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Pittsburgh's Freedom House Ambulance Service: The Origins of Emergency Medical Services and the Politics of Race and Health

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ABSTRACT

This manuscript explores the history of the Freedom House Enterprises Ambulance Service, a social and medical experiment that trained "unemployable" black citizens during the late 1960s and early 1970s to provide then state of the art prehospital care. Through archives, newspapers, personal correspondence, university memoranda, and the medical literature, this paper explores the comparable, yet different roles of the program's two leaders, Drs. Peter Safar and Nancy Caroline. Despite its success in demonstrating national standards for paramedic training and equipment, the program ended abruptly in 1975. And though Pittsburgh's city administration cited economic constraints for its fledgling support of Freedom House, black and majority newspapers and citizens alike understood the city's diminishing support of the program in racial terms. The paper discusses Safar and Caroline's well-intentioned efforts in developing this novel program, while confronting the racial, social, and structural constraints on the program and the limits of racial liberalism.

KEYWORDS: emergency medical services, Freedom House, Peter Safar, Nancy Caroline, race, medicine, paramedics, Pittsburgh, African Americans

THE FREEDOM HOUSE ENTERPRISES AMBULANCE SERVICE

Standing before a group of physicians and medical staff in a crowded emergency department bay at the University of Pittsburgh's Presbyterian Hospital, an emergency medical technician (EMT)[1] described the following patient newly arrived to the hospital by ambulance transport:

> We have a 19-year-old man who experienced a dizzy spell without syncope while lifting some cartons at work. His past medical history is negative except for a heart murmur present since childhood. He is on no medications. On physical exam he was alert and diaphoretic. His pulse was irregular, ranging from 38 to 110, his BP was 110/70, and his respirations 20. The rest of the physical exam is negative except for a short systolic murmur. His EKG showed evidence of a brady-tachy syndrome.[2]

The technician then handed the patient's EKG rhythm strip to an "astounded physician [who was] still in a state of shock when [he] left."[3] Though this scene is commonplace across emergency departments today, it astounded physicians during the 1970s for several reasons: Prior to the late 1960s, critically ill or injured patients were transported to hospitals in the back of police cars, hearses, and paddy wagons.[4] Pre-hospital care emphasized speedy and reliable "transportation without treatment."[5] There were no formal requirements for hospital transporters, and most lacked even basic first-aid training. Equally striking, this exemplar of the new profession of EMTs, employed by the Freedom House Enterprises Ambulance Service, was a disadvantaged black resident of Pittsburgh's Hill District previously considered "unemployable."[6] Freedom

1 There are notable differences in training between emergency medical technicians and paramedics, with paramedics having more advanced training than emergency medical technicians. Caroline and Safar helped create pilot courses for both basic and advanced emergency medical services training, although their writings used the terms interchangeably.

2 Brady-tachy syndrome is a variant of a relatively uncommon heart rhythm disorder now more commonly referred to as sick sinus syndrome. For reference, see Michael Semelka, Jerome Gera, and Saif Usman, "Sick Sinus Syndrome: A Review," *American Family Physician* 87 (2013): 691-696. For full quotation, see Nancy Caroline, "A Year in the Life of the FHE Medical Director: Random Collections," From the papers of Nancy Caroline, Arthur and Elizabeth Schlesinger Library on the History of Women in America, Radcliffe Institute for Advanced Study, Harvard University, Cambridge, MA (Hereafter cited as Caroline Papers), Series V, Subseries A, Freedom House Ambulance Service (Files 40.6-46.25).

3 Ibid.

4 Nancy L. Caroline, "Medical Care in the Streets," *Journal of the American Medical Association* 237 (1977): 43-46.

5 Correspondence between Peter Safar and Nancy Caroline, Caroline Papers, Series V, Subseries A, Freedom House Ambulance Service (Files 35.9-35.10).

6 Don M. Benson, Gerald Esposito, Jerry Dirsch, Raymond Whitney, and Peter Safar, "Mobile Intensive Care by 'Unemployable' Blacks Trained as Emergency Medical Technicians (EMTs) in 1967-69," *Journal of Trauma* 12 (1972): 408-421. See Peter Safar, Gerald Esposito, and Don M. Benson, "Emergency Medical Technicians as Allied Health Professionals," *Anesthesia and Analgesia* 51 (1972): 27-34. See also J. McCormick, E. Ricci, and M. Sullivan, "An Evaluation of a Model Ambulance Service," *Emergency Medical Services* 3 (1974): 32-38.

House paramedics helped usher in a new era in paramedic training, but within less than a decade, would find themselves excluded from the system they helped to create.

Freedom House was a black-run ambulance service during the 1960s and 1970s that demonstrated the feasibility of a paramedic-staffed emergency medical services (EMS) system and led to the development of national standards in emergency care.[7] Trainees were recruited from among the poor, black, and unemployed citizens residing in Pittsburgh's inner-city neighborhoods. Conceived in 1967 to address the "dovetailing needs" of the Black community for healthcare and decent employment, Freedom House was envisioned as a laboratory to test standards for national paramedic training.[8] Although the Pittsburgh program received national attention and became the gold-standard for paramedic training in the late 1960s, its work ended prematurely in 1975, when the program exhausted its funding and EMS privileges were transferred to a predominantly white service.

In this telling, the Freedom House story is a success story: a narrative of how two progressive physicians provided emergency healthcare to a disadvantaged community while improving work opportunities for unemployed black citizens. The story of Freedom House is ostensibly one of two physicians' attempts to democratize medical care that had previously only been provided by physicians. It is a racial history of health professions that runs alongside broader threads of social and racial justice in medicine. And its narrative challenges conventional accounts of academic medical centers' failures to connect meaningfully with their surrounding communities.[9] Yet reckoning with Freedom House as a brief moment in the history of medicine also requires an assessment of the limitations of this model, the struggles the organization faced, both between the goals of its two founders and the broader challenges of local Pittsburgh politics in the late 1960s and early 1970s.

Much of this history is examined through the lens of the program's medical leaders, Peter Safar, M.D. (1924-2003) and Nancy L. Caroline, M.D. (1944-2002).[10] Safar and

7 Correspondence from Nancy Caroline to Professor Prentis regarding medical school activities, Caroline Papers, Series V, Subseries A, Freedom House Ambulance Service (File 28.7).

8 Ibid.

9 To be sure, academic medical centers in other large cities in the United States (e.g., New York, New York, Cincinnati, Ohio, and Seattle, Washington) were actively engaging with poor and underserved citizens during this time. Nevertheless, most health, social, and hospital reform movements in the twentieth-century United Stated States historically depended heavily on community efforts. For additional discussion of health reform and grassroots social movements in the United States, see Beatrix R. Hoffman, "Health Care Reform and Social Movements in the United States," *American Journal of Public Health* 93 (2003): S69-79. For discussion of how local, community, and philanthropic efforts that influenced black hospitals and health care institutions for indigent and disenfranchised black citizens, see Vanessa Northington Gamble, *Making a Place for Ourselves: The Black Hospital Movement, 1920-1945* (New York: Oxford University Press, 1995).

10 The data that inform this study draw from the Peter Safar Archives at The Wood Library-Museum of Anesthesiology, American Society of Anesthesiologists, Schaumburg, Illinois; the Nancy Caroline Archives at the Arthur and Elizabeth Schlesinger Library, Radcliffe Institute for Advanced Study, Harvard University, Cambridge, Massachusetts; and the Clendening History of Medicine Library, Kansas University Medical Center, Kansas City, Kansas. Primary materials also include mass-circulation newspapers from both majority white and black communities in Pittsburgh.

Caroline were two physicians with different backgrounds, perspectives, and motivations. Safar, concerned largely with promoting the program locally and nationally, saw his challenge as the need to bring into alignment larger political interests in urban development under the Great Society programs and emergency medical systems. Caroline, often working outside the medical center, was in touch with and sensitive to racial politics at the individual level. Both Safar and Caroline, however, recognized the opportunity to engage poor black citizens in grassroots work to establish and develop an EMS service.

A melodramatic reading of the medical leadership during the Freedom House experiment would emphasize the tragedy represented by Freedom House's demise. While successful in establishing the standards for EMS training, Freedom House ended abruptly and was not replicated. Moreover, Safar and Caroline failed to sustain socioeconomic and professional progress among its predominantly black paramedics. A dramatic reading, however, recognizes Safar and Caroline's willingness to engage in a progressive social program during a period of uncertainty about the role of government in providing social resources to promote the well-being of certain members of society. This paper considers the limits of racial liberalism, a commitment to social progress to address historical racial and socio-political discrimination, in the history of Freedom House.[11] In it, I argue that Safar and Caroline's efforts were well-intentioned and consistent with racial liberalism, while structural, economic, and racial constraints were significant barriers to the continuation of the program and the advancement of Freedom House paramedics and leaders.

The social history of medicine has focused on progressive health activists as protagonists facing a struggle against logistics, politics, and ignorance to champion the health needs of the poor and marginalized. At times these advocates came from the communities they advocated for, but often they came from liberal or radical white allies.[12] In recent years, however, a number of scholars attending to the history of race, health, and civil and social rights have pointed to the importance of understanding the limitations of white liberal approaches to health equity. Following the example of Alondra Nelson, Keith Wailoo, Dennis Doyle and others, this paper will examine both the achievements and the sources of frustration between Safar, Caroline, and the communities they served.[13] It was a fateful irony, as an ex-Freedom House paramedic observed, that the role of poor black neighborhoods in helping establish the field of emergency medicine

11 Many scholars have discussed the history of racial liberalism. As social historian Dennis Doyle argued, "racial liberals expected that racial inequality would decline as African Americans received greater access to public resources." Doyle further contended that the "drive to understand a black patient's social circumstances without reference to race actually blinded [individuals] to racism." For reference, see Dennis A. Doyle, *Psychiatry and Racial Liberalism in Harlem, 1936-1968* (Rochester: University of Rochester Press, 2016).

12 Beatrix R. Hoffman, *Health Care for Some: Rights and Rationing in the United States since 1930* (Chicago: University of Chicago Press, 2013).

13 Alondra Nelson, *Body and Soul: The Black Panther Party and the Fight against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2013); Keith Wailoo, *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health* (Chapel Hill: University of North Carolina Press, 2001). See also Dennis A. Doyle, *Psychiatry and Racial Liberalism in Harlem.*

could be erased so quickly from the national memory.[14] This paper seeks to resuscitate the memory of Freedom House, a grassroots socio-medical program that ended prematurely, as an exemplar of disadvantaged citizens who affected change within their local communities.[15]

RACE, HEALTH CARE AND SOCIAL CHANGE IN THE 1960S

While Peter Safar and Nancy Caroline figured prominently in the history of Freedom House, the social, economic, political, and racial contexts that shaped the paramedics' tenure played an equally important role.[16] Freedom House paramedics were among the least valued in American society: "unemployable" blacks in the path of Pittsburgh's aggressive urban renewal efforts. Though with different emphases, Safar and Caroline galvanized agents and institutions that fit with larger social ideas promoting emergency services—ideas such as equity, equal opportunity and universal access to medical care. Though complex and varied themselves, these local and national trends in health and society helped create an environment which allowed for the emergence of programs such as Freedom House.

Emergency medical care in the 1960s was limited by an undeveloped EMS infrastructure. Morticians and police officers hurriedly transported patients from the community to the hospital in the back of police cars, hearses, and paddy wagons in a process known as "scoop and run."[17] While generally responsive to citizens' calls, these emergency responders lacked formal training and equipment or were trained in outdated modes of resuscitation and unfamiliar with new methods emerging from

14 Nancy L. Caroline, "Emergency! 'Freedom House' Saved Lives – Yours and Theirs, But Now It Is Mostly Shunted Aside and Forgotten," *Pittsburgh Magazine* (1977): 43-86. Caroline Papers, Series V, Subseries A, Freedom House Ambulance Service (Files 40.6-41.7, Mem.22).

15 Ibid.

16 Accounts of the Freedom House Ambulance Service tend to follow one of two narratives and highlight the involvement of either Peter Safar or Nancy Caroline. In the first, the Freedom House ambulance service was a brief experiment representing a pivotal step in the creation of technical emergency response services, modern ambulances and emergency medical systems. Safar's resuscitation research and advocacy work figure prominently in this history. The second account of the Freedom House narrative focuses on the program's role as a continuation of efforts at empowerment from the War on Poverty that lingered on into the Nixon administration with social programs such as Model Cities. In this account, Nancy Caroline — whose career moved from academic medicine more toward social justice over time — is brought to the forefront. This account of Freedom House departs from these separate accounts and discusses the complementary medical and sociological goals of Safar and Caroline, respectively.

17 EMS would eventually evolve into formally trained paramedics adept at evidence-based resuscitation methods. The speedy transfer known as "scoop and run" opposed the views of many early EMS pioneers, who largely advocated practice known as "stay and play." The principle of scoop and run was that patients should be transported to medical and trauma specialists with minimal delay. It prioritized short transport times over stabilizing patients at the scene. This practice grew out of the "golden hour," or the concept that post-traumatic morbidity and mortality increased dramatically during the hour after injury. For Safar, the moments en route to a hospital dramatically influenced morbidity and mortality. See Safar, Esposito, and Benson, "Emergency Medical Technicians." See also Peter Baskett and Peter Safar, "The Resuscitation Greats. Nancy Caroline – From Mobile Intensive Care to Hospice," *Resuscitation* 57 (2003): 119-122.

hospital-based cardiopulmonary resuscitation (CPR) research.[18] Moreover, the lack of uniform standards and reliance on the transportation-without-treatment approach hampered early attendants, resulting in fragmented care and poor outcomes.

In spite of challenges facing emergency services during this period, medical, social and political factors supported its growth. The 1950s was a time of greater national optimism, a sentiment largely influenced by the social activism of the anti-war, civil rights, and women's rights movements.[19] The United States economy grew by 25% between 1961 and 1965, and the Democratic majority increased government spending in tandem. This growth coincided with President Lyndon Johnson's Great Society initiatives, which expanded civil rights, public welfare, transportation, housing, education, urban development, and public health. As the national health care expenditure grew from $12.7 to $71.6 billion between 1950 and 1970, the federal government broadened its focus on the sciences to include health care systems research.[20] Two key pieces of federal legislation, the Hill-Burton Act of 1946 and the Kerr-Mills Act of 1960, increased health expenditures during this time by expanding local hospitals and increasing healthcare access to the poor and underserved populations, respectively. The subsequent establishment of Medicare and Medicaid programs in 1965 extended resources to the elderly, disabled, and poor, complementing the earlier Kerr-Mills Act.[21]

Changes at the federal level further supported the development of Freedom House locally. The Presidential Commission on the Causes of Civil Disorders endorsed a study on race relations and socioeconomic inequality during the 1960s, which concluded that civil disorders such as the urban riots of the 1960s "reflected an inability of black ghetto residents to gain dignity and to share in society's material prosperity."[22] Many people held the premise that all individuals should have access to medical care, irrespective of their ability to pay, a view that transcended partisan differences. In fact, Kentucky, a traditionally conservative state, passed hospital licensing laws in 1961 stipulating that no one should be denied emergency medical care.[23] Though the Emergency Treatment and Labor Act of 1986 was decades away, the impetus for its passage was provided during this post-war period. Thus, the 1960s transformed the economic landscape and opportunity for emergency medicine.

During the post-war period, veteran physicians, adept at translating field advances from the war to civilian practice, likened the emergency room to the wartime nurse-staffed "accident room" for critically ill and injured patients.[24] These facilities were

18 Though cardiopulmonary resuscitation (CPR) has evolved, the CPR promoted by Safar and colleagues at the time was the standard of care. See Safar, Esposito, and Benson, "Emergency Medical Technicians."

19 Anne K. Merritt, "The Rise of Emergency Medicine in the Sixties: Paving a New Entrance to the House of Medicine," *Journal of the History of Medicine and Allied Sciences* 69 (2014): 251-293.

20 The increase in health expenditure from $12.7 to $71.6 billion represented an increase from 4.5 to 7.3% of the gross domestic product. See Merritt, "The Rise of Emergency Medicine in the Sixties."

21 Ibid.

22 Benson, Esposito, Dirsch, Whitney, and Safar, "Mobile Intensive Care by 'Unemployable' Blacks."

23 Merritt, "The Rise of Emergency Medicine in the Sixties."

24 Andrew T. Simpson, "Transporting Lazarus: Physicians, the State, and the Creation of the Modern Paramedic and Ambulance, 1955-73," *Journal of the History of Medicine and Allied Sciences* 68 (2013): 163-197. See also Merritt, "The Rise of Emergency Medicine in the Sixties."

staffed by resident physicians and nurses in civilian hospitals. The expansion of this practice into civilian institutions coincided with the emergence of physician specialists staffing emergency departments in small community hospitals, a practice which preceded the formal specialization of emergency medicine.[25] In fact, the American Board of Emergency Medicine was not formally approved by the American Board of Medical Specialties until 1979.[26]

Physicians were also cognizant of the challenges facing emergency medicine. The National Academy of Sciences-National Research Council (NAS-NRC) Committee on Trauma and Committee on Shock's 1966 publication entitled *Accidental Death and Disability: The Neglected Disease of Modern Society* helped increase awareness of the EMS system. This statement increased public support for emergency services and placed the onus on policymakers to remedy its shortcomings through legislation. As urban historian Andrew Simpson argued, rather than individual agency and technological innovation, government action primarily through the NAS-NRC Committee on EMS and local experiments helped create the national standards for paramedic training. Moreover, the NAS-NRC Committee led to the passage and enactment of the EMS Systems Act of 1973, marking a clear shift in focus from pre-hospital transport to healthcare models of emergency services delivery.[27]

Samuel Neely, M.D., a former military surgeon and chairman of the NAS-NRC ad hoc committee on artificial ventilation, invited Safar to co-develop a new NAS-NRC committee to implement national emergency services guidelines.[28] By 1964, Safar drafted the first guidelines for a community-wide organization for paramedics with the support of the Allegheny County Medical Society, the Health and Welfare Association, and the Hospital Council of Western Pennsylvania.[29] Safar served on the committee from 1961 to 1966 and recognized that local efforts were inadequate without federal guidelines. In response, the NAS-NRC committee published said guidelines in *JAMA* in 1968 that led to the Emergency Medical Services System Act of 1973.[30]

Physicians and policymakers alike recognized trauma as a major public health issue. In 1965, President Johnson established the President's Commission on Highway Safety to study motor accidents.[31] The National Highway and Safety Administration (NHSA), created in 1966, further increased government support for emergency care. Deceleration injuries from high-speed travel increased morbidity, which drew national attention to prevention. In addition to supporting the University of Pittsburgh's curriculum development through the United States Department of Transportation, the NHSA also funded research in Miami, where anesthesiologist Eugene Nagel trained

25 Merritt, "The Rise of Emergency Medicine in the Sixties."

26 Peter Safar, *Careers in Anesthesiology, Volume 5* (Park Ridge: Wood Library-Museum of Anesthesiology, 2000), 232-238.

27 Simpson, "Transporting Lazarus."

28 Samuel Neely coined the phrase "trauma as a neglected disease" in 1957.

29 Peter Safar, "On the History of Emergency Medical Services," *Bulletin of Anesthesia History* 19 (2001): 1-11. See also Safar, *Careers in Anesthesiology*.

30 Safar, "On the History of Emergency Medical Services."

31 Ryan C. Bell, *The Ambulance: A History* (Jefferson: McFarland and Co., 2013).

paramedics under a similar model. By equipping EMTs to provide CPR, read electrocardiograms, and perform defibrillation and other techniques, Nagel's team demonstrated that non-physicians could successfully administer advanced cardiac life support.[32]

The national conversation about public safety continued through the 1970s. In his 1973 State of the Union address, President Richard Nixon shocked the nation by citing that more than 115,000 people died unnecessarily annually. He promised to target EMS systems and improve them, but subsequently vetoed the Emergency Medical Systems Development Act of 1973, arguing that there was no need for the program. Despite the testimony of a group of physicians supporting the initial legislation, Congress failed to override the veto. Nevertheless, Congress introduced a narrower bill (without non-EMS clauses) that was quickly passed and signed into law, securing additional support for EMS.[33]

Despite the fact that the aforementioned advances made some social and health reforms possible, they did not signal "a gradual and inevitable trajectory of evolutionary progress in race relations."[34] Invisible political mechanisms underlying "putatively race-neutral liberal social democratic reforms. . ..and by the more overtly race conscious neoconservative reaction against liberalism. . ." supported destabilizing practices such as urban renewal and white flight.[35]

Though avoidable deaths from inadequate pre-hospital care were common for citizens regardless of their race, social class, or income during the late 1950s and early 1960s, race impeded access to medical care. Racial tensions during the 1960s coupled with a scarcity of resources in predominantly black residential neighborhoods in large cities such as Pittsburgh led social activists throughout the United States to promote social and racial equality (including healthcare) for all Americans. And while both black and white Americans suffered the consequences of inadequate medical care—perhaps best epitomized by the eventual death of Pennsylvania Governor David Lawrence from cardiac coma after sustaining cardiac arrest and collapsing at a public event in 1963—disadvantaged blacks such as Pittsburgh's Hill District residents faced a far greater burden.[36]

Pittsburgh, known for its jazz music and black arts scene, was at the vanguard of the civil rights movement and was the birthplace of Pulitzer Prize winning playwright August Wilson (1945-2005). Wilson set his play *Two Trains Running* in Pittsburgh's Hill District.[37] Although fictional, Wilson's account encapsulated social and political

32 Eugene Nagel, "History of Emergency Medicine: A Memoir," *Bulletin of Anesthesia History* 19 (2001): 1-10. See also Simpson, "Transporting Lazarus."

33 Manish N. Shah, "The Formation of the Emergency Medical Services System," *American Journal of Public Health* 96 (2006): 414-423.

34 Daniel T. Rodgers, *Age of Fracture* (Cambridge: Harvard University Press, 2012).

35 George Lipsitz, *The Possessive Investment in Whiteness* (Philadelphia: Temple University Press, 2006).

36 Joe William Trotter and Jared N. Day, *Race and Renaissance: African Americans in Pittsburgh since World War II* (Pittsburgh: University of Pittsburgh Press, 2013).

37 August Wilson, *Two Trains Running* (New York: Theatre Communications Group, 2007). For additional reference, see Alan Nadel, *May All Your Fences Have Gates: Essays on the Drama of August Wilson* (Iowa City: University of Iowa Press, 1994).

issues critical to Pittsburgh during the 1960s. His protagonist, Memphis Lee, is an African-American entrepreneur described as a "self-made man whose hard work, diligence, persistence, and honesty is consistently challenged by the circumstances of his life."[38] Like many African Americans in Pittsburgh in the 1960s, Memphis Lee is caught in a struggle to maintain ownership of his property in the wake of the city's aggressive urban renewal efforts.

As social historian J. William Trotter wrote in his history of race in Pittsburgh during the late twentieth century, "virtually every institution serving the public discriminated against blacks in some form or fashion," either by excluding blacks from services or restricting their access to services.[39] Although the precise extent to which race limited access to emergency care nationally during this period is unknown, both black and white citizens perceived differences in treatment based on race.[40] Police, morticians, and private ambulance drivers routinely disregarded or turned down service to some areas if they felt unsafe.[41] As one white male nurse employed in Pittsburgh stated,

> Let's face it, the poor areas of the city get the worst type of service in every way, and this includes ambulance service. Most privately-run ambulance services don't like to go into the poor areas. . . Most privately-owned services have white drivers and white attendants. The poor areas are usually black. And on emergency calls you can run into some pretty tough situations, stabbings and shootings, and the like. Many white attendants don't like these calls because of these factors.[42]

Thus, while ambulance service improved access to health care for the general population, black citizens did not realize these advances to the same extent as their white counterparts.

Moreover, Trotter argued that "local law enforcement officials reinforced racial hostility through disproportionately high rates of arrests and incarceration of African American residents."[43] His analysis offers a better understanding of the indignity black Hill District residents may have faced when forced to rely on police officers for transportation to the hospital.[44] Pittsburgh police leaders often defended criticisms of disproportionately punitive treatment of black residents, frequently citing their own difficulties in obtaining convictions for police misconduct. Louis Mason was a black Pittsburgh city councilor who argued that police behavior in Pittsburgh was "too

38 Wilson, *Two Trains Running*, 7.
39 Trotter and Day, *Race and Renaissance*, 14.
40 George Cheever, "Freedom House Ambulance Service: Revolution in Emergency Medical Care," *University Times*, 23 July 1970.
41 Ibid.
42 Richard F. Long, "Ambulance Service Comes to the Inner City," *Publication of the Office of Economic Opportunity*, July 1971, 8-9.
43 Trotter and Day, *Race and Renaissance*, 14.
44 Anita Srikameswaran, "Pioneer Medics to Gather Again," *Post-Gazette*, 7 November 1997.

ingrained with racism to change."[45] Because police provided most medical transport during this period, an authority granted by local leaders after World War II, these systemic racial inequities and fraught tensions with local police officers were often on the minds of Pittsburgh's black citizens.[46]

The high density of poor blacks in Pittsburgh's inner cities was driven by an unemployment rate three times that of working-age whites.[47] Freedom House Enterprises, Incorporated (FHEI) was a predominantly black non-profit corporation whose mission was to increase employment opportunities for underserved citizens in Pittsburgh ghettos.[48] FHEI partnered with Community Action Pittsburgh, which helped attract initial private funds for the ambulance service from the Edgar J. Kaufmann Foundation, Allegheny Conference Foundation, Sarah Mellon Scaife Foundation, Ford Foundation, Falk Medical Fund, Pittsburgh Foundation, and the Office of Economic Opportunity (OEO).[49] The city of Pittsburgh and the OEO provided initial public funds for Freedom House. Each year, Freedom House received $135,000 from the Model Cities action program of the U.S. Department of Housing and Urban Development and $100,000 from the City of Pittsburgh as part of the Manpower Development and Training Act stipends.[50]

The War on Poverty increased the number of black political activists, including social workers, teachers, and government workers.[51] In Pittsburgh, FHEI responded to the issues facing black neighborhoods by providing direct services to the local black community in addition to indirect services to the larger, often white, community.[52] For instance, under the direction of Mr. James McCoy, the organization supported local white businesses threatening to leave the city's underserved areas due to economic hardships, property loss, vandalism, and poor access to insurance coverage.[53] This type of investment was consistent with FHEI's larger mission to "maintain and expand the economic base of the Negro community."[54] This strategy was perhaps necessary, as local schemes by city leadership eventually weakened Freedom House Enterprise's economic base in favor of other priorities.

45 Trotter cited a study by the American Friends Service Committee's Pre-trial Justice Program, "which concluded that African Americans in Pittsburgh were more likely than whites to be charged with a minor offense, confront higher bail amounts, and spend more time in jail awaiting trial."

46 Trotter and Day, *Race and Renaissance*, 125-130.

47 Ibid.

48 Roger Stuart, "Ex-Jobless Rushing to Rescue" *Pittsburgh Press*, 17 November 1968, 1-2.

49 Cheever, "Freedom House Ambulance Service." See also, Dale McFeatters, "'Super' Ambulances Make Debut Here," *Pittsburgh Press*, 8 April 1969. For additional reference, see Long, "Ambulance Service Comes to the Inner City," 1-2.

50 Andrew T. Simpson, "Health and Renaissance: Academic Medicine and the Remaking of Modern Pittsburgh," *Journal of Urban History* 41 (2015): 19-27.

51 Mary E. Triece, *Urban Renewal and Resistance: Race, Space, and the City in the Late Twentieth to the Early Twenty-First Century* (Lanham: Lexington Books, 2016). For additional reference, see Thomas J. Sugrue, *Sweet Land of Liberty: The Forgotten Struggle for Civil Rights in the North* (New York: Random House, 2009).

52 Stuart, "Ex-Jobless Rushing to Rescue."

53 W. Taylor, "In Eight Years, Freedom House Doing Great Job," *New Pittsburgh Courier*, 7 June 1975.

54 "Ambulance Services Continue," *Pittsburgh Courier*, 14 August 1971.

PETER SAFAR AND NANCY CAROLINE LEAD THE FREEDOM HOUSE AMBULANCE SERVICE

As the previous section describes, the development of EMS grew out of the convergence of community activism with advances in critical care medicine.[55] Despite Safar and colleagues' work in cardiopulmonary resuscitation research during the late 1950s, prehospital mortality remained high during the 1960s. Safar attributed this high mortality to inadequate care outside of the hospital.[56] Safar was born in Austria and educated at the University of Vienna.[57] He later trained in surgery at Yale University and in anesthesiology at the University of Pennsylvania.[58] Known as the "father of cardiopulmonary resuscitation," and arguably one of the most influential figures in the history of medicine, Safar gained his reputation as a leader in raising standards for resuscitation in Baltimore, Maryland during the 1950s.[59] He is perhaps best remembered for developing cardiopulmonary resuscitation at Baltimore City Hospital and for establishing the first multidisciplinary critical care unit in the United States at the University of Pittsburgh.

Safar and colleague James Elam, M.D. (1918-1995) advocated for mouth-to-mouth resuscitation largely based on observations of ventilation during the poliomyelitis epidemic.[60] Elam's research demonstrated that tilting the head backwards and applying mouth-to-mouth ventilation were superior to back-pressure-arm-lift methods for ventilation.[61] Safar and Elam went on to develop films and public materials to teach mouth-to-mouth resuscitation to the lay public. They argued that every able-bodied individual above 10 years of age should learn artificial respiration and that lessons should be introduced early and frequently reinforced by the media.[62] He coupled these findings with the contemporaneous development of external heart compression, which led to the development of cardiopulmonary resuscitation in 1960. This enabled him to identify the bystander as the "potentially weakest link in the life-support chain."[63] He proved that

55 Merritt, "The Rise of Emergency Medicine in the Sixties."

56 Peter Safar, "Tribute for Freedom House Enterprises Ambulance Service (Mobile ICU)" [press release]. University of Pittsburgh School of Medicine, Caroline Papers.

57 Peter J. Baskett, "Peter J. Safar, the Early Years 1924-1961, the Birth of CPR," *Resuscitation* 50 (2001): 17-22.

58 Ibid.

59 Srikameswaran, "Pioneer Medics to Gather Again."

60 Nagel, "History of Emergency Medicine." See also, Nancy L. Caroline, "Bringing Them Back Alive and Well, Dr. Peter Safar's New Research Institute Here Will Probe the Deepest Fathoms of Life and Death," *Pittsburgh Magazine*, March 1978.

61 Although Safar's emphasis on ventilation in cardiac arrest was state-of-the-art at the time, ventilation has been demonstrated to not be as important as uninterrupted, high-quality, rapid chest compressions. Moreover, mouth-to-mouth ventilation is not in current cardiac arrest protocols.

62 Caroline, "Bringing Them Back Alive and Well."

63 Peter Safar was not the first physician to describe prehospital care and emergency systems as the "weakest link" in trauma care. A member and former chairman of the American College of Surgeons Committee on Trauma, Robert H. Kennedy, M.D. first used the term in the College's 1954 Oration on Trauma. For additional reference, see Brian J. Zink, *Anyone, Anything, Anytime: A History of Emergency Medicine* (Philadelphia: Mosby Elsevier, 2006). See Caroline, "Medical Care in the Streets," 43-6. See also Safar, "On the History of Emergency Medical Services." For further historical reference, see Bell, *The Ambulance*.

mouth-to-mouth ventilation and CPR were superior to other techniques of manual resuscitation.[64] Not only could the lay public learn these techniques, but also they could perform them safely, consistently, and effectively in emergency situations.

As a critical care physician, Safar was interested in resuscitation principles inside the intensive care unit. His work demonstrated, however, that pre-hospital care and intensive care were opposite ends of a continuum of critical care medicine. As such, he believed that further developments in intensive care were limited by high prehospital morbidity and mortality. Thus, he shifted his clinical and organizational focus to the precarious moments before hospital arrival.

Although many cities contributed to the development of EMS, Pittsburgh played a significant role. Local Pittsburgh leaders, concerned about African Americans' access to medical care in general and emergency medical transport in particular, approached Safar during the late 1960s for counsel on acquiring vehicles to transport black residents to the local Presbyterian Hospital for checkups.[65] A leader in mobile intensive care unit design, Safar also understood the mortality and morbidity in underserved neighborhoods. He recognized this as an issue of poor access to health care and a potential avenue to expand emergency services locally and nationally. He agreed to provide his expertise on EMS design in exchange for the opportunity to train underemployed Hill District residents as EMTs. In this way, Safar procured a vehicle to test plans for a national EMS training program through the Hill District community, while community leaders secured support for local ambulance services.

The National Research Council formally endorsed the Freedom House Enterprises training course in 1968. The course taught disease diagnosis and recognition, rescue techniques, and common field encounters.[66] Donald Benson, M.D. was appointed the founding medical director in 1967, while James McCoy and Robert Zepfel served as president and project director, respectively. Benson was one of Safar's critical care fellows from 1968-1969. His interest in EMS began as a medical student in the early 1960s.[67]

The federal government provided the initial funds for Freedom House. Governmental funding agencies required that employees were selected through the Opportunities Industrialization Center (OIC), an organization founded in 1964 on the principle of self-help.[68] OIC provided employment and life skills training, instruction,

64 Safar, "On the History of Emergency Medical Services." See also, Nagel, "History of Emergency Medicine."

65 Ibid.

66 Caroline, "A Year in the Life of the FHE Medical Director." See Benson, Esposito, Dirsch, Whitney, and Safar, "Mobile Intensive Care by 'Unemployable' Blacks." See the Caroline Papers: Correspondence from Nancy Caroline to Professor Prentis; Caroline, "Bringing Them Back Alive and Well;" Caroline, "The Conception, Birth, Crucifixion, and Resurrection of an Ambulance Service;" Caroline, "The Pittsburgh EMS Disaster;" Correspondence from Nancy Caroline to Peter Safar (1974-1975), Caroline Papers, Series V, Subseries A, Freedom House Ambulance Service (File 29.4).

67 Benson, Esposito, Dirsch, Whitney, and Safar, "Mobile Intensive Care by 'Unemployable' Blacks." See also Safar, "Tribute for Freedom House Enterprises Ambulance Service (Mobile ICU)."

68 H.A. Muller, "An Emergency Health Services System for Pennsylvania," *Para-Medical Journal*, Fall 1975.

and greater economic opportunity for disenfranchised citizens.[69] The OIC was unable to recruit a sufficient number of participants, however, which allowed Safar and Benson to recruit directly from the Hill District and formalize their employment through the OIC. This was a major criticism of FHEI by physician leaders of the program, who resented the fact that the organization's leadership (comprised of members of the business community), rather than physician leaders, assumed responsibility for trainee selection and recruitment.

The trainees provided 24-hour service to Pittsburgh's Hill District and Oakland police districts.[70] Of the 70 applicants, 25 candidates, ranging from 18 to 66 years of age, were eventually selected as trainees.[71] Each had a limited employment history with low paying or menial jobs, and many did not possess a high school diploma.[72] Freedom House defined underemployed individuals as those engaged in part-time work with little success in securing full-time work and individuals working full time with a gross annual income less than $3,000. At the end of the course, which ran concurrently with high school equivalence degree programs, 17 of the 21 eligible students received equivalency diplomas.[73]

The training program was an intensive 32-week course.[74] The first 16 weeks consisted of general education provided by the Pittsburgh Board of Education, while the second half of the program consisted of EMS material in addition to both standard and advanced Red Cross first-aid courses.[75] The roughly 300-hour classroom course was followed by nine months of field training.[76] Safar directed the hospital-based technical curriculum and the first class of Freedom House paramedics started orientation in June of 1968. The clinical phase of the training started in two districts beginning in July 1968. Freedom House paramedics saw a large volume of patients during the first year of operations, with 5,868 total calls between 1968 and 1969.[77] Of these calls Freedom House paramedics transported 4,647 patients, 366 of whom had life threatening diseases and injuries. Calls were dispatched from the Presbyterian University Hospital Emergency Department and a satellite station at nearby Mercy Hospital.

Several years after the start of Freedom House, Safar's growing renown in the field of critical care medicine garnered the attention of Nancy Caroline, a young and enterprising physician who hoped to train in Safar's critical care program at the University of Pittsburgh. Caroline was educated at Radcliffe College (Harvard College) in

69 Safar, Esposito, and Benson, "Emergency Medical Technicians as Allied Health Professionals." See also Muller, "An Emergency Health Services System for Pennsylvania."

70 "Full Ambulance Service Set in Hill, Oakland," *Pittsburgh Post-Gazette*, 2 July 1968.

71 Benson, Esposito, Dirsch, Whitney, and Safar, "Mobile Intensive Care by 'Unemployable' Blacks." See also Safar, Esposito, and Benson, "Emergency Medical Technicians as Allied Health Professionals."

72 Caroline, "The Conception, Birth, Crucifixion, and Resurrection of an Ambulance Service."

73 Benson, Esposito, Dirsch, Whitney, and Safar, "Mobile Intensive Care by 'Unemployable' Blacks."

74 Ibid.

75 Cheever, "Freedom House Ambulance Service." See also "Full Ambulance Service Set in Hill, Oakland."

76 Cheever, "Freedom House Ambulance Service."

77 Benson, Esposito, Dirsch, Whitney, and Safar, "Mobile Intensive Care by 'Unemployable' Blacks." See also, Nagel, "History of Emergency Medicine." For additional reference, see Caroline, "Whatever Became of FHE?"

Cambridge, Massachusetts, and completed her medical education and training at Case Western Reserve University in Cleveland, Ohio. In 1974, she entered a critical care fellowship program at the University of Pittsburgh.[78]

Safar recruited Caroline to direct Freedom House while she completed her critical care fellowship. Although Freedom House was started six years prior to Caroline's arrival, she led a major overhaul of the EMS curriculum, restored a sense of stability to the program and expanded the program's teachings nationally in her three years as medical director. She resonated with the program's socio-medical goals, especially the opportunity to care for a disadvantaged population while providing meaningful work for underemployed blacks in the inner city.[79] She had previously participated in civil rights events in the southern United States and lunch sit-ins in the north and understood that Freedom House was an opportunity to improve the city's medical care while simultaneously encouraging black enterprise.[80]

Later considered the "mother of paramedics," Caroline believed that "an individual is as much the physician's patient when he is injured and lying on the street as when he appears at the physician's office or is seen in the hospital."[81] Her views on physicians' responsibilities were rooted in the belief that over time, physicians had retreated from patients most in need. Doctors, she argued, largely abdicated their responsibility to treat patients wherever they were ill or injured.[82] For Caroline, physicians assumed a moral responsibility for the welfare of patients, although care delivered by skilled technicians "under strong physician command via radio [was] as good as what the physician [could] do at the scene."[83] And her work with Freedom House was unique in that she provided direct medical oversight by participating in rides with trainees. She quickly realized that trainees needed a broader education in the basic diagnosis of disease if they were to recognize and treat a wide range of common emergency conditions. This training stressed basic concepts such as recognizing important vital signs, performing triage, developing clinical acumen, and exercising clinical judgment.[84]

78 Baskett and Safar, "The Resuscitation Greats." See also Eugene Nagel, Mickey Eisenberg, and Barbara Ward, "The Mother of Paramedics: A Tribute to Nancy L. Caroline, MD," *Emergency Medical Services* 32 (2003): 30-32.

79 For Caroline's formal writings, see Caroline, "A Year in the Life of the FHE Medical Director." For additional correspondence, see Correspondence from Nancy Caroline to Professor Prentis. See also Baskett and Safar, "The Resuscitation Greats." For Caroline's history of the FHE service, see Caroline, "The Conception, Birth, Crucifixion, and Resurrection of an Ambulance Service." For additional reference, see Correspondence from Nancy Caroline to Peter Safar (1974-1975), File 29.4.

80 Correspondence between Nancy Caroline and Eugene Nagel, Caroline Papers, Series V, Subseries A, Freedom House Ambulance Service (File 54.11).

81 Nagel, Eisenberg, and Ward, "The Mother of Paramedics."

82 Nancy L. Caroline, "Quo Vadis, Rampart One?" *Journal of the American College of Emergency Physicians* 6 (1977): 376-379.

83 "The Pioneers of EMS: Legends, Leaders, Visionaries," *Intercom*, Vol Fall 2003: Emergency Medical Services Institute.

84 Caroline's model of riding with EMTs on ambulance calls continued and was carried forward in the emergency medicine residency program founded by Ronald Stewart, M.D. where resident physicians responded to EMS calls by radio and drove to the scene in sport utility vehicles to join paramedics and assist in providing care. See Safar, *Careers in Anesthesiology*. See also Caroline, "A Year in the Life of the FHE Medical Director." Correspondence from Nancy Caroline to Peter Safar (1974-1975);

Caroline officially assumed the leadership of Freedom House in 1973, after several years of fragmented and interrupted leadership. Safar had spent a year on sabbatical, while Benson took a leave to serve in the military. Caroline wrote that Freedom House trainees exhibited low morale, partly due to inadequate leadership and partly due to concerns about whether the program would continue to receive adequate funding. She felt her first task was to reestablish order, increase morale, and promote accountability, which she accomplished by monitoring every call and marking every report, asserting herself with a constant presence. She instated an unpopular debriefing session during which each paramedic presented cases to peers, a practice which held paramedics accountable for their errors and omissions in the field. These changes had the effect of increasing group morale, instilling a sense of individual and shared responsibility, and ultimately supporting trainees' professional identity as EMTs.[85]

As the beginning scene of this paper demonstrates, emergency room reporting accounted for a significant part of trainees' work. Caroline's training program focused on oral presentations, demonstrating the importance of clear, concise and compelling communication. To be sure, they were initially discouraged in this practice by what they perceived as disrespect during their interactions with nurses and physicians. The paramedics' growing proficiency and skill afforded them with greater control in later clinical interactions. Over time, trainees such as the gentleman who opened this paper flourished and Caroline took pride in knowing that this new cadre of black medical professionals—previously deemed unemployable—had gained a level of respect by the medical staff. Freedom House trainees, medical directors and hospital leadership understood that EMTs must confront not only the difficulty of navigating a previously undeveloped professional role, but also do so as black men and women within a traditionally white larger medical profession.[86]

Although Freedom House paramedics faced racial antagonism in some of their clinical encounters, the historical record suggests that their overt racial challenge came from their interactions with white colleagues, and to an equally significant extent, the police force, fire departments and city leadership simultaneously working behind the scenes to undermine their professional legitimacy. Yet race also functioned within Freedom House in some encouraging ways. Freedom House trainees' daily lives and experiences undoubtedly shaped their self-perceptions and how they viewed their own work. As one Freedom House trainee affirmed, "When I go into some of the poor, black neighborhoods, the kids gather around to talk to me. They are impressed to see a black

Correspondence from Nancy Caroline to Professor Prentis; Caroline, "The Conception, Birth, Crucifixion, and Resurrection of an Ambulance Service."

85 Caroline, "A Year in the Life of the FHE Medical Director." See also, Correspondence from Nancy Caroline to Peter Safar (1974-1975); Caroline, "Adventures in the Ambulance Trade," FHE articles and correspondence, 1972-1979, Caroline Papers, File 40.7; Nancy Caroline, "Will the Real Paramedic Please Stand Up?" *Emergency Medical Services*, March 1977.

86 Though both men and women were employed by FHE, men accounted for the vast majority of paramedic positions. According to the Pittsburgh Courier, Darnella Wilson was one of six female paramedics, and was the city's first black female paramedic. Pearl Porter was another woman who trained as a paramedic. At least eleven women served as dispatchers while others were employed as secretaries. See R. Suber, "Black Female Paramedic Hopes to be City's First," *Pittsburgh Courier*, 6 March 1976.

man like myself in a responsible position. Their attitude is 'gosh if he made it, maybe I can.'"[87] For the first time in many of the previously unemployable citizens' lives, they made decisions that were important to the wellbeing of a society in which they historically felt excluded.

LOCAL RESISTANCE TO EMS EXPANSION IN PITTSBURGH

Pittsburgh Mayor Joseph Barr's tenure spanned 1959 to 1970. Barr largely supported initiatives that benefitted black residents, including police restraint in the riot of 1968, the War on Poverty programs, fair housing laws, rent withholding programs, the Manpower Development and Training Act funds for Pittsburgh, and general support for black political organizations. Blacks were growing increasingly frustrated, however, by the slow pace of change. Blacks voted largely Democratic and NAACP president Byrd Brown touted the fact that the largest voting bloc in Allegheny County comprised black residents.[88]

Though African Americans saw some social improvements under Mayor Peter Flaherty's tenure from 1970 through 1977, including fair housing provisions and increased numbers of blacks in municipal offices, his administration also supported policies and programs that were often at odds with black voters. These policies included reductions in social welfare programs and the transfer of a large proportion of federal funds to priorities for which blacks had little support, including "police and fire departments, which continued to resist federal affirmative action mandates and hired few blacks."[89]

Pittsburgh politics were not lost on Safar, who often saw politics as a necessary means to an end. The majority of the problems that Caroline later inherited in 1975 were political in nature, including inadequate funding and escalating tensions between Freedom House and the municipal government, problems which were ongoing since Freedom House's inception. Safar grew frustrated by the city's reluctance to permanently fund Freedom House well before Caroline. He criticized the city administration for not permitting paramedics to perform ambulance work without police interference, and for not allowing Freedom House to train police personnel to provide higher acuity care for districts in which they were privileged. He and Benson led an open attack on Mayor Peter Flaherty in 1973. In their letter, Benson and Safar called the police ambulance service a "disgrace" and rallied for action on the public's behalf.[90]

Although Safar and Benson's letter was successful in encouraging the mayor to institute police training in resuscitation, the policy had little effect on police practices. Police officers still maintained control of emergency communications and withheld from Freedom House the opportunity to work with often the most severely ill and

87 Long, "Ambulance Service Comes."

88 Ibid.

89 Ibid.

90 Peter Safar, Letter to Mayor Peter Flaherty, RE: Urgent need for Pittsburgh ambulance service improvements, Caroline Papers, 4 April 1973.

injured patients.[91] Police were required by city ordinance to transport patients to the nearest hospital. Many community hospitals, however, lacked advanced coronary care units; many patients referred to these community hospitals with limited resources often received inadequate care.[92] By contrast, Freedom House was not beholden to the city requirements and could transport patients to hospitals capable of providing appropriate care. They were also more comfortable with longer commutes because they were able to provide initial care at the scene and for patients en route to the hospital.[93]

Freedom House technically had contractual privileges to take calls in three of the city's districts, but were only called in these districts for minor cases. Even then, police officers would hurry them along to quickly transport patients to and from hospitals. As Caroline's personal notes reveal, she initially attempted to remedy the discrepancy between their stated and actual privileges through official channels. She made personal trips to speak with the police administration. Despite reassurances, however, Freedom House did not receive additional calls until Caroline purchased a police radio to monitor police calls and respond to the calls uninvited. When Freedom House arrived at the scene at the same time as police without invitation, the EMTs merely dismissed the fact as a coincidence and offered their services unsolicited.[94]

Some police officers favored Freedom House simply because they felt emergency medical transportation was a distraction from more pressing police matters. Over time, however, police observed the skills of the Freedom House paramedics in comparison to their own and began to recognize their limitations in caring for the critically ill. They also recognized the superior skill and adeptness of the Freedom House paramedics. Eventually police officers routinely requested Freedom House personnel during high acuity cases—even in districts to which Freedom House was not assigned.[95] Caroline recounted one radio communication in which a police officer requested Freedom House at the location of an incident in the Forbes neighborhood, which was outside of their assigned district. Freedom House overheard the conversation and instructed the dispatcher to inform police the EMTs were on their way to the scene. When a private ambulance intercepted the incident, the dispatcher asked the officer if Freedom House should be called off. The officer replied: "Hell no! We need someone here who knows what they hell they're doing."[96] Trotter echoed similar attitudes towards Freedom House, writing "understandably, when whites in the area called for emergency care, they would sometimes tell the dispatcher to 'send Freedom House.'"[97]

Public support for EMS expansion was largely biracial and bipartisan. Daniel Berger, president of the Pittsburgh chapter of Americans for Democratic Action, spoke in favor

91 Mattie Trent, "Incorporates Concepts Developed by Freedom House," *Pittsburgh Courier*, 6 December 1975. See also Dolores Frederick, "Lives Hinge on Better Emergency Care, Wecht Says," in *The Great Ambulance Debate*, *Pittsburgh Press*, 15 May 1973.

92 Nagel, "History of Emergency Medicine."

93 "Too Often, Distress Call Brings Ride to Eternity," *Pittsburgh Press*, 23 July 1972.

94 Caroline, "Bringing Them Back Alive and Well." See also, Caroline, "A Year in the Life of the FHE Medical Director;" Caroline, "Emergency!" Files 40.6-41.7, Mem. 22.

95 Caroline, "Emergency!"

96 Ibid.

97 Long, "Ambulance Service Comes."

of expanding Freedom House citywide before the Pittsburgh City Council. He argued that surplus funds from 1973 were available and could be used to fund Freedom House's expansion until the program could acquire more stable funding and eventually become self-sufficient. Such a funding structure was a major limitation for the program throughout its existence. As Freedom House grew increasingly dependent on soft funds, it was forced to earn additional money by transporting patients for elective hospital transfers. At the same time, the city government objected to spending tax funds on EMS, arguing that emergency care was the responsibility of the county.[98]

The grounds for the city's resistance to Freedom House had much to do with suburban fire departments, which were not supportive of the program.[99] Safar and colleagues had initiated the nation's first Community Council on EMS because Safar believed emergency services needed full-time staffed professionals to advance his ideas. Suburban fire departments believed that the council's goals (influenced by Safar) would eventually require them to retrain or would consider their training insufficient. The close-knit fire departments then pressured the county commissioners and local authorities to obstruct Safar's efforts, despite Safar's ability to seize deferral grant dollars for the region to upgrade ambulances services and equipment through the council.

As a result of these political pressures from suburban departments, Mayor Barr and his unsympathetic city administration reduced the city's annual grant from $100,000 to $50,000.[100] Several private grants were either reduced or discontinued altogether, which was perhaps more devastating than the city's cuts. Although the FHE board did not officially dissolve the program until 1975, the program's funding challenge began to grow in intensity in 1970, when Peter Flaherty succeeded Joseph Barr as mayor. The Community Council on EMS hoped to improve the region's EMS standards to the level developed by Freedom House.[101] The fate of the council was compromised in 1971 when the city's withdrawal of sponsorship disqualified the council from receiving federal planning grants of up to $160,000.[102]

As the circulating majority newspapers of the time demonstrate, both FHE leaders and EMS council members understood that Freedom House's federal funds were solely provisional. After the federal funds were to be discontinued in 1975, Freedom House would have to secure funding through emergency council programs.[103] The city administration's withdrawal caused Freedom House to lose $700,000 in grants from the NHSA. As a result, the EMS council had to secure matching funds from the U.S. Department of Transportation and U.S. Department of Health, Education and Welfare.

98 Aki Mukaili, "Freedom House, Mobile Medicine's Best," *Pittsburgh Courier*, 1 December 1973, 1-2. See also, Trent, "Incorporates Concepts."

99 Trent, "Incorporates Concepts."

100 Dolores Frederick, "Telemetry Keeps Doctor, Emergency Unit in Touch," *Pittsburgh Press*, 25 July 1972, 1-2.

101 Caroline, "A Year in the Life of the FHE Medical Director."

102 Henry W. Pierce, "Emergency Care Upgrading Urged," *Pittsburgh Post-Gazette*, 15 February 1972. See also, "Emergency Situation," *Pittsburgh Post-Gazette*, 15 July 1972. For further reference, see "Hunt Says No to Ambulance Fund Proposal," *Pittsburgh Post-Gazette*, 19 October 1972.

103 Dolores Frederick, "District Lets Medical Service Funds Slip Away," *Pittsburgh Press*, 27 July 1972.

William Hunt, M.D. was a retired surgeon and the commissioner of Allegheny County. He opposed funding the council and rejected its plans to expand the services citywide, on the grounds that the county "look[ed] askance at any kind of program where there is prolonged obligation when federal funds run out." [104] Thus, Hunt feared that the city's sponsorship of the council and EMS service would obligate the county to fund Freedom House indefinitely. Furthermore, Hunt argued, the city was not legally permitted to "provide primary medicine through the Health Department."[105]

Safar and Hunt vocally and publicly disagreed. Safar claimed that Hunt misrepresented the county government's authority, which at the time gave the commissioner responsibility for "health, safety, and welfare."[106] Safar accused the county of misinterpreting its authority as a general mandate "for controlling communicable diseases only."[107] In response, Hunt suggested that the city devise a hospital-based network of ambulance services to incorporate volunteer fire departments and police departments. The council rejected his proposal, arguing that the volunteer training did not meet federal standards. Nevertheless, Hunt did not believe the volunteer ambulance services needed the additional training proposed by the council.[108]

The council and the city administration reached an agreement in October 1972, whereby the city commissioner would sponsor the council's federal grant application provided the county would not be obligated to provide primary medical care. The commissioner's agreement also stipulated that volunteer fire and police departments and private agencies were included in all levels of a citywide EMS system.[109] As a result of the agreement to upgrade EMS standards, tensions escalated in the ensuing months. By spring of 1973, newspapers throughout Pittsburgh covered the tense relationship between Safar and police chief Robert Colville. Flaherty accused the university's continued criticism of the police's ambulance service of being politically motivated. Further inciting tensions, Safar released a letter to Flaherty criticizing the police force, signed by 22 physicians and community leaders. Police superintendent Robert J. Coll, Jr. defended the work of the police administration.[110]

Colville argued that Safar's expectations were unreasonable, that police were not given additional training in medical care beyond the Red Cross course, and that police responded to EMS demands largely because the medical community had gradually abdicated its responsibility to care for patients over the preceding 20 years.[111] He accused Safar of vilifying police because of the medical community's own short-sightedness. Yet Safar wanted control of the police training, even offering to train the policemen to his

104 Ibid.

105 "County Lagging on Emergency Health Aid Plan," *Pittsburgh Post-Gazette*, 26 September 1972. See also Frederick, "District Lets Medical Service Funds Slip Away."

106 Dolores Frederick, "Ambulance Training Step Up Ok with FOP," *Pittsburgh Press*, 3 May 1973.

107 Ibid.

108 Ibid.

109 Dolores Frederick, "Emergency Care Plans Okayed," *Pittsburgh Press*, 26 October 1972. See also "Hunt, Pitt Doctor Trade Views in City Ambulance Service Battle," *Pittsburgh Press*, 6 May 1973, A22.

110 Trotter and Day, *Race and Renaissance*, 127.

111 Thomas Hritz, "Flaherty Calls Pitt Blast on Ambulances Political," *Pittsburgh Post-Gazette*, 28 April 1973.

exacting standards at no cost to the city. He argued that the police department's ten-hour Red Cross first aid training course was "barely [at] the Boy Scout level," which conveniently exempted them from civil liability under the Pennsylvania Good Samaritan Act.[112]

Safar was perhaps most frustrated by the fact that his own city's administration failed to implement standards that its citizens helped achieve in 1968. Safar cited Columbus, Ohio, Seattle, Washington, and Nassau County, Long Island, New York, as cities that implemented these standards with great success. He proposed that he and other physicians would teach police and civilian trainees, which would upgrade the EMS standards without an increase in taxes or county expenditures. Safar asked the city to reallocate its $1.5 million in funding from police salaries and fees to private companies to fund a city-wide expansion based on the Freedom House model. This reallocation and cooperation between the city and council, he argued, would raise the city's EMS delivery standards to the national standards.[113]

Hunt argued there was no need for change and that reasonable individuals disagreed with Safar's contention that the EMS standards were national standards.[114] Safar chastised Hunt as uninformed, and challenged Hunt to prove that the police could pass the most basic qualifications of the American Registry for Emergency Medical Technicians—qualifications that Freedom House trainees not only met, but helped establish.[115]

Freedom House began preparing for its phase-out of service in May 1974. Funding from Model Cities grants and the council arrived too late to change the course of its inevitable dissolution. Colville attempted to regain full control of the city's ambulance service for the police during this time without providing the police additional training, while the Freedom House board president Paul Williams negotiated with Flaherty to secure employment for Freedom House paramedics.[116] In a letter to Paul Williams, Flaherty wrote "FHE resolved September 22, 1975 to cease operational services of FHE as effective 10/15/75."[117]

While the city administration had favorable regard for the FHE model and its achievements, this appreciation was nonetheless limited by race, socio-economic considerations, and a larger desire for control of EMS operations. Moreover, the city's expanded ambulance service (referred to as the superambulance service) that replaced Freedom House was essentially an implementation of the Freedom House model. The most noticeable difference between the superambulance and Freedom House was its makeup. That is, Freedom House was primarily staffed by indigent blacks from Pittsburgh, whereas the superambulance was only about 40% black. Moreover, of the

112 Dolores Frederick, "Emergency Care Progress Bypasses City," *Pittsburgh Press*, 2 May 1973. See also, Dolores Frederick, "Just How Much is a Life Worth?" *Pittsburgh Press*, 13 May 1973.

113 Ibid.

114 See "Hunt, Pitt Doctor Trade Views in City Ambulance Service Battle."

115 Frederick, "Just How Much is a Life Worth?"

116 Dolores Frederick, "City's 5 'Super Ambulances' Ready for Road, But Await Plan," *Pittsburgh Press*, 18 August 1975. See also "Aid May Fail to Stall End of Ambulances," *Pittsburgh Post-Gazette*, 7 June 1974. For additional refernece, see "Council Seeking Ambulance Plan Info from Pete," *Pittsburgh Post-Gazette*, 20 June 1974.

117 "Ambulance Service to Expand by January," *Pittsburgh Courier*, 1976.

26 trainees who signed a contract to work with the city, only 12 remained as employees a few months later. Though Flaherty cited financial constraints as the primary reason for not implementing Freedom House's citywide expansion, he proposed hiring salaried police officers earning between $12,000 and $14,000 annually compared to Freedom House EMTs who had earned between $8,000 and $9,000. This police expansion doubled the city's annual operating costs for the police-run service.[118]

Although the city administration explained their withdrawal of support for Freedom House during the 1970s as economics-driven, racial factors likely influenced their decisions. Employing predominantly white policemen, firemen, and superambulance participants was costlier than expanding through the Freedom House program. Moreover, an all-black paramedic service that set national standards, led by medical leaders who pioneered the development of those standards was undoubtedly seen as a threat to the financial and professional well-being of white suburban paramedics. As one paramedic exclaimed "If this was a mostly white organization, I don't think this thing would be happening."[119]

Mayor Peter Flaherty was succeeded by Richard S. Caliguiri in April 1977. Caliguiri immediately began the city's transition to the citywide ambulance service.[120] Furthermore, the city invested $4.5 million annually into the program for maintaining training, vehicles and services. These new paramedics, mostly private citizens, were trained under the city's new model in collaboration with former Freedom House leaders, utilizing state of the art EMS equipment, a helicopter, and a communications system capable of receiving calls from a centralized radio command.[121]

Mayor Caliguiri promoted an economic development and urban renewal vision that supplanted the city's reliance on the manufacturing industry with the service industries.[122] He was largely successful in this endeavor, creating new university collaborations and public-private partnerships. While this plan allowed greater use of venture capital and public monies to support the growing research and development, biotechnology, and medical research industries in the region, it did so at the expense of many of the social and economic empowerment programs that had characterized the prior period. Thus, the factors leading to the demise of the Freedom House experiment were deeply rooted in the resistance of the city leadership and its changing priorities under the new economic development plans.[123]

118 Caroline, "Emergency!" In addition, see "Ambulance Service to Expand by January," Robert Flipping, "City Policemen to Assume Freedom House Tasks," *Pittsburgh Courier*, 8 June 1974. See also, Suber, "Black Female Paramedic Hopes to be City's First;" Trent, "Incorporates Concepts Developed by Freedom House."

119 Trotter and Day, *Race and Renaissance*, 128.

120 Safar, "Tribute for Freedom House Enterprises Ambulance Service (Mobile ICU)."

121 "Partners for life," *Pittsburgh Post-Gazette*, 1978.

122 Simpson, "Transporting Lazarus."

123 Ibid.

WHAT HAPPENED TO FREEDOM HOUSE?

This account relies primarily on Safar and Caroline's writings—a form of archival bias which could be remedied in future studies through oral histories of paramedics, residents, advocates, and civic leaders. To approach the Freedom House archive, then, it is imperative to acknowledge the limitations of this methodology and examine with some caution the statements of founders whose writings might overstate its unfortunately foreshortened legacy. Freedom House was a unique and unusual confluence of different interests, motivations, and expertise scarcely referenced in history. This paper has so far highlighted the comparable, yet different visions represented by Safar and Caroline—one represented by Peter Safar's desire for bureaucratic efficiency and change, and the other by Nancy Caroline's quest for social justice. Outside Freedom House Enterprises, both the initial successes and the unfortunate demise of the program were dependent on difficult compromises that the Pittsburgh academic medical center struck with the changing initiatives of the city's government—compromises that bent, often tacitly, to the pressure of racial divisions within the city.

Safar's contribution to the history of Freedom House is one of importing emergency services to a poor neighborhood in the rustbelt city of Pittsburgh. This came about because Safar's interest in prehospital care grew out of earlier work in critical care, and, by extension, cardiopulmonary resuscitation. Earlier in Baltimore, he developed ideas and techniques to train unlikely persons (e.g., ten-year-old children) to perform life-saving medical interventions that were previously only under the purview of American doctors.[124] Later, in Pittsburgh, he advanced similar ideas about prehospital care, training unemployable blacks to pioneer emergency medical services.[125]

Safar's writings suggested awareness of the problems facing disenfranchised blacks in the United States. He acknowledged the complex interplay of race, health and society in the 1960s, in which resources "tend to become particularly taxed in ghetto districts" as a result of the especially "appalling conditions among the nation's underprivileged."[126] Although Safar's early writings suggested Freedom House's sociologic goals were central to its mission, his later writings suggested that race was not as strong an anchor for him. In an unpublished manuscript, Safar wrote:

124 Caroline, "Bringing Them Back Alive and Well."

125 While the historical record does not address how Safar constructed the term "unemployable," it was ostensibly synonymous with underemployed or unemployed to describe otherwise disenfranchised blacks in the job market. This paper challenges this assumption given Safar's separate acknowledgement of underemployed compared to unemployable (which arguably denoted a more intrinsic character). This is evident in Safar's statement that "prior to entering the training programs, few of these unemployed or underemployed students possessed 'marketable' skills, and all reported chaotic work histories. We considered a person 'underemployed' if working part time and looking for full-time employment, or working full time and making less than $3,000 per year." Furthermore, black newspapers at the time often used other terms such as "ex-jobless." Safar also suggests that the unemployable individuals of Freedom House were not initially sought for job placement. He acknowledged that "although a physician from the program participated in the screening, he exercised little choice, since the primary goal remained selection of unemployables." Moreover, Freedom House was unable to recruit sufficient volunteers with initial screening criteria, which enabled its medical directors to go into the future trainees' neighborhoods to find individuals willing to participate in the program.

126 Benson, Esposito, Dirsch, Whitney, and Safar, "Mobile Intensive Care by 'Unemployable' Blacks."

> What makes an ambulance service effective? What enabled the Freedom House Service to save some lives (fewer than it could have) and to achieve national acclaim, was primarily the life support capability and professional conduct taught the EMTs by a few devoted physicians, primarily Drs. Benson and Caroline. The medical leadership, not the fact that it was a black service, catalyzed EMS developments at local, state and national levels, in spite of the obstacles. Some members of the Freedom House Board repeatedly stated that "some physicians and paramedical leaders associated with the University Health Center made their careers through Freedom House and then abandoned it." This is a ridiculous and absurd statement. The fact is that most of these individuals were "famous" before they initiated the Freedom House program and their (gratis) initiating, frustrating efforts over the years made Freedom House what it was, not the reverse. Without the combination of interests in 66/67 described above, and without the motivation to combine medical and sociologic goals, we would have found another existing ambulance service to test and implement the evolving national standards.[127]

Safar was clear in this assessment that the success of Freedom House owed more to its physician leadership than the racial composition of its predominantly black fleet. Furthermore, he acknowledged that the Freedom House board felt the white physicians were using the program as a professional stepping stone, whether or not they were already "famous."[128] And Safar held firmly that the goals achieved by Freedom House would have been demonstrated by other existing services.

Safar's public disputes with then-city commissioner Hunt further illustrated his established priorities. Safar's arguments to Hunt focused on the city's obligation to its citizens, its reluctance to approach national standards, and its abandonment of the community's "health, safety, and welfare."[129] Safar did not use race as a prima facie reason to advocate for the expansion of Freedom House. He did not cite the dignity trainees gained nor the successes of black Freedom House trainees in earning high school, college and graduate nursing, physician assistant, and public health degrees. Thus, while his public writings reflected his view of Freedom House as a race-conscious socio-medical experiment, his unpublished works and his political efforts underscored his focus on medical rather than sociological goals of Freedom House. The eventual success of disadvantaged and disenfranchised citizens made the case for the implementation of a national EMS system more compelling. At the same time, Freedom House achieved Safar's national standards with federal funds earmarked for war on poverty initiatives, while Safar simultaneously held positions about Freedom House that minimized the significance of socio-economic disparities for black citizens.

On the contrary, Safar defended the disproportionate success of white Freedom House employees and leaders compared to their black counterparts. White trainees left

127 Safar, "The Freedom House Saga," Caroline Papers.
128 Ibid.
129 Frederick, "Ambulance Training Step Up Ok with FOP."

Freedom House to achieve high-ranking administrative positions within the city at a far higher rate than black employees. White alumni Glenn Cannon and Rick Orange became director and assistant director of the City of Pittsburgh Mobile Intensive Care Unit (MICU) Service, respectively; Gary Fulton became the training coordinator for the city of Pittsburgh's paramedics, and Gary Burnworth became director of the Valley Ambulance Authority.[130] In fact, despite the racial implications of Freedom House's demise, Safar doubled down on how unimportant race was going forward in the same manuscript:

> Sociologically, needs and opportunities have changed. From the beginning of the Civil Rights Movement until the recent past, blacks had to find security and demonstrate their strengths and capabilities largely through group action, such as the predominantly black FHE service. More recently, training and job opportunities for blacks in health care careers have improved. Also formerly all-black services like FHE, have increasingly appointed non-blacks.[131]

Safar's aforementioned assertion that training and job opportunities for blacks were improved contradicted the employment outcomes of his own trainees at the demise of Freedom House. Furthermore, he did not seem to appreciate the detrimental effect of previously black self-help organizations, such as Freedom House, transitioning to organizations that chiefly supported white trainees. Thus, it is not surprising that Safar did not anticipate the ultimate outcome of his negotiation to include suburban fire and police departments in plans for a citywide expansion —the eventual exclusion of the black Freedom House EMTs who pioneered his exacting standards.

Although well-intentioned, Safar's tendency to assume an understanding of black citizens' circumstances while simultaneously proclaiming that black Americans "unite in effort with non-blacks and thereby catalyze equal opportunities for minorities and the evolution of American Society in general. . .and thereby further the black cause more than he could by working in a purely black organization" is misinformed at best and dangerous at worst.[132] This echoes the analysis of Dennis Doyle's study of the paradoxes of the historical relationship between white progressive Jewish psychiatrists and African-American mental health activists in early twentieth-century Harlem, although the stakes of racial politics had shifted somewhat in 1960s-1970s Pittsburgh.[133]

Safar's vision for an emergency medical system based on efficiency included (and eventually excluded) unemployable blacks because Safar understood that laymen — indeed children — could save lives with adequate training by experts.[134] When Freedom House Enterprises leaders approached Safar to enlist his expertise in designing ambulances to transport black residents to nearby hospitals, he recognized an opportunity to test emergency standards in the same population. While he acknowledged

130 Caroline, "Whatever became of FHE?"
131 Safar, "The Freedom House Saga."
132 Ibid.
133 Trotter and Day, *Race and Renaissance*.
134 Caroline, "Bringing Them Back Alive and Well."

the sociological goals, his stated views on the significance of race for EMS work suggested he was more concerned with Freedom House's medical goals. Thus, most importantly, he envisioned Freedom House would demonstrate that paramedic-staffed MICUs with superior ambulance design and equipment were feasible, could achieve desirable health outcomes, and could be implemented nationally to reduce prehospital morbidity and mortality.

Like Safar, Caroline's experiences also helped her to perceive the social circumstances plaguing black citizens of Pittsburgh and to air these grievances with the Freedom House board. In an unpublished manuscript, Caroline opined that Freedom House "should have been the success story of the century."[135] While eulogizing the Freedom House Ambulance Service, she extolled the black paramedics "who gave so much of themselves during eight years. . . [and] cleared the path for the kind of paramedic services now glorified. . ."[136] Yet Caroline also acknowledged the perceived failures of the very system for whom these men and women worked. In terms far more strident than Safar, she lamented that rather than being supported in their pursuit of professional and socio-economic advancement, Freedom House paramedics "have been shunted aside, forgotten, left to return to the street corners and watch the parade pass them by."[137]

Caroline developed a sympathy for African-American community organization during her prior involvement in the civil rights movement in Ohio. She had lived among predominantly black communities and treated black families in the underserved areas of Cleveland, Ohio as a medical student.[138] And she continued this involvement in promoting racial equity during her tenure at Freedom House where she rode with the paramedics in the streets and became intimately familiar with their socio-economic and racial hardships. Thus, it is not surprising that Caroline's writings reflected a deeper consciousness and awareness of the unique struggles of the Freedom House paramedics compared to Safar. She was committed to the black paramedics and held close to her commitment to Freedom House. She grew frustrated with the persistence of racial politics and with the preferential treatment of the city's predominantly white ambulance service. When working in local EMS no longer met the social ideals to which she ascribed, she turned her attention to the ways she could improve medical care internationally.

How do the complex relationships Safar and Caroline had with Freedom House — as both medical directors of the program whose goal was to address a health need in the black community and as social advocates for the disenfranchised unemployables — help explain the outcome of Freedom House? The contradiction between Safar's narrative of mutual social and medical progress and his view that race was secondary to the goals of Freedom House may explain his efforts to advocate for the continuation of the program. On the other hand, Caroline clearly identified more with her role as a social advocate for disadvantaged blacks. Unlike Safar's minimization of race at the demise of

135 Caroline, "Whatever Became of FHE?"
136 Ibid.
137 Ibid.
138 McCormick, Ricci, and Sullivan, "An Evaluation of a Model Ambulance Service."

Freedom House, Caroline highlighted the disparate outcomes between black and white paramedics:

> For eight years, they had stuck with the organization while they watched white trainees leave FHE to assume high administrative positions with City and County EMS agencies. . .. They [white trainees] had all done their apprenticeship with FHE, and now they were in control and Freedom House was odd man out.[139]

And Caroline lamented the paths many were forced to take at the dissolution of Freedom House, with many "back on the streets, looking for work and remembering."[140] While she did not discuss race specifically in her final address to Freedom House personnel at the time of its demise, she nevertheless empathized:

> All of you. . . have profoundly affected thousands of lives: the young and the old, the wealthy and the indigent, the prominent and the anonymous—you have served them all, and for eight years you have provided them with a quality of prehospital care unequalled anywhere in this city. You have weathered setbacks, disappointments, uncertainties and frustrations to build an advanced life support service which is second to none.[141]

Safar and Caroline were strong advocates for improving medical services that increased health care access in marginalized black communities and for developing a program that benefitted black trainees while challenging pathologizing notions such as Moynihan's culture of poverty theory.[142] Yet Safar and Caroline also worked alongside groups with limited means of protecting themselves. Thus, the two leaders operated from a position of privilege where they reaped disproportionate benefits from the partial successes of the program while the Freedom House paramedics carried the disproportionate burden of its failure.

CONCLUSION

Reflecting on the history of the Freedom House Enterprises Ambulance Service shows how it readily became a symbol hope for many citizens, irrespective of race and class. Safar, Benson, Caroline, and Pittsburgh's community leaders led a revolution in American public health and emergency medical care. By enlisting African Americans from the lowest social ranks and training them to become paramedics who would eventually help establish the national standards for EMS, Freedom House proved that ordinary individuals could be trained effectively to exacting standards of patient care.

139 Caroline, "Whatever Became of FHE?"

140 Ibid.

141 Ibid.

142 Daniel Geary, *Beyond Civil Rights: The Moynihan Report and its Legacy* (Philadelphia: University of Pennsylvania Press, 2017). See also, Daniel Aksamit, "How the Pathology Became Tangled: Daniel Patrick Moynihan and the Liberal Explanation of Poverty since the 1960s," *PS: Political Science & Politics* 50 (2017): 374-378.

Though both Caroline and Safar had comparable goals for social and economic advancement, their differences in perspective influenced their complex relationship with the Freedom House service. Caroline rode with the paramedics in the streets. Thus, she could speak with authority when she affirmed the thousands of lives Freedom House saved. By becoming their friend and advocate, she was able to recount the setbacks, disappointments, and anxieties they faced over those eight years.

Despite Safar and Caroline's understanding of the social circumstances, their experiences riding with personnel on ambulances, or their knowledge of the racial politics of Pittsburgh, neither could effectively marshal their disparate efforts to place racial progress at the center of the arguments to expand Freedom House throughout the city. To be sure, Safar and Caroline's different backgrounds, perspectives, and motivations did not appear to have a negative effect on the day-to-day operations of Freedom House. And their comparable goal to set national standards and meet sociological goals were partly realized. Thus, the history of Freedom House serves as an example of the importance of linking social and medical initiatives in medicine, and illustrates in part the mutually influencing ways in which health and social life undergird the social welfare of the community.

While explicit in their efforts to promote matters of health and address racial inequalities, Safar and Caroline operated in a context that made it difficult for them to avoid being complicit in the practice of exploiting the largely poor, black community. The inherent contradictions in the two leaders' positions on Freedom House foreshadowed the contradictions inherent to the organization in which the former won out and was transferred to a white paramedic service (and led Caroline to take her social justice vision overseas). These contradictions expose the limits of liberal policies to remedy racial disparity when designed chiefly by well-meaning white allies who themselves benefitted from the inequity of their relationship with their poor, disenfranchised subjects.

While some Freedom House paramedics went on to productive careers in healthcare, education, business and administration, still others did not fully realize the dream of social progress that Freedom House leaders set forth. Safar and Caroline unfortunately fell short in sustaining Freedom House. Yet the history of their successes and failures—which enabled previously unemployable persons to directly improve the lives of thousands of citizens—equally deserves to be resuscitated. And though forgotten by many, the legacy of Freedom House still rings loudly in the howling sirens stretching across the United States today.

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