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HOMELESS CLIENTS' CIRCULATION IN EMERGENCY CARE: RETHINKING POVERTY GOVERNANCE AS URBAN IMPASSE

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ABSTRACT

Studies concerned with how local states govern the urban poor have long focused on the state's attempts to control, criminalise and exclude individuals from public spaces. Researchers recently shifted this focus; they increasingly engage with organisations and front-line practices relating to care. Underlying these analyses is the question of how urban governance rubs off on front-line work and conditions for the urban poor. In their research, scholars rarely study through which organisational mechanisms front-line workers and clients encounter each other. This article addresses 112 calls issued for unhoused individuals by third parties in *Urgency*, a city in Germany. It sheds light on institutional and everyday logics that regularly bring third parties, emergency care front-line workers and marginalised clients into contact. These calls often blur boundaries of illness and poverty and care and control and result in clients' circulation in emergency care: an urban impasse for front-line workers.

Key words: Poverty governance; urban impasse; homelessness; emergency care; third party calls

INTRODUCTION

Scholars have studied how the urban poor are policed, arguing that processes of neoliberal urban transformation were flanked by an increasing contact between controlling (non) state agencies and the visible – 'undesired' – urban poor (Smith 1996). In the *punitive city* framework, encounters between agencies and clients are a result of the local state's attempt to increase and exert control over public space or part of the discretion and intention to punish the poor, pushing them out of desirable urban spaces. Studies have shown punitive urbanism, urban neoliberalism and policies aggressive against the poor have been pronounced in the United States (e.g. Von Mahs 2013) and have informed studies in other contexts. Comparative

studies have challenged the so-called U.S.-Americanization of other contexts (Von Mahs 2011) and accounts focused on the portrayal of cities as entirely punitive (DeVerteuil *et al.* 2009).

Studies of the governance of urban poverty have emphasised complexity and ambivalence, including a variety of agencies that unhoused and other marginalised individuals encounter, addressing other institutional responses in European cities (Von Mahs 2011; e.g. Bonnet 2009): Scholars have countered the repression hypothesis with complexity (Marquardt 2013, p. 151), conducting studies on organisations and front-line workers who provide marginalised individuals with health-care, food, shelter, social support and rehabilitation and showing how caring and controlling logics often coexist and blur (e.g. Bonnet 2009;

Marquardt 2013; Stuart 2014; Seim 2017). These studies have refined understandings of the complex institutional arrangements that influence the conditions and experiences of the urban poor in contemporary cities (Marwell and Morrissey 2020, p. 245).

The focus of these studies was often on (non)state agencies, front-line workers (those 'governing') and on their clients (those being 'governed'), implicitly reproducing a distinction between the sphere of the state and that of society (cf. Mayrl and Quinn 2016). This distinction suggests caring or controlling programmes of (state) agencies, front-line workers' implementation of such programmes and frontline workers' use of discretion (e.g. punish or care) to get them 'in touch' with individuals and communities. The state, in other words, decides when, where and how to intervene. Empirically, encounters between state actors and clients are more complex, often involving third parties, for example, calling ambulances, police or social services for those who appear in need of assistance, as nuisance or as deviant to third parties (Herring 2019). The caring or controlling intent of these calls may match or contradict the mandate of an organisation or the self-understanding of a front-line worker; they may also match or contradict the expectations of those for whom the call is issued. Institutional logics and logics of the everyday relate these actors of different positions; their encounters bear the potential for ambivalence and dilemmas. The article addresses the front-line dilemma of emergency care in *Urgency* by referring to the notion of an *urban impasse*. The notion of the urban impasse reflects on recurrent encounters between emergency care front-line workers and marginalised, unhoused clients, as stipulated by 112 calls of third parties. In such operations, unhoused clients are not 'rescued' from marginality, but ambulance-transported back-and-forth the street and hospital. In other words, *urban impasse* reflects on the (unintended) poverty governance in which emergency care providers are called to engage in.

While rescue services and ERs focus on urgent and severe health problems, aiming at preserving health and saving lives, their low-threshold access often brings them in touch with marginalised individuals and their psychosocial needs (Boscher *et al.* 2002; Siegrist 2009;

Breuer *et al.* 2020a, 2020b), a less known and studied side of these organisations (Seim 2020, p. 7). Their connection to the poorest people in cities has earned them the designation 'social safety net' (Gordon 1999; also: Seim 2017, pp. 101–102), yet their mandates translate into specific trainings, professional dispositions, rules and equipment that do not address psychosocial needs and disadvantaged conditions (e.g. homelessness, unemployment, addictions, illegalisation, hunger and mental health problems). Passersby and other third parties frequently issue 112 calls for unhoused individuals whose situation blurs the boundary between acute health problems and long-term effects of marginalisation. Because rescuing clients from marginality is not the mandate of emergency care organisations, their help often appears as 'a bandage on deeper social wounds' (Seim 2020, pp. 173–174), a bandage that does not prevent clients from returning to homelessness and again appearing as helpless or nuisances to passersby or other third parties.

Emergency care relies on people calling 112, but calls that trigger clients' circulation produce work ambivalence. These calls may unintentionally create frustration among front-line workers, normalise clients' situations and conditions in healthcare settings and reproduce (systemic) disregard (cf. Biehl 2012). Before showing this empirically, the next section introduces into the literature on poverty governance and the less studied role of third parties in governing the urban poor. This is followed by a presentation of the case of circulating unhoused individuals in *Urgency* and the methodology used. The vignette of Mr. Hannerz, an unhoused man found unconscious by passersby and transported to a nearby ER by an ambulance crew, 3 times in less than a week, guides the analytical section. His case exemplifies the urban impasse experienced by front-line workers in the field.

POVERTY GOVERNANCE: STUDIES ON THE AMBIVALENCE OF CARE AND CONTROL

Neoliberal urban transformations in the 1990s informed critical accounts on the sidelining of the visibly poor (cf. Mitchell 1995, 1997;

Smith 1996). Researchers have documented how (non)state agencies remove undesired people and behaviours, such as begging, public drinking, urinating, rough sleeping and drug use, to 'safeguard the attractiveness of city centres for capital investment' (Johnsen and Fitzpatrick 2010, p. 1,716). New York and Los Angeles became prime examples of such developments and became models for researchers to conduct similar studies in other national contexts (DeVerteuil *et al.* 2009; DeVerteuil 2014).

Like their U.S. colleagues, researchers with a focus on European cities have portrayed the formation of excluding laws (Von Mahs 2011), street sweeps, criminalisation of survival practices (Belina and Helms 2003) and the use of CCTV and private security agencies to expel individuals and groups from places to control the visibility of so-called anti-social behaviours (Eick 2003, 2012; Wehrheim 2002; for an overview, Lawton 2018, DeVerteuil 2014). With urban renewal, gentrification and privatisation of space, as observed in various geographical contexts, revanchism and neoliberalism have become popular accounts in urban geography (May and Cloke 2014, p. 894), accounts that have long informed 'our understandings of the geographies of homelessness in U.S. cities but also well beyond' (DeVerteuil 2014, p. 875). DeVerteuil *et al.* (2009, p. 647) remarked that researchers studied homeless geographies exclusively in terms of collapse. Instead, DeVerteuil *et al.* (2009, p. 647) proposed studying 'the increasingly varied and complex geographies of homelessness that characterize the contemporary city', paying attention to other (e.g. extensive welfare) and complex institutional arrangements and their governance of the urban poor.

While U.S. and European urban researchers share an understanding of our time as 'marked by a particular absence of social justice' (Mitchell 2013, p. 353), May and Cloke (2014, p. 898) held that urban governance may not be entirely punitive against marginalised groups (also Von Mahs 2013). Studies on urban revanchism and neoliberalism have been concerned with the ethics of care 'on the abstract', addressing people's exclusions from the right to the city (Milligan *et al.* 2007; DeVerteuil *et al.* 2009). In a recent methodological turn,

there has been a shift in the scope of many studies, explicitly including the concept of care, and repositioning research approaches. Researchers have moved their focus from an analysis of abstract political agendas, punitive rhetoric and expressed intentions to actual practices at the street level (Blokland 2012, pp. 488–489), including a wide range of agencies that influence the daily lives of the urban poor.

This turn in urban scholarship amplifies the complexity and ambivalence of poverty governance, challenging the distinction between care and control. Seim (2017) showed, for example, how the local state governs the urban poor through an intricate arrangement of caring and controlling agencies in a US city, studying the frequent contact between an impoverished clientele and the ambulance, hospital and police. Poverty governance here becomes the by-product of everyday inter-organisational encounters and exchanges, as well as bureaucratic and capitalist forces. Hennigan and Speer (2018) suggested blurring the binary between caring and controlling organisations altogether (see also May and Cloke 2014). The authors showed how caring organisations, such as shelters, become part of the 'punitive and exclusionary project of capitalist urbanization', where police officers employ caring tactics (May and Cloke 2014, p. 1). Relatedly, Marquardt (2016) showed how assisted-living homes for unhoused people in Berlin are not simply spaces of exclusion, but they are spaces of care in which governmental techniques take effect. Care does not exclude control, and neither does control exclude caring practices or agendas. Similarly, Stuart (2014) showed for Los Angeles, how the police collaborate with shelters in specific urban areas and become 'recovery managers', using coercion to incentivise homeless individuals into rehabilitative programmes (for a similar study in England, see Johnsen and Fitzpatrick 2010). Von Mahs (2011) addressed the interplay between exclusionary urban policies, aiming at safeguarding public order and safety, especially in privatised urban spaces, and the increase of targeted social services for homeless people in Berlin, coupling coercion with welfare. Bonnet (2009) analysed how railway companies addressed groups of unhoused

and undocumented migrants on privatised property in Lyon and Milan by appointing social community organisations. In both cases, the agencies relied on incentivising, rather than coercing, individuals to leave the railway properties, producing, as Bonnet (2009, p. 1,038) concluded, a tenuous boundary between social and security policy.

As Marwell and Morrissey (2020, p. 245) point out, poverty governance scholars have largely been focused on perspectives of front-line workers or the experience of clients who get categorised, sorted and steered into specific institutional paths (Marwell and Morrissey 2020, p. 245). The question of how the urban poor are governed usually translates into how (non)state agencies and their front-line workers attempt to implement organisational rules and programmes, often with a focus on front-line workers' discretion (Herring 2019, p. 771). Such a perspective pays too little attention to the organisational mechanisms that relate (non)state actors to each other. It obscures how and why caring/controlling organisations get in touch with and process clients and the ambivalent and paradoxical situations that may arise from their encounters.

The role of third parties who relate (non)state agencies with clients to manage the urban poor has been rarely studied, despite third parties' empirical involvement in managing the urban poor (Herring 2019, p. 773). In the context of intensified third-party policing, Garland (2001, p. 170) pointed out that civil actors 'composed of "a third governmental sector [...] positioned between the state and civil society, connecting the criminal justice agencies with activities of citizens, communities and corporations"', (in Herring 2019, p. 773). Herring (2019) showed most encounters between the police and the homeless in San Francisco result from third-party complaints and in what Herring termed 'complaint-oriented policing'. Herring (2019, p. 779) described an organisational mechanism that relates (non)state actors and manages homelessness in public: 911 and 311 calls that require the police and city's customary service to follow-up on demands from citizenry, homeowner associations and businesses.

While Herring (2019, p. 774) based their study on the literature on gentrification and the punitive city, Herring did not aim to analyse its direct role in complaint-oriented policing practices nor to point to other possible causes. In this, Herring departed from many former approaches. Instead of suggesting a connection between city-wide (and national) rhetoric and agendas and on-the-ground practices (DeVerteuil 2019, p. 1,056), Herring (2019, p. 774) identified 'structural and organizational pressures placed on the police to manage marginality that extend beyond the field of criminal justice and how they manifest in police interactions'. Rather than the on-the-ground realisation of revanchist agendas, the focus is on the ambiguous bureaucratic and organisational mechanisms involved in complaint-oriented policing.

Herring's (2019) case study joined ethnographic studies on poverty governance that show how the interplay of sheltering, supporting, rehabilitating, sanctioning, expelling and routing logics produces unintended consequences. Herring's case resulted in 'the reproduction of homelessness, a deepening of poverty, and ultimately suffering' (Herring 2019, p. 794). While Herring (2019) addressed 911 and 311 calls for policing unhoused individuals, this article sets out to study 112 calls that reached the ambulance service in *Urgency*. In contrast to earlier empirical cases, the ambulances' and ERs' mandates do not explicitly address urban marginality. However, everyday logics of third-party calls (assumingly motivated by issuing help but also by expelling unwanted people from places) and institutional logics of a low-threshold access to emergency care connect ambulances and ERs with a marginalised client population (cf. Seim 2017, 2020).

This article aims to rethink poverty governance as an urban impasse resulting from the ambivalences and unintended consequences of third-party calls. Therefore, the article draws on institutional logics and logics of the everyday. Institutional logics represent organisational policies, rules and mandates that impact, rather than predetermine, practices and expectations of front-line workers and their clients (Andersen and Vedsted 2015, p. 241). People derive doxic understandings

from these logics, that is, dominant interpretations that help or prevent situational alignment of practices and expectations and ease social encounters (Blokland *et al.* 2022, this issue). Everyday logics relate to what Blokland (2019, pp. 108–109), extending Misztal's (2001) concept of normalcy, termed 'normative' and 'situational normalcy'. While the former relates to what is perceived as normal in what 'ought to be' in terms of standards and values, the latter relates to frequent and repetitive experiences in everyday life that make occurrences and performances appear situationally normal (though they 'ought not be').

Writing about care and control in relation to organisational mandates, front-line work and ambivalences necessitates reflection on 'what ought to be' in terms of organisational mandates and normative considerations of care and what has become situationally normal due to the circumstances and institutional contexts in which front-line work has evolved. To account for the different positions in the field and perspectives on practices and mandates, I follow Bonnet's (2009) approach to differentiating between emic and etic understandings. A distinction between caring and controlling policies and practices from an emic perspective, is meaningful for agencies and front-line workers (cf. Bonnet 2009, p. 1,032). It helps in re-establishing symbolic boundaries between institutional logics and organisations (e.g. between social service and the police) (cf. Lamont and Molnár 2002); it reproduces the self-understanding of actors and their organisations' legitimacy and positions in fields (Bonnet 2009, p. 1,041). From the sociologists' standpoint – or the etic perspective – in Bonnet's (2009, p. 1,032) terms, the emic standpoint is regularly challenged. Community services issued under the label of care may not be classified as caring in intent or consequence by those who conduct analysis on them (Bonnet 2009, p. 1,042; also: Marquardt 2016). The distinction between emic and etic perspectives appears useful in terms of conceptualising an epistemological break between the perspective in the field and that of its academic analysis (Bonnet 2009). The distinction also serves as a reminder of the different positions and

potential differences in perspectives within a field itself (e.g. of clients, front-line workers, peers and superiors), and the potential critical reflections that front-line workers conduct on their work themselves (see Bonnet 2009). Accounting for the different positions in the field allows to indicate whether, for example, a paramedic or 112-caller describes a practice or call as caring, controlling or disregarding.¹ This framework underlines the fragmented and ambivalent nature of poverty governance and, in the case of 112 calls for unhoused individuals, accentuates an urban impasse situation.

CONTEXT AND METHODOLOGY

Local governments provide measures of care and control targeting the urban poor. The contexts in which homelessness develops are complex and differ between more comprehensive welfare states, such as Germany,² and less extensive systems, such as the United States, providing people with different access to income, housing, health and social support (Von Mahs 2013, p. 1,039). While laws in German cities are not explicitly anti-homeless, they often affect unhoused individuals sleeping or consuming in specific places (see Von Mahs 2011; Marquardt 2016). Social agencies cater to people without shelter, access to food, income or healthcare. An agency estimated that in Germany in 2018, around 41,000 people were unhoused and had to reside on the streets,³ many of them in cities like *Urgency*. Public health research has explicitly addressed encounters between ambulance crews and unhoused individuals in Germany (Boscher *et al.* 2002, Siegrist 2009, Breuer *et al.* 2020a, 2020b), demonstrating the medical and social needs of unhoused clients and the difficulties of addressing the latter during operations.

As in other parts of Germany, the fire brigade of *Urgency* organises and responds to a great share of ambulance operations in the city.⁴ Rescue services provide first aid for medical emergencies and account for those situations in which an emergency cannot be immediately excluded by dispatching an ambulance crew. Rescue services in different cities (inter)nationally document an

increase in their use. Sieber *et al.* (2020) observe an annual increase of rescue operations of 5% in Germany; a considerable share of operations concern non-urgent health problems. *Urgency* is a German city of more than one million inhabitants, in which providers observe increased use and frequent encounters with patients who not only suffer ill health and injury but also (psycho) social needs.

The regular contact between emergency care agencies and unhoused individuals informed this research. The paper relies on fieldwork conducted during February 2018 and May 2019, a time period in which I spent more than 300 hours of participant observation in emergency rooms and fire department stations. Additionally, I conducted formal interviews ($n=34$) with nurses, doctors, rescue workers and paramedics in different positions within their organisations (front-line, supervision and planning).⁵

After presenting my research proposal to the medical director of the fire brigade, I was granted access to conduct fieldwork at multiple stations. On ride-alongs, I observed one to three shifts at each station and held formal interviews. ER managers granted access to three hospital ERs, so I could follow patients' trajectories into the hospital and capture the changes in work and client groups that surround the category of the emergency.⁶

I wrote fieldnotes during operations and rides from the hospital to the station or to the next operation, or I recorded fieldnotes verbally after shifts. In ERs, I took notes in a similar fashion while observing encounters between nurses, doctors or clients.

I used abductive coding for fieldnotes and interviews, using interrelating data collection and theorising in an iterative process (Atkinson 2018, p. 415). Literature on poverty governance informed the research. Findings in the field led to framework expansion and the inclusion of literature on fields, organisations and institutional logics (cf. Emirbayer and Johnson 2008; Marwell and Morrissey 2020).

I use pseudonyms for the city studied, places and people, starting with an empirical vignette focusing on Mr. Hannerz. The vignette is complemented by information gathered in interviews and ethnographic fieldwork.

THE URBAN IMPASS OF SOCIAL MARGINALITY AND ITS 'RESCUE'⁷

The Ambiguous Category of the 'Helpless Person': In one operation of the ambulance service, I accompanied rescue worker Marcus and EMT Nick. The crew and I were dispatched to attend to Mr. Hannerz, a 'man on the ground, asking for help', as described in the emergency notification for the crew. When the crew and I arrived at the location, a passerby approached us, relieved at the sight of the crew:

'Good afternoon, I called. We went for a walk, and then he was lying here, motionless. I do not know if it was right to call 112, but you do not worry when someone lies there. We could not go away. But then he woke up and wanted a smoke. If you can smoke, it cannot be that bad, right? Maybe it was wrong calling you'.

Marcus replied, 'No, it's absolutely right that you called us. Everything's fine. We'll take care of him now'.

Literature on prosocial behaviour terms calls like the one made for Mr. Hannerz *civic courage* (Greitemeyer *et al.* 2006). If a person evaluates someone else to be in danger, they should feel responsible for intervening on the other's behalf, an expectation that is legally mandated in Germany.⁸ Calling 112 for a helpless person is normatively (and legally) normal. Acts of civic courage suggest bystanders' interventions remedy critical situations, for example, a robbery or assault, and help in acute medical emergencies.

In Mr. Hannerz's case and that of other unhoused individuals, these acts lead, however, to a paradoxical situation. Third-party calls can result in the circulation of individual clients. As Marcus learnt after Mr. Hannerz' transport to an ER and an exchange with a nurse, Mr. Hannerz had been in the same emergency room 3 times in less than a week. Later, Marcus explained that passersby regularly called 112 for people sleeping in public on benches or on the ground, classifying sleep or a bent posture as indicative of a need for urgent medical attention. Although Mr. Hannerz' health condition did not appear highly acute to Markus, he suggested the ER transport because, Markus explained, 'Another crew would have been dispatched

sooner or later.' The transport to the ER appeared to temporarily 'hold' Mr. Hannerz's circulation between the street, ambulance and ER (see also Herring 2019), a circulation that the 112 call triggers and institutional logics stipulate.

In the control centre of *Urgency's* fire brigade, dispatchers process all incoming 112 calls and create 'alarm keywords' to inform crews who are available, proximate and appropriate (i.e. according to the crew's level of training and equipment in the ambulance).⁹ To determine or exclude an emergency, dispatchers use a dispatching programme and algorithm. Processes for incoming calls and the use of symptom-oriented questions substantiate dispatch decisions. The more details, the better the dispatcher can classify the situation. 'When in doubt', as fire brigade station supervisor Mr. Ludwig explained, the dispatching system produces situational unambiguity by assuming the worst case and sending for immediate help. The underlying institutional logic of emergency procedures is that of *high alert*, a logic used to reduce risks and provide patient safety. It bridges communicative and informational gaps over the phone by sending prompt help. It is when front-line workers arrive at a site that they make further evaluations of the client's condition. The encounter is followed by transports to ERs, where further examination and treatments are issued, if indicated.

As Poloczek (2002 in Ellebrecht 2020, p. 78) shows for the city of Berlin, frequently used alarm key words dispatchers assigned to 112 calls in 2001 were 'helpless person' or 'person in distress',¹⁰ amounting to 46% ($n=77,087$) of all operations. Ellebrecht (2020, p. 177) assumed this number is indicative of the role of third-party calls for others in public and, presumably, a large share of the social suffering the ambulance service processes every day. The category of the helpless person suggests a person called 112 for someone personally unknown to the caller, as shown by the lack of details and communication about the medical condition of the person for whom the call was issued (Ellebrecht 2020, p. 177). In the case of a helpless person or person in distress, the dispatcher bridges the lack of information they receive over the phone, using a general code

to dispatch an ambulance. Even though the ambulance service and rescue work depend on calls for helpless persons, in this study, front-line workers showed ambivalence when talking about some of these calls. The next section shows how front-line workers perceived a share of 112 calls issued to unhoused individuals as 'shallow' forms of care and acts of exclusion.

'So-Called Civic Courage' for Unhoused Individuals: Homelessness is often accompanied by long-term and chronic health conditions and accumulated social disadvantage. Conditions on the street and limited access to institutionalised resources, such as regular healthcare, food, housing and regular income, produce and exacerbate existing bodily and mental problems, increasing the likelihood of acute medical episodes (e.g. drug and alcohol intoxications, traumatic injuries; see Boscher *et al.* 2002).

The passerby for Mr. Hannerz expressed care and worry when witnessing a person lying motionless on the ground, potentially a sign of a medical emergency. Front-line workers described how passersby often issue 112 calls from a distance for unhoused individuals who appear helpless, unconscious or worse (i.e. in medical states that are difficult for laypeople to determine or unambiguously categorise from a distance or even from proximity). An issue for front-line workers laid, however, not in a 'false' assumption and worry of a medical emergency but in what appeared to be 'a lack of effort' to gather more information on people's conditions or asking if they needed professional help. Mr. Bechtel, from the rescue service's planning department, described that the *worried citizen*, a term frequently used in this context, is often 'not worried enough':

'It is not like, Walter is so drunk, and he is so ill that he wants help, but someone passes him and calls [112]: "There is a man, I think he is dead". "Is he breathing?" "Well, I do not know. I did not check". "Does he have a pulse?" "I do not know". "Where are you now?" "In the [subway], on my way home". "Yes, great".'

Mr. Bechtel's rendering of a fictitious conversation between a 112-caller and the ambulance dispatcher exemplifies front-line observations that passersby do often not approach individuals for whom they issue 112 calls. In some cases, people for whom third parties call 112 from a

distance indeed need acute medical attention, possibly suffering medical conditions in which every minute counts (cf. Breuer *et al.* 2020a, 2020b). More frequently, however, front-line workers said they encounter marginalised clients in situations where passersby mistook their situations as medical emergencies and did not approach or contact the person. William, a rescue worker in an inner-city station, recounted such an operation with an unhoused client:

‘The other day, someone lay in the subway station and slept in his sleeping bag, and someone called [us]. [...] And then I talked to him: “Are you alright?” “What? Yes, yes, everything is fine”. “Yes, someone called and worried”. “Yes, yes, I’ve heard that before”. ‘Okay”’.

Clients who appeared involuntary to front-line workers informed discussions in the field about the thoroughness or sincerity of the care by 112-callers. Mr. Meyer, another station supervisor, assumed it might appear easier to call 112 than to give a person a shower, give them something to eat or speak to them to see if they are sleeping (i.e. normal situation) or unconscious (i.e. matching the institutional logic of life rescue). Ambulance crews saw a mismatch between their expectations of civic courage, that is, what front-line workers understand as actual support, and what callers seemed to be doing: passing on responsibility by determining acute health needs from a distance and triggering institutional mechanisms of emergency care.

Whereas the crew who transported Mr. Hannerz did not assume ‘shallow’ or ‘bad’ intentions by the passerby who called 112, in other instances, calls appeared as acts of exclusion for front-line workers, as Anton, a rescue worker and supervisor of a team, described. Anton portrayed his inner-city dispatching area and its nightlife as very lively: Drug consumption in clubs would regularly result in medical emergencies but also in situations in which bar owners or police officers would try to ‘get rid of an unpleasant guest’. They would sometimes call an ambulance. In a similar vein, such excluding calls would be issued for unhoused people. Anton continued:

‘We have many homeless here, and it is the same for them. There are frequent calls, of course, from non-affected people who simply want the person to disappear from the place where they are now lying’.

Callers appeared to make (mis)use of the institutional logic of high alertness and the mandate to transport clients to the ER.

Third-party calls did not exclusively involve passersby, residents, or shop employees; as other research scholars showed and front-line workers described, 112 calls issued for unhoused individuals regularly involve police officers and professional peers (Seim 2017, 2020; Herring 2019). While police officers can refer to jurisdictional boundaries and define an operation as medical, front-line workers assume calls regularly represent burden shuffling: shuffling undesirable clients and work onto each other (Seim 2017, 2020; Herring 2019).

112 callers who use services to exclude or shuffle people away from the street, shop entrances, staircases of apartment buildings and the like violate the rescue service’s mandate and front-line workers’ professional ethics. In this perspective, third-party calls result in excluding marginalised bodies from specific places, matching Von Mahs’ (2013 in Pospěch 2021, p. 7) observation that unhoused people are more likely to encounter anti-homeless policies and their enactment in urban, private spaces.

The section showed ambiguous situations, resulting from emic and etic readings of operations and situations in which front-line workers position calls and their work as actually caring, not caring enough, or excluding. The next section addresses potential unintended outcomes of third-party calls that turn unhoused individuals into ‘regulars’ in healthcare settings.

The Case of the ‘Regulars’: When the dispatcher sent Nick and Marcus to help Mr. Hannerz, the crew found him in an area that ambulance crews frequent to help individuals from the so-called ‘public scenes’. A nearby square is used to sell and consume illicit drugs. It is also used for sleeping. Ambulance crews connect intoxication from drug and alcohol consumption with this area.

From the cues the crew gathered from the emergency protocol they received at the station to the first impression of Mr. Hannerz lying on the ground in an area known for the consumption of alcohol and drugs, rescue worker Markus relied on routine encounters in the area when asked, ‘Did you take something?’ Repeated encounters informed

Markus's impression at the logic of exception was overthrown by everyday logic, creating a sense of situational (and spatial) normalcy. This normalcy feeds on repetition (see also Blokland 2019, p. 108). Front-line workers in the ambulance service often stressed they liked their work for its variety in operations, where 'no two days are alike', yet there are routine calls (see also Seim 2020, pp. 33–34). The contact between unhoused individuals and the ambulance, often for repetitive social and health conditions, is part of such routines. These recurrent encounters form expectations of clients, symptoms and spaces, leading crews to anticipate 'what the case is about' from initial cues.

When people regularly use emergency care services, they turn an exceptional service into a routine service for varying reasons: chronic illnesses, psychiatric diagnoses, drug or alcohol dependence, and, in other cases, recurrent third-party calls for helpless people (cf. Booker *et al.* 2015; Breuer *et al.* 2020b). In a recent study, Breuer *et al.* (2020a) identified 131 homeless clients as high and super frequent¹¹ users, who came in frequent contact with the ambulance service in Berlin and made up for 2.1% of the total operations within 12 months (03/2018–02/2019). Because not all calls result in an encounter and transport, the percentage is most likely higher, as the authors pointed out (Breuer *et al.* 2020a, p. 22). The study showed ambulance crews often encountered unhoused clients in specific districts and 'hot spots', that is, specific sites within these districts (Breuer *et al.* 2020a, p. 20), demonstrating the frequent contact between emergency care organisations and marginalised individuals. These findings were reflected in interviews for this study. Paramedic Mrs. Walden described that she and other crews regularly transported homeless clients and, at times, particular individuals multiple times in one shift. She explained:

'So, they [staff in the ER] just let them sober up for a short time and then they [clients] leave again. And then of course they carry on [consuming drugs and/or alcohol]. So it happens that in one shift, the ambulance takes a person to the hospital, maybe twice in one shift, then the shift changes, they pick up the

same person again, bring him back to the hospital and the hospital says, "Oh, we already had him twice today!"'

Clients who consume substances and spend time and sleep in certain public places can stipulate a circulation between the street, specific ambulance crews and hospitals, resulting in regular encounters. Fire station supervisor Mr. Neumann described how he knew from cues, like the public toilet at a specific square, time of the day and gender that they were dispatched to their regular client, Vivian, whom he and others at the inner-city station got to know over the years. The recurrent contact partially shifts institutional-anonymous relations into institutional-familiar relations (see Blokland 2003, p. 115) and thus contradicts key characteristics about people-processing institutions (cf. Lipsky 2010 [1980]). Mr. Neumann and others in the field expressed positive feelings towards these singular transformations of clients into regulars, as it was 'nice' to understand the circumstances in which regulars came to live.

The familiarity with individual clients can also become a risk. In a workshop for emergency personnel, a discussant medical doctor, Ms. Bakke, presented a specific case of a regular client associated with alcohol dependence. She used the case to describe the problem of anticipating a client's condition based on familiarity:

'A 70-year-old man – You know him well because you shuffled him 20 times already into the emergency department this year. You meet him in the night at the street corner. He is drunk, as usual, has no orientation, is restless, talks a bit unclear, sees things. (...) This does not seem to be urgent. (...). The psychiatrist decides to not check his marks, and he had a bleeding and died. These patients, the well-known, are, in young and old age, vulnerable to neglect, that we do not look at them closely. He was 20 times in the emergency department. You know him already. It is always the same, and suddenly, it is differently for one time. And this relates to the old and the young'.

The everyday logic of familiarity resulting from regular encounters may result in normalising conditions and symptoms. This may either be the case, as front-line workers become

familiar with an individual client or become familiar with similar conditions of clients and related operations, producing what Maynard-Moody and Musheno (2003, p. 79) called a 'group category'. Although homelessness is characterised by a variety of conditions, causes and people, third-party calls (also self-reference for emergencies) frequently bring front-line workers in contact with unhoused individuals through particular operational causes or key words (involving consumption of alcohol and drugs, substance intoxication and psychiatric emergencies, as studies show; cf. Boscher *et al.* 2002; Breuer *et al.* 2020a), producing situational normalcy and informing the classification of individuals as part of a group category: 'the homeless'. Classifying and categorising are fundamental social practices (Bourdieu 2018), making social life manageable: allowing individuals to distinguish between people and meeting certain ends, that is, distributing services. The sorting of an individual into a group category can also be obstructive. As Ms. Bakke described, normalising conditions and symptoms based on categories may result in neglect of transports, examinations and treatments, opposing the logic of high alert.

A risk of normalising conditions may also concern passersby and other third parties. Reports of public deaths of people who were mistaken for sleeping on the ground suggest how survival practices, such as sleeping in public, may be perceived as situationally normal by urbanites and front-line professionals. In those cases, the familiarity with certain areas, practices, and particular unhoused people may mould a frame (see Misztal 2001) into which people put their situational trust of not witnessing a medical emergency but, cynically, of either encountering poverty as normalised urbanism (cf. Gerrard and Farrugia 2015) or a familiar unhoused person, normalising their condition.

For front-line workers, regulars can be a positive diversion from institutional-anonymous relations and a 'source of frustration', as fire-station supervisor Mr. Neumann concluded. Encounters with regulars can make front-line workers realise the little effect their help often has on conditions and clients' psychosocial needs. After bandaging

a serious wound of an unhoused man, for whom a shop employer called the police, who, in turn, called 112, Dr. Meinhard described how she felt morally obligated to care for his wound, even though there are social agencies catering to homeless and non-health-insured people's long-term and chronic health needs. Providing care for his wound, she was aware that she was 'not going to solve the homeless problem'. Fabian, from the rescue service's planning department, said some regular clients become a 'cue ball' in a system that responds to calls and treats acute bodily symptoms but does not respond to chronic conditions. The low-threshold access to the field and third-party calls brought unhoused clients into regular contact with healthcare settings 'not designed' for their needs (cf. Karutz 2014). In these cases, front-line workers literally put on a bandage when there are deep social wounds and unintentionally became part of a wide field of poverty governance (see Herring 2019, p. 793). To socially inflicted suffering, emergency care settings are restricted to providing acute and 'superficial' responses (Seim 2020, p. 80).

In some front-line workers' descriptions, frustration about regular operations involving unhoused clients is mixed with social stigma and evaluations of healthcare-related deservingness (cf. Bourgois *et al.* 2017). Some nurses, doctors and rescue workers commented negatively on clients, distancing themselves from caring for the client group as not being part of their profession and mandate (see also Seim 2020). In a context of increasing numbers of cases that challenge operational procedures, a resource dilemma experienced on the ground may well exacerbate such responses towards clients. They may, in turn, stipulate clients' distrust, negatively affecting clients' cooperation and agreement to be transported when acutely ill or injured (cf. Boscher *et al.* 2002, p. 513; Karutz 2014, p. 34).

CONCLUSION

This article lays out a specific organisational mechanism that results in regular (and recurring) encounters between unhoused

individuals and front-line workers tasked with emergency care. Research scholars have described the rescue service and ERs as social safety nets. Front-line workers in these settings often prove the last resort of providing (health)care to socially marginalised clients; yet emergency care organisations are not provided with the mandate and institutional leverage to offer trajectories from the street, treat chronic ill health, nor address psychosocial needs. In conversations with rescue worker Marcus and EMT Nick, a crew whose operation I observed, Marcus put the reference of the social safety net into perspective, saying that an ambulance transport to the ER and ER assessment did not help in operations that were not primarily medical.

Operations in the rescue service entail medical emergencies for unhoused individuals; more often, however, crews encounter and transport marginalised clients for long-term health problems, lack of shelter and suffering inflicted by a lack of social and welfare support. 112 calls can stipulate a circulation of clients between street, ambulance and ER. While this circulation might situationally benefit clients who receive medical assessments, treatments, overnight stays, food, or clothing, based on the discretion of frontline workers, this helps reproduce, rather than eradicate, marginal social positions (Seim 2017, p. 451) – usually not with intent. For front-line workers, regular encounters with marginalised clients challenge their professional understanding of providing help and making a difference in situations of bodily and psychological extremism, instead of managing normalised poverty in the city. At the same time, emergency care depends on passersby and other third parties being alert, attentive and calling 112 for others who appear to be in need. Even though front-line workers problematise the unintended consequences of recurrent 112 calls and encounters for specific clients, they stressed the importance of third parties calling: an urban impasse situation.

The article aimed at rethinking poverty governance as an urban impasse. It follows other research in addressing the non-coherent practices – and ambivalence of services rendered to the urban poor. Different actors evaluated their encounters with marginalised

clients differently: understandings of care were perceived as control, exclusion and disregard. Practices of care and control thus represent an analytical continuum, rather than distinct properties of agencies, policy goals, or practices. Conceptually speaking, the ambivalence arising from the importance of 112 calls by third parties for life rescue and their perceived effects for some (e.g. the circulation of individual unhoused clients) makes this a case of an urban impasse for frontline workers. Future research needs to include the clients' perspective and further explore the notions of care, control, disregard and the urban impasse.

Endnotes

- ¹ I reformulate Bonnet's (2009) use of the term *etic* as a view and evaluation of practices by others.
- ² Institutional arrangements and the doxic understandings they reproduce may affect how third parties understand and respond to encountering homelessness – responding with care instead of exclusion (cf. Von Mahs 2011). Explicitly analysing this relation is, however, outside the scope of this article. The article focuses on 112 calls by third parties for unhoused individuals and different related (*emic/etic*) understandings.
- ³ The numbers are likely to be underestimated as they exclude the number of registered homeless refugees. Source: Bundesarbeitsgemeinschaft Wohnungslosenhilfe e.V., 2018: PRESSEMITTE ILUNG. https://www.bagw.de/fileadmin/bagw/media/Doc/PRM/PRM_2019_11_11_Schaeztung_Zahl_der_Wohnungslosen.pdf (Accessed: 10.9.22).
- ⁴ A smaller proportion is delegated to non-profit organisations like the German Red Cross or the Workers' Samaritan Federation.
- ⁵ I did not talk to clients during an ambulance operation but interviewed those with less urgent health problems in the ERs and ER waiting rooms ($N=66$).
- ⁶ The PhD project was concerned with the changes in the field of emergency care, studying them as a classificatory struggle.
- ⁷ Parts of the empirical analyses are based on my dissertation and have been previously published as Krüger, Daniela (2023): 'It Has Become Normal to Call 112'- Classificatory Struggles over the

Increased Use of Emergency Care in Urgency. Dissertation: Humboldt-Universität zu Berlin.

⁸ According to the German Criminal Code Section 323c.

⁹ Ambulance crews can post-alarm or cancel further help by crews when encountering the patient on the ground to further adapt rescue means to the patient's needs.

¹⁰ Translated from German: 'Hilflose Person/ Person in Notlage'.

¹¹ The authors (Breuer et.al, p. 18) differentiated between low (4 ambulance contacts per year), medium (5–6 ambulance contacts per year), high (7–10 ambulance contacts per year) and super (11 and more ambulance contacts per year) frequent users.

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