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A Phenomenological Study of Customs and Border Protection Officers' Perspectives and
Their Influence on Becoming an Emergency Medical Technician

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A Phenomenological Study of Customs and Border Protection Officers' Perspectives and
Their Influence on Becoming an Emergency Medical Technician

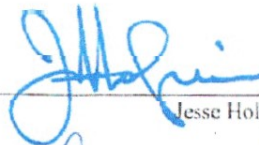
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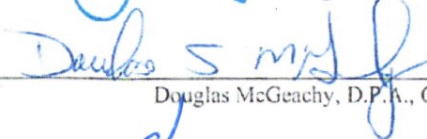
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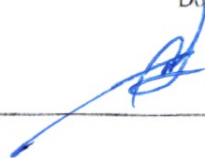
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ABSTRACT

U.S. Customs and Border Protection is the major agency regulating commerce and travel in the United States. Although one of its primary foci is intercepting illicit goods and people, it also provides another important public service—responding to medical situations when encountered. Customs and Border Protection has employees who are also emergency medical technicians though this number is small. The purpose of this phenomenological study was to explore the motivational factors for Customs and Border Protection officers who are also emergency medical technicians. The theoretical framework for this study was based on self-determination theory. A purposeful sample was used to recruit participants for in-depth interviews. Although there are emergency medical technicians in other states and other components of Customs and Border Protection, this study only focused on officers working in California. Results from this study revealed three motivating factors and five benefits for participants. The researcher also discovered people’s lack of knowledge of EMS within Customs and Border Protection as a major challenge for participants. The researcher recommended basic education explaining what EMS encompasses in Customs and Border Protection and raising awareness of its benefits. This study can be expanded by conducting similar studies with other components and states in Customs and Border Protection to determine whether there are similar results. In turn, this study can be used to improve the agency’s response to medical situations.

Keywords: motivation, law enforcement, emergency medicine, emergency medical technician, EMT, emergency medical services, EMS, first responder, self-determination theory, communication

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I am thankful for CBP in giving me the chance not only to learn and grow as a first responder but also to understand what it means to be an effective public servant.

DEDICATION

This study is dedicated to my parents, Raymond Wai-ming Ng and Irene Ng.

Thank you for your continued guidance and wisdom in life.

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CHAPTER 1: INTRODUCTION

The purpose of this phenomenological study was to explore the motivational factors of U.S. Customs and Border Protection officers (CBPOs) who take on the additional role as an emergency medical technician (EMT). This chapter begins with the background to the study, statement of the research problem, purpose statement, research questions, significance of the problem, definitions, and the organization of the study.

Background

The U.S. federal government underwent a series of changes in the aftermath of the September 11 terrorist attacks. Among them was the creation of the White House's Office of Homeland Security that later evolved into a "stand-alone, Cabinet-level department to further coordinate and unify national homeland security efforts" (U.S. Department of Homeland Security [DHS], 2022, Department Creation section, para. 2). Of the 22 different federal departments and agencies that make up DHS, the largest component is U.S. Customs and Border Protection (CBP, 2022a), an agency with over 60,000 employees.

As one of the world's largest law enforcement agencies, CBP's (2022a) primary mission is to keep "terrorists and their weapons out of the U.S. while facilitating lawful international travel and trade" (para. 1). With such a huge undertaking, it is not surprising to see that CBP is also made up of its own components to help achieve this critical objective. All components are instrumental to CBP's overall success, from the lesser known forensic scientists working under the Laboratories and Scientific Services Directorate to the frontline personnel who interact most with the public: Border Patrol agents (BPAs), air interdiction agents/marine interdiction agents (AIAs/MIAs), and

uniformed employees from the Office of Field Operation (OFO), namely CBPOs.

Among these three, CBPOs are perhaps the most recognized by the public because of their work locale. Unlike their BPA and AIA/MIA counterparts, CBPOs are stationed at 328 ports of entry in all 50 states, U.S. territories, and six foreign countries (CBP, 2021b, 2022b). BPAs, on the other hand, are primarily assigned to the physical and geographical borders separating the United States from Canada and Mexico. AIAs/MIAs are similarly established.

In addition to the immigration and customs laws CBP enforces, it is also expected to perform a litany of other tasks. One such example is the COVID-19 pandemic, which occurred at the time of this study. Even prior to the pandemic, CBP was responsible to recognize sick travelers who might be carrying deadly diseases, requiring the “timely identification and reporting to state and federal health authorities” (Fishbein et al., 2010, p. 649). Spanning two presidential administrations, this lingering pandemic had forced CBP into the uncharted territory of enforcing Title 42 of the United States Code, “which prohibits entry into the United States when the Director for Disease Control believes ‘there is a serious danger to the introduction of [a communicable] disease into the United States’” (Flores, 2021, para. 1). Although this role is not usually handled by law enforcement, protecting the public from a communicable disease still falls under CBP’s responsibilities. However, Fishbein et al. (2010) raised legitimate concerns with how “CBP personnel have competing priorities and limited public health training” (p. 649). This issue is further exacerbated by the back-and-forth rhetoric between CDC and CBP with the denial of sickly persons. Although CBP can deny them entry, it is rarely done without indisputable evidence or expert recommendation.

Another type of situation CBP encounters on a regular basis is travelers experiencing medical emergencies. In fiscal year 2018, “Officers assigned to ports of entry along the California border with Mexico provided medical assistance to 967 travelers in distress” (CBP, 2019, para. 1). This clearly illustrates the importance of having personnel who possess some level of medical training.

CBPOs are typically assigned to their ports of entry. They differ from police officers who have vast patrol areas to cover although larger ports such as Los Angeles and Long Beach seaports require CBPOs travelling several miles from one shipping terminal to another. However, this does not suggest that CBPOs are any less prepared than their police counterparts in case they encounter someone experiencing a medical emergency. With medical emergencies comprising a significant number of calls for police departments to respond to, there is a growing trend of using them in assisting EMS providers during contact with people in medical distress (Hawkins et al., 2007; Husain & Eisgenburg, 2013). Providing quality medical assistance in the prehospital setting can be key to patient survival. In a case in which a person is suffering from cardiac arrest, CPR must be started

within two minutes. After three minutes, global cerebral ischemia (the lack of blood to the entire brain) can lead progressively worsening brain injury. By nine minutes, severe and irreversible brain damage is likely. After 10 minutes, the chances of survival are low. (Brouhard, 2020, para. 6)

Response times from EMS providers vary upon the port of entry. There can be virtually no wait time in large airports where a rescue team from multiple agencies is already staged at the jet bridge ready to retrieve a patient. In remote land ports of entry,

however, it can take several minutes for the one local EMS agency to arrive and initiate care. This does not bode well for patients who are suffering from life-threatening conditions requiring immediate care. Fortunately, CBPOs possessing medical training and initiating care are an essential part to the chain of survival for patients. Starting basic lifesaving measures, such as CPR, utilization of an AED, and in some cases, even performing advanced life support services, greatly prolongs a patient's chance of survival before the arrival of local EMS and subsequent transport to the proper medical facility, typically a hospital, for definitive care and treatment.

There are four levels of EMS certification. In order of progression, they are emergency medical responder (EMR), EMT, advanced emergency medical technician (AEMT), and paramedic (National Highway Traffic Safety Administration [NHTSA], 2007; National Registry of Emergency Medical Technicians [NREMT], n.d.-a). EMRs were not included in this study because they only “perform basic interventions with minimal equipment” (NREMT, 2021, p. 2). The amount of training and time to the next level of EMT is significantly higher and more involved. Furthermore, California “does not regulate EMR programs. The lowest level of EMS training they handle is EMT” (Beating Heart Center, n.d., para. 4). CBP operates in a similar fashion, delineating between EMRs and EMTs.

Statement of the Research Problem

A great deal can be accomplished in 60 min. People can exercise, read a book, take a nap, catch up with friends over the phone, spend quality time with family, study the Bible—the possibilities are endless. On the other hand, the same 60 min can also offer grief: being stuck in a long-winded classroom lecture, waiting in line at the

Department of Motor Vehicles, travelling less than a couple of miles in rush hour traffic—possibilities at this end also know no bounds.

Now imagine the following: a mentally ill man slowly waded into public bay waters in the presence of onlookers. Emergency responders were called and arrived at the scene to assess the situation. For 60 min, the same aforementioned 60 min, firefighters and police simply stood by and did nothing as they and other shocked witnesses watched the man drown. As unbelievable as this sounds, this incident unfortunately occurred in Alameda, California. Although there are excuses and speculations for why first responders failed to rescue this man in crisis, one explanation does carry merit. After “budget cuts forced the department to discontinue water rescue training and stop maintaining wetsuits and other rescue gear” (Thanawala, 2011, para. 6), there were no properly trained personnel and equipment to initiate a rescue. Even if there was a first responder who was previously trained and had prior experience, the first responder would be violating agency policy and possibly facing disciplinary action because

their procedures are guided by a 2003 water rescue policy, drafted by the island agency’s fire labor management team. Among other restrictions, only certified rescue swimmers could enter the water for a rescue, no matter how deep in the ocean. Each fire engine would have a rescue swimmer on board ready for deployment. (Gafni, 2011, para. 15)

Furthermore, a 2009 memo warned firefighters not to enter waters to initiate a rescue or search under any circumstances because of a certification lapse (Gafni, 2011). Even the division chief admitted his actions would have been different if the incident

occurred off duty, but his on-duty response would have required him to stay within his department's policies and procedures (Gafni, 2011). As a result of this incident, a new policy was implemented immediately "allowing an on-scene commander to decide how to respond to water distress calls" (Gonzales, 2011, para. 10). Unfortunately, this was too late for the drowned victim.

Unlike a policy failure artificially blocking a person's natural tendency to help, there is a psychological barrier when it comes to medical situations. In general, people may fall victim to the bystander effect during these emergency occurrences. In general, people may fall victim to the bystander effect during these emergency occurrences. Darley and Latané (as cited in Cieciora, 2016) identified three reasons that influence a person's decision to intervene: "diffusion of responsibility, diffusion of blame, and thinking that another person is already taking action to help" (para. 6). Of these three reasons, "the belief that another bystander in the group will offer help" (Emeghara, 2020, Diffusion of Responsibility section) is perhaps the main reason people decide not to help. CBPOs are trained to respond to a variety of emergencies, including those that are medical in nature. Unfortunately, they are not exempt from the bystander effect, albeit to a lesser degree, because of their expectation to respond. However, having little or no medical training and equipment can mean the difference between life and death as evidenced grimly in the Alameda drowning case.

In addition to proper training and necessary equipment, there are some situations in which time also plays a major role. Examples of such situations are medical emergencies in which patients often have only a few precious minutes before their chances of survival decrease significantly. In severe trauma cases, the term *golden hour*

is the tenet “that an injured patient has 60 minutes from the time of injury to receive definite care, after which morbidity and mortality increase significantly” (Rogers & Rittenhouse, 2014, p. 11). Popularized by a U.S. military surgeon who specialized in trauma, the term golden hour has a natural tendency to be associated with traumatic injuries, especially during military combat. However, the golden hour is also applicable in nontraumatic emergencies.

Acute ischemic stroke patients who were treated within 60 min from the onset of symptoms led “to excellent outcomes in all patients, irrespective of age and pre-existing comorbidity” (Advani et al., 2017, p. 1). However, there is also skepticism whether treatment within the golden hour has a positive impact on trauma patients. Lerner and Moscati (2001) stated there “are no large, well-controlled studies in the civilian population that either strongly support or refute the idea that faster is universally better in trauma care” (p. 759). According to Newgard et al. (2010), there is “no association between EMS intervals and mortality among injured patients with physiologic abnormality in the field” (p. 235). Despite the lack of scientific evidence supporting the golden hour tenet, the effectiveness of trauma care is still time dependent on a rapid response (Collopy et al., 2015; Hoemeke et al., 2021; Navarro, 2011). Some first responders even take traumatic injuries one step further with the “platinum 10,” which occurs in the first 10 min of the golden hour.

In severe cases such as a femoral bleed, one liter of blood can be lost in 1 min, placing a person “into Stage II Hemorrhagic Shock and that can drop your chances of survival down to 14%” (Davis, 2018, para. 9). The average adult has about 4.5 to 5.5 liters of blood (Geggel, 2016, para. 2). For context, a person suffering this type of injury

without intervention will bleed out faster than half the time required to properly brush the teeth. Although timely responses for any emergency are important, the researcher agrees that emphasis should be placed on well-used rescue time such as determining whether one has the right tools to stabilize a patient (Collopy et al., 2015; Klein et al., 2019).

Medical situations that are not trauma related are classified as medical. Similar to trauma, some medical instances require an immediate intervention, such as the aforementioned acute ischemic stroke. Another medical-based emergency is those people suffering from a heart attack. The most critical aspect for heart attack patients is to begin CPR with emphasis on chest compressions to help “move oxygen in the blood to the brain” (Thrasybule, 2020, para. 3). Furthermore, the average time for EMS to respond is between 6 and 9 min, which unfortunately corresponds to the reduced chances of survival when the brain has been deprived of oxygen after 5 to 10 min (Thrasybule, 2020). The importance of timely responses cannot be overstated when it comes to medical emergencies regardless of whether they are trauma or medical based.

As a public agency, CBP does a disservice when it fails to provide an adequate medical response to those who need it. The Alameda drowning case, when multiple responders failed to produce some sort of rescue plan for 60 min, illustrates this stigma. Fortunately, there are CBPOs who are also trained EMTs. When a medical emergency occurs, these CBPO EMTs temporarily put away their law enforcement personalities and instead turn on their medical mindsets when responding. Unfortunately, the number of CBPO EMTs represent only a small number when compared to the entire workforce.

Through participant interviews, this study investigated common themes or reasons influencing participant decisions to become EMTs. Although there are studies that

investigate the motivational factors influencing individuals working in specific occupations, there is an absence of literature with law enforcement professionals voluntarily supplementing their skill sets with what can be considered a second occupation in medical training and knowledge. This is not to say these hybrid officer positions do not exist—quite the contrary in fact. According to Hilal and Jones (2014), “While integrated first responder agencies are not necessarily a new concept, it is estimated that a very small number of jurisdictions have fully integrated functions of law enforcement, fire suppression, and emergency medical services” (para. 1). However, it can be understood that the few agencies Hilal and Jones cited as being fully integrated are due to the condition of employment and not to part of an individual’s independent willingness to take on additional roles after an initial hiring.

Self-determination theory (SDT) served as the framework for this research. The theory “grew out of the work of psychologists Edward Deci and Richard Ryan, who first introduced their ideas in their 1985 book” (Cherry, 2021, para. 6). According to Deci, “Self-determination refers to a person’s own ability to manage themselves, to make confident choices, and to think on their own” (Lopez-Garrido, 2021, para. 2). The pinnacle of SDT is when individuals become autonomously motivated. This can be achieved through intrinsic or extrinsic motivation means. Deci identified three basic psychological needs in autonomous motivation that people need “in order to achieve psychological growth” (Cherry, 2021, para. 10). These three needs are autonomy, competence, and relatedness.

Currently, the decision to become an EMT in CBP is completely voluntary. Although CBP does offer limited opportunities and training for individuals expressing

interest to become an EMT, it is not guaranteed because candidates must pass a test administered by the NREMT. Moreover, being an EMT is considered a collateral duty in CBP. A collateral duty confers no added benefit, financial or otherwise. For this reason, many employees tend to avoid having one because they see it as having more work. Some collateral duties are pertinent to the agency's operational success, such as vehicle maintenance, radio updates, or firearms inventory. This type of collateral duty is mandatory and typically assigned by management to officers whom they consider are responsible and trustworthy. Other collateral duties, such as being an honor guard or chaplain, are not considered operationally necessary and therefore not required.

Strangely, EMTs are also part of this nonessential collateral group despite the copious amount of training required. Regardless, autonomy is demonstrated by participants' independent will to become an EMT. Participant competency is measured by the ability to intervene and provide treatment to travelers suffering from medical distress. At a minimum, participants have achieved a competency requirement because of achieving the passing score to become a certified EMT. Field experience further adds to the competency of participants. Lastly, the theory was used to analyze participant feelings and attitudes in determining whether there is a connection to other EMTs.

Purpose Statement

The purpose of this phenomenological study was to explore the perspectives, experiences, and reasons that influence CBPOs at ports of entry in California to take on additional role as an EMT.

Research Questions

The following two research questions guided this study:

1. What are the perceived motivational factors that contribute to one becoming an EMT?
2. What are the perceived benefits of becoming an EMT as a CBPO?

Significance of the Problem

Public safety is a complex subject. Its definition and role are dependent upon the person being asked. However, certain characteristics about public safety are generally understood and widely accepted, with law enforcement and EMS being the prominent mainstays of public safety. The Bureau of Justice Statistics (2021) describes law enforcement as “the agencies and employees responsible for enforcing laws, maintaining public order, and managing public safety” (para. 1) and EMS is “a system that provides emergency medical care” (NHTSA, n.d., para. 1). Both services have clearly defined goals and purposes. The ways gone about achieving them are challenging enough individually for public administrators, let alone when they are combined.

The data collected in this study could be beneficial to CBP in two areas as a public service agency. First, the ability to increase CBP’s effectiveness as an overall organization through the use of its EMTs can be achieved with the results of this research. Administrators can incorporate some or all the motivational factors and benefits into an officer’s position to attract more employees showing interest in receiving medical training.

Although it is beneficial to have employees trained at the EMT level, it may not be entirely practical, especially at ports with limited resources. However, having some level of medical training is still better than not having any at all. In turn, medically trained CBPOs can then be called upon to respond independently or assist other agencies

during a medical emergency. This is especially useful at more rural ports where local EMS arrival and subsequent transport to a hospital may take longer compared to urban areas.

Administrators can also address specific concerns from CBPO EMTs in cases in which there are conflicting duties such as suspending treatment on a patient to continue processing travelers. New policies can be created in an effort to minimize such conflicts between CBPO EMTs and management as well as avoiding potential lawsuits from patients whose treatment was abruptly stopped.

Second, CBP's legitimacy can be further strengthened. As a uniformed agency, officers tend to be looked up to as first responders when something unfortunate occurs, such as crimes, vehicular accidents, active shootings, plane crashes, and medical situations. Failing to perform its main objective in addition to a host of other responsibilities associated to law enforcement delegitimizes CBP as a public agency.

With ports of entry in all 50 states, U.S. territories, and six foreign countries, it is reasonable to state that public perception of CBP is, at the very least, visible and known. The data from this study can help CBP refine its EMS directives and policies so during a medical emergency, a uniformed CBPO EMT providing medical care can perform in a competent and uniform manner. This reassures the public that CBP is a well-prepared agency ready and able to respond to any situation that arises.

Having increased legitimacy and effectiveness is a boon to any organization. Moore (1997) originally stated various ways for public organizations to "increase their value to the public in both the short and the long run" (p. 10). In over 2 decades, these methods have remained unchanged, Mark Moore reiterating them as "the addition of new

outputs or functions” (Harvard Kennedy School Executive Education, 2019, 3:52).

CBP’s creation itself is an example of this in the aftermath of the September 11 terrorist attacks.

Creating and integrating an EMS program within its mission is the latest endeavor in CBP’s continuance of adaptability. However, the program is still in its infancy.

Without a doubt, mistakes will be made. At times, these growing pains can be overwhelming, and the decision to abandon the program may be tempting. These are not valid reasons to do so. Issues should not be ignored or avoided, rather, they should be embraced and used as learning opportunities to improve upon the program. The data from this study were aimed to help CBP refine its EMS program. Ultimately, this results in CBP becoming a more legitimate and more effective public service agency.

Definitions

Advanced Life Support (ALS). “Advanced Life Support (ALS) is a set of life-saving protocols and skills that extend beyond Basic Life Support (BLS). It is used to provide urgent treatment to cardiac emergencies such as cardiac arrest, stroke, myocardial infarction, and other conditions” (ZOLL Medical Corporation, n.d., para. 1). “ALS procedure includes invasive interventions, such as endotracheal intubation for airway management, and intravenous catheters for drug and fluid delivery” (Kondo et al., 2021, p. 2).

Basic Life Support (BLS). “Basic Life Support, or BLS, generally refers to the type of care that first-responders, healthcare providers and public safety professionals provide to anyone who is experiencing cardiac arrest, respiratory distress or an obstructed airway” (American Red Cross, n.d., para. 1).

Emergency Medical Services (EMS). EMS is a general term used to describe “a system that provides emergency medical care” (NHTSA, n.d. para. 1).

Emergency Medical Technician (EMT). An EMT, less commonly referred to as an emergency medical technician-basic (EMT-B), is “to provide basic emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation” (NHTSA, 2007, p. 20). Typical duties for an EMT include but are not limited to using airway adjuncts, documenting patient medical histories, assisting with oral glucose for suspected diabetes illnesses, and applying specialized garments for fracture stabilizations (NHTSA, 2007).

Advanced Emergency Medical Technician (AEMT). An AEMT, expands upon the scope of practice an EMT-B can perform. In addition to the basic duties, an AEMT can provide “limited advanced emergency care” (NHTSA, 2007, p. 21). Some duties an AEMT can perform that an EMT-B cannot include but are not limited to using an airway adjunct in areas other than the trachea and establishing intravenous and intraosseous access (NHTSA, 2007).

Paramedic. Paramedics, uncommonly known as EMT-P, is typically the highest level of a prehospital medical provider. In addition to performing the tasks of an AEMT and EMT-B, a paramedic’s “primary focus is to provide advanced emergency medical care for critical and emergent patients who access the emergency medical system” (NHTSA, 2007, p. 21). Some procedures paramedics are authorized to perform include but are not limited to starting medications for patients and performing endotracheal intubations (NHTSA, 2007).

Prehospital Care. Prehospital care “encompasses a range of related activities, including dispatch, response to the scene by the ambulance, treatment and triage by EMS personnel and transport to a care facility via ground and/or air ambulance” (Varghese, 2020, p. 70). The tenet to prehospital care is that the EMS rendered to a patient is performed at the scene of the incident. These actions can include concerned persons simply dialing 9-1-1 to report a medical emergency, layman bystanders performing CPR on an unconscious teenager at a pool party, or experienced paramedics stabilizing a conscious victim from a major vehicle crash.

Organization of the Study

The study examined the motivational factors that influence CBPOs to become EMTs. This chapter introduced the background to the study, statement of the research problem, purpose statement, the research questions, significance of the problem, and the definitions. Chapter 2 reviews the literature relevant to the study, including specific overviews of CBP and EMS. The theoretical framework is also discussed thoroughly. Chapter 3 details the methodology of the research, including the population, research sample, and limitations. Chapter 4 presents the data collection and findings of this research. Chapter 5 concludes with the major findings of the research and recommendations.

CHAPTER 2: REVIEW OF THE LITERATURE

Customs and Border Protection (CBP) is a large, complex agency, and EMS is also a multifaceted topic. This chapter reviews the relevant literature of both subjects with the goal of providing a thorough understanding of them. In addition, literature for self-determination theory (SDT) is also discussed in detail in this chapter.

The first section provides the details of CBP's Office of Field Operations (OFO). The second section examines the defining characteristics of EMS and highlights the key requirements of being a certified EMS professional. The concluding section examines the theoretical framework.

Overview of CBP OFO

As DHS's largest member, CBP is similarly composed of multiple components (see Appendix A). Within its makeup, the

Office of Field Operations (OFO) is the largest component in CBP and is responsible for border security—including anti-terrorism, immigration, anti-smuggling, trade compliance, and agriculture protection—while simultaneously facilitating the lawful trade and travel at U.S. ports of entry that is critical to our Nation's economy. (CBP, 2022e, para. 2)

OFO employees can be found at all 300 plus ports of entry. Although Customs and Border Protection officers (CBPOs) make up the majority of OFO employees, CBP Agriculture Specialists (CBPASs) and Customs and Border Protection Technicians (CBPTs) are also included. As their title suggests, CBPASs are focused primarily on importation hazards associated agricultural commodities, but their training also includes “their targeting capacity and efforts to detect agricultural and biological terrorism-related

materials” (CBP, 2020, p. 4). CBPTs’ duties are broader, allowing them to be placed wherever they are needed.

CBPTs provide “a full range of technical and clerical activities in support of functions and program of the office” (CBP, 2020, p. 4). CBPTs can be found working on the frontline beside CBPOs and CBPASs but can also be found working behind the scenes performing “cashier duties, fee collections, timekeeper functions, local property officer duties, and vehicle management” (CBP, 2020, p. 5). CBPASs and CBPTs play an integral role to CBP’s overall success, but they do not carry firearms because of their specific duties in CBP being “fundamentally different from law enforcement” (CBP, 2020, p. 10). Therefore, responses to any type of incident including medical situations are initially performed by CBPOs to ensure scene safety.

The duties and responsibilities for CBPOs vary greatly from port to port. Large ports enable managers to formulate specialized teams and units. Conversely, small ports do not have this luxury. CBPOs at smaller ports are often burdened with additional tasks, known as collateral duties, many of which are administrative in nature. Some of these are mundane, even monotonous. For example, a CBPO assigned to conduct a biweekly inventory count of PPE instead of roving and conducting random enforcement inspections is not an efficient use of resources. This collateral duty can be easily completed by a CBPT, especially if the PPE is located within a secure storage room on government property.

Collateral duties are also unequal. Some are more involved than others. In the case of the collateral duty safety officer (CDSO), it is legally mandated that “each agency provide training for collateral duty safety and health personnel and all members of

certified occupational safety and health committees commensurate with the scope of their assigned responsibilities” (National Archives and Records Administration, 2022a; Webpage ECFR Content). Because of this requirement, both DHS and CBP have directives permitting their employees who are assigned as CDSOs to take official work time to perform safety-related duties and training (U.S. Department of Homeland Security, 2008).

CBP Emergency Medical Technician Roles

In comparing an emergency medical technician (EMT) with a CDSO, they share some general characteristics. They both fall under the categories of health and safety. They both require formal training and continuing education to maintain proficiency. However, one crucial difference between them is that a CDSO is mandatory whereas an EMT is not, even though “more than 1,200 USBP agents and 275 CBP Officers have voluntarily taken on the additional responsibilities and training required to maintain EMT or paramedic certifications as a collateral duty” (“Assessing the Adequacy of DHS Efforts,” 2020, p. 14). Although the total number of CBP EMTs represents only a fraction of its entire workforce, there is something to be said about these individuals who decided to take on this added role, with CBP’s first EMT class being offered and taught in 2019 (Mason, 2019). The goal of this study was to identify the factors that motivate CBPOs in becoming EMTs.

Selected Overview of EMS

EMS is an enormous subject that branches off into many different subtopics and cross disciplines. It would be a great feat of ingenuity to condense such a topic into something manageable to read, but this study only focused on the few aspects of EMS in

the United States relevant to this research. This section provides a brief history and evolution of EMS in the United States, the current status of EMS at the prehospital setting, and the key characteristics of being an emergency medical professional.

EMS History

EMS in the United States has progressed since its earliest inception, but there is still room for improvement. Evidence of this can be seen by the lack of standards in becoming an EMS professional, which is dependent upon local jurisdictions.

The concept of EMS arose during wartimes. As early “as the Greek and Roman eras, chariots were used to remove injured soldiers from the battlefield” (Institute of Medicine, 2007, p. 31). However, the benchmark for “modern EMS is considered to have started with Jean Dominique Larrey, Napoleon’s chief physician, who organized a system to treat and transport injured French soldiers” (Shah, 2006, para. 2). Larrey realized “leaving wounded soldiers on the battlefield for days without treatment dramatically increased morbidity and mortality, weakening the fighting strength of the army” (Institute of Medicine, 2007, p. 31).

This model was also replicated during the U.S. Civil War when “the Union Army developed an organized system to evacuate soldiers from the field” (Shah, 2006, para. 3). After the Civil War ended, the concept of transporting sick and injured people remained in the civilian world. In 1865, Cincinnati became the first city in the United States to offer ambulance service, and New York City followed suit 4 years later (Suess, 2018). Unlike today, ambulances were primarily associated with patient transport—only the most rudimentary medical care was given, if any. It took a century before the EMS finally had its first major reform.

NHTSA

Up until the 1960s, a nationwide conglomerate of local organizations and agencies, almost always inconsistent, made up the EMS system of the United States. At this time, a combination of political and medical factors influenced President Johnson to create a committee regarding highway safety (Shah, 2006). Though various reports came out, the most impactful was *Accidental Death and Disability: The Neglected Disease of Modern Society* (Ferbrache, 2016; Institute of Medicine, 2007; Shah, 2006), more commonly known as “the white paper.” This 1966 report “documented the absence of emergency quality care” (Shah, 2006, para. 11), including the lack of treatment protocols and having too few trained medical personnel, among the top inadequacies.

In response to the white paper, the “law established the cabinet-level Department of Transportation to accelerate highway traffic safety programs and improve EMS” (Shah, 2006, para. 11). Within the Department of Transportation, the NHTSA was created and

given authority to fund improvement in EMS. Among those improvements, NHTSA developed a national EMS education curriculum and model state EMS legislation. NHTSA’s 70-hour basic EMT curriculum became the first standard EMT training in the United States. The department developed more extensive advanced life support (ALS) training several years later. (Institute of Medicine, 2007, p. 33)

For the first time in its history, the United States had created uniformity in its EMS system. Though not perfect, it certainly marked a substantial improvement.

NREMT

This monumental step in EMS system reform was daunting. To help with this transition, the NREMT (n.d.-a) was established in 1970, and its “mission is to provide a valid, uniform process to assess the knowledge and skills required for competent practice by EMS professionals throughout their careers, and to maintain a registry of certification status” (para. 2). However, it is still predominantly states and their local jurisdictions that decide whether to follow the NREMT’s recommendations. This is largely in part because the NREMT can only certify individuals as EMTs.

According to the National Commission for Certifying agencies, certification is the “process, often voluntary, by which individuals who have demonstrated the level of knowledge and skill required in the profession, occupation, role, or skill” (NREMT, n.d.-c, Certification section, para. 1). To engage in actual practice, an individual must undergo licensure, which is “the state’s grant of legal authority, pursuant to the state’s police powers, to practice a profession within a designated scope of practice” (NREMT, n.d.-c, Licensure section, para. 1). Many states do recognize the NREMT’s certification process to some degree, even including it in the licensure process.

However, there are still many inconsistencies. For example, California requires NREMT certification for initial licensure; North Dakota requires NREMT certification for continued licensure; Alaska only recognizes NREMT certification for paramedics to be initially licensed; West Virginia requires NREMT certification for continued licensure for intermediate EMTs (Trueemergency, 2019).

With so many variations, the National Association of State EMS Officials (NASEMSO) was established as an equivalency of the NREMT. As its name implies,

NASEMSO's (n.d.) focus is on state, territorial, and tribal jurisdictions. Despite their target audience, both organizations share the main principles of EMS. For example, the NREMT states that all four levels of EMS certification are aligned with the scope of practices as defined by the NASEMSO and cites them in their policies. However, CBP is a federal entity operating in of all 50 states. Therefore, it follows the NREMT's criteria for its EMS procedures. Although the NASEMSO also plays a crucial role in EMS, this study was based on the NREMT standards.

Types of EMTs

The terms *EMT*, *medic*, *first responder*, and *paramedic* are often used interchangeably. Although these titles are used to identify people providing aid, there are vast differences in the type of medical response that can be legally provided. Some states are also more diverse than others in differentiating medical personnel. The state of Alaska divides an emergency medical technician-basic (EMT-B) into three levels: EMT-1, EMT-2, and EMT-3 (State of Alaska Department of Health and Social Services, 2018) with each progressing level involving more training and duties. Alaska also includes a specific instructor role under its EMS system. This is in addition to the state's recognition of the NREMT's top two levels of certification: advanced emergency medical technicians (AEMTs) and paramedics.

Some states like Wisconsin still recognize the outdated EMT-Intermediate (EMT-I) level (Wisconsin Department of Health Services, 2022). With a couple of variations of the EMT-I, the NREMT's AEMT curriculum goal was to replace it to achieve a layer of uniformity, but a number of EMT-Is still exist for some reason. Until all EMT-Is are phased out because of natural attrition of retirement or age, EMT-Is are

legally recognized EMS professionals who require local agencies to write protocol and procedures specific to them whenever they perform their duties.

Complicating things, New York classifies EMT-Is and paramedics as AEMTs (New York State Department of Health, 2022). Although technically true, this can cause confusion among the public who may erroneously assume all EMTs have the same skill sets. Again adding further confusion, states recognize additional variants of advanced EMTs. In Tennessee, a critical care paramedic is the highest level of licensure in the state (Tennessee Department of Health, n.d.). However, these top tier positions have prerequisites of first being an experienced paramedic.

With this understanding, the study's focus was on three of the four levels of certification recognized by the NREMT: EMT, AEMT, and paramedic. As discussed in Chapter 1, emergency medical responders (EMRs) are not included in the study because of the substantial difference of training and education to the next level of an EMT-B. In California, the state requires that EMT-B training

consist of not less than one hundred seventy (170) hours. These training hours shall be divided into:

- (1) A minimum of one hundred forty-six (146) hours of didactic instruction and skills laboratory; and
- (2) A minimum of twenty-four (24) hours of supervised clinical experience. The clinical experience shall include a minimum of ten (10) documented patient contacts wherein a patient assessment and other EMT skills are performed and evaluated. (Required Course Hours, 1989/2017)

Satisfactory completion of an EMT program is only a partial step in becoming a certified EMT. The next step is perhaps the most difficult part. For states that follow the NREMT curriculum, candidates need to achieve a passing score on an examination set up by the NREMT. Candidates are given three opportunities for testing. If candidates are unsuccessful on their third attempt, a remedial course is required before further attempts are permitted. According to the NREMT (2018), the success rate of EMT-B candidates on their first attempt was no higher than 73% in the past 10 years. Once passed, a candidate is recognized as a certified EMT by the NREMT. This was the minimum requirement for participants in this study.

As stated previously, candidates who have been certified by the NREMT continue on with the overall process as an EMS professional by obtaining local licensure. Although the former merely acknowledges an individual who has demonstrated the skills in a profession, it is the latter that grants the ability for that individual to legally practice (NREMT, n.d.-c). Because of CBP's being a federal entity, it is not required to ask its EMTs to register locally or with the state. However, this does not preclude participants from doing so voluntarily. CBP policy also permits certified EMTs to perform their EMS duties without being licensed. This is because CBP functions not unlike that of a state entity in which a medical directive has been established and overseen by the DHS Chief Medical Officer.

Advanced Life Support Versus Basic Life Support

The path from an EMT-B to an AEMT or paramedic only becomes more difficult. The NREMT currently lists 405,421 nationally certified EMS personnel among its four levels (NREMT, n.d.-c). Excluding the 10,053 EMRs certified at each level leaves

395,368 EMS personnel who are EMTs, AEMTs, and paramedics. Of this new subtotal, 108,991 paramedics account for 27.57%, 17,989 AEMTs account for a mere 4.55%, and 268,388 EMTs account for the bulk of the EMS personnel at 67.88%.

The time and rigorous training and education required to become a paramedic can be considered the main factors in the disparity when compared to EMTs. Not only is there a wider variety of topics learned, but they also are covered in greater detail, “including anatomy, physiology, advanced life support, advanced pediatric life support, and basic trauma life support” (Jordan, 2020, About Paramedic School section, para. 16). In California, paramedic hopefuls also need to demonstrate leadership skills as a team leader when fulfilling their 1,094 minimum training hours (Required Course Hours, 1989/2021). Realistically, becoming a paramedic takes even more time because many programs require candidates to have at least 6 months of experience as an EMT-B before being accepted into a paramedic program.

This difference is also what separates EMTs performing basic life support (BLS) services and paramedics who perform advanced life support (ALS) services. It may be assumptive to believe that better patient care would be given if all EMS personnel were ALS providers. However, this is neither realistic nor effective. Brennan (2020) conducted a study with patients suffering from cardiac arrest, major trauma, and respiratory distress, arguably the most common types of reason that EMS are summoned. What was found was beyond the simple question of BLS versus ALS for patient care. Brennan stated, “Some patients will benefit from advanced interventions such as fluid resuscitation and dysrhythmia management, while others require rapid transport to definitive care in the operative suite” (Take Home Points section, para. 24). Ryyänen et

al.'s (2010) observational study had a similar result: "ALS seems to improve survival in patients with myocardial infarction and BLS seems to be the proper level of care for patients with penetrating injuries" (para. 5). The researcher did not entertain the debate of superiority between ALS and BLS. He only drew on the inconclusiveness of previous research in highlighting the importance of having both ALS and BLS providers.

AEMTs

AEMTs serve as an intermediary between an EMT-B and paramedic. Although they only account for 4.55% of the NREMT's adjusted total of EMS providers, there may be an explanation for this small niche. Unlike EMT-Bs, "Advanced EMTs have an intermediate skill level and can do things like starts IVs, administer breathing treatments for asthma patients, and give epinephrine for allergic reactions" (Matheson, 2021, para. 5). Acquiring these skills in California requires an additional 160 hours of training beyond that of an EMT-B including five demonstrations of leadership competency (Advanced EMT Training Program Required Course Hours, 1987). In comparison to a paramedic, becoming an AEMT is much less demanding. This begs the question: "Why are there not more AEMTs?"

The researcher was unable to find any substantiative sources to provide an answer but offered a few reasonable conjectures. As mentioned previously, the NREMT's classification of AEMTs was to bring uniformity among the EMS community, especially from states that still recognize EMT-Is. Unfortunately, they have yet to accomplish this. Although states still have their own criteria for EMT-Is, there is consensus on what paramedics are and the skills they are able to perform. This leads to EMS programs and

schools focused solely on the levels of EMT-B and paramedic. With AEMT training programs being noticeably absent, the number disparity is the presumptive result.

The number of ALS skills AEMTs can perform that EMT-Bs cannot is also not much greater. For example, the NREMT considers the use of a supraglottal airway device falling under the scope of practice for an AEMT. However, some local EMS jurisdictions consider this device as a BLS skill because “supraglottic airways vary widely among services based on local data, protocols, provider level and medical direction” (Sullivan, 2018, Know Your Service’s Protocols section, para. 12).

One area in which AEMTs clearly have an advantage over EMT-Bs is the expanded list of medications they are allowed to administer under their scope of practice. According to the Asthma and Allergy Foundation of America (n.d.), 25 million Americans have asthma, and 3,524 people died from it in 2019. Patients suffering from asthma will no doubt benefit more from the additional medical care received from an AEMT than from an EMT-B.

However, there is a host of other medical issues such as heart attacks that render an AEMT not much more useful than an EMT-B. Thomas (2020) stated that over 30 million U.S. adults were diagnosed with heart disease in 2018, and “about 647,000 Americans die from heart disease, making it the leading cause of death in the United States. Heart disease causes 1 out of every 4 deaths” (para. 5). Patients suffering from heart attacks at a prehospital setting have the best chances of survival through a paramedic’s ability to administer heart rhythm medications, something AEMTs cannot do.

Numerically speaking, more people in the United States suffer from heart disease than from asthma. It was not the researcher's intention to proclaim one's prevalence over the other; rather, this comparison was made strictly from an EMS operational standpoint. It appears to be more beneficial to the public to have more paramedics serving 5 million more patients effectively than AEMTs.

However, there is another justification that holds more ground—literally. A rural area and its nearby “geography does play a role in the higher local percentage of advanced EMTs” (Castañeda, 2016, para. 10). In 2016, only 104 AEMTs were registered with California, about half of whom were in San Diego and Imperial counties (Castañeda, 2016). According to the medical director of San Diego County Emergency Medical Services, “If given a choice, emergency medical systems prefer paramedics, but hiring them isn't always possible. Advanced EMTs are mostly ‘beneficial for those rural areas that have difficulty recruiting and retaining paramedics in their systems’” (Castañeda, 2016, para. 3). This sentiment was echoed by the EMS personnel division chief at the California Emergency Medical Services Authority in which “paramedics in a ‘really slow, rural area’ might leave ‘to get more experience going into the big city.’ Those rural areas might then turn to advanced EMTs as a better option than relying on EMTs” (Castañeda, 2016, paras. 5-6). Moreover, San Diego and Imperial counties are situated on the border with Mexico where CBP has substantial presence.

According to the spokeswoman of the San Diego sector, Border Patrol agents (BPA), “encounter a lot of migrants that are left stranded out in the mountain areas or the desert” (Castañeda, 2016, para. 11). It is not just migrants to whom Border Patrol respond. Regular hikers and even fellow agents in this mountainous region have received

medical services, specifically intravenous administration to combat the effects of dehydration caused by the blistering heat. The Border Patrol Search, Trauma and Rescue Unit, 14 of whom have advanced EMT certification, had rescued 20 people in San Diego (and over 100 the previous year) at the time of this article's publishing (Castañeda, 2016). The number of people saved is dwarfed compared to those in a city, but considering the hundreds or even thousands of unmarked and unlit square miles Border Patrol must cover, the number is quite impressive.

Becoming an EMT at any level is an involved process. Yet there is still something that drives this small number of CBPOs who decide essentially to take on a secondary occupation on top of their regular duties. The purpose of this study was to discover any common factors or characteristics among CBPO EMTs who voluntarily take on this role and as a result provide better public service during medical emergencies.

Prehospital Care

There has been growing emphasis of care placed during the prehospital setting, which is usually on site of a medical situation. In trauma cases, major advances in the prehospital setting "have evolved with the aim of improving performance and outcomes in the prehospital phase in key areas including new techniques, tools, and procedures. These include airway management, circulatory access, control of bleeding, physiological monitoring, scoring systems and training" (Oliver et al., 2017, p. 979). It is indisputable denying that short rescue times to a hospital attribute directly to patient survivability, but Klein et al. (2019) considered these updated techniques, when effectively used in the prehospital setting, are even more important. Wandling and Cotton (2020) also reinforced this sentiment:

Modern trauma systems should place an increasing emphasis on the prehospital setting. Early identification of life-threatening haemorrhage [sic], initiation of blood product resuscitation, and minimization of blood loss in the prehospital setting are key and have the potential to reduce the considerable burden of downstream physiological derangements that result in multiple organ dysfunction.

(p. 330)

Despite increasing literature stressing the importance of prehospital care, the delivery aspect should not be overshadowed. These two elements work in tandem to maximize the chances of patient survival.

Prehospital care also presents additional challenges. Unlike the environment at a hospital, the scene of a medical incident is not controlled. One issue that is held in high regard is patient dignity. Unfortunately, the trend is that receiving prehospital care more often than not occurs in areas under the public view. According to Abellsson and Lindwall (2015), “In some prehospital emergency situations, the patient experiences feelings of vulnerability and loss of dignity” (p. 269). In their study, Abellsson and Lindwall identified two contrasting factors affecting patient dignity. Preserved dignity is achieved through actions of respecting a patient’s will at the time of incident, protecting their privacy, and generally being there for a patient; humiliated dignity, on the other hand, occurs when patients feel abandoned, disrespected, or neglected through offensive comments, treated in a nonchalant manner, or downright ignored (Abellsson & Lindwall, 2015).

Another prevalent issue for patients in a prehospital setting is the feeling of safety. Abellsson and Lindwall (2015) mentioned, “Patients lose control of their bodies and

encounter unfamiliar faces in an emergency situation” (p. 269). It would not be unreasonable to anticipate feelings of uncertainty and fear during these situations. An EMS provider ought to alleviate these distressful feelings. Péculo-Carrasco et al. (2020) attempted to define what safety is in a prehospital setting but were unable to do so. This was due to participants’ subjectivity of perceived threats to safety. However, the researchers were still able to offer examples of positive and negative experiences that influenced their perception of what safety is (Péculo-Carrasco et al., 2020). They identified six categories, “with the greatest effect on feeling safe were related to Information and communication, Person-centred [sic] care and Professional competency, without losing sight of other factors such as Accessibility and response times of the emergency teams, Equipment and Healthcare setting” (Péculo-Carrasco et al., 2020, p. 4720). Patient dignity can be asserted as being encompassed, at least partially, with safety under the categories of person-centered care and professional competency.

Fortunately, CBPO EMTs are well versed in protecting patient safety and dignity. First, all CBP employees receive training and annual refreshers to safeguard the privacy of travelers. Second, CBPO EMTs should have higher levels of empathy toward patients from their past EMS experiences. Third, CBPO EMTs are familiar with the layout of the ports of entry they work at. Deviance from normal operating procedures can be easily rectified by reshuffling lanes of vehicle traffic, rearranging passenger queues, and using side doors to lead crowds away from scenes of interruption. As a last resort, CBPO EMTs may exert their law enforcement authority to order onlookers away or ask colleagues to forcibly remove individuals if necessary.

Providing care in the prehospital setting will continue to evolve and improve as new research becomes available. Currently, “Research gaps are partly due to prehospital care being a relatively young research area” (Söderholm et al., 2019, p. 2).

Unfortunately, the uncontrolled environment that is the mainstay of a prehospital setting coupled with the unlimited combinations of unique medical cases will severely hamper this progress. Sometimes, the effectiveness of current practices are called into question, such as finding no alleged benefit providing ALS over BLS in time-sensitive conditions that are myocardial infarction, respiratory failure, stroke, and trauma (Sasson & Haukoos, 2015). However, even Sasson and Haukoos (2015) admitted this as being unlikely because of the limitations of their study being conducted in an urban setting.

Advancements in technologies also help improve care in the prehospital setting. According to Barr (2012), “Many of the advancements in EMS technology revolve around the use of wireless information technology, now being used in electronic health records or to track and transmit a patient’s vital signs” (para. 4). This sped-up process can help EMS providers quickly identify signs of trouble and select the appropriate treatment, especially in medical episodes in which each precious second counts toward patient survivability. In addition, new tools such as the EZ-IO vascular drill can help deliver needed fluids and medications into patients when inserting an IV line is too difficult (Barr, 2012).

There is no doubt more time is needed to discover new and innovative ways of improving the quality of patient care in the prehospital setting. Whether it is improving upon existing knowledge, eliminating and replacing outdated procedures, or creating new inventions, the trend of providing better medical assistance at a prehospital will only

grow as it is considered “an essential part of the continuum of emergency health care” (National Academy of Sciences, 2012, p. 3-1). Furthermore, the researcher could not find one instance in which research diminished or discouraged the medical care performed at a prehospital setting. Instead, it was the opposite; essentially, researchers recognized the importance and expectation of care to be provided at a prehospital setting to some degree. The only exception to this is scene safety in which providing medical assistance is neither feasible nor reasonable due to the physical and present dangers to EMS responders.

EMS Integration in Law Enforcement

Traditionally, law enforcement officers would wait for fire departments or local EMS agencies to provide aid for patients. This is no longer the case because there is a change in thinking from the public expecting “officers to render aid and attempt to save lives” (Heiskell, 2016, para. 1). On the surface this seems reasonable, begging the question why there are not more law enforcement agencies expecting their officers to do so. According to Eldridge (2020), “Limited training, vague policies, and few consequences for inaction” (para. 4) are reasons why law enforcement officers fail to provide medical aid. Steps have been taken addressing this issue with some departments providing more training to their officers beyond the basic first aid learned at the academy and equipping patrol cars with necessary equipment (Heiskell, 2016). Despite the training, officers are still reluctant to render aid.

Each department dictates its own procedures. In turn, it creates a “wide variation in how the policies are written and enforced” (Eldridge, 2020, para. 6). Although unfortunate, it is not without merit. A major metropolitan police department has much

more resources to invest in training and equipment for medical responses than a small department with only a half dozen officers. Still, there is always room for improvement, especially when only half of the country's 50 largest police departments "require officers to provide aid whenever possible" (Eldridge, 2020, para. 5). A possible explanation for the lack of emphasis on providing medical aid can be attributed to law enforcement culture:

Historically, police departments have followed an unwritten policy on focusing on law enforcement duties and leaving first aid to firefighters or paramedics.

Medical training is often cursory at best and rarely addresses the difficulty of transitioning from using force to providing aid, leaving many officers feeling unprepared to render help. (Eldridge, 2020, para. 11)

Outdated policies and poor past practices over time also instilled officers' "mindset that attempting to provide any medical care would get them in trouble. Furthermore, many officers were told by their supervisors not to get involved in medical care for fear of being sued, fired, and/or put in jail" (Heiskell, 2016, para. 4). Although police departments around the United States are revising their medical policies to better align with public opinion, progress is slow and often riddled with strife. One such instance involved a rookie officer admitting to a lack of confidence in performing CPR despite being trained. A subsequent investigation revealed a cheating scandal "where officers were certified in CPR despite never practicing on a dummy or even opening the textbook" (Eldridge, 2020, p. 31). This is an abominable failure because of its disservice to the public. Moreover, this lack of trust only creates more animosity between law enforcement agencies and those who perceive them negatively.

Hampering the progress even further is the judicial system. Eldridge (2020) stated that no “federal law mandates that officers provide first aid directly, and the courts have been reluctant to examine the issue” (para. 19). Currently, a circuit court’s decision ruled that an officer’s responsibility to act has been fulfilled once an ambulance has been called (Eldridge, 2020). This may be a legal maneuver by the courts to avoid imposing a one-size-fits-all approach. Though there is a finite number of police departments in the United States, each possesses its own specific issues that may not be necessarily feasible to solve. However, this point is speculative and requires further research but does not negate the fact that there is indeed disagreement on how much medical aid, if any, should be given by law enforcement officers.

There are also situations when a law enforcement officer, even if medically trained, should not and would not provide aid to injured persons. These occur when there is a clear and present imminent threat to the public or law enforcement officers themselves. Such a case would involve an active shooter in which officers “are taught that the tactical situation always has priority over any medical care and the top priority of responding officers to an active shooter situation is to rapidly locate the active shooter or shooters and stop the killing” (Heiskell, 2020, para. 7). Injured and dying victims are to be ignored because the focus is on neutralizing the threat or threats. Ignoring these desperate cries and pleas for help is not only unnatural and inhumane but also necessary during these deathly stressful moments.

By no means do these reasons even come close to an exhaustive list as to why there are not more officers who ought to be medically trained. It only raises public awareness to this concept of crediting law enforcement officers with a degree of medical

competency with the assumption that this has always been the case when it has not. There are some police agencies that have integrated the medical aspect into their law enforcement duties, but this is not the norm. Even fewer still are departments that integrate fire suppression skills along with EMS in addition to law enforcement duties (Hilal & Jones, 2014). Again, this is atypical. Most departments still do overwhelmingly law enforcement-related work as they are expected to while rendering medical aid takes a back seat. However, as public preference appears to favor more medical training for law enforcement, agency administrators would be wise to heed this call. Although the history of EMS integration in the few law enforcement agencies is no doubt useful, the researcher believes there is a whole trove of data that can be gathered and analyzed if more law enforcement agencies were to adopt the medical aspect into their departments. A detailed review could then be conducted in the future to determine which aspects work well and which need refining. This would be for the betterment of the public by law enforcement agencies.

Motivation

There are various motivational frameworks in the field of public administration. Their purpose is to identify trends and implement them in hopes of offering better services in the public sector. Perhaps the most recognizable theory is Abraham Maslow's hierarchy of needs, depicted by a pyramid with five tiers. From the bottom-up, the needs are physiological, safety, love and belonging, esteem, and self-actualization. Maslow initially stated the bottom needs must be met first before satisfying higher needs but later clarified that complete satisfaction is not needed before moving on to the next need (McLeod, 2022). Maslow continued to refine his model, adding three more levels of

needs for a current total of eight tiers. At the highest tiers of both the initial and revised models are self-actualization and transcendence, respectively. These two tiers do attempt to look at an individual's self-motivation, such as seeking personal growth or service to others (McLeod, 2022), but they are part of Maslow's overall hierarchy. Therefore, isolating these two tiers to answer the research questions would only produce at best a skewed and impartial outcome, one that is not truly representative of motivation in this study.

Another recognizable motivational theory is Douglas McGregor's Theory X and Theory Y. Theory X assumes people naturally dislike work and they must be controlled in some way to achieve an organization's goals whereas Theory Y focuses on an individual's intrinsic drive to become self-directing, seek more responsibility, and be more creative in overcoming challenges (Morse & Lorsch, 1970). Although it would be instinctive to select Theory Y over Theory X, some situations do warrant the opposite. For example, control must be exerted upon a lackluster employee who continues to underperform.

Frederick Taylor's scientific management is yet another motivational theory. The theory is based on four principles (Brooks, 2011):

- Organizational leadership should develop standard methods for doing each job using this theory.
- Workers are selected for a job based on their skills and abilities.
- Work is planned anticipating interruptions.
- Wage incentives should be offered to boost productivity.

It is profoundly difficult, if not impossible, to implement a scientific management style in law enforcement or the medical field because of their unpredictable nature. However, even if this was not the case, Taylor's theory does not align with this research because it requires management investment to motivate employees. This is also true with McGregor's theory.

SDT

The theoretical framework best suited for this study was Edward Deci and Richard Ryan's SDT. According to these two key theorists, there are two defining characteristics of SDT. First, SDT "examines how biological, social, and cultural conditions either enhance or undermine the inherent human capacities for psychological growth, engagement, and wellness, both in general and in specific domains and endeavors" (Ryan & Deci, 2017, p. 3). Second, SDT places "emphasis on the different types and sources of motivation that impact the quality and dynamics of behavior" (Ryan & Deci, 2017, p. 14). This study focused on participants' motivation and its influence on them to become EMTs.

Autonomous Motivation, Psychological Needs, and Intrinsic/Extrinsic Traits

There are two types of motivation in SDT. The first type is autonomous motivation, which is when a "person experiences volition—to the extent that he or she assents to, concurs with, and is wholly willing to engage in the behaviors" (Ryan & Deci, 2017, p. 14). Ryan and Deci (2017) believed there are three psychological needs that must be met for people to become autonomously motivated.

First, autonomy is the ability to feel control of one's behaviors, decisions, and goals, free from outside influence (Cherry, 2021; Lopez-Garrido, 2021). Its hallmark is

that “one’s behaviors are self-endorsed, or congruent with one’s authentic interests and values” (Ryan & Deci, 2017, p. 10).

Second, competence refers to one’s sufficient ability to perform a task or possess a high degree of skill (Cherry, 2021; Lopez-Garrido, 2021). However, competence is easily thwarted when “challenges are too difficult, negative feedback is pervasive, or feelings of mastery and effectiveness are diminished or undermined by interpersonal factors such as person-focused criticism and social comparisons” (Ryan & Deci, 2017, p. 11).

Third, relatedness is feeling connected to others “typically when they feel cared for by others. Yet relatedness is also about belonging and feeling significant among others” (Ryan & Deci, 2017, p. 11). Relatedness is important because it builds support within a social group (Cherry, 2021). However, “Feelings of relatedness are undermined by competition with others, cliques, and criticism from others” (Lopez-Garrido, 2021, para. 17). If one or all components are missing, a person cannot be autonomously motivated.

Another way autonomous motivation can be interpreted is intrinsic motivation. By definition, intrinsically motivated behaviors are “autonomous; they are experienced as being volitional and emanating from one’s self” (Ryan & Deci, 2017, p. 14). The characteristics of one’s makeup include the “internal drives that inspire us to behave in certain ways, including our core values, our interests, and our personal sense of morality” (Ackerman, 2018, para. 10). Simply put, being intrinsically motivated “means you do it because you find it interesting and enjoyable” (The Brainwaves Video Anthology, 2017, 6:21). However, autonomous motivation can also be extrinsically achieved. People can

be “extrinsically motivated insofar as the behavior yields outcomes that are personally valued or important, in which case the behavior is likely to be experienced as relatively autonomous” (Ryan & Deci, 2017, p. 14). Breaking news, war stories, harrowing articles, or witnessed close calls can all be examples of extrinsic motivation that can be autonomously motivating, but this can only occur when individuals place value in themselves and internalize it as their own. This makes it “even more autonomous when such identifications have been integrated with one’s other values and beliefs” (Ryan & Deci, 2017, p. 15).

Controlled Motivation, Extrinsic Traits

The second type of motivation in SDT is controlled motivation. According to The Brainwaves Video Anthology (2017), “Controlled motivation refers to doing something in order to get some reward or to avoid punishment. It means doing something because you’re feeling pressured, demanded, obliged to be doing it” (2:16). Going to work for a paycheck is a relatable example. Controlled motivation is explicitly driven by extrinsic factors and thus can be understood as extrinsic motivation. Unlike autonomous or intrinsic motivation, extrinsic motivation “can vary widely in the degree to which they are controlled” (Ryan & Deci, 2017, p. 14). It is important to realize not all extrinsic motivation should be perceived negatively. Many behaviors controlled by extrinsic motivators such as traffic laws are required for the benefit of society. As explained in the previous section, however, extrinsic motivation can also be autonomous motivation. To clarify, controlled motivation cannot be autonomous.

Autonomy-Control Continuum

Because of the complexities that make up life, it is “useful to think of motivation on a continuum ranging from ‘non-self-determined to self-determined’” (Ackerman, 2018, para. 15). There are three major characteristics of the continuum (see Appendix B). On one side is amotivation. There are different types of amotivation dependent upon which psychological need or needs are absent, and the most severe is having all three absent. Opposite amotivation is intrinsic motivation, occurring when all psychological needs are met. According to Ackerman (2018), “In intrinsic regulation, the individual is self-motivated and self-determined, and driven by interest, enjoyment, and the satisfaction inherent in the behavior or activity he or she is engaging in” (The Self-Determination Model section, para. 21). Wedged between these two extremes are various levels of extrinsic motivation. Ackerman stated that although individuals should strive for self-determination, “We can’t help be motivated by external sources—and that’s not necessarily a bad thing” (para. 22). Simply, it is completely normal to bounce around the continuum within life’s various social contexts.

Similar Triadic Theories

There are other motivational theories that share some characteristics of SDT. One theory is existence, relatedness, and growth (ERG) by Clayton Alderfer (Robitalle, 2011). Aldefer identified these three needs as necessary for individuals to become motivated. This is not dissimilar to the three psychological needs of SDT. However, ERG theory should be understood as a simplification of Maslow’s initial hierarchy of needs model that had five tiers (Cuofano, 2022). Bhasin (2021) and Cuofano (2022) summarized the three needs:

1. Existence refers to the first two levels of Maslow's hierarchy by which basic physical and psychological needs of survival must be met.
2. Relatedness refers to the social needs and positive interactions between people, which is aligned with Maslow's third and fourth levels.
3. Growth refers to the individual's self-development for personal achievement and growth, which is represented by the top level of Maslow's hierarchy.

There are also three key differences between ERG theory and Maslow's hierarchy. Different levels can be pursued simultaneously, the order of needs vary among individuals, and the unfulfillment of a higher need causes a person to regress to a lower level need that is easier to satisfy (Robitalle, 2011). At first glance, these three needs made ERG a potential framework for this study. However, "ERG theory is an extension of Maslow's hierarchy of needs" (Cuofano, 2022, para. 3). The focus of these three needs still encompassed the bottom tier basic needs of the hierarchy, which was not the focus of this study.

Another motivational theory similar to SDT is David McClelland's three needs theory. In this theory, the three characteristics that affect an individual's motivation are power, motivation, and achievement. These three characteristics parallel the three psychological needs of SDT: achievement to competence, power to autonomy, and affiliation to relatedness (Clayton, 2020). However, there are several factors that separate these two theories. In Barman's (2015) article "McClelland's Human Motivation Theory," he stated, "According to McClelland, these motivators are learned" (para. 3). In addition, this theory is also straightforward, focusing on results. Kurt (2021) explained,

Individuals motivated by power may need clear expectations and steps needed to advance in their careers. Individuals motivated by achievement may need regular opportunities to solve a problem. Individuals motivated by affiliation may need consistent feedback on the job that they are doing. (How it is used section, para. 15)

Individuals also possess all three drivers, but their motivation is ultimately dominated by one need (Barman, 2015). SDT on the other hand, focuses on inherent values. Although it can be argued that these values are also learned, it is ultimately the individuals who decide whether these values coincide with their beliefs or merely behavioral control.

More important, SDT is not a framework that focuses on how to get individuals motivated. There are other motivational frameworks besides ERG and three needs theory that do share SDT's three psychological needs in some way or form. Clayton (2020) stated, "But where SDT departs from these is the emphasis it places on the importance of intrinsic motivation. And it also focuses us on the interrelatedness of these three [psychological] elements" (6:02). This study explored the motivational factors of participants becoming EMTs, which was deeply personal for them. This study also did not seek ways to motivate participants to perform better at work. SDT was appropriate for this study because the events experienced by participants were analyzed and associated with their psychological growth as EMTs. Participants also demonstrated the strong connection among the three psychological needs when they expressed frustration with a major challenge that was revealed through in-depth interviews. This is presented in Chapter 4.

Relevance

Ryan and Deci (2017) stated that SDT has both a practical and critical function. In practical terms, SDT highlights the various contextual features that affect self-regulating motivation; critically speaking, social contexts, which in this case is the workplace, are examined and compared among themselves in determining the adequacy of helping or damaging the human motivation to thrive (Ryan & Deci, 2017). Ryan and Deci also suggested that these factors can be identified and measured, fostering an environment where “SDT can be thoughtfully and systematically applied within varied social contexts, including families, classrooms, sports teams, health clinics, interactive media, and workplaces” (p. 4). Studies have supported this claim. Guay (2021) presented an overview of education studies based on SDT, revealing relevant observations in providing “support for the various postulates of SDT” (p. 87). At the workplace, Thibault Landry and Whillans (2018) conducted research that “offers empirical evidence in support of the universal importance of employees’ psychological need satisfaction in the link between reward satisfaction and employee functioning” (p. 21). Although there is scarce literature about SDT being used in the workplace to improve employee performance, it certainly does not detract organizations from at least trying to implement such measures even if to a minimal degree.

As an agency, CBP could replicate this process with the data from this study with the expectation of attracting or influencing potential candidates showing the same qualities and characteristics from the CBPO EMT participants thus increasing the agency’s legitimacy and effectiveness as a public service organization. Moreover, this is not exclusive to only EMTs. This process can also be used in other collateral or

specialized positions within CBP; however, research in these other disciplines should be conducted prior to application.

CHAPTER 3: METHODOLOGY

Customs and Border Protection (CBP) is a large agency that has many different components. Among them, of particular importance is its ability to respond to medical emergencies. The purpose of this research was to identify whether there were any aspects within the participant responses that may be useful in helping CBP refine its medical program and procedures. The purpose statement and research questions are presented again in this chapter. The research design and research instrumentation sections follow. In the final section, methodological assumptions and limitations are discussed as well as ethical procedures taken for the protection of human subjects. The methodology chapter ends with a summary of the material presented.

Purpose Statement

The purpose of this phenomenological study was to explore the perspectives, experiences, and reasons that influence Customs and Border Protection officers (CBPOs) at ports of entry in California to take on an additional role as an emergency medical technician (EMT).

Research Questions

There were two research questions from this study. The questions are as follows:

1. What are the perceived motivational factors that contribute to one becoming an EMT?
2. What are the perceived benefits of becoming an EMT as a CBPO?

Research Design

The research conducted in this study was based solely on an exploratory, qualitative approach: a phenomenological case study. Creswell and Creswell (2018) defined phenomenological research as

a design of inquiry coming from philosophy and psychology in which the researcher describes the lived experiences of individuals about a phenomenon as described by participants. This description culminates in the essence of the experiences for several individuals who have all experienced the phenomenon. This design has strong philosophical underpinnings and typically involves conducting interviews. (p. 13)

Qualitative studies tend to be narrowly focused on specific and small cases, but they “generally unearth enormous amounts of information” (King et al., 1994, p. 4). In addition, undertaking this research will “satisfy the curiosity and desire for better understanding” (Babbie, 2001, p. 92), which is among the primary reasons for an exploratory study. As such, this research followed these principles. To comply with federal law and requirements set by the researcher’s Institutional Review Board (IRB), this section details the process to ensure and preserve the integrity of the research.

Participants from this study did not include vulnerable populations defined by the Office for Human Research Protections (n.d.-a) as pregnant women and fetuses, prisoners, and children. Furthermore, the basis of this study was primarily the lived experiences of CBPO EMTs and was classified as minimal risk:

Minimal risk means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those

ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests. (Office for Human Research Protections, n.d.-b)

There was a possibility that some of these lived experiences could invoke feelings of discomfort and negativity, perhaps even posttraumatic stress disorder in the most serious cases. However, it was presumed that CBPOs are considered to have sound minds because of the position requiring them to carry a firearm and to make good judgements on a daily basis. These factors permitted the study to undergo an expeditious review rather than a full IRB review. However, the other aspects in protecting participants' rights still needed to be adhered to.

All participants completed a signed consent form (see Appendix C), acknowledging their willingness to participate in the study. The consent explained the purposes of the research and its proposed benefit: helping future administrators use the data in improving CBPOs of field operations' EMT program in aspects of prospective candidates and agency benefits. Participants' privacy and confidentiality in their participation and responses were guaranteed by the researcher himself to the best of his ability. This included conducting interviews during off duty hours and avoiding the use of government equipment. Participants and work locations were labeled alphanumerically (P01, P02, P03, etc.). The interviews were conducted through the teleconferencing software Zoom, telephone, or in-person. Individuals were made aware that interviews would be recorded and subsequently saved with the sole reason for accuracy during the transcription process. Participants were also given opportunities to

skip over questions they did not feel comfortable discussing and the option to completely withdraw from the interview at any time without consequence.

At the time of this research, Zoom had a list of reported security issues but was still generally safe to use (Spadafora, n.d.). It is unreasonable to expect Zoom or any of its alternatives to be free of vulnerabilities and have a “100% secure solution against data breaches” (Cyber Management Alliance, 2021, Better Alternatives section, para. 35). This reasoning also holds true for the recording software, Otter.ai. However, the content of these interviews, while personal, should not have any value deemed worthy to be targeted by cyber criminals. Still, the researcher engaged in best practices of cyber security, including downloading the latest software patches, avoiding the use of public Wi-Fi, and running antivirus software. The researcher was the only person to have access to the data, which were saved onto his personal password-protected laptop.

As mentioned previously, there was a possibility for a participant’s past experiences to invoke some feelings of discomfort. Although this study posed minimal risk, the researcher informed participants to use CBP’s Employment Assistance Program (EAP) if needed. EAP is a service “that provides cost-free and confidential assessment, short-term counseling, referral, and follow-up services to employees and their eligible family members who have personal and/or work-related problems that may affect attendance, work performance, and/or conduct” (CBP, 2022d, para. 1). There are certain cases such as harming oneself or others in which EAP cannot maintain confidentiality and must alert proper officials, but this is still within their responsibilities of helping.

The interviews were conducted on an individual basis for several reasons. First, the researcher could focus more attention on a participant’s response. Body language and

other nonverbal signs could be picked up more easily with only one participant, enabling the researcher to ask appropriate follow-up questions according to these cues. Second, conducting a group interview, while saving time, can lead to the bias of social desirability:

Social Desirability Bias is a form of response bias in which people prefer to answer questions about how their responses will be interpreted by others rather than reply truthfully. The respondents will choose socially acceptable answers or politically correct responses. (Ricee, 2020, para. 4)

In a one-on-one setting, participants were able to offer genuine responses without the fear of embarrassment or negative judgement that may persuade them to say otherwise. On the other hand, this type of setting could encourage participants to boast more than they normally would in a group setting. However, the researcher considered boastfulness as an innate characteristic of motivation, which again was the goal for this research. There were also fewer interruptions and distractions. Overall, conducting interviews on an individual basis produced an environment conducive for this study.

With the process detailed, individuals then chose whether they still wanted to participate in the study. There was no type of compensation given to participants other than a \$10 gift card to Target as a small token of appreciation. There are strict guidelines for federal employees receiving gifts. Furthermore, participants were law enforcement officers who are often held to a higher standard. However, the gift card did not pose an issue for two reasons. First, the gift offered did not stem from official work duties. Even if this were the case, the dollar amount is permitted under law and employees may accept unsolicited gifts valued at \$20 or less per occasion by any one person and not exceed \$50

per calendar year (National Archives and Records Administration, 2022b). Once potential participants signed and returned the consent form to the researcher, they became an official participant in the study. The researcher then contacted participants via email to schedule interviews and begin collecting data.

The researcher believed in good conscience that he was qualified to conduct this study. At the time of this study, he was a CBPO with over 15 years of law enforcement experience. He had worked in various ports of entry in several states, spanning the three modes of transportation into the country, which included both northern and southern land border crossings, seaports, and airports.

While on assignment in Alaska, the closest U.S. town was more than 90 miles away. Contacting local officials to coordinate health services when a medivac or even a deceased patient arrived unexpectedly outside normal business hours proved challenging. On the other hand, working at the nation's busiest port of entry in San Ysidro and neighboring Otay Mesa, where drug or alien smuggling attempts occur almost daily, proved to be a different set of challenges. People hiding in the unventilated floorboards of a car for 3 hours to sneak into the country had to be treated for heat exhaustion before being further processed. The inability to speak their language to gain a better assessment only added to the difficulty. Individuals suspected of being under the influence of drugs also had to be treated accordingly even after being combative with officers.

Then, there is everything in between. The researcher had responded to vehicular accidents, especially trucks, while working at the seaport. Truckers who are often paid by the number of containers they deliver frequently skip out on the safety aspects and driving standards. After obtaining a container from a shipping terminal, truckers often

hastily drive out of the exit, sometimes without securing the container onto the chassis. It would not be uncommon for the container's contents to shift suddenly during a sharp turn, causing the entire truck and chassis to turn over. Some truckers also exercise poor judgement by ignoring the railroad crossing signs of an oncoming train, resulting in a collision.

Shipping terminals are just as dangerous. Terminal and commercial trucks, reach stackers, heavy forklifts, and shipping cranes all move constantly in different directions and near one another. Not only is the terminal large, but its layout also changes periodically to accommodate the flow of imports and exports. Assisting ambulances and the fire department in finding the location of an incident was also a part of the researcher's duties.

Last are airports where medical incidents are more easily fathomable. The researcher has responded to more serious incidents from diabetic episode to a child's scratch. Although the airports have dedicated fire and EMS response from local agencies, the researcher's presence was still helpful, providing crowd control or important facts leading up to a medical incident.

The researcher was also a nationally and state certified EMT with over 4 years of experience. Perhaps more relevant was his own volition to become an EMT. After responding to a medical incident at work, he recalled his inability to provide adequate medical assistance. If not for a more capable colleague, the outcome for the patient would have been extremely grim. The experience had a negative and lasting effect on the researcher. Providing medical assistance is part of an effective law enforcement officer's

duty, and he realized he lacked this important skill set. Therefore, he embarked on a journey to address this issue.

The researcher looked at various EMT programs, including one CBP offered. Unfortunately, the CBP program was only scheduled sporadically with preference given to units on special teams. He eventually was able to find an EMT program not associated with the agency and balance his CBP duties and schedule, including mandatory overtime, with the local EMT program. After passing the program, he was awarded the opportunity to take the certifying exam presented by the NREMT. Only after achieving this milestone did he officially become an EMT.

CBP now offers interested individuals who want to become EMTs official training classes. Although candidates must still go through a curriculum and successfully pass the NREMT exam, CBP candidates are being trained during official work hours, unlike the researcher's experience. This distinction was beneficial because it avoided any possible conflicts of interest with the study. Furthermore, the researcher recalled the academics, training, exams, and overall time needed to become an EMT. Although he had not reached the levels of an advanced emergency medical technician (AEMT) or paramedic as some of his colleagues, he still possessed the fundamentals of becoming an EMT. Moreover, he not only understood the roles and responsibilities of both EMS provider and CBPO but also understood the challenges presented when the paths of these two roles cross.

Lastly, the researcher was also a collateral duty safety officer (CDSO) in his work unit and was aware of the administrative burdens associated with it. Although not glamorous, he understood the importance of this position aside from the legal mandates

as mentioned in Chapter 2. There are overlaps between the duties of a CDSO and an EMT, one of which is conducting the monthly AED maintenance. An EMT is not as effective if an AED is either nonfunctional or nonexistent just as a CDSO is ineffective if not trained in using an AED with follow-up care. The researcher believed being a CDSO works in conjunction to being an EMT to maximize his effectiveness as a public servant.

Population

The population for this study was CBPO EMTs. At the time of the study, there were “368 CBP officers are certified as EMTs, four as Advanced EMTs, and 13 as Paramedics” (CBP, 2022c, para. 11). Although the CBP’s other components also have EMTs, such as Border Patrol agents (BPAs) or air interdiction agents/marine interdiction agents (AIAs/MIAs), or even within the Office of Field Operations (OFO) component, such as an agriculture specialist EMT, only CBPO EMTs were included in this study. The researcher did not have intentions to disregard the motivational factors for non-CBPO employees who became EMTs, rather it was because of other factors that may not have represented this study’s specific research questions. These reasons are further explained in the limitations section of the chapter.

Sample

A purposeful sample of CBPO EMTs stationed in California was selected for this study. The researcher, through his chain of command, received authorization to seek participants for his study. The CBP official in charge of a port of entry is suitably titled the port director. CBP’s official email system, with the port director’s permission, was initially used to contact people to participate in the study.

Participants were given a set of directions, included in the consent form outlined previously in this chapter. Participants were contacted by the researcher through nongovernment communications. Participants must have also indicated they were over 18 years of age and were not subject to any current disciplinary action or review during the time of the interview.

The researcher ensured that the 10 interview questions asked would provide enough insight into participant response to begin collecting meaningful data for this study. If necessary, more participants would have been recruited through snowball sampling until saturation had been met. Creswell and Creswell (2018) defined this point “when gathering fresh data no longer sparks new insights or reveals properties” (p. 186).

Instrumentation

There were two instrumentations for this study. The first was the researcher who conducted the interview. The second was the interview itself, which was the main instrumentation. Ten interview questions were asked of participants:

1. Why did you become an EMT?
2. What have been your experiences as a CBPO EMT?
3. What are some things that you find rewarding as a CBPO EMT?
4. What are some factors that influence your engagement as a CBPO EMT at work?
5. What are some benefits as a CBPO EMT?
6. What are some challenges as a CBPO EMT?
7. How do you feel about EMTs in CBP OFO?
8. What are some things you believe CBP OFO should know about an EMT-CBPO?
9. What are some things you believe the public should know about an EMT-CBPO?

10. What do you see in your future as an EMT-CBPO?

The interview questions are found in Appendix D. Response elements that contained personal or private details were changed or omitted if necessary and annotated accordingly within the research. The researcher presumptively went into each interview knowing participant responses might include descriptive details and could elicit strong emotions and possibly cause undue stress and harm for the participant. Even with IRB approval from the university, the researcher exercised due diligence to the best of his ability in protecting the safety and well-being of participants. This included regular reminders throughout the interview process that participants could withdraw from the research at any time without suffering consequences. In addition, the researcher could have halted an interview if he, in good conscience, believed the interview process harmed participants without their realization. Furthermore, participants were also reminded of the EAP's service.

Data Collection

The researcher conducted interviews using Zoom videoconferencing, telephone, and in-person. Otter.ai was the program selected to record and transcribe interviews. Although Zoom has the capability to also record interviews, Otter.ai was compatible with all three forms of communication. The preferred method was either Zoom or in-person interviews compared to over the phone because "sometimes, verbal responses are too inarticulate or ambiguous to permit interpretation. However, the interviewer may be able to understand the intent of the response through the respondent's gestures or tone" (Babbie, 2001, p. 260). Responses were recorded verbatim, but noting the nonverbal gestures and cues provided further context during review. The researcher also took

handwritten notes on other relevant topics without interrupting participants to help with the flow of responses, and follow-up questions were asked after each participant response.

Data Analysis

The subjective nature of the research means that the measure of data would be overwhelmingly copious. The amount gathered from participant interviews was sizeable not only in volume but also in detail. To help organize this data, the researcher used Quirkos as the primary method for data analysis. After participant interviews were transcribed, they were uploaded to Quirkos. The researcher subsequently created different nodes, all of which related to this study's purpose of identifying motivational factors. Participant responses were assigned to different nodes accordingly. The organizational functions and simple interface from Quirkos enabled the researcher to identify themes much more easily and reduced the possibility of overlooking data that might otherwise have been missed. The data were then interpreted in a logical manner that answered the two research questions posed in this study.

Limitations

There were several limitations to this study. First, only CBPO EMTs were included in this study. The research questions only sought the motivational and agency benefits from CBPOs. As mentioned in Chapter 1, the different components within CBP involve vastly diverse duties and environments between them. These differences are enough to reasonably assume the motivational factors in OFO are not the same. Even within OFO, there are other nonofficer positions for which an employee may be an EMT.

However, this study only explored a CBPO's status as an armed law enforcement officer with the duty and expectation to respond to medical emergencies.

Second, permission to conduct this research was only approved for two of the three field offices in California thus reducing the number and diversity of participants. Third, some participants were already EMTs prior to CBP employment or before being stationed in California. Although their motivation may be different from those who became an EMT after onboarding with CBP, the researcher firmly believed their decision to remain an EMT was relevant for this study because it was still completely voluntary for employees to become or remain as EMTs at CBP. As mentioned in Chapter 1, being an EMT does not confer extra benefits such as additional pay though this researcher discovered unofficial and intangible benefits perceived by the participants. Although there is an expectation for CBPO EMTs to respond to medical emergencies, management generally cannot force them to be involved in other related aspects of being an EMT such as providing medical training to others.

In this study, there were two assumptions for basing participants on self-determination theory (SDT): behavior is driven by growth and "autonomous motivation is important" (Lopez-Garrido, 2021, para. 8). Without these two assumptions, participants may not offer genuine responses for which this study aimed to seek with SDT.

There is also the nature of the qualitative case study itself. Even if the exact guidelines and line of questioning established were followed, the study cannot be replicated because of the "social setting and circumstances of an initial study" (Bryman, 2004, p. 273). Small nuances like the researcher's tone of voice can also produce

different results. Last, there is the argument of the lack of rigor in case study research and how case studies “provide little basis for scientific generalization” (Yin, 2003, p. 10). However, a rebuttal is not against its ability for generalization but is the value of refining theory and theoretical inferences made from qualitative studies that establish and assess the limits to generalizability (Bryman, 2004; Denzin & Lincoln, 2005).

Summary

This chapter described the methodology used for this research. CBPO EMTs were the participants for the study and were asked a series of questions conducted by the researcher via interviews. All interviews were recorded and participant responses transcribed verbatim. A narrative analysis was subsequently used for data analysis. Safety measures were also discussed in this chapter. The findings of the study are presented in the next chapter.

CHAPTER 4: RESEARCH, DATA COLLECTION, AND FINDINGS

Overview

This phenomenological study explored the motivational factors that influenced Customs and Border Protection officer (CBPO) emergency medical technicians (EMTs). This chapter begins with a restatement of both the purpose statement and research questions of the study. Next, the research methods and data collection procedures are explained. This chapter concludes with the presentation and analysis of data conducted in this study before ending with a summary of findings.

Purpose Statement

The purpose of this phenomenological study was to explore the perspectives, experiences, and reasons that influence CBPOs at ports of entry in California to take on additional role as an EMT.

Research Questions

The following two research questions guided this study:

1. What are the perceived motivational factors that contribute to one becoming an EMT?
2. What are the perceived benefits of becoming an EMT as a CBPO?

Research Methods and Data Collection Procedures

This study explored two relevancies of CBPO EMTs: their motivational factors and the perceived benefits. The specificity of this research also helped identify the population and sample. The researcher determined the most appropriate method of collecting data for this study was to conduct interviews in which participants were asked

10 questions relating to their EMT status. Participants were given the option to conduct the interview through Zoom, telephone, or face-to-face.

Prior to collecting data, the researcher received permission from both California Baptist University and Customs and Border Protection (CBP). The university's requirement is its IRB's approval, indicating that the researcher has done everything within his control to minimize harm to participants. This included either offering services or advising participants where to seek help if the need arose. The IRB's approval was granted for this research on December 4, 2021, authorizing 1 year from this date to complete the research (see Appendix E).

Receiving permission from CBP was more complex. Although there are 20 ports of entry in California (CBP, n.d.-g), they are managed by only three field offices: San Francisco, Los Angeles, and San Diego. The person in charge of a field office is the director of field operations (DFO).

The researcher did not contact the DFO but instead the area port director (APD) for permission to conduct this study for a couple reasons. First, DFOs are part of the Senior Executive Service (SES). According to CBP (2022f), "SES is typically responsible for high-level decisions, CBP's vision and interacting with external stakeholders and Congress" (Career Progression section). These positions are also appointments, with their duties focused on administration rather than actual operations. Second, DFOs look over other regions beyond the location listed in their field office. For example, the San Francisco Field Office also includes Hawaii; Commonwealth of Northern Mariana Islands; Guam; and Reno, Nevada. Third, DFOs typically serve as a liaison between CBP executives at headquarters and their field offices.

The researcher had reason to believe contacting such high-level government officials for a research project would not have been a priority for them, and there was therefore a high likelihood of not being able to continue with this study.

On the other hand, contacting the APDs, or their designee, was a much more viable option. Even though APDs are also part of the SES, they have much more awareness of their daily operations and employees within the ports they oversee. For example, the San Francisco APD not only gave permission to conduct the study, but he also mentioned a recent CBPO academy graduate who was also an EMT (see Appendix F).

The Los Angeles Field Office was much more meticulous in authorizing this study. Request to conduct the study was vetted through their Office of Chief Counsel, which took a few months from beginning to end. Ultimately, permission was granted, with a strong reiteration that the research was to be conducted solely off government time and property, was not sanctioned or endorsed by the agency, could not use or improperly disclose nonpublic information, included viewpoints from participants who were speaking solely in their personal capacities, and included a disclaimer to be in compliance with the Whistleblower Protection Act (see Appendix G).

The San Diego Field Office did not grant permission for this study. Initially, an academic proposal was required to be considered. The main points in the academic proposal were to include what the researcher was trying to accomplish and how the study could benefit the agency. The researcher indicated the study was strictly for personal enrichment with improved public service from CBP as a possible benefit. After submission, the assistant director informed the researcher that conducting observations

could not be supported because of the operational tempo and all resources being used (see Appendix H). The researcher noticed this discrepancy in the assistant director's response. Two attempts were made to clarify that the data collection method was participant interviews and not observations. In addition, data collection would be conducted on nongovernmental time. A voicemail highlighting these points was left on the assistant director's phone. An email was also sent the following day, but no reply was received. The researcher decided at this point any further attempts would not be career enhancing and ceased further contact.

In all three field offices, the researcher contacted the APDs or their designated officials through the chain of command. The San Francisco Field Office was first to authorize the researcher to conduct the study and took the least amount of time to do so. This was most likely because of its being the researcher's home port. The San Diego Field Office did not give permission for the researcher to conduct this study. The Los Angeles Field Office was the last to respond because it took the longest amount of time to review the study. However, it ultimately granted permission to the researcher. The researcher then contacted participants through email using CBP's emailing system with permission to do so for the initial notification. Subsequent communications, such as personal emails and text messages, were done on nongovernment time and devices to set up interview times.

A total of 10 participants responded to the researcher. There were two paramedics, one advanced emergency medical technician (AEMT), and seven EMTs. To be eligible for the study, participants must have been a CBPO and current EMT, AEMT, or paramedic and not the subject of any disciplinary action at the time of interview.

Participant interviews were conducted in three ways: one participant through Zoom, five participants through telephone, and four participants through face-to-face. To ensure consistency throughout all interviews, the researcher read his IRB-approved Interview Protocol and Script (see Appendix I) prior to starting each interview, reminding participants all responses would be recorded, their identities would be protected, the Employment Assistance Program (EAP) was available if discomfort or distress occurred, and all other relevant disclosures but most important, the 10 interview questions pertaining to being an EMT.

In choosing a recording program, transcription accuracy is arguably the most important criteria. The researcher ultimately chose Otter.ai to record all interviews, whether through Zoom, telephone, or face-to-face. According to Wu (2021), “Otter has up to a 95% accuracy rate when transcribing text” (para. 9). Furthermore, its “software is so effective that in 2018, Zoom licensed its software for use in its cloud recording feature” (Wu, 2021, para. 10). Because this study also used Zoom for interviews, the researcher cited these two reasons for using Otter.ai. Another feature was the identification of common phrases or repeated words in a recording though this was not always useful. For example, the word *EMT* came up in all the transcripts, which proved unhelpful because this study was based on CBPO EMTs. Once Otter.ai finished transcribing a recording, it exported it into various types of document files. Microsoft Word was among them and was selected by the researcher. The researcher declared he had no relationship with Microsoft, Otter.ai, or any of their affiliates in any way, shape, or form other than being an ordinary paying consumer of their products.

The unedited interviews and transcriptions made up the raw data for this study. Despite the researcher's best attempts in preparing for the interviews, such as finding private settings or ensuring strong cellular phone signal, minor issues still occurred. For example, the interviews conducted through Zoom and telephone sometimes cut out or had a lagging response, and the researcher had to ask participants to repeat or clarify their answers. Face-to-face interviews did not have such connectivity issues and produced more passionate and emotional responses from participants. However, the researcher believed these issues had minimal negative impact to the overall quality of the interviews conducted.

Prior to data analysis, this raw data first needed to be refined. After the completion of an interview, the researcher replayed each recording in its entirety with a copy of the transcription in Microsoft Word. Despite its high accuracy rate, Otter.ai still incorrectly transcribed words or phrases, which could be due to topic specific terminology, uncommon acronyms, homonyms, or background noise. To ensure the integrity of the study, the researcher reviewed the recordings slowly, editing the corresponding transcripts as many times as needed until accuracy was at or as close to 100% as possible. Once this was accomplished, the newly refined data were analyzed using the qualitative analysis software Quirkos.

The researcher selected Quirkos because of its simple user interface. Document files are imported into the software, and the text appears on the right side. From that point the researcher began highlighting text regarding the research questions asked in this study and anything else related to them. The highlights created circles, called quirks, on the left side of the software. This is when the researcher began the process of coding

themes. The themes found pertaining to this study are presented in the next section. The researcher declared he had no relationship to Quirkos or its affiliates in any way, shape, or form other than being an ordinary paying consumer of its product.

Presentation and Analysis of Data

For this study's first research question, the researcher identified three factors that influenced a CBPO's decision to become an EMT that are shown in Table 1. They are conventional factors, episodic factors, and inherent factors. These factors do not stand independently; rather, they all overlap one another to various degrees. Although one may exert more influence, all three factors are present in influencing a participant's decision in becoming an EMT.

Table 1

Motivational Factors That Influence a CBPO's Decision in Becoming an EMT

Factor	Characteristics and subcategories
Conventional	Respectable Profession Familial Influence
Episodic	Positive Negative
Inherent	Innateness Self-Interest Individual Will Personal Growth Self-Challenge Self-Reward Helping People Reliable for Others Possessing Specialized Knowledge

Note. CBPO = Customs and Border Protection officers; EMT = emergency medical technician.

For this study's second research question, the researcher found five benefits to being a CBPO EMT. They are autonomy, unique opportunities, additional training,

building relationships, and satisfaction of helping others and are shown in Table 2.

Participants demonstrating self-determination theory's (SDT) three psychological needs are also discussed in sections where applicable.

Table 2

Perceived Benefits of Becoming an EMT

Benefit	Attributes
Autonomy	Trust, flexibility, responsibility
Unique opportunities	Merit-based special assignments
Additional training	Personal and professional development
Building relationships	Personal, organizational, collaborative
Satisfaction of helping others	Intrinsic fulfillment from helping others

Conventional Factors

Conventional factors are the typical norms associated with working in a corresponding line of work. In this study, the two characteristics that make up conventional factors are Respectable Profession and Familial Influence.

Respectable Profession

Three participants had interest in working as firefighters, but one major prerequisite required EMT certification. Although one could argue that fighting fires and treating patients are two completely different tasks, they are both necessary in society and as such are typically considered as respectable professions. Participant 03 also stated, "All the positivity around" being a firefighter. In addition, job stability, decent pay, and good retirement were mentioned by participants as qualities of a respectable profession. However, they also acknowledged this is largely dependent on agencies or cities that have the revenue or resources to be able to do so. Lastly, participants cited the nature of

the job itself—although not necessarily backbreaking, it does require hard work and effort but at least provides an honest means of living.

Familial Influence

Familial influence also impacted participants' decision to enter the medical field. Participant 08's mother was a nurse in a hospital. As he was growing up, he had many talks with her about the work that she did, including "all the people she's helped." These conversations eventually led him to have a desire to want a level of medical knowledge to render aid and help others when the need arose.

Participant 09 was among one of the oldest participants of this study, recollecting a time when fire departments solely fought fires and EMS dealt only with medical situations. However, it "is now the 'national standard' to merge those services (Stein, 2022, para. 8). Recalling this difference, Participant 09 stated his family of firefighters dissuaded him from becoming a fireman himself, but instead he found interest in the medical field as another means of helping people.

Participant 05 brought an interesting perspective of familial influence. As a person of Asian descent, Participant 05 stated there was the associated stereotype, "either you become a doctor, lawyer, or accountant." Participant 05 stated he always wanted to help people but also knew medical school was expensive. He opted to join the military because one of its benefits was paying for tuition. Furthermore, Participant 05 had an older brother who was already serving and encouraged him to fulfill his passion in helping others through the military.

Episodic Factors

Episodic factors are special events that occurred in the participants' life that influenced their decision to become an EMT. These events include both positive and negative experiences. After high school, Participant 03 was unsure what to do but continued his general education studies with a few of his friends during college. They discussed many prospects, including talks about becoming firefighters. However, the final push occurred when his younger brother became injured from a skateboarding accident:

He ended up breaking his arm, and I could still remember the look on his face and the feeling that I felt, the feeling of hopelessness, and the feeling that I didn't know what to do. And all I could do was call for help. And I promised myself that I would never, ever feel that again. I would educate myself. So if anything ever happened like this again, I'd know what to do and so I never feel that feeling again. (Participant 03)

Participant 03 was approximately 19 years old at the time of this incident. Such a traumatic incident can linger and have long-lasting effects on people, especially for someone who is still technically a teenager.

Similarly, Participant 09's experiences also started off grimly. He shared two unpleasant incidents. The first incident involved "a lady literally dying in the bathroom of a fast-food restaurant" (Participant 09). Despite all the chaos that ensued, Participant 09 was able to provide some care, which "brought her back so at least she had the dignity to be able to die in the hospital 2 weeks later unfortunately, but at least not on the toilet of a bathroom at KFC." The second incident "was a biker accident" (Participant 09). The

researcher noticed some minor signs of distress after Participant 09 shared these experiences and decided not to have him elaborate on the second incident.

As with Participant 03, Participant 09's beginnings occurred in his younger years. However, he did possess some rudimentary medical skills, which enabled him to preserve the life of his first patient and helped him to realize the critical importance and need of EMS.

Participants 03 and 09 already had some inclination of wanting to work in the medical field, but these medical episodes helped solidify their decision to become EMTs. Under SDT, these examples can be classified as extrinsic motivation. After these traumatic experiences, both participants internalized and integrated them into their own sets of values and beliefs (The Brainwaves Video Anthology, 2017; Ryan & Deci, 2017).

Participant 04 spent a significant amount of time in the military. During his time, he had "seen guys get injured, get hurt pretty badly." In these situations, Participant 04 stated he was not medically trained and only took directions from others to help assist. He also stated he was fortunate never to be "found in a situation where I was the guy that had to somehow keep this person alive" (Participant 04). To avoid such a scenario, Participant 04 took the initiative and became medically educated and trained. Like Participants 03 and 09, these experiences were Participant 04's extrinsic motivation to become an EMT.

Not all episodes stem from negative circumstance. Participant 06 took a proactive approach when he became a father. Children can be eternally rewarding for any parent, but raising them is rife with challenges. Their inquisitive nature and curiosity allow them to understand the unpleasant facts but sometimes at a cost. For example, children learn

eating a healthy meal neutralizes the feeling of hunger. However, they are quick to not only learn eating a sizzling hot meal right from the oven burns the tongue and other parts of the mouth but also learn a serious lesson in pain. Although unpleasant, these inevitable situations are a part of growing up. With four children, Participant 06 became an EMT because he “wanted to be able to attend to them in a medical situation.”

Responsible parents can capitalize on these teachable moments, but they must first be prepared to handle the situation medically.

Inherent Factors

Inherent factors are innate within a participant. There are no scientific reasons or logical explanations to justify them other than simply the participant’s volition. Inherent factors are composed of three categories: Innateness, Self-Interest, and Self-Reward.

Although all categories are self-explanatory, the self-reward category has more depth because of what a participant considers rewarding.

Innateness

The simplest category in inherent factors is Innateness. Essentially, it is something that is part of a person. In this study, six of the participants mentioned passion as an innate motivator. However, the type of passion differed among them. Participants 03, 05, 07, and 09 mentioned the passion of helping people, and Participants 01 and 10 stated it was the passion of learning medicine. Participant 09 stated it best: “[It] was just something I wanted to do.” Regardless of where it took them, the feeling of passion had significant influence among the participants.

Self-Interest

There are three subcategories within Self-Interest. The first is Individual Will, followed by Personal Growth and Personal Challenges.

Individual Will. Participants offered a variety of their personal reasons why they became EMTs. Five participants stated learning about medicine was what interested them (Participants 01, 05, 08, 09, and 10). Participant 02 stated his journey to become an EMT began about a decade ago:

I was interested in survivalism and that sort of thing. So there was a number of skills I wanted to develop, and at the top of the list was medical training. And so that's what first motivated me to become an EMT and wanted to get that initial EMT training.

Fire science, a common prerequisite to become a firefighter, was mentioned by Participants 03 and 06 as their initial influence to become EMTs. Participant 07 stated she already "had been involved with search and rescue." When asked how, she further elaborated that her decision was due in part to watching a presentation as a high school sophomore in which "the helicopter part was really exciting, and I wanted to be a part of that."

Personal Growth. The second subcategory is Personal Growth. Personal growth can also be viewed as self-improvement. Participant 02's initial interest in survivalism segued him into learning about basic medical skills and eventually enrolling in an EMT program.

Participant 08's early conversations with his mother helped him "develop a desire to eventually have some skills and be on a certain level, or some kind of medical aid or

something like that.” After being hired though, Participant 08’s desire had to be put off because there were other law enforcement duties and tasks that took precedent.

However, his desire never subsided. In fact, Participant 08 became one of the first successful EMT graduates from the recently established EMT academy offered by CBP’s Office of Field Operations (OFO).

Participant 10 shared this commonality also as a newly minted EMT from the same academy, but her beginnings were different. Unlike Participant 08, Participant 10 was an EMT prior to joining CBP. She originally wanted to become a paramedic firefighter, and one of the prerequisites required 6 months’ experience as an EMT. Participant 10 quickly realized, “The more I did the job, the more I realized that there was still a lot to learn. And I wasn’t comfortable signing up for a paramedic program without having some solid knowledge and experience under my belt.” For reasons not revealed, Participant 10 had a few hiatuses as an EMT. However, her desire to better herself as a medical provider continued despite those breaks, resulting in her current status as an CBPO EMT and firearms instructor.

Even after becoming EMTs, participants continue to better themselves. The majority of participants take on additional responsibilities as EMTs. One such duty includes teaching CPR to other CBP employees. Participant 01 mentioned that he was “able to learn how to instruct better,” despite his preference of hands-on learning over lecturing. Participant 02 stated, “Being an EMT inspired me to be the health and safety officer.” In the instances in which there is a medical emergency, Participant 03 acknowledged an excitement factor, which “draws you in and makes you want to do it more and become better at it.”

Self-improvement is not reserved only at the workplace. It can take place elsewhere as Participant 02 stated:

Being an EMT inspired me to take additional courses like wilderness first aid. And also with scuba classes. They have, like scuba rescue people, and I'm kind of interested in that too. And they have a class that just deals with administering oxygen, which we already know how to do, right? So actually, the EMT thing has helped me more with my hobbies than my job.

Participant 04 noted the constant changes and improvements in medical technology and practice. He realized that learning never stops:

In the medical field, things are constantly being discovered, new types of ways and medication. We learn so much every day. From past instances where this may not be the best way to have done this. We're going get together as a medical community, and now we found a better way to do it, and we're going get that out.

Whether or not these personal betterments are beneficial or applicable at the workplace could be discussed elsewhere. The fact that participants voluntarily decided to go through the process of self-improvement demonstrates autonomy, a psychological need that is required to become autonomously motivated in SDT. Autonomy is the ability to be in control of one's behaviors, decisions, or goals, which frees one from outside influence and "one's behaviors are self-endorsed, or congruent with one's authentic interests and values (Ryan & Deci, 2017, p. 10). In this study, none of the participants mentioned feeling coerced in any way as they continued to self-improve.

Self-Challenge. The third and last subcategory is Self-Challenge. Participants in this study not only were EMTs but also were law enforcement officers. Unfortunately,

the large disparity between having another EMS provider versus another officer for support is obviously noticeable. In the latter case, it is comforting to have a barrage of fellow officers to help control a law enforcement situation. But in the former situation, CBPO EMTs often have only themselves to rely on when they encounter a medical emergency. Depending on the type, an emergency can be challenging and serve as a testament of an EMT's competency.

Competency is another psychological need for autonomous motivation in SDT, referring to one's sufficient ability to perform a task or possess a high degree of skill (Cherry, 2021; Lopez-Garrido, 2021). In multiple instances, participants demonstrated competency during their CBP careers, validated by praise or sincere thanks from those being helped. Participants 03 recalled the time they had a "confirmed field save," responding to a scene even before the fire department showed up, and "ended up just giving CPR to this guy, and we ended up shocking right on the scene and brought him back."

In another instance, Participants 03 and 05 responded to an asthmatic patient who was experiencing respiratory distress. Participant 03 was only able to provide minimal treatment because he was an emergency medical technician-basic (EMT-B). However, Participant 05 was a paramedic, allowing him more options to treat the patient. After administering drugs to the patient, "He ended up recovering" (Participant 05). It should also be noted that Participants 03 and 05 were Special Response Team (SRT) operators. In 2018, migrant caravans were attempting to enter through the southern border of the United States. Given Participant 05's impressive credentials and status as a paramedic, he was "Tasked to run the entire medical section for CBP in San Diego sector and to be

the liaison with all those Washington managers and all the high-ranking folks.” Taking charge of such a monumental task is certainly no easy feat. When asked, Participant 05 credited his military training and experiences in accomplishing this task:

If I didn’t learn any of the skills from the military, I would have said this was overwhelming. I don’t know what I’m doing. But a lot of the stuff I’ve done in the military, you know? It just transferred over and I was like, yes, I’ve done it before. I know what I’m doing.

Participant 01 responded to a traveler who collapsed after a long flight. Along with a good Samaritan who also happened to be a physician’s assistant, Participant 01 worked on the traveler for over 30 min before local EMS arrived. During this time, Participant 01 resuscitated the patient from cardiac arrest. The patient was then transported to a local hospital for further definitive care. After a week, the patient recovered and was subsequently discharged from the hospital. As a result, Participant 01 received personal praise from the executive assistant commissioner at CBP Headquarters. Participant 07 responded to patients suffering from “potential strokes or seizures.” Participant 09 was regularly called on by managers while working at the border to treat any traumatic injuries on suspects prior to their arrest.

Self-challenge is not limited to only the actual treatment of patients though it is undoubtedly the most important in terms of survivability. As Participant 03 stated, “It’s a lot more work. It’s a lot more responsibility.” With only 24 hr in a day, time management is a skill participants must have while tending to the many administrative tasks associated with being an EMT, which include but not limited to enrolling in continuing education courses for biannual recertification purposes, writing reports,

conducting classroom training, inventorying medical supplies, and maintaining emergency medical equipment. These tasks are all in addition to the regular duties of a CBPO.

Self-Reward

This study identified three types of rewards in the Self-Reward category. They are helping people, being reliable for others, and possessing specialized knowledge.

Helping People. Remarkably but perhaps unsurprisingly, all 10 participants mentioned in one form or another about the satisfaction in helping people. Participants 06, 03, 05, 09, and 10 mentioned that it did not matter who the recipient was: family members, children, the public, fellow officers and other colleagues, or even suspects.

Reliable for Others. Being reliable for others was also a sentiment expressed by four participants. As mentioned in the previous section, Participant 05's extensive military and medical background caught the attention of senior CBP leaders who asked him to take a leading role in the San Diego sector in overlooking the migrant caravans crossing into the United States. Participant 05 stated that he felt honored to represent CBP in taking charge of the operation "as the person they can trust and rely on." However, Participant 05 admitted that had it not been for his training in the military, he would have found the task "overwhelming." Participant 03 had also been relied upon many times. Early in his career, Participant 03 recalled multiple instances when "They would call me for all the medicals." This was due to his prior profession as an EMT.

People asking for medical assistance usually do so because they are either ill or injured. This already shows their reliance upon a medical professional. It is also likely that patients become mentally vulnerable, especially during serious incidents.

Participant 07 stated the reassurance given and to “be able to help them or share them or explain what’s going on” can really mitigate a patient’s anxiety.

Participant 10 was a firearms instructor. Working in a capacity when injuries are quite probable, she “made sure to talk to my team and just give them some of the medical knowledge that I had.” Whenever there were questions, Participant 10 stated they would go to her and “have an open discussion.” She would also inform her superiors as well, not only as a firearms instructor but also as an EMS professional. When CBP conducts a tactical enforcement operation, the chances of injury are much higher than regular, daily duties. Participant 10 would graciously volunteer and stated, “I will 100% be available if they need me.” Ultimately, Participant 10 made “sure that everybody knew that they could grab me at any point in the day if anybody would need anything.”

Helping people and being reliable for others demonstrates relatedness, the last psychological growth needed for autonomous motivation in SDT. Relatedness is feeling connected to others and vice versa; this is important because it builds support within a social group, especially when someone is being cared for (Cherry, 2021; Ryan & Deci, 2017). One social group identified by participants in this study was fellow CBP employees. This was prevalent with Participant 10:

Sometimes officers tend to withhold information from coworkers, whether or not they’re feeling sick, or you know, they’re having chest pains because of the fear of judgement. And once people realize, okay, you’re an EMT and you’re my coworker, there’s a level of understanding, and the officers are very open to disclosing. I have assisted with an officer who was having chest pain in the past. And the only reason it was addressed because he knew I was an EMT in the past,

he knew I had the experience. We do have certain officers with medical conditions, and they'll immediately disclose, "Hey, I know you're an EMT. I have this situation. If this and this happens, just want you to know I might need you to come and assist." And I like being available to them.

Relatedness does not have to come directly from a treatment standpoint. In Participant 05's case, his very impressive skill set and reputation earned him the connection of top level managers of CBP. Relatedness can also come from the far reaches of helping others. In other instances, relatedness comes from interacting with like-minded individuals or agencies. This would be the case for other EMS agencies, another social group identified in this study, that cross paths with CBP. Participant 07 stated, "It's been good to build relationships" with the bicycle medics from the fire department, eventually establishing enough trust for CBP EMTs to participate in some of the fire department's more advanced medical training.

Yet another far-reaching effect from helping others comes from teaching basic medical classes to officers. After attending a CPR class, a rather stoic officer's attitude and tone completely changed after Participant 07 approached him the day after to talk about the class, and the officer even expressed interest to become an EMT.

Participant 07 stated, "It's about inspiring others, helping others." Other participants shared the same sentiment. Participant 03 mentioned how multiple officers from different classes have come back to thank them and ask for more training because of the unfortunate timing of actually witnessing and intervening in a medical situation only days after taking the training. All these instances only enhance and make the connections between participants and different social groups stronger.

Possessing Specialized Knowledge. Possessing specialized knowledge is the last type of reward. For this study, specialized knowledge includes both education and the skill sets performed relating to medical treatment. Participant 02, and more than half the participants, admitted liking the fact they “have a baseline of knowledge more than most people” directly because of having medical training. Although this can be interpreted as egoism, this researcher viewed it positively as competency because it results in helping others. Participant 06 emphasized that becoming an EMT is not difficult, but “If you want to become an EMT, they don’t make it where you can just cruise through and just do like the minimum kind of thing.” Of course, having knowledge is only half the equation because one must also be able to demonstrate proficiency in the actual treatment of patients. But once this criterion has been met, the reputation of a capable CBPO EMT spreads quickly as Participant 07 stated, “It sets you apart and distinguishes you.” Hence, possessing specialized knowledge also reinforces relatedness as the demand for a participant’s skill set is sought after by fellow colleagues, supervisors, or anyone else who requires it.

All participants in this study became EMTs after being autonomously motivated. However, the process in which participants achieved it varied. It did not appear that a definitive claim could be made in determining whether extrinsic or intrinsic motivation was the sole factor among participants in becoming EMTs. All participants were intrinsically motivated by possessing the triumvirate of the characteristics of psychological needs that SDT is based on. Autonomy was fulfilled by participants’ decision to become EMTs; competency was exhibited by participants’ ability to pass the written test and demonstrate skills as required by NREMT; relatedness was presented by

participants' expressed willingness and actions to help others. However, four cases of extrinsic motivation were also cited by participants as their primary reasons for becoming EMTs.

Autonomous motivation also did not indicate instant change from participants becoming EMTs. In some cases, extended periods of time were passed, such as completing military service or the birth of multiple children. An interesting finding was that the passage of time did not appear to be a hindrance to participants who are were autonomously motivated. Six of the participants in this study were either EMTs already or had possessed some adequate amount of medical training prior to joining CBP, and four of the participants became EMTs after becoming CBPOs. At the very least, this demonstrated the lasting propensity for these participants to become EMTs that was not otherwise achieved earlier.

Autonomous motivation can also be strengthened by the three psychological needs that complement one another cyclically. This demonstrates one of SDT's fundamental differences from other types of motivational theory: when there is a focus on the interrelatedness of the three psychological needs. Initially, participants' autonomy led them to acquire the knowledge and skills that are expected of EMTs. Participants then demonstrated their competency through practice and experience while building up relatedness among those who were being helped. Upon completion of this study, participants still retain their passion and drive as EMTs. Relatedness continues from CBP managers, colleagues, or other parties who call upon participants for their competency. To maintain competency, participants exercise autonomy by seeking out ways to continually improve their skills.

For this study's second research question, the researcher identified five benefits participants associated with as CBPO EMTs. They are autonomy, unique opportunities, additional training, building relationships, and satisfaction of helping others. The order listed does not imply or indicate any type of hierarchy or ranking of preference.

Autonomy

In this study, autonomy has been understood as being one of the three components that make up psychological needs. In this section, autonomy is viewed as a benefit. Its secondary meaning can be understood in the more general sense rather than being associated with the characteristics of motivation. There were three attributes in autonomy: trust, flexibility, and responsibility.

Participants differed from other CBPOs because they were EMTs. When a medical emergency arises, management or other colleagues often seek participants to respond. During medical treatment, trust is generated because those lacking the medical qualifications witness firsthand the work put forth by the participants. Depending on the severity of the medical situation or patient outcome, the trust earned can be significant.

In turn, this begins a sense of expectation for participants to respond to medical emergencies whenever they occur. This can be refreshing, especially when work at times can be monotonous. Participant 07 found, "Variety and autonomy to be motivating. And so certainly to go and be able to do medical things is a good change of pace. But it's also rewarding just to be helpful." Participants also had more flexibility. The majority of CBPO EMTs also function as instructors and teach various first aid trainings to other CBP employees. Along with the CBP manager overseeing the EMS program, participants chose when, where, and how classes were taught.

Although the participants were not in absolute control, this added flexibility allowed them more time to prepare the appropriate training materials for classes, resulting in a better quality of class compared to something put together haphazardly. Participants also acquired more leeway in their schedules when attending training. Participant 02 stated being “Allotted plenty of training from my employer and supervisor, and if I had to take days off to attend some other training, they give it to me.”

Responsibility is the last attribute of autonomy. At a minimum, all participants were required to maintain their EMT certifications every 2 years, which includes having a certain number of hours for continuing education and performing specific medical skills. Participants who also taught must ensure training records have been documented properly. Although not difficult, these extra responsibilities can take quite some time to complete. Typically, added responsibility has a negative connotation attached to it. Participants, at the very least, tolerate this because they are still able to excuse themselves from regular duties in completing these administrative tasks.

Unique Opportunities

Although not mandatory, CBPO EMTs who volunteer to help the agency expand its EMS program can be afforded unique opportunities not available to other CBP employees. Participant 01 recalled travelling to San Diego twice to attend a CBP instructor course with less than 2 years on the job, but his previous 10 plus years’ experience as a medical provider more than compensated for it.

Participant 03’s EMT experience enabled him to become “one of the main cadre for medical” personnel CBP’s SRT basic selection course.

Participant 05, as mentioned previously in the chapter, was “Tasked to run the entire medical section for CBP in San Diego sector and to be the liaison with all those Washington managers and all the high-ranking folks.”

Participant 04, who is also an SRT operator, stated that they “oftentimes get tapped on the shoulder by headquarters to participate in natural disasters response.” In addition, Participant 04 “had the opportunity to deploy overseas to provide individual first aid kit (IFAK) training to Guatemala federal officers, training in the embassy for the Marines.” During the time of this writing, Participant 03 had also just returned from providing training to CBP employees assigned to Abu Dhabi in the United Arab Emirates.

The researcher acknowledges the opportunities presented to Participants 03, 04, and 05 were most likely due to their statuses as SRT operators. However, he insisted on including these unique opportunities because of the medical training still being necessary to instruct others. CBPO EMTs who are not SRT operators also have the opportunity to travel to different ports to teach.

Additional Training

Participants mentioned receiving additional training as a benefit. As stated previously, EMTs are required to possess a certain number of continuing education hours to maintain their proficiency. There are several ways to fulfill this requirement, such as instructing or enrolling in anatomy, biology, or pharmacology classes relating to EMS. Receiving additional training is also another way to fulfill this requirement. Participant 06 expressed excitement when CBP announced classes to teach advanced

skills for EMTs. The additional medical training is not unique to CBP. Participants 01 and 07 attended a pediatric training hosted by the local fire department.

Building Relationships

Building relationships is a major benefit, both on a personal level and organizational level. On a personal level, participants build relationships with fellow officers and other EMTs. Participant 07 recalled how she helped change the attitude of a newer officer “who you couldn’t tear him away from his phone” into one in which he became more interested in becoming an EMT. Participant 07 was also able to inspire a younger officer whom she described as “very eager to help” into the world of EMS. This type of mentorship can also be seen between senior and junior CBPO EMTs. Participant 09 stated that with his 30 years of experience, he uses each medical response as a teaching opportunity:

It’s not to belittle them, but something that could actually harm the patient and be like, okay, hold on. Let’s do this and not this. Because if it hurts the patient, I don’t give a damn if I hurt your feelings or piss you off. I’m going to tell you to step away. I’m the senior medic and I have more training than you.

Of course, there must be tact during these teaching moments. It is equally important in how well the senior and junior CBPO EMTs deliver and receive the message. The senior EMT should foster a constructive, learning environment. Participant 10 stated, “We can have an open discussion about what you would think in the situation, and I think we’re all pretty open to discussing anything we have questions about to each other.” This creates a positive environment in which patient treatment is improved because of “the trust really that I have with my fellow officers” (Participant 08). On the other hand, if the junior

EMT “takes a level of knowledge and runs with it and thinks that they’re now a doctor of medicine” (Participant 09), not only is an opportunity to improve wasted but also the chances of further injuring the patient is increased. Furthermore, the relationship between both senior and junior EMTs become strained.

On an organizational level, participants act as ambassadors for CBP.

Participant 07 mentioned how buying coffee for a San Francisco Fire Department (SFFD) medic drastically changed the relationship between SFFD and CBP. Of course, this must be reinforced with CBP’s ability to respond to medical emergencies. Fortunately, this has been proven by CBPO EMTs with “The fire department coming back and saying, you and your guys did an outstanding job. You saved this person’s life” (Participant 03). Each agency gets to slowly familiarize itself and understand what its challenges and strengths are. When common goals are recognized, both agencies can mutually work together to increase efficiency—in this case, patient care. As a result, a professional courtesy develops and evolves into collaborative training, such as when Participants 01 and 07 took part in the pediatric advanced life support training hosted by the SFFD.

Satisfaction of Helping Others

Perhaps the biggest benefit participants saw to being a CBPO EMT was the satisfaction of helping others, especially those who benefit directly from medical treatment. As discussed in the Self-Reward section, all participants stated in their own ways their desire and satisfaction received from helping others. This was best described by Participant 03:

There’s no other feeling more gratifying in the world. And so, like, you give somebody a gift or something, they say thank you. But when you actually do

something, spend some time, and help somebody especially on the worst day of their life, there's nobody more appreciative, especially when you have your small piece of actually saving that person's life or someone saving somebody's life that that person cares about and they come up to you looking straight in the eyes, shake your hands, say thank you so much for everything. That's sincerest thanks. It's the best feeling in the world.

With colleagues, participants expressed the desire of helping others to be paid forward.

Participant 03 shared his optimism with the EMS program:

It's starting to get bigger and blossom; we're getting to a point where the numbers of people that we have trained are becoming very substantial, and it's just a matter of time before the people that we've touched will go out and help whether it's within the agency or external of the agency. We will help countless amounts of people.

Participant 04 echoed this sentiment and stated it is rewarding in "having that kind of force multiplier and seeing that kind of grow on its own."

Challenges

During the course of this study, the researcher discovered that participants continued to demonstrate autonomous motivation in bettering themselves as medical providers. Participants were also asked about the challenges they faced. Although this study focused on the motivational factors in becoming an EMT, the researcher believes these challenges need to be addressed because they pose a direct threat to SDT with even one participant considering leaving the agency. CBP is not immune from common challenges present in all industries and organizations, such as the lack of time and

resources, but this section addresses the specific issue raised by participants: the lack of understanding from managers.

Lacking Understanding/Knowledge

The most pressing issues participants faced was the lack of understanding of the EMS program within CBP. This happens both in the field and in administration.

Participants 02 and 03 shared that most CBP employees, including managers, do not know what EMTs do or what needs to be done. When incidents occur in the field, a brief report is typically generated. The report format is standardized so it can be used for various types of incidents, including medical situations. More important, a non-EMS provider can input this report. On the other hand, CBPO EMTs who respond to patients fill out a patient care report, which includes much more detailed information. It includes a patient's baseline vitals, medical history, treatments administered, and most importantly, refusal or transfer for further care. Although filling out the form may not necessarily require a lot of time, other aspects of responding to a medical situation can. As Participant 01 explained, restocking items used in treatment or even "15 minutes to get a cup of water. I'm exhausted after doing CPR for the last half an hour. Can I at least get a breather?" Typically, managers expect their employees to return to performing their regular duties upon completion of a medical call. This extra time CBPO EMTs need is not something they are accustomed to, especially when there is a hoard of impatient travelers waiting to be processed.

Many managers are also wholly unaware of a CBPO EMT's presence and capabilities. Participant 06 shared this frustration because this had occurred multiple times:

I can't count the number of times where I'd be standing right next to a supervisor and they'd say, "Oh we have a medical ... hey," and they point to some random officer and I'm like, "Sir, Ma'am," you know I'm an EMT?

Managers also need to realize when to relinquish control during a medical situation to a trained provider:

I've had instances where, you know, a supervisor or above has come over, and said, "Oh, give her a bottle of water. Go do this and that." And you know, it's like all due respect man, but you know, this is my scene. There's no other medically trained people here right now so you know, don't come over here and tell me how to treat the patient or whatever when you don't know anything about it. It's just that mentality of them to take control because they're upper management. (Participant 06)

This is important because without adequate training, helping a patient may inadvertently make a medical situation worse. For example, a hypoglycemic patient trying to eat some candy ends up fainting after struggling to open the stubborn wrapper. A natural inclination is to help the patient eat, but this is a major contraindication because the patient is no longer conscious and able to chew. The likelihood of choking and blocking the patient's airway has been greatly increased. A medical provider who could have just treated the patient with intravenous fluid now has to contend with an even more serious issue of maintaining a patient's airway.

Good intentions for conscious patients can also be problematic for employees who offer assistance. Participant 06 highlighted this point well:

There'll be people that have no medical background trying to say well, now this person has to remain seated on the ground even though they say I feel comfortable standing up or whatever, and they don't know that you know, I guess they probably don't know that. You know, if this person doesn't have any, like, altered state of mind, if they can make their own decisions, they can tell all of us to hit the road and just do whatever they want. I think as law enforcement with no medical background, you're thinking well, no, they have to, they gotta wait for the for the EMT or the paramedics to come and then that'll handle it.

Except in certain cases, patients can deny treatment from anyone at any time, even after treatment has begun. Although it may be difficult to resist the urge to help others, doing so otherwise constitutes committing assault and battery. This does not exclude CBP employees from being held liable unless it is law enforcement related. For example, CBPOs can ignore a subject's objection to treatment if injuries occurred during an apprehension. However, CBPOs cannot intervene without legal consequences against a regular traveler's desires to be left alone despite the seriousness of a medical situation.

These situations take away the autonomy from participants. Treatment options for patients are dangerously and erroneously decided by individuals who do not possess the same level of medical training, if they possess any at all, as those of participants. The feeling of relatedness is also strained between participants and their superiors. Even in cases after a participant treats a patient, they are not given enough time to restock their supplies or a break, which also decreases their autonomy and increases animosity with authoritarian supervisors.

Participants expressed administrative frustration with their immediate EMS chain of command because none were EMS providers though this might not be the case in other ports within CBP. However, participants stated that lacking a managerial EMS provider adds friction. When ordering supplies, it takes more time and communication when participants need to justify why certain equipment is needed. For example, a participant places an order for glucometer test strips from Brand A. The agency decides to purchase test strips from Brand B instead because they are cheaper. This results not only in a waste of test strips because the brands are incompatible but also in a waste of money. Furthermore, the participant is still without the test strips for the time being.

Another administrative challenge is setting up a memorandum of understanding (MOU) between CBP and local agencies to improve patient care. Collaborations are common in CBP. According to CBP (2021a), “Since the Reimbursable Services Program began in 2013, CBP has expanded it to include 241 stakeholders” (para. 4). This number is only a fraction of an unknown total because there is a myriad of lesser yet required partnerships, such as customs brokers or bonded warehouses, needed to complete the cycle of legitimate travel and trade.

CBP can easily dictate these collaborations to its partners because it is the leading agency tasked with enforcing these laws. According to Lee et al. (2012), “Trust among network members plays an important role in facilitating collaborative dynamics that enable positive outcomes to be achieved more readily” (p. 610). Although facilitating legitimate trade and travel are among one of CBP’s primary missions, so too is its obligation to help people. This includes the intervention of providing medical aid for those who are sick or injured.

When a CBPO EMT responds to a medical situation, it can take the local EMS agency a few minutes afterwards to arrive. In emergencies when patients only have a few minutes to be transported to receive definitive care, CBPO EMTs must be given all available tools to help the patient. Having paramedics respond would be the best option, but this is unlikely because of their rarity. More than likely, EMT-Bs would respond, but they are limited in their scope of practice in comparison to a paramedic. However, EMT-Bs can receive additional training to perform more advanced skills that are not normally associated with EMT-Bs. Of course, this must be accepted by the local EMS agencies through a MOU.

Participant 05 recalled seeing EMTs from other CBP components who were able to offer services and treatments not normally within their scope of practice, but this was due to “a MOU or agreement with the hospitals and they have that opportunity to do that.” Participants remarked on the absurdity of CBP managers without medical knowledge who are tasked with setting up such MOUs. Another point of frustration participants shared was the inability to set up an MOU between CBP and the local EMS agency allowing CBPO EMTs to participate in a ride-along program to continue their proficiency. Most of the participants stated that skills are perishable, which is a detriment to patient care. Although there are other ports and components of CBP in the United States that have established MOUs with local agencies, this appears to be the exception rather than the rule.

The EMS program in CBP is still relatively new. Naturally, the agency is proceeding cautiously as the program evolves with most managers erring on the side of caution. Participant 10 stated how her superiors “prefer that we keep things to ourselves

and that we don't overstep our boundaries." It is common for there to be competing goals of CBP and its EMS component, which can be a drain of resources. A supervisor may see a treated and stabilized patient as someone who has recovered enough to leave the inspection area whereas a CBPO EMT views this same patient as someone who may relapse and require more treatment, especially if the patient is unwilling to be transported to a medical facility. The supervisor may even see this instance as the CBPO EMT undermining authority and avoiding routine work, which unfortunately can happen. This type of assumption is not just reserved for management because other "people think it's a scam" (Participant 01). Again, these criticisms undermine the feelings of relatedness between participants and their social groups (Lopez-Garrido, 2021).

Summary

There were three motivational factors that contribute to one becoming an EMT and five benefits identified for CBPOs who became EMTs. The three factors are Conventional, Episodic, and Inherent. The qualities and characteristics of SDT were also demonstrated in participants within these three factors. Ultimately, all participants were autonomously motivated at some point before becoming an EMT. The five benefits identified were autonomy, unique opportunities, additional training, building relationships, and satisfaction of helping others. Lastly, the main challenge that participants faced was managers who lacked understanding of EMS. Although this issue was not part of the study's research questions, its relevance was too important not to be included because of its negative effect on SDT.

CHAPTER 5: FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of this study was to explore the perspectives and experiences that influenced Customs and Border Protection officers (CBPOs) at ports of entry in California to take on the additional role as an emergency medical technician (EMT). The following two research questions guided this study:

1. What are the perceived motivational factors that contribute to one becoming an EMT?
2. What are the perceived benefits of becoming an EMT as a CBPO?

This study was conducted through in-depth interviews with participants. The population in this study was CBPO EMTs. The sample was 10 CBPO EMTs stationed in various California ports of entry. Self-determination theory (SDT) served as the theoretical framework for this study because of its focus on motivation types, which were the defining points for participants becoming EMTs.

Major Findings

For the first research question, this study found three factors that influenced participants becoming EMTs: Conventional factors, Episodic factors, and Inherent factors. Intrinsic and extrinsic motivation, the core principles of SDT, were present in participants and were categorized into these categories accordingly. For the second research question, this study found five benefits for CBPO EMT. These five benefits were autonomy, unique opportunities, additional training, building relationships, and satisfaction of helping others. This study found that even after becoming EMTs, participants continued to demonstrate autonomous motivation in themselves to continually improve. An interesting finding was that it also did not appear the route

taken to become an EMT affected this trait. Of all participants, only one went through the Office of Field Operations' (OFO) EMT academy. Another participant underwent EMT training through a different Customs and Border Protection (CBP) component in becoming an EMT, and the remaining eight participants became EMTs through means not associated with CBP.

Unexpected Findings

During the course of this study, the researcher discovered one recurring challenge that participants raised during the interviews: the lack of knowledge regarding EMS from fellow colleagues, management, and even the public. The researcher believed this information was pertinent to the study because it directly contradicted the study's purpose. Although autonomous motivation was achieved by participants in becoming EMTs, negative actions can adversely affect and damage autonomous motivation to the point at which participants actively cease to remain EMTs.

Conclusions

Participants became EMTs after becoming autonomously motivated under SDT. This was achieved through various individual experiences. Some experiences were more impactful than others, but it was the overall culmination of events that led participants to become autonomously motivated. Interestingly, the process to become an EMT was not instantaneous, and some participants took some time before becoming one. The benefits identified in this study are also consistent with the overall theme of SDT.

Implications for Action

The researcher recommends two implications for action, which can be divided into an organizational response and an individual response. The response on the

organizational level should continue the encouragement for the EMS program in CBP's OFO. A participant's journey to become an EMT after achieving autonomous motivation is a process that takes time. On the other hand, eliminating autonomous motivation through criticism and distrust appears to be an easier process. Fortunately, the lack of knowledge can be remedied somewhat easily through educational awareness at this organizational level. This can be done through various mediums: internal electronic learning modules, email memorandums, agency webinars, or even live trainings conducted by CBPO EMTs at larger ports of entry that have extra bodily resources. Currently, these methods are all within CBP's capacity. Of course, this educational awareness should be given accordingly because of the individual challenges and operational needs of each port of entry. Ports of entry staffed with only one employee may not be able to do anything at all. Ultimately, the port director should decide the most suitable method and amount of educational awareness, but there are certain facts about CBPO EMTs that all employees ought to be aware of.

First and foremost, CBPO EMTs who are nationally certified with the NREMT can perform the same levels of medical assessments and emergency treatments as other EMS professionals. In some instances, CBPO EMTs who are paramedics can perform more than responding emergency medical technicians-basic (EMT-Bs) from a local agency. Managers must also be aware of the issue of patient abandonment. According to Wolfberg and Wirth (2021), "The legal definition of patient abandonment requires abrupt termination of a provider-patient relationship without affording the patient an opportunity to obtain replacement care" (Patient Abandonment section, para. 17). Exigent circumstances exempted, managers cannot legally order a CBPO EMT to stop after

treatment has started on a patient because they are bound to that patient until they are relieved by another EMS provider who can give the same level of care or higher to the patient. Managers who work on the front line should be trained in contingency planning of daily operations for such situations requiring a shift in personnel resources.

For nonmanagerial CBP employees, education can be simply knowing who the CBPO EMTs are, knowing their work locations, and being well-versed in operating a radio or any other communications device. Education for managers at or near the top can incorporate other lessons more relevant to them, such as legal and liability issues with chief counsel in the unlikely event a CBPO EMT performs negligently.

Another recommendation is to help OFO recognize the talent and utilize CBPO EMTs in ways beneficial to the agency. This is already being demonstrated by the San Francisco Field Office, which is fortunate enough to have a meaningful presence of EMTs. EMTs have been sent to smaller, outlying ports within their area of responsibility to provide training. Other field offices within CBP can also follow San Francisco's example if they are able to. Alternatively, CBP can also pull its EMTs from around the country to provide training at ports it deems most fitting. This greatly reduces the time, cost, and burdensome bidding process of finding a reputable vendor. This also provides EMTs within CBP opportunities to work with other colleagues with whom they may not normally work with and learn something new working in a different environment.

Lastly, OFO needs to work with the field offices to encourage employees who express interest in becoming EMTs. OFO is already doing what is expected to raise awareness of the EMT program such as highlighting successful medical interventions throughout the country in its electronic newsletter. CBP can also look into additional

compensation for EMTs because of their requirement of ongoing recertifications. However, it is a field officer who can encourage and motivate those expressing interest in being EMTs. Each field office has its own unique challenges, but this should not preclude each field office from dissuading employees in becoming EMTs. To start, field offices can offer resources and references in becoming an EMT, even if those methods are not through CBP. Partnerships with local schools that have EMT programs or having a CBP liaison can bridge the gap for those exhibiting genuine interest in becoming an EMT. Field offices can also provide other incentives for EMTs, such as time-off awards, outreach opportunities, attending medical seminars, or participating in interagency training. By placing emphasis on the importance of EMTs and the positive impact they have, field offices and thus CBP can effectively motivate individuals in becoming EMTs.

The individual response involves more effort. CBPO EMTs are probably the best asset in helping to develop the EMS program at CBP. They have firsthand knowledge of how their ports of entry operate, the number of personnel who express interest in receiving medical training, and relationships with more proactive managers. CBPO EMTs should take the opportunity to reach out to these managers and request a review in implementing a local medical response. To help increase the chances of getting a program started, CBPO EMTs need only to humbly remind their higher-ups about the positivity of CBP that follows a successful intervention to a medical emergency—and the crediting manager in charge of this initiative.

Although it may be discouraging for CBPO EMTs if a local port denies a medical response program, it does not mean CBPO EMTs should stop trying. Managers are not immune to attrition because of retirement or transfers. CBPO EMTs can reattempt their

efforts with new managers, hopefully one with a more open mind. In the meantime, CBPO EMTs can make an impact for colleagues who are still interested in learning about how to respond to medical calls or to even become EMTs themselves. Although this mentorship is not channeled through official agency means, it is still impactful. EMTs can give encouragement to other CBPOs in ways that are extrinsically motivating thus creating a new set of individuals who are autonomously motivated to become EMTs.

Another way to instill positive change within the EMS program is for CBPO EMTs to get promoted and fill positions at headquarters to help lead the program. Working at the national level may detract opportunities for CBPO EMTs to work firsthand with patients, but their position in implementing and regularly updating EMS policy throughout the nation no doubt helps those who are providing patient care in the field.

Regardless of which implications for action are taken, as the number of CBPO EMTs and their abilities to help provide care during medical emergencies increase, so too does the effectiveness and legitimacy of CBP as a public service agency.

Currently, the lack of knowledge of EMS that CBP has to offer from employees themselves makes it difficult for CBPO EMTs to respond in the event of a medical emergency. Erring on the side of caution may be suitable for certain situations but not in the case of medical situations. Often, medical situations have the tendency to degrade very quickly. As a law enforcement agency, CBP's pledge to protect the public falls short. On the other hand, the image of CBPO EMT assisting or even resuscitating a patient not only improves CBP's image but also improves the overall reputation of law enforcement agencies.

Recommendations for Further Research

This study explored CBPO EMTs within two of the three field offices in California. Further research can be expanded by conducting interviews with other EMTs within CBP. CBP's diverse operations in the United States and abroad may affect the motivational factors for EMTs elsewhere in the agency. Border Patrol agents (BPAs) assigned to the most remote areas in the United States may be medically trained because of necessity rather than autonomous motivation. The same is also true for air interdiction agents/marine interdiction agents (AIAs/MIAs). Even within OFO, employees other than officers, such as agriculture specialists or technicians, may have different motivational factors. States with differing requirements may also affect the outlook for individuals becoming an EMT outside of California.

A cost-benefit analysis should also be conducted within OFO. The requirements and maintenance of being an EMT are a heavy investment. It is extremely difficult, if not impossible, to place a price value on the effectiveness of medical intervention because of the infinite possibilities of a medical emergency. This is especially true in cases when a resuscitation is successful. For the public, including the patient or the patient's relatives, no price is too high when medical intervention is administered to prolong life. Administrators foolish enough to criticize these interventions not only risk career suicide, but they also reveal their detestable moral character. Unfortunately, there is still the reality of operational cost and feasibility from the agency standpoint. Even though a decision to forgo EMT training for a one-manned port of entry with a low-traveler count may be easy, the opposite could be true for an extremely busy port of entry with hundreds of CBPOs; thus, research in this aspect is needed.

There should also be further research into the motivational factors of individuals who work exclusively in the field of EMS. In general, EMS professionals do not earn high salaries. Affluent cities are an exception, and their EMS agencies are well funded. However, this is typically not the case. In rural areas, wages can be particularly low. Although earning enough to live on is a major factor, there may be other reasons why people become EMTs. There are generic articles and websites describing and enticing individuals to work in this field, but there does not seem to be any substantive research conducted into the motivational factors and reasons for individuals becoming an EMT at this time.

Lastly, there appears to be a cultural shift in training law enforcement officers with basic medical skills. Because of recent high-profile, use-of-force incidents with law enforcement, the ability for officers rendering medical aid, or lack thereof after such incidents, tends to be mentioned more likely than not during initial media reports. Immediate medical intervention has the potential to reduce the vast array of emotions and feelings from the community, especially in controversial use-of-force incidents. This may change the dynamics for those pursuing a career in law enforcement. Similar to how fire departments incorporate medical skills training into their curriculum when they previously did not, prospective law enforcement officers may now need to possess another skill set in what appears to be a new trend. Research needs to be conducted in determining whether this trend will affect the quality of candidates in law enforcement agencies.

Concluding Remarks and Reflections

There have been profound impacts on the researcher upon the completion of this study. A great deal of information was exchanged during the course of participant interviews, including personal details. The researcher feels honored to have earned this trust from participants and privileged to uphold their anonymity. More importantly, the researcher has attained a much deeper level of understanding as to why participants do what they do. The researcher also has a renewed sense of respect for participants and their service despite the struggles and challenges they face without most people even realizing. The researcher has also achieved a greater understanding of the three psychological needs of SDT in relation to himself. Thus, it is not surprising that these impacts consistent with the theme of this study have become motivation for the researcher to continue improving upon himself as an EMS provider. The researcher hopes the knowledge gained in this study can be used to bridge the gap between CBPO EMTs and those who are unaware of their immeasurable benefits. Ultimately, the benefactors can be anyone, including readers of this study.

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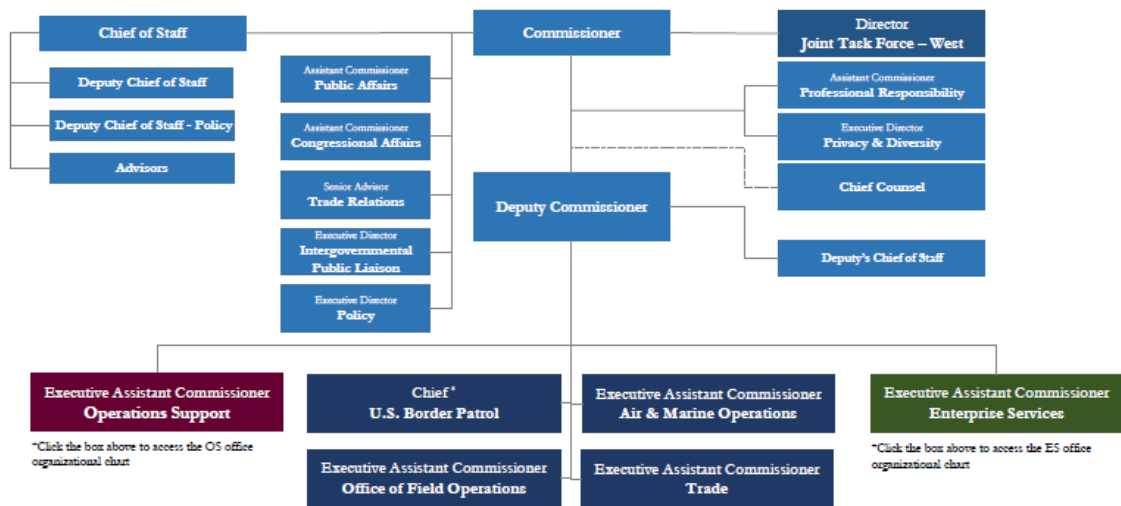
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APPENDICES

APPENDIX A

CBP ORGANIZATION CHART

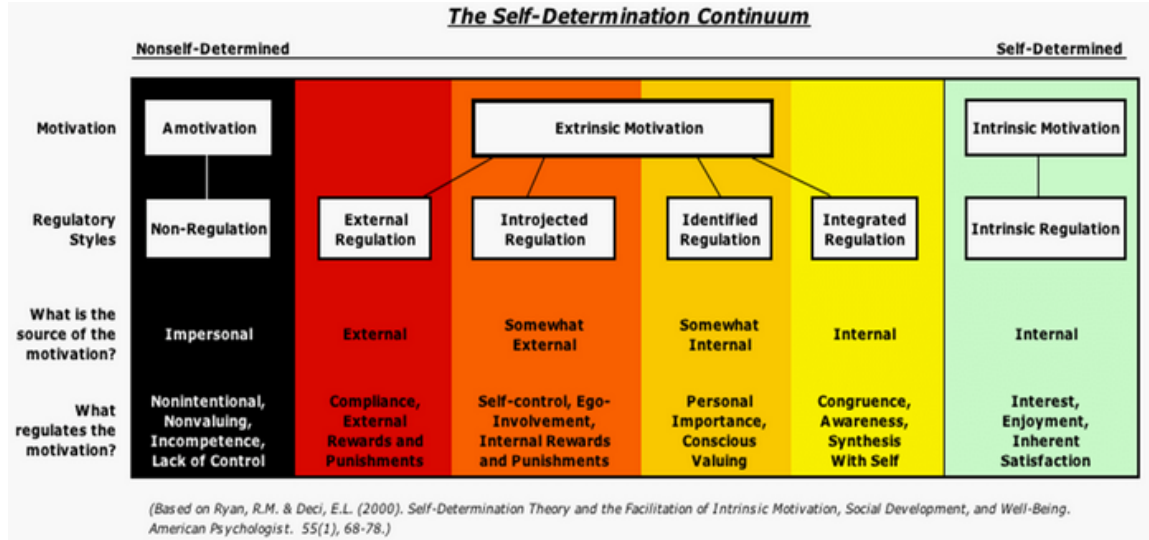


*Chief of USBP has rank of Executive Assistant Commissioner



Note. From *CBP Organization Chart*, by U.S. Customs and Border Protection, 2017, October 25, CBP.gov webpage (<https://www.cbp.gov/document/publications/cbp-organization-chart>).

APPENDIX B
SELF-DETERMINATION CONTINUUM



Note. From “Self-Determination Theory and How It Explains Motivation,” by C. E. Ackerman, 2018, June 21, The Self-Determination Model, Scale, and Continuum section, *Positive Psychology* (<https://positivepsychology.com/self-determination-theory/>).

APPENDIX C

PARTICIPANT INFORMED CONSENT

Study Title: EMT Motivating Factors

Researcher: Henry Y. Ng

Dear Prospective Participant,

My name is Henry Y. Ng and I am an EMT/CBPO at SFO Cargo. I am also a doctoral candidate in the Doctoral of Public Administration program at California Baptist University Online and Professional Studies. I am conducting research in hopes of gaining a deeper understanding of the motivating factors influencing an individual becoming an EMT at CBP.

You have been selected as a possible participant in this study because of your status as an EMT-CBPO and would like to focus on your experiences. CBP management has been informed of the study and has given me approval to conduct the study. CBP did not sanction this study—it is strictly an original piece of research as part of the requirements to graduate. With this understanding, your participation must be done using non-government systems and not during official time. This initial notification is the only exception.

The following is a list of expectations should you choose to participate:

- Your participation will involve an interview conducted through Zoom where you will give an honest response to 10 interview questions regarding motivating factors.
- Interviews will not exceed 60 minutes.
- Your participation is strictly voluntary. Even if an interview has begun, you may withdraw at any time without consequence. You may skip any questions you do not want to answer.
- There will be safeguards in place to protect your privacy and anonymity, such as alphanumeric labeling (P01, P02, P03, etc.) for participants.
- The interviews will be saved for transcription purposes only—no one else other than I will have access to this information.
- All data will be destroyed after five years of publication of this research.
- In the unlikely event of a data breach, all participants will be informed about the violation. Furthermore, the researcher will work alongside CBU in seeking the most appropriate action with affected participants.
- You will not be paid for participating in this research study, but a \$10 Target gift card will be given to you as a small token of appreciation.
- There are no reasonably foreseeable risks, discomforts, or inconveniences as a result of participating in this study. However, should you experience any type of issue, you may contact me (the researcher), CBU Counseling Center (951-689-1120, <https://www.calbaptist.edu/counseling-center/>), or CBP's Employee Assistance Program at 1-800-755-7002.

The researcher is Henry Y. Ng. The chair overseeing this research is Dr. Jesse Holguin. Please feel free to contact either parties if you have any questions, concerns, complaints, feelings of harm, or would like to talk to any member of the research team.

This research has been reviewed and approved by the Institutional Review Board at California Baptist University. They can be reached through email at irb@calbaptist.edu if your questions, concerns, or complaints are not being satisfactorily answered by the research team. You may also contact them regarding your rights as a research participant.

What are the next steps once you choose to participate in the study:

The researcher will need a signed **Statement of Consent** which confirms the researcher has explained the purpose of this research and the intended outcome.

- The Participant understands that upon receiving the signed Statement of Consent, the researcher will contact me by email to establish a mutually agreeable date and time to participate in a Zoom teleconferencing interview.
- The Participant understands the researcher will ask questions about experiences as an EMT-CBPO.
- The Participant acknowledges that **ALL INTERVIEWS WILL BE RECORDED** for the sole purpose of research and will not be made available to anyone else other than the researcher.
- The Participant are aware the interview should be completed in 60 minutes or less.
- The Participant understands responses given will be confidential and anonymity will be preserved using alphanumeric code in all writings that pertain to research findings.
- The Participant acknowledges their name will not be associated with any results of this study.
- The Participant may contact the researchers or irb@calbaptist.edu for additional questions.

By digitally signing this form, you acknowledge that you have read the informed consent, you understand the nature of the study, your interview will be recorded and potential risks to you as a participant, and the means by which your identity will be kept confidential. Your signature on this form also indicates that you are 18 years or older and that you give your permission voluntarily to serve as a participant in the study described.

Name: _____
Please print your name on the line above.

X:
Please provide a signature on the line above.

Date: _____
Please date on the line above.

Please email this form back to me if you agree to participate at
HenryY.Ng@calbaptist.edu. I will then contact you by email to set up a mutually
agreeable date and time to conduct the interview. Thank you!

APPENDIX D

INTERVIEW QUESTIONS

1. Why did you become an EMT?
2. What have been your experiences as a CBPO EMT?
3. What are some things that you find rewarding as a CBPO EMT?
4. What are some factors that influence your engagement as a CBPO EMT at work?
5. What are some benefits as a CBPO EMT?
6. What are some challenges as a CBPO EMT?
7. How do you feel about EMTs in CBP OFO?
8. What are some things you believe CBP OFO should know about an EMT-CBPO?
9. What are some things you believe the public should know about an EMT-CBPO?
10. What do you see in your future as an EMT-CBPO?

APPENDIX E
IRB APPROVAL



Institutional Review Board

To: Henry Y. Ng; Institutional Review Board

Cc: Jesse Holguin



Tue 12/07/2021 10:24

RE: IRB Review

IRB No.: 036-2122 EXP

Project: A Phenomenological Study of Customs and Border Protection Officer's Perspective and Their Influence on Becoming an Emergency Medical Technician

Date Complete Application Received: 11/16/2021

Date Final Revision Received: 12/04/2021

Principle Investigator: Henry Ng

Co-PI: N/A

Faculty Advisor: Dr. Jesse Holguin

College/Department: OPS

IRB Determination: Expedited Application **Approved** – Faculty research using anonymous survey questionnaires; no minor participants; no more than minimal risk/risk appropriately mitigated; no deception utilized; acceptable consent procedures and documentation; acceptable data protection procedures. Data collection may begin, in accordance with the final submitted documents and approved protocol.

Future Correspondence: All future correspondence about this project must include all PIs, Co-PIs, and Faculty Advisors (as relevant) and reference the assigned IRB number.

Approval Information: (Expiration: Full Review Only) Approval is granted for one year from date below. If you would like to continue research activities beyond that date, you are responsible for submitting a Research Renewal Request with enough time for that request to be reviewed and approved prior to the expiration of the project. In the case of an unforeseen risk/adverse experience, please report this to the IRB immediately using the appropriate forms. Requests for a change to protocol must be submitted for IRB review and approved prior to implementation. At the completion of the project, you are to submit a Research Closure Form.

Researcher Responsibilities: The researcher is responsible for ensuring that the research is conducted in the manner outlined in the IRB application and that all reporting requirements are met. Please refer to this approval and to the IRB handbook for more information.

Date: 12/07/2021

APPENDIX F

APPROVAL FROM SAN FRANCISCO FIELD OFFICE

NG, HENRY Y

From: [REDACTED]
Sent: Tuesday, August 10, 2021 10:33 AM
To: NG, HENRY Y
Subject: FW: Memorandum for school study
Categories: Purple Category, Blue Category, Green Category

Hi Henry,

PD has approved your request to conduct interviews.

He also mentions a trainee that's an EMT – not sure who that is.

[REDACTED]
Acting Watch Commander

☎: (415) 517-2428

✉: [REDACTED]



From: [REDACTED]
Sent: Tuesday, August 10, 2021 10:27 AM
To: [REDACTED] >
Subject: RE: Memorandum for school study

I'm okay with it. There is also one of the trainees who is an EMT. Can't remember his name but [REDACTED] probably knows.

[REDACTED]
Area Port Director
Area Port of San Francisco
415-782-9219 (office)
415-308-9023 (cell)

From: [REDACTED] >
Sent: Tuesday, August 10, 2021 10:14 AM
To: [REDACTED] >

Subject: FW: Memorandum for school study
Importance: High

Sir,

West Bay A-TCET CBPO/EMT Henry Ng is requesting authorization to interview CBP EMTs for a graduate research project.

Please see attached.

Thank you,

[REDACTED]

Acting Watch Commander

☎: (415) 517-2428

✉: [REDACTED]



From: NG, HENRY Y <HENRY.Y.NG@CBP.DHS.GOV>

Sent: Sunday, August 8, 2021 4:39 PM

To: [REDACTED]

Subject: Memorandum for school study

Hello [REDACTED],

Attached is my memorandum regarding my school study. Could you please pass this on to APD [REDACTED]?

Thank you,

Henry

APPENDIX G

APPROVAL FROM LOS ANGELES FIELD OFFICE



U.S. Customs and
Border Protection

DATE: February 15, 2022

MEMORANDUM FOR: CBPO Henry Y. Ng

FROM:

[REDACTED]
Deputy Assistant Director, Border Security,
Los Angeles Field Office

SUBJECT:

Addendum re: Approval for Request to Interview CBPO EMT
Employees for Dissertation Research

Based on the information provided, your request to contact CBP Officers within the Los Angeles Field Office who are also certified Emergency Medical Technicians ("EMT") for your California Baptist University ("CBU") dissertation research has been approved. However, this approval is granted with the understanding that you are familiar and comply with the applicable Standards of Ethical Conduct for Employees of the Executive Branch, 5 C.F.R. Part 2635, as well as the CBP Standards of Conduct, Directive No. 51735-013B (Dec. 9, 2020). As you noted in your request, when reaching out and conducting voluntary interviews with CBPO EMTs, you are in the position of a private individual researching CBP and its employees. Furthermore, the CBPO EMTs who participate in your interview during off-duty hours will be speaking in their personal capacities as well.

Please note the following ethical guidance:

- You may not use or improperly disclose nonpublic information, including sensitive, classified, or otherwise protected information acquired as part of your official duties and which is not generally available to the public. 5 C.F.R. § 2635.703; 18 U.S.C. § 1905; CBP Standards of Conduct, § 7.5.1.
- To avoid an inadvertent disclosure of nonpublic information by CBPO EMTs during your voluntary interviews, please remind your interviewees that they are speaking in their personal capacities and to refrain from disclosing any nonpublic information, including any law enforcement sensitive information. 5 C.F.R. §§ 2635.101(b)(14) and 2635.703; 18 U.S.C. § 1905; CBP Standards of Conduct, § 7.5.1.
- You may not make unauthorized use of official time or Government property for your activities related to CBU and your dissertation research. 5 C.F.R. §§ 2635.704 and 705.
- As noted in your request, your interviews with CBPO EMTs are voluntary and will occur off duty and not on Government property, which will avoid any misuse of position or violation of official time regulations. 5 C.F.R. §§ 2635.704 and 705.

- As noted in your request, during off-duty hours you may use CBP's email system once to contact CBPO EMTs within the Los Angeles Field Office and inquire about participating in a voluntary interview for your dissertation research. Any subsequent follow-up and coordination with CBPO EMTs for your dissertation research must be made using your non-government email address and not during on-duty official time. 5 C.F.R. §§ 2635.704 and 705; CBP Standards of Conduct, § 7.9.1.1; CBP Directive No. 5230-031A, "Limited Personal Use of Government Office Equipment Including Information Technology" (Jul. 15, 2010).
- As noted in your request, you are seeking to interview CBPO EMTs who are not subject to disciplinary action. We recommend stating upfront that you are seeking potential CBPO EMTs (who are not subject to disciplinary action) for voluntary interviews in furtherance of your dissertation research, thereby avoiding any inadvertent disclosure of a CBPO's disciplinary action.
- You may not give the appearance that CBP sanctions or endorses your dissertation research. If you reference your title and employment with CBP, you must provide an appropriate disclaimer that the views presented in your dissertation are your own and do not necessarily represent the views of CBP or the United States. 5 C.F.R. §§ 2635.702(b) and (c).
- To ensure compliance with the Whistleblower Protection Act, 5 U.S.C. § 2302(b)(8)-(9), please be advised of the following disclaimer and then please provide this disclaimer regarding the prohibition of disclosing nonpublic information to each CBP interviewee before the interview:

These provisions are consistent with and do not supersede, conflict with, or otherwise alter the employee obligations, rights, or liabilities created by existing statute or Executive order relating to (1) classified information, (2) communications to Congress, (3) the reporting to an Inspector General or the Office of Special Counsel of a violation of any law, rule, or regulation, or mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety, or (4) any other whistleblower protection. The definitions, requirements, obligations, rights, sanctions, and liabilities created by controlling Executive orders and statutory provisions are incorporated into this disclaimer and are controlling.

If the nature of your dissertation research and/or voluntary interviews of CBPO EMTs within the Los Angeles Field Office changes, you will need to submit another written request for review and approval. Please direct any questions to your immediate supervisor. Thank you.

APPENDIX H

DISAPPROVAL FROM SAN DIEGO FIELD OFFICE

NG, HENRY Y

From: [REDACTED]
Sent: Tuesday, October 26, 2021 9:51 AM
To: NG, HENRY Y
Subject: SYS Study

Good Morning,

The San Diego Field Office unfortunately cannot support your request to interview CBPO EMT's and conduct observations at the San Ysidro Port of Entry. At this time the operational tempo as well as the threat level is high and all resources are being utilized to address.

[REDACTED]
Assistant Director, Frontline
San Diego Field Office
(760)768-2310

APPENDIX I
INTERVIEW PROTOCOL & SCRIPT

STUDY TITLE: EMT Motivating Factors

TIME OF INTERVIEW: _____ DATE: _____

TOTAL NUMBER OF YEARS WORKING AS A CBPO: _____

TOTAL NUMBER OF YEARS AS AN EMT: _____

The following provides an outline to guide the interview process for each participant to maintain consistency.

I. Introduction

Hello and thank you for your participation in my research study on motivational factors to become an EMT. My name is Henry, and I am currently a doctoral candidate at California Baptist University, Division of Online and Professional Studies. This research will help me in fulfilling the requirements needed to earn a doctorate in public administration.

You have read, acknowledged, and signed the inform consent letter that explains the intent and characteristics of the study, as well as authorizing the recording of our interview.

I will ask you 10 questions regarding your EMT status as a CBPO. The entire interview should be conducted within 60 minutes. When time is nearing this mark, I will let you know. We will not go beyond this limit unless you agree to do so.

II. Disclosure

As a reminder, your participation in this study strictly voluntary. You may withdraw from the study at any time without any negative repercussions to you. All responses you provide will be kept confidential where only I will have access to it. Any identifiable or private information will be withheld or changed. As a small token of appreciation, you will receive a \$10 gift card to Target upon completion of the interview. Please feel free to disclose as much about your experiences as you are comfortable with. There are no incorrect responses.

Please be aware that I may be taking some notes during our conversation. If there are any questions you cannot answer or choose not to, we will skip those questions. If at any time, including after completion of the interview, you feel distressed, please know that EAP is a confidential and free service that is available to you at any time. Their number is 1-800-755-7002.

Did you have any questions before we get started?

III. Interview Questions

1. Why did you become a CBPO?
2. What are some things that you find rewarding at work?
3. What are some factors that influence your engagement at work?
4. Why did you become an EMT?
5. What are your experiences as an EMT while working at OFO?
6. What do you believe are some benefits as an EMT-CBPO?
7. What are some challenges as an EMT-CBPO?
8. How do you feel EMTs in CBP OFO?
9. What are some things you believe CBP should know about an EMT-CBPO?
10. What are some things you believe the public should know about an EMT-CBPO?

IV. Debriefing

Thank you for your participation. The information you shared with me today will remain confidential. No one other than I will have access to it. Any and all private and identifiers will be omitted from my dissertation.