EMERGENCY CARE: EMOTIONAL CONTROL An exploration of what constitutes emotional labour for a UK paramedic

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Abstract

This thesis draws on a small-scale, mixed-methods study of paramedics working for the North East Ambulance Service National Health Service Trust in order to extricate whether the performance of emotional labour is significant for the paramedic role. A depth in meaning is created through the development of a generic quadripartite integrated framework to the process of emotional labour which is built initially from the founding knowledge pertaining to the customer service sector and the professions but which is subsequently contextualised for use by this inquiry through exposure to the prehospital emergency care discourse. This quadripartite framework explains how performances triggered by antecedents carry consequences that can be mediated through interventions whose significance has previously been overlooked. This framework transposes into a deductive 'a priori' codebook / template within which data stemming from both qualitative and quantitative data streams is both organised and explained.

As the voices of the paramedics are released from interview transcripts they mingle with observed scenarios to create a richly layered account highlighted by the judicious use of descriptive statistics offered by two self-reports. In addition to addressing the principal research question that inquires 'what constitutes emotional labour for the UK paramedic' this thesis also enlarges the sociological imagination on organisational emotionality by exposing how the framework fuses the interactional demand on a role with the individual process of emotional labour previously theorised as separate entities. The occupational model which emerges from this fusion carries potentiality across sectors but its value to this inquiry lies with how it situates emotional labour at its core and in so doing, amplifies how emotional labour lies at the core of the paramedic role.

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A&E	Accident and Emergency.....	..... **35,43,44,46,78,109,117,119, 122,128,134,135,142,143,163,172,179, 220,234,306**
AGCAS	Association of Graduate Careers Advisory Services	..... **9, 265, 270,295**
BASICS	British Association For Immediate Care...	..... **98,110,136,147,156,185,204,225**
BBC	British Broadcasting Corporation.....	.....**127,165,168,265,270,297,298**
BMJ	British Medical Journal.....	..... **124**
BPA	British Paramedic Association.....	..... **35,165**
CAQDAS	Computer Assisted Qualitative Data ..... Analysis Software	..... **96**
CEO	Chief Executive Officer.....	..... **38, 69, 174**
CF	Compassion Fatigue.....	..... **56, 205, 210**
CHI	Commission for Health Improvement.....	..... **38, 302**
CIPD	Chartered Institute of Personnel and..... Development	..... **28,30, 302**
CISD	Critical Incident Stress Debriefing.....	..... **59, 215**
COP	College of Paramedics.....	..... **35,165**
COPD	Chronic Obstructive Pulmonary Disease...	..... **115, 119**
CPD	Continuous Professional Development.....	..... **36, 105, 165, 214**
CPR	Cardio Pulmonary Resuscitation.....	..... **56, 76,86,87,120, 121,125, 138,172, 194, 202,206, 210**
CQC	Care Quality Commission.....	..... **38,76, 91,127, 303**
DFT	Department For Transport.....	..... **114, 304**
DOH	Department of Health.....	.....**34,38,39,41,70,79,91 115,119,171,176,230, 233, 234, 268,305**
DNR	Do Not Resuscitate.....	..... **87, 120**
ECSW	Emergency Care Support Worker.....	..... **166, 172**
ECG	Electrocardiogram.....	..... **124**
EI	Emotional Intelligence.....	..... **92**
ESRC	Economic and Social Research Council.....	.....**68,70,71,75,80, 249, 251, 258,259,264, 307**
FPHC	Faculty of Pre-hospital care	.....**36,308**
FRS	Fire and Rescue Service.....	.....**132,133,134,156,229**
FWI	Family-Work Interference.....	..... **22,185**
GNAA	Great North Air Ambulance.....	..... **136, 137**
GP	General Practitioner.....	.....**89,109,110,135,136,147,156,185,204,225**
HCPC	Health and Care Professions Council.....	.....**35,313**
HSCIC	Health & Social Care Information Centre.	..... **37, 315**
HPC	Health Professions Council.....	..... **35,36,37,88,105,155, 315**
HQ	Head Quarters.....	..... **67,69,78,81,84,98,106,107, 145, 148, 149, 151, 155, 163, 169, 174, 175, 187, 216, 221, 225, 229, 251**
HWI	Home-Work Interference...…….	..... **21,22,50,184,185,187,188,230**
IV	Intravenous…….	..... **126**
JRCALC	Joint Royal Colleges Ambulance Liaison.. Committee	..... **37,171,173,230,317**

MERI	Mann Emotional Requirements Inventory	..... **10,67,68,73,79,80,82,93,94,100,101, 107,129,130, 131,134, 137, 140, 147, 155, 156, 157, 180, 182, 199, 227, 241, 278,289,290, 291, 292,293,294**
MI	Myocardial Infarction.....	..... **125**
MOH	Ministry of Health.....	..... **35, 322**
NAO	National Audit Office.....	..... **39, 322**
NEAS	North East Ambulance Service.....	.....**67,68,69,71,72,74,75,76,80,82, 85,87,89,108,112,115,116,119,127,134, 149, 165, 169, 171, 174,175, 176, 187,219, 227, 261, 296, 297, 320, 323, 325, 327, 333, 340,384, 385, 387**
NEPHO	North East Public Health Observatory.....	..... **115,119, 323**
NHS	National Health Service.....	..... **8,10,11,34,35,36,37,39,40,49, 69,67,73,75,89,91,107,118, 127, 133, 171, 172, 174, 230, 233, 234, 250, 252, 259, 260, 264, 265, 266,272, 278, 313, 316, 323,324**
NRES	National Research Ethics Service.....	..... **73, 324**
ONS	Office for National Statistics.....	..... **116,119,123, 325**
ORCON	Operational Research Consultancy.....	..... **39**
PCI	Percutaneous Coronary Intervention.....	..... **173**
PIS	Participant Information Sheet.....	..... **73,77,78,79,80**
PRF	Patient Report Form.....	..... **162**
PTSD	Post Traumatic Stress Disorder.....	.....**45,57,60,191,205,208,210,231, 236**
REC	Research Ethics Committee.....	..... **75,76,78,79,81,85,90,272,278**
RTA	Road Traffic Accident.....	..... **57,124,125,133, 144**
RTB	Return to Base.....	..... **141,145, 212**
SIDS	Sudden Infant Death syndrome	..... **120,121**
UK	United Kingdom.....	.....**8,9,10,11,37,41,61,62,93,107, 115,119, 122, 133, 136, 171, 183, 221, 222, 226, 227, 232, 236,250, 259, 264, 265, 304**
USB	Universal Serial Bus.....	..... **79**
WHI	Work-home Interference	..... **56,57**

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I am indebted to Durham University and the ESRC for giving me this opportunity to engage with what has proved to be a fascinating line of research, offering a new perspective on the paramedic role in the UK. In particular, I thank my principal supervisors past [Dr Ian Roberts] and present [Dr Tiago Moreira] for their invaluable support and input. I would also like to thank Professor David Byrne for steeping in as second supervisor when the previous incumbent absconded to pastures new. I would also like to warmly acknowledge Dr Sandi Mann of the University of Central Lancashire for allowing me to use the MERI as a supplementary form of data collection in my enquiry, free of any charge and Professor Andrew Lane of Wolverhampton for taking the time to send me both materials and potential sources of information.

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Janet Lawrence **May 2015**

Chapter 1

A New Look at Emotional Labour

1.1 Purpose and Scope of the Study

> "Emotion's potential multifacetedness suggests that any one approach to understanding 'it' will be just that – one approach. It is necessarily partial, meaningful only in terms of the philosophy that informs it, the medium through which it is conveyed and the receiving audience"
>
> Fineman, 2004: 721.

Consequently, I ask all those with an interest in this study to be mindful of that caveat as emotions lie at its core. They are central to my concept of emotional labour that "requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others" (Hochschild, 2003:7). My decision to investigate emotional labour arose out of my very first reading of 'The Managed Heart' published by Hochschild in 1983 which I found riveting because it resonated with my last period of fulltime employment as a Human Resource manager from which I took voluntary redundancy in 2000. During that employment I had set competences for customer service agents without being aware of the emotional labour they entailed. Hochschild enabled me to identify how its invisibility had led to it being overlooked and consequently, unrewarded. As a result it has become a "passionate concern", which according to Moustakas (1990: 27) is a prerequisite for any research study.

My choice of context reflects a lifelong interest in medical matters that was piqued by how the top six most stressful occupations in the United Kingdom [UK] which includes ambulance work have a common denominator in emotional labour (Johnson, Cooper, Cartwright, Donald, Taylor and Millet, 2005). As there had been no empirical research published substantiating that link I identify a "real and living doubt" (Peirce, 1955: 11) that I investigate in this thesis through exploring the emotional labour performed by a small group of UK paramedics employed during 2008-9 by one NHS [National Health Service] ambulance service located in the north of England.

1.2 Aims

The first of two broad aims I set for my thesis is to enlarge the sociological imagination on the emotional organisation. Although Arlie Hochschild (1975, 1979, 1983) stimulated a revival of interest in this area [stagnant since the 1920's (Barbalet, 2001) despite the intervention of C. Wright Mills (1951, 1956)] it remains under developed. The research field divides into two streams with the first focused on occupations and the nature of their interactional demand for emotional labour (Leidner, 1993; Bellas, 1999; Harris, 2002) and the second on the regulatory process undertaken by the individual (Rafaeli, 1989; Pugh, 2001; Grandey, 2003; Diefendorff, Croyle and Gosserand, 2005). In exposing a lack of theoretical guidance for and practical application of how these two streams may integrate, Wharton (2009) offers a gap in knowledge for my thesis to bridge.

My second aim is to determine the extent of the emotional demand on the UK paramedic, a role described by Boyle and Healy (2003) as a constant oscillation between the Mysterium [wisdom, compassion, care] of Life and the Onus [deception, disregard, negligence] of death. Although the occupational profile for the paramedic recognises the job is "stressful and emotional" (AGCAS, 2002: 1) and a link between those two attributes has been exposed (Clohessy and Ehlers, 1999), stress-related sick absences continue to rise (Fifield, 2013). As Regehr and Bober (2005) claim 25-30% of paramedics experience symptoms of stress at any one time a study of their emotional labour is long overdue.

1.3 Overview

This thesis unfolds over six chapters to first suggest and then confirm emotional labour lies at the core of the paramedic role. This positioning, in acknowledging "the self is what is ill or hurt or restricted, not simply a set of bodily functions and processes" (Williams, 2006: 8) brings relational skills to the fore and in doing so, displaces the logistical skills traditionally associated with prehospital emergency care. In this first chapter I examine the seminal work by Arlie Russell Hochschild (1983) on emotional labor in which I note the criticism (Wouters, 1989; Bolton and Boyd, 2003; McClure and Murphy, 2007) and acknowledge the challenge presented in alternate theories (Callahan and McCollum, 2002; Bolton, 2005; Miller, Considine and Garner, 2007)

before determining emotional labour retains currency for my inquiry. Accordingly I further an understanding of its integral process by extending the conventional three stages of antecedents, strategies and consequences (Rafaeli and Sutton, 1987; Grandey, 2000; Huynh, Alderson and Thompson, 2008) with a fourth: interventions. Using this quadripartite process I create a generic quadripartite integrated framework through which to both explain emotional labour more fully and integrate the field.

In chapter two I develop a common perception of both the paramedic role and the NHS ambulance service paying particular attention to the national operating standards as these influence both public and professional identities and form a significant source of strain. I follow this short discourse by contextualising the framework I develop in chapter one in order to develop a steer for my inquiry. Altogether I raise a total of eight subsidiary research questions within the framework through which to clarify and distinguish what constitutes emotional labour for the UK paramedic. My intention to use a hybrid process of deductive and inductive thematic analysis within a social phenomenological architecture (Fereday and Muir-Cochrane, 2006) accommodates this framework as an 'a priori' deductive codebook / template (Crabtree and Miller, 1999).

In chapter three I justify and describe the methodology through which I address my research questions. The predominant methodology is qualitative within which I select methods of participant observation, semi-structured interviews and document analysis. However, I add two self-reports in an emotion checklist and the Mann Emotional Requirements Inventory [MERI] which forms an embedded supplementary quantitative dataset to turn my strategy into mixed methods. As each represents a form of self-observation of prior subjective experience (Wilson, 1999) they fit into my worldview which reflects the social phenomenological tradition. In adhering to the three postulates advocated by Schutz (1967) of logical consistency, subjective interpretation and adequacy the paramedic voice is heard without influence or edit. Set within a reflexive frame I present my findings within principal themes that emerge from the data to reflect neither fiction nor fancy but the everyday world of my participants.

Chapters four and five explain in rich detail the demand on the paramedic for emotional labour. I use excerpts of raw data which allow the voices of the paramedics to preserve the subjective integrity of the analysis whilst quantitative descriptive statistics offer numerical support. In chapter four I present my findings on situational antecedents

which I extract from the data corpus out of recognition that these constitute the interactional demand on the role. I expose a heterogeneous assembly that I cluster into six themes which are not confined to the run but extend over standby to challenge the assertion by Mannon that it is the run which confers all meaning for the paramedic. In chapter five I present my findings on the remaining three categories of antecedent along with the strategies, consequences and interventions from which I identify a series of eighteen themes that acknowledge an effortful process of paramedic emotional labour.

Chapter six concludes my thesis by first drawing attention as to how I satisfy the aims I set for my inquiry. The sociological imagination is I argue enlarged through my development of a generic quadripartite integrated framework of emotional labour in which the interactional demand on the role and the individual process of emotional labour previously studied as separate entities by those working in the field (Wharton, 2009), are fused. Through the creation of an occupational model I amplify that fusion and in so doing, satisfy Bradley and Schaefer's (1998: 26) demand for "a helpful simplification of reality." This model whose primary purpose in extricating meaning for prehospital emergency care does not preclude its adaptation and application to other occupations illustrates in a glance how emotional labour resides at the core of the paramedic role and is fundamental to the interdependent system of modern health care (Erickson and Grove, 2008).

But in order to fulfil my second aim of answering the question as to 'what constitutes emotional labour for the UK paramedic' I bring together the essence of my findings in respect of the eight subsidiary questions I presented over the previous two chapters. As I bring paramedic emotional labour out of the shadows (Bolton, 2005) I return to those who challenge the concept to suggest there is a middle ground before considering the implications of my findings for prehospital emergency care in the UK. The demand on emergency services is at a crisis point (Pearson, 2014) but the saviour in the shape of the Keogh review (NHS England, 2013) needs the support of the paramedics on the frontline and for that, their labours need to be recognised which would I argue, also enable recommendations by Francis (Mid Staffordshire NHS Foundation Trust, 2010) to take hold. Finally, I identify the limitations to my study and opportunities for future development before I close chapter six and my thesis with a final reflection on my journey that I began in ignorance but ended with both a heartfelt appreciation for and enlightenment of the prehospital emergency care delivered by paramedics in the UK.

1.4 Hochschild and 'The Managed Heart'

It remains an imperative to begin any study of emotional labor by outlining its main tenets as set out by Hochschild (1983, 2003, 2012) within 'The Managed Heart' as these continue to shape research (Wharton, 2009). Hochschild's treatise stems out of the change in the industrial economy from goods to service and how "in processing people, the product is a state of mind" (Hochschild, 2003: 6) achieved through the transmutation of freely given, private emotion work, into publicly performed emotional labor, ritually exchanged for a wage. Emotion work represents the effort involved in trying to evoke or suppress a feeling. It represents a form of currency through which emotional dues are paid, debts are recovered and gifts bestowed. It can be performed in one of three ways: by the individual upon themselves, by the individual upon another or by another upon the individual. In each case, cognitive, bodily and expressive techniques combine to fuse situation, frame and feeling into the conventional response. For example, a funeral [situation] is a time of loss [frame] that expects sadness [feeling] so a tendency to laugh goes against convention and is suppressed through solemn thoughts [cognitive], keeping still [bodily] and crying [expressive] (Hochschild, 1979).

The influence of both organismic and interactional theorists particularly Freud (1911, 1915, 1923) and Goffman (1959, 1961a, 1967) are apparent in Hochschild's explanation. Using insights from Freud, she argues the unconscious mediates between instinct and social acceptability, using ego-defense mechanisms [e.g., repression, suppression and sublimation] as appropriate so that a context appropriate emotion is expressed. In so doing, emotion is managed. From Goffman's affective deviant, characterized by Hochschild (2003: 224) as "the person with the wrong feeling for the situation and for whom the right feeling would be a conscious burden" comes the notion that managing feeling is effortful i.e., work. Drawing on Goffman (1959) and his analogy of life as theatre, Hochschild likens the management of feeling to acting. However, Hochschild maintains Goffman's actors only manage their outer impressions i.e., they surface act. Although this is a legitimate technique another form of acting she terms 'deep acting' is more sincere. Both techniques evoke and/or suppress emotion. Surface acting is impressionistic, pure deceit but only in respect to others not the self unlike deep acting in which the self also is deceived. Whilst the former is considered 'acting in bad faith' the latter takes the moniker 'acting in good faith' (Rafaeli and Sutton, 1987) of which there are two variants. An individual can directly exhort the

emotion or induce it indirectly through using emotional props e.g., memories. Feigning is easy because it becomes unnecessary (Hochschild, 2003).

Emotional labor represents the "transmutation"(ibid: 19) of the private system of emotion work I just described. The institution takes over from the individual as the locus of control; expression and feeling both become public acts and a commercial resource. Hochschild suggests emotional labour is a requirement in one third of all jobs although for those occupied by women that share rises to half. These jobs all share three characteristics:

> "First, they require face-to-face or voice-to-voice contact with the public. Second, they require the worker to produce an emotional state in another person - gratitude or fear, for example. Third, they allow the employer, through training and supervision, to exercise a degree of control over the emotional activities of employees"
>
> Hochschild, 2003: 147.

Although Hochschild exempts the professions from her third clause in recognition, "they supervise their own emotional labour by considering informal professional norms and client expectations" (ibid: 153). However, irrespective of whether an encounter is professional or commercial Hochschild maintains the exchange lacks balance as workers are obliged to establish trust and goodwill with their client/customer even when confronted by anger or disrespect. The ledger is supposedly evened by a wage" (ibid: 86) but in reality there are hidden costs as the true self is continuously put at risk by the demand to "co-ordinate self and feeling so that work seems to be effortless." In exposing how workers are exploited emotionally Hochschild has received numerous plaudits but she has also been criticised for creating a monolithic concept in which management control subverts human agency (Lewis, 2005).

1.5 Criticism and Challenge

Bolton (2005: 60) succinctly captures what I consider is the principal thread linking the critics of emotional labour in her comment of "an oversimplified dichotomy." In setting the private sphere of the home in absolute contrast to the public sphere of work

Hochschild, according to Wouters (1989), denies employers and workers common interests that he argues they can share and therefore workplace emotions can also be personal not solely commercial. An argument picked up by Bolton and Boyd (2003) who point to how Hochschild emphasizes the alienation of the worker whose performance is controlled through surveillance yet individuals "own the means of production" (ibid: 293) and therefore they decide what calibration of feeling will be vested in each performance. Accordingly Bolton (2005) argues the organizational vista is not a flat, lifeless dictation that Hochschild's exposition of emotional labor suggests but one in which knowledgeable social actors continually negotiate and contest the parameters set for their work role. This image is amplified by McClure and Murphy (2007: 106) who drawing on Marx (1976), argue use/exchange values which underpin the private/public spheres represent two aspects of a commodity that exist in "a complex dialectic relationship of economic and social exchange" neither of which is capable, without the other, of fully explaining organisational emotionality.

In the wake of this criticism, a number of alternate multidimensional constructs have been proposed (Callahan and McCollum, 2002; Bolton, 2005; Miller, Considine and Garner, 2007). Both Callahan and McCollum (2002) and Bolton (2005) set their typologies within the overarching term 'emotion management' and recognise emotional labour can be differentiated according to whether it is an imposed or desired course of action. The former recognising organisational or commercial edicts govern the customer service sector whilst the latter recognises internalised ethical rules of conduct govern the behaviour of professionals. However, each also recognises emotion has to be managed in workspaces that are not governed by formal rules what Goffman refers to as "back regions" (Goffman, 1959: 114). Here an individual can distance themselves albeit momentarily, from the "bundle of obligatory activity" (Goffman, 1961a: 86) that characterizes official forms. The inherently social self is able to perform according to informal or socially acquired rules. Bolton (2005: 135) elaborates,

> "people in organisations use them to create and maintain familial bonds, to relieve anger and anxiety, to register their resistance to demands made of them by management and to take time to offer extra emotion work as a gift to colleagues or customers and clients".

Although these quadruple (Callahan and McCollum, 2002; Bolton, 2005) or quintuple

(Miller, Considine and Garner, 2007) agendas broaden the scope of organisational emotionality they do so using a varying nomenclature which has also attracted criticism. For example, Callahan and McCollum (2002) label official forms of emotion management: autonomous emotional labour and emotional labour and social forms: emotion work and indirect emotional labour whilst Bolton (2005) labels her official forms: prescriptive and pecuniary and social forms: presentational and philanthropic. McClure and Murphy (2007: 105) maintain all they have achieved is, "confusion" and a "semantic morass" (McClure and Murphy, 2007: 105) leading Erickson and Grove (2008) to argue for the return of emotional labour to explain all instances of emotion management in occupational contexts.

Within sociology, numerous studies appear to support this argument (Wharton, 2009) dividing broadly into those that explain emotional labour through the interactional demand on the role (Leidner, 1993; Harris, 2002; Theodosius, 2008) and those that explain it through the management process undertaken by the individual (Rafaeli, 1989; Morris and Feldman, 1997; Grandey, 2003). Within the former cohort Theodosius (2008) identifies how different aspects to a role including its interdependency require a different form of emotional labour but like her contemporaries she does not explore the individual process apart from the consequences attached to performances (Wharton, 2009). This is the province of the second cohort who exposes how the subjectivity of emotion and its management by the individual worker can be considered an effortful three stage process involving antecedents, strategies and consequences (Rafaeli and Sutton, 1987; Grandey, 2000; Huynh, Alderson and Thompson, 2008).

Irrespective of which avenue is traversed, Wharton (2009) offers me a cogent argument for the continuation of research into emotional labour. In pointing to how interactive work remains central to the functioning of society she makes it clear there is an obligation to further understanding as to those factors that shape it e.g., customer/client expectations and how these affect the emotional experience of workers e.g., well-being. As each of the multidimensional agendas I have mentioned includes emotional labour in one or more forms, in order to be able to fully explain organisational emotionality, I consider emotional labour retains validity and I focus my inquiry accordingly. In response to the lack of theoretical guidance, exposed by Wharton (ibid), as to how the two research avenues could integrate, I develop over the remainder of this chapter a generic theoretical framework.

1.6 A New Look

The process of emotional labour is conventionally regarded as having three stages in antecedents, strategies and consequences [alternatively referred to in the literature as outcomes] (Grandey, 2000; Erickson and Grove, 2008). However, ancillary to the final stage of consequences, the term I choose to adopt, are acts of mediation or interventions. A focus on reactive forms such as counselling (Newton, Handy and Fineman, 1995) means this facet has been overlooked. Yet interventions have many alternate forms capable of reducing or even preventing negative consequences (Mann, 2002). Consequently I argue it represents a fourth stage without which a full explanation of the process is forfeited.

1.6.1 Antecedents

Antecedents take the form of either a predisposition, e.g., personality or a trigger e.g., abuse. Although one or more variants of each have been examined (Grandey, 2000) no study has created a definitive list. Consequently I extract possibilities for my own list from traversing the two avenues of research on emotional labour which take me into both sociological and psychological disciplines. As the extraction suggests antecedents fall into four types: situation, job, organisation or individual, (Bolton, 2005) I use those categories to impose a structure on this section.

1.6.1.1 Situation Antecedents

The principal situational cue is the customer/client interaction (Hochschild, 2003) although performances are also cued by interaction with others on the outside of the organisation e.g., associated professionals (Harris, 2002) or on the inside e.g., colleagues (Grandey, Kern and Frone, 2007) or the self in the form of memories (LeDoux, 1998). Although memories can be explicit and untroublesome they can also be implicit and harmful when they are activated by an associated stimulus. A name, place, situation, sound or smell are all potential stimuli which invoke a mental reconstruction of an emotionally laden event. LeDoux (1998) remarks how implicit memories cannot be eradicated and become “unconscious sources of intense anxiety that potentially exert their opaque and perverse influences throughout life” (ibid: 245) and may therefore present time and time again.

Performances of emotional labour with both outsiders and insiders vary in accordance with the nature of the interaction (Grandey, 2000); its duration; frequency (Morris and Feldman, 1996); variety of emotion to be managed (Hochschild, 2003); audience expectations (Harris, 2002) and the biography of prior expectation (Hochschild, 2003). Routine interaction demands a smiley face irrespective of personal feelings that Grandey (2000: 102) refers to as "chronic expectations" whilst a difficult interaction due to: hostility (Grandey, Dickter and Sin, 2004); verbal abuse (Grandey, Kern and Frone, 2007); disrespect; lack of cooperation; rudeness; sexual harassment (Williams, 2003) or being "informationally unclear" (Rupp and Spencer, 2006: 975) represents a less frequent, acute event but one which demands greater emotional control in order to preserve the impression of cordiality. Interactional injustice which is a blanket term covering all of those different types of difficult interaction can also cue emotional labour through its witness on a co-worker (Spencer and Rupp, 2009).

The duration and frequency of an interaction has a significant bearing on an individual's performance (Rafaeli and Sutton, 1989; Morris and Feldman, 1997; Kruml and Geddes, 2000). Frequent short interactions [two to three minutes at most] tend to be managed through a scripted response requiring little effort (Rafaeli and Sutton, 1989; Morris and Feldman, 1997) whilst less frequent longer interactions tend to be unscripted which increases the demand on the individual (Morris and Feldman, 1997; Kruml and Geddes, 2000) as does the greater the variety in emotional display. Morris and Feldman (1996) emphasise in particular how frequent changes between positive [affirming], neutral [fair] and negative [disciplining] emotional displays demand a greater effort. Audience expectation is linked to status and power as role receiver but Harris (2002) remarks how each member may hold a different expectation requiring a different display of emotion and apply different sanctions if delivery fails to satisfy. The last situational cue of prior expectation is explained by Goffman (1983: 4),

> "Each participant enters a social situation carrying an already established biography of prior dealings with the other participants or at least with participants of their kind; and enters also with a vast array of cultural assumptions presumed to be shared".

Hochschild (2003) maintains this knowledge allows an individual to avoid the pain of acting inappropriately which Goffman (1956) condenses into the avoidance of

embarrassment in order to prevent shame, humiliation, unease or hostility from disrupting a situation. All of the antecedents I have discussed in this subsection can act as a sole motivator of emotional labour however it is more likely that antecedents from one or more of the three remaining categories will intersect (Bolton, 2005) or overlap (Syed, 2008).

1.6.1.2 Job

Hochschild (2003) creates a continuum along which jobs requiring emotional labour are aligned. One pole, taking the metaphor of a toe, anchors those jobs that provide a service and a product of "sincere warmth" whilst at the other pole or 'heel' jobs extract payment and their product is "sincere suspicion" (ibid: 147). Between these two extremes lie all performances which vary according to: autonomy; task variety; task routineness (Morris and Feldman, 1996, 1997); hassles and uplifts (Basch and Fisher, 1998); security (Harris, 2002); job satisfaction (Grandey, 2003) and role identity (Ashforth and Humphrey, 1993) which Rafaeli (1989) considers is influenced by corporate insignia.

Job autonomy is a significant predictor because when control rests with the individual they experience fewer conflicts between felt and expressed emotions resulting in less effort (Morris and Feldman, 1996, 1997; Johnson and Spector, 2007). Although jobs characterized by a variety of tasks are more demanding as emotions are in constant flux (Morris and Feldman, 1996, 1997) task routineness is also associated with an increased demand due to the lack of control an individual has over what they do. Daily hassles emanating from the work environment e.g., weather (Kanner, Coyne, Schaefer and Lazarus, 1981) or the nature of the job e.g., overload (Frankenhaeuser and Gardell, 1976) and uplifts e.g., supportive colleagues (Basch and Fisher, 1998) all provoke emotion that must be controlled in the presence of others irrespective of whether it is negative or positive (ibid). More than just a hassle, insecurity of tenure is highlighted by Harris (2002) as increasing demand in order not just to control fear over the future but also to create a favourable impression and remain employed.

Job satisfaction defined as, "a pleasurable positive emotional state resulting from the appraisal of one's job or job experiences" (Locke, 1976: 1300) remains a holistic measure of employee outlook (CIPD, 2010). Although established as a consequence of

performances (Wharton, 1993; Abraham, 1998; Cote´ and Morgan, 2002; Lewig and Dollard, 2003) displeased or dissatisfied workers have been identified as having to manage their emotions more than those who are happy in their role to suggest it is also antecedent (Parkinson, 1991; Adelmann, 1995; Grandey, 2003). The final antecedent in this section is role identity. Ashforth and Humphrey (1993) comment how the stronger an individual identifies with their role the greater their tolerance of and compliance with emotional demands. Drawing on Salancik (1977) they make the point, role playing leads to role taking and once committed to an identity individuals seek to "express fidelity" (Ashforth and Humphrey, 1993:99) which is particularly true of professionals. However, as they internalise their occupational norms the demands on their role increase, as they became more valued by others. Rafaeli (1989) adds how demand is also increased by a uniform or other corporate insignia e.g., name badge, as it makes individuals more aware of whom and what they represent.

1.6.1.3 Organisation

The organisation cues performances through both its climate (Sutton and Rafaeli, 1988; Grandey, 2000) and culture (Hochschild, 1983; Rafaeli and Sutton, 1989). The climate or work environment influences performances in accordance with how favourably it is perceived. Policies on recruitment, training, rewards, sanctions, standards and levels of communication, trust and commitment all contribute. Feeling positive about the work environment encourages acceptance of "normative expectations" (Sutton and Rafaeli, 1988), reduces dissonance and lessens the demand for emotional labour (Grandey, 2000; Zapf, 2002; Bono and Vey, 2005). Goffman (1967: 91) is abundantly clear on organisational responsibility with respect to climatic conditions,

> "The environment must ensure that the individual will not pay too high a price for acting with good demeanour and that deference will be accorded him. Deference and demeanour practices must be institutionalized so that the individual will be able to project a viable, sacred self and stay in the game on a proper ritual basis".

Hochschild (2003: 101) makes the point that good working conditions particularly a climate of openness and support that mirrors a family environment induces a form of gratitude which "lays the foundation for loyalty" thus ensuring corporate expectations

influence interaction both inside and outside formal workspaces extending emotional labour to offstage destinations. Harris (2002) picks up on this to emphasise how professional performances are appraised against preconceived public expectations which act to cue performances to which Bolton (2005) adds how the general public as consumers of services, as well as goods, expect to receive deference and respect.

These expectations permeate the culture which has two faces: formal and informal. The formal residing in a company handbook or training module details rules of acceptable conduct and sanctions for non-compliance (Hochschild, 2003; Rafaeli and Sutton, 1989). Explicit display rules coupled with surveillance and/or monitoring cue increased effort (Rafaeli and Sutton, 1989; Grandey, 2003; Brannan, 2005). But there is an embedded tension between the competing imperatives of volume [throughput targets] and quality [customer/client satisfaction] that also directs performances which may be contrary to expectation if an employee is pushed beyond their limits (Sewell, 1998; Taylor and Bain, 1999; Brannan, 2005). The informal culture stems from peers who acting as role models, allow new employees to observe, imitate and gain feedback and as storytellers, reinforce acceptable conduct. Of the two faces it is the informal that is the more powerful (Rafaeli and Sutton, 1989) as individuals seek to be recognised first and foremost as a legitimate member of their work group (Statt, 1994).

To complete this subsection are two cues allied to both the environment and culture. The first, organisational justice has three forms: interpersonal [respect from authority]; informational [available, clear and honest] and procedural [consistent and fair] violations against which cue emotional labour (Cohen-Charash and Spector, 2001; Viswesvaran and Ones, 2002; Spencer and Rupp, 2009). The second has two parts in hassles e.g., malfunctioning equipment and uplifts e.g., recognition for a job well done. Whilst organisational hassles mirror injustices, uplifts mirror justice (Basch and Fisher, 1998).

1.6.1.4 Individual Antecedents

The individual is cued to perform by their predisposition in respect of gender, experience and temperament (Hochschild, 2003) and/or additional cues in the form of: social class; status; age; fatigue (ibid); illness (Vickers, 2001); ethnicity; religion (Syed, 2008); personal baggage (Bolton, 2005), skills (Wharton, 2009) and

home-work interference [HWI] (Frone, Russell and Cooper, 1992). Gender is a controversial cue in that it is both supported (Hochschild, 2003; Pierce, 1995) and challenged (Lewis and Simpson, 2007). According to Pierce (1995) emotional labour is a gendered experience that places additional demands on women. Hochschild (2003) explains that is because all women carry the silent label of 'mother' that implies they are in tune with the feelings and needs of others leading them to be helpful, cooperative and deferent in the workplace. However, Fondas (1997) remarks how feminine qualities such as empathy, sensitivity and cooperation are now seen as essential for both sexes. Yet Lewis and Simpson (2007) retort the historic rationality of organizations is unchanged as emotion has simply been added leading to a dual discourse in which emotion has both a soft, feminine side and a hard masculine side linked to quantitative methods, surveillance, accountability and targets. Both sexes therefore perform emotional labour albeit differently.

Experience either through age or on the job leads to better overall control and expression of appropriate emotion. Sincerity is enhanced through being able to draw on that history to facilitate deep acting (Hochschild, 2003). Life experience is a well supported antecedent (James, 1992; Staden, 1998; MacKintosh, 2007) as is age (Gross, Carstensen, Pasupathi, Tsai, Skorpen and Hsu, 1997; Kruml and Geddes, 2000; Lockenhoff and Carstensen, 2004). Temperament in the form of: empathy which is the ability to feel, share and understand the emotional state of another (Kruml and Geddes, 2000); emotional expressiveness (Pugh, 2001); emotional stamina (Turner and Stets, 2005); confidence (Harris, 2002); sense of humour (Meisiek and Yao, 2005); sociability, enthusiasm (Hochschild, 2003); hardiness (MacKintosh, 2007); self-monitoring (Grandey, 2000) and four of the big five personality variables in conscientiousness, extraversion, agreeableness and neuroticism (Diefendorff, Croyle and Gosserand, 2005) all cue emotional labour. Individuals whose combination of traits leads to a positive outlook in which they value interaction tend to act less than those whose outlook is negative, as it takes more effort for those individuals to respond positively in a difficult situation as their negativity is exacerbated (ibid). Meisiek and Yao (2005) remark how sharing a joke or funny story, ubiquitous across organizations, is not always appropriate necessitating the suppression of joy or anger, if it is used impoliticly.

With respect to class Hochschild (ibid) aligns emotional labour with the middle class as

their jobs oblige them to "transform their show of personality into a symbol of the company" (ibid: 154) which neither applies to the routine mechanical jobs of the lower classes nor the idiosyncratic power held by the upper classes. Status is linked to freedom of expression with those lower down the workplace hierarchy less free and therefore required to perform more emotional labour (Sloan, 2008; Wharton, 2009). Hochschild also draws attention to fatigue as an antecedent as it has to be hidden whilst Werth (2011: 11) draws attention to how illness and disability increase the acting requirement, as the individual worker has to overcome stigma and "be accepted as a normal person".

Ethnic/religious/moral values can transfer to the workspace introducing tension which cue emotional labour if both interactants hold opposing views (Syed, 2008). Personal baggage e.g., aspirations can also serve as a cue if they conflict with organisational directives (Bolton, 2005). Social, communication and acting skills are all implicit in performances of emotional labour irrespective of whether they are customer service encounters or client consultations (Wharton, 2009). HWI also termed family-work interference [FWI] which completes both this subsection and quadrant on antecedents has steadily gained momentum, as child and elder care have had to be integrated in households where all adult members work (Frone, Russell and Cooper, 1992). Domestic conflict, family responsibilities and non-work hassles all intrude on the workspace, exerting a demand on individuals to mask their worries and anxieties (Bolger, DeLongis, Kessler and Wethington, 1989). The potential for HWI to spillover onto colleagues heightens its significance (Brummelhuis, Bakker and Euwema, 2010).

1.6.2. Strategies

Performances of emotional labour cued by one or more antecedents vary according to the emotion that has to be managed and the rule and technique applied to it. In this section I examine each of those three constitutive elements in turn.

1.6.2.1 The Emotions

Although Theodosius (2008: 91) makes the point "emotion management is about the management of emotions" and therefore the emotions need to be identified she considers a definition to limit their exploration to which I counter, emotion is nebulous

and giving it a form makes it conspicuous and therefore undeniable. However, emotions defy definition within the parochialism of a single discipline (Turner and Stets, 2005) so I clarify what is meant by the term through taking fragments of insight and piecing them into a workable synthesis. Emotions can therefore be considered an intense reaction, part physiological (LeDoux, 1998; Turner, 2000) part cognitive (Arnold, 1960; Frijda, 2000) to a specific stimulus [event, object, name, place, sound, smell person, memory or even imagination] (LeDoux, 1998; Solomon, 2004). They are labelled through reference to a common, culturally specific meaning system and vocabulary (Gordon, 1990) and each obliges an individual to tune their overt behaviour to accord with their sociocultural understanding of their situation (Goffman, 1961a; Hochschild, 1998) and their intentions (Briner, 1999). "It is emotions that put the sensed *imperative* into social duties, *the ought* into morality, the *feeling* into respect, and the *sting* into conscience" (Wentworth and Ryan 1992: 38) and that applies to public as well as private spaces.

There are around one hundred emotions in which individuals can say they are fluent (Turner and Stets, 2005) however a small number of studies have whittled those down to twenty-seven emotions common to the workplace (Fisher, 1997; Basch and Fisher, 1998; Briner, 1999; Mann, 1999) which I list in Table 1.1. Although there is common accord, it is not absolute. Arguably there is a notable omission in surprise. Experienced positively, surprise materialises as astonishment and negatively as shock (Ortony, Clore and Collins, 1988). As either may have to be managed in order to present an appropriate emotional response and/or manipulate the emotional response of another I regard it as an oversight which increases that total to twenty-eight.

1.6.2.2 Rules

Every encounter carries rules as to what constitutes an appropriate emotional response (Hochschild, 2003). These may be formal e.g., commercial script or informal e.g., cultural understanding (Bolton, 2005) but each acts to govern the type and intensity of felt emotion and/or the type and intensity of expressed emotion (Ekman, 1973; Holman, Martinez-Iñigo and Totterdell, 2008b). Both can be restrictive or expansive but negative emotion is more likely to be associated with the former and positive with the latter (Brotheridge and Grandey, 2002; Diederorff and Gosserand, 2003).

Briner (1999)	**Mann (1999)**	**Basch & Fisher (1998)**	**Fisher (1997)**
Pride	Pride	Pride	Pride
Self-reproach [embarrassment, guilt, shame]	Embarrassment Shame	Embarrassment	Embarrassment
Appreciation [admiration, respect]	Admiration		
Reproach of others [contempt, disdain, appalled]		Disgust	Disgust
Gratitude [feeling indebted, thankful]			
Anger [annoyance, fury, outrage]	Anger	Anger Annoyance	Anger
Gratification [self-satisfied, smug]			
Remorse [self-anger, penitent]			
Joy [delighted, cheerful, joyful]	Happiness	Happiness	Happiness
Distress [distraught, uneasy, shock, misery]	Sadness Hurt Dismay	Sadness Hurt Unhappiness	Unhappiness
Happy-for [pleased-for, delighted-for]		Pleasure	Pleasure
Sorry-for [compassion, pity, sympathy]	Sympathy		
Resentment [envy, jealousy]		Bitterness	
Gloating			
Hope [anticipation, excitement]		Optimism	Optimism
Fear [apprehension, anxious, worried, scared]	Anxiety	Fear Worry	Worry
Satisfaction [gratification, hopes-realised]		Pleasure	Pleasure
Fears-confirmed			
Relief		Relief	
Disappointment [dashed-hopes, despair]	Disappointment	Disappointment Frustration	Disappointment Frustration
Liking [[affection, adoration, attraction, love]		Affection	Affection
Disliking [detest, hate, loathe, repelled-by]			
	Enthusiasm	Enthusiasm	Enthusiasm
	Boredom		
	Interest		
	Intimidation		
		Power	

Table 1.1: Workplace emotions

When emotion rules and felt emotion converge a genuine display emerges from an automatic and effortless process (Zapf, 2002) to produce a state of emotional consonance (Zammuner and Galli, 2005) or equivalently, emotional harmony (Rafaeli and Sutton, 1987). But when the felt emotion differs in type or even intensity from that which is prescribed emotional dissonance occurs (Middleton, 1989) and this has to be managed through using an appropriate technique. If dissonance is not managed and felt emotions are displayed, resulting in what is termed, emotional deviance (Rafaeli and Sutton, 1987) consequences are likely to follow. As Thoits (1985) argues, the whole point to managing emotion lies in the transformation of deviant feeling.

The literature suggests two rules predominate in the suppression of negative emotion and amplification of positive emotion (Schaubroeck and Jones, 2000; Brotheridge and Grandey, 2002; Diefendorff and Greguras, 2006; Zapf and Holz, 2006; Holman, Martinez-Iñigo and Totterdell, 2008a). Mann (1999) argues emotion is suppressed in 25% of interactions although this figure is raised to 50% by Gibson (1997) and 66% by Erickson and Ritter (2001) whilst feigning is a property of 20% of interactions (Mann, 1999). But as Elfenbein (2007) points out, different rules apply to different interaction partners and there will be an optimum for each that will be instrumental in producing the desired outcome.

1.6.2.3 Techniques

Hochschild (2003) associates the management of emotion with just two techniques in surface and deep acting. Although this notion of a duality has been challenged (Bolton, 2005) and other techniques have emerged (Elfenbein, 2007) both retain currency in contemporary discourse (Brotheridge and Lee, 2002; Grandey, 2003; Diefendorff, Croyle and Gosserand, 2005). Surface acting adjusts the display of emotion but does not alter how an individual feels which leads to inappropriate feeling being suppressed (Holman, Martinez-Iñigo and Totterdell, 2008b). Displaying emotion not felt creates an inauthentic performance but if the role is valued e.g., professionals or a strong sense of obligation directs compliance with display rules e.g., charity workers (Stenross and Kleinman, 1989) an authentic sense of self is uncompromised. Feeling coerced however into giving an inauthentic performance can make the worker feel a hypocrite, compromising their sense of self and alienating them from their work (Mann, 1997). Individuals who lack life experience (Dahling and Perez, 2010); do not value

interpersonal relations (Diefendorff, Croyle and Gosserand, 2005); dissatisfied with their work (Parkinson, 1991; Adelmann, 1995; Grandey, 2003) or hold a negative outlook (Diefendorff, Croyle and Gosserand, 2005) are more likely to use this technique rather than the alternative of deep acting, as it is easier to achieve (Mann, 2002).

Deep acting adjusts inner feelings to suit the situational demand resulting in a genuine expression of the desired emotion (Holman, Martinez-Iñigo and Totterdell, 2008b). This performance not only appears authentic but is considered authentic by the individual (Hochschild, 2003). This technique is used more by employees who value interpersonal relationships (Diefendorff, Croyle and Gosserand, 2005) or who are older and therefore more skilled in emotion control (Hochschild, 2003; Dahling and Perez, 2010). It is also associated with situations that are less routine or longer in duration which offer opportunity for emotional attachment (Diefendorff, Croyle and Gosserand, 2005).

Of the two techniques, surface acting is considered the less effective firstly because individual well-being is compromised by the increased energy demanded by the cognitive effort in suppressing undesirable emotion (Richards and Gross, 1999, 2000; Holman, Martinez-Iñigo and Totterdell, 2008b) and secondly, it can be decoded by recipients who expect sincerity in return for their loyalty and respect (Groth, Hennig-Thurau and Walsh, 2009). Although effort is also expended when an individual engages in deep acting this is offset by gains in personal authenticity from positive customer feedback (Holman, Martinez-Iñigo and Totterdell, 2008a).

Diefendorff, Croyle and Gosserand (2005) maintain surface and deep acting are compensatory techniques utilised only when an individual is unable to spontaneously respond in an appropriate way. Bolton (2005) drawing on Archer's (2000: 197) description of emotionality as, a "continuous running commentary", argues situations vary and therefore the demand for emotion management varies which permits true feelings to be expressed particularly in routine interaction. Hochschild (1983) was actually the first to acknowledge genuine emotion could be expressed in the workplace but only through a particular and rare form of deep acting she terms passive deep acting. However, Diefendorff, Croyle and Gosserand, 2005) argue it is a distinct and effortful process in its own right and as such, has a right to its own part in the commentary.

Humour in addition to being antecedent is also a complex technique (Roy, 1973;

Collinson, 2002; Bolton, 2005). It can be used to suppress boredom (Roy, 1973) and anger (Fine, 1988); offer relief and promote affection (Francis, 1994; Collinson, 2002); add joy to the workplace but also fear (Bolton, 2005). Collinson (2002) remarks, bullying, harassment, discrimination and insults can all be disguised with a veneer of humour. Meisiek and Yao (2005: 163) describe it as a "powerful ingredient in communication at the work place" either through its suppression and censorship or conversely, its manufacture and reproduction.

Elfenbein (2007) draws on Gross (1998a, 1998b) to add two pre-engagement techniques: situation selection and situation modification. In the former, individuals limit their exposure to situations in which they anticipate undesirable emotions may be encountered or they increase exposure to those evoking desirable emotions. But both rely on the organisation permitting such manipulation. In the latter, the situation itself is modified to avoid the occurrence or recurrence of toxic emotional states e.g., an individual may change their role within the organisation in order to change the audience with whom they have to interact.

1.6.3 Consequences

Consequences alternatively referred to in the literature as outcomes (Grandey, 2000; Erickson and Grove, 2008) divide into positive and negative (Bono and Vey, 2005).

1.6.3.1 Positive

Positive consequences to performing emotional labour are recognised as increasing levels of: personal accomplishment (Brotheridge and Grandey, 2002; Zapf and Holtz, 2006); self-esteem (Zapf and Holtz, 2006); empowerment (Stenross and Kleinman, 1989; Leidner, 1993; Tolich, 1993); community spirit (Shuler and Sypher, 2000); professionalism, respect (Harris, 2002); job satisfaction (Wharton, 1993; Adelmann, 1995; Cote´ and Morgan, 2002; Brotheridge and Grandey, 2002; Diefendorff and Richard, 2003); ontological security/identity (Stryker, 2004; Bolton, 2005) and well-being (Holman, Martinez-Iñigo and Totterdell (2008a, 2008b).

Well-being is significant because it is "a state of contentment which allows an employee

to flourish and achieve their full potential" (CIPD, 2007: 4). It reflects an individual's physical, mental and social health and encompasses both their job satisfaction (Hülsheger and Schewe, 2011) and role identity (Burke, 1991, 1996; Stryker, 2004). Situations that amplify positive emotion enhance satisfaction e.g., when job resources [energy, autonomy, social support] exceed demands (Holman, Martinez-Iñigo and Totterdell, 2008b). Stryker (ibid) comments how when identity is confirmed by others a positive stream of emotion [joy, satisfaction and pride] enhances self-esteem and security which strengthens both commitment and conformity to role expectations.

1.6.3.2 Negative

Negative consequences to performing emotional labour are largely psychological (Hochschild, 2003) and linked to situations which promote negative emotion e.g., high job demands and/or low resources (Holman, Martinez-Iñigo and Totterdell, 2008b). As regulating emotion uses energy specifically glucose (Schmeichel, Demaree, Robinson and Pu, 2006; Gailliot and Baumeister, 2007) individuals whose resources are depleted faster than they can be replaced are compromised (Muraven and Baumeister, 2000). Surface acting in which the individual needs to continuously monitor their actual against desired emotion drains resources and enhances strain (Cote, 2005; Grandey, 2003; Martinez-Iñigo, Totterdell, Alcover and Holman, 2007). Both the suppression and feign of emotion are implicated (Zapf, 2002) with the suppression of anger in particular linked to both stress and somatic complaints (Cottington, Matthews, Talbot and Kuller, 1986). Deep acting also depletes resources but at a slower rate (Holman, Martinez-Iñigo and Totterdell, 2008b) and consequently it has been shown to be less harmful (Bono and Vey, 2005). If energy levels are allowed to fall too low adverse symptoms manifest to warn rest and nutrients are needed but if these go unheeded (Elfenbein, 2007) the risk of both psychological e.g., burnout and physical consequences e.g., hypoglycaemia and diabetes (Chandola, Brunner and Marmot, 2006) increase.

Burnout, a complex syndrome of emotional exhaustion, depersonalisation [felt distance from others] and diminished personal accomplishment (Maslach, 1976) is the end-game of strain with stress occupying the middle ground. Workplace stress is defined as, "an unpleasant emotional experience associated with elements of fear, dread, anxiety, irritation, annoyance, anger, sadness, grief and depression" (Motowildo, Packard and Manning, 1986: 618) and is often accompanied by somatic complaints e.g., headaches

(Mann, 2002). Hochschild (2003: 131) comments how stress is "a thread woven through the whole work experience" which drains resources allowing emotional exhaustion to set in. Consequently, individuals become "robotic, detached and unempathetic" (Albrecht and Zemke, 1985: 114).

Those who readily identify with their role are at particular risk of burnout (Hochschild, 2003). Ashforth and Humphrey (1993) explain the stronger a role defines the individual the more likely obligations attached to it will be internalized, leading to job stressors and performance failures being more keenly felt. Internally their identity will be threatened if their process of self-verification against standards fails (Burke, 1991, 1996) and externally, if their performance fails to match expectations held by others (Stryker, 2004). Whilst anxiety stems from internal incongruence (Burke, 1991, 1996) embarrassment and guilt result from external disconfirmation leading to a consequential lowering in self-esteem, adjustments to behavior and even resignation in extreme circumstances (Stryker, 2004). However, Hochschild (2003) maintains those individuals who acknowledge their performances are an act are at less risk although they will feel inauthentic or estranged depending on whether they attach blame to their separation of self from their role or not.

1.6.4 Interventions

Interventions act to diminish negative and amplify positive consequences. Whilst the individual has a free choice over some interventions others are available only at the discretion of the organisation (Mann, 2002).

1.6.4.1 Individual

Interventions open to individual choice include: calming strategies [deep breathing, displacement, humour, diary keeping, relaxation and visualization techniques]; cognitive restructuring [self talk, restructuring situations and reframing performances] (Mann, 2002); social support (Brotheridge and Lee, 2002); social relationships (Hobfoll, 1989); venting emotion, religious appeal (Carver, Scheier and Weintraub, 1989); exercise (Salmon, 2001) and substance use e.g., smoking (Chaplin, Hong, Bergquist and Sinha, 2008). With respect to calming strategies I consider taking deep breathes holds merit for its ease of use anytime an individual needs space to dissolve errant emotion

and refresh. Although humour comes with a caution for circumspection (Meisiek and Yao, 2005) I agree with Beck (1997) that it is a valuable mediator as it can be used publicly within interactions to provide: a breathing space (Astedt-Kurki, Isola, Tammentie and Kervinen, 2001); relieve tension (Sutton, 1991; Francis, 1994; Beck, 1997; Mann, 2002); redefine threats and restore equilibrium (Francis, 1994). In private spaces, where it takes the form of insider or 'black' humour, it not only diffuses harmful emotions but fosters togetherness (ibid).

From cognitive structuring, I extract the power of self talk or the intermittent internal dialogue one can have with oneself to provide reassurance during a difficult situation, as also holding similar merit. This intervention recasts a situation so it is less threatening and easier to handle which allows emotion to dissipate. Seeking social support [emotional and/or informational] informally from co-workers (Hochschild, 2003; Abraham, 1998; Brotheridge, 2001), supervisors (Cordes and Dougherty, 1993) and/or family (Hochschild, 2003; House, Umberson, and Landis, 1988) allows an individual to offload their emotion and obtain: sympathy; reassurance; relief and advice from those they entrust will understand their position. Rewarding social relationships stemming from reciprocal support act to buffer stress (Hobfall, 1989). However, all of these interventions suggest emotional distress is the property and therefore responsibility of the individual (Giga, Cooper and Faragher, 2003). But individual interventions carry limited effectiveness without organisational support (Cooper and Cartwright, 1997; Kompier and Cooper, 1999; van der Klink, Blonk, Schene and van Dijk, 2001).

1.6.4.2 Organisational

Interventions at the organisational level start with recruitment and the selection of individuals who understand "the rules of the game" (Hochschild, 2003: 95). Through achieving a good person-job fit (CIPD, 2012) the likelihood of negative outcomes e.g., turnover are reduced (Edwards, 1991). Training both initial and recurrent is then able to provide a "protective cloak" (Hochschild, 2003: 29). Although the efficacy of training events has been challenged (Elias and Murphy 1986; Schreurs, Winnubst and Cooper, 1996) they remain a valid mechanism for reducing strain (Giga, Cooper and Faragher, 2003) and stifling burnout (Totterdell and Parkinson, 1999; Grandey and Brauburger, 2002; Brotheridge and Grandey, 2002; Grandey, 2003). But for these measures to be effective they need to be set in an environment perceived to be supportive (Thomas and

Ganster, 1995; Babin and Boles, 1996; Cropanzano, Howes, Grandey and Toth, 1997) which is achieved through: genuine concern and recognition by managers (Rooney and Gottlieb, 2007); listening to employee concerns; disseminating accurate information to protect individuals from rumour (Schabracq, Cooper, Travers and van Maanen, 2001); attending to organisational hassles e.g., staff shortages (Giga, Cooper and Faragher, 2003); permitting and encouraging an emotional dialogue (Mann, 2002); establishing peer support networks, providing professional support (Hogan, Linden and Najarian, 2002) and authorizing downtime (Mann, 2002).

Peer support networks in which the organisation provides contact details of trained volunteers who can share experiences carry mutual benefits (Hogan, Linden, Najarian, 2002) although Strazdins and Broom (2007) caution supporters themselves can be subject to adversity [work or personal life] thus depleting the resources they have available for others to draw on. Professional caretakers e.g., psychologist offer a more structured approach which focuses on both emotional and instrumental support [advice, problem-solving, coping strategies] but Hogan, Linden and Najarian (2002) warn they may induce dependency.

The most effective intervention an organization can offer following an emotional episode is downtime (Mann, 2002).

> "As with physical labour, after a sustained period of emotional labour, an alternative or a rest are necessary"
>
> James, 1989: 27.

Somewhere within the "mosaic of emotionalised zones" (Fineman, 2003: 37) that maybe formal e.g., restroom or informal e.g., car park, a period of downtime allows individuals opportunity to rest, relax, avail themselves of informal support and restore their energy levels and emotional equilibrium. Lundberg (2005) argues a lack of rest and recovery time represents the greatest health problem faced by workers in modern society. However, for interventions to be truly effective they must be bespoke, participatory, regularly evaluated and address both prevention and management of negative outcomes (Giga, Cooper and Faragher, 2003).

1.7 A Generic Quadripartite Integrated Framework of Emotional Labour

Having established there are four not three stages to the process of emotional labour I arrange these in a cyclical design on the basis of two ideas. First, I take from Rafaeli and Sutton (1987) and their notion of the emotional transaction how one encounter can entail many performances e.g., the delivery of bad news accompanied initially by an expression of sympathy may entail a subsequent suppression of distress if it is received with an outpouring of grief which may progress to fear if anger ensues before the receiver signals acceptance, prompting the suppression of relief (Clark and LaBeef, 1982). Second, I take from Huynh, Alderson and Thompson (2008) the notion of a duality in how consequences influence antecedents e.g., a positive consequence to performances in job satisfaction will strengthen commitment to the role which will prompt future performances to accord with role expectations.

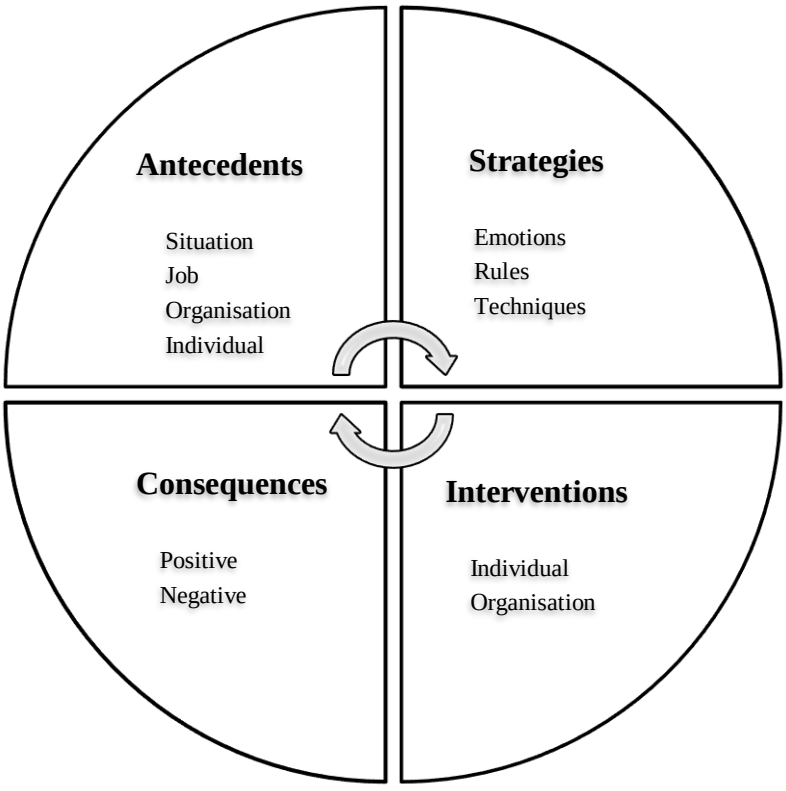


Figure 1.1: A Generic Quadripartite Integrated Framework of Emotional Labour.

Through combining those two ideas with my argument there are four not three elements to the process of emotional labour I derive the cyclical framework I show in Figure 1.1.

This generic framework integrates the interactional demand on the occupation with the individual process of emotional labour through recasting that demand as situational antecedents. This transition I argue allows emotional labour to be understood from both that of the giver and receiver without one perspective neglecting the other as traditionally has been the case (Wharton, 2009). In the final chapter to this thesis I will develop an occupational model based on this framework which opens up the possibilities within this fresh integrative look at emotional labour.

1.8 Concluding Remarks

Emotional labour, conceived by Hochschild (1983) has reopened the sociological debate on organisational emotionality attracting both plaudits and criticisms. However, a surfeit of criticism particularly in respect of her intractable dichotomy has led to the development of a small number of alternate lenses that recognise emotional exchanges can occur in the workplace without a profit being attached (McClure and Murphy, 2007). Although these new agendas are intriguing they have not secured the authority to persuade me to abandon the emotional labour field. Accordingly I take a fresh look and through doing so, I identify a missing component to the process I term interventions. As these act to diminish negative and amplify positive consequences their influence has, I argue, been overlooked. I redress this through the development of a generic quadripartite framework to the process of emotional labour in which antecedents, strategies and consequences are joined by interventions. Within this framework I argue situational antecedents can be recast as the interactional demand to fuse the two research streams which have divided the field. In the next chapter I contextualise this quadripartite integrated framework as I purposefully examine the literature on prehospital emergency care. This generates a steer for my inquiry and exposes the questions for it to address.

Chapter 2

Prehospital Emergency Care

2.1 Introduction

In this chapter I first outline the paramedic role within the wider panoramic of the NHS ambulance service to establish a common perception of the nature of the job and the organisational climate in which it is undertaken. I then apply the generic framework I developed in chapter one to the prehospital emergency care literature in order to develop a contextual understanding of emotional labour. But as Boyle (2002, 2005), Boyle and Healy (2003) and Filstad (2010) provide the only glimpses of this concept through the paramedical lens I also draw on wider ambulance and health service discourses to populate the framework and construct a steer for my inquiry.

2.2 The Paramedic Role

In essence, paramedics "are trained to drive what is in effect a mobile emergency clinic and to resuscitate and/or stabilise patients using sophisticated techniques, equipment and drugs "(NHS, 2011a). As a consequence they must hold a full clean C1 [vehicle between 3500Kg and 7500Kg] and D1 [minibus between six-sixteen passengers] driving licence (NHS, 2009c). Individuals suited to the role have a calm reassuring manner, good communication and team-working skills and are able to use their initiative (ibid). They are alerted to an emergency by Control Room dispatch officers who monitor their response against benchmarks I detail later in the chapter and attend incidents either as one half of a double-crewed ambulance or as solo responders in rapid response vehicles.

2.2.1 History

The role of the paramedic is steeped in a history of transportation. But whilst the mode of transport has changed from pole stretcher to motorised vehicle (Batten, 1996) the core requirement to 'scoop and run' remains integral to the role. This is particularly evident in Government initiatives that emphasise response times (DOH, 2007). The role of the ambulance bearer has, according to Haller (1992), military roots that can be

traced back to 1000 BC however, the paramedic timeline only stretches back to the middle of the 1980's. It sprang from an increasing recognition of the value in prehospital emergency care that had begun twenty years earlier, with the publication of the Millar Report (MOH, 1966a, 1966b). This report condemned the unsystematic and inadequate training of ambulance staff who acquired their operational knowledge from first-aid classes given by voluntary organisations to benefit the general public (Enstone, 2008). Millar recommended they should be detached to hospitals for exposure to anaesthesia, surgical interventions, post mortems and A&E protocols (MOH, 1966a). For the first time, since the conception of a national ambulance service in 1919, there would be a nationally approved qualification in Ambulance Aid (Caple, 2004).

During the 1970s, pre-hospital emergency care leapt forward partly due to the media exposing the 'golden hour' during which definitive care by a paramedic expedited patient recovery (Caple, 2004) and partly due to the availability of new equipment e.g., mobile heart defibrillators (Chamberlain and Nolan, 2008). This medicalisation led to the ambulance service transferring out of local authority control where it had resided following the National Health Act 1946 into the NHS. In the early 1980's, the introduction of a new standard for ambulance personnel entitled those holding an Ambulance Aid certificate to be automatically renamed technicians. From 1986, an additional twelve weeks training involving detachment to a hospital to gain experience in endotracheal intubation and intravenous cannulation techniques was provided to enable ambulance personnel whose ethos had been 'scoop and run' to take the title 'paramedic' and 'stay and treat' (Caple, 2004).

2.2.2 Professional Status

In June 1999, state registration was extended to paramedics and professional status conferring protection of title and graduate entry followed in 2003 (Ball, 2005). Paramedics are regulated by the Health and Care Professions Council [HCPC] formerly known as the HPC and registrants total over twenty thousand (HCPC, 2014). Their professional body is the College of Paramedics [COP] formerly known as the British Paramedic Association [BPA]. As a result of professional accreditation the traditional route to becoming a paramedic via the technician grade has closed. Prospective paramedics either apply for a student paramedic position with an ambulance trust and attend university on block release or attend an approved full-time university course in

paramedic science and then apply for a qualified position with a trust of their choice (NHS, 2011a). In order to maintain their registration, without which they are unable to work in the NHS, paramedics have to commit to continuous professional development [CPD] and satisfy audited standards I tabulate in Table 2.1.

Must be able to use a range of integrated skills and self-awareness to manage clinical challenges effectively in unfamiliar circumstances or situations
Must be able to maintain a high standard of professional effectiveness by adopting strategies for physical and psychological self-care, critical self-awareness, and by being able to maintain a safe working environment
Must understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team
Must be able to identify anxiety and stress in patients, carers and others and recognise the potential impact upon communication
Must know how psychology and sociology can inform an understanding of physical and mental health, illness and health care in the context of paramedic practice and the incorporation of this knowledge into paramedic practice
Must know how aspects of psychology and sociology are fundamental to the role of the paramedic in developing and maintaining effective relationships
Must know how to select or modify approaches to meet the needs of patients, their relatives and carers, when presented in emergency and urgent situations

Table 2.1: Paramedic standards of proficiency (HPC, 2007: 5-15).

Instrumental to the legitimisation of this new identity and its institutionalisation is the process of internal and external reframing which Goodrick and Reay (2010) point out is neither quick nor easy. It requires first of all, a progenitive connection to the past which I argue is evident in how the role still accentuates driving skills but of a mobile clinic rather than an ambulance. Second old labels must reflect the normalisation of new meanings which I argue is apparent in how emergency care once thought of as basic first-aid now means the application of sophisticated techniques, equipment and drugs. A third strategy is to alter existing identity referents. Although the ambulance service retains identity as an emergency service it has become associated with the term 'pre-hospital care' which is recognised as a branch of medicine practised by the ambulance service (FPHC, 2014) which up-skills the role and couples it to healthcare professional. Fourth, the institutional connection has to reflect societal requirements which the

historical timeline I have provided endorses and lastly, testimony must emanate from accredited authorities to which Freidson (1983) adds the need to take into account the conceptions held by interactant partners as to how the new professional role will be accomplished.

As an emergent profession, paramedics have had to root themselves in an established order in which their subordination is assumed and their clinical capability strictly controlled. This control lies with the JRCALC [Joint Royal Colleges Ambulance Liaison Committee] which was set up in 1989 to develop and review national guidelines on paramedic clinical practice. Although the committee includes ambulance service personnel it also draws members from across both medicine and nursing with the Chair taken from the former (JRCALC, 2007a). It has legitimised the role through extending its clinical skill-set which has encroached on the jurisdiction of medical practitioners e.g., administration of the pain relieving opiate Morphine (JRCALC, 2007b). As "negotiation contributes to the constitution of social orders and social orders give form to interaction processes" (Allen, 1997: 514) I propose the JRCALC hold the master key to paramedic identity and position within healthcare.

2.2.3 Terms and Conditions of Employment

Paramedics are required to work both day and night shifts, averaging 37.5 hours a week in order to provide 24/7 cover over 365/6 days of the year. NHS pay scales place paramedics in pay band 5 and team leaders in pay band 6 with each band increased by up to 25% for working unsociable hours (NHS, 2011b). An allowance towards professional registration fees is also added (HPC, 2011). Annual leave starts at twenty-seven days rising to thirty-three after ten years of service with an additional eight days added in lieu of bank holidays. All paramedics unless they opt out, automatically become members of the prevailing NHS Pension Scheme (NHS Careers, 2013).

2.2.4 The Ambulance Service

The provision of prehospital emergency care across the UK is split into separate regional authorities. The ambulance service for England sits within the NHS and is delivered through a series of regional independent trusts that together employ over thirty thousand staff of which roughly a third are paramedics (HSCIC, 2013). Each trust

is led by a Chief Executive Officer [CEO] supported by a board comprising both non-executive and executive directors. The Operations Director is responsible for the accident and emergency service and his/her chain of command extends down through divisional management to the paramedics.

The culture of the service is one of command and control with a tendency towards bullying and blame (CHI, 2003). The service bears the hallmarks of its military roots with rigid protocols, lines of authority and the privileging of masculinity in forms of expression and coping (Boyle, 2002). According to Wankhade (2010) there are four distinct subcultures: executive, manager, engineering and operator, each with its own agenda. Paramedics reside in the operator subculture and are what Lipsky (1980: 3) refers to as "street level bureaucrats" although they are only semi-autonomous as they must defer to Control Room dispatch officers. These officers form the pivot or engineering subculture around which the service revolves as they allocate priority, dispatch response vehicles and manage overall performance. The management culture is a buffer zone between those who deliver the service and those responsible both economically and politically for it i.e., the executive. A number of stakeholder reports have been influential in both cultural reform and rebellion. First there was Millar and then Bradley or to give its correct title, 'Taking Healthcare to the Patient' which states,

> "Ambulance services need to look, feel and act differently. Improving skill levels and introducing greater career progression opportunities will be a vital ingredient of this change but it will not be enough. To achieve higher levels of job satisfaction in a positive culture of continuous improvement requires strong leadership and effective management which ensures all staff feel well informed, supported, valued, listened to and involved in the future developments of their organisation and their profession"
>
> DOH, 2005a: 28.

However, just 10% of ambulance personnel report being involved in decisions and less than a quarter feel encouraged and supported to develop their potential (CQC, 2009). Change, Wankhade (2010) remarks, is more likely to cause the four subcultures to collide and divide rather than coalesce as a lack of communication and mutual

understanding inevitably leads to pockets of covert resistance. Nisbet (1970) explains how groups become strengthened through animosity and defensiveness towards others leading to the phenomenon of 'us versus them'. This, according to Mahony (2001), characterises ambulance services. Thurnell-Read and Parker (2008) elaborate this polarity as 'doing' [practice of care by road crew] versus 'knowing' [theory of care by management] common to all emergency services.

2.2.5 Operational Standards

Operational standards or response times commonly referred to as ORCON date back to 1974 and represent a mechanism used by the DOH to improve both the efficacy and effectiveness of the service (NAO, 2011). As they are subject to on-going scrutiny and revision the standards I present in this section are those that applied across 2008-2009 when my fieldwork took place. Those standards used a tripartite categorisation of '999' calls as 'A' [immediately life threatening], 'B' [serious but not immediately life threatening] or 'C' [not serious or life threatening]. The first two of which were subject to audited response times (NAO, 2011) where 75% of category 'A' calls had to be answered in eight minutes [A8] and 95% of category 'B' calls in nineteen minutes [B19] . In addition, when the response to a category 'A' call was made by a single responder who requested transport a fully equipped ambulance had to arrive within nineteen minutes, 95% of the time [A19]. Nationally 74.3% of calls achieved the A8 standard, 91% the B19 and 96.9% the A19 (DOH, 2010).

The response time for Category 'C' calls was subject to local availability of a resource rather than a national standard (DOH, 2004a). From April 2008 a new system of measurement, 'Call Connect' revised timings to start from when a '999' call connected to the Control Room and not from when three key pieces of information [location, telephone number and chief complaint] had been obtained from the caller as previously (DOH, 2011). In theory, this cut the response time, illustrated in Figure 3.2, to ninety seconds (Woollard, O'Meara and Munro, 2010). A new system of call prioritisation, NHS Pathways, an automated, scripted, clinical assessment tool for non-clinicians enables calls not in need of an emergency response to be routed elsewhere (Whitfield, 2009). Although deemed robust with 0.034% risk of under-triage and therefore fit for purpose (Turner, Lattimer and Snooks, 2008) it is not infallible and has attracted criticism (Donnelly, 2010a, 2010b).

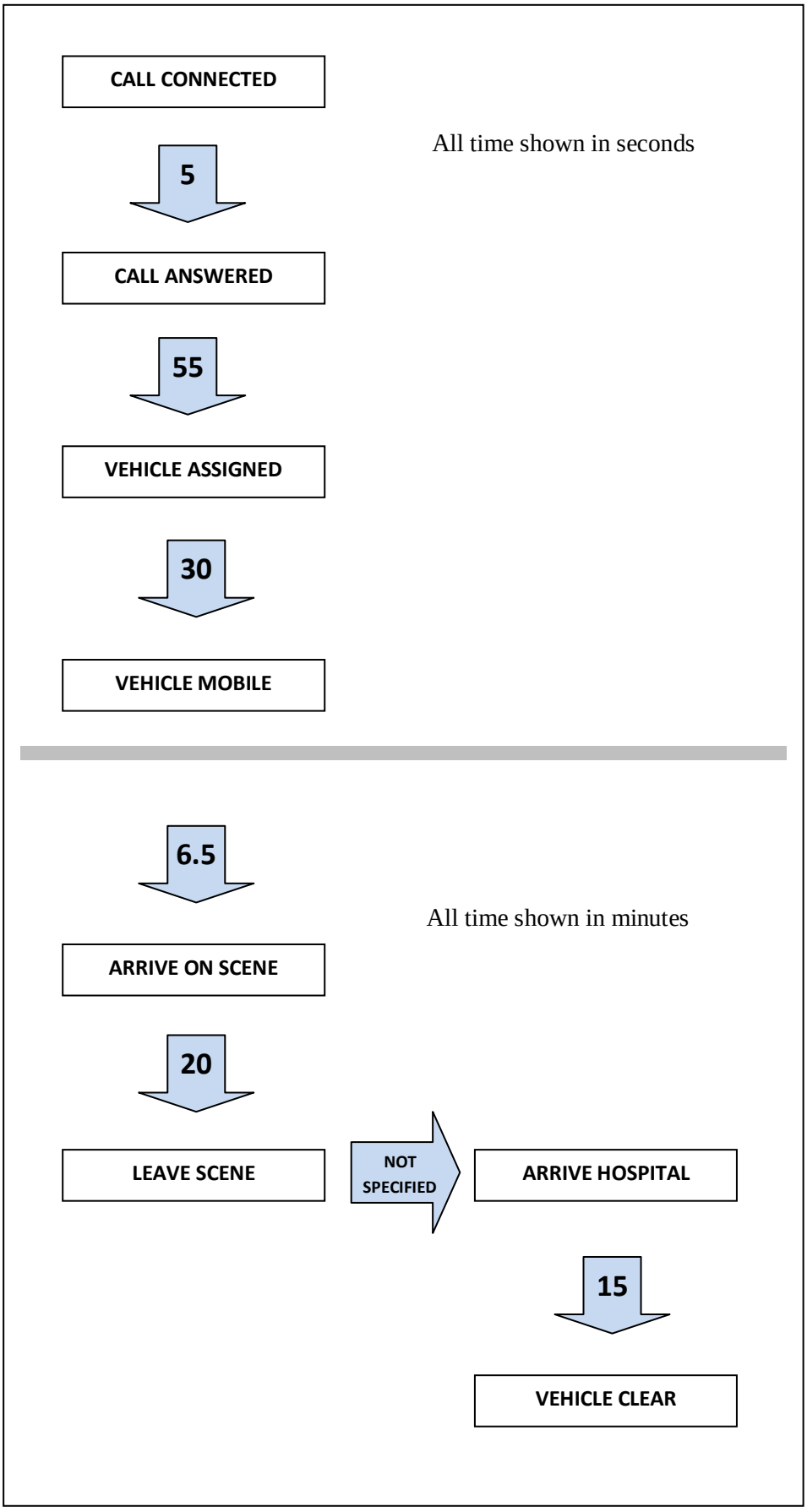


Figure 2.1: Category ‘A’ call cycle (NHS, 2008c).

Although service standards, Call Connect and Pathways are designed to improve patient outcomes, the evidence is scant other than for cardiac arrest (Stephenson, 2010). However, that is also disputed. Woollard, O'Meara and Munro (2010) claim the response window for survival following an arrest is only four/five minutes at most. By diverting emergency resources into stopping the clock they argue clinical standards are being put at risk, as training is being curtailed to fund vehicles. Response times by accentuating driving ability over clinical skill also undermine the professional image of the paramedic. The introduction of clinical quality indicators (DOH, 2010) do not in my opinion reverse that degradation as response times remain a prominent measure of performance.

2.3 The Contextualised Framework

In this section I apply the generic quadripartite integrated framework of emotional labour I developed in chapter one to the prehospital emergency care literature. I extract contextualised meaning and supplement this with knowledge derived from other domain-specific discourses when and where I consider meaning could be enhanced. I retain the convention of discussing interventions last to facilitate understanding. Altogether I raise eight subsidiary questions that will enable me to address what constitutes emotional labour for the UK paramedic.

2.3.1 Antecedents

As there has been no audit of antecedents within any healthcare domain (Erickson and Grove, 2008) I scrutinise the prehospital literature for contributions. The emergent stream populates all four categories of antecedent that I discuss in the same order as the previous chapter beginning with those pertinent to the situation.

2.3.1.1 Situation Antecedents

The principal situational cue in the prehospital emergency care domain is the patient who forms a legitimate use of emergency resources when some form of emergency intervention is required and the paramedic can utilise their medical expertise and skills (Mannon, 1992). When a high level of technical skill is warranted this constitutes an urgent patient (Boyle, 2005) which either forms a 'good' run e.g., trauma, heart attack

(Palmer, 1983a) which motivate and energise with the ultimate 'save' inducing what Palmer (ibid: 168) terms the "trauma junkie" or it constitutes a 'bad' run e.g., retrieval of body parts which the paramedics consider dirty work (Mannon, 1992). A low level of technical skill constitutes a non-urgent patient that Boyle (2005) remarks form the paramedics' routine workload and requires the most emotional labour although she does not distinguish these other than to include most specifically elderly females with dementia. As the paramedics also class patients subjectively as deserving or undeserving of their skill and attention "based upon moral judgements" (Boyle and Healy, 2003: 361) their status as legitimate cannot be assumed leading to some patients e.g., injured drunk driver (ibid) demanding both a moral and emotional circumspection so their antipodal cultural and/or socio-economic values do not affect the professional response. The illegitimate label automatically applies to patients who make inappropriate requests for emergency assistance who subdivide into patients with minor or pretend complaints (Mannon, (1992); patients whose complaint is underpinned by loneliness and/or incapacity and those who use the ambulance as a free ride to hospital appointments (ibid). These all diminish 'the buzz' associated with emergency care (Annandale, Clark and Allen, 1999).

Patients also categorise between alive and dead although an immediate death is regarded as a potential resuscitation (Mannon, 1992). Encounters with dead patients without hope of resuscitation are never routine as each stirs a deeply poignant mix of emotions (Bolton, 2000b; Furman, 2002) which may be intensely felt due to the fraught conditions in which it is often witnessed or pronounced (Palmer, 1983b). Another distinction is between adult and child with children recognised as more emotionally challenging than an adult (Boyle, 2005) as they demand an intense sympathetic response which reflects their naivety, unfulfilled potential (Mannon, 1992) and the forcefulness and/or distress of their parents (Dingwall and Murray, 1983). Irrespective of their complaint children are considered special patients who the paramedics are pleased to assist (Mannon, 1992). This also applies to those patients who are pleasant, cooperative (Palmer, 1989) and trusting (Strous, Ulman and Kotler, 2006). Trust defined as confidence in both the technical and social ability of others (Rowe and Calnan, 2006) is instrumental to the patient encounter as therapeutic intervention relies first on the patient providing a full and honest account of their symptoms [informational justice] and second submitting to treatment that maybe invasive (Theodosius, 2008).

In contrast patients who are angry, belligerent, hostile, anxious, frightened, hysterical or apathetic displease the paramedics as they are more demanding of their placatory skill and attention (Palmer, 1989). As Regehr, Goldberg, Glancy and Knott (2002) remark any emergency run however trivial carries the capacity to become emotional, if a poignant connection is realised with any aspect of the situation I argue those patients who exhibit similarity or familiarity to the paramedic (Shorter and Stayt, 2010) will also be more demanding. Patient expectations of service quality which amplify into heroic acts (Boyle, 2002), life saving efficiency (Mannon, 1981), general problem-solving capabilities (Boyle, 2002) and swift transportation (Boyle, 2005) also increase demand. However, Mannon (1981: 12) comments patient encounters last "a relatively short time" to deny the "strong emotional attachments" correlated with a high demand. But as Palmer (1983b: 86) points out, there is "a sliding scale of care and concern for patients with different characteristics" that overrides those criteria.

Performances are also cued by other outsiders in relatives, incident bystanders, observers (Boyle and Healy, 2003), emergency services personnel (Metz, 1981), A&E personnel and the media (Palmer, 1989) and insiders in the form of peers particularly work partners (Filstad, 2010), managers (Boyle and Healy, 2003) and the self in the form of memories (Clohessy and Ehlers, 1999). Relatives ensure the patient is rarely encountered at home alone (Allen, 2000; Allen and Pilnick, 2005) and performances of emotional labour serve to either maintain authority in the face of ignorance, aggression, fear, anxiety and grief (Palmer, 1989) or diffuse emotion so a deferent relative can be helpful and act as an advocate for the patient (Verhaeghe, Defloor, Van Zuuren, Duijnstee and Grypdonck, 2005). Bystanders, an inevitable consequence of encountering a patient in a public environment form an unpredictable mass (Metz, 1981). Whilst most are calm, curious even helpful they can become hostile, intimidating and an angry mob (Palmer, 1989). However, Boyle (2002: 138) argues the masculine character of the paramedic role acts as an "emotional shield" allowing them to give orders, castigate transgressors and retain authority. The curiosity exhibited by official observers on the other hand is welcomed for the opportunity to impress (Palmer, 1989).

Authority at an incident is not however assured as it is open to challenge by officers in the other emergency services [police and fire] extending their authority over the medical component. The latter are regarded as unduly competitive and arrogant and consequently attract contempt (Metz, 1981) although Mannon (1992) observes how

personal friendships between the two can overcome rivalries. The former in respecting the paramedics' medical authority and helping them by controlling traffic, crowds and danger are more likely to become friends (Mannon, 1992). Paramedics require a tight emotional rein as their position of medical authority deflates on arrival at A&E (Palmer, 1989; James and Wright, 1991). Here, their professional credibility built on trust and respect with some doctors is challenged by others who remain ignorant of paramedic capabilities and accordingly treat them condescendingly as subordinate provoking anger (Palmer, 1989) with those dubious of that association with 'dirty work' (Mannon, 1992) excluding the paramedics from their medical mystique (Palmer, 1989). Whilst nursing staff can be friendly (Palmer, 1989) and respect the paramedics' need for a swift, smooth handover they can also be dismissive (Mannon, 1992) leading to handover reports being given but unheeded (Metz, 1981) which provokes anger and contributes significantly to role strain (Palmer, 1983a). The nurses' attitude, according to Palmer (ibid), is a symptom of feeling threatened by the encroachment of the paramedic role on their medical jurisdiction. Media encounters the last of the outsiders serve to foster public relations and promote a positive public image provided animosity is kept in check over their intrusive nature (Palmer, 1989).

Insiders taking the shape of peers represent a significant source of emotional labour because the group identity of road crew (Mahony, 2001) overrides emotion felt by the individual so even if they are absent or personally exempt from an argument their emotional response is expected to mirror the consensus (Seger, Smith and Mackie, 2009). There is also an informal obligation on all paramedics to provide support to each other through allowing experiences to be shared and emotion including fear, anxiety and self-reproach offloaded as and when required (Jonsson and Segesten, 2004). However Jonsson and Segesten (ibid) segregate one close friend or confidant as significant in that respect. The most important peer is the work partner as they make a run emotionally satisfying when the relationship is harmonious or exhausting when it is discordant (Palmer, 1989). Associated with a harmonious relationship Mannon (1992) identifies a number of individual qualities of which I select: dependable; trustworthy; appropriate behaviour; willing to get involved; positive and enthusiastic as significant for promoting a close, satisfactory partnership. But a partner has to earn trust and it takes a copious amount of emotional labour to accommodate personal characteristics and mesh together although once established bonds are reluctantly broken (Mannon, 1992). In contrast a

discordant partnership is one in which one or both members are egocentric, negative, unreliable, behave inappropriately or display aggression (Mannon, 1992).
The last insiders are the mangers whom Mahony (2001) reports are judgemental, uncaring, authoritarian and intimidating. Although not explicitly referred to in the prehospital literature on emotional labour troublesome memories are reported by Thompson and Suzuki (1991) as common to ambulance workers. Alexander and Klein (2001) indicate they represent a historic source of distress for 62.4% of paramedics and a current source for 45.8%. Through their link to PTSD (Clohessy and Ehlers, 1999) the need for paramedics to perform emotional process work which Boyle (2005) argues is an integral part of emotional labour aimed at dispersing deviant emotion and returning a "normative emotional state " (Boyle, 2005: 49) is not inconsiderable.

This discussion has highlighted how the emotional demand on the paramedic is not restricted to the patient interface but situated in encounters with a variety of other interactants of which I identify relatives/carers, bystanders, emergency services personnel, hospital staff, colleagues and managers as further principal types. Arguably those encounters also form replicable events (Boyle and Healy, 2003), for which the paramedic can draw on their biography of prior expectation in order to anticipate the emotional content and lessen its demand. Although not explicit in the literature I contest this is applicable to the role. However, to expose the full extent of emotional labour undertaken by UK paramedics, I raise the following question for my research to address:

- Which interactions carry a demand for emotional labour and how do these vary both within and between categories?

2.3.1.2 Job Antecedents

The one aspect to the prehospital emergency care role that all those researching the field emphatically agree upon is its lack of routine (Metz, 1981; Palmer, 1983a; Palmer, 1989; Mannon, 1992; Tangherlini, 1998; Boyle, 2005; Filstad, 2010) which represents both the most enjoyable and frustrating aspect of the job (Boyle, 2005). The work tempo is described by Metz (1981) as alternating between passively waiting and purposefully hurrying which places the emotions in constant flux as backstage these must convey a cynical nonchalance but switch frontstage into a caring, compassionate

persona (Boyle (2002). Frontstage performances are not however static as the emotional demand varies with the extremes of the job and the larger proportion of less urgent work found between which the paramedics consider boring in comparison (Boyle, 2005).

Out on a run the paramedic does not have complete autonomy. Although they have authority to deny treatment or deny an individual transport to hospital if neither is warranted, they are subject to surveillance. As Metz (1981: 48) comments, from the moment they indicate their availability at the start of a shift, they wear an "electronic leash". Mannon (1992) remarks how personal time, as a direct result, cannot be anticipated but must be created. Hassles are identified of which paperwork (Metz, 1981) and complaints (Mahony, 2001) are the most notable. Paperwork provokes anger either through its excess (Grigsby and McKnew, 1988; Hart, Wearing and Headey, 1993, 1995) or pedantry symptomatic of the litigation threat (Allen, 1998). Unfounded complaints Mahony (2001) argues are intrinsic due to emergency situations being highly emotive and the paramedic vulnerable to blame when a life is lost.

Dirty work represents an aspect of the job that attracts scorn rather than admiration. The term 'dirty work' coined by Hughes (1951) refers to occupations and tasks society regards as degrading so rather than applauding those who bear that mandate they are stigmatised and the work disavowed (Ashforth and Kreiner, 1999). Prehospital emergency care is dirty work because firstly its practitioners have to handle bodies that are filthy, smelly, diseased, oozing, mutilated, decomposing or dead. Secondly, they are forced to practice in dirty, noisy, crowded, dark, unsanitary, poverty-stricken or exposed environments (Mannon, 1992). In particular their 24/7 accessibility increases their exposure to unsafe environments particularly over a weekend when both the streets and A&E become war zones with physical and/or verbal abuse leaving bewildered staff angry, hurt, vulnerable and powerless (Hislop and Melby, 2003).

Job satisfaction perhaps surprisingly given those circumstances is reportedly high (Filstad, 2010; Alexander and Klein, 2001) which should lessen the demand for emotional labour, according to the retail studies I examined in chapter one. However, the prehospital literature suggests the paramedics perform a "significant amount" (Boyle, 2005: 51) of emotional labour about which they are "generally positive" (ibid: 62) which coupled with their perspective "providing care for others is personally gratifying" (Alexander and Klein, 2001: 79) implies job satisfaction heightens demand.

The final antecedent in this subsection is role identity which Mahony (2001: 138) encapsulates in the term ‘on-road’ staff which serves to distinguish the tight-knit community formed by those who work on the frontline of prehospital emergency care from management. Boyle (2002, 2005) splits the road staff identity into a duality in which the carer occupies the frontstage where Palmer (1983a) splits it further into four concurrent identities. The first, medical authority, is confirmed when others defer and challenged when they show disrespect. The second, lifesaver, is reinforced through stabilising a deteriorating patient or a successful resuscitation but falters if a patient goes sour or dies. Third, information specialist is reinforced by a correct diagnosis and undermined by mistakes and last that of partner is confirmed through effective and efficient teamwork but undermined by indifference. The second half or macho identity proposed by Boyle (2005) occupies the backstage where it follows a strict hegemonic masculine code in which displays of emotion are inhibited. Through daily interaction [relational and narrative] all identities are claimed and confirmed (Monrouxe, 2010).

For the newly qualified, claiming role identity requires they release old identities and replace those with the norms and values associated with the new group (Filstad, 2010) including beliefs about emotions and how these should be interpreted and handled (Lois, 2001). The need to fit-in overrides any challenge to those beliefs increasing demand (Hornsey, Grice, Jetten, Paulsen and Callan, 2007). Palmer (1983a) adds the paramedic vocabulary along with their uniform, equipment and vehicles all serve as visible reinforcements of identity and as props to support performances. But in order to ascertain what aspects of the job influence UK paramedic performances of emotional labour I raise the question:

- Which factors relating to the nature of the job trigger emotional labour?

2.3.1.3 Organisation Antecedents

The organisational climate is one of contrasts between Australian services described as “militaristic” (Boyle, 2002: 136) in which training privileges physical and technical competence and an emotional discourse and support is denied and Norwegian services likened to “one big happy family” (Filstad, 2010: 375) in which training encompasses emotional as well as medical knowledge, an emotional dialogue is encouraged and support is openly provided. Only Filstad (2010) provides any information on terms and

conditions of employment through detailing the recruitment and selection process. This arduous process aims to secure a good person-job fit and for the small percentage who are selected their gratitude, Filstad reports, positively influences their performances.

The formal culture described as "harsh" by (Boyle, 2005: 62) and "macho" by Filstad (2010: 376) acts to keep outsider encounters empathetic but stoical so uncontrolled emotion does not compromise the well-being of patients and/or colleagues or damage public confidence through failing to match their expectation of a heroic performance (Boyle, 2002). But this rule or expectation is learnt and reinforced through informal socialisation with peers rather than any formal appraisal process (Filstad, 2010). Service standards induce, according to Mahony (2001), a clash between organisational targets and paramedic objectives. Whilst efficiency governs the first, effectiveness governs the second. Boyle (2005) comments how structural efficiency has led to work intensification in which paramedics are sent on run after run without recovery time. As a consequence the paramedics are thwarted in their attempt to do their best for their patients due to time constraints and their performances are exacerbated by residual anger over the lack of investment in resources to which they attribute responsibility.

The informal culture in both services acts to inform and support organisational expectations. In the Australian service "officers are expected to display the softer emotions of compassion, empathy, and cheerfulness in public, while refraining from any expression of grief, remorse, or sadness in the company of other officers" (Boyle, 2005: 49) which limits emotional expression to a narrow range outside of which the paramedics risk being ostracised. They have to take particular care not to pollute backstage areas with emotion but appear nonchalant (Boyle, 2002) so a collective masculinity can form an impermeable barrier to repel outsiders including those from other parts of the organisation (Boyle, 2002). Not so in the Norwegian service where a liberal emotional dialogue characterises a supportive backstage (Filstad, 2010). As this discourses suggests ambulance service emotionality can be considered a continuum anchored at one end by recognition (Filstad, 2010) and denial at the other (Boyle and Healy, 2003), I raise the question with respect to UK paramedics:

- Is emotional labour acknowledged by the organisation or is it constrained?

Organisational injustices, hassles and uplifts also apply to the ambulance service. The

first is evident in complaint handling (Mahony, 2001); the second in poor facilities (James and Wright, 1991) and the third in support systems (Filstad, 2010). I explore the significance of each through augmenting a question I raised earlier to inquire:

- Which factors relating to the nature of the job **or to the organisation** trigger emotional labour?

2.3.1.4 Individual Antecedents

Predispositions within prehospital emergency care have been identified in: experience (Boyle, 2002; Boyle and Healy, 2003; Boyle, 2005; Filstad, 2010); gender (Boyle, 2002, 2005) and temperament (Mannon, 1992; Boyle, 2005; Filstad, 2010) of which experience is regarded as the more significant. Trainees learn about emotion management on the job where it is an effortful process to fit in with more experienced colleagues through refraining from emotional talk or expression not culturally sanctioned. However, with experience comes a sense of belonging enabling disclosure and a speedier return to norms of emotional control following violation. It also brings situated knowing rather than panic which is reflected in personalised coping strategies (Boyle, 2005; Filstad, 2010). However, this correlation is disputed as Mannon (1992) reports paramedics become more susceptible to burnout as they approach their late thirties/forties, "at a time when their medical wisdom is at its peak, their physical and emotional reserves are waning" (ibid: 200). Consequently I raise the following question:

- Is experience a factor in performances or their effects?

Gender is challenged in the prehospital context as Boyle (2002) argues male and female paramedics are bound up in a hegemonic masculinity, blanketing any separation. Both are expected to "keep up a constant 'masculine' demeanour of self-control and stoicism while simultaneously presenting a 'caring' and 'feminine' demeanour to patients" (Boyle, 2005: 62). As Boyle's account reflects a predominately male paramedical service in Australia [90%] it is not necessarily the same in the UK where that percentage drops to around 66% (NHS, 2009e) so I raise another question to inquire:

- Is the experience of a female paramedic different from that of her male colleagues?

Temperament is identified in terms of hardness (Mannon, 1992; Boyle, 2005; Filstad, 2010), sense of humour (Tangherlini, 1998), empathetic ability (Palmer, 1989; Boyle, 2002; Boyle, 2005; Scott and Myers, 2005), trustworthiness (Filstad, 2010), confidence (Palmer, 1989), self-control (Palmer, 1983a), adaptability (Filstad, 2010), religious beliefs (Boyle and Healy, 2003) and positive outlook (Boyle, 2005). Of these, an empathetic ability is lifted out because it is central to the persona of a paramedic (Boyle, 2002). Hardness, in some ways is the opposite characteristic but is cited as essential for survival through the "veneer" (Boyle, 2005: 56) it offers against the horrors associated with emergency care (Boyle and Healy, 2003; Boyle, 2005; Filstad, 2010). A sense of humour is both a positive cue in it can relieve anxiety and negative as "to joke or not to joke is a thin invisible line" (Filstad, 2010: 379).

Skills in communication and acting are acknowledged as part of the paramedics' toolkit (Boyle, 2005) and Filstad (2010) adds another cue in status remarking how the higher the position an individual holds in the organisational hierarchy the freer they are to express their emotions. To which Palmer (1989: 123) adds his observation outside of the organisation paramedics are "forced to negotiate their positions and worth with others in interactions of an 'emergent' nature" making their status and its emotional demand more variable. Fatigue is another cue implicit in the reference to "constant pressure to be emotionally 'up' for the duration of a shift" (Boyle, 2005: 56). I add HWI even though the home is recognised as a site of support (Boyle, 2005) and HWI is reportedly of no consequence for the paramedic (James and Wright, 1991) as I contest its link to poor concentration (Demerouti, Taris and Bakker, 2007) raises a concern. I investigate all of these individual antecedents through the augmentation of a question I raised earlier:

- Which factors relating to the nature of the job or the organisation or **to the individual** trigger emotional labour?

2.3.2 Strategies

In the context of prehospital emergency care Boyle (2005) subsumes emotion work into emotional labour. She does so on the grounds that the appraisal and regulation of emotion experienced by the paramedic outside of service encounters through which they achieve a "normative emotional state" (ibid: 48) is quintessential. She explains how

emotion can persist after a run and has to be processed to avoid compromising future performances and well-being. Filstad (2010) follows suit arguing medical work is a combination of professional labour and gifted emotion work. However, irrespective of whether the strategy is internal or externally directed the three elements I revealed in chapter one remain the same and I discuss each in turn beginning with the emotions.

2.3.2.1 The Emotions

Of the twenty-eight emotions I identified in chapter one as common to the workplace twelve are explicit in the prehospital emotional labour literature. Of these five are positive: joy; sympathy; satisfaction; hope and affection and seven negative: fear; distress; anger; remorse; disgust; dislike and boredom (Boyle and Healy, 2003; Boyle, 2005; Filstad, 2010).

Positive	Negative
Joy	Fear
Sympathy	Distress
Satisfaction	Anger
Hope	Remorse
Affection	Disgust
Pride	Dislike
Interest	Boredom
Enthusiasm	Anxiety
Relief	Self-reproach
Admiration	Intimidation
Gratitude	Disappointment
Surprise [astonishment]	Surprise [shock]
	Resentment
	Embarrassment

Table 2.2: Prehospital emergency care workspace emotions.

However, anxiety congruent with fear in chapter one is discrete within context where it

represents a low-level state of concern an undesirable event may take place that characterises the prehospital interface between patient and paramedic (Boyle, 2005). In contrast fear is a more intense but less common state invoked when concern exceeds an individual's threshold (Ortony, Clore and Collins, 1988). This split increases those emotions explicit within the literature to thirteen. A further five emotions in pride, interest, enthusiasm (Mannon, 1992), self-reproach (Jonsson and Segesten, 2004) and intimidation (Tangherlini, 1998) are added by those working within context but outside the conceptual field to increase the total further to eighteen. Of the remaining eleven I identified in chapter one I retain six that I consider implicit in the literature: relief; admiration; gratitude; surprise; disappointment and resentment. I justify their retention as follows: relief is experienced when negative expectation is disconfirmed e.g., patient not as ill as expected (Ortony, Clore, and Collins, 1988); admiration follows the witness of expertise or stoicism (Mann, 1999); gratitude is felt when others cooperate (Fredrickson, 1998); surprise may be experienced as shock e.g., a complaint is received unexpectedly (Ortony, Clore and Collins, 1988) or in its opposite valence as astonishment e.g., receiving appreciation from an unexpected quarter (Ortony, Clore, and Collins, 1988); disappointment can surface from a lack of recognition (Basch and Fisher, 1998) whilst resentment arises over attention awarded to someone that is perceived as undeserving. I add another implicit emotion through splitting embarrassment from self-reproach as it is invoked when a social standard is violated by others e.g., nudity whereas self-reproach emanates from the violation of moral standards held by the self e.g., blasphemy (Ortony, Clore and Collins, 1988).

I discard the remaining five emotions I identified in chapter one. Gratification defined as self-satisfied or smug I consider to be a facet of satisfaction and happy-for a facet of joy. Gloating, defined as delight in misfortune experienced by others (Ortony, Clore and Collins, 1988) I consider an anathema for healthcare professionals. I position fears-confirmed as synonymous to disappointment and power with authority which I consider antecedent as it reflects the status of both the sender and receiver in an interaction. Altogether I argue there are twenty-five discrete emotions occurring in prehospital workspaces that I extend to twenty-six allowing for the two faces of surprise as shown in Table 2.2. As uncovering the discrete emotions situated in a performance will intensify the meaning being generated, I raise the question:

- Which emotions are constituent of the paramedic performance?

2.3.2.2 Rules

Boyle and Healy (2003) suggest paramedics are subject to specific but informal rules which direct them to amplify positive emotion [cheerfulness, empathy and compassion] in public whilst suppressing negative emotions [grief, sadness, remorse and boredom] with colleagues. Those rules mirror the directive across healthcare (Martinez-Iñigo, Totterdell, Alcover and Holman, 2007) but whereas healthcare professionals are expected to feign positive emotion more than they suppress negative emotion (Zerbe, 2000) Mannon (1981) insists the suppression of negative emotion is the most prevalent rule in the prehospital environment. Boyle (2002, 2005) stresses as does Filstad (2010) this rule set is learnt via the sanctions of senior colleagues so in the absence of an explicit formal rulebook I augment the previous question to inquire:

- Which emotions are constituent of the paramedic performance **and which rules are those emotions subject to?**

2.3.2.3 Techniques

Both surface acting and deep acting are deployed within the prehospital emergency care environment (Boyle and Healy, 2003; Boyle, 2005). Surface acting is regarded as a constant in paramedic performances due to the unpredictable nature of the job which requires the paramedic to constantly switch faces both within and between runs (Boyle, 2005). It is often accompanied by empathy and/or humour. Empathy which consists of three elements: identifying and understanding the perspective of the interactant (cognitive), feeling their emotion (affective) and communicating this to them (behavioural) encourages disclosure of information to aid diagnosis and treatment (Palmer, 1989; Boyle, 2005). But empathy also mediates ‘hateful’ emotion such as anger or mistrust thus facilitating a calm, professional interaction (Strous, Ulman and Kotler 2006). Humour is regarded as both a therapeutic technique as it alleviates pain, anxiety and embarrassment and an integrative technique as it promotes positive relationships with patients and colleagues (Boyle, 2005) although it comes with that caution for circumspection I pointed out in chapter one, as it is not always appropriate to an emergency situation (Filstad, 2010).

Deep acting by paramedics is defined by Boyle (2005) as objectifying the patient in order to limit attachment and avoid false hope. This differs from Hochschild (2003) in that it requires felt emotion and attachment to be denied rather than exhorted to enable technical skills to be deployed without impediment although patient anxiety is still recognised and ameliorated. It is synonymous with affective neutrality used by medical practitioners as a means of maintaining professional distance (Smith and Kleinman, 1989; Martinez-Iñigo, Totterdell, Alcover and Holman, 2007). Although disparaged, Boyle (2005) claims the pressure of the job encourages its use whilst Palmer (1989) infers it is a means of emulating the medical profession from whom the paramedics seek respect.

The prehospital literature also endorses the use of genuine expression but contrary to the view of Diefendorff, Croyle and Gosserand (2005) it is legitimised in only a few situations. The most notable is the death of a child when a display of grief is not considered deviant but compassionate. All paramedics permit incidents involving children to sanction a state of emotional harmony (Boyle, 2002, 2005). Additional techniques exposed in the prehospital literature on emotional labour are those of spirituality and shielding (Boyle and Healy, 2003). The former refers to how the paramedics draw on their religious beliefs to offset their distress and offer comfort to both patients and their relatives. The latter, confined to offstage areas, shields family members from the unpleasant aspects to the job so they can share work experiences but as Boyle (2005) remarks this extends the paramedics obligation to perform emotional labour into their off-duty.

As Boyle (2005) suggests surface acting is the more prevalent technique I augment the previous question in order to investigate:

- Which emotions are constituent of the paramedic performance, which rules are those emotions subject to **and through which techniques are they managed?**

2.3.3 Consequences

Lois (2001) remarks how emergency workers in repeatedly negotiating the boundary between life and death put both their physical and emotional wellbeing at risk. A paramedic can find themselves on a high following a successful resuscitation which

Boyle and Healy (2003: 352) claim is "the best drug in the world" but cast in the depths of despondency if the resuscitation fails. The role is therefore I argue characterised by emotional peaks and troughs which respectively carry positive and negative consequences.

2.3.3.1 Positive

Positive consequences to performing emotional labour explicit in the prehospital emergency care literatures are increased levels of personal accomplishment and professionalism (Boyle, 2005); confirmation of identity (Boyle, 2005; Filstad, 2010) and job satisfaction (Filstad, 2010). The first two, according to Boyle (2005), stem from the delivery of an affectively neutral performance whilst the third is achieved through both self-verification of a competent persona [medical and emotional] and verification by others (Filstad, 2010). This may reflect the trust and appreciation of patients (McQueen, 2004) and/or endorsements by colleagues who represent an omnipresent judge of competence both technical and emotional (Palmer, 1989; Filstad, 2010).

Finally, job satisfaction is achieved as performances of emotional labour enable the delivery of good quality care irrespective of circumstances and sound relationships with both patients and co-workers (Filstad, 2010). Implicit within the literature is compassion satisfaction (Boyle and Healy, 2003) a contributor to job satisfaction. However, I separate it as it reflects the intimate engagement with the patient e.g., alleviating anxiety I consider a potent gain for any healthcare worker. It is described as the ultimate reward for connecting emotionally with patients as meaningful interaction creates cycles of joy and enthusiasm which heighten morale (Coetzee and Klopper, 2010) and protect against negative consequences particularly stress (Hooper, Craig, Janvrin, Wetsel and Reimels, 2010) which in turn enhances well-being. This gain is under stated yet as I mentioned in chapter one well-being stems from contentment which is fed by both job satisfaction and identity so performances of emotional labour which amplify positive emotion particularly satisfaction and pride will also enhance well-being.

2.3.3.2 Negative

Negative consequences explicit within those studies that have investigated paramedic emotional labour are largely psychological and include: emotional exhaustion (Boyle,

2005); burnout (Boyle and Healy, 2003); stress (Boyle and Healy, 2003; Boyle, 2005; Filstad, 2010) and PTSD (Boyle, 2005). Also explicit is work-home interference [WHI] (Boyle, 2005) to which I implicitly add: vicarious traumatisation (Boyle and Healy, 2003), somatic complaints including fatigue (Boyle, 2005) and disconfirmation of identity (Filstad, 2010). Emotional exhaustion precedes burnout which I explained in chapter one. Although Mannon (1992) suggests burnout has a sudden onset others consider it is a gradual process (Dominquez-Gomez and Rutledge, 2009; Coetzee and Klopper, 2010) in which exhaustion or compassion discomfort (Coetzee and Klopper, 2010) progresses through compassion stress into compassion fatigue [CF] a type of burnout particular to caregiving professions (Joinson, 1992) that I consider the more meaningful term. In all forms, psychopathology carries a prevalence rate of 33% (Alexander and Klein, 2001).

Stress for paramedics divides into clinical and administrative (Mitchell, 1984) although more often it is a blend of the two (Clohessey and Elhers, 1999) that builds overtime (Robinson, 1993; Alexander and Klein, 2001) leading to the symptoms I outlined in chapter one (Halpern, Gurevich, Schwartz and Brazeau, 2009b). Clinical stress emanates from medical emergencies that provoke feelings of helplessness (Alexander and Klein, 2001) and overwhelming compassion (Halpern et al, 2009b) within which lurk the memories waiting to return as latent but potent carriers of anguish and guilt (Clohessy and Ehlers, 1999). Clinical stress is also situated in every performance of cardiopulmonary resuscitation [CPR] (Beaton, Murphy, Johnson, Pike and Cornell, 1998) which represents a core skill that is rarely successful (Timmermans, 1999) yet in offering hope leads to pressure even aggression to continue even when it is futile (Compton, Madgy, Goldstein, Sandhu, Dunne and Swor, 2006).

Administrative factors however have a far greater impact on stress levels (Clohessy and Ehlers, 1999; Mahony, 2001) as these are pervasive covering: work intensification; conflicting objectives and privileging of corporate targets over staff needs; unfounded complaints; restructuring; lack of participation in decisions; lack of early retirement opportunities (Mahony, 2001); inadequate back-up and dispatch errors (Alexander and Klein, 2001); lack of recognition from superiors (van der Ploeg and Kleber, 2003); managerial conflict, shift work and standby (Clohessy and Ehlers, 1999).

According to Clohessy and Ehlers (1999) ambulance personnel are at increased risk of

developing PTSD not just through exposure to major trauma but because their routine work is also stressful and it is in that routine that the majority of emotional labour, according to Boyle (2005) is performed. PTSD is often accompanied by the emotion of self-reproach particularly its form of shame and/or guilt (Royal College of Psychiatrists, 2010). "Guilt is about doing; shame is concerned with being, with what you are" (Jonsson and Segesten, 2004: 221) and it is suppressing shame, in order not to be unmasked as helpless and unworthy of the status of paramedic that exacts a toll. As those paramedics who experience self-reproach carry a marker for PTSD (ibid) its selection as one of the discrete emotions to be investigated by my inquiry is endorsed. PTSD carries a prevalence rate of 15% (Rentoul and Ravenscroft, 1993; Clohessy and Ehlers, 1999) and as the risk of developing it is progressive (Bennett et al, 2005) it endorses that notion experience offers no protection (Mannon, 1992). Ultimately psychopathology leads to job dissatisfaction (Alexander and Klein, 2001).

WHI manifests in marital discord/breakdown partly due to the impact of shift work on family/free time (Clohessy and Ehlers, 1999; Mahony, 2001) and partly to the spillover of suppressed, negative emotion which finds release within the home environment (Montgomery, Panagopolou and Benos, 2005). Somatic complaints e.g., headaches are reported by 25% of female and 20% of male ambulance personnel at any one time and are associated with psychological as well as physical demands (Aasa, Brulin, Angquist and Barnekow-Bergkvist, 2005). Having to constantly manage emotion drains resources particularly glucose as I discussed in chapter one and this inevitably leads to fatigue. Boyle (2005) comments how it can take three days to recover both emotionally and physically from a demanding shift in which every run represents a legitimate use of paramedic resources.

Professional identity is compromised by self-reproach as I have discussed but identity is also at risk when any emotion is displayed contrary to norms or expectations that lead others to express disapproval (Palmer, 1989). Each of the four facets to paramedic identity I presented earlier in the chapter is put at risk by stress which increases the possibility of an inaccurate diagnosis and apathetic treatment (Hammer, Mathews, Lyons and Johnston, 1986). Vicarious traumatisation or the empathetic response to trauma experienced by others either through exposure to circumstances that contextualise it e.g., toys at a road traffic accident [RTA] or through narratives (Austin, Goble, Leier and Byrne, 2009) also results in distress which can surface in detachment

or lapses in concentration (Wastell, 2002). As these negative consequences outweigh the positives which I consider be under explored I raise the open question:

- What are the consequences for the individual in having to actively manage their emotions?

2.3.4 Interventions

The suppression of negative emotion is a prominent rule for the paramedic and is adaptive short-term (Clohessy and Ehlers, 1999) but overtime it becomes maladaptive (Pennebaker, Barger and Tiebout, 1989; Joseph, Dalgleish, Williams, Yule, Trasher and Hodgkinson, 1997; Wastell, 2002), reinforcing my decision to incorporate interventions into an understanding of the emotional labour process. Whilst some interventions can be deployed by the paramedic under their own volition others require organisational authority.

2.3.4.1 Individual

The prehospital literature on emotional labour reveals paramedics utilise interventions before, during and between runs (Filstad, 2010) as well as at the end of a shift (Boyle and Healy, 2003; Boyle, 2005). Before and between runs, paramedics can utilise a positive inner dialogue or self-talk to reduce anxiety (Filstad, 2010) although for this intervention to succeed, Jonsson and Segesten (2004) remark, their prior experiences must reflect an ability to cope. Mannon (1992) adds an observation that the crew room can enable a positive outlook by supporting fun and games to relieve tension. He urges the display of 'Thank You' cards as visible reminders of public appreciation and esteem.

During a run Boyle and Healy (2003) refer to how a paramedic may draw on their religious beliefs in order to ease distress. They also objectify (Boyle, 2005) or depersonalise the patient (Mannon, 1981) through likening them to a carcass or they focus on a physical task (McGrath, Reid and Boore, 2003) to remove any need for an emotional response from the situation. Between runs taking an informal timeout enables adverse effects to dissipate but securing space requires creativity as organisational surveillance coupled with indifference curtails legitimate opportunities (Boyle and

Healy, 2003). When circumstances permit seeking social support and the opportunity to debrief informally are restorative (Filstad, 2010) to which Mannon (1981: 14) adds there is no substitute for the "consciousness of kind" provided by colleagues. At the end of a shift the family is a prime source of support. Boyle (2005: 63) suggests family and friends are "hidden employees" as they absorb the toxicity that the organisation fails to recognise. Other techniques used by paramedics to restore their emotional equilibrium include: exercise and meditation (Boyle and Healy, 2003).

Anytime, anywhere the paramedics can utilise breathing exercises (Boyle and Healy, 2003) to reduce anxiety and regain focus. Humour is also ubiquitous as a means of coping (Boyle, 2005; Filstad, 2010) and is used to make the tragic appear routine (Filstad, 2010) but mostly backstage where paramedics engage in black humor and tell 'war stories'. As these represent a form of debriefing they provide relief but they also serve as "emotional guideposts" (Tangherlini, 1998: 64) through which a paramedic is able to gauge their ability to cope. Developing a veneer of hardness (Boyle and Healy, 2003; Boyle, 2005) is a protective wrapper the paramedics can apply to their role although it is not universally endorsed as it obscures empathy (Boyle and Healy, 2003). A more effective intervention lies in balancing engagement and detachment which requires an individual to focus on the present, be pragmatic, make conscious choices about their level of involvement, set boundaries and whilst potentially making a difference for their patient, let go of responsibility for the outcome (Carmack, 1997). However, Wastell (2002: 884) maintains settling responsibility onto the individual "is at best misguided and at worst negligent".

2.3.4.2 Organisational

There are only two interventions recognised in the literature that the organisation may authorise for use by the paramedic. The first of which is counselling (Boyle and Healy, 2003; Boyle. 2005; Filstad, 2010) and the second, Critical Incident Stress Debriefing [CISD] (Boyle, 2002). However neither is favoured by paramedics. Boyle and Healy (2003) report counselling is undermined by issues of trust and confidentiality coupled with the perception mental health professionals who conduct those sessions hold a limited understanding of the realities of prehospital emergency care. CISD is undermined through being linked to stress which is considered weak and therefore contrary to the paramedic identity (Boyle, 2002). The use of this intervention is also

associated with an increased risk of PTSD (Rose, Bisson, Churchill and Wessely, 2009) which coupled with the notion routine not traumatic incidents require the most emotional labour and lead to the most stress (Bennett, Williams, Page, Hood, Woollard and Vetter, 2005) negates its usefulness.

Halpern, Gurevich, Schwartz and Brazeau (2009a) identify two additional interventions that require organisational authorisation in a formal timeout and emotional support from line management. The former allows the individual to decompress at their own pace, in their own way, with a valued peer e.g., work partner, ideally for between thirty to sixty minutes subject to service constraints whilst the latter entails management acknowledging the individual's experience, valuing their contribution and offering material help. However, for any intervention to be successful it must first be approved by the individual (Alexander and Klein, 2001) and secondly, applied in a climate that is supportive (Halpern, Gurevich, Schwartz and Brazeau, 2009a). There is, according to Boyle (2005), a failure to recognise the need for organisational emotional support outside of the two formal mechanisms I have outlined which she attributes to how the masculine culture prioritises technical over emotional competence. As a consequence there is an expectation "you have to cope" (Boyle, 2005: 45) and those that cannot have to seek support at home which presents difficulties for those who have none available due to status or familial flux (ibid).

Reghr and Bober (2005) propose a non-linear continuum of evidence-based interventions in which both politically acceptable and feasible organisational initiatives sit alongside culturally appropriate and accessible individual initiatives as the solution. Whilst the former promote well-being and prevent ill-being across the organisation the latter both prepare the individual for and aid recovery from stressful and/or emotional events. As Reghr and Bober point out, "one-size-fits-all-approaches"(ibid: 149) deny the subjectivity of the emotional response that a continuum endorses. This however needs to be continuously monitored and developed so it does not become static or judgemental. As the significance of interventions is understated within context where availability is not equivalent to effectiveness I complete my inquiry by asking:

- How can the consequences of having to manage emotion be mediated?

2.4 Concluding Remarks

The paramedic role has evolved away from its traditional image of 'scoop and run' into 'stay and treat' where the ability to drive although still a core requirement, is cast into shadow by an array of diagnostic and life-saving skills. Professional status has legitimised this change but the role remains subordinate within the medical order. Within the ambulance service operational standards inhibit autonomy and the culture inhibits emotional expression. As a consequence, emotional labour integral to interaction both inside and outside the organisation, is understated and its negative largely psychological consequences are not being adequately redressed as there are a distinct lack of accessible and acceptable interventions.

The generic quadripartite integrated framework I developed in chapter one has enabled me to purposefully examine the literature on paramedic emotional labour and associated discourse in order to contextualise my framework to both steer my inquiry and aid my analysis. As I develop meaning within each of the quadrants I expose uncertainties from which I construct eight subsidiary questions for my inquiry to investigate and I create deductive codes that transition the framework into an 'a priori' deductive codebook. In the next chapter which I preface with those subsidiary research questions I detail my methodological approach through which I secure the answer as to what constitutes emotional labour for my sample of UK paramedics.

Chapter 3

Research Strategy and Methods

3.1 Introduction

The two avenues of research which divide the field on emotional labour utilise different strategies. Studies which focus on the occupation utilise mainly qualitative methods within an ethnographic envelope to expose how client interactions represent acts of emotional labour but ignore the process employed by the individual to manage their emotion (Harris, 2002; Boyle, 2005; Scott and Myers, 2005). In contrast, studies focusing on the individual and their emotion regulation (Morris and Feldman, 1997; Pugliesi, 1999; Grandey, 2003) utilise mainly quantitative methods to investigate one or more facets of the management process but ignore the job in which they are situated. As I aim to integrate these two streams I decide to adopt a mixed methods strategy which I both justify and describe over the course of this chapter.

3.2 The Research Questions

In chapter two, I exposed a number of doubts regarding what constitutes emotional labour for the UK paramedic and I raised a subsidiary research question for each that I collect together and reproduce below:

i. Which interactions carry a demand for emotional labour and how do these vary both within and between categories?

ii. Which factors relating to the nature of the job or to the organisation or to the individual trigger emotional labour?

iii. Is emotional labour acknowledged by the organisation or is it constrained?

iv. Is experience a factor in performances or their effects?

v. Is the experience of a female paramedic different from that of her male colleagues?

vi. Which emotions are constituent of the paramedic performance, which rules are those emotions subject to and through which techniques are they managed?

vii. What are the consequences for the individual in having to actively manage their emotions?

viii. How can the consequences of having to manage emotion be mediated?

3.3 Choice of Strategy and Overall Design Considerations

Fineman (2005) exhorts interpretative approaches are best suited to exploring emotion as it is fundamentally subjective whilst Stern (1980: 20) recommends grounded theory for ‘‘investigations of relatively uncharted waters’’ both of which suit the nature of my inquiry. However, as I become increasingly aware my time with each participant could be severely compromised by operational requirements I decide to take a more pragmatic approach. As Tashakkori and Teddlie (1998) claim the research question is more important than methods I decide to incorporate two self-reports into a mixed methods strategy through which I would gain both a micro view of the emotions, rules and techniques integral to performances of emotional labour that might otherwise be denied and a macro view of patterns particularly in respect to gender and experience that I highlighted in chapter two hold particular interest. As I develop a theoretical framework I consider it expedient to use this, in its contextualised form, as an ‘a priori’ deductive codebook / template (Crabtree and Millar, 1999) and employ a hybrid form of thematic analysis to analyse the data (Fereday and Muir-Cochrane, 2006). I reason I can minimise the possibility of “missing information” which Crabtree and Miller (1999: 108) indicate is a pitfall with deductive template-driven analysis through combining this with an inductive data-driven approach.

My design, as I illustrate in Figure 3.1, reflects one of the four mixed methods designs Creswell and Plano Clark (2007) argue have emerged within social research over the last decade. It is predominantly qualitative as I endorse Fineman’s recommendation those methods are more suited to an exploration of subjective experience and more likely to offer “insight, plausibility and texture” (Fineman, 2004: 736) but I embed those two self-reports which take the form of an emotion checklist and an emotion

requirements inventory to form a small supplementary quantitative dataset. As I regard each as a form of self-observation of prior subjective experience (Wilson, 1999) these do not oppose my worldview.

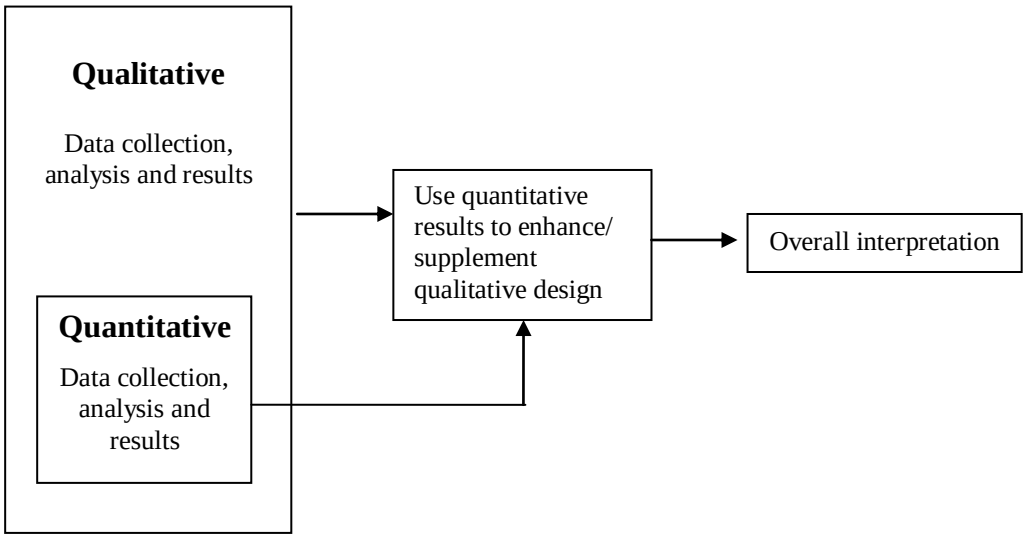


Figure 3.1: Mixed methods embedded design (Creswell and Plano Clark, 2007: 68).

I strengthen my choice of design with five supporting arguments. Irwin (2008) provides the first two in claiming qualitative and quantitative knowledge only provide a partial picture if used independently and individual data may remain unexplained if aggregate structures are not investigated. Hesse-Biber (2008) provides the third convincer through situating mixed methods in a conversation where each informs the other to produce a synergistic, multi-layered understanding. Morris and Feldman (1996) offer me a fourth pertinent argument in favour of this strategy through suggesting emotional dissonance may be too sensitive for subjects to reveal face to face. Whilst the final argument takes the form of an endorsement by Byrne (2002) that mixed methods can link if the focus is on cases rather than variables.

As my design is weighted in favour of a qualitative approach this methodology guides its worldview. Hughes and Sharrock (1997: 5) claim social researchers increase the legitimacy of their inquiries by adhering to a known methodology, based on "indisputable truths" about how the world is known. Although Kuhn (1970) and his

followers are adamant that qualitative and quantitative domains represent separate paradigms each bounded by an epistemology that prevents an indiscriminate use of individual methods, others are less authoritarian (Layder, 1993; Feyerabend, 2004). According to Bryman (1988) the epistemological purity of any method cannot be determinate as each can be doubted. I therefore consider the following ontological and epistemological positions do provide an accreditation for the knowledge generated by my study.

Constructionism is the pertinent ontology as emotions do not exist independently but are embedded within social interaction. They are not static but subject to manipulation and modification so each instance will be unique in its intensity and composition and specific to the social interaction in which it is aroused. As Hochschild (1998: 11) remarks, "in managing feeling, we partly create it" so it is constantly undergoing revision. Although organisationally, rules and procedures impose constraints suggestive of an external reality, these are also subject to revision and therefore unstable (Bourdieu, 1990). Cultural scripts direct performances (Goffman, 1961a) and a common meaning system allows individuals to synthesise bodily sensations and behaviours into a recognisable entity which they label through reference to a learnt, culturally specific vocabulary (Gordon, 1990).

The relevance of interpretivism as the accompanying epistemology is succinctly captured by Rowe (2005: 291) in her remark, "we live in meaning like a fish lives in water". Every action carries meaning for the individual and conveys meaning to others that influences for both, their future action. But it does not follow that the meaning is the same or leads to the same response. Hence understanding cannot be gained through the ethos of the natural sciences as it cannot be predicted or understood through general laws. It requires a phenomenological eye in which the social world is revealed through each individual's perspective. In support of this philosophical stance, I adopt the three postulates of social phenomenology proposed by Schutz (1967) in order to promote the subjective reality of my participants and guard against any fictional intrusion.

The first postulate is logical consistency which translates to theoretical rigor or appropriateness of method and reasoned argument (Fereday and Muir-Cochrane, 2006). I satisfy this first of all by paying careful attention to my concept and extricating a

clear theoretical framework which I contextualise in preparation for field exploration. Secondly, I utilise predominantly qualitative methods as those are best suited to exploring subjectivity and lastly I present my analysis within the bounds of the theoretical framework exposing the links between codes, participant responses, themes and the research questions. I satisfy the second postulate of subjective interpretation that requires an acknowledgement of context and preservation of the participants' subjective viewpoints (Fereday and Muir-Cochrane, 2006) through first providing a contextual appreciation of the paramedic role and the ambulance service in which the role is enacted. Second I use excerpts of raw data to illustrate and support my analytical interpretation. The third and final postulate of adequacy concerned with consistency and credibility resonates, according to Fereday and Muir-Cochrane, with member checking which I employ to allow my participants the opportunity to validate quotations, emergent themes and my findings.

However, the goal for qualitative researchers exploring emotionality is, according to Gubrium and Holstein (1997: 9), "to capture, even re-enact, the subject's experience and to describe that in full emotional colour". Not an easy task, as according to Douglas (1985), standard field methods are not able to penetrate deep enough into a person's psyche to where feelings are stored. He considers participation in the field of study is essential to facilitate the intimacy and comfort necessary for disclosure which ideally should be mutual. In directing the researcher to "know thyself and play to thy strengths" (ibid: 29) Douglas exposes the need to detect any blinkers that may inhibit a climate of openness as he considers it imperative the researcher is able to confront comfortably those same issues he/she wants to educe from their respondents.

Douglas completes his advice for achieving not just interpersonal comprehension but reciprocal self-discovery by offering three rules of engagement. The first entails listening to and communicating a genuine interest in the respondent. The second revolves around the expression of feeling and sharing of experience. Third and last the researcher is urged to demonstrate sensitivity and exhibit a warm and caring attitude. I react intuitively to this advice and select participant observation along with semi-structured interviews and focus groups as my main qualitative methods to which I add a segment of document analysis through which to become politically aware in preparation for data collection but also to add depth to my analysis. However, I have to abandon my intention to use focus groups due to insurmountable difficulties. For

practical purposes my liaison officer within the North East Ambulance Service NHS Trust [NEAS], suggests involving paramedic team leaders only as they congregate twice a year at headquarters [HQ] to discuss service improvements. Although I acquiesce to this suggestion, operational requirements continually relegate my slots till eventually it becomes impossible for me to secure a session long enough i.e., in excess of thirty minutes, for a liberal and purposeful discussion.

In order to supplement my qualitative data collection with a micro view of the emotions to determine which matter to the paramedics (Theodosius, 2008) I design an emotion checklist in the absence of a precept but to ascertain which rules they apply to those emotions and their use of surface and deep acting management techniques I use the commercially available MERI. Although I decide to use both self-reports in direct response to time constraints I recognise additional benefits particularly in consistency. The checklist allows each paramedic to consider the same set of emotions without intimidation or interviewer bias (Bryman, 2004) thus conferring an authority on data extraction. In addition, it also provides a mechanism through which I can orientate their thoughts on the emotionality of their role and foster involvement with my inquiry. As the checklist does not suggest the emotions listed will be experienced I consider it impartial. An example is contained at Appendix 3.1.

The MERI came to my attention whilst I was reading the book 'Hiding what we feel, Faking what we don't' published by Mann (2002) just prior to my fieldwork, in which she includes a copy for personal use. I was attracted by how it offers a simple mechanism through which I could highlight the extent and spread of emotional labour and also provide feedback to prompt respondent validation and fulfil authenticity criteria. As numbers confer authority (Fineman, 2004) I anticipated being able to draw attention to the distribution of performance values to pique interest particularly that of the ambulance service with whom I am obligated to share my findings. On further investigation I find the MERI had been validated and used to investigate emotional labour performed by other health professionals (Mann and Jones, 1997; Mann, 2004; Mann and Cowburn, 2005) which persuades me to apply to the author for permission to customise and use it in my study which she grants.

This inventory comprising a series of seventeen statements relates to a single interaction and I reproduce it as a set of five in order to explore the emotional labour my

participants engage in with each of the principal interactants I identified in chapter two. As the statements mirror interview questions it offers consistency as I am able to pose the same set in respect of each interactant type to each participant without interviewer bias or the boredom attached to repetition. It also permits each respondent to pace their completion therefore minimising degradation in their responses and conferring authority on data extraction. Similarly to the checklist, it too carries the potential to orientate thought and foster involvement so I come to the conclusion not to use it would represent a lost opportunity. An example of the MERI is contained at Appendix 3.2 and I offer further explanation of both self-reports later on in this chapter.

Although grounded theory came naturally to mind as I was constructing my ESRC proposal I replaced that intention with the hybrid form of thematic analysis used by Fereday and Muir-Cochrane (2006) as this allows me to utilise my framework as an 'a priori' deductive codebook / template (Crabtree and Millar, 1999). This organises the data corpus and enables me to identify meaningful data segments or codes deductively but also permits me to add to my analysis inductively. As thematic analysis also allows different methods to communicate (Boyatzis, 1998) I am able to connect the quantitative data to form one coherent analytical stream from which I can identify emergent themes through which to address my research questions. In addition it affords me the opportunity to confirm the utility of my theoretical framework as the usability of this central idea, in which I fuse the two established avenues of research on emotional labour, depends according to Huynh, Alderson and Thompson (2008), on whether it can transcend the theoretical and demonstrate validity through practical application.

3.4 The Research Site

Out of all the ambulance services in England I select NEAS as the research site for two reasons. First, it had a paramedic workforce of sufficient size to generate a diverse mix of volunteers and second, it was accessible. The last criterion carried personal significance as I was not in a position, for the reasons I allude to in chapter six, to stay away from home. The NEAS workforce totalled at the time of my approach approximately 2,000 out of which the A&E tier constituted 1,070, of which 58% were paramedics. A chart illustrating the structure of the organisation (NEAS, 2011a) is contained at Appendix 3.3.

In order to provide 24/7 cover 365/6 days of the year NEAS require 250 paramedics to be on duty at any one time, working a six week fixed rota within which they secure one full week off-duty. This is followed by two weeks on relief anywhere in their division. They work an average of 37.5 hours a week and each shift spans twelve hours starting at either 7am or 7pm during which the paramedics are entitled to two thirty minute unpaid meal breaks. The first has to take place between 10:30 – 13:00 [22:30 – 01:00] and the second 14:00 -17:00 [02:00 – 05:00] with a minimum requirement of two hours between each. If a meal break is allocated outside of those bands or forgone altogether a five pound compensatory payment is paid (NEAS, 2006).

NEAS serve a population of 2.66 million spread over 3,200 square miles. Its HQ and Control Centre are based at Newcastle upon-Tyne but the paramedics disperse across fifty-one ambulance stations spread around the region (NEAS, 2011a). During the time my fieldwork takes place i.e., between April 2008 and March 2009 NEAS receive 405,000 emergency or urgent calls for assistance. Of these, just over 340,000 result in an ambulance being despatched, equating to over 900 a day of which 79% take a patient to hospital (NHS, 2009b). NEAS exceed all of the national targets I specified in chapter two. The A8 standard is achieved for 75.7% of calls and the A19 for 99% which represents the best performance by any of the twelve English ambulance trusts for that year. The B19 standard is also exceeded by 0.6%.

3. 5 Access

Access to the research site is brokered through a letter I write speculatively to its CEO in early May 2007 whose contact details I ascertain via an internet search as I was a complete outsider with no internal contacts or knowledge of the ambulance service. This letter results in an invitation to attend a Research and Development Committee meeting at HQ in August 2007, in order to present my research proposal in more detail. I secure access following negotiation of the "research bargain" (Bryman, 2004: 518) which has four conditions: approval is secured from my local NHS Ethics Committee; fieldwork is delayed until April 2008 to avoid the busy winter period; an NEAS supervisor is appointed to facilitate my research and the organisation holds a veto regarding participants. The first three I readily agree to however the final condition encapsulates an ethical dilemma I discuss in the next section.

3.6 Ethics

In this section I detail both the ethical principles underpinning my study and the dilemmas I faced through which I confirm the ethical process is continual and dynamic not contractual (Roberts, Henderson, Willis and Muir-Cochrane, 2013).

3.6.1 Ethical Principles

The principles of best practice issued by the ESRC (2005), Table 3.1 refers, act as my guiding mantra but in addition, I take care to abide by the ethical governance voiced by the DOH (2005b): respect; honesty; integrity; openness and accountability.

1. Research should be designed, reviewed & undertaken to ensure integrity & quality.
2. Research staff & subjects must be informed fully about the purpose, methods & intended possible uses of the research, what their participation in the research entails & what risks, if any, are involved. Some variation is allowed in very specific & exceptional research contexts for which detailed guidance is provided in the policy guidelines.
3. The confidentiality of information supplied by research subjects & the anonymity of respondents must be respected.
4. Research participants must participate in a voluntary way, free from any coercion.
5. Harm to research participants must be avoided.

Table 3.1: Best practice (ESRC, 2005: 1).

3.6.2 Considerations and Ethical Dilemmas Prior to Fieldwork

Oliver (2003) identifies a number of issues that need to be addressed prior to the start of fieldwork relating to: recruitment; methods; informed consent; harm; gatekeepers; permissions and approval.

3.6.2.1 Recruitment

Fairness is the concern with respect to the identification and recruitment of potential

participants (ibid). I decide to advertise to ensure my research is overt and open to everyone but as there is only a finite number of opportunities to participate I devise a simple contingency plan. This takes the form of a first come first served selection process which I plan to make known on the organisation's Intranet if I need to use it. However, the organisation makes it plain they wish to scrutinise the names of those I select and remove anyone they perceive to be a troublemaker thus challenging the representativeness of my sample. Bryman (2004) comments how this restriction is not uncommon in organisational research and has to be accommodated so I reach agreement any replacement will be made by me from what I hoped would be an excess of volunteers so that the stratification of my sample remained the same and the volunteers none the wiser! As it turns out substitutions are not an issue which conveniently removes any ethical dilemmas around restriction and exclusion. I openly admit that I was relieved not to have to face this issue as it would have been difficult to convey rejection so as not to cause harm or violate the principles underpinning my research inquiry. If it had arose I would have asked my NEAS supervisor to explain the organisation's position to any excluded individual so that decision did not attach itself to me personally in order to minimise the impact of a hostile grapevine on my study.

Associated with recruitment is the issue of inducements. Oliver (2003) urges avoidance on the grounds they will potentially alter both relationships and data whilst Clark (2010) points to how volunteers come forward primarily to make a difference which makes payment unnecessary. However, Farrimond (2013) comments non-payment equates to taking advantage in a culture where paying people for their time is the norm and insists on a pragmatic rather than an absolute moral approach. I decide to discuss this issue with my NEAS supervisor who advises a small inducement is in order as the organisation has struggled to secure volunteers in the past for its own research projects. I choose to offer a mystery gift and make a small donation to an appropriate charity in order to emphasise that opportunity to make a difference whilst also acknowledging participation would be rewarded. The mystery gift takes the form of a goody bag containing sweets and an inexpensive but useful pen light.

3.6.2.2 Methods

Although the research proposal I submitted for ESRC sponsorship suggests I would

use participant observation as one of my methods, I held doubts over its ethicality, as it is intrusive and compromises patient privacy. However, when I propose just interviewing participating paramedics at their base station with my NEAS supervisor he smiles at my naivety and explains how the paramedics generally spend very little time on station other than for a meal break so I have no choice but to go out on shift with them. I had not realised how busy the ambulance service actually was or how little personal time the paramedics would have available over the course of a shift so I had to push my doubts to one side. I ameliorate any lingering concern particularly when it is suggested I undertake two consecutive day shifts in order to secure enough time for a meaningful data collection by reminding myself patients, irrespective of their vulnerability, are merely the supporting act and not my main focus. In addition, I would request permission to enter private places, protect confidentiality by not recording any personal details and offer my contact details so further information on my study could be obtained, in a public information sheet, Appendix 3.6 refers.

With respect to interviews, Oliver (2003) stresses the importance of making potential participants aware of how their data will be recorded, as the common practice of using an audio or video recorder can be intimidating. As I plan to use an audio-recorder to preserve the integrity of the data I make this known to potential participants through their information sheets, Appendices 3.7 and 3.11 refer. I acknowledge this may have influenced some potential participants to withdraw but I did not want to lose the accuracy inherent to using a recorder or make the interview process any harder by having to deflect attention to my notebook which may have undermined the intimacy I hoped to develop. I did invest in a small, discreet yet powerful recorder that I describe later in this chapter to make it as unobtrusive an experience as I possibly could.

The use of questionnaires raises three issues: anonymity; completion and return (ibid). Anonymity I satisfy through using a numeric coding system in which each participant is identified but only I understand that code. I facilitate completion of both self-reports with clear and unambiguous instructions that I subject to a peer check but I also give my participants the option to delay completion until I am in the field and can address their queries face to face. The cost of return which Oliver (ibid) insists needs to be free I handle through giving my participants two options both of which carry no charge. The first is to return those self-reports electronically and the second is to hand them back in person whilst I am on their station.

3.6.2.3 Informed Consent

The cornerstone of ethics in social research is informed consent. It is adeptly explained through the following extract from the Nuremberg code,

> "The voluntary consent of the human subject is absolutely essential. This means the person involved should have legal capacity to give consent, should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching or any other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision"
>
> Reynolds, 1982: 143.

But as Oliver comments it is difficult to know how much knowledge to impart. I adhere to National Research Ethics Service [NRES] guidance (2006) for NHS projects and provide a participant information sheet [PIS] to both groups of participants [paramedics and managers], examples of each are contained at Appendices 3.7 and 3.11 respectively. These explain both the nature and purpose of my research but I adopt readily comprehensible and familiar terms as opposed to proffering my theoretical framework to avoid confusion. I also include my contact details [email and telephone] through which to provide further information to enable the individual to decide whether to put their name in the frame. As I did not decide to use the MERI until after my fieldwork had begun I did not mention this self-report in the paramedic PIS, in hindsight, I should have amended it. Similarly, I should have amended the consent form which I based on the example provided by NRES (ibid) Appendix 3.14 refers, which stresses for both groups how they hold the right to withdraw at any point thus underlining voluntary participation. I take consent from each paramedic at the beginning of my first shift in the field with them and I ask each manager to give their consent just prior to interview.

3.6.2.4 Harm

As Oliver (2003) points out, integral to the principle of informed consent is an

obligation to anticipate undesired consequences. But as Roberts, Henderson, Willis and Muir-Cochrane (2013) counter, without knowing how open participants will be the researcher cannot quantify risk. However, I identify a potential but slight risk of harm to the paramedics through being asked to recount emotional and stressful events which I minimise by allowing them control over what information they impart and the right to withdraw at any stage. I also identify a professional risk associated with criticism of their management chain and organisation if the paramedics perceive me as a vehicle for escalating complaints and expect results in return for their participation. Rubin and Rubin (1995: 13) comment how "qualitative research blurs easily into advocacy" so I decide to encourage openness whilst also making it known, out of respect for their confidences I will not be able to intervene on any individual's behalf but I would be sharing my findings with the directorate who have promised to act beneficently.

There is also a need, as Farrimond (2013) makes clear, to assess the often overlooked fragment of ethics relating to researcher safety. The risk of harm to me is formally addressed via the University's internal risk assessment procedure. I identify four potential hazards in: accident; assault; infection and clinical participation but in my enthusiasm to gain approval, coupled with my ignorance of what I might be exposed to I minimise those risks. The first two hazards are consequently rated as medium and the last two as low. In respect of the first I establish I am insured through both NEAS and the University both of whom accept that risk is minimal. With respect to the second I anticipate wearing a stab vest but when I discover these are not issued to members of the ambulance service I do not acquire one as I do not want to be ridiculed either publically or privately so I rely similarly to my participants, on avoiding violence!

To counter the risk of infection I decide on a strategy of good personal hygiene: laundering clothes worn in the field at 38° to destroy bacteria as advised by NEAS; using an antibacterial preparation in the shower after participating in the field; wearing protective disposable gloves as and when appropriate and using an antibacterial hand gel as frequently as possible. I also take advice with regard to possible vaccinations from NEAS who inform me these are unnecessary. To address risk associated with clinical participation I establish I am covered against Medical Malpractice under an extension to the University's policy on public liability. Although Farrimond (ibid) suggests participants might put researcher safety at risk through aggressive or inappropriate behaviour that did not occur to me. However, I always make my itinerary

known and carry both a mobile phone and personal attack alarm on my person as extra precautions due to travelling alone to remote stations. I never felt threatened but in hindsight I should have anticipated that possibility.

3.6.2.5 Gatekeeper(s)

Gatekeepers control access to their organisation and seek to protect it from breaches of confidentiality. As they also act to minimise disruption to day-to-day operations establishing a sound working relationship is imperative (Oliver, 2003). My NEAS supervisor appoints a member of his team to act as my gatekeeper with whom I build a very effective relationship. She helps me establish my management cohort by making preliminary approaches on my behalf and smoothes my path with the resource scheduling team with whom I need an on-going relationship. As my volunteers come forward one or two at a time scheduling my field trips represent a constant and additional demand on this team that my gatekeeper ensures remains cooperative.

3.6.2.6 Permissions and Approval

Approval for my study has to be secured from three different sources. University procedures coupled with that first condition of access by NEAS dictates I approach the NHS Research Ethics Committee [REC] first. This is not an easy path as all aspects of the design have to be fully determined with all supporting documentation e.g., consent forms definitive articles as copies have to accompany the application form. At the time of my application that complex document comprises thirty-four pages although NRES provide guidance (NRES, 2006). In appendices 3.1 through to 3.15 but excluding 3.2 there are copies of those supporting documents which include my original research proposal through which I secured ESRC sponsorship but subsequently develop in light of a further and more rigorous literature review.

Approval to proceed, Appendix 3.17 refers, takes three long anxious months mainly due to various delays in obtaining additional information and assurances for the REC. Their initial review, to which I am summoned, exposes in addition to a small number of changes to the supporting documents, two main concerns. The first is over my emotional well-being for which I require a letter of support from the Occupational

Health Team at NEAS which takes me time to arrange. I hold no such concern because I have witnessed numerous births, deaths, surgical procedures and post-mortem during a brief career in nursing in my early twenties so I am confident my emotional well-being will not be jeopardised. I did not however anticipate perhaps naively, considering evidence to the contrary (CQC, 2009), being exposed to violence.

The second issue concerns my choice of role. I had decided on observer-as-participant (Gold, 1958) given the extensive skill set of the paramedic and the litigation threat. Although this choice is endorsed by NEAS the cardiologist on the REC insists, most vociferously, an ability to help with CPR is not just highly desirable but essential. Added to which a lay member on this committee asks how I would feel if I am asked at an inquest into an unexplained death, why I stood by and did nothing? The intensity of that discussion prompts me to review my role. Although my NEAS supervisor remains adamant no clinical assistance is expected I make the decision to attend a one day, certificated course in first aid run by NEAS through the University that includes CPR skills. I knew I would not be able to live with the guilt if I withheld assistance on the grounds I was merely an academic observer.

University approval is a much more straightforward and less irksome affair. The only concern is for my personal safety whilst accompanying paramedics responding at speed to a '999' call. Accidents do happen and they can be fatal so their associated risk cannot be designated anything other than severe. But the likelihood of an accident happening is classified as low so the risk of injury to me is considered by the principal Health and Safety officer for the University to be acceptable. On reflection, this approval, Appendix 3.18 refers, in which I delight, represents a superficial judgement although to be fair knowledge of the ambulance service at that point in time was scant. There were no real life documentaries on television to colour the lay understanding of respected professionals providing an emergency service to people grateful for that assistance.

The final level of approval rests with the Research and Development Committee for NEAS. This is automatic as they had already issued a letter of approval, Appendix 3.19 refers, following my presentation and had been fully involved with my REC submission so within two weeks of receiving written confirmation from the REC all authorities are filed and my first field trips are scheduled.

3.6.3 Ethical Issues Arising During Fieldwork

The dynamical nature of the ethical process is emphasised in the ethical issues I encounter during the research process which stem from my methods and intent regarding the use and storage of data.

3.6.3.1 Participant Observation

Issues relating to the use of participant observation fall into one of two categories: intrusion or intervention (Oliver, 2003). With respect to the former, Oliver urges the researcher to minimise any disturbance to the social ecology, advising them to merge into the background and accept rather than challenge the customs and values of their participants. I am able to merge into the background partly because the paramedics are used to having an observer accompanying them on runs so my presence is not an unusual situation and partly through heeding the advice given by Mannon (1992) of being willing to help when asked. As I wear a fluorescent jacket labelled 'Ambulance' I am invisible as an observer/ researcher to both the public and patients. This allows me to help out without challenge but also demands I remain alert and sensitive to circumstances so I never react inappropriately.

If I am engaged in conversation by a patient, relative or bystander I defer anything other than pleasantries to the attending paramedic. But I am advised by my participants that it is not necessary to point out to patients I am a researcher but leave it to them to inquire. As I mention in the PIS that I will be guided in my actions by my participants I acquiesce although I keep copies of the public information sheet to hand at all times and explain myself if asked directly. With my participants I take part in small acts of resistance that gain them an unauthorised measure of personal time without comment but as I am not able to contain my interviews to a formal space due to the workload these often intrude. But I endeavour to keep those intrusions as short as possible.

Intervention, Oliver notes, becomes an issue when values conflict between those held by the researcher and those by their participants. I am very open-minded and not inclined towards snap judgements so I am confident of being able to hold my values in check. This however proves difficult when a female patient visibly distressed needs

reassurance that is not forthcoming. I am not able to stop myself from reaching out to hold her hand but generally I abide by the rule patient contact is out of bounds unless I am asked to help which I am forced to insist I will only do if it is non-invasive. "The adventure of being in the field blossoms" according to Bogdewic (1992: 58) once trust and comfort have been established and I find myself becoming involved in rather than just witnessing the highs and the lows of paramedic' performances as I reveal in the next chapter but not to the extent that the analytic purpose of my research is forgotten.

3.6.3.2 Interviews

With respect to interviews I identify three issues: time; content and mode of recording (Bryman, 2004). Time is an issue because it is not possible to state with any certainty how long interviews will last. Although the managers I interview at HQ have diarised my time with other appointments operating as a check it is not possible to interview the paramedics in one uninterrupted episode. Operational needs frequently reduce my interviews to a series of snatched conversations but as their PIS simply states discussions will extend over two shifts I employ consistency rather than length as my check. Content is an issue because the REC, as Roberts, Henderson, Willis and Muir-Cochrane (2013) point out, regard the interview as a structured process in which the questions they approve will be voiced but in reality, discussion is unstructured for which those questions act as a guide. I decide to submit key questions only Appendix 3.10 refers so I am able to incorporate those in a broader spread without compromising my ethical principles.

Although I prefer to use an audio-recorder I recognise how some people find this intimidating so I revert to using a notebook if a participant specifically asks not to be taped and cannot be persuaded otherwise. As discussions take place in a wide variety of spaces outside the privacy of the ambulance station I often have to write my field notes after the event. Finding time to talk means I have to be creative but also sensitive to context even though it means sacrificing a verbatim account. For example, I could discuss an issue with a participant whilst we stand in the admitting queue in A&E if they are not attending the patient but I am not able to record it and blatantly expose their participation. As Oliver (2003) points out it is important to take all steps necessary to achieve peace of mind in those who participate in an inquiry and that means putting

them not the research first. Accordingly, I make it known any names I inadvertently record will be erased and replaced by their anonymous identifier.

3.6.3.3 Self-Reports

My fieldwork has just started when I come across the MERI. After I obtain permission from the author for its customised use in my study I request permission from the REC to include it. Their decision I include in Appendix 3.20 endorses my viewpoint it simply represents a series of questions I could just as easily ask. As I had already undertaken two field trips I decide not to amend either the PIS or the consent form [which I have already acknowledged I should have done] but explain the inventories as a late addition that as a consequence are optional, in a separate communication so each paramedic is exposed to the same open invitation. I send a set attached to an explanatory email to the two participants I had already observed but for the remainder I send them out in advance of my field trip.

3.6.3.4 Data Use and Storage

Issues relating to the use and storage of data I handle in accordance with the Data Protection Act 1998 and DOH (2005b) requirement all systems for recording data are robust. I inform my participants through their PIS how I will handle their data and protect their confidentiality which represents the most significant issue in respect of data collection (Oliver, 2003). I use the anonymous identifier I allocate to each participant to distinguish both their audio and transcript files to satisfy this. I duplicate the code sheet in case of loss with each copy kept in a locked box at a separate location. No electronic copy is kept in order to protect against potential risk of association by an unauthorized access. I also place password protection on each of those files and copy them at regular intervals onto a universal serial bus device [USB] to ensure no data given in good faith is lost. This USB is also kept in secure storage but at a separate location to the code sheets.

3.6.4 Ethical Issues after Fieldwork

I identify data validation, reporting of results and data disposal as significant issues for my study once the fieldwork has been completed (Oliver, 2003).

3.6.4.1 Data Validation

Validation of the data becomes an issue if and when participants request a copy of completed questionnaires and transcripts (Oliver, 2003). In respect of the first I make it known I am happy to send an electronic copy of the individual's own self-reports on request to their NEAS email address. I also inform each of my participants I will send them a personal profile with respect to their MERI scores. I am not asked for and would not have sent any individual information relating to any of the other participants. Fortunately none of my participants ask for a copy of their transcript, which as Oliver remarks, turns the taped recording of the data owned by them into an interpretative document owned by the researcher i.e., me. I do however seek my participants' permission with respect to any quotations of theirs I wish to include in my thesis in support of my analysis in which a validation is implied in their acquiescence to my request.

3.6.4.2 Reporting Results

Although Oliver suggests research participants have no moral or ethical right to the results of the study until these become available within the public domain I encourage my participants to comment on both emerging themes and draft findings which I forward to their NEAS email address. This process of member checking I consider essential to satisfy Schutz's third postulate of adequacy and underpin the quality of my study. Requests to read my conclusions and/or the whole thesis I handle through the promise of access once the thesis has been admitted. I explain to my participants that I will ensure a note as to how they can obtain access will be placed on the NEAS Intranet at the appropriate time.

3.6.4.3 Data Disposal

Openness is the key issue with regard to the disposal of data (Oliver, 2003). I diarise all computer and paper files to be destroyed once the thesis has been admitted. However, as the Economic and Social Data Service based at the University of Essex require all researchers funded by the ESRC to submit their data for a review of its potential long-term academic use I also make a note to contact them first. All my participants are made aware of this through their PIS in which I also inform them that if they withdraw from

the research at any point prior to the thesis being submitted their data will be destroyed immediately and any reference to it removed. I emphasise following a request by the REC how their data is an integral part of my thesis and once I have submitted it their data becomes undeletable from that point on. As it turns out, no one withdraws and all the data I collect forms part of the analytical body to this thesis.

3.7 The Sample

The first of two non-probability convenience samples I draw from the paramedic stratum within NEAS to which I attach the label 'Group One'. The second sample I draw from the management stratum at HQ to which I add a trade union representative and attach the label 'Group Two'.

3.7.1 Group One

Gerson and Horowitz (2002) maintain qualitative studies utilising interviews, require a sample size of at least sixty for the conclusions to be convincing yet Warren (2002) claims thirty is sufficient. As there are no hard and fast rules as to what constitutes an optimum size the practicalities of time and cost intrude (Bryman, 2004). I opt for thirty-six paramedics for Group One to allow the antecedents of gender and experience, I identified as potentially significant in chapter two to be investigated without imposing too much on the goodwill of the ambulance service. I stratify the sample equally between the two categories of male and female but split each into three levels of experience [early, mid, late career] forming six categories altogether.

My reasoning behind the split of experience into three is not based on any academic insight but reflects the opportunity to investigate the impact of professional status. By restricting the early category to under five complete years, I aim to access the perspective of those who have either just completed or are still following the new academic route I mentioned in chapter two. By setting the late career category at greater than ten years of service I aim to expose the perspective of seasoned participants as the paramedic position only stretches back to 1986. The intervening group of between five and ten years of experience sets itself although I consider those individuals would be more open to the new professional identity than those with a longer service history. Table 3.2 highlights, how in addition to gender and experience, each participant also

holds a status of either paramedic or team leader and a position of either crew member or solo rapid responder. These additional categorisations are not deliberate as I was totally unaware of them prior to my fieldwork but they confer additional perspectives and increase the representativeness of my sample.

Although I am aware of a caution against advertising on the grounds self-selection yields a narrow representation (Gerson and Horowitz, 2002; Liamputtong and Ezzy, 2005), I decide to use this technique to attract potential participants, Appendices 3.4 and 3.5 refer. The alternative of obtaining a full list of paramedics and their demographic profile from NEAS and establishing a randomly generated selection specifically invited to take part I dismiss on the grounds it would take considerably more resources for little or no gain. The first advert to 'sow the seed' of the idea is uploaded by my gatekeeper to the NEAS Intranet in January 2008 and followed by a second a month later. A third and final advert is scheduled for the March edition of the in-house publication 'The Pulse' but ends up in the February issue instead. A critical printing error results in a further advert and an email from the Operations Director to all his paramedics that prompts a flow of interest but no participants!

I also design a poster to go up on every ambulance station notice-board in order to maximise awareness. As my liaison officer indicates a cultural dislike of questionnaires, I emphasise their absence on the poster on the understanding neither the emotion checklist nor the MERI fall within the organisational definition of a questionnaire. In addition, a plea for participants is also posted on the trade union [Unison] website as recruiting this group is fraught with difficulty. With hindsight I attribute this to suspicion of my intent as it is not until I establish personal credibility that volunteers snowball. As I accompany each of my participants they introduce me to their colleagues who they encourage to take part in my study on the basis of their experience which they indicate is enlightening. In addition they bolster their perception of me by indicating I am easy to talk to, happy to help and most significantly not part of HQ but independent. But as a result I acquire a surfeit of male volunteers. As the months slip past and my shortfall of female participants shows no prospect of redress I decide to adjust my categories by extending each of the three male categories to eight and reduce the mid and late career female categories to three. This allows me four months into my fieldwork to offer a place to each of the volunteers I had acquired and keep my overall sample size to thirty-six.

me	Gender		Experience			Status		Position	
	Male	Female	<5	5-10	>10	Paramedic	Team Leader	Crew	Rapid Response
1	*		*			*		*	
2		*	*			*			*
3		*	*				*		*
4	*			*		*		*	
5	*				*	*			*
6	*		*			*		*	
7		*		*			*		*
8	*			*			*	*	
9	*				*		*	*	
10		*			*		*		*
11	*			*		*			*
12		*	*				*	*	
13	*				*	*		*	
14	*		*			*			*
15	*		*				*	*	
16	*			*			*	*	
17	*		*			*		*	
18	*		*			*			*
19		*		*		*			*
20	*				*	*			*
21	*			*			*	*	
22		*	*			*			*
23		*			*	*		*	
24	*			*		*		*	
25		*	*				*	*	
26	*				*	*		*	
27	*				*	*		*	
28	*			*		*			*
29	*				*		*	*	
30		*	*			*		*	
31	*		*			*			*
32		*		*		*		*	
33	*			*		*		*	
34	*				*		*		*
35		*			*	*		*	
36	*		*			*		*	
	24	**12**	**14**	**11**	**11**	**24**	**12**	**22**	**14**

Table 3.2: Stratification of Group One.

3.7.2 Group Two

The purpose to Group Two is to provide background information on the ambulance service and the organisational climate/culture particularly details of local policies and procedures impacting on paramedics. All of which I consider essential preparation for Group One interviews, as ignorance of cultural codes, values and conflicts can sanction distortion (Rubin and Rubin, 1995). Appropriate personnel are identified at a meeting with my liaison officer in February 2008 at Ambulance HQ and it is she who makes first approaches on my behalf. In addition to the Operations Director and the Strategy and Clinical Standards Director I speak with the Control Centre manager and managers from Resource Scheduling, Staff Development and Occupational Health and a trade union representative, making this sample seven in total.

3.8 The Reflexive Frame

Ely (1991: 179) remonstrates, "doing qualitative research is by nature a reflective and recursive process" however, it is not an absolute one (McKay, Ryan and Sumsion, 2003). There are a number of variants what Lynch (2000: 27) refers to as "reflexivities" although these have a common root encapsulated by Finlay and Gough (2003: xi) as the "thoughtful, self-aware analysis of the intersubjective dynamics between researcher and researched." I seize, as Gilgun (2010) instructs, upon that notion of awareness and accordingly I infiltrate my account with an open and honest expression of my personal values and I situate personal experiences within my analysis. However, in acknowledging research is primarily about those that inform it, not the researcher, (Gilgun, 2010) I only do so when it strengthens my findings.

Although personal reflexivity helps to promote trustworthiness it leads to an impoverished account, according to Gough (2003), if it is not accompanied by other forms. Accordingly I weave both functional and disciplinary reflexivities through my account in a tripartite relationship (Wilkinson, 1988). Undoubtedly my inexperience in reflexive practices lies at the bottom of my attraction to using this plait as the reflexive frame for my study but as it prompts critical self-reflection from conception to conclusions I consider it adequate. With respect to functional reflexivity I have examined my decisions regarding strategy and methods and made my reasoning

explicit. I also explore in the chapters that follow my relationships with my participants that may have led to some voices being privileged over others.

The final strand of disciplinary reflexivity concerns the progress and challenge posed by the research to the discipline in which it is situated (Gough, 2003) but also, according to Gilgun (2010), writing to specific audiences. I incorporate the former firstly through clearly identifying the shortfall in both conceptual and contextual knowledge my research addresses. Secondly through illustrating how in enlarging the sociological imagination I incorporate a challenge to the discipline to recognise its potential. The latter I address by leaning towards the academic in style but mindful of my obligation to the REC to disseminate my findings within its contextual arena I tailor the content in an attempt to satisfy both.

3.9 Data Collection

The delay imposed by NEAS to the start of my fieldwork persuades me against a pilot study. Although desirable in order to eliminate confusion, disinterest and empty data (Bryman, 2004) I did not want to challenge the hospitality of NEAS by having to extend my fieldwork into the winter. Observing two shifts with thirty-six participants at a rate of two a week I reasoned would take five months. However, this soon proves unrealistic partly due to the paramedic rota and partly due to a lack of personal stamina exacerbated by bereavement. As NEAS stipulate I can only observe over day shifts for reasons of safety there are only seven shifts in each paramedics' standard six week rota when they are available. Added to which I find completing two twelve-hour shifts with anything up to two hours of travelling time either side exhausting and need to factor in recovery time.

NEAS are very accommodating of my needs and allow me to extend my timeframe not once but twice as I have to take a complete break from my fieldwork following bereavement. As a consequence it takes practically a whole year to collect the data from all thirty-six of my participants, as I illustrate in my fieldwork diary in Appendix 3.16. I send each participant the two self-reports for completion four weeks prior to my arrival on station and collect these either on arrival or subsequently but no later than two weeks after my field trip. Data collection of both the qualitative and quantitative datasets from each paramedic therefore spans a maximum period of six weeks.

3.9.1 Qualitative Methods

From the qualitative paradigm I utilise participant observation, semi-structured interviews and document analysis to collect data with respect to all eight of my subsidiary research questions.

3.9.1.1 Participant Observation

Participant observation is defined by Bogdan (1972: 3) as "research characterised by a prolonged period of intense social interaction between the researcher and the subjects, in the milieu of the latter, during which time data, in the form of field notes, are unobtrusively and systematically collected". It aims to "generate practical and theoretical truths about human life grounded in the realities of daily existence" (Jorgensen 1989: 14). Although time consuming and therefore costly it allows the researcher to identify and gather data on the who, what, where, when, why and how of interest rather than having to piece together clues from interviews in which verbalised behaviours may not mirror reality (Bogdewic, 1992).

Although I had doubts about employing this method as previously discussed, I quickly engage with the intimacy it offers that Douglas (1985) considers emotional researchers need to foster, in order to encourage their participants to behave naturally. As I become attuned to cultural terms and colloquialisms I use these to make my researcher status less threatening and to promote a conversational tone to encourage responses (ibid). As a result of making my participants aware I am a certified first-aider I am able to sway along the participation continuum (Bogdewic, 1992) depending on circumstances. On a few occasions e.g., accompanying a participant into a management meeting I adopt the role of the complete observer that anchors one pole of the continuum and is characterised by no interaction. However, I do not adopt the role of complete participant at the other pole, as this is characterised by concealed identity.

The majority of my fieldwork lies between those two extremes with my role either an observer-participant as demanded of the majority of clinical situations or a participant-observer when exceptionally an extra pair of hands is required to help ready a patient for transport, apply pressure/dressings to a wound or administer CPR. I am generally comfortable with either role although I am on occasion challenged in respect to the first

by the unpredictability of mentally ill patients. On one particular run where the patient being attended exhibits signs of mental distress I am told to stand behind my participant and on another to stay out of sight in the ambulance whilst my participant attends to them in their home. As I am not able on either occasion to run from my anxiety but have to face up to it I realise this is exactly what the paramedics themselves have to do but on a regular rather than exceptional basis.

With respect to the second role I am challenged by the brutality of CPR. If I am asked to assist I willingly do so as I am trained and comfortable in using those techniques. But I feel distress over how elderly people in poor health are exposed to strenuous resuscitation techniques rather than being allowed to pass away peacefully. Although in discussion my participants generally agree with this sentiment they make it clear to me they have no choice but to initiate CPR if there is no DNR order. I respond by raising a DNR for my mother who was very poorly in a nursing home at that time as I did not want her to be exposed to the indignities associated with CPR as I knew they would be futile and more importantly, contrary to her wishes had she been able to voice them. Not an easy thing to do but my fieldwork makes me face the reality of her situation rather than continue to deny it.

The most significant challenge to my role as participant-observer occurs in the enormity of a critical incident in which my status as an 'ambulance' responder is assumed. This arises partly from how I wear a standard NEAS jacket emblazoned on the back simply with the word 'Ambulance' as previously mentioned which had been given to me to wear by my first participant and partly from being accepted by my current participant as someone they could count on for help. Although I am able to perform the basic first-aid they ask of me under their supervision I do feel anxious I might be judged by others at the scene as less than competent. I am conscious of how there is no time to explain my presence particularly to the air ambulance crew who subsequently attend the incident and engage everyone in stabilising the patient and organising their evacuation. Although I am able to follow any instruction I am given my anxiety remains until the helicopter takes off when it is replaced by a euphoria that remains with me for several days. I give more details of this incident I label T1 in the next chapter but this brief abstract signals how participant observation is not a method to be chosen lightly but in full knowledge of the responsibilities that accompany it.

By accompanying each participant over two consecutive twelve hour day shifts I should have accrued 836 hours of observations over the five-months spanning April through to August 2008. However, I only accrue 660 hours from April through to the end of March 2009, Appendix 3.16 refers. In July 2008 I take, albeit with some reluctance, the decision to reduce the number of shifts I observe with my seventeen remaining respondents from two to one. I do this in order to maintain progress whilst having to increase the care I give to my seriously ill mother. This undoubtedly compromises my data collection, as time to build a rapport and ease the respondents into an emotional dialogue is shortened and the data has to be captured over half the time.

In November 2008 I have to take an enforced twelve week break when my mother passes away. However, I do observe over a total of 276 runs. I use both an audio-recorder and a series of A5 notebooks to collect field notes into which I also incorporate my personal feelings to allow my account to be strengthened by a reflexive emotional engagement and drive for further understanding that this encourages (Fielding, 1993). I record in particular details of my relationship with each participant and the depth of rapport I achieve and what factors influence this to allow any bias in my collection and subsequent analysis to be determined and exposed.

3.9.1.2 Interviews

Interviewing is "an art that cannot be achieved by following rules or particular methods" (Liamputtong and Ezzy, 2005: 60). It requires, according to Taylor and Bogdan (1998: 99) "an ability to relate to others on their own terms." As emotional experience "is not readily or fully disclosed through superficial interview exchanges" (Gubrium and Holstein, 1997: 65) patience and tenacity are both required. Douglas (1985) advocates the sharing of anecdotal experiences to soften an interview into a less threatening conversation. Fortunately, I have my past experience of working in a hospital that I share which not only softens interactions but strengthens my credibility and acceptance. As I decide against a pilot, I rely on my extensive experience of designing and conducting interviews during a previous employment in Human Resource Management, in order to get them right first time.

I hold the first interviews with managers [Group Two] at HQ during March 2008. The interview guide reflecting the organisational aspects of my contextualised theoretical

framework is prepared as part of the NHS submission for ethical approval, Appendix 3.13 refers. From this I create a mind map on one page of my notebook to avoid distraction from turning pages and to provide a jotter for additional questions as advised by Liamputtong and Ezzy (2005) who act as my mentor. I follow their advice in setting up a database in order to keep track of all activities from the initial approach to the final claim for travel expenses and debriefing with someone familiar after each interview so residual emotion does not impede the next one. My NEAS liaison officer willingly undertakes this role for which I remain most grateful. Each interview is recorded and as soon as practicable afterwards I secure a private space to ensure no malfunction has occurred and there are no passages presenting difficulty in interpretation. As I sometimes have difficulty with accents I carry out this check whilst details of the interview are still fresh so that if the interviewee has to be contacted to confirm and/or fill gaps as appropriate, it is still fresh in their minds also (ibid).

The second set of interviews takes place with my paramedic cohort. However, a one hour uninterrupted semi-structured interview I deem a first-rate collection is to prove the exception rather than the norm it had been with the managerial group. I admit to being naive but I envisaged my interviews being conducted in the relative comfort, quiet and privacy of the ambulance station even if they were segmented between runs. This expectation, as I am to discover on my very first shift, is unrealistic. The demand on the service is frantic that day and there is no time to do more than break the ice with my participant. To compensate they offer to stay for thirty minutes at the end of that shift. As they are keen to do so I accept and we talk in a corner of the station yard as the shift changeover inside is hectic and noisy. The emergency service is even busier on the second shift next day with the second meal break suspended until 18:15pm just forty-five minutes before the end of the shift. My participant offers me that time as it is too late for them to eat before going home and we talk in the back of an ambulance this time as it is cold outside. We have to beat a hasty retreat when the relieving crew who come in early have a run but in those two thirty minute slots I manage to secure my data.

Although this baptism is less than ideal it proves to be one of my better experiences as my interviews with my other participants who are one half of a crew more often than not comprise a series of short snatches of focused conversation between runs. I rank those which take place within the relative quiet and comfort of the ambulance station a second-class collection and those which take place in the ambulance cab on route to or

from an incident which makes audio recording and note taking difficult a third class. Interviews whilst on standby vary as solo responders are often stationary for longer periods than ambulance crew as ambulances are more in demand. However, irrespective of which vehicle I am in the threat of a run hangs in the air. This creates a tension which I acknowledge may have impaired the attention given to my questions and limited the paramedics' responses.

Although the conversational tone softens the formality of my discussions which are as a consequence less threatening their segmented nature makes it more difficult to maintain threads. I compensate for this by making a careful note of where I am with my questions and the last response given by my participant in my notebook so I can quickly recap when we resume. Sometimes I am able to pick up each thread and develop these without interference but at other times, I have to cut them off prematurely if circumstances such as an intervening bad run, has wiped the paramedics' thoughts. Opportunities for me to enlarge some areas of interest are inevitably curtailed as a consequence of not having longer, uninterrupted sessions.

Data collection becomes particularly fraught when the time available in which to collect it shrinks due either to operational requirements or participant comfort and I find myself constantly reining in the freedom I afford my participants to chat and reviewing whether each question I want to ask has been saturated by previous participants. I do not apply any hard and fast rule to this which crops up only after I have reduced my observations to one shift but simply omit questions which have generated a uniform response in favour of those that show less typicality. I acknowledge my decision to be selective in this way may have obscured exceptions but I decide securing a breadth of data is important in order to expose all of the nuances to paramedic emotional labour.

The questions I pose touch on each quadrant of my contextualised framework for which I use those I submitted to the REC for their approval as a partial rather than absolute list as I have previously explained. I draw a mind map of areas to cover but as these interviews focus on the subjective elements of emotional control I endeavour to create the intimacy recommended by Douglas (1985) by making a mental image so I can chat without diverting my attention. Alongside this, I keep in mind a list of probes whose purpose is to minimise sidetracks, encourage detail, clarify uncertainty, check experience against hearsay, determine evidence/bias and most importantly, convey

attention (Rubin and Rubin, 1995). These take the form of a brief comment e.g., 'Go on' or a gesture e.g., Nod of the head. Knowing when to use these is an important skill, Seidman (1991: 67) comments "laughter is often a good cue for a probe or further exploration" as it is often used as a cover for uncertainty that needs to be explored rather than ignored. I check my data at the end of each shift to avoid later queries although on occasion I am too tired and resort to following up the occasional query through email.

3.9.1.3 Document Analysis

To extend the breadth of my knowledge and add meaning to my data analysis I access both public and private documents. A number of documents reside in the public domain. From the DOH I scrutinise key publications with respect to the ambulance service e.g., 'Improving Working Lives for Ambulance Staff' (DOH, 2004b) and 'Taking Healthcare to the Patient' (DOH, 2005a). Assimilating this later report referred to colloquially as Bradley after the author proves particularly fortuitous as it is subject to a number of scathing comments by my participants who always ask me if I have read it and being able to answer 'Yes' emphatically and discuss it critically enhances my credibility. I also peruse various publications from the NHS including 'Meeting the Challenge: A Strategy for the Allied Health Professions' (NHS, 2000).

The Healthcare Commission who subsequently rebrand themselves the Care Quality Commission [CQC] provide performance ratings for each NHS trust and the results from annual NHS staff surveys (CQC, 2009). As the latter are broken down by trust they are particularly useful as I can allude to their sections on stress and job satisfaction in my discussions as a means of introducing those topics. Historic information is however context specific and needs to be treated with caution (Habermas, 1984) so I do not attempt to validate the content but use it as a springboard to ascertain the views of each of my participants. From the private domain of the research site, documents pertaining to local policies on discipline, diversity, flexible working, absence and recruitment are made available to me via my liaison officer. These policies represent those most likely, in my opinion, to crop up in discussion and I consider it would be useful to have prior knowledge to both prevent distortion of responses and increase the pertinence of my questions.

3.9.2 Quantitative Methods

Only a small number of studies (Mann, 1999; Brotheridge and Lee, 2003; Glomb and Tews, 2004; Chu and Murrmann, 2006) have sought to devise measurement scales for emotional labour even though the advantages of being able to do so are widely articulated due to the implications of the concept for wellbeing (Brotheridge and Lee, 2003). I consider a resurgence of interest in the field of organisational emotionality that has led to the development of multiple strands of inquiry (Ashkanasy, Zerbe and Hartel, 2002) has diverted attention particularly the seductive lens of EI (Fineman, 2003) whose charm has attracted a number of researchers investigating emotional labour (Grandey, 2000; Cote, Miners and Moon, 2006; Mikolajczak, Menil and Luminet, 2007; Austin, Dore and O'Donovan, 2008; Cheung and Tang, 2009; Joseph and Newman, 2010). As each study has developed its own conceptual measure none carry a universal endorsement. Similarly, I find none of the measures have been castigated on the grounds of either reliability or validity. As Fineman (2005: 7) points out, they all benefit from being "buttressed by reputational gatekeepers, such as editors of key journals, where measurement is taken as an unquestioned gateway to scientific truth." This, in my opinion, leaves the decision as to their use, open to each individual researcher.

3.9.2.1 The Emotion Checklist

The purpose behind my design of the emotion checklist, Appendix 3.1 refers, is to collect data as to which of the twenty-five discrete emotions I identified in chapter two as relevant to the paramedic workspace [surprise has two faces but is listed as one emotion] are most often genuinely expressed, suppressed or feigned. It reflects a judicious amalgamation of positive and negative emotions to invigorate thought. Whilst I recognise each adjective could be assigned different interpretations by my participants, I regard any risk to the credibility of the data is offset by the fact those words form part of the common vocabulary. Each participant would also be able to check meaning with me, should they wish to do so, during our time together.

This checklist also provides further information as to which interaction partner is most often associated with each emotional response and it allows the paramedics to qualify their answers with specific examples. The data is linked to the sixth subsidiary research question I list at the beginning of this chapter that inquires which emotions are

constituent of the paramedic performance, which rules are those emotions subject to and through which techniques are they managed but it also supports questions four and five. All but one checklist is completed and my collection rate of 97% is one Mangione (1995) classifies as 'excellent'.

3.9.2.2 The MERI

The MERI was developed by Mann (1999) in response to the need for a reliable measure of emotional labour in order to establish both its costs, e.g., stress and benefits e.g., job satisfaction so the former could be minimised and the latter maximised. Having ascertained the two previous attempts at operationalising this concept by Hochschild (1983) and Morris and Feldman (1996) were contradictory as each defined an internal state but measured external characteristics, Mann incorporates both states in her measure. It is designed specifically to be used by the individual as a means of monitoring their own emotional labour but it also allows for comparisons to be drawn between roles and organisations. It uses three dimensions in which the first is external [expectations or rules] and the other two internal [suppression and faking of emotion] which were subjected to four pilot studies (Mann and Jones, 1997) before being tested in a large scale study of 137 employees [both genders] occupying both management and shop-floor positions across twelve UK companies (Mann, 1999). Mann reports in establishing significant correlations the overall measure of emotional labour and its constituent items demonstrate a high internal consistency and validity.

The MERI consists of seventeen statements each with an identical Likert scale attached which ranges from one to eight where one signifies full agreement and eight total disagreement with the statement. The individual in circling the point on the scale that corresponds to their level of agreement derives a score ranging from a low of seventeen [17 x 1] through to a high of one hundred and thirty-six [17 x 8] which determines which of four levels of emotional labour they perform as I illustrate in Figure 3.2.

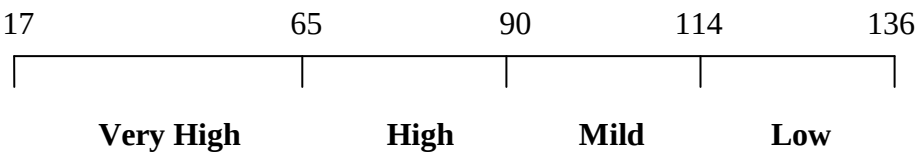


Figure 3.2: Emotional labour scale

I reproduce the MERI as a set of five with each addressing a typical encounter with one of the principal interactants I identified in chapter two. Although I ask my participants to complete the first in respect of a typical interaction with a patient I offer them a choice in each of the other four inventories between two interactants in order to minimise disinterest and degradation of answers associated with prolonged repetition. In the second inventory I offer a choice between a relative/carer and a bystander which I group together on the basis these are outsiders encountered in the vicinity of the patient. The third inventory entails a choice between a police or fire and rescue service officer which I group together as these represent fellow emergency service professionals. In the fourth inventory the choice is between a doctor and nurse I group together as these represent fellow healthcare professionals whilst in the last inventory the final choice is between a colleague and manager which I group together as organisational insiders. As the layout of the inventories is clear and each statement uses the same format and scale I consider their completion presents no difficulty which the collection of one hundred and eighty inventories, yielding a 100% or 'excellent' response rate (Mangione, 1995) confirms. The statements on the MERI, Appendix 3.2 refers, provide data in support of research questions one, four, five and six that I list at the beginning of this chapter.

3.10 Transcription

Oliver, Serovich and Mason (2005) urge all qualitative researchers to adopt a reflexive attitude towards transcription at the design stage of the research process, in order to ensure participant confidentiality and data integrity are preserved. They argue the tendency to view transcription as a chore has led to its power, as a vehicle of representation, being overlooked. In particular, they draw attention to the need to decide and declare where along the continuum between naturalism and denaturalism, an inquiry's transcription style resides. In doing so, the researcher can ensure steps are taken, before data collection begins, to enhance the rigor of the information exchange and subsequent analytic process.

As my inquiry is concerned more with meaning than the mechanics of the spoken word, I adopt a denaturalised style. I do not surrender a verbatim account but pay no attention to accents, periods of silence or involuntary vocalisations e.g., sneezing. I recognise however "the rich detail of qualitative data could be lost if the transcript is purged of all non-verbals or tokens" (ibid: 1285) so I incorporate references on my audio recordings

to any hand/head gestures. Response tokens e.g., 'Mmm' are clarified and slang terms and/or paramedic speak identified and challenged as and when so subsequent interpretation is not compromised. In order to demonstrate respect and preserve the integrity of the data, any excerpts I select as quotations have their authenticity checked prior to being incorporated. This provides a counter for the criticism levelled by Schegloff (1997) that a denaturalised style prevents individual voices from being heard.

Bryman (2004) argues each hour of recorded speech equates to between five and six hours of transcription activity yet it is not a mechanical process but one which offers the potential for reflexivity and so will vary depending on how much of that activity occurs. As McKay, Ryan and Sumsion (2003) comment, whilst transcribing the researcher is returned to their interview with a participant and can hear how they shaped the data through expanding some responses, inhibiting others or missing opportunities to enlarge or include a particular topic. Certainly, I could hear where I had let opportunities slip past as I let a couple of my participants complain about personal issues for too long before taking control. I learn from these however as they occur early on in my fieldwork. As I had taken note of a remark by Bryman (2004) how data can quickly accumulate into an overwhelming quantity I endeavour to transcribe both recorded data and accompanying field notes immediately after each field trip.

3.11 Data Analysis

In this section I first discuss my analysis of the qualitative dataset which I examine as it is built with the assistance of the analytical software NVivo. Second I discuss the the details of my analysis of the quantitative data which I analyse at the end of the fieldwork with the aid of the statistical software Minitab. Third and last I discuss my extraction of a "coherent synthesis" (Saldana, 2009: 149).

3.11.1 Qualitative Data Analysis

Coding for some qualitative researchers has become a contentious issue due to being seen as prescriptive or even positivistic (Mayan, 2009) although for others it is still a craft through which research transitions from satisfactory to excellent (Strauss, 1987; Saldana, 2009). I align myself with the latter viewpoint and accordingly split the process into four stages. The first two take place ahead of the first data collection whilst

stages three and four are iterative, taking place immediately following each collection. Although the third stage involves a manual exercise the others utilise the computer software package NVivo. Throughout my analysis I thread a process of validation in the form of member checking which replaces my original intention of using focus groups.

3.11.1.1 NVivo

Although computer-assisted qualitative data analysis software [CAQDAS] has been likened to Frankenstein's monster for removing cognisance from the researcher (Fielding, 2002) it does enable transparency whilst disabling the tedium inherent to managing large quantities of data. And most importantly, it "doesn't get tired and miss sections of data" (Agar, 1983: 26). My decision to use NVivo reflects that last sentiment but also how I am familiar with and enthusiastic about its coding and modelling capabilities. A visual representation of the data facilitates dissemination but is equally of use as a means of keeping track of ideas from first beginnings to more involved and complex arrangements, what Gibbs (2002) refers to as its auditing function. There is a temptation always to reject first ideas and with NVivo they can still be discarded but without loss, as they are easily saved in a separate model for later reflection. Coding, as Liamputtong and Ezzy (2005:267) remark, is "central to the analysis process" and NVivo contrary to their opinion, is I argue, more efficient than cut and paste.

3.11.1.2 Coding Stage 1

The first stage of the coding operation involves setting up an NVivo project with two parent nodes. The first of which, I label 'Process' and the second, 'Shifts'. Under 'Process' I attach a node for each quadrant of my framework. The first of these 'Antecedents' splits into the four types: 'Situation'; 'Job'; 'Individual' and 'Organisation'. Under the second quadrant: 'Strategies' I create the nodes: 'Emotions'; 'Rules' and 'Techniques'. I split the third quadrant 'Consequences' into two nodes: 'Positive' and 'negative' and similarly I split the final quadrant 'Interventions' into 'Individual' and 'Organisation'. Each of these nodes further divides to reflect the categories/codes I identified in chapter two as significant.

Under the second parent node 'Shifts' whose purpose is to organise the data stemming from my observations I attach a child node for each of my participants. I label each with

their coded identifier and set up attributes to hold data on status [student, paramedic or team leader], position [crew or rapid response] and base station [location, size and facilities]. I split each of those nodes into two which I label 'S1' and 'S2' to represent each of the two shifts I observe. I set up attributes on both to record information relating to shift times and meal breaks and I split each into 'Runs' and 'Standby' both of which I develop as the fieldwork progresses. Setting up this NVivo project represents the first step in the transition of my theoretical framework into a deductive template.

3.11.1.3 Coding Stage 2

Stage two of the coding process entails opening an analytic memo for each of the eight subsidiary research questions into which I add notes primarily after reading each transcript to confirm/ disconfirm deductive codes, identify inductive codes and potential themes and incorporate ideas. I also set up a memo I label 'fieldwork' to which I scribe my thoughts on my experience including memorable incidents, my relationships with my participants and personal low and highlights. As Spindler and Spindler (1992: 66) comment, "only the human observer can be alert to divergences and subtleties that may prove to be more important than the data produced by any predetermined categories". Those memos provide me with a secure area to record my thoughts so they are not lost.

3.11.1.4 Coding Stage 3

Stage three of the coding process is split into three parts. First I read the transcript I have just completed and then after rereading it a few times I segment dialogues carrying potential on the hardcopy [I find those less tiring to read and as a consequence easier to work with initially] from nondescript areas of data free conversation so the latter can subsequently be ignored. Saldana (2009: 19) uses the rather apt term "lumper coding" to describe this process. Second I examine those data areas carrying potential to decode, segment and link broad passages of the electronic transcripts to each quadrant node of my deductive template. I then revisit each quadrant node in order to encode keeping in mind a code is a segment of data "that captures the qualitative richness of the phenomenon" (Boyatzis, 1998: 1) but which can also summarise the data (Saldana, 2009). I group codes sharing characteristics into categories (ibid) and I link those and any freestanding codes to lower order nodes and whilst doing so, identify potential quotations. Third and last I add pertinent thoughts to my analytic memos.

3.11.1.5 Coding Stage 4

The fourth stage of the coding process entails first of all enhancing the node structure 'Shifts' in my NVivo project. For each shift S1 and S2 I set up a node under 'Runs' for each run I observe over using a simple incremental numeric identifier and I attach an attribute for the run type [A, B, C or aborted]. For the first three run types I attach child nodes for each category of interactant my participant encounters. There is one for the patient [usually there is just the one patient but on occasion this splits into two] with attributes: age; sex [male or female] and outcome [hospital, alternate transport or home]. In addition I set up nodes to hold data on the other deductive categories of interactant the paramedic encounters: relatives; bystanders; emergency services personnel; hospital staff; local managers; work partner; colleagues; observers [which subsumes encounters with representatives of the media] and lastly the self to hold data on intrusive memories. I add carers inductively into the same category as relatives as patients are as I am to observe often attended in residential care facilities where a carer acts as a surrogate and I add inductive categories: General Public; Control [dispatch officers]; Air Ambulance crew; GP/ BASICS as appropriate.

Under 'Standby' I set up a node for each period which again I label with a simple incremental numeric identifier and attach attributes for: location [station, car park, other]; facilities [food, drink, toilet and communications] and duration. Each period of standby also has a node attached for each category of interactant encountered. Apart from Air Ambulance crew, GP/ BASICS doctor and bystanders those could duplicate those encountered over a run to which I add a further inductive category I label 'HQ' to hold data relating to encounters with the Operations Directorate and support areas.

The second part to this fourth stage of the coding process entails revisiting highlighted areas on each transcript yet again but with a line by line precision. I check each segment of data I identified as holding meaning is either attached to an existing node under 'Process' or represents an inductive category/ code leading to the creation of a new node. Conscious of a remark made by Saldana (2009) that coding is not formulaic I find meaning through considering a number of different methods: elemental methods [Process, Descriptive and In Vivo] and affective methods [Emotion and Values] e.g., 'driving' [Process]; 'buzz' [Descriptive]; 'macho' [In Vivo]; 'anger' [Emotion]; 'free ride' [Values] in order to extract every datum.

3.11.1.6 Coding Validation

As I have already mentioned I originally intended to validate my qualitative data during focus groups but for reasons previously stated these do not take place. Consequently, I employ the strategy of member checking recommended by Ezzy (2002) and Saldana (2009) to satisfy the third and final postulate advocated by Schutz (1967) of adequacy. As the data accumulates I present emergent themes to my participants in order to confirm, clarify and strengthen ideas. However, it demands a certain amount of perseverance on my part to maintain an analytic engagement with the data whilst also actively engaged in what proves to be extremely exhausting fieldwork.

According to Saldana (2009) perseverance is one of seven attributes an individual requires to code well. They must also be organised; flexible; creative; able to handle ambiguity; have an extensive vocabulary and be rigorously ethical. Out of which, he selects an extensive vocabulary as the most important, maintaining words are the qualitative equivalent of numbers. However, I argue, perseverance is more important because I find collecting new data is full of possibilities which act as a motivating force whereas data already collected becomes less engaging as it becomes familiar.

3.11.2 Quantitative Data Analysis

Each of the two self-reports yield descriptive statistics in the form of distributions, frequencies and ranks and I discuss each in turn.

3.11.2.1 Minitab

No justification for the use of statistical software needs to be made as it has become the norm (Bryman, 2004). My decision to use Minitab, out of all the packages available, reflects my long association with this software and its ease of use for simple statistical operations and the presentation format I desire.

3.11.2.2 The Emotion Checklist

The data from the emotion checklists I collate onto a series of spreadsheets with one for each gender in respect of each of the three approaches to managing emotion that could

be noted on the checklist [genuine expression, suppression and feign of emotion]. Within each of those six spreadsheets I stratify the data by level of experience to yield a total of eighteen data streams in support of questions four and five and six. I also tabulate the frequency of each of the twenty-five discrete emotions and rank these in a simple table and I collate any supporting comments made on the checklists by both emotion and management strategy to facilitate their incorporation into my analysis.

3.11.2.3 The MERI

For each paramedic set of inventories I open a corresponding spreadsheet on which I enter the value highlighted for each statement into a matrix. As each inventory yields an emotional labour score I transfer this onto a master spreadsheet along with the mean for the set to enable me to draw graphical representations. I choose to use dot plots as these represent an assembly of individual values and accordingly, my phenomenological eye is able to observe albeit indirectly my participants viewpoints in relation to one another. I use four plots altogether with the first exposing the distribution of individual scores for each of the five principal interaction categories in support of my first subsidiary research question. The second plot exposes the spread of the overall means by experience and the third by gender in support of the fourth and fifth research questions respectively whilst the fourth and final plot exposes the spread of means across the sample in support of my overarching principal research question.

In support of my sixth subsidiary question I tabulate each participant's emotional labour score for statements five, six, ten, eleven, twelve and thirteen by interactant type and I stratify these first by gender and second by experience. These tables allow me to examine: any propensity to feign positive or negative emotion [statements five and six respectively]; any propensity to suppress positive or negative emotion [statements ten and eleven respectively]; any tendency to surface act [statement twelve] and any tendency to deep act [statement thirteen]. Each entry occupies one of three positions: equal to the norm for the population, as determined by Mann (2002); greater than the norm signifying their performance involves less of that activity than in other jobs or conversely below the norm which indicates their performance involves more of that activity than is required by other jobs. I illustrate frequencies as percentages on each table. Although I could extract even more data from the inventories I deliberately choose not so the quantitative dataset does not overwhelm my qualitative analysis.

3.11.2.4 Validation

The data I collect via the emotion checklist is reviewed with each participant during my time in the field. I consider this process of convergent validity establishes that instrument as a viable means of recording data as to the emotions aroused in paramedic workspaces. The MERI did not require validation as a new measure having already been put through that process by Mann (1999). But I generate a personal profile from each set of inventories using the interpretative guide provided by Mann (2002) to offer each participant feedback. This affords them an opportunity for appraisal and intervention to further satisfy Schutz's postulate of adequacy. As no dissent is expressed I consider this instrument also provides me with valid data.

3.11.3 Synthesis

The final stage of my analysis involves the extraction of a "coherent synthesis" (Saldana, 2009: 149). I achieve this by first establishing a connection between the two parent nodes of 'Process' and 'Shifts' in my NVivo project. As the data I collect under both 'Run' and 'Standby' nodes relates to interactions it corresponds to situational antecedents and therefore I establish a connection for both at the 'Situation' node. I also connect the quantitative data streams from the emotion checklists to the 'Emotions' node under 'Strategies' before attaching each of the data streams stemming from the MERI. These disperse with the first from which I draw a plot of performances across principal interaction types connecting to the 'Situation' node. The second and third I connect to 'Individual' antecedents as each exposes clusters and spread within the characteristics of experience and gender. The fourth I connect to the highest node of 'Process' as it relates to overall performances. Of the remaining six, I attach the four in respect of statements five, six, ten and eleven to 'Rules' and the two relating to statements twelve and thirteen to 'Techniques under the 'Strategies' node. With all of the data organised within the bounds of the template, I examine the data corpus to identify/clarify themes, which represent "a pattern in the information that at minimum describes and organises the possible observations and at maximum interprets aspects of the phenomenon" (Boyatzis, 1998: 161) through which to explain my data and address my research questions. I tabulate my principal themes in Tables 3.3 to 3.6 and list my deductive categories/codes in Appendix 3.21 which I refresh along with my framework and analysis following a second sweep of the literature after the fieldwork is completed.

Research Question	Theme	
	Label	Meaning
Which interactions carry a demand for emotional labour and how do these vary both within and between categories?	Clinical mandate	Clinical interaction with patients
	Professional mandate	Interaction with professionals in health or emergency services
	Collegial obligation	Supportive interaction with peers
	Public obligation	Interaction with members of the public
	Organisational obligation	Interaction with established and honorary members of the organisation
	Autobiographical obligation	Control of intrusive memories
Which factors relating to the nature of the job or to the organisation or to the individual trigger the paramedic into having to manage emotion during professional interaction?	Engagement	Characteristics of the job which promote paramedic fidelity
	Disengagement	Characteristics of the job which undermine paramedic fidelity
	Low morale	Aspects of the organisational climate/ culture which exert a negative influence on paramedic loyalty
	Fitness	Dispositional characteristics that fit the role
	Impediments	Personal factors which impede performances
Is the experience of emotional labour by the individual paramedic acknowledged by the organisation or is it constrained?	Taboo	Dialogues on emotion are not encouraged and emotional labour is not acknowledged
Is experience a factor in performances or their effects?	Fitting-in	Inexperience leads to increased effort
	Maturity	Experience increases awareness of emotion and regulatory skill
Emotional labour is considered a gendered experience that places additional demands on women so is the experience of a female paramedic different from that of her male colleagues?	False advantage	Female paramedics perceive their performances are favourably differentiated through natural advantage

Table 3.3: Principal themes: Antecedents

Research Question	Theme	
	Label	Meaning
Which emotions are constituent of the paramedic performance, which rules are those emotions subject to and through which techniques are they managed?	Abuse	Emotions provoked by a lack of respect
	Compassion	Emotions triggered by desire to help others
	Habitus	Emotions induced by professional habitus
	Intuition	Rules applied to emotion are intuitive not formally prescribed
	Empathy	Empathy represents the core technique within which all other techniques are situated

Table 3.4: Principal themes: Strategies

Research Question	Theme	
	Label	Meaning
What are the consequences for the individual in having to actively manage their emotions?	Gains	Performances of emotional labour produce both professional and personal gains
	Losses	Performances of emotional labour produce both professional and personal losses

Table 3.5: Principal themes: Consequences

Research Question	Theme	
	Label	Meaning
How can the consequences of having to manage emotion be mediated?	Voluntary	Acts of mediation under the control of the individual
	Authorised	Acts of mediation authorised by the organisation

Table 3.6: Principal themes: Interventions

3.12 Quality

Flick (2007) indicates quality is no longer about just stating and adhering to a specific philosophical outlook so I use the two-fold criteria of trustworthiness and authenticity proposed by Guba and Lincoln (1994) through which to discern the quality of my study. I adopt this mechanism on the basis my study is predominantly qualitative and those criteria represent a simple and straightforward application that can subsume the supplementary quantitative element. The first criterion of trustworthiness breaks down into four elements: credibility, transferability, dependability and confirmability. The first of which I satisfy through the 'a priori' theoretical framework/ template which provides a "clear trail of evidence" from the literature through to the analysis (Fereday and Muir-Cochrane, 2006:84) and also by following good practice and incorporating respondent validation. I achieve the latter through giving all my participants an opportunity to comment on my draft findings in good time for any dissent to be addressed. However, no depreciatory comments are received. Instead the responses I receive via email resemble that by F31 (5 July 2011), "*what a really accurate reflection."* The second element I satisfy through the provision of rich, thick description to allow others to assess the applicability of the findings to other situations. The third I address through detailed record keeping so final conclusions can be audited. The last element in confirmability I satisfy through an open and honest expression of my own values and theoretical leanings.

The second criterion of authenticity breaks down into five constituent parts: fairness; ontological; educative; catalytic and tactical. The first of which I achieve through giving a voice to all viewpoints not just the most seductive although I acknowledge some voices are stronger than others. These belong to those individuals more in tune with the concept of my study and hold less suspicion over its purpose. As a consequence they are more forthcoming than others and their dialogue holds greater depth allowing me to illustrate a point more effectively through their voice than any other. Although I spend more time with rapid responders on standby over which I am able to establish a stronger rapport and intimacy to facilitate their disclosure, I have taken care to ensure my data extraction does not favour that or any other subgroup through keeping an informal tally of the voices I thread through chapters four and five in support of my analysis. These confirm I develop an empathetic relationship with each of my participants even though each represents a transient attachment of twenty-hours or less.

The second element I ascertain by first asking each participant why they have volunteered and what they hope to achieve through doing so. My first participant replies,

> *"we are responsible for our own training, our own professional standards and things, and really I thought well if I volunteer for it, it shows I have shown an interest. I can obviously use documentary evidence that I can put into my Continuous Professional Development file and the last thing is probably it might be of benefit to the trust or you know other people like, including myself"*
>
> M11, 2008: 48-53.

I am left in no doubt that my study represents an interesting diversion that is helpful in providing evidence of CPD as that comment made by M11 is one example of many. The paramedics just prior to my fieldwork had been asked to keep a portfolio in order to "*actually prove that they are up to date not just with the clinical practice but just everything that is going on*" (F21, 2008: 646-648) for their regulatory body the HPC in support of their registration so my study is opportune in that respect. Overall I am led to believe the paramedics gain a deeper understanding through comments such as that by M13 (1 July 2011) who regards their participation as "enlightening."

Educative authenticity I ascertain by enquiring of each member whether their knowledge of emotional labour has led to improvement in their relationships with others to which they largely express their hopes it has although they do not offer any supporting comment. Both catalytic and tactical authenticity I satisfy through enquiries of both the individual and their organisation as to whether the findings have enabled change to be identified and if so, has that knowledge led to action being taken or proposed. A remark I hope will prove to be a portent, is made by the Clinical Director NEAS (24 June 2011) on reading an early draft of my thesis,

> "*there is some very useful feedback both very positive and also there is some learning for us as an organization"*.

3.13 Equipment

The main pieces of equipment I purchase specifically for this study are an Olympus DS50 conference kit and AS2300 transcription kit as I anticipated running focus groups. The former includes an audio recorder with a sensitive stereo microphone that can be detached from the base unit. As Liamputtong and Ezzy (2005) comment, the use of an external microphone allows it to be positioned closer to the participant who is likely to talk quite quickly and/or quietly when revealing sensitive information. The DS50 also has a remote control facility. This enables me to record without participants being distracted by the process, lessening its intrusiveness (Bryman, 2004) and facilitating a more intimate relationship as Douglas (1985) advocates. However, it does not prevent 'off-the-record' episodes. As Warren (2002) discusses these seem to be an inevitable part of qualitative interviews and need to be captured even if it is just in essence of what is not being said!

3.14 Reflecting on Methods

My decision to opt for a mixed methods strategy proves opportune as I find the realities of prehospital emergency care out in the field, constitute a far more hostile environment in which to conduct research than I had expected. I have to settle for a mix of second and third rate data collections due to having to swiftly cede time and time again to operational requirements and I admit to becoming a little resentful if the run which provokes the suspension of an interview is aborted or turns into a non-emergency. I have to deploy my own mask to keep my resentment and anxiety around time ebbing away hidden. Would I have narrowed my focus if I had known what I would be up against? I can truthfully answer 'No', as I wanted to take a broad brush in order to saturate my framework to establish its credentials and present a qualified account.

With hindsight my anxiety around securing enough volunteers prompts me to adjust my categories too early in respect of my Group One sample. If I had not been delayed and constantly felt less pressure I would have undertaken a pilot which I now regard as an essential not desirable prerequisite. The pilot would have revealed the suspicion around initiatives perceived as stemming from HQ and the ambivalence towards professional identity both of which inhibit interest and prevent a more even spread across both gender and experience that I could have countered. Although the number of female

volunteers is disappointing the final makeup of the sample does reflect the gender split within the service at that time (NHS, 2009e).

Although I am comfortable with my decision to use the two self-reports to compensate for the limited time available for interviews I acknowledge I could have used the MERI's with more purpose. First I could have distinguished the work partner from colleagues and local managers from those based at HQ to make the fifth MERI a four-way rather than two-way choice. This would have allowed me to provide additional evidence in support of the significance of the work partnership and the nature of my participants' relationship with HQ. Also if I had split those carrying a choice into two or four piles as appropriate and randomly allocated them to my participants I could have differentiated the emotional demand further without increasing the effort asked of each participant. As I had not planned on using the MERI but included it in a rush after my fieldwork had begun I did not fully realise its evidential scope which with a little more thought I could have done.

3.15 Concluding Remarks

As Irwin (2008: 419) remarks, qualitative and quantitative strategies, "are not distinct domains of social phenomena but rather, different kinds of accounts of social phenomena" that in merging enlarge the canvas of our understanding. By deploying a mixed methods strategy I am able to add depth to my perspective of what constitutes emotional labour for the UK paramedics in my sample. My transcripts provide me with a thick base layer of the interactional demand on the paramedic role whilst data from my two self-reports highlight the emotions pertinent to the paramedic workspace and their strategic decisions that otherwise I would have had to gloss over. I am also able to incorporate numerical glints of both commonality and difference to heighten the authority of key analytical points that might otherwise have been debased. My analytical composition set within the confines of the deductive template unfolds over the following two chapters. As it does so, it demonstrates the essential ingredient of social phenomenology in theoretical rigor (Schutz, 1962) and confirms the usability of the theoretical framework without which it would lack validity (Huynh, Alderson and Thompson, 2008).

Chapter 4

Research Findings – Part I

The Interactional Demand

4.1 Introduction

In this chapter I present and discuss my findings with respect to situational antecedents which I recognise as the interactional demand. I expose how this demand is not contained within the run but extends over standby to encompass the whole of a shift thereby challenging the assertion by Mannon (1992: 102) that for the paramedic, "the run is the beginning and the end of any thoughts and meanings given to their work." I identify principal themes in clinical and professional mandates to which I add public, organisational, collegial and autobiographical obligations through which I structure my account. I expose concordance with my deductive categories/ codes and reveal inductive additions and I contrast the run with standby to expose how there are different strengths in demand but common threads. As I bind my observations with the paramedics' voices to first present those interactants encountered on a run and second on standby subcategories form to explain variance within each category of interactant. By drawing on the quantitative data stream I also highlight variance between categories that allow me to fully address which interactions carry a demand for emotional labour and how these vary both within and between categories to conclude the chapter.

4.2 The Run

A run is called when NEAS Control Centre dispatch officers alert the paramedic to an emergency and it ends when the paramedic signals they are clear. I illustrate in Figure 4.1 how I observe the number of runs over the course of a shift to vary from zero to eight. Each run, as Mannon (1992) comments in chapter two, represents either a legitimate or illegitimate use of emergency resources. Although every member of my sample agrees patients who are alive and do not need any form of clinical intervention represent an illegitimate use of emergency resources and those who are either alive or classed as an immediate death in need of their full skill set constitute a legitimate use, other associations are subjective. As Boyle and Healy (2003) intimate, each paramedic holds and applies their own moral standards to patients, which leads to drug overdoses

for example, being classed by some paramedics as undeserving and an illegitimate use of an emergency resource whilst for others they represent a life and death emergency and deserve the opposite, legitimate label.

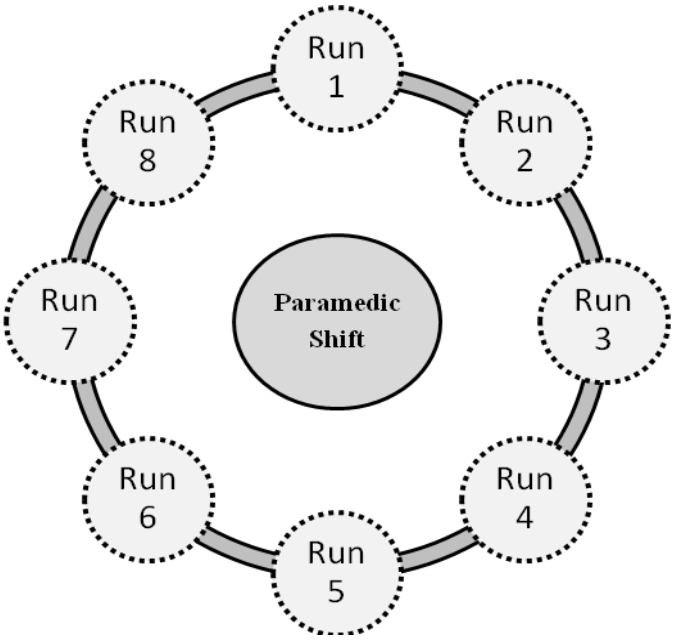


Figure 4.1: A paramedic shift.

However, each run regardless of classification unless it is aborted, potentially exposes the paramedic to the same audiences (Palmer, 1989) which I identify and map in Figure 4.2 from my observations. As I recognise a variance in the paramedics' response to different encounters I cluster interactants. The first cluster of two deductive categories: 'Patients' and 'Relatives' to which I inductively attach 'Carers' to the latter I explain through the theme 'Clinical Mandate' [green on the map] as I acknowledge emotions are managed with these interactants under the direction of the paramedic code of conduct [see chapter two] but are done so willingly and with compassion. Theodosius (2008) identifies a similar form of emotional labour she terms instrumental which Bolton (2005) proposes is encapsulated in prescriptive emotion management.

As the paramedic code of conduct also instructs the paramedics to build and sustain professional relationships I cluster the deductive category 'Emergency Services' with three inductive categories. As I acknowledge medical interaction within the hospital environment is not restricted to staff in the deductive category 'A&E' I subsume this into a larger category I label 'Hospital Staff' and I create a category I label 'GP/

BASICS' and a category I label 'Air Ambulance' and I explain all four categories through the theme 'Professional Mandate' [blue on the map]. This reflects the interdependency Theodosius (2008) captures in collegial emotional labour.

Figure 4.2: A map of the interactional demand on the paramedic over a run.

As I recognise the paramedics are obliged to manage emotion during encounters with bystanders to an incident in order to preserve their authority but also how they have to interact with the wider public to preserve their reputation I cluster the deductive category 'Incident Bystanders' with an inductive category I label 'General Public' and I explain both through the theme 'Public Obligation' [orange on the map]. A further obligation to comply with organisational directives arises with the two deductive

categories of ‘Managers’ and ‘Observers’ and the inductive category I label ‘Control’ which I cluster and explain through the theme ‘Organisational Obligation’ [red on the map]. This form of emotional labour Bolton (2005) captures in pecuniary emotion management. Although the deductive category ‘Media’ as honorary insiders would also be explained through this theme it is unqualified in my study and therefore I exclude it. Two other categories of insiders in ‘Colleagues’ and ‘Work Partner’ I cluster together and explain through the theme of ‘Collegial Obligation’ [purple on the map] as I recognise the paramedics are obliged to offer support to each even though they do so willingly. Theodosius (2008) encapsulates this within collegial emotional labour but whilst she extends this form across the multidisciplinary healthcare team I recognise those wider encounters as distinct.

There is a final obligation I explain through the theme ‘Autobiographical Obligation’ [grey on the map] I link to the deductive category ‘Self’ in acknowledgement troublesome memories carry potential to be seriously disruptive if not controlled. Boyle (2005) refers to this as a distinct form of emotional labour she terms emotion process work. I use dotted lines to indicate how each interactant including the patient as I explain later is either present or absent. My observations spread across the full spectrum of ‘999’ calls and I intertwine these with the voices of the paramedics accessing both their autobiographical archives and the bank of stories owned by others but to which they also have a key to reveal the extent of paramedic interaction and its demand.

4.2.1 The Clinical Mandate

Through the theme ‘Clinical Mandate’ I explain the emotional labour that links the two categories ‘Patients’ and ‘Relatives/ Carers’. Patients I array along a continuum where their position reflects one of three deductive subcategories: ‘Taxi’, ‘Routine’ or ‘Emergency’. Patient encounters within the first I explain through its links to six deductive codes: ‘adult’; ‘minor’; ‘lonely’; ‘free ride’; ‘anger’ and ‘illegitimate’. These adult patients have complaints that do not warrant the use of an emergency ambulance and demand a great deal of anger management. I observe a prime example of a minor complaint prompting a ‘999’ call in a woman given a Chinese burn by her son who is advised by my participant amid a restrained annoyance to take an aspirin. An elderly lady who lives in sheltered accommodation and feeling lonely telephones her warden for a chat, provides an example of the second code. As the warden is not available her

call is routed automatically to NEAS to whom she claims to have fallen but the crew and I find her sitting in a chair totally unconcerned. She refutes that fall but claims instead she is having a heart attack when questioned as to why she has rung '999'. Her vital signs do not confirm this but as she has a historic slight irregularity she is taken to hospital as a precaution. On route the paramedics' suspicions are further aroused when she refuses pain relief and confirmed when she admits she just wanted a chat. By then it is too late to reverse the process she has unwittingly or knowingly fallen into. Either way she endorses that suggestion put forward by Palmer (1983a) that being both a comforter and a conversationalist are part of patient expectations even if those roles provoke exasperation and annoyance.

At the other end of the age scale a young woman provides an example of a free ride. She is in the early stages of pregnancy and places a '999' call I label CP1 to take her to hospital for a check up. Although the attending paramedic is polite the driver whom I am observing vents some of his anger once out of earshot. His annoyance which he mostly suppresses runs deep as next day when I ask him what makes him feel stressed whilst at work he quickly replies, *"those patients that take the ambulance service for granted like that pregnant teenager. They could have got a taxi or even the bus but no they wanted a free ride into the hospital"* (M31, 2008: 138-140). These patients are illustrative of many examples I observe of the illegitimate use of an emergency vehicle.

As M24 (2008: 105) remarks, *"jobs are tedious if your skills are not needed other than your social skills which you need all the time".* Although Pathways filters calls, individuals claiming certain symptoms e.g., severe chest pain, have to be sent a paramedic and *"a lot of patients are wise to the protocol and know what to say to get attention"* (M24, 2008: 106-107). The Communications Director (2008: 90) indicates awareness campaigns to reduce '999' calls actually, "*encourages people. It puts it into their mind"* as F21 (2008: 41-44) confirms,

> *"Last summer holidays, last year, we went on the local news and everything, saying to the teenagers 'Don't ring '999', this is the kind of accident, this is the kind of thing we are dealing with. This really hard hitting thing and they went up by 100%, doubled overnight".*

The Operations Director (2008: 277-283) acknowledges the frustration,

> *"Most of the frustrations from the staff we have found is about the inappropriate use of the '999' service and I think I am right in saying if every single job you dealt with, from a crews perspective, warrants their skills and knowledge and they missed their meal break or worked over their shift would not matter one bit. It is those other calls".*

However, with no solution imminent the majority of paramedics in my sample accept they have to manage their anger with this type of patient as *"there is only so much you can do really"* (F12, 2008: 193-194).

Boyle (2005) attributes the bulk of the workload and the requirement for the most emotional labour particularly the suppression of boredom to the subcategory 'Routine' but as I find a greater variety of patient than the two [intoxicated and dementia] implicated by Boyle I split this subcategory inductively into three. The first I label 'Habitual' holds a large cohort formed by patients whose predicament stems out of their lifestyle choices to which I link deductive codes: 'adult'; 'non-urgent'; 'low skill' and 'intoxicated' and inductive codes: 'alcoholics'; 'smokers'; 'drug users' ; 'anger'; 'fear'; 'dirty work' and 'compassionate gift'. My participants all share the sentiment expressed by F16, *"drunks are the worse sort of job as they don't really need an ambulance"* (2009: 74-75). Intoxicated adult patients are non-urgent and low skill as they do not generally require clinical intervention other than basic first aid but they do require copious amounts of emotional labour as M14 (2008: 60-65) indicates,

> *"We were called to a drunk Muslim male. I was not heavy handed. I helped him up and he went into the kitchen for a knife and tried to stab me. I was angry both with him and with the Ambulance Service. I felt fear as not in control and I realised the uniform is no protection from danger".*

This account confirms Tangherlini's (1998) exposition that danger lies just beneath the surface of the role and can flare up any time, making unpredictability an undisputable key characteristic. The following account I label D1, offered by F12 (2008: 76-91),

endorses how quickly a passive situation can change into an intense emotional demand,

> *"A nothing job at the beginning. Somebody who had basically fallen asleep on the bus and the driver could not wake them up so we went and it was a young lad who was drunk and he had fallen asleep. He was fine at first and we had a bit of a laugh then all of a sudden he turned nasty and he blocked our exit to get off the bus. He stood in the doorway and pulled a screwdriver out of his pocket and said he was going to kill us. There was myself, another observer and the other paramedic on the bus and we were stuck on the bus with him for about five minutes. Luckily the person I was working with saw what was happening and she managed to get the police and they came and arrested him – that was pretty scary. It wasn't even one of those jobs where you thought this could be a bit dodgy here. You had no warning of it at all. He was so…. and I really believed that he was not joking. He actually had a mobile in his pocket and he rang the police on his mobile and said you had better get another ambulance down here because I have got three paramedics on the bus and I am going to stab them to death".*

The job is degraded when 'dirty work' associated with intoxicated patients defines its content, as M21 (2008: 96-100) comments,

> *"Weekend night shifts you come in and you know all you are going to do is mop up vomit off drunks. Last weekend night shifts I worked I had three people in a row who actually vomited on me, at times you just think you know what am I doing here".*

However, when those who have drunk too much decide they are safe to drive a car the anger management they provoke escalates. I do not observe any drunk drivers but one of my volunteers mentions how *"drink driving incidents require a lot of emotional control*" (F22, 2008: 46) which she explains is due to their untimely, often messy but entirely preventable consequences. As there are 8,620 drink-drive accidents in 2008 across Great Britain involving 12,990 casualties and 400 fatalities (DFT, 2010) this particular drain on the paramedics' emotional resources is not inconsiderable.

The alcoholics I observe exhibit various degrees of delirium tremens brought on by withdrawal. On one run to an emaciated male in late middle age living alone I observe how the paramedics' clinical mandate extends into a compassionate gift. As one paramedic comments, "*you are sort of everything in this job.....you are a bit of a marriage counsellor, social worker, childminder*" (F11, 2008: 750-752) and certainly on this occasion the patient's need is more social than medical. His claim of persistent abdominal pain triggers the emergency response but his physical condition does not warrant a clinical intervention. However, his home is filthy with excrement trodden into the carpets and mouldy crockery strewn around so the paramedic goes into social worker mode and arranges for a community health practitioner to visit before we leave. However, a few hours later we are summoned to return as no visit materialised and later that day he diverts an emergency resource for a third time. Between April 2008 and March 2009, NEAS attend 7,056 individuals for alcohol-related problems (Rae, 2009) which roughly equates to twenty a day. As the North East has a higher incidence of drinking carrying risk of harm than any other region of the UK (DOH, 2005c) and hospital admissions for liver disease are also higher than the national average (NEPHO, 2006) alcoholics also form a significant routine cohort.

The alcoholics along with the smokers and drug users are classed as addicts. Although the paramedics recognise addiction is a strong and habitual desire that significantly reduces willpower and leads to significant harm (Pickard, 2012) they also consider it can be overturned and therefore these patients are agents of their own predicament. However I find myself sympathetic particularly towards those whose emergency call is due to smoking as my father had been a smoker which made me aware of how difficult it can be to give up. Accordingly I feel a profound sadness on a run to one of the 41,000 new cases of lung cancer diagnosed each year (Cancer Research UK, 2011). The patient's wife calls '999' when his pain becomes too much. She reveals he had been in pain for sometime but did not want to cause a fuss. His dignity and that of his family are admired by me and the crew who comment on his bravery as they could tell by his body odour he did not have long left to live.

Smokers also present with emphysema, a form of Chronic Obstructive Pulmonary disease [COPD] for which smoking is responsible for 80% of cases (Petrie, 2005). It normally strikes heavy smokers particularly males between fifty and seventy years of age and is incurable. One sufferer calls '999' during an acute breathing crisis although

he is only in his mid forties and struggling to breathe even with oxygen assistance. He has been unable to stop smoking even though he knows it will make him one of the 29,100 who die slowly from chronic lung diseases each year (ibid). As a non-smoker I cannot identify with the strength of his compulsion or why his predicament does not influence those paramedics who smoke to abstain. I am left with the view their immediate need to de-stress outweighs any long-term consequences not yet symptomatic. Across Great Britain, 21% of those aged sixteen or over, smoke and of those, it is the heavy smokers who are least likely to quit (ONS, 2009b) making this group another recurrent user of emergency care and trigger of emotional labour.

Drug users present as overdoses of either Class 'A' or Class 'C' drugs. One run to a Class 'A' overdose of Heroin finds the patient unconscious. He requires a pharmacological intervention in the form of the opioid antagonist Naloxone commonly referred to as Narcan which is carried on emergency ambulances to reverse acute overdose and respiratory depression. But as this individual is unconscious he also has to go to hospital. The paramedic I am with draws the antidote but he withholds it until we are close to A&E. He explains the patient is powerfully built and likely to be aggressive on coming round and he does not want either of us to be harmed. As the patient is unconscious this does not cause me any anxiety. But when his aggression materialises just after handover I realise how close I was and the perilous position the paramedics are placed in by this type of patient.

Another Class 'A' overdose I observe involves Cocaine when a regular user increases their dose from one to four grams. The level of stimulation he experiences is more than he anticipated and he calls '999' but the paramedic is quick to diagnose a panic attack. This requires anxiety management and a certain amount of suppressed amusement as the patient's girlfriend turns up threatening to dump him on account of his out of control habit. Each of those two overdoses exposes the paramedic to potential harm from an individual but a third overdose of the Class 'C' drug Cannabis exposes the crew and myself to a known drug den. The patient is experiencing breathing difficulties and chest pain but he declines hospital admission following advice on how to relieve those symptoms. It is an uncomfortable, intimidating atmosphere as everyone is aware of the illegal status of the activity but it is ignored out of fear of reprisal. Between April 2008 and March 2009, NEAS attend 3,604 patients for drug-related symptoms (Rae, 2009) emphasising how this subcategory also represents a significant emotional demand.

Another cohort of patients I routinely observe exhibit some form of mental distress I categorise as 'Mental Illnesses' to which I link the deductive codes: 'adult'; 'non-urgent' and 'low skill' and inductive codes: 'self-harm'; 'suicide attempts'; 'anger'; 'anxiety'; 'fear' and 'unpredictable'. I do not link dementia as the paramedics do not refer to it and I do not observe any patient exhibiting that condition. The paramedics single out adults with mental illnesses because they are unpredictable which exacerbates anxiety and induces fear as can be determined in the following vignette I label Psych1,

> *"A certain incident happened with a crew that was really stressful. It was a psyche patient, police were called, he absconded naked from the scene, they found him, put him on the back of the motor and he promptly snapped fingers. `There you go look at that`. Obviously he just was not there. He assaulted the crew, he trashed the ambulance. This guy he drank pepper spray like it was coke. It took seven coppers to get him on the floor so obviously a frightening situation because really they are the most unpredictable people the psyche patients and you don't know what they are going to do especially if they are at that stage. Being in a confined area like the back of an ambulance there is not a lot you can do, bearing in mind it has taken so much force to put him down. They have got to the hospital with three coppers sat on top of him on the stretcher"*
>
> M12, 2008: 223-236.

I include those that self-harm within this subcategory as their practice of secretive, compulsive and destructive behaviour is considered a sign of mental distress (Mental Health Foundation, 2014a). Self-harmers represent the group of patients I personally find disturbing but this is due more to the inadequacy of the mental health service than anything else. One run I label SH1 actually starts out as an urgent response to a young female claiming to have swallowed a copious number of Paracetamol tablets. On arrival it becomes clear she is known to the ambulance service for carrying knives and I am asked to remain in the ambulance. I feel annoyed as as I had not been subject to a similar request but this soon disappears when the crew return and I detect unease between them. They report the patient sat waiting for them with a carving knife by her side and as they exchange banter over the size of that knife their fear momentarily

surfaces. My anger turns to gratitude for their consideration of my safety but this is swiftly overridden when I spot the patient approaching the ambulance. She is however quickly intercepted and kept talking until the police who had been automatically alerted by Control arrive. The paramedics discuss how they have to put speed first in a Paracetamol overdose which requires suppression of anxiety and amplification of confidence in order to project their authority and stay in control.

This patient had not taken any tablets but had cut her arms and rung '999' for attention. She is reclassified as non-urgent but taken to hospital following a police search as a precautionary measure. Another incident involves a young man who has cut his arms and swallowed the razor blade. He is another frequent flyer [regular caller to '999'] with the same modus operandi so his need for a mental health intervention has also been inadequately met. Yet another frequent flyer who I also encounter makes sixty '999' calls in six months (Wearmouth, 2009) so it is no surprise to note hospital records rank the North East top of hospital admissions due to self-harming (NHS, 2011d). As one in three self-harmers repeat within one year (Royal College of Psychiatrists, 2007) I foresee these patients continuing to test the paramedics' clinical mandate and moral responsibility in addition to exerting an emphatic demand for emotional labour.

Suicide attempts are voluntary acts but as 90% of these are the product of some form of psychiatric disorder (Mental Health Foundation, 2014b) I include them in this subcategory. These patients are, as I observe, subject to a moral judgement and as a consequence more likely to prompt anger rather than sympathy from my participants. M22 (2009: 56-58) voices the majority viewpoint they represent an abuse of a limited emergency resource, following a run to a suicide attempt by a young woman who has taken a quantity of Amitriptyline [anti-depressant] tablets,

> *"These people do not mean to kill themselves and they repeat time and time again, using up resources for what?"*

I shrug my shoulders in reply, as I consider mental illness is provoked by circumstances outside an individual's control and therefore the mentally ill need sympathy not rebuke. I find quite a number of my volunteers have attended not just one suicide attempt by hanging but several and my story, S1 when pressed to recount what incidents I have attended holds no interest. During 2008, male suicides total 3,263 and female suicides

1,019 in England with those figures rising in 2009 to 3,330 and 1,060 respectively (ONS, 2012). As hanging is the male suicide method of choice (Biddle, Brock, Brookes and Gunnell, 2008) those statistics equate to eight per day so it is an incident most, if not all paramedics will encounter particularly within NEAS, as the North East tops the regional statistics (NEPHO, 2008). This subcategory of patients form part of the paramedics routine work as mental disorder affects one in six of the population within the UK (Mental Health Foundation, 2011a) with a higher than national average in the North East (NEPHO, 2008). This prompts me to express my hope the Crisis Care Concordat (DOH, 2014) will deliver an improved mental health service.

Another cluster of patients I explain as routine are those recognised as having an illness prone to bouts of deterioration requiring regular intervention I categorise as 'Chronic Illnesses'. I link the deductive codes: 'adult'; 'non-urgent' and 'low skill' along with inductive codes: 'COPD'; 'Cancer' and 'sympathy' to this subcategory. Patients diagnosed with COPD due to airborne pollution, genetics or a consequence of childhood lung disease (British Lung Foundation, 2011), are included in this category as the only intervention the paramedics can offer is transport to hospital. I observe one patient struggling to breathe even when assisted by oxygen and a nebuliser who asks to be left alone to die rather than go to hospital prompting a wave of sympathy from both me and the rapid responder I am with. As a progressive condition affecting around three million people across the UK for which there is no immediate prospect of a cure, COPD represents a continuing routine demand on the ambulance service. Patients with cancer form a similar demand as every two minutes across the UK a new case is diagnosed (Cancer Research UK, 2015) with the palliative control of pain, as I observe, involving the ambulance service each time the pain escalates with transport to hospital again the only remedy paramedics can offer. All of these patients classified as routine share the common characteristics of a non-urgent run requiring a low level of skill which as a consequence induce boredom in the paramedics which they have to control.

Patient interaction I explain through the subcategory 'Emergency' links the deductive codes: 'adult'; 'child'; 'urgent'; 'immediate death'; 'trauma'; 'save'; 'buzz'; 'enthusiasm'; 'legitimate' and 'high skill' to which I inductively add: 'asthma'; 'diabetes' ; 'sympathy' and 'maternity' through which I recognise both births and miscarriage. Although patients in this subcategory both adult and child are eagerly anticipated as they represent a legitimate run with most requiring a high level of skill

the paramedic has to suppress their enthusiasm in order to present an appropriate demeanour particularly when the patient represents an immediate death. Until a death is certified it is suspended and the patient regarded as a potential 'save' which legitimises the run (Mannon, 1992). Although the patient does not interact hence the dotted line on the interactional map the paramedic still has to manage emotion aroused by their presence to benefit themselves, others at the scene and patients subsequently encountered. I observe an immediate death on my second shift out in the field when an elderly gentleman with a terminal illness passes away. But his wife of long-standing is unable to let him go and telephones for assistance. There is no 'DNR' order so the paramedic crew have no choice but to administer CPR as rigor mortis is not established. I assist in the futile attempt encapsulated in the comment *"we were on a hiding to nothing there"* (M11, 2008: 615-616). Although the lifesaver identity carries an obligation to suspend death that is rarely achievable this paramedic hopes otherwise, as he subsequently comments, *"it did not have the full outcome that we would have liked"* (ibid: 614-615) with which he reveals his disappointment. Altogether I assist in three attempts at CPR on a patient whose 'death' cannot be reversed and each time I share a veiled disappointment with my participants.

There are two other deaths I observe to which I attach the label 'S1' to the first. This signifies the suicide of a young man who has hung himself from a tree on a patch of waste ground using a dog lead. Although he is still warm when the crew and I arrive he is found on examination to be beyond help as his neck is broken. The knowledge death has come quickly and he has not suffered as he would have done through suffocation is no consolation and again there is a sense of disappointment a save is not achievable. At the second death I am advised to breathe through my mouth on approaching the corpse as his appearance [swollen torso below a battered skull covered in mould and congealed blood] suggests his death is not immediate but occurred some days previously. The police also attend and suspecting foul play take control which excuses the paramedic I am with from having to certify the death. It is with a genuine shared relief rather than disappointment on this occasion that we turn our backs and walk away.

The immediate death of a child is always emotive and demanding particularly when the danger of co-sleeping, a well documented source of sudden infant death syndrome [SIDS] (BMJ, 2013) has been ignored. F23 (2009: 58-60) recalls one incident in which,

"A two year old had been lying with mother on the couch and she had fallen asleep and woke to find the baby dead".

Having to attend a SIDS is not uncommon but for that paramedic the emotional demand is exacerbated by its familiarity which I discuss later in the chapter,

"My crewmate had a baby exactly the same age at the time and it was really hard to keep it together".

Copious amounts of emotional labour are required with children as M12 (2008: 253-257) testifies,

"You know you can't burst out into tears in front of a family and sometimes you get a tear in your eye when its children you can't help it. I am quite unemotional when it comes to being in the job but I have had tears in my eyes and had to fight them back when I have been trying to resuscitate a bairn".

The majority of my participants when asked to describe their hardest run inevitably involve a child either as the patient, as in CPR1, as M17 (2009: 64-66) recounts,

"The worse job I have ever had was that one year old who was crushed when a patio door fell on her. I was on scene doing CPR for fifteen minutes before a crew turned up. I knew it was hopeless but you try and keep on trying, for the parent's sake".

Or as a significant member of the scene, as M11 (2008: 463-470) recalls,

*"It was a hanging. Family found him, daughter found him, they had a little daughter, in a cul de sac, hung best part of *,hundred people out of the cul de sac looking and I walked out with the bags but coming towards me is a seven year old girl asking 'Is my Daddy going to be alright' I held her and as I said to you the other day, you don't ever lie to anybody, tell the truth and use the word 'dead'. I said 'I'm sorry honey we did everything we could but I'm afraid*

Daddy is dead' and I picked her up and took her into next doors house.....that was hard".

This vignette emphasises how an incident completely void of clinical skill can be fully demanding of an individual's emotional competence. Although children are absolved of any responsibility regarding their condition and consequently awarded a legitimate emergency status, incidents involving a child do not excuse the parents who I observe on a couple of occasions are rebuked for calling '999' instead of taking their child straight to A&E. There is also another aspect to the role in child protection as M11 (2008: 406-408) reveals,

"We could go to one where the kids have obvious signs of abuse or it could be the case that Mum and Dad are complete and utter idiots, have not got a clue about how to look after the kids".

Paramedics are trained to spot signs of abuse and/or neglect that they are obliged to report to the relevant authorities even if, they are attending another member of the household. In those instances M11 (2008: 403-404) informs me *"you don't want to make known your feelings of what is going on to likes of people in the house"* in order to retain authority. Arranging protection exacerbates demand as the paramedics have to control their frustration in addition to any distress associated with the situation.

The vast majority of patients I observe are however adult and alive of which there is an infinite variety, as F13 (2008: 363-364) explains,

"You never get two people the same. They can have the same symptoms but the person is different".

Although I do not observe any patient in the throes of an asthma attack the UK has one of the highest prevalence rates in the world (Asthma News, 2012) and a number of my participants have witnessed an attack which they all report is horrific making them thankful they do not have the condition themselves and genuinely sympathetic towards those who do. Also in this category I include diabetics as without prompt treatment death is inevitable and this knowledge creates a sense of urgency and covert anxiety.

Patients with Hypoglycaemia I find very satisfying to observe as rapid assessment/ treatment transforms them within twenty minutes from barely conscious to full of good humour and apology. As F33 (2009: 73-740 remarks,

> *"They often present as a possible stroke and then after taking glucose they soon recover and go from being silent to extremely talkative"*.

With five hundred new cases a day adding to the 2.3 million already diagnosed with diabetes creating an expectation of four million by 2025 (Diabetes UK, 2010) I consider the ability of paramedics to diagnose and remedy both hyper as well as hypo states has to represent a skill largely ignored but on which society is fast becoming dependent.

Although births are regarded by some of my participants as routine I explain these as emergencies because outside of hospital they are rare constituting less than 3% of the total (ONS, 2010). Trainees eagerly anticipate a birth as F16 (2009: 65-69) remarks,

> *"Best job of all was delivery of first baby. We had just arrived on to the labour ward and the midwife asked me if I wanted to continue looking after the patient as she was just about to deliver that was great as I was able to deliver the baby in a good environment with all the support I might need at hand".*

Although F16 avoids the unhygienic, cramped, unsupportive and technically deficient environment of the ambulance and achieves, along with a good outcome, a story to share in which she can cement her road crew membership (Palmer, 1983a) births do not always constitute a good experience as M31 (2008: 100-102) explains,

> *"I had a breech birth, which started out Ok. The baby's bottom and legs came out and they were wiggling but he was stuck and there was nothing I could do about it and he died. I will never forget that job".*

His experience is unfortunate as a normal delivery is the usual outcome (Lingen-Stallard 2009). However, I observe a palpable relief among the more experienced when a birth is

avoided due to a shared biography of what can go wrong. Miscarriage exposes the paramedic to an example of 'dirty work' which can carry an inordinate demand for emotional labour as the account offered by M11 (2008: 365-389) I label PD1 for future reference reveals,

> *"All we got was she is twenty weeks with stomach pains. Got to the house and she had given birth in toilet. I rolled my sleeves up and put my hand down the toilet. Got a towel, picked it out and wrapped it up like a baby and took it down. What affected me more than everything else was she was sixteen, she had only told her Mum and Dad a couple of weeks previously. She had a boyfriend. It was not your typical bloody sixteen year old lass that had got pregnant by some scrote. He was a lovely little sixteen year old lad. He was heartbroken, she was heartbroken, Mum and Dad was heartbroken. We have got the baby here, I have come to ambulance with baby, put it on front seat and put fucking seatbelt round it like you know and come back in the house. She did not want to see it and I said you don't have to but she is with me and she is going to be fine. We will look after her. I just said to her 'Look can I just ask you a favour sweetheart', she said 'What's that', I said 'You look like you could do with a bloody big hug and I need a hug and all'. It was just like holding my daughter, we sorted it out and we talked about it and it was fine".*

Although an empathetic response makes the situation bearable for that teenager it represents a strain on the attendant paramedic who forms an attachment to the patient even though their contact is of a short duration.

Those patients Boyle (2005) labels 'urgent' and Palmer (1983a) labels 'trauma' I observe taking the form of an RTA, heart attack or a combination of the two. A paramedic's ability to swiftly extract information from the patient leading to an ECG being performed is, I observe, vital to a motorcyclist involved in a collision with a car. His ECG reading is faxed direct to the local Coronary Care unit allowing staff to anticipate his arrival. Having the right expertise on hand and the right drugs available as

the patient comes through the door makes a difference to both survival and recovery as the following narrative given by M11 (2008: 601-612) highlights,

> *"I mentioned before that acute MI the other night. I went in, looked at him knew he was ill. Twelve lead diagnosis straight away, he got the full range of the drugs he could have. I got good access quickly; I was complimented on it by the person I was working with. Short, sharp triage, in fact I was getting venous access while they phoned up. I said tell them I will phone them back as I am getting IV access now.. that was done. Got on the phone to *. Get him in, got him in. Followed it up next day with a phone call: 'How is * doing?' 'He is up and about having a shower, going to discharge him tomorrow'. He had left anterior descending coronary artery high up that was why it was a widespread anterior MI...'Thanks very much. Just tell him the paramedic who attended was just asking after him', 'Ok * no problem' and I felt fucking brilliant".*

The buzz associated with a 'save' which more than makes up for the tedium of the routine workload is compounded when the patient is young, as F21 (2008: 41-42) comments, *"a fifteen year old in cardiac arrest, he was successfully resuscitated that success makes it all worthwhile".* Saves are few as the odds of successful CPR are low as previously discussed. As a consequence they are celebrated albeit quietly and form a vital ingredient of job satisfaction. They also give credence to the argument by Palmer (1983a) that saves preserve the integrity of the lifesaver image.

The most memorable traumatic incident I attend results from a collision between a car and a motorbike I briefly referred to in the previous chapter where I labelled it T1. I accompany a rapid responder early one morning to the scene of an RTA to find a young male motorcyclist lying in the middle of the road thrashing about quite violently albeit soundlessly. The police have stopped the traffic so it is eerily quiet. The motorcycle lies prone on the ground beside its rider, allowing petrol from a damaged tank to seep out and mingle with blood to form a large acrimonious pool. The rapid responder advises me the agitation in the patient is indicative of a major head injury and he is quite likely to die before further help arrives. Stunned by this expectation I am genuinely relieved to be asked to comfort the young female car driver who is in shock but this does not last

long as I am summoned back to help. I am asked to apply traction whilst the paramedic removes the biker's helmet. As I kneel in front of the paramedic I am forced to confront the possibility part of the young man's head may come away with his helmet or brain tissue may spurt into my face as I had been exposed to many stories by my other participants in which this had occurred.

Although I admit to feeling anxious almost fearful I am also conscious of wearing a high visibility jacket emblazoned with the word 'Ambulance' and therefore I need to behave in accordance with the expectations attached to that label. As I have witnessed a post mortem as I previously mentioned I know deep down I can cope but it is still a relief to see although swollen and bruised the patient's head is intact. However, he has two deep neck wounds which are now exposed and haemorrhage freely all over me. However, this is swiftly abated by a pressure pad given to me to apply so the paramedic I am with can set up an IV. In due course the air ambulance arrives and the patient air lifted to hospital leaving my participant quietly satisfied whilst I am elated.

Across the continuum patient demand is further explained through the two deductive subcategories: 'Pleasing' and 'Displeasing' to which I link the deductive codes: 'pleasant'; 'compliant' and 'trust' to the former and 'hysterical'; 'apathetic'; 'angry'; 'belligerent'; 'hostile' ; 'frightened'; 'expectations'; 'similar'; 'familiar' and 'trust' to the latter along with an inductive code: 'sad'. Displeasing interaction I argue represents the greater of the two demands due to the variety of emotion that has to be managed. However, the vast majority of patient interaction I observe form pleasing exchanges in which the patient complies with all requests for information and treatment decisions. Trust is however recognised as having to be earned, as M11 (2008: 436-438) indicates,

> *"You have got to sell yourself....you have got to make the person you are dealing with feel like the most important person in the world regardless".*

This also applies to patients who form a displeasing interaction due to their additional demand. M21 (2008: 235-240) confirms this includes both those who are hysterical and those who are apathetic,

> *"Sometimes you get people who are absolutely hyper and you think*

well this is a minor problem but you still have got to respect the fact that to them it's a major event and you get others who are having a major event and they don't comprehend what is going on and you have got to manage them differently".

The link to the unpleasant patient I evidence in a remark by F11 (2008: 721-725),

"I go into every job open minded and just think I will find out when I get there. You try to be personable and friendly and nice but with some people that does not work because they are not nice people or whatever you do you cannot do enough. You do your best and you really go over the top and it is still not enough".

The hostile patient is evident in the comment, *"we take a lot of abuse and can be assaulted"* (M22, 2009: 30) which prompts me to examine the statistics where I find a quarter of the staff on the frontline for NEAS report receiving physical violence or abuse from patients during the year my fieldwork takes place which is above the average for the ambulance service (CQC, 2010) which in itself is subject to greater levels of violence and abuse than any other part of the NHS (BBC News, 2004). In further remarking, *"we have to take it without giving any back"* M22 (2009: 56) confirms the hostile patient is a significant demand. Although F11 (2008: 748-753) agrees angry, belligerent patients are demanding she also indicts sadness,

"*If people are angry or aggressive you have got to try and contain that and it goes the other way as well, if people are very sad you have got to try and obviously not cheer them up but try and reassure them".*

Expectations I evidence relate to how patients as knowledgeable consumers of healthcare expect to exercise choice. F11 (2008: 693-697) explains their demand,

*"People always ask what hospital they are they going to. You just know as soon you say which hospital they are going to its, 'Oh well my notes are here can I not go to the * or wherever'. You seem to be defending your actions and it gets a bit tiresome sometimes".*

Similarity makes the patient encounter displeasing as F33 (2009: 54-56) comments, "*you tend to identify with situations and that can make things harder to deal with"*. It is particularly poignant for parents as Lewis (2005) intimates in chapter one and F23 revealed earlier. However, similarity is not limited to filial reminders, as M38 (2009: 82-85) comments,

> *"The first time I was in * after my mother died in A&E, I was directed to the same cubicle. Another example is being sent to a job and the person has your name and is the same age or, as in the case recently the patient was in bed that was exactly like my own, same cover and everything".*

The additional demand associated with familiarity is poignantly etched in the following vignette offered by F13 (2008: 442-462),

> *"There is only one particular job that I will never ever forget and it was nothing traumatic and it was nothing out of the ordinary. It was someone who went into cardiac arrest and we got the job and we did what we had to do but half way through what I was doing I looked down and I knew him. So like I was stumped that I didn't recognise him straight away to start with and then I went in to 'I know you mode' and started organising. Not only did I know him but he lived three doors away from us and his little children played with my little children and he was playing golf and he was with his mate and I said to his mate 'Do not phone * so that was how I organised. I rang me Mam and told me Mam what had happened. 'Don't tell * but tell her to come to the hospital.' * was waiting for us as we came out after dropping him off. * had just turned up and she was joking on, 'That stupid bugger, fancy playing golf when he was not very well' and I'm going, 'He's dead.' He was dead at forty-two. When I got home the kids were sitting on me step - 'Me Mam says me Dad's dead and you were there'. It was such an accusation and I went 'Yeah' and off they went and not one of them has spoke to us about it".*

Familiarity extends beyond the patient and the run in that particular narrative to intrude

on social and private spaces. It takes on a critical hue due to the poignancy of the connection as Regehr, Goldberg, Glancy and Knott (2002) identify in chapter two.

As the majority of the paramedics in my sample live in the catchment area for their station it increases the likelihood they will, at some point, have to attend someone they know but they do not look forward to that possibility, "*I dread having to attend someone I know"* (F16, 2009: 79) as it places an additional demand on their social skills [overcoming any embarrassment or intimidation felt by either the patient or themselves for example] and increases their level of responsibility as they know they will be held to account. This concern is exacerbated for Community Paramedics, as F23 (2009: 29-32) remarks, "*patients and potential patients will be known and possibly seen regularly so it will be difficult to keep them at a distance"*.

These findings indicate patient interaction is diverse and can be explained as a continuum anchored at one end by those taking the metaphor of 'Taxi' and the other by those taking the more concrete descriptor of 'Emergency' with the 'Routine' sandwiched between. The paramedic connects emotionally with each patient a few minutes before their physical encounter when Control advises them of their preliminary details. This either raises expectation or indifference depending on the nature of the patient's complaint. With respect to the first the paramedics' joyful anticipation of an emergency has to be managed whilst in respect to the second anger has to be restrained in order for the paramedic to greet the patient in a professional manner. Accordingly I argue the biography of prior expectation I identified in chapter one but which did not contextualise is appropriate to the paramedic role and I add this inductively to each subcategory.

Within each subcategory I find demand also varies according to whether patient interaction categorises as 'Pleasing' or 'Displeasing'. However, there are exceptions. As Tangherlini (1998: 139) remarks "young children are the epitome of the innocent victim" and consequently they form a pleasing interaction even if their complaint does not require an emergency response and familiarity like similarity, inevitably form a displeasing interaction due to the extra demand. This diversity, according to Morris and Feldman (1996), correlates to a high demand for emotional labour. When I evaluate the MERI inventories relating to patient interactions I find twenty-five paramedics [69%] perform a very high level of emotional labour with patients and a further nine [26%] a

high level. As I illustrate in Figure 4.3 only two paramedics score above ninety so although the majority of paramedics in my sample concur,

> *"You need to acknowledge you have emotions as they are essential for doing the job well"*
>
> M35, 2008: 23-24.

there is a minority thread detracting ever so slightly from the weight of that conviction. As the Communications Director (2008: 108-112) indicates *"about 7% of all calls we attend are genuinely life threatening"* I endorse the finding by Boyle (2005) paramedic emotional labour is mostly performed across their non-urgent workload.

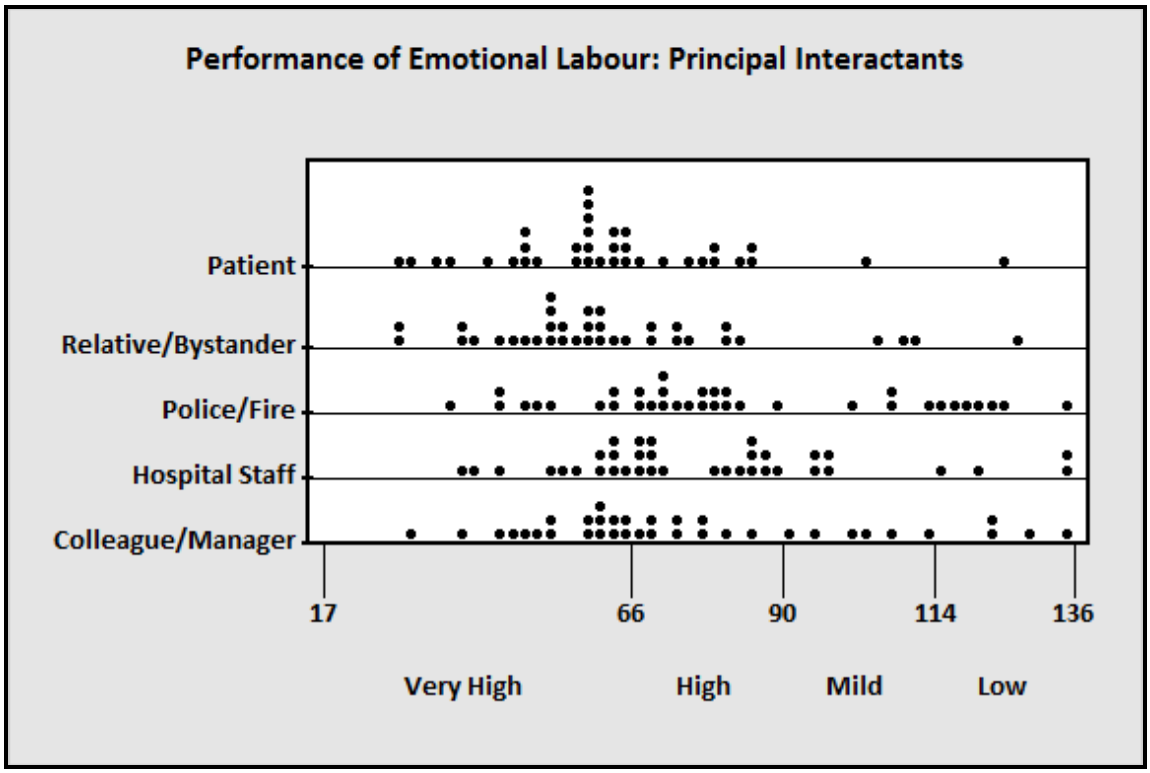


Figure 4.3: Emotional Labour: Meri scores for principal interactants.

The clinical mandate extends to both relatives and carers as the patient encounter is rarely singular and their input is often, as I observe, vital to diagnosis and treatment decisions. I explain these encounters through two inductive subcategories: 'Agreeable' and 'Disagreeable' to which I link deductive codes: 'anxiety'; 'helpful'; 'deferent' and 'grief' to the former and 'indifferent'; 'ignorant'; 'fear' and 'aggressive' to the latter, of which M11 (2008: 411-422) provides a prime example,

> *"On jobs where you have got a seriously ill patient with a broken neck, broken femur, 03:00 in the middle of *, you know he is a scrote who has been up to no good and that patient's Dad comes running up that is the size of Giant Haystacks and starts ragging you about and picks up the patient saying 'Come on son' and he has got a broken neck and you are trying to get him out of the way and all he wants to do is beat you up. You are trying to act professional, not inflame the situation, protect yourself, protect your patient, and protect your name. Umm and wanting to beat the hell out of the guy that is doing this to you because you know between the two of you could give him a right good kicking - you know what I mean. You ignore that. You have got to like say 'Sir, will you please stand back and let us carry on with the job, if you want to help us, if you stand here and hold that'. We try and give them something to do".*

As Allen (2000) comments in chapter two and M11 reveals, illness generates a communal response which requires, according to Palmer (1989), an air of authority in order for the willingness of relatives or carers to offer assistance not to turn into interference with the added risk of harm to the patient however unintentional. The majority of encounters with relatives I observe place them in the 'Agreeable' category as they helpfully provide information and gladly defer to paramedic instruction. I observe in particular how those hovering anxiously but without malice in the presence of a patient who has collapsed, defer to being gently shepherded away by my participants to avoid them witnessing the brutality of CPR. On each occasion they wait patiently for the outcome and although they are grief-stricken they react with appreciation and gratitude when given sad news but M32 (2008: 30-31) suggests those relatives can also become disagreeable,

> *"Having to tell relatives their loved one has not made it is very stressful as their reactions are unpredictable".*

Relatives can also impose an additional demand in the form of a protective web, as M28 (2008: 54-55) indicates, *"I am always honest with patients even those who are dying except when the family wish otherwise"* to again attract that label disagreeable. I find interaction with relatives through my evaluation of the MERI scores for that category in

which twenty-four out of twenty-seven scored are below ninety [89%] with seventeen below sixty-six [63%] entail a high to very high level of emotional labour. Although I do not ask my participants to score an interaction with a carer I propose these are not that dissimilar as I observe a contrast between those that are helpful and those that are indifferent when attending a patient in the confines of a residential or nursing home.

4.2.2 The Professional Mandate

Through my theme 'Professional Mandate' I explain the demand for emotional labour made by interactants in the two categories: 'Emergency Services' and 'Hospital Staff'. Encounters with emergency service personnel split into the two deductive subcategories: 'Police' and 'Fire' and I identify two subcategories inductively: 'Respect' and 'Disrespect' which distinguish interactions across both. I link the deductive codes: 'helpful'; 'mutual respect' and 'friend' to the first subcategory and 'authority'; 'arrogance'; 'rivalry' and 'contempt' to the second along an inductive code 'resentment'.

All interaction I observe with police officers and discuss with my participants I categorise as 'Respectful' as these relationships are described as "*brilliant*" (F32, 2008: 83) due to an acknowledgement of boundaries and deference to paramedic authority, as evidenced by M23 (2008: 150-151), *"they don't want to touch on to our domain so they call us out for anything that is medical"* and professional acknowledgement which M24 (2008: 167-168) evidences, *"the police are more supportive and appreciative and see paramedics as on a par"*. Respect is mutual as each relies on the help of the other. M16 (2008: 27) in commenting "*we rely on their support particularly on a Friday/Saturday night"* draws attention to how the paramedics rely on police protection particularly from drink induced violence over the weekend but in removing the injured swiftly from the streets they help the police regain their authority and mandate of an orderly community leading to many becoming "*friends*" (M24, 2008: 152).

In contrast I categorise interaction with the fire and rescue service [FRS] 'Disrespectful' as the paramedics describe those relationships as *"a bit iffy"* (M31, 2008: 76) due to rivalry over the medical authority and the arrogant manner in which the FRS fracture its boundaries, as M16 (2008: 29-31) intimates,

> *"A paramedic has clinical responsibility for patients but that is not always acknowledged by the FRS who will try to take over at an RTA for example and reach for the cutting gear when it is not necessary".*

A perceived lack of activity adds contempt, "*they hardly get called out perhaps once a week and they get paid far more than we do"* (M21, 2008: 326-328). Across the UK in 2007 [the last complete year for which statistics are available prior to my fieldwork] the FRS attend 800,000 callouts (Communities and Local Government, 2009) whereas the ambulance service in England alone attend 6,000,000 emergency calls (NHS, 2008a) to offer substance to this bone of contention. Added to which is a simmering resentment over a disparity in pension arrangements,

> *"Biggest issue for me is that of pension rights. We should be entitled to the same rights as the other emergency services. Feel more valued if that was the case"*
>
> M34, 2008: 115-117.

At the root of this lies the attachment of the ambulance service to the NHS whilst the FRS and the police are attached to the Home Office. As a result both benefit from preferential terms which allow them to retire after thirty years service on a full pension (Hill, 2006; Thurley, 2011) whilst a paramedic has to work forty years (NHS, Pensions, 2012). Although this resentment should apply to both the FRS and the police I find the FRS bear the brunt of all hostility.

However, not all interaction with the FRS is characterised by disrespect. The strain of maintaining an overt professional relationship is reduced when both services share a station, *"with more shared stations I think barriers are starting to break down"* (M24, 2008: 166-167) or share training, *"we do training with them which helps us appreciate each other more"* (M25, 2008: 92-94) or public service events *"I do the 'Learn and Live' road show which is brilliant.....we have been with these firemen for three years and we like doing it"* (F21, 2008: 91, 95-97). Respect also categorises interaction when FRS officers are retained, *"there is a good relationship with the retained fire fighters but not the regular fire crews"* (M28, 2008: 92-93) as increased contact and awareness of each other's role helps to foster friendships. The contrast in demand for emotional labour between the two emergency services is emphasised by the MERI scores which

show a greater demand from the FRS with 81% of scores under ninety compared to 60% for the police.

Encounters with 'Hospital Staff' divide into the two deductive subcategories: 'Doctor' and 'Nurse' and interaction with both I explain using two inductive subcategories: 'Professional Regard' and 'Professional Disregard' to which I link the deductive codes: 'respect'; 'trust' and 'friendly' to the former and 'ignorance'; 'medical authority'; 'subordinate'; 'condescending'; 'threat'; 'anger' and 'dismissive' to the latter. Nurses are demanding because, as F33 (2009: 85) remarks, "*they see us as a nuisance*"and this disregard of the paramedic leads to interaction routinely provoking the control of anger. I observe how this is particularly evident when A&E departments are busy and the paramedics have to stack patients on trolleys in corridors without the admitting nurse acknowledging their presence. But it is more apparent as new patients are appraised as routine or worse still, as a frequent flyer. In those circumstances, the attendant paramedic is discredited by the lack of interesting symptomatology which, as I explained in chapter two, diminishes the thrill for A&E staff. M13 (2008: 135-136) in remarking how, *"a lack of respect is evident when A&E nurses walk away during handovers, it is belittling"* confirms nurses are dismissive and exhibit a total disregard for the paramedic.

However, when the service is less frantic, interactions are friendlier and carry more regard although I observe how some A&E departments even when they are busy always receive the paramedics with professional courtesy and others not so busy exhibit, *"disinterest in what you have to say and keep you waiting"* (M17, 2009: 92) for no apparent reason. One paramedic considers admitting nurses do this on purpose to remind the paramedics they are *"beneath them in the hierarchy"* (F14, 2008: 83) whilst M28 (2008: 105-106) suggests their hostility is related to a perceived threat to their medical authority, *"I think there is some jealousy as to what paramedics are able to do and also some condescension.* M12 (2008: 421-422) offers an explanation for the former, *"we don't have to run to a doctor and say shall we give him this, can we give him that, you know take instruction".*

Certainly the paramedics are able to administer a wide range of drugs including Morphine and intubate an unconscious patient for which most nurses are not licensed. Each of my participants reports condescending remarks made by nurses but I select

"*there must be a lot you can do with bandages"* (M23, 2008: 758-759) and the ultimate insult, of a nurse informing a patient awaiting transfer, "*their taxi is here"* (M16, 2008: 33) as illustrative. Ultimately ignorance is indicted as the cause of 'Professional Disregard' as M21 (2008: 300-301) comments, *"paramedics are not taken seriously by nurses who don't seem to know what paramedics can do"*.

Relationships with doctors are mixed as M31 (2008: 72-77) comments,

> *"It's a mixed bag in terms of respect from A&E staff* as s*enior doctors tend to be Ok but junior A&E doctors are not so respectful*".

As F14 (2008: 82) confirms "*A&E consultants do regard paramedics as fellow professionals*" and M17 (2009: 64-65) remarks, *"I feel we are well supported at the local hospital in *. The A&E consultants listen to what we have to say and makes sure the team listen also"* I categorise those interactions as 'Professional Regard' with interaction with more junior staff categorised as showing 'Professional Disregard' as M17 (2009: 89) confirms, *"junior doctors do not respect a paramedic's opinion".* As Mannon (1992) explains, any expansion of the paramedics remit over prehospital emergency care is largely dependent on securing the sanction of the medical fraternity to whom they acknowledge they are subordinate "*there is a hierarchy with doctors at the top*" (F12, 2008: 521).

Although the paramedics acknowledge 'dirty work' as I discussed in chapter two distinguishes their activities, it is perceived to add rather than detract from their capability. Accordingly they consider all *"hospital staff are still ignorant of what a paramedic is all about"* (M33, 2008: 106) and *"need to appreciate the mucky end of emergency work"* (F33, 2009: 85-86) which leads to the majority of these interactions taking the form of a 'Professional Disregard' with the minority categorising as a 'Professional Regard' for the paramedic role. Figure 4.3 illustrates a high demand for emotional labour is prompted by hospital staff as twenty-eight [78%] of my sample return a MERI score below ninety. Nurses are confirmed as the more demanding with 79% of their scores below ninety compared to 75% of doctors of which just one individual falls into the very high band compared to eleven nurses.

Interaction with a 'GP' either embodies a mutual professional respect I explain as

'Professional Regard' or are subject to the strain of ignorance, placing them in the alternate subcategory, of 'Professional Disregard', as F12 (2008: 413-419) elaborates,

> *"It's funny you know sometimes you meet some great ones and they give you a hand. They give you a really good handover and they really kind of involve you and other times they hand you a letter and say they are booked into the * or wherever and walk off. I think it is probably is more the older doctors where paramedics were not around when they were doing their training. There was just ambulance drivers who arrived with the stretcher and a cap and took everyone away you know".*

All encounters carry the potential for transition and I observe how one GP achieves this. I accompany a rapid responder on a run to a supermarket where an elderly gentleman has taken a tumble. On diagnosing a dislocated shoulder the paramedic requests an ambulance. But as we wait for it to arrive a woman comes over and announces she is a BASICS doctor [GP trained in trauma care that is able on request to add value over and above baseline paramedic skills (British Association for Immediate Care, 2008)] who I add into the inductive category 'GP' and consequently relabel 'GP/ BASICS' and she proceeds to examine the man. I observe how a forced smile on the paramedics face hides her irritation at being pushed to one side and demeaned in front of a group of bystanders which she considers a disregard of her professional status. However, when that GP confirms her diagnosis and with a warm smile comments, *"you are obviously in good hands. I know when I'm interfering. I will leave you"* (F21, 2008: 866-867) she confers a regard for the professional judgement of the paramedic and in so doing changes her status and memory of that encounter I label GPT1.

Interaction with Air Ambulance personnel occurs when NEAS request their help to treat and evacuate seriously injured patients I also explain through the paramedics' professional mandate. The North East region of the UK is served by the Great North Air Ambulance [GNAA] which is a registered charity flying around 1,000 missions annually (GNAA, 2011) with a crew of an advanced paramedic and a prehospital care specialist doctor. I observe one mission on the occasion of T1 when interaction is cordial and respectful with each interactant displaying a professional regard for the other. Although the doctor immediately assumes the position of medical authority it is

given not taken. He discusses the patient's condition with the paramedic before involving him and me in securing the patient on a scoop stretcher and carrying this to the helicopter. The handover is completed with smiles, appreciation and mutual respect. Although the added value GNAA provide is recognised and regard shared it can also be withheld. M37 (2008: 1430-1441) recalls how first on the scene of a plane crash he drags the injured pilot to safety but is staggered to subsequently find out,

> *"It had been in the newspaper and the way it was written and worded, it had come from the paramedic off the Air Ambulance that hacked me off a bit as well...the fact she never even saw my patient until she climbed into the back of the police helicopter you know but she saved his life and dragged him out of the aeroplane".*

By taking the position of medical authority away from the road paramedic this GNAA paramedic is considered to show a professional disregard for her road colleague and her actions prompt an outpouring of animosity, as M37 (2008:1438-1441) elaborates,

> *"She is an ordinary paramedic that went from the road to the aircraft. She is one of a lot who have done it and get above their station and they think they are better".*

Sustaining a professional relationship with air crew involves copious amounts of suppressed emotion I discern in a further remark by M37 (2008:1434-1435) in the absence of any qualifying MERI scores, "*I would like to put the record straight but what the hell is it going to gain. I just let it go".* Figure 4.3 illustrates 33% of the MERI scores for the category 'Hospital Staff' fall within the very high band in comparison to 25% of those for the category 'Emergency Services' which makes them the lesser of the two demands encompassed by the paramedics' professional mandate. Although with 69% of my sample returning MERI scores below ninety in respect of an interaction with the emergency services this category still induces a high level of emotional labour for two-thirds of my sample.

4.2.3 Public Obligation

Interaction with the deductive category 'Incident Bystanders' I explain through the

theme ‘Public Obligation’ as the paramedics, in order to retain authority, have to keep their emotions particularly fear, intimidation and anger in check. I link the ‘General Public’ as an inductive category to this theme in recognition the paramedics encounter the public in circumstances other than at an incident where maintaining a positive image and reputation motivate performances. I explain bystanders using the inductive subcategories: ‘Helpful’ and ‘Hostile’ and I link the deductive codes: ‘helpful’ and ‘curious’ to the former and ‘mass’; ‘intimidation’; ‘hostile’ and ‘anger’ to the latter. Paramedics have to be especially mindful of the public in the form of bystanders in order to secure authority as they form an unpredictable mass, as Metz (1981) points out in chapter two and M12 (2008: 72) confirms, as he recalls being told, “*there was about a hundred people watching you*” as he attempted CPR at the scene of a fatal assault. As the police have taken authority at that scene the paramedic is not intimidated by the *“hostile crowd”* (ibid: 73) unlike at another incident where he recalls,

> *“There are four casualties. Everybody is screaming come here mate, come here. Somebody is saying, if you don’t go there I will kill you”*
>
> M12, 2008: 274-276.

In order to fulfil their clinical mandate paramedics have, on occasion, to coax curious bystanders into helping, as M12 (2008: 63-66) goes on to explain,

> *“When you are at a particular scene where you need more hands than what you have got, you try and engage people to do jobs they can do but they need supervision and telling how to do it“.*

Interaction with bystanders can therefore also be categorised as ‘Helpful’ but helping can turn into a ‘hindrance’ which I code inductively and link to the ‘Hostile’ category from the account given by F12 (2008: 977-986),

> *“We went for a bloke once, fitting in * and this first aider was sitting on top of him, across his pelvis with his hands on his shoulders while this poor guy is trying his hardest to have a fit and he is pinning him to the floor but his head is back and no one is looking at his airway and he is gurgling on his own tongue because they are intent that he is*

not going to thrash about and hurt himself. Literally, we had to physically drag him off this bloke and put him on his side and let him continue his fit you know. We gave him something to sedate him. We were like 'Bloody hell get off him man, he is going to choke' and he is a first aider and you feel like saying to them 'If you are a first aider, who taught you because they need pulling up' or 'You should know better' but we don't do it do we, we just carted him off to the hospital".

On that occasion the behaviour of an over-zealous first aider is counterproductive however well-meant and demands anger management. The sentiment voiced by F22 (2008: 34-35), *"the very worst thing is a lack of respect, lack of cooperation when called to an incident"* I find is one in which each member of my sample shares. Their dominant viewpoint, bystanders safe in their anonymity are worse perpetrators of abuse than patients I find contrary to Grandey, Kern and Frone (2007). Although only nine inventories are completed on bystander interaction these show a paramedics' public obligation with this category entails a high to very high level of emotional labour as all but one score under ninety [89%] and all but two under sixty-six [78%].

The encounters I observe with the 'General Public' over a run I categorise inductively as 'Antagonistic' to which I link the deductive codes: 'anger'; 'hostile' and 'intimidation', as the paramedics have to exercise every inch of self-control so they do not split their professional mask. On one occasion a motorist berates a paramedic I am observing for obstructing the roadway whilst a critically-ill patient is loaded which necessitates a sharp intake of breath and a polite apology which they later reveal as a front for their anger at the intimidating tactics employed by the motorist. However, ambulances do not need to be stationary for emotional control to be challenged as flashing blue lights provoke erratic decisions. Although I hear many expletives being hurled at motorists and pedestrians who impede progress on route to a patient these are replaced by the silence of self-control on route to hospital with the patient aboard which my observations inform me, takes a great deal of effort.

4.2.4 Organisational Obligation

The paramedics' interaction the two deductive categories of 'Managers' and

‘Observers’ and inductive category ‘Control’ I explain through the theme of ‘Organisational Obligation’. This is linked to two inductive categories: ‘Motivating’ and ‘Authoritarian’ to which I link the deductive code: ‘impress’ and inductive code: ‘professional interest’ to the former and deductive codes: ‘uncaring’; ‘authoritarian’ and inductive codes: ‘resentment’; ‘dismissive’ and ‘anger’ to the latter. I do not encounter any divisional manager whilst on a run but M12 (2008: 172-175) informs me they can be summoned to a critical incident and recalls the characteristic, uncaring behaviour of his manager, summoned to RTA1 I detail later in the chapter,

> *“He says to the crew who were second there, can you go back to * as there is no cover. We stayed around for about three quarters of an hour while they tried to cut this guy out and then he says to us can you go back on the road now”.*

A lack of support leaves my participant incredulous but as it is expected he will defer to authority he has to suppress his anger and clear for the next run, in doing so he provides an example of authoritarian interaction with divisional management. The paramedics’ organisational obligation to perform emotional labour with their managers to which I add more detail later in the chapter is confirmed to run at a high to very high level by their MERI scores as thirteen out of the fourteen inventories relating to managerial interactions score under ninety [93%] with eleven of those under sixty-six [79%].

Observers are allocated to crews often without prior notice. But they are generally welcomed as they afford an opportunity to impress and garner respect for prehospital emergency care which categorises them as ‘Motivating’. In addition to the trainee paramedics identified by Palmer (1989) I inductively code: ’researchers’; ‘student nurses’; ‘medical students’; ‘management’ and ‘support personnel’ from my discussions with my participants, of whom M38 (2009: 120-124) singles out management,

> *“Management need to do a full set of shifts to really appreciate what it is like on the road. Anyone can do a single shift. * came out on night shift and only stayed until two am so what does she know. After four on the trot you are really tired and the job becomes more of an effort. that’s what they need to experience”.*

One twelve-hour shift I agree is relatively easy but I am exhausted after two. The Operations Director admits to me he has never worked a twelve-hour shift and that fact, in all probability, has led to the acrimony expressed by M38. As an observer I am often extended the courtesy of the much more comfortable seat in the cab rather than having, as the third man, to sit in the back of the ambulance. However that apart, I am generally regarded as one of the crew with instructions to carry this or fetch that which affords me a privileged view of the role. There are only two occasions when my status of researcher is apparent. The first is an innocuous burst of showing-off designed to impress with respect to driving skill on blue lights that Palmer (1989) indicates is de rigueur and the second, on the occasion of SH1 when the attendant paramedic exhibits concern for my safety. Overall my experience as an observer out on a run is typified by a display of professional interest in my study and amiable relations which I foster through developing a favourable impression by taking care to behave appropriately in recognition those whose behaviour fits the "norms of social appropriateness" (Huston and Levinger, 1978: 123), appeal to others. I interpret this as outwardly calm, in control and not averse to getting dirty. I discuss my relationship with my participants further on in this chapter as in all cases it develops over periods of standby.

Contact with 'Control' is limited to notification of a run and clearance voice-to-voice rather than face-to-face. Runs are generally greeted with enthusiasm although that is short-lived if further details classify the patient as a free ride or worse still a late run. If a run is notified within the last thirty minutes of a shift it is likely to overrun as it can take anything from one to three hours to return to base [RTB] from an admitting hospital leading to resentment. As M13 (2008: 106-108) remarks,

> *"Late jobs can add two hours to the end of a twelve hour shift but any late start the next day has to be authorised and that is not easy to arrange. We are not allowed that sort of autonomy".*

I observe over a number of late runs but if I am on station and I have a long journey home I decline that last run out of self-preservation. But the paramedics reluctantly accept *"everyone is given late jobs and they just get on with it"* (M38, 2009: 28) as they are expected to defer to dispatch officers authority. They adapt their off duty to accommodate the possibility of late runs, as F12 (2008: 494-497) reveals,

> *"You learn not to arrange anything definite such as a meal in a restaurant as inevitably you won't be able to make it".*

But late finishes are perceived as holding intent because they "*could be avoided with a little more effort on the part of dispatchers"* (M34, 2008: 49-50). At the end of a run the paramedics resent being hassled as it undermines their professionalism which I evidence in the remark *"I feel Control checking up as whether we are clear or not is a form of harassment"* (M24, 2008: 152-153). As the paramedics regularly infer Control "*let us know who is boss"* (F11, 2008: 172) through dismissing their needs in order to meet delivery targets I explain all interaction with Control through the subcategory of 'Authoritarian'.

4.2.5 Collegial Obligation

The paramedics' emotional labour with the two deductive categories: 'Colleagues' to which I link the deductive code 'supportive' and 'Work Partner' to which I link the two deductive subcategories: 'Harmonious' and 'Discordant' I explain through their link to my theme 'Collegial Obligation'. On a run I observe how paramedics regularly congregate outside A&E with colleagues from across NEAS where their interaction involves casual banter which is supportive as it encourages disclosure and dispersal of residual emotion, as F11 (2008: 376-383) reveals,

> *"There are quite a few times where you turn up at the hospital and there is a crew outside who have had a bad job and one of them has has been upset and crying. No one thinks anything but sympathy for them. It is not knocked down in fact I would say it is encouraged because I think if you are displaying emotion like somebody being upset outside a casualty it shows you are recognising it has happened and you are dealing with it as opposed to being very quiet and withdrawn".*

The category of 'Work Partner' I label 'Harmonious' links the deductive codes: 'positive'; 'appropriate behavior'; 'dependable'; 'trustworthy'; 'close'; 'mesh' and 'satisfactory' and inductive code: 'compassionate gift' whilst 'Discordant' links the deductive codes: 'negative'; 'unreliable' and 'inappropriate behavior' and the inductive

codes: ‘anger’ and ‘embarrassment’. The first person each crew member seeks out at the start of a shift is their work partner and each member of my sample agrees with M34 (2008: 51), *“relationship with your partner makes or breaks the job”.* A harmonious, satisfactory relationship depends on each member being positive as each is vulnerable to the outlook of the other (Hatfield, Cacioppo and Rapson, 1994), as M22 (2009: 34-35) confirms,

> *“I like to be positive and I am affected by others being negative. Your work partner is vital to wellbeing and to be truthful my current partner is hard work”.*

This unreliable relationship is characterised by *“negativity and moaning”* (ibid: 61) and the management of anger. M34 (2008: 110) in commenting how, “*it would be good to be able to change”* suggests it is not the only discordant partnership which F15 (2008: 45-46) confirms through providing evidence of inappropriate behaviour by her partner leading her to control embarrassment at the handover of a patient,

> *“Partner indicated to A&E staff that patient was suffering from ‘dying swan’ syndrome.....over dramatisation”.*

A stable harmonious working relationship is paramount for the specific reason, “*you have to be able to trust one another in this job”* (M18, 2009: 53-54). Consequently those paramedics whose partnership is close and dependable do not take kindly to being split up even just temporarily. As one team leader comments, *“they are like married couples you know and they won’t be separated”* (F21, 2008: 370-371). Although Mannon (1992) identifies a willingness to get involved as an ideal partnership characteristic, I observe how that can translate into a compassionate gift of sympathetic understanding in which one member of the partnership excuses the involvement of the other. During the incident I label S1 the attendant paramedic allows their partner to stand back to avoid distress that he knows would otherwise adversely affect him for the rest of the day. Through offering compassion he adds strength to what is already a strong bond in which their personalities, competence and experience mesh to form a close, dependable working relationship. I find no evidence to support the deductive codes: ‘egocentric’ and ‘aggression’. Twenty-two inventories are scored following an interaction with a colleague and of those I find thirteen [59%] are under ninety with

eight of those under sixty-six [36%] to confirm the provision of collegial support also requires a high level of emotional labour from the majority of my sample even if willingly given one to the other as friends.

4.2.6 Autobiographical Obligation

Every paramedic I find is accompanied by a certain amount of emotional baggage on a run they report becomes heavier as their autobiography becomes more and more saturated with traumatic experiences. I therefore explain this form of emotional labour associated with my deductive category 'Self' through which they disperse distress and remorse to maintain a normative state, as their 'Autobiographical Obligation'. I link the deductive code 'troublesome memories' to this category in recognition these return unbidden when a particular sense is activated. Wentworth and Ryan (1992: 33) remark "to the extent that we are our memories, emotions are both the locks and the keys" and for M12 (2008: 158-170) distress over RTA1 he recalls below, is kept locked away until it is reactivated through crossing that bridge, confirming memories remain unconscious sources of intense anxiety that defy eradication as LeDoux (1998) infers.

> *"RTA one Saturday morning, very foggy, down at * an Izuzu trooper gone across the bridge in * too fast and gone straight into an artic head on. This Izuzu trooper had just crumpled. It was shifting, they were going to a wedding. It was shifting and the guy was trapped, the whole engine was around him. He must have turned in to try and save his missus. He was trapped. There was no chance we were ever going to get him out but as we came round the corner the thing went into flames. We were literally twenty seconds away when this thing went up in flames. As soon as we got out the people who had stopped obviously because they could not get past were shouting 'She is still alive' and we could not get to her. We were the first on scene. There was another crew who came two minutes behind us. We could not get to her. The fire bobbies turned up, put it out and she was pregnant so it was gut wrenching really and to this day I can still see it and I can replay every bit of the job, certain jobs you can do like. I still get chilled going over the bridge to this day. Things like that stop you".*

Another participant comments how the national habit of laying flowers and personal memorabilia at the scene of accidents also triggers troublesome flashbacks they have to manage. For another, I provide the key albeit unintentionally as PD1 is recounted by the paramedic involved with some difficulty. They remark how when thinking about that night, *"it does prick the back of your eyes a little bit like"* (M11, 2008: 395) confirming the angst felt by M12 is not uncommon. The demand inherent to the paramedics' autobiographical obligation is encapsulated in the remark by F13 (2008: 428-432),

> *"It's a fine line between allowing yourself to dwell on things and moving on. If you dwelled on something that was supposed to be normal for us when something bigger happens what would you do*"*?*

Personally, I find memories of one patient are soon overlaid by those of another. However, certain patients, certain incidents, remain just under the surface of my consciousness to provide me with an indelible reminder of my time on the road.

4.3 Standby

At the start of every shift until the first run is called the paramedics are on standby to which they return between runs as instructed by Control. Potentially if they RTB there is a wide pool of interactants in addition to their work partner with whom they can share information, stories or expertise; offer solidarity or a sympathetic ear and participate with in acts of resistance as part of their obligation to provide collegial support. However, I observe a further nine categories of interactant encountered on a run can also be encountered on standby and I map this interactional demand in Figure 4.4. I add another category I label 'HQ' inductively to this map to which interaction with those members of head quarters from the Operations Directorate, Resource Scheduling and Occupational Health are linked. These interactions are all explained through the paramedics' organisational obligation which I find forms, along with their collegial obligation, the principal triggers of emotional labour on standby.

4.3.1 Collegial Obligation

On station during periods of standby I observe how the paramedics have more time to provide that vital service in collegial support through which the paramedics destress,

protect self-esteem and remove self doubt all of which constitute 'supportive' behaviour linked to my theme 'Collegial Obligation'. I do not segregate the work partner whilst standing by on station but absorb them into the category 'Colleagues' as I observe they become indistinguishable. I evidence the link to deductive codes: 'group identity' and 'confidant' and inductive code 'compassionate gift' in this section. Supportive interaction disperses emotion and reminds an individual their experience is shared not solitary which reinforces group identity, as F11 (2008: 249-253) suggests,

> *"Talking to your colleagues on station and having a moan about whatever it is that has got on your nerves that day and you find they have got a story for you as well about something that has happened to them. It does make you realise you are not the only one that feels like that".*

It can develop into a compassionate gift when relaxation time is forgone for a colleague as F11 (2008: 317-332) aptly illustrates in the following vignette I label C1,

> *"We had a lad on our station who had a really bad job. It was a child that was knocked over and killed and he was there dealing with it on his own for ten or fifteen minutes before the crew turned up and when the crew turned up he was still the most senior person there and he had to deal with this horrible job and he has got kids and I think it probably affected him more because he was probably thinking about his own kids. He came back to station and we were upstairs and there was just him, me and our team leader and then more people arrived and I was thinking maybe we should give him a bit of space but we ended up actually having a group counselling session probably between six of us and it was good because there was a mixture of staff. There was my team leader who has been on the road for fifteen years or something and there was two new people there and we all had a session and he just talked through the job and we made comments and really it reassured him that he did his best and afterwards I thought that was really good the way that worked out. We all had something to say and he you know had a bit of a cry and he got everything out. He said he felt a bit better after it".*

Some paramedics however as M23 (2008: 1013-1015) remarks, rely on a small number of carefully selected confidants,

> *"We all have our own people who you can bounce off. Some things you can bounce off one person that you could not bounce off another so you may have two or three".*

Figure 4.4: A map of the interactional demand on the paramedic during standby.

There is as Mannon (1992: 184) observes no substitute for that "consciousness of kind". As I have already mentioned the MERI scores confirm a high level of emotional labour is performed by the majority of the paramedics in my sample in order to satisfy their

'Collegial Obligation' but Figure 4.3 also indicates a wide spread of scores. Of the ten falling into the mild to low bands on the manager/colleague axis nine of those are attributed to interactions with colleagues. This subgroup is unsurpassed by any other to confirm a paramedics' 'Collegial Obligation' represents the least demanding form of emotional labour performed by my sample.

4.3.2 Organisational Obligation

Interaction on standby with organisational insiders taking the form of managers, observers, dispatchers and support personnel based at HQ I explain through my theme of 'Organisational Obligation'. I explain interaction with 'Managers' through the link to those two subcategories of 'Motivating' to which I add a link to an inductive code 'caring' and 'Authoritarian' to which I evidence links to the deductive codes: 'intimidating' and 'judgemental' whilst those with 'Observers' I explain through the link to the subcategory: 'Motivating' to which I link inductive codes: 'attraction' and 'empathy'. Interaction with 'Control' I explain through the link to the subcategory 'Authoritarian' to which I link the inductive code: 'anger' and those with 'HQ' I also explain as 'Authoritarian' to which I evidence links to the deductive codes: 'uncaring'; 'judgemental' and 'authoritarian' and inductive codes: 'distant'; 'obstructive'; 'inconsiderate' and 'confrontational'.

Divisional Managers regularly visit their stations and whilst on standby I observe how they often find fault with small things e.g., dirty cups stacked in the kitchen leaving the paramedics to suppress anger over what they perceive as uncaring behaviour as these were left unwashed when a run was called. But as M11 (2008: 390-392) testifies, in acknowledging a job well done, e.g., PD1 they can also act in a caring manner, offering praise and reaffirming identity,

> *"District Manager come up and saw me. He said 'Right * I have been hearing good things about you'. I said, 'What are you on about', '* had a little chat with me. You were absolutely 100% a star with that prem baby'".*

However, interaction I allocate to the 'Motivating' subcategory form exceptions as interactions with managers mostly reinforce the belief, "*we are a statistic, a number, a*

bum to put on a seat to drive an ambulance and to attend"(M12, 2008: 32-33) by ignoring the individual inside the uniform as the following vignette from M17 (2009: 37-46) implies,

> *"I had an accident a year ago and the car was a write-off. I hit a patch of black ice and crashed into a lamp post. The policeman who attended acknowledged the weather conditions were bad and that I was unlucky however NEAS did not acknowledge the conditions and held me personally responsible. I was treated like a criminal and sent on a refresher driving course. The cars are family saloons...not fit for purpose. There was no concern for me personally. I had strained my back and had two weeks off. On return I had an interview with management that caused me a lot of stress for which I needed another two weeks off. I was made to feel that unless I admitted responsibility disciplinary proceedings would follow".*

In this account M17's manager is judgemental and intimidating and shows neither regard for the difficulties the road crew face nor trust of his subordinate. M32 (2008: 66-68) neatly sums up the nature of these relationships,

> *"We are regularly pushed beyond our emotional limits by managers exercising their authority rather than by the job itself ".*

Consequently, the majority of interaction with managers is characterised by how *"managers expect subservience"* (M32, 2008: 42) and explained through the subcategory 'Authoritarian'.

The only observer the paramedics encounter on standby during my time in the field is me. I am conscious of the need to make a favourable first impression to invite affiliation (Huston and Levinger, 1978) so I dress as I had been advised in old but still relatively smart outdoor clothing so I am comfortable but unconcerned about getting dirty. But I concentrate on establishing a cognitive compatibility (Byrne, 1969) through reading all current reports on the ambulance service so I appear knowledgeable and through reminding my participants I am not connected with HQ also independent. As attraction

prompts self-disclosure (Chaikin and Derlega, 1974) I align myself to the mood of each participant, give them my full attention and I participate in acts of resistance without comment.

My relationships do however vary according to the level of comfort with emotion and degree of openness exhibited by each participant. I admit to feeling a little disappointed with those female participants reluctant to disclose although contrary to Chelune (1976) I also feel that same disappointment with my male participants. I do admire those of my participants who recognise and acknowledge the emotionality of their role as open discussion is culturally inhibited and I appreciate the depth of intimate detail M11, M12, F11 and F12 offer in particular which may explain the strength of those voices. Overall I explain my interaction with all my participants through the subcategory 'Motivating' through which I recognise both the candid and insightful exchanges which take place and my empathetic relationship I leave to F31 (2008: 109-111) to describe,

> *"I have really enjoyed talking with you. It has been like having my very own counsellor along. If you ever want a reference for becoming a paramedic you just need to ask because I think you would make a really good one".*

Dispatch officers in Control sanction standby and accordingly regularly remind the paramedics they are "*simply a resource"* (M24, 2008: 49) which strains relations. Anger increases when the first meal break is late, as M24 (2008: 79-81) remarks,

> *"If it is at a reasonable time, the rest of the day is more manageable, if it is not then I get frustrated and can be short with Control".*

Or, forgotten altogether, *"having to do a shift with just one half hour break that's back braking"* (M16, 2008: 47-48). The unpredictability of comfort breaks is also hard to handle as there are usually no facilities. M16 (2008: 64-65) confirms,

> *"Being sent on standby and then moved to another standby point without a comfort break is irritating".*

I find myself desperate for a comfort break on more than one occasion and I also experience the hunger and fatigue associated with a late meal break right from the start of my fieldwork. On my second shift with my first participant our first break is authorised at 13:30 pm and the second at18:15 pm as I have previously mentioned so I can appreciate why,

> *"Lads on the road they try all ways to get one over on Control. There is this 'Us and Them' philosophy"*
>
> M37, 2008: 369-370.

Contact with personnel based at HQ is voice-to-voice rather than face-to-face. As *"calls made to HQ and emails particularly of a clinical nature are not returned"* (M25, 2008: 73-74) my sample unanimously label HQ as distant and impersonal. But they single out Resource Scheduling who allocate shifts and authorise leave as their primary contact. M21 (2008: 274-279) describes those interactions as obstructive and confrontational,

> *"Resource scheduling are seen as the enemy, a `can't do` area rather than a support area. They are significant in arousing negativity as inflexible. They make it difficult for staff to have their leave when they need it. All leave must be booked in advance in complete weeks therefore staff go sick when they need an odd day off as otherwise it is disputed and often refused so now most staff avoid that confrontation".*

This account suggests emotional control is abandoned in favour of resistance but perhaps with good reason as M14 (2008: 46-48) endorses a lack of consideration, *"I could not get time-off for my honeymoon. Resource Scheduling standard reply is a `No`."* The road crews regard this team as *"obstructive"* (M16, 2008: 49) and feel victimised because schedulers "*seem to think we are not entitled to a life outside of work"* (ibid:50) which provokes resentment. But they also acknowledge *"whinging, moaning and complaining will get you nowhere"* (M11, 2008: 218-219). As I observe how contact across HQ provokes mainly negative emotion I explain all interaction as 'Authoritarian'.

4.3.3 Public Obligation

Encounters with the general public on standby I explain through my theme 'Public Obligation' to which I link an inductive subcategory 'Benign' and evidence a link to the deductive code: 'helpful' and inductive code: 'amiable' of which M37 (2008: 653-659) provides an example,

> *"'How are you, have you been busy at work, was that you who went to so and so?' Obviously they are fishing to find out what was wrong with so and so but you cannot really tell them because of confidentiality rules and regulations and all the rest of it. You cannot say 'Oh ay she had a spot on her arse the size of whatever' that's what they are sort of fishing for. But then when they don't get that sort of information then they think 'I would not mind him coming to see me if that was the case' you know".*

Being part of the local community makes paramedics like M37 "*more like one of the lads*" (ibid: 662) but in being more approachable there is a cost in circumspection so rules relating to confidentiality are not fractured and public opinion is not damaged. Interaction whilst still benign can also be helpful. I observe a young man rush towards the ambulance in which I am sat gesticulating madly at the crew. They are initially suspicious as hoax calls are all too common (Payne, 2009) and the young man has little English. But their initial scepticism is unfounded when they discover a painter and decorator seriously injured on the pavement a short distance away. He has fallen from a cherry picker and needs oxygen, morphine and a spinal board which make the crew thankful their suspicions did not cause them to ignore that helpful member of the public.

4.3.4 Autobiographical Obligation

Many intrusive memories are recounted to me whilst on standby which I explain through the link between my category 'Self' and deductive code 'troublesome'. However, not all memories can be explained through that link as there are alternate positive accounts characterised by satisfaction and pride. To explain those I recognise and link an inductive code: 'rewarding' to this category. A troublesome memory is unlocked for F11 (2008: 336-349) on standby in a town centre when she takes an

opportunity to purchase some supplies and glances at the display of newspapers as she waits to pay,

> *"It was a little girl who collapsed at sports day and died. It was one of these congenital heart things that they did not know they had and it sort of went out of my mind for a couple of months and I remember I was standing in this shop and I saw this face on the front of the * and I thought God I recognise that kid and I didn't know why so I bought the paper and I read it and it was not until I read it that I realised it was her. It was not until then that I felt like it had affected us and I felt worse then than actually I did after the job. I actually felt more emotional then than I did after the job. It was as if it had just happened actually that was how it felt. It was as if I had just done it".*

M31 (2008: 168-175) is prompted through asking me which incidents I have attended to recall his memory of a hanging a colleague attended which I label S2,

> *"Don't bother me but a colleague of mine went to one on a farm. Guy had left a letter for his son on the kitchen table that he was in the barn and not to go in but to call the emergency services, which he did. My colleague found the guy who was in his seventies swinging from a rope in the barn. His eyes were bulging and his tongue was protruding and he was purple, asphyxiated, awful way to go. If you break your neck it's quick but if you suffocate it is not and this colleague could not forget this guy's face. He had nightmares for weeks and every time he opened the wardrobe in his bedroom he would see this guy's face. He left the service eventually".*

Through prefixing this narrative with that nonchalant opening comment M31 signals he is comfortable around trauma, emotionally in control and therefore a legitimate member of this occupational group unlike his unfortunate colleague (Boyle, 2005) who is left with an indelible imprint which exerts a perverse influence on his daily life (LeDoux, 1998) to the extent he takes drastic action and withdraws from the service.

Illustrative of rewarding memories is that of an incident which occurs in 2007 when my participant attends a seventeen month old female child with a rash. He suspects Meningitis and administers Benzyl Penicillin before she is rushed into hospital. This prompt diagnosis and treatment saves her life although the disease claims both hands and some toes. Her story attracts full media attention and in continuing to do so, allows the paramedics involved to restore memories that are satisfying and rewarding. However, these emotions have to be controlled to accord with the nonchalant demeanour expected of paramedics backstage (Boyle, 2002). In confirming there has to be a horror or miracle attached to an incident for it to survive into story form as Tangherlini (1998) suggests, each of these memories emphasise how a paramedics' autobiographical obligation is role defining.

4.3.5 The Mandates

Neither the paramedics' clinical nor professional mandates prompt more than an occasional performance of emotional labour that I observe whilst standing by but those instances validate the inclusion of these categories. With respect to their clinical mandate I observe an example of interactions I explain through the subcategory 'Pleasing' when a patient, accompanied by a relative, calls into a station to express their gratitude following an incident. Although the paramedics are pleased by that show of appreciation their poor recall exacerbated by a cultural inhibition I explain in the next chapter prompts a polite but feigned response. With respect to the professional mandate I observe an example of interaction I explain as 'Professional Disregard' when a community paramedic based at their local hospital is admonished by the hospital matron who is annoyed by what she considers an abuse of hospital facilities [eating biscuits they found in the communal kitchen without permission] which prompts a feigned expression of apology.

4.4 Acknowledging the Interactional Demand

To address the question which asks: which interactions carry a demand for emotional labour and how do these vary both within and between categories, I first draw attention to the fifteen different categories of interactant this chapter has shown carry a demand for emotional labour by the paramedic that I cluster into six distinct groups. The first of which contains patients, relatives and carers, all of whom constitute the paramedics'

clinical mandate as interaction is directed by the HPC standards of proficiency I outlined in chapter two although emotional labour is willingly performed. The lack of homogeneity amongst patients leads to a diverse and unpredictable demand of which those who present with a genuine emergency represent a minority as do those at the other end of the patient continuum who are considered to use the ambulance as a taxi. The majority form the routine workload which I argue is far more diverse and demanding than Boyle (2005) or her contemporaries have exposed, as it encompasses several different categories in addition to mental illness; regularly exposes the paramedic to abuse and challenges their ability to apply a moral circumspection.

Across the patient continuum the demand also varies according to whether the patient is considered pleasing or displeasing which reflects their: attitude; expectations; age; familiarity and similarity. Using the percentage of MERI scores indicative of high to very levels of emotional labour i.e., above point 17 and below point 90 on the emotional labour scale as a means of ranking the demand a paramedics clinical mandate represents at 92% the second highest. Taking the percentage of MERI scores falling between those same two points as a means of also differentiating the demand within categories patients carry the highest at 95% whilst relatives who subdivide into agreeable and disagreeable depending on their level of aggression return 89% which permits me to argue they are less demanding than patients. Although carers are not scored I align these with relatives as they are I observe similarly helpful or hostile.

The greatest demand lies in the paramedics' organisational obligation which returns 93% of interactions with a score below 90 on the emotional labour scale. However, these scores reflect only the subgroup of managers based locally or at HQ. Although encounters with observers would arguably lessen this demand based on my findings those with Control would heighten it so I consider those two categories to cancel each other out to leave that statistic representative. Whilst interaction with observers and some with managers are motivating the latter are more likely to be explained as authoritarian due to the expectation the paramedics' will defer to authority which implies control of anger and resentment. A further two categories of interactant are explained through the paramedics' public obligation. Interaction with incident bystanders is explained as helpful when they show concern for others but hostile when it intimidates or hinders the paramedics' enactment of their role. Encounters with the general public are explained as benign when they constitute an amiable exchange and

antagonistic when self-interest leads to these becoming intimating and abusive. Using the MERI scores for bystanders as indicative of the paramedics' public obligation this demand is ranked third as 89% of MERI scores fall under ninety on the emotional labour scale.

The paramedics' professional mandate extends across both health and emergency service interactants and the combined MERI scores for those two categories return 74% falling between the salient points ranking this demand fourth. I do not consider the two categories of GP/BASICS and Air Ambulance neither of which has been scored would distort that statistic as interaction across the health domain to which each belong, share similar characteristics. Interactions with hospital staff are in any case the more demanding as 78% of MERI scores fall under ninety compared to 69% for emergency services personnel. Within the hospital category interaction with both medical and nursing staff is explained as exhibiting professional regard when it is valued and exhibiting a professional disregard when it is dismissive which is more likely during interaction with nurses. This is reflected in their MERI scores of which 79% are under ninety compared to 75% of doctors. Across the emergency services interaction with police is respectful as they acknowledge the paramedics' medical authority whilst interaction with the FRS who challenge that authority categorise as disrespectful. The MERI scores confirm the FRS constitutes the greater demand of the two as 81% fall under ninety compared to 60% for the police.

Emotional labour as a collegial obligation encompasses the two categories of work partner and colleagues. Although I do not differentiate the work partner the MERI scores for the latter in returning 59% below ninety position collegial support as the lesser demand of the five scored. Generally interactions with colleagues are explained as supportive within which gifts of compassion are bestowed and those with the work partner as harmonious although there are exceptions where a negative attitude prompts some interaction to categorise as discordant. The last strand, autobiographical obligation through which both intrusive and rewarding memories are managed, has no MERI score to qualify it but in chapter two Clohessy and Ehlers (1999) suggest intrusive memories are common and Boyle (2005) indicates residual emotions have to be managed so I argue these are at least as demanding as collegial support and position them in joint fifth place. Across categories I argue all interaction can be explained through two themes: 'Friend' which links the subcategories: 'Pleasing'; 'Agreeable'; 'Respectful';

‘Professional Regard’; ‘Helpful’; ‘Benign’; ‘Motivating’; ‘Harmonious’ and the deductive code ‘supportive’ and inductive code ‘rewarding memories’ and ‘Foe’ which links the subcategories: ‘Displeasing’; ‘Disagreeable’; ‘Disrespectful’; ‘Professional Disregard’; ‘Hostile’; ‘Antagonistic’; ‘Authoritarian’ and the deductive code ‘troublesome memories’ to distinguish demand in terms of the effort required although my findings indicate emotional labour represents a high to very high level of demand both within and between categories.

4.5 Concluding Remarks

In this chapter I have revealed how situational antecedents represent the interactional demand for emotional labour. This demand can be explained for the paramedic in descending order of intensity as their: organisational obligation; clinical mandate; public obligation; professional mandate and joint last collegial and autobiographical obligations. Within each of those delimitations I explain interaction as either friend or foe where the former represents the lesser demand. As I observe and take note of performances of emotional labour extending over standby they signal a challenge to the assertion by Mannon (1992) that the ‘run’ represents the prime contextual signifier. Although I consider the ‘run’ may adequately explain the paramedics’ clinical and professional mandates it falls short of explaining each of their obligations particularly to their colleagues and organisation. Accordingly I propose the paramedic role is only fully explained by the ‘shift’ and in the next chapter I will add weight to that argument.

Chapter 5

Research Findings – Part II

The Process of Emotional Labour

5.1 Introduction

In this chapter I present and discuss my findings with respect to the process of emotional labour initiated by the interactional demand I presented in chapter four. The chapter is split into four sections each corresponding to one part of that quadripartite process and addressing one or more of the remaining seven subsidiary research questions. In the first section I draw on both paramedic voices and the quantitative data stream to develop meaning for each of the remaining three categories of antecedent: job, organisation and individual. I explain the organisation's attitude to emotion and reveal whilst experience is significant in paramedic performances I find the opposite applies to gender. In section two I also draw on the quantitative data stream to develop meaning in respect to the strategy an individual adopts to deliver those six forms of emotional labour I identified in the previous chapter and I highlight in particular how abuse intertwines with compassion to define public performances. In section three I follow my convention and skip ahead to explain the consequences for the individual attached to their performances of emotional labour. I explain these as gains and losses before I bring this chapter to a close with the final section on interventions which I explain split into those the individual can voluntarily select and those that have to be authorised by the organisation.

5.2 Antecedents

In this section I present my findings and construct an answer as to which factors relating to the nature of the job or to the organisation or to the individual trigger emotional labour through exploring each in turn.

5.2.1 Job Antecedents

Aspects of the job which trigger emotional labour do so through either strengthening fidelity, which I explain through the theme of 'Engagement' to which I link the

deductive codes: ‘uncertainty’; ‘variety’; ‘hurrying’; ‘job satisfaction’; ‘autonomy’ and ‘road crew’ and inductive code: ‘ideal tempo’ or dampen it, which I explain through the opposing theme of ‘Disengagement’ to which I link the deductive codes: ‘unpredictable personal time’; ‘waiting’; ‘operational hassles’; ‘dirty work’ and ‘surveillance’ and inductive code: ‘profession’.

The uncertain nature of the job along with a lack of routine and constant variety I find engage the paramedics as the following exchange with M33 (2008: 28-29) confirms,

> *Researcher: What do you especially like about your job?*
> *Respondent: I find the variety and uncertainty stimulating.*
> *It stops me getting into a rut.*

Variants of which, “*I love this job you never know what is going to happen*” (M32, 2008: 22), *“no two days the same”* (M26, 2008: 18) *“every day is different so the variety and uncertainty constitute a challenge”* (M18, 2009: 44-45) emphasise the additional emotional demand I discussed in chapter one that stems from variety does not detract from but strengthens paramedic fidelity.

The work tempo acts to engage when it is characterised as ‘hurrying’ even if that means, as I observe, the pace becomes flat out and exhausting. The ideal tempo is *“one job per hour with a couple of really good jobs in the mix that test your skills”* (M36, 2008: 28-29). Those good jobs are essential as F16 (2009: 73-74) remarks *“the least satisfying kind of day is when it’s a busy shift but nothing seems to have been done”.* Being busy also engages through carrying an intrinsic coping mechanism “*being busy prevents anyone from dwelling on any one incident*” (M33, 2008: 66) even though it compromises personal time.

Job satisfaction I am left in no doubt by each of my participant’s acts to motivate appropriate behaviour in which emotional labour is implied because they relish opportunities to “*help people*” (M17, 2009: 105) and *“make a difference”* (M13, 2008: 58). It represents a prime example of a duality in that it motivates performances which return the same antecedent as a positive consequence. Motivation climaxes in the “ trauma junkie” (Palmer, 1983a: 168) of which I find evidence in the comment, *“the feel good buzz from making a difference is addictive”* (M36, 2008: 29) to which I add

personal testimony from attending T1. But F12 (2008: 325-327) infers trauma is not an essential ingredient,

> *"Who would work for seven hours and do job after job after job and not get your dinner break if you didn't love what you did? The majority of the people here love what they do and that is what keeps people here at the end of the day".*

The paramedics have autonomy through being "street level bureaucrats" (Lipsky, 1980: 3), as they bear full responsibility for their clinical decisions and the emergency care received by patients. M22 (2009:29) comments, *"I am my own boss. I make the decisions"* to which M17 (2008: 107) adds he particularly likes how there is "*no one looking over my shoulder".* Each paramedic agrees with M13 (2008: 49) *"being answerable to myself"* drives their performances.

As I discussed in chapter one role identity precipitates emotional labour when it is valued and display rules are followed out of a genuine desire to conform. My participants regularly identify themselves as, "*road crew*" (F32, 2008: 91), "*lads on the road*" (M37, 2008: 369), "*people who work on the road"* (F21, 2008: 1142), "*staff on the road*" (M12, 2008: 214) and share the view expressed by F12 (2008: 319-321),

> *"The job on the road is the best job you can get because you are dealing with people and you are helping them and you are achieving something".*

These comments confirm their identity is encapsulated in the term 'road crew' which is strong and cohesive. M11 (2008: 308) in commenting, *"when I stitched that paramedic badge on I was bowled over with pride"* confirms membership is highly valued and consequently, I argue being part of the road crew motivates, engages and secures appropriate behaviour. I am left in no doubt the use of the adjective 'road' acts as a visible reinforcement of identity (Palmer, 1983a) although I find no evidence my deductive code of uniform acts in a similar capacity and not only serves to set the paramedics or doers of emergency care apart from non-doers as Thurnell-Read and Parker (2008) intimate in chapter two but also ensures the majority are not usurped by the minority who must strive to fit-in.

As Boyle (2005) indicates in chapter two the split between frontstage and backstage identities is acute as I observe tough argumentative talk on standby being suppressed and replaced by compassionate concern when a run is called which swiftly develops in the car or ambulance into the professional caring persona with which the paramedics are expected to greet their patients to offer a measure of support for the claim by Palmer (1983a) the ambulance acts as a supporting prop to performances. I find this frontstage identity also splits into the four Palmer (ibid) identifies with each presenting a challenge to the paramedic. I observe how the medical authority is challenged in GPT1 by a retired surgeon who stops to proffer a diagnosis of a fractured humerus when the paramedic has diagnosed a dislocated shoulder and continues to question her use of Morphine for the patient's pain. His intrusion provokes anger she has to manage as she comments, *"there is no point in standing there and getting into a row with him as he obviously sees himself as far superior"* (F21, 2008: 893-894). The lifesaver identity cues emotional labour when trying to save a child as I discussed in chapter four. The information specialist triggers demand when *"patients are evasive"* (M13, 2008: 67) which makes diagnosis fraught rather than straightforward. The last identity of partner I also discussed in chapter four is a significant trigger as an effective *"partnership is key to job satisfaction"* (F15, 2008: 34-35).

The unpredictability of personal time Mannon (1992) identifies in chapter two as inherent to emergency work, represents a significant challenge to paramedic fidelity. Although the majority of my participants express a preference for twelve-hour shifts, "*the twelve hour shifts are hard but worth it for the time-off* " (M16, 2008: 52) the demands of the rota system set by the Resource Scheduling team with which they are obliged to comply, disengage,

> *"Over Christmas I had ten twelve hour shifts in two weeks, just the way my shifts fell over Christmas and New Year and we were literally getting in at six-thirty relieving the crew, getting back at two having us break, out till seven or eight and it was just relentless"*
>
> M12, 2008: 515-518.

As both physical and emotional labour use energy as I discussed in chapter one the demands of the job are excessive. As six weeks on the regular rota is followed by two

weeks on relief a long set of contiguous shifts is not unusual leading to relief being regarded as "*a bone of contention"* (M17, 2009: 120) exacerbated by late notification of those additional shifts, as M34 (2008: 47-48) explains,

> *"With relief you cannot plan anything in advance as you don't know where you will be asked to work or what shift you may have to cover".*

The timing of meal breaks which come under the auspices of Control represents an on-going source of tension as they are often late or missed altogether as I discussed in the previous chapter leading to the commonly held view, "*meal breaks are important to us but not to Control"* (F32, 2008: 38) which M24 (2008: 53-54) indicates also applies to comfort breaks,

> *"As a rapid responder I should have a comfort break after an hour on standby but that time is often exceeded"*.

Late finishes affect everyone and also have to be accommodated although not without strain. With no control over the rota, meal breaks, comfort breaks or shift finish times my participants report a sense of alienation which surfaces in their likening of themselves to an *"automaton*" (M32, 2008:79).

When it is quiet which I observe can mean flat calm I observe how the paramedics become frustrated and tetchy as they prefer to be out on a run rather than waiting. M37 (2008: 453-454) remarks how when he is stood down for a meal break he always implores Control *"if a job comes in give us a shout".* Operational hassles taking the form of complaint handling, paperwork, uniform, driving and equipment all dampen fidelity. The threat of a complaint, as Mahony (2001) identifies in chapter two, I find is intrinsic to the role. As one paramedic remarks, *"it is that kind of a job where people will always make complaints"* (F21, 2008: 542-543) but they go on to say *"it is how it gets dealt with that matters really.*" Bad experiences disengage, as F11 (2008: 672-675) testifies,

> *"Some of the things people do complain about are ridiculous and they probably should not even get as far as the crew knowing about it but*

they do and the way you are tret by the investigating people. I have not had a good experience".

Although the threat of a complaint from a society grown accustomed to litigation (Furedi, 2000) is accepted as part of the role what irks the paramedics is how *"there is a perception that crews are always to blame when a complaint comes in"* (M22, 2009: 32-33) and how their anxiety is unrecognised, as M38 (2009: 33-37) comments,

"I was informed there was a complaint against me that management were looking into. I worried all the next day about it but no one got in touch and a week later I am still none the wiser as I cannot think of any reason. Management should realise I would be worried".

This culminates in the acknowledgement expressed by F23 (20089: 78) "*if the shit hits the fan I would be on my own*".

The Patient Report Form [PRF] is a prime example of a paperwork hassle as it has to be completed in duplicate by the attendant paramedic with both personal and clinical details for each patient. One copy accompanies the patient on handover to A&E staff without, I regularly observe, more than a glance in its direction but the second copy sent to HQ to provide a clinical audit trail, comes under intense scrutiny. Time pressures I observe inevitably lead to indecipherable writing, mistakes and omissions that are flagged for good reason but which escape the paramedic who perceives this criticism as yet another example of how the nature of the job is under appreciated,

"All they care about are your PRF's right if you get pulled up for court or you get a complaint"

F12, 2008: 423-424.

Uniform prompts a negative response when "*there is not enough uniform"* (F23, 2009: 65) and the paramedics are unable to change soiled items. Driving is a significant component of the job which although it represents an uplift for a few, "*I enjoy driving on blue lights as I have been trained to drive fast*" (M13, 2008: 49-53) it is a hassle for the many as, "*driving on blue lights is getting so dangerous as people are selfish*" (F32, 2008: 102-103). The paramedics indict equipment as an irritant on the grounds it is

either not fit for purpose e.g., Stryker chair or it compromises their well-being e.g., bags. They explain the carry chair for patients is both heavier and more difficult to manoeuvre than its predecessor and the equipment bags are cumbersome as M24 (2008: 143-144) explains,

> *"They are too heavy and often result in multiple trips that can be up and down stairs before the patient can be treated effectively".*

Consequently I sympathise with M24 (2008: 147-148) who pleads,

> *"All paramedics want are the right tools to do their job competently without their wellbeing being compromised".*

Dirty work is acknowledged in that reference to the ambulance service as "*the mucky end of emergency work"* (F33, 2009: 86) but I find my participants are habituated to it as I am informed it only disengages in its extreme form e.g., total dismemberment following collision with a train whereas surveillance in all its forms acts to disengage. Every minute of the paramedics time is monitored through that "electronic leash" (Metz, 1981: 48) by Control to whom they must defer and with whom there is no negotiation. inhibiting recovery between runs, as F11 (2008: 163-166) reveals,

> *"Control don't know the situation in every job and sometimes something that sounds quite mediocre can still be emotionally stressful and you know if you have taken longer than nineteen minutes you get a message, 'Please clear for 999'".*

Reminders may be polite but they privilege targets and carry authority that is reinforced through a sting in the tail as F11 (2008: 156-159) reveals,

> *"We get a printout every month of all the stations, how many jobs they have done. It's called a turnaround time from getting to hospital to punching in 'Clear'. It gives the average turnaround time and it is highlighted who is taking too long".*

Although constant surveillance prompts, as I observe, acts of resistance e.g., obscenities

issued at dispatch officers with the radio switched off through which the paramedics limit disengagement they can be provoked into a total disconnection. This occurs in the incident RS1 with a crew from NEAS just after I complete my fieldwork. They attend a patient who has suffered a stroke and instead of taking him direct to hospital they divert to their base station because their shift has overrun. The patient, left in the ambulance for another crew to take to hospital subsequently dies leaving the organisation to face national scrutiny and the crew disciplinary procedures (BBC News, 2009d).

Although identity as road crew engages that of a profession I code inductively disengages. Contrary to my expectation, being recognised as a profession has had little impact and internal reframing is a long way from being complete. M32 (2008: 90-91) comments how, *"state registration has not changed the way I feel about my job or the way it is done"* to which M22 (2009: 91) adds *"I regarded myself as a professional before it came in"*. Although I find there is a shared viewpoint amongst those new to the job, "*I think it has given us some form of recognition*" (F15, 2008: 85) I find those with a longer service history hold a different perspective in, *"being state registered is the biggest sham, rip-off, con whatever you want to call it"* (M37, 2008: 148-149) as it "*has not changed a thing apart from the fact there is now a fee to pay...no perks*" (M31, 2008: 62) to which newcomers are reluctant to disagree except in private exchanges with myself. State registration is not as I expected a source of pleasure but a perpetual source of irritation that acts to dampen engagement particularly when it is due for renewal, as this is accompanied by a potential forfeit, as M24 (2008: 176-178) explains,

> *"If you are late renewing your registration the trust downgrades you to a technician until you have paid up"*.

CPD through which *"practicing paramedics are able to inculcate change and embrace the continuous development of a world leading modern health care service"* (COP, 2014) does not inspire my participants. Their disengagement stems directly from a lack of flexibility around the timing of CPD training courses, as M24 (2008: 180-181) implies, *"we have to do CPD as part of our registration but can only do so on our days off with any time accrued taken off by agreement"*.

The BPA which at the time my fieldwork takes place is the paramedics' professional body is perceived as, *"another cost with no benefits"* (M26, 2008: 93) and membership

is low. Consequently, I find myself having to agree with M33 (2008: 97) "*I think it will take a long time for state registration to have an impact*" when I had expected to find state registration readily embraced for the opportunity it offers to garner respect from both other professionals and the general public.

The change in recruitment to direct entry following state registration has also bombed. Instead of it being viewed as inclusive through which professional recognition and parity is enhanced, it is divisive,

> *"There is a sense of elitism amongst the old hands as becoming a paramedic was like a beacon they could only reach through clocking up years of experience. The new ones have kind of diluted their status"*
>
> M18, 2009: 96-99.

However, as I discussed in chapter two, claiming identity obliges the students to fit-in with their senior colleagues who in emphasising, "*it is first and foremost a practical job and academic second"* (M32, 2008: 84) act to subdue any challenge to the dominant long-standing group identity of road crew. They defend it through first questioning the suitability of the new recruitment scheme. F23 (2009: 25-27) comments,

> *"Some of us old hands are concerned about the type of person coming in through the direct entry scheme. The pay and conditions are quite good now and may be are attracting those who would not otherwise be interested".*

Secondly they undermine the efficacy of the new academic training programme. F33 (2009: 22-25) remarks,

> *"Traditional route is best in my opinion as new paramedic training does not offer enough personal contact with patients to enable trainees to become both confident and proficient before having to take complete responsibility for patients as they may be teamed with ECSW or even out on their own in a car".*

Accordingly I argue role identity of a 'profession' is not as dominant as that of 'road crew' which remains the prime motivator of performances of emotional labour both within as well as without the group so that membership is endorsed not jeopardised which leaves identity tied to the occupation not reframed as a profession. Although there are aspects to the role which dampen the paramedics' fidelity it is, as I have highlighted, robust. Engagement is deep rooted in the satisfaction which stems from the ability, inherent to the job, of being able to make a difference and help people. As I evidenced in the previous chapter how paramedic interaction utilises a high level of emotional labour I close my explanation of job antecedents by disputing that assertion by Grandey (2003) highly satisfied workers act less.

5.2.2 Organisational Antecedents

In this subsection I explain organisational antecedents through the theme of 'Low Morale' to which I link the two deductive categories: 'Climate' and 'Culture' and two deductive codes: 'injustice' and 'hassles' and I address the question as to whether emotional labour is acknowledged by the organisation or constrained through the theme 'Taboo'. The organisational 'Climate' to which I link my deductive codes: 'policies'; 'training'; 'openness' ; 'support' and inductive codes: 'communication'; 'misplaced priorities'; 'political' and 'public' I describe as cloudy because even though there is a view *"terms and conditions of employment are good"* (F15, 2008: 74) there is a lot of dissent expressed over certain policies. "*The sick policy is not perceived as fair as it prejudices those that are genuinely ill*" (M16, 2008: 65-66) as it permits three absences only over twelve months. As F11 (2008: 597-599) explains,

> *"If you have three separate days off in a year that is worse according to the service that is worse than having four months off with a bad back because although its four months off it is only one period of sickness".*

Although common to every member of the organisation, this policy is considered particularly harsh on the road crew who have to contend with "*sick people coughing and spluttering all over you"* (F11, 2008: 602-603). However, in providing opportunity for resistance it offsets the policy on annual leave that obliges the paramedics to take whole weeks within designated calendar blocks. As F12 (2008: 254-262) explains,

> *"People will take three episodes, stay well for twelve months, take three episodes stay well for twelve months, take three episodes because they cannot get their annual leave, they cannot get their holidays when they want. It is a stab in the back for management, as a payback I will take my three episodes because I know I won't get called in...People say I will save my sickness for a time when I need it".*

Equal opportunities legislation has led the organisation"*towards discriminating against men"* (M31, 2008: 116-117) according to my male cohort. This notion stems from how all minorities in the service including women are being actively encouraged to apply for job opportunities but there is a more potent explanation, as M26 (2008: 74-77) reveals,

> *"When they get pregnant they are taken off the road and given light duties but the light duties argument does not hold for males who may have a bad back for example and should not be lifting just as a pregnant female should not be".*

However, concern over equal opportunities is dwarfed by the legacy of discontent left by the meal break dispute. M33 (2008: 45-47) explains,

> *"The meal break dispute went to arbitration and management said beforehand they would abide by its findings but then reneged on it when it went in our favour that left a sour taste in everyone's mouth".*

Instead of being paid to be available over a meal break the paramedics are now stood down and whilst they are not interrupted neither are they paid. Although I find this change is welcomed by those of my participants who want to refuel in peace, *"at least now once you are here you have got half an hour and you know that half an hour is yours so it's loads better"* (F13, 2008: 206-207) others do not want a fatality on their conscience, *"I have to take meal breaks when I would rather work through"* (M34, 2008: 92-93). The incident where a teenager had choked to death on a pen top due to a delayed response attributable to the nearest paramedic crew being on a meal break (BBC News, 2007) is often raised with me as it occurred within the region.

Significantly no formal training is provided on emotion and how to handle it even though emotions are recognised within the paramedic standards of proficiency,

> *"There is no training on emotion management. You have to rely on finding an experienced paramedic who you can trust to be your role model and mentor as it is a skill learnt on the job. It would be a good thing if there were a training module"*
>
> M21, 2008: 246-249.

So whilst the "*job is paid well and the holidays are good"* (M22, 2008: 26-27) I find specific policies and the absence of formal training on the emotional aspects to the job cloud that contentment. Communication, another vital dimension to the corporate climate, is described as *"appalling"* (F32, 2008:92). After observing across several stations I am inclined to agree communication could be improved. However I do not agree with M21 (2008: 267-274) that HQ are to blame for all of the confusion he alludes to below as team leaders carry responsibility on station,

> "*HQ perceive themselves as good communicators but staff don't understand why new rules are introduced because they are just put out on the Intranet without any justification. There are so few IT terminals that half the time staff simply haven't been able to logon and therefore don't know things have changed. Sometimes changes are faxed to stations if they relate to drugs protocol and these faxes get pinned up on the notice board but there is no system for checking all staff have seen them. They are often ignored because so much info is churned out and the important pieces are swamped by those of lesser significance".*

There is however an established pattern of "*a top down passage of ideas without consultation"* (ibid: 285-286) aided by how *"you cannot challenge anything"* (M32, 2008: 29) that leaves the road crew firm in their belief, "*suggestions and comments go unheard and our needs are ignored"* (M24, 2008: 139-140).

Although NEAS *"tries to be an open organisation"* (M13, 2008: 37) I find the majority viewpoint is "*there is a closed dialogue on emotions*" (M14, 2008: 68) partly because,

"It is taken for granted that emotions and stress are part of the job and therefore do not need to be acknowledged"

M27, 2008: 40-41.

This makes it a particularly difficult workspace for student paramedics,

"I don't think the trainees are able to voice their fears. They are expected just to get on with it as they knew what they were getting into"

F23, 2009: 81-82.

But I find this reserve is more general, M16 (2008: 37) explains, *"asking for help on an emotional level is perceived as a sign of weakness"*. Although the experienced acknowledge, "*you do need to be able to talk about jobs*" (M36, 2008: 50) as, *"those that bottle things up are just storing up trouble for themselves in the future"* (M22, 2009: 69-70) they are also restrained as the organisation *"does not actively promote an emotional dialogue"* (F33, 2009: 30).

There is an expectation *"all paramedics can cope and will carry on coping"* (F12, 2008: 503-504) that almost excuses the organisation. As M17 (2008: 30-31) comments, *"support seems to depend on who is on duty in Control and how busy it is"*. As there is no formal policy it is regularly overlooked, as F21 (2008: 255-258) indicates.

"They will go to a job which is something totally out of the ordinary and again nobody will ring up and say, 'Are you alright after that job that was not very nice' they are just expected to get on with it".

"*The organisation rarely enquires if ok following a traumatic incident*" (M27, 2008: 41-42) and these can be horrific as M32 (2008: 70-74) recounts,

"The worst job I have had to go to was one Christmas to a nineteen year old female involved in a farm accident with a piece of machinery that had severed both arms and breasts from her body. She was dead of course. I was not offered any support after it and when I was summoned to appear at the Coroner's Court as we can be to sudden

deaths. I informed management and was told I would be given no time off in lieu".

Overall, emotional support is described as *"hit and miss"* (M25, 2008: 56) leading M38 (2009: 51-53) to argue,

> *"Emotional support needs to be reviewed. I don't know whether the organisation could do anything to improve it but it should still be reviewed as the long-term consequences are not being addressed".*

M24 (2008: 47-50) attributes this to misplaced priorities,

> *"NEAS vision is 'Patients come first' whereas it should be 'Paramedics come first' as former applies to paramedics who need support of organisation".*

Consequently I propose emotional support is a salient issue even though it is commonly understood, "*a combination of a lack of resources and the volume of calls received negates any real attention to emotional needs"* (M34, 2008: 60-62) there are implications, as F22 (2008: 64-65) indicates,

> *"The ambulance service runs on goodwill. There is low morale and a sense they are pushing you to your limits".*

Although both Australian and Norwegian emergency medical services come under public sector control, none of the literature I examine refers to either the political or public climate so I widen my definition of the organisational climate in order to inductively acknowledge both as they each have an adverse affect. Within the UK there are three political masters in the DOH, NHS and JRCALC and each I find has capacity to provoke anxiety and anger amongst the paramedics in my sample. The DOH, in addition to the imposition of state registration (DOH, 1999) which, as I have discussed has not been welcomed, are also responsible for the introduction of rapid response vehicles to the emergency fleet and the change in treatment for Category 'C' patients. Whilst the DOH insist rapid responders improve the patient experience Unison claim lives are being put at risk in order to meet stringent response times (Weaver, 2007). In

response, my participants even those who indicate *"I prefer to be on the car"* (F22, 2008: 31) agree the use of rapid responders, "*massages the figures"* (M37, 2008: 533). As F23 (2009: 69) explains, "*the first vehicle on scene stops the clock"* to which F21 (2008: 346-348) adds the patient experience is hardly improved when, "*you are going to a cardiac arrest or something and you think I am on my own here*" knowing effective CPR needs two responders. Although I witness Category 'C' calls being assessed, treated and left at home without issue there is a lot of unease around doing so, F21 (2008: 550-560) explains,

> *"When I did the Cat 'C' course we were saying, 'You know we are going to fill in this paperwork and leave somebody at home and the first time we make a bad call and the patient suddenly gets worse or somebody dies you know and we have left somebody at home and the family are going to complain. What is going to happen then, are we going to get the sack? No. Well we will you know' and there was a lot of people quite cynical about it saying 'I am not going to do it, I don't want to do the Cat 'C' course, I don't leave anybody at home, I take everybody to hospital' and the whole idea of Pathways and the Bradley Report and Cat 'C' and everything is to try and... I think they want to keep a million...they want to reduce A&E attendances by a million a year over the country and you know we all have to do our bit and people are saying 'I am not bothered I am taking everybody into hospital'".*

NHS efficiency reforms have led to the introduction of the emergency care support worker [ECSW] to replace the advanced technician (NHS, 2009c) who crews an emergency ambulance in partnership with a paramedic. This new role is regarded as, "*cheap alternative to technicians"* (M34, 2008: 117) by my participants who express dismay over perceived redundancies but also fear of the additional stress attached to sole responsibility. As a trade union representative (2008: 612-615) explains,

> *"They don't dislike the ECSW's, they just don't like working with them because before they had someone to advise and help them and now they don't. They just have a driver and some of them sit in the cab".*

The JRCALC has also contributed unease through proposing a derogatory change to the skill set. The Clinical Director (2008: 491-502) explains,

> *"There is a move around a thing called primary PCI which is replacing thrombolytics in heart attacks. There is a lot of move that we have to implement there and it is kind of like seen by staff as deskilling them because they are able to do a definitive care injection at the minute but we are going to stop that and just say take the patient quickly to a hospital, so they are going to see full circle because that's what they did a long time ago, pick them up and take them to hospital".*

Any notion of regression particularly returning to 'scoop and run' is greeted with horror when I refer to those comments by the Clinical Director. The public climate is perceived by my sample as largely hostile due to public confidence in the ambulance service being regularly eroded through negative media reports. The Communications Director (2008:747-8) provides a prime example, in his relay of a statement made at a public meeting by a local councillor who knows how to attract media attention,

> "*I don't think people living in this area should bother calling for an ambulance they should just dial an undertaker".*

As a result I can easily understand why F21 (2008: 33-34) considers,

> *"We are under appreciated by the public, who will say things like they would prefer their relative to see a doctor".*

The culture to which I link my deductive codes: 'informal'; 'formal'; 'family'; 'socialisation'; 'liberal' and 'macho' and inductive codes: 'alien'; 'operator'; 'engineering'; 'manager' and 'executive' through which I recognise the culture splits into four subcultures each holding their own agenda, as Wankhade (2010) proposes in chapter two. The paramedics reside in the operator culture which M24 (2008: 46), in voicing, *"open, friendly, tolerant and supportive"* perfectly describes the liberal informal culture I observe and experience as I am never sidelined but welcomed and drawn into both conversations and activities. As Filstad (2010) remarks in chapter two

the informal culture is where newcomers acquire appropriate behaviours through socialisation,

> *"Watching, copying other members of staff. As you sort of learn the job you pick up things...that is a good way of handling that…that is a good way of handling that... so it is learnt behaviour"*
>
> M12, 2008: 578-582.

However this "*family atmosphere*" (F22, 2009: 66) is punctured on certain stations. M26 (2008: 36) warns "*you can be stabbed in the back"* whilst F16 (2009: 50) indicates *"gossip is a big problem"* and F33, 2009: 27-28) considers, "*a macho culture is still evident particularly at certain stations where it has rubbed off on females who can be unfriendly and even aggressive*".

Divisional management isolated from both the road crew and the executive board at HQ form the manager subculture. As I discussed in the previous chapter the paramedics find the behaviour of these managers is inconsistent as they can just as easily be helpful and recognise a job well done as authoritarian and obstructive depending on circumstances, leading to the remark, "*it is a mix of mini-cultures within and between both divisions and stations"* (F16, 2009: 43-44).

The executive culture envelopes the CEO and his directorate based at HQ who are described as "*too distant and impersonal*" (M27, 2008: 72) leading to,

> *"Bit of a 'Them and us' culture. NEAS is pyramid shaped with paramedics a thin strip at the bottom and a top level HQ whereas it should be inverted with a small HQ at the bottom supporting a wide band of paramedics on top"*
>
> M24, 2008: 41-46.

With the paramedics accounting for just over a quarter of the whole organisation whilst HQ account for 56% (NHS, 2009b) that comment by M24 is not unfounded. As *"support services that is HQ are seen as increasing whilst the front line is contracting"* (M36, 2008: 61-62) and *"HQ have everything they want whereas out on the road*

people have to wait" (M14, 2008: 28-29) all the paramedics I speak with feel akin to second class citizens. I am made acutely aware of a collective sense of alienation through their comments,"*HQ is like another world*" (M35, 2008: 44), *"HQ is like a foreign territory"* (M22, 2009: 38) This pervasive sense of alienation severs the paramedics from the rest of the organisation to echo the finding by Mahony (2001) and reinforce the group dynamic proposed by Nisbet (1970) in chapter two.

Interaction varies but the paramedics persistently claim, "*we are treated as automatons and HQ play on our goodwill* (M32, 2008: 79) leading to the addendum "*you are only valued for what can be delivered*" (M16, 2008: 54). I find agreement the organisation *"does not give frontline staff enough support partly because management do not appreciate what the job is really like"*(M36, 2008: 58-59). As "*crews are not expected to have feelings*" (M38, 2009: 40) this exempts emotional support. The formal organisation the paramedics consider, "*is still a macho culture*" (M26, 2008: 40-41). Any desire, *"emotion should not be taboo but recognised and open"* (F12, 2008: 536) is thwarted by the enculturation of masculine values. I evidence denial in a comment by M18, (2009: 56-58),

> *"It is the norm that emotions are not spoken about which makes it difficult for anyone to broach a conversation about them".*

And stoicism in a comment by M12 (2008: 46-48),

> *"There is sometimes a kudos that paramedics don't need any support because they just do it, it's their job. If they see something that is awful, it does not matter, it's their job".*

Accordingly I reject the optimistic claim by M24 (2008: 136-137), *"traditionally there has been a macho culture but that is dispersing and it's becoming more informal"*. But I support the more modest assertion by F32 (2008: 82) the culture is "*still macho but softening"* through which to describe both the formal and informal culture in NEAS.

The engineering subculture encompasses the Control Room which my participants perceive as embodying, *"targets are the main focus not patients*" (F23, 2009: 67-68) that contrasts sharply with their own view as I am constantly reminded, "*patients are*

my priority not targets" (F32, 2008: 30) which F12 (2008: 424-433) confirms,

> *"They care about did you get to the job in eight minutes they don't care about you got to that lady, you managed to cannulate her, you didn't move her, you supported her legs, you gave her pain relief and when she went to hospital she was comfortable and happy with your care and treatment. They don't care about that but I care about that and most of the other paramedics on the road care about that".*

Being regarded merely as "*a bum to put on a seat to drive an ambulance and to attend"* (M12, 2008: 32-3) by dispatch officers undermines the paramedics' professionalism prompting those acts of resistance I mentioned in the previous subsection. But it also carries another more serious threat to patients, as M11 (2008: 279-285) reveals,

> *"They are willing by virtue of the fact that they are my employer to put me in some situations where I could not be providing the best of care to the patient. Such as that bus has not had an AS17done today which is a daily vehicle check. It has been running light on equipment all day through no fault of our own but due to the nature of the workload that we have had".*

The idealised requirements of the Bradley Report (DOH, 2005a) of which I included an extract in chapter two are unlikely to be realised as far as the road crew are concerned for either themselves or the service when the organisation treats them as "*bums on seats*" (M31, 2008: 131).

These findings lead me to describe organisational emotionality within NEAS through the theme 'Taboo' which links my findings in respect of the codes: 'openness'; 'support'; misplaced priorities'; 'alien' and 'macho'. I position NEAS alongside their Australian counterparts which I justify on the grounds an open emotional dialogue is thwarted by emotion having a connotation of weakness that does not fit the core organisational macho value of stoicism. As I engage in an emotional discourse with my participants I am able to penetrate their generally held reserve but whilst those pockets of discourse are acknowledged to offer relief this is short-lived. The descriptors for emotional support offered by the paramedics indicate it is inconsistent and their

viewpoint suggests their needs come second to those of the organisation. Both the climatic conditions and the culture emphasise the paramedics are a resource, alienated from the organisation by its pursuit of politically inspired targets without deference to their human frailties. This has led to the view organisational priorities are misplaced as effective service delivery stems directly from the paramedics on the frontline whose effectiveness should take priority. This suggests the advice issued by Goffman (1967) in chapter one has not been assimilated. Without any evidence to support an organizationally driven commitment to understanding emotion and its management process I answer the question as to whether the experience of emotional labour by the individual paramedic is acknowledged by the organisation or constrained, with a nod towards the latter.

Organisational injustice is evident in the remark by F32 (2008: 35) "*some people are better looked after than others"*. But it is complaint handling through which injustices are most frequently brought to my attention because, as M28 (2008:70) remarks, *"whenever there is a complaint you are guilty until proven otherwise"*. Organisational hassles are encapsulated in poor facilities I evidence through the remark by M14 (2008: 34-8), "*facilities vary between stations but generally they are not great"* and I select a comment by F31 (2008: 53-56) as indicative of the general annoyance,

> "*We have no spare electrical sockets upstairs and we have been waiting three months already for some so we can have additional IT facilities which are needed because we cannot access the Intranet from home and therefore cannot check our shift allocation"*.

The frustration of not knowing which combination of shifts have to be worked whilst on relief until the last minute is compounded by having to come to the station to find out. As F32 (2008: 27-28) comments, *"It's a good job, brilliant in fact but organisational politics spoils it"* to voice an opinion with which I close this subsection as it is one to which I find no one is to disagree.

5.2.3 Individual Antecedents

In this subsection I first present my findings relating to the individual predispositions of experience, gender and temperament before I add my findings as to other individual

cues I find significant for paramedic emotional labour. I explain my deductive category of 'Experience' through two themes: 'Fitting-in' and 'Maturity' in order to differentiate performances and address the question as to whether experience is a factor in performances or their effects. I link the deductive code 'fit-in' and inductive codes: 'out-going'; 'circumspect'; 'competent' and 'vulnerable' to the former and deductive codes: 'wisdom'; 'age' and 'stamina' and inductive codes: 'life experience' and 'vulnerable' to the latter. Although I recognise life-experience in chapter one it did not contextualise and therefore is not part of my deductive template so I add it inductively.

"*You have to fit in*" (M24, 2008: 132), as Filstad (2010) points out in chapter two and M11 (2008: 95-97) explains, *"you have got to be able to work with people you have never met before for twelve hours in the front of an ambulance and provide patient care".* As the relief rota sends the paramedics to different stations across their division fitting-in requires extra effort, as M11 (2008: 104) explains, *"on relief I work with different people all the time and I have to amend the way I am with certain people."* F12 (2008: 83-84) in commenting, "a*nyone who keeps themselves to themselves isn't ostracised but considered to be hard work*" implies being outgoing and joining not abstaining from conversation and activities on station smoothes that process. However, M11 (2008: 261-265) in advising, "*listen to gossip but don't act upon it"* indicates circumspection is also needed particularly as newcomers can make "*a very bad impression very quickly"* that is "*very difficult to backtrack on*". The effort involved in fitting-in is exacerbated by having to learn at the same-time how to interact competently with patients. As F12 (2008: 94-98) explains,

> *"It is definitely an alien thing to say 'So why have you called us' and then just clam up and not be able to say anything else because you don't know what else to say. They go 'Oh yeah I have taken an overdose' and you go 'Ok then', you don't want to pry, you don't want to say why have you done that and why have you done this that only comes with like experience".*

Fitting-in requires, as I illustrate in Figure 5.1, a high to very high level of emotional labour as 100% of the means I extract from the inventories and plot according to experience, show those paramedics with the least experience i.e., less than five years, all score below ninety on the emotional labour scale. It is however a process eased by

maturity as "*it is a practical job best suited to someone with life experience*" (M25, 2008: 23). Through sharing prior experiences of which I find military service fairly common the paramedics signal not only their suitability but their resilience and trustworthiness, qualities I indicated in chapter two transforms the individual into a worthy partner. They also have a cache of stories to enliven standby of which I am not the only avid listener but most importantly they know how to handle people from all walks of life they will encounter as patients, as M11 (2008: 447-455) informs me,

> *"I think the more mature members of staff not so much having been on a long-time but people like myself who are older can adjust and tailor and just hit the right thing whilst the younger members of staff who might not have had as much experience in dealing with members of the public might have a bit of a problem with that".*

As I show in Figure 5.1, ten out of the eleven paramedics holding ten or more years of service utilise a high to very high level of emotional labour for which M38 (2009: 142) voices the explanation, "*you get better at hiding emotion*". Performances by this cohort differ from those with the least service through returning a higher percentage of 'very high' scores [64% opposed to 43%]. However, on closer examination, I find four individuals whose service is less than five years who return a very high score have previous experience of the military or other emergency services. Altogether 80% of performances utilising a very high level of emotional labour are attributable to experience of life and/or the job. Accordingly, I explain performances by neophytes whose inexperience on the job is offset by life experience alongside those of my more experienced cohort through the theme of 'Maturity' in recognition age, as Mannon(1992) proposes in chapter two similarly acts to exacerbate emotional labour.

However to address my research question I first explore differences in stamina and vulnerability. I find agreement the role makes inordinate demands both physically and emotionally that increase with tenure as Mannon (1992) predicts, in the comments, "*A&E is a job for young people*" (M31, 2008: 153) and "*it is not a job for an old man"* (M33, 2008: 87-91). The inexperienced are vulnerable as M25 (2008: 52-53) remarks,

> *"New paramedics are not given the support they should be given. They talk a good show but it isn't backed up".*

Although the effects of performing emotional labour are lessened for those with a longer service through having had more time to "*learn coping strategies"* (M36, 2008: 39) this does not confer an immunity to trauma, as M38 (2009: 43-47) intimates,

> *"A crew here attended a fatality....a crushing but were not given any time to reflect and deal with their emotions. I attended something similar. Guy working on a tractor became trapped beneath and his skull was completely crushed. When 'Clear' given another job. When asked to be stood down was told 'You have been on long enough, did not think it was a problem for you'".*

An on-going lack of support leaves the paramedics vulnerable to adverse effects throughout their career as F21 (2008: 1277-1278) clarifies, *"experience helps with routine deaths but not those that are out of the ordinary"*.

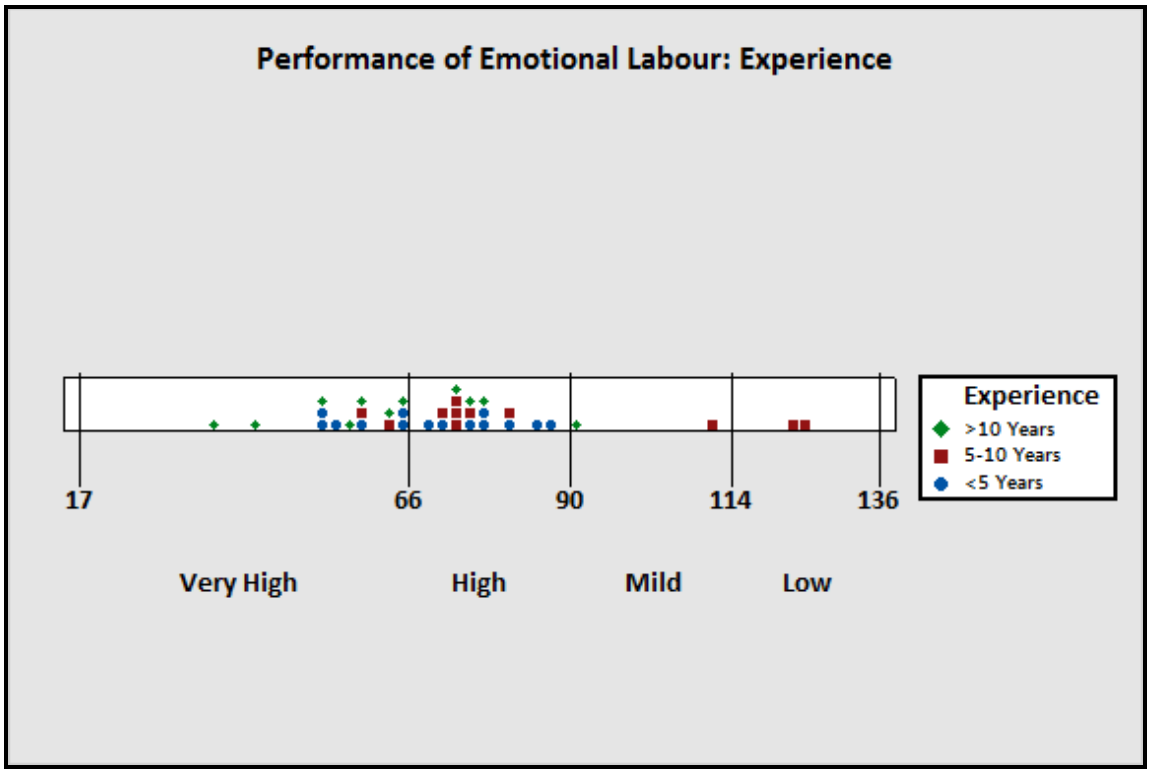


Figure 5.1: Emotional Labour: MERI mean scores stratified by experience.

This discussion allows me to address the question as to whether experience is a factor that limits the amount of acting and/or the effects of doing so. Within my sample I find experience does not diminish the demand for emotional labour but exacerbates it. New

recruits utilise a high to very high level of emotional labour in order to both fit-in with more senior colleagues and manage their fledgling interaction with patients. But maturity in life and/or the role brings a greater awareness of and expertise in emotional control that I argue leads to the emotions of those individuals being managed more. Although I find the consequences attached to managing emotion are eased through personalised coping strategies these do not abate as the more experienced paramedics remain vulnerable to the same threat to their resilience as their junior colleagues. Whilst my observations allow me to confirm experience undoubtedly hones both clinical and emotional competences the argument of attrition put forward by my more experienced cohort prompts me to agree with Mannon (1992) these come at a cost.

Gender I explain through the theme of 'False Advantage' which links the two deductive subcategories: 'Male' to which I link the deductive codes: 'stoicism'; 'caring and 'hegemonic masculinity' and inductive codes: 'tears'; 'homogeneity' and 'manual' and 'Female' to which I link the deductive codes: 'stoicism'; 'caring' and 'hegemonic masculinity' and inductive codes: 'sociable'; 'sympathetic'; 'maternal' and 'natural suitability. My female participants claim they hold a natural advantage which differentiates their performances from their male colleagues. They make four assertions in support of this claim with the first made by F23 (2009: 73-74) who suggests they are more in tune with emotion due to being more sociable,

> *"Women talk more to each other and to others so I think they find it easier to deal with emotions and emotional situations".*

The second made by F12 (2008: 508-510) asserts they are more sympathetic,

> "*I was called out to a man whose wife had died three days ago and we cried together and I sympathised with him. A male paramedic would not have done that but it was what he needed".*

Whilst the third by F21 (2008: 1283-1284) creates advantage through reference to the maternal instinct, Hochschild encapsulates in that silent label 'mother' in chapter one,

> *"I think female paramedics identify more with parents when an incident involves children that are ill".*

To which F33 (2009: 40-42) adds the fourth which emphasises a natural suitability for a caring role,

> *"I think female paramedics are more empathetic and therefore their experience with patients is better. They can more easily reassure and obtain information".*

The individual traces I compile from the emotion checklists contained in Appendices 5.1-5.3 dispute those claims. Appendix 5.1 shows sympathy is genuinely expressed by 50% of males compared to 25% of females whilst Appendix 5.3 shows it is also feigned by more males [54%] than females [42%]. For Shields (2002) tears communicate emotion too intense for words to convey and do not, I find, distinguish the female paramedic, as Brownmiller (1984) argues. M12 (2008: 256-257) confirms,

> *"I have had tears in my eyes and had to fight them back when I have been trying to resuscitate a bairn. You know it is natural human emotion isn't it? You can't help it".*

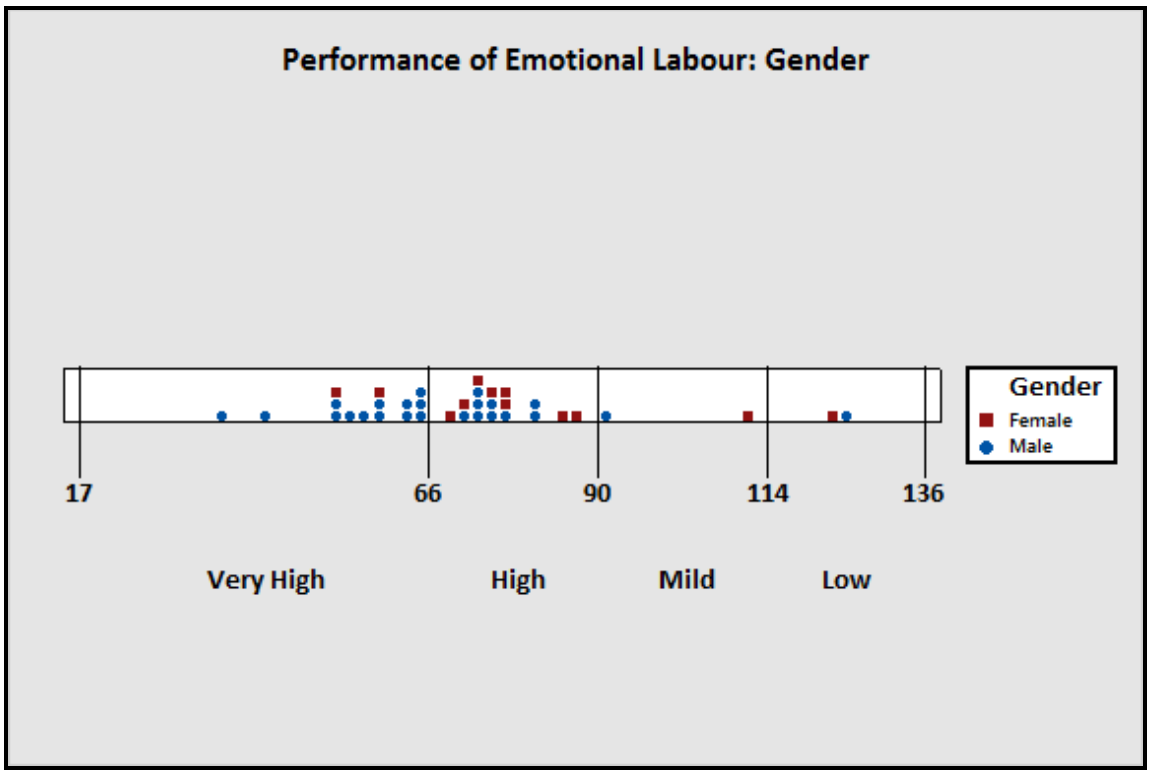


Figure 5.2: Emotional Labour: MERI mean scores stratified by gender.

The male perspective is one of homogeneity in which both genders are equally as likely to go to bad jobs, as M12 (2008: 330-333) informs me, *"it does not matter whether they are male/female, all male, all female that ambulance will go to that job. Nothing is taken into account of what you are going to".* Following which *"in terms of emotional support both sexes are treated the same*" (M31, 2008: 114). The comment, *"too much female bravado about*" (M22, 2009: 70) suggests the female paramedics do not just replicate masculine behaviour in stoicism but make sure it is noticed. Although they seek to differentiate themselves it is within not without the hegemonic masculinity. In Figure 5.2 I plot the means I extract from the inventories by gender to illustrate performances by both mostly require a high to very high level of emotional labour. This plot offers no support for that notion of female advantage. There is no significant cluster of female performances and although the plot suggests male paramedics are more likely than females to use a very high level of emotional labour I recognise the cohorts are unequal and therefore I decide to extract no significance from this.

Accordingly I address my research question which inquires, is the experience of a female paramedic different from that of her male colleagues, with a perceptual 'yes' but an actual 'no'. I argue in recognising the role remains, "*a male type of job*" (F13, 2008: 87) which is *"more manual than anything else"* (M31, 2008: 52) so "*when it comes to moving and handling it is expected that the men do better"* (F13, 2008: 88-89) the female cohort seek to authenticate themselves in a traditionally male workspace through emphasising their natural suitability for the caring aspect to the role. However, this advantage is unsubstantiated. I neither observe nor gain from discussions with the male cohort any impression this is representative of their reality. In addition, the quantitative data for both cohorts does not reveal significant differences therefore I declare the notion of female advantage is false and emphasise performances by both male and female paramedics incline towards similarity in their utilisation of high levels of emotional labour. I therefore conclude the UK paramedic workspace similarly to that of Australia, as Boyle (2005) identifies is equally demanding of both males and females.

With respect to temperament and skills I link both of these deductive categories to the theme 'Fitness' as I recognise certain individual qualities and abilities suit the role and induce performances as both Boyle (2005) and Filstad (2010) intimate in chapter two. I link and evidence deductive codes: "*empathy*" (M38, 2009: 27); "*sense of humour*" (M32, 2008: 37); "*trustworthiness"* (M11, 2008: 115); "*adaptable*" (F12, 2008: 80);

"*confident manner*" (F37, 2008: 103); "*able to control their emotions* " (M15, 2008: 23) and "*a positive outlook"* (F15, 2008: 69) but not 'hardness' or 'religious belief' and I also link inductive codes: "*compassion*" (M32, 2008: 39); "*sensitive*" (M24, 2008: 117); "*calm*", "o*pen-minded*" (M34, 2008: 33); "*methodical*" (F31, 2008: 25); "*streetwise*" (M22, 2009: 44); "*common sense*", "*patience*" (F16, 2009: 93); "*pragmatic*" (F22, 2008: 39); "*conscientious", "self reflective"*(F25, 2008: 23-24) and "*honesty"*(F33, 2009: 47) to fully describe the ideal temperament which increases commitment as I explained in chapter one and prompts performances to accord with paramedic standards.

Skills to which I link the two deductive codes; 'communication' and 'acting' increase the individual's ability to recognise when emotional labour is required and to perform appropriately. "*People skills are very important*" (M32, 2008: 37) particularly the ability to "*be able to both talk and listen"* (F15, 2008: 26) as communication is"*98% of the job"* (F13, 2008: 304) without which, the paramedics would, *"find out nothing"* (F13, 2008: 310), making it key to the role as M33 (2008: 40-42) emphasises,

> *"Communication is the key skill. An individual needs social skills in order to be able to talk to the patient, reassure them and get the information he/she needs to make an assessment of their condition and needs".*

Acting skills I evidence in the remark by F16 (2009: 82) *"I am aware that I am acting out a role"* and how M11 (2008: 447-448) indicates, *"as you go in the house you put a certain frontage on"* although neither remark indicates the level of competence of the actor.

There are a number of other factors that impede performances through their negative effect I explain through the theme of 'Impediments' I link to the deductive codes: 'status'; 'fatigue' and 'HWI' and inductive codes: 'personal baggage' and 'illness' both of which I recognised in chapter one but which did not contextualise. As I find a paramedics status vacillates I agree with Palmer (1989: 123) a paramedics' status is "mutable." The incident I label GPT1 provides a prime example. The status of the attending paramedic is initially high as I observe both the patient and bystanders to the incident in the supermarket visibly smile and express relief at her arrival. But I observe how her status dips sharply when a retired surgeon appears on the scene questioning

both her diagnosis and treatment decisions provoking concern all round. This paramedic acknowledges, where medical practitioners are concerned, "*I don't think we will ever achieve the status that they have got with the public*" (F21, 2008: 854-855) and suppresses her obvious annoyance conveyed to me in a disdainful look. However, her frustrations are alleviated when her status is re-inflated by the BASICS GP who I mentioned in chapter four, warmly issues praise before resuming her shopping. In recognising, *"at the end of the day it's up to me, if the job goes tits up, it's me who carries the can"* (ibid: 872-873) that paramedic confirms patient care has to override that personal impediment of animosity no matter how much effort is required.

Fatigue I evidence directly in red rimmed eyes, yawns and general slowness particularly in those paramedics on the last day of a set of shifts. As one of my participants remarks, "a*fter four on the trot, you are really tired and the job becomes more of an effort*" (M38, 2009: 123-124). Fatigue exacerbates emotional control because tiredness, as F12 indicates, is an impediment to the exercise of both clinical and professional mandates,

> *"You have got to maintain professionalism whether you are tired or not. Sometimes it is hard. Sometimes you do not want to but you have to act as the patient's advocate at the end of the day, you have to do what is right by them"*
>
> F12, 2008: 311-313.

HWI, ignored in the prehospital literature, is in my view pertinent due to it being de rigueur for a personal mobile phone to be carried. Although my participants all agree, *"you would be totally isolated if you did not have one"* (F11, 2008: 273) they are a distraction, as my exchange with M22 (2009: 80-81) suggests,

> *Researcher: Do you ever have occasion to bring stress into work?*
> *Respondent: Only time is if I am on the phone to my wife and she is stressed about the kids. I am stuck at work and cannot do anything*

HWI also arises through worries over elderly parents and children what Frone, Russell and Cooper (1992) term FWI in chapter one. F33 (2009: 51) provides examples in her comments, "*I worry about my father who is eighty-five and lives alone*" and how on night shift she is *"often fearful for my two children in particular my daughter who is*

seventeen. I like to know she is in and alright" (ibid: 54-55). Pets left at home alone are also a source of this cue, *"I worry a lot about the dog"* (F12, 2008: 492) as is illness in a loved one, "*my girlfriend has got Myalgic Encephalomyelitis. If she is not very well then that doesn't make me very happy so when I come into work I am not particularly happy and maybe don't do my job quite how I should"* (M12, 2008: 317-320). However not everyone claims to be affected and I present a contrary viewpoint encapsulated in the comment by F15 (2008: 72), "*I'm good at switching off between home and work and vice versa*" to emphasise it is individually significant.

Personal baggage and illness combine in the two examples I use to close this section. In the first anxiety over the possible return of an illness previously treated successfully accompanies M28 (2008: 68-69) who comments, *"I am waiting for some test results and I am a bit worried about them"* whilst M23 reveals since being diagnosed with a particular illness he feels his status has changed, "*from being the shining star to feeling you are getting dumped*" (M23, 2008: 1049) which has left him with a lingering anger which impedes his performances particularly with the organisation.

5.2.4 Acknowledging the Antecedents

I conclude this section by constructing an answer as to which factors relating to the nature of the job or the organisation or the individual trigger emotional labour: Aspects of the job which cue performances either engage or conversely, disengage fidelity. Role identity vacillates between the two as whilst the paramedics exhibit a strong and cohesive occupational identity as 'road crew' they are dismissive of the trappings associated with formal professional recognition. State registration in particular is an obligation they undertake with reluctance rather than anticipation so although a professional identity is descendant rather than invention, socially desirable and accredited it has failed to connect. Consequentially it is fragmentary and fragile suggesting the internal reframing, I outlined in chapter two, is incomplete and it is their occupational identity rather than that of a profession which continues to motivate performances.

As street level bureaucrats the paramedics renew their engagement on a daily basis which encourages role appropriate performances but this is degraded by constant reminders they are expected to defer to dispatch officers. The tempo also engages when

it is busy but when it is quiet this can splinter. The unpredictable nature of the job exerts a positive influence through its inherent uncertainty and constant variety but this turns negative when a lack of control over meal breaks, comfort stops, shift finish times and rotas compromises the paramedics' personal time. A tendency to disengage is also cued by operational hassles of which I highlight complaint handling, paperwork, uniforms, driving [although this can also induce an uplift] and equipment. Ultimately the satisfaction gained from making a difference acts to minimise disengagements and cue positive responses.

Organisational antecedents cue performances through enveloping the paramedics in a miasma of low morale that exerts a negative influence on their performances. It is evoked through policies that are perceived as unfair particularly those related to sick absence and meal breaks to which poor communication, lack of involvement, restrained emotional dialogue and inconsistent emotional support add to the toxicity. Although the informal culture local to ambulance stations lightens morale through being more open and supportive this still reflects traditional macho values which act to keep emotion firmly on the sidelines. The formal corporate culture at HQ reinforces rather than dispels those lingering macho values through its denial of emotional labour and its effects leading me to describe emotion within NEAS as taboo.

The paramedics are alienated by a lack of recognition and respect from organisational insiders at HQ who they perceive as being preoccupied by self-aggrandizement which hardens their identity as road crew and contributes to that notion of 'them versus us' undermining initiatives particularly those that prioritise targets over patient care. Organisational injustice in the form of complaint handling is significant for provoking anger and similarly poor facilities which represent the most significant organisational hassle do likewise. Widening the definition of organisational to include both the political and public climates reveals to further sources of anger. The former is significant because it carries the power to impose change and threaten identity whilst the latter I argue is even more significant particularly as regards morale, as it carries a pervasive influence through the paramedics having to confront on a daily basis the negativity generated by a lack of public confidence.

Individual antecedents include experience, temperament, status, personal baggage, fatigue, skills and HWI but not gender for which I find agreement with Boyle (2005)

prehospital emergency care represents for both genders, a similarly demanding workspace. Experience is significant for newcomers whose emotional labour is cued through having to fit-in with their more senior colleagues not just on station but around their division. However, this ability is enabled by life experience which returns similar performances in emotional labour to those paramedics with a longer service history who exhibit enhanced skill in emotional control. Although the more experienced can counter adverse affects with personalised coping strategies these do not provide full immunity leaving them just as vulnerable as their more junior colleagues to distressing incidents.

Temperament is significant in that dispositional characteristics, of which I select empathy and a sense of humour as illustrative, increase a paramedics' fitness to the role and their motivation to behave appropriately which includes the management of patient anxiety. People skills particularly in communication are identified as significant for the paramedic as these facilitate and secure the correct diagnosis and delivery of a compassionate response. Status, fatigue and HWI each impede performances. As I have shown status fluctuates in line with respect and when that is withheld it carries a high demand for patience. Fatigue I find is inevitable over a twelve-hour shift but when it is compounded by a lack of rest and/or nutrients it can be hard to contain and over a set of shifts demand escalates. HWI although not recognised in the prehospital literature can take many forms, all of which I argue can impede the paramedic who carries, in the guise of a mobile phone, their multiple identities (Goffman, 1961a) in their pocket.

5.3 Strategies

In this section I present my findings and construct an answer as to which emotions are constituent of paramedic performances, which rules those emotions are subject to and through which techniques they are managed by examining each clause in turn.

5.3.1 The Emotions

Each of the twenty-five discrete emotions I identified in chapter two as significant for the paramedic workspace I find are constituent of their performances. In Table 5.1 which represents my collation of thirty-five completed emotion checklists [one was declined] I present those emotions split between the two deductive subcategories: Positive and Negative in support of this assertion. The paramedics in my sample each recognise,

> "*Emotions, in dealing with them they are a huge part of this job"*
>
> F11, 2008: 752-753.

Although the traces I include at Appendices 5.1 - 5.3 demonstrate the individuality of each paramedic's emotional response there are, as I illustrate in Table 5.1, commentaries (Archer, 2000) which I explain through three themes. The first 'Habitus' links those emotions that form a tacit understanding of appropriate behaviour core to the role that extends across the shift in which the paramedics' autobiographical obligation is rooted. Through the second 'Compassion' I recognise a specific linkage of emotions that arises out of the paramedics' clinical mandate and collegial obligation. In the third 'Abuse' I link those emotions that arise from enactments of the role accompanied by the threat of abuse that I find is not partisan but embraces all interactants. Within each explanation I lift examples of the comments given by the paramedics on their checklists to support my analysis in order to minimise any projection of my own conceptualisation of paramedic emotionality and to preserve subjective integrity, as demanded by Boyatziz (1998).

The paramedic 'Habitus' links the deductive codes: 'enthusiasm'; 'pride'; 'satisfaction'; 'gratitude'; 'admiration' and 'self-reproach' and the inductive code 'confidence'.

Consistent with their claim, *"this is a really good job"* (M17, 2009: 33) the emotion most often aroused is enthusiasm but in order to fit-in, junior colleagues have to "*learn to curb enthusiastic interactions with patients and colleagues*" (M12) as they can be "*criticised for being keen"* (M16). Senior paramedics mindful of their organisational obligation over *"management ideas"* (F31) also have to openly express enthusiasm they may not actually feel with both managers and junior staff. Pride in reflecting a sense of accomplishment is evoked by successful outcomes, as M24 (2008: 98-102) confirms,

> *"I went to a cardiac arrest in the street recently with crewmate and it took us just thirty minutes from taking the call to leaving the person in hospital having given them what treatment we could at the scene and on route. We were a well-oiled team and it gave me a lot of satisfaction and pride. A good worthwhile job sets you up for the day and you go home feeling proud".*

But it is antipathic to appropriate behaviour, as F13 (2008: 332-333) remarks *"we are limited by the appropriateness of saying 'look at us we are great'. It's not the nature of the job".* Similarly satisfaction which is also a positive outcome to role performances has to be controlled when, *"you do a good job on someone who subsequently dies"* (M12). It is also cued as part of the paramedics' collegial obligation "*with new staff and trainees to give confidence"* (M31).

Gratitude I find is difficult for the paramedics to acknowledge as, *"it is sort of an unwritten rule that we are not here for the accolades"* (M22, 2009: 37-38) so their agreement, *"feedback from grateful patients makes it worthwhile"* (M25, 2008: 26) is not vociferous. Arguably this habituation also explains why gratitude is just as hard to give, "*with patients offering tea etc"* (M33), *"drunks going on about how good we are"* (M25) and "*with bystanders who offer help but in reality are a hindrance* "(M14).

Although those paramedics new to the role attempt to fit-in through expressing admiration, "*when a new paramedic you tend to admire more experienced colleagues*" (M14) it is not encouraged as any appreciation is "*not part of culture*" (M31). Self-reproach is triggered by "*something that has not gone well*" (M13) or *"has been said"* (M32) and although there is an element of reflection attached to the role, *"I carry out a self critique/appraisal of every job"* (M14) it is not the norm to carry guilt. However, it

is normal for ambulance personnel to defuse their reaction to trauma by employing an inner dialogue that permits them to debrief and contain distressing memories and any associated shame (Jonsson and Segesten, 2004). Through this inner dialogue (Archer, 2000) which I refer to as their autobiographical obligation they confront their reaction and disperse negative emotion either independently or through seeking support in order to heal and restore equanimity what Boyle (2005: 48) refers to as their "normative emotional state" in chapter two. Failing to manage self-reproach adequately is implicated in PTSD as I mentioned previously. It is evident in S2 as the most potent form of shame disconfirms identity to the extent it becomes impossible for an individual to claim it.

In addition to those six emotions I add confidence as although the literature I examine prior to constructing my checklist did not flag it as an emotion my participants argue it is. Barbalet (2001) clarifies confidence is an emotion as it satisfies all relevant criteria concerning feeling, sensation, expression, cognition and disposition. He defines it as "self-projected assured expectation" (ibid: 101) arguing "confidence, in bringing a possible future into the present, provides a sense of certainty to what is essentially unknowable, so that assured action with regard to it may be engaged" (ibid: 88). I agree therefore it is significant for the paramedic as their protocols although proven, do not come with a guarantee and their role identity obliges them to assume authority in demanding situations, as is evident in the account given by M12 (2008: 268-278),

> *"If you take the job to its fundamentals someone is calling you for assistance because they can't deal with a situation. You turn up, as I said before, you are it, you are the help and if you can't deal with it there is no one to turn to and say 'Give me a hand here I don't know what to do' you are it so yes, you have to bear that really in the front of your mind that you can't in any given situation say 'Oh God what do I do here, I am floundering I don't know what I am doing'. You do do that, you turn up to a situation and go 'Oh shit, who do I go to first'. There are four casualties, everybody is screaming come here mate, come here, somebody is saying if you don't go there I will kill you, you know what I mean. You think 'Christ what do I do' but you put a face on it, you have to and you get on with it".*

Valence	Emotion	Genuine	Suppressed	Feigned	Total	Rank
Positive	Enthusiasm	**16**	**11**	**11**	**38**	**2**
	Sympathy	**15**	**5**	**18**	**38**	**2**
	Interest	**15**	**4**	**19**	**38**	**2**
	Pride	**14**	**17**	**1**	**32**	**5**
	Surprise	**9**	**12**	**11**	**32**	**5**
	Hope	**9**	**11**	**10**	**30**	**6**
	Gratitude	**14**	**4**	**12**	**30**	**6**
	Satisfaction	**15**	**8**	**7**	**30**	**6**
	Joy	**11**	**9**	**9**	**29**	**7**
	Relief	**12**	**11**	**2**	**25**	**10**
	Admiration	**12**	**10**	**2**	**24**	**11**
	Affection	**9**	**5**	**7**	**21**	**13**
Negative	Anger	**9**	**32**	**1**	**42**	**1**
	Disgust	**11**	**24**	**1**	**36**	**3**
	Anxiety	**9**	**22**	**2**	**33**	**4**
	Dislike	**8**	**25**	**0**	**33**	**4**
	Distress	**7**	**24**	**1**	**32**	**5**
	Disappointment	**7**	**20**	**2**	**29**	**7**
	Resentment	**8**	**18**	**2**	**28**	**8**
	Fear	**6**	**20**	**1**	**27**	**9**
	Boredom	**6**	**21**	**0**	**27**	**9**
	Self-reproach	**9**	**14**	**1**	**24**	**11**
	Embarrassment	**7**	**17**	**0**	**24**	**11**
	Intimidation	**5**	**18**	**0**	**23**	**12**
	Remorse	**9**	**7**	**2**	**18**	**14**

Table 5.1: Paramedic workspace emotions

Under the theme of 'Compassion' I link the deductive codes: 'sympathy'; 'interest'; 'hope'; 'joy'; 'relief'; 'affection'; 'surprise'; 'disgust'; 'anxiety'; 'dislike'; 'distress'; 'resentment'; 'boredom'; 'disappointment'; 'embarrassment' and 'remorse'. Sympathy is triggered with patients *"to ease the situation"* (M18) or "*to gain cooperation"* (M23) which also extends to "*relatives"* (F21). In commenting, "w*ith some patients particularly self abusers my morals/ethics collide",* M14 confirms sympathy is challenged by moral standards as Boyle (2005) proposed in chapter two and I elaborated in chapter four. It also arises under the paramedics' collegial obligation with colleagues "*in order to support them*" (F31).

Interest is cued by "*patients who are too communicative or not communicative enough"* (F16). Whilst the paramedics have to prompt the latter to aid diagnosis they do not want to encourage the former. Although obtaining a history is a vital part of the job this emotion also benefits "*psychiatric patients who need attention in order to keep them calm"* (F32). Interest is another emotion cued by "*colleagues"* (M33) but M14 remarks this has to be dampened because "*it is not accepted behaviour to show too much emotion*". Hope is triggered by "*poorly patients who may not make it"* (M12) and with relatives as M38 explains, *"expectations are so high now and they want the impossible"*. It is also an emotion that arises during interaction with colleagues over "*improvements to working conditions*" (M25). Joy is associated with *"births"* (M14) as F33 remarked *"you can't help smiling"* (F33, 2009: 70) which communicates empathy.

Affection is cued in those paramedics who readily identify, "*nature of job requires attentive loving care*" (F16) particularly with "*children to make them compliant*" (M31). Relief is cued when the prospect of encountering undesired trauma is not realised such as "*when you expect to find a child not breathing but when you get there they are"* (M23) or when there are "*multiple casualties and another crew turns up to help*" (M31) but it also arises through "*offloading demanding patients onto hospital staff"* (M31). Surprise I find takes the form of astonishment in *"things told by patients"* (F32) although M13 provides a more potent example in describing "*Samurai sword incident, patient held his severed arm in his hand"* to which I would have experienced shock. Colleagues also cue this emotion through either their "*news*" (M31) or "*stories*" (M23) to which a suitable response has to be given to maintain that vital group cohesion Nisbet (1970) identifies in chapter two.

Disgust is the most prevalent negative emotion and is cued particularly by the "s*tate people live in particularly with children"* (F21) and "*the way some patients are treated by families* (M25). But it also arises through encounters with colleagues who exhibit a "*lack of personal hygiene*" (M31) but with whom the paramedics are obliged to work. Anxiety arises in situations where "*all best efforts and patient still going downhill and there is nothing else to do"* (M33). It also surfaces "*with colleagues when travelling to potentially difficult jobs"* (M15) evoking a need for reassurance and encouragement when new to the role. Dislike is provoked by *"aggressive in your face patients"* (F23), "*self abusers"* (M24) and "*relatives when their unrealistic expectations are not fulfilled"* (M14) but also by "*some working relationships*" (M27).

Distress arises over "*difficult situations around death*" (F12) but it is also prompted by familiarity in, "*taking someone known to me to hospital for probably last time as terminal with cancer"* (F33). Resentment is cued by "*relatives*" as they "*often have a clear aim of what they want to happen and can make things difficult*" (M27). But it is also cued by colleagues when attitudes collide *"friend also paramedic cried after a bad job but I didn't and I was called a hard bitch*" (F13). Disappointment has to be controlled both "*when you think you are going to a decent job that turns out to be rubbish"* (M16) and "*patient outcomes not as good as hoped for"* (F31). It is acutely felt by the paramedics when recognition is withheld, *"I have not had one manager say 'Well done' for anything"* (M12, 2008: 45-56).

Boredom stems primarily from qualitative underload but there is an interactional component as, "*often patients are boring and mundane to listen to"* (F15) and "*conversations with colleagues*" (F21) similarly. Embarrassment is cued in compromising patient situations, "*incidents involving young females scantily dressed"* (M33) or "*male patients who are exposed"* (F31) although it can also be provoked by "*relatives after event when grateful"* (F21) and by *"behaviour of colleagues in front of others"* (F31). Remorse in terms of its definition of "a compassionate reluctance to inflict pain" (Allen, 1990: 1016) is cued through a conscious recognition treatment causes as well as relieves pain. This leads, as I observe, to apologies being profusely issued particularly during cannulation but the paramedics do not carry regret as F21 (2008: 1298-1299) remarks, *"Everything I do for a patient is done with the best of intentions, I don't play God"*. Relatives also provoke an expression of remorse following unsuccessful CPR when I observe the attending paramedic commiserate and

explain they did all they could. This emotion can also arise interacting with colleagues, as (M13) remarks, "*I gave colleague wrong drug although he made light of it".*

To the theme of 'Abuse' I link the remaining three deductive codes: 'anger'; 'fear' and 'intimidation'. As I noted in chapter four, abuse is implicated in a quarter of encounters with patients,

> *"We take a lot of abuse from certain patients and can be assaulted but the forms for reporting it are generally not completed as they do not result in any action being taken"*
>
> M22, 2009: 30-32.

But that comment by M22 implies the true picture is hidden. However, abuse is not confined to that group but flares up in encounters with each interactant type. It is triggered on a run mainly by those "*aggressive in your face patients*" (F23) but also through encountering "*drunk drivers and abused children*" (F21) and inappropriate calls resulting from a "*lack of understanding of '999'*" (F11) that I highlighted in the previous chapter to which I add, "*interference and hostility from relatives and bystanders"* (M22), "*other road users who are inconvenienced by ambulance and ask for it to be moved"* (M14) and the *"way tret by hospital staff when taking patients in"*(F33). It is also triggered on standby by "*colleagues*" (F15) and management particularly their *"bad decisions"* (F12). M31 in remarking "*no specifics but frequent*" confirms my impression anger is omnipresent leading me to argue, contrary to Boyle (2005), anger not anxiety is the principal emotion that defines paramedic performances of emotional labour.

Fear is triggered by patients with the propensity for violence such as those I presented in Psych1 and SH1, in chapter four. But it is also triggered by the attitude of relatives as M38 informs, "*when you know things are not going right and the outcome is going to be bad, relatives can easily turn from for, to against you"* and arise out of nowhere, "*when two lads climbed in car with a broken glass wanting a lift"* (F21). Intimidation is also triggered by patients particularly *"drunks"* (F33) and "*psyche patients*" (M12) but also by the attitude of bystanders as F22 comments, "*incident at martial arts centre I was circled by various males who behave aggressively as I was assessing/ treating the patient".* As insider provocation is apparent in comments: "*bolshy colleagues who want*

what they want" (M31) and "*Control with late jobs*" (M17) I argue abuse is a thread woven throughout the shift.

Although humour is also noted as missing on a small number of the checklists I reject it as an emotion on the grounds it is a regulatory strategy (Sampson and Gross, 2012). The discrete emotions constitute of paramedic performances therefore total twenty-six with the addition of confidence to the positive string and divide equally between the two valences as surprise takes only the positive face of astonishment in my inquiry.

5.3.2 Rules

The rules paramedics apply to their emotions I explain through the theme of 'Intuition' to which I link the deductive codes: 'informal'; 'healthcare' and 'tradition' and inductive codes: 'upbringing'; 'experience' and 'role model'. There is no formal organisational rule book, as my exchanges with M31 (2008: 90-92) reveals,

> *Researcher: How do you know which emotions to express?*
> *Respondent: Upbringing I guess. There are no organisational guidelines.*

Awareness of the paramedic standards I presented in chapter two is scant, from which I conclude these have not been assimilated and do not consciously direct performances. Situated knowing stems from upbringing as M31 implies or out of "*experience*" (M35, 2008: 23) in which there has been opportunity for "*copying other members of staff"* (M12, 2008: 580). But "*some people set a good example and some people don't"* (F11, 2008: 769) leaving each individual to find "*an experienced paramedic who you can trust to be your role model and mentor"* (M21, 2008: 246-248).

As Boyle (2005) suggests in chapter two, I find the paramedics in my sample recognise which rules to apply to emotion informally in the absence of formal guidance. They offer support for her assertion those rules first require they are positive and compassionate frontstage in public. Although Table 5.1 indicates only 31% of my sample has genuinely expressed joy of which cheerfulness is a token and 43% sympathy that stables with compassion. However, I extract from Appendices 5.4-5.7 and illustrate in Table 5.2 the percentage of paramedics who suppress or feign each valence of

emotion across principal interaction categories and this shows 97% of my sample feigns positive emotion with patients and 89% with relatives or bystanders. However, as this table also indicates positive emotions are suppressed by 89% in respect of patients and 83% in respect of relatives and bystanders I challenge the generality of Boyle's frontstage rule.

Emotion	Rule	Patients	Relatives & Bystanders	Hospital Staff	Emergency Services	Colleagues & Managers
Positive	% Suppress	89	83	80	75	70
	% Feign	97	89	86	81	86
Negative	% Suppress	94	94	89	80	89
	% Feign	78	78	83	72	73

Table 5.2: Paramedic workspace rules

Boyle's other rule requires the paramedic to suppress negative emotion backstage with colleagues. In support, I find negative emotion, as shown in Table 5.2, is suppressed by 89% of my sample during interactions with colleagues or managers. However, negative emotions are also feigned by 73% added to which positive emotions are suppressed by 70% and feigned by 86% so I argue Boyle's second rule also lacks general validity.

At first glance both Table 5.1 and Table 5.2 suggest the general rule applicable across healthcare of suppressing negative emotion and expressing positive emotion, advised by Martinez-Iñigo, Totterdell, Alcover and Holman (2007) in chapter two, also includes the prehospital context. However, as Table 5.2 shows positive emotions are also suppressed and negative emotion feigned across encounters by a majority in the sample I argue this rule set also cannot fully explain paramedic performances. Tradition, according to Mannon (1981), should prompt the paramedics to suppress negative emotion which Table 5.2 confirms is a prominent rule but not the most dominant as Table 5.2 endorses the claim by Zerbe (2000) that feigning positive emotion takes precedence. Although this evidence suggests each of the three rule sets informs the paramedic response to a greater or lesser extent I conclude this subsection by arguing the subjectivity in paramedic responses I evidence through a comparison of the individual traces contained in Appendices 5.1-5.3 indicates it is their intuition as to what

constitutes appropriate conduct that directs their performances.

5.3.3 Techniques

For Theodosius (2008), empathy is the hallmark of the professional healthcare worker and I observe how it regularly directs the paramedics' clinical mandate in order to soothe patient anxiety and garner trust and cooperation irrespective of circumstances. It also influences the paramedics' performances of collegial support. Accordingly I develop the theme 'Empathy' and I link the deductive codes: 'empathy'; 'surface acting'; 'deep acting'; 'genuine expression'; 'humour' and 'emotional shielding' to it but not 'spirituality' of which I find no evidence. Empathy is core to the role as Boyle (2005) points out and F12 (2008: 80-82) confirms,

> *"You definitely have to maintain empathy. You have to care about what you are doing. You have to care about the patients. Once that goes you should not be here"*.

Empathy defines the clinical mandate. M23 (2008: 838) comments, "*you need empathy even with the regulars"* and M37 (2008: 3126-130) indicates it applies to all ages,

> *"I've got this belief that you get to their level. I've seen me lying on the floor on my belly talking to kids on the floor you know and it's the same with little old people in bed. You don't stand towering over above them you just get down. 'Can I sit on the side of the bed' and you sit and hold their hand or something to make them more relaxed"*.

Personal experiences exacerbate it as M24 (2008: 118-120) reveals,

> *"My family history has helped me as my sister committed suicide and my father died from cancer and both of those events really prepared me for this job...helped me understand what others go through"*.

Both surface and deep acting techniques are initiated by empathy. The comment, *"you do put on a face and keep your own feelings hidden"* (M35, 2008: 22) is illustrative of surface acting. The transient nature of the job encourages the use of this technique as

there is little time in which to develop attachment as M26 (2008: 81-82) remarks, *"you need to empathise without getting involved in this job. Pick up, drop off and don't follow through, as there is no time for attachments".* The paramedics are adept at switching faces as Boyle (2005) infers and I observe how the smiley face with which they confront patients often changes swiftly to their professional face as the patient's need for reassurance is overtaken by the need to concentrate on an intervention. Boyle remarks how it is easy to switch from smiley to professional but not so the reverse which my observations confirm. But I evidence the paramedics support for Boyle and Healy's (2003) claim that surface acting is a constant in paramedic performances through their responses to statement twelve [I felt the other person expected me to have a particular 'face'] on the MERI which I collate and include in Appendix 5.8. These show 100% agreement in respect of interactions with patients and no less than 89% agreement across the other categories.

The use of deep acting I also evidence directly from the scores to statement thirteen [I psyched myself up to feel an expected emotion] on the MERI which I collate and include in Appendix 5.9. I did not ask my participants for examples of deep acting as I considered it too difficult a concept for them to grasp and distinguish from surface acting in the time available. My findings reveal it has however been used by all but five paramedics [14%] in one or more interactions. Although used less often than surface acting it is still used by twenty-five [69%] of paramedics during interactions with patients. As the most experienced use it more often they support the notion proposed by Hochschild (2003) that deep acting correlates to experience. It is not however, a question of selecting deep acting over surface acting, as Appendices 5.8 and 5.9 support that argument by Mann and Cowburn (2005) that both can be used in one interaction.

Genuine expression I find is also used to a varying extent by twenty-one [60%] paramedics, Appendix 5.1 refers, which indicates a vein of emotional harmony (Rafaeli and Sutton, 1987) runs through my sample. This technique is used more by females [67%] than males [54%] offering a modicum of support to that notion of female expressiveness I discussed earlier. It is less likely to be used by those with ten or more years of service which accords with my finding experience brings greater control. Whilst the predominance of positive emotions support the notion of a healthcare rule set I argue the absence of any discernible pattern within the individual traces I include in Appendix 5.1 confirms paramedic' performances are a subjective construction.

Humour is another deductive technique the paramedics employ to soothe patient anxiety and gain trust. I observe how it is used to good effect to quell hysteria and distract a young female patient who has severed a brachial artery. But there is always a caveat,

> *"Some people take to humour better than others. Some people like you to be deadly serious and not say anything you know you have got to gauge it"*
>
> M12, 2008: 585-586.

Humour is also used empathetically to deliver the paramedics professional mandate and fulfil each of their obligations. I observe how in S1 the anxiety of a rookie policeman who has to accompany the patient to the morgue is alleviated by a jokey remark made by my participant. He recalls, *"I had been talking on the mobile phone and I put it on top of the body and I said 'See you look after that for me'"* (M23, 2008: 46-47) which raises a smile and prompts other instances of black humour to manage the distress attached to that particular death. My distress is deflected by the second crew member informing me we will meet Morticia at the morgue. This prompts me to recollect the comedy television series 'The Addams Family' featuring a family of vampires, one of whom is called Morticia. When we arrive at the morgue and I see the likeness it takes an enormous effort on my part to suppress a smile. When F22 (2008: 49-52) subsequently remarks, *"one of the emotions that has to suppressed quite often is humour as it is not always appropriate"* I find my head nodding vigorously in agreement.

The final technique I evidence is shielding family members offstage as Boyle (2005) suggests in chapter two. As M21 (2008: 150-152) explains, "*family know what I do and often want details of incidents they have heard about but I don't tell them much, as they want to know more than what is good for them*".

5.3.4 Acknowledging Strategies

I conclude this section by constructing an answer as to which emotions are constituent of the paramedic performance, which rules those emotions are subject to and through which techniques they are managed: There are twenty-six discrete emotions identifiable in paramedic performances of emotional labour that are equally distributed between the two valences of positive and negative. Although each performance is an individual

construction the emotions can be explained as three commentaries. Out of the first, the paramedic habitus, I extract two threads in compassion and abuse to leave enthusiasm, pride, satisfaction, gratitude, admiration, self-reproach and confidence at its core through which the paramedics claim and confirm their identity. Compassion within which sympathy, interest, hope, joy, relief, affection, surprise, disgust, anxiety, dislike, distress, resentment, boredom, disappointment, embarrassment and remorse are situated is evoked during the delivery of the paramedics' clinical mandate with most, if not all of those emotions also arising out of the paramedics' obligation to provide collegial support. The remaining three emotions in anger, fear and intimidation form a thread of abuse that runs through all interaction characterised by a lack of respect. As anger is managed more than any other emotion I argue it defines paramedic performances.

There is no formal organisational guidance as to which rules should direct the paramedics' emotional responses and there is no evidence to suggest those implied by the paramedic standards published by their regulatory body have been assimilated. Although the paramedics present a positive demeanour to patients whilst controlling negative emotion with colleagues to accord with the informal rule set proposed by Boyle (2005) and suppress negative emotion more generally to accord with the traditional prehospital care rule proposed by Mannon (1981) neither fully explain their responses. The general rule applicable across healthcare of suppressing negative emotion and amplifying positive emotion advised by Martinez-Iñigo, Totterdell, Alcover and Holman (2007) is also informative but not determinant.

The paramedics in my sample use their own interpretation of professional conduct to guide their genuine expression, suppression or feign of emotion as each encounter demands. A range of techniques are initiated by empathy which the paramedics universally acknowledge as key to their role. Surface acting is a constant in paramedic' performances to endorse the finding of Boyle and Healy (2003) but I argue it enables a professional persona to be maintained whilst handling disrespect and abuse more than patient concerns. Deep acting, genuine expression and humour are all used however the latter is subject to circumspection. The paramedics also shield family members in order to share some of their activities and in so doing, relieve the emotional pressure inherent to a job whose raison d'être is to save life but for that to happen, lives have to first be in danger of being lost.

5.4 Consequences

In this section, I present my findings and construct an answer as to the consequences both positive and negative for the individual that arise from the demand to perform emotional labour.

5.4.1 Positive

Positive consequences to performing emotional labour I explain through the theme of 'Gains' as I recognise the amplification of positive emotion in satisfaction, joy and pride in particular boost both well-being and identity. This theme links the deductive codes: 'personal accomplishment'; 'professionalism'; 'confirm identity' and 'job satisfaction' contained in the deductive category 'Positive' all of which I evidence. But these often materialise together when the performance is for the benefit of the patient as the following vignette, I label CS1 suggests,

> *"We went to an elderly lady in cardiac arrest. The odds were stacked against her but we got her back. She went off again at the hospital, they wanted to call it but we urged them to give it a bit longer. We advocated for the patient. She survived and on discharge from hospital sent in a letter of thanks to her angels of the north...that made me immensely proud of what we did for her"*
>
> M14, 2008: 86-90.

In this account personal accomplishment is heightened through successful CPR which, as I mentioned in chapter two, is rarely achieved but when it is it serves to verify the paramedics' identity as a life-saver. Professionalism is enhanced through persuasive advocacy which also verifies those other two aspects to identity Palmer (1983a) described in medical authority and information specialist as the paramedics' diagnosis is deferred to. The fourth aspect to identity, I outlined in chapter two, is also verified, as the use of the pronoun 'we', implies the outcome stems from an effective partnership. Appreciation by the patient reinforces all four positive consequences.

Job satisfaction within which I argue compassion satisfaction is a major component

radiates out from that account by M14. As I discussed in chapter two, compassion satisfaction is a distinct form of job satisfaction through which the paramedic connects emotionally to the patient and it is particularly evident in the relief of pain,

> *"Get the pain sorted out. Getting them to hospital pain free then you feel like you have done something that's the best feeling"*
>
> M11, 2008: 174-176.

Alleviating anxiety is also associated with compassion satisfaction and arises each time *"someone who does not want to go to hospital and they need to and you manage to convince them to go"* (M21, 2008: 205-208). As I expected from examining the literature, job satisfaction also arises out of opportunities that demand paramedic skill and attention in which compassion satisfaction is implied. These situations include births, again due to being a rare event, as I mentioned in the previous chapter. M22 (2009: 49-50) is not my only participant to intimate, *"most satisfaction comes from delivering a baby, works every time"*.

Job satisfaction is primarily linked to *"good outcomes"* (M31, 2008: 83) but not exclusively. F23 (2009, 102-104) comments *"technical competence can be as rewarding even if the outcome is negative"* and "*there is also a certain amount of satisfaction when you know the ambulance has been checked and is fully equipped and ready to go"*. The experience of satisfaction is intrinsic to role performances and extends beyond the paramedic patient interface, as F11 (2008: 652-661) remarks,

> *"When you are able to use your skills in the way you are trained to do to really make a difference and help somebody. It does not have to be all blood, guts and gore it might just be something emotional like you know the way that you treat a bereaved relative, feeling that you have done a good job or somebody just saying 'Thanks' you know that they really appreciate your help and also when you have successful outcomes to your jobs like successful resuscitations or you get somebody who is really ill and something you have done makes a difference treatment wise that gives me a lot of job satisfaction and that is why I wanted to do this job".*

Confirmation of identity occurs when performances accord with or surpass expectation set by the self or others both of which are apparent in that extract. I also observe how it materialises as a positive consequence to the professional encounter with a BASICS GP I labelled GPT1 when the suppression of annoyance on the part of the paramedic enables that GP to confer professional regard they might otherwise have withheld. Although appreciation is culturally inhibited it does surface on occasion. I presented in the previous chapter an account by M11 of his encounter with his divisional manager following PD1 in which his latent satisfaction and pride and his managers recognition combined to confirm his legitimate occupancy of the role.

In chapter one I described well-being as contentment which encompasses both job satisfaction and role identity. When I ask my participants to describe how job satisfaction feels, they inevitably reply, similarly to M13 (2008: 61), "*contented...gives me an internal glow".* Well-being is enhanced through making a difference which I evidence not only in remarks made by the paramedics of which, "*it feels good to help others*" (M26, 2008: 21) and *"a good worthwhile job sets you up for the day and you go home feeling proud"* (M24, 2008: 102) are indicative but also through my own experience in T1. It generated in both me and the attending paramedic that buzz Boyle and Healy (2003) identified in chapter two whose addictive nature and capacity to overturn negative emotion inherent to bad jobs is confirmed by F16 (2009: 64), *"a good job generates a buzz that makes all the bad jobs worthwhile"*.

However, Boyle (2005) argues emotional labour is situated more in the routine to which I find agreement, as a number of my participants echo M33 (2008: 25-26),

> *"The majority of the job is mundane although having said that it is the best job in the world".*

As I observe over more runs that involve patients characterised as routine rather than emergencies and I illustrated in chapter four high amounts of emotional labour are utilised in performances I reaffirm Boyle's assertion. But I also argue to close this subsection that both job satisfaction and wellbeing represent gains inherent to each performance of emotional labour in which identity is taken or confirmed irrespective of the nature of the run.

5.4.2 Negative

The negative consequences to performing emotional labour I explain through the theme of 'Losses' in which I recognise the exacerbation of negative emotion particularly anger detrimentally influences both well-being and job satisfaction. This theme links the deductive codes: 'compassion fatigue'; 'clinical stress'; 'administrative stress'; 'PTSD'; 'fatigue'; 'WHI'; 'somatic complaints' and 'disconfirm identity' contained in the deductive category: 'Negative' but not 'vicarious traumatisation' of which I find no evidence. The first stage of CF is compassion discomfort characterised by tiredness, a lack of enthusiasm and attention to patients which I find evidence of in comments, *"I feel fed-up and I want to be anywhere but here"* (M31, 2008: 144) and *"I can get frustrated with less than genuine patients"* (M33, 2008: 71). Discomfort manifests as the number of working hours accrues,

> *"Who could maintain the same standard of care seven shifts in a row when you are absolutely exhausted? You can't, you can't provide that for the patients because you can't even think straight sometimes"*
>
> F12, 2008: 288-290.

The second stage, compassion stress, adds symptoms particularly in a *"lack of concentration, lack of patience"* (F12, 2008: 202) and irritability of which I find evidence in responses by my participants to my question as to whether they experience stress and if so how does it makes them feel,

> *"I feel uptight and irritable. Tired and angry and I experience tension in the back of my neck"*
>
> M13, 2008: 71-72.

The final stage of CF characterised by diminished activity or avoidance is less evident although I consider requests such as that made by F32 (2008: 66), *"I have asked to reduce my hours until I retire"* and the thread of weariness I detect in comments such as that by M24 (2008: 110-111) *"I really enjoy this job and have no plans to retire early but I cannot see me going on beyond sixty"* to be indicative of its presence.

Stress in its clinical form is an encumberment to the identity of lifesaver, as Beaton, Murphy, Johnson, Pike and Cornell (1998) point out in chapter two. As CPR only carries a 1% survival rate outside of hospital (Lennon, 2009), it forms a significant source of clinical stress for my participants as M24 (2008: 79) confirms, *"CPR is very stressful as it demands both physical and mental effort"*. It is compounded for rapid responders who have to control both anxiety and anger when backup is slow to arrive, as F21 (2008: 388-403) indicates,

> *"If the patient is in cardiac arrest then I would feel yeah stressed because I would be feeling the stress of the family and the stress of the fact that there is probably a complaint coming at the end of this. Nine times out of ten when you really need an ambulance they are the kind of patient you could not possibly get in the car that is quite stressful when you know somebody is really desperately ill".*

This lone role is I discussed earlier in the chapter a source of engagement but it is also a significant source of stress. So too is the uncertain nature of the job as F21 (2008: 492-494) also points out,

> *"A lot of the time you get to a Cat 'B' and you get there and they are worse than any of the Cat 'A''s you have ever had"*.

A deteriorating condition means "*you end up taking them in on blue lights*" (ibid: 2008: 496-497) which exacerbates anxiety as I observe on the one occasion when an error initially made in a patient's diagnosis prompts them to be activated whilst the paramedic hurriedly corrects the treatment protocol. Clinical stress also arises out of managing anxiety generated by Category 'C' patients as M37 (2008: 561-567) comments,

> *"If we get it wrong then we are at fault. We may well have examined them and checked everything and decided they did not need to go to hospital and something happens half an hour or an hour later it is still down to me as it was my decision to leave him".*

With inappropriate patients it arises from anger as F11 (2008: 190-192) comments, *"the thing that mostly stresses me out is, how can I put it, sort of the public abusing the*

system" which I observe first-hand. M31 implicates the teenager at the centre of CP1 as a prime example,

> *"Those patients that take the ambulance service for granted like that pregnant teenager. They could have got a taxi or even the bus but 'no' they wanted a free ride into the hospital".*

However, I find clinical sources of stress are tolerated because as F11 (2008: 189) remarks "*there are stressful things but you get used to dealing with them"* whereas administrative sources are not so easily managed. I select complaint handling and conflicting objectives as illustrative of many as each forms a thread woven through performances which affirms that notion of duality I presented in chapter one. Complaints are, as I have discussed, accepted as an inevitable part of the job by my participants but they initiate stress through provoking anger, exacerbated by a tendency for them to be handled badly, as F11 (2008: 672-693) reveals,

> *"I know getting a complaint is not a good experience but the two I have had have been terrible. They make us really angry when I think about the way I was tret. I feel very angry about it because the outcome of them was I was not at fault and actually it was commented that I was doing a good job and you are sort of sitting there thinking I have gone through all this stress for absolutely nothing".*

Conflicting objectives between Control and the road crew materialise in a disregard for personal time which as I have discussed can affect meal breaks, comfort stops or shift finish times. "*Late finishes kill relaxation time*" (M34, 2008: 49) whilst *"standby's are both uncomfortable for crews and frustrating in that that time is not productive"* (F15, 2008: 95-97). A lack of consideration with respect to comfort breaks increases stress for female paramedics, as F14 (2008: 70-72) comments,

> *"On a couple of occasions I have had to go home to change my uniform due to heavy periods and a lack of comfort breaks".*

Whilst overlooking the paramedics' need for rest and refuelling not only inhibits optimum performances, as F13 (2008: 194-200) suggests,

"I get annoyed if I get hungry and if I have been out over me banding time like you can be out six seven hours sometimes and you start, I'm only human, you start to get hungry, you start to get ratty and then they give you another job ".

But carries more serious implications, as M35 (2008: 56-58) comments,

"The late meal breaks cause ill health and resentment and then the organisation wonders why people will not do anything for them".

As PTSD is beyond my expertise I restrict my evidence to S1 as a probable example. Fatigue contributes to each of the deductive codes I elaborate in this section but *"tiredness*" (F21, 2008: 202) carries additional consequences as it provokes resentment and anger, M31 (2008: 149) confirms, *"I can be short-tempered and that is down to tiredness".*

WHI is understated, as F16 (2009:95) explains, *"the more you do the job the more it can be compartmentalised".* But I find there is evidence in the comments, *"mainly I switch off but traumatic incidents and high stress levels can interfere"*(F12, 2008: 493-494), *"I try to switch off at home...but I know because I get told that I can be short-tempered and that is down to tiredness"* (M31, 2008: 148-149) and particularly *"sometimes use all of your niceness up on the shift and go home and shout at the wife and the kids"* (M22, 2009: 76-78) it is a consequence to performances.

The increased risk of hypoglycaemia and diabetes due to work demand, irregular breaks and poor eating habits (Collins, 2004) are regularly alluded to and one of my participants discloses they have developed diabetes. As I not only observe but experience irregular or missed opportunities to refuel I agree with F11 (2008: 180-183) resources drained by demand are not adequately replenished,

"You do get really hungry when you are on the go all the time. Sometimes though all you can do is you have a chocolate biscuit in your bag and you quickly eat that while you are filling your form out ready for your next one. It does not really go with a healthy lifestyle".

But the most frequent somatic complaint is *"headaches"* (F12, 2008: 202). However I am left in no doubt as to the long-term physical consequences when in discussion with M21 (2008: 289-290) he remarks, *"few staff make it to retirement age most finish via early retirement or death...a lot die"* which prompts me to argue stress is also intrinsic to the role.

Disconfirmation of identity arises when doubt is expressed by others. Not all paramedics are as fortunate as M11 as M12 (2008: 241-243) recounts a story of the aftermath to a physical assault by a mentally disturbed patient on another crew in which their request for downtime is greeted with derision by their divisional manager,

> "*They are in the office. 'Do you think you are suitable for this job'? One was a female who ran out into the toilets. He followed her knocking on the door saying 'I don't think you are good enough for this job' type of thing".*

A lack of recognition which van der Ploeg and Kleber (2003) present as a source of stress in chapter two also devalues identity. I am regularly informed *"I have not had one manager say 'Well done' for anything"* (M12, 2008: 45-56) leading to the echo, *"I do not feel valued"* (F15, 2008: 74). The issue, according to M18 (2009: 133-134) lies in how the *"organisation is a big beast now and we feel as though we have been swallowed up and left without an identity"*. When performances go unrecognised identity relies on self-verification but this is put at risk by negative emotion e.g., disappointment dampening that process. When stress manifests, as M13 (2008: 1771-173) remarks, *"it compromises my professionalism as I feel unable to give 100% or holistic response to patients"*.

But it is the failure to deliver an empathetic performance which places identity at most risk, which I evidence in the following remark by F12 (2008: 203-204) which completes this section,

> *"I find myself becoming firm and authoritarian in my tone of voice and sometimes I can be abrupt with patients which is really a slip in professional standards"*.

5.4.3 Acknowledging the Consequences

I conclude this section on consequences by addressing my research question which inquires, what are the consequences for the individual in having to actively manage their emotions, which I interpret as gains and losses: Paramedic gains in terms of personal accomplishment, professionalism, role identity, job and compassion satisfaction and wellbeing often occur together through the amplification of positive emotion particularly satisfaction, joy and pride which stem from opportunities to engage emotionally with others and make a difference. Compassion satisfaction is particularly heightened through alleviating pain and patient anxiety but also stems out of the joy associated with childbirth. Job satisfaction is heightened by good outcomes particularly those associated with traumatic incidents but it also stems from any situation no matter how mundane in which identity is taken or confirmed. Well-being is enhanced as positive emotion reinforces self-esteem and contentment with the demands of the role.

Paramedic losses are more extensive and take the form of CF, stress both clinical and administrative, PTSD, tiredness, work-home interference, somatic complaints and disconfirmation of identity all of which arise when demand on the individual outstrips their resources. The paramedics are prone to tiredness that depresses their enthusiasm when their working hours accrue beyond what they consider reasonable. Tiredness indicative of compassion discomfort transposes into anger and resentment without intervention leading to compassion fatigue and the ultimate consequence of withdrawal. Clinical stress is inherent to the paramedics' identity of lifesaver and its obligatory deployment of CPR which is compounded in rapid responders who cannot share the demand. It is also provoked by inappropriate patients who deny both the paramedics and those with a genuine need, of an emergency response. Unlike clinical stress which is accepted as an inevitable component of the role administrative stress is regarded as preventable. It is as a consequence the more potent of the two particularly as it resides insidiously in a lack of recognition and lack of respect by the organisation which carries the potential for physical as well as psychological harm. Stress is intrinsic and acts to disconfirm identity when it intrudes into performances with patients. PTSD which is beyond the scope of my inquiry lies in wait for those who ignore or who are denied an effective intervention.

5.5 Interventions

In this section I present my findings and construct an answer as to how the consequences of having to perform emotional labour can be mediated by the individual either at their own volition or through the sanction of the organisation in order to amplify gains, mitigate losses or simply recover emotional equanimity.

5.5.1 Individual

Interventions available for the individual to deploy under their own volition I explain through the theme: 'Voluntary' to which I link the deductive category: 'Individual' and associated deductive codes 'beneficent atmosphere', 'self-talk', 'objectification', 'physical task', 'balance', 'calming', 'timeout', 'informal debriefing', 'black humour', 'family', 'relaxation' and 'hardness' but not 'religious beliefs' of which I find no evidence. Before a run I observe how the crew room can offer the individual a beneficent atmosphere, irrespective of the state of the facilities, in which they can relax, take quiet satisfaction from the 'Thank You' cards on display and engage in banter and practical jokes with colleagues to promote a positive state of mind. When a run is called I observe how some of my participants will engage in positive self-talk to alleviate anxiety particularly if the initial notification suggests a bad run. This positivity invariably opens out to embrace their partner and on occasion myself. On route to S2 I sit in the cab next to the driver who informs me the run is a suicide attempt. He psyches himself up through reciting a mantra under his breath before including me in this self-help initiative by explaining what he is doing and why it works to soothe his anxiety.

During a run, I find objectification evident in the remarks *"I tend to depersonalise the patient in order to cope"* (M27, 2008: 53) and *"I can disassociate myself from it you know. It's not me, it's not my family"* (M23, 2008:72-73). Sometimes the paramedics focus on a physical task as McGrath, Reid and Boore (2003) suggest and the following account by F21 (2008: 1278-1280) infers,

> "*I had a stillborn once and although there was nothing that could really be done I still intubated the baby so that at the end of the day I knew I had done everything possible".*

This account also provides evidence of balance between engagement and detachment proposed by Carmack (1997) as this paramedic regulates her distress through being pragmatic and setting a conscious boundary to her involvement which allows her to let go of responsibility for the loss. Calming strategies are also deployed as I observe one paramedic urge their partner to join them in counting to ten to disperse anger before attending a patient who is known to them as a frequent flyer and whose complaint they anticipate [correctly] will be a non-emergency. This intervention can also include a compassionate hug between work partners as M11 (2008: 456-462) reveals,

> *"Breaking down on the job....touch wood it has not happened to me. It happened to a colleague of mine but she kept it in check. She broke down, kind of like the right time during a job and again it was a big hug, 'Come on * get yourself together', big breath, wipe the eyes, get on with it".*

This account also endorses how the cultural norm of stoicism is both valued and internalised.

Between runs I often observe how the paramedics try to find space for a time-out usually just a couple of minutes in duration after handing over their patient to A&E staff. If they are not immediately summoned to another run by Control they use this time to make use of hospital facilities or chat to colleagues from other stations in order to restore their energy. But it can require creativity as Boyle (2005) mentions and acts of resistance as Boyle and Healy (2003) propose. I observe how these coincide in a slow RTB or in an extended breathing space outside casualty where emotion can be vented without censure,

> *"There are quite a few times where you hear of somebody having a bad job or you turn up at the hospital and there is a crew outside who have had a bad job and one of them has been upset and crying no one thinks anything but sympathy for them because you know it must have been bad if they have been reacting like that"*
>
> F11, 2008: 376-379.

Informal debriefing I find is a common intervention as Filstad (2010) intimates which

usually takes place on station where the paramedics *"talk about emotional issues/situations between themselves but not with a wider audience"* (M28, 2008: 62-63). Although not everyone is able to share as M11 (2008: 328-330 comments,

> *"I would no sooner walk into that restroom and sit down with my head in my hands and say 'Oh I have had a terrible job blah, blah, blah', I wouldn't, I would not do it. I would try and collect myself".*

The majority of paramedics, as Jonsson and Segesten (2004) identify, rely on a carefully selected confidant and have a close circle of friends, "*we all have our own people who you can bounce off"* (M23, 2008: 1013-1015). But this does not prevent them from sharing another intervention in black humour which I find similarly to Filstad (2010) and Boyle (2005) is ubiquitous,

> *"There is no more of a sick sense of humour than when you get a group of paramedics together and you get awful jobs and you have to make light of it and if you are on the outside, sitting in the room, you would think 'Oh God how can you laugh about that' but you have got to do it"*
>
> F11, 2008: 780-783.

The hanging incident S1 which I attend provides two examples of how black humour is used to offset negative feeling in others as I have already discussed. I am regaled with numerous funny stories whilst on standby which are also gruesome and/or crude but these are not meant for public consumption. They have a coalescent quality that reinforces identity through being indicative of stoicism and an ability to cope.

At the end of a shift support falls to family members, as Boyle (2005) suggests in chapter two. Taking suppressed emotion home to vent is a cultural necessity as M12 (2008: 211-217) reveals,

> *"Nine times out of ten it is just hidden away. People will not say, 'Oh that was a crap job and I feel you know'. They will take it home and maybe discuss it there because they don't want to lose face or don't want to be seen as a bit weak".*

M36 (2008: 44) makes the point *"a supportive partner is essential"* whilst M21 (2008: 264) in adding "*family network and in particular my partner are my rocks*" suggests this informal support network is more extensive. However, the ideal is when the paramedic's partner is also in the ambulance service,

> *"It really, really helps because you don't need to explain and when you have finished your sentence there isn't a blank look there, they really understand what you are talking about and that is vice versa as well"*
>
> F11, 2008: 806-815.

Other interventions employed at the end of the shift through which the paramedics relax and recuperate include: "*running*" (M31, 2008: 146); *"going to the Gym"* (M13, 2008: 78); "*walking the dogs*" (M18, 2009: 125); *"hot baths* (M24, 2008: 88); "*an early night"* (F31, 2008: 62); *"alcohol"* (F12, 2008: 206) and "*listening to music*" (M36, 2008: 41). The importance of being able to decompress is made abundantly clear,

> *"I think if you hang on to emotions you would not last very long in this job because you have extreme highs and then lows and if you hung on to everything and everybody you know and you really got too involved with everything it would just drive you mad"*
>
> F11, 2008: 362-365.

Hardness is indicated by one paramedic as a developing intervention, *"you do become hardened to the job over time"* (M22, 2009: 84) offering support for the finding by Boyle and Healy (2003) but although this may increase resilience it also obscures empathy as the majority in my sample recognise, concurring with M35 (2008: 23-24),

> *"You need to acknowledge you have emotions as they are essential for doing the job well"*.

I complete this subsection by presenting my findings in respect of two inductive codes. The first, 'reflexive practice' part of CPD is offered as an intervention as it enables not just clinical decisions but also emotional and coping aspects to a situation to be

reviewed and steps taken to strengthen these, as M11 (2008: 165-167) indicates,

> *"It is not just doing the job but doing it to the best of your ability and self critiquing yourself afterwards and identifying weaknesses and taking steps to correct those weaknesses".*

The second inductive code 'Withdrawal' acknowledges the ultimate intervention is to reduce the demand like F32, who I mentioned in the previous section, has asked to reduce her contracted hours. Although she is the only one of my participants who has done so I find that desire more widely expressed,

> *"I would like to see some sort of wind-down initiatives for older staff where they could do say, the 'Urgents' or work reduced hours"*
>
> M31, 2008: 153-155.

It is not just age but the nature of the job which, as Mannon (1992) predicts in chapter two, eventually exacts a toll that needs to be mitigated so medical and emotional wisdom is not lost by the service,

> *"I think those of us who work on A/E would benefit from a pre-retirement strategy whereby we could work maybe within specialist teams with no blue lights or time pressures. It would improve motivation and health"*
>
> F31, 2008: 101-103.

However, reducing the demand relies on the cooperation of the organisation.

5.5.2 Organisation

Interventions offered by the organisation I explain through the theme 'Authorised' as these are not freely available but have to be sanctioned. I link my deductive category 'Organisation' and associated deductive codes: 'counselling'; 'downtime' and 'recognition' but not 'CISD' of which I find no evidence to this theme along with two

inductive codes: ‘peer support’ and ‘training’. Although the organisation expects the paramedics to cope with all of the demands on their role, as I mentioned earlier in this chapter, it provides a safety net in a counselling service. However, this carries negative connotations as I pointed out in chapter two. F31 (2008: 59-60) questions its genuineness,

> *“The organisation feels it has done its bit by offering external counselling, which has come about through fear of post-traumatic stress disorder and what it might cost”.*

Whilst M23 (2008: 477-478) queries its effectiveness,

> *“If you go for counselling you cannot tell them what you really think or feel because they have got to act on what you really think or feel”.*

But the real issue is, *“there is a bit of a stigma attached to counselling”* (F11, 2008: 296) as it comes under the remit of Occupational Health at HQ and referral is made through line management, whose uncaring attitude discourages requests,

> *“You can have a referral if you need to, to Occy Health but who wants to come to a manager and go ‘I need an Occy Health referral because I am feeling emotionally distressed over my job’ because then they will say ‘Are you capable of doing that job’. It is a horrible situation to be in because you feel like you have no one to talk to, to turn to, to talk about emotional issues”*
>
> F12, 2008: 155-159.

Not everyone is dismissive as M12 (2008: 128-134) remarks,

> *“I think it should be compulsory for you to go maybe once every six months or once a year to see someone from an outside organisation because as macho as people want to be there is always something that is bothering them you know. It is usually kiddies you don’t get back or a really traumatic job where you have seen things that*

people don't want to see. But the build up from that over years and years it must have a psychological effect on you".

Whatever the paramedics' opinions or perceptions are regarding counselling this is not an option open to them whilst on shift unlike 'downtime'. Although this is considered the most worthwhile intervention an organisation can provide, as Mann (2002) points out in chapter one and Halpern, Gurevich, Schwartz and Brazeau (2009a) confirm for context in chapter two, it is not standard policy. Downtime has to be sanctioned by Control Room dispatch officers whose attitude varies as I have discussed and M13 (2008: 29-32) confirms, *"support seems to depend on who is on duty in Control and how busy it is".* There is however a view it is available on request,

"If you rang up Control and said 'Look I have just had a bad job can you give us a minute'.....it has been done a couple of times and they have done it"

F11, 2008: 166-168.

Although that comes with a caveat, *"to get stood down you have to be quite firm and direct"* (M24, 2008: 55) but it is not that simple, as the culture is inhibitory,

"People do not routinely ask for downtime as they perceive it as weak but it should not be a question of them having to ask, it should be routine"

M38, 2009: 49-50.

F15 (2008: 56-57) makes the point, *"triggers are personal so downtime is needed for different reasons at different times by different people"* so it needs to be voluntary not authorised. Not everyone would take it, as F12 (2008: 275-282) insists,

"I don't expect downtime between jobs. When you clear you are saying you are clear to do another job and I don't expect them to go 'Oh bless us someone has died let's send her back'. Yeah the horrific ones you expect a little bit of leeway to get a cup of tea or even a little bit extra at casualty, Control are aware of that and they are quite fine

about it so I don't think, they have got their restraints and they have got their timescales and their management to please and I can't blame them for sometimes getting short and angry because we all do, it's part of the process".

Some of my participants report they always have downtime offered to them, "*personally I have always been given downtime following a bad job"* (M33, 2008: 63-64) whilst that need in others is dismissed, *"man shot himself through the mouth. I went into the Control room soon after and instead of sympathy was given another job"* (F32, 2008: 42-44). However, I observe how Control contact the crew who attend the incident I label S1 to make sure everyone is Ok and allocate forty-five minutes downtime. This however, is subject to fervent discussion involving everyone on station as to whether that concern is genuine or purely for my benefit. As I mostly hear echoes around the region of how, "*Control needs to be more consistent more aware of what it is like on the road*" (F14, 2008: 58) I endorse the argument it is inconsistent.

The third intervention brought to prominence in the literature of which I cite the encounter between the paramedic involved in PD1 and their manager as evidence it takes place, is recognition. Although this carries significant potential as F12 (2008: 445-448) informs me,

"For management to go, 'Right we are going to have a meeting and I want to thank you all for everything you have done I am proud of the way you treat patients'....that's all it would take.....that's what people would be happy with".

I offer no other examples that I suggest is due to how recognition is not a part of the culture as I have discussed. But in acknowledging how *"a 'thank you' makes you feel ten feet tall"* (M32 (2008: 22-23) indicates this intervention carries potential to significantly boost morale. The fourth organisational intervention I add inductively is peer support but it is discredited, as M22 (2009: 74-75) explains,

"There is a peer support network but it does not tend to be used as there is a lack of trust around it and the nominated officers are not respected".

Unlike Peterson, Bergstrom, Samuelsson, Asberg and Nygren (2008) I find little evidence of the informal support and encouragement a peer support network should provide. Instead I find it is the antithesis of a confidential telephone helpline because its members are "*known for gossip"* (F31, 2008: 75) added to which, *"peer supporters do not know enough about what has gone on to be helpful"* (M31, 2008: 105-106) and even if they did "*face to face interaction works best where personal issues are concerned"* (M35, 2008: 31-34). It does not appeal to the inexperienced as M12 (2008: 120-121) remarks, "*if you are new to the job, you are not going to try and demean yourself in front of your colleagues".* As I observe contact details posted up on station notice boards are out of date I ponder whether that explains why it is not used as M24 (2008: 68-69) comments,

> *"I have actually used it and it was effective so I consider it to be a good idea but again there is no current info on station".*

But his endorsement is the only one I receive leading me to agree with M36 (2008: 54) it needs "*a fresh start"* as it is bypassed in favour of,

> *"Getting back to station and talking to people on station is my peer support and that is everybody's to be honest"*
>
> F11, 2008: 70-71.

The final intervention the organisation could provide is training. Although Schreurs, Winnubst and Cooper (1996) challenge the efficacy of education programmes I find support amongst my sample although NEAS do not provide any as I have previously mentioned and M13 (2008: 83-85) confirms,

> *"There is no formal training module on well being, stress or emotion management. I think it would be a good idea if there were".*

Training is needed for a deeply emotional aspect of the job, *"we need a course on how to deal with death and dying"* (M33, 2008:114). Although Williams (2012) insists nurse educators are best placed to service the emotional training needs of student paramedics my participants refute her assertion. They are vehemently opposed to their training being nurse-led, as it is"*not geared to the transient nature of the job*" (M14, 2008: 79)

which *"undermines its acceptability"* (M21, 2008: 298) and leaves questions unanswered for the students who "*have to ask more than they would if paramedics took their modules*" (M18, 2009: 102-103). These comments lead me to argue credibility demands it is designed and run by a paramedic educator.

5.5.3 Acknowledging Interventions

I conclude this final section on interventions with an answer to my one remaining research question that inquires, how can the consequences of having to manage emotion be mediated: The paramedics deploy a range of interventions that I distinguish as voluntary and authorised in order to amplify gains, mitigate losses or simply recover emotional equanimity. Voluntary interventions include positive self-talk through which the paramedics prepare for a run particularly when they anticipate a bad job. During a run negative emotion is dissipated through evoking a calming strategy e.g., counting to ten or objectifying the patient in order to contain distress. Through delivering all possible treatment interventions the paramedics can also keep a balance between engagement and detachment that enables them to leave the patient without experiencing remorse. Between runs they take advantage when and where they can but mostly outside A&E or in their vehicle of opportunities for an informal time-out. Usually no more than a few minutes in duration these are nonetheless sufficient to create a restorative break in the demand. But it is on station on standby that the paramedics seek out their preferred intervention between runs of informally debriefing with colleagues under their shared obligation to provide collegial support.

Throughout a shift the paramedics use black humour as the occasion demands to offset a range of negative emotion but particularly distress. They may also engage in reflexive practice during or at the end of a shift to identify and discharge any residual emotion from incidents they have attended in order to restore equanimity. At the end of a shift they call upon family members to assist them in debriefing particularly if they have been inhibited from doing so in the workspace due to a lingering machismo and participate in activities which encourage relaxation e.g., exercise. The ultimate intervention is to reduce the demand through withdrawal either by reducing the hours spent in the workspace or by changing the nature of that participation to a less demanding role but to do so the paramedics need the cooperation of the organisation.

The organisation can authorise five different interventions in: counselling; peer support; down-time; training and recognition. However, external counselling and peer support are discredited and rarely accessed due to a lack of trust whilst down-time cannot be relied upon as it can just as easily be denied as proffered. As the road crew and the rest of the organisation situated within HQ are estranged they each hold a critical perspective of the other which denies each an appreciation of the other's needs and subjects all initiatives and requests to suspicion and uninformed scepticism. As a result the paramedics find their need for down-time restricted to those occasions that the organisation defines as harrowing, their voices which clamour for a training module going unheard and the simplest of interventions in recognition, overlooked. There is no continuum of interventions, as Reghr and Bober (2005) propose for the paramedics in my sample to tap into.

5.6 Concluding Remarks

Over the course of this chapter I have explained the process to emotional labour constituent of the paramedic role. Performances are triggered by a wide variety of factors related to the job, organisation and the individual and involve the management of twenty-six discrete emotions. Without any formal preparatory training or guidance it is an effortful process but paramedic responses shaped by empathy produce gains in compassion and job satisfaction through which their identity is regularly taken and confirmed. However those positive consequences are tempered by losses which manifest as compassion fatigue and stress. These diminish well-being and satisfaction and ultimately disconfirm identity through provoking behaviour the paramedics recognise as contrary to professional conduct. However losses can be mitigated and gains amplified by the judicious use of an intervention of which some are deployed at the discretion of the individual whilst others have to be authorised by the organisation. Throughout this elaboration I have situated answers to seven of my subsidiary research questions. In the next and final chapter I take the essence of those to which I add that of the interactional demand I developed in chapter four to conclude my findings with a composite address as to what constitutes emotional labour for the UK paramedics in my sample.

Chapter 6

Final Conclusions and Reflections

6.1 Introduction

In this final chapter I first present the six contributions I make to the sociological imagination on organisational emotionality that both enlarge and enrich it. I draw attention to my occupational model which carries potential beyond my context of prehospital emergency care but which facilitates my answer to my principal research question as to what constitutes emotional labour for the UK paramedic. This raises implications I discuss in light of both the Francis inquiry and Keogh review that each recognise urgent change is needed in order to improve both the capability and capacity of the ambulance service to deliver an effective and timely emergency response. In returning to the criticism of emotional labour I exposed in chapter one I propose, in light of my findings, an appeasement before I consider the limitations to my study and possibilities for future research. Both this chapter and my thesis come to a close with my final reflections on the challenges I faced and overcame to complete this study.

6.2 Enlarging the Sociological Imagination on Organisational Emotionality

To enlarge the sociological imagination on organisational emotionality I have taken a fresh look at emotional labour and through so doing satisfy the first of my two aims with six contributions. The first is a primordial audit of antecedents I list in Table 6.1 which I develop from both my literature review and field work. I am not claiming this is an exhaustive list but one to which others can add and expand. My second contribution lies in my development of the established threefold regulatory process of emotional labour undertaken by the individual comprising antecedents, strategies and consequences into a quadripartite process through the addition of interventions. As these act to amplify positive and mitigate negative consequences to performances their exclusion cannot, in my view, be justified. I redress this omission theoretically in chapters one and two and empirically in chapter five. I establish how there are a number of interventions available to the individual to deploy under their own volition before, during or between encounters to which the organisation can add others available on their authority within and without the work environment in order to promote gains and mitigate the losses consequential to performances.

Individual	Situation
Gender Age / Experience Temperament Social class Status Skills Fatigue Illness / disability Ethnicity Religious / moral values Personal baggage Home-work interference	Insiders Outsiders Memories Routineness Frequency Duration Compound or single interaction Status of interactant Attitude/ behaviour of interactant Expectations of interactant Familiarity of interactant Similarity of interactant Interactional injustice Audience expectations Biography of prior expectation
Job	**Organisation**
Service or payment Tempo Uncertainty Unpredictability of personal time Role identity Autonomy Task routineness Task variety Occupational norms Operational hassles and uplifts Job satisfaction	Climate [Local / Political / Public] Culture [Formal / Informal] Openness of emotional dialogue Level of emotional support Monitoring [supervision / surveillance] Organisational injustices Organisational hassles / uplifts Expectations [internal / external] Work intensification [targets]

Table 6.1: Antecedents to emotional labour

My third contribution is to first highlight how the process of emotional labour is cyclical not linear as illustrated by Mann (2005) amongst others, as it reflects both that notion of the emotional transaction (Rafaeli and Sutton, 1987) in which interaction is recognised as a continuous two-way exchange and the duality proposed by Huynh, Alderson and Thompson (2008) in which consequences to performances influence subsequent antecedents. Second I offer the generic quadripartite integrated framework of emotional labour I construct from applying these two ideas which I illustrated in chapter one as my most significant contribution as it offers sociologists an integrated perspective in which the interactional demand on the job in the guise of situational antecedents and the individual process of emotion management can both be explained. Through this framework which also represents a deductive tool I address the concern by Wharton (2009), research in this field has neither provided any avenue for those two streams to meet nor any helpful theoretical guidance.

My fourth contribution takes the form of an occupational model I illustrate in Figure 6.1. According to Bradley and Schaefer (1998: 25), "a good model condenses the confusion of the world into a form that is both comprehensible and helpful" and this model explains in a glance how emotional labour lies at the core of a role. Through recognising situational antecedents form the interactional demand and elevating their position in my framework to an outer ring I am able to emphasise the interactive connection between each interactant and the individual process to emotional labour. I explain the model using the paramedic role as an example but this model is, I suggest, readily transferable. Around the rim of the model I position each category of interactant a paramedic can encounter over a shift which I argue forms their replicable work unit by amalgamating the two interactional maps I developed in chapter four. The first maps those interactants encountered over a run and the second those on standby. The paramedic [**P**] at the centre of those maps is peeled back to reveal their internal process of emotional labour employed with each interactant. Out of necessity I skeletonise the framework to fit and minimize the labels for each quadrant [**A**ntecedents; **S**trategies; **I**nterventions and **C**onsequences]. As Schutz (1964: 7) maintains "the task is to make explicit the meaning and significance these structures and relations have for the observed agents themselves" my labels reflect the paramedics vocabulary and I use colour to differentiate the variance in demand which follow the conventions I adopted in chapter four. I also dot the interactional lines which radiate out from the individual at the centre and connect with each category to indicate each may be present or absent at

any one moment in time which allows the demand to be evaluated in different locations of both time and space e.g., day and night shift or run and standby.

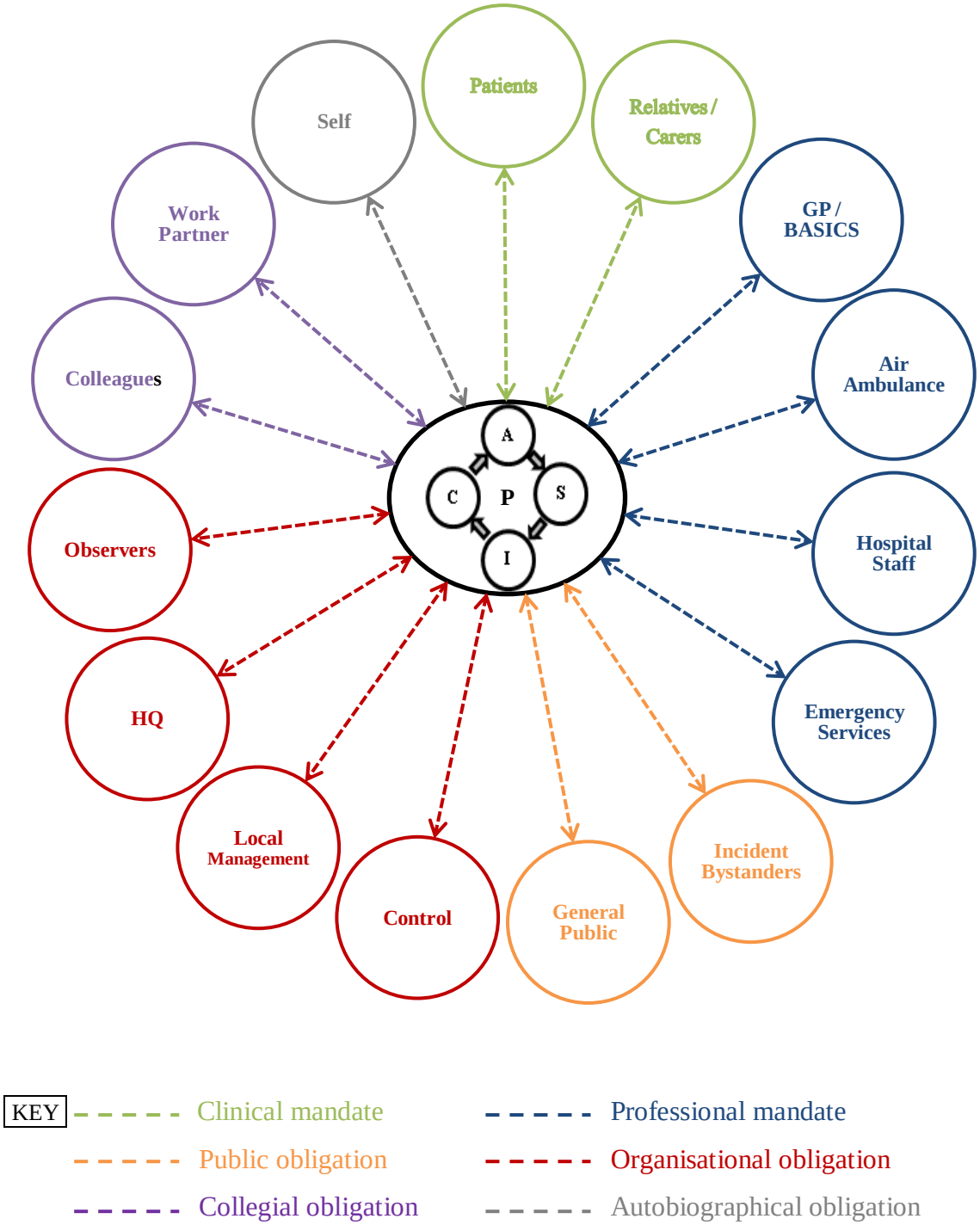


Figure 6.1: Paramedic model of emotional labour

Although I choose to explain the interactional demand on the paramedic and the process of emotional labour separately these could easily be combined. The model facilitates an explanation of demand by interactant category e.g., patient or group of categories e.g.,

clinical allowing each to be compared to and contrasted with others. It also accentuates the sociological origins and purpose of emotional labour by removing any need for a psychological understanding of the neurological processes that accompany emotion. Through addressing the question as to what constitutes emotional labour for the UK paramedic in the next section I demonstrate its practical application and through doing so confirm its utility (Huynh, Alderson and Thompson, 2008).

My fifth contribution to the sociological imagination on organisational emotionality both supports and extends the notion emotional labour is multilayered (Theodosius, 2008) as I find in the context of prehospital emergency care there are six stratums in clinical; professional; public; organisational; collegial and autobiographical. Clinical is mandated as I explained in chapter two and loosely relates to a combination of the two forms of emotional labour: instrumental and therapeutic proposed by Theodosius (2008). The demand from fellow professionals across both emergency and health services is also mandated but whilst Theodosius (ibid) explains it alongside the demand by peers as collegial I split it into the distinct form I label professional. This mirrors prescriptive emotion management proposed by Bolton (2005) and recognises the motivation is respectful cooperation rather than support.

The informal obligation to provide support I explain as collegial. I also argue there are three other obligations on the paramedic to perform emotional labour. Organisational expectation in compliance and deference to authority represents an obligation similar to pecuniary emotion management proposed by Bolton. As authority and reputation have to be upheld in public spaces I distinguish those performances as another obligation I term public and finally the autobiographical form recognises the demand for normativity that Boyle (ibid) labels 'emotion process work' but recognises as emotional labour, as it is directed by occupational not social rules and carries economic value in maintaining the paramedic as an effective resource. Accordingly I argue emotional labour is a composite term and each occupation may be explained using different forms both shared and occupation specific.

My sixth and final contribution lies in how I elaborate what is known about the emotional labour performed by the paramedic and in so doing, enlarge what is known about that occupation in general. As I have just discussed emotional labour represents a strata which splits into numerous layers and in the next section I will identify how the

demand within each also varies to extend the interactant pool far wider than either Boyle (2005) or Palmer (1989) propose. I will also challenge the defining emotion of anxiety proposed by Boyle (ibid) and present details on each of the four aspects to the process of emotional labour that have until now remained unexamined. But my major contribution within context lies in providing a primordial UK empirical study. This offers a benchmark from which a deeper understanding and knowledge can develop.

6.3 What Constitutes Emotional Labour for the UK Paramedic?

The question as to what constitutes emotional labour for my sample of UK paramedics represents my principal research question and in constructing my answer I satisfy the second of my two aims. As I illustrate in Figure 6.2, in which I plot the mean scores from each set of inventories thirty-two out of the thirty-six paramedics [89%] in my sample perform a high level of emotional labour across their principal interactions and fifteen [47%] of that group utilise a very high level. As there are just three individuals [8%] adrift of that main field I establish emotional labour as significant for the paramedic role which I further explain by bringing together the essences of my answers to each of my eight subsidiary questions contained within chapters four and five.

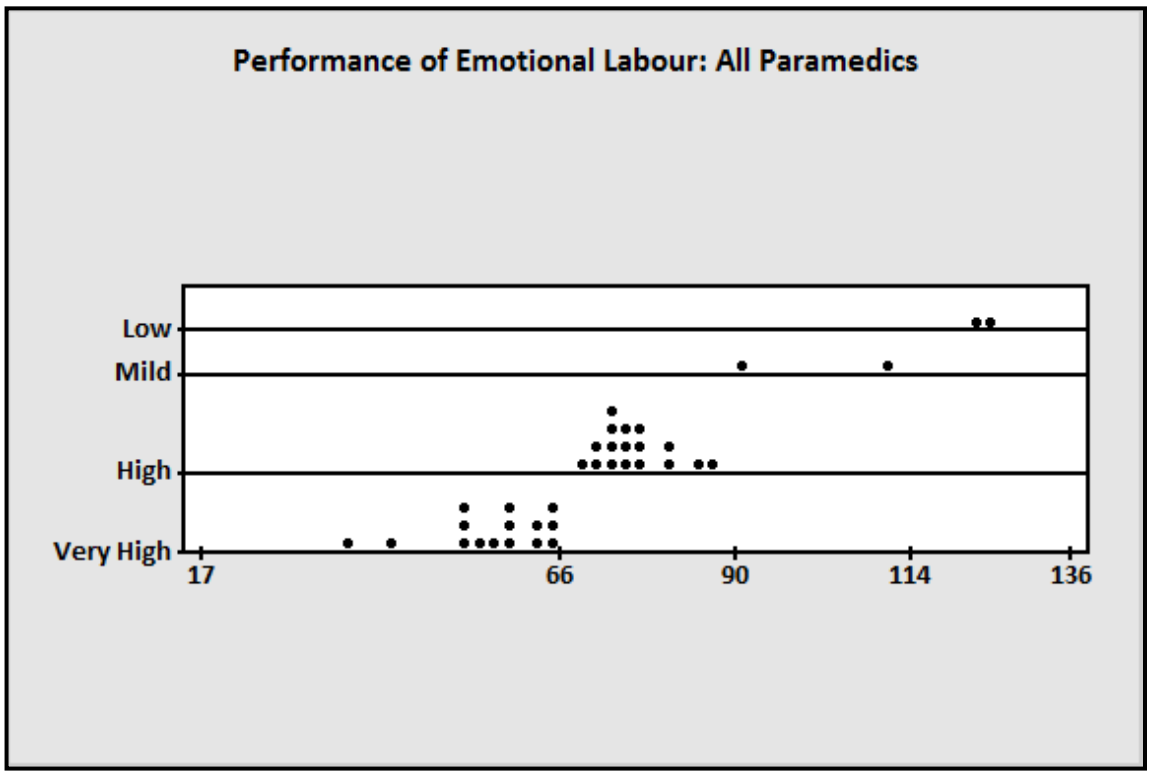


Figure 6.2: Emotional labour: MERI mean scores across the whole sample

In general, interactions across the prehospital emergency care work space, [highlighted through both interview and observational methods] trigger emotional labour when anxiety surfaces; empathy is aroused; gratitude or abuse is received; respect is undermined or memories return. Patients represent the greater demand of all interactants the paramedic encounters and performances are explained by their clinical mandate in which they are required by their professional regulatory body to identity and mediate emotion of which anxiety is singled out. The paramedic connects emotionally with the patient, a few minutes before their encounter when they are notified of a run, as preliminary details coupled with their biography of prior expectation amplify or dampen their levels of enthusiasm, anxiety and confidence. Patients are not however a homogeneous group but split into three subcategories which reflect their clinical status: taxi; routine or emergency all of each carry an emotional demand requiring in particular the management of anger, boredom and enthusiasm respectively.

The bulk of the workload, as Boyle (2005) predicts falls into the routine category however this is far more diverse and demanding than she describes. It includes along with those she identifies as intoxicated or suffering with dementia a number of patients whose habitual use of stimulants e.g., drugs and cigarettes prompt circumspection to guard against any subjective moral judgment applied to their use of emergency resources impeding an appropriate performance. This extends to the mentally ill which subsumes dementia but includes those that self-harm or attempt suicide and which can also extend to those with chronic illnesses that reflect lifestyle choices. Within each subcategory patients differentiate further according to whether they fulfill the criteria of friend or foe. The former in being amiable and compliant are pleasing and accordingly lessen demand whilst the latter displease through their attitude, expectations, level of similarity or familiarity to the paramedic to exacerbate demand. The clinical mandate extends to relatives and carers who also represent a significant demand in which those who are agreeable and helpful lessen it and those who are disagreeable due to ignorance and/or aggression exacerbate it.

In assuming responsibility for the patient regardless of the circumstances the paramedic becomes their advocate and this carries a demand for negotiation with colleagues across both emergency and health services so encounters proceed without conflict, tension or subliminal jealousy obstructing a common purpose in auspicious outcomes. As the paramedics are mandated to build and sustain these relationships I explain this form of

emotional labour as their professional mandate. Team work in defining modern health care makes cooperation and consensus vital (Nancarrow and Borthwick, 2005) which evokes a significant demand particularly with nursing staff who can be dismissive and contemptuous. However, all interaction across the health domain which includes medical practitioners in all their guises and air crew carries the potential to signal professional regard when it confers respect or disregard when it provokes anger. Of the two emergency services the FRS represent the greater demand primarily through their rivalry and challenge to the paramedics' medical authority which denies respect.

Out on a run the paramedics are obliged to perform emotional labour with incident bystanders in order to maintain authority and deliver their clinical mandate unhindered by intimidation and abuse. They also perform more widely with the public in order to preserve their reputation both instances of emotional labour I encapsulate in their public obligation. Colleagues also form an obligation that extends over standby but this is tempered by reciprocity and in particular the gift of compassion that in extraordinary circumstances alleviates strain in the receiver to the detriment of well-being in the giver. As friends and as confidants collegial interaction is supportive and represents the least demand across interaction categories and although there are exceptions the majority of exchanges invoke the lesser demand of friend. Another obligation which intrudes onto standby rests on the individual themselves to manage the emotions invoked by troublesome memories I term autobiographical which acts to preserve both competence and identity aided by those memories which in contrast are satisfying and rewarding.

Their final obligation, previously unrecognized, is to defer to organisational directives and forfeit personal needs with grace. This emerges as the dominant form of emotional labour as it represents an expectation which extends across both the run and standby to douse each and every shift regardless of clinical performances. Divisional and executive management along with support areas at service HQ of whom the paramedics particularly single out dispatch officers and schedulers all expect the paramedics to defer to their authority. This leads to considerable anger when the individual inside the role is ignored leading to recognition, refueling and support being withheld. Observers as honorary insiders provide a contrast in that they motivate performances designed to impress and raise awareness of the role. Through this elaboration I have swelled the audiences with which the paramedic engages from seven (Palmer, 1989) to fifteen but as each of those subdivides at a minimum into friends and foe I argue the demand for

emotional labour is far greater and more diverse than previously acknowledged.

Within each encounter emotional labour is exacerbated by the intersection and/or overlap of cues stemming from factors relating to the job, organisation and the individual paramedic themselves. A high level of job satisfaction which is positively influenced by the unpredictable and extremely varied nature of the job, coupled with an intrinsic professionalism distinct from professional status which is a largely ambivalent concept engage the paramedic, strengthening fidelity which motivates performances to accord with expectation. This engagement however is dampened by negativity generated by surveillance, a lack of personal time and operational hassles of which complaint handling is identified as the most significant. The organisation, for which emotion is taboo, reinforces the cultural divide of 'them' i.e., offstage managers versus 'us' i.e., onstage road crew, Mahony (2001) pointed out over a decade ago as an unhelpful yet common characteristic of ambulance services. Indifference which surfaces in the identification of the paramedics as a resource subject to authority, coupled with a closed dialogue on emotion and a lack of emotional support all serve to alienate the paramedic whose performances are influenced by their incubation of negative emotion particularly anger. The wider political organisation which embodies the DOH, NHS and JRCALC further deflates motivation through the imposition of change to which the paramedics fail to connect e.g., state registration. Individually, experience either of life or on the job increases effort contrary to the view of Filstad (2010) but confirming the warning issued by Mannon (1992). However, gender is not, as Boyle (2005) intimates, significant in the prehospital emergency care workspace to challenge those who consider emotional labour is women's work (Pierce, 1995). Dispositional characteristics in particular an empathetic ability and a sense of humour and skill particularly in communication signal the fitness of the individual to the role and increase the likelihood they will perform appropriately whereas impediments in the form of a mutable status, fatigue and HWI all hinder performances.

Encounters are not however static and the paramedics' emotions oscillate across twenty-six discrete emotions I reveal are constituent of their workspace which split equally between positive and negative and increase those explicit in the prehospital emergency care domain by fourteen. These interlace into a plait of which there are three strands. The first is the paramedic habitus in which the management of enthusiasm, pride, satisfaction, gratitude, admiration, self-reproach and confidence enable the paramedics

to claim and confirm their core identity. The second is compassion through which the paramedics deliver their clinical mandate and fulfill their collegial obligation by managing sympathy, interest, hope, joy, relief, affection, surprise, disgust, anxiety, dislike, distress, resentment, boredom, disappointment, embarrassment and remorse. The final strand in abuse encompasses the three emotions of anger, fear and intimidation of which anger, symptomatic of the unpartisan lack of respect afforded the paramedic, is pervasive and consequently has to be managed more often than any other emotion to challenge Boyle's (2005) assertion anxiety defines paramedic performances. All performances however are an individual construction of each paramedic's interpretation of professional conduct as the emotions form no distinct occupational pattern.

This interpretation is based on intuition, informed by those rules general to healthcare advised by Martinez-Iñigo, Totterdell, Alcover and Holman (2007) and supported by appropriate role models in the absence of formal guidance. Within the core technique of empathy and the appropriation of *"a professional mask"* (F15, 2008: 97) surface acting emerges as a constant in performances with patients as Boyle and Healy (2003) forecast. But it is joined by deep acting, emotional switching and humour in the delivery of each of the six forms of emotional labour as appropriate but without conscious deliberation or regard for the consequences. These take the form of gains in self-esteem, compassion and job satisfaction when positive emotion particularly joy, satisfaction and pride are amplified through establishing an emotional connection and making a difference particularly to patients. Paramedic well-being and confirmation of identity represent further gains that are bolstered through any situation with outsiders or insiders where performances are acknowledged. Losses occur in the form of compassion fatigue, stress, PTSD, tiredness, WHI, somatic complaints and the disconfirmation of identity when the demand for emotional labour outstrips the individual's resources. As Gailliot, Baumeister, DeWall, Maner, Plant, Tice, Brewer and Schmeichel (2007: 334) import, "the agentic, effortful activities of the self use significant amounts of glucose and are impaired when the supply of glucose is depleted" which results performances becoming degraded, well-being diminished and identity disconfirmed as the individual fails to manage deviant emotion and meet the expectations held by others.

Those consequences to performing high levels of emotional labour highlight the importance of mediation. The individual paramedic can deploy an intervention under

their own volition or sanction by the organisation to offset losses, restore equanimity and promote gains. Paramedics voluntarily deploy: positive self-talk; calming strategies and black humour. They find space for unofficial time-outs and seek relief through striking a balance between engagement and detachment but it is informal debriefing on station with trusted colleagues through which they participate in a shared obligation to provide collegial support that represents their preferred intervention. The organisation has a further five it can sanction in counselling, peer support, training, recognition and down-time. However these are not freely available as the first two are discredited and although the third is desired it is also absent. The fourth is inhibited by hegemonic masculine values to an occasional act and down-time is restrained by the operational demand. As Reghr and Bober (2005) point out in chapter two there is a need for a continuum of interventions that recognises need is subjective and consequently allows the individual the choice as to which to use and when. The organisation I argue does not need to fear severe disruption to targets from making down-time freely available as my findings indicate it would form an intervention excessive only in theory, as knowing it was available, would be just as instrumental.

I conclude my response, as to what constitutes emotional labour for the UK paramedics in my sample by confirming it is an integral core component as Boyle (2005) suggests but it is unrecognized. This may reflect either it is being performed well and therefore is invisible (Bone, 2002) as it is "a shadowy and ill-defined form of knowledge work" (Bolton, 2005: 155) which makes it intangible or, it is being dismissed due to an historical association with the nursing profession through which the perception emotional labour "takes time and requires considerable knowledge of the patient as a person" (James, 1992: 503) has become established. But my inquiry has shown how a transient relationship in which both intimacy and attachment are denied does not remove the necessity for emotional labour from the patient encounter. Zinn (1988: 3296) argues all medical interaction "is unavoidably emotion laden" and my findings suggest the ability to manage emotion is more significant than clinical skill, as M31 (2008: 86) confirms, "*1% of the job is clinical the rest is attitudinal"*.

Mannon (1992), through arguing the run gives the role its meaning, obscures how achieving a confident state of readiness before and between runs is also an important aspect of role identity. Time spent on standby enables residual emotion to be offloaded, support and encouragement secured and identity reaffirmed. However, standby is also

where tempers flare unless restrained, emotional baggage gains weight and stress lingers. Whenever interventions are foregone stress feeds back into the emotional labour process as I have illustrated to form a vicious circle. The magnitude of which becomes apparent when meaning is generated by the shift rather than the run. The latter I determine is inadequate as a signifier of paramedic performances as it privileges encounters with patients and demeans time spent standing by and in so doing, leaves paramedic wellbeing and identity partly not wholly explained. The reason paramedics are located in the top six of the most stressful occupations listed by Johnson, Cooper, Cartwright, Donald, Taylor and Millet (2005) lies not with those infrequent emergency runs but with the omnipresent demand to perform emotional labour that extends beyond the paramedic-patient interface.

6.4 Contextual Implications

This thesis carries implications for prehospital emergency care in that emotional labour cannot be flagged and then ignored without consequence particularly in light of the Francis report (Mid Staffordshire NHS Foundation Trust, 2010) and subsequent public inquiry (Mid Staffordshire NHS Foundation Trust, 2013) which highlight numerous failings across the whole of the NHS. In response the DOH (2013) has indicated the culture of the NHS needs to inspire compassionate care and staff must have both the "capability and capacity" (ibid: 68) to deliver it. With respect to capability the ambulance service cannot, I argue, assume an individual applying for a position as a student paramedic will be able to cope with the emotional demands attached to situations they had previously been unable to imagine, as that represents a Herculean expectation. Those emotional demands need to be identified and explored for the benefit of both new recruits and established personnel through an open dialogue and training as I have shown these hold the key to compassionate prehospital care. To facilitate that process and support the well-being of both staff and patients, accessible support systems need to be developed of which the paramedics approve, as without those, emotions will continue to transpose silently into harm (Wastell, 2002) before erupting without warning in a cascade of consequences e.g., RS1.

With respect to capacity, demand on the ambulance service has increased and patients with serious but non-life threatening complaints are being forced to wait several hours

for a response and as a consequence, the paramedics are greeted more with anger than relief (Nelson, 2014). Measures introduced to help the service respond more efficiently, e.g., NHS 111 telephone helpline have led to more ambulances being dispatched for trivial complaints (Johnston, 2013). As A&E departments cannot absorb this flow, ambulances are stacked outside casualty units for up to eight hours before patient handover (Donnelly, 2013). As I have discussed, non life-threatening complaints require considerable amounts of emotional labour as taking an emergency vehicle out of service is perceived as an abuse of the system. When performances are extended that strain increases and negative consequences are compounded.

The intentions set out in the Keogh urgent and emergency care review (NHS England, 2013) to treat more patients outside of hospital boundaries in order to minimise that waiting time will I argue simply shift not lift that emotional burden as taking responsibility to treat and leave a patient at home is anathema to those who subscribe to the ethos of scoop and run as I have discussed so that Keogh recommendation carries a caution. The road crew hold the key to the acceleration, deceleration and derailment of initiatives as their anger can build into resistance e.g., RS1. So whilst I acknowledge there are costs attached to recognising the emotional demand in training and support systems these would I argue be offset by uplifts in morale, reduced absenteeism, patient satisfaction, organisational cohesiveness and reputation. At a time when Government cuts in the operating budget have effectively reduced manpower on the frontline increasing pressure on existing staff (Pearson, 2014) inertia not only inhibits the recommendations from the Francis inquiry (DOH, 2013) from coming to fruition but represents I argue a latent powder-keg of which ignorance is no longer a valid excuse.

6.5 Returning to the Challenge to Emotional Labour

Although I argue emotional labour should be regarded as a composite term covering many different forms I also argue it does not fully explain organisational emotionality. Within organisational workspaces an individual holds multiple identities (Goffman, 1961a) and in chapter five I presented evidence of how familial identities intrude which I supplement with my observation friendships also intrude onto the workspace. Within these intrusions when the occupational mantle is divested, albeit momentarily, social rules govern exchanges e.g., teasing and activities e.g., practical jokes, leading me to

label these, ‘acts of fellowship’ and argue that whilst emotional labour may explain an occupation it is not able to explain the management of emotion by the individual occupant in those “back regions” (Goffman, 1959: 114) where their private self pulls away from and subdues their public self. I consider therefore there is a valid point being made by Bolton (2005) and others who challenge the absolutism of emotional labour. Although I agree with Bolton (2005) that organisational emotionality has both official and social forms and I offer support for her agenda in my account through aligning clinical and professional mandates alongside prescriptive emotion management and organisational obligation alongside its pecuniary form to which I add acknowledgement her presentational form is similar to what I previously termed ‘acts of fellowship’ I struggle, as does Theodosius (2008), with her fourth form: philanthropic. This is similar to what I term ‘compassionate gift’ through which additional compassion is offered to both patients and colleagues. This is, according to Theodosius (2008), intrinsic to those occupations which care for others and carries an exchange and debt in gratitude. I agree as I incorporate philanthropic within clinical and collegial forms of emotional labour.

Callahan and McCollum (2002) also present a similar inconsistency. They split emotional labour into three forms. Autonomous emotional labour explains what Bolton (ibid) labels ‘prescriptive emotion management’ and emotional labour her pecuniary form of emotion management on which I map my clinical/professional mandates and organisational obligation respectively. These reside without complaint in the economic hemisphere but their third form they label, ‘indirect emotional labour’ which represents the effort required to manage activities which are undertaken on behalf of the organisation but which fall outside of the job description they position in the social sphere. However, as the individual is representing the organisation in those instances their performances are directed by organisational not social rules and as there is exchange value in respect and reputation this is I argue another example of an incorrect alignment. In my opinion, confusion can be minimized and understanding enhanced if organisational emotionality is split simply into economic and social strata as McClure and Murphy (2007) propose in chapter one. This would allow all forms of emotional labour to be explained within the former hemisphere and all social forms of emotion management in the latter. In presupposing the underpinning principles of emotional labour explain the first and those of emotion work the second, labels within each stratum will not need to include either ‘work’ or ‘labour’ and therefore will not mislead.

6.6 Study Limitations

The small number of respondents and uneven spread particularly across gender negate any generalizations I could take from my inquiry to the wider paramedic population. Yet my small scale study suggests the concept of emotional labour is significant for prehospital emergency care paramedics in the UK and therefore further research on a much larger scale would both verify my findings and add depth.

6.7 Future Research

The generic quadripartite integrated framework to emotional labour I develop in this thesis provides a guide for future sociological inquiry in which the interactional demand on an occupation and the regulatory process undertaken by the occupant can be understood symbiotically rather than discretely. Further studies would validate this framework and develop knowledge of each quadrant. The occupational model I construct through the recasting of situational antecedents facilitates the comparison and contrast of the demand for emotional labour on different occupations within the same domain e.g., healthcare or between domains e.g., healthcare and education. Further studies would validate this model and offer ranking processes e.g., Johnson, Cooper, Cartwright, Donald, Taylor and Millet (2005) more substance and meaning.

Contextually, the demand for emotional labour by organisational insiders in the form of managers particularly the suppression of anger needs further investigation as I exposed in chapter one the link between this strategy and stress and in chapter four how this demand not only pervades the shift but represents the most significant form of emotional labour. In addition I have shown professional identity to be an ambivalent concept which is also worthy of further investigation in particular how outsiders influence its reframing. Each of the cardinal points to the conceptual framework also provide for specific inquiries to develop a more robust account. In particular I am not able to draw definitive conclusions with respect to gender due to the unequal stratification of my sample which could be rectified. Similarly experience also could be clarified. Finally, I place a marker against PTSD as this link to emotional labour needs to be further explored in light of how self-reproach, implicated by Jonsson and Segesten (2004), represents an emotion I identify at the core of paramedic identity. However, I consider the ultimate challenge for future sociological inquiry lies first in the

recalibration of emotion so that it is perceived as strong rather than weak and second with the realignment of emotional labour to a neutral rather than gendered position in order to facilitate acceptance of the concept across all occupations and organisations.

6.8 Final Reflections

The reflections I include in this section highlight how research plans are not hermetically isolated but tempered by reality. The decisions I made were influenced by unforeseen personal circumstances and the unanticipated hostility of the prehospital environment.

6.8.1 Personal

Once my fieldwork was underway [April 2008], it quickly became an exhausting process due to the deteriorating health of my mother and my role as her principal carer. Consequently, I made a decision in the middle of August 2008 to reduce the number of shifts I undertook with my seventeen remaining respondents from two to one. This undoubtedly compromised data collection, as time to ease the respondents into an emotional dialogue was shortened and data had to be captured over a single shift. Although I had an interview guide, each discussion took its own individual path and some questions were omitted to allow the answers to others, room to develop. But with only one shift there was no opportunity to go back over the data to either clarify or enlarge it. When my mother passed away [November 2008] I had completed twenty-nine of my field trips which came to an abrupt halt. Although I resumed my fieldwork at the end of January 2009 both my morale and motivation were low. I had opportunity to extend my time out in the field but I kept to my schedule as my energy levels had not recovered. With hindsight I underestimated my ability to recover from bereavement.

6.8.2 Professional

Prehospital emergency care in my opinion represents a hostile environment for a researcher on a number of fronts that need to be taken into account. First of all, it is simply not practical for a qualitative researcher to confine themselves to data collection via interview within the relative comfort of the ambulance station as I had originally planned on doing. There are few opportunities to collect data through structured

interview techniques as time spent on station by emergency services personnel is minimal and cannot be predetermined. Although they should return for meal breaks these are not guaranteed and when they do occur refueling has to take priority. The only alternative involves participant observation and that poses a number of challenges.

The first of these is stamina as the researcher needs to factor in the physical demand. My day out in the field often started with the alarm set for 04:15am so I could be on station as instructed fifteen minutes prior to the official shift start time of 07:00am after travelling anything up to eighty miles. Those days finished at 21:15pm provided there had been no late runs. In between, each shift comprised twelve hours of almost constant activity within which time to hydrate, refuel and take comfort breaks was unpredictable leading to spells of real discomfort. The second is the nature of the job in that it is dirty work. There is adverse weather and outdoor hazards e.g., traffic to contend with along with bodily fluids, violence and horror. To opt-out of a job is not a practical proposition as emergency services personnel can be dispatched to a job from a remote standby point and in any case to do so, would lose credibility and both potential participants and data.

The third challenge is the mental demand that arises both from witnessing scenes that as a researcher you never expect to encounter and also from the frustration of erratic data collection. With respect to the first I found there were a number of worlds circling my own of which I was unaware. I had not appreciated the extent of drug-taking, self-harm or suicide attempts that constitute daily occurrences within the region or that I might attend a murder scene. Although I accompanied one of my participants to a hanging I found witnessing any individual in distress was equally as demanding as I had to reign in my natural reaction to reach out which as I have mentioned I did not always succeed in doing. In respect of the second, data collection is only ever going to be erratic as it has to fit inbetween emergency responses that vary in both frequency and duration. I propose foresight through engaging in a pilot and patience are both needed in equal measure in this environment. The fourth and last challenge is safety. There is limited protection available for the researcher against the unpredictable and potentially violent behaviour of patients who are intoxicated or mentally unstable. As both represent an increasing demand on the service, researchers need to be wary. Although I was naive fortunately I came to no harm. I consider I rose to each challenge not perfectly I admit but well enough to be accepted by my participants which enabled me to obtain a deep insight into the realities of their role for which I consider myself privileged.

Appendix 3.1

Emotion Checklist

Study: 'Emergency Care: Emotional Control' Researcher: Janet Lawrence

Work-related Emotions Checklist [Version 1.0 / 10 October 2007]

Please consider your experience as a paramedic and indicate with a ✓whether you have been able to genuinely express each emotion in the following list (continues over the page) and/or whether there have been any occasion(s) when that emotion has had to be suppressed or feigned. If any of the emotions listed have not been experienced whilst working as a paramedic, leave that row blank. In respect of emotions suppressed or feigned please indicate the nature of the incident and/or interaction that refers. If neither refers please ✓ other and use the comments box to explain further. Also use this box to exemplify any notation of the incident/interaction boxes.

Key: **P**atient; **R**elative; **B**ystander; **E**mergency Services [Police, Fire]; **H**ospital staff; **C**olleagues; **M**anagement; **O**ther

Emotion	Genuine	Suppressed	Feigned	Occasion										Comments
				Nature of incident	Type of interaction							Other		
					P	R	B	E	H	C	M	O		
Enthusiasm														
Boredom														
Disappointment														
Sympathy														
Joy														
Gratitude														

Emotion	Genuine	Suppressed	Feigned	Occasion									Comments
				Nature of incident	Type of interaction							Other	
					P	R	B	E	H	C	M	O	
Distress													
Hope													
Anxiety													
Satisfaction													
Embarrassment													
Fear													
Affection													
Resentment													
Admiration													
Interest													
Anger													
Self-reproach													
Intimidation													
Disgust													
Surprise													
Remorse													
Relief													
Dislike													
Pride													

Appendix 3.2

Mann Emotional Requirements Inventory©

Developed by Sandi Mann PhD
University of Central Lancashire, Preston, UK

Modified by Janet Lawrence BA, MA, MBA Durham University, for use in the Emergency Care: Emotional Control research study with express permission of the author

Instructions: There are five separate inventories each containing seventeen statements.

Inventory A: Encounter with a patient
Inventory B: Encounter with a relative or bystander
Inventory C: Encounter with member of police or fire services
Inventory D: Encounter with a hospital doctor or nurse
Inventory E: Encounter with a NEAS colleague or manager

For each inventory, consider a typical encounter and for each statement, indicate the strength of your agreement with it by highlighting or marking in some way the relevant point on the scale.

For inventories B/C/D/E also indicate which of the alternatives refers by deleting those not appropriate
e.g., Relative / ~~Bystander~~

INVENTORY A: ENCOUNTER WITH A PATIENT

1 During the encounter I hid (or tried to hide) a lot of emotion from the patient.

Agree 1 2 3 4 5 6 7 8 Disagree

2 Because of events in my personal life or at work, I felt negative (e.g. depressed, upset, angry, frustrated) BEFORE this encounter but felt I had to try and hide my feelings and put on a 'brave' face to the patient.

Agree 1 2 3 4 5 6 7 8 Disagree

3 Because of events in my personal life or at work, I felt positive (e.g. excited, happy, proud) BEFORE this encounter but felt I had to try and hide (or tone down) my feelings from the patient.

Agree 1 2 3 4 5 6 7 8 Disagree

4 During the encounter, I felt that I was 'acting' a role or taking on a role such as helper, advisor, expert, teacher, parent, counsellor or boss.

Agree 1 2 3 4 5 6 7 8 Disagree

5 At some point during the encounter I felt that I intentionally conveyed (or attempted to convey) a positive emotion or feeling that I did not really feel but that was appropriate at the time (e.g., interest).

Agree 1 2 3 4 5 6 7 8 Disagree

6 At some point during the encounter I felt that I intentionally conveyed (or attempted to convey) a negative emotion or feeling that I did not really feel but that was appropriate at the time (e.g.,disgust).

Agree 1 2 3 4 5 6 7 8 Disagree

7 During the encounter, I felt that the patient expected me to take on a role such as helper or advisor etc.

Agree 1 2 3 4 5 6 7 8 Disagree

8 I felt that I acted differently in this encounter than I would have done at home or with friends.

Agree 1 2 3 4 5 6 7 8 Disagree

9 I felt a bit ‘fake’ as if I was not really being ‘me’ at some point in this encounter.

Agree 1 2 3 4 5 6 7 8 Disagree

10 I felt that I suppressed, hid or tried to hide positive emotions (e.g., joy, pride) at some point in this encounter

Agree 1 2 3 4 5 6 7 8 Disagree

11 I felt that I suppressed, hid or tried to hide negative emotions (e.g. anger, frustration) at some point in this encounter

Agree 1 2 3 4 5 6 7 8 Disagree

12 I felt that at some point the patient expected me to have a particular ‘face’ or disposition (e.g., they expected me to act friendly, concerned, sympathetic, cool, emotionless)

Agree 1 2 3 4 5 6 7 8 Disagree

13 I ‘psyched’ myself up so that I would genuinely feel any emotion that I was expected to feel (e.g., enthusiasm)

Agree 1 2 3 4 5 6 7 8 Disagree

14 At some point, I laughed or frowned because it was expected rather than because I found something amusing or distressing

Agree 1 2 3 4 5 6 7 8 Disagree

15 At some point I felt stressed or found it a strain because I could not show my true feelings as they would not have been appropriate

Agree 1 2 3 4 5 6 7 8 Disagree

16 At some point during the encounter I felt stressed or found it a strain because it was difficult to maintain the role (e.g., helper, advisor, expert etc) I had took on

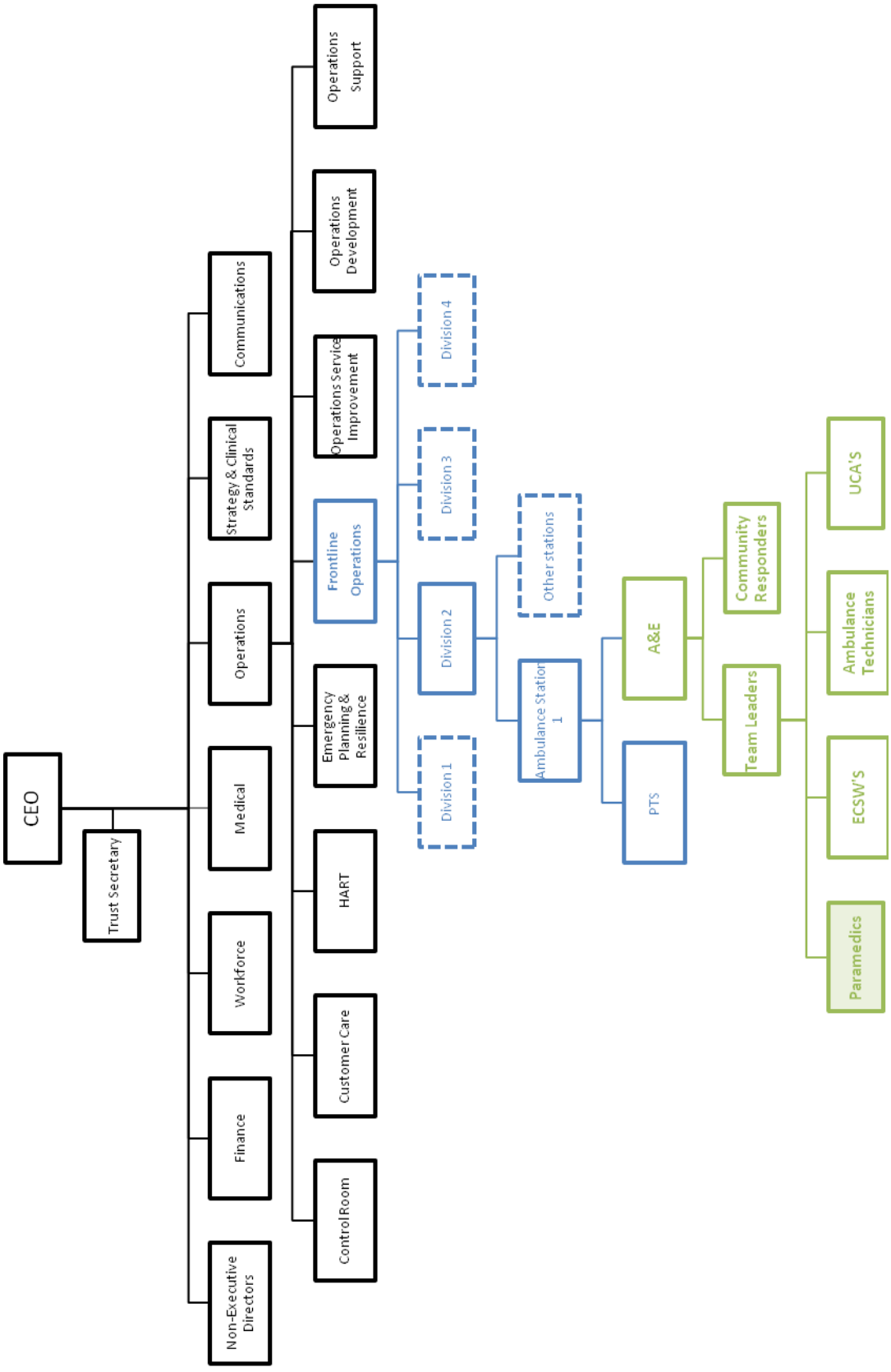
Agree 1 2 3 4 5 6 7 8 Disagree

17 I felt that there was a protocol or rules about how I spoke or acted in this encounter

Agree 1 2 3 4 5 6 7 8 Disagree

Appendix 3.3

Organisational Structure Chart NEAS 2008-9



Appendix 3.4

Study: 'Emergency Care: Emotional Control'
Researcher: Janet Lawrence
Advertisements for Volunteers [Version 2.0 / 07 January 2008]

Intranet Advert 1:

Calling all paramedics - Does your well being and professional identity matter to you?

If your answer is yes, you may be interested in participating in a new research study scheduled to start in April of this year. There are **no** questionnaires. Participation will mainly involve talking about your experience as an emergency care provider to a researcher from Durham University. In return you will receive a small but useful mystery gift. Watch this space over the next few weeks for more information.

Intranet Advert 2:

Calling all paramedics – this month's edition of 'The Pulse' gives the details you have all been waiting for - the new research study that is designed with your well being in mind. Volunteering is easy - all it takes is a quick email to the contact address in the article to receive full details of the study and exactly what your involvement will entail. If the number of volunteers exceeds the number being sought there may have to be a selection process. But thirty-six is the magic number to be split equally between the sexes and covering all levels of experience so there are plenty of opportunities available. And don't forget there is a mystery gift for everyone who volunteers.

Main Advert for 'The Pulse':

Calling all paramedics - Does your well being and professional identity matter to you?

If your answer is a yes you may like to volunteer to take part in a research study to be undertaken by Janet Lawrence from Durham University scheduled to begin in April of this year. Janet is a research student who after many years working within a variety of different fields including Human Resources has developed an interest in how wellbeing and professional identity are both underpinned by how individuals and their organisations acknowledge and handle emotion. A number of studies amongst ambulance personnel have focussed on critical incident exposure and how this can lead to post traumatic stress syndrome but no study to date has considered how everyday interactions and the more routine incidents can often lead to emotions being suppressed or faked. Suppression of emotion in particular has been linked to physical, psychological and social harm so it is not something that should be ignored. However, the control of inappropriate emotion often referred to by the term emotional labour, can also be a positive experience resulting in increased personal and professional esteem. So what can trigger each of these states for you?

By sharing your experiences with Janet, during the course of your normal shift, as the workload permits, you will help to increase understanding of what constitutes emotional labour for the paramedic that could potentially reduce stress and enhance job satisfaction across the whole of your profession. Interested? - Would you be prepared to be accompanied and observed over the course of two consecutive day shifts to facilitate understanding of your job and provide time for that discussion? If you think you might then further information on the study and exactly what your participation would involve is available to help you decide. And don't forget the mystery gift! Please send an email to janet.lawrence@dur.ac.uk headed 'Paramedic – more info' and Janet will send you an information pack by return. Janet is a trained researcher and holds a BA [combined social sciences], MA [social research methods] and MBA [master's degree in business administration]. But these qualifications are surpassed by her regard for the work that you do and the need to ensure your profession remains one in which individuals can aspire to work without their wellbeing being compromised.

Appendix 3.5

Poster Advertisement

Calling All Paramedics

Does your Wellbeing and Professional Identity matter to you?

If you answered YES, then you may like to volunteer to take part in a research study scheduled to start in a few weeks time.

There are NO questionnaires!

All you have to do is share your experience and opinions with a researcher from Durham University during the course of your normal shift.

In return you will receive a mystery gift and either the Ambulance Services Benevolent Fund or the Great North Air Ambulance (your choice) will receive a £1 donation, so simply by volunteering you can also raise much needed funds for these registered charities.

Interested?

Email janet.lawrence@dur.ac.uk for an information pack.

Just head the email 'Paramedic—more info' (there is no need to write a message)

You won't regret taking part but you may regret not having your say about your profession and how it could be improved.

Appendix 3.6

Shaped by the past, creating the future

School of Applied Social Sciences

[insert date]

Study: 'Emergency Care: Emotional Control'

Researcher: Janet Lawrence
Public Information Sheet [Version 2.0 / 30 November 2007]

I have accompanied the paramedics called out to you today because I am observing them at work, as part of a research study into their wellbeing.

If you have any concerns about my being present or, would like further information about this study, please do not hesitate to contact me.

I can give you my utmost assurance that no information personal to you will be recorded.

Janet Lawrence BA, MA, MBA
Durham University
School of Applied Social Sciences
32 Old Elvet
Durham city DH1 3HN

Appendix 3.7

Shaped by the past, creating the future

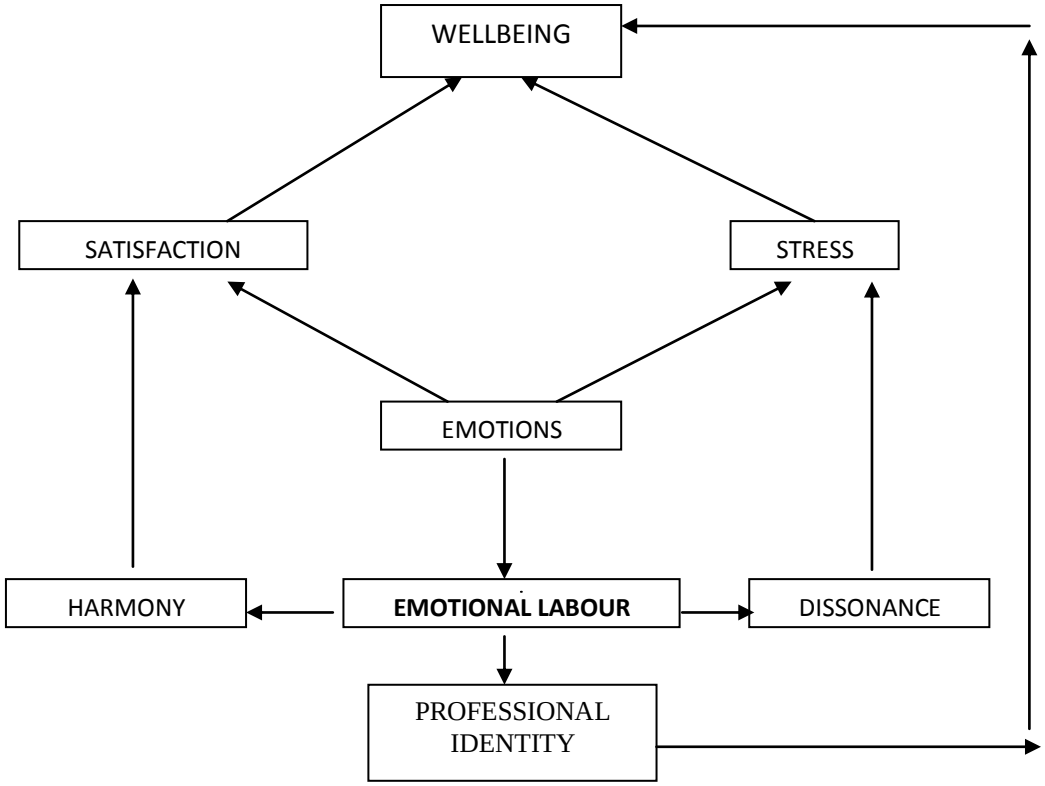
Durham University

School of Applied Social Sciences

Study: 'Emergency Care: Emotional Control'

Researcher: Janet Lawrence
Participant Information Sheet: Group 1 [Version 2.0 / 30 November 2007]

I would like to invite you to take part in this research study that is sponsored by Durham University and funded through the Economic and Social Research Council [ESRC]. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. If anything is not clear or, if you would like more information, please email me at the address given on page 4. Take time to decide whether or not you wish to take part. The purpose of this research is to ascertain what constitutes emotional labour for paramedics by exploring the links shown in the diagram.



Emotional labour can be defined as the effort involved in regulating the expression of emotion [through either suppression or faking] so that only those emotions appropriate to the situation are displayed. When those appropriate emotions conflict with those that are being felt, dissonance occurs and this can lead to stress. When there is a match between what is appropriate and what is felt emotional harmony results and this contributes to job satisfaction. A number of studies have been carried out across the UK NHS to ascertain what induces emotional labour amongst health-care workers in order to derive effective interventions. But no research to-date has been published that investigates this concept from the perspective of the paramedic. This study closes that gap. In doing so, it will also address another gap relating to how the performance of emotional labour influences professional identity. These two areas of knowledge will form the basis of a thesis to be submitted for a research qualification.

If you decide to participate in this study you one will be one of a group of thirty-six paramedics split by gender and experience into six subgroups. Your participation will involve being accompanied and observed over two consecutive day shifts during the period April – December 2008 [as agreed with you], to facilitate a clearer understanding of the work that you do and the interactions you encounter. I will take my lead from you at all times. In respect of the suitability of a run, I would not expect to accompany you if it were considered problematic in any way and I will sit where instructed in the ambulance/car. My role will be that of a non-participant observer.

You will be asked a series of questions relating to your work as a paramedic for NEAS and you will also be asked to consider which emotions, from a list provided, you have had occasion to either hide or fake and when that has happened and with whom. A checklist of emotions is included as part of this information pack, in order for you to become acquainted with this aspect of the study. I will review it with you so it does not have to be completed in advance unless you would find it useful to do so. Our discussion will be fitted in around your operational duties. Your answers will be recorded on audiotape to facilitate analysis. But the information that you give will be kept strictly confidential with an anonymous code being used as an identifier rather than your name. Although verbatim quotations may be used in my thesis they will not be attributed to you personally. Data will be stored and handled in accordance with the Data Protection Act 1998. All data files held on computer will be protected by a password known only to myself. All audiotapes will be kept in a secure storage facility

at the university and destroyed along with all computer files once the thesis has been admitted. This is likely to take place sometime between October 2009 and March 2010. However, there is a possibility that these arrangements will be overridden by a requirement, placed on all researchers funded by the ESRC, to submit their data for review by the Economic and Social Data Service based at the University of Essex, for its potential long-term academic use. This review has to take place within three months of the research being completed and could result in the data from this project being digitally preserved indefinitely. Whatever the decision, I will let you know. If you withdraw from the research, at any point prior to the thesis being submitted, your data will be destroyed there and then and any reference to it will be removed from the study. However, once the thesis has been submitted your data will be an integral part of it and I will not be able to delete it.

In addition to speaking with you, I will also be speaking with a small number of representatives from HQ in order to gain a more holistic insight into the organizational culture and I will also be holding focus groups with Team Leaders to further explore themes that may emerge from this stage of the study. Once the analysis is complete I will give everyone who participates written feedback and a chance to comment. An article in 'The Pulse' will inform the whole trust of the outcomes. However, neither of these events will happen until mid 2009.

By participating in this research you should become more aware of your own wellbeing but I cannot guarantee any benefit for you as an individual. You will however contribute to a body of knowledge that carries the potential to make a difference across the whole of your chosen profession. There is a slight risk to you in that you may be exposed to some discomfort through the recounting of emotional and stressful events. But this will be minimised by allowing you control over what information you give and the right to withdraw at any stage. I must stress that all information you do give will be confidential and therefore I will be unable to action any grievances or complaints concerning your employment with NEAS on your behalf. I will however endeavour to address any concerns or complaints relating to my research. If I cannot rectify these to your satisfaction and you wish to complain formally you can do this through the complaints procedure of Durham University. The university has in force a policy providing legal liability cover to the value of £25,000,000 and the research activities I have described are included within that coverage that is provided through U.M. Association Ltd of

Tavistock Square London. If I witness any activity whilst I am observing you at work that causes me concern I will, in accordance with established NEAS policy [document QSSD 340 refers], raise the matter with my appointed NEAS supervisor George Marley. However, your identity would only be revealed if he considered further investigation / action was required. All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favorable opinion by County Durham and Tees Valley 2 Research Ethics Committee.

It is now up to you to decide. I will ask you to sign a consent form if you agree to take part [copy to be retained by you] but you will still be free to withdraw at any time, without giving a reason. Please reply using the form provided if you wish to participate. All participants will receive a goody bag containing a raffle ticket and a small but useful piece of equipment as a gesture of thanks and a £1 donation will be made to either the Ambulance Services Benevolent Fund or the Great North Air Ambulance, as decided by you.

Janet Lawrence BA, MA, MBA
Durham University
School of Applied Social Sciences
32 Old Elvet,
Durham City DH1 3HN.
Tel: 0191 3346827 Home: 01388 517616
Email: janet.lawrence@dur.ac.uk

Appendix 3.8

Shaped by the past, creating the future

School of Applied Social Sciences

Study: 'Emergency Care: Emotional Control'

Researcher: Janet Lawrence

Volunteer Details Form [Version 1.0 / 10 October 2007]

I confirm that I would like to take part in the above study.

Name:

Gender: Male / Female [delete as appropriate]

Length of experience as a paramedic: [whole years rounded down]

Total years in ambulance service [whole years rounded down]

Current ambulance station:

32 Old Elvet, Durham, DH1 3HN

Telephone +44 (0)191 334 6838

Appendix 3.9

Shaped by the past, creating the future

Durham University

School of Applied Social Sciences

[Insert date]

Study: 'Emergency Care: Emotional Control'

Researcher: Janet Lawrence

Participant Invitation Letter: Group 1 [Version 1.0 / 10 October 2007]

Dear

I would like to invite you to participate in the above research study. The exact dates of your participation will be agreed in due course taking into account operational needs and any personal commitments you may have. In the meantime, you may like to review and complete the checklist included in your information pack.

If you have any outstanding concerns or questions, please email me at janet.lawrence@dur.ac.uk and I will respond by return.

I am looking forward to meeting you and finding out more about the job that you do.

Yours sincerely,

Janet Lawrence

32 Old Elvet, Durham, DH1 3HN
Telephone +44 (0)191 334 6838

Appendix 3.10

Study: 'Emergency Care: Emotional Control'

Researcher: Janet Lawrence

Interview guide / key questions: Group One [Version 1.0 / 10 October 2007]

General:

1. What prompted you to volunteer for this study?
2. What do you hope will come out of it?

Professional Identity:

1. Why did you become a paramedic?
2. What training have you received to work specifically as a paramedic?
3. What qualification(s) do you have that relate specifically to your job?
4. What qualities do you think a person requires in order to work effectively as a paramedic?
5. Can any of these be acquired on the job through experience? Or does a person require them from day one as a trainee?
6. What are the best aspects of the job?
7. What are the worst aspects?
8. What do you regard as your key skill?
9. Is it important to you to be recognized as a member of a profession?
    i. Why?
10. How do you think paramedics are perceived by the public/ hospital staff/ other emergency services?
11. Is there anything that could change that would improve the standing of paramedics as a profession?

Emotions and Emotional Labour:

Questions in this section will relate specifically to a review of the checklist completed by the individual. If they choose not to complete it then questions one and two will be

asked ahead of all others in this section. Those that complete and discuss their checklist will also be asked question three onwards.

1. Do you ever find yourself having to suppress any emotions in order to work effectively?

    i. If yes, which ones predominate?

    ii. When do these tend to be triggered?

    iii. How does having to manage your emotions in this way make you feel?

2. Do you ever find yourself having to fake any emotions whilst at work?

    i. If yes, which ones predominate?

    ii. When do these tend to be triggered?

3. How do you feel in having to manage your emotions in this way?

4. Do you consider emotional control to be a key part of your job?

    i. Why do you say that?

5. What, if anything, could change to make the emotional side of your work more comfortable?

6. Is the control of inappropriate emotions and their replacement with more appropriate ones something you would regard as integral to being a professional?

    i. Why?

<u>Wellbeing:</u>

1. Can you describe what stress feels like for you personally both in terms of your emotional and physical response?

2. What do you do specifically to alleviate stress?

3. Is there anything else you could do that would reduce or even eliminate the stress you experience?

4. Have you ever made use of the services provided by Occupational Health?

    i. If yes were they effective?

5. Have you ever made use of the Peer Support Network?
    i. If yes was it effective?
6. Is there anything else you would like to see the organization provide?
7. What specifically makes you feel satisfied in your work?
8. How could your satisfaction at work be enhanced?

Culture:

1. How would you describe the culture for someone who is unfamiliar with NEAS?
2. What advice would you give to a new entrant about the organization?
3. Do you think paramedics are valued by the organization?
    i. Why?
4. Are paramedics fully supported by the organisation?
    i. What makes you say that?
5. Do you think the organizational culture supports an open emotional dialogue?
    i. Why do you think that?
6. Everything considered do you think NEAS is a good organization to work for?
    i. Why?
7. Is there anything else you could tell me that you think would be of interest that we have not covered?

Shaped by the past, creating the future

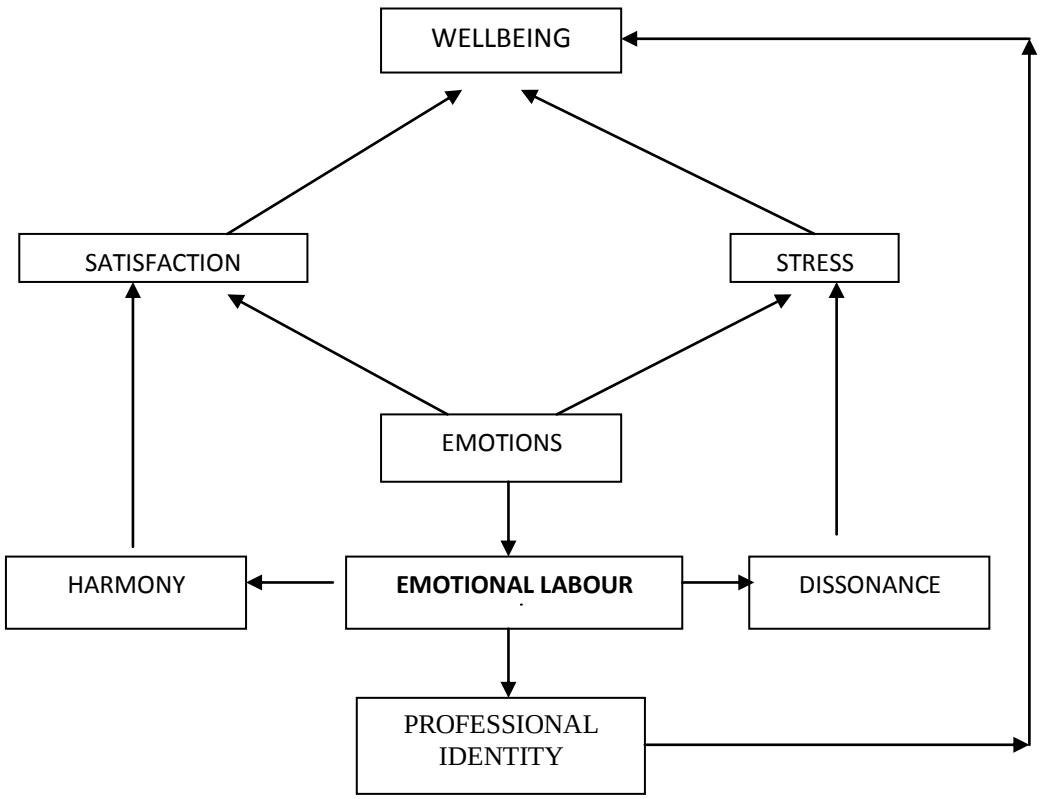
Durham University

School of Applied Social Sciences

Study: 'Emergency Care: Emotional Control'
Researcher: Janet Lawrence

Participant Information Sheet: Group 2 [Version 1.0 / 10 October 2007]

I would like to invite you to take part in this research study sponsored by Durham University and funded through the Economic and Social Research Council [ESRC]. This information sheet explains why the research is being done and what it involves for you. Please take time to read the following information carefully. If anything is not clear or, if you would like more information, please email me at the address given on page 3. The purpose of this research is to ascertain what constitutes emotional labour for paramedics and how the performance of such, impacts on both professional identity and wellbeing. The diagram below shows how these concepts are linked.



Emotional labour can be defined as the effort involved in regulating the expression of emotion [through either suppression or faking] so that only those emotions appropriate to the situation are displayed. When those appropriate emotions conflict with those that are being felt, dissonance occurs and this can lead to stress. When there is a match between what is appropriate and what is felt emotional harmony results and this contributes to job satisfaction. A number of studies have been carried out across the UK NHS to ascertain what induces emotional labour amongst health-care workers in order to derive effective interventions. But no research to-date has been published that investigates this concept from the perspective of the paramedic. This study closes that gap. In doing so, it will also address another gap relating to how the performance of emotional labour influences professional identity. These two areas of knowledge will form the basis of a thesis to be submitted for a research qualification.

You will be one of a small group of managers to be interviewed. The interview itself should take about one hour. The questions will predominately relate to your role and the policies/initiatives delivered by your department and how these impact on the paramedics. But they will also explore your personal views on the culture of NEAS and the professional standing of paramedics. The interview will be recorded to facilitate analysis. But the information that you give will be kept strictly confidential with an anonymous code being used as an identifier rather than your name. Although verbatim quotations may be used in my thesis they will not be attributed to you personally. Data will be stored and handled in accordance with the Data Protection Act 1998. All data files held on computer will be protected by a password known only to myself. All recorded data will be kept secure and erased once the thesis has been admitted. This is likely to take place sometime between October 2009 and March 2010. However, there is a possibility that these arrangements will be overridden by a requirement, placed on all researchers funded by the ESRC, to submit their data for review by the Economic and Social Data Service based at the University of Essex, for its potential long-term academic use. This review has to take place within three months of the research being completed and could result in the data from this project being digitally preserved indefinitely. Whatever the decision, I will let you know. If you withdraw from the research, at any point prior to the thesis being submitted, your data will be destroyed there and then and any reference to it will be removed from the study. Once my analysis has been completed I will give everyone who

participated some written feedback and a chance to comment. An article in 'The Pulse' will inform the trust generally of the outcomes. However, neither of these events will happen until mid 2009.

By participating in this research you will contribute to a body of knowledge that carries the potential to make a difference across the whole of the paramedic profession. Any risk to yourself is minimised by allowing you control over what information you give and the right to withdraw at any stage. I must stress that all information you do give will be confidential and therefore I will be unable to intervene in any personal matter. I will however endeavour to address any concerns or complaints relating to my research. If I cannot rectify these to your satisfaction and you wish to complain formally you can do this through the complaints procedure of Durham University. The university has in force a policy providing legal liability cover to the value of £25,000,000 and the research activities I have described are included within that coverage that is provided through U.M. Association Ltd of Tavistock Square London.

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favorable opinion by County Durham and Tees Valley 2 Research Ethics Committee. I will ask you to sign a consent form before the interview [copy to be retained by you] but you will still be free to withdraw at any time, without giving a reason.

Janet Lawrence BA, MA, MBA
Durham University
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Durham City DH1 3HN.

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Email: janet.lawrence@dur.ac.uk

Appendix 3.12

Shaped by the past, creating the future

Durham University

School of Applied Social Sciences

[Insert date]

Study: 'Emergency Care: Emotional Control'
Researcher: Janet Lawrence
Management Invitation Letter [Version 1.0 / 10 October 2007]

Dear

Thank you for agreeing to meet with me on ..... at..... in room..... .I attach a copy of my research proposal and an information sheet, outlining what it means for you to participate. I am interested in gathering information from you on what the key issues are for *[insert function*] in relation to the employment/deployment of paramedics. I would also appreciate hearing your perspective on the culture of NEAS to enable me to develop a more holistic understanding of both the formal and informal facets to the organisation.

If you have any concerns or would like more information ahead of our meeting please email me at: janet.lawrence@dur.ac.uk and I will respond by return. It is my intention to record the interview using an audio recording device and I will ask you to give your informed consent immediately prior to the interview commencing.

I am looking forward to meeting with you and finding out more about NEAS.
Yours sincerely,

Janet Lawrence

32 Old Elvet, Durham, DH1 3HN
Telephone +44 (0)191 334 6838

Appendix 3.13

Study: 'Emergency Care: Emotional Control'

Researcher: Janet Lawrence

Interview guide / key questions: Group Two [Version 1.0 / 10 October 2007]

Function:

1. Could you describe your area of responsibility in terms of its structure and what services it provides particularly in regard to paramedics?

2. What are the key issues for your area in particular those that impact on paramedics?

3. How does your area fit into the overall organization?

Professional Identity:

1. Do you think paramedics are valued by the organization?

2. What makes you say that?

3. How do you think paramedics are perceived by the public?

4. by hospital staff?.....by the other emergency services?

5. Is there anything that could change that would improve the standing of paramedics as a profession?

Culture:

1. Have you always worked for NEAS?

2. How would you describe the culture for someone who is unfamiliar with NEAS?

3. What advice would you give to a new employee about the organization?

4. Do you think the organizational culture supports an open emotional dialogue?

5. Why?

6. Everything considered do you think NEAS is a good organization to work for?

7. What makes you say that?

8. Is there anything else you could tell me that you think would be of interest that we have not covered?

Appendix 3.14

Shaped by the past, creating the future

School of Applied Social Sciences

Study: 'Emergency Care: Emotional Control'

Researcher: Janet Lawrence

Participant Consent Form [Version 1.0 / 10 October 2007]

Please initial box

1.	I confirm that I have read and understand the information sheet dated …… for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.	☐
3.	I understand that the interview/focus group in which I participate will be recorded using audio equipment and verbatim quotations, with suitable anonymity, may be used in the study report.	☐
4.	I agree to take part in the above study.	☐

Name of Participant	Signature	Date

Name of person taking consent	Signature	Date

32 Old Elvet, Durham, DH1 3HN

Telephone +44 (0)191 334 6838

Appendix 3.15

Study: 'Emergency Care: Emotional Control'

Researcher: Janet Lawrence

Research Proposal [Version 1.0 / 10 October 2007]

This research proposal links to the Economic and Social Research Council [ESRC] theme of work and organisation. It is centred on the concept of emotional labour, initially interpreted by Hochschild (1983), as an additional means whereby service sector organisations could increase their competitive edge. However, its fundamental mechanism of emotion management that entails suppressing real feelings in order to display appropriate ones also applies to less commercial enterprises such as the provision of state controlled health-care. Although a number of studies have examined this concept within the UK National Health Service [NHS] primarily in nursing, no research to date has been published that focuses specifically on the emotional labour required of a UK paramedic. This research proposal closes that gap.

Theoretical Background

Emotional labour, since Hochschild (1983) first outlined its central tenets of surface (display of appropriate emotion) and deep (attempt to feel the appropriate emotion) acting, is increasingly being seen as a primary means of understanding how both the personal and the professional competence of the individual health-care worker affect treatment outcomes. Life and death situations routinely expose the paramedic to a spectrum of emotion from joy through to distress that has to be managed to enable them to deliver appropriate medical/technical procedures and psychological support, without succumbing to dysfunctional levels of stress (Mark, 2005). Mann (2005) in exploring this concept within the nursing profession highlights the need for knowledge on what induces emotional labour across the range of occupations within the health-sector, in order for effective interventions to be derived. As Fineman (2003) points out, emotions are not optional but lie at the core of professional identity and its realisation.

Aims and Value to Others

At its broadest, this proposal aims to enhance the growing body of sociological thought

on the significance of emotions, building on work by Elias (2000) and Barbalet (1998) amongst others. Secondly, it seeks to contribute to the body of literature that addresses emotion in organisations such as that provided by Fineman and Mann and to develop the health-care model of emotional labour put forward by Mann (2005). Lastly, at its most specific, this research aims to highlight the meaning of emotional labour for the individual paramedic in terms of both wellbeing and professional identity. The occupational profile for the paramedic recognises the job has stressful and emotional elements but that these are offset through the availability of debriefing and counselling systems (AGCAS, 2002). However, the public sector union Unison, report increasing levels of early retirement and sick leave in the ambulance service due to stress that they believe is partly the fault of a macho culture that prevents an open emotional dialogue (BBC News, 1999). Clohessy and Ehlers (1999) highlighted the susceptibility of paramedics to post traumatic stress disorder particularly following attendance at fatal road accidents and they too placed responsibility on a culture that minimised emotional reactions. These contradictions therefore require exploration and clarification. This part of the research should be of benefit to all paramedics within the UK NHS and their professional associations, as a study by the firm of business psychologists Robertson Cooper (2004), places the paramedic in the top six of stressful occupations. As the skill level of the paramedic increases (BBC News, 2005) so too will their value to their employer hence this research should assist Ambulance Trust Management in their review of organisational culture and the efficacy of policies for alleviating stress and potential burnout. As the NHS is centrally funded this research should also be of interest to the Department of Health.

Research Questions

- First, what triggers the paramedic into suppressing or feigning their emotions? An orientation towards caring does not bestow immunity against dissonance (Mann and Cowburn, 2005).

- Second, what are the consequences for the individual in having to actively manage their emotions? Montgomery, Panagopolou and Benos (2005) highlight how work/family interference exacerbates stress in health-care workers.

- Third, is experience, in terms of the length of time on the job, a factor that limits the amount of acting and/or the effects of doing so, as suggested by Boyle and Healy (2003) in their study of a public-sector provider of pre-hospital emergency care in Australia?

- Fourth, emotional labour is, according to Pierce (1995), a gendered experience that places additional demands on women so how is the experience of a female paramedic different from that of her male colleagues?

- Fifth, what emotions contribute to a feeling of job satisfaction and how are these triggered?

- Sixth, how does emotional labour influence the professional identity of the paramedic?

- Seventh and last, is the experience of emotional labour by the individual paramedic acknowledged by the organisation (in terms of open dialogue, values, training and accessibility of support systems) or, is it constrained?

Methodology

This research proposal is based on the ontology of constructivism, as emotions are neither static nor external entities that have an existence independent of the individual. At the organisational level, established rules of conduct and standardised procedures do impose constraints on the individual that direct their performance, suggesting an external reality does exist. But the handling of a given situation by an individual, decisions made, emotions that are managed will always be a construction, based on their personal experience and subjective interpretation of events (Bryman, 2004). The epistemology associated with this ontological position is that of interpretivism. The initial methods for gathering data are to be observation and qualitative interviews. The North East Ambulance Service NHS Trust is the field site of choice.

Observation of paramedics will enable the day-to-day minutiae of organisational life and the many and varied relationships encountered by the paramedic to be examined. It will facilitate rapport and enable a dialogue on emotion to emerge, as the participant

becomes comfortable with both the researcher and research topic. A taped qualitative interview, exploring the subjective elements of emotion management, will be conducted piecemeal, in accordance with both operational requirements and participant comfort, during the period of observation. Intranet bulletins and a formal article in a relevant publication such as 'The Pulse' will make personnel within the trust aware of the planned research and how they may participate. All those who respond to the advertisement for volunteers will be sent a participation information pack containing an information sheet, emotion checklist and an affirmative reply form that asks for brief personal details to facilitate the construction of a sampling frame.

A convenience sample of thirty-six interviewees will then be drawn from this frame. Although this figure is not absolute as it depends on time and resource availability. The sample will be stratified by gender and again by experience in order to adequately explore the perspectives of both female and male paramedics at three different points in their careers. A semi-structured approach should facilitate an open dialogue and the generation of rich information that can be compared across these groups. The criteria, against which the quality of this part of the study can be judged, are those of trustworthiness and authenticity. In particular, respondent validation will be sought, as both educative and catalytic authenticity, rely on the participants endorsing their accounts and the emergent themes.

However, as the findings will be specific to the small group of paramedics that are to be interviewed they could be dismissed as not conclusive. Therefore, it is intended that concepts emerging from the interview data will be explored in focus groups across a wider frame of volunteers (a minimum of twenty-four). A small number of interviews with ambulance trust management (a minimum of four to include operations, human resource management, training and occupational health) will complete the study and enable a more holistic understanding of the culture and how it responds to the emotional toil of its constituents to be generated. This pool of data satisfies the argument put forward by Gerson and Horowitz (2002) that qualitative studies require a minimum of sixty interviews in order for the conclusions to be convincing, an outcome that this study particularly aspires to.

Ethics

It will be of utmost importance to reflect the ethical governance required by the

Department of Health [DOH] as well as the principles of good ethical practice, put forward by the Economic and Social Research Council. In this study, a universalist stance will ensure no infractions of either occur. Informed consent will be multi-pronged. Initial details regarding the nature and purpose of the research will accompany the advertisement for volunteers. Each respondent will be able to clarify the nature of their participation before putting their name forward. Those selected for interview or to participate as a focus group member, will be briefed and given another opportunity to ask questions. But as Bryman (2004) points out minor transgressions may be unavoidable, as it is not possible for example, to state with certainty how long interviews or group sessions will last.

There is a potential risk of harm to participants through the recounting of emotional and stressful events. This will be minimised by allowing them control over what information they give in the interview/focus group and the right to withdraw at any stage. There is also a professional risk associated with potential criticism of the management chain and/or employing body. Participants may view the researcher as a vehicle for escalating their complaints and may expect results in return for their participation. It will need to be made clear at the outset that pseudonyms or a code will be used to protect their privacy and a blanket of confidentiality will prevent any singular intervention. This proposal will comply with the DOH (2005) requirement that all systems for recording data are robust and that the data, as well as the findings, are open to critical review.

Supervisor

Dr. Tiago Moreira

Durham University

School of Applied Social Sciences

32 Old Elvet

Durham City DH1 3HN

Tel: 0191 3346836 Email: tiago.moreira@dur.ac.uk

Timetable

Year 1 [2006-7]:

First exploratory literature review leading to review and redefinition of proposition and research questions
Establish support and professional networks
Elicit support and access from NEAS NHS Trust
Submit proposal for ethical approval to appropriate NHS Local Research Ethics Committee
Submit university ethics and risk assessment forms
Clarify methodology and start to write

Year 2 [2007-8]:

Develop a plan for the fieldwork and all prepare all supporting documentation
Advertise for volunteers and select sample for paramedic group one
Complete a period of observation with paramedics [participant group one]
Organise and conduct interviews with paramedics [participant group one]
Organise and conduct interviews with management [participant group two]
Transcribe data using NVivo to manage and code themes
Organise and conduct focus groups with paramedic team leaders to clarify/confirm emergent themes [participant group three]
Transcribe data using NVivo as before
Second literature review and writing-up of additional chapters

Year 3 [2008-9]:

Complete analysis
Interpret data with respect to research questions
Final literature review
Draw conclusions
Discuss/present final analysis in the company of all interested parties
Possible publication of preliminary results
Final review/edit and submission of thesis

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Appendix 3.16

The Fieldwork Diary: Hours of Observation Accrued by Gender & Experience

No	Dates	Males			Females		
		<5	5-10	>10	<5	5-10	>10
1	17-18 April 2008	24					
2	28-29 April 2008				24		
3	03-04 May 2008				24		
4	08-09 May 2008		24				
5	16-17 May 2008			24			
6	20-21 May 2008	24					
7	10-11 June 2008					24	
8	14-15 June 2008		24				
9	20-21 June 2008			24			
10	27-28 June 2008						24
11	02-03 July 2008		24				
12	11-12 July 2008				24		
13	16-17 July 2008			24			
14	23-24 July 2008	24					
15	1-2 August 2008	24					
16	5-6 August 2008		24				
17	5-6 August 2008	24					
18	16-17 August 2008	24					
19	22-23 August 2008					24	
20	28 August 2008			12			
21	2 September 2008		12				
22	8 September 2008				12		
23	14 September 2008						12
24	20 September 2008		12				
25	24 September 2008				12		
26	29 September 2008			12			
27	14 October 2008			12			
28	21 October 2008		12				
29	1 November 2008			12			
30	20 January 2009				12		
31	25 January 2009	12					
32	14 February 2009					12	
33	14 February 2009		12				
34	5 March 2009			12			
35	10 March 2009						12
36	27 March 2009	12					
	Totals	**168**	**144**	**132**	**108**	**60**	**48**

Appendix 3.17

Ethical Approval Letter: NHS REC

NHS

National Research Ethics Service

County Durham & Tees Valley 2 Research Ethics Committee

Professorial Unit of Surgery
University Hospital of North Tees
Piperknowle Road
Stockton-on-Tees
TS19 8PE

Telephone: 01642 624164
Facsimile: 01642 624164

18 January 2008

Miss Janet Lawrence
Wingate Hill
Westgate
Bishop Auckland
County Durham
DL13 1LP

Dear Miss Lawrence

Full title of study: **To ascertain what constitutes emotional labour for the paramedic and how the performance of such impacts on both their professional identity and wellbeing**

REC reference number: **07/H0908/85**

Thank you for your letter of 08 January 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA. There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Application	5.5	16 October 2007
Protocol	1	10 October 2007
Interview Schedules/Topic Guides	Group one V 1	10 October 2007
Interview Schedules/Topic Guides	Group 2 - Version 1	10 October 2007
Advertisement	Intranet Advert 1 & 2 Version 1	10 October 2007
Advertisement	Main ad for volunteers - Version 1	10 October 2007
Letter of invitation to participant	1	
Letter of invitation to participant	Management letter Version 1	10 October 2007
Participant Information Sheet: Public Info sheet	2	30 November 2007
Participant Information Sheet	2	30 November 2007
Response to Request for Further Information		08 January 2008
Insurance details		04 December 2007
Leter from Margaret Wilkinson		12 December 2007
Letter from George Marley		07 January 2008
Revised pages of application form		08 January 2008
Volunteer details form	1	10 October 2007
Work related emotions checklist	1	10 October 2007

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from http://www.rdforum.nhs.uk/rdform.htm.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

Here you will find links to the following

a) Providing feedback. You are invited to give your view of the service that you have received from the National Research Ethics Service on the application procedure. If you wish to make your views known please use the feedback form available on the website.
b) Progress Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
c) Safety Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
d) Amendments. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
e) End of Study/Project. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nationalres.org.uk .

07/H0908/85	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Leigh Pollard

pp **Rachel Duncan**
Chair

Email: leigh.morgan@nth.nhs.uk

Enclosures: Standard approval conditions
Reference Group Leaflet

Copy to: Prof Anthony Forster, Dean of Faculty of Social Sciences & Health, Dean's Office, South Lodge, Science Laboratories, South Road, University of Durham, DH1 3LE

Mr C Cessford, Director of Strategy & Clinical Standards, North East Ambulance Service NHS Trust, Scotswood House, Amethyst Road, Newcastle Business Park, Newcastle upon Tyne, NE4 7YL

Appendix 3.18

Ethical Approval Letter: Durham University

School of Applied Social Sciences — Research Ethics & Risk Assessment FORM B

FOR OFFICE USE ONLY

SECTION 6: OUTCOME OF APPLICATION

a) The proposal is satisfactory and should be accepted as it stands.	~~YES / NO~~
b) The proposal should be accepted subject to the conditions noted below.	YES / NO
c) The applicant should submit a new proposal in the light of the comments noted below.	~~YES / NO~~

Comments *(for forwarding to the applicant)*

Please check with University Health and Safety Officer* the possibility of reducing risk/severity of injury from ambulance accident from medium to low. If mail correspondence can be attached as evidence

* Paul Zealand ext 42663

Signed Helen Charnley Date 31 January 2008

Name (block capitals) HELEN CHARNLEY

A COPY OF THE APPROVED FORM MUST BE KEPT ON FILE.
STUDENTS MUST SUBMIT A COPY OF THE APPROVED FORM WITH THEIR PROJECT/DISSERTATION.

-------- Original Message --------
Subject: Re: PhD ethics approval
Date: Wed, 06 Feb 2008 13:00:02 +0000
From: janet lawrence@durham ac uk <janet.lawrence@durham.ac.uk>
To: CHARNLEY H.M. <h.m.charnley@durham.ac.uk>
CC: p.r.zealand@durham.ac.uk
References:
<C3137360EED5FC42AF72063EA4B396190114CD39@EXDUR1.mds.ad.dur.ac.uk
>

Hi Helen,

I have just spoken with Paul Zealand in respect of the field assessment for my PhD study and in particular, the rating of an accident as a medium risk. As Paul and I discussed, paramedic crews respond to a 999 call at speed and do go through red lights that places them and any occupants of their ambulance at risk of possible injury should a collision occur. However, as it is not feasible for them to moderate their speed to lessen the risk to myself the overall rating for an accident remains at medium risk. But this is countered by the fact that accidents are extremely rare and professional help is readily at hand. On that basis this risk is considered by Paul to be rated accurately and deemed acceptable.

Regards,

Janet

CHARNLEY H.M. wrote:
> Dear Janet
> congratulations on getting through all the layers of NHS ethical
> approval. Your study looks really interesting - and exciting!
>
> I have approved your ethics application subject to one small step.
> Please would you contact Paul Zealand, health and safety officer (extn:
> 42663) and check if the risk of injury as the result of ambulance
> accident might be reduced to low. I have spoken to Paul and he is ready
> to discuss this with you. If the risk really is medium then that's OK
> but at least there will be some evidence of engagement with university
> health and safety structures.
>
> Once you have done that, please send me an email (copied to Paul) - and
> attach a copy to your application. I have returned the file to Jill
> Lea.
>
> Best wishes
> Helen
>
> Helen Charnley
> Director PGR
> x 41470
>
>

Appendix 3.19

NEAS Ethical Approval Letter

North East Ambulance Service NHS
NHS Trust

Ambulance Headquarters
Scotswood House
Amethyst Road
Newcastle Business Park
Newcastle upon Tyne
NE4 7YL

Tel: 0191 273 1212
Fax: 0191 273 7070

colin.cessford
Email:_____@neas.nhs.uk

Our Ref: CC/AH

5 September 2007

Miss Janet Lawrence
Wingate Hill
Westgate
Bishop Auckland
COUNTY DURHAM
DL13 1LP

Dear Janet

SOCIOLOGICAL RESEARCH STUDY

Following discussions at the Research and Development Committee Meeting, on Thursday 30 August 2007, I would like to confirm in writing approval for your research to commence, subject to the following:

- that you receive approval for your research from the NHS Ethics Committee,
- that your work with the NEAS commences from *April 2008* onwards,
- that an NEAS Supervisor is appointed to oversee your research,
- that a selected pool of Paramedic volunteers is sourced.

I trust that the above is satisfactory with yourself.

Your future point of contact should be George Marley, Clinical Development Manager, who is contactable on 0191 2264884 or george.marley@neas.nhs.uk.

Many thanks.

Yours sincerely

Colin Cessford
DIRECTOR OF STRATEGY AND CLINICAL STANDARDS

cc – Mr G Marley, Clinical Development Manager.

Appendix 3.20

NHS REC MERI Inclusion Approval Letter

SL31 Minor amendment to non-CTIMP
Version 3.2, October 2007

NHS

National Research Ethics Service

County Durham & Tees Valley 2 Research Ethics Committee

The Tatchell Centre
University Hospital of North Tees
Piperknowle Road
Stockton-on-Tees
TS19 8PE

Telephone: 01642 624164
Facsimile: 01642 624164
Email: leigh.pollard@nhs.net

19 June 2008

Mrs J Lawrence
Wingate Hill
Westgate
Bishop Auckland
County Durham
DL13 1Lp

Dear Miss Lawrence

Study title: **To ascertain what constitutes emotional labour for the paramedic and how the performance of such impacts on both their professional identity and wellbeing**

REC reference: **07/H0908/85**

Thank you for your recent letter notifying the Committee of the amendment to the above study.

The amendment has been considered by the Chair. The Chair does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

However, the Chair has recommended that you change the participant information sheet and consent form to reflect the inclusion of the questionnaire. Please be aware this is a recommendation and is not mandatory.

Documents received

The documents received were as follows:

Covering letter
Questionnaire

SL31 Minor amendment to non-CTIMP
Version 3.2, October 2007

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

[REC reference number]:	**07/H0908/85**	**Please quote this number on all correspondence**

Yours sincerely

Leigh Pollard

Leigh Pollard
Committee Co-ordinator

E-mail: leigh.pollard@nhs.net

Appendix 3.21

Deductive Codebook

Q1: Situational Antecedents

Category: Patients
- Subcategory: Taxi
  - Code: adult
  - Code: minor
  - Code: lonely
  - Code: free ride
  - Code: anger
  - Code: illegitimate
- Subcategory: Routine
  - Code: adult
  - Code: non-urgent
  - Code: low skill
  - Code: drunks
  - Code: intoxicated
  - Code: boredom
  - Code: disinterest
- Subcategory: Emergency
  - Code: adult
  - Code: child
  - Code: urgent
  - Code: trauma
  - Code: enthusiasm
  - Code: save
  - Code: buzz
  - Code: legitimate
  - Code: high skill
  - Code: immediate Death
- Subcategory: Pleasing
  - Code: adult
  - Code: child
  - Code: pleasant
  - Code: compliant
  - Code: trust
- Subcategory: Displeasing
  - Code: adult
  - Code: hysterical
  - Code: anxious
  - Code: apathetic
  - Code: angry
  - Code: hostile
  - Code: frightened
  - Code: expectations
  - Code: familiar
  - Code: similar
  - Code: trust

Category: Relatives
- Subcategory: Agreeable
  - Code: anxiety
  - Code: grief
  - Code: helpful
  - Code: deferent
- Subcategory: Disagreeable
  - Code: ignorant
  - Code: fear
  - Code: aggressive

Category: Incident Bystanders
- Code: helpful
- Code: curious
- Code: mass
- Code: hostile
- Code: intimidation
- Code: anger

Category: Emergency services
- Subcategory: Police
  - Code: authority
  - Code: helpful
  - Code: mutual respect
  - Code: friend
- Subcategory: Fire
  - Code: authority
  - Code: arrogance
  - Code: rivalry
  - Code: contempt
  - Code: friend

Category: A&E
- Subcategory: Doctor
  - Code: ignorance
  - Code: medical authority
  - Code: subordinate
  - Code: condescending
  - Code: respect
  - Code: anger
  - Code: trust
- Subcategory: Nurse
  - Code: ignorance
  - Code: medical authority
  - Code: threat
  - Code: anger
  - Code: dismissive
  - Code: respect
  - Code: friendly

Q1: Situational Antecedents cont:

Category: Managers
- Code: authoritarian
- Code: uncaring
- Code: judgemental
- Code: intimidating

Category: Observers
- Code: impress
- Code: help

Category: Colleagues
- Code: supportive
- Code: group identity
- Code: confidant

Category: work Partner

Subcategory: Harmonious
- Code: dependable
- Code: trustworthy
- Code: appropriate behavior
- Code: close
- Code: willing to get involved
- Code: mesh
- Code: satisfactory
- Code: positive

Subcategory: Discord
- Code: egocentric
- Code: negative
- Code: inappropriate behavior
- Code: unreliable
- Code: aggressive

Category: Self
- Code: intrusive memories

Q1: Job Antecedents
- Code: uncertainty
- Code: variety
- Code: job satisfaction
- Code: buzz
- Code: unpredictable personal time
- Code: dirty work
- Code: operational hassles
- Code: identity
- Code: autonomy
- Code: surveillance
- Code: waiting
- Code: hurrying

Q1: Organisational Antecedents
- Code: injustice
- Code: organisational hassles

Category: Climate
- Code: policies
- Code: training
- Code: openness
- Code: support

Category: Culture
- Code: informal
- Code: formal
- Code: family
- Code: socialisation
- Code: liberal
- Code: macho
- Code: nonchalance

Q1: Individual Antecedents
- Code: Code: status
- Code: fatigue
- Code: HWI

Category: Experience
- Code: fit-in
- Code: wisdom
- Code: stamina
- Code: age

Category: Gender

Subcategory: Male
- Code: stoicism
- Code: caring
- Code: hegemonic masculinity

Subcategory: Female
- Code: stoicism
- Code: caring
- Code: hegemonic masculinity

Category: Temperament
- Code: empathy
- Code: sense of humour
- Code: trustworthiness
- Code: adaptable
- Code: positive outlook
- Code: hardness
- Code: confident
- Code: religious belief
- Code: self-control

Category: Skills
- Code: communication
- Code: acting

Q2: Strategies

Category: Emotions

Subcategory: Positive

Code: joy
Code: sympathy
Code: satisfaction
Code: hope
Code: affection
Code: pride
Code: interest
Code: enthusiasm
Code: relief
Code: admiration
Code: gratitude
Code: surprise [astonishment]

Subcategory: Negative

Code: fear
Code: distress
Code: anger
Code: remorse
Code: disgust
Code: dislike
Code: boredom
Code: anxiety
Code: self-reproach
Code: intimidation
Code: disappointment
Code: surprise [shock]
Code: resentment
Code: embarrassment

Category: Rules

Code: informal
Code: healthcare
Code: tradition

Category: Techniques

Code: empathy
Code: surface acting
Code: emotional switching
Code: deep acting
Code: genuine expression
Code: humour
Code: spirituality

Q3: Interventions

Category: Individual

Code: beneficent atmosphere
Code: self-talk
Code: objectification
Code: physical task
Code: balance
Code: calming
Code: timeout
Code: informal debriefing
Code: black humour
Code: family
Code: relaxation
Code: hardness
Code: religious beliefs
Category: Organisation

Category: Organisation

Code: counselling
Code: CISD
Code: downtime
Code: recognition

Q4: Consequences

Category: Positive

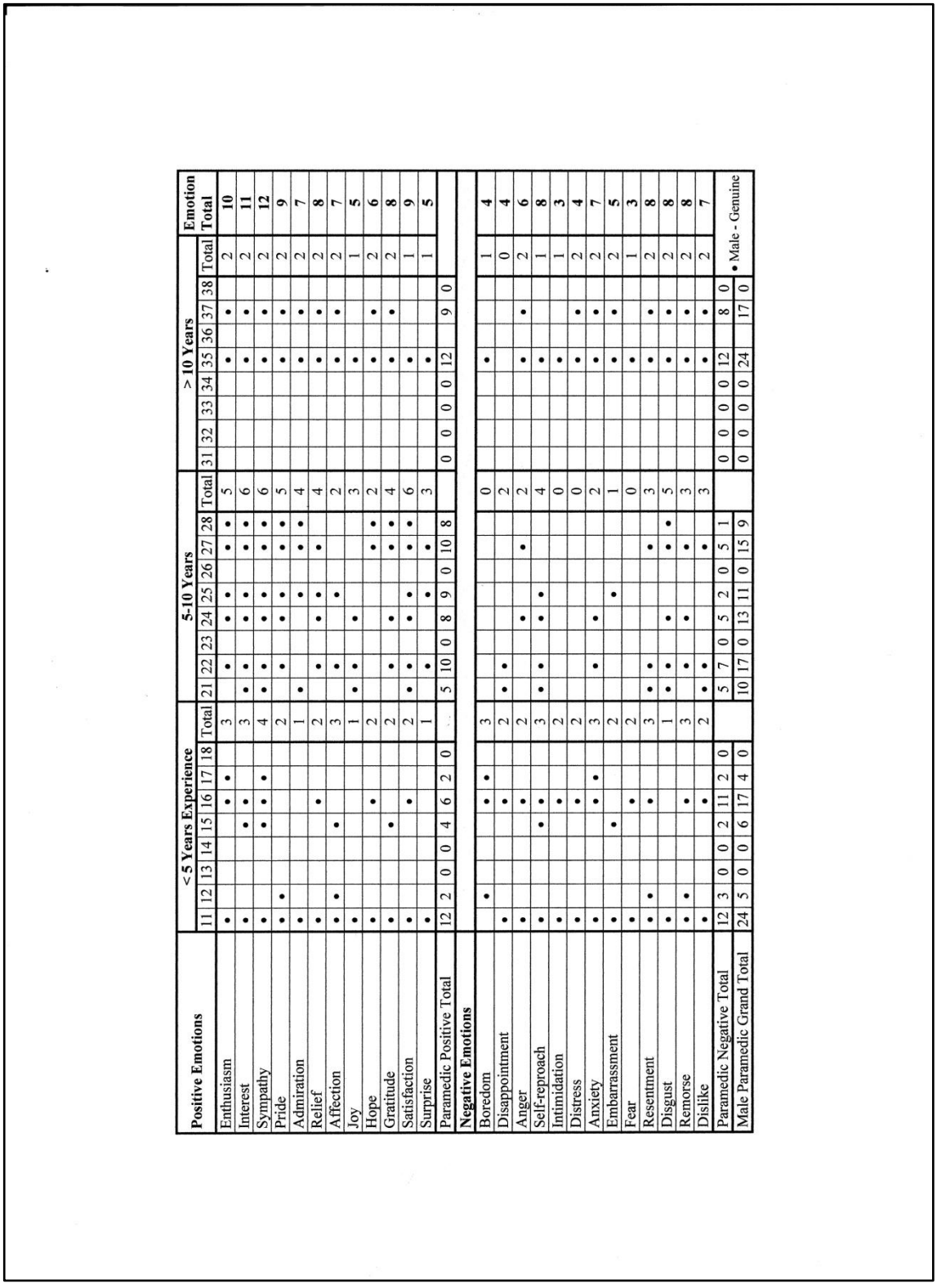
Code: personal accomplishment
Code: professionalism
Code: confirm identity
Code: job satisfaction

Category: Negative

Code: compassion fatigue
Code: clinical stress
Code: administrative stress
Code: PTSD
Code: fatigue
Code: WHI
Code: somatic complaints
Code: disconfirm identity
Code: vicarious traumatisation

Appendix 5.1

Genuine Expression of Emotion: Individual Traces



Positive Emotions	< 5 Years Experience									5-10 Years										> 10 Years										Emotion Total
	11	12	13	14	15	16	17	18	Total	21	22	23	24	25	26	27	28	Total	31	32	33	34	35	36	37	38	Total	
Enthusiasm	•					•	•		3		•		•	•		•	•	5					•		•		2		**10**
Interest	•				•	•			3	•	•		•	•		•	•	6					•		•		2		**11**
Sympathy	•				•	•	•		4	•	•		•	•		•	•	6					•		•		2		**12**
Pride	•	•							2		•		•	•		•	•	5					•		•		2		**9**
Admiration	•								1	•			•			•	•	4					•		•		2		**7**
Relief	•					•			2		•		•	•		•		4					•		•		2		**8**
Affection	•	•			•				3		•			•				2					•		•		2		**7**
Joy	•								1	•	•		•					3					•				1		**5**
Hope	•					•			2							•	•	2					•		•		2		**6**
Gratitude	•				•				2		•		•			•	•	4					•		•		2		**8**
Satisfaction	•					•			2	•	•		•	•		•	•	6					•				1		**9**
Surprise	•								1		•			•		•		3					•				1		**5**
Paramedic Positive Total	12	2	0	0	4	6	2	0		5	10	0	8	9	0	10	8		0	0	0	0	12		9	0			
Negative Emotions																													
Boredom		•				•	•		3									0					•				1		**4**
Disappointment	•					•			2	•	•							2									0		**4**
Anger	•					•			2				•			•		2					•		•		2		**6**
Self-reproach	•				•	•			3	•	•		•	•				4					•				1		**8**
Intimidation	•					•			2									0					•				1		**3**
Distress	•					•			2									0					•		•		2		**4**
Anxiety	•					•	•		3		•		•					2					•		•		2		**7**
Embarrassment	•				•				2					•				1					•		•		2		**5**
Fear	•					•			2									0					•				1		**3**
Resentment	•	•				•			3	•	•					•		3					•		•		2		**8**
Disgust	•	•							1	•	•		•			•	•	5					•		•		2		**8**
Remorse	•	•				•			3		•		•			•		3					•		•		2		**8**
Dislike	•					•			2	•	•					•		3					•		•		2		**7**
Paramedic Negative Total	12	3	0	0	2	11	2	0		5	7	0	5	2	0	5	1		0	0	0	0	12		8	0		• Male - Genuine	
Male Paramedic Grand Total	24	5	0	0	6	17	4	0		10	17	0	13	11	0	15	9		0	0	0	0	24		17	0			

Positive Emotions	< 5 Years Experience							5-10 Years				> 10 Years				Emotion Total
	11	12	13	14	15	16	Total	21	22	23	Total	31	32	33	Total	
Enthusiasm			•	•	•	•	4	•	•		2				0	**6**
Interest				•	•	•	3		•		1				0	**4**
Sympathy				•	•	•	3				0				0	**3**
Pride	•			•	•	•	4		•		1				0	**5**
Admiration	•		•	•	•		4		•		1				0	**5**
Relief	•			•	•	•	4				0				0	**4**
Affection						•	1		•		1				0	**2**
Joy	•		•	•	•	•	5		•		1				0	**6**
Hope				•		•	2		•		1				0	**3**
Gratitude	•		•	•	•	•	5		•		1				0	**6**
Satisfaction	•		•	•	•	•	5		•		1				0	**6**
Surprise	•		•	•			3				0	•			1	**4**
Paramedic Positive Total	7	0	6	11	9	10		1	9	0		1	0	0		
Negative Emotions																
Boredom				•			1		•		1				0	**2**
Disappointment				•	•	•	3				0				0	**3**
Anger	•			•			2		•		1				0	**3**
Self-reproach			•				1				0				0	**1**
Intimidation	•				•		2				0				0	**2**
Distress				•		•	2	•			1				0	**3**
Anxiety				•		•	2				0				0	**2**
Embarrassment					•	•	2				0				0	**2**
Fear				•	•	•	3				0				0	**3**
Resentment							0				0				0	**0**
Disgust				•	•	•	3				0				0	**3**
Remorse				•			1				0				0	**1**
Dislike					•		1				0				0	**1**
Paramedic Negative Total	2	0	1	8	6	6		1	2	0		0	0	0		
Female Paramedic Grand Total	9	0	7	19	15	16		2	11	0		1	0	0		• Female - Genuine

Appendix 5.2

Suppression of Emotion: Individual Traces

Positive Emotions	< 5 Years Experience						5-10 Years			> 10 Years			Emotion Total
	11	12	13	14	15	16	Total	21	22	23	Total	31	32	33	Total	
Enthusiasm						♦	1				0	♦			1	2
Interest							0				0				0	0
Sympathy							0				0				0	0
Pride		♦	♦			♦	3	♦		♦	2	♦		♦	2	7
Admiration							0	♦			1				0	1
Relief							0				0	♦			1	1
Affection							0				0				0	0
Joy							0				0	♦			1	1
Hope					♦		1				0	♦			1	2
Gratitude						♦	1				0				0	1
Satisfaction						♦	1				0				0	1
Surprise						♦	1			♦	1	♦			1	3
Paramedic Total	0	1	1	0	1	5		2	0	2		6	0	1		
Negative Emotions																
Boredom			♦		♦	♦	3	♦			1	♦	♦		2	6
Disappointment			♦				1			♦	1	♦	♦		2	4
Anger	♦	♦	♦	♦	♦	♦	6	♦	♦	♦	3	♦	♦	♦	3	12
Self-reproach		♦				♦	2		♦		1		♦		1	4
Intimidation		♦				♦	2		♦		1	♦		♦	2	5
Distress	♦	♦	♦			♦	4		♦		1	♦	♦	♦	3	8
Anxiety	♦	♦	♦		♦		4	♦		♦	2	♦	♦	♦	3	9
Embarrassment				♦		♦	2	♦	♦	♦	3	♦	♦	♦	3	8
Fear	♦		♦			♦	3	♦		♦	2	♦		♦	2	7
Resentment			♦	♦			2	♦	♦		2	♦		♦	2	6
Disgust	♦					♦	2	♦	♦		2	♦		♦	2	6
Remorse							0				0				0	0
Dislike	♦			♦		♦	3	♦	♦	♦	3	♦	♦	♦	3	9
Paramedic Total	6	5	7	4	3	9		8	7	7		11	8	9		♦Female - Suppressed
Female Paramedic Grand Total	6	6	8	4	4	14		10	7	9		17	8	10		

Positive Emotions	< 5 Years Experience									5-10 Years									> 10 Years									Emotion Total
	11	12	13	14	15	16	17	18	Total	21	22	23	24	25	26	27	28	Total	31	32	33	34	35	36	37	38	Total	
Enthusiasm		◆	◆	◆		◆		◆	5	◆					◆			2				◆				◆	2	**9**
Interest			◆	◆					2									0					◆			◆	2	**4**
Sympathy		◆		◆		◆			3									0		◆						◆	2	**5**
Pride		◆	◆	◆	◆			◆	5	◆		◆			◆			3					◆			◆	2	**10**
Admiration		◆		◆					2			◆	◆			◆		3	◆			◆	◆			◆	4	**9**
Relief		◆		◆				◆	3	◆		◆			◆			3	◆		◆				◆	◆	4	**10**
Affection				◆				◆	2									0			◆		◆			◆	3	**5**
Joy		◆	◆	◆					3			◆			◆			2					◆		◆	◆	3	**8**
Hope		◆	◆	◆				◆	4	◆		◆		◆				3	◆							◆	2	**9**
Gratitude		◆		◆					2									0								◆	1	**3**
Satisfaction		◆		◆				◆	3						◆			1					◆		◆	◆	3	**7**
Surprise			◆	◆				◆	3	◆		◆						2	◆		◆		◆			◆	4	**9**
Paramedic Positive Total	0	9	6	12	1	2	0	7		5	0	6	1	1	5	1	0		4	1	3	2	7		3	12		
Negative Emotions																												
Boredom			◆	◆	◆			◆	4	◆		◆	◆	◆	◆	◆		6	◆	◆			◆		◆	◆	5	**15**
Disappointment		◆	◆	◆	◆	◆		◆	6		◆	◆	◆	◆	◆	◆		6	◆	◆					◆	◆	4	**16**
Anger	◆	◆	◆	◆	◆	◆	◆	◆	8	◆	◆	◆		◆	◆	◆	◆	7	◆		◆		◆		◆	◆	5	**20**
Self-reproach		◆	◆	◆			◆		4			◆						1	◆		◆		◆		◆	◆	5	**10**
Intimidation		◆	◆	◆				◆	4			◆	◆	◆	◆			4	◆	◆	◆				◆	◆	5	**13**
Distress	◆	◆	◆	◆		◆		◆	6	◆		◆		◆	◆			4	◆	◆	◆	◆	◆			◆	6	**16**
Anxiety	◆	◆	◆	◆		◆		◆	6			◆		◆	◆			3	◆		◆		◆			◆	4	**13**
Embarrassment		◆	◆	◆					3	◆					◆			2	◆		◆		◆			◆	4	**9**
Fear	◆	◆	◆	◆		◆	◆	◆	7					◆				1	◆		◆		◆		◆	◆	5	**13**
Resentment			◆	◆	◆			◆	4			◆		◆	◆	◆		4	◆		◆		◆			◆	4	**12**
Disgust	◆	◆	◆	◆	◆		◆	◆	7		◆	◆		◆	◆	◆		5	◆	◆	◆		◆		◆	◆	6	**18**
Remorse		◆	◆	◆					3	◆				◆	◆			3								◆	1	**7**
Dislike		◆	◆	◆	◆	◆		◆	6		◆	◆	◆	◆	◆	◆		6	◆		◆		◆			◆	4	**16**
Paramedic Negative Total	5	11	13	13	6	6	4	10		5	4	10	4	11	11	6	1		12	5	10	1	10		7	13		
Male Paramedic Grand Total	5	20	19	25	7	8	4	17		10	4	16	5	12	16	7	1		16	6	13	3	17		10	25		◆ Male - Suppressed

Appendix 5.3

Feign of Emotion: Individual Traces

Positive Emotions	< 5 Years Experience							5-10 Years				> 10 Years				Emotion Total
	11	12	13	14	15	16	Total	21	22	23	Total	31	32	33	Total	
Enthusiasm							0				0	▪			1	1
Interest			▪			▪	2	▪		▪	2	▪	▪	▪	3	7
Sympathy	▪						1	▪	▪		2	▪		▪	2	5
Pride							0				0				0	0
Admiration							0				0				0	0
Relief							0				0				0	0
Affection				▪		▪	2				0	▪		▪	2	4
Joy							0				0	▪		▪	2	2
Hope							0	▪		▪	2				0	2
Gratitude							0				0	▪			1	1
Satisfaction							0			▪	1	▪			1	2
Surprise							0				0	▪	▪	▪	3	3
Paramedic Total	1	0	1	1	0	2		3	1	3		8	2	5		
Negative Emotions																
Boredom							0				0				0	0
Disappointment							0				0	▪			1	1
Anger							0				0				0	0
Self-reproach							0				0				0	0
Intimidation							0				0				0	0
Distress							0				0				0	0
Anxiety							0				0				0	0
Embarrassment							0				0				0	0
Fear							0				0				0	0
Resentment							0				0	▪			1	1
Disgust							0				0				0	0
Remorse							0				0				0	0
Dislike							0				0				0	0
Paramedic Total	0	0	0	0	0	0		0	0	0		2	0	0		▪Female - Feigned
Female Paramedic Grand Total	1	0	1	1	0	2		3	1	3		10	2	5		

Positive Emotions	< 5 Years Experience									5-10 Years									> 10 Years									Emotion Total
	11	12	13	14	15	16	17	18	Total	21	22	23	24	25	26	27	28	Total	31	32	33	34	35	36	37	38	Total	
Enthusiasm			▪	▪	▪	▪			4			▪			▪			2	▪	▪	▪					▪	4	**10**
Interest	▪	▪	▪	▪				▪	5		▪	▪			▪			3	▪		▪		▪			▪	4	**12**
Sympathy	▪	▪	▪	▪		▪		▪	6		▪	▪			▪			3	▪			▪	▪			▪	4	**13**
Pride									0									0					▪				1	**1**
Admiration			▪					▪	2									0									0	**2**
Relief			▪						1									0					▪				1	**2**
Affection									0						▪			1	▪				▪				2	**3**
Joy				▪				▪	2	▪				▪	▪			3	▪				▪				2	**7**
Hope			▪	▪					2	▪	▪				▪			3	▪		▪					▪	3	**8**
Gratitude		▪	▪	▪				▪	4	▪	▪			▪	▪			4	▪		▪		▪				3	**11**
Satisfaction			▪	▪					2									0	▪	▪			▪				3	**5**
Surprise				▪	▪				2	▪		▪			▪			3					▪		▪	▪	3	**8**
Paramedic Positive Total	2	3	8	8	2	2	0	5		4	4	4	0	2	8	0	0		8	2	4	1	9		1	5		
Negative Emotions																												
Boredom									0									0									0	**0**
Disappointment									0								▪	1									0	**1**
Anger									0						▪			1									0	**1**
Self-reproach									0									0					▪				1	**1**
Intimidation									0									0									0	**0**
Distress									0									0					▪				1	**1**
Anxiety					▪				1									0					▪				1	**2**
Embarrassment									0									0									0	**0**
Fear									0									0					▪				1	**1**
Resentment									0									0					▪				1	**1**
Disgust									0									0					▪				1	**1**
Remorse									0									0	▪				▪				2	**2**
Dislike									0									0									0	**0**
Paramedic Negative Total	0	0	0	0	1	0	0	0		0	0	0	0	0	1	0	1		1	0	0	0	7		0	0		▪Male - Feigned
Male Paramedic Grand Total	2	3	8	8	3	2	0	5		4	4	4	0	2	9	0	1		9	2	4	1	16		1	5		

Appendix 5.4

Suppression of negative emotion [MERI scores for statement 11]

Gender	Experience		Patient	Relative / Bystander	Emergency Services	Hospital Staff	Colleague / Manager
Male	<5	11	1.00	3.00	4.00	1.00	6.00
		12	5.00	8.00	2.00	1.00	7.00
		13	1.00	1.00	4.00	3.00	4.00
		14	5.00	3.00	5.00	3.00	2.00
		15	2.00	2.00	5.00	1.00	3.00
		16	2.00	2.00	1.00	8.00	2.00
		17	3.00	3.00	5.00	5.00	3.00
		18	1.00	2.00	8.00	2.00	1.00
		Set	100%	88%	88%	88%	75%
	5-10	21	5.00	1.00	1.00	5.00	8.00
		22	1.00	1.00	2.00	7.00	1.00
		23	2.00	6.00	6.00	7.00	7.00
		24	1.00	2.00	2.00	7.00	4.00
		25	4.00	4.00	4.00	6.00	6.00
		26	3.00	3.00	7.00	3.00	4.00
		27	8.00	8.00	3.00	8.00	8.00
		28	1.00	1.00	1.00	1.00	1.00
		Set	88%	75%	75%	38%	50%
	>10	31	4.00	5.00	4.00	3.00	3.00
		32	2.00	3.00	4.00	8.00	5.00
		33	2.00	2.00	2.00	1.00	1.00
		34	3.00	2.00	3.00	2.00	3.00
		35	1.00	1.00	5.00	8.00	7.00
		36	3.00	2.00	3.00	8.00	4.00
		37	3.00	2.00	3.00	2.00	2.00
		38	1.00	2.00	1.00	1.00	1.00
		Set	100%	100%	100%	63%	88%
	All		**96%**	**88%**	**88%**	**63%**	**71%**
Female	<5	11	2.00	1.00	1.00	1.00	1.00
		12	5.00	4.00	1.00	8.00	8.00
		13	3.00	1.00	8.00	1.00	1.00
		14	2.00	7.00	2.00	2.00	2.00
		15	1.00	7.00	6.00	6.00	7.00
		16	2.00	3.00	6.00	7.00	4.00
		Set	100%	67%	50%	50%	67%
	5-10	21	3.00	7.00	8.00	7.00	6.00
		22	8.00	5.00	8.00	8.00	8.00
		23	2.00	2.00	2.00	2.00	5.00
		Set	67%	67%	33%	33%	33%
	>10	31	1.00	2.00	7.00	4.00	3.00
		32	7.00	3.00	4.00	4.00	3.00
		33	3.00	1.00	6.00	6.00	1.00
		Set	67%	100%	33%	67%	100%
	All		**83%**	**75%**	**42%**	**50%**	**67%**
Sample			**91%**	**83%**	**72%**	**58%**	**69%**
			3%	**11%**	**17%**	**22%**	**20%**
			6%	**6%**	**11%**	**20%**	**11%**
Key			Suppressing negative emotions > population average [Score <5.8]				
			Suppressing negative emotions ≤ population average				
			Total disagreement with the statement				

Appendix 5.5

Suppression of positive emotions [MERI scores for statement 10]

Gender	Experience		Patient	Relative/ Bystander	Emergency Services	Hospital Staff	Colleague/ Manager
Male	<5	11	6.00	6.00	6.00	2.00	8.00
		12	4.00	8.00	7.00	8.00	2.00
		13	1.00	8.00	7.00	2.00	5.00
		14	4.00	3.00	4.00	5.00	4.00
		15	3.00	2.00	6.00	1.00	2.00
		16	7.00	7.00	8.00	5.00	6.00
		17	5.00	5.00	4.00	5.00	3.00
		18	4.00	2.00	8.00	2.00	1.00
		Set	88%	63%	50%	88%	88%
	5-10	21	5.00	2.00	5.00	8.00	8.00
		22	1.00	1.00	7.00	3.00	7.00
		23	2.00	4.00	4.00	4.00	7.00
		24	4.00	3.00	4.00	7.00	2.00
		25	4.00	4.00	4.00	6.00	6.00
		26	4.00	3.00	7.00	4.00	4.00
		27	8.00	8.00	8.00	8.00	8.00
		28	8.00	8.00	8.00	8.00	8.00
		Set	75%	75%	50%	50%	38%
	>10	31	4.00	4.00	5.00	6.00	7.00
		32	7.00	6.00	7.00	5.00	6.00
		33	1.00	2.00	2.00	1.00	8.00
		34	2.00	2.00	3.00	3.00	3.00
		35	8.00	8.00	8.00	5.00	8.00
		36	4.00	4.00	3.00	2.00	3.00
		37	6.00	7.00	3.00	2.00	2.00
		38	3.00	2.00	2.00	3.00	2.00
		Set	75%	75%	75%	100%	63%
	All		**79%**	**71%**	**58%**	**79%**	**63%**
Female	<5	11	3.00	4.00	5.00	7.00	7.00
		12	7.00	1.00	8.00	8.00	8.00
		13	3.00	1.00	8.00	3.00	8.00
		14	7.00	7.00	2.00	7.00	7.00
		15	6.00	6.00	6.00	6.00	7.00
		16	4.00	4.00	6.00	7.00	5.00
		Set	67%	83%	67%	33%	17%
	5-10	21	6.00	7.00	8.00	8.00	8.00
		22	8.00	8.00	8.00	8.00	8.00
		23	5.00	5.00	3.00	3.00	5.00
		Set	67%	33%	33%	33%	33%
	>10	31	2.00	2.00	7.00	3.00	3.00
		32	7.00	3.00	4.00	4.00	8.00
		33	3.00	4.00	6.00	3.00	2.00
		Set	67%	100%	67%	100%	67%
	All		**67%**	**75%**	**58%**	**50%**	**33%**
Sample			**75%**	**72%**	**58%**	**69%**	**53%**
			14%	**11%**	**17%**	**11%**	**17%**
			11%	**17%**	**25%**	**20%**	**30%**

Key	
	Suppressing positive emotions > population average [Score < 7.0]
	Suppressing positive emotions ≤ population average
	Total disagreement with the statement

Appendix 5.6

Feign of positive emotion [MERI scores for statement 5]

Gender	Experience		Patient	Relative/ Bystander	Emergency Services	Hospital Staff	Colleague/ Manager
Male	<5	11	1.00	8.00	7.00	8.00	7.00
		12	1.00	8.00	2.00	3.00	2.00
		13	7.00	2.00	8.00	6.00	3.00
		14	3.00	3.00	4.00	3.00	3.00
		15	3.00	3.00	6.00	3.00	3.00
		16	3.00	3.00	1.00	5.00	2.00
		17	3.00	5.00	4.00	4.00	3.00
		18	1.00	1.00	8.00	3.00	1.00
		Set	88%	75%	50%	75%	88%
	5-10	21	3.00	3.00	6.00	6.00	8.00
		22	2.00	2.00	1.00	2.00	1.00
		23	3.00	2.00	6.00	6.00	2.00
		24	3.00	2.00	1.00	7.00	4.00
		25	3.00	3.00	3.00	6.00	4.00
		26	1.00	4.00	8.00	5.00	4.00
		27	7.00	7.00	6.00	8.00	8.00
		28	1.00	8.00	2.00	4.00	1.00
		Set	88%	75%	50%	38%	75%
	>10	31	2.00	2.00	6.00	4.00	5.00
		32	4.00	3.00	5.00	6.00	2.00
		33	2.00	3.00	1.00	1.00	1.00
		34	3.00	2.00	2.00	3.00	3.00
		35	1.00	1.00	8.00	8.00	1.00
		36	3.00	2.00	1.00	5.00	5.00
		37	3.00	2.00	2.00	3.00	2.00
		38	2.00	1.00	1.00	1.00	1.00
		Set	100%	100%	75%	75%	100%
	All		**92%**	**83%**	**58%**	**63%**	**88%**
Female	<5	11	2.00	6.00	2.00	3.00	4.00
		12	1.00	1.00	8.00	8.00	8.00
		13	1.00	3.00	8.00	5.00	1.00
		14	1.00	2.00	6.00	2.00	3.00
		15	1.00	2.00	7.00	6.00	5.00
		16	3.00	3.00	5.00	5.00	5.00
		Set	100%	83%	33%	67%	83%
	5-10	21	5.00	7.00	7.00	6.00	7.00
		22	4.00	5.00	8.00	8.00	8.00
		23	3.00	4.00	5.00	7.00	7.00
		Set	100%	67%	33%	0%	0%
	>10	31	1.00	1.00	6.00	4.00	5.00
		32	7.00	3.00	3.00	3.00	5.00
		33	8.00	8.00	6.00	2.00	8.00
		Set	33%	67%	33%	100%	67%
	All		**83%**	**75%**	**33%**	**58%**	**58%**
Sample			**89%**	**81%**	**50%**	**61%**	**78%**
			8%	**8%**	**31%**	**25%**	**8%**
			3%	**11%**	**19%**	**14%**	**14%**
Key			Feigning positive emotions > population average [Score <5.5]				
			Feigning positive emotions ≤ population average				
			Total disagreement with the statement				

Appendix 5.7

Feigning negative emotions [MERI scores for statement 6]

Gender	Experience		Patient	Relative/ Bystander	Emergency Services	Hospital Staff	Colleague/ Manager
Male	<5	11	8.00	8.00	8.00	8.00	7.00
		12	6.00	8.00	7.00	7.00	7.00
		13	7.00	8.00	7.00	6.00	6.00
		14	6.00	4.00	5.00	4.00	4.00
		15	3.00	6.00	6.00	5.00	5.00
		16	6.00	6.00	8.00	5.00	7.00
		17	7.00	6.00	5.00	5.00	7.00
		18	6.00	6.00	8.00	6.00	5.00
		Set	63%	63%	38%	75%	50%
	5-10	21	5.00	7.00	6.00	5.00	8.00
		22	7.00	7.00	4.00	3.00	4.00
		23	8.00	7.00	7.00	3.00	8.00
		24	8.00	3.00	8.00	7.00	4.00
		25	3.00	3.00	3.00	6.00	4.00
		26	8.00	4.00	8.00	5.00	4.00
		27	8.00	8.00	8.00	8.00	8.00
		28	3.00	8.00	2.00	4.00	8.00
		Set	38%	38%	50%	75%	50%
	>10	31	7.00	7.00	4.00	6.00	4.00
		32	7.00	6.00	5.00	6.00	2.00
		33	3.00	3.00	3.00	8.00	8.00
		34	4.00	2.00	4.00	2.00	3.00
		35	8.00	8.00	8.00	8.00	8.00
		36	3.00	4.00	3.00	4.00	8.00
		37	7.00	3.00	7.00	3.00	3.00
		38	2.00	2.00	3.00	2.00	1.00
		set	50%	75%	75%	75%	42%
	All		**50%**	**58%**	**54%**	**75%**	**54%**
Female	<5	11	3.00	4.00	6.00	5.00	6.00
		12	8.00	8.00	8.00	8.00	8.00
		13	8.00	1.00	8.00	1.00	8.00
		14	7.00	7.00	6.00	7.00	7.00
		15	3.00	6.00	7.00	6.00	6.00
		16	6.00	5.00	5.00	5.00	5.00
		Set	50%	67%	50%	67%	50%
	5-10	21	5.00	7.00	8.00	7.00	8.00
		22	4.00	2.00	4.00	2.00	3.00
		23	7.00	7.00	7.00	8.00	7.00
		Set	67%	33%	33%	33%	33%
	>10	31	2.00	1.00	7.00	4.00	3.00
		32	1.00	3.00	7.00	4.00	4.00
		33	7.00	8.00	6.00	2.00	3.00
		Set	67%	67%	33%	100%	100%
	All		**58%**	**58%**	**42%**	**67%**	**58%**
Sample			**53%**	**58%**	**50%**	**72%**	**56%**
			25%	**20%**	**22%**	**11%**	**17%**
			22%	**22%**	**28%**	**17%**	**27%**
Key			Feigning negative emotions > population average [Score < 7.0]				
			Feigning negative emotions ≤ population average				
			Total disagreement with the statement				

Appendix 5.8

Surface acting [MERI scores for statement 12]

Gender	Experience		Patient	Relative/ Bystander	Emergency Services	Hospital Staff	Colleague/ Manager
Male	<5	11	5.00	1.00	2.00	6.00	1.00
		12	2.00	1.00	5.00	3.00	2.00
		13	7.00	1.00	7.00	3.00	2.00
		14	2.00	2.00	3.00	3.00	3.00
		15	2.00	2.00	6.00	2.00	2.00
		16	2.00	2.00	1.00	7.00	1.00
		17	3.00	3.00	3.00	5.00	5.00
		18	2.00	2.00	6.00	2.00	1.00
		Set	75%	100%	50%	63%	88%
	5-10	21	1.00	1.00	1.00	1.00	8.00
		22	2.00	8.00	1.00	1.00	2.00
		23	1.00	2.00	2.00	4.00	1.00
		24	3.00	2.00	3.00	4.00	4.00
		25	2.00	2.00	1.00	2.00	2.00
		26	3.00	2.00	3.00	6.00	3.00
		27	1.00	2.00	3.00	3.00	4.00
		28	6.00	8.00	4.00	7.00	2.00
		Set	88%	75%	100%	75%	88%
	>10	31	3.00	3.00	4.00	3.00	1.00
		32	4.00	3.00	1.00	1.00	1.00
		33	1.00	3.00	3.00	3.00	2.00
		34	1.00	1.00	8.00	4.00	1.00
		35	1.00	2.00	1.00	1.00	1.00
		36	2.00	2.00	2.00	3.00	2.00
		37	2.00	1.00	5.00	1.00	4.00
		38	1.00	2.00	1.00	2.00	1.00
		Set	100%	100%	75%	100%	100%
	All		**88%**	**92%**	**75%**	**79%**	**92%**
Female	<5	11	2.00	2.00	2.00	4.00	3.00
		12	1.00	1.00	8.00	8.00	8.00
		13	1.00	1.00	8.00	1.00	1.00
		14	6.00	2.00	2.00	7.00	5.00
		15	1.00	3.00	4.00	5.00	7.00
		16	4.00	3.00	5.00	5.00	4.00
		Set	83%	100%	50%	33%	50%
	5-10	21	2.00	4.00	7.00	7.00	7.00
		22	2.00	4.00	8.00	8.00	8.00
		23	2.00	3.00	4.00	2.00	7.00
		Set	100%	100%	33%	33%	0%
	>10	31	1.00	1.00	7.00	3.00	2.00
		32	7.00	7.00	2.00	3.00	3.00
		33	7.00	8.00	6.00	8.00	8.00
		Set	33%	33%	33%	67%	67%
	All		**75%**	**83%**	**42%**	**42%**	**42%**
Sample			**83%**	**89%**	**64%**	**67%**	**75%**
			17%	**3%**	**25%**	**25%**	**14%**
			0%	**8%**	**11%**	**8%**	**11%**
Key			Surface acting > population average [Score < 4.2]				
			Surface acting ≤ population average				
			Total disagreement with the statement				

Appendix 5.9

Deep acting [MERI scores for statement 13]

Gender	Experience		Patient	Relative/ Bystander	Emergency Services	Hospital Staff	Colleague/ Manager
Male	<5	11	8.00	8.00	8.00	8.00	8.00
		12	8.00	8.00	8.00	8.00	7.00
		13	7.00	8.00	8.00	2.00	3.00
		14	4.00	4.00	4.00	4.00	3.00
		15	4.00	3.00	5.00	3.00	2.00
		16	5.00	5.00	5.00	8.00	8.00
		17	6.00	6.00	5.00	6.00	3.00
		18	2.00	2.00	8.00	6.00	1.00
		Set	63%	63%	50%	63%	63%
	5-10	21	8.00	6.00	5.00	5.00	8.00
		22	8.00	8.00	1.00	2.00	7.00
		23	7.00	3.00	3.00	6.00	7.00
		24	8.00	8.00	8.00	8.00	8.00
		25	6.00	5.00	4.00	6.00	6.00
		26	7.00	7.00	8.00	5.00	4.00
		27	8.00	8.00	8.00	8.00	8.00
		28	5.00	8.00	4.00	5.00	8.00
		Set	25%	38%	63%	75%	25%
	>10	31	4.00	4.00	5.00	4.00	6.00
		32	6.00	7.00	6.00	6.00	6.00
		33	8.00	3.00	2.00	4.00	8.00
		34	2.00	3.00	2.00	3.00	3.00
		35	8.00	8.00	8.00	8.00	8.00
		36	3.00	2.00	1.00	1.00	1.00
		37	7.00	6.00	6.00	6.00	7.00
		38	5.00	5.00	3.00	4.00	3.00
		Set	63%	75%	88%	88%	63%
	All		**50%**	**58%**	**67%**	**75%**	**50%**
Female	<5	11	1.00	3.00	1.00	6.00	5.00
		12	7.00	8.00	8.00	8.00	8.00
		13	8.00	8.00	8.00	8.00	3.00
		14	7.00	3.00	7.00	7.00	7.00
		15	8.00	8.00	7.00	6.00	7.00
		16	4.00	4.00	5.00	5.00	4.00
		Set	33%	50%	33%	50%	50%
	5-10	21	7.00	7.00	8.00	8.00	8.00
		22	8.00	8.00	8.00	8.00	8.00
		23	3.00	4.00	5.00	7.00	7.00
		Set	33%	33%	33%	0%	0%
	>10	31	1.00	4.00	7.00	3.00	2.00
		32	7.00	6.00	8.00	7.00	1.00
		33	7.00	8.00	6.00	8.00	8.00
		Set	33%	67%	33%	33%	67%
	All		**33%**	**50%**	**33%**	**33%**	**42%**
Sample			**44%**	**56%**	**56%**	**61%**	**47%**
			25%	**8%**	**8%**	**8%**	**20%**
			31%	**36%**	**36%**	**31%**	**33%**
Key			Deep acting > population average [Score < 6.7]				
			Deep acting ≤ population average				
			Total disagreement with the statement				

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