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Professionalizing Emergency Medical Services (EMS): Still at the Crossroads

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PROFESSIONALIZING EMERGENCY MEDICAL SERVICES (EMS):

STILL AT THE CROSSROADS

by

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(Under the Direction of Daniel Chapman)

ABSTRACT

In this work, I examine the failure of Emergency Medical Services (EMS) to professionalize over the course of its existence as an occupation. I consider how popular culture has contributed to a conflicted identity between what the public sees and how EMS providers view themselves. I believe that EMS has been restrained from professionalization due to oppression by physicians in a manner consistent with how two other allied health professions, pharmacy, and physical therapy, once were. I explore the professionalization of these two occupations to identify similarities and differences that may provide insight into next steps needed by EMS providers to professionalize. Joe Kincheloe explains how the shift in education of vocational workers from learning 'how' to learning 'why' might be perceived as insubordinate by dominant groups, which for EMS would include physicians. I have used critical theory as a method of self-reflection through speculative essay. I encourage EMS educators to employ a critical pedagogy through an enhanced curriculum that will propel students to ask more 'why' questions as they seek to join the interprofessional healthcare teams of today's healthcare landscape. I propose that EMS as educated healthcare professionals can fill a gap that can lower healthcare costs, improve the quality of patient care and outcomes, as well as satisfy the patient's needs more successfully in the home and community as opposed to other sites of care.

INDEX WORDS: Emergency medical services, Paramedic, Community paramedic, Critical theory, Critical pedagogy, Cultural studies, Professionalism, Curriculum, Integrated healthcare curriculum, Interprofessional education

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by

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DEDICATION

This work is dedicated to three of the most impactful individuals I have been blessed to know in my life. The first is my grandmother, Ms. Wilma Lewis. She was a child during the Great Depression, born to farming parents in rural Georgia. She married and became a widow with five children while still a young woman. After remarrying and adding a sixth child to the family, she found an opportunity to return to school as a middle-aged adult. She chose practical nursing as a career and completed her studies while still carrying out her duties as a wife and mother. She always put her children and family first, but was able to work in her chosen career, using those skills to care for her mother-in-law, husband, and mother until their deaths. She continued to care for others until the toll of the work was more than her body could handle. She had an incredibly challenging life but remained a Christian woman, putting God and family first. She continues to sacrifice her own happiness and needs for her family to this day. I always knew that there were no challenges that could not be overcome if I followed the example she set for me. All things happen for a reason and I hope she knows I am the woman I am today because of her influence. I love and admire her with all of my heart.

The second person I will be forever grateful for his influence left this world on February 14, 2014. Mr. L. Stephen Mobley was like a father to me; teaching me the 'family' business. He was considered one of the fathers of EMS in Georgia and I was so blessed to have crossed his path in 1995. I say that because our first encounters were not very cordial. For a reason that is unknown to me, he decided to mentor me in this field, a man's profession at that time, and supported my academic and career goals. He did not just support them, he made them challenges that I was pushed to overcome. He made sure that nothing I worked for was easy and made no accommodations simply because he liked me. He taught me the importance of earning my place and succeeding the right way in this industry. I was driven to make him proud of me before he passed away and I think that I did. Earning this degree was the only outstanding promise I had left to fulfill. I will rest easy knowing that in the end, I did not disappoint. He lives on in my heart every day.

The third, and by no means the least important, of the individuals that I was blessed to have in my life was R. David Bean, Retired GA Paramedic #19. He was my best friend, my mentor and my biggest fan. It is not often in life that you connect with someone the way that we connected. We had no reason to become best friends; we did not live near one another, did not regularly work together and were separated by over 20 years in age. We had known each other casually from interactions at professional conferences and statewide meetings for several years. Our friendship was really cemented when I asked him to 'hold the door' at an EMS conference in 2001 on Saint Simon's Island. After that, we were inseparable souls. He became such an important part of my life, supporting my development as an EMS instructor, an EMS administrator, and a doctoral education student. He loved my children and was a part of my family, as I became a part of his. I try to avoid expressing regret over any decisions that I make in life because each decision brings so much unplanned joy that to regret it would be saying that joy was less than what could have been and we just can't know that. However, I do regret not completing this degree before he passed away. He invested so much support in the process from the very first days I enrolled that he truly deserved to see how that work paid off by being able to read this dissertation, not just to see me graduate. He was my sounding board for every course I took and every paper I wrote. The closest I came to throwing in the towel were the first two months after his death. Knowing I would have not only disappointed him if I allowed myself to fail, closing the chapter to make him proud has been what has pushed me to finally earn this degree. Finishing this work without him leaves it feeling just a little incomplete and myself without his final approval. I hope that he knows, up in heaven, that I could not have done this without him. Despite missing him deeply in my soul, I know he continues to 'hold the door' for me.

I dedicate this achievement to each of these three amazing influences on my life. This is not the end for me. I will continue the work that each of them believed I was capable of.

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This has been a long journey and it has inhabited a significant portion of my adult life. My family has been incredibly patient and supportive of me throughout my entire post-secondary education, but most understanding through the years of doctoral study. I was fortunate to have a supportive spouse, Merritt, during the most expensive and time-consuming portions of this degree. Although we are no longer together, he will forever have my gratitude and admiration for the selfless support he provided. My oldest son, Kristian, tolerated me with all of the grace a teenage boy could after nights of reading and writing through the core courses of this degree. My daughter, Katelynn, and my younger son, Andrew, have always had a mom who was in school with homework and writing. My children have been the greatest sources of my procrastination as I struggled to balance work, family, and school. I also became a grandmother to Bailey during these last two years and she captured my heart from the start. Every moment in life is fleeting so when chances arose to devote time to making memories with her, I took them. I do not regret one time that I put their needs first even as it resulted in more semesters of enrollment. I also hope that each of them are inspired to continue learning long after their formal education is completed. As I wrapped things up, probably during the most stressful years, I have been blessed with a partner, Stephen, who takes it all in stride. No matter how stressed I become, he is there to talk me down. I probably would not have physically survived these last months without his calm, supportive demeanor.

There truly are too many friends and people who have helped me succeed in a career that I loved to list them all but there are some who have cheered for me, pushed me when needed, listened when I wanted to talk through concepts or ideas, encouraged me despite this long journey or trusted me with opportunities that not only allowed me to learn more about EMS but also about myself. Over the past 25 years, I was blessed with the friendship and support of Rich Elliott, Richard Lambeth, Karen Grabenstein, and Marty Billings. Nothing keeps you motivated like someone who will call you out when you need it most. I am so grateful for the trust that Reg James and Pete Quinones had in me as I learned so much from them over the course of my career.

Even though I did not follow the most standard of paths through the doctoral program, I recalled Dr. John Weaver's explanation that this degree could be whatever I wanted it to be. And so, it has been. It has allowed me to discover so much about myself as a student, educator and individual that I would have never known without the professors I was blessed to study under and the many hours of reading, exploration and reflection I have invested to reach this point. I knew Dr. Weaver would be an important professor to have on my committee because he was the person who helped me enter the program and I could not imagine exiting without his guidance. Dr. Grigory Dmitriyev introduced me to critical theory early in my program and I knew this was the theoretical lens I needed for my work. Dr. Joseph Crosby joined my committee late, but he was my mentor for my master's degree and has been an amazing contributor to this degree as well. He understands the vision I have for my work in healthcare education and made time for me despite the professional demands he could not have foreseen in 2020.

Although not a member of my committee, I am so honored for the influence and inspiration of Dr. William 'Bill' Reynolds as I searched for my space in this field. He introduced me to the Bergamo Conference and to so many influential curriculum scholars that I would never have had the opportunity to meet or hear speak had I not entered this program. During one of those conferences I was fortunate to get to know Dr. Dan Chapman who agreed to be my chair when I found myself suddenly in need of one. As he joined the faculty at Georgia Southern after my core courses were completed, our paths may not otherwise have crossed. I am confident there were semesters he felt I would drift away, leaving my studies incomplete when he did not regularly hear from me. But he did not abandon me and for that I am so grateful. I have been blessed to have had advisors in every degree at Georgia Southern University who encouraged and supported my persistence to complete including Dr. David Stone (Retired), Dr. Joseph Crosby and Dr. Daniel Chapman. Without them, I likely would have given in when finishing seemed so difficult. I am however happy to say I am finally a triple Eagle!

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CHAPTER 1

INTRODUCTION

Purpose of the Study

The purpose of this research is to examine how past and current factors such as initial education, reimbursement methods, variations in scope of practice, political influence, regulatory limitations, self-identity and public image have impacted the professionalization of EMS. The study intends to examine these issues through the format of the speculative essay.

Overview of Topic

Popular culture introduced paramedics to us in January 1972 when the show *Emergency!* first aired on NBC (Yokley & Sutherland, 2008) The show highlighted the emergency medical response of the Los Angeles County Fire Department. Until this point, most people across the United States had limited knowledge of medical response by the fire department or private ambulance services. The show was conceived due to the interest in emergency rescue. It was not intended to introduce the public to emergency medical services (EMS). That was simply a byproduct of the show. The initial research was based on physical rescue situations but it was during the orientation to the fire department phase of the research that the idea of basing the show on response to medical emergencies and action in the hospital emerged as the foundation. In the show, the fire department-based EMS model delivered care in dramatic emergency situations from which all survived. The concept of EMS and prehospital care has three primary challenges that are influenced by the way EMS was introduced to the public. The first is how the role of EMS in the communities is perceived by the public primarily introduced through the media. The second is specific to the governance, control and financing of the system at the national, state and local levels. Finally, the contribution by individuals, associations and groups in EMS that have led to a perceived lack of professionalism and respect by other professionals in healthcare, public safety, as well as the community. The significance of these three areas of influence will be more evident through the development of this paper.

The EMS system, Los Angeles County Fire Department, that the television show *Emergency!* was based on became the expectation for the American public because there were no others to compete or compare to with equal visibility. Despite the fact that there were private ambulance services and other types of emergency responders located around the country, the fire-based model was the first seen by the masses viewing the television show. Since what was shown had to comply with the Los Angeles County Fire Department standards as monitored by on-set technical advisers, interactions that could occur in real emergency responses were edited out. (Page, 1979) The presence of a positive outcome for all patients also helped cement an unrealistic expectation of emergency services in the minds of viewers. This media representation was acknowledged in the *EMS Agenda for the Future* (1996) as being "impossible to overestimate the influence of the media on the evolution of EMS." (p. 64) The show, unbeknownst to its actors, also set the level of expectations that society would have for emergency care of their own. According to Mantooth (2018), he had no idea of the impact the show would have until the national tour he was featured in concluded at the induction ceremony of *Emergency!* into the Smithsonian Museum of American History in 2000. Of course, Mantooth (Johnny Gage) was not a real paramedic so he was not out responding to emergencies as those he represented were. He could not have known that the representation of every patient surviving during each weekly episode would become the expectation of citizens who encountered paramedics or required treatment by EMS. Mantooth (2018) said that NBC set the parameters for what could or could not be portrayed on the series and patients were not allowed to die on the show in those first few years. These types of false portrayals did not end with the survival of all *Emergency!* patients.

Other popular culture-based portrayals of EMS, and paramedics specifically, were equally as damaging to the ability of the public to form an accurate perspective or expectation for their own encounters with EMS. In the 21st century as the healthcare landscape continues to evolve, that mistake must be addressed through a coordinated effort by those within the field. False representations and stereotypical expectations should be addressed by EMS professionals because

"while the media might hasten change, we cannot be certain that the changes created are those that would have been chosen had the impetus been different." (National Highway Traffic Safety Administration, 1996, p. 64) The ability to transition this industry to one that is perceived as professional by both the public and other members of the healthcare community should be driven by EMS personnel. The purpose of this study is to examine how past and current factors such as initial education, poor reimbursement, variations in scope of practice, political influence, regulatory limitations, and public image have impacted the development of professionalism in EMS. An additional purpose of this project is to not only advocate for development of professionalism in EMS but support the ability of EMS professionals to take an active role in providing care outside of the hospital that does not result in a transport when not necessary. This would offer significant benefits for both the patient and the overtaxed emergency departments, including decreased cost (for patient, health system and tax payers), increased quality of life through provision of care in the right place and improved patient satisfaction as they are not forced to experience the delays of attempted treatment in a system that is busy dealing with real emergencies.

Industry Snapshot – Levels of Licensure

According to the *2011 National EMS Assessment*, there were 203,807 credentialed paramedics total in 48 states reporting. This was 21% of the total of all reported levels of credentialed emergency medical services (EMS) providers. (NASEMSO, 2014) There are four nationally recognized levels of EMS providers: Emergency First Responder (EFR), Emergency Medical Technician (EMT), Advanced EMT (AEMT) and Paramedic. EMS providers each have a pre-defined scope of practice which designates what skills, medication administration, or procedures a provider at the individual levels may perform. In most states, the evaluation tools used to determine competence based on the minimum knowledge and skill performance for each level, are offered through the National Registry of Emergency Medical Technicians (NREMT). Candidates at each level are tested on the standards outlined in the EMS Education Standards document. The EFR and EMT levels have cognitive testing through NREMT with psychomotor

assessments through the state or program. The AEMT and Paramedic levels require a combination of cognitive and psychomotor exams offered by NREMT. (National Registry of Emergency Medical Technicians, 2019)

Regarding training and range of skills, the EFR is the lowest level of provider. The courses for training EFRs are typically around 40 to 60 hours in length with both didactic and skill-based components. They are community-based courses hosted at local fire or EMS agencies with a growing number occurring in the high schools. There are national standards for this level of provider within the National EMS Standards, as well as a national exam that graduates may challenge offered through the National Registry of EMTs. The Red Cross also offers a program for this level of provider. The EMS National Scope of Practice Model outlines the recommended scope for this level of EMS provider. The EMR is trained to deliver life-saving care while waiting on an EMS response. (National Association of State EMS Officials, 2019) The next level of provider is the Emergency Medical Technician (EMT). This is the first level of provider with a scope of practice consistent with transportation of the sick or injured. Not all states allow this level to staff ambulances as one of the two EMS providers. Most EMS providers licensed in this country are at this level. EMTs can provide some basic emergency care in addition to cardiopulmonary resuscitation (CPR) and general first aid skills. There is still a need for medical oversight and although this may be the highest level of provider in some areas, this level focuses primarily on assisting with advanced tasks. These courses average 110-150 hours of didactic and skill-based learning, depending on the sponsoring host for the course. Many of these are taught in the community or career college settings, although they may be taught at the community agency level as well. The Advanced Emergency Medical Technician (AEMT) is the most recent addition to the list of provider levels. Over the last two decades, it has evolved from a level referred to as EMT-Intermediate (EMT-I). In some states, this level of provider still exists. The AEMT is slightly more advanced in what knowledge is required and skills that may be performed within their scope of practice. These courses also may be taught in several settings such as the community agency,

technical or community colleges. These courses include the EMT level of education and require an additional number of didactic and skill labs, as well as field-based clinical rotations. There has been a recommendation in the National EMS Scope of Practice Model (2019) to require that AEMT programs be nationally accredited as early as 2025.

The paramedic is the highest nationally recognized level of EMS provider based on skills and knowledge. In 2013, the National Registry of Emergency Medical Technicians (NREMT), began requiring that paramedic candidates seeking NREMT Certification must have completed an accredited paramedic program. The NREMT offers exams, both cognitive and psychomotor, that are designed to assess the EMS student graduates' level of competency upon successful completion of an initial education program. There are currently 46 of the 50 states that require NREMT certification for initial state level licensure. (The National Registry Data Dashboard, 2017) All 50 states require a state license for paramedic practice. All four (4) remaining states recognize NREMT for initial state licensure as an option but do not require it. National professional organizations, including the National Association of EMS Educators (NAEMSE), National EMS Management Association (NEMSMA) and International Association of Flight and Critical Care Paramedics (IAFCCP), engage in representation of paramedics and other EMS professionals. After the publication of a joint position statement with recommendations on the necessity of requiring a degree at the paramedic level, a debate has erupted among the stakeholders of EMS, primarily being opposed by the fire departments and fire-related professional organizations. (Caffrey, Barnes, & Olvera, 2018) Due to conflicting descriptions of paramedic roles, responsibilities and work-related affiliations, there is increased effort among professional associations to finalize the educational preparation, practice environment and scope of practice of the paramedic. Although all credentialed EMS professionals play a role in provision of prehospital care, this research focuses primarily on the identity of EMS providers at the paramedic level as the highest nationally credentialed level capable of the most impact on the community's health from an EMS perspective.

Paramedicine – Gaps/Opportunities/Challenges

In the beginning, EMS existed in small pockets where progressive medical care supported the initiative that started with the 'White Paper' of 1966. According to Sadler, Sadler, & Webb (1977), national statistics revealed accidents as the leading cause of death for individuals under the age of 37 and fourth overall for all ages. The most prevalent cause of these accidents were motor vehicles. The leading cause of death for all ages at that time was heart disease. Other accidental deaths were also deemed preventable if there was immediate medical attention available to these victims. The solution was to provide funding and structure to strengthen the fragmented and inadequate emergency care already available in the early 1970's.

Because there are changes to the national healthcare landscape with greater emphasis on out of hospital care, it is important for EMS providers, paramedics in particular, to have the opportunity to affirm an identity as a health care provider as opposed to a transportation provider in order to evolve and be recognized by their peers as health care professionals. There are several challenges even as this transition may occur. Financial sustainability is a key reason for concern as EMS moves into new roles. (O'Connor, 1999) Reimbursement for EMS services has previously been dependent on the transportation of the patient where a base rate, depending on the patient complaint and care provided, is paid in conjunction with a per mile allowance. The Center for Medicare and Medicaid Services (CMS) has been bound by law, the Social Security Act, to reimburse EMS as a transport benefit, not as a healthcare benefit. Being reimbursed as a transportation benefit removes the influence of severity of illness, complexity of care and other supporting factors that might alter reimbursement in a manner more consistent with payment by diagnosis related group (DRG) that is used by inpatient healthcare entities for the purpose of billing and reimbursement. A DRG-based amount is based on an average of the resources needed to treat Medicare insured patients who share the same diagnosis-related care. There are several influencing factors that may modify the amount to be reimbursed, including labor-related costs, non-labor-related costs, adjustments based on hospital location, cost of living in the area where the hospital is

located, percentage of low-income patients treated by the hospital, as well as an add-on if the treating hospital is an approved treating hospital. There are other modifiers or outlier payments that may increase the amount reimbursed if the patient has an expensive case. (Centers for Medicare & Medicaid Services (CMS), 2019) While hospitals may seem like an unlikely setting to share comparisons, several of the influencing factors are also relevant to ambulance services. The cost of readiness for an ambulance is both a labor-related and non-labor-related cost. Location is pertinent due to the lower response/transport volumes in some cities/counties/parishes while the availability of acute in-patient care, surgical resources or specialty care may be at such a great distance that it leaves citizens of the area without ambulance coverage as a result of longer trips. Demographics play a part in how much reimbursement can be obtained from ambulance services in some communities. If there are high numbers of uninsured or under-insured patients, services may struggle with stretching limited reimbursement dollars to cover unit hour costs. Unit hour costs are calculated as the sum of all related costs necessary to operate an ambulance for one hour. These costs include hourly wage rates and benefits cost of two personnel to staff the unit consistent with regulatory standards, the cost of the ambulance for one hour of use, wear and tear, as well as fuel, cost of capital equipment necessary for patient care on the ambulance, support service hourly cost share such as communications, billing, fleet, logistics, training, compliance and administrative personnel, as well as average cost of disposables for that hour of use. It does not include any revenue therefore these costs exist whether the ambulance is treating/transporting a patient or not. Costs go up when the actual care and transport begins based on additional supplies used. This varies based on the complexity of the case, like what is seen in the DRG based system. For a patient who is being resuscitated, there are much higher costs due to the amount of medications, supplies and equipment being used. This contrasts with a patient who may be transported for pain that is not severe enough for treatment during transport, but the patient has requested to be transported. According to the Social Security Act (1979), §1861 (s)(7), “ambulance service where the use of other methods of transportation is contraindicated by the individual’s condition, but only

to the extent provided in regulations." A significant issue with how EMS is reimbursed is that this single definition has contributed to limited options for EMS to obtain funding for the care provided during the transport component of health care. Because EMS is uniquely situated as part of public health, healthcare and public safety, the expectations of this system are much broader than those of other individual healthcare entities or public safety agencies. According to the EMS Agenda 2050 (2019), "The public generally expects that when they call 911 for a medical emergency, someone will come – day or night, rain or shine…" (p. 25) In order for EMS agencies to be capable of providing these responses, at any hour of the day, day of the week and at all skill levels, there must be a funding mechanism for the cost of readiness. The cost of readiness are those costs associated with the agency's ability to maintain the necessary capability to meet those expectations 24 hours a day, every day of the year. (National EMS Advisory Council Committee Report and Advisory, 2016). As it currently stands, EMS responds to every call for assistance within the communities where they are the designated agency for medical and trauma emergencies. There are no insurance screenings or assessment of ability to pay. Regardless of insurance status or the potential for reimbursement of costs, these patients are treated and/or transported to definitive medical care. However, there are also no state or federal funds to offset the costs associated with care of patients who are under- or uninsured.

Funding

Medicare and Medicaid payments for treatment and transport are typically less than the agency's cost to provide the service under the current reimbursement models. The current reimbursement model established by the Center for Medicare and Medicaid Services (CMS) is based on a fee-for-service structure that is used by providers and facilities, such as physicians and outpatient care centers that are not acute in-patient facilities such as hospitals. There are four payment definitions specific to the fee-for-service models. Ambulance services bill based on Healthcare Common Procedure Coding System (HCPCS) supported by an International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). Ambulance

services do not use Current Procedural Terminology (CPT) codes because these are based on procedures and services furnished in specific settings. (Medicare Learning Network, 2019a) There are three levels of service: Basic Life Support (BLS), Advanced Life Support, Level 1 (ALS1) and Advanced Life Support, Level 2 (ALS2). BLS and ALS1 may be services provided as Emergencies or as Non-Emergencies. Because of the types of interventions or medications required to qualify as an ALS2 transport, it does not have a modification to be Non-Emergent. There are also two additional HCPCS codes. The first is Specialty Care Transport (SCT) which requires additional training/documentation or statutory regulations. SCT reimbursement is supported by the need for supplies or services beyond the scope of a licensed Paramedic. The Paramedic may provide SCT level of care if they have had additional training for the use of SCT equipment or provision of SCT procedures. The Paramedic Intercept (PI) is specific to the use of a paramedic to assist with ambulance transport by an agency that may only offer Basic Life Support (BLS) level of care. There are additional requirements and as of July 2019, only some entities in western counties of New York State were able to meet the criteria to bill this HCPCS. Private insurances also recognize HCPCS as the standard coding system for reimbursement of claims to ambulance services. Additionally, there are requirements specific to whether the transport is medically reasonable and necessary, covered destinations, and the distance between the pick-up and drop-off locations. (Medicare Learning Network, 2019)

The Centers for Medicare & Medicaid Services (CMS) (2019a) began a pilot based on innovative efforts to provide some reimbursement of costs where patients are triaged at the scene of the emergency and either treated there without transport or transported to a more appropriate location, besides the emergency room, for their issue. Traditional payment models are based on transport of the patient to a covered destination. Covered destination options are extremely limited. The hospital's emergency department is the primary destination for most patients although under Medicare guidelines, with additional documentation supporting medical necessity, covered destinations may also include rehabilitation or skilled nursing facilities, long term care facilities

free standing surgery or treatment offices or dialysis centers. Transportation to any type of physician's office would not be a covered destination.

Training

This is just one of the areas where the need for more advanced educational preparation would benefit paramedics. As far back as 1996, in the *EMS Agenda for the Future*, it was recognized that "as EMS care continues to evolve and become more sophisticated, the need for high quality education for EMS personnel increases." (p. 33) The National EMS Management Association (NEMSMA) provided a definition of paramedicine that was updated by the EMS 3.0 collaborative consisting of multiple EMS stakeholder associations. This collaborative has worked to identify paramedicine within the health care system as it is reformed. The groups include NEMSMA, NAEMSE, NAEMT, NAEMSP and NASEMSO. There is some differentiation with consideration of paramedicine as both a discipline and a profession. The National EMS Advisory Council (NEMSAC) provided a recommendation to the Department of Transportation and Federal Interagency Committee on EMS (FICEMS) (2014) that paramedicine be defined as, "the standard generic term nationally for the discipline and profession within the health care field that encompasses emergency medical services, medical transportation, community paramedicine and mobile integrated health care services." (p. 5) Paramedicine has increased in complexity such that anticipated needs as a member of the healthcare team will require higher level technical and communication skills. Paramedic initial education in the United States is much less than in other countries where paramedics also have roles in health care and public safety. (Caffrey, Barnes, & Olvera, 2018) The primary concern by the fire service agencies are that requiring additional education by mandating an entry level degree will potentially limit the number of new paramedics entering the profession. (International Association of Fire Chiefs, EMS Section, 2018) If the roles of paramedics within the communities are expanded, there may be less need for paramedic level care on responding 911 ambulances.

Professionalization

As a result of EMS having a less academically rooted educational system, the availability of EMS research is also limited. The *National EMS Research Agenda* (2001) identified five impediments to the availability of high-quality EMS research. Two of the five, lack of highly skilled researchers in the industry and the inability of EMS professionals to recognize the importance of research for their industry, could specifically be addressed by enhancing the academic preparation of paramedics, as well as including more research emphasis within all levels of initial EMS education.

Existing research into workforce needs for EMS providers reflect that an additional 120,800 EMS professionals are needed by 2020. Data regarding workforce shortages is lacking due to several reasons. These include multiple levels of EMS providers and oversight, regulation and provision of EMS systems are handled by a wide variety of bodies. There is no consistency on a national, or in some cases, statewide, levels. Although the origins of the EMS provider levels and curricula were established within the Department of Transportation (DOT), they have not remained there. As each state assumed responsibility for the development of their own EMS systems, initial provider education and scope of practice changed. Workforce issues for EMS only agencies can be quite different from those where EMS workers are cross trained in other professions such as fire departments. (NASEMSO, 2014) There are several variables that have been identified as contributing factors to limited recruitment and retention of EMS providers. These include low wages, limited numbers of accredited paramedic programs and limited numbers of appropriately educated or credentialed instructors.

There is no research specific to effectiveness or necessity of academic degrees for paramedics in the provision of their duties. There is limited research specific to the benefit of academic degrees for both allied health professionals and public safety personnel. There is no data or research that suggests attainment of academic degrees by paramedics improves patient outcomes. Despite the lack of research, the addition of English, math and other liberal arts courses to

paramedic initial education through a minimum of an associate degree requirement would likely promote development of critical thinking skills and support the move from skilled technicians to patient care clinicians. (Eisenhauer, 2017)

This study will examine how the paramedic identity and role in prehospital care has evolved since the inception of emergency medical services to now. In order to understand why the current debate over the educational preparation of the paramedic, it is important to analyze the circumstances under which the emergency medical system was established including the role and identity of the paramedic throughout that process. The *EMS Agenda 2050* (2019) supports the necessity of EMS professionals to "take ownership of the future of their profession by implementing the principles of people-centered care, emphasizing the importance of education and embracing their role as providers of healthcare in non-emergent and emergent situations." (p. 11)

The path to professionalizing EMS will likely require the bar be raised by the regulatory bodies on a state-by-state basis. The professional associations are engaged in a debate that would be unlikely to end with a consensus recommendation based on the barriers and benefits not aligning among them. (International Association of Fire Chiefs, EMS Section, 2018) There are currently two states that require a two-year degree for entry at the paramedic level: Oregon and Kansas. There are pros and cons to leaving it to the states to decide. The most significant potential negative aspect is that it could make it more challenging to apply for reciprocity when moving to a new state unless there are stipulations that exclude existing licensed paramedics from another state or at the national certification level. A positive aspect is that it leaves the decision at the state level to determine what works best for that state's EMS system.

History of Emergency Medical Services

The military is responsible for the first ambulance services. In 1869, Bellevue Hospital of New York, established the first city ambulance service in America using horse drawn carriages. This was to provide movement of the patient to the hospital for care. As Cardiopulmonary Resuscitation (CPR) was established throughout the first half of the 20th century, these early

ambulance or medical responses were able to offer basic first aid and resuscitation in addition to transportation to the hospital. Hospitals, physicians, nurses, rescue groups, fire personnel and police were some of the first EMS responders. In 1966, Ireland was home to the first Cardiac Care Unit as established by Dr. Frank Pantridge in Belfast. It was specifically designed to offer cardiac services using a cardiac defibrillator, electrocardiogram (ECG) monitor and cardiac-specific medications. These are all tools that are used in the resuscitation and treatment of individuals who have lost their pulse and breathing because of a medical emergency involving their heart. The work of Dr. Pantridge, published in *Lancet*, would later spark the interest of Dr. Ralph Feichter, of Haywood County North Carolina. Dr. Eugene Nagel, from the University of Miami Medical School helped develop the first radio transmitter and modulator capable of cardiac telemetry and it was put into use with the Miami Fire Department's 'Physician Extenders' or paramedics.

From 1966 to 1970, the use and availability of paramedics was not widely known. During this time period, there were fire-based paramedics, paramedic rescue squads, hospital-based intensive coronary care units, city-based ambulance services, and the first private ambulance service to employ paramedics. Training for these paramedics was primarily provided and organized by physicians. The fire service was heavily involved in the establishment of EMS and rescue-based programs, which was publicly introduced in the television show, ***Emergency!*** in 1971. Paramedics did not limit their care to cardiac related illness. Following the discovery that in 1965, more people were dying on the nation's highways than in the Vietnam War, President Lyndon Johnson established the National Highway Traffic Safety Administration (NHTSA) as a result of the law, the National Highway Safety Act. In response to this finding, the National Research Council published the research paper, "Accidental Death & Disability – The Neglected Disease of Modern Society" otherwise known as "The White Paper." In the early 1970's the focus was on creating standardized education and training for these new medical responders. There was still a lot of variation in titles, hours of training, content of the training and regulatory authority for EMS personnel. The Department of Transportation (DOT) was responsible for establishing standardized

curriculum for EMS specific training programs. The first was an 81-hour training course. Paramedic training was not yet standardized and some programs contained thousands of hours of education. The role of public perception of EMS as a system, including its professional members will be examined. Initial education standards, agency affiliations and scope of practice are all pertinent to the development of the paramedic professional.

Personal Justification

This study is important because paramedics have the potential to become viable partners in the approach to health care in the future. In order to fully integrate with other allied health professionals, paramedics will need to earn an associate degree at a minimum from an accredited institution. According to the National Highway Traffic Safety Administration (NHTSA) (1996), "EMS of the future will be community-based health management that is fully integrated with the overall health care system." (p. iii) In 1996, the future role of EMS would lie within the nation's communities. Population health would hold greater significance and EMS personnel would help support wellness initiatives as well as provide preventive education to keep the individuals within their communities safer. Because paramedics are in the homes, workplaces and public spaces of the community, assessment of hazards, risk factors and existing conditions would be much simpler. The pre-hospital space is the paramedic's primary domain. Paramedics, their normal course of practice, could help with vaccine administration, health teaching, medication compliance, well-checks, injury prevention in the home, assist with navigation to the most appropriate site of care, as well as treat minor injuries or illnesses that would otherwise result in a transport to the emergency department that wasn't necessarily justified. These activities, all or even a few, would result in decreased healthcare costs, improved population health and improved patient experience in compliance with the Triple Aim of the Institute for Healthcare Improvement (IHI) and adopted as part of the national strategy for healthcare in the United States during the implementation of the Affordable Care Act. (Institute for Healthcare Improvement, 2019)

In 1996, I had only been involved with EMS for a couple of years. I was transitioning from an in-hospital healthcare provider role as a respiratory therapist to an emergency medical technician while earning my graduate degree in healthcare services administration. During that course of study, I became very familiar with the historical evolution of EMS in Georgia, reimbursement structures and regulatory oversight, including initial EMS education. Reading and hearing speakers refer to the prediction that 'in the future' EMS would evolve to be a stronger member of the healthcare community was exciting and ground-breaking for my peers already working in EMS. The agency where I was employed was part of a healthcare system with an affiliated hospital. The opportunities seemed endless. It is now 2019 and the EMS industry is just beginning to see some community-based roles forming and joining the healthcare team. The *EMS Agenda 2050* (2019) contains a statement much like the one from the *EMS Agenda for the Future* (1996) noting "…these EMS professionals must be prepared to play a much larger role in managing the health of the patient and community." (p. 12)

Review of Literature

The ability of the individuals within this field to change course or reinvent themselves without some form of coordinated and desired effort is unlikely. Although the numbers of EMS providers initially lured into the profession by *Emergency!* are dwindling, those they trained are still the majority. Solomon (1974) describes the positive influence of medical shows for public perception of physicians. The American Medical Association (AMA) was supportive of early programs that highlighted the roles of physicians through television, never speaking out to address any of the fictional representation of physician actions because they were not negative. When NBC aired a documentary that criticized medical economics, however, the AMA president was provided with an opportunity to rebut the criticisms on the *Today Show*, which also aired on NBC. No such opportunities have been documented for EMS representatives to clarify or rebut any negative portrayals of the paramedics or the industry during that era of television and film. According to Yokley & Sutherland (2008), *Emergency!* was unique in that the scripts were written

to be realistic and reflective of real life in the fire service. All the actual rules and regulations of the LA County Fire Department were followed in the scenes of the series to maintain accuracy. During the entire filming of *Emergency!*, technical advisors from the LA County Fire Department were on hand to provide guidance for shooting scenes to ensure real depictions were captured and that no incidents occurred that could impact the public image of the fire department. (Page, 1979) Mantooth (2018) validated this assertion using the wearing of the helmet while responding to incidents because it was department policy at that time as an example. Although there is greater visibility of EMS in the emergency response to incidents today in both real life and the media, the accurate depiction of these providers in popular culture is often misleading. It is important to understand why this marginalized understanding of EMS from both the public and its own providers has continued for this long to begin to formulate strategies to support a professional image and mutual respect among other healthcare providers. The very survivability of EMS as a member of the healthcare team may depend on whether it is aligned with members of other allied health groups as medical professionals going forward.

EMS, as a specific field of medicine, has limited research supporting the clinical aspects of care. There are even less studies examining the qualitative aspects of the field such as the adequacy of existing programs to prepare students for the full expectations of the practitioner. When examining the difference between who is a medical professional and who is not, much of it originates with the type of educational process that prepares the individual to perform within their field. EMS students are exposed to the concept of becoming a medical professional from the first level of initial education, the emergency medical responder (EMR). National EMS Standards (2009) contain competencies for each level of provider, differentiated only by depth, breadth, and actions required for each level unless a specific age group is otherwise identified. Each competency is further defined by what knowledge is required to achieve it. For the roles, responsibilities, and professionalism of EMS personnel, the depth ranges from simple at the emergency medical responder and technician levels to fundamental at the advanced and paramedic

levels. The breadth is foundational for the primary three levels of treating providers, the emergency medical technician (EMT), advanced EMT (AEMT), and paramedic levels. The EMR is the first responding level of emergency services provider. At no point in any level is professionalism of EMS personnel considered to be of complex depth or comprehensive breadth, nor is it at the integrative level as defined by the National EMS Standards. The National EMS Core Content (2005), which was created to define the universal body of knowledge for EMS providers, does identify professionalism as another component of the practice of EMS. Much of specific content is pertinent to clinical assessment, identification and treatment of medical and traumatic conditions. At the paramedic level, professionalism and the role of the paramedic as part of the continuum of care is covered on a total of four pages in a text with 1480 pages including the glossary and index (Caroline, Pollak, Elling & Smith, 2013) There is no better way to understand the deficient level of importance placed on instilling professional values in EMS students than to recognize how little time is devoted to it at the highest level of trained provider. Students read that they are considered a part of both the health care and public service community and that they will work alongside other professionals. A list of attributes is provided to the student along with definitions for each of them. The paramedic is also required to conform to the same standards as other allied health professions; however, those standards are never spelled out. There is much focus on image and appearance, as well as the ability to be prepared for any type of situation. Other than including continuing education as a component supportive of several attributes, level of education is not addressed. One paragraph is devoted to the participation of the paramedic in national EMS groups where involvement is encouraged. Paramedics are expected to have a professional attitude to earn the public trust. Defining professionalism and fully understanding its function in society is not achieved by making lists of desirable attributes. Wynia, Papadakis, Sullivan and Hafferty (2014) define professionalism as a motivating force, a belief system that emphasizes such actions as shared accountability and acknowledging the public's role in the setting of expectations for healthcare professionals. While the components of this concept may be

presented to the paramedic during initial education, the real world of EMS is inconsistent at reinforcing these concepts. If EMS as an industry is to earn the respect of other health professionals and the public to include becoming a full participating member of the healthcare team, consistent commitment to professional excellence and accountability must be adopted. In order to move forward with this transition, there is a need to understand what has prevented EMS from achieving medical professionalism over the span of the 50 years since the importance of having a fully functioning emergency medical system was identified. After 30 years, a national assessment of where the industry was and where it needed to be was published. After another 20 years, EMS has still not reached the goals set at that time. Bledsoe (2007a) states, "Perception is, unfortunately, reality to the general public. In EMS, we can do the possible but not the impossible. It's time the public understands this. But until we can change their mindsets, we must be proactive in updating our professional image." (The Future, para. 6)

Theoretical Framework

Cultural studies, as a theoretical framework, is where I primarily see the greatest impact to my study of this phenomenon. The cultural impact is influenced heavily by critical theory and reaches back into the site and type of education of most EMS providers. Professionalism, which is the expression of the identity of a professional, aligns well with the issues impacting the future of EMS. Defining professionalism is not a straightforward matter and depending on what discipline you are examining, may not share the same expectations as related to perceptions by members of the discipline or those outside of it. Historically, professionals were not necessarily members of society who were of superior status but rather those who held competence and knowledge within a specific field. In this way, the professional can exercise authority in society linked only to the field of expertise and unrelated to social status. (Roiphe, 2012 & Parsons, 1954)

Examining professionalism has illuminated characteristics that others have also identified as hallmarks of a profession including having a Code of Ethics, the ability to regulate itself, being able to identify what is unprofessional, as well as what is good practice within the

profession and what is not. Of the definitions located, several commonalities were noted. Professionals are a disciplined group with high ethical standards, who have obtained expertise in specialized knowledge and skills through education and training intended for provision to patients or clients. (Halldorsdottir & Karlsdottir, 2011)

Learning how to be a professional is a challenge for many healthcare students. Whether in the medical colleges in physician education or in the allied health programs, there has been increased attention on how professionalism is learned. Professionalism is not taught only in the classroom through a formal curriculum, but also in the clinical setting as modeled by the practitioners or through a hidden curriculum. According to Johnson & Hammond (2018), "Modeling of poor attitudes and behaviors predominantly in the clinical setting has been described as the biggest threat to the development of appropriate levels of professionalism." (p. 292)

Learning from modeled behavior is not limited to behaviors visualized but may also come from movies, televisions, social media and written media. Social media has become a common platform for EMS providers to display their feelings and share images or other content such as memes exploiting the pain, suffering and tragedy of their patients. A private group on Facebook was exposed by a news media reporter after a tip by one of the group's members. (Abubey & Basye, 2019) There are an unknown number of groups that attempt to screen potential members by evaluating profile pictures or requiring response to EMS-related questions. Although there was once a decompression strategy among public safety professionals referred to as "gallows humor," the most recent use of social media as described by the news report, exceeds the boundaries of what is acceptable even among other EMS professionals. (Lawrence, 2019) These groups and their influence represent the hidden curriculum that is educating using the wrong examples of professionalism for students. There are better resources available today to assist members of EMS, public safety and healthcare in dealing with the trauma that the day-to-day work often exposes them to.

Methodological Justification

Researching the benefit or necessity of professionalization of EMS would not be possible using a quantitative research design. The rationale for considering professionalization, while presumptively beneficial in multiple ways, does not generate a measurable change that could be evaluated using a quantifiable approach. There are several variables that have been unable to be clearly defined, therefore are unable to be measured. A study by Birden, Glass, Wilson, Harrison, Usherwood & Nass (2014) attempted to define professionalism in medical education. This was performed as a literature review, but results were that there is no universally agreed upon definition of medical professionalism. A qualitative design is more useful as an analytical approach. For EMS, any research design may be a challenge. Research in EMS is limited. According to the *National EMS Research Agenda* (2001), there are five impediments to high quality EMS research. These include a scarcity of skilled researchers, inadequate funding to support pre-hospital research, a lack of understanding of the importance of conducting research, lack of integrated information systems, and challenges in obtaining informed consent due to the nature of the interactions. The lack of research is not limited to clinical research but extends to general issues affecting EMS providers outside of patient interactions, including initial and continuing education, occupational safety and risk, as well as operational issues impacting the field, including its providers.

I am using a qualitative research design for this study with a theoretical approach. Qualitative research will allow me to examine how identity has been both socially constructed and internally perpetuated among EMS providers. Due to the limited availability of industry specific research, it becomes necessary to identify similar industry research and analyze its potential for application to EMS. The methodology for this project most closely resembles that of the speculative essay, described by William H. Schubert (1991) as a "form of rhetoric embodying speculative or personal knowledge." (p. 61)

While this project is clearly longer and more in-depth than an essay, the requisites or characteristics of the speculative as a method of inquiry would apply. There is limited to no research that has examined this problem to date. Much research and regurgitation of the history of EMS has been contributed with repetition, sometimes decades apart, of the inadequacies of the educational preparation, lack of research, dismal funding and misleading identity of the individuals working within this profession. What knowledge does exist does not address the issues as they have been and continue to be. To consider the speculative essay as a form of inquiry requires that the writer be a "connoisseur of the topic about which she is writing." (Schubert, 1991, p. 66)

The speculative essay will allow for analysis of professionalization as a potentially beneficial process for EMS using my personal knowledge applied to corroborating literature of two similar occupations that have been recognized as professions. I will note similarities and differences that reflect why these were chosen, as well as how physicians as a dominant profession have impacted the process. These are aspects that quantitative and many qualitative methods of inquiry are unable to address. The benefit of use of the speculative essay is that it "as a form of inquiry yields insight only as great as that mustered by its author…however, giving free reign to the insightful imagination is the best way to advance knowledge." (Schubert, 1991, p. 64-65)

Summary of Chapters

There are five proposed chapters. The first will be the introduction to the problem with a summary of the purpose of the study. In the introduction, the current role of the EMS provider, including perceived challenges encountered by EMS personnel will be examined. The existing debate concerning the need for an academic degree for a paramedic will be reviewed as well as speculation on the motivating factors of those who are opposed.

The second will be the theoretical framework. The focus of the research centers on the rationale behind why it could be appropriate to professionalize to be beneficial to healthcare and

for the advancement of the EMS professional. I will discuss the three specific influences of cultural studies, critical theory with the employment of a critical pedagogy, and the theory of professionalism. Included will be evidence of structural corroboration from other health professions given the inadequacy of existing research as acknowledged by professionals outside and within EMS. This includes the concept of professionalism and how it is influenced both by direct curricular focus as well as the hidden curriculum. To further explain the role of the hidden curriculum in the education of EMS professionals, critical theory will be included as it relates to this problem. Cultural studies has a relevant role in the development of identity for the EMS professional through both media representations and social media which contributes to self-imposed barriers to professionalization of the field of EMS and its providers.

The third will provide the history of both EMS and professionalism through a Foucauldian archeological approach. There will be an exploration of the historical role of paramedicine, why it has been viewed as a public service as opposed to a healthcare specialty, where there is potential within the modern health care landscape. I will also include some historical insight into the theory of professionalism.

> There is a notion of 'spirit', which enables us to establish between the simultaneous or successive phenomena of a given period a community of meanings, symbolic links, an interplay of resemblance and reflexion, or which allows the sovereignty of collective consciousness to emerge as the principle of unity and explanation. (Foucault, 2002, p. 21)

The fourth chapter will be the speculative essay which will examine whether EMS should or is likely to continue toward seeking professionalization through education or if it could remain a subordinate group beneath public safety and/or health care. The inquiry is primarily speculative with the intent of providing referential adequacy through the literature review and structural corroboration when compared with other professions that have made similar transitions.

Consideration of how this research can help support EMS professionals to take control of their future roles in both healthcare and public safety is important.

For the final chapter, I will share some reflections on what I have learned from my research, how I see the current situation for EMS as it has been influenced by the pandemic of 2020, as well as discuss some future research interests that relate to new knowledge from this journey. The challenges of this year have stimulated creative expression and enhanced problem-solving skills that may or may not stem from a critical pedagogy. They may, however, serve as evidence of what can be accomplished on a more regular basis from critically educated paramedics.

This study will add to the knowledge necessary to assist with determination of next steps for the practice of paramedicine. The move to professionalize is going to require some vision but primarily some stimulation to continue the push. Documents over two decades old have provided the vision but they have failed to provide the stimulation. Rather than continuing to express displeasure about the circumstances, perhaps it is necessary to confront the self-imposed barriers that have been ignored repeatedly by former and current EMS providers. A choice should be made between allowing others to construct an identity or for EMS professionals to construct their own.

Although there are position papers reflecting the perspective of individual or collaborations among professional associations, this study will examine historical documents, similar research among other allied health professions and relevant studies that may contribute to an informed recommendation. The National Association of State EMS Officials (NASEMS) (2014) noted that "the lack of high-quality, comparable data in modern EMS is commonly cited as a significant and critical limitation in our profession." (p. 33) Without research that examines everything from treatment protocols, scope of practice, reimbursement, education of EMS providers, and leadership of EMS organizations, the ability to contribute educated positions on these areas will continue to be weakened and subject to the opinions of others who would benefit

from suppression of forward movement toward professionalism. Once completed, the dissertation should assist others with understanding the necessity for paramedicine to emerge as a functional member of the health care team while maintaining its role as professional responder when needs arise.

CHAPTER 2

THEORETICAL FRAMEWORK

The theoretical framework is based in cultural studies as it relates to the constructions of reality and identity. This is relevant to the core of the purpose since there are self-identity and public image constructions that may be attributed to the delayed professionalization of emergency medical services (EMS). There is also an element of how public perception has reinforced the internally constructed identities displayed by some EMS providers. This has created a subcultural influence that EMS providers often embrace without realizing that it is likely perpetuating the perception that EMS lacks the professional attributes of comparable occupations. These unprofessional attributes have historically been displayed in popular culture as media representations with more recent contributions using social media.

Critical theory also plays a part in my theoretical framework, as influencing how identity and reality is constructed from early in the education process, as well as through the influence of a dominant ideology. There are some correlations with the professionalization process and identification of professional attributes. When consideration is given to the question of who benefits by delaying or preventing professionalization of the EMS occupation, some of the roots are best explained in the writings of critical theorists. This review will examine the works of specific authors and bodies of literature that contribute to an understanding of how or why actions of those with power could control whether an occupation would be recognized as a profession.

Finally, I have studied the definition of professions, the attributes of professionals and the process of professionalization. Professionalism as theoretical construct is influenced both directly through a formal educational process and indirectly by a hidden curriculum embedded in the educational process as well as within professional groups. Based on the absence of literature that speaks specifically to professionalization of EMS, the professionalization efforts of other occupations are examined.

Cultural Studies

Cultural studies takes to task the examination of linkages between how individuals, societies, and culture construct identities and produce how reality is perceived. The work of cultural studies is not limited to any one site of learning, methodology, or theory but includes those areas outside the classroom walls where such mechanisms as popular culture influence identity formation and social reality. Hall (1996) refers to "theoretical legacies or theoretical moments" in the history of cultural studies. (p. 263) These 'theoretical moments' would include the influence of philosophers organized around such institutions as the Frankfurt School or the Birmingham Centre for Contemporary Cultural Studies, of which he was a scholar. There are also recognized legacies of influence such as the traditions of British Cultural Studies, as well as the United States tradition. Within each tradition, individual philosophers have infused various theoretical contributions, often from within their own areas of study, dealing with the question of how popular culture has impacted the creation of reality. This review will attempt to outline the theoretical underpinnings highlighted by the philosophers' contributions with notations of any traditions within which they worked to discuss the creation of reality and the formation of identity.

Reality is a highly contested conceptual construct. Depending on one's theoretical perspective, a variety of factors or conditions have bearing on individual or collective realities. The objective reality would be stripped of all shading that occurs based on an individual's personal beliefs, as well as viewpoints that reflect cultural influence. This shading cannot easily be removed because all conditions and data are presented, by those who construct, or interpreted, by those who view, whether in daily life or as a form of text. Within each person's reality there exists an identity or frame of reference for where and how they are situated within daily life. Through this identity the individual can interpret or make meaning of their perceived or constructed reality. What constitutes reality is not static. It changes as conditions, values, and

beliefs change. Culture provides the conditions necessary to alter these individual values and beliefs and therefore reshape what is 'known' or perceived as reality.

Defining culture was a task undertaken by several moments, as well as theoretical orientations. Hall (1996) indicates that while there is a certain amount of openness to the field of cultural studies, a set of multiple discourses that were impacted by various methodologies and theoretical positions, it is still important that it be recognized as a serious enterprise or discourse. The first theory to examine is Marxism. As an institution, the Frankfurt School represented intellectuals in Germany who engaged the task of moving the focus of societal interpretation from a Marxist approach based predominantly on an economic foundation to one that incorporated aspects of life such as social relationships and the culture industry. Theodor Adorno and Max Horkheimmer identified the 'culture industry' as a term that represented the products of mass culture. Popular culture could serve to maintain social authority and general conformity of the masses in a similar manner as conformity within the workplace occurred. The individual would lead a prescriptive consuming life based on manipulative efforts. Walter Benjamin, also of the Frankfurt School, believed that changes in technology that improved the reproduction of culture, as was best seen in the example of photography and film, would change the way culture functioned in society. While Benjamin (1968) recognized that there was always the ability to reproduce art, "technical reproduction can put the copy of the original into situations which would be out of reach for the original itself." (p. 220) Benjamin placed emphasis on the production of meaning at the time an artifact was 'consumed' and interpretative changes occurred depending on when it was consumed. How an individual perceived the art would be altered by the historical circumstances under which it was viewed. This reproducible art could be consumed by the masses and expanded the ability of art to impact individual lives, as well as society as a whole.

Fundamental to the Marxist theory however is the notion of a relationship between the base and superstructures of society as well as how these are impacted by historical conditions.

Storey (2006) notes, “The Marxist approach to culture insists that texts and practices must be analyzed in relation to their historical conditions of production.” (p. 47) This is based on a predication that there are periods of history where each has a specific ‘mode of production.’ Each of these is responsible for how society is organized and defined. Within each there is a ‘base’ and a ‘superstructure.’ The ‘base’ was comprised of economic production and control of the materials of society, while the ‘superstructure’ represented the institutions of society including the media, major religions, government, legal system, schools, consciousness, and self. The production and distribution of goods and commodities were the means and modes of production. All social interactions were based on the relationship of an economic class to these means and modes of production. Those who controlled them also controlled the superstructures of society and the ways in which we think.

If, as Weaver (2005) states, “Power is also a major component of any definition of cultural studies,” then it is reasonable to see how the dominant economic class can define what is conceived or perceived as culture. (p. 20) The dominant culture becomes culture. Culture is not a static object to be defined once and remain indefinite, but an evolving influence affected by social relationships and changing conditions of the interactions between the base and superstructure. As a result of these changes, social realities are changed. In Marxism, ideology is all forms of consciousness among members of society. It includes how they relate to and represent themselves within their society. This would include the cultural products of the society because these are also subject to the relationship between the base and superstructure as it is historically situated. The function of ideology under the Marxist theoretical position was to maintain the interests of the dominant economic class.

Hall (1980) speaks of Althusser’s contribution to cultural studies relevant to his writings on ideology and states, “Thus for Althusser, ideologies were those images, representations, categories through which men ‘live,’ in an imaginary way, in real relation to their conditions of existence.” (p. 32) The theory of ideology is essential throughout not only the Marxist theoretical

approach to creation of reality but continues through other theoretical perspectives as well as a point of comparison or baseline for which to determine movement from various theoretical perspectives. It is also a significant component of the critical theoretical approach to analyzing reality and the cultural constructs that promote hegemony in society, particularly among the lower classes and those who are marginalized in society. Althusser did not limit the ideologies to those only relevant to the subordinate classes but also applicable to the dominant classes as well. Each class maintains their own social identities and realities, but under Marxist thought, any effort to control reality for the subordinate classes was based on the need to maintain economic dominance and control of the superstructure. The cultural products were determined then based on the historical moment and the relationships of that period.

Antonio Gramsci contributed to the Marxist theory through his work on the concept of hegemony. Hegemonic control was maintained by the dominant class, often negotiating or making concessions with the subordinate classes. Only when these efforts did not prevail would the dominant class resort to exerting their power through control of the superstructures of society to gain the cooperation or submission of the subordinate classes. The dominant hegemony then did not remain static either but always could be resisted or contested. Hegemony is particularly subversive in that the social reality perceived by the subordinate class is that which they believe is of their own construction. Gramsci identified that 'common sense' played a role in how ideologies functioned to construct reality. Hegemony could be maintained by playing on the idea that it was 'common sense' for society to exist in the way it was construed. Although Hall (1980) notes, "Like the structuralists, Gramsci steadfastly resists any attempt to neatly align cultural and ideological questions with class and economic ones." (p. 34) This was perhaps Gramsci's greatest divergence from traditional Marxist theory and moved him to a neo-Marxist theoretical position. Hall (1980) also felt that Gramsci's concept of hegemony was a significant contribution to the field of cultural studies. There is still some relevance of Gramsci's concepts of

commodification and the influence of power within other theoretical traditions that influence the construction of reality.

Althusser was often considered a Marxist Structuralist because he identified ideology as a system of representations. The ideological representation generates an illusion of reality that is represented by images, myths, ideas, or concepts. These are historically situated and influence our understanding of the world as we see it. Within the structuralist theory, cultural phenomena were not the products of conscious decisions, but rather abstractions that the individual made use of. Hall (1980) notes, "Culture was better understood as the inventories, the folk taxonomies, through which social life is 'classified out' in different societies." (p. 31) Cultural products served as tools with which individuals could use to construct their own realities. This is consistent with the theoretical work of Saussure relevant to semiotics and the ways in which language is used to organize and construct what is perceived as reality. Saussure divided language into two components: written inscription (the signifier) and a concept or mental image (the signified). The relationship between the two is somewhat arbitrary although additional parts can extend the meaning while changing the meaning may be accomplished by substituting others. Allen (1987) notes, "As Saussure pointed out nearly a century ago, words acquire meaning by virtue of their positions within a conceptual system of similarity and difference and not through any direct relationship with reality." (p. 4) Barthe expanded Saussure's ideas to restructure the relationship between the signifier and the signified as primary signification or denotation. His addition was a secondary level, that of connotation. Signification was assigned based on its anticipated use for defending prevailing power structures. This is relevant to popular culture in that most content is not necessarily true but a representational or fictional depiction and dependent on one's theoretical perspective. The structuralist theory of linguistics continued to emphasize the significance of historical periods of consumption with the two theoretical approaches: diachronic and synchronic. The synchronic approach considered the study of a given language at a specific moment in time. Barthe saw culture as encompassing the whole of everyday life but organized in

such a manner as to establish universal meanings defined by those in power, a myth. News media, in particular, serves this interest by establishing universal meaning. Silverstone (1999), notes in relevance to why it is important to study the media, "To acknowledge that so much of culture, our culture, our media culture, consists in the acceptance of the 'as-if-ness' of the world." It exposes a rhetoric of common sense.

Post-structuralists not only considered the systems of similarity and differences but relations of before and after and always in process. Cultural texts or practices include forms of popular culture. Each text could have multiple meanings dependent on what the dominant position was at the time of its reading/viewing and always in relation to power. Pinar, Reynolds, Slattery, and Taubman (2004) state, "A term borrowed from poststructuralism, and more particularly from the work of Jacques Derrida, text implies that all reality is human reality, and as human reality, it is fundamentally discursive, a matter of language." (p. 49) Everything is text. For Foucault, language was a discourse. Foucault examined the relationship between knowledge and power in discourses. Discourses produce knowledge, a weapon of power, and power produces reality. Popular culture then becomes a language, or discourse, that must be analyzed in relation to knowledge and power. Giroux (1996) states, "cultural studies places a major emphasis on the study of language and power, particularly in terms of how language is used to fashion social identities and secure specific forms of authority." (p. 48) It is often evaluated based on who is constructing the knowledge and whether it is a dominant or subordinate discourse. From Barthe's perspective, texts may carry unconscious meanings, providing limited opportunity for contradiction of dominant ideology. Foucault would allow for discourse as language does constitute us to speak, although what can be said may be constrained, particularly by those in power. Langman (1991) notes, "Insofar as language emanates from the public realm, even when used in the most personal of ways…it is another one of the means by which that persona is secured for the sake of social reproduction." (p. 179)

The Birmingham Tradition originated in the Birmingham Centre for Contemporary Cultural Studies. This is, according to Weaver (2005), "by far the most famous and influential tradition in popular cultural studies." (p. 35) Richard Hoggart is known to have been the first to announce the program at the University of Birmingham which raised significant concern about the field of cultural studies from among the social scientists of the day. The primary focus for Hoggart was literary. He recognized the significance of the working-class culture and the new mass culture as replacing the old. Hall (1980) notes, "Cultural studies then was either hopelessly unscientific or a product of the very disease it needed to diagnose—either way, a treason of the intellectuals." (p. 21-22) Hoggart was not in favor of the decline of culture offered for the working class as it lacked the legitimacy of what constituted the working-class culture. E. P. Thompson, also a first-generation scholar of the Birmingham Centre, was likewise concerned with the working-class culture. Thompson's definition of culture, as Hall (1980) notes, "was rooted in the collective experiences which formed the class in its larger historical sense." (p. 19)

Raymond Williams' most notable work was in regard to television; how information was presented and who controlled the messages being delivered. Williams still held that the form and function of communication media were influenced by specific social groups situated in history as is consistent with Marxist theory. Television broadcasts offered an opportunity to bring the outside world inside the home. Spigel (1992) notes, "With television, drama becomes an integral part of the material features of everyday life; it becomes one of the central modes through which people construct and understand their world." (p. xxiii) Television broadcasting brought culture inside the home. It offered the ability to transmit messages in the form of news, sports, politics, commercial advertising, and fictional programming. Television allowed the individual to become the passive viewer and consumer of culture while negating the need to think and analyze what was being seen. The effects of television on the construction of reality and as a cultural form should continue to be studied. Williams (1992) states, "Some part of the study of television's effects has then to be seen as an ideology; a way of interpreting general change through a

displaced and abstracted cause." (p. 113) The effects continued to be studied as a transmission of cultural form, supporting consumerism, and the construction of identities.

Stuart Hall was perhaps the most notable of the Birmingham Centre scholars. Hall considered multiple theories based on what they had to offer for the field of cultural studies. A primary theme in Hall's work was the theory of ideology. Hall (1996) describes ideology as, "the mental frameworks – the languages, the concepts, categories, imagery of thought, and the systems of representation – which different classes and social groups deploy in order to make sense of, define, figure out and render intelligible the way society works." (p. 26) He saw the theory of ideology as a way to analyze how certain ideas dominate and those things which would move the masses to take action against the prevailing system. Hall saw limitations in Althusser's notion of ideology as only that which served to reproduce because it did not consider those who work to subvert and struggle against the prevailing system. He embraced Gramsci's concept of hegemony. According to Rojek (2009), "Hall's contention is that media messages are embedded with presuppositions about beliefs and practices that shape everyday perceptions of reality. Further, these presuppositions operate finally to produce hegemony." (p. 51) These messages are used to present a particular image of the world and exist in texts as ideological forms. Hegemony is also not static and therefore influenced by the dominant classes and historical period under which society exists. Mass media has played a significant role in the hegemonic process.

Hall's most significant contribution to the study of popular culture was his thoughts on the concept of articulation. Slack (1996) notes, "Articulation is, then, not just a thing but a process of creating connections, much in the same way that hegemony is not domination but the process of creating and maintaining consensus or of co-ordinating interests." (p. 114) The elements of articulation include not only the elements of everyday life, but also the political and ideological practices through which individuals live. Linkages formed between and among the elements are not determined or absolute, nor are they static. They may be re-articulated as needed. In Hall's theory of articulation, the theory allows for the discovery of how an ideology

can empower with being reduced to economic, class, or social conditions. Hall (1996) describes the theory of articulation as, "both a way of understanding how ideological elements come, under certain conditions, to cohere together within a discourse, and a way of asking how they do or do not become articulated, at specific conjunctures, to certain political subjects." (pp. 141-142) Articulation then becomes the landscape for ideological struggles.

Dick Hebdige, another of the Birmingham scholars, offered insight into subculture as a form of resistance. Subculture is a way the subordinate groups use cultural forms to reflect a different meaning than that which was intended. It is the resistance of the dominant ideology by infusing alternative meanings into cultural commodities. Subcultures can generate messages aimed at disrupting the normal and challenging the consensus of the dominant culture, often without detection by the dominant culture. According to Hebdige (1979), "Subcultures are therefore expressive forms but what they express is…. a fundamental tension between those in power and those condemned to subordinate positions and second-class lives." (p. 132) Hebdige does not contest the presence of ideologies but notes that they exist in the everyday discourse. Hegemony is only sustained if the dominant classes are successful in maintaining the subordinate ideologies as a matter of common sense and ensuring acceptance by the subordinate groups. Ideology and social order as conceived by the dominant class is not guaranteed and it is as resistance to this condition that subcultures attempt to subvert their success. Hebdige (1979) notes that although there is resistance, these forms serve as a guarantee of continued subordination. Subculture becomes co-opted by the dominant cultures.

Hegemony is a key concept when considering why this profession has seen limited evolution over time. Although there may be question as to whether members of the profession would have supported changes, if one considers that hegemony is often maintained because members of the subordinate class believe that they are constructing their reality, then there may be a false perception of evolution or a lack of need for this to occur. As EMS professionals, we are dependent on physicians for medical practice and oversight. Physicians are a powerful group.

Fire departments, as one of the two dominant sectors of public safety, in many areas has retained or assumed control of the provision of EMS. In review of national documents and historical development of EMS as a profession, it was interesting to see how physicians and fire-based administrators have supplied advisors for the establishment, growth, and oversight of the profession. Freire (2003) notes, "The oppressors do not favor promoting the community as a whole, but rather selected leaders." (p. 143) It is yet another way to subvert the ability of those who are the members of the oppressed professional majority and hinders their ability to see beyond the 'false consciousness' which has been created. Although the profession has academically prepared, experienced, and willing members to take on the management of its own growth and sustenance, it continues to be heavily controlled by physician and fire department input.

Postmodernism offers yet another opportunity to theorize about the impact that popular culture has in creating reality. According to McRobbie (2007), there has been a migration away from the concepts of ideology and hegemony and toward modernism and postmodernism. Within this move there is more emphasis on formation of identity in a postmodern society. Baudrillard introduced the concept of hyperrealism as a characteristic mode of postmodernity. Hyperrealism suggests that both reality and simulation are experienced without difference and instead fold in on one another. Identity then becomes, according to McRobbie (2007), "submerged into and virtually indistinguishable from everyday life in all its contingency and with all its historical specificity." (p. 59) Within this hyperreality, individuals can choose to move beyond the limitations of their own realities to a constructed fictitious reality. This is seen in fan cultures as individuals make efforts to communicate with fictitious characters portrayed on television and in film. New realities can be constructed without real emotional investment on the part of the viewers. According to Hermes (1999), "Seeing media figures as real and as part of our everyday cultural and emotional experience is part and parcel of how media texts have come to have meaning." (p. 74)

These hyperrealities infuse all aspects of life beginning in childhood. Media depictions of fictitious realities can be consumed by even the youngest consumer. According to Steinberg (2011), the postmodern child no longer looks to the adult for permission to act, but instead has access to the same information as adults and assumes more independence than previously seen during childhood. Society is defining childhood through social transformations, technology, icons, and public figures. As changes occur, what constitutes the period of childhood also changes. Children can make meanings that were not necessarily ideologically inscribed. All of these works to contribute to the child's personal identity. No longer are children required to acknowledge the inequalities of society and economic disparities when reality is constructed through popular culture. It is also a failure of society to recognize the ability of the dominant class to shape personal experience through the power of popular culture. Carey, within the United States tradition, was a proponent of the field of cultural studies through his connection to the social sciences. His approach was predominantly through the field of communications. Carey (1989) felt that using symbolic work, we produce our own worlds. Once constructed, we would then occupy them. This is certainly applicable to the imaginary worlds created by children when their own realities are less than attractive and can easily be generated through extensions of popular cultural media available for them to consume. McRobbie (2007) notes, "The site of identity formation in cultural studies remains implicitly in and through cultural commodities and texts rather than in and through the cultural practices of everyday life." (p. 58) Grossberg (1997) sees this as a mechanism to structure mobility through territorializing and establishing a 'closed circuit' for everyday life. Those who benefit from this power are those holding economic capital. Popular culture then becomes a weapon that is used to disempower.

Grossberg offered an application of articulation as a means of understanding the affective nature of popular culture. In his discussion on authentic inauthenticity, Grossberg (1997) states, "Difference is relocated so that only the affective matters. An all images, all realities, are affectively equal – equally serious, equally deserving, and undeserving of being allowed to

matter, of being made into sites of investment in one's mattering maps." (p. 226) These affective bonds substitute for democracy in a world where the average citizen feels alienated from the democratic process. To understand cultural practices, Grossberg sees it as necessary to determine how popular cultural practices empower their audiences. Grossberg acknowledges that these postmodern events do hold a significant place in everyday life but there remains a limited knowledge of their effectiveness within the context of power and questions whether postmodernity serves as a historical reality. The failure of postmodern theory is not that it denies a reality behind the surfaces of everyday life but rather that it always forgets that there are many surfaces of everyday life and that reality is produced within the relations amongst these surfaces. (Grossberg, 1996, 166) It is possible then that the postmodern may not be as unreal as it is believed to be. This is in opposition to the notion that identity formation in cultural studies is located within only cultural commodities and texts as opposed to the cultural practices of everyday life as suggested by McRobbie (1994).

TV & Movies as Mediums

Popular culture has had a significant impact on the identity formation of EMS providers who were watching television in the 1970s and 1980s. If you are not involved in Emergency Medical Services (EMS), you may not recall Johnny and Roy or Squad 51. Chances are that even if you are not a nurse, you would recognize what profession Florence Nightingale is associated with. This is significant because an entire profession, while not in reality, is often presumed to have been built around popular icons. Bledsoe (2007a) notes, "Many of our images and ideas about EMS come from Hollywood, especially for those who grew up watching *Emergency!*." (The Perceived World, para. 5) Ambulances take people to the hospital and 'ambulance drivers' are the people who work on the ambulance. Some older generations may refer to the ambulance personnel as 'attendants' although no disrespect is likely meant by either term. Popular culture has not consistently or accurately done a favorable job of portraying EMS as a profession or its providers as healthcare professionals. This would be problematic for the

formation of identity by the public and has not contributed a forming a positive self-image for those who work within this industry. Bledsoe (2007a) states, "Even the classic *Mother, Jugs & Speed*, although entertaining, didn't represent EMS well. It depicted EMS providers as societal rejects concerned mainly with drinking and sex and portrayed private ambulance companies in an extremely bad light." (The Perceived World, para. 7)

By the mid 1980's, health related television had shifted toward hospitals, nurses and physicians. Turow & Coe (1985) reviewed a variety of network programming over the course of two weeks. Allied health professions were represented in 11 of the 214 episodes where medical professionals appeared. Of those 11, only three showed ambulance drivers/paramedics. Cinema portrayal of the paramedic was not generally kind. It is difficult to outright label it all as untrue, but maybe it is easier to deny the truth. *Bringing out the Dead* (1999) is a movie about a burnt-out New York City paramedic. It is based on a book by a real New York City paramedic, although that fact is not always highlighted.

> [Paramedics] see first-hand the frailty of the human form and the fragile strands by which a life can be sustained. They see the worst that human beings can do to each other, as well as to themselves. Without the benefit of the safety afforded by hospital walls or waiting rooms, they must go where their patients are, no matter what dangers await. And they do all this for an average annual salary of $30,000. (Leong, 1999, para. 1)

Although this is the lead-in to a review of the movie, it is not inaccurate. Even the salary is consistent with the actual annual salary of that decade. The movie itself spans only four days of a holiday weekend in New York City. The main character, Frank, has only been a paramedic for five years. The depth of his despair is seen with every patient interaction as he hallucinates those who have died while working with those who are living. He drinks in an effort to silence the voices that eventually consume him. Brown (2000), an emergency medical provider, disagrees

with the ability of the film to portray a realistic view into a paramedic's life, although "even some of the more despicable traits of the paramedics might not be that farfetched." (p. 184)

Similarly, also released in 1999, the movie *Broken Vessels* (Ziehl & Zal, 1999) was staged in an ambulance in Los Angeles with the main characters being the two medics. The storyline centers around a drug-addicted paramedic who uses while on the job and which ultimately ends his life. His rookie partner, fresh from Pennsylvania, is also pulled into the lifestyle where the drinking, sex and drug use occurs in the ambulance. Brown (2000) notes here that although the behaviors occur primarily in the ambulance, the focus of the film is primarily centered on drug addiction. Brown (2000) observes, "I doubt whether it will have much impact on the public's perception of these professionals." (p. 184) How can it not when Americans have limited real-world experience to compare it to? Part of the reason the public has limited access to what real-world experience looks like is the ego, the tough shell, the martyr of the average paramedic. While television and movies have portrayed EMS providers in what should be a fictional light, EMS providers have adopted many of these stereotypes and wear them as badges of pride. According to Grayson (2009), "It's simply that I don't do my praying out loud, and I don't do my crying in public." (p. 291)

Moving into the 21st century has not altered the limited, primarily negative, representations of EMS providers. The show "Trauma" aired in 2009, was specifically hailed as having paramedics as the main focus. Heightman (2009) provides a summary of the portrayal of paramedics as the opposite of what he viewed when watching "Emergency!" He outlines situations where EMS crew members are having sex in the ambulance and involved in other unethical behaviors. His descriptions of the paramedic characters reflect attributes such as being rebellious, cocky, reckless and sexist. This is how the American public gains misperceptions, in some cases, of EMS providers. These are not traits and actions of a group someone might think of as professionals. Heightman (2009) requests "Johnny and Roy, please don't watch this show.

Stop by my house, and we'll do shots of Ipecac instead." (para. 16) [Ipecac is a medication used to induce vomiting.]

As demonstrated by the various theories, the field of cultural studies is both multi-disciplinary and multi-discursive. It is because of this that a close look should be given to the impact popular culture has had on creating not only reality, but individual and group identities. Cultural studies is founded on the premise that cultural forms hold power and that cultural products can influence or be influenced by specific groups, as well as have the potential to be reproduced. Using multiple theoretical perspectives from scholars engaged in a variety of fields to undertake cultural studies has allowed for greater examination of what it means to construct reality and on formation of identity.

Critical Theory

Critical theory, in addition to cultural studies, is important to examine because of the significant influence on the interpretation of barriers, real or perceived, to the professionalization of EMS. The understanding of how EMS has remained an underrepresented or dare to say oppressed occupation as it relates to professionalization, begins with ideological influence. This invades all aspects of identity creation and one's perception of reality beginning with one's experiences in school.

Critical theory is also relevant in how cultural studies deals with the impact popular culture has in creating reality. The term 'critical theory' was first introduced by the scholars of the Frankfurt School. Critical theory has become a considerably large influence in a variety of disciplines. Morrow (1991) notes, "the vitality of critical theory in the domain of cultural studies is most evident in its capacity to respond to historical transformations and critically appropriate emergent currents of thinking." (p. 29) Critical theory allows for re-examination of the roles of ideology as it is applied to areas of cultural studies such as feminist theory, race theory, and media literacy. It encourages an investigation into who benefits from culturally constructed images and the dominant ideology. It evaluates how identities are formed based on a society of

inequalities. According to Kellner (2009) a critical media pedagogy, "teaches individuals how to critically read, interpret, and decode media representations and makes readers more critical and informed consumers and producers of their culture." (p. 20) Cultural studies should be self-reflective according to Grossberg (2009). Analyzing media through a critical lens allows the ability to determine how the media participates in reality construction. Because cultural production is a form of education, capable of generating knowledge and constructing identity, there should be critical analysis of the role of the dominant group and its influence over what constitutes culture. This offers similarities to the goals of cultural studies in what Carey (1989) describes as the efforts "to diagnose human meanings." (p. 56)

Cultural studies shares characteristics with critical theory in that they are both complex, interdisciplinary fields. They are also similar in that they have undergone changes relative to historical and political conditions, as well as always coming under debate. Formation of identities, and more broadly realities, are sociological processes influenced by historical and political conditions as well. Critical theory becomes vital to cultural studies to allow for the capacity with which to respond to these historical and political changes beyond the traditional Marxist theory specific to economic conditions. With the collective discourses within critical theory that consider gender, race, and class issues, there is a multiperspectival ability to critically analyze the construction of reality. According to Kellner (1990), "Critical cultural studies is concerned with analyzing certain resonant *images* which is one of the keys to ferreting out media effects." (p. 107)

A concept of critical cultural studies requires that a new space be created to encourage collaboration across the boundaries that have previously separated the fields of critical theory and cultural studies. Media studies are but one area where a crossing of borders would be essential to understand how power and social agency changes have impacted the formation of social identities. According to Giroux (2000), "While critical educators and cultural studies scholars have traditionally occupied separate spaces and addressed different audiences, the pedagogical

and political nature of their work appears to converge around a number of points." (p. 128) One of these areas is in the field of media literacy. A critical media literacy would include more than how knowledge and social identity are produced in cultural media sites but also within schools. Culture, and particularly popular culture, has become a major educational force in not only how one constructs a personal identity but also in relation to others. Weaver (2005) notes, "Critical media literacy recognizes that images do not represent reality but shape and define reality." (p. 101) A critical media literacy would encourage students to become active participants in critiquing how these images construct reality and shape their personal perceptions, as well as encourage educators to ask critical questions about what constitutes education. A critical educator can begin to challenge cultural texts and the opportunities that are available to their students when employed in the classroom setting.

Critical Pedagogy

While working through the research problem, the role of the educator and the way in which education is conducted must be examined. Wink (2005) defines it such that "Critical pedagogy questions not only the knowledge, but the method of delivery." (p. 32) This includes initiating discourse, most importantly in the classroom, but also among clinicians and managers of the profession as well as its educators. At least at some level and at times, I was an active, if not enthusiastic participant, in the banking model of education. Understanding what it means to disseminate knowledge under this model is not a common discussion among EMS educators. Freire (2003) notes, "In the banking concept of education, knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing." (p. 72) Workforce educators, while often experts in their fields, do not consider the value that the student should engage a critical inquiry of the education they are 'receiving.' This banking concept will not serve to encourage discourse in the classroom for the critical examination of how their own identities and realities are constructed. The dissertation will potentially provide

impetus for initiating this discourse among educators not only at a local level but among those who are active at the state and national levels as well.

If pedagogy is the interaction between teaching and learning, then a critical pedagogy examines the complexities surrounding how and through which this occurs. According to Lankshear, Peters, and Knobel (1996) it is "extending the scope of critical study to take in the wider educational structures and relations within the overall set of sociocultural practices that constitute the life of social groups and entire societies." (p. 150) Wink's text served as a directional guide to begin investigating critical theory in a broader setting. Wink credits Giroux as the first to use the term 'critical pedagogy.' As an education student, who was not a teacher in the K-12 system, it was a challenge to make the connections between thoughts and ideas applied to public school education and their role in the vocational classroom, where the teacher is likened more to that of trainer than educator. Giroux (1996) discusses the value of cultural studies in education by elaborating on the link between sites of learning and how the language of cultural texts can be used to structure not only social relations, but individual and social identities. The task of critical pedagogy in the endeavor of working through my research problem is to critique how the ideologies identified as both political and ethical for this profession can begin to empower its students and members to become more aware of the influences that may be working against their profession. It is a large divergence from the typical manner in which EMS education is conducted.

Kincheloe and McLaren (2003) state, "Indeed, qualitative research that frames its purpose in the context of critical theoretical concerns still produces…undeniably dangerous knowledge, the kind of information and insight that upsets institutions and threatens to overturn sovereign regimes of truth." (p. 433)

It should be considered whether the site of EMS education, as well as the content and constructed identities made in popular culture might be a form of hidden curriculum. Michael Apple provided a better understanding of exactly what could comprise a hidden curriculum. All

of these issues become relevant when considered from a critical perspective. Education is not neutral. Apple (2004) speaks to how this hidden curriculum can be seen among those students who are destined to be the workers of society. "If, on the other hand, students' probable destinations are seen as that of semi-skilled or unskilled workers, the school experience tends to stress punctuality, neatness, habit formation, and so on." (Apple, 2004, p. 62)

The concept of the school reflecting society is not new, nor is it hidden. Workforce education is the new buzzword for those students who are not planning to attend college but who want a career. A key difference is the type of education, as well as the existing methods that mimic the workplace. According to Kincheloe (1999), "They are learning 'how' not 'why'; indeed 'why questions' are often deemed downright insubordinate." (p. 20) Although he EMS education standards were written with thought to providing standards as opposed to providing static curricula. Complexity of knowledge and behaviors were considered with the advancement of each level of licensure. (National Highway Traffic Safety Administration, 2009)

The political nature of education is not different than the political control of professionalization. Based on one of the key attributes of a profession being the control of education of the professionals, political influence is comparable. For the consideration of moving an occupation to a profession, the educational site, criteria and curricula are all open to influence and judgement. Physicians have primarily controlled the education of paramedics as part of the societal superstructure, as well as one of the three original professions. The site and type of education for EMS providers has primarily been labeled as training, which is not on the same level as education. There is a dilemma of whether people are educated or trained when you consider the purposes of education. Kincheloe (1999) speaks to the confusion that exists between "being academically schooled" and someone who is considered to have been educated. (p. 11)

Each person has their own perspective limited by personal experiences, capacity to look beyond what appears to be most obvious, personal privilege, and/or willingness or ability to step outside one's own comfort zone. If individuals are shaped by personal experiences then their

capacity is limited to a product of the mold built by another's hand. Therefore it becomes essential to identify who or what constructs these molds and the purposes for which they exist. The first step is to acknowledge that there is a mold. As individuals, we are not born into the world as a finished product. Outside influences play a large role in how one views the world or constructs reality, as well as what constitutes identity within this world. Kincheloe (2000) describes the difficulty most Americans have in understanding that while school is held to be an equalizer, it is also the tool used to create the labor force. The only way to achieve this is to differentiate the type of education received by students. The process of schooling or an academic education exerts significant influence on that finished product. Schools play a significant role in what type of life a student will lead, the type of job they will do, and what their economic outlook will be. Schools exert influence over many years of a lifetime yet are questioned little in terms of the level of control that is exerted. Apple (2004) notes, "By being the primary institution through which individuals pass to become 'competent' adults, schools give children little choice about the means by which they are distributed into certain roles in society." (p. 122) Students are stratified throughout the schooling experience until they assume their roles with little to no questioning.

Curriculum is a prominent component of how students are educated. Kincheloe (1999) notes, "Students need to understand whose interests are being served by the curriculum, as well as the way the program views their own personal role in the enterprise." (p. 384) How can there be an expectation that an 'average person' recognize that curriculum can be influenced or written to achieve a desired outcome when most do not understand what those outcomes might be. To identify outcomes, it is necessary to consider who will benefit when these outcomes are achieved. One potential response would be any group seeking to control those receiving the education. Dominant groups who stand to gain from or require some form of compliance to retain their own roles in society are also those with the greatest access to influence. Whether the curriculum is written to achieve political or economic outcomes, Spring (2005) supports the assertion that there is not neutrality in knowledge. It is the result of decisions based on a political or economic

rationale. (p. 186) It is not relevant to this argument whether the formal site of learning is a public school classroom, a vocational college, or a private university; what is taught is still the curriculum and is developed by others with a stake in how it is comprised. The writers, developers, and approvers of the curriculum all bring influence. Decisions are made about what is included or excluded, the methods by which it is delivered, how it will be measured, as well as the amount and type of resources needed to deliver it.

In terms of curriculum content, the specific subject matter that will be included or excluded, is identified by those deemed to be experts, political appointees or elected officials, and in the case of workforce education, leaders in the field or government or state mandates. Some students may recognize that the curriculum serves as a mold within which their futures will be constructed. Resistance becomes visible in cultural or sub-cultural expressions of music, art, personal appearance, and language. While there is an early need to please those in positions of authority, it can begin to break down when increased efforts to control and suppress begin to be felt. Popular culture is one site where these struggles are seen. While there may be some sense of victory in this resistance, Grossberg (1997) notes, "The result is that often the very activities that empower us, the very forms of empowerment themselves, become politically disenabling, a weapon used against us." (p. 263) This is typically not known to those who believe they are expressing their resistance through various cultural modes. As mentioned above, schools become sites for incorporation of a hidden curriculum intended to promote social order and reinforce forms of monitoring as normal in society. Incorporation of this hidden curriculum that promotes compliance is essential to maintain the interests of dominant groups. Ayers (2004) notes, "Education is always enacted within a social surround, a community or society, and schooling always involves ushering the young into some social order or other, in an entire universe." (p. 9) This highlights a fundamental difference between what constitutes being educated and being schooled. It is a significant difference in how and what knowledge is imparted.

The power to define curriculum extends into the textbooks of workforce education no differently than it does in the K12 system. The uniform *National EMS Education Standards* represent minimum standards that students must meet to prepare them for practice. In the executive summary, the rationale for implementation of standards, as opposed to writing curricula, is to allow instructors and programs to either develop their own or "use any of the wide variety of publishers' lesson plans and instructional resources that are available at each licensure level." (National Highway Traffic Safety Administration, 2009, p. 1) This recommendation asserts that textbook publishing companies, representative of the authors of the textbooks, do an equally adequate job of providing the content of the education necessary to become an EMS provider. It is defining what constitutes knowledge. Graduates of EMS programs must meet exam pass rate benchmarks so program directors are reluctant to develop their own curriculum. To maintain consistency, teachers are instructed to rely on instructional resources supplied by the textbook publishers to deliver the content for the prescribed standards. Freire (1998) notes, "The development of the so-called teacher-proof materials is a continuation of experts' authoritarianism, of their total lack of faith in the possibility that teachers can know and can also create." (p. 8) States can intercede and have content added or removed based on political agendas and those of the dominant groups. One of the ways to address how texts contribute to the maintenance of the status quo is to employ critical literacy. According to Mulcahy (2008), "critical literacy examines texts in order to identify and challenge social constructs, underlying assumptions and ideologies, and power structures that intentionally or unintentionally perpetuate social inequalities and injustices." (p. 16) Through this mechanism, students and educators can begin to question how knowledge is constructed as well as look for the incorporation of agendas intended to serve the dominant groups. Whether speaking to a text utilized in the public school classroom or in a vocational program, hidden agendas can be seen when evaluted critically. In an EMS classroom, the text may utilize only fire-based EMS services in their photos to reinforce the relationship between the fire department and EMS. These subtle inclusions or exclusions to the

curriculum reinforced by the texts are one of the ways in which to create an ideology. The dominant groups construct what constitutes legitimate knowledge and the way in which this knowledge is to be interpreted. According to Shor (1992), “Knowledge is power only for those who can use it to change their conditions.” (p. 6)

Ideology is one of the ways in which to maintain order. It can be concealed from both those who dominate, as well as those who are dominated. Ideology can also be used to distort reality and creates a ‘false consciousness.’ As such, those who are subordinate do not see the oppression or how they are being controlled by dominant forces. It serves to conceal whose interests are most served by the way education is managed, jobs are obtained, and social mobility is accessed. Kincheloe and Steinberg (2007) assert that “Indeed, the test-driven reforms of the first decade of the twenty-first century use social mobility and academic excellence as ideological sirens to enlist public support for what is really an attack on the lower class and other marginalized peoples.” (p. 57) Cultural images and other media text aid in perpetuating a ‘false consciousness’ by reinforcing the dominant interests. Those who are considered to be workers are often least aware of how cultural images impact societal perception of the work they do. Vocational education is often associated with failure to be educated or an inability to learn such that these students are relegated to the workforce while positions and careers that require degrees in higher education remain out of reach. Acceptance of their place in society is justified through mediocre test scores and the encouragement of the school counselors based on the abilities or lack thereof as indicated by these standardized test scores. According to Kincheloe (1999), “The inequitable relations of power and privilege that put them in their uneviable situations are hidden by the ideology.” (p. 54) It conceals the inequalities that exist in conditions under which education takes place and vocational students are not taught to question their circumstances. Students are not empowered to consider what forces have acted upon their ability or limited aspirations. Students become focused on performing jobs and how to support themselves and their families so individual initiative is not engaged. Students who participate in programs where the educator assumes

responsibility for empowering students to consider these more complex interactions may begin to investigate who benefits by the curriculum being delivered as well as what role they play in the perpetutation of the circumstances being created. Kincheloe (1999) warns, "As long as vocational education is viewed as a core of skills to be mastered (and maybe even tested by state and federal standards boards), the attempt to gain self-knowledge and the empowerment that accompanies it is doomed to fail." (p. 201) This is relevant to creating hegemony.

Hegemonic influence saturates our everyday lives and creates what constitutes our understanding of the world. Hegemony is what is viewed as 'common sense' by those influenced. It allows the individual to embrace a system that supports the interests of the dominant groups. Schools serve as a vehicle to maintain this hegemony through the influence of the hidden curriculum. Meanings of how the world operates are disseminated as a form of 'common sense' and then legitimated. This understanding of the world is then the basis upon which students make decisions and accept the circumstances they find themselves in. Apple (2004) notes, "Power and knowledge are here again intimately and subtly linked through the roots of our common sense, through hegemony." (p. 96) The influence of a hidden curriculum is not limited to the primary and secondary sites of education but continues into the vocational education classroom, which includes the EMS classroom. Emphasis is placed on creation of the 'perfect' worker, the 'good' employee, and suppression of creativity. Students are trained to perform skills that will enhance their value as human capital for the employer. Just as in the earlier school classrooms, students are exposed to appropriate social norms that are maintained through daily interactions. Students are taught early how to deal with authority and what their roles are as the subordinates to these authoritarian structures of society. The employer is the authority in workforce education and reinforcement of these lessons continues. As graduates, these workers will assume the roles assigned to them and support the continuation of their own suppression without question. Kincheloe (2002) notes, "In the context of our concerns with ideology, representation, and hegemonic cultural pedagogy, power-wielders produce more information and values and shape

consciousness and identity more effectively than ever." (p. 193) Workers not only submit to the dominant authority and fail to question their own circumstances but tacitly support it through acceptance of the oppression as the normal way of things.

Freire (2003) discusses how those who are oppressed become then the oppressors because that is what constitutes their ideals. In order to be successful under their definition of what this means in an oppressive society, they must then assume the role of the oppressor without realization that they are the oppressed. They do not recognize that they are serving the interests of the oppressors. To escape this cycle, the individual must recognize the opressed condition and according to Freire (2003), "confront reality critically, simultaneously objectifying and acting upon that reality." (p. 52) The educator cannot deliver a solution to the student or simply inform them of the presence of this oppression but must assume a role that encourages students to critically examine their conditions and consider what it means to be oppressed. Retaining EMS training as the primary means of preparing the EMS provider will result in a continuation of this process.

In consideration of what it means to have a career or to do work as opposed to having a job, it is necessary to examine what role vocational education plays in determining who has access and through what means. In order to do this, similar constructs of the political nature of education as seen in schools should be applied to the vocational sites of learning. Vocational education needs to be deconstructed which implies that there may be meanings produced that were not necessarily intended, but are no less present, and they need to be uncovered. When evaluating what constitutes a workforce education program of study, there is still validity in considering the forces or groups that influence development of curriculum, what constitutes knowledge, and the manner in which it will be delivered. According to Storey (1996), "the term career refers to the sequence of social positions people occupy through their lives and the changing definitions of themselves and their world they hold at various stages of that sequence." (p. 143) Careers often define the individual and become what consitutes their reality. It is

important to consider cultural influences such as the significance a media figure or representation of groups/professions can have on the individual's identity and reality as it is constructed. These media texts are cultural sources of values, professional relations, and social heirarchy within the professional circle and are used to produce meaning. Hermes (1999) notes, "The availability of cultural sources of meaning is structured by societal power relations, as are the rules for using them." (p. 69) This is another example of how popular culture becomes disenabling in the way that Grossberg (1997) describes and may evolve to the point of becoming a weapon with which dominant groups are able to limit mobility of the subordinate groups. Although some cultural sources seem to linger for decades as seen by re-releases of popular media, cultural images produced by these texts should not be destined to be eternal. One of the examples for the EMS profession is the collections of the television serial, *Emergency!* (Webb, Cinader, & Shearer, 1972-1977), which reinforces the relationship of the EMS provider to the fire departments. If there is discourse and change as a result of critical reflection, new images can be formed to assist in construction of new identities as well as social realities. The key then becomes recognizing and embracing the need for critical research. In order to reach the next level it is important, according to Silverstone (1999) "to acknowledge that so much of culture, our culture, our media culture, consists in the acceptance of the 'as-if-ness' of the world." (p. 59) Studying media culture as it impacts how the profession is perceived should be an integral component of this critical research.

To begin this process, educators of students in workforce education should address how popular culture and media texts contribute to the construction of both individual identity and social reality. They should begin to question whether this limits the scope of influence and advancement or supports professional goals. Kincheloe (2002) notes, "Everyday life, while not unimportant, plays a lesser role in the production of identity as media representations take on greater importance." (p. 155) This is a new role for many educators in workforce education who often lack academic preparation to teach through higher education. Cultural studies becomes a

resource for those educators willing to embrace this role. Incorporating cultural studies into the classroom would then become a tool for educators to, according to Giroux (2009), "teach students how to look at the media…, analyze audience reception, challenge rigid disciplinary boundaries, critically engage popular culture, produce critical knowledge, or use cultural studies to reform the curricula and challenge disciplinary formations within public schools and higher education." (p. 89) Until educators begin to investigate the potential for what critical pedagogy can bring to the classroom, the status quo will remain. Giroux (2000) encourages educators to begin to ask new questions as popular culture increases its impact on how students see themselves. Students in workforce education are products of schooling that is constructed for the benefit of others. They are far less likely to reach the conclusion that they are on a path previously paved for them to follow. Challenging the status quo is no small feat. It requires a willingness to step outside the comfortable and to acknowledge that it is unlikely to be the popular path both among those who levy control and those who are controlled. Implementing a critical pedagogy requires as Apple (2001) describes, "the fundamental interruption of common-sense." (p. 64) All things taken for granted as being 'just the way things are,' must be questioned. Many of the students enrolled in EMS initial education programs are adult learners. Adult learners are better able to think critically about what this means in relation to their identity. In order to do this, they must distance themselves from what constitutes a 'common sense' way of thinking and explore new ways of knowing. Aronowitz (2000) notes, "The current academic system has fudged the distinctions between training, education, and learning." (p. 158) Nowhere is this seen more clearly than when evaluating a vocational student's perception of the purpose for attending classes. Critical teachers increase the likelihood that the adult learner may begin to view their purpose as being educated over being trained.

As long as training is an acceptable means of teaching students, students will not recognize that any limitations may exist. Particularly for the educator in vocational programs, it will be a challenge to recognize there must be a new method of engaging students for the focus to

change to education. Freire (1998) notes, "…to know how to teach is to create possibilities for the construction and production of knowledge rather than to be engaged simply in a game of transferring knowledge." (p. 49) Given that most vocational educators are skilled in the professions for which they teach and less often prepared as academics, learning to teach will require advancement of their own educations. Whether there is a change in the broad scope of the profession or not, students will benefit from being engaged in critical inquiry as individuals. Certainly for change to occur, the status quo must be broken. There is no less a political influence on vocational education than there is on any other form of education. It is important that both the educator and the student recognizes and Freire (1998a) reinforces, "that education is a political practice." (p. 72) Prior to any efforts being launched to engage others outside of the educational environment on how political influence may be affecting changes within the profession, both students and educators of the profession must address the political influences that are felt within the educational process.

Professions, Professionalism and Professionalization

The final influence of my theoretical framework is related to professions, professionalism, and the professionalization of occupations, including its members. Being labeled as a professional is an identity, which is formed through education and culturally influenced just as any other identity would be. Freidson (1970) notes that "Virtually all self-conscious occupational groups apply it (profession) to themselves at one time or another either to flatter themselves or to try to persuade others of their importance." (p. 3-4) When examining the application of this term, there is more complexity than simply identifying attributes and matching them to an occupation. There are greater forces that are derived from an historical origin of the first three professions and covered in theoretical influence specific to economic, social, and educational status that complicate the process. The first three professions as recorded are medicine, law, and the clergy. There are multiple definitions of what constitutes a profession, but most have similar characteristics or traits. "A profession is autonomous, self-directing, and

embodies trustworthiness through adherence to ethics and knowledgeable skill." (Bossers et al., 1999, p. 117)

Multiple sources consistently identify similar core attributes of a profession. Greenwood (1966) identified five attributes that distinguish a profession: systematic theory, authority, community sanction, ethical codes, and culture. (p. 10) He viewed occupations along a continuum ranging from well-recognized and undisputed professions to minimally skilled and the least attractive of occupations with many others interspersed throughout the continuum. Greenwood acknowledged that skill level is not a defining attribute given there are many highly skilled members of an occupation as opposed to those who are members of a profession.

The systematic theory is most visible in the professional spectrum where intellectual preparation occurs, primarily in institutions of higher learning. Professional authority is the second attribute of a profession. This authority, supported by the professional's education supports the faith invested in the professional by those without the same educational preparation, training or experience. The third attribute, community sanction, is the control over who is allowed to use the title or perform the work of the professional. This can include accreditation of education programs, establishment of admission requirements and licensing or screening for establishing qualifications to practice the professional skills. Professions should have a formal, written code of ethics as well as be self-regulated by an informal code demonstrating commitment to hold members of the profession accountable. Having a regulative code of ethics is the fourth attribute. The fifth attribute is the presence of a professional culture. This includes values, norms and symbols that represent the professional culture. Professional identification is an attribute of culture. Describing employment in a professional occupation as a career is representative of the professional culture. Some may consider it a 'calling' where the work/after-work lives blend such that there is a total personal investment. This was an early attribute specifically applicable to those who were physicians and clergy as they were thought to provide services for the benefit of mankind and not for monetary gain.

Those who possess the education and skills, as well as having other attributes are not guaranteed to be successful at integration in the profession. There must be successful integration with the professional culture. In EMS, there is definitely a cultural component that is not homogenous throughout the profession. While EMS could be considered a subculture of healthcare professionals, there are also subcultures within the EMS profession specifically. Fenwick (2016) refers to paramedics as an example of an occupational group with new demands for professional recognition. This type of demand is challenging the definition of 'profession' as well as sparking debates as to what constitutes professionalism. (p. 22)

Professionalization has a degree of competition due to the control it brings. In EMS specifically, there is a debate as to how and why professionalization should occur, who will develop the education, what theory for it looks like and who will establish the characteristic professional authority. Over the past 60 years, there has been an increase in demand for higher level professional and technical skills which has translated into an increase in social mobility. Just as individuals seek to improve their income and transition to professions where social status is perceived to be more prestigious, so have occupations. (Goode, 1966) This is the challenge EMS professionals are facing due to the lack of autonomy at the inception of the occupation. Professional authority has previously been controlled by physicians and fire service leaders at the national level with physicians holding the most control within states and at the local levels. The fact that physicians have been most vocal about limiting the ability of EMS to expand its role in healthcare is not surprising given the history of medicine as a profession with regard to what requirements must be met to be called a physician.

Hughes (1966) notes that "Not the least important of the symbolic steps in raising an occupation to more fully professional standing is to go in for research." (p. 67) This does not have to be the scope of professional work but may be of the occupation itself. The profession of medicine contains numerous areas of specialties, not including the division of labor shared among nurses, therapists, physicians, etc. Paramedics would also be included in these specialties and

division of labor as they practice in the pre-hospital environment. These patients have not previously been evaluated by a physician, so paramedics develop a field impression that drives the treatment provided based on pre-established protocols or direct physician orders. Research in this field could assist with the elevation of the occupation to a professional status, whether the primary intention or not.

In a study conducted by More and Kohn (1966) specific to the motivation of students of dentistry, findings suggested that in addition to other characteristics consistent with dentistry, they also were attracted by the independence it offered in comparison to those occupations subjected to more managerial control. This desire for autonomy is consistent among others in the more professional occupations. The study participants demonstrated a degree of self-directedness that would be inconsistent with what would be expected of those under authority figures. This is the type of environment that paramedics function in daily. Unlike what More and Kohn found among the dental students, paramedics may view features of their work as a motivation to choose EMS as a profession. According to Ludwig (2009), "Many people my age lined up to become firefighters and paramedics because of Johnny Gage and Roy DeSoto on *Emergency!*." (More than entertainment, para. 3)

Becker and Carper (1966) address the issue of professional identification noting that regardless of the profession, the manner in which the individual is socialized to the group is similar with regard to four areas of work identification. These four areas include occupational title, commitment to task, organization and institutional position and social position. For EMS professionals, their title and associated ideology as one of those areas, is huge. EMS professionals are very sensitive to the term 'ambulance driver' and often refer to nurses who use that term as 'doctor's helpers.' Paramedics will proudly display their level of certification on their vehicles, as well as articles of clothing, to ensure they are recognized for their achievement.

According to Becker and Carper (1966), "an important part of a person's work-based identity grows out of his relationship to his occupational title." (p. 102) The characteristics and

meanings associated with the names are often part of an ideology specific to those bearing the names. The ideology may be interpreted as a good thing for those within the occupation but viewed negatively by those outside of the occupation. Members of specific occupations may feel as if they identify with a set of work tasks and that only they are capable or performing those tasks correctly. Within EMS, each level of licensure or certification has a designated scope of practice, or list of tasks/skills that a person at that level may perform. The paramedic has the broadest scope of practice and is very protective of their 'right' to perform those tasks. Suggested changes in scope of practice to eliminate intubation as a paramedic skill and replace it with a blind insertion of a supraglottic device is an example. (Hsieh, 2017) Regarding institutional positioning, members of the occupation will identify with those organizations where they feel it is appropriate to work. This may include paramedics who choose to work in a 911 response agency as opposed to someone who handles interfacility patient transfers. Social position refers to where the occupational identity is viewed within the societal structure; most related to social-class position. The use of the term 'ditch doctor' to refer to a paramedic is based on the necessity at times to retrieve patients from the ditches of the roadsides.

Legitimacy is a central theme for professionals. Friedson (1970) notes that "the major occupational problem of paramedical workers stems from their paramedical status, which obliges them to work under the direction of the physician because their work is given legitimacy by its relationship to the physician's work." (p.70) This is assessed by examining the site of education, for example, as opposed to where skills are taught. It was not until mandatory paramedic program accreditation was required for eligibility to take the National Registry of Emergency Medical Technicians paramedic entry exam in January 2013 that the site of paramedic education was scrutinized. (National Registry of Emergency Medical Technicians, 2012) Prior to national accreditation requirements, program sites included technical colleges, hospitals, fire departments and independent educational sites. Each state established criteria for approval of EMS courses and licensing of instructors. According to Jackson (1970), universities have been a primary site

of legitimacy as there is knowledge learned within more so than sites where activities are used to teach skills. EMS professionals are sensitive to the differentiation among levels of certification or licensure. There is also an aversion to the media propagated title of 'ambulance driver.' Becker and Carper (1966) found that "names carry a great deal of symbolic meaning, which tends to be incorporated into the identity. "(p. 102) As another aspect of a profession, society grants the ability of the profession to license and mandate in order to control its work. Friedson (1970), "What the status reflects is society's belief that the occupation has such attributes and society's belief in the dignity and importance of its work. (p. 187) This is a critical point for EMS as the support of society may be questionable given the historical portrayal in the media and less visible organic acts of community-based agencies and EMS providers. The challenge then becomes how to overcome any pre-existing negative perceptions or identities to promote the public trust.

CHAPTER THREE
HISTORICAL REVIEW

"What are the circumstances in which people in an occupation attempt to turn it into a profession, and themselves into professional people?" –Everett C. Hughes

This chapter will focus on history; both the history of emergency medical services (EMS) and the history of professions, professionalism, and professionalization. A profession is represented by professionals, who generally display particular traits, exhibit certain behaviors and have completed specific educational requirements. By examining the influence of culture on identity and reality construction, framed using the lens of critical theory to identify the dominant groups relevant to EMS and within the prescribed requirements to achieve professional status, there is a need to determine whether professionalization is both necessary and beneficial sufficient to drive the process. Before making a determination as to whether an occupation should be regarded as a profession, it is essential to understand the occupation being considered.

The History of Emergency Medical Services

Although there is documentation supporting the transport of the sick or injured to a site of medical care dating back to Napoleon's time, the evolution of EMS as more than the transportation of the sick and injured did not occur until the mid 1960's. (Shah, 2006) Prior to the mid 1960's out-of-hospital care was mostly limited to first aid and transport. Paramedics were not the first to staff these ambulances or rescue units. These first units were staffed by firemen or ambulance attendants. Dr. William Grace, of St. Vincent's Hospital and Medical Center in NYC, has been credited as the first mobile coronary care unit. (Page, 1979) Beginning in 1964, Dr. Eugene Nagel began his involvement with the Miami Fire Department, where he created one of the nation's first emergency service programs. In 1967 he was teaching paramedics how to use telemetry with the ability to transmit electrocardiograms over telephones to the hospital. In 1968, Dr. Ralph Feichter began training Haywood County (NC) Rescue Squad volunteers for basic care and in 1969 provided "intensive training in cardiac pathophysiology, electrocardiography,

arrhythmia recognition, pharmacology, and CPR." (Page, 1979) These responders were the first non-physician paramedics to provide out-of-hospital coronary care. These two early services were not publicly heralded in the media nor were there television shows or movies highlighting their great work. It was not until after 1966 with the release of the 'White Paper' that focus was more directed to the benefits of having emergency medical personnel.

Public health has been a champion for EMS since before the release of the 'White Paper.' Studies were being done as early as the 1950's to determine what type of calls, or runs, were being made. In 1963, a study conducted by public health compared urban and rural traffic fatalities with regard to the specific cause of death. The point of drilling down to the cause of death was to determine if treatment in the field might have improved patient outcomes. In 1965, five general types of ambulance ownership and organization were identified. Private, for-profit organizations were operated predominantly by funeral homes. Private, volunteer organizations were second and primarily were used to fill community needs. The third were private services that were owned by larger industries and often located in areas where there was high risk of injuries but greater distances from definitive medical care. Fourth were those that were hospital-based. These often-had medical staff responding to patients on the ambulance. The fifth were public ambulance services, primarily operated by municipalities. Many of those were operated by the police departments. Even in 1965, while examining several barriers to meeting the public's need to have available ambulance services, financial issues plagued the industry. Currently in 2020, this issue prevails as a leading reason for closure of ambulance services as well as privatization in communities that can attract private providers. Despite the many papers which have criticized the poor quality of ambulance services, it is important to realize that just existing as an ambulance operation can become an overriding consideration. "Actually, if providing ambulance services does not prove to be economically feasible, not only will there be poor service, but there may be none at all." (Mitchell, 1965, p. 1721)

In 1965, the President's Commission on Highway Safety was created by President Johnson. It released a report identifying the public health burden associated with motor vehicle crashes. The National Academy of Sciences – National Research Council released its 1966 report, "Accidental Death and Disability: The Neglected Disease of Modern Society" which documented the absence of quality emergency care and was referred to thereafter as the 'White Paper' because it was recognized as the stimulus for the development of a large number of EMS systems around the country. The recommendations from these two reports became the foundation of the Highway Safety Act of 1966, which established the Department of Transportation. It provided federal guidance regarding the specification of ambulances, educational requirements of ambulance personnel, staffing, and communications. It also allowed penalties to be assigned to any state failing to follow the provisions for EMS. Many grants were offered so that multiple states used this funding to establish they own EMS systems. Focus remained primarily on improving the availability of care and transport of accident victims. Shah (2006) notes, "The assignment of EMS responsibility to the Department of Transportation, as opposed to the Department of Health, Education, and Welfare, reflected the view that EMS was primarily a transportation service and not a medical service." (pp. 416-417) Although there were clearly other injuries and illnesses, including sudden cardiac death being treated by EMS providers, the strongest linkage was to the care being provided on America's roadways. Many systems throughout the country flourished during the next decade. Successful programs were able to train paramedics to provide advanced cardiac care demonstrating that paramedics were capable of treating cardiac arrest. Unfortunately, federal leaders were divided in their support of continued efforts to regulate EMS and many states had fallen short of the intended 'final product' such that the EMS system was not receiving favorable reviews. The EMS Services Development Act of 1973 passed bringing additional grant funding to continue creating EMS systems and supportive of creation of regional systems.

One of the most interesting, and likely least known, programs is the Freedom House ambulance service from Pittsburgh. This service was conceived in 1967 as a potential solution to address healthcare deficiencies in the Black community as well as high rates of unemployment among the poor, black citizens. (Edwards, 2019) Dr. Nancy Caroline, who published one of the first paramedic textbooks for EMS education, partnered with Dr. Peter Safar, considered to be the father of cardiopulmonary resuscitation, to use Freedom House as a pilot site for developing standards for national paramedic training. (Sashin, 2020) The Freedom House remained a viable program until 1975 when funding was depleted and a predominantly white EMS agency assumed responsibility for providing service to the community.

By 1981, funding was shifting to Health Prevention Block Grants which decentralized EMS within the states. The decentralization hindered activities such as data collection which may have been helpful in securing future funding for EMS. The Health Prevention Block Grants were pivotal for maintaining EMS regulatory functions within several states. The elimination of these grants has further inhibited efforts to standardize and regulate the industry. It is interesting that the funding support began to wane just as EMS was getting screen time in Hollywood with the TV series, *Emergency!* (Webb, Cinader, & Shearer, 1972-1977) This TV series highlighted the activities occurring in the Los Angeles County Fire Department. In 1971, James (Jim) O. Page, was asked to coordinate the implementation of paramedic advanced life support services for the county. Jim would also be asked to serve as a technical consultant for the show. (Heightman, 2009) Page's description of how viewers should 'see' the characters and activities was consistent with those shared by the acter portraying Johnny on the series, Randall Mantooth. (Mantooth R. , 2013) There was always a professional appearance and attitudes, consistent with fire department regulations. Page would continue his career as an advocate for EMS and establish the publication, Journal of Emergency Medical Services (JEMS). He passed away in 2004. Even though Page was considered an EMS pioneer, he represented the fire service as much as EMS. Much of the documents, practices and mentors of EMS have been physicians or fire service

leaders. Changes will require challenging the dominant groups for the right to have EMS providers lead the profession.

Professional Origins

In order to understand the theory of professionalism, it is important to understand the origin of professions. There are those rooted in the European tradition and similarly those originating within America following its colonization. (Haber, 1991) The learned or status professions are medicine, law and the ministry as opposed to 'occupational professions' that are labeled as professions today. The learned or status professions are those which are founded in a liberal education, consisting of gratifying work and where one could expect to earn a comfortable income. This has not always been the case. Prior to this, the professions were believed to be rooted in service before self, such that payment was not needed beyond what was required to cover basic needs. The professionals were altruistic in their work and generous in using knowledge and skills for the greater good. According to Parsons (1954), "The professional man is not thought of as engaged in the pursuit of his personal profit, but in performing services to his patients or clients, or to impersonal values like the advancement of science." (p. 35) This concept is not consistent with the actions of physicians who sought professional status and the ability to exclude others seeking the same in the field of medicine. It is within this group that I will examine the similarities and differences among other allied health professions who have sought professional status.

The theory of professionalism, rooted in sociological origins, is a "theoretical model with which occupational groups can be analyzed." (Pavalko, 1971, p. 15) This theory emerged during the 1960's and 1970's after the 'trait approach' was abandoned in favor of an approach that examined occupations in relation to a professional model through the process of professionalization. During this time, the professionalization of medical fields merged with a Weberian study of professionalization. Magali Larson (1977), a Weberian theorist, defined professionalization as "an attempt to translate one order of scarce resources – special knowledge

and skills – into another – social and economic rewards." (p. xvii) During the 1970's allied health occupations sought to move out from under physician control and obtain professional status. There was greater focus on the mental aspects of the work performed by these allied health providers than skills being provided. Education compared to training also separates the professionals from the craftsmen. According to Hall (1969), the "professions stress mental prowess" as compared to "crafts stress manual dexterity." (p. 214) The members of the allied health occupations received education in formal educational institutions as opposed to worksites and apprenticeships. Some occupations were slower to transition to educational institutions, including EMS.

During the 1960's, expansion of state-supported services, commonly referred to as the 'human services' was occurring. This coincided with the institution of government financing of medical care, including hospital care for the elderly and indigent care for the poor through the establishment of Medicare and Medicaid. This set the stage for the ability of physicians to secure control of the medical professions as the key worker of healthcare. The public began to expect more in terms of quality of life and healthcare. (Freidson, 1975) The physician, as the most highly educated and gatekeeper of healthcare, was looked upon as the expert and the most qualified to diagnose and treat patients.

Physician Education & the Flexner Report

To better understand the significance of this struggle, it is important to understand the degree of entrenchment physicians had achieved during the 1800s as the de facto experts in medicine. In the United States, medical practice was separated into three medical professions: general medicine, surgery and the apothecary, or drug supplier. This separation was driven by Dr. John Morgan who received his medical doctor (MD) from the University of Edinburgh. In the 18th and 19th centuries, physicians had no standardized training although the wealthy generally received their education in Europe before returning to America to practice. (Haber, 1991) Classical learning was recognized as a pre-requisite for professions such as medicine, the law,

and the ministry. In 1880, seeking regulatory authority, physicians claimed that there was overcrowding in the profession and that if educational requirements were raised, the caliber of physicians would improve, as well as the potential benefit to raise the income.

To address educational inconsistencies, the Carnegie Foundation enlisted the services of an educator, Flexner to assess the curricular components of the medical schools in the United States and Canada. Between 1908 and 1910, Flexner visited all 150 of the educational sites delivering medical education, excluding those for persons of color. Flexner did not hold a medical or terminal degree. The structure of medical training at that time was very inconsistent with approximately 4000 hours dedicated to lectures and instruction. There were no consistent admission standards with some programs taking students who lacked a high school diploma. Laboratory and anatomy, or even basic science experience and coursework was often missing. Johns Hopkins and Harvard had programs most consistent with the German medical schools that Flexner had visited to develop his template of optimal training for American physicians. Flexner proposed a curriculum where the first two years of medical school post earning a bachelor's degree were spent learning through classroom-based methods and the final two years were spent in clinical and laboratory experiences. The use of teaching hospitals became a requirement for a medical school program. Flexner felt there was too much time listening and not enough time learning through interactions with patients.

The Flexner Report contributed to the establishment of not only medical education that has continued to the present time but influenced the development of other allied health professional programs. The removal of some content that did not fit the intellectual focus of the medical education developed by Flexner was transferred to specialty occupations. According to Bailey (2017), Flexner helped to solidify the status of physicians in America by writing a report that was favorable to those students who already had the access and financial means to obtain a medical education. This reinforced the more elevated status of the physician in society.

In 1888, the Supreme Court heard Dent versus West Virginia. The judgement from this case resulted in the ability of states to grant licenses and removed that authority from the federal level. The ability of states to license professionals meant that an occupation would be subject to a regulatory board where there would be increased expectations for quality of service and other avenues for consumers to have a voice in how the profession would be governed. (Kleiner, 2006) In addition, there was the establishment of processes that included such requirements as background checks, testing and baseline education levels prior to eligibility and being granted a license. As a result, physician licensing laws were strengthened, and physicians were identified as competent to judge who should be recognized as a physician based on the site and type of education. Other medical specialties began to form their own associations as a means of creating their own standards, educational requirements, and code of ethics. "A Code of Ethics indicates the profession's acceptance of the responsibility and trust with which it has been invested by society." (Halldorsdottir & Karlsdottir, 2011, p. 807)

By the turn of the century and in the early 1900's, at least eight professional associations had formed consistent with the professional project identified by Larson (1977). Flexner recognized the importance of accrediting bodies and licensing organizations in driving change. The eight associations or group of professionals included: dentists (1840), the American Medical Association (1847), pharmacists (1854), teachers (1857), social workers (1874), librarians (1876), lawyers (1878) and nurses (1896). Veterinarians and optometrists followed after 1900. According to Swisher & Page (2005), physical therapy was not viewed as a profession at its inception around 1965. It took 35 years for it to be recognized as a profession. At this point, physical therapists holding a doctoral degree can direct bill insurance for reimbursement of services. This is significant progress when compared to other allied health specialties forming around the same time.

Professionalism as a Reflection of Society

The quest to retain or attain status as a profession mirrors a similar quest for membership in the dominant groups. Elliott (1972) observed that "…the professions stand out as a group whose members share common socio-economic origins, educational experiences and lifestyles and a common, if confused, ideology of professionalism." (p. 143) The professionalization occurring among occupations and general growth of professionalism serves as a defining characteristic of industrial societies. This is not surprising given the issues surrounding class structure and focus on social mobility during the same time period as industrialization in the United States. An individual's occupation had traditionally been a reliable indicator of social status and correlates closely with income and education. (Reissman, 1959) As discussed in Chapter Two, the purpose of education and the quality of that education is linked to social status and income. Differentiated education is the tool used to create the labor force. Blau & Duncan (1967) note that "The distribution of the labor force in the occupational structure is increasingly determined by the educational system." (p. 180)

The professionalization of occupations impacts more than the attainment of professional status for the occupation. It also impacts the labor force within the occupation. (Brint, 1994) As standards are established, which can include educational requirements, the attainment of licenses to participate in professional activities is now subject to the individual's access to education. Given that access to education is affected by socioeconomic factors, this may limit the ability for an individual to choose that specific profession as an occupation.

Goode (1957) viewed professions as communities where the individual professionals shared a common identity. Once the individual gained access to the profession, they rarely left. The professional members shared common values, language, and definition of their roles within the profession. Pavalko (1971) describes the sense of community and common identity shared among members of a profession. He notes that there exists "…a distinctive culture, the shared values and norms of which function to reinforce a sense of common identity as well as to control

the behavior of members." (p. 24) The sense of community was one of eight characteristics Pavalko attributed to the theoretical model of the occupation-profession continuum. Ritzer (1972) also acknowledged the presence of a professional continuum that takes into account how people enter the occupation, an individual's attitude toward the occupation and how the occupation is perceived by the community. Ritzer identified six characteristics of professions which summarize many of the individual attributes identified by other scholars. The first is a general, systematic knowledge that only those within the profession possesses. The second is an authority over clients, or in this case, the authority over patients. This is one of the attributes disputed by physicians as being limited to their professional authority. The third is that professionals have a desire to put community interests ahead of self-interests. This is more of a symbolic motivation rather than an economic one. Members of a profession also maintain self-control rather than relinquish control to outsiders. The prevailing thought here is that only members of the profession can train or judge another member. The fifth characteristic is that the occupation is recognized by the community and the legal system as a profession. The final is that the characteristics themselves create a unique subculture that is different from any other occupational group. According to Collins (2019), "From a theoretical viewpoint, the formation of professions is determined by the same general principles that govern the formation of any kind of consciousness community." (p. 200) Any group possessing the six attributes could be considered a community but may or may not be recognized as a profession.

Medical Professionalism

"In a way unparalleled in any other industry, the physician controls and influences his field and all who venture near it." (Heistand in Freidson, 1970, p. 48)

In order to understand any profession, Friedson (1970) observes that one must remain apart from that which is being studied. Specifically, as he analyzed the medical profession, he believed that it would allow him to understand professions in general. As he addressed the medical profession as those who were healers or knowledgeable about sickness and management

of illness, he noted that not all who heal are called physicians and they are not all compensated for their work. This is an important distinction because the compensation for the work of managing sickness allows the membership to specific occupation. Friedson (1988) defines a profession as "…an occupation that has been given the right to control its own work." (p. 71) The physician, as a professional, not only controls his own work but possesses such specialized knowledge that he alone is allowed to determine the best course of treatment for the patient.

Friedson (1970) also examined the medical division of labor and how other occupations were viewed in contrast with physicians. "There have been many occupations – pharmacy being a good example –which provided services related to healing and which, if unregulated, could in fact become healing consultantships competitive with physicians' practices." (Friedson, 1970, p. 47) In addition to other direct competitors to physicians, it was determined that rather than try to eliminate them, gaining state control over them would be better because physicians could limit, supervise and/or direct their activities. This made it illegal to compete directly with physicians. Johnson (1972) emphasized the role of power in establishing and maintaining such control.

The tasks of nonphysicians today are not dissimilar from tasks originally performed only by physicians. These occupations, controlled by the physician, are considered paramedical in nature. There are four ways physicians have retained control of these paramedical occupations: control of or approved technical knowledge learned during training, performance of assistive tasks as opposed to direct diagnosis or treatment, presence of a subordinate or supervisory relationship to the physician and the lessened public prestige compared to that of a physician. The distinction of the paramedical worker is more sociological than technological which supports a hierarchical arrangement with the physician at the top. Those entering the paramedical professions are more likely to have a less prestigious background, coming from lower social origins and representative disproportionately by women and those "less valued ethnic, racial and religious groups in the United States." (Freidson, 1970, p. 53) The hierarchy is also reflected in the length and type of training the occupation requires. Those occupations that require longer and

more formal education is higher in the pyramid where the physician is at the top. According to Atkinson (1983), “Education promotes a consensual view of the legitimacy of certain varieties of knowledge, while masking the social differences it serves to promote and reproduce.” (p. 237)

Risk to recruitment lies in alienation of students who are not looking for intellectual occupations but rather one with an emphasis on service to others. During training, it is possible for students to be indoctrinated with a professional ideology such that the discovery of the subordinate relationships with other occupations may create discord. This is frequently seen in the interactions of nursing and EMS. The idea of challenging this hierarchical structure and seeking of autonomy is an option given the complexity of services and potential to locate an independent source of legitimacy. However, the ability to fully attain the autonomy of a profession, the paramedical occupation must control an area of work that does not require dependence and is separate from the main body of medicine, which is under the purview of the physician. According to Klegon (1978), “It is argued that the ability to obtain and maintain professional status is closely related to concrete occupational strategies and to wider social forces and arrangements of power.” (p. 259)

Although remaining subordinate to the medical profession, some occupations are still referred to as professions. The paramedical occupations may attempt to seek professional status by developing formal education and training standards preferably at a university, write a code of ethics and support licensing or registration of their members so that there is some control over who and where work can occur. Autonomy may still be only partial as it would still be limited by the dominant profession which in the case of medicine would be the physicians.
Dingwall (1983), “Not only do professions presume to tell the rest of society what is good and right for it: they can also set the very terms of thinking about problems which fall in their domain. They exemplify in an extreme form the role of trust in modern societies with an advanced division of labour.” (p. 5)

Professionalization of EMS

Vollmer and Mills (1966) differentiate between 'professionalization' and 'professionalism' where professionalism is an ideology that can stimulate members of an occupational group to become professional. Harries-Jenkins (1970) identifies six constituent elements of professionalization and 21 sub-elements. The six elements are structural, contextual, activity, educational, ideological, and behavioral. While not all sub-elements may apply to all groups, the six elements represent an attempt to further define what it means to be professional and are more universally applied. For EMS providers, occupational socialization has generated subcultural enclaves that both reinforces the public's stereotyped expectations and the role individuals within the occupation play. (Larson, 1977) There are still components of the six elements seen within the occupation however they are not necessarily aligned with what those in authority may desire. Depending on the type of agency employing the EMS provider, there may be variations in structural, contextual, educational, ideological, and behavioral attributes. These are seen most vividly in comparison of fire-based EMS agencies and private EMS agencies. The influence of fire administration on EMS is very different than that of a private agency's reporting structure. These influences differ often due to which of the activities is dominant as well as financial infrastructure of the agency.

The physicians involved in local EMS medical direction are not necessarily representative of the physicians who work at the national level to maintain limitations in EMS standards, scope of practice and ultimately prevent challenges to the status quo. As the EMS National Scope of Practice was being developed in 2006, an EMS attorney, Ann "Winnie" Maggiore, expressed concern about a statement in the final draft of the document related to how states might opt to assign skills to the different provider levels. (EMS Insider, 2006) States ultimately held authority when it came to determining scope of practice for the levels of EMS provider licensed or certified within the state. Where state agency representatives felt this gave states warning about assigning skills that were not properly taught and assessed, others viewed it

as promoting deviation from the standard that would be set by default by the National EMS Scope of Practice Model. In some states, such as Ohio, the National EMS Scope of Practice Model would remove skills from levels of EMS providers, which could ultimately be interpreted as lowering the standard of care provided in those communities where the skills were currently approved. The debate sparked national interest among EMS medical directors and physicians involved in emergency medicine. Ultimately the language was removed which reinforces the power held by physicians in determining and defining the education and skills of EMS providers.

Identity Formation in EMS

Perhaps one of the most troubling aspects of stimulating those within EMS to transition to a professional group of healthcare practitioners is that there is comfort in being those 'societal rejects.' If you assume the projected role of someone who is not held to the standards of a professional, then more is unlikely to be expected of you. The overarching problem with this is that even if the individual members of the EMS profession are not willing to change, healthcare is changing around them. To remain a contributing industry in the treatment and management of patients, some changes will have to occur. Failure to make those changes may result in the loss of EMS as an independent industry altogether. There are a couple of options but most likely both would be the result. Those who provide EMS within a fire service will simply remain part of the fire service and the treatment and transportation of emergency patients will be one of the duties of fire personnel. This model would remain consistent with the care Johnny and Roy began in the 70's. For some, this is not a bad outcome as will be discussed later when examining who benefits by the creation of different identities within EMS. According to Ludwig (2009), "Many people my age lined up to become firefighters and paramedics because of Johnny Gage and Roy DeSoto on *Emergency!*." (More than entertainment, para. 3) The other possibility is that the transportation identity, as assigned in the Social Security Act of 1973, will become the official one. Patients are already being transferred from one site of care to another by Uber or Lyft™ if

they are ambulatory, so what is now EMS will become the transportation choice for those patients who are unable to ambulate or sit upright; those who are stretcher bound.

There are those who would be happy to see EMS in its current configuration disintegrate leaving only those two identities behind. Bledsoe (2007b) states clearly that "we are our own worst enemy." (para. 2) He offers three issues that he believes supports that statement. The first of those is the recognition that for a profession to be heard, it must have a unified voice. Bledsoe was an EMS provider prior to becoming an emergency physician. There is an EMS organization like those that represent the medical professions, the National Association of Emergency Medical Technicians. It was founded in 1975, while the series *Emergency!* was airing on prime-time television. The membership numbers are a limited representation of the estimated number of licensed or certified EMS providers across the country. The NAEMT website reports they have over 65,000 members while the EMS Memorial site supports the rationale for a permanent EMS memorial by sharing that there are over 826,000 licensed or certified providers nationwide. It would be hard to sell the argument that the association represents the industry with a membership of less than 8% nationwide.

Bledsoe (2007) essentially reiterated what the EMS Agenda for the Future (1996) had already highlighted, "We must look to science to determine where prehospital medicine should go. An evolving body of literature is available to guide future EMS practices. We should use that information now." (The Future, para. 1) The conflicts that have existed between in-hospital allied health and out-of-hospital EMS providers has been an on-going issue for decades. The conflicts between some EMS providers and fire departments where the sponsoring agencies differ have also been a subject of concern. This goes behind competing agendas due to the necessity of transferring care in both of these environments with the best interests of the patient at the forefront. Rock (2009) makes an important distinction as to how the interactions should be viewed as opposed to how they are. Care for the patient occurs along a continuum as opposed to in a vertical hierarchy. Each interaction moves the patient closer to definitive care and better

outcomes. Rock observes that Bledsoe began writing about the issues as early as 2002 yet notes in 2009 that this has not improved.

Rock (2009) speaks of similar unprofessional behavior by in-hospital providers as that I have witnessed first-hand. Field personnel are treated as subordinate and disrespectful to the point of being asked to leave the emergency department by nursing staff. Many hospitals have employed hospital-EMS liaisons in an effort to improve relations although only the largest medical centers or systems are able to afford this extra administrative person. Rock (2009) notes that this inferior treatment occurs even if the EMS personnel have equal or higher levels of training, potentially lowering self-esteem and if observed by patients and/or their families, may create a concern for their competency in provision of treatment. In order to move to a more professional position in healthcare, EMS education should be driven by and provided by EMS professionals. EMS providers should administer their own quality improvement programs with the reinforcement that patient care occurs along a continuum, not in a subordinate to superior manner. Mistreatment and disrespectful or verbally abusive treatment has to end. Rock (2009) notes that it is not uncommon "to see EMS providers dressed in a slovenly fashion, smoking in uniform or wearing costumes that look better suited for an ice cream parlor worker than a trained professional operating on the front lines of emergency medicine." (para 13) Professional interactions among all providers should be the standard expected whether inside the hospital or in the field. We must hold ourselves to this standard.

Summary

Medicine has sought professional status for over 150 years. According to Hafferty (2000), "…organized medicine has argued that it should be granted legally based privileges and protections so that it could function as the sole source and arbiter of 'medical' work." (p. 20) The traditional fields of specialization, once incorporated into the broader profession of medicine, have achieved separation and established their own professional recognition. There is considerable change that has occurred and still looms on the horizon that could change the

physician-patient relationship. Where once patients sought medical advice, technology has begun to replace the face-to-face interactions. Since the 1970's, there has been much change in the economic structure of the health care system. It would not be a shock if physicians attempted to reclaim some of the autonomy and skills assigned to EMS providers in an effort to remain the gatekeeper to healthcare. There is a risk that by virtue of the silence and non-participation in the governance of our occupation, we may never attain professional status. In order to chart an informed future, it is necessary to understand the past.

CHAPTER FOUR

CONSIDERING PROFESSIONALIZATION

The focus of this research is to examine whether professionalization of emergency medical services (EMS) could be beneficial for the occupation and its providers. The inquiry is speculative with the intent of comparing the professionalization of two other fields, pharmacy and physical therapy. The literature review of the three major areas of influence, cultural studies, critical theory and professionalism is located in chapter two. An historical review of EMS was conveyed in chapter three. The primary point of consideration for this chapter is how professionalizing EMS could benefit not only the provider, but society and the healthcare system as a whole. I will start the essay with some thoughts on why professionalization could help position EMS as a solution or enhance the ability of EMS providers to fill a gap that currently exists in the healthcare continuum. I will also use comparisons on three points, the historical influence of physicians, education and identity development, with two other health professions to support my theory that the curriculum, as well as commanding ownership of it by academically prepared and experienced EMS leaders would have significant impact on the professionalization of this occupation and self-identity of its professionals.

Unfulfilled Aspirations

> Emergency Medical Services (EMS) of the future will be community-based health management that is fully integrated with the overall health care system. It will have the ability to identify and modify illness and injury risks, provide acute illness and injury care and follow-up, and contribute to treatment of chronic conditions and community health monitoring. This new entity will be developed from redistribution of existing health care resources and will be integrated with other health care providers and public health and public safety agencies. It will improve community health and result in more appropriate use of acute health

care resources. EMS will remain the public's emergency medical safety net.

(EMS Agenda for the Future, 1996, p.iii)

I was new to EMS in 1996 when the first EMS Agenda for the Future was released. I ordered the document and read it from cover to cover. I was enrolled in graduate school pursuing a healthcare administration degree and I could visualize how incredible it would be for EMS to assume these visionary roles in healthcare and in the community. The document was written by a steering committee under the direction of the National Highway Traffic Safety Administration (NHTSA) with the intention of providing a formalized plan for the future of EMS within the changing healthcare environment. At this point, EMS had been established for about 30 years and this document was written to serve as a tool to guide those charged with developing EMS infrastructure and involvement in community health. In addition to this document, a formal implementation guide was also released to assist with how to implement the course of action to reach the goals proposed in the agenda. It was estimated that long term objectives could take more than three years to be initiated.

In 2019, a follow-up document, EMS Agenda 2050, was published, again sponsored by NHTSA and written by a technical expert panel. In this publication, the emphasis was on what EMS might look like in 2050, both in agency and as clinicians. According to the vision, *in 2050*, "EMS is a versatile and mobile community healthcare resource, integral to regional systems of care that prevent and treat acute illness and injury, as well as chronic ailments. "and "EMS organizations collaborate with their community partners and have access to the resources they need, including up-to-date technology and a highly trained, healthy workforce." (p. 7) These predictions for EMS in 2050 are presumed to be as opposed to now, although that is not clarified in the document.

Healthcare System Considerations

There is the potential for benefit to society and the healthcare system if EMS were professionalized. Currently, EMS serves as a pathway for patients to enter the healthcare system

typically through the emergency department. Patient care is provided based on a field diagnosis that is made by the EMS provider and consistent with existing EMS medical protocols or live physician interaction. The patient is typically transported to a local hospital emergency department where additional assessments, diagnostics and definitive care is provided. EMS providers generally do not directly document their care or the patient's response to it in the hospital's medical record system, but rather submit separate documentation of the EMS patient interaction to be attached to the record later. Emergency room and hospital-based physicians assume the continued care of the patient, often without knowing what the real circumstances were surrounding this patient arriving in the emergency department. Unless the patient was critical at the time of arrival in the emergency department, EMS providers usually do not speak directly with the physician when handed off to the next caregiver. There may be a different physician assuming care of the patient should they be admitted. If they are admitted, the physician providing in-hospital care may only review the emergency department records but may not be aware of issues that were identified or addressed prior to this interaction at the patient's bedside. Once the patient has been cared for and is released to return home, the patient's care should, in theory, be turned back over to their primary care physician. The primary care physician may or may not even know the patient has been hospitalized until or unless the patient shares this information at a future visit.

This is where the role of a community paramedic, a relatively new subspecialty of EMS, has shown promise in helping keep patients out of the hospital and at home, particularly among the geriatric and chronic disease patient populations. Throughout the entire movement of the patient within the healthcare continuum, there are no consistent methods of ensuring relevant information about the patient's home environment is shared. For example, if a patient is a diabetic, they are likely on medication to control their blood sugar levels. EMS has the opportunity to identify whether the patient has the medication they should be taking at home, what the food pantry reveals about the patient's diet and whether there is a caregiver to assist the

individual with sticking to the prescribed diet or if there is an enabler there providing assistance to the patient in maintaining a non-compliant diet. They are better positioned to identify barriers to the patient being successful with managing their chronic illness such as financial limitations, transportation needs and health literacy. The wealth of information the EMS provider has access to would make a tremendous impact on the overall management and care for these patients. Integrating a community paramedic service for the purpose of assisting patients with chronic conditions with caring for themselves would help fill this gap that currently exists. According to Abrashkin, Washko, Zhang, Poku, Kim, & Smith (2016), community paramedics who were trained in using telemedicine enhanced, physician guided treatment were able to keep older patients with multiple advanced chronic conditions in their homes, when care could be provided there.

Similar to what occurred with the restructuring of medical education following the Flexner Report, the abundance of health-related information, new diseases, new technology and increasing numbers of pharmaceuticals, physicians and other allied health professionals struggle to remain abreast of all of this new information and continue to see growing numbers of patients. According to Han and Vapiwala (2019), this information overload is also impacted with the biological limitation of what the human brain can process efficiently and accurately. To address this, there is ongoing divisions of specialties to subspecialties and stratifying of responsibilities such that the most complex issues at handled at the specialists' level while more routine issues can be managed by subspecialists. (p. 192) EMS is a subspecialty of emergency medicine due to the provision of emergency care in the pre-hospital environment. The knowledge and skills used in this capacity can also be used in the provision of primary care, which in all honesty, is already the case among 911 patient populations. The Center for Medicare and Medicaid Services (CMS) is currently piloting an innovative reimbursement model, Emergency Triage, Treat, and Transport (ET3) that would allow EMS providers to treat patients outside of the emergency department or transport them to an alternative care site that could appropriately address the patients' needs.

(Goldman, Doetzer, Parkh, Carr, & Alley, 2020) The cost savings for this has the potential to be significant as it eliminates a potentially lengthy hospital stay and supports patient satisfaction by avoiding unnecessary time in a healthcare facility.

Additional benefits such as limiting exposure to infectious pathogens and decreasing hospital-inquired infections is an area where additional study is needed both for improvement in patient outcomes as well as cost savings. Managing a patient's care in the home, as opposed to an inpatient setting, has been identified as one of the services that paramedics could perform, if statutorily permitted by their state. This can include such activities as daily administration of an intravenous antibiotic, wound care or dressing changes, and diabetic-related treatment such as management of hyperglycemia. According to Sriskandarajah, Ritchie, Eaton, Sluggett, Hobbs, et. al. (2020), "Hospital in the home offers a number of proven advantages over inpatient care including improved cost effectiveness, decreased risk of nosocomial infection, and increased patient comfort and satisfaction." (p. 123) Avoiding infections is only one of the risks for patients who are admitted to a hospital. In 1999, the Institute of Medicine published a report on medical errors. The estimated annual deaths from medical errors was between 44,000 and 98,000 per year. This number surpassed other causes of death such as motor vehicle collisions, breast cancer and AIDS. Costs associated with these deaths, including the additional medical costs, ranged from 17 to 29 billion dollars annually. One of the areas identified as a contributing factor was the fragmentation or decentralization of the health care system. Patients who present to the emergency department, if transported by EMS, have received care and then are passed on to an emergency room physician, who treats the presenting symptoms and may admit the patient to the hospital. On admission, the physician managing care changes again but may include more than one ordering physician if the patient's issues are complex resulting in intensive care treatment that requires specialists. The patient may be handed off again to hospitalists, physicians who specifically treat admitted patients only, before finally being discharged to the care of their primary care physician. The primary care physician may or may not ever be aware the patient had

a hospital stay. Faulty systems, processes and conditions are identified as potential contributing factors that create opportunity for medical errors. The fragmented care and limited or absent communication about the patient's treatment or care would certainly leave openings for polypharmacy related issues, missed follow-ups and lack of understanding by the patient for how to manage their condition(s).

More recently, the Leap Frog Group reported approximately 206,000 preventable hospital deaths annually based on 30 publicly reported metrics. (Kavanagh, Saman, Bartel & Westerman, 2017) These deaths may be related to the patient developing bed ulcers, infections, emboli or from surgical errors and misdiagnoses. Although there is more emphasis on patient safety, not all of the errors are system related. The Agency for Healthcare Research and Quality reported 86 hospital acquired conditions (HAC) per 1000 patient discharges for 2017. Compared to the reported 99 HACs per 1000 patient discharges for 2014, there was a reported savings of $7.7 billion and approximately 20,000 fewer deaths from 2015 to 2017.

Hospital at home is not a single healthcare provider program. It requires an interprofessional team of care providers. These models do not eliminate physicians, or other allied health professions from the healthcare continuum but rather allow paramedics to fill a gap in care that continues to increase healthcare costs and is potentially more risky for the patient. It does require that paramedics address the issues of physician influence, education and professional identity, as well as what barriers that may be encountered as EMS seeks autonomy within their occupational realm. The pre-hospital environment is not without territorial issues from public safety agencies, such as fire departments. This is unique to EMS in some areas, though not all. I will address the three points of physician influence, education and professional identity for EMS in comparison with the effects on the professionalization of pharmacy and physical therapy.

Historical Influence of Physicians

My first point of comparison is the historical influence of physicians on each occupation. In the historical review of EMS, as described in Chapter Three, EMS had no coordinated agencies

that were sustained prior to the mid 1960's. There were civilian transports of patients using hospital interns in Cincinnati and New York City in the mid to late 1860s. There were some volunteer rescue squads on the east coast but no consistent provision of service or evolution of practice. Prior to trained EMS providers, funeral homes would use their hearses to transport patients to the hospital, if they were alive, or the funeral home, if they were deceased. Following the 1960s, physicians led the charge for establishing formalized mobile cardiac care units, hospital-based ambulance services, private ambulance services and the fire-based rescue squads. By this time, pharmacy had already completed the professionalization process. Physical therapy saw a more their professionalization process begin in the early 1900s. Compared to pharmacy and physical therapy, EMS is a very young occupation. This is pertinent because the comparison among the three is influenced by variables related to periods of time such as wars, legislative changes, socioeconomic influence, the status of organized healthcare, and education. These will be addressed within the periods of history for each occupation.

Professions were held in high regard with deference to the professionals primarily because professionals as Dingwall (2008) noted, "are licensed to carry out some of the most dangerous tasks of our society – to intervene in our bodies, to intercede for our prospects of future salvation, to regulate the conflict of rights and obligations between social interests." (p. 4) There was only a loose definition of profession based on sociological study of work, or the influence of practices, cultures, control, and environments on jobs and careers, as discussed in Chapter Two, and with the exception of the three learned professions, medicine, law and the clergy, any other occupation seeking professionalization was most likely to be a subservient occupation controlled by one of those three. There is an historical component to any profession, but of those that transitioned from the three, medicine has had the most occupations affiliated with it go through professionalization. It is important to examine how professionalization occurred in order to determine if there exists a specific impetus or necessity that drives the process. Professionals are not just individuals with specific labor attributes but also include social and economic relativity.

Generally speaking those representative of the dominant groups in society tend to have the greatest material wealth and fill positions within professions that others who represent members of the lower classes, socially and economically are less likely to be qualified for within the professional realm. There is the influence knowledge brings as the occupation transitions from a primarily skill-based trade to an education-based profession. Knowledge is divided differently between the two. One might say that trades concern themselves with the what and professions focus on the why. That division of knowledge is very powerful, particularly when considered in the context of healthcare. Allied health occupations are divided between those more consistent with trained technicians and those more consistent with educated professionals. The lines are more clearly defined within the healthcare hierarchy by the sites of learning, as well as the possession of academic degrees. In keeping with the comparisons of pharmacy and physical therapy, both have trained technicians, or assistants, who are certified to complete tasks or skills under the supervision of the licensed professionals. The technical colleges, work-based educational programs and the continuing education departments of four-year colleges or universities generally offer or sponsor the training programs for these skilled technicians. Neither require degrees, however they cannot practice independently of the professionals charged with oversight of their activities. In both occupations, the entry level provider must possess a doctoral degree to practice. With regard to EMS, there are certified, trained providers at the entry point of the occupation with the paramedic being the highest trained, but in most cases, without a degree.

The division of knowledge supports not only the division of labor but of social order. According to Dingwall (2008), “Professionals achieved monopolies by organizing more effectively than consumers and by capturing the legislature to supply favorable regulation.” (p. 79) With this organization, influence generates support and support influences regulatory agencies and governments. Essentially, professionals gain a degree of autonomy through legislative or regulatory authority that sets them above consumers and supports self-regulation.

The autonomy is what I believe has most threatened physicians and resulted in their resistance to the professionalization of the allied health occupations.

As the older of the three occupations, pharmacy, prior to its milestones in American history, had a British history that helped with professionalization continuing in the United States. That British history is relevant for review as part of the professionalization process. The British pharmacy is traced back to the medieval apothecary where apothecaries were rivals of 18th century druggists, forerunners of the pharmacist. In 1617, apothecaries claimed a monopoly as compounders and medication suppliers, in competition with physicians and surgeons. Druggists were retailers of medication for the poor and those who rejected medical theory, preferring home remedies, religion or personal beliefs over science. The Pharmaceutical Society of Great Britain was formed in 1841, was recognized by the state as a Royal Charter in 1843 and the Pharmacy Act was passed in 1852, which protected the title of pharmacist and pharmaceutical chemist. In 1868, new legislation restricted the sale of poisons and dangerous drugs to pharmacists registered with the Society. Prior to this, anyone could gain access to these poisons and dangerous drugs, which were often used in ways inconsistent with healing. Compared with the field of medicine, this was the same time period where physicians in the United States were beginning to separate into general medicine, surgery and the apothecary or drug supplier. The position of the apothecary in Britain likely contributed to it being recognized in America as a separate area of specialty. It was at this point in the United States, the position of the pharmacist, as we know it today within the healthcare structure, began to evolve.

When medical school education moved away from an apprenticeship model during the 1820's and 1830's and into the formal college system, the physicians' knowledge base for pharmaceuticals began to decline. Apothecaries of the early 1800's continued to assume a subservient position to physicians until the late 1840's when counter prescribing began. The Philadelphia College of Pharmacy was founded in 1821 in America as the first formal college to train pharmacists. It also allowed for pharmacists to take control of pharmacy education as

opposed to physicians. The University of Michigan added the first public school of pharmacy in 1860. Meaningful pharmacy legislation was passed in the 1870s. During this time period, William Procter Jr., also known as the Father of the American Pharmacy, was entering the profession. He began in an apprentice role but later attended and graduated from the Philadelphia College of Pharmacy in 1837. By the late 19th century, pharmacy had been recognized as a profession. From 1875 to the 1920s, pharmacists were still developing a self-identity within healthcare. It was not until 2000 that the six-year Doctor of Pharmacy degree was required at the entry level. The curriculum for the Doctor of Pharmacy degree is on an eight-year revision cycle, with the most recent occurring in 2016. The standards from 2016 emphasize the integration of experiential and didactic educational experiences, including the concept of collaborative care. There is less focus on the pharmaceutical products and more on the provision of patient care through pharmaceutical interventions. (Crass & Romanelli, 2018)

For physical therapy, the occupation started to grow in the early 1900s. Physical therapy emerged more notably following World War I when rehabilitation of injured soldiers required therapeutic exercise. Pennsylvania was the first state to license physical therapists in 1913 and schools for Reconstruction Aides were established in 1917 and 1918. (Swisher & Page, 2005) Physical therapists saw a surge in demand due to the polio epidemics of the 1940s and 1950s. Interestingly, the majority of physical therapists were female and physicians were primarily male, which may have influenced the subservience of the providers to physicians longer than had the gender representation been different. Women who provided physical therapy, including massage, were sometimes viewed as suspect when working with male patients. In the early 1920s, the Council on Physical Therapy within the American Medical Association recognized physical therapy as a profession and the American Women's Physical Therapeutic Association (AWPTA) was formed. It was later renamed the American Physiotherapy Association (APA).

Connections to EMS

Although EMS was very limited during the 19th and first half of the 20th centuries, what is relevant to note in this comparison is that both pharmacy and physical therapy were started as subspecialties that physicians needed to provide care for their patients. These were activities and knowledge possessed and/or performed by physicians prior to the period of time from the late 19th century, but as medicine began to prioritize the educational needs and activities of the physician, these duties received less attention. Physicians began to delegate the knowledge and skills necessary to others. For pharmacy, physician education no longer focused on compounding principles and uses of drugs. The wounding of soldiers and epidemics created needs for rehabilitative treatment that exceeded the numbers of physicians available to do these tasks. Physicians held a similar primary role in EMS before delegating to the EMS providers. Initially, physicians often responded to the scenes of complex patients but as their hospital-based responsibilities grew, they were less available to be in the pre-hospital setting. Physicians continued to consult with paramedics using radio transmissions to provide guidance and instructions on how to treat a patient. Electrocardiograms (ECGs) could be transmitted from the scene to the physician at the hospital using radio waves and allowing physicians to use the diagnostic test, formerly only conducted in hospitals, to develop a treatment plan for paramedics to implement. The next phase of lessening physician involvement occurred as patient care protocols were developed. Paramedics would not have to call the physician for orders and guidance on how to treat patients with specific disease or injury assessment findings. Paramedics would only call if the pre-approved protocols were not helpful or additional care was needed. Paramedics could effectively determine a field diagnosis based on the patient's complaints, a patient history and physical assessment and use of diagnostics then treat the patient before and during transport to the hospital's emergency department without talking to a physician. The intention was to use physician-driven quality improvement tools to ensure there were no medical errors and that standard of care had been provided appropriately.

The presence of representation through national associations has also been a component of EMS. The National Association of Emergency Medical Technicians (NAEMT) was formed in 1975 following the efforts of the National Registry of Emergency Medical Technicians (NREMT) which was established in 1970 in response to the "White Paper" discussed in Chapter Three. The NREMT offered examinations based on the national standards for training of emergency medical technicians. Although NAEMT has attempted to form relationships with state-level associations to provide more concentrated representation, they have not been successful. This has resulted in fragmented representation at the federal level on issues impacting the occupation as a whole. Compared with pharmacy and physical therapy, as well as physician groups, this has left EMS at a significant disadvantage to undertake the professionalization process as there are competing voices in places that matter most. This leaves EMS to depend on education to play a key role supporting the professionalization process given the unique body of knowledge and skills necessary for the providers to deliver the services in a competent and professional manner.

Influence of Education

My second point of comparison is the formalizing of the education process. For pharmacy, the time from 1875 to the 1920s, saw the work become less complex, although the educational requirements for the pharmacist increased. Mundane tasks were relegated to assistants still found in apprenticeship roles. Today, there are pharmacy technicians who handle packaging of prescriptions under the oversight of the pharmacist. Pharmacy education in 1925, required only three years of college. In 1932, it increased to four years and then to five years by 1960. The activities related to compounding of drugs continued evolving such that approximately 80% of prescription medications required compounding, or mixing, combining, altering of ingredients to make a medication, in the mid 1920's, then approximately 26% in the mid 1940's and by 1974, just over 1% required it. Medications were being conveniently packaged for single doses and compounding was no longer necessary. Despite this, a doctoral degree was identified as the requirement for licensure as a pharmacist.

In 2001, the American Physical Therapy Association (APTA) identified six elements necessary for physical therapy to be fully professionalized. Of those six, one was the establishment as a doctoral degree, Doctor of Physical Therapy (DPT), as the entry level to the profession. Creighton University established the first DPT program in 1993. The degree requirement for entry into the profession was instituted in 2016.

For EMS specifically, physicians were responsible for the development of the paramedic curriculum. The last curriculum released for paramedics from the Department of Transportation in 1998, before the introduction of the National EMS Standards, listed primarily advanced degree paramedics and nurses as the authors, the subject matter experts were almost exclusively physicians (28 of 35), while the other eight held a nursing license or advanced degree, including one pharmacist. The lack of a formal EMS occupation necessitated that there had to be a dominant group to develop the occupation both educationally as well as practically regarding skills. What once was a necessity, need not be required today with the numbers of EMS professionals obtaining advanced and specialty degrees enabling them to take control of educational standards. The failure to take this responsibility definitively is the result of insularity of the leaders within the occupation for undocumented reasons. I think there are several possible reasons based on my personal interactions with my peers such as feelings of inadequacy, concerns of appearing disrespectful to physicians and a belief that it is a level of control or responsibility that should be retained primarily by physicians. Until and unless there is personal investment, belief and accountability within our industry, the perception will continue to be the reality.

Developing an Identity

The final point of comparison is related to the development of the professional identity. The primary reason cited for the struggles of pharmacy to become a profession was its dualistic occupational role, or identity, as both a professional and tradesman because of the selling of other products associated with pharmacies but not always of a medicinal nature. Pharmacy, according

to Gosselin & Robbins (1999), receives the least attention from social scientists. Pharmacists are rarely represented, if ever, as the 'hero' within the popular media such as books, movies and television. Dr. Doug Ross from the television show *ER*, is the most well-known representation. The United States pharmaceutical industry has almost completely taken over the art of pharmacy today. Modern contributions to patient care are clinically based such that pharmacists are considered primary care providers for medication use management. It has only been within the past 30 years that pharmacists have acquired wider licenses allowing them to engage in care and management of patient conditions, including the ability to question physician interventions related to pharmaceutical treatment when it seems inappropriate, ineffective or damaging. Use of antibiotics and prescription narcotics are two areas where pharmacists have made a significant impact in patient medication management. Throughout the evolution of the profession, physicians still struggled to retain sole control of diagnosis of patient illness, the ability to prescribe medications and to treat illness or injury.

The remaining five elements identified by the ATPA necessary for physical therapy to be fully professionalized included: evidence-based practice, autonomous practice, direct access, practitioner of choice, and professionalism. These are relevant as comparative points for other allied health professions undergoing professionalization. Physical therapists today have much more autonomy than other health professions due to their ability to have direct patient access, in their own offices, and ability to see or treat patients without a physician referral. They may also choose to subspecialize. (Allied health professions, 2001) Similarly, many of the allied health professions seeking professionalization have begun the process by upgrading entry-level credentials, accreditation of educational programs and transitioning to licensure by state-level regulatory bodies. According to Hughes (1971), "the way to understand what professions mean in our society is to note the ways in which occupations try to change themselves or their image, or both, in the course of a movement to become 'professionalized.'" (p. 377)

Autonomy – Professionalization Complete

Regardless of the allied health field examined, professional autonomy is the desired result of occupations seeking to become professions. The process of professionalization is what is necessary to achieve this. The benefit to occupations having professional autonomy, is that its members then have control over decisions or procedures related to the work, as well as control of its economic resources, which can be used to enhance service delivery, purchase new equipment, support continuing education or increase the number of EMS providers to meet the needs of the community. All of these improvements feed back into the system to enhance treatment and transport, when needed, for the sick and injured. This may be in the form of fees or charges related to the performance of services or the sale of goods. The public defers to these professionals based on the specialized knowledge, integrity, and altruism they are recognized as possessing. (Freidson, 1970a) Physical therapists perform services for which they bill. The pharmacist sells medications and dangerous drugs after using their knowledge and skills for completing the work necessary to make those products available. EMS providers offer the service of determining a field diagnosis, identifying a treatment plan, treating the patient and transporting, when requested, to a location for continuing or definitive care. This process helps address the provision of healthcare in the right spaces, controlling of healthcare costs and impacting the patient's quality of life by minimizing unnecessary trips to the hospital and patient responsibility costs. Regardless of the medical or allied health occupation going through the professionalization process,

> Professional autonomy is limited and weakened by the relationship of one profession to another (dominance), by the influence of other social institutions (rationalization and deprofessionalization), and by the internal disposition of the profession itself (insularity). (Sandstrom, 2007, p. 98)

The autonomy of EMS providers is indeed limited and weakened by the dominance of the medical profession through physicians who control what skills paramedics may perform and what medications they may deliver. (Callaham, 1997) The preference would be that EMS would be represented in an integrated health system model of care, such that its realm of subspecialty is pre-hospital, in consultation with other health care professionals as needed to provide optimal care to the patients.

Social institutions including insurance providers and other professionals (i.e. nursing, fire service) have been able to influence the autonomy of EMS. Insurance providers limit reimbursement because EMS services are billed as a transportation benefit with limited acknowledgement that patient care occurs during that transport. There is recognition that care is provided because EMS agencies are required to bill according to level of service, advanced versus basic, as well as whether the care and transport occurred during emergency or non-emergency conditions.

Fire service, whether local, state or national, has influenced the autonomy of EMS by absorption of EMS response and transport within the fire departmental structure, controlling access to 911 requests using zoning and local or state government, as well as actively opposing efforts to transition from a technical-based occupation to an academically-prepared profession. (International Association of Fire Chiefs, EMS Section, 2018) I have personally been denied access to a 911 patient by a firefighter arguing that the medical patient was their concern until *they* decided to turn over care because my ambulance service was the private, contracted provider and not a government agency. I have had a female paramedic subordinate physically moved to the side by a male firefighter while caring for a cardiac arrest patient because he disagreed with her treatment. It is also nearly impossible for EMS personnel to work together to achieve professional autonomy when individuals and groups intentionally detach from the professional activities of others within the industry, as seen in the unprofessional use of

social media and assumption of rogue mentalities (Abubey & Basye, 2019) The intention is not to work against the established healthcare system but to integrate with it as a contributing member of the healthcare team.

Professional autonomy is founded in public trust and is granted based on the occupation's ability to meet health or social needs of the public. The public may be less inclined to trust a group of 'professionals' who proudly and publicly represent themselves as outsiders, rejects and the unappreciated, within healthcare and within their communities. Those with professional autonomy have a degree of social power that should be used to advocate for patients, who are often at their most vulnerable. The individual, or patient, should be able to trust that the treatment and recommendations are based on professional knowledge and skills specific to that provider. There is great power that is fueled by that trust. According to Sandstrom (2007), "we must recognize that professional autonomy extends well beyond the professional-patient relationship and originates in social and political relationships within society." (p. 99) This professional-patient relationship is influenced by such attributes as type of clothing, ability to speak and write clearly, as well as engage in professional discourse with other health professionals for the benefit of coordinated patient care and disease management. When compared with pharmacy and physical therapy, EMS providers may find they are lacking in some of these areas, and often intentionally so because of the type of clothing that is worn, the lack of professional, fixed spaces to see and treat patients, baseline education level and their episodic interactions with patients

Some EMS providers support the concept of professionalization in order to justify an increase in the pay to providers as a result of restructuring reimbursement methods. This push for increased wages is not a new issue. Whenever increasing educational requirements for entry to the profession is discussed, the response is almost always related to rebuttal that this would not be seen with a corresponding change in pay

because reimbursement is unlikely to change as a result of this new requirement. It really becomes a 'chicken versus the egg' argument. Until the changes occur, we won't really know if reimbursement structure would be more likely to change. Without documented research, the primary impetus for change varies depending on the patient population, economic status of the local healthcare facilities and commitment of the EMS agency. There are a lot of 'ifs' and too much speculation for most states to push for higher education and degrees at the entry level without some assurance that organizations would pay correspondingly. This discussion is not new. The issue of low wages has been a topic of contention throughout the history of EMS. Higher wages accompanied by decreased reimbursement compromises the very existence of the EMS infrastructure within the communities. (Mitchell, 1965) EMS has an inherent cost of readiness that must be supported with funding, regardless of source, before any additional expenditures are considered. This cost of readiness includes vehicles with initial required supplies that often tops $100,000, fuel, wear and tear maintenance for the vehicles, diagnostic equipment maintenance, facilities with associated costs, communications infrastructure, supply and logistics personnel, scheduling or staffing personnel, billing or accounting personnel, clinical oversight, supervision and management infrastructure, as well as the EMS personnel necessary to staff the unit for the time it is available for use. These costs are broken down into the amount necessary for all of this to occur per hour or unit hour costs. The charges continue for every hour the unit is available whether it responds to and transports a patient or not. Reimbursement or tax-based support of these unit hour typically fall short or barely break even which results in ambulance agencies looking for ways to generate revenue outside of sole 911 requests. Increasing wages without documented evidence of an observable outcome would be not only a hard sale for the industry but a financial struggle.

The Problem of Research

It has been 23 years since the first EMS Agenda for the Future was published. In that document, there were detailed descriptions of how EMS would and/or should look in the future. The document generated excitement and anticipation although as of 2020, not many of those predictions have taken shape. In fact, in an article by Neely, Drake, Moorhead, Schmidt, Skeen & Wilson (1997), predictions at that time mirror what they are today and in general have not changed over the passage of time. Healthcare costs were rising, reimbursement structure was changing, Medicare and Medicaid reimbursement rates were declining, labor and supply costs were increasing, and the healthcare delivery system was transforming. At that time, health maintenance organizations (HMOs) were a new insurer with strict service utilization requirements. There was a lot of focus on appropriate care, at the right time and in the right place. Different cost and payment structures were deployed that challenged providers to have predictable costs. Neely, et. al. (1997) stated that "EMS systems of the future will have an additional mission: to get the right patient to the right place at the right time." (p. 799) As of 2020, over 20 years later, EMS has still struggled with this mission in some states more than others.

Whenever discussions of professionalization arise, there are accompanying discussions about the scope of practice and what degrees are most appropriate for the paramedic to possess to provide competent patient care. Physicians have been lodging concerns about the safety and ethical integrity of allowing paramedics to practice beyond what they currently are allowed to do, often citing the lack of research, which is unfortunately a legitimate deficiency. When expanding the paramedic scope of practice was discussed last in the late 1990's, physicians published multiple articles in the peer-reviewed journals focused on emergency medicine related issues. It was not likely EMS providers, the paramedics staffing the ambulances, were going to read these articles. Callaham (1997) authored one of three articles published in the same volume and issue of the *Annals of Emergency Medicine* related to the deficiencies of EMS research and concerns

related to continued provision of prehospital care. According to Callaham (1997), "EMS should not even continue its present course, much less expand, until its ability to monitor and report clinical outcomes (and identify adverse effects) is at least as good as that of a hospital." (p. 789) He clearly called to question the ability of EMS to perform evidence-based care such that transport and reassurance of patients might be the most optimal approach for providers to take as opposed to actually treating them.

The lack of EMS research is problematic to say the least. Despite the fact that an EMS *National Research Agenda* was published in 2004, in response to the recognition of the necessity of advancing quality research in EMS in the *EMS Agenda for the Future,* research in EMS continues to be significantly less than other medical specialties. According to Spaite, Criss, Valenzuela & Meislin (1997), "Reliable scoring methods, severity scales, and outcome measures are lacking; and, it is ethically and logistically difficult to justify withholding the 'standard of care' in an effort to understand the impact of EMS interventions." (p. 791) In order to truly determine the value that any pre-hospital intervention or model of EMS care, there has to be appropriate research. This is very hard given the challenges associated with research in EMS. Not all systems are the same. The variations in EMS systems, specifically looking at the environment in which care is delivered, such as urban versus rural, create a challenge because findings are not necessarily transferrable. There are too many variables and the same issues arise when evaluating in-hospital research. There are too many differences to make the findings applicable to both in and out of hospital groups. Perhaps one of the most concerning, even more than the lack of academically prepared researchers, providers who are skilled with conducting good research or the cost to perform the research is the potential necessity of withholding what has been deemed as the 'standard of care.' The most valid studies have random inclusion with blinding on the part of the provider and patient as to which intervention the patient would receive. There is no way to have an experimental group because it crosses ethical borders to withhold the standard treatment from any patient, especially someone who is having an emergency and is

likely unable to give informed consent. The very nature of emergency care is that patients are experiencing an emergency, by their own definition, and may not be competent under those circumstances to give consent. According to Spaite, et. al. (1997), there are two methods proposed as a starting point for implementing expanded-scope EMS services given that research is so limited. The first is to simply deploy it, while keeping in mind that doing so should not prevent primary responses to cardiac arrest patients. The second suggestion would be to deploy it as an 'add-on' to existing EMS response. Examples of this might include adding alternative providers, such as nurse practitioners to the system so that services that communities already struggle with, such as childhood immunizations, could be incorporated into these programs. Some EMS agencies have incorporated the use of nurse practitioners in proposed models of community paramedicine, the newest service line or level of care within EMS.

The historical significance of this type of response is critical to inform EMS providers today of the significance of medicine's resistance to professionalize the occupation. There is much to be learned by examining the struggles and responses of other allied health professions, such as pharmacy and physical therapy, as they have professionalized while facing similar oppression by physicians. The most significant change to EMS has to come from within. Those from outside of the occupation will continue to create barriers and further the hegemonic conditions of subservience to medicine, of not being educated enough, of not having the capacity to offer more to the patients encountered. Just as pharmacy and physical therapy recognized the opportunity to assume responsibility for a unique body of knowledge that would only add to the volume of knowledge physicians are expected to retain, EMS is now seeing the opportunity to assume responsibility for providing definitive care in the home and community. Our healthcare system is overwhelmed and overpriced. It is an opportunity for EMS to 'step up' to the plate and demonstrate our willingness to meet the challenge and address the needs of our communities.

The 'Frank' Identity

There seems to be no shortage of EMS providers willing to assume the martyr's role and continue to live out the persona of EMS represented in popular culture as the bastard child of public health and public safety, bravely providing care in the worst environments and at the darkest moments of our patients' lives. Perhaps that fulfills the individuals of our occupation sufficiently that change seems unnecessary. Some seek to reflect the opposite of the clean-cut, crisp uniform, regulation appearance of the Johnny and Roy personas of *Emergency!* There have certainly been interactions between EMS and fire that have soured EMS providers on anything that resembles representative of the fire service. I personally think we, the paramedics of EMS, have more to offer and the changes occurring in healthcare seem to support that position. I don't think it requires greater conformity to the persona created by the paramedics on *Emergency!* I think it requires adopting a different, but still professional persona. Whether it is Frank or Johnny members of this profession identify with, Macedo (2000) explains, "…people often identify with representations that they are either comfortable with or that help deepen their understanding of themselves." (in Freire, p. 23) Reflection and a critical examination of why these representations are presented to the public is necessary to acknowledge the reproduction of oppression using popular culture so that it effects the individuals' sensibility.

Having been one of those street paramedics, responding to patients who called 911 to get a ride to the hospital because it was closer to the liquor store than where they were presently located or to those who had a toothache at three o'clock in the morning that was keeping them awake or to the intoxicated homeless person who had defecated on himself emanating a smell that encouraged police to request transport to the emergency department as opposed to taking him into custody. It would have been very easy to assume the outcast role and I would be lying to say that I did not from time to time in those wee morning hours. The role of Frank in *Bringing Out the Dead* may have fit some nights, when there was no rest, only tones after tones signaling yet another call for EMS response There were calls that could leave you emotionally and physically

wasted and others that were like shots of pure adrenaline to our veins because of the challenge they brought to our knowledge and skills. Those were definitely the minority. Some were patients experiencing true emergencies, but there were nights where it was impossible to identify any reason for us to be summoned. According to Frank (Cage), "I came to realize that my work was less about saving lives, than about bearing witness. I was a grief mop. Sometimes it was just enough that I showed up." (Leong, 1999)

Addressing the Students

Assuming a new role in healthcare means abandoning the martyr identity and taking responsibility for how others see us as well as how we see ourselves. It means that part of the educational process must include teaching and modeling medical professionalism. According to Spandorfer (2001), there are several challenges to teaching professionalism. Students experience a dissonance that is generated by what they see in the actions of their professors and in the clinical settings by those deemed to be professionals with what they are taught in the classroom. This is one of the critical reasons to address the curriculum and education of EMS providers during the initial education process. It is necessary then for educators, according to Weaver, Wilson & Langendyk (2014) "to employ pedagogical strategies to assist students to identify and resist the negative influences of the hidden and informal curriculum." (pp 598-599) EMS educators must challenge themselves to practice what they teach. EMS students should be encouraged to challenge negative representations of an EMS provider, whether displayed by peers, on social media or in popular culture.

When examining the current sites of EMS education, the 'typical' EMS student is not the student who graduated at the top of their high school class. EMS education primarily occurs in vocational or community colleges, some within fire agencies and some within the private sector. While teaching at a local technical college, several of my own students admitted they were enrolled in my EMT course only because Cosmetology was full. Some of my students were the unsuccessful practical nursing majors who had not been accepted into the nursing program.

Many were working adults, some who had not graduated but earned a general education diploma (GED) years after dropping out of high school. "Vocational schools were the places teachers sent their weakest pupils. Expectations for these students were lowered, and throughout the twentieth century, the vocational track ensured that students who entered it would experience little social or economic mobility." (Kincheloe, 1999, p. 140) Regardless of their background, education was seen as a way to become more or to be liberated from their current circumstances whether financial, physical or mental. These students often blamed themselves for their circumstances without recognition of how the educational system may have failed them at best or led them willingly to this position at worst. Perpetuating the harm of education without critical dialogue would be negligent on the part of the educators. Students should not be treated as vessels to be filled with information but as active participants in the inquiry and learning process. Not only should they be learning skills and knowledge about an occupation, but they should also be learning to question the dominant ideology; to ask why, to communicate and to become active participants in their occupation. These are the students best served by what Freire (2000) identifies as "problem-posing" education, which requires an abandonment of the banking concept of education. The teacher is no longer bestowing a gift of education but rather becomes jointly responsible for the learning process. According to Freire (2000), a "problem-posing education involves a constant unveiling of reality" where there is "*emergence* of consciousness and *critical intervention* in reality." (p. 81)

Bringing My Experience to the Conversation

The field of EMS is one in which I have invested three decades of work and from where my personal knowledge is drawn. Having served as an EMS provider at the paramedic level, worked as an emergency medical dispatcher, as well as being a licensed EMS educator, I have witnessed interactions among those in my field and other allied health professions. Having an advanced degree in healthcare administration has allowed me to better understand the political and financial influence of changes in regulation and legislation to the EMS industry. It has been

during routine interactions that I have witnessed the belittling of EMS providers, the disrespect for the knowledge they possess and the lack of understanding of the scope of practice many are afforded under their state statutes. Because my background has not been visible to those representing other allied health professions, I have also been the recipient of negative off-hand comments, disrespect, and general disregard as a contributing member of the healthcare team. It is easy to understand why EMS providers become defensive when referred to as 'ambulance drivers.' The reference to being a driver minimizes the education and training obtained to provide care to patients outside the climate-controlled walls of the hospital.

The difference in compensation when compared to the level of responsibility is insulting to say the least, even if I subtract the environment from the equation. As a registered respiratory therapist with an Associate's degree and a member of the adult intensive care team at a teaching hospital, I was making approximately $13.50 hour in early 1996, working 12-hour shifts. In that capacity, I worked primarily under direct orders of a physician and in collaboration with nursing and representatives from clinical pharmacy, physical therapy, the lab personnel and dieticians to manage the respiratory status of complex patients. In late 1996, I worked as a paramedic with a Bachelor's degree in Biology and enrolled in a Master's degree program, on an ambulance in a southern, urban area where I earned approximately $10.35 per hour working 24-hour shifts. In that capacity, I was responsible for responding to emergency requests for medical or trauma patients, regardless of the severity, rapidly identifying the cause of the emergency and treating the whole patient with little more than some bandages, a defibrillator, intravenous fluids and medications in a box where my movement was limited to a two foot by six foot space, in addition to diesel supplied by my partner as vehicle operator. I often had to do this alone as there were no additional personnel close enough to me to warrant the wait when compared to the transport time. I did not have a team of professionals to assist me or offer their knowledge and expertise. I have taken a deceased child from his mother in the middle of a city street to run to the box I worked in while futilely trying to restore life using every instrument and tool at my disposal.

While it is important to acknowledge that what I have experienced may not be the same as what other EMS providers have experienced, my reflections contribute to this written form of philosophical inquiry. My background, lived experiences and education allow me to be that critical educator who supports authentic learning, questions a curriculum saturated by the dominant ideology, and can see in the eyes of my students all of the lived knowledge that they bring to the classroom. "Almost never do they realize that they, too, 'know things' they have learned in their relations with the world and with other women and men." (Freire, 2000, p. 63)

Three Elements to Address

I have identified three elements of the professionalization process that need to be addressed within the EMS occupation. The first element to address is instituting the formal education of the paramedic. The curriculum must be expanded to include general collegiate studies and academic preparation. Exposure to coursework that promotes critical thinking, encourages social responsibility, and requires professional discourse will be a good first step in placing the individuals with this background on a more level playing field when it comes to respect from other medical professionals. Even if EMS, nationally, were to start with requiring an associate degree, it would be a positive step toward professionalization. As paramedics begin to be viewed as the healthcare professionals they should be, expectations on reimbursement for care provided may be better represented at the national level. With increased reimbursement, the educational preparation may also be increased to meet population healthcare goals in ways that EMS best can. Just because the disparities in reimbursement and pay should be addressed, it doesn't make the economics of EMS the primary point of contention. It is just a necessary part of the conversation.

None of this will matter, however, if the individuals who make up this occupation do not first see and carry themselves as professionals. Critical theory is relevant to this necessary transformation. According to Freire (1998), "It's important always to bear in mind that the role of the dominant ideology is to inculcate in the oppressed a sense of blame and culpability about

their situation of oppression." (p. 78) EMS providers must recognize their own culpability in perpetuating this state of unprofessionalism. It is time for EMS providers to do professional things such as joining industry associations, seeking opportunities to conduct research, and develop collaborative relationships with their health and public safety peers. Continuing education is critical to remaining compliant with current standards of care. Instead of being forced to take advantage of learning opportunities or waiting for employers to pay for conference fees, EMS providers should seek educational opportunities that will move them forward as clinicians, educators or administrators. Developing a career path is important for personal and professional growth.

Finally, for EMS, there is a dichotomy within its identity. EMS exists as a safety net for the community as a public safety provider, but also contributes to the health of the community as both a member of public health and the healthcare system. This duality was introduced in *Emergency!* and is still relevant today even if the model presented is not the best option for all communities. In my analysis of the professionalization comparison with pharmacy and physical therapy, there is much similarity to how the opportunity presented itself such that physicians could no longer address these specialty areas while still meeting their primary responsibilities to the management of their patients' health needs. All three occupations have unique bodies of knowledge and skills needed to provide competent care to their patients. All have representative national associations capable of representing their respective positions on issues that impact the occupation at the national level. All have a technician-level trained provider capable of performing tasks that support the work of the higher credentialed provider. Where pharmacy and physical therapy have had much less identity representation in popular culture, EMS has had some negative representation, as well as self-perpetuated social media identities that could influence a patient's degree of trust. I do not believe EMS is beyond the point of redemption, however there needs to be an active effort on the part of the individuals who are responsible for

the education of providers, as well as individual accountability for changing how the occupation and its providers are perceived by others within and outside of the healthcare community.

CHAPTER FIVE

REFLECTIONS

"Critical theory promotes self-reflection that results in changes of perspective."

(Kincheloe, 1999, p. 197)

This final chapter is definitely not my end. I am perhaps more inspired today than I have been in the past decade. This is just a revival. It is the beginning of opportunities to critically reflect and act on my belief that EMS will play a significant role in this new healthcare landscape. I also recognize that it allows for greater responsibility to contribute to solutions, growth and encouragement of my future students to question the status quo. I would like to believe EMS will continue toward seeking professionalization through education and that EMS will finally realize all of those goals set in 1996. Although I do not feel confident, I would like to think there could be consideration among my peers of how this research can help support EMS professionals to take control of their future roles in both healthcare and public safety. I have great hopes that we will see an increased number of our providers complete an academic degree before entering or return to earn one after becoming more involved in the field. I teach the capstone course in an EMS administration program and every student either inspires my hope or dashes it. This is just a small sample of individuals who are pursuing a degree, but I know there are others. I encourage research and presentations every term, whether within their agency, at conferences or in stakeholder groups to benefit their community. I emphasize how important it is for them to read the literature, identify those concepts, ideas and practices that will help their communities, their peers or the profession continue to evolve. It's what I did in my graduate program and it only inspired more curiosity.

While researching for my dissertation, I pulled out articles from my time as an administrator in south Atlanta. There was an article from a decade ago and I found it ironic to see the same issues related to identity are still being debated, "One of the biggest issues facing EMS is that we're not sure what we really are." (Bledsoe, 2007, para. 1) We still do not, which is why I

have such an interest in the identities of EMS providers. The consensus has been that EMS has a blend of responsibilities from healthcare, public safety and public health which has put the providers of EMS in an ongoing tug-of-war among the three. When it comes to how EMS providers view the relationships they have with patients, moral and ethical principles are applied more consistently with that of physicians and other healthcare professionals. "The process of professionalization can thus be seen, in part, as a process of increasingly protective measures to define the boundaries between the sacred company of those within the walled garden and those outside." (Jackson, 1970, p. 10) If one considers the sanctity of the three learned professions, then the expectation of those who enter that realm must be the same. EMS professionals are bound to the same confidentiality as that of a physician, lawyer or clergy. By formally labeling EMS as a profession, that expectation is strengthened and respected in the eyes of the patient and the community. There are four areas that I would like to examine further in the future: encouraging more research in EMS, developing professional individual and occupational identities, promotion of degrees for paramedics and the importance of subspecializing for EMS as part of the healthcare system.

Deficiencies in EMS Research

Hsieh (2017) stated that the fact that EMS is not self-regulated is one of the reasons why it is not considered a profession. He further notes that we rely on others, citing government agencies as an example, to establish the EMS practice guidelines and that this is likely one of the greatest reasons EMS is unable to professionalize. The sharing of the revised National EMS Scope of Practice (2019) for public comment created an opportunity for EMS professionals and others who were interested to share thoughts on the skills included, as well as removed, from what had been previously assigned in the 2005 version. This was an important opportunity due to the fact that public comment and open meetings have not traditionally been the standard for EMS related changes at the national level. The National Scope of Practice document does not include skills authorized within each state, although some states seek more or less involvement from

occupational representatives depending on the regulatory structure within the state. Within the industry, the National EMS Scope of Practice *should* have created more consistency, with a national perspective, facilitating reciprocity among states and to drive standardized education for each of the identified levels of EMS provider. The amount of representation that occurred is not known outside of formal reviewers, contributors from the advisory groups and task force . This lack of reporting on critical activities, such as sharing comments on a national document, reflects the shortcomings of quantitatively measuring data points capable of being measured. With such limited data already available for processes and activities within EMS, this reinforces the lack of initiative in conducting EMS research within and outside of the clinical realm. Without strong EMS representation and advanced education, EMS providers likely don't realize what opportunities are being missed by not asking for this information.

For there to be a transition for EMS providers from skill-based technicians who are trained in occupational classrooms to educated professionals, there must be a better understanding of how and/or why there is an issue or problem such that a change is needed. The divide between healthcare professional and transportation benefit must be bridged if EMS is to survive in the new healthcare landscape. While the contribution to public safety is not negligible, there is no reimbursement tied to those activities. The future reimbursement of EMS is tied to the ability to contribute to the health and wellbeing of people like all other forms of healthcare. Evidence-based care is the standard of care and EMS is severely lacking in research to determine if the care currently being provided is appropriate based on evidence.

> Progress in prehospital emergency patient care is needed. There is not enough high-quality EMS-related research to drive improvements in patient outcome, and vast amounts of money are being spent for patient care with little rigorous evaluation of the effectiveness of that care. (National EMS Research Agenda, 2001, p. 7)

This was 17 years ago and yet there still a significant deficit in emergency medicine research.

EMS providers receive minimal information during the initial training process related to the importance of conducting research, how to read and understand research, including what is required to conduct research. With uninformed EMS providers entering the field, it then falls to the administrators of EMS agencies or medical directors to teach this information if there is a desire for the agency to engage in research-related activities. Within the current *National EMS Education Standards* (2009), there is a research content area, included as a means to address the importance of medical research in supporting outcome-based care. At the paramedic level, graduates of EMS programs are expected to understand the impact of research on prehospital care, the importance of data collection, the role of evidence-based decision making and how to use research principles to interpret the literature in order to advocate for evidence-based practice of medicine. The concept of implementing evidence-based practice is relevant as elements of professionalism are discussed. This is a very short chapter in most paramedic textbooks with limited focus on mastery of the cognitive content. Initial education is the most reasonable site to inject additional information on the importance of research for a profession. "EMS education systems must be compatible with an academically based approach to EMS education that parallels the education process of other allied health professions." (National Highway Traffic Safety Administration & Maternal Child Health Bureau, 2001, p. 30) Evidence-based medicine is critical for supporting standard of care in how patients with similar conditions are treated such as what antibiotic to use for certain types of bacteria. If EMS understood the concepts behind using evidence to support patient care better, it would be useful in justifying activities that promote professional engagement with patients consistent with the community paramedicine movement.

This research cannot come a more critical time in the budding evolution of EMS as a healthcare profession. Mingled within the national debate over whether a degree, even at the Associate's level, is essential for entry level paramedics, there is also a power struggle occurring between fire-based EMS leadership and non-fire-based EMS leadership. The winner of which

will likely be the driving force behind future changes to the EMS profession. O'Connor (1999) supported the 'vision' of EMS as described in the *EMS Agenda for the Future*, stating "EMS does not exist to perform isolated interventions, but rather is one component of an integrated health care system." (p. 46) The whole concept of where EMS is or should be in terms of assuming a primary role in healthcare is somewhat of a dichotomy where the two primary barriers to research, lack of well-trained researchers and a reliable source of funding that would support the research are missing. Funding sources want to give money to researchers with a strong track record of research that meets identifiable needs but since there are not many of these in EMS, funds are not really being directed to support it.

Identities of EMS Today – Individual and Occupational

Individual Identities

Despite the rhetoric of what roles EMS should play and how EMS should look 'in the future',' the reality is that it is influenced no less than every other occupation or profession today. The typical response for almost any need is that there is an 'app for that.' How appropriate then that we find ourselves struggling with brokenness across multiple domains and in multiple sites throughout society. "All of our institutions – whether workplaces, schools, courts of law, or hospitals – have been shaped by the technical fix mentality, which assumes that system problems, be they mechanical or human, can be solved by technical solutions designed by outside experts." (Kincheloe, 1999, pp. 33-34)

We have come a long way from the identities and infrastructure shared with America every week on *Emergency!* Although as an EMS provider, not a firefighter, I laughed at the fact that Johnny and Roy had to have their helmets on as they rode in the rescue truck to their patients. At least they had dress code standards in place, representative of what their definition of professional should look like. Today, it's almost an 'anything goes' representation. Employers have set standards for dress code that limits visible body art, yet find they have to relax those standards to fill vacant positions due to staffing shortages felt nationwide. The applicants of

today have bad driving records and do not understand why that might be a problem for an EMS agency. Of course, nurses on *Emergency!* still wore nursing caps and they definitely don't do that anymore. Change is inevitable but finding a way to express identity in an occupation that must be represented by individuals who instill trust and faith from their patients, their peers and the community cannot be dismissed.

Bledsoe (2010), a nationally recognized emergency medicine physician, EMS medical director, professor and former paramedic, submitted an article titled, "We Have Met the Enemy & He is Us!" In this article, he called out EMS providers on their selfish lack of professional interest, failure to join professional organizations at the state or national level, and essentially a refusal to fight to take ownership of their own profession. "So can the apathy! Quit being EMS keyboard warriors! Join the organizations of the profession that pertain to your work. The future of EMS is dependent upon such actions." (Bledsoe, 2007b, para. 9) This is a rare plea from a physician, a representative of the group essentially considered to be an opponent of the professionalization of EMS, to ignite some incentive in members of the occupation where he started his own career journey. This was more than a decade ago, ten plus years, and yet nothing today has really changed. EMS providers take to the keyboard rapidly to express displeasure using social media outlets such as Facebook and Instagram. Private groups share memes and EMS-related images while claiming that this is merely a form of decompression through the use of "gallows humor" as though making fun of frequent patients or our healthcare peers will alleviate the mental stress EMS providers are exposed to day in and day out. There are some EMS providers who feel this exceeds the acceptable level of decompression and simply reflects the self-created, self-perpetuated persona of a group of marginalized healthcare and/or public safety providers. (Abubey & Basye, 2019, Lawrence, 2019) These issues continue to speak to the lack of a professional identity that will only hold us back even if we attempt to move forward with professionalization.

Occupational Identity

At what point can we, should we or why won't we look within for solutions? EMS is just one allied health occupation among many that have spawned over the years from the increasing demands to specialize for everything. The concept of a general practitioner is almost obsolete. Emergency medicine had already assumed a specialized role within the field of medicine. In the past decade, we now have specialized physicians who are EMS board certified. The need for more engagement and treatment in the pre-hospital environment has supported the sub-specialization of emergency physicians to EMS physicians. These are the physicians who fill the roles of medical director for progressive EMS ground and air agencies. The closer degree of medical oversight provides an opportunity for EMS agencies to explore research opportunities, pilot new equipment and enhance the continuing education for its personnel. Not all EMS agencies have access to or can afford this level of medical oversight, but the criticality of their patients does not decrease simply because the access to that level of physician is missing. It is in this gap where technology may be able to assist through use of telemedicine; bringing the physician to the patient in the field with audiovisual capability and some diagnostic tools that share information over the web to the physician's workstation.

While not resting on a hard line of division, EMS and Fire are two distinct and different professions. It was exciting to see Johnny and Gage respond from the fire station on *Emergency!* then roll into the emergency department where they became a part of the healthcare team. Just as we have seen the need for specialties within the field of medicine, there should be specialties within public safety. The body of knowledge, while overlapping in some areas, is still distinct to each profession and necessary for individuals to be fully educated in to allow them to meet the demands of the public. There is a need for some level of interprofessional education in the public safety realm but there should be distinction on where emphasis should be for the specialized components.

Based on rising healthcare costs, increasing numbers of under- and un-insured patients, the effects of pandemic level infectious diseases, and limited access to care in many areas of the country, assuming a 'wait and see' position is no longer an option for healthcare providers. Insurance companies and patients are demanding cost-effective, timely, and quality care. Payers are looking for quantifiable justification of their reimbursement dollars. Hanging a diploma on the wall or carrying a license in your pocket may not be sufficient justification to receive payment for services rendered. Research and data are necessary to provide that justification. Data collection and outcomes tracking are just two ways that EMS providers can seek justification. Unfortunately for EMS, previously only considered a transportation benefit, what is enough to justify services provided for the payers is not clearly known. Other allied health professions have the benefit of being educated in research principles, statistics, and reporting strategies to better prepare them for justifying their benefit to patient outcomes.

EMS and the Economics of Healthcare

"I would like to make it clear that I know full well how difficult it is to put in practice a policy of development that would put men and women before profit." (Freire, 1998, p. 117) There is significant interest in the capitalization of healthcare as it relates to access to care, cost of care and quality of care. It is a legitimate question to ask who benefits from the inequalities in healthcare and not incorrect to respond with the dominant groups. However, there are acres of landscape that are shades of gray. I recognize the challenge in accepting what is perceived as a cut and dry conservative position in a society that needs the most liberal of approaches. I would argue that there is so much more to this issue than pure profit or limitless free care. Apple, in examining market influence on education, offers perspective that can easily be applied to market influence on healthcare. When you consider healthcare as an institution, the appeal for a conservative approach is as Apple (2000) notes, "One of the reasons some people listen carefully to rightist criticisms is because there *are* problems in these institutions." (p. 9) There are significant problems in healthcare right now and there has been for quite a while. I have been in

the field of healthcare for 30 years. I have worked in rural, suburban, urban and teaching hospital environments. I have treated the indigent with as much intensity and resources as I have the rich. When patients have presented to me for care, the presence or absence of insurance, an ability to pay, color, educational level, ethnicity, religion, gender identity, or sexual preference has played no part in the degree of effort and compassion that I poured into those encounters. If every aspect of life was free or financial obligations were not a part of the process of providing care, I would envision that all healthcare providers would make similar approach to their patient encounters. However, just as education is not neutral, healthcare is not neutral. While it is unlikely there would be a bipartisan solution that addresses every aspect of the healthcare industry's influence on our lives, I think that where change can occur, that effort should be made.

EMS providers, perhaps because of our existing place in healthcare, has the potential to address many of the known health disparities in a cost-effective way. As society considers health justice and the ethicality of healthcare distribution, the approach of the healthcare provider must exhibit a respect for the cultural and personal needs of the individual. One of the reasons EMS has been identified as a potential change agent for healthcare is the low 'cost' of the individual providers. According to the Occupational Outlook Handbook (2020), the 2019 median annual salary for an EMS provider was $35,400 with a diploma or certificate of completion being the entry level educational requirement. A phlebotomist, requiring only a high school diploma, had a median annual salary of $35,510. A fire fighter, with no degree requirements, had a median annual salary of $50, 850. Examining other healthcare providers where a degree is required for entry level, the ultrasound and cardiovascular technicians who hold an associate's degree had a median annual salary of $68,750, the registered nurse holding a bachelor's degree in nursing had a median annual salary of $73,300, and a physician's assistant requiring a master's degree had a median annual salary of $112,260. Of all of these professions, EMS is the only one where providers can assess, perform diagnostic tests and administer medications that could save or end a person's life independently in an unsupervised environment without direct physician oversight

and validation of treatment plans. Yet it is the lowest median annual salary and one of the lowest educational requirements of all listed.

Restructuring of reimbursement for care from a fee-for-service model, which is based on a pricing scheme similar to that of a taxi ride (base rate plus mileage) to a model that addresses value based reimbursement with benchmarked outcome expectations would be a great start, particularly if it is consistent with the other healthcare facility and professional billing strategies. It would also seem reasonable to take patient engagement into consideration so that everyone involved has a stake in the outcome. The National Health Service (NHS) of the United Kingdom offers free care for its citizens, however according to Coulter (2011), "healthcare in the UK appears less patient-centred than those in several other rich countries. An engagement strategy should take account of the varying requirements of patients and citizens…" (p. 10) The United States may not be ready for full implementation of universal healthcare or a single payer system for many reasons, however you cannot solve a problem by continuing to do things the way you have always done them so that alone supports the need for changing how healthcare is delivered.

There are many options that have little to no research to support them, but which have limited risk to the patients to start. The hospital in the home model has the potential to impact healthcare costs, quality of care provided and patient satisfaction with care. EMS providers are uniquely trained to identify life threats making them more attuned to situations that should trigger sending the patient to a hospital for more advanced care. EMS is also already in the home, available to see and treat patients 24/7/365 which is significant when you look at the cost of readiness for any healthcare provider. The ability to provide health care at the right place and in the right time is an area that EMS can contribute to at a lower cost than most other healthcare providers. While the current reimbursement structure is inadequate to continue providing EMS the way we have always done it, a more accountable reimbursement strategy could help with controlling the cost of providing healthcare well above what would be needed to absorb any

increases while still providing the quality care patients deserve at an overall lower cost to the system.

Building a Foundation in Education

While it is unclear if there is a sequential process to the professionalization of EMS, assuming that this is where the occupation is going, a proper and strong foundation is an essential component. Regardless of the location, the need for EMS personnel has now slowed. Nationally EMS agencies struggle to staff their ambulances, whether they are 911 responders or to address the medical transportation needs of patients. The National EMS Education Standards (2009) "define the competencies, clinical behaviors, and judgments that must be met by entry-level EMS personnel to meet practice guidelines defined in the *National EMS Scope of Practice Model*." (p. 7) The most current version has been released for public comment as of November 2020. This revision has been led by the National Association of EMS Educators (NAEMSE), a national association that works to shape the future of EMS medical education through collaboration with its membership and other EMS education stakeholders. The education standards are presented as the minimal terminal competencies for entry-level EMS clinicians at each level. They are not a curriculum, but are considered non-prescriptive so as to increase teacher autonomy, as well as to be responsive to student learning needs and the may be needed locally in the communities where the EMS educational program is located. A summary of changes in the 2020 document were limited to standard clinical content updates and the addition of tools to assist curriculum writers. With regard for the need to be responsive to diversity, equity, inclusion and cultural humility, the updated changes only note that references are found in the document and to expect further adjustments. As to the need for improved or increased clinical decision making, at the paramedic level, a standard addressing the evaluation of decision-making strategy for cognitive errors is all that is noted. The document should be taken in context, however and that is how the education of EMS personnel supports the core mission of the provider related to their current position in their

communities. It does not reflect any curricular changes that would address future paramedic role demands.

Subspeciality Opportunities for EMS

Community paramedicine, described in chapter four, is sometimes referred to as mobile integrated healthcare. It is a new service line for EMS and its concept is not consistent nationally. Although it has seen a slow infiltration into some states, there are others that have state statutes preventing EMS providers from engaging in this type of patient care. There are two main camps regarding educational preparation for this type of EMS service. One group has established an extensive college-based program with the requirement for successful completion of a national examination for practice, while the other has suggested an internal training program, customized to meet the specific needs of the community where it is implemented should be sufficient. "Being academically schooled has become confused with the concept of being well-educated." (Kincheloe, 1999, p. 11) This quote is appropriate as it speaks directly to the tug-of-war that is dividing the groups helping to lead the community paramedicine movement. What it means is that having a program that is long and filled with hours of information does not make the recipients well educated on completion. The ability to be well-educated is not limited to formal sites of education. While one agency or organization wants an established set of performance-based benchmarks, the other wants to see educational programs standardized, accredited and a single source advocated. Are we not then at risk for losing sight of the whole point here? Are we not at risk for jeopardizing the leadership movement cultivated from within this profession as opposed to being led by the 'experts' of old? It is really as simple as the spirit of Lincoln's (1858) statement that "A house divided against itself cannot stand." If we do not start acting like a single profession, we will continue to be dominated by others. It is okay to have different approaches to achieve the same ends.

It seems reasonable to ask whether professionalization matters at this point? The elements identified in Chapter Four do not go away or become less important to our work. The

question now is does being labeled as a profession, being called a professional or successfully professionalizing mean anything in the grand scheme of things? Are we not seeing other professionals being deprofessionalized under the current healthcare landscape and are we not deskilled by the bureaucrats who still possess the ability to regulate our professional activities? It seems as though the real achievement is to be *perceived* as professionals and we hold that control in our hands right now. Ludwig (2009) notes, "It's undeniable that Hollywood makes movies in order to sell tickets, and unfortunately, EMS has been suffering from these money-making ventures." (Call to Action, para. 1) We are not bound to live out these personas in real life. Unless we start the change from within, we will continue to be subservient to physicians and disregarded as legitimate healthcare professionals by our peers.

Curricular Propositions

Based on potential opportunities for paramedics, I would like to see the curriculum revised to reflect not only preparation for these expanded roles, but to support a more holistic model that addresses the multi-disciplinary needs of the individual. Without a doubt, educators should employ a critical pedagogy that allows them to view sites of cultural production in schools, to question the curriculum and to acknowledge that education is not neutral. (Kincheloe, 1999) To consider the vocational aspects of the paramedic education is not to say that it is the evil in and of itself. It's the limitations that a vocational training course of study brings. Kincheloe (1999) describes the democratic vocational education as valuing intelligence, identify worthwhile values, and understand the conditions of work. The paramedic of the future should have a strong base of shared knowledge with other allied health professions as part of an interprofessional education. There should be general education courses that help cultivate an intellectual foundation that graduates will employ throughout their lives as functioning adults and members of society. The paramedic student should be able to think critically and question the influence of curriculum, intended and hidden, on their place within the healthcare community as well as society as a whole. (Olson, Klupp, & Astell-Burt, 2016)

Consistent with other health professionals, paramedics should have coursework in the area of the biosciences as this is the core for the understanding of health and pathology in the human body. Professionalism, including ethical and culturally sensitive competencies are essential for developing as a socially responsible and contributing member of the healthcare team. Communication skills are important for interactions with patients as well as participating in an interprofessional healthcare team environment. Research fundamentals and the importance of evidence-based care will support the paramedic professional's ability to investigate, understand and implement changes that improve patient outcomes.

The inclusion of system-based education for the assessment and management of acute and chronic illnesses and injuries may be taken as part of the interprofessional education so that the paramedic understands the role of each healthcare provider in the care of the patient. With increased focus on the health of the population and numbers of aging patients, paramedics should take coursework that examines individual and social determinants of health, public health concepts, mental health, as well as death and dying. Extended care that addresses the older patients who are aging in their homes and within their communities can help support a community-based strategy to support the quality of life of these patients.

As part of the entire process of treating patients, it is important to understand the costs of healthcare. There should be coursework that addresses the administration and management aspects of care delivery. Insurance, payers and liability associated with the provision of care is important to navigate the financial aspects of healthcare. While there are concerns that healthcare has evolved into a business, these do not change the reality that it has and like any other business, there are costs that must be addressed through reimbursement methodology and being paid for the services provided. Digital literacy is another component of delivery, documentation, and reimbursement of care that students should develop. Courses that address health technologies will provide a foundation that supports learning and change as these are implemented in the healthcare systems.

There is also much to be gained from immersion within the clinical site of learning. Similar to the educational structure proposed by Flexner, paramedics also need to have time in the field to learn. These clinical sites allow students to transition more smoothly from learning to work and provide an opportunity to evaluate how they manage the transfer of learning from the classroom to the real world. It is important to screen and monitor field-based educators as paramedic students begin to form their professional identities. As students learn and obtain the experiences necessary to construct meaning, there is the risk that their identity does not develop in a positive and healthy way. Nagarajan & McAllister (2015) note, "some work-integrated learning experiences can also inhibit the development of positive occupational identity." (p. 285) As discussed in my work, there are individuals in EMS who have negative or unprofessional identities that should not be perpetuated via transmission to students during learning experiences. There are also those who stand out with a professional persona, a servant's heart and a love of teaching; those who will become the educators.

From Provider to Educator

I currently hold a state license to teach initial and continuing education for all levels of EMS providers. I was one of the few to have a graduate degree and oversee an initial education program in the technical college system. I began my doctoral pursuits while holding that position. Readings from Freire, Apple, Giroux, and Kincheloe resonated heavily for me. I felt the conviction to be a critical educator and instill the desire to question everything in my students. As an EMS educator, I felt qualified to teach the content to my students. Having the license to teach, according to Freire (1998), "does not give persons a license to teach what they do not know." (p. 17) I do not interpret this to merely mean the body of EMS knowledge, but also the life experiences that allowed me to connect with my students and to appreciate the knowledge as experience that each brought to the classroom.

One of the areas most pertinent to the education of the healthcare professional, and most specifically the EMS provider entering the homes of people who are often without hope and at

their most vulnerable, is the cultural sensitivity and tolerance required to deliver care to those who may be unlike us. According to Freire (1998), "We start from the belief that our way of being is not only good but better than that of others who are different from us. This is intolerance." (p. 71) As EMS educators, it is incumbent to foster tolerance, compassion and empathy among our students. Approaching a patient who is scared, in pain or embarrassed requires more than an intentional ignoring of those feelings but rather recognition and validation. EMS providers must be advocates for the fair and equitable treatment of their patients without qualification. This is perhaps one of the most important competencies to assess and the hardest to teach.

Concluding personal thoughts

As a member of the EMS profession and witness to the attitudes and assumptions made about the individuals of the profession, it is important to incorporate these when relevant to the research findings. It has been my perception throughout my career that while in an EMS uniform and standing in a crowded emergency department next to my patient, that I was not considered to be a member of a professional group. I recognized that the other medical professionals such as nurses and therapists viewed medics as inferior in the academic hierarchy of care providers. I am different than most other members of the EMS profession because I have a different frame of reference. No one would have known the significant difference in this perception as compared to days when I stood in scrubs and lab coat in the middle of a group of other professionals at the bedside of the patient in an intensive care unit, managing a patient's respiratory system in the capacity of a respiratory therapist and as part of the larger patient care team. Most could not have known (nor would they ever ask) that my level of education and years of experience often exceeded many of their own. Having personally experienced and continuing to experience this 'talking down to' attitude, I feel my own experiences lend validity to my research.

Professionally, I may offend my own peers who find no limitations or barriers exist to prevent advancement of the profession and from the dominant groups who do not view

themselves as creating or sustaining limitations. It is necessary to provoke discourse even if it is initiated under a defensive posture if there is to be critical inquiry. Educators must begin take responsibility for what occurs within their own classrooms. If the research problem encourages debate, then it implies self-reflection about one's own thoughts and beliefs may be occurring. Freire (1998a), notes, "Teachers who do not take their own education seriously, who do not study, who make little effort to keep abreast of events have no moral authority to coordinate the activities of the classroom." (p. 85) When considering whether education is the appropriate site to initiate this discussion, particularly among those who teach, there is no other site I can identify that has more impact on the outcomes associated with the learners and future professionals of an industry. This is why I feel curriculum studies is the most appropriate location to begin having these discussions.

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APPENDIX A

EMS Agenda for the Future (1996)

This document acknowledges the development and growth of EMS in the 30 years since the release of the paper, "Accidental Death and Disability: The Neglected Disease of Modern Society," which prompted the formalizing of the early EMS systems. The health system was evolving at that time and there were changes that could have impacted the role of EMS within that system. The document was meant to provide a vision for EMS, as an out-of-facility provider of health care. If EMS were to develop the 14 attributes presented in this document and commit to investing the resources necessary to achieve the goal of improving the health of their communities, the results would be "an achievement with great benefits for all of society." (Agenda, 1996, p. v)

Available at https://www.ems.gov/pdf/advancing-ems-systems/Provider-Resources/EMS_Agenda_For_The_Future_2010.pdf

APPENDIX B

EMS Agenda 2050: A People-Centered Vision for the Future of Emergency Medical Services

This document was written by a technical expert panel appointed by the National Highway Traffic Safety Administration as an effort to create a plan for the next three decades of EMS. It is a follow-up document to the 1996 EMS Agenda for the Future, which was also to serve as a guide for the achievement of short- and long-term goals for EMS. In this document, the vision is identified as 'A People-Centered EMS System' that is capable of providing care that is comprehensive, quality, and convenient; evidence-based clinically; efficient and well-rounded; and preventive using a comprehensive, easily accessible patient record system. The EMS systems of 2050 should be designed around the six guiding principles: adaptive and innovative; inherently safe and effective; integrated and seamless; reliable and prepared; socially equitable; and sustainable and efficient. This document emphasizes that it reflects a new vision for the future of EMS over the next 30 years and does not acknowledge the status of the goals set in the 1996 document as a landmarks for where the vision and guidelines within this document start from.

Available at https://www.ems.gov/pdf/EMS-Agenda-2050.pdf