Paramedics in West Germany

Cooperations and Conflicts in a Contested Professional Field (1949–1990)

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Abstract Cooperations are almost inconceivable without conflicts. For this reason, this contribution will analyse the mutual interweaving of cooperations and conflicts from a contemporary perspective. A concrete example is the situation of the rescue services in the Federal Republic of Germany. Considering the involvement of a variety of different players such as doctors, non-medical healthcare professions, charitable organisations and professional associations, conflicts are bound to occur. In addition, doctors and paramedics are in professions that are subject to different hierarchical levels, which is why positions of power must be taken into consideration in relation to conflicts and cooperations, alongside the methods of treatment. This contribution will analyse two different perspectives of cooperations and conflicts. On the one hand, the aim is to clarify that conflicts can occur within cooperative working methods. On the other hand, it will demonstrate that cooperations can result from conflicts and that they can be seen as a type of innovation motor. Both developments occur on the micro level, i. e. in the concrete conflict between doctors and paramedics. However, they can additionally influence the supply structures on the macro level as well. This will be exemplified by the conflicts regarding the professional law for paramedics. In concrete terms, the focus of previous discussions was usually centred on the question of which tasks should be taken over by the paramedics and which tasks should remain exclusive to the doctors. Due to the difficult situation of sources, the analysis shall be based primarily on normative sources. Readers' letters shall at least indirectly offer the perspectives of concrete participants.

Keywords paramedics – rescue system – emergency service – professionalization – cooperation – Germany

Introduction

In today's society, cooperations seem to be increasingly growing in importance, whether in the field of major international politics, in business or in the field of medical science. Cooperations primarily expect that two or more people or parties work together, thus causing an improvement in the result of the work. The same rule applies to medical cooperations. The cooperations between different parties in the medical field are intended to improve the treatment of the patient. At first glance, this seems sensible and not problematic. However, should one think in somewhat more detail about both past and present cooperations, it quickly becomes clear that a frictionless procedure only occurs in rare cases. A majority of cooperations always seem to have been accompanied by conflicts of both greater and smaller magnitudes. For this reason, a concrete examination of cooperations must always include conflicts.

This means that cooperations have only rarely been free from conflicts. This applies particularly when different medical schools are involved. For example, we can consider the "quack debate" (*Kurpfuscherdebatte*) from the end of the 19th century. In 1939, this debate led to an end of the freedom to practice through the Non-Medical Practitioners Act (*Heilpraktikergesetz*). (Herold-Schmidt 1997: 43–95) However, all kinds of conflict can occur within a "school" or "direction," in which there is general consensus on the basic issues of healing. For instance, one could consider the different viewpoints of surgeons and internists with regard to the question of whether conventional therapy or an operation should be performed. Disputes

such as these gain an additional dimension with players who are located on different hierarchical levels. In addition to the different methods of treatment, positions of power within a profession are given special treatment here.

Paramedics and emergency doctors will form the core of the following examination, since they fittingly represent such a constellation based on a differing hierarchy. In Germany, paramedics are often the first people involved in the medical system that patients see in a case of emergency. For this reason, their actions are decisive for the further health of the patient. Apart from the profound relevance of their actions, the paramedics and their fight for a regulated profession are also of interest from a contemporary point of view. In the Federal Republic of Germany, the discussions about the role of non-medical treatment staff started at the beginning of the 1960s and lasted until 1989, when the so-called "Rescue Assistant Profession Act" (*Gesetz über den Beruf der Rettungsassistentin und des Rettungsassistenten – RettAssG*) was passed. Thus, there were almost thirty years of internal quarrels on the activities of the paramedic staff. At the heart of the negotiation processes of the rescue service was frequently the question of how exactly the cooperation between paramedics and emergency doctors should be organised and, consequently, the question of who is to assume which tasks within the rescue process.

Research and source situation

Whilst the history of doctors has been relatively well researched, the same can not be said for the history of non-medical professions. A small exception is nursing, whose historical development has been well researched in recent years, at least for the 20th century. However, therapists, assistants and other skilled healthcare professions have been dealt with a lot less frequently in historical research. Therefore, even research into the modern emergency services in Germany still contains major gaps. Only a short overview essay exists for the situation in the GDR.[1] For West Germany in the period after 1945, there is only the regional study by Andrea Praußе-Stangel on the creation and development of emergency doctor services in North Rhine-Westphalia[2] and a few technical pieces on patient transport, such as that by Holger Frerichs[3]. In addition, the thorough study by Nils Kessel on the history of emergency services in Germany between 1945 to 1990 should be mentioned.[4] In brief terms, Kessel records the general development of the rescue services in the Federal Republic and occasionally refers to the cooperations and conflicts involved. However, paramedics are not at the heart of his research. The rare preoccupation of historians with the emergency services in the Federal Republic of Germany is surprising, considering the potential of this field of research. However, it can also be partially explained with the difficult source situation. For example, there is scarcely any data on the emergency services in the Federal Republic of Germany, as no documents were kept at all for a very long period. Commonly, normative sources such as laws must be used, as the paramedics themselves or their professional associations kept or archived barely any written sources.

In consequence of the problematic source situation, the analysis of the normative side will hereafter primarily resort to statutory law as well as released and unreleased statements of the parties involved. However, it is essential not to display the normative and legislative context exclusively, but rather factor in the level of specific practices of negotiation. In order to comprehend the interconnection between conflict and cooperation on both the micro and macro level, ego-documents must be regarded as well. Finding letters, diaries or autobiographies dealing with conflicts between doctors and paramedics is nearly impossible to begin with. On the one hand, this may be due to the fact that this category of sources is hard to access in general. On the other hand, it can be attributed to the lack of importance usually ascribed to these kinds of conflict. Hence, they do not provide a sufficient reason to be written down. As a consequence, it is primarily readers' letters to trade journals that will be considered as ego-documents here, since they have been composed as reactions to professional articles covering the subject discussed and, therefore, do provide a specific reason for writing.

They may belong to the field of ego-documents, but their ability to make statements is considerably less than other testaments, such as diaries or private letters. Published readers' letters are not unproblematic as a source material. Furthermore,

the editorial staff will always select an assortment of letters suited for publication out of all the correspondence they receive. This way, they are able to control the depiction of the state of facts concerning certain subjects. Therefore, even though there may be a great number of readers' letters dealing with the same specific subject printed in one periodical, it doesn't necessarily imply an extensive significance of the subject in a public discourse. Initially, all it amounts to is the editorial staff choosing those specific letters for publication.

Consequently, it is necessary to be aware of these possible constructions and filters when dealing with letters to newspapers. Despite those limitations, readers' letters can present a prolific source for historic research, since they allow for direct insights into the emotional state of private individuals, which would otherwise elude historians. Thus, letters to newspapers can demonstrate which topics were popular at the time, which people were involved as authors and how a periodical positioned itself to the feedback from its readers. The letters utilized here all emanate from the periodical *Rettungsdienst. Fachzeitschrift für Rettungssanitäter und Notärzte*. It was the only specialist periodical for emergency services that printed letters from readers in the first place. Based on the set of problems described earlier, it does not seem reasonable to quantify the letters as empirical material because the results would not be able to clearly measure the relevance of the subject. Instead the letters in question should be understood as a qualitative source that allows to gain insight into the negotiation of situations of conflict between paramedics and doctors on the micro level.

Conflicts and cooperations as analytical categories

Conflicts constitute an omnipresent part of everyday life and are thereby a pivotal element of our social coexistence. Ever since the 1960s, the field of peace and conflict studies evolved into an interdisciplinary line of research, which analyses conflicts on various levels. It is particularly frequently represented in political science, which prevalently examines international conflicts between countries that may even lead to war. Moreover, conflict research has established itself as an important subdiscipline of sociology, which facilitated a more distinct theorization of the term conflict as a concept. However, there will be no attempt to formulate an expansive definition of the term conflict at this point, since any such endeavour would be bound to fail due to its plethora of meaning and its vast variety of manifestations. It seems important, however, to at least agree upon one basic understanding. As a general rule, conflicts can be classified as social states of affairs that involve at least two parties and can be ascribed to differences in their social standing and/or a differing set of interests of the conflicting parties. (Bonacker & Imbusch 1999: 75) This concerns both the participants as well as the motives behind the conflicts. The cause of conflict can usually be attributed to the distribution of scarce resources or is often a matter of prestige (Pelinka 2016: 18). Regarding the conflicts about authority between paramedics and doctors in the field of emergency services, it becomes apparent just how interwoven these two causes of conflict sometimes turn out to be. Even though both paramedics and doctors aim to attain recognition and prestige in the field of medicine, this is inextricably linked with questions of how to distribute duties and work activities between the two parties. For instance, if duties initially assigned to doctors were to be transferred to the paramedics, these circumstances could consequently lead to a decline of doctors actively working in the field of emergency medical services. Thus, certain resources such as work and finances would have to be distributed in another way. As this example distinctly illustrates, situations of conflict are inevitably connected to questions of power. Power is a pivotal component of conflicts, since conflicts lead to power on the one hand, but beyond that power also implicates more conflict (Pelinka 2016: 20). Depending on one's point of view, conflicts can be interpreted as either conditions or processes (Ide 2017: 9). In the case at hand, the conflicts between paramedics and doctors are regarded as processes because it is most notably the development and the consequent result that is of interest. In order to differentiate the conflicts in question, it seems reasonable to categorize them. Thus, conflict research distinguishes between consensual and dissensual conflicts, between constructive and destructive conflicts and, finally, between symmetric and asymmetric conflicts (Pelinka 2016: 77–79). Particularly the lat-

ter distinction appears significant for the analysis of conflicts in the field of medicine. The differentiation between symmetric and asymmetric conflicts is predicated upon strength or rather equality between the opposing parties and, therefore, includes the inherent balance of power between them. The power relations between doctors as prestigious professionals, that stand out due to their own professional association, professional standards, autonomy and academic training on the one hand, and other non-medical health professions such as nurses, alternative practitioners, physiotherapists or midwifes on the other, were and still are strongly asymmetric. None of the other professional groups within the field of medicine even remotely achieve the status attributed to doctors. Especially paramedics, whose occupation was mostly still a voluntary one in the 1960s and who, therefore, were not able to accomplish any of the traits of a normal profession, were facing the doctors in a heavily asymmetric conflict. In spite of this asymmetry, the paramedics within this conflict succeeded in getting some changes for their own benefit under way. The transition manifests itself not least because of a cooperative collaboration between the parties in conflict. As a consequence, Bonacker and Imbusch rightly point out that the elements of cooperation and conflict within most conflicts appear to be interrelated to a varying extent (Bonacker & Imbusch 1999: 76). The amount of potential elements of cooperation does not least derive from the nature of the conflict. Whereas so-called zero-sum games highly restrict the possibilities of cooperation due to the fact that the losses of one party equate to the victory of the "opposing" party, the nature of cooperation games is inherently different. The possibilities of cooperation are considerably larger here, because a cooperation can amount to an overall profit for both conflicting parties (Bonacker & Imbusch 1999: 76). While cooperation is not considered a part of the classic analytical approach within the field of conflict research yet, it is steadily increasing its importance in recent years. The term cooperation is usually understood as the coordinated bargaining of at least two parties. These bargains aim to realise common interests (Ide 2017: 11). The interconnection between conflicts and cooperations results from the mutual cause of conflict that links the opposing parties to each other. In doing so, two possible types of interconnection emerge and can be found in the case study at hand. Conflicts can arise from a cooperation on the one hand, and cooperations can originate from conflicts on the other and, therefore, can present a potential solution for situations of conflict. However, the extent to which this possibility is applicable is inextricably connected to the cause of conflict.

Epistemological interests and procedures

The following essay will look into the interweaving of cooperations and conflicts in more detail. It aims to demonstrate how inseparable the term cooperation can be from the term conflict and that it can be highly productive to put a finer point to the observation of the mutual interweaving.

In order to do so, two perspectives of cooperations and conflicts should be presented and analysed in greater depth. Firstly, it is important to clarify how cooperations can be marked by conflicts. Which conflicts resulted from cooperations and how were they handled? In many cases, the normal, known and comprehensible interplay of conflicts and cooperations is at the root of the issue. However, just as interesting is a change in perspective, which is to be tackled in a second step. The aim is to show that not only can cooperations lead to conflicts, but conflicts can just as easily lead to cooperations. This scenario does not necessarily limit itself to the micro level. To a greater degree, such processes can also influence the supply structures on the macro level. Hence, this essay would argue that conflicts can represent a type of innovation motor for cooperations. However, before these two perspectives are indicated using the example of the rescue service in the Federal Republic of Germany, there will be a brief introduction to the history of the emergency services in the Federal Republic of Germany, in order to explain the contemporary situation and problems.

Development of the rescue service in the Federal Republic of Germany

For a long period of time, the rescue service was solely charged with moving the patient or injured person to medical aid and not with providing med-

ical aid to the patient. This was also connected to the self-image of the doctors at that time. For this reason, the focus of the rescue service was initially only on the rapid transportation of the patient. From the point of view of the experts, personnel with special medical training was not considered a necessity, although a basic knowledge to ensure a patient's capacity for transport was indeed required. This notion remained fundamental until the end of the 1950s. This decade saw many changes which, as a consequence, also made an impact on the rescue service. On the one hand, the rapid motorisation of road traffic in and out of towns caused the number of accidents to expand sharply. Therefore, the significance of the rescue service grew considerably during this period. On the other hand, the medical developments of this period marked by a "can-do" euphoria, also registered further significant progress: At the beginning of the 1950s, the medical experiences gained from the Second World War were used to develop shock therapy with infusions and blood transfusions. This meant that it was possible to fight hypovolaemic shock, which occurred after a large loss of blood, at an early stage. The end of the 1950s entailed new knowledge in the pathophysiology of sudden death. This knowledge went hand in hand with the rediscovery of old reanimation techniques, whose use were now proven by scientific investigations: Resuscitation and external heart massage thus prevailed as primary treatment methods in case of circulatory arrest (Kessel 2008: 63).[5]

These new forms of treatment made time an ever more important factor in the rescue process. This meant that it was possible to help even more people, provided that medical treatment was provided in good time. However, the German rescue service was facing some major problems. Even though it was possible to improve transport continuously, natural limits were reached quickly here. Due to the rising number of accidents, this issue also became increasingly present in the public consciousness. The media soon declared a state of emergency among German rescue services.[6] The rescue service was considered in need of drastic improvement and thus reform. Ever since the turn of the century, the option of performing medical treatment directly at the location of an accident had occasionally been discussed. This idea was taken up again in the 1960s, since it was the best option for saving time during the rescue process. There may have been individual pockets of resistance against this fundamental reorientation, but slowly the so-called "Stay and Play" principle managed to exceed the "Load and Go" principle (Nössler 2012). The initiative of some experts meant that, in the mid-1960s, there was a slow reorganisation of the rescue service throughout the field of medicine. The medical historian Nils Kessel refers to this process a "Doctoring of the rescue service," meaning "a redefinition of the primitive, extra-clinical care by laymen with subsequent transport to a junior medical activity organised under a medical premise" (Kessel 2008: 74).[7] Thus, according to Kessel, "the acceptance of a definatory power and the formation of a hierarchy with regard to non-academic junior personnel" (Kessel 2008: 75) is included. As a result of this process, the rescue service was transformed into an area of medical care.

Conflicts in cooperations

In 1964, the initiative of Eberhard Gögler, the consultant of the Chirurgische Universitätsklinik Heidelberg, created the so-called Rendezvous System, which slowly took hold of the rescue service throughout Germany (Kessel 2008: 70). This system expected that doctors and paramedics travelled to the emergency location separately and would then collaborate as required. Three years prior to this, in 1961, the doctor Friedrich Wilhelm Ahnefeld developed the so-called emergency chain, which gave a basic structure to the tasks and measures to be performed in an emergency. Furthermore, it created a plan of task allocation whilst taking into account which medical professional would be expected to perform certain tasks under specific circumstances. Providing the optimum manner of help to the patient was considered the utmost priority (Kessel 2008: 70).[8] The rescue service thus became a field of work in which medical and non-medical staff should or had to work together.

Within this cooperative working model a variety of conflicts occurred, which can be traced back to a number of very different reasons. However, the different forms of training, knowledge and thus also the different hierarchy levels of doc-

tor and paramedic frequently played a central role. The issue of the differing hierarchical levels was portrayed as becoming particularly problematic in the periodical *Rettungsdienst. Fachzeitschrift für Rettungssanitäter und Notärzte*, as shown from the perspective of the paramedics:

> Or you, dear GP—do you feel embarrassed when the ambulance with the red stripes drives ahead and the "professionals" with their emergency cases, ECG and other equipment race into a flat? Are you ready to work together with "them" without emphasising your "Dr" in each sentence and defending the "Alpha animal" in you and towards your clientele? (Fertig & Landsleitner 1988: 729)[9]

As seen in the preceding example, it was common that conflicts broke out due to the basic difference in perception of the other. For obvious reasons, the opposing perspective was not discussed here. Therefore, it was clear that paramedics did not accept the superior position of the doctor, which inherently was bound to lead to disagreements. Remarkably enough, the description of such behaviour does not originate from a doctor but rather a paramedic as well. Based on his previous six years of work experience, paramedic Ulrich Beinke wrote a letter on the misconduct of several paramedics who make themselves out to be more important than they actually are, solely based on their uniform and despite their lack of a professional background. According to Beinke, this behaviour can be ascribed to profile neuroses that occur for many paramedics due to a lack of prestige attributed to emergency medical services (Beinke 1988: 36).

In a letter dating to 1986, The volunteer paramedic Klaus Wachsmuth reported that doctors switched to medical jargon on purpose in order to show their superiority to the paramedics: "Unfairly, jargon was then written on the admission form, as had been the case in the 1920s, so that the 'stupid paramedic' was unable to understand the situation […]" (Wachsmuth 1986: 485).[10] This statement shows that in the eyes of the paramedics, the communicative behaviour of the approbated doctors was arrogant and made no contribution to a cooperative work process.

Nevertheless, doctors also made use of the opportunity to send letters to the periodical *Rettungsdienst* in order to present their way of looking at things. The doctors often criticised inappropriate technical behaviour on the part of the paramedics and pointed out their unwillingness to accept said behaviour. As shown in the following excerpt, a doctor's son offered an example for the behaviour of a paramedic in his letter:

> My father (a GP with over 40 years of professional experience) is called out to an elderly patient on a Sunday morning as part of the standby service, who is complaining about pain in the lower part of her body. After an introductory examination, the diagnosis "appendicitis" is given and a KTW (patient transport vehicle) is requested, which arrives soon after. The paramedics and ambulance staff (maximum age 21 or 25 years) storm into the flat and the following discussion unfolds:
>
> Doctor: Good morning gentlemen. This lady must immediately be transported to the surgery unit of XY hospital. I have spoken with the doctor on duty, a bed is free, here is the acceptance and the transport document.
>
> Paramedic: (After a brief glance at the acceptance) So, appendix. So, we've got to carry the old hag. Can we put the alarm on?
>
> Doctor: I do not see any need for that. I require careful but speedy transport of the patient.
>
> Paramedic: Doctor, are you sure of your diagnosis? I mean if something bursts … (paramedic means a perforation of the appendix).
>
> Doctor: (Annoyed) Young man, have I been the GP of this lady and have looked after her for more than 20 years or have YOU?
>
> This is where the argument ended. The lady is loaded into the ambulance in a grudging and disinterested manner and transported. (Schmidt 1986: 485 f.)[11]

Even if this example has been constructed and exaggerated, it still manages to illustrate the problems. From the doctors' point of view, the medical knowledge of the paramedics was insufficient and this is why they were not regarded as medical colleagues of equal rank, which, in turn, led to conflicts within the required cooperation. A similar example has been described by the doctor Rüdiger Katterwe. He explained a case of mistreatment regarding an 81-year-old female patient on account of a paramedic that nearly led to the death of said patient. According to Rüdiger Katterwe, the situation would have been unproblematic if the paramedic in charge had solely done

the procedures he was authorized to do. Katterwe continues that any treatments extending beyond those authorized procedures, however, must be reserved for professionally trained individuals (Katterwe 1988: 118). It is not possible to determine from the sources how often this type of conflict occurred. However, the frequency of the printed letters on conflicts between paramedics and doctors allows one to draw the conclusion that it was not an individual case.

The conflicts depicted could lead to a disruption of the cooperation between doctors and non-medical professions and consequently cause a negative impact on the work result.

Cooperations as an option for solving conflicts

As previously mentioned above, conflicts could not only occur within cooperations. Moreover, conflicts could also form the starting point for cooperations and thus be the motor for change. As indicated in the preceding letters, the conflicts between the doctors and non-medical staff in the emergency services frequently dealt with the level of expertise and thus the competence of the paramedics. With the changed perception of the function of the rescue service and its transition into a medical field, the 1960s saw an increase in public discussion about the technical training of the rescue service personnel. Said discussion soon took on concrete terms with regard to the creation of a law that regulated the paramedic profession. The first demands for this could be traced back to the late 1960s. Before then, the "training" of the emergency response staff was limited to a standard first aid course of eight double units, which was followed by a further training course of twelve double units. Thus, the medical knowledge of the responders was equal to the knowledge anyone could pick up within two weeks. As mentioned above, the discussions on this subject carried on until 1989, the year in which the Rescue Assistant Profession Act was passed. Apart from financial matters, the focus of the lengthy discussions was the question of which activities could be carried out by the paramedics and which were to remain exclusive to the doctors. The parties involved had different ideas, which led to myriad conflicts between them. However, it was not just doctors and paramedics that were involved in the discussions and, consequently, the conflicts. Additional parties such as charitable organisations were factored into the discussion as well. The following section will present the positions of the central parties in more detail.

Paramedics

One of the most important parties within these disputes consisted of the paramedics, whose positions must be differentiated between full-time and part-time workers, as they were diametrically opposed in certain issues. Until the early 1960s, the rescue service in Germany was primarily staffed by volunteer employees of the charitable organisations. These employees were primarily responsible for the rapid transport of the patients to hospital. As sketched earlier on, the changes to the rescue service into a field of medical activity also caused the requirements placed on the non-medical personnel to change. In particular, the full-time paramedics wanted to improve their training, as that was also connected to the hope of expanding their own competences and, in consequence, an increased social standing for this profession. At the beginning of this transformation process, the voices of the full-time paramedics were rare in the political discussion arena and could barely be heard. This changed in the late 1970s, when a professionalisation of the full-time rescue service personnel occurred. In 1978, Ludgar Kossendey and Ludwig Stumpf, two employees in the rescue service, created the periodical *Der Rettungssanitäter*. This periodical was primarily intended for the full-time paramedics and provided information on developments in their profession. Hence, the periodical can be regarded as a first "connecting element" between the full-time paramedics. In the mid-1980s, the periodical was retitled *Rettungsdienst. Fachzeitschrift für Rettungssanitäter und Notärzte*, in order to reach an even larger circle of readers. Moreover, the first teaching manual for paramedics was created in this period as well, which brought order and revision to the knowledge required for the paramedic profession. Probably the most important step in the professionalisation process was the establishment of the first professional association for full-time paramedics. The *Berufsverband der Rettungssanitäter e. V.* (*BVRS*) was founded in 1979. Its primary objective was to

make progress with regard to the calls for occupational profiles for paramedics. In the same year, the first "Federal Congress for Paramedics" took place in Dormagen. The event was brought to life by the new professional association, whose aim was to bring together paramedics from all over Germany and to align them to a single line. In their totality, these professionalisation processes caused the full-time paramedics and their demands for a standard occupational profile across the whole of Germany to be better perceived and also recognised amongst the public. In concrete terms, they demanded the official recognition of paramedics as a legally-recognised profession based on training and examination regulations in order to efficiently control access to this profession. In the context of the disputes connected with these aims, the full-time paramedics also strove for an expansion of their tasks and competences. Some examples for the skills they included were intubations, injections and infusions.

By contrast, the voluntary rescue service personnel took an extremely critical stance against the demands of their full-time colleagues, because for them, each increase in the training requirements meant an ever-higher hurdle in performing their voluntary work. And there was scarcely any voluntary worker who had the opportunity to invest a lot of time in training or was prepared to do so for other reasons. There were certainly workers who embraced an opportunity for further training. However, these training units should be low-level and not particularly time-intensive. After the Rescue Assistant Profession Act was passed in 1989, the volunteer Gerold Hoopman wrote in a letter:

> Should volunteers now only be allowed to fill out forms or operate the steering wheel? What about disaster protection, ambulance services and all the social services which we provide on a daily basis? What use are training courses and instructions to us if we now no longer are given the opportunity to gain practical experience and to use this knowledge? […] How often is it that we are the only people who make a bigger impact through our presence than some expensive drug. A law has been passed. We are forced to meet challenging requirements. Not that we do not want to pass the course. On the contrary!!! But when? Thirty days of holiday, maybe sabbatical leave. And what about the family? What about the voluntary activities which must be tackled? In many charities, burn-out of the volunteers is inevitable and gets closer day by day. (HOOPMANN 1989: 752 f.)[12]

Two developments linked to the law are criticised in this excerpt. The first development outlines the devaluation of volunteer workers through restriction to tasks for which no further training is required and that are therefore degraded to supplementary tasks. And secondly, assuming that volunteer workers tried to complete the training course, another consequence would be an inevitable burn-out in these people.

Charities

A further key player in these disputes are the charities, including the German Red Cross (*Deutsches Rotes Kreuz*), St John's Ambulance (*Johanniter Unfallhilfe*), the Maltese Cross (*Malteser Hilfsdienst*) and the Workers' Samaritan Foundation (*Arbeiter-Samariter-Bund*). They were and still are responsible for a large proportion of the work ascribed to the rescue service in Germany and are thus the largest employers of paramedics. Even if the individual organisations and their views on the claims of the full-time paramedics differ in some areas, it can overall be seen that they were rather sceptical of the professionalisation attempts by paramedics. As a result, they prevented the passing of a rescue service act for a long time. The reasons for this were predominantly of a financial nature. The rescue services in Germany are primarily financed by the social insurance companies as well as funds from the federal states. Even into the 1970s, the rescue service was primarily staffed by volunteer helpers and untrained, full-time paramedics, so the personnel costs for the charities were very low. The charities saw two dangers in the possible introduction of a legally-controlled occupational profile: On the one hand, they feared a slow reduction of volunteer workers, who could no longer fulfil the new training directives. This departure would have to be compensated through the employment of new, more cost-intensive full-time personnel. Moreover, even in the early 1970s volunteers were still the central component of the personnel structure. In the Workers' Samaritan Foundation in 1971 for instance, 96 percent of the

people employed in the rescue service were volunteers, while in the German Red Cross it was still as many as 80 percent (Hahn 1994: 45). On the other hand, the charities feared that the possible increase in the training level of the full-time paramedics would cause an eventual demand for higher wages. This is why the charities were always intent on keeping up voluntary work as a pivotal pillar of emergency medical services (Malteser Hilfsdienst 1990). Since they didn't consider these developments to be financially viable, they remained critical of the creation of an occupational profile at a federal level for a long time. For example, even in 1986 the St John's Ambulance questioned the training period of two years, which they considerd too long. They expressed this opinion in comments on a planned law for the paramedic profession:

> However, independently of this, the question must (again) be asked as to how far the medical necessity for intensive training over a period of two years is even given. The (apparent) inadequacy of the currently practised 520-hour minimum training has, in the opinion of the St John's Ambulance, never been reliably and seriously proven. (Johanniter Unfallhilfe 1986)[13]

This only changed successively from the mid-1980s. Social developments and the fact that the rescue service was maintained 24 hours a day, seven days a week, had led to an increasing necessity for the employment of full-time personnel anyway. Additionally, volunteers slowly started to withdraw from the rescue service. This meant that the cost increases expected with an occupational profile were far less radical than a decade earlier. From then on, the charities worked to create a law for the profession of the paramedic. By doing so, they answered the contentual question concerning the expansions in competence required of the paramedics.

Doctors

Doctors were also important players. On the macro level, the German Medical Association (*Bundesärztekammer*) represented the doctors both institutionally and organisationally in the discussions on the rescue service. Other representatives were the *Bundesvereinigung der Arbeitsgemeinschaften der Notärzte Deutschlands* (*BAND*) and the *Deutsche Interdisziplinäre Vereinigung für Intensivmedizin* (*DIVI*). The latter was founded in 1977 as an umbrella association of anaesthetists, internists and paediatricians. Even as early as 1980, they founded a section which dealt especially with the rescue service (Lawin & Opderbecke 1999: 560 ff.). These organisations observed the attempts of paramedics to expand the competence of non-medical rescue service personnel and were also critical of them. Although one would initially expect that doctors would position themselves against the professionalisation attempts of the paramedics, this was not the case. In the public debate, both the German Medical Association and the other organisations argued for a legally-regulated occupational profile of the paramedics, because they were of the opinion that it was the only way to guarantee a high quality rescue service. In the discussions on the political level, it was the German Medical Association in particular that argued for a clear distinction between the tasks of doctors and those of paramedics. In a statement by the German Medical Association during the 1975 German Medical Assembly they said:

> Although the occupational profile of the paramedic belongs to the non-medical professions, *it must be assumed that in order to be able to handle their later task to the fullest extent, the paramedic must, during their training, learn such life-saving immediate measures that would commonly be ascribed to the scope of duties of the doctor. This includes injections, infusions and intubations, which they should have mastered fully. […]* The quality standard for training to become a paramedic must therefore be so high that the paramedic is, at all times, able to perform life-saving immediate measures such as injections, infusions and intubations. *However, the indication to do this must always remain in the sphere of responsibility of the doctor.* [Emphasis in the original] (Bundesärztekammer 1975)[14]

The German Medical Association was not trying to prevent the professionalisation of the full-time rescue service staff but was saying that it should happen within clear limits and only up to a certain point. This can also be seen in the fact that, since the beginning of the 1970s, the German Medical Association was calling for the occupational term "Rettungsassistent" (rescue assistant). By using

this title, the hierarchical position in comparison to the doctor could be derived semantically. With regard to the question of the competences of the paramedics, the German Medical Association demanded that the paramedics should master the execution of injections, intubations and infusions perfectly. However, they also were of the opinion that the indication for this and thus the responsibility for the execution of such activities must remain with the doctor. For the first time, there was at least the suggestion of a cooperation to solve the problem and this was brought forward for discussion. Doctors were keen to develop a pragmatic cooperation model, which should nevertheless still be subject to a certain amount of control. When discussing the draft of a paramedic law, a representative of the German Medical Association stated:

> *Mr Jachertz* emphasised that the German Medical Association saw a basic need for delimitation in the tasks of doctors and paramedics. However, this delimitation should be performed pragmatically to avoid cementation. Therefore, he welcomed that the draft took the appropriate development in the medical field into account. In this specific case, it was additionally necessary to keep an eye on the intended team work between the doctor and the paramedic. [Emphasis in the original] (Niederschrift 1972)[15]

Cooperations as a potential solution

With regard to the conflict surrounding the question of competencies required by full-time paramedics, the opinions of the above parties were so different in nature that it was not possible to agree on a joint course of action for a long time. It was not until 1989, and thus almost 30 years since the first discussions about the competencies of the non-medical rescue service personnel started, that a solution was created through the Rescue Assistant Profession Act. The law implemented the occupational profile demanded by the paramedics for a long time, although it did not automatically fulfil the desired demand for an expansion of competencies. The question as to which tasks the paramedics were permitted to undertake and which they were not was not included in the law. It was only this compromise that made it possible to create the law after almost 30 years.

However, the fact that in the negotiations, the term "Rescue Assistant" prevailed over the title of "Paramedic," clarified that the government wished for a continued and clear hierarchy between doctors and non-medical rescue service staff. In addition, the law indicated that the term rescue assistant merely referred to an "assistant to the doctor" (Rettungsassistentengesetz 1989), hereby clearly distinguishing the positions of doctor and rescue assistant. In the Non-Medical Practitioners Act, which defines the delimitation of medical and non-medical in Germany, it says: "(1) Anyone wishing to practice medicine without being a doctor shall require the permission to do so" (Heilpraktikergesetz 1939). Medicine shall be understood as "any professionally or commercially practised activity for the determination, healing or mitigation of illnesses, suffering or physical damage of people" (Heilpraktikergesetz 1939). The paramedic should thus only perform tasks which support the doctor in these activities. However, there is no specification of how support differs from the work of the doctor. It was particularly this ambiguity in the formulation of the law that was supposed to contribute to the cooperation between the two parties. Thus, the paramedic should follow the instructions of the emergency doctor. In turn, the doctor should delegate tasks to the rescue assistant. This form of cooperation usually proceeded without issues, providing that an emergency doctor was present. However, frequently this was not the case. Since the before mentioned Rendezvous System in the German rescue service expects that paramedics and the emergency doctor travel to the scene of an accident separately and, in many cases, no emergency doctor is sent to the location to begin with, the paramedic on site was often alone. In these cases, the *modus vivendi* took hold that the paramedic should exchange information with the medical head in the emergency HQ through close radio contact. If necessary, they should receive the permission to perform specific measures from them. However, this cooperation model may sound good in theory but it actually contained a range of pitfalls. Consequently, it was possible that radio contact failed or could not even be set up, particularly in rural regions. Alternatively, the emergency situation required immediate action, leaving no time for agreements between the paramedics and the

doctor. In these cases, the rescue assistant could take specific measures in the context of so-called emergency competence, which were only permitted to the emergency doctor but which could save the life of the patients. However, this action was highly problematic, because it frequently occurred under unclear legal conditions. This is due to the fact that the emergency competence, from a legal point of view, represented an individual decision, so theoretically the legality of its application had to be reviewed frequently. In order to prevent this problem to a certain extent, the German Medical Association presented recommendations for emergency competence in 1992. These recommendations aimed to specify certain regulations. In a first step, they described the status of the emergency situation and then named the activities which the paramedic could perform in an emergency if no doctor was present. These procedures included, for example, intubation without relaxants, venepuncture, the application of crystalloid infusions, the application of selected medication and early defibrillation. (Bundesärztekammer 1992) Acting in the sense of emergency competence was subject to the principle of relativity. That meant that the method with the least intervention but with the highest prospect of success should be applied. For instance, if breathing with a ventilation bag is rendered effective, then intubation with its greater risks is not permissible, because it is no longer relative (Bundesärztekammer 1992). However, the recommendations of the German Medical Association have not been updated since 2003.

In the mid-1990s, the continuing technologization, specialisation and further development of medicine reopened questions in public debate as to whether the training of rescue assistants was sufficient for the requirements of a modern rescue service. This was followed again by long disputes, which ended in 2014 with the passing of the "Law on the Profession of an Emergency Paramedic (*Gesetz über den Beruf der Notfallsanitäterin und des Notfallsanitäters – NotSanG*)". *NotSanG* may have been based on the Rescue Assistant Profession Act, but it also brought some new items. Firstly, the length of the training period for the new profession of the emergency paramedic was increased from two to three years, meaning that the abilities and skills of the employees were bound to be improved. Furthermore, there were changes with regard to the question of the responsibilities and the cooperation required between the participating parties. The wording of the act removed the previous designation of the paramedic as an "assistant to the doctor," adding a distinction of the tasks into "autonomous execution" and "team-orientated cooperation" (Notfallsanitätergesetz 2014). As a consequence, the authorisation for interdisciplinary cooperation was particularly emphasised as an independent training objective. On the one hand, this takes account of the developments in the profession, which were characterised by an increasing division of labour, differentiation of the activities and specialisation (Dielmann & Malottke 2017: 133). On the other hand, it also reflects the high significance of the cooperation concept in the present day, which is suggested by the use of the phrase "team". In linguistic terms, this change expresses that the title of 'Assistent' was given up in favour of '*Sanitäter*'. Therefore, it was no longer possible to discern a direct relationship between doctors and non-medical personnel. A glimpse into the periodicals reveals that these results are predicated on long-term developments and previously discussed ideas. One article in the journal *Leben Retten,* dating back to 1990, already formulated the concept of team work and cooperation as an ideal condition for collaboration. This idea is based on the Rescue Assistant Profession Act:

> If the paramedic gives a diagnosis deviating from the assessment of the emergency doctor or thinks a differing procedure to be more appropriate, it complies with good team spirit to collectively discuss the line of action in an a discrete and concise manner. The emergency doctor, however, holds the right to make the final decision. (Ufer 1990: 75)[16]

Summary

Starting with the increasing significance of teamwork and cooperation over the last 20 years, this essay prompted questions about the interweaving of cooperations and conflicts in the rescue service in Germany. Ever since the start of discussions on the rescue service in Germany in the mid-1960s, the distribution of tasks and cooperation between doctors and assistance personnel have frequently

been at the centre of attention. The beginning professionalisation of the full-time paramedics and the resulting demands made by them for an expansion of their competencies were a major factor in the formation of conflicts with the doctors, who saw their superiority in the field of emergency medicine as threatened. Moreover, conflicts within the cooperation were also created by the differing perceptions of the other parties. In this field, which was full of conflict and dealt with the question of the competencies of the paramedics, a form of cooperation was implemented as a solution. Cooperations can therefore not only lead to conflicts, they can also be solutions to conflicts. By implication, co-operations are inextricably connected to conflicts. Additionally, conflicts are also suitable for investigating cooperations and their innovative strength in more detail.

Nevertheless, the above essay was merely able to present a small section of the wide-ranging spectrum of cooperations and conflicts in the German rescue service. Only a more detailed investigation of the paramedic group from a microhistorical perspective would make sense for this question. Thus, the cooperation between full-time and voluntary members of the rescue service could be considered as an example, or even the relationship between paramedics and patients set against migration processes, which tend make the interactions between the paramedic and the patient more difficult. Research has not been carried out to a sufficient level in order to provide an adequate answer to such questions. From a contemporary perspective, the complex source situation would suggest the application of a questionnaire for the different groups with regard to a concrete cooperation in the sense of *Oral History*.

Notes

1 *Cf.* Burgkhardt A., Burgkhardt M, Jantzen T. & Kampmann J. 2008. Geschichte der Notfallmedizin im Osten Deutschlands. *Notfall + Rettungsmedizin* 8, 11: 571–578.

2 *Cf.* Prausse-Stangl A. 2007. *Entstehung und Entwicklung von Notarztdiensten in Nordrhein-Westfalen*. (Studien zur Zeitgeschichte Bd. 58) Hamburg: Verlag Dr. Kovač.

3 Frerichs H. 2005. *Vom Krankenkorb zum Rettungsdienst Friesland. Dokumente zur Geschichte der Krankenbeförderung und der Notfallrettung im Landkreis Friesland 1884 bis 2004*. Jever: Verlag Hermann Lüers.

4 Kessel N. 2008. *Geschichte des Rettungsdienstes 1945–1990. Vom „Volk von Lebensrettern" zum Berufsbild „Rettungsassistent/in"*. (Medizingeschichte im Kontext Bd. 13). Frankfurt a. M.: Peter Lang.

5 Original: „Aus den medizinischen Erfahrungen des Zweiten Weltkrieges war zu Anfang der fünfziger Jahre die Schocktherapie mit Infusionen und Bluttransfusion entwickelt worden. Damit war es möglich den Volumenmangelschock, der nach großem Blutverlust auftrat, im Frühstadium zu bekämpfen. […] Ende der fünfziger Jahre folgten neue Erkenntnisse über die Pathophysiologie beim plötzlichen Tod. Diese Erkenntnisse gingen einher mit der Wiederentdeckung älterer Wiederbelebungstechniken, deren Nutzen jetzt durch wissenschaftliche Untersuchungen belegt wurde: Die Atemspende und die äußere Herzdruckmassage setzten sich damit als Erstmaßnahmen beim Kreislaufstillstand durch" (Kessel 2008: 63).

6 *e. g.*: N. N. 1972. Beim Unfall bestimmt der Zufall. *Der Spiegel* 21: 52–66.

7 Original: „die Übernahme der Definitionsmacht und eine Hierarchisierung in Beziehung zu nichtakademischen Assistenzpersonal" (Kessel 2008: 75).

8 Original: „Mit ihr wurde ein Schema geschaffen, das festschrieb, wer wann welche Aufgabe hatte, um den Patienten optimal zu versorgen" (Kessel 2008: 70).

9 Original: „Oder Du, lieber Hausarzt – fühlst Du Dich blamiert, wenn der rotgestreifte Rettungswagen vorfährt und die ‚Profis' mit ihren Notfallkoffern, EKG und anderem Equipment in die Wohnung stürmen? Bist Du bereit, mit ‚denen' zusammenzuarbeiten, ohne bei jedem Satz Deinen ‚Dr.' hervorzuheben und das ‚Alpha-Tier' in Dir und gegenüber Deinem Klientel zu verteidigen?" (Fertig & Landsleitner 1988: 729).

10 Original: „Unfairerweise wird dann auf den Einweisungsschein ein Fachchinesisch geschrieben, wie es in den 20er Jahren einmal gebräuchlich war, damit der ‚dumme Rettungssanitäter' ja keine richtigen Schlüsse zieht […]" (Wachsmuth 1986: 485).

11 Original: „Mein Vater (Allgemeinmediziner mit über 40-jähriger Berufserfahrung) wird im Rahmen des ärztlichen Notdienstes am Sonntagmorgen zu einer älteren Patientin gerufen, die über Schmerzen im Unterleib klagt. Nach eingehender Untersuchung wird die Diagnose ‚Appendizitis' gestellt und ein KTW [Krankentransportwagen, P. P.] angefordert, welcher auch kurze Zeit später eintrifft. Die RS oder Rettungshelfer (Höchstalter 21 bzw. 25 Jahre) stürmen in die Wohnung, und nun beginnt folgendes Gespräch:

Hausarzt: Guten Morgen, meine Herren. Diese Dame muß sofort auf die chirurgische Abteilung des XY-Krankenhauses transportiert werden. Ich habe mit dem diensthabenden Arzt gesprochen, ein Bett ist frei, hier ist die Einweisung und der Transportschein.

RS [Rettungssanitäter, P. P.]: (Nach kurzem Blick auf die Einweisung) So ein Blinddarm, da müssen wir die Alte ja wohl tragen, können wir die mit Alarm fahren?

HA [Hausarzt]: Ich sehe darin keine Veranlassung, ich möchte nur einen schonenden und zügigen Transport für den Patienten.

RS: Herr Doktor, sind Sie sich in der Diagnose auch sicher, ich meine wenn so was durchhaut (RS meint wohl Perforation des Wurmfortsatzes).

HA: (Verärgert) Junger Mann, bin ich der Hausarzt dieser Dame und betreue sie schon über zwanzig Jahre oder SIE?

Hier endet die Kontroverse. Die Frau wird von den RS mürrisch und lustlos eingeladen und abtransportiert" (Schmidt 1986: 485 f.).

12 Original: „Soll in Zukunft der Ehrenamtliche nur noch Formulare ausfüllen dürfen oder das Lenkrad bedienen? Was ist mit dem Katastrophenschutz, den Sanitätsdiensten, allen sozialen Diensten, die wir täglich ausüben? Was nutzen uns Fortbildungen und praktischen [sic] Anleitungen, wenn uns nun nicht mehr die Möglichkeit gegeben wird, praktische Erfahrungen zu sammeln und dieses Wissen auch umzusetzen? [...] Wie oft kommt es vor, daß wir die einzigen sind, die nur durch die Anwesenheit mehr bewirken, als so manches teure Medikament. Ein Gesetz ist geschaffen. Hohe Anforderungen werden an uns gestellt. Nicht, daß wir die Ausbildung nicht absolvieren wollen, im Gegenteil!!! Aber wann? Dreißig Tage Urlaub vielleicht, eventuell noch einmal Bildungsurlaub. Und war [sic] ist mit der Familie? Was ist mit den ehrenamtlichen Tätigkeiten, die bewältigt werden müssen? Eine Überlastung der Ehrenamtlichen ist in vielen Hilfsorganisationen schon vorprogrammiert und rückt Tag für Tag näher" (Hoopmann 1989: 752 f.).

13 Original: „Davon unabhängig muß jedoch (erneut) die Frage aufgeworfen werden, inwieweit die medizinische Notwendigkeit einer intensiven fachlichen Ausbildung gerade über einen Zeitraum von zwei Jahren überhaupt gegeben ist. Die (angebliche) Unzulänglichkeit der z. Zt. praktizierten 520-stündigen Mindestausbildung ist aus Sicht der JUH zu keiner Zeit zuverlässig und seriös nachgewiesen worden" (Johanniter-Unfall-Hilfe 1986).

14 Original: „Obwohl das Berufsbild des Rettungssanitäters zu den nichtärztlichen Heilberufen gehört, *muß davon ausgegangen werden, daß der Rettungssanitäter, um ihn seiner späteren Aufgabe voll gerecht werden zu lassen, während der Ausbildung auch lebensrettende Sofortmaßnahmen erlernen muß, die grundsätzlich in das Tätigkeitsfeld des Arztes fallen. Dazu gehören Injektionen, Infusionen, Intubationen u.a., die er perfekt beherrschen sollte. [...]* Der Qualitätsstandard der Ausbildung zum Rettungssanitäter muß somit so hoch angesetzt sein, daß der Rettungssanitäter notfalls jederzeit in der Lage ist, lebensrettend Sofortmaßnahmen wie Injektionen, Infusionen und Intubationen durchzuführen. *Die Indikation dazu muß aber stets im Verantwortungsbereich des Arztes bleiben.* [emphasis in original] (Bundesärztekammer 1975).

15 Original: „*Herr Jachertz* betonte, daß die Bundesärztekammer grundsätzlich Wert auf eine Abgrenzung in den Aufgabenbereichen von Ärzten und Rettungssanitätern lege. Diese Abgrenzung solle jedoch pragmatisch vorgenommen und eine Zementierung vermieden werden. Er begrüße es deshalb, daß der Entwurf insoweit auf die jeweilige Entwicklung im medizinischen Bereich abstelle. Im übrigen müsse man gerade in diesem speziellen Fall die angestrebte Teamarbeit zwischen dem Arzt und dem Rettungssanitäter im Auge behalten." [emphasis in original] (Niederschrift 1972).

16 Original: „Stellt der Rettungsassistent eine von den Feststellungen des Notarztes abweichende Diagnose oder hält er eine andere Behandlungsweise für angezeigt, entspricht es gutem Teamgeist die Vorgehensweise gemeinsam, diskret und kurz zu erörtern, wobei dem Notarzt das Letztentscheidungsrecht verbleibt."

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Manuscript received: 05.04.2018
Manuscript accepted: 16.06.2018

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