

Heroes and Lies: Storytelling Tactics among Paramedics

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Abstract

Among paramedics, part of the working day consists of telling stories about emergency responses—rehashing the events that are the *raison d'être* of their profession. In the downtime between calls, the medics attempt to fit the day's events into their broader conception of their work. Among the medics in my fieldwork area, I have found a deeply cynical and self-deprecatory storytelling tradition—one that countermands the media representations of their field so neatly presented in globally popular television programmes such as *Rescue 911*. Rather than play into media presentations of them as silent heroes “just doin' our job,” paramedics tend to present themselves in their stories as anti-heroes, always ready with a sardonic quip in even the most horrific situations. This storytelling is part of the medics' tactical resistance to the various groups with whom they come into contact on a daily basis, including managers, field supervisors, hospital personnel, firefighters, police officers, bystanders, their patients and each other. In the course of their storytelling, medics often resort to strong language. For the sake of authenticity, this has been retained in the transcripts in this article.

Late one night you find yourself at the Emergency Room of a large metropolitan hospital. To get away from the crowded waiting room, you wander outside. By mistake, you exit the wrong door and find yourself in the ambulance loading zone. Clustered around the back of an ambulance, you notice three paramedics talking and laughing. “What,” you wonder, “could paramedics have to laugh about?” Nonchalantly, you wander closer. One of the paramedics is telling a story and the others standing around occasionally comment on his dark tale:

Medic 1: I did ACLS (Advanced Cardiac Life Support) on Lake Chabot, that was pretty cool. We got a call out to Lake Chabot for a person who'd committed suicide by putting on about four or five wool jackets and walking into the lake with his arms over his head and just dropping them into the water. So we get out there, and we had to wait an hour for the dive team to show up. [laughter] We weren't expecting too much. [laughter] Dive team finally showed up. And the genius firefighters said they'd found the body with a fish finder. Supposedly it was about twenty, twenty-five feet off shore. Well the diver shows up and starts his little routine and about five feet offshore he finds the body! So this whole time this guy was within literally arm's reach of us, just sitting on the shore, smoking cigarettes, shooting the shit. [laughter]

Medic 2: Oh shit!

Medic 1: They pull him out and this guy just looked like death warmed over. It was just ridiculous. So we're stripping him down, getting all his wet clothes off, and he has a little

bump under his chest. Put a monitor on him, dude's got a pacemaker! [laughter]

Medic 3: Oh man!

Medic 1: Beans! So now we have to work this guy. We intubate him, we start working this guy. Now there was about a two or three hundred-yard hike with a stretcher up to the ambulance and we couldn't do CPR [Cardiac-Pulmonary Resuscitation] that whole time ... When we finally got to the ambulance, [we] already had a channel for base hospital so we got a whole mess of drugs for him. It didn't work! [laughter] Got the guy to the hospital and the doctor said, "Nice knowing ya!" That was it.

Medic 2: That's a cool call. I had something kinda like that. We were ...

Just as the second medic is about to join the storytelling, a beeper sounds and the atmosphere quickly changes. One of the medics climbs into an ambulance while the other two wander back inside the hospital. As the ambulance pulls away, you are left in the parking lot of the hospital wondering about the conversation—was it an aberration or a view into a hidden dimension of work among ambulance personnel? At the very least, the conversation did not tally with representations of the field that appear on television.

Introduction

"Reality television" programmes that purport to tell the "true" stories of police and rescue personnel, and closely related dramatic series such as *E.R.*, have gained extraordinary popularity in recent years. [1] Indeed, programmes such as *Rescue 911*, *Cops*, *Code Three*, and *Real Stories of the Highway Patrol* almost guarantee that an evening spent in front of an American television will provide a glimpse into the chaotic underworld of the modern city where violence, murder, prostitution and drug dealing are everyday fare. [2] Since these programmes emphasise the heroic aspects of the work—chasing criminals or saving lives—they provide little opportunity for the emergency personnel to tell their stories in their own words. On *Rescue 911*, for example, the producers cast paramedics as B-actors in a second-rate docu-drama recreating memorable rescues, rather than allowing them to tell their stories as they would to each other. During the few moments when the paramedics do speak on *Rescue 911*, it is always within the confines of a closely scripted interview or an elaborately edited "sound bite." Although the situations documented on these programmes are also frequently the subjects of paramedics' personal experience narratives, on television visual presentation takes precedence over narrative description and the paramedics' personal perspectives are consequently downplayed. Accordingly, and somewhat ironically, reality television programmes fail to deliver what people tune in for in the first place, namely, a first-hand experience of everyday life on the front-line of the emergency professions. On television, the well-developed personal experience narratives that form a significant part of the working day are regrettably lost amid the glare of the lights and machinations of the camera crew. This lost folkloric dimension of the work, however, is one that holds significant importance for the workers and, in turn, for our understanding of occupational life.

Folklore and the Study of Occupational Culture

Studies of occupational culture generally include, to some degree, an evaluation

of the folkloric aspects of life in the organisation—the low-level, day-to-day, face-to-face interactions that exert extraordinary influence on the rhythms of the work and the environment of the workplace. The earliest studies of organisational cultures centred on questions of work environment and its effects on productivity (Trice and Beyer 1993, 23–32). Later studies went beyond considerations of productivity and were based more on models taken from cultural anthropology (Warner and Lunt 1941; Whyte 1943; 1948; Gardner 1945; Roethlisberger and Dickson 1946). The intention of many of these studies was to discern social structures and beliefs among workers in a particular organisation, frequently factories, warehouses or retail outlets (Whyte 1978). During the 1950s, while cultural anthropologists tended to shy away from studies of the workplace, some researchers, notably those from the Tavistock Institute in England along with Donald Roy in the USA, continued research on the culture of work organisations (Jacques 1951; Roy 1952; 1953; 1954; 1960; Dalton 1959). [3] In the late 1960s, the study of organisational culture became a widely accepted field of research, and qualitative assessments emerged alongside more traditional work (Mintzberg 1973; Pettigrew 1973). Much of this work continued through the 1970s and, during the 1980s; “organisational culture” became one of the buzzwords in management, due in large part to William Ouchi’s (1981) influential study of Japanese work culture and organisational structure, and Peters and Waterman’s (1982) examination of work culture in numerous American corporations (Trice and Beyer 1993, 29).

Although the idea that the culture of a work organisation can have a significant impact on the effectiveness of both the employees and the organisation itself is now a generally accepted concept among researchers, managers and workers alike, many studies of working life take an overly broad or simplistic approach to the description of that culture, rarely developing the type of thick description proposed by Gilbert Ryle and later Clifford Geertz (Ryle 1971a, 474–9; 1971b, 482; Geertz 1973, 6). It is precisely this type of thick description, however, that holds the most promise for understanding how people experience life in a particular organisation, and how they create for themselves and each other a cultural ideology that governs behaviours and interactions in that organisation. [4] Rather than exploring a work culture from the outside, or from the top–down perspective of management, a more nuanced understanding can be derived from extensive fieldwork among the workers themselves—the people who contribute to the creation of actual work culture.

Yves Allaire and Mihaela Firsirotu propose a synthetic view of organisational culture as a “system of symbols shaped by ambient society and the organisation’s history, used and modified by actors in the course of acting and making sense of organisational events” (Allaire and Firsirotu 1984, 216). Their view of organisational culture moves away from the top–down approach of much management literature, which either implicitly or explicitly suggests that managers can create organisational culture. Allaire and Firsirotu’s dynamic model recognises that the agents of change are the workers themselves, the “actors” who “use and modify” the organisation’s “system of symbols.” An examination of an organisation’s folklore that endorses this model reveals the profound effect that low-level interactions among workers have on the organisation’s function.

Folkloric examinations of occupational groups have been quite successful in exploring these unofficial dimensions of work culture. Numerous folkloric

studies of oral traditions—primarily narrative traditions—in work organisations have revealed how storytelling functions in these groups. Patrick B. Mullen’s (1988) investigation of narrative and folk belief among Texas Gulf Coast fishermen, along with Jack Santino’s (1989; 1990) numerous explorations of storytelling among various occupational groups, have shown the important role that storytelling can play in life in the organisation. Robert McCarl’s (1985) study of firefighters, his study of smokejumpers (McCarl 1976; 1978a), and Randle Hurst’s (1966) earlier consideration of a similar group, all capture, albeit to a lesser degree, the role that storytelling plays in the constant formation of culture in high-stress professions. As James Mannon (1992), Donald Metz (1981) and I (Tangherlini 1998) have all pointed out elsewhere, among ambulance personnel storytelling stands as one of the most developed aspects of the occupational culture. It clearly influences how emergency workers cope with the psychological trauma associated with their work; how they interact with the environment and the public; and how they interact with each other, management and other closely related agencies. This in turn mirrors Allaire and Firsirotu’s (1984) concept of the use and manipulation of organisational symbols.

Paramedic Culture and the Politics of Storytelling

During the past five years, I have conducted field research with a group of paramedics, or “medics” as they refer to themselves, in the San Francisco Bay area of northern California, focusing on their storytelling as a means to develop a “thick” understanding of life in the organisation. [5] Medics respond in their ambulances to any medical emergency that is phoned in to the “911” emergency system. Although in many cities in the USA medics are employed by the fire department, in many other communities (including my fieldwork area) they are employed by private companies that contract with the city or county government to provide emergency medical coverage. Medics are trained in advanced life support techniques and must undergo a rigorous year-long course in anatomy, biology, pharmacology, and medical procedures. After a six-month internship under the tutelage of an experienced medic, during which they hone their skills, learn the tricks of the trade, and accustom themselves to the rhythm of the workday, they receive their certification. Working in staggered, twelve-hour shifts, and deployed flexibly throughout the county, medics in my fieldwork area encounter an incredible range of medical emergencies (and non-emergencies) and interact with a cast of characters so utterly diverse that no Hollywood scriptwriter could ever do it justice. In the downtime between calls, they attempt to fit the day’s events into their broader conception of their work, frequently swapping stories with their partners (McCarl 1978b, 14). This occupational storytelling is quite common and is referred to emically as “bullshitting” or “telling lies.” These designators clearly indicate the tradition-participants’ awareness of the fictive element in many of the narratives. When several ambulance crews overlap at the ambulance loading dock of large urban hospitals, they gather to tell stories in narrative sessions that more often than not have the feel of heated competition, with medics vying against each other to tell the best story (Tangherlini 1998, 86).

Among the medics in my fieldwork area, I have found a deeply cynical and self-deprecatory storytelling tradition—one that countermands the media repre-

sentations of their field so neatly presented in globally popular shows such as *Rescue 911*. Rather than play into media presentations of them as silent heroes “just doin’ our job,” paramedics tend to present themselves as anti-heroes, always ready with a sardonic quip in even the most horrific situations. In many of their stories, the patients are undeserving, the bystanders are unpredictable, other emergency responders such as the police are horribly incompetent, field supervisors are obsessed with procedure, managers think of nothing but profit, dispatchers are woefully inarticulate, hospital personnel are dangerous, and the only ones able to bring a modicum of sanity to the bizarre situations they encounter are the medics themselves.

Through their storytelling, medics impose order on what are essentially unordered events and, as such, their storytelling mirrors Frank Kermode’s notion of the human need to provide beginnings and endings to the middle ground we inhabit: “in ‘making sense’ of the world ... we feel a need ... to experience that concordance of beginning, middle and end which is the essence of our explanatory fictions” (Kermode 1967, 36). By providing endings to essentially open-ended events, medics exert control over, and thus “make meaning” of, chaotic and possibly otherwise meaningless work experiences. Retrospective retelling of the sort medics engage in allows them a high degree of control over events that were often out of their control when they were happening. Narration of personal experiences posits the narrator as the authority and imbues him or her with power. The imposition of order on unordered events is not the only outcome of medic storytelling. It does, however, reveal that the medics are engaged in a far more elaborate behaviour than mere entertainment or a simple recounting of the day’s events. Rather, through their stories, they engage with the politics of life in the organisation.

Michel de Certeau (1984) explores the low-level politics that structure many of our daily lives, terming his approach the study of “the practice of everyday life.” Everyday life, particularly in a work organisation, can be fraught with political pitfalls. An individual’s status is often under threat, frequently challenged, occasionally subject to redefinition, and constantly renegotiated. In many work organisations, where employees work in close proximity to their managers, much of this takes place behind closed doors. In the ambulance company, however, many of these political concerns are out in the open, due largely to the decentralisation of the work, with medics roaming to the far-flung corners of the county, encountering their field managers infrequently, and generally being on their own, tenuously tethered to the central dispatchers by a makeshift link of telephone pagers and two-way radios. Accordingly, the sense of management censure in the medics’ work environment is far less severe than in work environments that impose greater spatial constraints on the employees. At the same time, the ambiguity of status that comes from the dispersed work environment—never knowing where one stands either literally or figuratively—resonates throughout the work culture and motivates the field employees to frequently consider their position. They do this, in large part, through their storytelling. [6]

Michel de Certeau proposes the concept of “tactics” and “strategies” as a means for explaining the types of political behaviours people are likely to employ and to encounter in their manoeuvrings through the politically charged

landscapes of their daily lives. These two concepts are eminently suited to an understanding of people's lives in work organisations and can perhaps help elucidate the importance of storytelling among medics. "Strategy," de Certeau proposes, refers to the techniques a powerful entity employs to further its own agenda. "Tactics," in contrast, refers to those techniques which those who lack authority employ to resist control (de Certeau 1984, xix). Where strategies are the purview of the organisation as a whole (in this case, the ambulance company as an entity), tactics belong to the workers (in this case, the medics). While the company devises strategies to deal with both its workers and the delivery of services, medics devise tactics to situate themselves in the organisation and to redefine the work environment to fit their own needs. But medics, as representatives of the ambulance company, can also employ "strategy," primarily doing so in their interactions with patients. In these situations, the medics are not the ones subject to control, but rather agents of control themselves. Storytelling, which the medics employ both tactically and strategically, is an endeavour that de Certeau describes as, "repertoires of schemes of action ... mementos [that] teach the tactics possible within a given system" (1984, 23).

Michel de Certeau further suggests that, "Tales and legends are deployed ... in a space outside of and isolated from daily competition ... In that space can ... be revealed ... the models of good or bad ruses that can be used everyday" (1984, 23). Medics do not, however, deploy stories "outside of competition," but rather use them in the context of the numerous competitions that structure their daily lives. Indeed, storytelling can be the object of competition itself. In a modification of de Certeau's model of storytelling and tactics, I propose not only that stories allow for the exploration of possible actions in a given situation, but also that the telling of stories itself is a form of action. In this light, medic storytelling can be seen as a tactical engagement with the organisation—its rules, its constraints, its expectations, its apparatus of surveillance, its rewards and its punishments—as well as with the myriad outside groups that medics encounter on a daily basis, including patients, bystanders, police, firefighters, and hospital personnel. In their relationships with people outside of the organisation, medics strive to present themselves as competent authorities on the pre-hospital care of the sick and injured, taking issue with any who challenge their authority. In their relationships with people inside the organisation (including each other), medics attempt to optimise the conditions of their work environment, taking to task those whose actions negatively affect these conditions. Much of this manoeuvring takes place through the storytelling.

Storytelling as a Psychological Outlet

In addition to these political uses—and just as importantly—medic storytelling serves as a psychological outlet for the emotions engendered by encountering human suffering on a daily basis. For medics, maintaining a psychological distance from the, at times grisly, sights that greet them at medical emergencies is a necessary part of surviving life in the ambulance service. Yet, even as their storytelling functions on this psychological level, it still transgresses procedures put in place by the organisation and accordingly can be viewed as a tactic. Although the ambulance company provides a formal interactive debriefing

setting known as Critical Incident Stress Debriefing (CISD), used primarily in the aftermath of multicasualty incidents or natural disasters and mediated by a psychologist, counsellor or manager, medics generally prefer the informal debriefing mechanism they have devised for themselves.

In the context of de Certeau's model, CISD can be considered a strategy employed by the organisation to ensure the mental health of its employees and, ideally, a higher degree of productivity. However, many medics express aversion to these structured, management-initiated storytelling sessions. Part of this aversion stems from the notion that repeated use of CISD can have a negative impact on their standing in the organisation. Furthermore, the general feeling among medics is that CISD makes them even more subject to the company's apparatus of surveillance, a surveillance that they frequently try to avoid. Finally, some medics fear that colleagues will consider them "weak" or "unable to cut it" if they avail themselves of this service too often. As a means to achieve a similar end—but without the formal structure or the perceived pitfalls of CISD—medics engage in informal storytelling. This allows them to explore the horrors of certain scenes, examine their own actions and, through the response of the other medics who make up the audience, achieve "closure" of these dramatic events, free from the potential management censure implicit in the formal CISD.

These informal "debriefings" allow medics to express a greater range of emotions (Tangherlini 1998, 64–6) than they can in a CISD session. Sometimes, storytelling of this nature takes on a darkly cynical character, with descriptions of gore or violence that go far beyond what is generally accepted in the more formal interactions:

Back east, I once was sent to meet a helicopter, bring the guy from the helicopter to the burn centre. He had chemical burns. He had chemical burns over ninety-nine percent of his body. And they were all second and third degree burns. You could barely tell this guy was human. He was just crisped. Met up with the helicopter and brought the guy to the burn centre, but you know, the unit just smelled like burned toast. Well, maybe not like burned toast. It's got a distinct smell, like burned hair. Sort of smells like that. Sort of more pungent. Just makes you want to go out and have char-broiled food or something, you know? It's got a tasty smell.

Flip comments such as the closing quip here are not an uncommon feature in medics' stories. The dark humour that pervades them often casts the horrible into the world of the mundane. These comments, of course, also help to trivialise, and thus make less horrific, grisly scenes of suffering and death.

Not all of the informal debriefing stories are filled with cynical banter. Indeed, at times, the storytelling is deeply moving and personal:

It was just terrible, it still kind of haunts me, I had nightmares about it for a while. It was a late night call for shortness of breath and we get there, and there's a family and they're pretty hysterical. We go down the hall and their teenage son is face down on the carpet in the bathroom with a history of asthma and he was purple. I mean, his respiratory was eight and it wasn't moving any air at all. And he was bradycardic and he was cold and unresponsive and there just wasn't that much we could do for him. We intubated him and we gave him epi and alupent and the whole works and rushed to the hospital and by the time we got to the hospital he'd coded. You know he was seventeen or eighteen years old

and there wasn't that much we could do for him. It just really upset me and the family was all in denial and he had a bunch of brothers and sisters who were around and watching us work him up in the kitchen. So they worked really hard in the emergency room and got his heart started again but he had dilated unresponsive pupils, and he died in intensive care about ten days later. It was just really terrible. It was just terrible that we couldn't do more for him.

In many of these informal debriefing stories, it is in fact the medic's inability to "do more" that constitutes the major crisis of the event and prompts the narrating. The story allows the medic to explore the possible range of action (thus echoing de Certeau's observation on storytelling as a repertoire of schemes of action)—in some stories to the point of violating company policy—and to determine whether something could have been done differently to reach a positive patient outcome. By eliminating that possibility, the medics exert a narrative power over an event in which they felt powerless.

Storytelling and the Negotiation of Power Relationships

Beyond providing a psychological outlet and an accompanying sense of closure, the storytelling contributes to the medics' development of an elaborate "presentation of self" which, in turn, is closely linked to their tactical deployment of stories (Goffman 1973). One of the defining features of medics' self-image is the notion of being able to "see it all" without recoiling in disgust or terror. In their stories, medics display an intriguing fascination with revealing things that are normally hidden, be they bodily organs, surprising sexual behaviour, criminal activity or medical malfeasance. Certainly, part of their work is to uncover the hidden and to venture behind closed doors. This need to access the out of sight both in geographic locales (a form of spatial surveillance) and on their patients' bodies (a form of medical surveillance) necessarily places them in a position of power. This power relationship to the environment and their patients is reflected in turn in their narratives. [7]

On the scene of emergencies, medics are clearly involved in a series of overlapping and at times contradictory power relationships. They must treat their patients, calm various bystanders, interact with police officers and firefighters and, via the radio, talk to emergency dispatchers and hospital personnel. All of these interactions are based on hierarchical relationships that are not necessarily clearly defined. Ideally, the patients are under the medics' care, yet in many instances the patients are reluctant or wholly averse to being treated. Bystanders, who should have little or no contact with the medics, can be bothersome and, in some situations, downright dangerous. While the police generally tend to assist paramedics, the goals of the two groups occasionally are in direct conflict with each other, as when medics are called to treat a violent criminal. Firefighters, who usually respond in tandem with the medics to provide assistance, are on occasion reluctant to assist in work that falls outside the narrowly defined field of extinguishing fires. At some calls, a field supervisor will also be present, adding yet another power relationship to the mix. Each one of these groups has certain expectations of how the medics should perform, in some cases derived from watching "reality" television programmes. Medics, of

course, have their own expectations of how these groups will and should react, and the resulting conflict in expectations can have significant consequences.

Steve, for example, tells an elaborate story that highlights the problems of negotiating these relationships:

We got a call for a shooting at the corner of Ninety-second and East Fourteenth and we come up and there's nothing there. But we look around the corner and there's two cops down there and a huge fucking crowd. So as we pull up, we see what looks like one guy down on the ground and he's bleeding from his head, and we pull past again to get in position, we get out, and as we're approaching we see there's actually two guys, one guy laying on top of him, kind of like underneath this car, with some screaming hysterical woman on top of them. And both of these guys have been blasted with shotguns.

So we get up there and the cops are standing there, just hemming and hawing and we're all, "Hey, get this lady out of here!" You know, she's just basically killing these guys, because we can't get near them. So these idiot cops manage to get her off, then the crowd starts in, "Why aren't you doing anything? Do some of that Rescue 911 shit!" and so on. Now the fire department's supposed to be there, but as usual, they're "staging" like three blocks away. [8] They keep saying, "The scene isn't secure, the scene isn't secure!" We've got two critical patients with a crowd of like 200, and we have 400 things to do in like two minutes and, of course, the cops really aren't helping us out at all. It was just fucked. It was totally fucked.

So anyway, we've got these two criticals, and our great portable radios we have of course aren't reaching dispatch. I'm trying to tell them we need a second ambulance, they don't answer me, so Stephanie goes back to the rig and calls for another unit. Now the geniuses back at dispatch think we need two units, so apparently they heard us the first time but just didn't bother to answer us, so now they think we need three units even though I told them we only had two patients.

So now this is the beginning of everything falling apart. The fire department is still "staging" about half a mile away, so we start working on these guys as best we can. Finally, the fire department shows up and we're having a few problems with them. You know, half the crew wasn't real sharp. So we start working on the patients, I'm just starting to intubate this one patient, and this lady comes and jumps on me. She's got a hold of my hair, this other one's got me going the other way, I don't think they're trying to hurt me or anything but they're just so hysterical they're trying to get over me to this poor guy who'd been blasted through the head. So one lady has got my hair and I'm going that way, and another lady is climbing over the top of me, I've got her by the neck. In the meantime I've tried to use my other hand to shove her away and keep this guy's airway open. I look and about ten feet away, there's a cop standing there just looking at me, not doing a thing. And I'm like "Holy shit, what is this guy doing?" He's just standing there.

All of a sudden he kind of wakes up and he runs over and grabs her by the hair and gets the other one too, but she's still latched on to my hair. It was just incredible. I'd been screaming at the police, "We've got a crowd!" After they pulled the ladies off of me, they grabbed one by the hair and threw her back onto the sidewalk, and then a fight starts—a couple fights start breaking out on the sidewalk—and then this huge fucking crowd starts pelting the police with bottles and stuff. Meanwhile we're still trying to treat these guys, having a hell of a time. It was like something out of a freakin' war movie.

Well anyway the two other units show up with a supervisor in tow, who was just a total fucking idiot, telling everybody where to go, and nobody's listening to him anyway. But it worked out fine for us, because we got boxed in by the fire and the police and couldn't do anything anyway. So it worked out all right, but a what a cluster fuck that was. Most of them go smoother than that, but that was one where the fire department was totally inept, the cops were basically asleep, the dispatchers were fucked as usual, and this supervisor was an idiot. Not to mention the fucking crowd.

In the narrative, Steve questions the abilities and authority of the police, the firefighters and, interestingly, the dispatchers and his own immediate supervisor. Interestingly, he makes no comment concerning the ultimate fate of the patients, a common feature of medics' stories. The story, told to a group of other medics, confirms instead many of the common negative evaluations of company management, police and firefighters.

Paramedics and Firefighters

In many urban areas, there is an ongoing turf war between private ambulance providers and fire departments over who can most efficiently and effectively provide primary 911 ambulance coverage. Since many fire departments respond as first providers to medical calls, they maintain that it would be quite easy to integrate paramedics into their system. In response, private providers and public agencies dedicated solely to ambulance services point out the inflexibility of stationing paramedics at fire stations: while houses and other buildings are immobile, people move about during the day. In my fieldwork area, many paramedics are wary of firefighters assuming the job of providing advanced life support treatment and transport because they fear for their jobs. They suspect that the fire department would simply retrain their own members to take on this added responsibility, and thus drastically reduce the paramedics' employment opportunities. This competitive tension between paramedics and firefighters—"the plugs," as many paramedics derisively refer to them—surfaces time and again in medic stories. [9] Often, the critique in these stories mentions firefighters' unwillingness to assist on medical calls, and their reluctance to enter potentially dangerous areas that have not been fully secured by police, regardless of how critical the patient's condition may be.

Paramedics and the Police

The relationship with the police is somewhat more ambiguous. On the one hand, the police can be quite helpful, as they are in Lars's comments concerning this working relationship:

The police here are really good. You call for the police and if you need them really quick, they're there and, by the same token, if a cop gets shot and we know about it, you know we're all over that quick too. We sort of take care of each other, and they know that we're right there for them, so they're right there for us.

Lars's endorsement of the quick action of the police stands in marked contrast to the lackadaisical response Steve details in his narrative earlier. Tom expresses an even more extreme attitude:

The partner that I had in Contra Costa County when we worked for Allied used to pack a gun. A lot of my buddies used to, because they were having trouble getting support from the police department, so they'd have to pretty much take care of themselves. It's true, we do have a lot of trouble getting support from the police departments, because they think that we all overreact and we're probably a lot wimpier than they are, and probably are, but anyhow they don't hurry when we call for help. It's criminal.

Perhaps these comments reveal an ongoing negotiation among medics over their collective response to the police. Negative evaluations may indicate to other medics that they should be cautious of relying too heavily on the police in dangerous situations. Positive evaluations may offer a degree of comfort, allowing the level of confidence necessary to work in the, at times dangerous, urban environment. In either case, the narratives emerge as a significant factor influencing medics' actions while on scene. The tactic of telling stories about the police does not solely contribute to a sense of resistance; it can be used rhetorically to bolster a sense of a positive working relationship as part of an ongoing debate over this relationship. [10]

The medics' relationship with the police extends beyond encounters at emergencies. Darryl details a humorous approach to patient care in which he uses the argot of the police to convince a patient to come for treatment:

Sometimes you have patients that are legally within their rights to refuse treatment, because they're still lucid enough to answer the appropriate questions to be a consenting adult and everything. But you know they're having a medical problem that's life threatening. I'm not talking bullshit, I'm talking about a life-threatening illness and everything and they don't want to go to the hospital. Typically, it's like elderly emphysema patients, they're just tired of going to the hospital. They don't want to go to the hospital, they don't care if they die, and they're just going to stay in there until they do, you know? Well, in reality, what would probably happen is they'd go unconscious and the family would call us back, but why? I'm basically a lazy person and you've got us there right now, let's deal with the programme, let's take you to the hospital.

So I just bullshit people. "Look, you're under medical arrest. You have no rights here. You're under medical arrest and you're in violation of the paramedic penal code if you resist medical arrest." And I quote some bullshit like section four, paragraph three, subtitle fucking three point two, which gives us the right to put you under medical arrest. Usually, you can bullshit people into going to the hospital, they'll go with you and everything. You don't have a choice, you're under medical arrest. "Uh, you're not going to put me under arrest, are you?" [11]

In this case, Darryl employs what is essentially part of the state's disciplinary apparatus (and thus a strategy in de Certeau's model) as a means for effecting expeditious care of a patient. Amusingly, relating this clear violation of company policy (a tactic) in a narrative setting offers other medics an opportunity to explore the potential outcomes of an otherwise off-limit action in a patient encounter scenario. The willingness to appropriate an element of the police's scope of action into their own practice further underscores the ambiguous relationship medics have with the police.

Paramedics and Management

Medic attitudes toward supervisors and dispatchers are not nearly as ambiguous—the relationship is a tense one. Supervisors' and dispatchers' control of the medics is based on surveillance. Michel Foucault, in his seminal study of the early prison, considers the role that surveillance plays in establishing power hierarchies and how the mere possibility of being watched can have a strong corrective effect (Foucault 1995, 249–50). Medics do not consider all company supervision to be negative or unnecessary. Indeed, used properly, the surveil-

lance can assist the medics in performing their duties. They do not, however, necessarily agree with management over what constitutes proper use of supervisory tools. To combat the company's strategic deployment of surveillance devices—roaming field supervisors, geo-positioning satellites, radios and pagers—the medics tell stories that question this surveillance and, just as importantly, the abilities of the managers to competently evaluate the information that they gather. For instance, Lars recounts a story in which the managers are overly dependent on the surveillance apparatus and unwilling to exercise a modicum of common sense:

One day, you hear them asking a unit for their 10–20 [location] and they're all like, "Oh, we're on Jackson Street." They're like, "Well, negative, we show your ambulance, well, we show your ambulance in the Bay." And they're like, "Well, we're not in the Bay." "Well, that's where we show your unit." I mean, the dispatchers were insisting that this ambulance was out in the Bay, because, that's where it was showing—out in the Bay. So, "Well, we show your unit out there." "You're right, you're right, you caught us, man, we're sailing! ... We've got fins, it's amphibious, and we're out here fishing. We'll bring it back up on land" (Tangherlini 1998, 205–6).

The story, and its telling to other medics, constitutes a form of narrative resistance to the apparatus of surveillance that controls the rhythms of the workday. Lars does not call into question the need for the equipment, but rather challenges the ability of the dispatchers to evaluate properly the information they receive. In a similar narrative told on another evening, Lars points an accusatory finger at a field supervisor [12]:

There was one supervisor once, God what an ass. They'd given us a call and we gave an ETA, dispatch asked us what our ETA would be to some street, and my partner gave an ETA of like six minutes or so. Now this supervisor had them look us up on the board, and then he drove from the site of the call to where we were posted and he came up to us at a hospital and he said it only took him three minutes to drive from the site of the call to where we were posted. This guy clearly had nothing better to do. And my partner was like, "Yeah, and?" Well, the two of them started arguing, just full out. So now I try jumping in, help my partner out, and said, "Well doesn't ETA stand for estimated time of arrival?" And the supervisor told me, "At ease, I'm not talking to you." He stuck his hand up in my face, and said "At ease." Like we were in the military or something. So that's the type of stuff we deal with.

Many of the medics' narratives criticise such unnecessary managerial zeal and interference. Repeated tellings of these stories in turn influence their attitudes toward the managers and their surveillance apparatus.

Resistance to management is not solely related to questions of post assignment. Perhaps the clearest tactical deployment of storytelling among medics occurs on those occasions when management questions their treatment of patients or their actions at the scene of a medical emergency. In these cases, medics respond with withering attacks directed not only against their field supervisors but also against the upper administrative apparatus of the company, represented in most stories by the anonymous "Quality Assessment," or QA, board. Tony's story illustrates this point well:

So we got to this Code 3 call and it was a problem breathing call. And we got there and we knocked on the door and the lady says, "Come in, come in. My brother, he just came in from New Orleans, he's having a breathing problem. I know he has a breathing problem, so it's probably what's going on. He was sitting here, and he fainted and I saw him having some kind of problem breathing! Can you check him out?" We're like, "Sure, where is he?" She said, "In the kitchen."

So we walked over to the kitchen, and there he was, flat on the ground. And I looked at him and I said, "Yeah, this guy is definitely having a breathing problem." [laughter] Like, a not breathing problem. And so we're working that up, and we didn't have anyone to help us out. So we were doing CPR and then we started doing one-man CPR on this guy because we wanted to start a line and start the drugs.

At this point, I haven't done anything to this guy, the monitor isn't even on him yet. And a fellow's walking by, and I'm like, "Hey, have you ever done CPR before?" And he's like, "No, but I've been trained." I said, "Great! Let me show you then. Sit down. [laughter] Extend, just like me, stand over his chest and start pumping his chest like this." So he started pumping his chest, I started breathing for him, my partner got everything else set up, put him on monitors, started intubating him. We ended up doing our thing on this guy and making a save on him. Ended up saving this guy. But I—I got QAed by the company for using a bystander to help with CPR. They wanted me to go find this guy and get a CPR card from him (Tangherlini 1998, 188–9).

Medics pride themselves on their ability to provide expert pre-hospital care to their patients and lash out at those who question this. When such challenges come from a quarter that is suspect in the first place, the response is all the more energetic. Here, despite saving a patient's life, Tony is called to task by his managers for not following the proper protocol and getting documentation from the bystander. In telling the story, Tony recounts an action that violates company policy but nevertheless—largely because of that violation—results in a desirable patient outcome. He relates the story to his partner, simultaneously seeking confirmation that his actions were proper and those of management were contemptible and making a direct challenge to the ability of the company to provide intelligent oversight.

Paramedics and Hospital Personnel

Of all the medics' work relationships, the one with hospital personnel is among the most complex, and revolves primarily around questions of competence. Unlike the challenges from the company, challenges from hospital personnel, particularly nurses and physicians, carry the added weight of coming from people higher up on the medical ladder. These challenges run directly counter to the medics' self-presentation as in-control medical authorities. While people generally defer in medical matters to the medics at the scene of an emergency, once at the hospital, they find themselves near the bottom of an entrenched hierarchical system.

Technically, medics "borrow" the licence of an attending physician when they are at the scene of a medical emergency, acting essentially as an extension of the physician. Because of this close tie, medics generally have a good relationship with emergency room physicians, and usually defer to them in medical matters. Occasionally, a medic will delight in telling a story in which his diagnostic acuity is better than that of a physician (usually an intern or resident), but stories

such as these are more often used to build themselves up than to criticise a physician's abilities. Bill, for example, tells a story in which the physician's diagnostic acuity is inferior to his own:

I was at Eden one time when they brought in this person who'd been shot with a shotgun in the back, and the doc took the X-rays on the back and he goes, "There's two pellets lodged next to the spine." Now this guy didn't get shot anywhere near the spine, so I was kind of hesitant. So I looked at the X-ray and I noticed that there were these little Phillips heads on the spots where he thought there were pellets next to the spine. Turns out they were screws from the backboard. He was all flipped out, thought that it was pellets near the spine (Tangherlini 1998, 23).

In most cases, such as this one, physician error is easily corrected and has no lasting ill effects. In short, stories that comment on physicians seem to be a tactical attempt on the medics' part to pull themselves up a rung or two on the medical ladder rather than to pull anyone down.

In contrast to the amicable relationship medics have with physicians, there is no such courtesy between nurses and medics. [13] In many counties, nurses and medics are engaged in a bitter turf war over the treatment of critical patients. Nurses question the training and abilities of medics, while medics deride the competence of nurses. Although part of the battle between nurses and paramedics has been fought out in state and local government, day-to-day engagements are routinely fought out over the radio and in the emergency rooms. As part of their attempt to claim duties they feel that they are qualified to carry out, medics use stories not only to build themselves, but also to tear down the elaborate professional image that nurses have constructed for themselves.

One of the clearest areas of conflict between paramedics and nurses concerns "field orders"—drug orders that paramedics are required to clear with a physician at the base hospital before administering them in the field. The prescription of these drugs is most commonly handled by a Mobile Intensive Care Nurse (MICN) standing in for a physician, and the negotiation of these orders can often be quite heated (Mellinger 1994). Tom comments on the lack of cooperation from MICNs in granting these requests, concluding that patient treatment suffers:

It used to be we had good relationships with MICNs, you know? We'd call them up, and you'd already given the medicine and they'd just give you the orders for it. But not anymore, man. You can't guarantee you're gonna get an MICN who's gonna cooperate. So, it's like, now, you've gotta wait. And when you're on the third or fourth floor of a building you ain't got time to get a hold of everybody. I mean, everybody knows that you just treat 'em and you call and talk about it later. But, nah, they don't like that no more. Patients don't get the medicine they need, they don't get treated anymore, not like they used to. 'Cause you never can tell whether or not you're going to get your drug orders (Tangherlini 1998, 20).

While both groups are ostensibly working collaboratively to insure the best possible patient care, in Tom's scenario, the nurses stand in the way of the efficient treatment of critical patients. Ultimately, the story stands as a direct challenge to the nursing establishment.

It would be misleading to say that medics and nurses never get along. However, in the storytelling tradition, nurses are routinely cast as incompetent bunglers who endanger patients with frightening regularity. Lars tells of an

encounter with an entire emergency room staffed with inept nurses and barely competent physicians. Despite his and his partner's persistence, and the timely intervention of a surgeon, it is unclear whether the patient survives:

We had a film crew with us that night, but the film guy had gone home. It was one of the first. NY Times, TV people and he had just gone home saying, "Nothing's happening." Two hours later we got a call on the bridge and we get there. It's interesting. We get there and the fire truck is saying "We can't find it." I went, "Well, lower deck of the bridge, before the island, it's the only mangled car sitting in front of a flipped over sport utility vehicle. It's three in the morning." I mean, how do you not find it?

So we get there and it's just us, the CHP and CalTrans. There was a sport utility vehicle that had stalled and the people had gotten out and the guy driving it said to his friends, "We better get over to the side of the road." And right after they get over to the side of the road this little car comes tooling along and no braking, nothing, it was like the guy never saw them, plows right into them. Flips the sport utility vehicle over, crushes the whole front of the little car.

So we get there and it's an old guy, eighty years old, and he's trapped in the car. And we start trying to pull open the door and us and this bystander and this CalTrans guy all ripped open the door, but he's pinned under the dash, you know his legs are pinned by the dashboard. And we start working him up and we pop in some IVs, there's still no fire truck yet. They finally show up. They cut him out of the car, it takes about twenty minutes to get him out, he's got a broken leg, a broken arm, he's conscious, he's talking to us, he's compensating really well, but his belly really hurts. But he's got a decent pulse and blood pressure so he's compensating well.

We get him in the ambulance and start heading to the General. It was very funny, I had this moment's thought, "Hey we could go to Bayview," but then I thought, "Nah, we can turn around here, we can go to the General." We turn around and we start heading towards the General. Now the difference between Bayview and the General is with Bayview if you have a trauma you just call up and say, "I have a trauma activation, have the trauma team ready," and they do. With the General, you have to call them and give an entire report to the nurse, then the nurse gets to decide if the trauma team is called.

So I call up and give a full report. Often with the General, what you do is sometimes you just kind of lead them, you say to the MICN, "And we're coming in Code 3 and we're starting IVs, and this is a trauma activation." So the nurse on the radio called in the charge nurse and the charge nurse decided that this guy did not meet trauma criteria. They have a little sheet there and they go through it, the little sheet, "OK doesn't meet this, this, or this. So nope, not a trauma activation." So we come in Code 3, you know we've extricated this guy, we've got him in C-Spine, stripped, two large bore lines going, it's perfect prehospital care.

We get to the General, we rush through the doors and the triage nurse stops us. And we're like, "No, we want to get him back to the trauma rooms. This is the trauma from the bridge." "Oh no, no, we're not going to make this a trauma." "Why not? Does this guy owe you money?" "Well it doesn't meet our criteria." "What criteria does this guy not meet? The guy's eighty years old, he's been in a high speed accident, it took us twenty minutes to extricate him, he's got two long bone fractures and his belly hurts. How is that not a trauma?" "Well he's not tachycardic and his skin signs are good." "Yeah, for now."

So they're like, "OK, you can put him in one of the trauma rooms." And we put him in a trauma room, and there's like one nurse there, and my partner says again, "This is a trauma. His belly really hurts. I think he's really hurt." The charge nurse starts getting upset. "We'll handle it from here, we've got it." And we're like, "Well at least a doctor should come in and look at him." So I go into the next trauma room where there's five doctors looking at a minor assault victim, making a big deal out of nothing, and I say, "You know, this guy

next door, I think he deserves at least one doctor." And they didn't like the way I phrased that. So finally a doctor goes in there and just gives him a cursory glance and says, "Oh yeah, I think he's all right." Leaves. My partner's saying, "He's really hurt, I really think he's hurt." Now his heart rate is OK, it's in the 80s or 90s, and his blood pressure is OK. But it starts to drop. His heart rate becomes slower and slower and at one point we went out and got fuel for the ambulance and came back and said, "Boy I hope they're doing something for this guy."

And we come back in and they're still not doing anything. Now his heart rate is forty and his blood pressure is like seventy and there's still only one nurse in there. And we're like, "What has this poor guy done? Why don't you like him? Why have you decided that he should die? His belly hurts, he's been in a major car accident and now he's got no blood pressure and his pulse is dropping. Any reason you're doing this?" We were getting upset. And I went and reiterated that this guy was dying. Finally a resident goes in there and says, "Well maybe he's having a heart attack." My partner and I are like, "A heart attack? We just pulled a Toyota off his legs! He's not having a heart attack. His belly hurts. He's injured." "Oh, but his heart rate is slow, it's unusual for a trauma to have a slow heart rate and low blood pressure." Yeah, unless all their blood has left their body and they're seeing the Pearly Gates.

So he gave him Atropine and I forget what else, some crazy med that you'd give to someone who is having a heart attack and whose heart rate is slow and you want to speed it up. But the problem is in this case you're gonna give him something to speed up his bleeding. His heart rate is slow and his blood pressure is dropping because he's going into shock, it's a protective mechanism, so they're gonna give him something to speed up his heart just to make sure they squeeze out the last ounce of blood. And still nobody is getting it.

Finally an attending [physician] happened to walk by and I go up to him and I said, "Listen you've got to go in there and take over because this poor guy is going to die. They're just not taking care of him." The charge nurse hears this and comes running over and says to my partner and me, "You two need to just relax, you guys are acting so weird about this." Weird about this? Weird about this? I said, "Well we're just trying to be advocates for our patient. We think he's really hurt." She says, "He doesn't meet any trauma criteria." "What trauma criteria doesn't he meet?" I say. My partner is just standing there with his jaw wide open, in shock, he can't say anything, he's so amazed. It's like a Twilight Zone episode.

And he says, "Well I guess it's not OK for paramedics to advocate for their patients. It's only OK for doctors and nurses to do that." And I said to the attending as I left, "Well there's nothing more we can do, it's in your hands. You either take care of this guy or you don't. Screw this." I didn't know what else to do. Here is a guy who is a textbook severe trauma and nobody will believe, nobody wants to listen. The charge nurse has just decided that this guy was not getting a trauma team and this resident was blowing it. And the attending was not interested.

There was one nurse who was very good and was concerned. She told us later on that a surgeon happened to walk by, touched the guy's belly, looked at what was going on with his vital signs, and freaked. Just snapped, said, "Oh my God, how long has this guy been here? Why weren't we called? Why weren't we called?" And they did a DPL, you put a tube into the belly to see if there's blood in there and it just poured out. And he was like, "Oh my God, we need to get him to surgery right away, get blood going." This is apparently two hours after the accident. This is in the trauma centre. This is the general hospital, this great trauma centre. They finally took him to the OR. I never found out what happened. I told our medical director and I never heard about it again. We tried to track him down, like weeks later in the ICU. I don't even know if he made it to the ICU.

In this long narrative, the only competent caregivers are the paramedics who, at every step of the way, are blocked by the entrenched hierarchies of the hospital from ensuring that their patient receives the necessary care. Ultimately,

the story stands as a direct challenge to the medical hierarchies that routinely strand medics on the bottom rung.

Paramedics, Patients and Bystanders

Paramedics' relationships with bystanders and patients are qualitatively different from their relationships with medical personnel, managers and other emergency providers. Since patient encounters are, in the vast majority of cases, a one-time only encounter (although medic stories abound concerning "frequent fliers"), the interactions are not governed by the same rules as those based on repeated interactions. [14] Because of this, medics frequently cannot predict how patients and bystanders will react to their presence. Many people have expectations derived from "reality television" programmes and are often angered when medics do not behave like their television counterparts.

In many American urban areas, there is a great distrust of the police among disenfranchised populations, and this distrust occasionally spills over to affect other service groups such as firefighters and paramedics. This distrust, based in part on a long history of racial bias, was certainly noticeable in my fieldwork area, as the majority of the patients came from minority populations while the majority of the paramedics were white. Not surprisingly, medics tell numerous stories concerning the unpredictability of both patients and bystanders. These stories, such as the one Steve tells earlier, contribute to a sense of "watchful readiness" (Gabriel 1991). Medics' interactions with bystanders are, of course, not all bad. There is, for example, Tony's story of the bystander who assists with CPR, but this episode stands in stark contrast to other stories in which bystanders attack the medics. The ambiguous relationship that emerges in medic stories about bystanders speaks to the need to determine the parameters of what is ultimately an imprecise—and accordingly potentially dangerous—relationship. Through their stories they are able to establish these parameters.

The relationship between medic and patient is more clear-cut: the patient is in distress and the paramedic is there to treat, stabilise and transport him or her. Ideally—and in the vast majority of cases—this clearly hierarchical relationship is maintained throughout the interaction, and patient care is delivered without any difficulty. But patients are not entirely powerless in the interaction—indeed, an adult patient can refuse treatment—and this leads to difficult situations at times. At least in their stories, medics are willing to break company policy to ensure a positive patient outcome (and, by extension, lessen the chance that they will be questioned by the QA board), as in the narrative about "medical arrest." Even when the medics do provide exemplary care, there is an open-endedness to the relationship since they rarely learn about the ultimate disposition of their patients. Unlike the "reality television" programmes, medics are rarely reunited with their patients, nor is there an outpouring of thanks. Indeed, medics often complain that their patients are surprisingly ungrateful:

You get these idiots, you know, complaining about the bloodstain on the couch from when you started the IV. You've essentially saved this person's life and they call up and complain about a little blood spot that you got on their couch! Not a thank you, not an, "Oh gosh you saved my loved one's life," or you saved my life, you saved whomever's life. No, it's "Who's

gonna pay for this blood on the couch?" It's incredible. You just can't imagine what people complain about. It's really funny. Yeah, you'll do a really good job on a call where you made the difference—which is a small minority of the calls, like maybe three or four percent. But you'll like bump into somebody's china cabinet and put a scrape in it and they'll call up and complain about you scratching their furniture or something or other.

And we're constantly stealing people's things. Dentures, wallets, I have a collection of Kaiser cards, I think 50 of them at least, at home. Not! But people are always calling up saying "Your ambulance driver stole twenty dollars from me!" Oh right. Or they kept my dentures! You know I have at least 50 pair of dentures at home. The whole closet is just full of memorabilia! Is that nuts? It's incredible.

Stories such as this one serve as an outlet for the frustration ingratitude engenders. Since this seems to be the predominant reaction of patients, medics seldom tell elaborate stories about ungrateful patients. Rather, any mention of patient ingratitude tends to be appended as an evaluative coda—"he didn't even thank us."

Perhaps to combat the negative attitude toward patients that can ultimately result from such stories, medics do sometimes tell stories of thankful patients. For example, in a narrative that focuses primarily on his first experience with an advanced medical procedure, Lars also talks about the thankful mother of his patient:

For a little while my partner Ramon and I were all over it. We'd just gotten new jackets, so we were saying it was our new jackets. Two weeks later, there were all these shootings, we got a call for a shooting, right near this hill and this park. We got there and the police were there. They were having trouble finding this guy, but they finally found him. He was up on a hillside, behind this house and there was this tall fence, they found him on the other side of the fence, in the park, wedged up against the fence and the hill. He was running from someone and he was trying to get over the fence, and as he was climbing this big fence, they shot him, he fell and they shot him a couple of times while he was on the ground. He was just lying there.

We got there, we had to climb this hill and over this fence, and we got to him and he was shot in the chest, he was in bad shape. Now he apparently lived in the neighbourhood, and somebody had run to his mother's house and she was waiting down at the bottom. We finally got down, and we start driving to the hospital. A firefighter is driving the ambulance, Ramon and I are in the back and the mom is sitting in the front.

Now the guy says he can't breathe, and now he can't breathe at all. His blood pressure is dropping, his pulse is going up and we can't really hear lung sounds on one side. It means he's got a tension pneumo-thorax. We should decompress him. Neither Ramon nor I had ever done a decompression. He goes, "I'll call it in, you decompress him." Uh, OK. So he hands me the thing. I've looked at the decompression thing, but now it feels like I'm pulling out a sword. It's a ten gauge IV needle that's three or four inches long. You pull this thing out of its little sheath and it's like drawing a dagger. "OK you're gonna feel better in just a minute I swear." I also thought the first time I did this it would be on someone who was unconscious or in cardiac arrest or in just such bad shape. But this guy is awake. So we pop it in, air comes out, the guy suddenly can breathe better, his pulse stabilised, he could talk now, but he got better. But blood starts shooting out of this thing. And I looked at my partner who's been a medic longer, so we pull the blood out with a syringe thinking that'll do it, but every time he breathes it keeps coming out. OK, but he feels better.

So we get to the hospital and we pull in, all the other units are waiting around, and we pull up and we open the back doors and we pull out this gurney that's got this big rescue basket on it, and there's dirt and leaves and blood all over the floor, and as we're going by,

this guy's got this pleural decompression thing in his side, squirting blood, and every one's like, "Wow, that's an outrageous call." Turns out it was air and blood, they put in a chest tube and sucked out over 1000 ccs of blood. But he lived. And it was just before Christmas. Like two weeks later, both Ramon and I got a box of chocolate and a big thank you note from the Mom who said, you know, "Thank you for saving my son's life, he was out of the hospital and he was home for Christmas." So, that was kind of fun.

Interestingly, in this far-ranging account, it is not the patient who thanks the medics, but rather a family member, a narrative manoeuvre that maintains the prevailing notion of patient ingratitude. Lars marvels at the gift of chocolates, telling the story as an example of unusual gratitude. Among medics, stories tend to relate the unusual; stories about mundane events have little chance of holding other medics' attention. [15]

Paramedics and Each Other

Perhaps the most intriguing relationships of all are those between the medics themselves. While the popular media frequently portray paramedics as silent heroes, medics tend to avoid the "hero" designation. Indeed, in their storytelling, there is an almost studied resistance to any self-portrayal that may come across as self-glorification. Rather, medics revel in the absurd or the comical; when they do succeed in performing something that in the hands of a television producer would be presented as an example of individual heroism, in their stories they tend to present these events as adrenaline-fuelled bungling that by pure chance results in a positive outcome, as in the following story:

We were almost in the accident. I was working with Ramon, we kept witnessing stuff. Stuff would happen in front of us. We were driving down the street that night and Ramon goes "Is that guy doing CPR on someone? Stop the ambulance." And then later on we were sitting in front of the theatre where they have *Phantom of the Opera* and then a woman passed out right in front of the place. So every time we get on the radio, we're like, "86 we've just been flagged down ... 86 we're at an accident ... 86 we're at ..."

So at like four in the morning we're taking a guy with the flu to San Francisco General and I'm in back talking with the guy, he's got the flu. There's nothing wrong with this guy, he's got the flu, so he doesn't really need an ambulance. And we're driving along and I hear this, I hear Ramon go, "Oh fuck!" And I hear this screech, kaboom, kaboom, just amazing. It sounded like things were crashing and banging forever. Now we'd been in an accident like two months before, so we were like "Oh shit," and I was "Oh no." He goes, "There was just the worst accident," and I look outside the side window and there's a car on its side in flames. Fire is just pouring out of it.

So I grab the fire extinguisher, I put on my helmet, and Ramon's calling it in, and I turn to the guy, the patient and I say, "Whatever you do, don't touch anything." And I jump out, and this car is burning and there's a guy trying to climb into the burning car. And Ramon goes over and he grabs the guy and he pulls him and he's like "What are you doing?" He says, "Oh my cousin's in there, my cousin's in there." And we look in and there's this guy and he's just stuck in the car, it's filled with smoke. So I get the fire extinguisher and I start spraying and I'm spraying and the flames go out. Whew. And then they started again, and I start spraying and the fire extinguisher starts running out, and finally the fire extinguisher is just about dead when the flames all go out. Whoa.

So then I turned to look around and there are cars all over the place. This car's on its side, there's a Jeep that's totalled, there's another car that's smashed. Everybody in the cars are

out, unconscious. Their heads are back and over, the guy inside this car is trapped and I look at the car in the intersection and there's a cop in it. Unconscious. And there's smoke and stuff. It was surreal. I get on the radio, "Looks like there's eight cars and at least two cops involved in this, couple of the cars on fire, and everybody's trapped." It's three or four in the morning so the city is quiet and seconds later all you hear is sirens from every corner of the city—a cacophony of sirens. Soon things are pouring in. They all think police are involved.

Turns out that these two cars were racing, drove right through the red light and slammed—of all things—into a police car. One flipped over, caught on fire, the Jeep was empty, but there were three guys in the other car and they were all unconscious. The police hear there's a police car involved, so there's just like dozens of police cars pulling up, fire department hears the cars are on fire, so they send everything, they woke up the fire chief, and every ambulance in the city wants to get in on this action, so our medical director showed up. Soon the intersection was filled—they sent two rescue squads, a hook and ladder truck, two engines, the fire chief, the battalion chief, seven ambulances, a captain, twenty police cars. I was like, "Uh-oh."

I turn to Ramon and I go "Did we do all this?" And he was like, "Yeah, I think that last radio transmission caught their attention." It was a pretty bad accident. My call was overkill, but I'd just put out a fire, so I was stoked on adrenaline. It took them like forty-five minutes to cut the guy out of the car—they had to lift it with airbags, stabilise it and then cut it open. Ramon and I were talking and we decided this was a really bad accident but the one we called in was far, far worse. We got a commendation on it though.

Rather than focus on individual heroism—which places the individual above the group—medics focus on the group. As such, these stories tend to build group cohesion. Indeed, those medics who do attempt to tell what are derisively known as "hero stories" soon find themselves without an audience and, if they persist, without partners. [16]

Conclusion

The stories medics tell play an important part in their tactical engagement with the myriad relationships that structure their daily lives in the organisation. Although some stories are deployed tactically solely as a means to define a specific relationship—for example, that between medics and nurses—the majority of the stories speak simultaneously to numerous concerns. Thus, it is not uncommon to find a single story that explores medic interactions with firefighters, the police, nurses, physicians, field supervisors, patients, bystanders and other paramedics while also commenting on the psychological burden of emergency response. Dependent on the context of the story performance, the tactical weight of the account can be shifted, something that medics are quite aware of, with one group or another bearing the brunt of the narrative critique. The stories are not, as de Certeau suggests, "outside of competition," but are in fact part of the day-to-day life of medics immersed in numerous competitions. Indeed, their storytelling constitutes a significant action in and of itself.

Not only do the stories influence how medics act and interact, but they also affect the structure of their organisation. In the ambulance service, supervisors and medics are often at odds—the medic storytelling acts as one of the clearest forms of tactical resistance to the organisation's surveillance apparatus that, in the words of one manager, is so accurate that "we know where they are to within three feet" (even if that lands them in the Bay). Certainly, stories and

their repeated telling can sway opinion, both inside and outside of the ambulance service. The telling of such stories has had significant impact both at, and away from, the negotiating table in situations such as fire department mergers, union contract negotiations, and the ongoing and protracted battles with nurses and their official representatives. Perhaps most important is the tactical role that storytelling plays in the everyday life of the paramedics as they negotiate the tricky pathways of their own organisation, establishing for themselves a sense of their own position within it.

Notes

- [1] *E.R.*, produced by Warner Bros, had its debut in 1994 on NBC and is currently in its sixth year of production (McNeil 1996, 245–6).
- [2] All of these television programmes focus on emergency responses of ambulance or fire personnel or police. *Cops*, which made its debut on Fox Television in 1989, follows police officers from various cities in the USA on their routine patrols. *Real Stories of the Highway Patrol*, which made its debut as a syndicated television series in 1993, provides both dramatic recreations of police emergencies as well as showing video footage culled from the archives of the California Highway Patrol. *Rescue 911*, which was first screened on CBS in 1989 and was in production through 1996, offers dramatic re-creations of emergency responses, generally selected from stories sent to the producers from various emergency services throughout the country. *Code 3*, which appeared in 1992 on Fox Television and ran through 1993, provided live footage of emergency rescues. For more production notes, see McNeil 1996.
- [3] See also Trice and Beyer 1993.
- [4] Barbara Czarniawska-Joerges, with her polemical dismissal of the fields of anthropology and ethnography, takes strong exception to the usefulness of the ethnographic approach to the study of work organisations, criticising it as being “poor in theory,” but provides little in the way of a tenable replacement for this approach (Czarniawska-Joerges 1988, 17–19).
- [5] For approximately five months in 1993, and for several weeks at a time in subsequent years, I went for “ride-alongs” with paramedics. These ride-alongs lasted either for twelve or twenty-four hours depending on the shift being worked by the paramedics. During the shift, I would accompany the medics on their calls and occasionally lend a hand by carrying equipment. In between calls, medics would sit at a post, at coffee shops or at emergency room loading zones and swap stories and I would record them, either using a video camera or a tape recorder. For a detailed description of my fieldwork area, see Tangherlini 1998, xxvii–xxix.
- [6] An amusing parallel to this figurative “consideration of their position” in the organisation are the frequent queries from the dispatchers asking paramedics for their “10–20,” or position, that comprise a large portion of the radio traffic.
- [7] Interestingly, the medic fascination with uncovering the hidden mimics aspects of control and surveillance to which they themselves are subjected. The most notable example of this surveillance is the company’s use of geo-positioning satellites to track their movements, thereby allowing managers and dispatchers to find and, ultimately, control them.
- [8] Firefighters wait for the police to secure a dangerous area before entering, which is referred to as “staging.”
- [9] The word “plugs” refers to fire hydrants, which are also known as fire plugs.
- [10] See also de Certeau 1984, xx; and Abrahams 1968.
- [11] See also Tangherlini 1998, 137–9.

- [12] Lars told another variant of this story on a different day; for that version, see Tangherlini 1998, 183–4.
- [13] Of course, it would be interesting to explore how physicians view their relationship with paramedics.
- [14] A great deal of literature in game theory supports the assertion that people will behave differently in situations where there is little chance for repeated interaction as opposed to situations where there will be repeated interaction. See, for example, Hamburger 1979, 107–14.
- [15] For more discussion of this phenomenon, see McCarl 1978b, 13; Neuman 1966, 178–80.
- [16] For a discussion of the paramedics who cannot escape the “hero story” mode, see Belkin 1995, and Tangherlini 1998, 81–3.

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