A PARAMEDIC'S STORY:

AN AUTOETHNOGRAPHY OF CHAOS AND QUEST

A Dissertation

by

JOHN A. DE LA GARZA

Submitted to the Office of Graduate Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

August 2011

Major Subject: Educational Human Resource Development

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Approved by:

Chair of Committee,	M. Carolyn Clark
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	Victor Arizpe
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ABSTRACT

A Paramedic's Story:

An Autoethnography of Chaos and Quest. (August 2011)

John A. De La Garza, B.S., Our Lady of the Lake University;

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Chair of Advisory Committee: Dr. M. Carolyn Clark

This research study represents a personalized account of my experiences as a San Antonio Fire Department (SAFD) paramedic. In this study I bring the reader closer to the subculture of the Emergency Medical Services (EMS) through the research methodology of autoethnography. This qualitative method allows me to be researcher, subject, and narrator of the study. Autoethnography requires considerable attention to reflection, introspection, and self-analysis through the use of the narrative. Written in first person voice, I am positioned in the narrative in a manner that allows me to communicate directly with the audience.

Through an insider's perspective, I have traced the time I spent in EMS by reflecting, interpreting, and analyzing a collection of epochal events that significantly impacted my life both personally and professionally. There are five themes that I have identified as salient to the meaning-making process of the study: (a) death and dying, (b) faith and spirituality, (c) job burnout, (d) dealing and coping with job-related stress, and (e) alcohol abuse. The events that I have selected for this study may be read and

interpreted as a prelude to what is a much broader narrative of my tenure in EMS and of other emergency responders' experiences as well. The study explores how my life was impacted beyond the immediate experience and how the story continues to evolve to the present day.

The study establishes a foundation for designing training programs to be used by public safety educators. Three theoretical elements of adult learning that help inform professional education strategies for emergency responders have been identified: (a) experiential, (b) narrative, and (c) transformative learning. The study also sensitizes the general public to the physical, social, and psychological demands that are placed on paramedics. It is important for the reader to know that these public servants are ordinary human beings doing extraordinary work in one of the most stressful and hazardous professions in the world.

DEDICATION

To my wife Dyna, whose unwavering support, encouragement, and most of all prayers made this journey a reality. In my eyes your personal achievements as a K-12 educator will always exceed any and all successes that I have experienced in my academic endeavors. You are a great teacher who appreciates the value of education at every level. I am forever grateful to almighty God for having you by my side.

To my daughter Sofia, whose patience and understanding—especially when Dad had to be in class—went above and beyond anything you should have had to endure while growing up. Thank you for your prayers and your support throughout the years.

To my parents, Manuel Jose and Maria Luisa, you had the faith and courage to move out of your "comfort zones" in 1950 and begin a new life in the great city of San Antonio, Texas. You worked hard and sacrificed much during very difficult times so that one day I would have the opportunity to achieve my dreams. Although it has been many years since your departure to heaven, my faith in God leads me to believe that you know about this special time in my life. Thank you for making it a reality.

To my EMS partner, Lee J. Carrola, Jr., you are the best paramedic I could have possibly paired up with in 1979. Life in EMS was much easier with you around. I could not have survived intact without you by my side. You were both a source of strength and comic relief—a combination of human qualities that only another "space cadet" can appreciate. Thank you for the best of times and for being there during the difficult times. You will forever be my brother.

ACKNOWLEDGEMENTS

To my committee chair, Dr. M. Carolyn Clark, whose personal mentorship and superior intellect in the field of adult education provided me with the guidance and inspiration I needed to reach the summit. Your positive and constructive critiques of my work have been meaningful and powerful. I believe that God places extraordinary people in each of our lives for a divine purpose. I will always remember you as one of those special individuals who took part in my life's journey.

To the other members of my dissertation committee, Dr. Dominique Chlup, Dr. Fred Bonner, and Dr. Victor Arizpe, your collective interest in my autoethnographic study served to validate the research path I chose. I will always appreciate the feedback and suggestions you offered me throughout this journey. You will be remembered for having played a very important part in my life in academia. Most of all, I want to thank you for being my friends.

Finally, I would like to thank all of the firefighters and paramedics I had the privilege of serving with over a span of 33 years. I would especially like to acknowledge the men and woman who worked at Station 6 during my time in EMS. I would also like to express my appreciation to the training officers who I worked with at the San Antonio Fire Academy. Each one of you made my career and my life much more meaningful for having shared in the experience.

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INTRODUCTION: PROLOGUE

I was more than certain that my belief in God was intact. Nevertheless, I found myself struggling to reconcile a brutal and destructive side of society with the Gospel of my Christian faith and with everything else I had learned during my eight years of Catholic religious education. I had the personal satisfaction of having treated many decent, law-abiding citizens who genuinely needed help; however, it was the bad people who really stood out. The bad were really bad. Their evil intentions were often manifested through deliberate and unconscionable acts of violence inflicted on others. I especially took such acts committed against innocent children very personal. By now I had also been a witness to a significant number of tragic, violent, and sometimes unexplained events that placed no fault on anyone. I carried within me the many unpleasant experiences of watching people die suddenly and unexpectedly.

Christmas 1981

I had been an altar server at the 300-year-old Cathedral only 10 years prior to becoming a firefighter. Needless to say that visiting the holy site made for a nostalgic moment. I was very acquainted with the physical layout of the historic church that still holds the remains of brave men who died at the battle of the Alamo. The side entrance that led to the church's sacristy was still open. This meant that the chances of encountering a priest were in my favor. San Fernando Cathedral was one of my favorite places, and it was on the way to Station 6. This would be my first Christmas away from

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This dissertation follows the style of the *Adult Education Quarterly.*

home. Having to be at work meant being away from family and close friends, and it also meant missing out on midnight Mass—a long standing family tradition. It had naturally occurred to me to stop at the Cathedral and ask one of the priests for Holy Communion and a blessing. I was intent on starting my shift with the spirit of Christmas alive and well within me.

"Hello father, my name is John and I am here to…
What can I do for you?
I am on my way to work and I won't get off duty until late tomorrow evening.
Do you want confession?
Communion, if it's not too much trouble for you.
Wait in the hallway…"

I was somewhat taken aback by his gruff tone of voice and business-like attitude. He left the door to the sacristy partially open. All I could see was his back as he tinkered with something inside a drawer. I got the uneasy feeling that I may have interrupted something important. It was, after all, Christmas Eve. He brought me Holy Communion after a short time. As soon as I received the sacred wafer, he turned around, went back into the sacristy, and closed the door behind him without saying a word to me. I never even got a chance to thank him. I never received my blessing.

Going to midnight Mass on Christmas Eve was more than just a family tradition. It was a time to reconnect with my faith and to reflect on what was truly important in life. It was one of those rare moments that resurrected the spiritual side of me. However, it was now 1981 and I was trying desperately to maintain a spiritual connectedness that had been eroding since 1979, the year I became a paramedic. I was trying to hang on to a strong belief that had been embedded in me as a child: that God is

real, that He is all loving and all forgiving, and that He is in control of everything in this world. This gave me the perspective I needed to do my job. "Believing" kept me level-headed, especially after losing a patient or witnessing a tragic, inexplicable event. Nevertheless, I was now beginning to have doubts about my faith. My spiritual light was growing dimmer by the day.

The Spirit Within

During the course of a shift, I would often reflect and pose the question, *"Why God? How can you allow this to happen?"* Although I was wise enough not to blame society's ills on the Almighty, maintaining the belief that *we are all made in His image* became a constant struggle for me. How could I find Christ in the heart of a murderer, a rapist, an abusive parent, or spouse? I felt myself becoming more cynical and less spiritual as my career progressed. The spirit within me was being compromised by a dark side that I never knew existed in society, much less in my own community.

I had hoped for a more meaningful and certainly a deeper spiritual experience than what I encountered with the indifferent priest. I had set my expectations much too high. I tried to put it all behind me as I drove to the firehouse, but his business-like attitude and his cold demeanor only left me with a feeling of more emptiness. Perhaps it was a prelude to what was to come over the 24 hours that followed. *The spirit within* had just taken a hit. Then, the madness began.

Shots Fired! Shots Fired!

It was Christmas Eve 1981. I did not want to be at work, and to make things worse, Lee Carrola, my regular partner was somehow able to get the shift off and go on

vacation. This meant that I was paired up with none other than Rudy B., a boisterous, self-proclaimed know-it-all who liked his liquor and constantly bragged about his women friends. As usual, Rudy was running late. In the meantime, I was working with a somewhat impatient Tom Laurel who was finishing up his shift. Tom had to wait until Rudy arrived before he could leave to go celebrate Christmas with his family.

"8-0-6, 8-0-6, respond to Iowa and Hackberry for a cutting.
That's The Rendezvous Club right on the corner there.
I know which one…they're starting early.
Ten-four, 8-0-6 is responding."

I had been on duty for only 20 minutes and already the first call was from what we often referred to as our local "knife-and-gun" club. Upon arrival, we found a 60-year-old man bleeding from his left ear. He was leaning up against a wall outside of the club. He was known as Old Man Bud to the other patrons. Today, old Bud was pretty wasted. The music from a jukebox inside the club was playing one of my favorite Aretha Franklin tunes that later proved to be poetic in light of what transpired.

R-e-s-p-e-c t…find out what it means to me…r-e-s-p-e-c-t…

"Looks like a pretty deep cut...
Let's get him inside the ambulance and take a better look.
Who did this to you?
My, my, my…wife did it."

I was cleaning his ear and prepping the cut for bandaging when I suddenly heard the sound of screeching tires followed by a woman screaming at the top of her lungs.

"Where is the cheating bastard?!?!?!
Where in the hell is he?!?!?!"

Then I heard popping—lots of popping. Something told me that this was not the sound of kids playing with firecrackers.

Pop…pop, pop…pop, pop, pop…pop.

Tom opened the side door to the ambulance and hurriedly slammed it shut.

"Shit!
What the hell is it Tom?!?!?!
She's firing…at this guy!
She's reloading!
Get down!!!"

Tom immediately dove for the stretcher and my entire body hit the floor horizontally all at once. We both lay there next to each other on the back of the ambulance. We left Bud sitting up on one of our bench seats, drunk out of his mind. We made sure we stayed clear of the angry woman's primary target.

On the way down to the germ-filled surface, I grabbed the radio's microphone and screamed into it, *"8-0-6! 8-0-6 to dispatch! Give us a 10-80!"* Ten-eighty was the code for paramedics in trouble. *"Shots fired! Shots fired!"* The intermittent popping from the jealous woman's pistol continued for another 30 seconds—an eternity. I later learned that Charlie Wood, the dispatcher at the other end of the radio transmission, had jumped out of his seat in the communications office at the sound of shots being fired and my screams for help.

"Where are you at, John Boy?!?!?
I'm on the freaking floor, Charlie!!!
Iowa and Hackberry, where do you think?!?!?
Pop, pop…pop, pop, pop.
You have the address right in front of you! You sent us here, for crying out loud!!!
Get PD over here now!!!
Ten-four, 8-0-6…they're on the way!!!
Keep your head down!
Thanks for the advice, Charlie…JUST GET THE FREAKING COPS OVER HERE!!!"

Although the gunfire had stopped, Tom and I did not dare raise our heads. I had visions of the gun-wielding woman opening one of our ambulance doors and carrying out the final phase of her execution. We thought she was right outside our ambulance waiting for us to open a door, giving her a reason to start blasting away. The police responded in full force. By that time, the gun-toting jealous wife was long gone. We were fortunate that she had not been a very good shooter. The other bar patrons had also been lucky. It was especially good for her husband, Old Man Bud, who by now was sobering up as we finished patching him up. *"I hope that this is as exciting as it gets for you guys,"* quipped Tom, in a tone filled with sarcasm.

"I'll be home for Christmas and I'll be thinking about you, John Boy!
Yeah, yeah, yeah…I am sure you will.
I'll be thinking about how we almost got to spend it in eternity with Old Man Bud…"
"8-0-6 is back in service."

Catching the Bus and Memories of Dad

Tom could not get out of the ambulance fast enough once we arrived back at the station. Rudy B., who had been waiting in front of the firehouse, quickly jumped into the cab. Charlie Wood was already dispatching us to another call. Tom was grinning from ear-to-ear as he exited the ambulance. I, in turn, felt a twinge of despondency as I realized that I was stuck with Rudy B. instead of Lee for Christmas.

"8-0-6, 8-0-6, respond to Iowa and Durango for a possible M-V-Ped.
It appears that a transit bus is involved.
You guys have a victim who apparently got run over by a bus.
SAPD is requesting."

Rudy was already in rare form. He hardly let me get a word in once he hopped into the ambulance. I instinctively tried to pick up any hint of alcohol coming from Rudy's

breath. Rudy had a bad reputation that preceded him everywhere he went. He'd been known to show up to work a little tipsy every now and then. This time he smelled clean. I was hoping it would stay like that for the remainder of the shift. As was customary on every call, I reached over to turn on the emergency lights and the siren; Rudy quickly grabbed the microphone to acknowledge we had received the transmission.

"Ten-four, 8-0-6 is responding.
Ooooh…run over by a bus. I hate when that happens…sounds nasty—messy, very messy.
How the hell are you, John Boy?
I'm just wonderful, Rudy…how the hell are you?
I'm just elated that I get to work Christmas and share it with you, sweetheart…
Look, don't even get me started with your bull crap.
Let's just hope for a quiet shift. I've already been to the OK Corral once today…
Yeah, I heard the excitement over the radio. You were so brave…just get the freaking cops over here!…ha ha ha ha!
Kiss my butt, Rudy.
We're going to need bullet proof vests pretty soon…just like the cops wear.
Are you kidding? They'll never spend the money on us for that!"

"8-0-6 is on the scene, dispatch. We are at Iowa and Durango."

The man was simply trying to catch the bus. Like many other downtown shoppers, he probably wanted to get home early to celebrate Christmas with his family. He didn't want to wait for a later bus. The tree, the presents, the eggnog, and loved ones must have been on his mind just a few minutes prior. He appeared to be in his fifties. He was carrying two shopping bags full of gifts. As we looked at the body laying there on the cold asphalt, Rudy and I tried to re-create what had happened.

"How did he get caught under the wheel?
He must have slipped as he ran to catch the bus.
He wasn't very smart for doing that.
Not being smart had nothing to do with it…a lot of people run to catch the bus."

A policewoman on the scene invited herself into our conversation. *"Poor guy, nobody around here seems to know him."* She proceeded to write her report without making eye contact with anyone.

"Just as I told you on the way over here…nasty, a real mess to clean up.
What do you think, John Boy…closed casket?
You are a sick man, Rudy…sick, sick, sick.
Yeah right, and I suppose that you're perfectly sane…just get the freaking cops over here! Ha, ha, ha…"

The victim's head had been completely flattened. It had burst just like a water balloon does when it hits the pavement. There was blood and brain matter splattered on the bus's white skirt panel located behind the rear wheel that had crushed him. The entire scene seemed surreal. The victim looked more like a mannequin with a flat head. The police woman unceremoniously extracted the man's wallet from the victim's back pocket. Rogelio Garcia, age 51.

The sun was setting early on downtown San Antonio. It was already turning into a wintry evening, and the temperature felt even colder with a lifeless body lying in the middle of the street on Christmas Eve. The other passengers had already been transferred to another bus that continued on its original route. Life for them would go on for now. A clearly shaken bus driver stood about 50 yards from where we had gathered with the policewoman. He was pacing back and forth on the sidewalk, nervously puffing on a cigarette. Rudy, as was his custom, expressed his twisted perspective in a loud voice.

"He's going to have a hell of a holiday weekend…poor bastard.
Just think of the paperwork this guy has to fill out tonight.
There are at least two families that are fixing to have a Christmas to remember.
Now, the bus driver, he probably won't be in the mood for any crushed pumpkin pie…

Or beef stew for some time, huh? Don't you think, John Boy?"

"Have you ever bothered to have your sick head examined?
I mean, save the jokes for your New Year's Eve party, and those hot babes you're always talking about…you know, the ones I've never seen you with."
"Say man, they're going to be at my house on the 31st…you're invited John Boy.
They're in the mood for some young stuff…you fit right in John Boy Walton.
No thanks, I already have plans. You are really sick in the head, you know that?"

We were just a few feet from Rogelio's body and so caught up in our empty and senseless conversation that we had not taken notice of the bus company investigators standing behind us, quietly staring. They had heard every word. They must have thought that we were a couple of mentally deranged individuals.

Rudy B. must have noticed my somewhat withdrawn and pensive demeanor as we made our way back to the station. *"Say man, Christmas is overrated you know…it's all so commercialized now."* I was quick to agree with him; however, I could not get Rogelio's two shopping bags full of gifts out of my mind.

"I hope that cop put those bags in her squad car and that she gets them to his family.
Nah…she'll probably take them home and give them to her kids…ha ha ha.
Don't worry about it. You're taking this way too personal…getting soft on me.
The old geezer should never have run to catch the bus in the first place…his fault.
He wasn't that old…
Let it go, man…just let it go."

Dad never owned a car. We took the bus everywhere. Times were different when I was growing up I suppose. I still have visions of my young father running to catch the *South Flores* and asking the driver to wait for the rest of the family to catch up. This was typical after a Sunday outing at Playland Park or a matinee at one of the downtown movie theaters. Mass transit was a way of life for us in the 50s and 60s. How many times had my dad run after a bus in his lifetime? Maybe he did it a couple of

hundred times—who knows? I felt myself internalizing the bus tragedy more than I normally would any other event. My dad could have shared the fate of Rogelio Garcia any number of times. At that very moment, I had a longing to be with my dad. I was at work and he was at home. I worried about him catching another bus.

It was Christmas Eve and in just the first two hours I had managed to dodge bullets from a jealous wife's pistol and had responded to a freakish bus accident that took an innocent life. I must have had the "deer in the headlights" look on the way back to the station. *"The house must be buzzing by now,"* I thought. *"Tamales, bread pudding, and getting ready for midnight Mass—I'd much rather be there."* I called home as soon as we arrived back at the firehouse. Dad was safe and sound and he had a ride to church. No catching the bus for him tonight. For the time being at least, my world seemed precariously right again. I overheard Rudy B. talking to Charlie Wood on the radio. *"8-0-6 is back in service."*

Oh Holy Night!

A few hours passed without us making a call. We actually got to semi-enjoy Christmas Eve dinner with our fellow firefighters back at the station. It was difficult to relax even when we weren't making calls. This is a side of EMS that most people never get to see. Gulping down lunch or dinner is done out of the necessity to eat everything on your plate without being interrupted by the dispatcher. I had lost my appetite. Captain Sayers had prepared steak and lobster with all of the trimmings for Christmas dinner. I had a little of everything, but mostly picked at my food. Rudy B. stuffed his face as usual. Then it started all over again.

"8-0-6, 8-0-6, respond to Flores and Travis for an injured party.
That's right down the street from the Cathedral.
Ten-four, 8-0-6 is responding to Flores and Travis."

As we drove toward our destination, we went by the historic church, which by this time was glowing in the splendor of Christmas. I could almost hear the choir and smell the incense of the holy celebration. I thought of the indifferent priest. Midnight was approaching. *"8-0-6 is on the scene…no injured party visible, dispatch."*

There was a bar on every corner at the intersection of Flores and Travis, and they were all rocking on this night. Suddenly, all hell broke loose. Two fights in separate bars began almost on cue. Patrons from the other bars quickly spilled onto the street and merged into one big free-for-all. In just a matter of seconds, Rudy and I were in the middle of a riot!

"8-0-6 to dispatch, you better send PD over here; we have a riot on our hands!
Ten-four, 8-0-6 are you requesting a 10-80?
No, not yet, but get them here quick!
Lock your door…These trolls are freaking crazy!"

Troll was a common term used by paramedics to describe less-than-desirable clientele, i.e., thugs, transients, drug dealers, pimps, prostitutes, child abusers, wife beaters, disorderly inebriates, and anyone else we didn't like.

Suddenly, the double doors from one of the bars swung violently open and a woman with a broken bottle buried it into a retreating man's face.

"Shit! This whole thing is falling apart…get a back-up!
Screw the back-up…Where the hell is PD?!?!
We're fixing to get our butts in a jam here!"

There were at least 30 bar patrons fighting at the intersection. We found ourselves right smack in the middle of the melee. The injured were starting to make their way to where we were. Soon there was blood smeared on the hood of the ambulance. The man with the now disfigured face was the one who needed immediate attention. I could see him on the ground bleeding profusely, but we could not get to him. A severe cut to the face was definitely life-threatening. The only way we could have reached him at that moment was to run over a few trolls. It was very tempting to step on the gas pedal and mow them down. This short-temperedness was a side of me that was becoming more and more common. I had my left foot on the brake, my right over the gas pedal, and the transmission gear in drive. Rudy's adrenalin rush was off the charts.

"Rev up the engine, John Boy! Rev it up…rev it up some more!
Maybe these trolls will get the message and move out of the freaking way!
Hey, you! Get out of the way! What kind of stupid are you?!?!?"

My tolerance level for dealing with trolls was at an all-time low, and Rudy, well, he was just being himself. Although losing control of my emotions was not an option, I often had visions of hurting a few trolls along the way.

So this is Christmas…and what have you done…another year over… For a second or two I became distracted by John Lennon and his Christmas song playing on the AM radio in our unit. We were so caught up in the chaos that I had forgotten to lower the volume. Hearing Lennon's song blaring through the speakers made me realize that I needed to tone down the adrenalin, and the bad wishes I had for the rioters. I turned the radio off. I took the engine out of gear and engaged the emergency brake. The palms of my hands were wet from squeezing the steering wheel so hard. There were

still no cops in sight. Rudy and I were it. We gingerly stepped out of the cab and began our version of patient triage in the middle of the dark intersection. Those who fit the "walking wounded" category were pointed toward Santa Rosa Hospital, which was two blocks away. The entrance to the emergency room could be seen from our location. We could make out silhouettes of injured revelers, stumbling and falling all the way to the hospital through the darkness of Travis Street. It was a very bloody scene.

The police showed up at about the time that we reached the new Scarface of San Antonio. He had lost quite a bit of blood but was still conscious. The jagged edges of a broken beer bottle had disfigured his face, but he was stable enough to be transported. I noticed the cops struggling with the woman who had been responsible for the facial makeover. They handcuffed her and took her to jail. *"Patch him up, load and go Code 3 to Santa Rosa!"* It was about a three-minute ride. Code 3 was the code used when transporting critically ill or injured patients. It meant a lot of flashing lights, blaring sirens, and ear-popping air horns all the way to the hospital.

"Why is there no I-V on this patient?" asked the head nurse as we wheeled in the patient into the emergency room. Almost on cue Rudy B. quickly and "conveniently" grabbed the now empty stretcher and made his way outside to the hospital's loading dock where the ambulance was parked. I resented the fact that he had abandoned me to deal with a medical staff that was already on edge on what was a very busy and bloody night. The head nurse turned to me and waited impatiently for my answer. She was clearly pissed off. Without making eye contact I responded, "*We were right down the street."* I pretended to be filling out the patient form while hiding my nervousness at the

anticipated verbal reprimand I was about to receive. Before she could get another word in, I spoke again. *"We figured that it was best to transport him immediately—as close as we were to you."* Then I heard the ER doctor speak. *"Very well, let's stitch him up and take him upstairs."* The nurses took over and the next thing I knew I was alone in the emergency room finishing up the paperwork. *Oh holy night!*

Merry Christmas, John Boy

The clock read 12:01 at about the time I heard Rudy B. give me a hardy, albeit facetious, *"Merry Christmas, John Boy!"* The sarcasm that emanated from his voice was directly related to the reality of mopping up blood off the ambulance floor.

"So, this is what you wanted to be when you grew up.
Isn't this just great? We're heroes, John Boy.
Listen to the crowd roar.
Rudy…knock off the bull crap.
I don't like being here anymore than you do.
Kiss my butt."

Rudy B. was starting to wear on my nerves with his humorless agitation. How I longed to be at midnight Mass with my Dad. Instead, I was mopping up some troll's blood off the ambulance floor and getting a dose of Rudy B's philosophy about life in EMS. That is when I realized that this whole EMS gig was really starting to suck.

The rest of the night consisted of responding to mostly routine calls such as a young girl experiencing migraine headaches, a drunk with dizzy spells, an elderly woman falling out of bed, and a diabetic who was running low on insulin. They were the types of calls that were routine and uneventful, but kept us awake and wore us down nonetheless. We pulled into the firehouse right at sunrise. By then we were beat up

pretty bad. At least for the moment, it seemed as if it was going to be a quiet day. Most party revelers from the night before would sleep-in, kids would play with their new toys, and traffic on the streets would be light. Finally, we would get some sleep. Not a chance. *"8-0-6, 8-0-6, make Jones Maltsberger and Airport Blvd. for a 10-29."* Ten twenty-nine was the code for a dead person. Rudy and I were in no mood to respond to confirm that somebody was dead. But that too was part of the job.

"That will be right off IH 37…
I know where it is…
Why do they keep calling us to confirm that people are dead?
We are emergency responders—we're in the lifesaving business!
Just shut up and make the call.
Ten-four, 8-0-6 is responding."

The scene was clearly visible as we approached the location. There were already a good number of police vehicles as well as the ever-present ambulance-chasing news reporters. The bullet-riddled body lay there—lifeless. It had been dumped off some time during the early morning hours. I noticed a young boy, about 13, over to the side sitting on a brand new bicycle. I must have been 12 when Santa brought me my first bike—one of the joys of waking up on Christmas morning. Then it hit me that *this was Christmas morning*, and for the first time in my life I was not home to greet it. It just didn't feel right. Instead, I found myself in a grassy embankment just off the airport property looking at a dead body. The moment siphoned off what little Christmas spirit I still had left in me.

My first thoughts were that the boy was a bystander, who along with the others was wondering what all the commotion was about. As I approached, I noticed that his small-framed body was trembling. *"Nice bike…Santa Claus?"* He paid no attention to

me nor did he respond to my overture about his new bicycle. He was straddling the two-wheeler with both feet touching the ground. I was about 50 feet from the body, which by now was surrounded by police, the medical examiner, evidence techs, etc. *"John!"* It was Rudy B., who had been talking to police. *"Over here!"* I walked toward him never losing sight of the boy. *"The kid found the body…he may have seen the people who dumped it off..."* Right then I felt that whatever adrenalin I was running on had drained out of my body. I now knew that I was running on fumes. I was pretty beat up, it was Christmas morning, and I did not want to be where I was—in an embankment with a lifeless, bullet-riddled body and a 13-year-old kid shaking with fear. It was the last thing I needed. I just wanted to get the hell out of there. Fatigue was setting in. Although Rudy and I always had a good working relationship, we were beginning to wear on each other. Rudy was never at a loss for words.

"He'll always remember his first bicycle whenever he watches The Godfather.
Are we done here?!?!?
Yeah, let me just tell the medical examiner that we're getting back in service.
Rudy, is that really necessary?!?!? I mean, come on, the guy is dead…he's a goner!!!

I hurried back to the ambulance not wanting to remember the young boy's face.

"8-0-6 is back in service."

"Not so fast buddy," said Charlie Wood, who was still dispatching calls.
"You're backing up 8-0-7 at Elsmere and St. Mary's for an unconscious M.I.

M.I. is the abbreviation for myocardial infarction, which is a heart attack.

We're sending a Fire unit also.
Ten-four dispatch, we're about seven minutes away.
We're the back-up, Rudy, no big deal…very routine.
The guys from 8-0-7 are good paramedics."

Nothing, however, seemed routine upon our arrival.

Noooooooooooooooooh!

The fire crew was standing around with their arms crossed. Their silence was deafening, and their body language reminded me of someone who was in denial of having witnessed something really bad. The paramedics from Station 7, Leroy Zimmerman and Patrick Garcia, were already inside the house. It seemed peculiar that so many emergency responders were just standing around doing nothing. As we entered, I noticed a young boy not much older than five by the Christmas tree in the living room opening gifts. He had an unsettling look on his face. His father was in the hallway that led to the bedroom. The dad was banging his head on a wall—hard, really hard. Two police officers were trying to restrain him. Rudy B. and I slowed our quick pace to almost a complete stop as we turned into the bedroom from a narrow hallway.

I remember feeling my goose bumps. By now we should have been wheeling the patient to the ambulance and giving her advanced life support. We saw Lee and Patrick standing over a lifeless body observing the electrocardiogram (EKG) monitor. *Flat line,"* said Patrick in a very matter-of-fact, yet emphatic tone of voice. *"She's been gone for a while."* There on the bed lay an attractive young woman who appeared to be in her mid-20s. She was still wearing a dress from the night before. She was dead. I broke the silence.

"What's the story, Pat?
She aspirated in her own vomit last night.
She what?!?!
The story is she had too much to drink…wasn't used to the hard stuff…went to sleep…she basically drowned…he's the husband and her six-year-old son is in the living room (opening gifts) waiting for his grandparents."

Then came one of the most freakish screams I have ever heard. "*Noooooooooooh!!!*" I felt the hair on the back of my head actually move. The husband had lost control and was physically harming himself. Rudy and I jumped in and tried helping the cops. He was not being cooperative nor was he being rational. He kept banging his head on the wall in what appeared to be a guilt rage. The last thing I wanted to see was the officers handcuff the man to keep him from hurting himself and others around. His son was by the tree opening presents as if to emotionally block out what had just happened to his mommy. I later rationalized that it was his way of coping with the tragedy that was unfolding before his eyes. He was in shock.

As if to add insult to injury, family began showing up with food and gifts for what appeared to have been a Christmas gathering, only to be greeted by the cold reality of having lost a loved one so tragically and unexpectedly. I was grateful that the two police officers had refrained from cuffing the distraught husband. He would have looked guilty of something. I was glad that the fire crew from Station 6 had decided to stick around. Trying to restrain half a dozen emotionally charged people and a suicidal husband was more than any two or four paramedics could handle.

A glazed ham had been dropped on the front lawn. Bags full of gifts, homemade desserts, and a tricycle with a large bow on the handle bars were scattered on the porch and throughout the front lawn. More police officers showed up. Family members were in shock, walking around in a daze. Someone took the little boy outside. There were loud cries, uncontrolled sobbing, and people falling to the ground in complete disbelief. Neighbors came by and nervously asked what was going on. The entire scene was like a

nightmare playing itself out. Rudy and I could not get out of there fast enough. I was glad that we had been the back up unit. 8-0-7 had to stand by for the medical examiner.

Old Man Bud may have deserved being a live target for his jealous wife. I was sure he'd get over his close call with the hereafter as soon as he took another drink. The rowdy bar patrons from the night before certainly got the stitches and tetanus shots they deserved. The man whose head was flattened had signed his own death warrant by running after one too many busses. I could somehow bring myself to "accept" and even "rationalize" the tragic and unfortunate incidents we had already responded to, but nothing could top what we had just witnessed. By now, I felt that my nerves were frayed beyond repair. Christmas morning had already unraveled for Rudy and me. In less than one hour, we had responded to two tragic scenes that had produced two deaths—one had been shot execution style, the other had drowned in her vomit.

I could not feel the warmth of the sun shining from a clear blue sky on what should have been a glorious Christmas morning. Rudy B. seemed to be basking in it, or at least that's how it seemed. I silently thought to myself, *"If that's the effect of drinking on duty, I may want some of it."* Rudy had a reputation for downing a few drinks on duty. There were others as well. I had visions of Rudy B. stopping for a six-pack of beer on the way back to the station, or maybe a bottle of Jack Daniels. For a moment I was even tempted to make the offer. I had never seen him "down one" at work. I did, however, have a strong suspicion that the rumors were more than just hearsay. He might have been good at keeping it hidden from public view and *under control*. However, he

wasn't always as good with the breath mints he chewed on during a shift to hide the obvious.

I never drank on duty. Therefore, I made it a point to be the driver on this particular shift. I was afraid that the "holiday spirit" may cause Rudy B. to get carried away and consume more "spirits" than what he was accustomed. He never offered me a drink because he knew what my position was regarding the rule-breaking practice. He may have also had doubts about me "keeping it quiet." By now, even those who imbibed on duty knew that I wasn't a snitch. Nevertheless, I wanted him to keep doubting. I always suspected that he hid the *hooch* and downed one every now and then in some back room at the firehouse. For a moment though, I pictured myself joining him in a holiday toast. *"What the hell? It may help me cope with the craziness of the job,"* I thought. After all, December 25th was no longer Christmas Day. It was insanity.

Cheers, Sweetheart

On the way back to the station I noticed that even the vociferous and highly opinionated Rudy B. was speechless. Putting events into "perspective" was one of his strengths—that and his penchant for making a sick joke out of every call we made and every patient we treated. He suddenly appeared withdrawn and deep in his own private thoughts. This was one scenario that had not been scripted in any medical journal or training manual. Someone may have told us there would be days like this but nobody, not even I, really believed there would be days like this. For once in his life, Rudy B. legitimately needed a drink, and so did I. Neither one of us knew what to think or do next. *"8-0-6 is back in service."*

The combination of fatigue, sleep deprivation, and the emotional rollercoaster ride we were on had begun to show its effects in the way we performed the remainder of the shift. Getting a call for an aching back or a twisted ankle after what we had just witnessed was enough to make us want to scream at people, but we didn't. Rudy B. suddenly seemed withdrawn. This was way out of character because nothing ever seemed to faze him. I was afraid that he may *hit the hard stuff* a little more now. There were eight hours left in the shift and I could not afford to be involved in any mishap that may result in us getting into trouble because of Rudy B.'s drinking habit.

"Have you been drinking?" I even surprised myself for drumming up the nerve to ask him in such a direct fashion. All I got from Rudy B. in response was silence and a one middle finger salute. We got back to the station. The firefighters who had responded to the young girl on Elsmere and St. Mary's were in the kitchen going about their clean-up duties in silence. Although talking about a traumatic event with fellow coworkers could have had a therapeutic effect for the crew, nobody was even remotely touching this one. Rudy B. and I were certainly in no mood to relive the tragic scene. We went upstairs to our semi-private cubicles and collapsed on our beds. It was just past noon. Christmas morning was no more.

The second floor of the old firehouse had painted windows and fluorescent lights that were turned off whenever anyone slept during the day. It was pitch black. Just before dozing off, Rudy B. mumbled in a very sarcastic tone, *"Cheers, Sweetheart."* *"Screw you,"* I quickly retorted, hiding my satisfaction that at least for now he wasn't

out back in a closet or in his car downing a shot of Jim Beam. Days later I heard from reliable crew members that Rudy B. had stayed dry the entire shift.

The Frosting on the Christmas Cake

By now, the fact that I was working on Christmas day was no longer an issue. I had come to the realization that the job sucked no matter what day it was. *I* was living in the *real* world, where there were no longer any thoughts of candy canes and stockings, Frosty, or Rudolph. The spirit of Christmas had long been shattered by a broken bottle-wielding woman who tore into a man's face. All that was real at the moment was the fact that we were responding to a child not breathing. That got my adrenalin rushing again. I drove the ambulance faster than I normally would. Rudy reminded me to slow down.

"8-0-6, 8-0-6, make the one hundred block of West Lullwood for a child not breathing.
Ten-four, 8-0-6 is responding to 100 West Lullwood.
Hey there buddy…don't you think you better slow down a little?
There's a lot more traffic now that people are out and about…
Don't tell me how to drive and I won't tell you how to treat a patient…
If they can't see the flashing lights or hear the horn and siren, well that's too bad."

We arrived at the modest home of a Spanish-speaking mother overcome with hysteria.

"*Señor, señor, aquí pronto! Mi hijo, es mi hijo…parece que está muerto!*
She thinks the baby is dead.
I know, I know what she's saying, John Boy—I know es-pa-ñol.
Calma, señora, calma por favor.
No esta muerto."

The child was a six-week old infant. The backdrop was a Christmas tree with torn gift wrappings scattered on the living room floor. In my hands was a baby who was barely breathing. I had my ear pressed against his chest to listen for breath sounds and his heart beating. They were barely audible due to the heavy congestion in his tiny

lungs. There were other kids in the house playing with their toys. They seemed to be completely oblivious to what might be happening to their baby brother. The mother would not stop crying. Although he was alive, it was difficult to hear breath or heart sounds so we rushed him Code 3 to Santa Rosa Children's hospital. I struggled with the mother's screams inside the cab while Rudy had to carry the infant in his arms in the back of the ambulance all the way to the hospital. Infants do not fit nicely on our stretchers.

Once at the hospital, we learned that the baby had been discharged the night before because he "seemed fine." Another hospital screw-up, I thought to myself. *"He's very congested,"* said the ER doctor. *"It was a good decision to bring him in…looks like we got him just in time…Merry Christmas."* We didn't bother acknowledging the doctor's good holiday wishes for us. We just turned around and walked through the emergency room's waiting area where the mother was being interviewed by the hospital staff. She appeared much calmer by then.

It was 3:30 in the afternoon. Rudy B. looked at his watch and said, *"Ninety more minutes and we're home free! Let's go back to the station to get relieved and get the hell out of Dodge City!"* Then we heard Charlie Wood on the radio again, *"8-0-6, are you back in service?"* Rudy B. had spoken too soon. I reluctantly keyed the radio's microphone and responded.

"Ten-four, we are just leaving Santa Rosa.
Make Commerce and St. Mary's in front of the Aztec Theater for a stabbing.
For a what?!?!?
That will be for a tourist who was assaulted and cut in the face according to PD.
Ten-four, 8-0-6 is responding to the Aztec Theater.

What a way to end the shift, John Boy.
I guess this one's for the road…
That's all we needed…another Scarface.
What's with this bullshit? Two face lifts in one shift?
You're bad Karma, John Boy."

When we arrived we found Reynaldo, a visitor from Corpus Christi who was bleeding severely from the face. He was in town to spend Christmas with family and friends. He was on his way to meet them at one of the restaurants on the River Walk. He had been assaulted with a knife. The assailant had made a clean cut on the cheek from mid-ear down to the chin. There was blood everywhere. We packed the wound with gauze and bandages, but we still had problems stopping the bleeding.

"We have to get some ringers in this guy pretty quick and load and go.
It's OK Ray; we're going to have to take you in to the hospital.
Are you sure? I have some people waiting for me at the Casa Rio restaurant.
I'll let the police know and they will notify them.
Let me suggest that you go to Medical Center Hospital.
John, cut out the bull crap and let's go!!!
OK, but we better make it a Code 3 Rudy; he's lost a lot of blood!"

I got the speed up to 90 miles per hour on IH 10. We came close to losing Ray on the way to the ER, but we got him there conscious and alive. Except for a nasty scar on his face, Ray was going to make it. It was important for us to end the shift on a positive note. Nevertheless, I could sense that both Rudy B. and I were running on fumes and on frayed nerves. So I decided to break a rule just to get us out of the shift by 5 p.m. As it turned out, I ended up bringing Rudy's sarcasm back to life.

"Well, this certainly puts the frosting on the Christmas cake.
Let's get back in service.
No, hell no…it's ten 'til five.
Let's get back to the station and get relieved first.
But that's against the rules, John Boy.
So are a lot of other things we do from time-to-time…aren't they, Rudy?

If we get back in service now, we might catch another run.
I just want to go home!"

We sped back to the firehouse without getting back in service—a clear violation of department rules. Christmas 1981 was winding down and I was ready for a stiff drink, or maybe even several. The A-Shift paramedics were already waiting when we pulled into the station's ramp. There was a brief exchange with the guys who relieved us. It seemed as if Rudy had just received a shot of B-12—he was pumped and ready to party. I was in no mood to hang around.

"Thank goodness that Mutt and Jeff are here already.
Hey guys, Merry Christmas…it's all yours."

How come we never heard you guys get back in service?
We did…we did get back in service. Didn't we Rudy?
Sure did…check the radio to see if the battery is charging."

"Hey, the back of the ambulance is filthy.
Clean it up…it's your baby now…have fun."

As I was leaving, I heard Arthur, one of the A-Shift paramedics complaining about having to clean the ambulance and re-stock it with drugs and other equipment. I could have cared less for not leaving the ambulance to his liking. All I knew at the moment was that my *shift from hell* was over.

The Cleansing

I actually felt a little upbeat when I got into my car. Once I started driving home, however, I felt myself starting to "shut down." The humming of the tires on the road made me drowsy. I figured that Rudy and I must have slept one hour during the entire shift. I wore a civilian jacket that I carried in the car to hide my uniform. I stopped at a

convenience store to buy a beer. I noticed a good-sized swath of dry blood on one of my pant legs. It must have been from the bloody riot at Travis and Flores the night before. That realization woke me up. I was still wearing my belt pouch, which consisted of a pair of very sharp scissors, hemostats, a bite block, and penlight—basic tools of the trade. The clerk looked at me in and odd kind of way. I must have looked like someone who was hung-over from the night before. I told him to put the can of beer in a brown paper sack.

When I arrived, I realized that I was going to have to remove a lot of the stuff I was wearing before entering the house. I was still living with my parents and my kid brother and sister. The arrangement was convenient and a lot cheaper. The house was big enough to afford me the privacy that I needed. Nevertheless, I had to seriously think about not bringing in any germs into the house.

It was about six in the evening. I left my work boots outside on the front porch. Everyone was in the living room watching TV, unwinding from the Christmas celebration. The greeting I received was the traditional, *"Merry Christmas…how was work?"* I did not respond. I just kept walking to the bathroom as I heard my kid brother say, *"Aren't you going to open your gifts?"* Once in the bathroom I very slowly and meticulously removed my uniform. I was careful not to let any of it come in contact with the walls, lavatory, tub, or floor. I put the uniform in a plastic trash bag. This one was not going to be washed. I was going to have to throw it out with the garbage. I was always careful not to take chances with spreading anything I may have been exposed to

during a shift. I stepped into the shower and just stood there for about 20 minutes with the hot water running.

Taking a long hot shower after working a hard shift had become more of a ritual than a hygienic necessity. I compared it to *a spiritual cleansing*. Part of me felt as if I was washing away sins in a baptismal font. I needed to cleanse myself of all the bad I had encountered during the shift and of all the bad I may have inflicted on anyone by my negative actions, reactions, inactions, and mistakes. Once I was through showering, I got into a pair of sweat pants and shirt and went straight to bed. I disposed of the uniform I had worn. I did not open gifts. I did not eat nor did I have the drink I longed for during the shift. I left the can of beer in the brown paper sack in the car. I never opened it. I didn't even wish anyone a Merry Christmas. I just went straight to bed and collapsed. I slept uninterrupted for about 10 hours.

Reflections on Christmas 1981

I did not report back to work until three days after New Year's Day. I exhausted a total of four shifts of sick leave. I felt like a walking zombie all through the remainder of the holidays. I went to a few clubs and parties with friends and had more than my share of drinks. I survived by staying away from the job for what amounted to a total of 12 consecutive days. Even while partying, I could not bring myself to take a celebratory holiday drink without thinking of the young mother who had drank one too many and had drowned in her own vomit. I never again took for granted the safety of pedestrians at a bus stop. Kids riding new bicycles reminded me of a Christmas morning shattered

by the sight of a bullet-riddled body. Church bells reminded me of an indifferent priest. Almost a month went by before I attended Mass again.

I always did my best not to "take the job home" with me, but this time I had. Becoming a paramedic had been, without question, the high point of my fire department career. Christmas 1981 was its tipping point. The experience changed my perspective about what it was to be an emergency medical responder in the big city. It was then when I realized that there was no glamour or glory associated with being a paramedic. For 25 years there were only two other people who knew about Christmas 1981: Rudy B. and Lee Carrola. I have never shared the story with anyone, not even my family—at least not until now.

CHAPTER II

DEVELOPING THE STUDY

My world would come to a standstill at the sound of Engine 12's wailing sirens and ear-popping air horn. Even at a very young age, I had become sensitized to the activities taking place in and around Firehouse No. 12. My ears were trained to listen for alarms being transmitted over the station's radio. On quiet nights I could actually hear the voice of the dispatcher a block away. I was the second of five siblings. Alonso's Grocery Store, St. Henry's Church and school, City Hall, and the fire station were all within walking distance from our modest home on Camp Street.

Old Firehouse No. 12 was located just 11 city blocks south of City Hall in downtown San Antonio. I had the privilege of knowing most of the firefighters who were assigned to the historic station that had once been the home for horse-drawn steam fire engines. The courageous men who served there were ideal role models for neighborhood kids like me. I remember raiding their soda water and bubble gum dispensers. I also had dreams of one day sliding down the pole from the second floor of the old station and hopping on the back of the shiny red American La France fire truck at the sound of the bell.

Needless to say that it was not a big surprise to the old "smoke-eaters" when they saw me wearing Firefighter's badge number 1308 on July 19, 1975—the day I graduated from the Fire Academy. By then, the Fire Department had added another layer of service that seemed even more exciting and adventurous than fighting fires. This new mission was EMS—the Emergency Medical Services. Nothing appealed to me more in

the summer of 1975 than becoming a “real” lifesaver—an Emergency Medical Technician Paramedic.

Becoming a paramedic in the San Antonio Fire Department (SAFD) meant that one was part of an elite group of professionals—the cream of the crop of the fire service. These were individuals who were not only firefighters but surrogate doctors on the front lines of emergency medical care in one of the largest cities in the country. The journey to becoming one of these emergency medical professionals was long, arduous, and competitive. In September of 1979 I became a certified paramedic—just four years after having joined the SAFD. I was 24 years old and I was ready to save the world.

Statement of the Problem

Paramedics are the backbone of any professional EMS system. They are the human component that is ultimately responsible for getting the job done. Although the quality of the specialized training and education received by San Antonio paramedics has always been regarded among the best in the nation, there remains one aspect of the job that has not been adequately addressed by educators and program designers. Historically, little if any consideration has been given to the psychological, physiological, and sociological impact the job has on the lives of these individuals. According to McEvoy (2004),

> Because emergency responders help people in stressful situations on a daily basis, we would expect them to have the skills to deal with any level of stress in their own lives. This might be true in some cases; more often, however, the

> personality characteristics that make a good firefighter, medic, or law enforcement officer also lead to increase stress for that individual. (p. ix)

Consequently, similar expectations have led program designers to assume that the human skills necessary to handle extraordinary levels of physical and psychological stress are inherent in firefighters and other emergency workers. Therefore, learning modules on how to manage stress, the effects of sleep deprivation, and the constant exposure to violence were not part of my paramedic training curriculum in 1979, nor did I receive any such training during the subsequent seven years of my continuing professional education.

It can be argued that the medical community, fire administrators, and firefighters believed then as much as they do now, that professional "smoke-eaters" were and are already "tooled" for such physically and emotionally demanding work. In retrospect, there seemed to be a collective naiveté among administrators, trainers, and paramedic candidates that firefighters were inherently courageous and, therefore, mentally and physically immune to the emotional roller coaster ride that paramedics have to endure.

Today, efforts that address some of these knowledge and skill deficiencies can be seen in the implementation of departmental health and safety initiatives. For example, more EMS systems are creating positions for a health and safety officer who is charged with identifying workplace factors that relate to physical and mental fitness (Hogue & Zimmerman, 2006). Such initiatives, however, seem to be few and far between, and often fall short of their intended goals. For example, although some departments like San Antonio provide an Employee Assistance Program (EAP), EMS operations may not

themselves easily avail to these types of interventions. Operations may be geographically spread out with minimal supervision and irregular work hours, especially in large city departments (Pollak, 2005). Furthermore, an EAP typically provides assistance once the problem is great enough to cause the employee to seek help. Current needs point to initiatives that will help emergency responders prevent stress-related problems from developing into major disabling conditions. It appears that most EMS providers continue to be deficient in providing comprehensive training on handling the adverse physiological, sociological, and psychological impact of the job for both new and incumbent paramedics.

Statement of Purpose

This study had a three-fold purpose. The first was to explore, in depth, the experience of being an emergency responder and to understand the impact it had on me in three domains: (a) psychological, (b) physiological, and (c) spiritual. The study explored how my personal and professional life has been impacted beyond the immediate experience. Secondly, the insight gained from such a personal study will help to inform continuing professional education for emergency workers in terms of enabling them to cope more effectively in what is unquestionably a high-risk, high-hazard occupation. Lastly, it is imperative that the general public be made aware of the physical, social, and psychological demands that are placed on paramedics. It is important for citizens to know that these public servants are ordinary human beings doing extraordinary work in one of the most stressful and hazardous professions in the world.

Research Questions

My ethnographic analysis of my tenure as a paramedic was guided by the following questions:

1. How did my profession impact me psychologically?
2. How did my profession impact me physiologically?
3. How did my profession impact me spiritually?
4. How did my tenure as a paramedic impact me professionally?
5. How did I manage the high levels of stress in response to the traumatic events that I witnessed?

Operational Definitions

For the intent of this research, the following terms apply:

Autoethnography: A qualitative research method that positions the researcher/narrator as both the investigator and the participant of the study. It is essentially a study of the "self," written and presented in first person tense.

EMS: Emergency Medical Service. This is the system that provides the emergency medical care that is needed by people who have been injured or have a medical emergency and need immediate care.

Narrative Analysis: Refers to a family of different methods used for interpreting texts that have in common a storied form.

Paramedic: An individual who has extensive training in advanced life support, including I-V (intravenous) therapy, pharmacology, cardiac monitoring, and other advanced assessment and treatment skills.

Design of the Study

This research study is an autoethnography, a form of investigation that is autobiographical in nature. Autoethnography is a qualitative research method that positions me as both the researcher and participant of the study. It is essentially a study of the "self" in context, and it is written in first person tense. Being the autoethnographer also positions me as the narrator of the study. Autoethnography requires considerable attention to introspection and self-analysis by the researcher. Therefore, my study is totally reliant on my observations and my interpretations of shared encounters and interactions that took place with colleagues, medical professionals, patients, and the general public from June 1979 to January 1986. I will develop the qualitative research method of autoethnography further in Chapter III.

Format of the Findings

This study is a subjective personal account of emergency medical response work that I performed between June 1979 and January 1986. It is an autoethnographic piece of literature that allows the data to emerge as it is written. It engages the reader to view the story as I experienced it in the first person. This approach is supported by Ellis (2004) who argues that the purpose of an autoethnography is "to practice an artful, poetic, and emphatic social science in which readers can keep in their minds and feel in their bodies the complexities of concrete moments of lived experience" (p. 30).

This study was analyzed as a "meaning-making" narrative. I intend to engage readers in a reflective analysis of personal experiences within different social and professional contexts. According to Ellis and Bochner (1996), "one of the uses of

autoethnography is to allow another person's world of experience to inspire critical reflection on your own" (p. 22). Therefore, it can be argued that a self-reflexive critique upon one's positionality as researcher inspires readers to reflect critically upon their own life experiences through the analysis and interpretation of an autoethnography.

The study is presented as a performance narrative. The purpose of the performance narrative is to help readers internalize the reconstruction of the researcher's experiences and to connect with her or his personal and professional identities. According to Riessman (2008),

> To emphasize the performative is not to suggest that identities are inauthentic, but only that identities are situated and accomplished with audience in mind. To put it simply, one can't be a "self" by oneself; rather, identities are constructed in "shows" that persuade. (p. 106)

My efforts to descriptively transcribe my lived experiences reveal characteristics of the performative approach that Riessman identifies. Evidence of an identity transformation from *John Boy* to *wounded storyteller* also comes to light in the performance of my chaos to quest story. I will develop the performance narrative further in Chapter III.

Significance of the Study

This study will provide EMS stakeholders—the paramedics themselves, administrators, shift commanders, educators, and the medical community a highly personalized account of one paramedic's experience. Hopefully, this will enable them and other emergency responders to reflect on their own careers by connecting with my experiences. Rarely do paramedics sit down with anyone outside of their profession to

talk about their job experiences. I believe that breaking their silence can be beneficial to those who are presently doing the job and to those who have done the job. Sharing their experiences and the impact that the job has had on their lives can assure those who are active in the profession that they are not alone in the physical, psychological, and spiritual challenges they face. Also, sharing lived experiences with those who have done the job can be therapeutically beneficial from a psychological perspective.

Although "opening up" the past can lend itself to reliving unpleasant events, it may also prove to become part of a healing process for those who once did the job. Such has been my experience since I broke my own silence after almost 30 years. Leaving the chaos that was EMS may have eliminated my daily confrontations with tragic events, but it did not eliminate the long-term effects of the experience. Notwithstanding the benefits to groups of past and present paramedics, channeling the outcomes of the healing process into "learning moments" for future emergency responders will be invaluable in terms of preparing them for the job.

This study lays a foundation for designing a training program to be used by public safety educators. It is important to recognize and address the social and psychological impact the high-risk job has on both the professional and on the personal lives of emergency responders. Figley (1995) argues that "recognizing this, we as practicing professionals have a special obligation to our students and trainees to prepare them for these hazards" (p. 17).

This study describes "the indescribable" to a general public that at best possesses a vague understanding of the stressful, high-risk profession of the emergency responder.

According to Riessman (2008), "the functions of narrative are obviously overlapping: a teller must engage an audience in order to argue, persuade, mobilize others to action and the like" (p. 10). Thus, the narrative is used to inform and educate an audience that is unfamiliar with emergency response work. People who request assistance from EMS are typically experiencing a major crisis in their lives. Help arrives in the form of paramedics—the human component without which EMS cannot function.

Therefore, it is important for outsiders to view paramedics not as miracle workers or mechanical beings without feelings but rather as individuals who, in addition to the high levels of work-related stress, face similar challenges and concerns that everyday life brings. Yet, the intersection of a paramedic's professional identity and personal life remains invisible to the outside world. This study sensitizes readers to the EMS experience; specifically, to the psychological, physical, and spiritual challenges faced by these modern-day lifesavers. Consequently, this will assist in promoting a better understanding between paramedics, their patients, and the general public.

Refiguring the Past Through Memory and Narrative

I am very cognizant of the fact that it is impossible to re-create lived experiences exactly as they occurred 30 years ago. Nevertheless, what has been significantly revealing to me while writing my story is the amount of detail I have been able to recall; I must, however, emphasize that my recollection of facts pertains *only* to certain events. According to Ochberg (1994), "Each life story selects, from an unlimited array, those moments that the narrator deems significant and arranges them in a coherent order. This fashioning of order is much more than a chronology" (p. 113). It is important for readers

to understand that this process of selective recollection should not be characterized as a premeditated effort on my part. It simply is what it is—a recall of memorable, epochal, life-jolting events that were transformative in nature and that became very personal. According to Freeman (1993),

> The word recollection holds within it reference to the two distinct ways we often speak about history: as the trail of past events or "past presents" that have culminated in now and as the act of writing, the act of gathering them together, selectively and imaginatively, into a followable story. This implies two things. First, without a trail of past events, there would be no story to tell. Second, without an act of the historical imagination, designed to give meaning and significance to these events and to glean the possible nexus of their interrelationship, there would be no past and indeed no *self* but only a sequence of dispersed accidents. (p. 47)

To have simply chronicled my narrative would have diluted the *performance* and *meaning-making* goals of the story. Therefore, I have subscribed to a literary style of writing that includes dramatic arcs and imaginary dialogue. Ochberg (1994) argues that "the credibility of any story depends on not only the facts it reports but also on the skillful deployment of those local rules of discourse that make storytellers and audiences intelligible to each other" (p. 114). My literary approach is designed to bring history into the present. My goal is to tell the story with an engaging and *meaning-making* purpose.

It is humanly impossible to remember every single emergency I ever responded to, much less the details associated with each call. There were literally thousands over a seven-year period. Notwithstanding the overwhelming number of responses, there were those "extraordinary" events that are now and forever embedded in my mind and in my soul. Memories of these continue to resurface even now in the present day. Either someone or some remotely related incident will invariably trigger these flashbacks, i.e., the birth of my daughter, Christmas, St. Francis Nursing Home, Whitman Middle School, the Rendezvous club, a news story about child abuse, a head-on collision on the highway, a drug overdose, a fire victim, the death of a friend or family member, or the birth of a niece or nephew.

The stories I have selected for this study are those that I carry with me—those that became part of my personal frame of reference 30 years ago. These events, in their immediacy, became part of my consciousness then and are still a part of me today. Collectively, they are to be interpreted as accurate representations of what is a much broader narrative, one that can never be adequately recollected nor told in its entirety.

Structure of the Dissertation

The dissertation is divided into ten chapters. Chapter I is the Prologue of my study. It is a first-person account of what took place over a 24-hour shift during Christmas 1981. Chapter II includes the introduction to the study, the statement of the problem, statement of purpose, research questions, definitions, design of the study, format of the findings, significance of the study, a subsection that discusses the refiguring of the past through memory and narrative, and it also includes the structure of

the dissertation. In Chapter III I present and discuss the Research Methodology of the study. Chapter IV is a detailed overview of public safety, especially as it relates to the Fire Service and EMS. My story continues in Chapter V, which consists of three vignettes that are a representation of me entering the chaos that was EMS. In Chapter VI I relate how that chaos became personal during my mother's illness and her sudden death. In Chapter VII I discuss how I attempted to managed the chaos while still in EMS. Chapter VIII is a discussion about me making a transition out of EMS into a more normal existence. Chapter IX is the analysis of my autoethnography, where I try to make sense of the story. In Chapter X I discuss recommendations that have implications for adult education in the training of emergency responders, the potential value my story for others, and future research. I have also included an appendix that consists of a limited number of documents and pictures that are of evidentiary value.

CHAPTER III

RESEARCH METHODOLOGY

I *tell my story* by subscribing to the autobiographical research genre of autoethnography. Autoethnography essentially positions the researcher as the "I" of the study. Thus, the researcher also becomes the sole participant in the study. This type of research writing is part of a qualitative methodological trend that legitimizes the researcher as the focus of the study.

Ethical and legal considerations compel autoethnographers to use pseudonyms in order to protect the identities of people mentioned in the study. These "imagined" names are assigned by the researcher to individuals who are relevant to the findings and analysis of the study. Some of the aliases that I use are composites of several paramedics with whom I worked. There are, however, two individuals who at my request did consent to the use of their real names for this study: (a) Lee Carrola, Jr., who was my permanent EMS partner, and (b) Dr. Darrel Parisher, the San Antonio Fire Department's Employee Assistance Program director. All other characters, including patients, are represented by pseudonyms that I have created.

The Autoethnography

According to Reed-Danahay (1997), autoethnography is a genre of writing and research that connects the personal to the cultural, placing the self within a social context. It is an autobiographical research approach that attempts to interpret the personal and intimate experience(s) of the researcher for the purpose of gaining a sociological understanding. Autoethnography meshes social research with the personal

narrative, and it is presented through a variety of literary methods. According to Ellis (2004),

> Usually written in first-person voice, autoethnographic texts appear in a variety of forms—short stories, poetry, fiction, novels, photographic essays, scripts, personal essays, journals, fragmented and layered writing, and social science prose. They showcase concrete action, dialogue, emotions, embodiment, spirituality, and self-consciousness. (p. 38)

My autoethnography is a nonfiction account written in first-person voice that can best be described as structurally nonlinear and linguistically chaotic—a representation of the turmoil that I experienced. There are no defined literary patterns, chronologies, or predictability to the sequence of events that took place. It is a collection of stories within a much broader story—a series of vignettes in the form of flashbacks and interludes, designed to substantiate the experiences as I lived them.

The most common characteristic shared by ethnographers and autoethnographers alike is that they both study lives in context. Therefore, "it is hardly a coincidence that some connection with ethnography is suggested in the use of the term autoethnography" (Wolcott, 2008, p. 211). Nevertheless, finding one exact definition of the term can prove to be somewhat elusive. According to Schwandt (2001),

> Originally defined as the cultural study of one's own people, autoethnography now commonly refers to a particular form of writing that seeks to unite ethnographic (looking outward at the world beyond one's own) and autobiographical (gazing inward for a story of one's self) intentions. (p. 13)

Caroline Ellis (2004) defines autoethnography as "research, writing, story, and method that connect the autobiographical and personal to the cultural, social, and political" (p. xix). Furthermore, Ellis (as cited in Ronai, 1992) calls for the use of one's own emotional experience as a legitimate object of sociological research to be described, examined, and theorized.

History and Development of Autoethnography

The acceptance of ethnography as a research practice in academia is a testament to its validity as a qualitative form of inquiry. In order to understand how the practice of autoethnography was developed, students of this genre should first become familiar with the history of ethnography. The historical timeline of qualitative research illustrates how autoethnography evolved from more traditional biographic and ethnographic research practices.

Ethnography

The origins of ethnography, a research framework where entire cultures are recorded, documented, and experienced, can be traced to the genre of anthropology. In the early 20th century, ethnography was mostly about the study of indigenous people in their native environments. According to Duncan (2004),

> Ethnography's extensive history as a research method began with the work of anthropologists during the early 1900s. At that time, ethnographers focused on exploring and describing the lives of "primitive" people, eager to show what life was like from the "native" point of view. (p. 3)

Ethnographers gathered most of their data by immersing themselves in these remote and exotic communities in order to *become one* with the subjects they were studying.

The work of these early ethnographers was grounded in interpreting the experiences of the primitive inhabitants as they performed their daily lives. This research practice demanded that the ethnographers become one with the culture in order to study it, interpret it, and ultimately narrate it. According to Schwandt (2001), "The native's point of view is one of the methodological innovations marking the emergence in the 1920s of participant observation as the scientific approach of ethnography" (p. 172). Attempts by ethnographers to become one with the culture demanded that they not only live with their subjects but that they live *as* their subjects.

Participant Observation

It can be argued that participant observation in ethnography was a prelude to the research practice of autoethnography. Participant observation suggests a total engagement with the subject's culture, which is inherent to autoethnographic research. This is also characteristic of reflexive ethnographies. Alexander (2005) has stated that "in reflexive ethnographies researchers critically reflect on lived experience in a particular cultural community (which may not be their own), specifying their exact relation to self and a particular society" (p. 423). In autoethnography, the researcher is an active participant who is involved in the process of reflexivity with the added dimension of being the subject of the study. Alexander (2005) further argues that "literary autoethnographies feature writer/researchers describing and interpreting *their* culture for audiences that are not familiar with the writer/researcher's culture" (p. 423).

The researcher not only analyzes her or his experiences but also injects context, which relates directly to the interpretations of the author's culture.

Life History Research

During the 20th century, the practice of ethnographic research eventually found its place in the more contemporary settings of the modern industrialized world. "Over time, Victorian interests in the exotic cultures of distant lands fell out of fashion. Ethnographic studies were more likely to be conducted closer to home" (Duncan, 2004, p. 3). The voices stirred by a world churning with protest and struggle for social justice provided a laboratory for researchers in search of social change narratives. According to Chase (2005), "the liberation movements of the 1960s and 1970s helped invigorate the life history method" (p. 654). Included in many of these narratives were eventful life stories that represented the social struggles of the time. The practice of ethnography allowed the researcher to present life history as a lived experience. According to Cole and Knowles (2001),

> In life history research we describe the world from the perspective of the people being studied. As researchers, we enter, *as far as possible*, the phenomenological field of our participants and work with them to understand the fullest extent the experiences and the meaning of those experiences to them. (p. 150)

The challenges that were presented to the establishment of that era provided opportunities for researchers to "walk in the shoes" of civil rights leaders, union

organizers, feminist authors, and draft dodgers. As a result, more innovative ways of conducting research began to emerge.

Researchers who subscribed to the life history method discovered that recording and reporting on the lives of storied individuals demanded a personal as well as an emotional commitment. During this process, "the researcher is present through an explicit *reflexive self-accounting*; his presence is also implied and *felt* and, the research text clearly bears his *signature* or *fingerprint*" (Cole & Knowles, 2001, p. 126). The co-construction of life history narratives required the infusion of the researcher's personal voice and reflexivity; therefore, demanding the researcher to position her or himself as a participant in the study. "Life history research texts explicitly (although, perhaps subtly) revealed the intersection of a researcher's life with that or those of the researched" (Cole & Knowles, 2001, p. 126). This revelation arguably led to recognizing the researcher as a participant worthy of expression within the context of the study being conducted.

Research in Postmodern Society

Significant shifts in epistemological paradigms occurred in the late 20th century. It was then that new research trends influenced by postmodernism were introduced. "The postmodern era made it possible for critical theories to emerge and take hold in academic inquiry and to open up the possible range of research strategies" (Wall, 2006, p. 147). Two examples of these emergent theories were feminist theory and critical race theory. "Other emancipatory theories, such as those aimed at addressing the power imbalances associated with race and class, also found a space in post modernity" (p. 148). Subsequently, researchers were introduced to the concepts of reflexivity, personal

voice, and participatory research as new strategies. Tierney and Lincoln (as cited in Duncan, 2004) also argue that the narrative approaches typical of ethnography began changing to facilitate a more personal point of view by emphasizing reflexivity and personal voice during the postmodern era.

The emergence of postmodernism in the latter part of the 20th century helped create a social platform for new voices to be heard in academic research. Wall (2006) posited that "the essence of postmodernism is that many ways of knowing and inquiring are legitimate and that no one way should be privileged" (p. 147). The new qualitative research frameworks that emerged challenged the positivist thought that hard scientific research was the only legitimate form of inquiry.

Denzin and Lincoln (2005) have suggested that the use of quantitative, positivist methods and assumptions had been rejected by a new generation of qualitative researchers who were attached to post-structural and/or postmodern sensibilities. These new trends have now emerged as legitimate research methods in the new millennium as well. Duncan (2004) has stated,

> In the 21st century, ethnographic approaches are being acculturated into a postmodern academic world. The desire to discover and make room for the worldview of others suits a postmodern sensitivity, in which no one right form of knowledge exists and multiple viewpoints are acknowledged and valued.

The emergence of more inclusive and participatory research practices has led qualitative researchers to embrace the concept of interpreting their own personal experiences as the focus of their research. This acculturation of ethnographic approaches into the

postmodern academic world has helped pave the way for recognizing the legitimacy of autoethnography as a research practice.

Adding the Auto to Ethnography

Ethnography is about the "it." The inclusion of reflexivity and personal voice in ethnography eventually led to adding the *auto* to *ethnography*, therefore, making autoethnography about the "me" instead of the "it." According to Wolcott (2008),

> The label autoethnography was first used by Karl Heider and more fully developed by David Hayano. Both are anthropologists and both used the term consistently with ongoing practice, doing ethnography from inside out, attempting to capture the view that a people hold of themselves. (p. 211)

This practice of *doing ethnography from inside out* has carved out a new method that influences researchers to relate their research questions and problems to their own experiences. While ethnography has been viewed primarily as a method used to study and learn about a person or group of people, autoethnography has become known as a method used to study and learn about *the self* and share that knowledge as it applies within a defined social context.

The Autoethnographic Self

Autoethnographies are typically accompanied by the emotions they often evoke in the researcher. According to Ellis and Bochner (2000), these texts are usually written in the first person and feature dialogue, emotion, and self-consciousness as relational and institutional stories affected by history, social structure, and culture. This qualitative method not only articulates story, but it also brings story to life. The researcher is

essentially given license to analyze *the self* and to present *the self* as a subject worthy of study—emotions and all. In order to accomplish this task, the researcher engages in the process of reflexivity, which in autoethnography is more than just a pause for reflection. In discussing reflexivity and voice as they relate to autoethnographic research, Wall (2006) states,

> The research community is relatively comfortable with the concept of reflexivity, in which the researcher pauses for a moment to think about how his or her presence, standpoint, or characteristics might have influenced the outcome of the research process. However, new "methods" such as autoethnography, founded on postmodern ideas, challenge the value of token reflection that is often included as a paragraph in an otherwise neutral and objectively presented manuscript. (p. 148)

Neutrality and objectivity are characteristic of third person narratives where the author, albeit a participant, is limited to the interpretations grounded in her or his personal frame of reference and not the experience of the viewer—the subject of the research study.

In contrast, the autoethnographer is both researcher and the subject of the study. She/he is the viewer who tells, sells, and analyzes her or his story clearly adding value to the experience of the reader. This also leads to understanding one of the benefits of autoethnography, which is the ability to evoke in the audience similar emotions experienced by the researcher. Pillow (2003) argues that "reflexivity is often understood as involving an ongoing self-awareness during the research process which aids in making visible the practice and construction of knowledge within research in order to

produce more accurate analyses of our research" (p. 178). The autoethnographer's engagement in the ongoing processes of self-awareness and self-analysis has implications for her or his research as it contributes to the construction of new knowledge.

Critiquing Autoethnography

One of the primary characteristics that distinguish autoethnography from ethnography is the manner in which the researcher is positioned in the study. Whereas in ethnography the researcher is positioned as the third person voice interpreting the interpretations of others, autoethnography positions the researcher as not only the voice of the narrative but as the subject of the research; subsequently, the autoethnographer interprets her or his experiences as they relate to a particular social or cultural context. "Autoethnography thus engages ethnographical analysis of personally lived experience" (Alexander, 2005, p. 423).

The emergence of new epistemologies in postmodern research has presented other challenges not only to traditional scientific ways of knowing, but also to long-established qualitative practices. Autoethnographic research has not yet enjoyed the popularity and respect of its ethnographic predecessors. According to Wall (2006), "Despite the influence of postmodern thought, the academic conventions are powerful, and there is resistance to the intrusion of autobiographical approaches to knowledge production and sharing" (p. 155).

With its use of *self* as a source of data, autoethnography has been criticized for being self-indulgent, introspective, and individualized (Holt, 2003). The tendency to

carve out a hero identity or a self-serving *feel-sorry-for-me* story is not outside the realm of human nature. Therefore, Sparkes (2002) suggests that "writers of autoethnographies and narratives of self (like any other form of representation) need to be aware that their writing *can* become self-indulgent rather than self-knowing, self-respectful, self-sacrificing, or self-luminous" (p. 214).

There are legitimate concerns to meshing fiction with nonfiction and fantasy with reality in autoethnography. "Some proponents of autoethnography and personal narrative acknowledge methodological issues associated with the technique" (Wall, 2006, p. 155). As the protagonists of their own stories, researchers engaged in autoethnography are presented with a powerful platform. Social, political, and academic agendas could in fact compromise the legitimacy of autoethnographies and bring the credibility of the author into question, especially when there are pre-existing doubts about the researcher's motives. Thus,

> autoethnographic accounts can suffer from several shortcomings resulting in an unscholarly representation of the research experience. These shortcomings include over reliance on the potential of a personal writing style to evoke direct emotional responses in readers but offer no deeper levels of reflection or analytic scholarship; lack of self-honesty and disclosure about the motivation for doing the research, resulting in the misuse of the role of author to justify actions or advocate the interests of a particular group; failure on the part of the researcher to see the relationship between personal experience and broader theoretical

> concepts, and his or her inability to defend against reasoned critique while still making claims to knowledge. (Parks as cited in Duncan, 2004, p. 11)

Parks' litany of potential shortcomings for autoethnographic accounts shall serve as a "validity" and "credibility" checklist for me to self-analyze, self-monitor, and to reflect on the process and the content of this study.

Validity

Autoethnography has met resistance in gaining acceptance as a form of research that can be adequately validated. The subjective use of *self* as the focus of the research automatically challenges the credibility of the researcher and thus the validity of the data. Holt (2003) argues that traditional criteria such as credibility, dependability, and trustworthiness are important, although not always easily applied to autoethnography. For example, in seeking to build trustworthiness in naturalistic studies, it is apparent that the series of strategies proposed by Lincoln and Guba (1985), i.e., prolonged engagement, persistent observation, triangulation, referential adequacy materials, peer debriefing, and member checks, may not be as neatly defined for autoethnographic studies. I would argue that validity is interpretive and dependent on context and the understandings we bring to the observation (Ellis, 2004).

The total reliance on *self* to present and interpret emerging data challenges the application of these and other traditional strategies that pertain to qualitative research. Although authors are concerned about issues of validity, reliability, and generalization, these elements take on different meanings in narrative research (Ellis, 2004). Realizing that my experience was not characteristically a singular one, I sought out my former

EMS partner who agreed to read several vignettes I had written for this study. To my pleasant surprise, he was able to verify and thus validate much of the information I had written. The reflective discussions we had about certain events were tantamount to engaging in a member check strategy, which served to validate the writings that pertained to both of us.

Narrative Inquiry

Narrative inquiry is a way of conducting case-centered research. The "cases" that form the basis for analysis can be individuals, identity groups, communities, or organizations (Riessman, 2008). In the context of an autoethnographic study, the case is clearly focused on the individual as the subject of the research.

This study is designed and presented as a "story told." Written in first person voice, I am positioned in the narrative in a manner that allows me to communicate directly with the audience. Therefore, I have subscribed to nontraditional methods of qualitative study analyses. Ellis and Bochner (2006) argue that "the difference between stories and traditional analysis is the mode of explanation and its effect on the reader. Traditional analysis is about transferring information, whereas narrative inquiry emphasizes communication" (p. 438).

I will engage readers to the extent that they position themselves in the narrative and attempt to experience it as closely as I have experienced it. With this strategy in mind, I intend for my narrative to have significant meaning—a meaning that I hope readers can internalize and apply in different contexts. The narrative framework that I have judged to be most relevant for my study is the work of Arthur Frank (1995), who

developed a typology of illness narratives. I will be specifically using two elements of Frank's typology, chaos and quest narratives, and then draw implications for transformative learning.

Lastly, the "telling" of my story requires the development of a performance narrative. According to Ellis (2004), "Performance of personal narratives makes hidden issues visible and in so doing opens the possibility of cultural transformation….It provides a face for trauma, disease, and oppression, and in that way is political" (pp. 207-208). A part of my life that I once considered to be "out of sight and out of mind" will now take center stage.

Illness Narratives

Narrative typologies typically emerge as stories unfold and take on a life of their own. According to Frank (2010), "Good typologies emerge, because like good stories, typologies have their own vitality" (p. 121). Such was my experience when I began writing my Christmas 1981 story. It was then I realized that I had a much broader narrative about chaos and rupture to explore. Frank (2010) further argues that "naming types of narratives enables people to understand what stories they are telling and how their own responses and plans—their sense of possibility—are conducted by those stories" (p. 123).

Arthur Frank (1995) is a sociologist and a cancer survivor who developed a three-fold typology of illness narratives, a particular genre of narrative that, while derived to understand the experience of acute or chronic physical illness, is also useful

for understanding other experiences of trauma. Frank's three-fold typology of illness narratives includes (a) chaos, (b) quest, and (c) restitution.

Frank's restitution narrative tells of being restored to the person he once was before his illness—before entering the chaos. In an illness, restitution narratives are always preferred to chaos narratives. "The plot of restitution in the context of an illness has the basic storyline: 'Yesterday I was healthy, today I am sick, but tomorrow I'll be healthy again'" (Frank, 1995, p. 77). Although the anxieties and frustrations attached to his illness may speak of an emotional separation, this should only be viewed as a temporary manifestation that is directly related to the physiological. Therefore, the expectations are that he will one day be made new again. Frank (1995) further argues,

> The purpose that restitution narratives aim toward is two-fold. For the individual teller, the ending is a return to just before the beginning: "good as new" or status quo ante. For the culture that prefers restitution stories, this narrative affirms that breakdowns can be fixed. (p. 90)

However, not "all" breakdowns can be fixed. It is important for readers to understand why Frank's restitution typology has no relevance to my chaos story. My chaos relates more to psychological and spiritual ruptures for which there is no complete restoration. Unlike the human restoration that takes place after an illness, I can never claim to ever being good as new or status quo ante even after having left the chaos, nor can I claim that the multiple layers of the traumatic events I have now added to my frame of reference can be unpacked and somehow repaired. There is no restitution to write about, nor will there ever be. There is no going back to the innocence of being John Boy.

Frank's typology enables listeners, who are mostly clinicians and family members, to hear different threads in the fabric of an ill person's story. What listeners hear in Frank's chaos narrative is incoherence—a byproduct of a downward spiral that begins and ends with his illness. "Chaos is the opposite of restitution: its plot imagines life never getting better" (Frank, 1995, p. 97). As the teller of his chaos story, Frank "is not heard to be living a 'proper' life, since in life as in story, one event leads to another. Chaos negates that expectation" (p. 97). His illness interrupts what would otherwise be a stable and predictable existence. Frank's physical illness envelopes his mind, his body, and his spirit, making it impossible for him to live a "normal" life—this is his chaos.

In contrast to his chaos narrative, Frank's quest narrative suggests a personal transformation taking place once he discovers that his illness is part of a journey that must count for something—that must have value. He embraces it with a sense of purpose beyond the immediate experience. According to Frank (1995),

> Quest stories meet suffering head on; they accept illness and seek to use it. Illness is the occasion of a journey that becomes a quest. What is quested for may never be wholly clear, but the quest is defined by the ill person's belief that something is to be gained through the experience. (p. 115)

While in the chaos of EMS, I also found myself framed in the frustration of a downward emotional spiral—one that found me longing to reconnect with some semblance of a normal life. The accumulation of unpleasant events chiseled away at my emotions to the point of wanting to forget the experience even as I was living it. By the

time I left the chaos, both my psychological and spiritual spools of emotions had unraveled and were hanging by a thread. I found myself consumed by the moment of the chaos that I was living. It impacted every aspect of my personal and professional life.

Much like Frank's story, my quest narrative is one that leads to personal transformation as well. My story reveals a "wounded paramedic" who now accepts the inevitable psychological, physiological, and spiritual impact of the chaos and who now chooses to share his experience with others—to make it count for something.

My Chaos Narrative

My story is essentially a chaos narrative that could not be told until now. According to Frank (1995), "the teller of chaos stories is, preeminently, the wounded storyteller, but those who are truly living the chaos cannot tell in words" (p. 98). From a literary perspective, my story is non-linear and incoherent. It is a story that is chaotic in its absence of narrative order. Events are told as I experienced life in EMS: without sequence or discernible causality. In her writings about Holocaust survivors, Lagerwey (1998) describes chaos narratives as "anti-narratives, stories lived rather than told. They reach beyond time, sequence, reflection, and meditation, and beyond the capacities of storytelling" (p. 39). Although I have written my chaos story as one that is being "told," it does not reflect traditional styles of storytelling. It is a story that is narrated outside of linear timelines, without literary structure or discernible coherence.

According to Frank (1995), the person living the chaos story has no distance from her or his life and no reflective grasp on it. *Lived* chaos makes reflection, and

consequently storytelling, impossible. "Yet, if the chaotic story cannot be told, the voice of chaos can be identified and a story reconstructed" (Frank, 1995, p. 98). This type of narrative can only be told when one has gained significant distance from the chaos. Frank (1995) further argues that "in the chaos narrative, consciousness has given up the struggle for sovereignty over its own experience. When such a struggle can be told, then there is some distance from the chaos; some part of the teller has emerged" (pp. 104-105). I left the chaos of EMS in 1986. The physical and emotional distance of 25 years that I now enjoy in 2011 allows me to finally reconstruct and tell my story. It has allowed me to extract and communicate meaning from the chaos as well as the quest that followed.

My Quest Narrative

The quest narrative has afforded me the voice I need in order to tell my story. Quest speaks to the hope that I maintained of being liberated from the chaos at the time I was embedded in EMS and to the hope that I express today of making my story count for something. Quest positions me as the hero of my story not so much for having survived the chaos, but for having persevered. According to Frank (1995), "The quest narrative recognizes that the old intactness must be stripped away to prepare for something new. Quest stories reflect a confidence in what is waiting to emerge from the suffering" (p. 171). Lagerwey (1998) also argues that "quest narratives offer an alternative style of closure, in which what has been lost remains lost, but the hero rises above challenges" (p. 39). My quest story began to emerge after I left the chaos and began the journey to some semblance of a normal life. I eventually found normalcy only to later discover

hidden wounds that manifested themselves in the form of physical, emotional, and spiritual challenges known only to me initially.

My quest story has me rising from the ashes not as a renewed being, but as one who has now prepared for something new. Although I experienced transformation while in the chaos, there is also strong evidence of personal transformation post-EMS. I emerged from the chaos as a wounded survivor who now chooses to become a wounded storyteller. What was lost in the chaos remains lost. However, what has now been found in the telling of the story is an opportunity to move toward healing. It speaks of my own personal transformation as a storyteller. According to Frank (1995), "The quest narrative tells self-consciously of being transformed; undergoing transformation is a significant dimension of the storyteller's responsibility. The end of the journey brings what Joseph Campbell calls a 'boon'" (p. 118). My boon is having gained an insight from the experience that will have value for me and possibly for others. It is me rising to the occasion in my decision to share my story and to make it count for something.

Performance Narrative

Reliving the chaos in my private thoughts has unfolded much like events took place—as only I can relate. Having "been there" has afforded me the advantage of interpreting the events through a first person lens. I do not need descriptive narrations for myself—I was there. Telling my story to a diverse audience of listeners requires a performance of "self." It requires the development of a sometimes poetic and imaginative writing style that brings the story to life for the readers. Bruner (2002) argues that a self is probably the most impressive and most intricate work of art we ever

produce. Performing the story avails me the opportunity to bring very personal and defining moments of my past to the present in dramatic form. According to Riessman (2008),

> When a narrator "acts out a story," it has immediacy. Past actions appear as if happening in the present, for time collapses as the past and the present fuse. The speaker's experiential involvement engages the listener emotionally, creating a two way narrative contract between teller and audience. (p. 109)

Performing my narrative allows listeners the possibilities to not only relive these events but to connect and identify with my experiences—to identify with the chaos that I lived. Thus, readers will bring their personal filters and interpret the story through their own individual lenses.

My story is a dramatized non-fictional account of events as they unfolded before my very eyes. I took this literary approach not simply for the sake of dramatizing but for the purpose of engaging audiences in what is a series of both evocative and at times emotionally unsettling vignettes. There is evidence of three linguistic features in my story that Riessman (2008) discusses with the performance genre in mind: (a) direct speech, (b) asides, and (c) repetition. I have selected three excerpts from my *Christmas 1981* story that represent characteristics of these.

Direct speech. The reconstruction of a dramatic moment and the impact it has on the reader is buoyed by the linguistic feature of direct speech. "Using direct (often called reported or reconstructed) speech builds credibility and pulls the listener into the narrated moment" (Riessman, 2008, p. 112). There is evidence of direct speech in the

following exchange between me and the EMS dispatcher. Here I find myself in the crossfire of a gun-toting jealous wife and her cheating husband:

"Where are you at, John Boy?!?!?
I'm on the freaking floor, Charlie!!!
Iowa and Hackberry, where do you think?!?!?
Pop, pop…pop, pop, pop.
You have the address right in front of you!
You sent us here, for crying out loud!!!
Get PD over here now!!!"

Asides. Asides are points where I as the narrator have stepped out of the action to engage directly with the audience (Riessman, 2008). Asides have the unique characteristic of a literary sidebar or interlude that supports the narrative by taking the time to explain certain nuances that pertain exclusively to the culture being studied. The following excerpt is indicative of me leaving the action momentarily in order to explain the meaning of the word "troll," as is used in the subculture that is San Antonio EMS:

"Lock your door!
These trolls are crazy!"
Troll is a common term used by paramedics to describe less-than-desirable clientele, i.e. thugs, transients, drug dealers, pimps, prostitutes, child abusers, wife beaters, disorderly inebriates, and anybody else who we don't like.

Repetition. Throughout the narrative, I use repetition to mark key moments in the unfolding sequence of events (Riessman, 2008). For example, 8-0-6 was the call number that identified my unit, which included the ambulance and everything else that went with it, including my partner and me. Every time I use the unit number, it alerts the audience that something important is about to occur or that something has occurred. The following lines are examples of this linguistic feature:

"8-0-6, 8-0-6, respond to Iowa and Hackberry for a cutting."
"8-0-6, 8-0-6, respond to Flores and Travis for an injured party."

"Ten-four, 8-0-6 is responding Iowa and Durango."
"8-0-6 is back in service."

The other. Performing my autoethnography has allowed me to represent myself as the "other." It has provided me with the opportunity to reflect and analyze my experiences much like an ethnographer does in a third person narrative. Therefore, I now believe that three Johns have emerged. One is the narrator, the second is the performer or actor in the story, and the third is the interpreter—the one who makes sense of the story. Performing the narrative has been both a revealing and liberating experience. It has brought events back to life as I lived them—in dramatic form. It has allowed me to re-enter the chaos; it has evoked emotions that have been dormant for over 20 years. Breaking the silence through performance has been emancipatory—like opening a flood gate of pent-up emotions. My story has re-surfaced from the depths of obscurity. It is a narrative that was once destined to remain untold.

Data Analysis

According to Ellis (2004), "When people tell their stories, they employ analytic techniques to interpret their worlds. Stories are themselves analytic" (p. 196). The analytic method one chooses should articulate the "how and why" of one's story. Riessman (2008) posits,

> As a general field, narrative inquiry "is grounded in the study of the particular"; the analyst is interested in how a speaker or writer assembles and sequences events and uses language and/or visual images to communicate meaning, that is, make particular points to an audience. (p. 11)

According to Merriam (1998), "the right way to analyze data in a qualitative study is to do it simultaneously with data collection" (p. 162). Thus, the telling and the analyzing of the story are interwoven in a literary web of physical, psychological, and spiritual meaning-making. There are three broad categories of narrative analytic techniques that I will draw on: (a) thematic, (b) structural, and (c) performative.

Riessman (2008) argues that in thematic analysis the focus is on the "told" rather than on the "telling" of the story; the focus is the content of the narrative (p. 58). According to Rossiter and Clark (2007), "just as themes in a literary work can be identified from recurring events or sequences, themes in the life story are recurring clusters" (p. 50). For example, a recurring theme in my narrative relates directly to the manner in which my Christian faith was challenged during my tenure as a paramedic. The following excerpt from my Christmas 1981 story describes how the repetitive exposure to senseless acts of violence prompted me to question how God could allow such actions to occur.

> *During the course of a shift I would often ask, "Why, God? How can you allow this to happen?" I was smart enough not to blame society's ills on the Almighty. However, maintaining the belief that "we are all made in His image" became a constant struggle for me.*

"Like thematic analysis, structural approaches are concerned with content, but attention to narrative form adds insight beyond what can be learned from referential meanings alone" (Riessman, 2008, p. 77). Telling my story depends on the recollection of epochal events as they occurred; thus, the narrative is presented as an evocative storyline. For example, responding to certain incidents often reminded me of people

who were close to me—of people I loved and cared deeply about. The following excerpts from Christmas 1981 reveals examples of a violent, yet reflective narrative.

> *The victim's head had been completely flattened. It had burst just like a water balloon does when it hits the pavement. There was blood and brain matter splattered on the white skirt panel just behind the rear wheel of the bus that had crushed him….How many times had my dad run to catch the bus during his lifetime? Maybe a couple of hundred times—who knows. I felt myself internalizing the bus tragedy more than I normally would any other event.*

According to Riessman (2008), "if thematic and structural approaches interrogate 'what'is spoken and 'how,' the dialogic/performative approach asks 'who' an utterance may be directed to, 'when' and 'why,' that is for what purposes" (p. 105). One of the goals of this study was to sensitize the general public to the EMS experience. I must, therefore, consider that "readers are inherently part of the interpretive process, bringing their positioned identities and cultural filters to interpretation" (Riessman, 2008, p. 111). This is especially true for an audience unfamiliar with the subculture of EMS. Riessman (2008) further posits that "performances are expressive, they are performances for others. Hence the response of the listener (and ultimately the reader) is implicated in the art of storytelling" (p. 106). My narrative is an emotional read. The events I describe are explicit, evocative, and raw. The way the story is performed will support its interpretation and subsequently its analysis.

Summary

The process of evocative reflection and introspection has given me the tools necessary to analyze the "self" as the "other." This separation is important in order to tell a story that would otherwise have remained untold. There are no ready-made templates or prescribed methods for writing and studying personal narratives. There are

only models and frameworks from which to select the most appropriate analytic techniques.

Although the analysis of the data relates to specific events, it is designed to develop a deeper understanding of the broader culture that is EMS. As an emerging research frame, autoethnography provides a model in which to understand the social world of paramedics. I believe that sharing the epochal and life-jolting events that I experienced can only broaden and deepen the scope of the challenging issues that confront the daily lives of these and other emergency responders.

CHAPTER IV

PUBLIC SAFETY

The origins of public safety in the United States can be traced to the days of the early settlers. Their thirst for independence and the rebellious spirit that followed were courageously represented by the volunteer fire companies they helped organize. It was not unusual to witness bucket brigades being formed at fires with one line of men to advance the full pails of water and a second line of women and children to return the empty pails (Fortney & Murnane, 2004, p. 56). Citizen firefighters rallying with buckets, shovels, and brooms to aid a neighbor threatened by fire became a common sight.

Early American icons could also be found among these brave volunteers who protected their fellow citizens not only from foreign and domestic enemies, but also from the ravages of fire—a constant threat in the new world. "Benjamin Franklin, the early American printer and statesman, generally gets credit for organizing the first community fire department in 1736 in Philadelphia, Pennsylvania" (Cote, 2004, p. 9). Recognizing that preventing catastrophes was the best strategy, George Washington and Thomas Jefferson encouraged the development of building regulations related to public health and safety. Throughout the centuries, public safety in America has seen many advances in the prevention and mitigation of disasters. The spirit of service and self-sacrifice made by the early volunteers remains very much alive among present-day emergency responders.

Modern Day Public Safety

Today, "career fire departments, that is, those departments that rely mostly or entirely on career firefighters, protect most U.S. cities, and therefore a majority of U.S. citizens" (Cote, 2004, p. 41). Modern-day public safety has evolved from horse-drawn fire engines and bucket brigades to a more sophisticated profession that is now tasked with training and preparing for an array of emergencies; this includes the dispatch of medical response teams who are trained to provide pre-hospital advanced life support (ALS)—the Emergency Medical Service (EMS). According to Pons and Murray (2006), "an EMS system is an organized, integrated program that allows for, and provides to an individual in need of acute medical assistance, the means to access and enter the health care delivery system in a timely manner" (p. 19). The frontline professional in any EMS system is the paramedic. "A paramedic is the highest position within the emergency medical service. This is the only position qualified to provide advanced life support" (Fortney & Murnane, 2004, p. 44).

The Fire Service and EMS

Since the 1970s, the convergence of emergency medical care and the fire service has worked well for many communities. "More than half of the emergency care delivered to major urban populations comes to the public by way of the fire service. Personnel are often trained as both firefighters and paramedics" (Post, 2002, p. 59). The initial responsibility for providing care to citizens involved in medical emergencies and other life-threatening events has historically fallen on both the local medical establishments and on fire departments. However, the structural and operative

demarcations that have existed between the two entities speak to their unique institutional characteristics and to their functional independence. The Emergency Medical Service (EMS) was designed to bridge this divide. Today, "EMS responds to medical emergencies acting as an extension of the local hospital system" (Cote, 2004, p. 175). Furthermore, "in most municipalities, EMS is a part of the fire department" (Pollak, 2005, p. 11).

The purpose of EMS is to provide on-site medical care by essentially transporting a hospital's lifesaving equipment and expertise to the scene of an emergency in an effort to give patients the best chance of survival. According to Biddinger and Thomas (2005), "over the past four decades, pre-hospital care and emergency medical services (EMS) in the U.S. have evolved rapidly from nonexistence into key links in the chain of survival for patients with acute injury or illness" (p. 117). Most of the key links in this chain of survival are firefighters who have been trained as paramedics.

Significance of Fire Department Affiliation

Although most communities in the United States opted to integrate EMS with their respective Fire Departments, others decided to structure it as a service directly connected to a hospital system or as simply an independent entity. An EMS system that is separate from the Fire Department may require the hiring of individuals with little or no fire and rescue expertise. Cities such as Austin, Texas, currently maintain such an EMS system. However, this type of arrangement does not offer much in terms of promotions to higher ranks nor the opportunity to give paramedics a way "out" of EMS

while remaining employed. For example, in 1986 I knew with all certainty that I desperately needed to leave the EMS division. There were three administrative options to choose from at the time:(a) resign from the Fire Department, (b) compete for promotion to the rank of Lieutenant, or (c) submit a request to be transferred to the fire suppression division. Resigning from the Fire Department was not an option. There were economic realities in my life that were totally dependent on me keeping my job with the Fire Department. I was not psychologically prepared at the time to invest the time and energy needed to study and compete for the rank of Lieutenant. I could not bring myself to open a book even during my time off from work. Therefore, I took the third option and submitted a written request for a transfer out of EMS back to the fire suppression division. This was made possible because all paramedics remained certified firefighters regardless of their time in EMS.

My request for a transfer out of EMS was granted in January 1986. Two previous requests had been denied due to a low number of vacancies in fire suppression and my low seniority. I was subsequently assigned to Ladder Truck Company 28 as a driver—a significantly less stressful assignment. Eight months after having left EMS, I was given the opportunity to opt out of my paramedic certification. I took the offer without any conditions or hesitation. This meant that I would never again have to return to the chaos of EMS. The best part of the arrangement was being able to remain employed with the Fire Department.

If I had been employed by an EMS organization not affiliated with a Fire Department, there is no doubt that I would have had no other option but to resign. This

would have meant the forfeiture of job seniority, quality health coverage, a good salary, and a defined pension plan. Given the option of transferring out of EMS gave me the opportunity to keep these and other benefits. Having the opportunity to explore other career options within a Fire Department is tantamount to having a "pressure relief" valve for those who need to get out of EMS.

It is important to note that a transfer request out of EMS does not happen automatically. It usually takes several requests before the paramedic is granted a transfer. As I have previously mentioned, it took three attempts, over a period of 18 months before I was allowed to return to the fire suppression division. Several administrative and operational realities have to fall into place before one is allowed out of EMS. The first requirement is that a paramedic can only make such a request upon having served a minimum of three years in the division. Those who meet this first part of the criteria are then put on an eligibility list in order of seniority. The paramedics with the most time in service in EMS are given priority. The process becomes moot if there are no vacancies to be filled outside of the EMS division.

Nevertheless, the ability to absorb individuals who need to transfer out of EMS gives the Fire Department and ultimately the municipal government many advantages. Avoiding a large turnover of workers keeps trained and experienced employees in the department who can still contribute in other capacities. For example, I was eventually promoted to the rank of Captain and spent the majority of my career as a training officer and later as an administrator at the department's Fire Academy. I feel that both the

department and I benefited greatly from these opportunities that otherwise would not have been available if EMS had been a separate entity.

Historical Background of San Antonio EMS

"San Antonio Emergency Medical Services began forming in October of 1972" (Cardenas, 2000, p. 108). Before EMS became a reality in San Antonio, the majority of private ambulances that provided emergency medical care and transport were owned and operated by local funeral homes. "Up to this point the only service available was a 'high speed horizontal, taxi ride' in a funeral home operated hearse style ambulance" (Cardenas, 2000, p. 108). San Antonio was not alone in terms of communities who provided a substandard service. Other major urban areas throughout the United States also found themselves relying on similar inadequate emergency lifesaving efforts.

> Until the late nineteen sixties, very few cities provided adequate emergency medical services. Most consisted of a large number of uncoordinated, competitive commercial and municipal ambulance services which responded to all types of calls, including emergency. Ambulance crews offered little or no real life-saving care; their primary function was to speed to the scene of the accident, load the victim, and speed to the hospital. (Rockwood, Mann, Farrington, Hampton, & Motley, 1976, p. 299)

To counter this great deficiency, medical communities in cities like San Antonio came together and collectively designed and instituted a system that today provides professional pre-hospital emergency medical care in the form of advanced life support (ALS). A major challenge for these medical pioneers was deciding who was best suited

to operate and administer an emergency medical service. "In San Antonio, the Fire Department was researched and found to be the perfect vehicle for the system. The Fire Department had the manpower that was already 'rescue' and 'first-aid' oriented" (Cardenas, 2000, p. 109). Furthermore, Pollak (2005) states,

> Fire departments in major cities appeared to be the most logical choice because many resources in addition to fire suppression are often available through the fire department; these include high angle rescue, hazardous materials management, complex extrication from motor vehicle crashes, or other specific types of rescue, such as swift water rescue. (p. 4)

Handing over the responsibility of emergency medical care and hospital transport to fire departments has made perfect sense to many local governments then and it continues to make sense today. Firefighters are already trained to respond to life-threatening emergencies and are, therefore, predisposed to the concept of advanced life support training. The San Antonio Fire Department's (2009) pre-hospital emergency medical care model is representative of systems that are found in other major cities.

> Serving the City of San Antonio and surrounding communities for over 35 years, the Emergency Medical Services (EMS) Division is under the command of an Assistant Fire Chief with a supervisory staff of 21 officers, and a force of 347 Emergency Medical Technician (EMT) Paramedics, who are certified or licensed by the State of Texas, and 18 civilian support personnel. (para. 1)

The San Antonio Fire Department has historically provided a large pool of firefighters who are poised to be trained as paramedics. All new San Antonio firefighters are

required to complete the necessary requirements for the EMT-Basic level certification during their fire training program. If and when they promote to the rank of Fire Engineer, the level required to gaining paramedic certification, these individuals already possess the basic tools that pertain to EMS. Consequently, both citizens and the local medical community have benefited significantly from this arrangement for over 35 years.

EMT-Paramedic Certification Curriculum

All San Antonio Fire Department (SAFD) uniform personnel are trained to the EMT-Basic level during the initial firefighter training. Maintaining this certification throughout their career is a requirement of employment. Both EMT-Basics and EMT-Paramedics from the San Antonio Fire Department are trained by the staff at The University of Texas Health Science Center-San Antonio (UTHSCSA). This contractual arrangement between the Fire Department and the medical school has been in effect since 1974, the year that the EMS was implemented in San Antonio. The program is staffed by professional instructors, several of whom hold advanced degrees as well as various certifications related to basic and advanced life support training. In addition, the program has an unlimited access to physicians, nurses, and other health care professionals who are associated with the university's teaching hospital.

EMT-paramedic training at the UTHSCSA is very intense. The six-month program leads candidates to national certification. The purpose for national guidelines has always been to create a more consistent delivery of EMS across the country (Pollak, 2011). Recruit paramedics in San Antonio receive over 1,000 hours of classroom instruction and hands-on clinical training.

> The EMT-Paramedic Program prepares students to function as team leaders in the pre-hospital setting. Students spend 670 hours in the classroom learning and practicing and 375 hours in clinical settings. After successful completion of the course of study, students are eligible to take the National Registry of EMTs certifying examination. (UT Health Science Center San Antonio, 2011, para. 1)

Approximately 60% of the training occurs in a classroom setting, and 40% consists of clinical hospital rotations as well as ambulance ride-outs. Working in emergency rooms, observing various surgeries in operating rooms, and assisting with the delivery of babies in maternity wards are part of the hospital clinical training. During ambulance ride-outs, candidates are required to respond with on-duty paramedics to emergency calls. This is as close as they come to carrying out the full duties of a certified paramedic before graduating from the program. During their clinical rotations, both at the hospital and on the ambulances, candidates are required to complete a specific list of training objectives. Examples of these tasks include: (a) basic patient assessment, (b) taking and recording vital signs, (c) preparing and starting I-V fluids, and (d) basic bandaging and splinting of trauma-related injuries. These activities are conducted under the constant supervision of doctors, nurses, certified paramedics, and members of the EMT-Paramedic program's training staff.

The level of training received by EMT-Paramedic candidates in San Antonio exceeds the standards set by the Texas Department of State Health Services (DSHS). DSHS establishes the guidelines and criteria for the eligibility, minimum level of

Paramedic education, and continued Paramedic education. Subject areas of paramedic education, both initial and continuing education, include but are not limited to:

> EMS systems, roles and responsibilities, well-being of the medic, illness and injury prevention, medical/legal issues, ethics, general principles of patho-physiology, pharmacology, venous access, medication administration, therapeutic communication, life span development, airway management & ventilation, patient assessment, history taking, techniques of physical examination, clinical decision making, communications, documentation, trauma systems & mechanism in injury, hemorrhage & shock, soft tissue trauma, burns, head & facial trauma, spinal trauma, thoracic trauma, abdominal trauma, musculoskeletal trauma, pediatrics, pulmonary, cardiology, neurology, endocrinology, allergies and anaphylaxis, gastroenterology, renal/urology, toxicology, hematology, environmental conditions, infectious and communicable diseases, behavioral and psychiatric disorders, gynecology, obstetrics, neonatology, pediatrics, geriatrics, abuse and assault, patients with special challenges, acute interventions for the chronic care patient, Ambulance operations, medical incident command, rescue awareness and operations, hazardous materials incidents, and crime scene awareness. (Texas Department of State Health Services, 2009, para 1)

The amount of didactic information and hands-on skills training requires candidates to immerse themselves in the six-month program. Much has changed in terms of new technology, new skills sets, and added tiers of certification since I

completed a similar program in 1979; however, not much has changed in terms of requiring students to process an overwhelming amount of new knowledge and skills in a very short period of time.

Stress Management Training for New Paramedics

The grueling pace of the initial training alone can lead to high levels of stress for new paramedics. In many ways, the process serves as a foreshadowing of the physical and psychological demands that await them once they hit the streets. According to the EMT-Paramedic National Standard Curriculum,

> The Paramedic must be able to deal with adverse and often dangerous situations which include responding to calls in districts known to have high crime and mortality rates. Self-confidence is critical, as is a desire to work with people, solid emotional stability, a tolerance for high stress, and the ability to meet the physical, intellectual, and cognitive requirements demanded by this position. (U.S. Department of Transportation, 1998, p. 47)

I recently met with the individual responsible for teaching stress management to the new paramedics. Dr. Darrel Parisher is a licensed clinical psychologist who is also the director of the San Antonio Fire Department's (SAFD) Employee Assistance Program (EAP). I asked him to describe his role in the stress management training that is given to new paramedics. He basically explained that there are two facets of stress that he discusses with them: (a) personal stress and (b) professional stress.

The discussion on personal stress serves as a reminder that paramedics, much like people in other professions, face problems brought on by ordinary life. The

candidates are introduced to the idea that personal stress can exacerbate work stress, which could have dire consequences if not recognized and managed correctly. Therefore, Dr. Parisher emphasizes the importance of keeping the stress in their personal life "manageable" in order to cope with that which is "unmanageable" at work. Personal stress is obviously the easier of the two facets for the paramedics to handle simply because they understand where it is originating—at home. This facet of stress can be seen in problems associated with marriages, children, personal finances, and with life in general.

Dr. Parisher explained that most of his presentation and discussion is centered on the second facet—professional stress. Professional stress is more difficult to handle because it is virtually impossible for paramedics to anticipate what type of events they will experience at any particular moment during a shift. In reality, paramedics have no control whatsoever over what they will encounter. The constant repetition of finding themselves in this predicament over a period of years clearly takes a toll on the overall wellness of individuals. It impacts the human mind, the human body, and one's spirit. One of Dr. Parisher's goals in this discussion is to get the emergency responders to understand the "normality" of being psychologically impacted by some of the events they will experience. The ability to recognize how these experiences may impact their personal lives is critical to having a successful career. Managing both facets of stress is the key to helping the new paramedics survive the chaos of EMS.

Continuing Professional Education in EMS

Designing and maintaining standards and consistency for delivering responsible patient care are imperative to the mission of the emergency medical services not only locally but nationwide. "Understanding the structure and capabilities of EMS is a critical component of emergency medicine, as the collaboration between pre-hospital and hospital-based providers determines the quality of emergency medical care delivered to the community" (Biddinger & Thomas, 2005, p. 117). Standardization of medical operating procedures and other protocols has been virtually synonymous with EMS since the idea was first conceived. Thus, EMS medical directors and fire department administrators have always pursued a high quality of care for all patients.

> In 1968, a special Task Force of the Committee on Emergency Medical Services of the National Academy of Sciences/National Research Council produced *Training of ambulance personnel and others responsible for emergency care of the sick and injured at the scene and during transport*, an attempt to standardize on a national level training requirements of ambulance attendants and others providing emergency care and services. (Rockwood et al., 1976, p. 301)

The level of training received by paramedics has evolved from first aid and basic life support to advanced life support, which has resulted in firefighters becoming the eyes and ears of physicians while responding to emergencies in the streets of both urban and rural communities.

> Paramedics are trained in advanced airway management, including endotracheal intubation, cardiac rhythm interpretation and defibrillation, and parenteral

> medication administration. Additionally, many paramedics are trained in cricothyrotomy and needle chest decompression when state and regional protocols allow. Pre-hospital care by paramedics is termed Advanced Life Support (ALS). (Biddinger & Thomas, 2005, pp. 117-118)

Much like other licensed health care professionals, paramedics are required to not only maintain proficiency in the knowledge and skills they learned in their initial training programs, but they must also stay current with the latest in medical lifesaving techniques and technology. Paramedics are constantly engaged in an extensive and advanced continuing education program. In San Antonio,

> Initial training for EMT-Paramedics meets Texas Department of Health standards, and covers areas such as advanced cardiac life support, basic pediatric care, and pre-hospital trauma life support. Building on this initial 1,000 hours of training, EMT-Paramedics also receive 40 hours of continuing education each year. As members of the SAFD, EMS personnel must also take continuing education classes on structural firefighting approved by the Texas Commission on Fire Protection in addition to their medical training. **(**City of San Antonio, 2010, para. 3)

Cutting-edge technology and the discovery of improved life- and limb-saving techniques requires continuing education designers and facilitators to be constantly developing and delivering updated training programs. The continuing education content areas developed by the UTHSCSA mirror those of the Texas Department of State Health Services.

Instruction in these content areas is presented in 40-hour increments over a four-year period, at which time a paramedic's certification comes up for renewal. Each year, active paramedics attend a week-long continuing education program that covers approximately one-fourth of the content required to maintain their certifications.

Stress Management Training for Incumbent Paramedics

Paramedics do not generally receive any new training related to stress management in their continuing education program. At best, there is a review of material pertaining to stress management taken from the textbook. Dr. Parisher, the Fire Department's EAP director whom I interviewed, stated that most of the education for incumbents actually occurs within the confines of his office. It is important to note that these sessions take place at the request of the paramedics themselves; they are completely voluntary.

Dr. Parisher unequivocally stated that the vast majority of problems these individuals bring with them are related to their job experiences. "Learning moments" for paramedics abound during these counseling sessions as Dr. Parisher helps them connect their personal problem(s) to work-related event(s) that may have triggered an emotional response. Insomnia, nightmares, unexplained anger toward loved ones, depression, binge drinking, etc., are but a few signs that may surface in a paramedic's personal life. A common characteristic among these individuals is their failure to make a problem-to-job connection prior to seeing the doctor. They are often surprised to discover that the emotions that often manifest themselves in their personal lives are a result of the job. These experiences validate the effectiveness of the Employee

Assistance Program (EAP) and the counseling sessions, but they also reaffirm the need for the further development of preventive measures.

Employee Assistance Program (EAP)

I have come to understand the concept of EAP as being an intervention tool that is most effective after an event has occurred. One example of this may be conducting a critical incident stress debriefing session for emergency responders after a multi-death incident. Although Dr. Parisher has designed preventive programs in the past, the implementation of such initiatives have been compromised by economic and logistical constraints that are often beyond his control. At the present time, there are over 1,400 employees working in the San Antonio Fire Department. Dr. Parisher must not only be available for them, but for all family members of active and retired personnel. He has been and continues to by the only mental health professional directly associated with the Fire Department. This is further evidence of the organization's historical lack of understanding of the serious impact of job stress on its employees. Therefore, it is physically and logistically impossible for him to be everywhere for everyone at any given time. Although most of his sessions are scheduled by appointment, there are those times when he has to respond to a critical incident at a moment's notice.

Therefore, it is clear to see why his program has historically had to focus on interventions that deal with problems that have already occurred. Another hindrance to maximizing EAP has been the physically decentralized layout of the Fire Department. Firehouses are spread throughout 400 square miles of urban and suburban sprawl. Paramedics work a 24-hour rotating schedule that involves four shifts. It is, therefore,

impossible for the doctor to make contact with each and every paramedic. However, during the writing of this research study, I learned that Dr. Parisher had recently formed and trained a peer support group and a critical incident stress debriefing team, both comprised of active firefighters and paramedics. These are individuals who work in the field and who have volunteered to be participants and leaders in these initiatives. Both programs have been active for the past two years. Although budget constraints and other factors continue to hinder the addition of a full-time staff, Dr. Parisher's efforts to form a network of peer counselors has been very effective.

Summary

Public safety in the United States has evolved from the days of sentry marksmen and volunteer fire brigades to a profession that provides highly trained individuals who are well-prepared for different types of emergencies. Paramedics in particular are expected to work well within their respective medical communities and with other emergency responders. They are trained to work as part of a team that possesses the latest in medical knowledge, skills, and technology. Paramedics are expected to work under the most intense and at times uncontrolled conditions. They maintain the most responsibility for victim care at the sight of an emergency.

The cumulative effect of being constantly exposed to highly stressful events often takes an emotional toll on these individuals. Although the initial and continuing education programs for paramedics of the San Antonio Fire Department are extensive, there continues to be limited attention given to the psychological well-being of these modern-day lifesavers. Most interventions by mental health professionals intended to

help these individuals are characteristically reactionary in nature. There are now new initiatives being proposed within the San Antonio Fire Department that address the need to improve on programs that are already in place, such as the EAP. The new focus is on designing preventive measures to help paramedics identify problems and to possibly intervene in a more proactive manner.

CHAPTER V

ENTERING THE CHAOS

I never grew tired of watching paramedics John Gage and Roy Desoto rush to the scene of medical emergencies on Squad 51 in Los Angeles County. These were the two main characters that formed part of the cast on the weekly television program *Emergency.* The made-for-television dramas celebrated the fire service by featuring daring rescues and emergency medical calls—still a novel concept for most communities in the 1970s. Even then I knew that the dramatic accounts of the characters' heroic feats were influenced by Hollywood writers and producers. Notwithstanding the fictional, albeit "based-on-a-true-story" episodes, the idea of becoming a real-life paramedic strongly appealed to me. I must have viewed every episode of *Emergency* that was ever produced.

I loved the job. I grew up fast because of it. Becoming a member of the San Antonio Fire Department gave me respect in my community, economic independence, and celebrity status in my blue-collar neighborhood. There just weren't many 19-year-old kids right out of high school making $742 a month and living out a childhood dream (see Appendix A). The year was 1975 and I was a fireman on Ladder Truck Company 33—it was truly the best time of my life (see Appendix B).

The experiences I had as a young firefighter during the first three years of my career can best be described as a collection of rude awakenings. It seemed as if I had crossed over an invisible threshold that separated the comfort and security of a structured and almost predictable existence, from a less defined chaotic reality of violence and

destruction that is rarely experienced by the average citizen. During this period of time, I responded to a significant number of major alarm fires, high water rescues, shootings, stabbings, heart attacks, drug overdoses, and just about any type of emergency one can imagine. Having been exposed to these and other challenges added new perspectives. Consequently, I never again looked at life and the world I lived in the same as I had prior to joining the Fire Department.

A promotion to the rank of fire engineer was an automatic invitation to attend The University of Texas Health Science Center for five months of intense medical training for EMS—the Emergency Medical Service. I was one of the few newly promoted engineers who volunteered. Then, on the morning of September 21, 1979, I woke up knowing that my dream of becoming a paramedic was about to come true (see Appendix C). All of the episodes of *Emergency*, the television show, had long been sent to syndication. Reruns were all that remained. Life was coming at me fast. Fiction had given way to reality (see Appendix D).

Welcome to EMS

I suddenly heard someone yell out, "*How does it feel to have a license to kill, John Boy?"* It was a slightly inebriated Rudy B., one of my classmates and now fellow paramedic. We were at our EMS graduation reception. I had previously been christened with the name "John Boy" at Station 33—right out of the academy. I had acquired the unsolicited moniker from my "good natured" firehouse peers. I think that I reminded someone of the character played by Richard Thomas on-the-then popular television series *The Waltons.* I also think that being 19 at the time I entered the department

contributed to the acquired celebrity name. I have learned to appreciate the well-intentioned and affectionate overture more now in the present day than I did then.

Yes, Rudy arrived drunk at our graduation ceremony. I could smell the alcohol on his breath with every word he spoke. Much like several of my contemporaries, Rudy had a drinking problem. I never drank prior to EMS, not even socially. Then I became a paramedic. I never could have imagined, not even on graduation day that I, too, would soon look forward to having a drink or two. I wasn't the least bit insulted, nor did I feel any sense of embarrassment by Rudy's disrespectful greeting, even though we were in the presence of family and friends. Wives, parents, significant others were at the gathering. My dad was in attendance.

By this time in my career, I was no longer a stranger to the sometimes abrasive and spontaneous commentary spoken by firefighters and paramedics. I, too, was guilty of participating in heavy-handed conversations, practical jokes, and dark humor, nor was I the least bit surprised at the alcohol abuse taking place among some of my colleagues. A veteran paramedic once told me that *getting wasted* was a way of coping with job stress. My response to him was, "*what stress? Two cool guys riding in a million-dollar ambulance playing doctor in the streets of San Antonio is not my idea of stress."* For me personally, it meant having freedom from the grip of firehouse captains; it meant power, privilege, prestige, and adventure while getting paid for doing the job of a lifetime.

I was barely 24 years old when I was tasked with the responsibility of making life and death decisions on the streets of San Antonio. In 1979, firefighters-turned-paramedics were still trying to find their professional identity. Even after having

received the best advanced life support training that was available at the time, making these types of decisions was still foreign to most of us. In the end, most of our education came from actually doing the job.

The Many Faces of Death

It did not take long for me to realize just how fragile life really was. One might read books or listen to first person accounts of what possibly lies ahead in the hereafter. Out-of-body experiences and bright lights are all legitimate accounts, I suppose. Prior to EMS, my perspective about death was limited to my Catholic upbringing. When God called you home, the break from this earth came clean and one's soul ended up in one of three places. It would be an understatement to suggest that my religious perspective about death received a big jolt once I became a paramedic.

Although I eventually came to accept the reality of people dying before my very eyes, I never quite got used to the idea. I often wondered if these patients were able to hear and see me "from the other side" as I tried desperately to keep the inevitable from happening. I wondered if they knew about the times I screwed up. I did, after all, make my share of mistakes—we all did. Being the last person on earth someone talked to was a little unnerving at first. Perhaps I internalized the experience a bit too much. I sometimes likened it to playing a tug-of-war with guardian angels or something more powerful than me on the other end of a rope—a rope that intersected life and death. Interestingly, there were times when I felt that I won a tussle or two…or perhaps it was just a matter of someone *on the other side* deciding to cut me some slack and allow me to claim a victory or two now and then.

Ricky

"8-0-6, 8-0-6, please respond to a stabbing victim at Fresno and IH 10…that will be for a stabbing, PD (police department) is requesting and standing by." I was working with Lee Carrola, my assigned partner—the guy I was *married to* in EMS for the better part of seven years. I didn't mind responding to a legitimate emergency once in a while. By 1981 a good portion of the population had grown accustomed to calling an EMS ambulance for just about anything that ailed them—headaches, toothaches, mosquito bites, ear aches, etc. As frontline paramedics, we thought that the public was getting way too spoiled when it came to calling for our services. Ironically, a stabbing incident was a welcomed request. It gave us an "all right" moment. I always looked at a trauma-related emergency as a real challenge and as an opportunity to apply the skills and knowledge I had learned in school. Dealing with trauma-related emergencies was one of my strengths. Knowing that someone's life was in my hands gave me a rush of adrenalin. To actually save a life was to experience the ultimate joy and satisfaction of being a paramedic.

"8-0-6 is at the scene, dispatch." The wound to the young man's abdomen appeared to be a small puncture. He was conscious and talking, but his skin appeared pale and clammy—a sign of possible hemorrhagic shock, despite no visible signs of bleeding. Upon conducting the routine visual examination, I noticed the brown "coffee ground" matter coming from his mouth. It was digested blood—a clear sign of internal bleeding. All of our training began to kick in.

"*Lee, we have an internal bleeder.*
Yep…we've got coffee grounds.

We need to stabilize him and just load and go.
Let's get the MAST trousers on him.
Hey buddy, can you hear me?
Stay with us now.
Don't go to sleep.
It hurts, really bad.
John, get the emesis basin.
He's puking all over the place."

I was fortunate to be working with a great partner. We worked like a hand in glove. We each knew in advance what the other was thinking and doing, especially when "the mud was hitting the fan."

"*Two ringers lactate I-Vs with large bore catheters are in.*
Let's get his blood pressure up, it's really dropping.
MAST trousers…let's hurry up.
Trousers are on and inflated.
Hey man, what's your name?
Stay with us, now…what's your name?
Ricky…Ricky Martinez.
OK, Ricky…hang on for the ride.
Let's go code 3…I'll call it in."

Military Anti-Shock Trousers, or MAST, are basically a contraption that looks like a pair of extra-large overalls that a farmer might wear. They are applied to the legs and the abdominal area. They are then inflated to divert blood from the legs and abdomen to the vital organs, i.e., the heart, lungs, and brain in patients who are bleeding severely. Lee was on the spot with the MAST trousers as I started the two I-Vs. It was Lee's turn to drive. I rode in the back of the ambulance with Ricky.

I actually liked treating trauma victims. There was very little guesswork involved. As usual, we had done everything by the book with Ricky. There was a very exact protocol we were required to follow for applying and for removing the MAST trousers once they were used on a patient. Lee and I, like most paramedics we knew,

were very conscious of this. To compromise the procedure in any way was to jeopardize the patient's life. Not doing this one by the book could get us into big trouble. We were able to get Ricky's blood pressure back to almost normal. The MAST trousers were literally keeping him from bleeding to death internally. I talked to Ricky on the way to the hospital. I had already submitted a report by radio, which alerted the appropriate medical team at the hospital for this type of emergency. In the midst of everything that was occurring, I noticed that the patient had a calm and pleasant demeanor about him. Ricky's normal skin color had returned and I assured him that he was going to receive the best possible care. He got comfortable enough with me to begin a conversation.

"I'm really sorry about this. I was stupid to have gotten mixed up in this mess.
Hey, things happen…the important thing is that you're going to be OK.
Your pressure is almost back to normal.
Thanks for being nice to me, sir.
No problem."

I always made a sincere effort not to get involved in personal conversations with patients. Even though I felt that Ricky wanted to talk about the "mess" he was in, I always brought the conversation back to what was going on with his injury. I tried my best to do this with all patients. I was not trained to be a social worker or a psychologist. I figured that the less involved I got, the better I could focus on the medical condition of the patient. I held an emesis basin under his chin as he continued to vomit digested blood. I continued to monitor his vital signs.

Upon arrival at the ER, we quickly transferred Ricky from our stretcher to the hospital's gurney. *"One, two, three, and over,"* I heard the head nurse command her medical staff in an assertive tone. *"Don't deflate those trousers,"* she said. *"We are*

standing by," I shouted back over other voices, monitors beeping, swinging doors, and the inflation of blood pressure cuffs. I got one more glimpse at the life we had just saved. Ricky had his color back and his blood pressure was close to normal. We did our job. *"I'm Dr. Smith, what do we have?"* The young doctor's high-pitched voice lacked the authoritative quality of the head nurse. Nevertheless, Dr. Smith was now in charge of the ER. *"Puncture wound to the upper right quadrant of the abdomen, did not recover weapon used, his vitals are…"*

I could see the look of disbelief on Lee's face from the corner of my eye as I was giving my report from my notes. It was at that very moment that everything and everyone in the room seemed to shift into slow motion. Suddenly, the ripping sound of Velcro filled the room. The young intern was literally stripping the MAST trousers off the patient! He was going against the very same medical protocol that had been pounded into our heads during our training. Only the individuals who applied them could remove them! How could he be doing this? The head nurse froze in her tracks as her jaw dropped almost to the floor. There was no time to react to the doctor's inexplicable actions because Ricky went "flat line" almost immediately. The head nurse screamed at the top of her lungs, *"Code blue! Code blue! Take him upstairs!"* Lee and I grabbed the hospital gurney and rushed Ricky to the OR (operating room) floor with a couple of ER nurses in tow. He was unconscious and gasping for air through the oxygen mask. We got as far as the swinging doors from where personnel from the OR took over. We never saw Ricky again.

We found patches of Ricky's digested blood in the elevator and in the corridors as we made our way back to the ER. I wanted to find the doctor and ask him what he had seen that we may have missed for him to have committed such a gross violation of medical protocol, or was he just plain stupid? He was nowhere to be found. We got back in service and went back to the firehouse from where we continued to respond to the routine emergency calls we had grown accustomed to.

Later that shift we received word that Ricky had died. I could not get it out of my head that I had been the last human being he had talked to in this life and that I had assured him that he was going to be fine. It was time to vent. Lee did it for both of us.

"This is bullshit!
I want to go back to the hospital and kick that doctor's ass!
Do you know where you and I would be right now if we had done what that cumquat doctor just did?"
We would be at the freaking chief's office signing pink slips.
We'd be lining up at the unemployment office tomorrow looking for a freaking job!
We'd be barred from handing out band aids!"

Lee was quite agitated, and I, too, was pretty pissed off. I sat in stunned silence listening to his voice rise above the sound of the air conditioner blower that was running full blast inside the cab of the ambulance. I was caught up in my own thoughts about not being able to save Ricky. Lee finally quieted down after about a three-minute tirade. The numb feeling I had was beginning to dissipate. The travesty that had been committed by the doctor was inexplicable. Lee and I discussed the notion of writing up the doctor in a formal report to the chief and the medical director. We contacted our supervisor. We were promptly "dissuaded" from doing such a thing by our EMS captain—Dave Rovalcaba.

"It comes down to your word against the medical community, not just the doctor. Here you have a couple of young firemen in their twenties against a licensed physician who just completed ten years of medical school and several internships. That's a tall order. Besides, your careers are just beginning. You, too, will make mistakes."

We quickly caught on to the captain's not-so-subtle message. We were being reminded that we were firemen first, then paramedics. My thoughts turned to Ricky and his premature departure from this earth. He was the first patient to die on me. I took his passing very personal. I was a rookie paramedic who still had a lot to learn.

"8-0-6 is back in service."

You Killed Her

Captain Rovalcaba was right. I would eventually make mistakes. It had been three years since I began my career in EMS, and I was starting to show signs of mental and physical fatigue. I was experiencing one of the worst episodes of job burnout. The incident occurred on a day when I really did not want to be at work. I did not understand why the patient was being so combative.

Virginia was a cafeteria worker at Whitman middle school just a few blocks north of the firehouse. She was about 50 years old. Her speech was slurred but also sounded abrasive and antagonistic to Rudy B. and me. She was flailing her arms in a way that appeared physically threatening to both of us. She caught the side of my face once, but I knew that it had not been a deliberate swing. We managed to get her on the stretcher where we strapped her arms tight to keep her from hurting us and herself. Her daughter showed up unexpectedly. She was a registered nurse (RN). The last thing paramedics want is another medical professional telling them what to do or critiquing their work, especially at the scene of an emergency. Rudy B. and I were no exception.

"This could get ugly," I told my partner outside of the unit. We attempted to get vital signs as well as connect the EKG leads on her but were not successful.

I lost my temper and verbally chided Virginia for being so uncooperative. To my surprise, the daughter was very supportive and even assisted us in attempting to calm her mother. I actually yelled at Virginia a couple of times but got little cooperation. Then, the unthinkable happened: she unexpectedly *crashed*. Virginia quit breathing and her heart stopped. We immediately worked to save her life with the help of her daughter, who under the circumstances held up exceptionally well. We rushed Virginia to the Downtown Baptist hospital where Dr. Raines and the ER staff did everything they could to bring her back. She was pronounced dead within the hour.

There was total silence on the way back to the station. There were several questions swirling around in my mind. Had I lost my focus? Was my burnout interfering with my ability to do the job? Finally Rudy B.'s dark sense of humor surfaced when he half-jokingly told me, *"You killed the old woman. She interrupted your afternoon nap…admit it…you killed her."* I did not respond. This dark sense of humor was all too common among us. However, this was one time that I regretted being an active participant.

I was not in the mood for comic relief at that very moment. I sat silently in deep thought as I questioned my own actions and inactions—my emotional temperament. Rudy B. suddenly turned serious and said, *"I wonder if the daughter is going to have something to say about this…she is an RN, you know. We weren't at our best back there."* I now had to live with the uncertainty about how I had handled this call. I grew

concerned and was beginning to have second thoughts about my ability to do the job much longer. How many more of these calls was I going to have? It was time for a reality check. My status as a "valued commodity" and my low seniority in the EMS division meant that I was expendable. I should have stayed home that day.

"8-0-6 is back in service."

Am I Going to Die?

The call came in for an elderly woman complaining of not feeling well. *Sick party* calls were not all that unusual for our area, especially when they involved the elderly. Nursing homes, assisted living, and other home care facilities dotted our immediate response area. Jane's request was somewhat unusual in that nothing really hurt. She simply had a slight discomfort and a premonition. *Am I going to die?"* she asked. I ignored her question as I strapped the blood pressure cuff to her right arm.

"What hurts?
Nothing……Am I going to die?
No, Jane, you're not going to die…at least not if I can help it.
Why did you call us?
I am feeling a slight discomfort on my left arm.
Do you have any pain?
No… but I want to know if I am going to die.
No! You're not going to die!"

For someone in her late 70s, Jane's vital signs were exceptionally good. According to our standard medical operating procedures (SMOPS), Jane did not meet the criteria of a mandatory transport to the hospital. There did not appear to be any other underlying medical problems, and none of her medications addressed psychological or psychiatric issues. We were about to have Jane sign the release on our patient form

when I thought of asking her what hospital she preferred. Rudy B. had a disturbed look on his face as if to tell me that this was not a life and death emergency.

"What hospital does your doctor practice at, Jane?
Humana Metropolitan-downtown.
You know, that's just a few blocks from here.
Why don't we just give you a ride down there and have the doctor take a look at you?
OK…but am I going to die?"

Jane got her purse and a light sweater, and we slowly walked her to the ambulance. We had her sit on the stretcher to the hospital. I rode in the back with her. She repeatedly asked if she was going to die. I repeatedly responded, *"No, you are not going to die"* all the way to Humana Metro-downtown. The entire trip took less than ten minutes. Nevertheless, I had to put up with Rudy B.'s complaining all the way back to the firehouse.

"You know that she could have gone by taxi or called a neighbor to take her in.
She didn't even have to go. Why did you insist?
Hell, I don't know…
…Maybe because she kept asking if she was going to die…
… Or because her left arm felt funny to her, or because she's in her late 70s.
I guess I kind of felt sorry for her…being alone and all. She seemed scared.
Oh, oh…you're getting soft on me now John Boy…don't get soft on me now.
Besides, Metro is only 5 blocks from her home. Nothing was lost."

Jane basically got a high dollar taxi ride courtesy of EMS. No I-Vs, no oxygen masks, or bandages…just a ride on a hunch.

It was about 3 a.m. on a slow night. Rudy B. and I were fast asleep when the hot line at the firehouse rang. I jumped out of bed thinking we had inadvertently turned the radio off and missed a call. When I answered the phone I had to ask the voice on the other end to speak louder. I was still half asleep.

"This is Dr. Harris from Metro-downtown.
Yes sir, this is De La Garza from 8-0-6.
Did you all bring in a 78-year-old female earlier tonight?
Yes, we did.
She kept asking if she was going to die.
Yes, that's the one.
Did you get any history on her regarding heart or cerebral vascular problems?
According to her, she had none except for the low dose blood pressure meds…
…but her vitals were normal. Why?
She had a massive heart attack about 20 minutes ago and died.
Wow! She kept asking us if she was going to die.
You did the right thing by bringing her in. Thanks.
Whoa! Rudy, hey Rudy…we scored a touchdown!
What the hell…this better be good…I was fast asleep for crying out loud!
You remember the old woman we took to Metro earlier?
What about her?
She died at the hospital.
What?!?!?
Yep…we dodged a bullet.
Imagine if we had left her at home.

I cannot even begin to explain what might have been if we had not transported Jane to the hospital. We certainly could have justified our actions by making references to our medical protocol. She did not meet the criteria for transport. But how would it have looked if we had just left her at home? She would have died just hours, or maybe minutes after having had EMS check her out. We could have possibly faced a high-level investigation. Our medical knowledge and skills would have certainly come into question, as well as our "logical" explanation for leaving her behind. This was one of those *gray area* calls that could have easily gone either way for us. Was I ever relieved that I had listened to my sixth sense. Rudy B. acknowledged the decision to transport her as having been the right one. *"From now on I'm going to pay close attention to your hunches, John Boy."* Rudy B. and I threw high-fives feeling relieved that we had made

the right call. We went back to bed. It was three o'clock in the morning and a woman named Jane had just died.

Jim, This One's Dead!

Jim Cairns and I were very good friends. We had both entered the Fire Department and EMS together in the same training classes. Although not regular partners, we often worked details together on "D" shift. One Sunday evening, I was detailed to work with Jim at Station 13. It was just after supper when we heard the dispatcher on the EMS frequency.

"8-13, 8-13, make The Robin's Hood for a shooting. That will be for a multiple shooting. 8-22 will be your back-up."

This was a popular south side hangout for drug dealers, pimps, and prostitutes.

"Sunday night, it's probably a false alarm.
Don't bet on it.
These trolls never sleep.
8-13 is responding, dispatch."

Upon our arrival we saw a large crowd in the parking lot, and another group of people at the door of the club waving us in. SAPD had not yet arrived. It was just Jim and me.

"8-13 to dispatch please send us a backup.
It appears that we have multiple victims and tell PD to get over here quick!
8-22 is your back-up, 13.
Ten-four, dispatch…tell them to hurry.
You check inside, I'll check the parking lot."

Large crowds at night without any back-up or police officers in sight always made me nervous.

"Sir, sir, look…over here!
Whoa! Jim, I got three down in the parking lot!"

There were three young men who appeared to be in their 20s laid out on the asphalt one besides the other. Jim replied,

"I got a shooting victim inside!"

I knew then that we were each working solo until help arrived. I ripped the first victim's shirt open and immediately saw a bullet hole in the middle of the chest. There was no breathing, no movement, and no palpable pulse. I had the EKG monitor so I placed the leads on him—flat line.

"Jim, this one's dead!"

Jim also had his hands full. My adrenalin rush was causing me to yell out the obvious each time. I did the same for the second victim who also had a bullet wound in the middle of his chest.

"Jim, this one's dead!"

The third victim was no different than the other two.

"Jim, this one's dead!"

I remember thinking in the middle of the chaotic scene that whoever shot these guys was very good with a gun. The thought that he may still be around wielding a firearm made me nervous. I suddenly heard Jim cry out for help.

"John, this one's alive!
I need two ringers lactate and MAST trousers!"

Just then 8-22, our back-up, arrived to assist as well as SAPD. It turned out that the victim Jim was working on was the club's bouncer, and it was he who had shot and killed the three men I had just declared dead. We later discovered that they had tried to force their way into the club after having been denied entry. They had followed three

women who had previously shunned their advances. The women had asked the bouncer to keep the three men out of the club. The bouncer complied, the three men argued and in an instant they were dead. They never had a chance. The bouncer turned out to be a very good shot. We rushed him to the hospital and saved his life.

The remainder of the shift was uncharacteristically quiet, even for a Sunday night. We never got another call. Nevertheless, it was difficult for me to unwind having declared three young men dead at what had been a very violent crime scene. This one call seemed to have zapped all of my physical and emotional energy for the entire shift. The three young men were still lying in the parking lot of the Robin's Hood when we made our way back to the station after having delivered the bouncer to the hospital. The medical examiner and the officers from homicide were collecting evidence. As a war veteran, Jim had a different perspective.

"Heh, heh, heh; reminds me of the body counts we used to have in Viet Nam.
It's de-ja-vu all over again for me…poor bastards.
Let's go home and get some sleep."

Momma! Momma! Bobby's Dead!

Lee and I were at McDonald's trying to eat dinner when we were dispatched to Hackberry and Iowa for an MV-Ped (motor vehicle-pedestrian) accident. It was about 10:00 in the evening. Upon our arrival, we saw the body of a young African-American man lying in the middle of the intersection. He had been struck by a truck while crossing the street. It was an accident. He died instantly. We covered him up with a yellow disposable blanket that we carried for such incidents. I took down the information we needed for our report. Lee declared him dead, and I then proceeded to

ask the police officer in charge at the scene if the medical examiner was responding. Due to the large volume of calls that evening, we were being told by our supervisors to get back in service as soon as possible. I argued with the police officer.

"Is the M.E on his way?
Nope, that's what I'm talking about.
The M.E. is not responding to this one.
Someone just contacted this young man's family and they are on their way.
They think that he is still alive.
We don't go to the morgue…and we can't take a dead body to a hospital.
What the hell am I supposed to do?
You didn't hear me the first time… his family is on the way!"

I went to the ambulance and conferred with Lee.

"What do we do? This cop is really pissed and sounds worried.
Call dispatch and have them contact the morgue.
Let's load him up.
OK, OK, officer we're taking him."

As soon as we got the body in the ambulance, I quickly closed the door and ran to the passenger seat in the cab. I was in no mood to ride in the back of the ambulance all by myself with a corpse. It was Lee's turn to drive. Suddenly, I heard the cop say, *"Here they are, you guys better high tail it out of here."* The family had arrived. I looked through the passenger rearview mirror and saw a bystander talking to them and pointing our way.

"Come on, let's go!
They're following us Lee.
They probably weren't told that this guy is D-O-A.
What are we going to do when they drive up behind us at the morgue?
You better call ahead and have PD stand by.
They should have a security detail there, wouldn't you think?"

I got on the radio while Lee attempted some evasive maneuvers. He even sped up at times to try to lose the family.

"They're still on our tail.
Well, here we go…
8-0-6 to dispatch we are at the Bexar County morgue.
We are at the back entrance loading dock and there is nobody here.
The doors are locked.
Oh crap, here they are…they're getting out of the car!"

I then heard the loud cry of a young girl.

"Momma! Momma! Bobby is dead, Momma!
Bobby is dead…heeeeee's dead!
Noooooo! It can't be! Not my Bobby!"

The older lady who was screaming had to be restrained by family members. She threw herself on the ground at the entrance to the morgue's parking lot. Just then, a physically imposing figure from the huddled group approached us. I remember hearing a very deep voice.

"Say, say, who you got in there?
You got a dude named Bobby in there?
Yes sir…I am so sorry.
Why don't you take him to the hospital?
Tell me, why don't you take him to the hospital?
Momma! Heeeee's dead momma!
I am so sorry sir; he is…
Don't give me that crap…"

He slowly and hesitantly made a half turn and retreated back to the grieving family. I could distinguish five other adults who got out of the car. The same lady who was distraught lay on the ground, sobbing uncontrollably. *"It must be the mother,"* said Lee.

It would be an understatement to say that there was tension in the air. Both Lee and I, who were still in the cab with our doors locked, were growing increasingly nervous and frustrated that there was no sign of anyone coming out from the morgue to

assist us or the family. Emotions were running high and we had a lifeless body in the back of our ambulance.

"Where in the hell is PD and why don't they open the freaking door for crying out loud?
Are you sure this is the morgue?
This is it man.
It's just that I've never been here before."

Finally, one of the large imposing doors opened. We were greeted by a night attendant as well as a Bexar County deputy sheriff. We then proceeded to transfer Bobby from the ambulance to the morgue. We had him completely covered from head to toe. The family was collectively distraught and despondent at the sight of their loved one lying lifeless on our stretcher. The deputy did not allow them to follow us in.

Once inside, the lights were turned on by the attendant. There they were. Row after row of dead people with manila tags attached to their toes. We were used to seeing dead people, but not in mass quantities. We certainly weren't used to transporting anybody to the morgue. It wasn't part of our job function. We were accustomed to delivering live patients to hospital emergency rooms. This was quite a contrast. There was nobody there to get a status report or ask any questions about vital signs or anything related to the condition of our patient. It was frigid cold inside. I am not ashamed to say that the place gave me the creeps. It was no time to be the proud, cool, and macho paramedic around this place. With the help of the attendant, we transferred Bobby's body as fast as we could to one of their gurneys, signed the necessary paperwork, and got the hell out of there. In the meantime, the family in the parking lot had been escorted around to the front entrance for their share of paperwork to fill out. This entire call, from beginning to end, was a true representation of just how chaotic and

unpredictable the job was. One minute we were eating at McDonald's, the next minute we found ourselves inside the morgue delivering a body. *"8-0-6 is back in service."*

Looks Like a Mannequin

I had seen several dead bodies immersed in formaldehyde at the medical school, as well as a multitude of others who had died either in my presence or just minutes before my arrival. This one was different.

"8-0-6, make the 500 block of East Lullwood for a shooting.
You're backing up 8-28.
Ten-four we are on the way."

Every medical call, regardless of the way it was dispatched, was unpredictable. Three possibilities existed whenever a shooting was reported: (a) the shooting was either over, (b) still in progress, or (c) it was about to happen. We were met by an older gentleman at the door. At about the same time, Allen Martinez from 8-28 was walking out of the house singing something. That's right, in the middle of a shooting scene, he was singing something along the lines of, *he didn't know the gun was loaded,* to the rhythm of a popular commercial tune of the time. I did my best to ignore him.

"Allen is one sick puppy, don't you think, Rudy?
He seems pretty normal to me…heh, heh, heh.
Geez, look at this John Boy.
What the…?
Is that a real person?
Looks like a mannequin.
That's a hell of a way to check-out.
Do you know what this guy reminds me of?
I'm afraid to even ask, Rudy.
Did you ever get one of those hollow chocolate candy rabbits for Easter?
Remember when you took the first bite off one of the ears, and it made a big hole?
Why don't you go and join Allen outside and help him write the rest of the lyrics to his song?"

A 65-year-old gentleman was slumped over in an office chair in front of a desk in a room that appeared to be a study. The backdrop for this tragic scene was a beautiful home in the historic Monte Vista neighborhood. There were five loaded handguns on the desk laid out in front of the victim. An overzealous homicide detective made it known that he was in charge of the scene.

"Yep, he's a goner all right.
Don't touch anything!
Everything in here is evidence!"

The gun that he used to literally blow his brains out was on the floor just inches below his right hand. Half of his face and cranium were gone. There was blood, bone fragments, and brain matter all over the walls and the ceiling. We could see the inside of what was left of his head. All that remained was the inside of his scalp. There was no bone or brain matter; there was no blood underneath the thin layer of skin. He looked like a "clean" mannequin with a hole in its head, or like the chocolate candy Easter rabbit with a hole in its head that Rudy so vividly described. It appeared that SAPD and the medical examiner were well in control of the scene. I gathered the necessary information for our report and left. It was one of the most gruesome sights that I had ever witnessed.

"8-0-6 is back in service."

Death Becomes Routine

"*8-0-6, make Flores and Woodlawn at the St. Francis nursing home for a 10-29.*
It's three o'clock in the morning and we have to go confirm a death.
This has to change.
We are here to save lives, not confirm deaths.
Go call somebody who gives a…10-4, 8-0-6 is responding."

We drove around the back parking lot to the rear entrance as was customary. The home was just four blocks from the firehouse and it was one of our regular stops. We were met by Sister Marie, one of several Sisters of St. Francis who did a phenomenal job tending to patients under the direst of circumstances. Her Irish accent reminded me of the sisters who taught me at St. Henry's Catholic School. Most of the patients at this nursing home were destitute and terminally ill. Rarely did we see any visitors. There were usually four patients to a room. Tired and bleary eyed, Lee and I made our way inside.

"Good morning Sister Marie.
Yes, good morning gentlemen…The deceased is in Room 5.
I am on the phone with the Police Department…I'll be with you in just a moment."

Lee and I found ourselves standing at the doorway of Room 5 where we could see four bed-ridden patients, two on each side. They all had their eyes shut and were unresponsive to our presence in the room. Their breathing was not all that apparent. Sister Marie had forgotten to give us a bed number, and she was still busy on the phone.

"Which one is the dead guy?
I haven't the slightest.
Take your pick.
Well, there is one quick way to find out."

We proceeded to go around placing the EKG leads on each of their chests and connecting them to our monitor. None of them moved, flinched or even twitched when we examined them.

"Make sure we're getting a good read on the monitor.
Shake the leads. They're working fine.
This one is alive.
So is this one.
Well, then it must be…sure enough…the last one…we have a flat line.

8-06 to dispatch, we have a confirmed 10-29.
The staff here is waiting for PD to take a report. Do you want us to stand by?
Negative…just go ahead and get back in service."

Years later I came to reflect on calls such as this and realized just how routine being around death had become.

"8-0-6 is back in service."

Resurrection

There were times during my tenure as a paramedic that I felt completely inadequate. People dying in my presence seemed to take on a morbid sense of normalcy that is difficult to put into words. I tried my best to reconcile my self-deprecating ineptness with the one inevitability of life—death. Nevertheless, just as I would come close to "giving up on my mission in life," I would suddenly experience an unexpected and inexplicable moment that would renew my faith in what I was doing.

Lazaro

It was a hot and sticky August afternoon when we got the call for a *sick party* just a few blocks from Station 6. As I have previously mentioned, a sick party call could be just about anything. Sometimes it was just someone not feeling right. Roman was not my regular partner, but he was a very good paramedic in his own right. He was easy to work with and had a terrific sense of humor. It was hard not to notice the smell of a freshly cut lawn upon our arrival at the address. We were hastily escorted inside by a neighbor to the kitchen of a cold air-conditioned home. Once inside we came upon Lazaro who was sitting on a chair. He was about 60 years old. He had his hands on his

knees with his elbows locked and leaning forward. Lazaro was sweating profusely and was struggling to breathe. He told us that he had just cut and trimmed his lawn.

Roman went back to the ambulance to retrieve our EKG monitor because of the manner that our patient was breathing and perspiring. Something just didn't look or feel right. I was attempting to get Lazaro to slow his breathing down when he suddenly keeled over and fell flat on his face on the floor in front of me. *"Roman, unconscious M-I…call for a back-up!"* I yelled. I quickly got down on the tiled floor, put Lazaro on his back and began chest compressions. The EKG monitor showed ventricular fibrillation, which called for us to shock his heart back into rhythm. Pat and Lee, our back-up from 8-0-7 along with the firefighters from Station 6 arrived within minutes. In no time at all, there were EKG wires, I-V lines, oxygen tubing, and other medical equipment "decorating" the kitchen floor. The sounds of an AMBU bag pumping air, an EKG monitor beeping every second, and the thumping of chest compressions were an indication of paramedics working a patient whose heart had stopped.

We had Lazaro intubated and were forcing air into his lungs while we continued with CPR and shock treatments to his heart. I had seen many like this before but never had I had one die in front of me like he did. Medically speaking, Lazaro was gone—he was dead. After a while, he went flat line. In the middle of the chaos, I noticed a priest accompanied by a family member enter the kitchen. He must have been from Our Lady of Sorrows Catholic church just a few blocks away. I was preparing another I-V bag and I could see the priest from the corner of my eye as he reached through all of the wires and tubing to anoint Lazaro's forehead with holy oil. The most amazing thing happened

just a few seconds after the priest made the sign of the cross on our patient. Lazaro sat up! We were reading the EKG strip which showed ventricular fibrillation. This meant that his heart was basically quivering—not pumping blood at all!

"He's still showing V-fib.
That's impossible!
Why is he sitting up?
Let's call medical control.
The hell with that, let's just load and go!"

We rushed Lazaro to the Downtown Baptist hospital where he proceeded to pull out his endotracheal tube and cuss out the nurses who were struggling to restrain him. We were trying to keep him from disconnecting his I-V line. *"He's going to be all right,"* said Dr. Raines. *"You guys did this one by the book…great job!"* I was looking around for the priest to see if he had traveled to the hospital. I never saw him again.

How much credit was I willing to take for this one? It was very rare to see someone come back from the dead like that! *"It must have been the priest,"* I told Roman. *"It had to be. This guy was good!"* Roman was quick to downplay my belief in the power of intercessory prayer. He made sure to give ourselves some of the credit for bringing Lazaro back after being flat line. After all, one of the best ER doctors in the city had just paid us the ultimate compliment. Roman countered, *"So if the Almighty has the last word, what are we doing here anyway? I mean, what is the purpose of having doctors, nurses, and paramedics?"* Roman had posed a familiar question that was typically asked by non-believers or by those believers who were simply weak in their faith. My best response was, *"we are His instruments."* I knew what I had seen. I had witnessed Lazaro rise from the dead. *"8-0-6 is back in service."*

The Miracle Worker

There was a time in the early 1980s when we had a batch of high grade heroin hit the streets of San Antonio. Overdosing on any illegal substance was rarely seen outside of the street junkie, the prostitute, or the homeless transient. However, the nearly pure heroin that arrived during this period of time had a different clientele. The users were mostly middle to upper middle class teenagers and young adults who had suddenly found a new pastime. The problem was that most of these new users were less tolerant to the lethal chemicals entering their blood systems than regular users.

"8-0-6, make French Place and St. Mary's for a possible O.D.
Ten- four…8-0-6 is responding.
An overdose? That's the Trinity University area.
Must be a false alarm."

"8-0-6 is on the scene.
You better send a back-up and PD out here, we have a possible heroin O.D. and he is flat line with no pulse and no respirations.
This guy is dead.
Get an I-V and the Narcan started, Rudy.
Have you done this before?
Yeah, once…trust me…get that started.
Hey you, over there, do you know CPR?
Yes…I think I do.
Good enough. Start chest compressions.
I need to get this breathing tube down into his lungs.
So, stop the compressions when I tell you to.
Let me bag him first and try to get some O-2 into him.
Where in the hell is 8-0-7?
They're out on another call.
We're getting 8-19 instead.
Crap…they were just leaving Methodist a minute ago!
OK…is the I-V in?
Yes.
He's still flat line; no pulse, no breathing.
Get the Narcan and slowly inject it through the port.
OK…I hope this works."

"Hold on…shit! Hold him down!
Take it easy man! You're fine…you're fine…talk to me…look at me!
Get this crap out of my arm!
What do you think you're doing!
Hey, leave that in there…please!
Screw you! Do you know how much that white powder cost me dude???
You ruined my high you piece of shit!
Who gave you permission to puncture my arm???
I'm gonna sue you man…I'll get you fired.
Hey man, calm down. You were a goner; you were dead.
Your friends called us…you had no pulse, and…
You're full of crap!"

The patient proceeded to yank out the I-V tube from his arm, got up from the stretcher, ripped the EKG leads off his chest, and kicked the rear ambulance door wide open and went on his way. We never even got his name for our report. There was nothing that we could legally do to stop him, nor did we want to. Besides, he was being too violent. Narcan was the universal antidote for opioid overdoses like heroin. It worked very fast, reversing the effects of the drugs—sometimes too fast. It literally brought the patient back to life when administered within minutes of overdosing. However, it didn't bring them back to their senses. It only made them want the drug even more.

The college student we brought back to life was lucky in the sense that he had passed out in the presence of friends who were smart enough to call for help immediately. I administered Narcan on at least two other occasions during my career and was always amazed at just how powerful it was. Ironically, the heroin users whose lives were saved proceeded to scold me and my partner in the most vile and disrespectful manner each time. I never took the insults personally—I never took the time. I was always fascinated by how fast the antidote worked. I would simply sit back and watch

the patients come back from *the edge* only to have them cuss me out all the way to hell and back. I always referred to Narcan as *the miracle worker*.

Jonathon Lee

I witnessed many sad endings for too many people during my EMS experience. However, where there was death, there was also life—new life in the form of babies. I *helped* deliver five new citizens to the world during my tenure as a paramedic. I emphasize *helped* because I came to gain an appreciation for the mothers who were and are the true heroes in the miraculous endeavor of *giving life*. I prefer to say that I was simply there to offer my assistance. We knew we had a potential delivery whenever the dispatcher would call out the words *Oh Boy* over the radio. The correct medical term was OB-GYN, which of course is the acronym for Obstetrics-Gynecology. Nevertheless, *Oh Boy* caught on during the early days of EMS and became part of the paramedic lingo.

"8-0-6, make 718 West Elsmere for an Oh Boy…that will be for an Oh-Boy; the woman appears to be already in labor." It was 5:00 in the morning on a Sunday in mid-July. We had just collapsed in our beds after getting pounded with call-after-call on Saturday night. We still had two hours to go before being relieved. OB-GYN emergencies typically resulted in us transporting the mother-to-be to the hospital. They were for the most part routine calls—check vitals, start an I-V, and transport. We were met at the door by a middle-aged couple. It turned out that they were going to be new grandparents.

"Hurry, hurry, she's in the bedroom!
Oh, oh…Lee, we're going to need the OB kit.
I got it right here.
She's crowning…water bag burst some time ago.
It's alright Miss, we have everything under control.
Looks like you're going to be a mom today.
Ahhh!!! Can you please hurry and take me in!!!
I am afraid that there is not going to be time for that.
Let's call Bexar Med and let them know that we're delivering here and now."

The baby's head was already showing. This was my third. My partner Lee had never delivered one before.

"Here it comes…are you the new grandma?
Yes, yes I am.
OK hold your daughter's hand and tell her to keep pushing.
Aaahhh!!!

A few minutes later, there he was, a healthy baby boy…a ray of sunshine on a Sunday morning right at dawn! Lee clamped the umbilical cord in two places, just like we were taught at the hospital during training. *"Now, hand me the scalpel."* I cut the cord between the two clamps. We placed the baby on top of the mother's belly just below her breasts where he didn't waste any time getting fed. I was in the back of the ambulance with the mother and the little guy when he suddenly decided to exercise his lungs. It was about the same time that Lee was keying the microphone on the radio to give dispatch our hospital destination. Arthur, the dispatcher, excitedly asked, *"Is that the baby crying?"* Lee quickly retorted, *"No, that's my partner John. He's crying because he wants to go home."* A lot of laughter followed after that exchange—at my expense, of course.

About two weeks later Lee and I were summoned to the administrative headquarters by the EMS chief. This type of request usually meant that one of us or

maybe both were in trouble. To our delightful surprise, Chief Anaya held in his hand a thank you card from the mother of the baby we had delivered two Sundays prior. In the card she wrote a few lines of sincere gratitude and she also mentioned that she had given her baby boy both of our names—Jonathon Lee (See Appendix E). The chief then proceeded to give each of us a letter of commendation signed by the Fire Chief and thanked us for a job well done. We never made it a practice to visit any of our patients. Lee and I made the exception this one time and went to personally thank the new mom on West Elsmere for taking the time to write the nice card that got us both a departmental commendation and also to meet our namesake who was now two weeks old and all cleaned up.

Jonathon Lee's birth and the accolades that followed represented one of those *few and far between* moments of my EMS experience. Much like the experiences I had with death and dying, this event also had profound spiritual significance for both my partner and I, albeit a very positive one. It was a moment to savor for the rest of our lives!

The Children

It was the children who always got to me. Just about every emergency responder will say that nothing tugs at her or his emotions more than children being harmed in any way shape or form. Sometimes the harm had occurred several months prior to us responding, as was the case with Anna. Other times, pain and death reared their ugly heads in an instant, much like the accidental fires that claimed Armando's sister and a baby named Nicole. And then there was the premeditated abuse—the most

reprehensible form of harm that can ever be inflicted on an innocent child. That is what we encountered one afternoon at Charlie's Ice House.

Anna

"8-0-6 to dispatch.
Go ahead 8-0-6.
We are requesting Bexar Med on channel 4 we are transporting to Santa Rosa.
Ten-four, 8-0-6…you have channel 4.
This is Santa Rosa, go ahead six.
OK, we have a 12-year-old female who is in her third trimester.
This is her first…10-9, 8-0-6?"

10-9 was the code used to request that a radio transmission be repeated.

"Could you please repeat 8-0-6???"

I could sense the tone of disbelief in the nurse's voice at the other end of the radio communication. I started my report from the beginning.

"Yeah, we have a 12-year-old female who is almost full term.
She is, I believe, in her eighth month."

"Her vitals are normal but she is complaining of abdominal pain
and claims to be experiencing contractions; probably a false alarm…just want to
take the appropriate precautionary measures and bring her in.
Our E-T-A to Santa Rosa medical is about 15 minutes."

"Have you checked for crowning 8-0-6?
NO! No we have not! I don't believe it is necessary at this time!
Ten-four, we'll be waiting."

There was no way for me to adequately describe what my feelings were toward Anna—a little girl who was at the moment justifiably terrified. Her little body was trembling. I really didn't know *what* to feel, except sadness. She looked like a kid who was hiding a basketball under an oversized t-shirt but who could not get rid of it. Although medical protocol called for us starting an I-V, we decided against it. And there

was no way that we were going to examine her for crowning!!! Why inflict anymore pain, anymore fear, or embarrassment? She appeared to be in good health. I wasn't quite sure what to do except have her sit on the stretcher and let us take her to the hospital. I didn't know whether to treat her as a child or as an adult. I chose the former, but nevertheless, I was still at a loss for words. I stuck to the basic verbal exchanges. *"Sit here. Relax; you're going to be fine. We have to take you in to get checked out. Is anyone coming with you?"* She sheepishly shook her head. She would not speak to me or Gene, who was working a detail in place of my regular partner. She avoided making eye contact.

I could not help but think that Anna had conceived when she was eleven years old. Was it rape? Was it incest? Who was the father-to-be? Where the hell was he? Tonight at least, Anna was all alone. We never saw a parent, a brother, a sister, or friend—no one around except a lady who appeared to be holding a one-way conversation in Spanish with the little girl. She was one of Anna's neighbors. I was quick to identify her as a *curandera*—a medicine woman in the tradition of Mexican faith healers. The *curandera* was chanting a prayer while sweeping Anna's little body with a small tree branch with plenty of green leaves. As a young boy, I too had experienced a *barrida*—a sweeping—or two, when I visited my mother's birthplace of Santiago, Mexico. I vaguely recalled the experience, but it later helped me appreciate the significance that it had for many people. Fortunately, Gene Morales, my temporary partner also understood the circumstances. So, it was easy for both of us to allow the

medicine woman inside the ambulance to complete her ritual. Actually, we were just glad to have an adult female around who knew this little girl.

The contrast between a medicine woman sweeping our patient with tree leaves and the backdrop of an ambulance equipped with the latest in lifesaving medical technology was striking. For the moment, two highly trained professional paramedics were playing second fiddle to a *curandera* from the barrio. We might as well have thrown out every policy and procedure under the ambulance, along with the gargantuan Physician's Desk Reference handbook we carried with us. For a few minutes at least, a medicine woman from the barrio held center stage. Anna seemed to have calmed down quite a bit after the sweeping. She no longer appeared scared. She quit trembling. The *curandera* stayed behind while we transported Anna to the hospital.

Although the medical staff at the Santa Rosa knew in advance about the patient we were delivering, every one of them froze momentarily when we entered the ER with Anna on the stretcher. It almost seemed as if nobody wanted to take the first step, or perhaps nobody knew exactly what to do under the circumstances. Anna, after all, was just a baby…who was expecting a baby. I wondered how many more children conceived only to have their babies aborted and buried in back yards and alleys deep in the barrio. As ironic and incomprehensible as it may seem, Anna and her baby may have been two of the lucky ones.

"8-0-6 is back in service."

Baby Nicole

She was barely two years old. The grandfather was babysitting and had the little toddler with him inside his garage. What made him open the gasoline can near a hot water heater while his granddaughter was just a few feet away is beyond explanation. The heavier-than-air gasoline fumes quickly found an ignition source in the boiler's pilot light and *flash!* In an instant, the baby suffered burns to 90% of her tiny body. Once we arrived, we knew immediately that she did not stand much of a chance of surviving, but nevertheless, with a world-class U.S. Army burn ward in our backyard, we had to give her every chance we could. We transported her to Brooke Army Medical Center (BAMC – pronounced BAM-C). The poor innocent little thing was screaming at the top of her lungs. I will never forget her screams.

"8-0-6 to Bexar Med, we have a child with severe burns and we are Code 3 to BAMC. Please alert the burn center for us and transmit our report.
Ten-four, that's affirmative.
John Boy, you're going to have to haul ass on this one!
I got it, I got it…hang on!"

Nothing got my adrenalin going more than a child's life hanging in the balance. This was clearly a non-negotiable *load and go, Code 3,* and everyone on the road had better get the hell out of the way. We called for a back-up unit to tend to the grandfather who also suffered severe burns. We never even took a good look at him. Baby Nicole was priority one. I don't ever remember driving as fast as I did trying to get that baby to BAMC alive. The fact that the incident occurred at dusk on a Saturday evening meant that there wasn't much traffic on the streets, nor inside Fort Sam Houston Army Post—the home to BAMC.

I remember turning the corner on New Braunfels Avenue off Interstate 35 on the way to the Post. Lee later told me that the ambulance was on two wheels as I negotiated the 90 degree turn. Lee was the unlucky one of the two, having to carry the baby in his arms in the back of the ambulance. Once inside Fort Sam Houston, I pulled out all of the stops and I basically rode the brakes through the intersections while stepping on the gas pedal. I soon noticed an MP (military police) on my tail in a marked army vehicle with his emergency lights on and siren blaring. I thought it only fitting that we had a police escort to the hospital. It would soon be revealed to me, however, that the officer was actually trying to pull me over for speeding on a military installation. Couldn't this knucklehead see that we were running Code 3? It did not matter. Army rules are Army rules. We got the baby to BAMC emergency room in what must have been record time for the distance traveled. Lee carried her inside and the medical staff rushed her to the burn ward where she was pronounced dead even before we could get back in service.

It took a while for my adrenalin rush to subside and for the news about baby Nicole's death to sink in. I was standing in the portico outside of the BAMC ER where our ambulance was parked with the engine still running. I can still smell the overheated brake pads and see the smoke coming from behind the wheels. Then the MP, whom I had prematurely assumed to be my escort to the hospital, began reading me the riot act. I recall the high-pitched tone of his voice. The young man looked more like a teenager to me. He was barely 20 or 21 years old.

"Do you know how many federal traffic violations you just committed on this base?
I can cite you for negligent driving and excessive speed.
You ran four stop signs and two red lights.
You're supposed to come to a complete stop even in an emergency.

And also, you had total disregard for your own safety as well as those of pedestrians and other drivers on this base, not to mention your patient."

He really got under my skin with the last statement he made. Right then I yelled back at the top of my lungs, *"MY PATIENT IS DEAD!"* After that contentious exchange, the MP shut up, made a half turn, and walked to his car, and drove off.

I was still in a daze. Lee later told me that I had the *thousand-yard stare* the entire time. *"You were looking right through that toy cop, way off into the distance, oblivious to everything he was saying."* Little did Lee know that I was trying to decide whether to punch the MP in the face or not. That would have landed me in a federal prison somewhere. It might have been worth it if baby Nicole had lived.

"8-0-6 is back in service."

Baby Nicole was barely a toddler. I sometimes sit and contemplate how it has been possible for me to have lived through so many close calls and yet make it to middle age—only by the grace of the Almighty. Baby Nicole, a perfectly healthy child, never reached her third birthday. It hardly seemed fair then and it still doesn't sit well knowing that she died. Others like her also slipped through my hands. Such are the cards we are dealt with each and every day. How often I throw them away only to pick them up later as I live to play another hand.

Armando

The night sky was lit up like an orange fireball as soon as we made the turn onto Laredo Highway. We were responding to a second alarm fire out of Station 25, deep in the south side of San Antonio. When we arrived, we were told to hold in a staging area about one city block from the two-story home that was burning like a roman candle. I

could feel the radiated heat on my face as I stepped out of the ambulance. *"8-25 go ahead and come on in on the windward side. We have a 12-year-old child who is badly burned."* We proceeded to navigate through the smoke, heat, fire hoses, fire trucks, and firefighters until we finally arrived at the command post. The boy was standing up. He was trembling from the pain of the burns he had received to his head, face, and upper torso. The clothes he was wearing had melted into his skin. We walked him to the ambulance and I covered him with two clean linen sheets. Jackie Johnson, my partner that evening, cut open two bags of ringers lactate, and we poured the solution on the sheets. His name was Armando. He was screaming at the top of his lungs.

"Where is my sister?!?!?!?
I am sure she's in the other ambulance.
I need you to hang on because I can't have you sit or lay down.
Now, just calm down!"

Even now, after 30 years I often asked myself, *"was I stupid or what?"* This kid's life was hanging by a thread, not to mention that he was in excruciating pain, and here I was telling him to calm down! I was undoubtedly letting my emotions get the best of me. Armando's burns were so severe that he could not sit or lay down on anything; so we both stood in the back of the ambulance hanging on to each other for dear life. Even wrapped in linen sheets soaked with ringers lactate solution, he screamed the entire time. I braced myself with my feet spread across the ambulance floor and grabbed on to an overhead rail on the ambulance ceiling. Armando just kept on screaming. Jackie, my partner at 8-25 on that shift asked me,

"Do you want to go straight to the burn unit?
No…no way. We need to stabilize this kid.
Let's go to Southwest General…we're five minutes away.

BAMC is 20 minutes away.
We'll transfer him later."

We got Armando to the nearest hospital where the medical staff in the emergency room went to work on him. In the interim we were called back to the fire for a firefighter overcome by smoke. While we went back to tend to one of our own, 8-16 was dispatched to the Southwest General Hospital and transferred Armando to BAMC. We later found out that the young boy had received his burns while trying to save his 13-year-old sister whose charred body was later found on the second floor of the home. She had hid in a closet—a common reaction by kids caught in a burning home. Oh, what a night.

Jackie and I reported back to work the following evening. We picked up an order of the best fried fish on the south side and settled in at the firehouse to eat dinner. The topic of our conversation since the shift began had been Armando. Then the hot line rang.

"Station 25, Thompson speaking may I help you?
Oh, I'm sorry to hear that…thanks for the call…goodbye."

There was a reflective pause by Jackie as he hung up the phone. *"Armando died."*

At that very instant, I dropped my fish fillet on my plate and lost my appetite.

"Who was that?
It was one of the nurses from the Southwest General.
How did she know? I mean he went to BAMC, didn't he?
Networking, I guess."

Not only did we lose our appetite, but we lost our will to do anything. Jackie thought that it would be a good idea to visit the ER staff who had treated Armando at Southwest General the night before. We were subconsciously seeking to be consoled.

The doctor on duty was not the same one who had attended Armando the night before. Dr. Burns was not regarded as a good physician by anyone on staff. He was considered professionally arrogant, obnoxious, and was never at a loss for words when it came to voicing his opinion about anything. As we were all trying to find some sense of collective consolation over the little boy's death, we heard the uninvited voice of one Dr. Burns.

"That boy would have lived if you all had taken him straight to Brooke Army Medical. There wasn't much they could do for him here.
Yeah, but we figured that he needed to be stabilized before making the 20-minute run all the way to BAMC.
San Antonio has the best burn facility in the nation.
You should have thought about that."

Just like that he walked away. Jackie had a clenched fist the entire time Burns was giving us the third degree. Some of the hospital staff chimed in.

"Don't pay any attention to that eccentric, pompous windbag.
Everyone knows that he couldn't cut it as an Air Force doctor.
Now he talks like a graduate out of Johns Hopkins."

I didn't know if the staff was patronizing us or if they were serious about the underachieving doctor.

We were seeking consolation for not saving the little boy's life and affirmation that we had made the right decision in taking him to the Southwest General over the burn unit immediately. We found neither that evening. In fact, our encounter with Dr. Burns only made our emotional wound deeper and more painful. It made us doubt and second guess our decision even more. *"I'm going to call BAMC myself,"* said Jackie*." I know a nurse down there who will get us more information."* A few minutes later I heard an exhilarated Jackie.

"He's alive! I just spoke to my friend at BAMC and she told me that Armando is alive!
Wow! Are you sure? I mean, is she certain?
Yes, she was one of the nurses who attended him last night and she said that he is in the Burn-ward at the moment.
Thank you, God!"

There was a news article in the local newspaper about Armando some six months after the fire. It was a bitter-sweet narrative about how he had survived his burns after multiple surgeries and about how nobody had yet informed him that the 13-year-old sister he had attempted to save had perished in the fire.

Charlie's Ice House

We responded to Charlie's Ice House for an injured party just east of downtown. An ice house in San Antonio is equivalent to a bar with a "family atmosphere." Outdoor picnic areas with tables, swings, and merry-go-rounds for the kids are merged with an indoor bar for the adults. We were out of our response area covering for 8-0-5, whose ambulance was being serviced at the Fire Department shops. One of the patrons tripped and banged his head on a table after having downed one too many beers. He never lost consciousness and was not feeling much pain anyway. He refused to be transported to the hospital. After he signed a refusal, Lee and I prepared to get back in service when something unusual caught my eye.

There was a group of men sitting around on a picnic table drinking beer. On top of the table sat an African-American boy who appeared to be about three years old. He was corralled by the arms of a middle-aged man who was nursing a beer and puffing on a cigarette. It appeared that the boy was with his dad. What struck me was that the toddler was not acting like one would expect a normal three-year-old to act. He was

quiet and withdrawn. I initially suspected that the adult men at the table had given the child beer to drink. I very discreetly made my way to where they were sitting. As I approached, I noticed at least a dozen white spots on the little boy's arms and legs. I had seen these before on other kids, but not on one this young. They were old cigarette burns—*too many old cigarette burns*. Most of them were already healed. What to do?

We made our way back to the ambulance and pretended to be filling out paperwork. We were stalling. I got on the radio and called dispatch requesting SAPD to make the scene. Soon, two patrol cars arrived. I briefed one of the officers. The man and the boy were still at the table. The police officer asked us to leave.

"We got it from here.
If we need you guys, we will call you back.
It would be best if you all would get back in service.
If you stick around here, this guy may figure out that it was you who called us.
He could then try to track you down."

The police officer was very persuasive. It made all the sense in the world to leave the scene.

"What kind of sick bastard would do something like that to a poor defenseless kid?
That little guy is already traumatized for life. You can just tell by the look in his eyes.
It's as if he knows better not to cry, whine, get down, and run around because daddy will burn him."

There just wasn't any way to rationalize what we had just witnessed. All I wanted to do was hurt the man.

A few shifts later we came across one of the police officers who informed us that the father had been taken into custody, but was released on bail a few days later. The child was reported to child protective services (CPS) and was returned to the mother. It appeared that the couple was not married. CPS was conducting its own investigation.

That was the last information we ever heard regarding the incident. I was almost certain that Rudy B. and I would one day be called to testify at some court hearing or criminal trial. It never happened. We never heard anything official or unofficial ever again. We never knew the outcome.

CHAPTER VI

CHAOS COMES HOME: MY MOTHER'S DEATH

I suppose that I was in as much denial as my mother was with the palsy that appeared on the left side of her face. *Nervios, es todo lo que tengo* (Nerves is all that's wrong). Although she kept insisting that her facial paralysis was part of her "nerves," I knew deep down that neither one of us was truly convinced that was the case. Dr. Boris, our family physician, advised her to get an MRI. She declined. *Muy caro* (too expensive). My dad's health insurance did not cover the cost of an MRI in 1984. Nevertheless, I was willing to come up with the $2,000 myself. She still refused.

The palsy eventually led to dizzy spells, vertigo, and falls. One week after I married my wife, mother agreed to go to the county hospital annex where she was told that she needed extensive tests and possibly surgery. Mother was diagnosed with a benign tumor that was pressing up against her brain stem. It was the size of a golf ball and growing. I was the closest thing to a doctor in my family, so naturally Dad turned to me for guidance and advice. I eventually grew to hate the fact that I knew too much, and yet not enough. I had a deeper understanding of what the doctors were telling us, especially what they were saying "between the lines." Yet, I was not a physician and was powerless to suggest any medical strategy. Oh, how I longed to be a normal person again.

Decision-Maker

Medical Center Hospital (MCH) was the county hospital. It was also a learning institution that was affiliated with The University of Texas Health Science Center

(UTHSC). This was the place where I had received all of my medical training. So it was no surprise for me to see Dr. Coakley, the head neurosurgeon at MCH, in my mother's room. I had sat through many of his lectures. Now, mother was one of his patients and I was the point man in the family. I had to make major medical decisions based on what Dr. Coakley and his team were telling us.

"The tumor will eventually shut off her heart and her ability to breathe on her own. What are the chances of her surviving this type of surgery?
Eighty percent.
Whoa!
Do you mean that there is a twenty percent chance that she won't make it through the operation?
That is correct.
But there is a 100% chance that she won't make it if we just leave it in there.
This is a benign tumor and it will not respond radiation or any other outside intervention.
I suggest that you discuss it with your dad and the other family members.
You may want to seek the advice of a priest as well."

Dr. Coakley was known for being all business and no emotion—a true professional in his own right. Even though I could relate to his professional disposition, I was extremely uncomfortable with the choices he was offering. Nevertheless, the doctor and his staff knew that I was the one who the family was relying on to make the decision.

Hey, She Made It!

I spent the night before the surgery by my mother's bedside in the intensive care unit (ICU). Hospital rules did not allow visitors for long periods much less an overnight stay in the ICU; however, the medical staff made allowances for me to stay given my professional background and paramedic status. I also knew that they had received instructions by Dr. Coakley. I always appreciated the respect and permission given to enter and leave the ICU at all hours.

Mother was quite nervous and restless. Who wouldn't be? I somehow managed to catch a few minutes of sleep. I held together emotionally most of the night until about 5 a.m. when they came to prepare her for surgery. To my dismay, the head nurse came to me and informed me that the consent form that had been previously signed by the immediate family had been "misplaced," and therefore, I was going to have to sign another release. I was the only family there at that hour. I suddenly felt the weight of the world fall on my shoulders. I was the only one around and they were wheeling her into surgery. As I signed, I began to sob uncontrollably. I kissed my mother on the cheek as she told me *"OK…esta bien."*

I went home and collapsed from exhaustion. I had been awake for the better part of 36 very stressful hours. Nine hours later the phone rang. My wife had already come home from her teaching job. It was my brother Hector informing us that mother had come out of surgery and that everything appeared to be fine; however, she was very restless and asking for me specifically. We rushed to the ICU where we found her still groggy from the heavy dose of anesthesia she had received. Dr. Coakley was conducting a very basic neurological response exam.

"Ask her to move her right foot…now her left.
Ask her to twirl her hands at the wrist.
She appears to be coming out of the surgery just fine.
We will run more tests in the coming days.
For now, you all should know that she has permanent hearing loss to her left ear.
Other than that, she appears to be fine.
Thank you Dr. Coakley. I am forever grateful to you and your wonderful staff."

I was ecstatic that mother had survived the nine hours of surgery. Surprisingly, my father and other family members appeared sad and somewhat subdued. They could not

fathom my mother having lost hearing in one ear. It was then that I realized that I did, in fact, *know too much* about what was happening from a medical perspective, but not enough to explain that loss of hearing in one ear was the least of our worries. She was alive. *"Hey, she made it!"*

Saying Goodbye

While we were still in the ICU recovery area, my wife noticed that my mother was trying to convey through her body language that I should go around the bed and hold her hand. I quickly complied. She held my hand tight. I then noticed that she was holding my wife's hand on the other side of the bed as well. After she held us both for a short while, her restlessness went away and she finally relaxed. *"I'll come to check on you first thing tomorrow, OK?"* She nodded and dosed off. *"For now, we need to let her rest,"* said Dr. Coakley rather emphatically. *It is going to take some time for the anesthesia to completely wear off."*

The telephone rang at about 2 a.m. It was my younger brother Hector who was staying the night in the ICU waiting area.

"Mom went into a coma.
What?
The doctor is here. He wants to talk to you.
This is Dr. Anderson the attending physician for the ICU this evening.
Your mother went into a coma. We have connected her to a ventilator.
There does not appear to be any neurological function in her brain at this time.
We will continue to monitor closely and Dr. Coakley will talk to you in the morning.
What happened?
It is really hard to say at this time.
We will run an MRI in the morning to take a closer look to see what is going on."

I knew that this was very bad news. Hector did not have much of a clue as to the gravity of the situation until he saw a priest arrive to administer the last rites. I was so

exhausted that I just collapsed again and did not wake up until 7 a.m. at which time I rushed to the hospital. When I arrived, I saw two nurses maneuvering mother's bed out of the MRI lab. Dad, other family members, and some friends were present. They looked very sad. I looked at mom and I instantly knew that she was gone.

Dr. Ruiz, who was part of the staff that was attending to mother met with us in the family room adjacent to the ICU.

"Dr. Coakley wants her back on the ventilator for now.
He will study the MRI and is hopeful that she may show some signs of improvement within the next 72 hours.
But I have to prepare you for the worst. Her prognosis does not look good."

Mother remained on artificial life support for eight days.

"I am very impressed and extremely proud of how you and your family have held together during this trying time, but I have to tell you that the time has come for you to make a decision. Her kidneys are completely shut down, her heart and lungs are totally dependent on the ventilator, and there are no signs of any brain activity."

Notwithstanding his hallmark business-like demeanor, Dr. Coakley was actually teary-eyed as he laid out the options on the table. My uncle Louis (dad's younger brother), my aunt Nelda, dad, Father Bill Mitchum, the EMS chaplain, and I ceremoniously walked in to the ICU to see mother one last time. The sound of the ventilator was deafening as Father Bill led us in prayer through our tears. Then he spoke to us in a gentle, but assertive tone. *"This is just a machine. Maria is no longer with us. She left this world several days ago. It is time to shut it off."* We all walked out. I asked to speak to Dr. Coakley. *"Shut it off. OK…fine. You're doing the right thing."* Even after all I had been through in EMS, I could not bear to go back into the ICU to watch the nurse turn off the ventilator. My brother Hector was the lone witness. Later, my wife helped me to

reflect back on mother's gesture to hold both of our hands in the recovery room. *"Don't you remember? She was saying goodbye."* Mother died on a Friday and her funeral and internment were held the following day. Just like that, she was gone. Suddenly, the fragileness of life that I had become all too familiar with had manifested itself in the woman who had given me the very gift.

Going Back to Work

One of the toughest challenges I ever faced in my professional life was working in EMS, while my mother was in the middle of her own chaos narrative, and later having to report back to the firehouse after her death. I found myself making quick detours to the tenth floor every time we delivered a patient to the Medical Center hospital. Lee, Rudy B., and others were always very patient and understanding of my situation. I would on occasion encounter Dr. Coakley or one of the other physicians who were attending to my mother. Her prognosis never changed much during the turbulent 19 days that she spent in the hospital. Not only did my actions speak to the love and affection I had for her, they were also a reflection of my personal and professional connection to the community of doctors and nurses who were handling her. I wanted to stay informed, even as I braced myself for the inevitability of a worst case scenario. Then she died.

My mother's passing was especially hard for many reasons. I had been the "point man" who was relied on to making some very difficult choices. I had been the one who doctors, nurses, and family members had turned to when they needed a decision to be made. I had been the one to sign the release of liability the morning of her surgery.

I was the one she asked for before she slipped into a coma from which she would never come out.

My mother had died suddenly and unexpectedly at the age of 57. It was not a complete surprise to me that my parents had not done any funeral planning up until this point in their relatively young lives. My emergency responder instinct to act kicked in immediately. Dad was in no condition to do anything except grieve. I went from signing the paperwork that released my mother's body from Medical Center, to arranging a funeral mass, to selecting a casket, and finally to purchasing a cemetery plot all in one nightmarish day. In less than 24 hours of having been declared dead, my mother's remains were receiving Father Jordan's blessing at her graveside in San Fernando Cemetery.

Even though I had been away from work for over a week, I felt that I needed some extra time off. I contacted Chief Curtis Fitzgerald who was the EMS division chief at the time. He allowed me an extra shift of bereavement leave, which essentially gave me an additional four days off. Even with the extra time off, I still felt emotionally numb when I reported back to 8-0-6. Besides offering their condolences, my colleagues made it a point not to talk about my mother's passing. They understood how difficult it was for me to come back to the job after suffering such a personal loss.

I reported back to work grief stricken as well as mentally, physically, and spiritually exhausted. I felt that I was at the end of my rope as a paramedic. Upon returning back to work, Lee and I responded to two separate incidents where the patients had symptoms identical to the ones my mother had experienced prior to being diagnosed

with her brain tumor. Each time I wondered if the coincidence was somebody's idea of a sick joke, or if there was some sort of divine providential connection to making these calls. I chose to believe the latter. 8-0-6 was back in service.

CHAPTER VII

MANAGING THE CHAOS

I suppose that I could make a convincing argument for having run a higher-than-normal risk for contracting a communicable disease. The fact is that I came into contact with patients who carried everything from common cold bacteria to those infected with the HIV virus. I became ill more frequently, and I used more sick-leave hours during my seven years in EMS than at any other time in my career. Many of my colleagues also experienced prolonged bouts with illnesses attributed to exposure and weakened immune systems brought on by the physical and psychological stressors of the job. In terms of dealing with the potential for serious exposure, I would have to describe my tenure in EMS as the time before the AIDS virus was discovered and the time after.

Exposure

Taking the time to don latex gloves, plastic face shields, and protective gowns was simply not practical; especially when one was constantly being dispatched to one emergency after another. The different strains of flu that appeared every year along with communicable diseases such as hepatitis and tuberculosis were a constant threat. In typical firefighter fashion, we treated these hazards as just another part of the job—as accepted risks. We were, after all, firefighters before we were paramedics. We were invincible…at least we were in our minds. The discovery of AIDS quickly changed these distorted attitudes and misinformed beliefs. The donning of latex gloves did eventually become an accepted and routine practice.

The Woman in Yellow

"8-0-6…go ahead, this is six.
Go to channel four please.
Ten-four, we're switching to four.
What's up guys? Not much. We're just cruising around the neighborhood.
Waiting for a call.
Well, you got your wish.
This one is a little different than what you all are used to".

"Respond to the 100 block of West Laurel for a sick party.
The catch is that this patient has what the husband has described as a severe case of infectious hepatitis.
We don't know much more than that.
Be sure to find your latex gloves and wear them.
Cover your faces if you have a helmet with a shield or something.
Are you serious, a helmet with a face shield?
The husband of the patient is in the house, but he doesn't sound too coherent.
He isn't making much sense. He may be inebriated or maybe has some mental issues.
The patient needs to be transported to BAMC.
Ten-four we are responding to West Laurel.
By the way, do not use your sirens when you are getting near."

"What in the hell is going on, Lee?
Are these people famous or something?
Hey, do you remember where we carry the box of latex gloves?"

This incident occurred several years before the HIV virus was identified as a major health threat. This meant that we rarely bothered to wear any extra protection on calls. The only precautionary measure we were always reminded of was doing a thorough hand-washing after handling a patient.

Her skin was yellow. It was more yellow than the pages in the phone book. She didn't even look real, but she was alive and conscious lying face up on a cold kitchen floor. Her husband, who had apparently been drinking for most of the day, was in the dining room talking in a very loud and animated voice to either a ghost or his shadow. There was nobody else in the house. He was obviously a chain smoker as well.

"Sir, we're EMS.
I believe you made the call?
Yes…yes I did.
She needs to go to BAMC.
How long has she been here on the kitchen floor?
Since yesterday I think."

There were no apparent bruises or signs anywhere on her body that may have suggested domestic violence. She almost seemed frozen in her position. The yellowness of her skin and her deep stare almost made her appear mummified. Lee and I both made our way back to the ambulance to retrieve the stretcher.

"What do you think, John?
Hell, I don't know.
I sure as hell don't want to put my hands on her…even with these silly gloves.
Man she's yellow!
Let's cover the stretcher completely with a couple of these disposable blankets.
Hey Lee, grab about three extra linen sheets.
When we get back inside, we'll convince the old man to help us load her.
You and I will wrap her in the three linen sheets.
I'll ask the husband to support her head or something.
You think he'll want to?
I mean, he left her on the kitchen floor for two days, and he doesn't seem to be all there.
I don't want to get near the air she is breathing or run the risk of turning into a cough or a sneeze coming from her mouth and nose."

Lee and I were not smokers, but every now and then we would buy a pack of cigarettes to carry with us in the ambulance. Smoking was something out of the ordinary for us. Lighting one up would, if for a brief moment, distract us from the craziness of EMS. It was just a silly way of coping.

On the way back into the house, I made what sounded like one of the stupidest requests of my professional career.

"Hey Lee, give me a cigarette.
What?
You too…light one up.

What the hell are you talking about?
Just do it."

We walked back into the house puffing on our Marlboros. With lit cigarettes hanging from our mouths we proceeded to cover the woman with three linen sheets. We never came in direct contact with her skin. We stayed away from her head and face, which we left uncovered. The kitchen windows and the door to the outside were open, so there was plenty of ventilation in the house. Our smoking seemed to have drawn the husband's attention.

"Do you have a cigarette you can spare?
Yeah, you want one? They're Marlboros.
That's fine. Thank you…thank you…you fellows are so kind.
Say Lee, give him the whole pack.
Thank you!
Sir, is there any way that you can give us a hand here?
Sure, anything you guys want.
We need for you to support your wife's head while my partner and I lift her from her back and legs…OK?
Yes, sure, anything I can do to help you fine men. She's a very good woman."

Lee quickly caught on. The cigarette offer from someone in authority did wonders to gain the man's trust, and as a result, we were able to get some much needed assistance from him. My strategy was to minimize the possibility of us becoming exposed to any mouth or nose secretions. Once in the ambulance, we convinced the husband that it would be better for him to ride with someone else to BAMC. He quickly agreed.

I was the "doctor" on that particular shift and Lee was the driver. As we were leaving the scene, I opened the window that connects the cab to the back of the ambulance where the patient rides. *"Lee, go up to the next block, take a right and stop the ambulance."* I was determined not to take the 15 minute ride to BAMC with a

seriously infected hepatitis patient in the back of an enclosed ambulance. All I needed was for her to cough or sneeze once and that would be it! Our actions went against the policy of not ever leaving a patient alone. I could argue that although I may have bent the policy, I did not break it. I stayed in contact with her all the way to the hospital by communicating through the window that connected the cab of the ambulance to the box where the patient rode. I explained to the woman that it would be a short ride to the hospital and that I needed to turn in the report from the cab, which I did. She agreed with the arrangement. We didn't vitalize her nor did we risk coming into contact with her blood by starting an I-V. I alerted the medical personnel at BAMC by radio. By the time we arrived, they were all decked out with gloves, masks, and gowns. They had prepared a separate room for our *lady in yellow*. Their actions served to justify and reaffirm the precautionary measures that Lee and I took, except for maybe *lighting up* with a couple of *Marlboros* in front of our patient. Lee never let me forget that one.

My concern for our health and safety did not end with transporting her to BAMC. Later that evening, Lee and I delivered a patient to the Downtown Baptist hospital where we sought the advice of some of the medical personnel we had befriended over the years. They suggested that we begin the series of gamma globulin injections just to help prevent the possibility of infection. These injections are very painful and have side effects such as vomiting and serious diarrhea in some people. I told Lee that I would hold off on scheduling shots for us until I found out what type of hepatitis our patient had. I called BAMC from my home the following day.

"Hello, I am John De La Garza from EMS unit six. We took a patient to your hospital yesterday that apparently had a serious hepatitis infection. I am concerned about the

possibility of exposure, so I was wondering if you could fill me in on what she was diagnosed with.
I am sorry sir, but we are not allowed to give out any patient information over the phone. I hope that you understand how important this is to both my partner and I. Let me have the doctor in charge talk to you."

Soon a Major Caldwell came to the phone. I introduced myself and explained my concerns to the doctor.

"All I can tell you is that the patient does not have infectious hepatitis. Her jaundice is primarily a result of severe cirrhosis of the liver due to a long history of alcohol abuse. So, I don't think that you have anything to worry about.
Thank you, doctor, and thank you, God!"

I called Lee at home to give him the good news to which he responded, *"It must have been those Marlboros we were smoking."*

HIV-AIDS

Paramedics were as much in the dark about what AIDS was, what it wasn't, and how one could become infected by it. The only argument that most people seemed to agree on at the time was that HIV was a problem that originated and primarily existed within the gay community. Beyond that, those of us in EMS were not getting much more information about HIV back in 1982. We were told to take extra precautionary measures with *all* patients. This basically meant for us to wear latex gloves on every call.

I think that what was most disconcerting to all emergency responders was that AIDS had suddenly appeared on our front door step as an overnight phenomenon. The reality was that we probably had already come in contact with infected patients; we simply never knew it because nobody else did. This was especially worrisome to those

of us working out of Station 6 because we were geographically located in the middle of what was considered to be San Antonio's gay community.

There were a number of well-known gay clubs and bars in our immediate response area. We even knew some of the proprietors by name. The year was 1982, and being gay was not something you publicized or openly admitted to in a place like San Antonio. However, there always appeared to be an air of acceptance of gays living in and around the neighborhood that surrounded the firehouse. Most residents, including the firefighters, had basically grown "accustomed" to the idea of living in close proximity to the gay community. Nevertheless, based on the limited information we were getting at the time, those of us working in this particular area had more of a reason to be concerned. The requests for transfers to our previously popular station by firefighters and paramedics suddenly came to a screeching halt.

"*8-0-6, make 200 West French for a fall. It will be at a house party just east of Main Avenue."* Fiesta week was in full swing and the city was abuzz with parades, parties, and revelers. Frank Zimmer was working a detail with me. Zimmy, as we liked to call him, had been raised on a farm and spoke with a country drawl.

"I wonder what the ladies will look like at this party, John Boy.
You never know.
Maybe we'll get lucky and meet a couple of good-looking ones.
8-0-6 is on the scene, dispatch."

Cars parked on both sides of the narrow street and the Polynesian gas torches in front of a two-story home made it easy for us to locate the address. However, there was no artificial lighting, just the torches, with lots of people eating, drinking, dancing, and just enjoying themselves. We used our penlights to navigate through the crowd.

All we could make out at first were silhouettes of the party-goers. *"EMS is here…over here fellas…he's over here."* As we made our way deeper into the crowd, we began to notice that there were only men at this party. We did not see any women. We were guided to a concrete stairwell that started at ground level in back of the house. The stairs led straight down to a basement about 12 feet from where we stood. At the bottom of the stairs, was a young man, Paul, who was holding his right arm and favoring his right shoulder. He was sitting up and appeared to be in severe pain. There was a doctor at the party who immediately identified himself.

"He fell from the top…from about here. I am Dr. Davis. Do you have a cervical collar?
Yes we do, doctor. Did he lose consciousness?
I don't think so.
Let's take a look."

The landing at the foot of the stairs did not provide much room, so we gingerly maneuvered around our patient and opened a door that led to a basement. Dr. Davis stayed at the top of the stairs. Fortunately, we now had artificial light shining through the doorway of the basement. We were not wearing our gloves.

I reached to turn Paul over when I noticed about a two-inch laceration on his forearm. It did not appear to be deep, but there was a good amount of blood streaming down his arm. I instinctively opened the trauma box and pulled out two pairs of gloves. I gave one pair to Zimmy, and in the same motion I looked up the stairs and saw about a dozen sets of eyes trained on us. I wondered if I had looked too paranoid in my haste to get the latex gloves on. This was one time when I was glad we had a doctor in the crowd. It appeared that Dr. Davis was satisfied with the standard of care we were providing for Paul. Nevertheless, the silence from the group around us was deafening. I

thought about pulling out the silly masks we were given to wear, but under the circumstances decided against it. We never wore those things anyway, but the thought of using them at this incident did cross my mind.

We had already begun taking extra precautionary measures each time we handled patients, especially those with open wounds or cuts. Needless to say, there were more than a few reasons for us to be especially nervous about this particular call. First, it was very evident to Zimmy and me that we were at a gay party. Much of what we knew and understood about AIDS at the time pointed to the gay community. As medical professionals, we understood that anyone, gay or straight, could be infected; however, based on the limited information we had been given at the time, we felt that the chances of coming into contact with an HIV positive patient at this party had increased exponentially.

Secondly, we knew that our actions would be carefully scrutinized by the many witnesses who were present. Would we treat their friend just like we would any other patient? Would we transport him to the hospital? How would we handle him? Would we even put our hands on him? There had already been a good dose of public outcry by gay activists for being unfairly singled out as the cause of the virus. It was undoubtedly a very confusing time for everyone. I can proudly and unequivocally state that San Antonio paramedics, especially those of us assigned to Station 6, never refused treatment to anyone. However, I will not deny the fact that we all experienced a heightened sense of awareness and nervousness, and we took extra-precautionary measures when treating someone we knew was gay. We were genuinely concerned for our safety.

"Let's get some gauze and one of those five-by-eight bandages, Zimmy.
Let me clean him up.
Go ahead and put some Betadine directly on the cut…
That's it, now apply the five-by-eight bandage with some pressure.
Let's wrap it up with some gauze.
Can you move your fingers?
Yes…OK…
How is the C-collar working for you? Is it too tight?
No…it's fine.
OK, what hospital do you want to go to?
The Baptist downtown is where I go."

Then I gave Dr. Davis the courtesy of asking him if there was anything else he wanted us to do. *"You gentlemen did a fine job. Thank you for your assistance."* Paul was able to walk to the ambulance. The ride to the hospital was uneventful and very routine.

Once we delivered the patient, we made our way to an unoccupied part of the ER and proceeded to do a very thorough hand-washing. Later, Zimmy noticed three blood spots on my right shirt sleeve as I was filling out the patient form. The blood stains appeared to be relatively fresh. *"Looks like the blood soaked right through, John Boy. Hell, I better check my own clothes."* I immediately went into one of the restrooms inside the ER, removed my uniform shirt and took a close look at my arm where the blood would have been. There was none on my skin from what I could tell; nevertheless, I scrubbed my arm with soap and water as best that I could. I wore gloves. I walked out of the hospital in my white undershirt. I had removed my badge and nameplate from my uniform shirt and had made the decision to dispose of it. *"Let's get back to the station on the double so that I can get into another shirt."* Zimmy's uniform was clean. Upon returning to the station, I stripped down completely and showered. I scrubbed what would have been the affected area of my right arm with a shower brush. I

brushed so hard that the skin in the area looked like a sunburn. I got into a new uniform and finished the shift.

Lee and I happened to deliver a patient to the Downtown Baptist on the following shift. I knew a nurse in the ER who was kind enough to check on Paul's blood test results. *"He came back negative for HIV. Great…thanks!"* I took the liberty to approach Dr. Raines, the ER physician and told him what had happened with the blood that soaked through my shirt sleeve.

"There is nothing to worry about even if he had been positive.
What do you mean?
Well, did you have any open skin in the form of cuts, scratches and the like?
No.
Did you get any of his blood in your eyes?
No.
You wear glasses, so that's good. Did you get any in your mouth?
No.
And even if you had answered yes to any of these there would still be nothing to worry about.
Why not?
Because there is nothing anybody can do anyway."

And just like that he made a half turn and walked away.

"What a reassuring guy!"

"8-0-6 is back in service."

HIV-AIDS was the social issue that shook the entire world in the latter part of the 21st century. As frontline emergency medical responders, we were essentially part of the first line of defense when it came to communicable diseases. Being at a gay party with dozens of eyes trained on our every move was a representation of the added pressure and stress that the HIV phenomenon brought to our job. I had initially found the presence of a physician at the scene, who happened to be gay, somewhat disturbing. My partner and

I had to deal with the added pressure of being under the microscopic view of someone who had both a medical and social perspective. This could have spelled double jeopardy for us if we had handled it wrong. I believe that giving the doctor the professional courtesy of "calling some of the shots" led to the supportive role that he played.

This particular incident, which had the potential of blowing up in our faces, turned out to be uneventful in terms of how we handled the immediate scene. However, the incident kept haunting me for a few days as a result of having come in contact with blood from the patient we had handled—someone considered being a high-risk for having HIV-AIDS. It was not until the following shift when I found out that our patient had been HIV negative that I was able to relax. Finding allies under the most unlikely of circumstances was a very effective way to manage difficult situations. I got better at it as the years went by.

Maggots

It is ironic that I wasn't even a paramedic when I responded to my very first EMS call. I was still considered a rookie firefighter at Station 33 when Captain Joe Perales asked if I wanted to "ride out" with the medics. The only condition was that I ride out during the evening hours only.

"8-33 make Southwest 36th street and Inez for an injured party.
There you go…go get 'em John Boy!
8-33 is responding."

I was riding out with two of the best paramedics in the business: Tom Tibedow and David Garcia.

"You can carry the trauma box and follow us inside when we get there.
Just try to look official…like you know what you're doing (laughter).

8-33 is on the scene."

I went for the trauma case in the rear of the ambulance while Tom and David proceeded into a small house ahead of me. It appeared to be a little bigger than a tool shed situated in the middle of a very big property lot. Halfway to the tiny dwelling, I saw the two paramedics hastily come out through the front door with their hands over their faces. One of them lost his dinner behind an oak tree on the lot.

"Now what do we do?
Well, we need to call the health department.
What are they going to do? It's still a medical problem.
We're going to have to take her in.
What's going on?
You'll find out in a minute.
I can't even begin…
Call SAPD so that they can document this and call Chief Mel and have him respond.
You're going to think twice before you volunteer to ride with again John Boy.
You may regret that you did this time."

Tom and David regained their composure and prepared to re-enter the premises. This time I was right behind them. What I witnessed next was the most grotesque sight I have ever witnessed up until this time in my life. There sat a lady in a corner with half of her face missing. She was alive, conscious, and breathing normally. I could see bugs moving around inside of what used to be her face! It was a severe case of a botfly maggot infestation…inside this lady's head! I could see veins, tissue, and bones. Her husband was there. His incoherent speech was evidence of mental health issues. There were no signs of any liquor or drugs in the house. They both appeared to be in their 60s or early 70s. Soon the police arrived, as well as our district fire chief. They were there primarily to document and to assist in strategizing on how to move this poor woman to the ambulance and then to the hospital.

"You're going to have to earn your pay today, John Boy.
We're going to need your help.
Just tell me what you want me to do."

We ended up covering up the woman the best that we could with four white linen sheets. We also covered up the stretcher. Tom and I sat in the back of the ambulance with the lady who we transported to the old Bexar County hospital. Once there, the staff took even more precautions and quarantined the woman.

We were then told that we were going to have to be quarantined also—Tom, David, and me. They later scrapped that idea and decided instead to have us shower with an antibacterial/antiviral solution at the hospital and dispose of our uniforms. We were given green hospital scrubs to wear and were sent home after filling out the exposure reports. The ER doctors were concerned that we may now be carrying some of the botfly larva ourselves. *"Go home and shower some more. Call this number immediately if you experience any symptoms such as unexplained headaches and fever."*

All three of us reported back to work the following shift. We learned that the woman had died on the same night that we had transported her to the hospital. The report that we received through the unofficial back channels was that the botfly maggots had eaten into one of her carotid arteries. She then bled to death.

Laughter

Even in the middle of the chaos that was EMS, there were times when all of us experienced some semblance of comic relief in our work. The dark humor aside, there were incidents that made for some great conversations and laughs even many years later. Some of the more comical events have been responsible for legends being born. Such

was the case with an encounter I had with a group of Bandidos at *The Wet 'n Wild,* and with my boxing debut on the city's West Side. Times like these served to remind me not to take myself and the job too seriously. Sometimes it worked.

The Wet 'n Wild

The Wet 'n Wild was a "gentlemen's club" that featured topless women dancers. It was mostly frequented by blue collar types who worked in the downtown area. Its regular customers also included members of the Texas Bandidos motorcycle gang. It was also a popular place for an occasional all-out brawl. Let's just say that we transported several "injured parties" from the establishment over the years.

"8-0-6, respond to the Wet 'n Wild for seizures.
That will be for a young woman having seizures at the club.
That's a first.
It must be one of the dancers…they're the only women there.
Ten-Four dispatch, 8-0-6 is on the way."

Upon our arrival, we were met by one of the club's bouncers who whisked us backstage. It was in fact one of the dancers who had experienced a *grand mal* seizure. She was just coming out of it. *"She had just finished her routine when she had the attack,"* said the manager. The skimpy robe she was wearing barely covered her naked body.

"OK, Lucy…is that your name?
Yes.
Do you remember where you are?
I'm at the club.
Are you on Phenobarbital or any other meds?
Yes, they're in my purse in the dressing room.
OK, what hospital do you want to go to?
I don't want to go.
You have to.
Medical Center I guess."

Before Lee could say another word, I volunteered to go for the stretcher. I had to make my way out through the audience. It was dark and there was a crowd full of Bandidos that night. They were big burly men with long hair and beards, lots of tattoos and body piercing. These guys were basically the equivalent to the Hells Angels from California. As I walked through the audience, I noticed through the corner of my eye that a dancer had just started her routine on the stage. The music was loud and the Bandidos were rowdy. I instinctively looked up to the stage that was now behind me over my right shoulder. To my surprise, I recognized the dancer from my San Antonio College days. My jaw must have dropped to the floor. I kept walking toward the entrance with my head turned toward the stage when suddenly I felt my feet go out from under me. I had tripped over a chair on the dark floor and fell flat on my face. The trauma box I was carrying flew in the air several feet and hit one of the Bandidos. At that point, I thought I was a dead man. Instead, what I heard next was the entire audience erupting in laughter.

"Hey, the fireman fell on his ass!
That's what he gets for staring at naked women while on duty…ha, ha, ha, ha!
Hey, let's report him to the chief…ha, ha, ha, ha!"

It would be safe to say that the crowd at the Wet 'n Wild that night wasn't exactly the pro-establishment type. Seeing someone in a badge and uniform acting in an official capacity make a complete fool of himself was priceless. Lee had heard the commotion from backstage and figured that John Boy must have gotten himself into something if there was that much laughter. I happened to be dusting myself off when he poked his head through the curtain. Fortunately for me, there were no other firefighters

around. I was an unknown to the crowd, but not to Lee who began laughing once he figured out what had happened. The dancer never got a clear look at me with the stage lights shining in her eyes. After we had delivered the patient to Medical Center, Lee asked, *"What went on in the club when you went for the stretcher? I heard a lot of laughter. I don't know, someone must have told a dirty joke or something."* This embarrassing, albeit hilarious moment, was going to remain a private matter. *"8-0-6 is back in service."*

The Terror of the West Side

It was a quiet Sunday afternoon in mid-July. I was working a detail at Station 8 on San Antonio's West Side with Mike Sepulveda, a.k.a. *The Hulk*. Mike was an avid bodybuilder. His exaggerated physique almost resembled that of the fictional cartoon character whose nickname he now owned. There was no doubt that Mike was strong…very strong. It was an *all in the family* shift as Mike's father Henry, the captain at Station 8, was also on duty. Henry Sepulveda was one of the most respected senior officers in the department. I was at the kitchen table of the old firehouse working on an assignment for a summer course I was enrolled in at Our Lady of the Lake University. Mike was, as expected, in the weight room on the second floor working out. Then it happened.

"8-0-8, respond to 19th and San Luis for an MV-pedestrian…
There are several reports of a truck running over somebody at the intersection.
Ten-four, 8-08 is responding to 19th and San Luis."

I yelled up the port hole to the second floor, *"Let's go, Mikey!"*

Mike slid the pole while I started the ambulance.

"Just tell me where to go.
OK, go to 19th and take a right, we should be able to see something if there's anything."

There was plenty. As soon as I made the turn onto 19th street we saw a crowd of about 40 or 50 people at the intersection. They were all pointing across the street at a pickup truck that had torn through a chain link fence and landed on somebody's well-manicured lawn…and there was someone lying underneath the truck! As I came to a complete stop, another "customer" approached the ambulance swinging his arms violently and throwing punches. The bloodshot eyes and pinpoint pupils told me that this guy could be high on methamphetamines. He looked physically strong. I locked my door as he tried to punch his way through my side of the ambulance. He broke the rearview mirror.

"What the hell? This dude is high on something.
He's probably the owner of the pick-up. He probably ran over the guy.
Mike, Mike…where the hell are you going?
Don't leave me here alone with, with, with Cassius Clay!
I have to get to the guy underneath the truck! I think he may still be alive.
Mike, this guy over here is on meth or something dude, and the crowd…
I don't know what they're going to do! Mike, don't go.
Call for a 10-80!
8-0-8 to dispatch…give us a 10-80! We need SAPD here quick!"

Mike got out of the cab, grabbed the trauma box and began his walk toward the injured man underneath the truck, but he didn't get far. The crazy guy trying to punch out my window went around the front of the ambulance to confront Mike. Mike's command of the Spanish language improved immediately. He through every cussword he had ever learned at *Cassius Clay* and told him to back off. Then the unthinkable happened. They locked arms and went to the ground immediately. They disappeared right in front of the ambulance as I sat inside the cab.

"Dispatch! Give us a 10-80, I mean NOW!!!
My partner is being assaulted!
PD is already on the way, 8-0-8!
John! John! Get over here! Oh crap.
Mikey, are you OK?"

I slowly opened the door and grabbed the metal clipboard—my weapon of choice for the time being. I shuffled my feet as I made my way around to the front of the ambulance. When I got there, I saw my partner, *The Hulk*, on top of the poor wretched soul who just seconds before had broken my rearview mirror. I very lightly put my hands on Mike's shoulders and pulled back on him real easy.

"Mike, Mike, let him go Mikey…he's turning blue…you're turning green…
The back of your shirt is tearing…not worth it.
You're killing him, man…just ease up on your grip.
Down goes Frazier! Down goes Frazier!

OK, OK, get off my back, John!
Get on top of him!
Who me?
Are you freaking crazy?
Get on top of him, I tell you!!
I need to go and check out the guy under the truck!"

Mike's face was so red it was turning purple. He had rivers of perspiration just streaming down his face. Once I saw the distended neck veins, I did what he asked of me.

So there I was sitting on top of this madman. I had both of my knees on his chest with the weight of my entire body pushing down on him. *Cassius* (the nickname I had already given him) pretended to have calmed down. He asked me rather politely in Spanish if I would get off his chest. So, after getting assurance from him that he wasn't going to get violent on me, I gave in to his wishes…big mistake. As soon as I relaxed,

he pushed me out of the way and jumped to his feet. I stood up and held the clipboard in front of me with both hands in a defensive posture. He, in turn, clenched both fists and reclaimed his boxing stance…and then he came after me punching and swinging violently. I used the metal clipboard as a shield but he still managed to land a couple of right hooks to my left shoulder. They stung. This guy was strong. Then he swung at my head and I ducked once, and then again. On the third swing, he caught the left side of my head. I momentarily lost my balance. I kept back-pedaling wishing and hoping that someone from the crowd would jump in and declare a technical knockout, anything! Instead, the bystanders appeared to be giving me long odds and placing their bets.

About the time *Cassius* began winding up for another round of punches, I saw in the distance a most welcomed sight. It was the first police squad car fishtailing as he made a 90-degree turn onto 19th street at full speed, then another, and yet another. About six squad cars showed up along with Captain Henry—Mike's dad—and both fire trucks from Station 8. Immediately there were about four pairs of cop hands on *Cassius Clay,* who had been trying his best to kill me! They took him off his feet and plastered him up against the side panel of the ambulance. My heart was racing at 100 miles per hour. I threw down the clipboard as I felt myself hyperventilating. There was only one thing to left do.

"All right you sorry bastard, come on…come at me, tough guy!
Do you want to fight? Huh? Do you? Come on you sorry ass poor excuse of a man.
Are you scared? Huh? Are you afraid of me now?
What's the matter, you gonna wimp out on me?
Come on, let's fight! You ain't so bad…you ain't so bad now…are you big guy?"

I was later told that I looked just like Sylvester Stallone in his *Rocky* character during the fight scenes of the now iconic movie. I was in my version of a boxer's stance with both fists in the fighting position moving back and forth in a semi-circle pattern. As I paused to catch my breath, I noticed that all of the cops and the firefighters had stopped in their tracks to see what all the commotion was about. Everyone was staring directly at me in complete disbelief. It was not exactly a Norman Rockwell moment, but it seemed as if the entire scene had frozen into one of his paintings. Mike was laughing so hard that he was down on his knees on the ground holding his stomach. It turned out that the guy underneath the truck had been hiding there from his buddy—*Cassius Clay*. He didn't even suffer a scratch. Then everyone, cops, firemen, and even some of the bystanders started laughing really hard. Here was the West Side's version of *Cassius Clay* being held up in the air and against the ambulance by three of the biggest and meanest cops in San Antonio, and I was ready to fight him! Was I brave or what? It was hilarious! Tommy Landrum, one of the firefighters who knew me well from our days at Station 33 sarcastically quipped, *"John Boy, I didn't know you knew so many cusswords; if only your mother could hear you now…what shame!"* The entire group laughed for about three minutes nonstop.

Once I realized what had happened, *I* began laughing uncontrollably. My entire body was shaking, and I suddenly felt weak at the knees. The adrenalin rush was reversing itself. I had to sit on the ground. I was sopping wet with sweat. Mike came over and gave me a big "monster" hug in front of everyone and officially christened me as *The Terror of the West Side*. We laughed about the entire episode during every

waking moment of that shift. Even now, whenever I come across one of the firefighters who witnessed the entire event, especially my buddy, *The Hulk*, they are quick to remind me of the day that "John Boy" De La Garza grew up to become *The Terror of the West Side*.

Substance Abuse

On-duty drinking was an accepted practice at some firehouses. I had been a witness to a beer party or two during my young career. Fortunately for me, I always seemed to find a coworker who shared in my belief of not participating in this rule-breaking practice. Nevertheless, I did have the unpleasant experience of two paramedics showing up to work drunk on separate occasions. I was fortunate in that I never witnessed any of the regular paramedics at Station 6 ever arrive to work under the influence of alcohol or any controlled substance, nor did I ever see any of them drink on duty. Both of the incidents I am referring to occurred early in my EMS career, and they involved individuals from other stations.

I clearly understood the unspoken and unwritten edict of "protecting our own" in the Fire Department. There are certain rules by which the men in blue abide. "Dumping" someone for breaking a rule was simply not done, or it was done at the risk of being chastised and labeled a snitch for the rest of your days in department. As a firefighter, it had been easy for me to "walk away" whenever I encountered someone drinking on duty. There were always "friends" around who knew how to discreetly handle such problems.

One of the Elite

I had been looking forward to working with Jared Smith, long considered to be one of the elite paramedics in EMS. Needless to say, I was extremely disappointed when he showed up to work smelling like a brewery, barely able to stand on his own two feet. Someone had actually given Jared a ride to the south side fire station he worked at because he was too drunk to drive. Now he was supposed to go out on the streets and save lives. I was 24 years old and in only my first month in the lifesaving business. Here I was suddenly and unexpectedly faced with a major dilemma. I quickly discovered that I could no longer just "walk away" from this situation. I could not even begin to fathom the idea of showing up to the scene of a medical emergency with a *drunk-on-his-butt* Jared Smith! However, I also knew what the consequences would be for Jared and for me if I did the right thing. I especially feared doing the wrong thing, which was nothing.

It was my good fortune that the firefighters at the station quickly sprung into action at the sight of one of our own showing up to work "wasted." They filled Jared with fresh black coffee and put him to bed so that he could "sleep it off." One of the crew members from the fire truck, a certified paramedic who was no longer assigned to EMS, agreed to ride with me while one of San Antonio's "finest" sobered up. We were fortunate in that we were not dispatched to any major emergency during the first seven hours of the 14-hour night shift. We didn't even get our first call until "super paramedic" was able to stand on his own two feet without falling on his face. The firefighters, Jared's regular crew, turned out to be angels on my shoulder that night.

The Fill-in

On another occasion, I was paired up with Larry, a visiting paramedic who was sent from an outlying station to fill-in for Lee who was off on sick leave. Larry showed up so drunk that he fell asleep inside the cab on the way to our first call. We were working a 14-hour night shift, so I had no problem leaving him in the dark cab of the ambulance while I handled mostly routine calls on my own. Nevertheless, I decided to call the shift Captain after our second call. We were lucky that neither one of the calls had been major emergencies that would have required both of us working a patient. In coded language, I basically told Captain Rovalcaba that Larry was very "sick" and that he needed to go see a doctor. The Captain came over and quietly took my "sick" partner off the ambulance and sent him home. We made sure that Larry slept for a few hours before we let him get in his car and drive off. Captain Rovalcaba called in an off-duty paramedic to finish the shift on overtime pay. A couple of months later I learned that Larry had been "involuntarily" transferred out of the division.

These are but two examples of how some of my colleagues attempted to manage the chaos of EMS with alcohol. These incidents also reveal how coworkers and supervisors attempted to manage what was apparently a much bigger and serious problem at that time. None of the managing strategies, however, addressed the underlying problem of substance abuse. It was a case of managing the chaos one incident at a time and of ignoring a more serious and systemic problem within the department.

CHAPTER VIII

FROM CHAOS TO QUEST

I always did my best to leave the job where it belonged—on the streets of San Antonio. The last thing I wanted to discuss at the dinner table or on a night out was what had happened at work. Patching up gunshot victims, extricating mangled bodies from car wrecks, comforting the grief-stricken, and being a witness to patients dying were supposed to be the last things on my mind once I left work. They never were. Rarely did I even remotely discuss the job with anyone outside of the firehouse. Who would want to hear about shootings, stabbings, trauma, strokes, heart attacks, rape, and death? Who would begin to understand the madness? Who would want to take the time to listen, anyway? This was the rationale for keeping my emotional rollercoaster ride a private matter.

My relationship with some of my former colleagues has remained strong throughout the years. Unfortunately, many of them have fallen victim to the negative fallout of the job. Several are on their second or third marriages. Others have taken to alcohol and other forms of controlled substances even years after having left the chaos. Some have run into trouble with the law for committing acts of domestic violence against loved ones. Rudy B. is a recovering alcoholic. I don't know where he is.

As for me, my wife was and has been my *Rock of Gibraltar*. A great educator in her own right, she inspired me to work to be promoted to Lieutenant and subsequently to the rank of Captain. She also encouraged me to pursue a graduate degree. Through her prayers and unwavering support, I became the Training Coordinator at the San Antonio

Fire Academy. More importantly, she brought me back to the roots of my Christian faith. I am currently a member of St. Joseph's Catholic Church and active in the parish's ministry as a lector. Although the spiritual separation from my faith never closed completely, the remaining gap has narrowed significantly over the past 25 years. It has taken several years for the emotional scars of EMS to heal. There are still many that remain open. I hardly ever refer to anybody as *troll* anymore—well, maybe sometimes. Life, any life, is too precious to demean or to throw away.

During the writing of this dissertation, I have often found myself reliving many of my past experiences in an emotional way. I actually felt my adrenalin rushing again as I recounted rushing Baby Nicole to the hospital. Many of the sounds, the voices, the cries, and smells have resurfaced. On several occasions, I have had to walk away from my desk just to get off the emotional ride. I often reminisce about those tumultuous seven years and the people I worked with, the people who I was able to save, and those who got away from me. In the end, I am proud to say that I survived EMS.

Memories of the time that I spent as a medical first responder have always evoked strong emotions and feelings that I have been reluctant to share with anyone until now. However, nothing can compare to the emotional jolt I felt once I began writing about these experiences in the spring of 2007. This is when my professor and now dissertation committee chair, Dr. M. Carolyn Clark, introduced me to the qualitative research practice of autoethnography in the Life History Research course she teaches. It was then that I was inspired to write my Christmas 1981 story as a class assignment. Shortly after I began writing about this epochal 24-hour period, I realized how much my

job as a paramedic had impacted my life. I discovered how much of my experiences I had internalized and how much of my personal identity had been shaped during this time in my life. The seven years that I spent in the Emergency Medical Services (EMS) division of the San Antonio Fire Department were the most significant of my professional career. It is a period of time that I had chosen to bracket as a defining time in my life; but in the midst of my doctoral program, I was beginning to see that I needed to reflect on those years in a systematic way and understand how they had shaped me.

Leaving the Chaos

The prestige of becoming a paramedic in the big city lost its luster as fast as a woman buried a broken beer bottle into a man's face on Christmas Eve. Like so many of my colleagues, there was a time in my career when I began to look forward to transferring out of the EMS division. It was 1984, my fifth year of working as a paramedic, when I realized I needed to get out. Being part of the Fire Department's elite no longer appealed to me. However, I didn't know then that I would have to wait two more years before I could escape the chaos. Submitting a transfer request was not an automatic ticket out of EMS. There was always a waiting list that was based on seniority. I basically had two other options while waiting for a transfer request to be approved—studying for promotion to the rank of Lieutenant or resigning from the Fire Department altogether. Promoting within the department required self-discipline and rigorous study habits. Although I knew that I possessed these qualities, it was impossible for me to focus on studying while still embedded in the chaos of EMS. It was difficult for me to maintain any level of consistent interest in any outside endeavor.

The chaos had completely enveloped me. My time off was spent resting and simply doing everyday chores around the house and running errands. The nights before going back on shift were the ones I dreaded the most. Anticipating another 24 hours of madness often kept me awake.

Quitting the department was not an option. The job I had with the Fire Department was about as secure as they came. I never wanted to relive my dad's experience of being laid off from work time and again as he had during the economic recession of the 1970s. Those had been some tough times for him and the family. Nevertheless, I tried my best to stay positive knowing good and well that one day I would be out of EMS forever.

I had begun to pursue an undergraduate degree in 1979, the year I entered EMS. My mind and spirit were still intact during my early years as a paramedic. Working towards a degree turned out to be a fun and exhilarating experience at the time. The college classroom afforded me the opportunity to escape the chaos of EMS. In 1982 I earned an undergraduate degree from Our Lady of the Lake University where I met my future wife. We married in 1984. In 1985 I was offered a job as an adjunct instructor in the Fire Science Department at San Antonio College. It didn't take long for me to realize that I had found a new niche—teaching young adults at the college level. I was finally allowed to transfer out of EMS in January of 1986.

Finding Quest

The most difficult challenge leaving EMS was walking away from a great partner—Lee Carrola. He was and is like my own brother even to this day. I was

initially assigned to Station 1, which is located just behind the Alamo in downtown San Antonio. After six months, I transferred to Station 28. This provided a much quieter venue than downtown, and it afforded me the time to study for promotion. I was responsible for driving and operating an aerial ladder truck that had four firefighters assigned to it. It was the perfect assignment. However, the threat of re-entering the chaos of EMS at a moment's notice was always looming and somewhat disconcerting.

I had left EMS under the administrative condition that made me a part of a reserve pool of paramedics. This meant that I could have been pulled back into EMS at anytime without having any say or recourse. The worst part of my conditional departure from EMS was that there was the unthinkable possibility of being reassigned to wherever there was a need to fill a vacancy. This meant that there was no going back to Station 6 or to Lee, the best partner in the world. I could not even begin to fathom re-entering the chaos, much less working with a partner other than Lee at another firehouse.

I was required to attend four hours of advanced life support continuing education classes every month in order to stay current with my paramedic certification. Although I valued the training, I disliked the fact that I was just a phone call away from getting sucked back into the chaos. As I look back at this time retrospectively, I can now see that my chaos narrative was still being written even after I left EMS. I believe that the uncertainty of being reassigned at any time was just as stressful as doing the job itself.

Then one day I was unexpectedly struck by divine providence. I received a surprise phone call at Station 28 from Deputy Chief Curtis Fitzgerald. Getting a call from the person who was second in command of the entire department meant that it was

important. In a very businesslike manner, the chief advised me that my seniority in rank made me eligible to opt out of the reserve pool of paramedics if I so desired. The condition was that I would lose my paramedic certification, which meant that I would never be able to return to EMS. It was music to my ears. I believe that I never gave the chief a chance to finish his sentence. I quickly and emphatically responded, *"I do not have any desire of ever returning to EMS. I gladly accept your offer to opt out of my paramedic certification."* I literally felt one of the biggest weights I have ever carried in my life lifted off my shoulders the second I hung up the phone. I was so happy that I paid for the entire crew's dinner that night out of my own pocket. I had never really gained any separation from the chaos, while I was still in the paramedic reserve pool—not until that very moment

My subsequent promotion to Lieutenant in 1987 gave me the opportunity to be assigned to the fire academy as a training officer—an eight-to-five job. By then I had been teaching at San Antonio College for almost two years—something that I was beginning to enjoy more each semester. I also discovered a renewed interest in the Fire Department by becoming an instructor at the Academy. Consequently, I was able to lengthen my Fire Department career by many more years than I ever anticipated.

Later that same year, my father fell victim to heart disease and died. It had been three years and one month since my mother's departure. My dad had always been my hero. He was only 63. Losing him was devastating. My emotions were already frayed from having lived through a tough seven years and my mother's own sudden and unexpected death. However, unlike the time of my mother's death, I did not have to re-

enter the chaos when I returned to work. It was much easier to grieve in the controlled environment of the Academy than it had been in EMS.

I was eventually promoted to Fire Department Captain and later earned the title of Training Coordinator at the Fire Academy. I spent 21 of my 33 years in the department serving in different capacities at the training division. In 1999 I enrolled as a graduate student at Texas A&M University, which led to a Master of Science degree in Educational Human Resource Development in 2002. Shortly thereafter, I received and accepted offers to teach in the public safety management program at St. Edward's University in Austin, Texas, and in the school of business and technology at Webster University's San Antonio campus. In 2002 I applied and was accepted to Texas A&M University as a doctoral student in pursuit of a degree in Adult Education. I began the program in 2003. Even today, most people who have known me personally and professionally identify me as "the guy at Training" or "the one who is always going to school." Most are not aware, however, that it was the seven years in EMS that had the most significant impact on my life.

Initiating the Employee Assistance Program (EAP)

My promotion to Lieutenant in 1987 led to an assignment as a training officer at the Fire Academy. By happenstance, the Fire Department's health and safety coordinator at the time was in the process of forming a stress management committee. His initial strategy was to build a case for developing program interventions that addressed job-related stress and possibly initiating a much needed Employee Assistance Program (EAP). I immediately knew that I had to be a part of this effort. My

enthusiasm for wanting to participate must have been obvious to the health and safety coordinator. He promptly appointed me to chair the committee. Since having gained significant distance from the chaos, I can now say that my direct participation in this endeavor was also a part of my quest journey. My passion for helping former colleagues, many of whom were still EMS, became very personal. I believed that my experiences of having lived in the chaos could actually have some value for them and others who were still doing the job.

The long-term efforts of the committee for stress intervention resulted in the hiring of a licensed psychologist as the Fire Department's first Employee Assistance Program director. All of us who had participated took pride in knowing that we were the first fire department in the country to have a full-time psychologist directing an EAP program. Dr. Darrel Parisher, who I have previously mentioned in this study, was hired on the recommendation of the committee. As the EAP director, he immediately began helping many of my colleagues and he continues to do so today. The EAP was a major achievement for the department and I drew much satisfaction from having participated directly in its design and implementation.

Irrational Fears and Hidden Demons

I did not leave the chaos unscathed. Internalizing my work as a paramedic is clearly evident as a manifestation in my chaotic self-story. Even now, during the writing of this research study, I have been told by Dr. Parisher that I am one of many emergency responders he has counseled who meet the criteria for Post Traumatic Stress Disorder (PTSD). The negative psychological fallout from the chaos I lived has manifested itself

in different ways throughout the years. In terms of my EMS experience, I have heard the doctor tell me time and again, *"You went through a lot more in your seven years as a paramedic than most people go through in a lifetime."* Those words had never really resonated with me until now that I have been engaged in this research study—a process that actually began in the spring of 2007. My informal sessions with Darrel have afforded me a safe and secure venue in which to vent and share stories about my irrational fears and hidden demons. There has always been a "connection" between who I was back in the chaos to who I have become in the present day. However, it is one that I historically chose to connect with an obscured dotted line. There has always been a personal reluctance on my part to revealing the obvious—a reluctance to connecting the dots. That has now changed.

In 1987 I had a near panic attack on an otherwise uneventful flight between Washington D.C. and San Antonio. One year later I cancelled a trip to Puerto Vallarta, Mexico, at the last minute because I realized that I could not bring myself to travel by air any longer. A 1991 family road trip to visit friends in Colorado was interrupted by at least two episodes of hyperventilation on the interstate that required me to stop on the side of the road to control my breathing. After spending three days in Denver, I shortened my family's vacation by four days and drove nonstop for 20 hours until I reached San Antonio. My biggest regret was putting my wife and then three-year-old daughter through that unpleasant experience. In 1993 I was invited to be a presenter at a seminar sponsored by the Orange County California Fire Department. All of my expenses were paid for and I was set to go, but I walked off the plane that was to take me

there before the crew could close the door to the fuselage. On a road trip to Florida with my family in 2009, I pulled off the highway before crossing the bridge over the Mississippi River in Baton Rouge, Louisiana. It was not until my wife assured me that we could turn around and drive back home that I was able to cross the bridge.

Approximately 10 years went by before I took a trip outside of my comfort zone—about a 300 mile radius from my home in San Antonio. Dallas, Houston, South Padre Island, and my mother's hometown of Santiago in northern Mexico represented a self-imposed travel perimeter. Not only was I very familiar with these destinations, I knew that they were close to home—a day's drive at best. Beyond this range, I felt as if I would hit a "point of no return." I would begin to experience a great amount of fear and anxiety—a sense that I would not make it back home alive. It is important for readers to understand that these and other irrational fears did not exist prior to my time in EMS. Most of these demons began to surface after leaving the chaos.

Breaking out of my self-imposed travel perimeter has been tantamount to taking a giant step forward—like learning to walk again. Although it doesn't feel quite as normal as it should, going over a suspension bridge has gotten much easier. My next goal is to get on a passenger jet and travel like I once used to do. In retrospect, I now wonder how much of this might have been avoided, or at least lessened, if my colleagues and I had been provided with some semblance of an Employee Assistance Program back when we were all living the chaos that was EMS.

Writing Christmas 1981

Studying life stories through different genres of research and through different analytical lenses opened up an entirely different world of research for me. Nothing, however, caught my attention more than being introduced to the autobiographical genre of autoethnography. Initially, I wasn't sure that I fully understood the concept of studying the "self." I believe that my first attempts to internalize and understand everything there is to know about autoethnographic research overwhelmed me. After having read several examples and having engaged in class discussions facilitated by Dr. Clark, I began to make a strong connection with the autobiographic genre.

One reading that I connected with almost immediately was Carol Ronai's (1992) autoethnographic account, *The reflexive self through narrative: A night in the life of an erotic dancer/researcher.* In her story, Ronai presents herself as the researcher, the narrator, and ultimately the subject of the research. Her analysis is a reflection of the "why," "when," "how," and "for whom" her story is told. I found the crafting of her narrative and subsequent interpretation fascinating from the perspective of it being a process of research—a compelling qualitative study. Ronai's self-study prompted me to recall an epochal 24-hour period in my life—Christmas 1981. I soon realized that my story was one that was embedded in me, as much as Ronai's was in hers. Like Ronai's story, my account also featured self-reflection, emotion, introspection, and transformation.

The final class assignment in the Life History Research course was to write a personal autoethnographic story. I began transcribing some of my thoughts even before

Dr. Clark approved my written proposal for the assignment. The experience of reconstructing the events of Christmas 1981 proved to be deeply reflective and evocative. I was surprised at my willingness to share a part of my life that had previously been "off limits" to the outside world—including my family. At first I was somewhat amazed at being able to recall so many details that pertained to the events of that epochal 24-hour time period.

My emotions ran the full gamut from exhilaration to sadness, from laughter to reliving sorrowful and painful moments. I cried tears of joy as I reminisced about the great bunch of people I had the opportunity to work with in the midst of some extraordinary and difficult circumstances. There were moments of sadness knowing that I wasn't always at my best when I needed to be. I know that I made mistakes that had consequences for people's lives. Guilt crept in as I reflected on having once doubted my faith in an all-loving and all-forgiving God. I felt the adrenalin flowing once again as I recalled trying to physically restrain a man who had tragically and unexpectedly lost his young wife on Christmas morning. I could have written the 27 pages in one sitting; however, reliving the emotions caused me to walk away from the project several times. It didn't take long before I realized that my Christmas story was part of a much greater and significant narrative. It is a story about me and about all who have ever done the job.

In her feedback comments, Dr. Clark reaffirmed what was already being revealed to me. She indicated that I had the makings of a much bigger story, but only if I would be willing to "open it up" for a much broader audience. I now knew that expanding my

story presented a great opportunity for conducting autoethnographic research. However, it also presented me with a dilemma. How much of my experience was I willing to share with the outside world? This became an important issue once I considered that there may be certain facts about the job that former colleagues might not want me to divulge. The manner in how we dealt with on-duty drinkers as well as the dark humor we relied on to cope with the job are but two examples of issues we liked to keep "in-house." In the end, I decided that this was "my story" to tell and no one else's.

During the summer months that followed, I decided to go forward with doing an autoethnography about my EMS experience for my dissertation. I contacted Dr. Clark and asked her if she would consider being the chair of my committee. She gladly accepted. I began collecting my thoughts as well as categorizing some of the more epochal moments that I experienced. I subsequently met with Dr. Clark to finalize my degree plan, form a dissertation committee, and to develop a research strategy that would ultimately lead to the completion of this study.

Retirement

Although my plan to retire after a minimum 30 years of service had been in place for several years, designing a strategy for completing my doctorate degree influenced my decision to leave the Fire Department in 2008. In retrospect, it was the Life History Research course that set the wheels in motion toward a new chapter in my life. The irony was that "looking back" had caused me to "move forward" a little faster.

Back in 1975, the old firefighters from Station 12 had advised me to savor every moment. They had told me that the time would simply fly by. My plan to stick around

for 30 years seemed like an eternity at the age of 19; needless to say that I did not heed the words of the wise smoke-eaters who themselves were on the verge of retiring at the time I was entering the department. Then, one morning, after 33 years of wearing a uniform, I woke up and headed to the Fire and Police pension office to sign my own retirement papers. The year was 2008. The moment of separation was bittersweet. I felt the presence of the many great individuals I had the privilege of working with during a career of a lifetime. I considered each one of them to be a very special part of my extended family.

I decided to write a farewell letter that I hoped would capture my feelings about them, the profession, and the department that I had come to love so much. It was published in the association's monthly newsletter—the *Grapevine*—just prior to my last day at work. The following is an abbreviated version.

I'm So Glad We Had This Time Together

The year was 1975 when a skinny, 140 pound, 20-year-old rookie sporting a full head of black hair walked into 33's firehouse…his life has never been the same since. It didn't take long for someone to find an appropriate nickname that fit. Thus, he was soon christened with the name, "John Boy."

Today, I am the one who gets to turn out the lights on the old gang from 33's...I am the last of the last.

I would like to wish each and every one of you a long, and safe, and prosperous career. Take care of each other, for by doing so you take care of all who have gone before and all who will come after you. And if you ever have doubts about anything remember this: prevent harm, survive, and be nice.

It has been a pleasure and an honor to have worked with each and every one of you. I know that you will make the Fire Department and the City of San Antonio very proud. Good luck and God Bless!"

This is John "John Boy" De La Garza signing off for the original gang from Station 33…

Fraternally,
John A. De La Garza
Captain/Training Coordinator
San Antonio Fire Department

Time in Service:
February 17, 1975 – February 29, 2008

At the time, I had felt that this was the best way for me to say goodbye to everyone—to the firefighters, paramedics, fire inspectors, and training officers who I had served with at one time or another. To my astonishment, that meant well over 1,000 people. Wow! Where had the time gone? I paused and reflected on the words of wisdom the old timers from Station 12 had shared with me three decades prior. They had truly been very wise men.

My Extended Family

I still consider members of the San Antonio Fire Department, both active and retired, to be a significant part of my extended family. To divorce myself either physically or emotionally from the fire service is simply a non-negotiable proposition. I feel extremely fortunate to know that many in the department still seek me out not only for professional advice but for fellowship and camaraderie. During the writing of this dissertation, I was asked to give the commencement address to the graduating class of new firefighters—class 2010-Alpha—on July 8, 2010. I proudly accepted.

It felt good to be in my Fire Captain's dress uniform once again. Although my speech was addressed specifically to the new firefighters, it was also a personal reflection of my strong affection for the people who continue to preserve a wonderful

tradition of service. However, the occasion came at a time when I was in the middle of writing my chaos narrative. This meant that my speech presented the challenge of reconciling a joyous celebration with the harsh realities of what my life had been in EMS.

Commencement Address to Class 2010-Alpha

Chief Hood, Chief McNulty, distinguished guests, ladies and gentlemen, and to the members of class 2010-Alpha, thank you for giving me the wonderful opportunity to address you on this very special occasion…it is truly an honor.

To say that you, the graduates, are about to embark on a journey that defies the meaning of the word "mediocrity," well…that would simply be an understatement.

There is, after all, nothing mediocre about the fire service. Just a few years ago I, too, was a fire cadet trainee, and much like you my excitement and anticipation about the career I was about to embark on continued to grow with each passing day at the Academy. My training experience also culminated in a graduation ceremony…on one July 18th…and the rest, as they say…the rest is now history. A few days after graduation, I found myself responding to alarms as a probationary firefighter on ladder truck 33.

That was the summer of 1975... It was truly the time of my life.

Your presence here today is a testimony to our community that the unselfish commitment to serving humankind has not lost its appeal...that it is still very much in style. Outside of our military, you represent one of the last bastions of heroes in a society that at times seems to value the world of make-believe… more… than it values the world of reality. Nevertheless, today we are here to announce and acknowledge that YOU are the real deal. Therefore, my message for you is simple, and it is as follows…

Today, you become America's heroes.
It is important for you to keep in mind that this is not a drill…From this day forward, your mission has begun; there are no more dress rehearsals.

In the very near future, you will come to appreciate the countless amounts of repetitive drills that your instructors have put you through over the last 25 weeks. You will also come to value the hundreds of textbook pages and notes you have been required to read over and over and the many written and practical skills examinations you have had to endure.

Your appreciation for having completed such a demanding and challenging program will be manifested the day you respond to your first alarm…and at every alarm from now until you leave the fire service. It is during these critical moments that you will come to value the knowledge and skills imparted to you by your instructors and why you were told to do it again and again until you got it right. It is then and only then when everything you have learned will come together and make perfect sense.

There will be times when the challenges you face will seem overwhelming. I vividly recall the prophetic words of one of my training officers at the academy—words that still resonate with me even today.

"There will come a day during your career," the captain said, "a day when you will ask yourself, 'what am I doing here?' a day when you will contemplate your true purpose in life; a day when you will wonder if you made the right career choice." Within a year's time of hearing these fateful words, I found myself living out a scenario much like the wise captain had foretold.

One early Sunday morning, in the aftermath of a two-alarm fire, I sat in the back of an EMS unit breathing through an oxygen mask. The paramedics had me connected to an EKG monitor with an I-V needle running fluids through my arm. And yes, I sat there contemplating, asking myself, "What…am I doing here?"

I will take the liberty and assume that every New York City firefighter pondered over that very question on the morning of September 11, 2001. And who would blame them if they did? One day you, too, may ask yourself, "What am I doing here?" But like many who have served before you, you will not quit, you will in fact persevere, and you will succeed in this endeavor because there is no doubt in my mind that you have been well prepared for such a day.

I do not have to describe to you in detail what you might encounter when responding to a medical emergency, a vehicle accident, or a hazardous materials incident. I do not have to illustrate to you how dangerous it is to enter a burning building, and I don't have to remind you about the importance of maintaining crew integrity while conducting a primary search. You already have a good idea, a good feel for the nature of these and other challenges that await you…now you must experience them firsthand.
The best human quality that you can subscribe to now is patience…the best virtue—humility. Courage will show its face…at the proper time…in its proper place…not because you are inherently brave, but because you are simply doing the job you've been trained to do…the job that you love to do.

You will not be allowed to select who you serve. That has already been decided for you. You will serve all who call on you during the most difficult time of their lives. More importantly you will have taken an oath—an oath which permanently seals your commitment to serving every man, woman, and child—a sacred duty indeed.

You will be appreciated by some and scorned by others. You will know sincere thanks, human kindness, misunderstanding, sadness, helplessness and disappointment, and you will experience joy and gratitude when you least expect it. You will see unrestricted emotion, destruction, foolishness, pain…and death. But you will also experience the goodness of the human spirit, and your faith will be made new again.

From your first alarm, up until your last day in the Fire Service the people you serve will expect acts of heroism. They should expect nothing less. Your first heroic act will occur just a few minutes from now—when you take the oath of the office of firefighter.

You will be the good neighbor and a respected person endowed with a traditional trust that will be tested many times…and this will make your sacrifice worthwhile.

Keep in mind that this community will hold you to higher professional and moral standards. You never want to compromise these standards because if you do you will have compromised the trust that the public has placed in you. The trust of the people you serve will always be your strongest ally, your strongest advocate. Don't ever take it for granted…don't ever lose it.

Each semester I assign my Public Safety Management students at St. Edward's University to do a little bit of research concerning mission statements written for Fire and Police Departments throughout the United States. Without failure, there is always a student who finds one of my personal favorites.

Prevent Harm, Survive, Be Nice. These five words make up the entire mission statement of the Phoenix Fire Department. Prevent Harm, Survive, Be Nice. It is as simple a statement as it is compelling…it is as personal as it is inclusive. If you ever experience the need to quickly regain your perspective as a public servant, I would encourage you to remember these five words not so much as a mission statement, but as a way to live your life: Prevent Harm, Survive, Be Nice.

If you are as blessed as I have been, one day, perhaps 20 or even 30 years from now, you, too, will look back on a career that never seemed like a job but more like a way of life. If you succeed, and I know that you will, you will find yourself owning an impressive resume of experiences and accomplishments that will serve as a testimony to your devoted service to humankind.

You will know that you made the right decision on July 8th, 2010.

As I look back on my own list of accomplishments, I can say that I feel satisfied, fulfilled, and carry within me a tremendous sense of pride, but I also know that the only reason you see me standing here today is not because of a long list of achievements, but because Almighty God has granted me the grace to do so. Don't ever lose your faith…

And if I had to do it all over again, I would not change a thing; for I love the Fire Service, I love the San Antonio Fire Department…and I know that you will love it as well.

In closing, I would like to once again offer you my sincere congratulations and remind you that today you become…America's heroes.

Good luck and thank you very much for having me.

The Irony in My Speech

One of the personal achievements that I am especially proud of is having trained over one 1000 firefighters during my 21 years at the Fire Academy. This partly explains my natural inclination to inject the qualities of inspirational leaders and of great communicators into my speech. I thought of Knute Rockne, the legendary Notre Dame football coach, and of George C. Scott in his academy award-wining role as General Patton. Here was an opportunity, if only for a brief moment, for me to be like these iconic figures. I am proud to say that I delivered the goods in grand fashion. The Fire Chief made it a point to tell me personally that my speech was the best keynote address he had ever heard. Accolades from former colleagues and others in attendance soon followed. It was undoubtedly one of my finest moments.

As I have previously mentioned, I wrote and delivered the keynote address at the time that I was writing this dissertation. Although I now characterize the experience as a shining moment, writing and delivering my speech proved to be more of a challenge than what I first thought it might turn out to be. The reality was that some of its content stood in stark contrast with my autoethnography, which was already in progress. For example, at one point I alluded to the importance of adhering to the edict of *prevent harm, survive, and be nice* as a way to live one's life in the Fire Department. However,

deep in my subconscious I could hear the sarcastic riles of former colleagues, *"yeah, right…sure, you tell them John Boy. That's exactly the way it is. You must be full of crap."* I will acknowledge that the "high volume" emanating from these voices of yesteryear in my head were due to the irony of me painting a portrait of invincible "action heroes," during a time that I was writing a narrative of personal chaos and rupture—a "real" story of an emergency responder.

I would have been remiss if I had not included at least some of the harsh realities of the job in my speech. I described a personal experience of being trapped at a fire and the challenges it had presented me physically and psychologically, but in the end I persevered just as they would some day. I went as far as mentioning death, but in the same breath I suggested that the good in all circumstances would somehow outweigh the bad. I may have been guilty of constructing too rosy a façade of mostly fun times and sunny days ahead.

Taking the occasion and the diverse audience in attendance into consideration, it was only natural to keep the content and the delivery of the speech positive and upbeat. Nevertheless, deep in my subconscious I had already been reliving the seven-year chaos of my EMS experience. The reality was that I saw a lot of John Boys in the graduating class of 2010-Alpha who were about to get a rude awakening. I wondered in silence how they would turn out 30 years from now.

Four months after I delivered my keynote address to the new firefighters, Ladder Truck Company 35 was involved in a rollover accident while responding to an emergency. All four firefighters riding in the truck were injured. Among them was a

graduate of class 2010-Alpha—one of the new firefighters who had heard and applauded my speech back in July. It took several hours for rescue workers to extricate him from the overturned ladder truck. His road to a full recovery is still in progress as of the writing of this dissertation—a rude awakening, indeed.

CHAPTER IX

MAKING SENSE OF MY STORY

Theoretical Framework

I have selected three theoretical frameworks that will be useful to the analysis of my autoethnographic study. The framework that I have judged to be most helpful in this endeavor is Arthur Frank's (1995) typology of illness narratives, specifically the chaos and quest narratives. Secondly, I have identified a transformative learning theory framework grounded on Jack Mezirow's (2000) frame of reference model and William Randall's (1996) life story method. Finally, I have selected the work of Rogers et al. (1999) that helps me examine the language of the unsayable as it applies specifically to the excessive use of alcohol in EMS.

The Chaos Narrative

According to Frank (1995), "The chaos narrative is always beyond speech, and thus it is what is always lacking in speech" (p. 101). Frank further argues that "when such a struggle can be told, then there is some distance from the chaos; some part of the teller has emerged" (p. 104). I have met the challenge of stepping outside of the "self" in the "telling" of my story. In attempting to analyze it, I must once again seek distance and separation from the narrative in order to uncover a deeper meaning and understanding of my experience.

I tell the story as I remember it taking place. Emotional wounds are identified under each salient theme and there is rupture from the person I was before; thus, there is chaos. One such rupture with my past involved the indifference and callous attitude I

developed toward death and dying. Another involved the growing separation of "self" from my spirituality. Fending for my psychological and physical well-being at times bordered on paranoia. The emotional wounds are byproducts of the seven-year rollercoaster ride that I have lived to tell about after much reflection and introspection.

Frank (1995) argues that, "Chaos is never transcended but must be accepted before new lives can be built and new stories told" (p. 110). Although Frank was speaking in the context of his illness narrative, his statement is also true of my EMS narrative as I lived it then and as I interpret it today. Remnants of physical, spiritual, and psychological ruptures that I experienced have followed me throughout my life. My entire EMS experience represents a profound change in my life—a tipping point. My chaotic self-story is a reflection of a transformation that occurred in the immediacy of the experiences. However, being unable to tell the story in real time made it impossible to notice the depth of the changes even as they were taking place. Now, after 25 years, writing my story has exposed open wounds that have never closed completely.

The Quest Narrative

Like many who have survived personal wounds and ruptures in their lives, I eventually carved my way out of a chaotic existence. Some of the wounds have healed while others are in the process of being sutured—some will always remain open. However, having designed a roadmap to exit my chaotic existence provided me with hope—a light at the end of the tunnel. Visualizing me leaving the chaos narrative and moving onto a more preferred existence had affective value then. Seeking quest while still in the chaos narrative speaks to the hope I had of one day restoring my life

physically, spiritually, and psychologically—of moving forward to bigger and better things.

I always knew that I would one day leave the Emergency Medical Services division. The greatest challenge was to leave it unscathed—a virtually impossible endeavor. My story of quest began 10 months after I responded to my last medical call. It was not until then that I was given the administrative option of waiving my paramedic certificate. This virtually guaranteed that I would never return to the chaos of EMS again. True quest, however, began only after I decided to write about my experiences in the spring of 2007, some 20 years after having left the chaos.

My story, which continues to evolve, is one of quest that for now has culminated in the writing of this dissertation. "The genesis of the quest is some occasion requiring the person to be more than she has been, and the purpose is becoming one who has risen to that occasion" (Frank, 1995, p. 128). "Breaking the silence" and telling my story is part of the "rising to the occasion" of which Frank speaks. Prior to writing *Christmas 1981*, I never considered what possibilities the telling of the story would bring. My quest narrative has revealed some of these possibilities as it implies a meaning-making transformation taking place after having left the chaos. My hope is that it will have some value for me and for others who have lived and survived their own chaotic stories.

Like Arthur Frank, I too am a "wounded storyteller" but in a different context. The diverse audiences I have targeted will hear the different threads in the fabric of an emergency responder's story. Having left the chaos has been only part of a journey that

is still unfolding—one that continues to emerge and that carries its own purpose of quest and transformation.

Transformative Learning

Transformative learning is an integral part of adult development. Clark (1993) argues that "transformative learning shapes people; they are different afterward, in ways both they and others can recognize" (p. 47). The process can be gradual or sudden, and it can occur in a structured education environment or in the classroom of ordinary life. The focus of transformative learning in this study involves my professional life experiences outside of a traditional classroom setting. I have selected two lenses for looking at the theoretical framework of transformative learning as it applies to my study. First, I used Jack Mezirow's (2000) lens that identifies transformation through an individual's frame of reference. Secondly, I used William Randall's (1996) lens of experiencing transformation through the life story.

My introduction to the method of autoethnography in 2007 culminated in the writing of my Christmas 1981 narrative. I found the experience of reflecting, reliving, and writing the epochal story to have transformative value. Upon the completion of *Christmas 1981*, I came to the realization that I had a much bigger story to tell. This autobiographical activity directed attention to a broader EMS narrative, and it revealed the relationship between the construction of my self-narrative and transformative learning (Rossiter & Clark, 2007).

Mezirow

Emotional, life-altering experiences speak to the possibilities of transformative learning opportunities—they speak to the human soul. Mezirow (1997) argues that, "transformative learning is the process of effective change in a frame of reference. Adults have acquired a coherent body of experience—associations, concepts, values, feelings, conditioned responses—frames of reference that define their life world" (p. 5). Among this unique set of characteristics are the professional experiences that inform a contextual knowledge base. According to Taylor (2008), "It is the revision of a frame of reference in concert with reflection on experience that is addressed by the theory of perspective transformation—a paradigmatic shift" (p. 5). Therefore, it can be argued that an individual will experience transformation naturally when her or his frame of reference is jolted by an epochal event or a series of such events.

Mezirow (1997) also posits that "a frame of reference encompasses cognitive, conative, and emotional components, and is composed of two dimensions: *habits of mind and a point of view*" (p. 5). According to Cranton (2009), "habits of mind are uncritically absorbed from our family, community, and culture, and remain unexamined until we encounter a discrepant perspective that leads us into the reflective process" (p. 96). Such was the case with the rupture I experienced with my Catholic faith while in the chaos narrative. These habits of mind also referred to as meaning schemes, "are specific manifestations of our meaning perspectives" (Mezirow, 1994, p. 223). I would argue that my personal *habits of mind* and *points of view* about the world I lived in were suddenly and significantly altered and transformed between 1979 and 1986.

Mezirow (2000) affirms my argument by stating that “transformations in habit of mind may be epochal, a sudden, dramatic, reorienting insight, or incremental, involving a progressive series of transformations in related points of view that culminate in a transformation in habit of mind” (p. 21). I would describe my seven-year tenure in the subculture of the Emergency Medical Services division as the incremental/progressive part of my transformation. The experiences that can be characterized as epochal, dramatic, and immediate were uniquely transformative. The extraordinary magnitude of such incidents had the effect of immediately altering my frame of reference—the effect of *shock and awe.*

Randall

William Randall proposes the re-storying process as a new way of understanding transformation. According to Randall (1996), “transformative learning goes to roots of our being. It is not a matter of merely adding to our store of information. It involves critical self-reflection” (p. 224). He looks at the re-storying process in terms of four overlapping levels: (a) existence, (b) experience, (c) expression, and (d) impression. I have identified the first three levels of his process as germane to my study.

Existence, which Randall refers to as our *outside story*, “takes in all of the uninterrupted, unevaluated events of my existence, one after the other, from morning to night, conception to now, bottom to top” (Randall, 1996, p. 227). My chaos narrative is a significant part of my existence—of *my* outside story. My outside story consists of the raw data gathered from the personal and epochal events that I have written and narrated. According to Randall (1996), “my outside story corresponds to the physical object of a

particular novel. It is the paper, ink, and binding that comprise the thing itself, as well as the history of the manufacture" (p. 229). It is the hard copy of events lived within my life story. My record of having "existed" in a chaos narrative can be confirmed through witness accounts, written reports, ledgers, departmental files, and other artifacts.

Experience, on the other hand, is my *inside story*, and is comprised of what I *make* of the facts—or *make up* from them—within me, subjectively. This inside story is essentially the story-behind-the story—it is *my life*. My "experience" is the "meaning" that I have interpreted from, and attached to, my existence. This is my story as I have come to know it, as only I can write it, narrate it, and interpret it—without limitations. "It is the novel as I experienced it, as I reconstruct it in the reading: its atmosphere, its unfolding in time, its reality within me as an entire story-told" (Randall, 1996, p. 229). At this level, my story searches for personal meaning. The experience evolves as a meaning-making process of interpreting the chaos that was possible only after having gained some distance from my chaotic existence.

The third level, expression, is my *inside-out story*. At this level, I take my inside story, abridge it, edit it, and package it for the world beyond me. In other words, I am transformed by the experiences of my life and I have now storied them for others (Randall, 1996). This is where I craft my story for the purpose of communicating its meaning to the outside world, not caring what impressions or reactions there may be. "My inside-out story is my summary of part, or all of that world, for the purpose of communicating about it with others" (Randall, 1996, p. 229). It is the re-storying of my existence and of my experience within that existence. "If we think of ourselves as

having, or more fundamentally, *being* a story, then we can see that story as an object of study and of personal growth" (Rossiter & Clark, 2007, p. 163). Re-storying a new understanding of ourselves has the potential of being uniquely transformative.

Language of the Unsaid

Looking at my story through a critical lens prompted me to apply characteristics of another analytical tool—the unsaid narrative. Each time I read and reflected on my autoethnography, I discovered a much bigger landscape being painted. I now realize that I consciously, albeit only superficially, touched on the theme of alcohol abuse. There are two reasons for not elaborating on this in the narrative. First, I believe that I was being protective of some of my former colleagues as well as of the Emergency Medical Services in general. I do not believe that the actions of a few should taint the efforts of the many who participate in this high-risk, high-hazard profession and who choose not to work under the influence of alcohol or other controlled substances. I would never attempt to justify the actions of those who chose to drink while on duty. However, I now have a better understanding as to why some of my colleagues behaved in such an irresponsible manner while on the job. Secondly, I felt that having dwelt on this omission would have given me a presumptuous advantage as the hero of my narrative—a powerful position indeed.

As the interpreter of my story, I now feel compelled to include some of what has been left unsaid. My position is supported by Rogers et al. (1999) who state, "In interpretations that include the significance of the not-said, the researcher assumes the additional responsibility of naming, in some way, what is unspoken, and perhaps

unspeakable, from the participant's point of view" (p. 81). In the context of my autoethnography, I, as the researcher, am charged with this responsibility argued by Rogers et al. (1999). Therefore, I have included the omission in my analysis.

By definition, this autoethnography had to be a much focused study. I recognize that there are other problems relevant to the culture of EMS that may have been left unsaid in my research. I acknowledge that issues relating to gender, race, and ethnicity come into play in the fire service. However, I also believe that these should be part of a much broader story of EMS and public safety in general. By necessity, I had to be selective; therefore, I have determined that these elements do not fit into my story at this time.

Analysis

"You actually did all of this?" I was somewhat taken aback by the inquisitive nature of my wife's reaction after reading my *Christmas 1981* story. It was followed up by my then 19-year-old daughter's own interrogation. Surprisingly, my initial response was reflective silence. Prior to then, I had never really stopped to think about the magnitude or the significance of all that I had lived through those seven years. This was the first time that I had ever shared any part of my EMS story with anyone outside of the Fire Department. "Yes, I guess I did," I responded in a somewhat pensive and deeply reflective manner. It had taken 25 years for me to "open up." Now, I had to figure out what it all meant.

Autoethnography requires considerable attention to introspection and self-analysis by the researcher. My purpose in the "telling" of my story was to describe the

indescribable to an audience outside of the fire service and to relate a familiar story to those who have had the same experiences. My purpose in "analyzing" my autoethnography is to try and make sense of what is a much more significant story in my life, not just for me but for the benefit of other emergency responders.

Salient Themes

The themes that have emerged in my study are intertwined with the three theoretical frameworks I have identified for the analysis of this study: (a) Frank's (1995) typology of chaos and quest, (b) Mezirow's (2000) and Randall' (1996) transformative learning models, and (c) the language of the unsaid narrative by Rogers et al. (1999). The emergent themes I have identified as salient to the meaning-making process of the study are: (a) death and dying, (b) faith and spirituality, (c) job burnout, (d) dealing and coping with job-related stress, and (e) alcohol abuse.

Death and Dying

Rarely did I get so much as a glimpse of a deceased relative at a funeral when I was growing up. My parents would either keep me away from funerals altogether, or at a distance from an open casket. Like many others who grew up under the umbrella of over-protective parents, I came to fear the only inevitability of life—death. The irony is that I later came to accept death and dying as a very routine part of my job. It was followed by an attitude of callous indifference. I now know that my reactions were in part due to the emotional numbing that many emergency responders rely on in dealing with stress and other unpleasant undertakings such as death and dying.

In this job you develop a wall of coldness to people dying. You deal with it as it comes every day. A wall has to be built. Sometimes, something happens that penetrates that wall. The highs and lows that you experience are extreme. (Zamelsky, 2008, p. 43). The suddenness of death is devastating. Listening to the screams and gut-wrenching cries of a mother, a wife, or a significant other responding to the death of a loved one is emotional torture. Unexpectedness only adds to the rupture, the sudden tear that cuts deep and leaves an emotional wound that rarely heals entirely.

The unexplained. Notwithstanding the impact of the unexpectedness of death, there was also the "unexplained." There were times when I must have shared a premonition or two, as was evident in the following vignette.

> *What hurts?*
> *Nothing…Am I going to die?*
> *No, Jane, you're not going to die… not if I can help it anyway.*
> *Why did you call us?*
> *I am feeling a discomfort on my left arm.*
> *Do you have any pain?*
> *No, but I want to know if I am going to die.*
> *No! You're not going to die!"*

We took Jane to the hospital even though she did not meet the criteria for EMS transporting. Jane died a few hours later. What made us take Jane to the hospital was my gut feeling—nothing more. It had nothing to do with my superb knowledge of medicine. I was just as inclined not to take her to the hospital when something tugged at my conscience. Neither Rudy B. nor I believed that Jane was going to die. From a medical perspective, there were no signs or symptoms that offered any evidence of the unthinkable occurring. On the other hand, Jane had a premonition that I ended up sharing.

The unexpected. My unexpected trip to the morgue with a dead body and a family in tow was a good example of the suddenness of death.

> *I then heard the cries of a young girl.*
> *Momma! Momma!*
> *Bobby is dead, Momma!*
> *Bobby is dead…heeeeee's dead!*
> *Noooooo!*
> *It can't be!*
> *Not my Bobby!*
> *The older lady who was screaming had to be restrained by family members.*

At first, I didn't quite know how to handle the emotional turmoil brought on by death. I mostly relied on my ego to mask any emotional involvement and tried my best to numb my own feelings by acting professional. Rarely, if ever, did I offer condolences to anyone for their loss. I did my best to stay preoccupied and busy by writing a report or cleaning equipment while waiting for the police or the medical examiner to arrive. As time went on, death and dying simply became part of the job. It became routine.

Death becomes routine. Death becoming routine was evident in the following excerpt.

> *Who's the dead guy?*
> *Take your pick.*
> *Well, there is one quick way to find out.*
> *We proceeded to go around placing the EKG leads on each of their chests and connecting them to our monitor. None of them moved, flinched, or even twitched as we examined them.*
>
> *Make sure we're getting a good read on the monitor.*
> *Shake the leads. They're working fine.*
> *This one is alive.*
> *So is this one.*
> *Well, then it must be…sure enough…the last one…we have a flat line.*
> *8-06 to dispatch, we have a confirmed 10-29.*

As I reconstructed my story, I reflected on such events and realized just how conditioned I had become to death and dying. It became as normal and expected as showing up for work and filing the paperwork or filling up the gas tank on the ambulance. I eventually developed an attitude of indifference toward death that seemed almost businesslike and at times callous.

Faith and Spirituality

During my eight years of Catholic school, I was taught that even though there are bad people in the world, we should still love them. As a paramedic, the challenges to this Christian-Catholic upbringing were manifested in a secular versus spiritual tug-of-war as I struggled with justifying how I could come to love a father who would repeatedly burned his two-year-old son with a lit cigarette, or the man who would have sexual relations with an 11-year-old girl. This struggle took on a more dramatic good-versus-evil dimension during Christmas of 1981, when I came to witness an extraordinary number of tragic events and the consequences of violent acts committed by what I thought were crazed individuals. I refer to it as a crisis of faith—a spiritual separation—chaos.

I always carried a St. Joseph's prayer card and a rosary in my uniform shirt pocket while on duty. I never really prayed meditatively while at work; nevertheless, the two religious artifacts served as a security blanket. I had experienced enough close calls at fires and at medical emergencies at this juncture in my career to realize how fragile human life was, including my own. Carrying my faith in my pocket was equivalent to having a peer support group with me at all times. The irony was that while I maintained

a strong belief in my Christian God, my faith was being increasingly challenged every day that I reported to work. This is evident in the following passage from my narrative:

> *How could I find Jesus in the heart of a murderer, a rapist, an abusive parent or spouse? I felt myself becoming more callous and less spiritual.*

There was never any doubt that my emotions followed me home after each shift. I rarely talked about my work with anyone outside of the firehouse. I once described to Lee the effect that a hot shower had on me after working a 24-hour shift. I explained how it was a way of me coping with my emotions. I attempted to describe this in the following passage:

> *Taking a shower after working a shift was more like a symbolic cleansing. I treated the entire shower experience like a religious ritual. It was as if I were washing away my sins in a baptismal font. I felt a need to cleanse myself of all the bad I had encountered during the shift, and of all the bad I may have inflicted on anyone by my negative actions and reactions.*

Was my Catholic frame tugging at me? Perhaps, but interpreting the shower experience as a religious one had implications for both my emotional and spiritual well-being. Treating it like a religious ritual allowed me to stay connected to the spiritual, albeit by a thread. The word cleansing is right out of the Catholic liturgy. The washing away of sins was an admission of my imperfections—of my professional screw ups. After all, I did have people die on me. I did make mistakes. Therefore, the cleansing after each shift was not only a hygienic necessity, it was an attempt to restore some semblance of order to my life while I was still in the chaos.

Spiritual rupture. I often found myself looking for meaning in the senseless violence and the destructive acts inflicted on humans by other humans. The spiritual storm brewing inside of me was converging with my job and my ever-growing

negativity towards everything, including my Catholic faith. This was reaffirmed by the indifferent priest I encountered on my way to work that Christmas Eve:

> *Finally, he brought me Holy Communion.*
> *As soon as I received the sacred wafer, he turned around went back into the sacristy and closed the door behind him.*
> *I never even got a chance to thank him.*
> *I never got my blessing.*

The result of this particular encounter could not have come at a worst possible time in my life as I struggled to reconcile my Catholic faith with the violent and destructive nature of my job. Although the priest had granted my request to receive communion on my way to work, I was left with an uneasy feeling that his indifference and cold demeanor had set the stage for what turned out to be the *shift from hell*. I was right. He never gave me his blessing, which I took personally. This only added to my "crisis of faith" during what I believe was a major transformational period in my life.

In retrospect, I now realize that I was dealing with a spiritual separation—a rupture with my faith—chaos. Although this crisis of faith had been building since 1979, the year I entered EMS, it truly began to proliferate during my tenure as a paramedic. Frank (1995) argues that chaos feeds on the sense that no one is in control. There is evidence in the first passage that I was beginning to believe that no one, not me or any Supreme Being, was in control of the madness I was witnessing on the job. I felt that I was in a spiritual tailspin. I was experiencing what can best be described a form of spiritual abandonment.

The rapid succession and the magnitude of the tragedies that I witnessed on December 24th and 25th, 1981, were remarkable even for a seasoned paramedic. The

fact that I was able to relive these incidents and share them in written word with illustrative commentary is a testimony to the consequential impact they had on me. Having been raised by very devout Catholic parents, Christmas for me was one of the holiest days on the calendar. This only added to the poignancy of the spiritual chasm I was experiencing. I began to feel the goodness and the holiness of the season fade into history. I recall feeling somewhat melancholy as I reflected on the days of Christmas past on the way to a call:

> *8-0-6, 8-0-6, respond to Flores and Travis for an injured party…That's right down the street from the Cathedral. As we drove toward our destination, we went by the church which by this time was glowing in the splendor of Christmas. I could almost hear the choir and smell the incense of the holy celebration. Midnight was approaching.*

Reality struck me like a wall of bricks just minutes later as we unexpectedly found ourselves in the middle of a riot.

> *Suddenly, the double doors from one of the bars swung violently open and a woman with a broken bottle buried it into a retreating man's face.*
> *Shit! This is falling apart…get a back-up!*
> *Screw the back-up…Where the hell is PD?!?!*
> *We're fixing to get our butts in a jam here!*

The entire experience that was taking place was much like a perfect storm that had been packaged just for me as I struggled to reconcile my faith in God with the bad that I witnessed every time I went to work—with the chaos. Later in the narrative, I described the scene where a blood-soaked corpse greeted a young boy riding his new bicycle on Christmas morning near the airport:

> *The bullet-riddled body lay there, lifeless. It had been dumped some time during the early morning. I noticed a young boy, about 14, over to the side sitting on a brand new bicycle. I must have been 12 when "Santa" brought me my first bike,*

> *one of the joys of waking up on Christmas morning. Right then it hit me that this was Christmas morning! For the first time in my life, I wasn't home to celebrate.*

Once again, the contrast of the good that can be seen in a young boy riding a new bicycle on Christmas morning with the bad emanating from a lifeless body filled with bullets was evident. Then we responded to what was probably the most symbolic of any call on Christmas day:

> *We arrived at the modest home of a Spanish-speaking mother overcome with hysteria.*
> *Señor, señor, aquí pronto! Mi hijo, es mi hijo…parece que está muerto!*
> *She thinks the baby is dead.*
> *Calmarse, señora, calmarse por favor.*
> *No esta muerto.*
> *The child was a six-week old infant. The backdrop was a Christmas tree with torn gift wrappings all over the living room.*

Although the child lived, the symbolism and the contrast of good things happening versus bad were also evident in this particular incident. I continued to struggle. How was I supposed to maintain any semblance of spirituality in the middle of all this madness? I never expected to internalize the collective impact of my experiences the way I did. I began to personalize the job more than I needed to and that was a mistake. It led me to relate everything to the battle between good versus evil in society. It was the tipping point of my career; it was the proverbial final nail in the coffin of innocence lost—a true rupture with my spirituality.

My spiritual war culminated with my decision to convert Christmas 1981 to just another day on the secular calendar. There was evidence of a very tangible separation from my spirituality. I came to believe that Christmas no longer existed as I had known it to exist. The 24-hour shift in question was a continuum of negativity that began with

an indifferent priest, followed by a young widower banging his head on a wall on Christmas morning, and which ultimately ended with a tourist having his face cut up by a thug. Consequently, a significant part of my spirituality had surrendered to the reality of a cruel world. Although it had already been in the works for some time, my spiritual rupture was made complete on Christmas 1981.

Resurrection. My inclusion of a Resurrection subsection under the Death and Dying heading is a reflection of those rare moments that offered some semblance of renewal and validation in what I was doing. Resurrection pertained to the little miracles that kept my spiritual light flickering through the chaos. The experiences I had with Lazaro coming back from the dead and later with the birth of Jonathon Lee had a strong spiritual connection. Tisdell (2003) argues that, "spiritual experiences come in a variety of forms, including what is perceived as a physical or emotional healing, dreams, synchronistic experiences, or other events that seem to get at the wholeness of life" (p. 68). Other experiences that turned out to be positive were simply a consequence of good science, such as Narcan, a drug the antidote for heroine overdoses. I often referred to it as the miracle worker.

In retrospect, I realize that my reaction to Lazaro coming back from the dead at the hands of a Catholic priest may have seemed a bit melodramatic for my partner as well as for a secular audience; however, my strong Catholic faith was *pulling me* into believing that it was the Almighty who had intervened. Consequently, it was an unplanned, unexpected spiritual experience I strongly connected with, but at the same time resisted. Tisdell (2003) argues that spiritual experiences seem to happen by

surprise. "These moments of catching a glimpse of the wholeness of Life, the interconnectedness of all things and one's more authentic self generally cannot be planned" (Tisdell, 2003, pp. 34-45). The chaos and uncertainty of everyday life in EMS lent itself to such surprises—both good and bad. Witnessing Lazaro come back to life was one such surprise.

Although my spiritual frame of reference was almost exclusively grounded on my Catholic faith, I often relied on it to make sense of the chaos that I was living. According to Tisdell (2003), "significant spiritual experiences are those that seem to get at the interconnectedness of all things. They seem to happen especially when the energy of the Life-force is most obvious, as in birth, death, and near-death experiences" (p. 86). The birth of Jonathon Lee solidified the lifelong connection I have had with my most significant EMS partner—Lee Carrola. Jonathon Lee's birth, like all births, was a miracle. It was a moment to savor.

Burnout

I experienced several bouts with what I would describe as severe job burnout throughout my EMS career. Job burnout and the effects it had on me is a salient theme that is interwoven with other themes throughout my narrative. As previously mentioned, burnout became the epicenter of my existence. Its negative effects were felt both professionally and personally. I believe that job burnout is an example of what Frank (1995) describes as an "anti-narrative of time without sequence, telling without mediation, and speaking about oneself without being fully able to reflect on oneself" (p. 98). Unable to create distance from the chaos, burnout became a physical, mental, and

spiritual nemesis. I was unable to explain it or make sense of it at the time, nor was I able to just *shake it off*—I just lived with it. Its impact manifested itself in an attitude of indifference toward patients, colleagues, and just life in general. Sometimes it contributed to human error on the job. The story about the cafeteria worker who I misdiagnosed was an example of this manifestation.

> *"You killed the old woman. She interrupted your afternoon nap…admit it…you killed her." I did not respond. This dark sense of humor was all too common among us. However, I was not in the mood for comic relief at that very moment. I sat silently in deep thought as I questioned my own actions and inactions—my emotional temperament. Rudy B. suddenly turned serious and said, "I wonder if the daughter is going to have something to say about this…she is an RN, you know. We weren't at our best back there." I grew concerned and was beginning to have second thoughts about my ability to do the job much longer. It was time for a reality check.*

Knowing that neither Rudy B. nor the patient's daughter—the RN—had identified any signs or symptoms of a heart attack gave me some sense of relief, believing that we had done everything possible to save her. However, there was no mistake in my mind that I—we—had erred. This event is an example of how my principled and straight-laced attitude began to change as a result of job burnout. Although I continued to witness mistakes by my peers and other health care professionals, I was rarely inclined to bring it to anyone's attention. Incidents such as this were evidence of my own professional shortcomings. Who was I to point the finger at anyone anymore? In my mind, I was no longer capable of placing any blame on the young intern who had pulled the MAST trousers off of Ricky.

Paramedic Stress

All of my experiences in EMS became intertwined with every aspect of my being. Negotiating my emotions in the stressful environments that I encountered is probably the most salient of the themes. These feelings were constantly being funneled into a whirlpool of emotions that I dealt with on a daily basis. Nevertheless, I planned and eventually carved out a path that led to an escape from the chaos. However, there was never any going back to being John Boy.

Responding to certain incidents often reminded me of people who were close to me—of people I loved and cared deeply about. My dad had always been my hero. My father was a blue collar worker with an eighth grade education who had proudly served his country during World War II. He never owned a car because he could not afford one. This closeness that I felt for my dad was evident in my concern for his well-being after responding to a tragic accident. The following excerpts are from the *Christmas 1981* chapter of my narrative. In it I describe, with a certain amount of detail, an incident that jolted my emotions on that Christmas Eve:

> *How many times had my dad run after a bus in his lifetime? Maybe he did it a few hundred times—who knows? I felt myself internalizing the bus incident more than I normally would any other. My dad could have shared the fate of Rogelio Garcia any number of times. At that very moment I had a longing to be with my dad. I was at work and he was at home. I worried about him catching another bus.*

However, none of the experiences during Christmas of 1981 had more of a long-term impact on my spiritual and emotional well-being than the one I described in the following passage:

> *There on the bed lay a pretty young woman who appeared to be in her twenties. She was dead. "What's the story Pat? She aspirated in her own vomit last night. What?!?! Story is she had too much to drink…wasn't used to liquor…went to sleep…she basically drowned…he's the husband; her son (six years old) is in the living room (opening gifts) waiting for his grandparents." Then came one of the most freakish screams I have ever heard…"Noooooooooooh!!!"*

Even now, I can still see and hear the husband banging his head on the wall in the hallway. It was Christmas morning. I can still see the little boy trying to block out the insanity of the moment by opening gifts. If there is one incident that has become my "press release" for those who say that firefighters and paramedics don't earn their pay, this is it. The spirit of Christmas gave way to a "reality check." December 25th was now just another day on the calendar and my job really sucked. My emotional rupture was now complete. My nerves had been anesthetized. My attitudes about life and death were changing.

Frank (1995) argues that "in the chaos narrative, troubles go all the way down to bottomless depths. What can be told only begins to suggest all that is wrong" (p. 99). Dealing with my emotions was a rupture in and of itself. My emotional disposition was intertwined with the other themes as well as with my desire to escape the chaos. I refused to believe that I was experiencing a burnout crisis at the time. My analysis, however, reflects those bottomless depths of which Frank speaks. Disowning Christmas was tantamount to rejecting part of my faith. The need to check on my father's well-being after a call bordered on paranoia. My emotions ran the full gamut throughout the entire story as they did throughout the seven years: from the cocky attitude of a young paramedic ready to save the world to the reality of mopping up blood from the floor of an ambulance on Christmas Eve.

Internalizing my work as a paramedic on a more personal level has clearly been a manifestation of my chaotic self-story. According to Boudreaux and Mandry (as cited in Bounds, 2000, p. 2), "Stressors that impact paramedics can be categorized into the following groups:

1. Administrative or organizational factors
2. Clinical or patient care factors
3. Factors related to the public
4. Environmental factors not related directly to the public.

There is little, if any argument among mental health professionals that paramedics suffer emotionally from the negative consequences associated with their job. "Paramedics are not only exposed to human suffering and tragedy on a daily basis but in addition are frequently in situations where their own safety is in jeopardy" (Regehr, 2005a, p. 97). The emotional rollercoaster ride experienced by these first responders is unlike that found in any other occupation. Of all the public safety branches, the EMS profession seems to be impacted more severely by the consequences of occupational stress (Bounds, 2000).

A paramedic is constantly surrounded by tension. First, there is an inherent stress in being an emergency responder because of all the terrible physical injuries that one encounters. Accidents themselves yield unpleasant and horrid scenes. There is also the dissonance that one experiences when one person inflicts physical harm on another person. I say dissonance because there is no way to rationalize brutality. There is also

the incomprehension at the injustice of it all, i.e., “Why do bad things happen to good people?” or “How can a loving God allow this to happen?” etc.

The stressors that are inherent to the job itself are often compounded by other political and social realities. For example, “administrative or organizational factors that contribute to stress among paramedics include insufficient salary, limited career options and lack of support from administration, other uniformed services and hospital emergency personnel” (Tomoda, 2003, p. 71). This problem is often exacerbated by having to report to administrators who are unfamiliar with the actual job of the emergency responder.

Patient care or clinical factors also contributing to stress include threats of injury, illness, or death and mass casualty trauma (Tomoda, 2003). Other contributing factors are the public’s lack of awareness about EMS and the resultant abuse of the system by those who do not understand its true purpose. “The appropriate use of an emergency medical service is a subjective construct. Individuals within the public have grossly different interpretations of situations that require an emergency response from a local ambulance provider” (Bounds, 2000, pp. 38-39). Finally, there is a conscious and justifiable concern among paramedics regarding the exposure to contagious and transmittable diseases. Constantly faced with a hostile working environment in terms of being exposed to HIV-AIDS, tuberculosis, hepatitis, meningitis, and other blood and airborne pathogens is another factor contributing to paramedic stress.

The stress category that appears to be least explained is the one caused by clinical and patient care factors. These factors, I believe, are the stress-related elements

that had the most significant impact on my life. Mental health experts now agree that the chronic exposure to such stressors can lead to symptoms of Post Traumatic Stress Disorder (PTSD) in paramedics and other emergency responders. According to Haslam and Mallon (as cited in Cash, 2006), "emergency workers are at high risk for developing PTSD. Emergency workers are exposed to traumatic stressors on a daily or weekly basis" (p. 59). The constant exposure to illness, trauma, and death combined with the inherent risks associated with being in the "rescue business" has a cumulative effect on the emotional well-being of these professionals.

> Post-Traumatic Stress Disorder affects people who have been exposed to traumatizing events or conditions…A traumatic event usually involves a threat to one's own life or to someone close, or the witnessing of an actual death or serious injury, especially when this occurs suddenly or violently.
>
> (Hurrel, Murphy, Sauter, & Levi, 1998, p. 5.13)

It was not uncommon for me to experience a significant number of these extraordinary events in a matter of one 24-hour shift. These experiences were repeated constantly over a seven-year period. "Cumulative stress may present with psychological reactions such as fear, dull or non-responsive behavior, depression, guilt, oversensitivity, anger, irritability, and frustration" (Pollak, 2011, p. 46).

Coping

I always made a conscious effort to take control, or at the very least, appear to be in control of any and all situations regardless of the magnitude of the event. I used a variety of strategies with which to cope with the chaos.

The human ego. I frequently sought refuge behind the status given to me as an authoritative figure in my community. My position was buoyed by the paramedic patch on my shirt sleeve and the badge on my chest—proud symbols of my professional identity. Thus, I often came to rely on the power of the human ego in my efforts to handle high-risk and high-hazard events. Seaward (2000) argues that

> The purpose of the ego is to protect the self from harm when danger is present or a perceived threat is near. The ego does this in a number of ways, which Sigmund Freud referred to as "defense mechanisms," including denial (This isn't happening), rationalization (It's ok because everyone does it), repression (I don't remember that happening), or projection (You made me hit you). (p. 8)

Like many of my colleagues, it was not unusual for me to appear to be mentally, physically, and even spiritually unaffected by the constant pounding of responding to medical emergencies. I shrugged off the sleepless nights and the close calls as being part of the job—it was OK because my colleagues were having the same experiences. It was the "macho" thing to do. My actions and reactions as a paramedic were reaffirmed by Mitchell (as cited in Glendon & Coles, 2001) who suggests that, "ambulance personnel are idealistic, devoted, goal oriented, histrionic, and dynamic and have high energy levels" (p. 170). To these characteristics I would add, 'at times egotistical with a false sense of invincibility.'

Dark humor. Dark humor was another coping mechanism on which many of us in EMS relied. Tangherlini (1998) states that "the psychological burden of dealing with traumatic death can further be alleviated with the dark humor that pervades many medic

stories" (p. 64). It was not uncommon to hear comments such as, "*that DOA (dead on arrival) who hit the utility pole the other night looked like De La Garza does at 3 in the morning*, or, *John was pissed off that that the old woman interrupted his afternoon nap so he killed her."* Upon arrival as a backup unit to a shooting, I overheard one of the medics from the first ambulance singing a catchy song as they were leaving the scene. It included the lyrics: *he didn't know the gun was loaded.* I soon discovered that the *he* in the improvised jingle had shot himself in the head with a revolver. Comic relief often came at the expense of our patients; however, neither they nor any bystanders were ever made aware of it. We always kept our morbid sense of humor to ourselves. We were always professional when we needed to be.

Emotional numbing. Another coping mechanism that helped me get through the chaos was the emotional numbing of the senses. According to Regehr (2005a), "emotional numbing is one of the strategies used by emergency responders to cope with stressful events" (p. 99). Often masqueraded as an attitude of indifference, this "numbing of emotions" began to surface in the manner that I conducted myself with patients. This callous personality that developed as part of my professional identity carried over into my personal life to the point that it became noticeable to family and friends. Regehr (2005b) argues that "this strategy of emotional numbing has consequences for the responders and for their families. Family members may perceive the police officer, firefighter, or paramedic emotionally distant and unfeeling" (p. 255). Such was the emotional disposition and demeanor I publicly conveyed as I dealt with my mother's illness and subsequent premature and unexpected death. I subconsciously

allowed my professional identity to "kick in" for the sake of maintaining some semblance of order and continuity not only for myself but for the family. I only cried when I was alone.

Alcohol Abuse and the Unsaid

Another emergent theme was the prevalence of alcohol abuse in EMS. I presented this theme by exposing the drinking problems of some of my colleagues, especially those who drank on duty. I discovered during the process of this analysis that my portrayal of these individuals was also a reflection of my own challenges with the consumption of alcohol at the time.

One of the biggest disappointments of my young career as a firefighter was discovering how prevalent substance abuse had become in the department. Even more disappointing was the amount of alcohol that was being secretly consumed on duty. Evidence of this was everywhere even at my own paramedic graduation ceremony:

> *Rudy B. had arrived at the graduation ceremony slightly intoxicated. I could smell the alcohol on his breath every time he spoke. Rudy had a drinking problem…By this time, I was no stranger to dark humor of some firefighters and paramedics, nor was I surprised at the alcohol and substance abuse taking place within the department.*

I sometimes found myself stopping at a convenience store on the way home after working a 24-hour shift, and I would buy a couple of beers to help me "unwind." I would leave the beer can in the brown paper sack and drink while I sat in my car in the store's parking lot. This may not have seemed so unusual except that my shift ended at 7 a.m. This meant that I was usually downing a couple of cold ones around 8 o'clock in the morning when "normal" people were on their way to work, kids were boarding

school buses, and the sun was rising from the east. I must have looked like some of the alcoholics I knew from the old neighborhood. They would sit in their cars all the while looking suspicious. They would drink their favorite brew out of bottles or cans wrapped in brown paper sacks behind Melvin's gas station. Had I become one of them? I never once mentioned my own drinking problem in the narrative. I now realize that I used Rudy B.'s alcohol problems to talk about my own. This became more evident in the following passage:

> *I had visions of Rudy B. stopping for a six-pack of beer on the way back to the station, or maybe a bottle of Jack Daniels. For a moment, I was even tempted to make the offer. I had never seen him "down one," at least not at work. I did, however, have a strong suspicion that Rudy B. drank on duty. He was good at keeping the drinking hidden from public view and under control. He wasn't as good with the breath mints he chewed on all shifts to hide the obvious. I never played the "drinking on duty" game.*

The tendency to position oneself as a hero in the story is not that unusual for a participant in any narrative. A hero can do no wrong. Rarely does a protagonist in any narrative want to reveal weaknesses that might expose his or her vulnerability. Did I have a drinking problem? I probably did at the time. It might have been in its initial stages, but it was a problem nonetheless. Fortunately, my appetite for alcohol subsided once I transferred out of the EMS division. Although I cannot characterize my drinking problem as worthy of checking myself into a substance abuse clinic or joining Alcoholics Anonymous, it is representative of how the job was leading me down the same path of dependence that some of my colleagues were on. Although I may have made Rudy B. the face of substance abuse, I consciously refrained from developing the theme. I feared that it would negatively taint the heroic job that my colleagues

performed for many years—even those who fell victim to drugs and alcohol. I now have a deeper appreciation and understanding of their actions, which were essentially a byproduct of a very chaotic existence.

My position as the protagonist in the story afforded me the status of hero—of super paramedic. Frank (1995) argues that, "the person who has lived chaos can only be responsible to that experience retrospectively, when distance allows reflection and some narrative ordering of temporality" (p. 108). I have discovered that the genre of autoethnography has given me an "advantage" in being both the researcher and the storyteller. Nowhere was this better represented than in the alcohol abuse theme that I have now identified in the interpretation of my story.

As I looked at my story analytically, I began to negotiate with other parts of my past. I was eventually able to gain some emotional distance from the narrative. This led to the admission of my own drinking problem—something that I consciously left out of the main narrative. Although I never participated in firehouse "beer busts," I now realize that I was not much different than those who did. The fact of the matter is that I began to look forward to gulping down a couple of beers in the morning hours following a busy shift—much the same way as many of my colleagues did.

Summary

I have presented three theoretical frameworks that have been beneficial to the analysis of my story. My selection of Arthur Frank's (1995) illness typology has enabled me to identify the different layers of my chaos narrative. Like Frank, I too am a wounded storyteller but in a different context. My selection of the transformative

framework speaks to the immediate and incremental transformation I experienced while living in the chaos and finding quest. Mezirow's (2000) process of effective change in a frame of reference relates directly to the transformative learning that I experienced during and after my time in EMS. Randall's (1996) process of being transformed through the re-storying of one's life involved a considerable amount of critical self-reflection on my part. This helped me "connect the dots" from the person I was while in the chaos, to the one I have become today. During the analysis of my story, I came to recognize and acknowledge my reluctance to share my own struggles with the consumption of alcohol. This led to my use of the unsaid narrative as per Rogers et al. (1999). I also identified a number of themes that contributed to the interpretation of my story. Collectively, the theoretical frameworks and the emergent themes that I identified were of great benefit in helping me recreate the more salient parts of my narrative and ultimately help me make sense of my story.

CHAPTER X

CONCLUSION: THE VALUE OF MY STORY FOR OTHERS

I recently discovered that several of my former peers have been living with physical and emotional challenges that can be traced back to the time they served in EMS. My brief encounters with some of them have yielded stories that now serve to validate my personal journey. Many of these former lifesavers have not surprisingly taken an interest in my autoethnography. They have inspired me with their personal accounts of the chaos they lived. I have found their narratives to be quite extraordinary; even more telling is the fact that their stories sound very similar to my own. My most common response to them has been, *"I never knew that we were going through the same thing."*

At least two of my former colleagues revealed that they have developed severe claustrophobia, often manifested as a fear of flying; others suffer from agoraphobia. One almost had a panic attack when driving over a suspension bridge in Europe. Another was fearful of traveling beyond the city limits of San Antonio. Today, he is afraid to leave his home. One told me how he would drink as many as eight beers during a shift just to cope with the job. Bouts with nightmares, alcoholism, chronic depression, insomnia are but a few of the problems they have shared. The similarities in our stories have given me cause to reflect and bring scrutiny to a training program that in all fairness was still in its infancy back in 1979. I must assume that EMS training program designers at the time were still moving through stages of "trial and error" and were more

focused in developing and delivering advanced life support training to, rather than for, firefighters.

The program that I graduated from at The University of Texas Health Science Center-San Antonio (UTHSCSA) was among the best in the nation. Its reputation remains intact and it continues to be the primary source of training and education for San Antonio Fire Department paramedics. Looking back retrospectively, the trainers who were involved in the design and delivery of our paramedic program did a phenomenal job in getting us trained and certified in a period of just five months. However, the primary focus of the training we received was always about caring for others—not for ourselves. On-scene safety, proper lifting techniques, and how to protect ourselves against unruly patients were some of the personal protection issues addressed. Except for a brief session on dealing with death and dying facilitated by one of the Fire Department's chaplains, not much more was done in the area of helping us prepare for the emotional investment that the job demanded.

Adult Learning Strategies

Although new paramedic recruits have been tasked with absorbing and learning an overwhelming amount of information in a very short period of time, training programs still fall short in their attempts to addressing some of the realities and consequences of an emotionally charged profession. Incumbents, those who have already added layers of epochal and life-jolting experiences to their frames, are also vulnerable to the negative fallout from the job. For example, the most recent, unsolicited conversations I have had with former colleagues have served to validate my own

physical, psychological, and spiritual struggles. A fair number of these former lifesavers have been diagnosed with PTSD. This is further evidence that addressing the psychological effects of the job has not received its due diligence by program designers.

My impromptu encounters with former colleagues have led me to believe that there is a potential value to incorporating well-established adult education strategies in training programs that specifically address the emotional aspects of the job. Designing and developing problem-based and situated cognition learning strategies based on lived experiences could add *real world* value to the professional education of the student. This case study approach would be most beneficial to new recruits who have yet to venture out into the real world of EMS. Also, constructing new knowledge through personal narrative can lead participants to engaging others with similar experiences. Incumbents would stand to benefit the most from this strategy.

The short stories that I have informally heard from former peers speak to the possibility of incorporating two theoretical elements of adult learning into a training program: (a) narrative learning and (b) experiential learning. It is important for readers to understand that although each offers a different analytical lens, they are not to be viewed as separate categories but rather as interwoven elements that will contribute to the learning process.

Learning Through Experience

Fenwick (2000) posits that "A learner is believed to construct, through reflection, a personal understanding of relevant structures of meaning derived from his or her action in the world" (p. 248). I envision both paramedic recruits and incumbents participating

in case studies, problem-based learning, and role playing exercises derived from their respective narratives. In discussing the value of participation learning from a situated perspective, Fenwick (2000) posits that *knowing and learning* are defined as engaging in changing processes of human activity in a particular community. The community of emergency responders certainly lends itself to participation learning strategies. Furthermore, Tisdell (2003) argues,

> Adult learning and development take place in many contexts, sometimes in individual settings and sometimes in group settings. Individually, we may construct new knowledge in self-directed learning efforts or when we make new meaning out of significant life experiences or through our interaction in significant relationships. (p. 13).

Therefore, the concepts of personal reflection, community, life experiences, and self-directed learning are characteristically supportive of learner-centered activities for emergency responders.

According to Fenwick (2000), "the term experiential learning is often used both to distinguish the ongoing meaning making from theoretical knowledge and non-directed informal life experience from formal education" (p. 243). In terms of the application of this theoretical element, my focus is on the reflection/constructivist theory and on the participation/situated theory. Writing autoethnographically required me to be reflective, which allowed me to re-create a true "meaning-making" perspective under the umbrella of experiential learning theory. Fenwick further argues that

> Reflection, a constructivist perspective, is a prevalent and influential adult learning theory that casts the individual as a central actor in a drama of personal meaning-making. The learner reflects on lived experience and then interprets and generalizes this experience to form mental structures. These structures are knowledge, stored in memory as concepts that can be represented, expressed, and transferred to new situations. (p. 248)

This constructivist perspective applies neatly to paramedics and their stories. To write about oneself is to write about one's social and professional experiences. As such, autoethnography is grounded in the art of storytelling. In the context of one's profession, storytelling is a tool that brings one's experiences to life.

> Storytelling acts as a means for individuals both to interpret their experiences in the organization and to position themselves within the organizations. Examining the role of storytelling among paramedics, in turn, affords an opportunity to develop a better understanding of how a medic views his or her occupation. (Tangherlini, 1998, p. xxi)

Storytelling is a tool a learner can use not only to reflect on her or his experiences, but to interpret and to construct meaning as well. Fenwick (2000) posits that, "a learner is believed to construct, through reflection, a personal understanding of relevant structures of meaning derived from his or her action in the world" (p. 248). Most of the stories paramedics tell center on the reflection of their own experiences. Although re-living some of my experiences has been painful, I believe that sharing information with other paramedics can lead to valuable learning moments. "Paramedics

consider storytelling an opportunity to exchange information. For example, stories about combative patients, unexpected hazards, or surprising outcomes all provide medics with important experiential information. Thus, to some degree, the stories serve a didactic purpose" (Tangherlini, 1998, p. xxvi).

Paramedics also learn by participating and interacting with the experiences of other paramedics through situated learning. "Although reflective practice and situated cognition both involve learning from real-world experiences, how these experiences are interpreted is often vastly different" (Merriam, Caffarella, & Baumgartner, 2007, p. 178). In situated cognition, "knowing and learning are defined as engaging in changing processes of human activity in a particular community" (Fenwick, 2000, p. 253). Also in situated learning, one cannot separate the learning process from the context in which the learning is presented. Therefore, "knowledge is not a substance to be ingested and then transferred to new situation but, instead, part of the very process of participation in the immediate situation" (Fenwick, 2000, p. 253). Re-creating situations by designing problem and scenario-based exercises are invaluable learning strategies. Participating in and interacting with past experiences produces new experiences that can be referenced in future real world situations by the learners.

Narrative and experiential learning strategies can lead to meaning-making and transformative learning experiences. Innovative applications of teaching methodologies on the part of the facilitator are vital to engaging the participants and to promoting transformative learning. For example, Mezirow (1997) proposes that learning contracts, group projects, role play, case studies, and simulations are classroom methods associated

with transformative education (p. 10). Methodology that employs interaction, an important facet in adult learning, could be used to engage the participants in meaningful dialogue—a vital strategy for emergency responders.

Learning Through Narrative

Paramedics already tell their stories to other paramedics. "Most of the stories medics tell center on their own experiences or on the experiences of the medics they know" (Tangherlini, 1998, p. xxii). Asking incumbent paramedics in a continuing education setting to write a work-related narrative could initiate valuable meaning-making learning moments not only for them but for other emergency responders. I may have written *Christmas 1981* much sooner if I had been given the opportunity in a continuing education setting. According to Mackerarcher (2004),

> Narrative thinking allows us to store and describe information for which no clearly defined propositional knowledge is available. Such thinking uses storytelling as a means for establishing themes of human behavior describing human life in its social context, without offering explanations or causes. (p. 111)

Telling my story to former colleagues has already paid dividends in terms of having them "open up" and sharing their experiences. Storytelling empowers the teller. For example, telling my story has had a therapeutic effect on me, one that has helped me heal some of the wounds that have been open for over 25 years. I also see proof of this empowerment in my former peers once they begin sharing their own stories. They suddenly appear to become passionate about telling their stories and how they were impacted by the events.

Narrative thinking leads to narrative knowing and subsequently narrative meaning. Giving voice to the learner through the use of narrative enhances the learning experience by fostering a self-reflective learning environment. Adult educators use stories in their teaching routinely, to illuminate content, to facilitate learning, and to link learning to the life experience of the learners (Rossiter & Clark, 2007). This student-centered approach lays the foundation for collaborating and constructing experiential learning strategies.

Narrative learning is grounded in storytelling: on how well stories are told, how well they are received, and how well the learner can make sense out of them. According to Clark (2010),

> Being storytellers means that this is our way to bring some kind of coherence to the chaos of experience that bombards us daily. Narration is a sense-making act. It's what we do as individuals but, importantly, as individuals situated within various social contexts. (p. 3)

Stories, narratives, myths, tales, and ritual capture aspects of this world in ways not readily available through more traditional instructional methods (Dirkx, 1997). Rossiter and Clark (2007) further argue that narrative learning means learning through stories—stories heard, stories told, and stories recognized (p. 70). Merriam et al. (2007) posit that "as a means of understanding adult development, a narrative framework sees the life course as the unfolding story, one constructed and interpreted by the individual" (pp. 213-214). Every individual has a story to tell. Every individual *is* a story. Every person possesses a historical timeline of events from which her or his story unfolds. Stories are

everywhere. We tell them, we live them; our views of reality, of life itself are shaped by them in ways beyond our awareness (Rossiter & Clark, 2007).

Some stories are life-changing—epochal. They often serve to change habits of mind and points of view. Thus, individuals experience "learning moments" throughout their personal and professional lives that contribute to their development as adult learners. Injecting these moments in the narrative can prove to be beneficial to the education of others in the profession. Rossiter and Clark (2007) argue that

> Narrative education is aligned with the foundational belief that the essential connection between experience and learning offers a way to effect the connection by using the natural way in which all of us make sense of our experience that is by storying it. (p. 10)

Regarding the autoethnographic narrative, Ellis and Bochner (as cited in Riessman, 2008) write,

> The narrative rises or falls on its capacity to provoke readers to broaden their horizons, reflect critically on their own experience, enter emphatically into a world of experience different from their own, and actively engage in dialogue regarding the social and moral implications of the different perspectives and standpoints encountered. (p. 192)

It is my belief that personal stories coming from paramedics would contribute to the education and professional development of other emergency responders. "When we appreciate the centrality of narrative to meaning making, we begin to understand the importance of stories and storytelling to the education endeavor" (Rossiter & Clark,

2007, p. 71). The objective for adult educators would be to channel this new knowledge into relevant "learning moments" that would help emergency responders come to understand the range of challenges and emotions they face in the public safety arena.

Adult education strategies for paramedics, both candidates and incumbents, are typically a representation of traditional styles of learning pedagogy. There is no arguing the fact that these types of learning approaches are necessary for the development of paramedics and other emergency responders. However, including more personal learner-centered strategies such as the ones discussed here could add significant value to the learning experiences of these modern-day lifesavers.

Recommendations

I believe that it is important for every paramedic candidate to be made aware of what the job entails both physically and psychologically during the first week of the training program. As previously mentioned, Dr. Parishers's current involvement with recruit paramedics is limited to a two-hour long presentation and discussion on stress management. His purpose is to provide a level of awareness of the mental and emotional challenges that await them. Regardless of how many times a new recruit may hear the words *"Don't take the job home with you,"* the fact of the matter is that the job follows you home and everywhere else you go. It virtually becomes a part of your life. Its impact is felt in an individual's faith, marriage, family life, and virtually every aspect of her or his existence. How can program designers prepare these individuals to enter this chaotic existence? Even today there are no training manuals sitting on a shelf that address these and other realities about the job. Educators in this arena must find

innovative ways to prepare new paramedics for both the physical and emotional demands that the job entails.

I would also like to address EMS stakeholders, primarily administrators who make policy, as well as shift commanders and supervisors, who are responsible for the performance and well-being of paramedics. It is through the actions and inactions of these individuals that paramedics function. These officials have the ability to influence policies that could lead to the design of interventions that address the handling of personal and emotional challenges associated with the job. Knowing what actions to take or who to contact when one senses problems within or with a colleague could save lives.

Inclusion of Spouses and Significant Others

I would recommend the involvement of spouses or significant others in a two or three-hour long training session during the first week of training. Representatives of all departments and agencies that play a role in the success of EMS would be given the opportunity to describe and discuss their respective roles. This list would include, but not be limited to, EMS and hospital administrators, supervisors, emergency room physicians and nurses, and veteran paramedics who have done the job for at least three years. Each presentation would build on the previous one and culminate in a discussion on managing the job both personally and professionally. This type of learning strategy would prove beneficial to both the candidates and their significant others. The ideal facilitator for such an effort would be the EAP director.

Journaling

Requiring paramedic candidates to journal their experiences during the clinical phase of their training could prove to have both short- and long-term benefits. Journaling in a medical context is not a novel idea. There is evidence of reflective writing exercises being used in the education of medical practitioners. Rita Charon has defined the practice as *narrative medicine*. Charon (2001) argues that "Reflective practitioners can identify and interpret their own emotional responses to patients, can make sense of their own life journeys, and so can grant what is called for—and called forth—in facing sick and dying patients" (p. 1899). In an EMS setting, recruits would become engaged in writing reflectively about their experiences shortly after the completion of their ambulance ride-outs and hospital rotations. Each candidate would be encouraged to describe any significant emotions they may have experienced during and after an epochal event or after a series of incidents. I realize that this would be difficult to achieve in a culture dominated by men who do not see themselves as having any emotional or psychological vulnerabilities. However, I do believe that this would at the very least initiate a process of getting individuals to feel comfortable with the idea of "opening up" at any time during their career. This approach would establish an accepted practice throughout the division and eventually throughout the department.

Peer Support Training

A peer support training program that includes firefighters and paramedics trained by mental health professionals such as Dr. Parisher is already in place. I believe that this is one intervention that can lead to others once it gains trust and credibility among the

rank-and-file. Training "insiders" to monitor and provide counseling and guidance during difficult times can prove to be a valuable strategy. Also, continued support to efforts by Dr. Parisher to form and maintain a critical incident stress debriefing team is essential. These two interventions should be viewed as "ice breakers" to the previous recommendations I have mentioned. The key is establishing trust and credibility by involving the very individuals who are impacted directly by the chaos of EMS. The message here should be, "taking care of our own."

I am very cognizant of the fact that recommendations such as the ones I have mentioned here are difficult to achieve given the fact that the culture of emergency responders is typically one that never likes to admit to vulnerabilities or weaknesses. The public safety professions are characteristically dominated by males with Type "A" personalities. Many of these individuals have virtually programmed themselves never to display their emotions, on or off duty. To propose preventive interventions that would promote mental wellness and awareness could be interpreted by some in the professions as an admission to personal vulnerabilities and weaknesses. Although I personally feel that these are valid concerns, they should not be interpreted as reasons for not moving forward with programs that promote preventive interventions.

Concluding Thoughts

My autoethnography is not a singular story. There is more than ample evidence throughout the narrative that there are others who played a significant role in it. They, too, have their stories to tell. I strongly believe that my study gives many of my former colleagues a platform for them to share their own reflections. What initially motivated

me to tell my part was the epiphany I experienced when writing *Christmas 1981*. Tattered memories of a difficult time in my life filled with raw emotions and invisible wounds that never quite healed suddenly came to life again. This later turned into a personal quest to find meaning to the chaos I had lived and to make it count for something more than simply a personal experience. It was a continuation of a journey that had lay dormant for over 20 years.

Paramedics, too, often lose their faith, their families, and a sense of who they are. The dark and negative events they face in the performance of their duties eventually take their toll on the human body and on the human spirit. My eyes have witnessed countless acts of violence, tragic accidents, and sudden death. Nobody has yet developed a comprehensive intervention that helps emergency responders deal with the negative fallout from these experiences. Much progress has been made in addressing these and other related issues that impact so many lives; however, there is more that needs to be done.

Program designers who develop and conduct emergency medical training for paramedics have done phenomenal work in addressing better and safer ways to do the job. They have been very effective in capturing and delivering new knowledge and in developing innovative lifesaving strategies as well as the technology that helps paramedics do their jobs—to save lives. Nevertheless, the world that emergency responders interact with remains hazardous, stressful, and it is one that continues to require a considerable amount of risks—risks that only special individuals are willing to take. I was one who took those risks. I am proud to say that I was one of those special

individuals. I can also say without any reservation that I would never volunteer to do the job again.

REFERENCES

Alexander, B. K. (2005). Performing ethnography: The reenacting and inciting of culture. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 411-441). Thousand Oaks, CA: Sage Publications.

Biddinger, P. D., & Thomas, S. H. (2005). Prehospital care and emergency medical services. In S. V. Mahadevan & G. M. Garmel (Eds.), *An introduction to clinical emergency medicine: Guide for practitioners in the emergency department* (pp. 117-129). New York, NY: Cambridge University Press.

Bounds, R. G. (2000). *Factors affecting stress in pre-hospital emergency medical services*. Doctoral dissertation, Texas A&M University, College Station, TX. Retrieved from Pro Quest (AAT 9994214).

Bruner, J. S. (2002). *Making stories: Law, literature, life.* New York, NY: Farrar, Straus & Giroux.

Cardenas, H. (Ed.). (2000). San *Antonio Fire Department history*. Paducah, KY: Turner Publishing Company.

Cash, C. (2006). *The Wiley concise guides to mental health: Post traumatic stress disorder.* Hoboken, NJ: John Wiley & Sons.

Charon, R. (2001). Narrative medicine: A model for empathy, reflection, profession, and trust. *The Journal of the American Medical Association, 286*(15), 1897-1902. Retrieved from http://jama.ama-assn.org/content/286/15/1897.full.

Chase, S. E. (2005). Narrative inquiry: Multiple lenses, approaches, voices. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 651-679). Thousand Oaks, CA: Sage Publications.

City of San Antonio. (2010). *San Antonio Fire Department: Emergency Medical Services division*. Retrieved from http://www.sanantonio.gov/safd/emsdiv.asp.

Clark, M. C. (1993). Transformational learning. *New Directions for Adult and Continuing Education, 57,* 47-56.

Clark, M. C. (2010). Narrative learning: Its contours and its possibilities. *New Directions for Adult and Continuing Education, 126,* 3-11.

Cole, A. L., & Knowles, J. G. (2001). *Lives in context: The art of life history research.* Walnut Creek, CA: Alta Mira Press.

Cote, A. E. (2004). *Fundamentals of fire protection*. Quincy, MA: National Fire Protection Association.

Cranton, P. (2009). Transformative learning and AVE for social sustainability. In P. Willis, S. McKenzie, & R. Harris (Eds.), *Rethinking work and learning: Adult and vocational education for social sustainability* (Vol. 9, pp. 93-101). Mawson Lakes SA, Australia: Springer.

Denzin, N. K., & Lincoln, Y. S. (2005). The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 1-32). Thousand Oaks, CA: Sage Publications.

Dirkx, J. M. (1997). Nurturing soul in adult education. *New Directions for Adult and Continuing Education, 74,* 79-87.

Duncan, M. (2004). Autoethnography: Critical appreciation of an emerging art. *International Journal of Qualitative Methods, 3*(4), Article 3. Retrieved from http://www.ualberta.ca/~iiqm/backissues/3_4/pdf/duncan.pdf.

Ellis, C. S. (2004). *The Ethnographic I: A methodological novel about autoethnography*. Walnut Creek, CA: Alta Mira Press.

Ellis, C. S., & Bochner, A. P. (Eds.). (1996). *Composing ethnography: Alternative forms of qualitative writing*. Walnut Creek, CA: Alta Mira Press.

Ellis, C. S., & Bochner, A. P. (2000). Autoethnography, personal narrative, reflexivity: Researcher as subject. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 733-768). Thousand Oaks, CA: Sage Publications.

Ellis, C. S., & Bochner A. P. (2006). Analyzing analytic autoethnography: An autopsy. *Journal of Contemporary Ethnography, 35*(4), 429-449.

Fenwick, T. J. (2000). Expanding conceptions of experiential learning: A review of the five contemporary perspectives on cognition. *Adult Education Quarterly, 50*(4), 243-272.

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). London, England: Brunner-Routledge.

Fortney, J., & Murnane, L. (Eds.). (2004). *Fire service orientation and terminology*. Stillwater, OK: Oklahoma State University, Fire Protection Publication.

Frank, A. (1995). *The wounded storyteller: Body, illness, and ethics*. Chicago, IL: The University of Chicago Press.

Frank, A. (2010). *Letting stories breathe: A socio-narratology.* Chicago, IL: The University of Chicago Press.

Freeman, M. P. (1993). *Rewriting the self: History, memory, narrative*. New York, NY: Routledge.

Glendon, I., & Coles, F. (2001). Stress in ambulance staff. In P. A. Hancock & P. A. Desmond (Eds.), *Stress, workload, and fatigue* (pp. 167-199). Mahwah, NJ: Lawrence Erlbaum Associates.

Hogue, D., & Zimmerman, L. (2006). Occupational health issues. In J. Brennan & J. Krohmer (Eds.), *Principles of EMS systems* (pp. 314-325). Sudbury, MA: Jones & Bartlett.

Holt, N. L. (2003). Representation, legitimation, and autoethnography: An autoethnographic writing story. *International Journal of Qualitative Methods, 2*(1). Retrieved from http://www.ualberta.ca/~iiqm/backissues/2_1/html/holt.html.

Hurrel J. J., Murphy, L. R., Sauter, S. L., & Levi, L. (1998). Mental health. In J. M. Stellman (Ed.), *Encyclopedia of occupational health and safety* (pp. 5.1-5.21). Geneva, Switzerland: International Labour Office.

Lagerwey, M. D. (1998). *Reading Auschwitz.* Walnut Creek, CA: Altamira Press.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Newbury Park, CA: Sage Publications.

Mackerarcher, D. (2004). *Making sense of adult learning* (2nd ed.). Toronto, Canada: University of Toronto Press.

McEvoy, M. (2004). *Straight talk about stress: A guide for emergency responders*. Quincy, MA: National Fire Protection Association.

Merriam, S. B. (1998). *Qualitative research and case study applications in education*. San Francisco, CA: Jossey-Bass.

Merriam, S. B., Caffarella, R. S., & Baumgartner, L. M. (2007). *Learning in adulthood: A comprehensive guide* (3rd ed.). San Francisco, CA: Jossey-Bass.

Mezirow, J. (1994). Understanding transformation theory. *Adult Education Quarterly, 44,* 222-244.

Mezirow, J. (1997). Transformative learning: Theory to practice. *New Directions for Adult and Continuing Education, 74,* 5-12.

Mezirow, J. (2000). Learning to think like an adult. Core concepts of transformation theory. In J. Mezirow (Ed.), *Learning as transformation: Critical perspectives on a theory in progress* (pp. 3-34). San Francisco, CA: Jossey-Bass.

Ochberg, R. L. (1994). Life stories and storied lives. In R. Josselson & A. Lieblich (Eds.), *Exploring identity and gender: The narrative study of lives* (Vol. 2, pp. 113-144). Thousand Oaks, CA: Sage Publications.

Pillow, W. S. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *Qualitative Studies in Education, 16*(2), 175-196.

Pollak, A. N. (Ed.). (2005). *Emergency care and transportation of the sick and injured* (9th ed.). Sudbury, MA: Jones & Bartlett.

Pollak, A. N. (Ed.). (2011). *Emergency care and transportation of the sick and injured* (10th ed.). Sudbury, MA: Jones & Bartlett.

Pons, P. T., & Murray, R. (2006). EMS systems. In J. Brennan & J. Krohmer (Eds.), *Principles of EMS systems* (pp. 18-29). Sudbury, MA: Jones & Bartlett.

Post, C. J. (2002). *Omaha orange: A popular history of EMS in America*. Sudbury MA: Jones & Bartlett.

Randall, W. L. (1996). Restorying a life: Adult education and transformative learning. In J. E. Birren, G. M. Kenyon, J. Ruth, J. Schrootz, & T. Stevensson (Eds.), *Aging and biography: Explorations in adult development* (pp. 224-247). New York, NY: Springer.

Reed-Danahay, D. E. (1997). *Auto/Ethnography: Rewriting the self and the social*. Oxford, England: Berg.

Regehr, C. (2005a). Bringing the trauma home: Spouses of paramedics. *Journal of Loss and Trauma, 10,* 97-114. doi: 10.1080/15325020590908812.

Regehr, C. (2005b). Crisis support for families of emergency responders. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment, and research* (3rd ed., pp. 246-261). New York, NY: Oxford University Press.

Riessman, C. K. (2008). *Narrative methods for the human sciences.* Thousand Oaks, CA: Sage Publications.

Rockwood A. C., Mann, C. M., Farrington, J. D., Hampton, O. P., & Motley, R. E. (1976). History of emergency medical services in the United States. *The Journal of Trauma, (16)*4, 299-308.

Rogers, A. G., Casey, M. E., Ekert, J., Holland, J., Nakkula, V., & Sheinberg, N. (1999). An interpretive poetics of languages of the unsayable. In R. Josselson & A. Lieblich (Eds.), *Making meaning of narratives: The narrative study of lives* (Vol. 6, pp. 77-106). Thousand Oaks, CA: Sage Publications.

Ronai, C. R. (1992). The reflexive self through narrative: A night in the life of an erotic dancer/researcher. In C. Ellis & M. G. Flaherty (Eds.), *Investigating subjectivity: Research on lived experience* (pp. 102-124). Newbury Park, CA: Sage Publications.

Rossiter, M., & Clark, M. C. (2007). *Narrative and the practice of adult education.* Malabar, FL: Krieger.

San Antonio Fire Department. (2009). *2009 annual report*. Retrieved from http://www.sanantonio.gov/safd/PDFs/2009%20annual%20report.pdf.

Schwandt, T. (2001). *Dictionary of qualitative inquiry*. Thousand Oaks, CA: Sage Publications.

Seaward, B. L. (2000). *Managing stress in emergency medical services.* Sudbury, MA: Jones & Bartlett.

Sparkes, A. C. (2002). Autoethnography: Self-indulgence or something more? In A. P. Bochner & C. Ellis (Eds.), *Ethnographically speaking* (pp. 209-232). Walnut Creek, CA: Alta Mira Press.

Tangherlini, T. R. (1998). *Talking trauma: A candid look at paramedics through their tradition of tale-telling.* Jackson, MS: University Press of Mississippi.

Taylor, E. W. (2008). Transformative learning theory. *New Directions for Adult and Continuing Education, 119*, 5-15.

Texas Department of State Health Services. (2009). *Continuing education content areas*. Retrieved from http://www.dshs.state.tx.us/emstraumasystems/ceareas.shtm.

Tisdell, E. J. (2003). *Exploring spirituality and culture in adult and higher education.* San Francisco, CA: Jossey-Bass.

Tomoda, S. (2003, January). Stress at work. In *Public emergency services: Social dialogue in a changing environment* (Sec. 4.5.1, pp. 71-75). Geneva, Switzerland: International Labour Office.

U.S. Department of Transportation. (1998). *EMT-Paramedic: National standard curriculum.* National Highway Traffic Safety Administration. Retrieved from http://www.ems.gov/pdf/NSCparamedic1998.pdf.

UT Health Science Center San Antonio. (2011). *EMT-Paramedic certification* (Department of Emergency Health Sciences). Retrieved from www.uthscsa.edu/shp/ehs/emt-paramedic.asp.

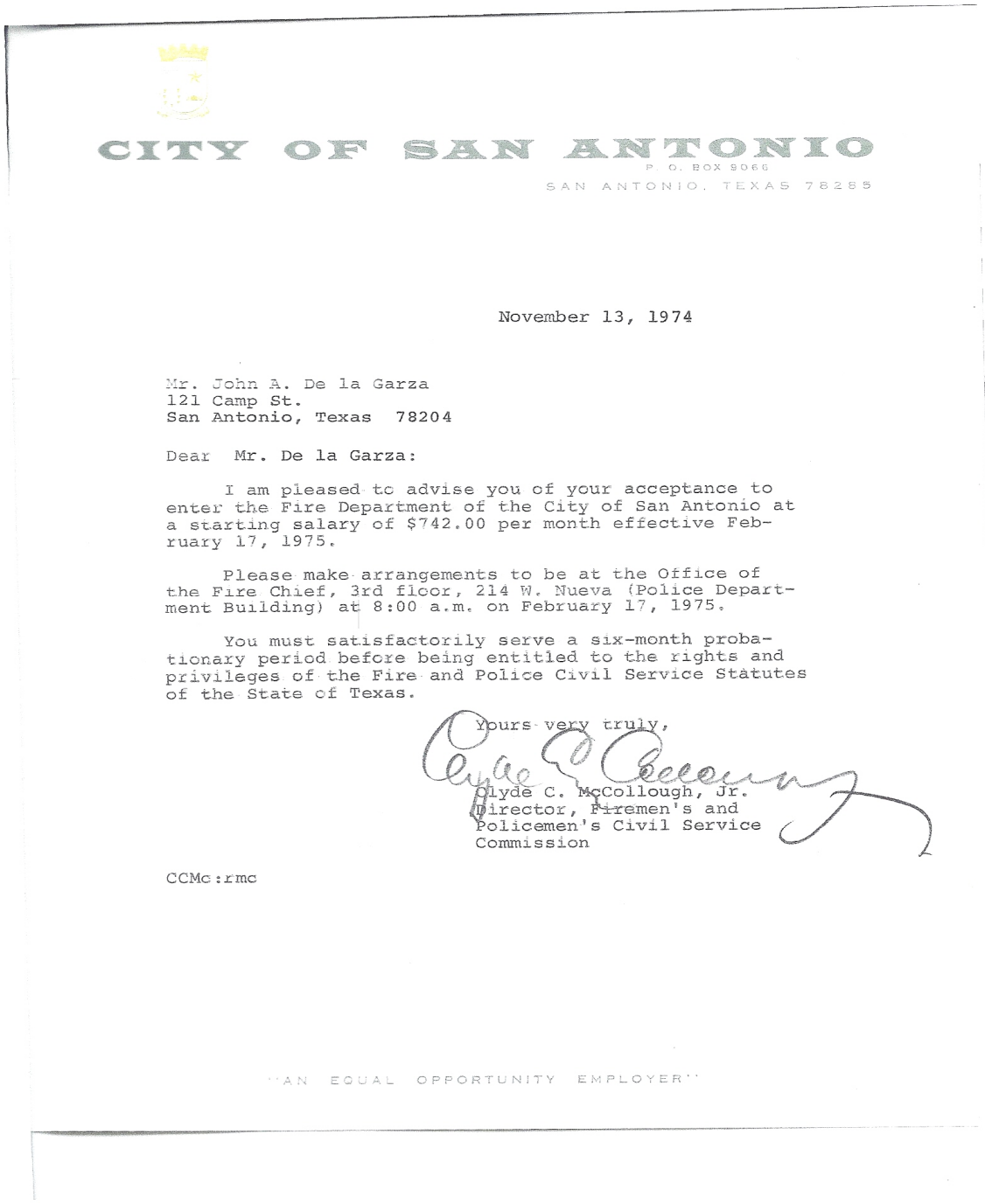
Wall, S. (2006). An autoethnography on learning about autoethnography. *International Journal of Qualitative Methods*, *5*(2), Article 9. Retrieved from http://www.ualberta.ca/~iiqm/backissues/5_2/html/wall.htm.

Wolcott, H. F. (2008). *Ethnography: A way of seeing*. Lanham, MD: Alta Mira Press.

Zamelsky, B. (2008). *Memoirs of a firefighter paramedic.* Bloomington, IN: AuthorHouse.

APPENDIX A

LETTER OF ACCEPTANCE INTO THE SAN ANTONIO FIRE DEPARTMENT



CITY OF SAN ANTONIO

P. O. BOX 9066
SAN ANTONIO, TEXAS 78285

November 13, 1974

Mr. John A. De la Garza
121 Camp St.
San Antonio, Texas 78204

Dear Mr. De la Garza:

I am pleased to advise you of your acceptance to enter the Fire Department of the City of San Antonio at a starting salary of $742.00 per month effective February 17, 1975.

Please make arrangements to be at the Office of the Fire Chief, 3rd floor, 214 W. Nueva (Police Department Building) at 8:00 a.m. on February 17, 1975.

You must satisfactorily serve a six-month probationary period before being entitled to the rights and privileges of the Fire and Police Civil Service Statutes of the State of Texas.

Yours very truly,

Clyde C. McCollough, Jr.
Director, Firemen's and
Policemen's Civil Service
Commission

CCMc:rmc

"AN EQUAL OPPORTUNITY EMPLOYER"

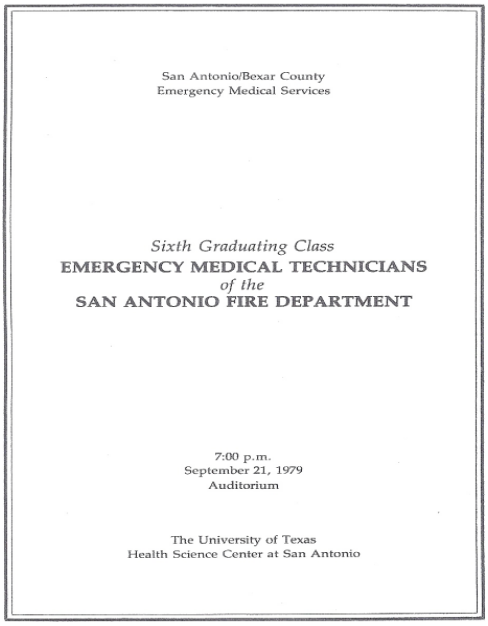
APPENDIX B

FIREFIGHTER ON LADDER TRUCK COMPANY 33

1975

APPENDIX C

GRADUATION OF SIXTH PARAMEDIC CLASS

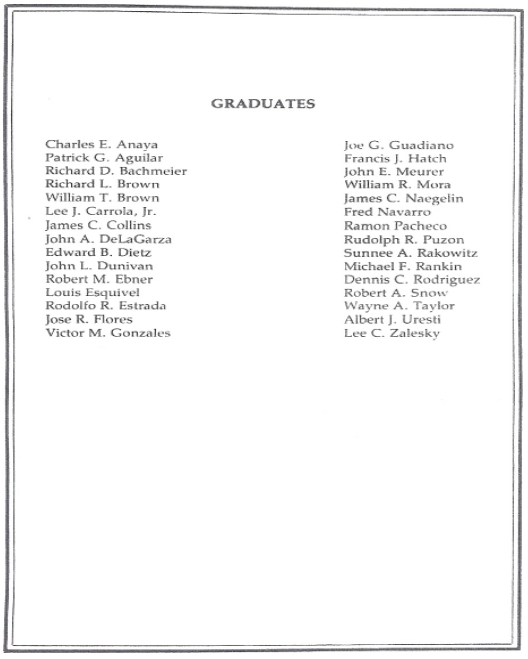


San Antonio/Bexar County
Emergency Medical Services

Sixth Graduating Class
EMERGENCY MEDICAL TECHNICIANS
of the
SAN ANTONIO FIRE DEPARTMENT

7:00 p.m.
September 21, 1979
Auditorium

The University of Texas
Health Science Center at San Antonio



GRADUATES

Charles E. Anaya
Patrick G. Aguilar
Richard D. Bachmeier
Richard L. Brown
William T. Brown
Lee J. Carrola, Jr.
James C. Collins
John A. DeLaGarza
Edward B. Dietz
John L. Dunivan
Robert M. Ebner
Louis Esquivel
Rodolfo R. Estrada
Jose R. Flores
Victor M. Gonzales
Joe G. Guadiano
Francis J. Hatch
John E. Meurer
William R. Mora
James C. Naegelin
Fred Navarro
Ramon Pacheco
Rudolph R. Puzon
Sunnee A. Rakowitz
Michael F. Rankin
Dennis C. Rodriguez
Robert A. Snow
Wayne A. Taylor
Albert J. Uresti
Lee C. Zalesky

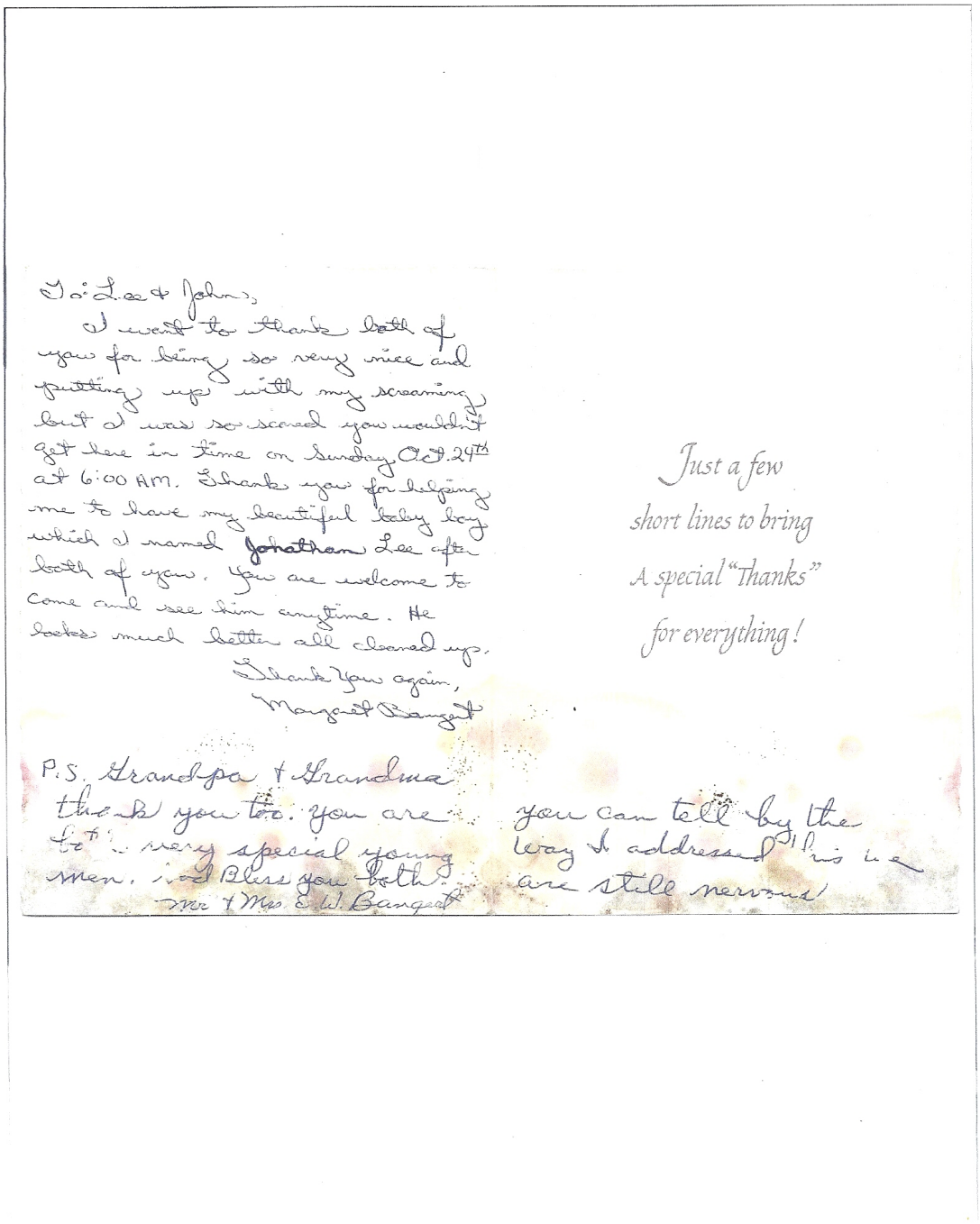
APPENDIX D

CERTIFIED PARAMEDIC ASSIGNED TO AMBULANCE UNIT 8-0-6

1981

APPENDIX E

THANK YOU CARD FROM JONATHON LEE'S MOTHER



D: Lee & John,

I want to thank both of you for being so very nice and putting up with my screaming but I was so scared you wouldn't get here in time on Sunday, Oct. 24th at 6:00 AM. Thanks you for helping me to have my beautiful baby boy which I named Jonathon Lee after both of you. You are welcome to come and see him anytime. He looks much better all cleaned up.

Thank You again,
Margaret Bangert

Just a few
short lines to bring
A special "thanks"
for everything!

P.S. Grandpa & Grandma thank you too. You are two very special young men. God Bless you both.
Mr & Mrs E.W. Bangert

you can tell by the way I addressed this we are still nervous!

VITA

John A. De La Garza
Department of Educational Administration and
Human Resource Development
511 Harrington Tower
Texas A&M University
College Station, Texas 77843

EDUCATION

2011	Ph.D., Educational Human Resource Development Texas A&M University College Station, Texas
2002	M.S., Educational Human Resource Development Texas A&M University College Station, Texas
1982	B.S., Spanish Our Lady of the Lake University San Antonio, Texas

EXPERIENCE

2006 – Present	Adjunct Professor, Public Safety Management St. Edward's University, Austin, Texas
2003 – Present	Adjunct Professor, Human Resource Development Graduate Program Webster University, San Antonio, Texas
2002 – 2007	Guest Instructor, College of Education and Human Development Graduate and Undergraduate Studies Texas A&M University, College Station, Texas
1985 – 2007	Adjunct Professor, Protective Services Department San Antonio College, San Antonio, Texas
1975 – 2008	Captain/Training Officer, Fire Lieutenant Paramedic-EMS, Fire Engineer San Antonio Fire Department, San Antonio, Texas

This dissertation was typed and edited by Marilyn M. Oliva at Action Ink, Inc.