits in a 2011 sample (Meisel et al. 2011). 
Augustine reports a slightly higher figure of 17% and adds that about 39% of patients who arrive at 
the ED via EMS are admitted, which is more than twice the rate for walk-in patients (2014).

Apart from the task of taking patients from the scene of an accident or illness to the 
hospital, it is also common for EMS personnel to transport patients experiencing a medical 
emergency from a long-term care facility accustomed to an EMS presence, or for interfacility patient 
transfers between hospitals. The latter is an especially important source of revenue for for-profit 
ambulance services and may be done by the same crews that bring patients to the emergency room. 
For many economically disadvantaged patients without a primary doctor, EMS may be the patient’s 
primary means of accessing medical care for acute or chronic medical conditions.
Shah (2006:414-423) also suggests that EMS in the future could take a larger role in public and community health, since it already responds to many calls that are not true emergencies. He suggests that in the future, EMS could take on responsibilities like reporting on living conditions in detail to public health authorities, educating the public about health and hygiene measures, and screening for preventable diseases when they are called to a residence. It remains to be seen whether this proposal will see broader implementation in the future, since the EMS system today is highly focused on acute care and stabilization for transport to a hospital, rather than spending extended periods of time for evaluation and care at the scene.

Finally, owing to difficult working conditions, many health workers in other occupations gain their initial exposure to healthcare work from working in EMS before transitioning to a new line of work. EMTs and paramedics’ medical experience makes them competitive candidates for nursing, physician assistant (PA), physician (MD/DO), and other health profession programs. Sometimes, bridge programs exist specifically for EMTs and paramedics retraining for other health fields, particularly nursing (Solheim 2016).

These observations showcase the high degree of integration between EMS and the burgeoning American healthcare industry, with EMS workers keenly aware of the different working conditions among healthcare occupations ranging from their own to nurses, PAs, and physicians. It is reasonable to suppose that these other occupations present a model that EMS workers would seek to apply to their own work.
CHAPTER 3: METHODS & DATA OVERVIEW

Methods

This project aims to address the question of how EMS workers practice and reconcile the competing roles of volunteer and professional at work. Answering this question required intensive study of several separate fire stations with ethnographic observation and semi-structured interviews of EMS providers, in order to gain insight into the working experiences of individual EMS workers. My fieldwork involved joining emergency workers in the full extent of daily activities (responding to emergency calls, providing medical care to patients on-scene, and transferring patients to hospital emergency rooms) and recording detailed observations on the relations between professional staff, volunteers, administrators, and patients. As an active volunteer EMT, I was well-positioned to integrate myself in the routines of the ambulance department at each agency and conduct this type of fieldwork in a safe and unobtrusive manner.

My semi-structured interviews with personnel, spread across several fire stations detailed below, evaluated the reactions staff and administrators have to professionalization, organized labor, the challenges they face at work, and their prospects for emergency services in the future. I prepared an interview guide with a representative set of questions (Table 1 below) about each interviewee’s personal experiences, their understanding of their own station, and their understanding of the broader field of EMS in the United States. Not all interviews were transcribed for quotations, but quotations have been chosen to be as representative as possible of the results of all 29 interviews and all fieldwork I conducted. All research subjects and locations mentioned in this work have been given pseudonyms to protect their privacy.
Tell me about your history in EMS?

What prompted you to start volunteering/working in EMS?

What motivates you about working in EMS? What are you hoping to get out of it?

What personality traits or skills would you say mark a good EMT?

Do you have any thoughts on the way the fire service/EMS are seen by the public?

Tell me about the social environment of your agency/firehouse?

If someone described an EMT as a healthcare worker, would you consider that accurate?

Do you have any connections or attachment to the town this agency is in?

Could you tell me about the relations between volunteers and paid staff in firefighting/EMS?

Have you noticed ways that EMS/the fire service have changed since you started in it?

If you had the opportunity, what would you change about the way EMS is done?

What’s the largest challenge that your department is facing at this point in time?

Table 2: Set of representative semi-structured interview questions for EMS providers.

In total I visited four EMS agencies, two each in the Philadelphia and Washington, DC metropolitan areas, to conduct interviews with EMS providers and firefighters. I identified potential agencies to visit through convenience methods (see details below for each station). I interviewed 29 providers in total across the four agencies. Two of these agencies, one in the Philadelphia area and one in the DC area, permitted me to conduct fieldwork, allowing me to conduct 80 hours of observation recorded in fieldnotes for further analysis. Demographic information of the interviewees is listed in Table 2.
Table 3: Summary of firefighters and EMS providers interviewed with the question set in Table 1. “FF” is short for “Firefighter” and “PM” for “Paramedic.” Age is reported with a tilde when presumed and not directly given by the interviewee.
Interviewed participants comprised a variety of backgrounds. Out of 29 interviews, 7 were with women (21%) and 22 with men (79%). Compared to nationwide statistics for EMS (Schafer et al. 2015), the sample of participants I interviewed is roughly representative of the nationwide gender balance among first responders. EMS workers are about 75% male, while firefighters are 95% male nationwide. Racially, one participant was black (3%), two Asian (7%), one of unknown race, and the rest were white (86%). My interviewees were somewhat more likely to be white than the national average for first responders (78% nationally). Black and Hispanic first responders (8.5% and 9% nationally) were also underrepresented.

Eleven participants were actively working for pay in EMS (although some volunteered as well at a second agency), and the rest were exclusively volunteer. All but four interviewees had EMS training and experience, and many participants were simultaneously firefighters and EMTs due to both types of service being present in the same station. The median age of the respondents was 42, compared to the nationwide average of 36 for paid staff and 40 for volunteers (Cash et al. 2019).

Field Sites

A total of four EMS agencies were visited over the course of this project, with fieldwork completed at two of them. Data below concerning their organization was taken from individual interviews, fieldnotes, and department sources.

All four sites were in suburbs of major metropolitan areas on the East Coast of the US, which I chose both due to convenience and a desire to identify settings where paid and volunteer staff were most likely to be found working side by side. Rural areas tend to lean more heavily volunteer and urban areas tend to be more dominated by paid staff (King et al. 2018). Of the four field sites, all had median household income greater than the national median, and three of the four
had a greater proportion of non-Hispanic white residents than the national average. The fourth was heavily majority-minority. As a result, this sample of field sites does fall short of being nationally representative of EMS services in diverse community settings, and further research into EMS in community settings more representative of lower-income individuals, people of color, and inhabitants of rural and urban areas is necessary to obtain a complete picture of EMS across the United States in the future.

Summerfield

Summerfield Volunteer Fire Department (VFD) became a field site after I contacted several firehouses within an hour of my own residence in the suburbs of Washington DC via their public-facing websites. My main contact at Summerfield was a non-officer volunteer who invited me to visit only for interviews with volunteers, and in total I completed five. It is a combined firefighting/EMS station in an affluent inner suburb of Washington, DC. The station contains both volunteer and career staff who share the space but are organized as two administratively separate departments sharing the same space. Emergency services in the densely populated Summerfield County are highly coordinated at the county level, and all career staff are employed by a countywide fire and EMS department, who place them in stations across the entire county. Some volunteer fire departments that predated the organization of Summerfield County Fire & EMS, including at Summerfield VFD, retain significant numbers of personnel in a historic station, but were not reported to occupy more than one station per volunteer department.

At Summerfield, the colocation of career staff from Summerfield County Fire & EMS in a station building owned by the Summerfield Volunteer Fire Department offers many opportunities for interaction between volunteers and career staff. Though a complete tour could not be done because I was only permitted to visit for interviews, the Summerfield station is large, operating three
fighting vehicles and two ambulances, and the building contains a gym, living space for career firefighters around the clock, and a classroom space with seating for at least thirty people which is regularly used for training courses. Responders from Summerfield VFD may be called upon to assist other units from elsewhere in the area due to extensive mutual aid agreements. For operations, Summerfield volunteers operate separate vehicles from the career staff. The Summerfield Volunteer Fire Department comprises both firefighters and EMT-B personnel, but paramedics are all career staff under Summerfield County Fire & EMS.

Summerfield serves a suburban area including a major interstate highway and arterial suburban roads, a station on the DC Metro, upper-middle-class suburban residential areas, and nursing homes; and it borders a dense urban center within the county containing multiple high-rise buildings. The inhabitants of Summerfield are very high-income with a median household income of $201,570 compared to a nationwide median of $60,293. The racial composition of Summerfield has a higher proportion of non-Hispanic whites (72.6% versus 60.4% nationwide) and Asians (18.2% versus 5.9% nationwide) and a lower proportion of black and African American individuals (2.0% versus 13.4% nationwide), native Americans (0.2% versus 1.3% nationwide), and Hispanic and Latino individuals (4.1% versus 18.3% nationwide) compared to national proportions (US Census Bureau 2020).

Candor

Candor VFD became a field site through referral from a friend who worked in EMS, who knew an administrator there. That administrator, who oversaw the entire volunteer department, was my primary contact. I visited Candor VFD to conduct interviews with volunteers and career staff (with 11 total done) as well as 60 hours of fieldwork aboard a volunteer emergency vehicle. Candor is also a combined firefighting/EMS department in the DC area, though located much farther from
the urban center in what might be more properly termed the exurbs. Similarly to Summerfield, the Candor station space is shared between administratively separate volunteer and career staff groups, but the station building itself is owned by the volunteers. The Candor career staff are also employed by a countywide fire and EMS department, Candor County Fire & Rescue (CCFR), and can be placed in stations across the county, but unlike at Summerfield VFD, the Candor Volunteer Fire Department operates multiple stations as well—four stations each with firefighting operations at minimum, and some with EMS as well. I interviewed personnel from both Candor VFD and Candor County Fire & Rescue in the Candor station building for this study.

The volunteers at Candor VFD operate one ambulance and one fire engine between 6pm and 6am on weekday nights, and around the clock on weekends. Outside of these times, emergency services in the town of Candor are exclusively provided by the career staff. The vehicles are shared with the career personnel when volunteers are not on duty, and in addition the career staff operate several firefighting and EMS vehicles exclusively. Volunteers are assigned to a given weekday night, during which they are on duty for the entire 12 hours per week, as well as weekend duty for the entire weekend once every five weeks. I observed a minimum of ten personnel at minimum on duty on any given evening. The building contains a large set of bunk and locker rooms for personnel, volunteer and career, who spend extended time there. The facility also contains offices, a kitchen, and a movie screening room, but not a classroom space comparable to Summerfield.

Candor VFD serves an exurban area that, while less dense than at Summerfield, is nonetheless extensively populated and heavily trafficked by commuters. The service area includes suburban-style housing, a trailer park, a major interstate highway leading to Washington DC, nursing homes, and numerous strip malls and big-box retailers. Several military bases are also in the area. The inhabitants of the Candor service area are also highly diverse and particularly include large
numbers of immigrants of Latino background. The Candor area is higher income than the national median, with a median household income of $89,629 compared to a nationwide median of $60,293. The racial composition of the town of Candor is heavily majority-minority with a higher proportion of black and African American individuals (24.5% versus 13.4% nationwide), Hispanic and Latino individuals (32.9% versus 18.3% nationwide), and Asians (9.2% versus 5.9% nationwide) and a lower proportion of non-Hispanic whites (29.2% versus 60.4% nationwide) and native Americans (0.4% versus 1.3% nationwide), compared to national proportions (US Census Bureau 2020).

Walton

Walton VFD was my main station as a volunteer EMT and was visited for interviews predominantly with the career staff on duty there as well as fieldwork as a member of the ambulance crew. As a member of the station, I obtained the consent of the captain of EMS operations to conduct research there and did research during my regular shifts, interviewing a total of five people and observing over 80 hours of time on duty for fieldwork. Walton VFD is a volunteer fire department that has hired career staff on a part-time basis to assist with coverage of emergency calls. The volunteer and career staff belong to a single organization administered by volunteer officers and a volunteer board of directors elected by the volunteer membership of the station. Emergency services in Walton-Oxley County are more locally organized than at Summerfield and Candor. The role of the county government is limited to emergency services oversight and dispatch, and there does not exist a comparable countywide firefighting and EMS department. Instead, emergency services are organized individually by the numerous townships and boroughs of the county. Most firehouses in the county are historically volunteer departments and many remain so, though career staffing in these departments, as seen at Walton VFD, has become more common recently.
At Walton, volunteer and career staff share the same station building, together operating two fire engines, a ladder truck, and two ambulances. In practice, usually two to four personnel are on duty at a given time and, due to call volume, it is rare to see more than one or two of these vehicles in use at once. The station contains bunk space for four people and a shower, as well as a kitchen and a crew room. For operations, volunteer and career staff operate the same vehicle together depending on who is available for a given call. Most of the time, two to four part-time career personnel are on duty in shifts. Walton responders are part of a common dispatching system for the county and work with a variety of volunteer and career personnel from other units in the county when dispatched to the same call. The Walton VFD station also hosts a paramedic operating out of an SUV that does not perform patient transport by themselves, but augments EMT-B ambulances when needed. The paramedic is not employed by Walton VFD, but by the private hospital system that runs most of the hospitals in the local area.

Volunteers at Walton VFD, especially in EMS, occasionally sign up for shifts but are not constrained to particular shifts they are bound to fill. More commonly, especially for volunteer firefighters, they respond from home or work when a call comes in instead of being on duty for a fixed period. This affords volunteers discretion as to which calls they prefer to participate in, and means that most EMS calls and routine fire alarm calls are serviced by the career personnel only. Volunteers maintain most of the vehicles in the station and congregate at the station weekly for training, fire department business, and maintenance. Paid staff are hired by Walton VFD to work part-time, signing up for regular shifts to ensure coverage around the clock aside from occasional gaps in service.

Walton serves a suburban service area that contains both white-collar and blue-collar residential areas, with the immediate Walton community being predominantly white-collar. The area
includes a college, nursing homes, detached residential housing, an interstate highway, and an arterial road with numerous strip malls and big-box retail stores. The inhabitants of Walton are relatively high-income with a median household income of $109,648 compared to a nationwide median of $60,293. The racial composition of Walton is heavily white with a higher proportion of non-Hispanic whites (80.1% versus 60.4% nationwide) and a lower proportion of black and African American individuals (6.5% versus 13.4% nationwide), native Americans (<0.1% versus 1.3% nationwide), Asians (5.4% versus 5.9% nationwide), and Hispanic and Latino individuals (3.1% versus 18.3% nationwide) compared to national proportions (US Census Bureau 2020).

Oxley

I identified Oxley VFD as a field site via referral from my coworkers at Walton. Oxley VFD is located about ten minutes from Walton in the same suburban county, Walton-Oxley County, and was visited for interviews exclusively with eight volunteers on duty there. Oxley VFD is, unusual for the area, an exclusively volunteer and exclusively EMS department sited next to a fire department (that only performs firefighting) which it split from several decades prior. Volunteers are on duty at the station 24 hours a day, seven days a week, in several shifts. Similarly to Candor VFD, volunteers are assigned to a weekday evening, which they work weekly, as well as occasional weekend duty.

The station contained approximately four personnel on any given evening I visited and operates an undetermined number of ambulances, though staffing levels seem sufficient for a single ambulance at a time. As I did not tour the entire facility, its size was undetermined, but contained a large conference room and offices, a crew room, a kitchen, and presumably also accommodations for volunteers staying overnight. EMTs at Oxley VFD, as at Walton VFD, cooperate extensively with other fire and EMS agencies in the area in the countywide dispatching system.
Oxley VFD, being in the next town over, has an overlapping service area to Walton VFD. The inhabitants of the township immediately surrounding Oxley are relatively high-income with a median household income of $111,367 compared to a nationwide median of $60,293. The racial composition of Oxley is predominantly white with a higher proportion of non-Hispanic whites (92.2% versus 60.4% nationwide) and a lower proportion of black and African American individuals (1.2% versus 13.4% nationwide), native Americans (<0.1% versus 1.3% nationwide), Asians (3.5% versus 5.9% nationwide), and Hispanic and Latino individuals (1.5% versus 18.3% nationwide) compared to national proportions (US Census Bureau 2020).
CHAPTER 4: ANALYSIS OF VOLUNTEERING

Participant observation and interviews allowed me to examine the state of EMS volunteering, and in particular to critically assess the commonly reported phenomenon of volunteer decline. My interviews corroborated the notion that volunteers in the study sites were potentially suffering a decline and suggested a number of contributing factors. Volunteers and paid staff in EMS both tended to attribute this decline to increasing training requirements and decreasing amounts of free time in which to volunteer and meet requirements for recertification. However, given the limited focus of my study on suburban areas, it would be an oversimplification to assume that this decline is uniform nationwide or that it will result in a total exodus of volunteers from EMS. Even with a reported decline in volunteers, there was nonetheless a thriving volunteer presence at several of the departments which was stable or growing, and many volunteers believed that the financial advantages volunteer EMS offered to local governments as opposed to paid EMS were powerful incentives to maintain it. As such, the state of volunteer EMS as I observed it could be summarized as a relative decline leading to stability.

Factors in Volunteer Decline

A widely reported trend in firefighting and EMS is a decline in the number of volunteers in the emergency services (AP 2006, Brittain 2015, Edwards 2019, NVFC 2019), a phenomenon that was corroborated in this study of four departments. In all four stations, study participants were aware of such a trend, even if their own station was not in a process of decline. Different causes have been put forth to explain the reasons behind this decline, such as onerous training requirements (Dedam et al. 2015, Edwards 2019, Fekos 2014), volunteers being forced to spend too much time fundraising (Brittain 2015), people moving away from home for school or work (Dedam
et al. 2015, McClatchy 2017), people feeling less connected to their communities (McClatchy 2017), and the rise of dual-income families. In this study, the most widely reported factors from interviewed firefighters and EMS workers was not having enough time to fulfill working requirements, including training hours. Also widely reported was limitation in the scope of activities volunteers could take part in, decreasing the enjoyment derived from the work environment, both in firefighting and EMS.

Respondents in this study believed that the biggest factor affecting volunteerism in firefighting and EMS was a lack of time to volunteer, especially given the time requirements for training when the provider cannot respond to calls. Though some investment of time initially was always required before one could begin fighting fires and responding on an ambulance, certification classes may only be held at certain times of year and may require in-person attendance continuously in large blocks of time. Respondents also suggested a contribution from a shift toward dual-income households. Ethan, a 59-year old paid firefighter/EMT at Walton VFD who worked full-time at a paper plant and volunteered as a firefighter in a neighboring town, was asked what he thought most kept people from volunteering. In his words, the issue was a lack of time.

“Time. These days, you have mom and dad work to get their kids to daycare, they come home, they got to get their homework done, they got to feed them, they got to bath them, they got to put them in bed. By the end when they finally get free time, they don't want to go out and volunteer to go out on firefights, they just want to relax.”

Gerald, a 41-year old coworker of Ethan who worked full-time as a police officer in a disadvantaged urban area, was also asked for his thoughts on the matter. He corroborated Ethan, and particularly focused on the idea of a dual-income household and the demands of parenting being obstacles to training and volunteering for extended periods.

“The world is a different place. The economy is a different economy. It's not the 70s and 80s and 60s, where the husband worked and the wife stayed home. That's not the trend. Two working adults in a household trying to raise kids. I'm saying it now. I have
two little kids, 11 and 7. I don't know that I could join a firehouse right now as a new member and be able to meet the requirements of all that education and still work and still take my kids to basketball and lacrosse and wrestling and cheerleading. It's a lot to do. It's a lot to ask of somebody coming in off the street at an older age.

What the training requirements are—hell, when I went to train fire school in 1994, it was 90 hours. Now in 2019 it's like 200 hours or 188 hours or whatever. That's a big commitment to ask somebody that's joining the firehouse, however old they are, that they have to be away from their family or away from their social life or whatever. We're already asking you to volunteer and come up one night a week for training and leave your family when the whistle goes off or the pager goes off for calls. By the way, you have to do vehicle rescue, you have to do CPR, first aid, you have to do hazmat awareness, you have to do hazmat operations, you have to do Fire One. On top of that, we want you to come up every time the whistle goes off too. That's a lot to ask somebody to do.” -Gerald

Accounts of a lack of time for volunteering were not limited to Walton VFD. At Oxley VFD, a 34-year-old volunteer who also worked full-time as a county administrator in EMS and had prior experience as a paid paramedic, reported that her passion to work as an EMT was so great that she had decided to sacrifice sleep in order to continue volunteering and meeting the shift schedule at Oxley.

“It's very hard [to find the time]. I mean, and there are very few families now that have a stay at home parent who could on the side dedicate time to the volunteer service and some-some way, shape or form. You know, I mean my husband works full time, I work full time and we have two young kids. Trying to find time to be at the firehouse or you're volunteering for the ambulance is really hard. I mean, for me I-I started carving out time for my sleeping schedule to do it because I missed it so much. So for me it was that the best answer was how do I how do I not spend time away from my family? I [don’t] sleep on Friday nights. That's when I'm going to dedicate my time.” -Beth

All of these accounts have shared themes of dual-income households with time-consuming obligations in work and parenting that compete with available time to volunteer, consistent with previous research by Heffernan (2013). In an explanation under the social exchange theory of volunteering, the benefits derived from volunteering no longer match the costs of lost time that could be put to other uses for many volunteers.
Another common theme was the complaint that training requirements have also increased over time and further squeezed new volunteers. Frank, a 23-year-old paid staff member at Walton who had volunteered in firefighting and EMS since the age of 16 and had numerous family members who also participated, indicated that training requirements were not as high in the past.

“The whole field is changing right now. Many, many years ago in the 70s, there was double the amount of volunteers if not more than that, that were giving time, effort, talents and energy into the field.

Now just due to the amount of training hours required, what a lot of these places, even though they’re volunteered or are expecting out of people is a lot more and different than what it was decades ago…

You have to go through 190 hours of training to be a certified state firefighter. That's just the minimum requirements, that entry-level, that says, "Okay, you can go into a live fire. Put this air pack on." Same with EMT. It's a good way to get your foot in the door [in many] places too but even just as a volunteer, having to go through EMT class and all of that, that's all, it's even more.

It's 288 [hours] if not more, then you have to do all the testing and skills and everything. It's a lot to do right now. Some people don't think that that's all. They weren't expecting you having to do all this. I think the field’s changing from that and while there are what some people view as career versus volunteer, at the same time, um, we're seeing a lot more of these combination departments there. Yes, they're career staff but at the same time, there are still people in the community or wherever that volunteer.” -Frank

It is worth noting that training is also not a one-off exercise when the volunteer is first certified. Many jurisdictions and agencies require continuing education to ensure providers stay up to date on the latest protocols and techniques and periodic recertification, requiring continuing investment in training in addition to time spent responding to calls. As the provider above notes, some of these problems with staffing shortages have driven the rise of EMS, and firefighting to a lesser extent, as a paid occupation.

Furthermore, changes in operational protocols have made EMS more tedious to some providers, further sapping volunteer interest. Michael, a middle-aged white volunteer at Summerfield
VFD who volunteered seeking the *esprit de corps* that also defined his career in the military, particularly noted the impact of increased documentation requirements after every call.

We've always been driven by protocols as you have wherever you work as an EMT, um, with, there's a little more rigidity now in the paperwork. And so it takes--just a BLS call, basic BLS call for a nosebleed, um, can then be another three hours of just waiting to get through, um, triage and getting all the paperwork done, putting it all into the [electronic patient care report] and then coming back here and filling out all the other paperwork as required.

Sometimes it can be, it's just, it's painful, which as a volunteer can be very frustrating because you can't get back into service until you've completed all your paperwork essentially. And so that can take--a call, sometimes can take three hours. And it's just really frustrating. And it's just a basic BLS call for uh, you know, a transport from one of the care facilities around here into [a neighboring county] or into Summerfield County. But then you could be hanging around triage if it's a busy day for 30 minutes until you can offload your patient--not offload, but hand over the patient--and then it can be another hour of filling out all the paperwork and then coming back here can be another 20 minutes getting all the paperwork done… you came here basically to interact with patients. So if you do a 12 hour shift on a busy day, you'd be lucky to get five calls. –Michael

Under a social exchange theory of volunteerism, this increase in tedious work and training requirements represents an escalation of the costs of volunteerism without increasing the benefits, as the rewarding aspects of helping patients or bonding with other volunteers take a smaller share of the time. In summary, a variety of shifts may be responsible for an overall decline in volunteer numbers from historical levels, encouraging the development of EMS as a paid occupation.

There is a possibility that volunteer declines in EMS are a self-reinforcing phenomenon. Frank suggested that a vicious cycle occurs with the departure of volunteers from a firehouse: when volunteers leave and call volumes remain constant, there will be fewer volunteers who can staff each call and each of them will have more work, leading to further departures or disengagement from being overwhelmed. This situation might eventually result in inadequate levels of volunteer staffing even when equipment is plentiful.

People aren't volunteering as much and that's leading not only to volunteers having a harder job to do because there aren't as many of them on a truck or an ambulance per
It's leading to more career staff or paid professional opportunities [in] places in order to adequately staff the truck and provide fire protection and EMS or whatever the case may be. It's everywhere, it's not just here in Walton. I have it in my municipalities. It's in [this neighboring town], it's in [that neighboring town] and it's everywhere.

The area around Walton may be especially prone to this problem as Frank observed it. Due to the way local governments were organized in this area, as mentioned in Chapter 3, it contains an especially large number of fire departments for its size and population. This concentration of fire departments may make each individual station more vulnerable to a decline in volunteers. Within a social-network theory of volunteering, another potential vicious cycle occurs with the loss of social networks in a volunteer fire department. Because social networks are assumed to be one of the primary factors anchoring a volunteer in a particular organization, the loss of some members is likely to weaken the social network as a whole and promote further losses in personnel.

**Continued Viability**

The interview accounts from this study give a largely pessimistic view of volunteerism in EMS. However, it is important to note that the location of this study in a suburban setting limits its applicability to other types of American communities. Given the large differences in call volume and local government budgets available for public services in different parts of the United States and in particular between urban and rural areas, it is difficult to predict the long-term fate of volunteering and paid EMS on a country-wide basis. While large metropolitan areas and affluent suburban areas (like those studied here) may be quite willing to invest in a predominantly paid firefighting and EMS service, whether many smaller communities can afford to switch to a paid model at all, much less a fully professionalized one with substantial benefits and concessions on working conditions, is very uncertain in the near term.
In the meantime, it is undeniable that even amidst a decline in volunteerism, volunteers remain a powerful force in firefighting and EMS, and in some places the predominant force. In the suburban areas I studied where the transition toward paid EMS is particularly pronounced and both paid and volunteer providers work side-by-side, there are groups of highly motivated volunteers who, whether out of a desire for pertinent experience for careers or as a long-term hobby, invest substantial time in the work—volunteers who were willing to commute long distances to get to a shift, to visit many stations in a region to find one they liked, and to stay on in the same station for years or even decades. Even if EMS volunteering nationwide is in decline, the decline is not evident at all in certain individual stations such as Summerfield VFD. Michael, who earlier mentioned the long and tedious work of documentation after calls, nonetheless noted that Summerfield VFD had several young professionals who, having recently joined, were now highly motivated volunteers.

“But there's a clique now. People here that are generally in their early twenties that have made a huge difference to the department. They've made a very positive impact. And so it's, it's funny. They're running the--virtually, this young group of people are running the department now and older graybeards, if you'd like to call them that, are stepping back, which is lovely. That's the way it's meant to be. Cause they'll take on that responsibility and become--hopefully not leave the department for a longer period of time.

That happened only about two years ago and it was based on maybe three or four of that younger group that were more motivated and one of them. Both--two guys who are interviewing [with you today] both fall into that category. And so there's a clique of them--there's about five or six now. That are in here all the time that are doing lots of hours, you know, between 600 and a thousand hours a year. That's a lot of volunteer time. It's a huge amount...

I don't see that problem [of staff shortages] here at the station. We've got more volunteers now than what we've had in the past. But I think that's because we've got a very good board and some good leadership in this group of younger people that are now incentivizing and, and building up the esprit de corps among the, you know, 20-somethings that are here in the station, which is great. It's wonderful to see.” -Michael

The existence of this strong group, described as a “clique,” also suggests the potency of social network effects to encourage and reinforce volunteering even as the costs of volunteering in time and monetary terms have increased and calls have become more tedious and frequent. This is
especially encouraged by the practice of volunteer shifts with the same people recurring for long periods, allowing strong social bonds to form within them. In the Oxley and Candor volunteer stations, shifts were reported to have distinct age and social groupings, perhaps intentionally encouraging new members to find peers they could relate to and bond with. Abby, a 24-year-old white volunteer EMT at Oxley VFD who began volunteering in college, indicated that she was very satisfied with the friendships that had developed within her shift.

“What's different from what I've seen from other EMS agencies and from firehouses is we don't live around EMS and telling horror stories. We come in and we talk about our days we hang out and have- we're actual friends just hanging out who are doing EMS together. We'll come back from a call and talk about it but we're not going to sit here and talk about the cardiac arrest from two weeks ago and then talk about hero stories like it's like we'll talk about it get it off our chest and then we'll play a games or watch a movie. We'll [mess] around for a while…

“I'd say most people who are here regularly and who choose to interact with each other and get involved, it is kind of like a family dynamic that I consider my crew my close family. We have two members starting today, I don't know if I get to meet them. They're kind of like our grandparents, they always come up and make sure that we're okay, like, "If you need anything let us know." You usually have one or two people that are willing to have your back no matter what.” -Abby

Abby paints a picture of a friend group for which EMS is a central activity as well as a group in which the danger and excitement of EMS work further encourages volunteers to care for each other, thus deepening social bonding. The result is that volunteers like Abby may have continued interest in volunteering for months or years into the future.

The power of these social networks to motivate continued volunteering is evident when volunteers are forced to choose between EMS and other important activities in their lives. For instance, Beth, who earlier reported on the time pressures on volunteers in EMS, made clear that she was willing to sacrifice sleep to volunteer as an EMT because it was so enjoyable for her. In interviews, she also reported a strong friendship with other volunteer EMTs dating back to when she joined her first fire department over 15 years prior. At Candor, volunteers informed me that one
of their officers was a woman who commuted from West Virginia weekly, a commute of more than 90 minutes each way, to continue volunteering there after many years of service. While there were likely other volunteer firehouses in West Virginia where she could have volunteered, the willingness to spend three hours per week commuting to Candor attests to the importance she placed in the bonds she had already formed in Candor. This willingness to sacrifice to continue volunteering attests to an extraordinary value placed on the experience, likely buoyed by longstanding friendships for which firefighting or EMS is the main context.

The existence of groups of highly dedicated volunteers, and the financial advantages to local communities to continue using volunteer labor, suggests that volunteerism will likely remain for a long time in some capacity. It was also interesting to note from a theoretical point of view that social network theories may be extremely useful for explaining both the overall decline in volunteerism and the persistence of a subset of highly motivated volunteers, while social exchange theory is largely useful in its explanation of the factors related to volunteer decline.
CHAPTER 5: ANALYSIS OF PAID EMS

Occupational Growth

Growth in the hiring of paid providers in firefighting and EMS has been significant in the jurisdictions studied. The loss of volunteers who no longer have the time has made this a requirement for communities to maintain adequate staffing to respond to emergency calls. This appeared to be more pronounced on the EMS side of many emergency services departments, due to a common perception that firefighting, particularly responding to large fires, was usually more interesting and dramatic than EMS calls, which came more often and were perceived to be less prestigious and more formulaic. EMS calls, being more frequent, are also more amenable to a shift-based staffing model rather than one where providers respond from home to the station when a call comes in. In fact, the demand for EMS staff has been so great that at least one paid provider at Candor, who preferred to do firefighting, became a paramedic first as a way of getting his foot in the door at a department where he could do both.

Urban and suburban areas, with larger population, call volume, and job bases, have also seen more expansion of paid EMS and firefighting than rural areas. A number of providers I encountered who volunteered or worked part-time in the Philadelphia area also had full-time jobs in a paid fire department two hours away in the DC area, so they could take advantage of higher wages while avoiding high housing costs in that area. These providers tended to work long (24 hours and over) shifts followed by several days off per week, allowing them to commute only a couple times per week.

This growth in paid EMS has come in a variety of organizational forms: paid staff working within a primarily volunteer organization, a predominantly paid agency of a local government, or a
private company with paid employees working under contract from the local government in a particular area. I predominantly encountered providers from the first two of these categories in this study, with a handful of paid staff encountered considering a switch to a private company. Paid providers could work full-time or part-time, with the paid providers at Walton VFD in particular being entirely part-time. Those working two jobs commonly had two emergency services jobs, whether in firefighting, EMS, or law enforcement.

The drive toward greater growth in the paid EMS market, as well as paid firefighting, is potentially also accelerated by a number of institutional factors. One is the impact of labor unions, which commonly represent law enforcement officers and are increasingly common for paid firefighters and EMTs, and another is the potential future impact of higher standards of EMS credentialing in the form of academic degrees.

Firefighter unions such as the IAFF express a pro-union labor stance on workplaces, often explicitly at the expense of volunteers. Multiple volunteers in this study expressed the opinion that the unions were in favor of reducing the presence of volunteers in firefighting and EMS to avoid volunteers working for free undercutting the wages and positions of paid providers. Jack, a middle-aged volunteer at Candor VFD who had worked with labor unions previously in his regular employment, expressed sympathy for the union cause in the emergency services but was explicit about their hostility to volunteers in EMS.

“I don't say that pejoratively, um, because the actions of labor unions have resulted, um, both in the police and the fire, have resulted in better working conditions for everybody…. [but] um, the union cares about, you know, the fire union in particular in my mind cares about three things, and it's their-- There's care about, um, salaries. Um, salaries and benefits, training and safety. Um, and so a number of any of those initiatives are things that are taxed or take tax dollars. And so the union's gonna view that-that any competition from anybody other than the labor union as taking away, uh, benefit for resources from their-from their membership, which is, by definition, true…
it's a whole bunch of administrative, uh, red tape that prevents volunteers in Summerfield County from surveying, from volunteering in different departments because they don't want them. Um, and I think that's pushed by the union. Again, I get it 'cause you know, uh, they don't like shrubs and they don't like, you know, don't like scabs coming into [union workplaces]. “ –Jack

This account from Jack is corroborated by previous news reports of disputes between unions and individual members who continued to volunteer on the side in other departments (see Chapter 2). This account of union hostility to volunteers is highly congruent with the neo-Weberian model of professionalization through social closure, a process in which unions have been suggested as a notable force along with strategies related to credentialing and licensing. However, not all paid providers interviewed were members of a union, expressed a positive view toward joining a union, or viewed them as relevant players in deciding the conditions of paid emergency services.

Another factor mentioned by an interview respondent was the promise of professionalization through a credentialing process. Beth, who was interviewed as a volunteer at Oxley VFD (see Chapter 4) but worked full-time at the county EMS office and had previous experience as a paid paramedic, was a particularly notable voice for professionalization as encountered in this study. She expressed a strong interest in developing EMS toward a labor model more similar to health occupations such as nursing or respiratory therapy, including the introduction of academic degrees up to a doctorate level to differentiate practitioners in the field from those involved in teaching.

Interviewee: Why can't I get my masters, my doctorate in emergency medical services as a paraprofessional or as a pre-hospital professional? You know, that limits me and you know, quite frankly, it limits what people’s view is of the profession as a whole. You know, so you've got that financial burden, you've got that lack of career trajectory. Um, I think that there is a real lack of career trajectory-- Say that 10 times fast, um, as well. You know, you could be a supervisor, you could be a street medic, you could be a chief, and that's about it. [laughs] I think there's really no-no advancement options.

Interviewer: So I guess, like, uh, if I- if like, more extensive EMS, uh, educational opportunities are available, including like many of these higher up degrees, what would change for the better about the field that way?
Interviewee: Um, if I told you I want to be a volunteer doctor, with a bachelor's degree, is that gonna work?

Interviewer: Probably not.

Interviewee: Right. Now, if I want to go and I want to teach med school with a bachelor's degree, that’s not gonna work.

Interviewer: Uh, unfortunately not.

Interviewee: Why are we allowing it to work for EMS? It's a credibility thing. And one of your first questions was, do I think that this is a medical career? Why is that even a question? And I'm not saying for you, but like, in general, why is that even a question? You know, I will tell you, at Walton-Oxley County Community College up until very recently, EMS was lumped in with trade schools, with the trade school. And I don't think that that's wrong, because it is a trade. I'm very proud to have a trade. But why wasn't it with allied health? There's something about the fact that nursing is not necessarily taught as a trade. It's moved forward, and it has done a world of good for nursing.

Beth, having worked both as a paid provider and a volunteer in EMS, was conflicted about the role of volunteering, but saw the possibility that the project of professionalizing the field might require the elimination of volunteers.

“You know, you also can't volunteer as a nurse, which is what people throw in my face all the time when I say that. And I say you're trying to kill the volunteers [in EMS]. And I say, no, that's not the point. [laughs] But they have a good point, you know, if we were to take away, you know, I-- It's such a hard question, because there's part of me that says, maybe we would be more viewed more in a professional manner, if we did away with volunteering. And as a volunteer, that statement breaks my heart. And I wouldn't want to see that, that loss of that opportunity to volunteer on the ambulance. At the same time I question, and I think a lot of people question, will we ever get out of that question of, are we health care providers, if we can still volunteer as it- at it, you know?” –Beth

Professionalization, the process of transforming an occupation into a profession, is a process extensively studied in the sociological literature as documented in Chapter 1. In this provider’s thoughts, the idea of professionalization, incorporating the process of certification, is clearly reflected. She saw a real need for professionalization to improve working conditions, which were described in stark terms.
“Um, you know, the reality is, let's talk about EMS from a paid perspective for a second. Um, it pays- it pays terribly. It pays absolutely terribly. Uh, you could spend the same amount of time going to school and-and get your associates and nursing as you do for your paramedic. Okay, and a nurse will walk out making $30 an hour, $40 an hour, $50 an hour. A paramedic is going to walk out I think in Walton-Oxley County, we're one of the highest paid, and the average paramedic in Walton-Oxley County, I believe, is $32.50, that's the max. For a paramedic, that's the max average, okay?

So that says something to me, that vast difference, you know, and think about your ability, your longevity in that field. You know, this is-- We joke around and say EMS is a young person's profession, it really is. You know, I'm 35 years old. And I gotta tell you helping people up and down the steps ain't as easy as it used to be when I was in my 20s. You know, and I'm not older by any stretch of the imagination, but, you know, the reality is it's hard on you. It's physically draining, it's emotionally draining, it's spiritually draining, and it doesn't pay for shit. [sic.] [laughs] That's really devastating.”

–Beth

Unionization and the escalation of credentials and licensing, which are both mechanisms for improving working conditions in a given occupation and involve a process of social closure in the neo-Weberian model of professionalization, are evidently at work or at least visible in the field of paid EMS. As paid EMS grows, these factors may come in continued conflict with the presence of volunteers.

Prospects of Professionalization

The development of paid emergency services, and especially paid EMS, will likely have far-reaching consequences for the structure of American communities, public services, and the landscape of blue-collar labor. This process apparently incorporates some of the key attributes of professionalization, a subject of intense interest in occupational sociology with significant implications for how a job is valorized and compensated by society and the labor market. EMS, being in the early stages of professionalization, may serve as an ideal subject of observation for this process.

Several characteristics of EMS make professionalization a favorable development for the occupation. Larson, for example, points to the importance of a professionalizing occupation being
salient and universal to the public (1979), and EMS indeed serves the entire population. It may be difficult to judge whether EMS conforms well to the dominant ideology of American society, another criterion, but EMS, like the other emergency services, enjoys wide public approval and respect. A proximity to other healthcare fields that have professionalized somewhat, such as nursing, may also be beneficial by offering a cultural association and a framework for achieving professionalization through academic legitimation.

Several large challenges, however, do exist to EMS professionalization. One of these is a lack of public knowledge of the nature of EMS work, as some providers reported the public has a low appreciation for the level of skill EMS providers possess, with an impression of them as “ambulance drivers” rather than healthcare practitioners with substantial training. Another problem is the already strong effect of market forces and corporatization on paid EMS, with companies such as AMR possessing large market share, and thus labor market power, in the provision of EMS. The nature of EMS as an emergency service closely attached to local government may also hinder the ability of EMS to extract monopoly rents as predicted by the neo-Weberian lens of professionalization as a process of social closure resulting in artificial monopolies.

These challenges to EMS professionalization, however, are not set in stone. One key process of professionalization, the setting and raising of credentials and licensing for entry, is clearly in motion. Climbing training requirements have been cited as a major factor deterring volunteer participation in this study (Chapter 4), favoring the expansion of a workforce that practices EMS full-time and can thus dedicate more time to training and credentialing. A continued interest in introducing new protocols and more training to enhance EMS capabilities and better serve the public, against which there appears to be little resistance, suggests this trend will not change soon. Labor unions also exist as institutions ready to push for a greater degree of social closure in EMS
work. The physically demanding nature of EMS work could strongly incentivize providers to seek better conditions in the long run, and a shortage of staff could afford existing practitioners bargaining power in jurisdictions where the local government has the budget to spend on expanding public services and an acute need for more staff.

**Paid-Volunteer Conflict**

The relations between paid and volunteer staff in EMS was a prime consideration in this study in light of the observed social forces that have advanced paid EMS and weakened volunteer EMS. Given some of the competing interests seen between paid and volunteer staff, conflict has been evident.

A significant number of the volunteers interviewed and shadowed in this study mentioned the existence of conflict between volunteers and paid staff in firefighting and EMS, with an intensity ranging from the silent treatment to physical confrontation. Jack, a volunteer lieutenant at the Candor combination paid/volunteer station, described the culture between the two groups as marked by competition over space in the same building and a failure by paid staff to render commonly expected courtesies to volunteer staff, indicative of disrespect.

**Interviewee:** All this to say that, um, where there has always been tension with the volunteers and the career and personnel in this County, that tension has gotten worse because, um, you know, it doesn’t make sense to have a truck company here and then, you know, in a place where we have the most limited, uh, housing in all of Candor VFD’s, uh, stations.

What that does is it means that we're re- we're rubbing together, um, because of the way, um, you know, career gets here at six o'clock, and so by the time for vo-volunteers so long, they're hungry, um, so can't, you know, they've taken over the kitchen, you know, can't get a word in edgewise in the kitchen. Um, there's people here constantly now, there is no place for a person to go and study or do their homework or study further stuff anymore...

I also know that nobody, no career person in his firehouse has ever referred to, uh, any of the volunteer officers by their rank and title. Even-
**Interviewer:** Which is, is that like the customary courtesy in the fire service?

**Interviewee:** You know, that's what I, you know, I was taught to, you know, you call everybody who a Lieutenant by call them Lou or Lieutenant until they tell you otherwise. You call everybody Captain or Cap until they tell you otherwise... It's a traditional courtesy. On top of that, it is a custom and a courtesy that you find that if you show up at a firehouse and you go and find a station officer and let them know that you're there... Um, and their personnel don't do it here, um, which is sad to see.

Um, as a person in the military, uh, I render customs and courtesies freely because, uh, it's a mark of respect on my end, and it reminds the officer, uh, of their obligation to take care of their personnel as well. Um, you know, it's-it's these little touches that keep, that build unit cohesion even when you have disparate services serving in the same house. None of that is happening here, um, and I cannot help but think that that is not by design either overtly or covertly. I've got no proof for [either], um, and I don't want, and I'm not trying to cast aspersions, um, but I haven't seen it happen, and I find it, uh, I find that curious. So there's tension now. I think more tension between [paid staff and] volunteer than has ever been.

Given the theoretical reciprocity of ranks between the volunteer and paid systems in Candor County, these differences in courtesy may have seemed especially hurtful to this lieutenant.

On the other side, Henry, a paid provider aged about 30 at PW2 who was in his second year in firefighting and EMS after leaving the military, reported that the volunteer-career conflict at the station was manifested in territorial sentiments around equipment when in the field.

One day, a tree fell and we needed a particular, we needed a saw. The engine didn't have a saw. There was another vehicle that had a saw. We grabbed that saw because we're quick, we're thinking quick. We're going to grab a saw, we're going to go over there, cut the tree, eliminate that problem, come back, clean the saw and then return it back to service and put it back in the vehicle. We were told not to do that, not to touch the vehicle. That's their [volunteer] vehicle and I'm like flabbergasted, but the community needed us, we needed to solve a problem, there's a tree, you have a particular tool that was paid by a taxpayer.

That's one of my biggest problems is the grabbing ahold of the station, grabbing ahold of its equipment. Where they say 'It's ours, not career. You have to ask permission, you have to, you cannot touch this. You cannot use [it],' and it's absolutely ridiculous.

–Henry

Paid and volunteer providers both recognized that there was a great sense of tradition tied to the idea of volunteers in the fire department, and that the arrival of paid personnel created a sense of
threat to some volunteers that likely fomented this sense of conflict. Henry suggested that this was more acute for older volunteers:

I don't have issues with the crews here, they're great. We work together, when we're on calls, there's no hostility. There are some people but there are more seasoned, been here around. It's not the new people. It's some of those seasoned people that have been here for 20, or whatever, 10 years volunteering, "You're taking this away from me" and I don't know this person. They just blame me because I'm part of the system. They create this hostility of, "I don't want nothing to do with you, I'm not going to talk to you". –Henry

Volunteers, for their part, argued that there was indeed an important aspect of tradition and history that would disappear if volunteering was lost in the fire service, including a great deal of institutional development that occurred under volunteers. Beth, a volunteer at Oxley who also had experience in paid EMS and now oversaw EMS operations as a county administrator, argued this was the case in Walton-Oxley County and thus explained some of the emotional causes for conflict.

“You have to understand the volunteers in Walton-Oxley County who have- who have really been the ones making the decisions, guiding the process. They have dedicated their whole lives in a lot of instances and they have put a lot of time, energy and effort into this. Um, you know, these systems, these radio operations, these you know, all-everything that you see in Walton-Oxley County was built on the backs of volunteers. Um, you know, and they have a right to be proud of all the hard work that they have done, um, in building this system. You know, paid professionals didn't-didn't give you what we have here in Walton-Oxley County today.

They didn't um, you know, so I so I think that there is a level of trepidation, um, when volunteers hear that things are going to go paid and I have a hundred percent respect for that because if you've dedicated your entire life to something um, you know, and then all of a sudden they're-they're bringing in someone who was quote unquote, a professional, a paid person to do it. You know, I think that there is a lot of fear.” – Beth

The fear among volunteers can thus be described as a fear of being closed off from the system they built for themselves by paid personnel they introduced into the system to supplement themselves. Consistent with the neo-Weberian model of professionalization as a process of social closure, conflict between paid and volunteer providers may be considered a competition for the power to decide who does the work of EMS, and by extension who can control the flow of rewards or
compensation from local government from that work. Jack identified the volunteer-paid staff conflict at Candor as not just a matter of separate social groups jostling for space, but a larger struggle between two groups for access to the same set of resources.

“The discord between career and volunteer, uh, in my opinion, uh, is one of economic proportions. It's a competition, a classic competition over limited resources, ie, tax dollars. Um, we're all competing for the same pot of money. Um, career guys are looking for increases in salary and benefits and all things that make their working conditions better for their members. Um, the volunteers are looking for those same tax dollars, uh, actually a fraction of those tax dollars, um, for resources and training, uh, so we can recruit more volunteers. Um, the union cares about, you know, the fire union in particular in my mind cares about three things, and it's their-- There's care about, um, salaries. Um, salaries and benefits, training and safety. Um, and so a number of any of those initiatives are things that are taxed or take tax dollars. And so the union's gonna view that--that any competition from anybody other than the labor union as taking away, uh, benefit for resources from their membership, which is, by definition, true.” –Jack

These interviews suggest that the paid-volunteer conflict can be interpreted as a symptom of an ongoing project of neo-Weberian social closure amidst a landscape of competition. While paid staff increase their presence in some jurisdictions, volunteers may feel threatened by a potential loss of control and relevance in a working landscape they have long defined. The continuation of this trend would be an indication of the growing strength of EMS as a paid occupation potentially on the road to professionalization.
CHAPTER 6: ANALYSIS OF SHARED ATTRIBUTES

While my reports of volunteer decline due to a variety of factors at the study sites and the simultaneous increase in paid EMS so far suggest an irreconcilable competition between the two groups for control of EMS, I also identified much evidence that these two groups are not entirely diametrically opposed. Assuming this idea would elide much of the complexity of the situation, which is that paid and volunteer EMS personnel are deeply enmeshed on individual and social levels, making it difficult to fully separate them. This becomes evident when examining several factors relating to how people come to work in EMS, how their daily lives and operations in EMS play out, their relations as EMS providers with the community, and their own ideals and models for EMS practice.

Reasons for Joining

The providers I encountered reported a variety of motivations for joining firefighting and EMS, whether as volunteers or paid staff. However, paid and volunteer EMS workers had remarkable congruities in the reasons they chose to join EMS and continue working in it. These include social bonds within their stations, altruistic desires to help the public, and a desire to acquire useful skills for professional or personal use.

Both groups shared much of the same interest in the social and altruistic aspects of firefighting and EMS work. In addition to a sense of pride in being able to help other people in the dire circumstances in which 911 is called, the teamwork inherent to firefighting and EMS was commonly reported as part of the appeal across all stations and for both paid and volunteer staff. Providers reported this to me as both an initial reason a provider joined and as a motivating factor
that kept them engaged. Providers often enjoyed both the collective nature of the work of fighting fires and tending patients, as well as the communal culture of firehouse social life.

Both volunteers and paid staff were united in describing the social life of the firehouse as intimate and family-like, an atmosphere forged by the collaborative nature of the work as well as long shifts in close proximity and the potential exposure to danger on calls. While I previously reported that this may be an important aspect of volunteer retention, paid staff members were similarly close to their coworkers. At Candor, two paid CCFR staff members gave very similar accounts of the closeness found in their workplace. Henry, a 30-year-old white firefighter and EMT who started working in EMS after leaving the military and intends to do so until retirement, noted that the long shifts and shared living space, including both work and rest routines, naturally gave way to closeness.

“For the time I've been a firefighter, when you're with your crew, once you get to know each other, everybody knows everybody's habits and their time and their space. No one's going away from each other. We all eat together, we train together, we'll do fitness together. We're always together. I never felt there was any cliques.” -Henry

His coworker Isaac, a 33-year old Asian paramedic and firefighter who made a change in career at the age of 30 to do firefighting in fulfillment of a childhood dream, described his peers as much more than coworkers.

“these are people that you go to-- you watching their back, they are watching your back on calls, making sure everybody's safe. It starts to bring like a very brother- or sisterhood like feeling, we become very close.” -Isaac

As with volunteer personnel at Oxley VFD and Candor VFD, paid staff members in firefighting and EMS are assigned to regular, repeating shifts with the same people, encouraging long-term closeness to develop in small groups.

Another common reason for joining EMS was a desire to build useful skills for work or for life, particularly in EMS. It was common to find both volunteers and paid staff seeking relevant
experience for other paid jobs, such as college students volunteering to seek medical experience for applications to medical and physician-assistant schools and paid staff who worked full-time as police officers and thought additional experience in EMS would be useful for their day jobs. One example is Abby, a volunteer at Oxley VFD who originally started volunteering to better understand the practices of first responders as related to her career in mental health.

“I initially got started because I wanted to gain the experience so that I could build a rapport with other first responders once I do get into practicing as a counselor and a therapist, but the more I’m here the more I enjoy going out into the community and helping people because I know that I am capable of doing it and I enjoy being with my friends as you saw downstairs. It is the main motivator now but I have always had that little backup of, "I want to do this for the experience for the rapport." - Abby

People highly evaluated the skill of being able to tend to someone they knew in a medical emergency even off-duty.

It is evident through these interviews that the reasons volunteers and paid staff were attracted to EMS could be surprisingly similar, and that these responders can see eye to eye on many of the cultural aspects of EMS work despite their differences in compensation.

**Geographic Mobility**

The traditional impression of American firefighting and EMS has been centered around protecting an individual’s own hometown. However, many volunteers and paid staff also shared a willingness to work at stations other than the one in their hometown or community of residence, in contrast to the traditional notion of the volunteer fire department as a community gathering place and a focus of town culture. While this development is not unexpected for paid EMS staff commuting to an employer, it was surprising to find this was the case for some volunteers. Many of the volunteers who chose to commute to a certain station to volunteer were drawn by the quality of the volunteering program available there, and they tended to be young adults. Ken was one example,
a volunteer at Summerfield VFD in his twenties who lived outside of the Summerfield service area but found his way to it after a search for departments that would offer him the greatest amount of time actually aboard the ambulance.

“So with work I needed a station flexible with my schedule. Summerfield is very easy to get to for me from DC. Summerfield VFD is part of the overall Summerfield County Fire Department—Fire and Rescue department, which has a very phenomenal reputation. Um, that said, other stations have certain fundraising requirements, which this station does not have, like when they do like Bingo and stuff like that that are charitable fundraising, charitable gambling—which requires the membership to be there and run the activities, which for me as a volunteer, I'm here to provide my services that I'm already not getting paid to do. I'm not necessarily interested in actively participating in raising funds so I can continue to volunteer. So that's part of the reason why I'm channeled into this station. As far as this county, because of the other—because of the reputation of this department.” -Ken

Given the many demands on a volunteer’s time, Ken was not the only person to seek a station where one could maximize the amount of time doing EMS work, as opposed to fundraising. Other volunteers chose to seek out stations to work at beyond their hometowns because their home station was served exclusively by paid staff, or the volunteer program was small or constrained in its degree of independence or utilization. Finally, some volunteers thought it was important to find a station with the right station culture and member composition to fit their interests. Catherine, an Asian volunteer in her late twenties at Summerfield VFD, reported she had talked to several stations across the DC area with an eye to finding one that had a large contingent of young professionals, like herself, without too many high school students. This behavior is overall highly reflective of the social exchange theory of volunteerism, where individuals carefully weigh volunteer opportunities and consider their potential benefits relative to the costs.

The result of this process is that many volunteers were willing to commute a significant distance to work at a particular department. Catherine had a 30-minute commute to volunteer, which was apparently not unusual. Some members who moved farther away from their usual station continued volunteering long afterward, assuming the burden of a new commute to continue their
As mentioned in Chapter 4, a volunteer officer at Candor VFD even commuted from West Virginia regularly to continue volunteering there, a distance of more than 90 minutes each way.

This method of shopping around for the best station bears a great resemblance to the practice of investigating different employers during a job hunt for the best working conditions, suggesting further similarity between paid and volunteer staff in their conceptualization of EMS as being a valuable and meaningful activity less due to their connection with a particular geographic area and more with the work itself.

Operational Cooperation and Public Perception

Despite the differences between them and reports of conflict, volunteers and paid staff continue to work closely side-by-side in emergency operations, and usually with a high degree of professional collegiality. At all study sites, I observed paid and volunteer staff working closely together on emergency calls requiring more than one unit. Due to the mixing of volunteer and paid units in many jurisdictions, workers from both groups share the same protocols, equipment, and expertise and practice them together to solve problems. EMTs from both volunteer and career backgrounds were trained according to the same national or state guidelines, even if there was variation in which school a provider earned their certification. Decision-making during emergency calls was largely driven by factors such as the presence of a paramedic with superior training over the EMTs, which unit arrived first on-scene, and by fixed protocols for responding to calls as opposed to paid or volunteer status. Of the providers interviewed, there was universal agreement that volunteers and paid staff were held to the same standards of training and competence, even though individual experience might vary.
Likewise, in my observations, both volunteer and paid staff enjoyed a largely positive reception among the public, which does not seem to be able to distinguish them. Jack, a middle-aged black volunteer officer at Candor VFD, agreed it was the last thing on their minds during an emergency.

“The populace, they don't know why [career staff are being introduced]. And it never dawned on them to ask why their fire trucks are a different color or why everybody's shirts don't quite look the same. Cause when they see the fire department, they see-they see us, whoever they get.

And if you got a combination response, like we have, like if we had an unconscious [person], and it's us [volunteers], the [paid] medic, and an ambulance or a truck that shows up, you know, all they're going to see is this big team of people wearing blue taking care of their loved one, and they're not going to stop to see whether or not, you know, my shirt looks different. They, you know, they're not worried about that right now, they can't tell.” -Jack

Paid and volunteer providers both spoke of the need to “be professional” around patients and their families to maintain the trust of the public. Ethan, a 59-year-old white paid firefighter and EMT at Walton VFD who worked full-time in a manufacturing job, compared the behavior of the ideal EMT to customer service that one might expect from other types of service workers.

“I would like the public to know that when they call 911, they're gonna get quality care and it's going to be efficient, it's going to be quick. Because that's basically when you dissect it down to the bone, we're all customer service people…and we have to give quality customer care to our people.” –Ethan

This ethos of customer service may derive both from the notion of providing care to the public as well as a perception that the goodwill incurred by the fire department is conditional and could be easily spoiled by bad experiences between patients and EMS providers. Gerald, a 41-year-old coworker of Ethan who worked full-time as a police officer, made it clear he believed that the public opinion of EMS could be easily soured by a bad experience.

“You could have a bad experience with fire personnel or EMS personnel if they're not treated appropriately or spoken to with respect or the respect that they feel like they should be given. I feel like that is our biggest problem because one bad encounter could put a big black mark on a department.
The Walton ambulance pulls up to Mrs. Smith’s house and somebody is having a bad
day and they give her a hard time or they don’t treat her nicely or whatever, Mrs. Smith
could be calling her councilpeople or telling her neighbors and that one bad encounter
could take a long time to correct or change the public image or at least her group of
friends image of what the service is really about. I feel like bad things that happen to
fire departments and EMS agencies are a direct result of how that fire department or
EMS agency handled an incident or portrayed themselves versus that somewhat always
negative opinion about the police.” -Gerald

Gerald’s comments were mirrored in the interviews I had with volunteer personnel. At Candor
VFD, I rode in the ambulance with an volunteer crew led by a lieutenant who insisted on a
debriefing meeting with his crew after every call, going over what went well and what could have
been improved with the belief that high standards were necessary to maintain public satisfaction.

Furthermore, when some members of the public looked more negatively upon EMS, both
paid and volunteer personnel bore the same stereotype of EMS as a minimally trained organization,
and both groups disagreed with it. There was a concern among both groups that their expertise was
not taken seriously, and that some members of the public saw them more as “ambulance drivers”
than extensively trained professionals with the capability to do medical exams and deliver complex
care. Henry, speaking as a paid CCFR firefighter and EMT in the Candor station, expressed
frustration that some members of the public did not understand this aspect of his work.

“I think the public should be more educated. I don’t think they see how much or how
complex challenges that we have as far as learning, being proficient at what we do, it’s
not-- I just sometimes feel people think we just fight fires and we just take people to
the hospital. We don’t just do that. We’re going to do pre-hospital care and we’re going
to evaluate you, we’re going to do all the things necessary that the hospital wants. Some
citizens just want to, ”Just take me to hospital.” No, we need to do pre-hospital care,
we want to evaluate you, we want to understand what your issue is and if we can give
you some sort of medication till we get you to the hospital.” -Henry

This was echoed by Beth, speaking as a volunteer at Oxley with both paid and volunteer
backgrounds as an EMT. She similarly complained that some patients expected EMS workers to
have little training beyond being able to drive a vehicle.
“I believe that there is a group of the populace who has not actually had any individual dealings with EMS as a person. They’ve never had to personally call an ambulance. And for them I almost feel like a lot of times we're, you know, we're just-- We're taxi drivers. We're glorified taxi drivers. You know, we come in, we pick you up and we take you to the hospital and that’s basically all we do.” -Beth

The evidence suggests that paid and volunteer EMS workers feel similar, if not identical, pressures to conform to an expected standard of professional behavior, regardless of whether or not they did the work as an occupation or considered it a profession. To most EMS workers I interviewed, “professional” did not refer to a person who practiced a profession in a sociological sense, but to anyone, paid or volunteer, who approached the work with a sense of seriousness and displayed a high level of conscientiousness and care when doing it. When they were successful in acting professional, the public was either unaware or unconcerned with whether they were paid or not.

**Transitioning between Paid and Volunteer**

One of the largest factors that made it difficult to characterize volunteers and paid staff as separate and competitive entities was the degree of social integration across these two groups. It was common to find providers who worked both as volunteers and paid staff, whether at separate times in their careers or simultaneously.

When I interviewed paid staff about how they entered their careers, they often reported volunteering first before transitioning to paid work, using it as an opportunity to see if it was a good fit for them and to build up relevant experience. Some, like the 23-year-old Frank at Walton, came from a firefighting family and volunteered extensively at a neighborhood station before they realized they could make a career out of it. Henry, a paid staff member at Candor, suggested that it might be advantageous to encourage prospective paid EMS workers to volunteer first, both to provide experience and to furnish local government with a ready pool of paid labor if the decision was made to establish a paid department in a particular community.
Whether it's firefighting or EMS, volunteering gives them an opportunity to see that [the value of working in emergency services]. Sort of interning, just come out here. I always talk to kids that, "Hey, I want to be in the medical profession." First thing I say, "You ever volunteer?" That's your gateway to understanding what you're going to get yourself into. I always advocate volunteering because now you're starting to see what prehospital care is and then you're going to walk right into the hospital. You're going to start seeing that, you're going to start understanding that and you're going to decide whether it's for you or not……

[There's a city in] Colorado, it was all volunteer. Then there was a point where the county government says, "Hey. We need to have paid people, we got to-- We have to do something." They're a combination system. What they did was they said, "We'll open up the job force to any volunteer that wants to become a career." Half of them decided to put their applications in, and they transitioned from volunteer to getting paid as the career person and then the volunteers that stayed volunteer stayed volunteer but that bond stayed together, didn't separate.

It was an easy transition. I've heard other jurisdictions, you have to start as a volunteer work your way up, and then if you wanted to be a career, there's that element as well…”

-Henry

Evidently, volunteering has acted as a strong feeder for paid personnel in this case.

Paid providers also commonly reported volunteering while holding jobs as firefighters or EMTs. This affiliation with multiple departments, sometimes referred to as “two-hatting,” has led to issues with unions such as the IAFF when the provider is a union member at their job but volunteers on the side (Barnhardt 2002, Nash 2002, Roh 2010). Several of the personnel I interviewed were interested in two-hatting or had done so at some point, such as Isaac, a 33-year-old firefighter and paramedic at Candor.

“I'm in a long-distance relationship. She lives like two hours away. So, yeah, she's in Delaware…[emergency services where she lives are] primarily volunteer. Still fire-based over there. So, I was even thinking every time that I come to visit, why don't I possibly volunteer over there and help out? It'd be nice to just go ahead and, you know, spend my time there. When she's at work, I can volunteer on the medic or at the engine or something like that, so.”

Many of the paid personnel at Walton VFD were also two-hatting, being volunteers at the same station in a neighboring town who found out about the part-time job opening at Walton from mutual referrals. As Gerald told me, “I wasn’t really sure why I was here, but most of the guys I
work with here are my friends and were my friends before I started working here [Walton].” Given a large number of interview respondents who two-hatted and a range of news articles from across the country describing two-hatting providers having disputes with the firefighter’s union, the practice seems to be relatively common.

Furthermore, a special case in the relationship between paid and volunteer EMS was Beth, a 34-year-old white volunteer at Oxley VFD at the time that I interviewed her. Though she did not say she had worked as a paid staff member and a volunteer simultaneously, she had switched back and forth at several points in her career, as she started her career at the age of 15 as a volunteer EMT in Walton VFD, became a paid paramedic after several years, and then shifting her focus to EMS education and administrative work for Walton-Oxley County before volunteering at Oxley. Beth exemplifies the trend of paid providers beginning their careers as volunteers, and she also demonstrated an internalization of ideals from both sides when we discussed the prospect of professionalization in EMS.

…there's something about the fact that nursing is not necessarily taught as a trade anymore. It's moved forward, and it has done a world of good for nursing. You know, you also can't volunteer as a nurse, which is what people throw in my face all the time when I say that. And they say you're trying to kill the volunteers [in EMS]. And I say, no, that's not the point. [laughs]

But they have a good point, you know, if we were to take away, you know, I-- It's such a hard question, because there's part of me that says, maybe we would be more-viewed more in a professional manner, if we did away with volunteering. And as a volunteer, that statement breaks my heart. And I wouldn't want to see that, that loss of that opportunity to volunteer on the ambulance. At the same time I question, and I think a lot of people question, will we ever get out of that question of, are we health care providers, if we can still volunteer as it- at it, you know?” –Beth

Here, Beth identifies the possibility that professionalizing EMS might result in the loss of volunteers, and that such a shift would likely lead to better conditions for paid EMS workers. Earlier in our conversation she identified this as a particularly necessary project given the poor work conditions in EMS in Walton-Oxley County and spoke especially clearly in favor of it among the EMS workers I
interviewed, drawing on her experience as an EMS practitioner, educator, and administrator. However, as a volunteer, she is saddened at this possibility given her own experience on both sides and highly values the availability of future volunteering opportunities. The models of paid and volunteer EMS are, in Beth’s case, not just a matter of two groups of people but of two parts of her own identity.

Through my research, various threads of evidence show that volunteers and paid staff are deeply intertwined in their work and social lives even as their interests may differ in the question of professionalization. Volunteers and paid staff enter the firehouse for very similar reasons, have similar processes for deciding which station to work in, cooperate extensively in emergency operations, face identical public perceptions, and readily transition between one role and the other. Some, like Beth, have identities and ideals from both the paid and volunteer sides. The effect of these factors in total makes it difficult to conceptualize volunteers and paid staff as diametrically opposed groups. The borders between the two groups are highly porous and blunt much of the sense of conflict and competition that might come from a strictly neo-Weberian interpretation of the situation in EMS.
CHAPTER 7: DISCUSSION

This study aims to capture the social world of emergency medical services in the US today as studied through participant observation and semi-structured interviews at four suburban agencies on the East Coast. I uncover evidence of conflict among some practitioners of EMS that is consistent with the neo-Weberian interpretation of professionalization, notably in the competition between career staff and volunteers over social closure and the power to determine the conditions of EMS work. However, this interpretation is moderated and complicated by a lack of clear separation of career staff and volunteers as distinct actors, and any perceived competition is blunted by the interdependence and intertwining of paid and volunteer EMS workers on both personal and social levels. Future sociological examination of professionalization in EMS should carefully consider this complication.

In Chapter 5, I document a sense of conflict and grievance between some volunteers and paid staff in the study sites, especially fed by a perception that volunteerism in EMS is in decline and that paid staff seek to replace volunteers entirely. This perception of competition for relevance can be examined according to the neo-Weberian model of professionalization, which describes it as a process in which a group of individuals in an occupation organize to create a “social closure in the market sanctioned by the state.” As I detail in Chapter 2, the contemporary working conditions of paid EMS provide a strong incentive for EMS workers to advocate for more occupational autonomy and control over their conditions; moreover, there have long been national EMS advocacy groups and government-supported standards that could serve as the basis for a professionalization effort. In addition, I describe increasing training requirements, often endorsed by state governments and national EMS groups, as a key factor contributing to weakening the ability of volunteers to supply necessary manpower in some areas. These forces have fueled the growth in paid EMS, which would
be consistent with the possibility that leading members of the EMS community are creating the conditions of a state-sanctioned social closure in the EMS labor pool that favors paid staff.

When volunteers describe conflict with paid staff, they mention a feeling that members of the local government were influenced to create conditions more favorable to paid staff, consistent with the state-sanctioned aspect of neo-Weberian professionalization. Interestingly, the volunteer description of competition with paid staff over resources and space in a single station extends the theoretical prediction by Abbott (1988) that competition between occupations is an essential part of the landscape of professionalization—here, it is evident that competition can exist not just between occupations, but also between people seeking two different models of the same kind of work, career or volunteer.

Notwithstanding the existence of this competition, however, I detail an essential confounding factor to the professionalization analysis of EMS, which is the interdependence and intertwining of paid EMS staff and volunteers in work and social lives. Career staff and volunteers are intermeshed in social and personal aspects. Socially, volunteers and paid staff continue to commonly rub shoulders in the social setting of the firehouse and in emergency operations, where both types of providers necessarily support each other. Volunteers and paid staff also commonly move between each of these classifications and commingle them even in a single person—paid staff at one station may volunteer at another station, and volunteers may join EMS as a path to paid work. A single individual may have conflicting aspirations for the future of EMS originating from both occupational and the volunteer roles. And finally, there seems to be little awareness or concern among the general public over the existence of two types of EMS providers, as long as they feel well-served by the available services. Paid staff and volunteers in EMS cannot be easily separated into discrete categories despite the evidence of competition over professionalization. Thus, the
professionalization process predicted by Saks under the neo-Weberian model is hindered and transformed by the presence of volunteers.

Policy Recommendations

Emergency medical services (EMS), a young occupation in the US, springs from a long heritage of volunteer emergency services that continues to influence the path of its professional development. Though a drive for expansion of EMS as an occupation exists in many areas and some parties wish to professionalize EMS into an allied health profession, the continued importance of volunteers suggests there will be no quick and universal transition to an all-career model for emergency services, nor would such a model necessarily be desirable for policymakers. As a result, managing the relationship between paid and volunteer staff working side-by-side will be essential for local governments and EMS agencies. Friction and conflict are evident in many cases between the two groups in practice, but the social connections and shared experiences of paid and volunteer providers suggest conflict is not intractable. Mitigating the possibility of conflict can be helpful for achieving the most effective utilization of both groups in firefighting and EMS operations.

Based on the observations in this study, I make a number of proposals for local governments interested in reforming their firefighting and EMS systems to better utilize volunteer and paid providers. First, in areas with a large density of independent volunteer fire departments but a decline in the number of available volunteers, consolidation of departments may be advantageous. In both of the major metropolitan areas studied, I observed that the presence of a large number of separate and fully provisioned organizations but a shortage of personnel resulted in a less efficient utilization of the available vehicles and other equipment than could otherwise be achieved. This situation also increases the organizational barriers to coordinating emergency services across a region, as Henry, a paid CCFR firefighter and EMT at Candor explained.
“…Having 10 different volunteer organizations, 10 different chiefs, 10 different--tax money being allocated to 10 different [entities]--makes no sense…when we're giving an organization or a leadership a task, [each individual organization] wants to protect this, [people] wants to grow that. When [what they have] becomes in jeopardy, they don't want to branch out, then you have this [effectiveness] that is just going to diminish.

Basically what I'm saying was, it should have started off as one department, and then you would have a unified group of people working together to build this legacy instead of 10 different personalities, 10 different leaderships, 10 different ways of doing things. Then you have this 11th organization that's going to take over. If that makes sense. The 11th organization being the career. I could be off on my numbers of how many, I'm only been here for two years, but I lost count of how many volunteer organizations but I just feel like it's Rome, and then you have all these other companies and there's no unification.” –Henry

Here, Henry discusses the inefficiencies he noted when a paid county-wide fire and EMS department was being established in his area. There were 10 separate volunteer agencies covering patches of the county, plus the newly established paid organization, for eleven total agencies involved in firefighting and EMS in a single county. Henry, perhaps drawing on his previous experience with the chain of command in the military, argues that the presence of so many departments, each with independent leadership, leads to disunity and inefficiency when serving the public and hindering cooperation. Each smaller organization wishes to maintain its own status quo and act on its own, and the EMS system at a county-wide level fails to reach its full potential.

Furthermore, the consolidation of small volunteer departments into a smaller number of large departments increases the pool of volunteers at each station, which could enrich the formation of larger social networks that help to sustain interest in volunteering and thus countering some of the self-reinforcing effects of a volunteer decline: a shortage of volunteers leading to a less interesting experience for the remaining volunteers, in turn encouraging further departures and a larger shortage. As we have seen, social network effects have been a crucial predictor in the retention or non-retention of volunteers in this study.
In stations where a low call volume decreases potential volunteer involvement, reducing the number of stations also increases call volume to a point where volunteers could use a shift system instead of responding whenever something comes in. Assigning shifts to volunteers can provide predictability for volunteers and increase involvement and accountability. Instead of going through the week with the possibility of having to leave work or home at any moment if there is an emergency call (and declining to respond to some calls because they cannot leave their current obligation), a volunteer with a fixed shift every week can schedule themselves accordingly and prepare to be fully available at that time, and to feel a heightened sense of responsibility for ensuring the group has a fully staffed crew. A regular shift also provides volunteers the benefit of a consistent group of fellow volunteers every time to bond with, sustaining continued volunteering consistent with the social network theories of volunteerism discussed in Chapter 1.

Nonetheless, there are costs to station consolidation, particularly concerning the deep traditions and history around community firehouses. For volunteers who participate mostly out of an interest in the work of being on a fire engine or ambulance this may be less of a problem, but many volunteers are motivated by a deep attachment to their community and a firehouse their family may have helped to staff for generations. Closing a firehouse and moving to that of a neighboring town may be a blow to tradition and seriously damage these volunteers’ interest in the fire service. Administrators seeking to consolidate will have to confront this possibility and ensure the sentiment of tradition is reconciled with the operational advantages of reorganization. Consolidation of departments is likely to be more of a consideration for volunteer departments, since paid agencies will likely have less trouble negotiating the relocation of employees from one job site to another based on operational efficiency.
A second possibility for reform, affecting both paid and volunteer staff, is the formation of all-paid and all-volunteer stations rather than combining personnel in a single station. This solution may be helpful for staving off conflict between volunteers and paid staff within the same agency and encouraging accountability within each group. I saw at Walton VFD, for instance, that a volunteer station employing paid staff could disincentivize volunteer participation, because volunteers reasoned that the presence of paid staff meant they were no longer needed. Paid staff, meanwhile, might feel the volunteers were offloading the undesirable work on them. In large stations where space is limited, career-volunteer segregation can also prevent frustration over ownership of the space, as noted at Candor. Finally, all-volunteer stations serving a larger area also encourage the development of a shift system to ensure regular staffing and consistency for volunteers. The main cost that could come from segregation of providers may be losing opportunities for social connection between paid and volunteer personnel, although this is somewhat mitigated by the presence of social connections outside the firehouse and these connections could be encouraged in other ways, such as organized events at the jurisdictional level. Overall, this cost may be acceptable if it limits the potential for volunteer-career conflict and leads to significant improvements in volunteer participation.

Conclusion

Emergency medical services (EMS) is a crucial public service that is uniquely provided by both volunteer and paid personnel in the US. Positioned between a long history of volunteerism and the rise of the healthcare industry, EMS faces competition from both its volunteer and career sides to define its future. Particularly salient is the possibility of professionalization as paid EMS workers seek conditions comparable to other healthcare workers, as studied through a neo-Weberian model of social closure legitimated by the state. Although some have feared that professionalization would
result in the total elimination of volunteers from EMS, I have shown in this study that social
network effects have contributed to volunteer resilience and that the division between volunteers
and paid staff in EMS is not a polar one, being moderated and complicated by a web of social
connections, shared experiences in operations, and a large number of providers with experience on
both sides. As EMS evolves at the crossroads of community life, professions, and the public sector,
it will continue to present a rewarding challenge for sociologists studying the rise of a new and
critical occupation.
REFERENCES


EMS Workers United. “AFSCME: The Union For EMS Workers.” Retrieved May 7, 2020a
(https://www.afscme.org/blog/webflow/ems/index.html#p1).


IAFF. “International Association of Fire Fighters.” *IAFF.* Retrieved May 7, 2020c
(https://www.iaff.org/).


(http://www.acepnow.com/article/emergency-medical-services-arrivals-admission-rates-emergency-department-analyzed/).


Greene, David Arnold. 2016. “Assessing Member Satisfaction Within the Volunteer Fire Service in South Carolina.” Oklahoma State University.


