Title of thesis

An exploration of emotional labour and emotion work in emergency pre-hospital care.

Submitted to Swansea University in fulfilment of the requirements for the Degree of Doctor of Philosophy.

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DECLARATION

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Abstract

This thesis explores emotional labour and emotion work in the context of the emergency ambulance service. The emergency medical service (EMS) provides constant response to life threatening situations and complex health care issues in the pre-hospital care setting. The emotional challenges of this type of health care work in the context of high demand is a crucial, though somewhat neglected area of research attention. Hochschild's theory on emotional labour (1983, 2003) and Goffman's (1959) dramaturgical concepts of front stage and backstage are utilised, supplemented with features of discourse and conversational analysis.

An ethnographic approach involving 280 hours of participant observation over a 10-month period and 24 in-depth interviews with EMS crews in one busy, urban, inner city ambulance station serving a large geographical area in the UK has been utilised to explore the emotional challenges of this work and the local ways of dealing with these.

The study findings suggest that EMS crews appraise and categorise their front stage work in positive and negative ways. Positive calls are expressed through local descriptors such being able to 'make a difference' and perceived 'genuine' need for the EMS and appear alongside emotions such as excitement which some crews suggested helped them deal with the more mundane types of work. Negative call appraisal was associated with questions of legitimacy of need for emergency assistance and predicated on normative ideologies. Crews constructed and populated categories displaying features of identity work, moral work and "negotiated order" (Strauss, Schatzman, Ehrlich, Bucher, & Sabshin, 1963), mobilizing their perceptions of the role of the EMS and the kind of work they should be doing. Negative categorisation was associated with frustration necessitating emotional labour by crews in the disguise and suppression of emotion and appeared to influence the interactions between them and patients.

The backstage setting in the form of the crew room was a central, regular, social gathering point where frontline frustrations were shared and processed through moaning, complaining, talking and humour. The crew room was a setting to talk to each other about difficult calls; where reflection was verbalized in questioning if they had done the 'right' thing and where reassurance was sought from colleagues. The reflexivity displayed by crews in the backstage setting appeared to emphasise positive affirmations rather than challenge and contributed to a sense of group identity.

This thesis offers new understandings of the challenges of the frontline EMS role, emotional labour and emotion work and drawing on participant observation, offers tentative implications these appear to have for crews' interactions with those who use the service. The backstage context and behaviours represent local ways in which frontline role challenges appear to be expressed and managed from the perspective of those who are directly involved in it.

The findings of this thesis offer unique contributions to the theory of emotional labour and emotion work in the emergency pre-hospital care context. These have implications for the inclusion of the concepts of emotional labour and emotion work in pre- and post-registration paramedic curricula, organisational recognition of the emotional demands of emergency ambulance work and staff support and for further research into the emotional challenges of this type of work.

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Chapter 1

Introduction to my thesis

1.1 Introduction

This thesis explores the emotional challenges which arise in contemporary emergency pre-hospital care and how practitioners interpret and respond in socially and culturally appropriate ways. A qualitative, ethnography has been chosen to facilitate exploration and understanding of the perspectives of emergency health care professionals; their interpretation of their role and the role of the Emergency Medical Service (EMS). I also examine how practitioners perceive and respond to conflicts between their role expectations and the reality of their clinical practice.

I utilise the theory of emotional labour (Hochschild, 1983, 2003) and emotion work and attempts to apply these conceptualisations to the health care and emergency pre-hospital care context. Goffman's (1959) dramaturgical concepts of 'regions'; front stage and backstage are used in framing the emotional demands of emergency pre-hospital care and are supplemented with features of discourse and conversational analysis.

My study centres on emotion and the emotional component of public service, interactional work in the context of the emergency ambulance setting. Emergency ambulance work has the potential to stimulate a wide range of emotions in those who provide and receive the service such as fear, anxiety, loss, grief, anger and shock, which necessitate and as such constitute work (Boyle, 2005; Williams, 2013a). Boyle (2005, p.46) describes this type of public service work as "emotion laden".

Emotion is a complex conceptual phenomenon which defies a single definition, although there is consensus that it includes a 2-stage process whereby an event stimulates an appraisal of significance to the individual and shapes an emotional response from them (Sander, 2013). Emotion is a multidimensional feature of human constitution which courts differing theoretical explanations and incorporates features of expression, action tendency, bodily reaction, feeling and appraisal which are important in conceptual and research endeavours (Coppin & Sander, 2016). Emotion and expression are closely connected phenomena and include facial, postural and vocal dimensions, action tendency relates to the responses which follow emotion such as avoidance, bodily reaction refers to the physiological associations accompanying emotion such as hormonal changes, feeling includes the subjective response, and appraisal refers to the cognitive elements (Coppin & Sander, 2016). The expressive, behavioural and action related dimensions of emotion can offer a basis for recognition, communication, analyses and understanding of this phenomenon (Jacob-Dazarola, Nicolas, & Bayona, 2016).

Hochschild (1983, 2003), is attributed with the conceptualisation of 'emotional labour', following her early inquisitions regarding the authenticity of emotional expression. Through research she explored this further and described the notion of emotion and feeling as malleable, workable states. Hochschild (1983, 2003) defined emotional labour as, "the induction or suppression of feeling to create an external appearance which makes others feel cared for in a convivial, safe place" (p.7).

Emotions are manipulated through the processes of surface or deep acting; the former changing the external appearance and the latter altering internal feelings to suit the perceived expectations of the situation. Hochschild (1983, 2003, p.18) referred to these expectations as "feeling rules" or norms which inform social behaviours in each situation such as sadness at a funeral or joy at a party. Emotional labour is needed when feelings do not coincide with expectations and emotions are disguised or altered to fit. The expressive, behavioural and action-oriented features of emotion and the work done to supress and disguise it (the emotional labour), will be the focus of the analysis and interpretation of data within my study.

My interpretation and analysis draw on theoretical and philosophical approaches which position individuals as perceptive, meaning giving, creators and constructors of knowledge communicated through the active interview (Holstein & Gubrium, 1995) and illuminate features of moral work, identity work (Shotter, 1984), normative ideology, the use of categorisation devices (Sacks, 1992) and the purposes to which these may be put.

In this chapter I provide an overview of the role of the EMS and the place of emotional labour and emotion work within this organisational context. I outline the underpinning theory of emotional labour as a theoretical framework to guide my study and clarify the need for further research. A comprehensive analysis of the theory of emotional labour is presented within my review of pertinent literatures in chapter 2.

I make apparent my reasons for interest and focus on the emotional demands of emergency pre-hospital care and clarify my aim and objectives for this research investigation.

I detail my methodological choices drawing on underpinning philosophical and epistemological beliefs about human beings; their subjective perceptive and interpretive capacities and my intention to illuminate and communicate these through the conduct of my study. The philosophical and theoretical foundations of my research are examined in chapter 3.

I present a brief overview of the chosen setting for my study; Bryn Station and the methods I used to retrieve and collect data. I also include details of my use of reflexivity throughout my study to enable an analytical and critical awareness of my positioning and the potential impact of this on my interpretation and presentation of the findings.

Finally, I explicate the structure and organisation of my thesis with a description of the focus and content of each chapter.

1.2 Role of the EMS

Contemporary emergency pre-hospital care involves the assessment, management, treatment and transport of patients with a variety of emergency physical, social and mental health problems (The National Institute for Health and Care Excellence, (NICE) 2020). Increasing technical skills enable response and management of a range of physical health problems from minor injuries to life threatening emergencies such as trauma and resuscitation. Emergency pre-hospital practitioners in the context of their frontline role are exposed to a potential myriad of human emotions in themselves and others such as fear, anxiety, loss, grief, anger and shock (Boyle, 2005; Williams, 2013a). These emergency professionals have to deal with others' emotions and their own as part of their frontline work. There are also the potential effects on their emotions after the events, which constitute a complex framework of what I refer to as 'emotion work'.

Hochschild (1983, 2003) used the term 'emotional labour' to communicate the work undertaken by flight attendants to maintain an appropriate public display when interacting with passengers. She differentiated between emotional labour and emotion management, the latter which was undertaken after the service provider and client interaction. Boyle (2005) however, perceives emotion work as a process requiring the appraisal of a number of emotional events which may continue beyond the events themselves. Boyle (Ibid) argues that although the setting changes from a public to a private one, the process of appraisal and regulation of emotion is the same. She thus adopts an inclusive perspective and proposes emotional process work (Thoits, 1985) after the event, to be central to emotional labour.

These early theoretical foundations and concepts have been utilised in my study as a framework on which to further explore the emotional demands of emergency pre-hospital care work. I will use Hochschild's (1983, 2003) concept of emotional labour to capture the work needed in frontline interaction and 'emotion work' to differentiate and identify the ways emotions are managed after the interaction.

Despite the emotional demands of frontline emergency work (Boyle, 2005; Williams, 2013a), emotion as a component of this work has received comparatively little professional, theoretical or research attention which may be related to cultural, epistemological and professional issues (Boyle, 2005; Williams, 2012).

1.3 My reasons for choosing the topic

My interest in the emotional labour of caring began early in my nursing career as a student nurse following a difficult episode of caring for a terminally ill patient and the associated first-hand challenges

of the hard, painful and lonely experience of this. As a student of a caring profession, I was totally unprepared for the emotional challenges of care work. Some years later as part of a Masters in nursing programme I was able to reflect on this experience and to critically examine the cultural and historical background of my profession through a reflective practice assignment for one of the modules. This opportunity enabled me to understand the experience and my struggle with the emotional demands of caring at that time. This has made me mindful as an educator and personal tutor of the work involved in caring for others and my role in educating and supporting students.

As a nurse with clinical work experience in hospital emergency settings I have worked in partnership with colleagues in the emergency ambulance service. However, my interest specifically in the emotional aspects of their work arose with my involvement in the educational preparation of pre-registration student paramedics in my educational institution in 2008. This reflected a wider, national movement of pre-registration paramedic education into the higher education establishment (British Paramedic Association, (BPA) 2006). As an experienced nurse lecturer and personal tutor, I offered my services and took up a role as personal tutor to six paramedic students for the two-year diploma programme in Paramedic Science.

As a personal tutor I facilitated reflection with my students, listened to their experiences and challenges and generally as with all my students, I looked out for them. I became increasingly aware of their work and its challenges and was mindful of their youth; one was just 17 years old. I read the local newspaper report of a fatal car accident involving a bus with local college students which stated that counsellors were available to support the college students who had witnessed the fatality and the trauma. The word 'student' immediately brought to mind my paramedic students and whether they had attended this incident, how they might have dealt with it and what support they would need and receive. I began to ponder more generally the emotional demands of their work, the sudden exposure to emotionally challenging events and their vulnerability. My own experience of emotional labour as a student nurse further sensitised me to their situation and began my quest to examine the emotional aspects of care work for student paramedics. I was able to subsequently undertake a small-scale research study supported by my educational institution, in which I explored the emotional demands of student paramedic practice from the perspective of those directly involved in it (Williams, 2013a & b). This study laid the foundations for my decision to further explore emotional labour and emotion work in the context of pre-hospital care for a Doctor of Philosophy.

1.4 My study aim, objectives and methods

It is my intention in this study to expand and develop understanding of the emotional labour and emotion work required in the cultural and professional context of frontline emergency pre-hospital care from the perspective of professionals who deliver this service.

My study objectives focus on:

- How frontline emergency pre-hospital practitioners perceive and describe the emotional demands of their role.
- How and in what circumstances are the emotional demands perceived and handled by social actors in the cultural and professional context of emergency pre-hospital care.
- What rules and expectations influence it and how it is managed within this organisational, cultural work setting?

Culture is a complex, multi-faceted phenomenon, the intricacies and meaning of which are best understood by those who are immediately and centrally placed within it (Geertz, 1973). It is my intention to situate understandings of emotional labour and emotion work in the context of emergency pre-hospital care in the interpretations, meanings and perspectives of the professionals who do this work. A qualitative, ethnographic research design and methods are best suited to my intention and purpose in this study and are congruent with my philosophical and epistemological beliefs regarding the nature and study of human beings as sentient, meaning giving, interpretive individuals. Ethnography is the study of culture from individuals in their natural environment, through sustained, close contact with them: listening, observing and interacting (Hammersley & Atkinson, 2019). Ethnography is the means by which we can come to understand others' perspective and interpretive world. Ethnographic study involves attention to matters of legitimation and representation of others' subjectivities and consideration of the positioning of the researcher (Brewer, 2000). Analytical realism (Altheide & Johnson, 1998) emphasises the subjective interpretation of the social world and facilitates a critical awareness of self as researcher in the setting through a continuous process of "validity-as-reflexive-accounting" (p.489). This approach has been utilised in my study to enable a critical, reflexive awareness of myself, my views, beliefs and perspectives and their influence.

My exploration of emotional labour and emotion work in emergency pre-hospital care from the perspective of practitioners can offer crucial understanding of their interpretation, meaning and significance of this facet of their work and how they deal with it. It is my intention in this thesis to build on my fundamental philosophical views on truth as a subjective phenomenon with the perception of respondents as active interpreters, creators and constructors of knowledge and meaning (Holstein & Gubrium, 1995). It is proposed that the interview offers an opportunity to stimulate and illuminate individual's interpretive capabilities in the process and product of the interview (Holstein & Gubrium, 1995). Theoretical perspectives of account giving as creative, active and purposeful constructions (Edwards & Potter, 1992) will also be utilised. These theoretical perspectives present individuals as active, creative, meaning giving and purposeful constructors of knowledge in the content and process of communication. Discursive analysis offers insight into the purpose to which the interview is used

(Coffey, 2012) and importantly why. The creative construction of personal accounts in relation to chronology and content may offer understanding of important issues such as identity, the threats to this and the work done to offer alternative versions of it (for example see Coffey, 2012). Discursive analysis of interviews with emergency pre-hospital practitioners on the emotional aspects of their work may show important occupational, professional and gender identity work and the organisational culture within the emergency ambulance service. Collectively these perspectives propose a basis for varied levels of complex analysis and enhanced understanding.

To address my objectives my study centres on the emergency ambulance service within a busy, inner city, urban ambulance station as part of an ambulance trust serving a large geographical area in the United Kingdom (UK). I have undertaken a total of 280 hours of participant observation over a 10-month period and conducted 24 in-depth research interviews with EMS crews to explore the emotional challenges of frontline emergency ambulance work. Appropriate documentary sources such as the Patient Care Record (PCR), Patient Pathway Guidelines (Welsh Ambulance Service NHS Trust, (WAST) 2013a), periodic formal communication to the crews in the form of memoranda from organisational management and informal documents such as magazines, messages and notices displayed on the crew room notice board have also been included and analysed to reflect the culture of this organisational context.

1.5 Reflexivity as an important part of my study

Reflexivity is considered an important feature of good research practice and a crucial accompaniment of ethnographic study (Aull Davies, 2008; Buscatto, 2021; Hammersley & Atkinson, 2019). My personal biography as a nurse and nurse educator are inevitable features of my 'lens'; the perspective through which I view and perceive the world of the EMS and my interpretations of it. Reflexivity offers a strategy for critical awareness of self and the potential impact of self on the process and products of research inquiry (Aull Davies, 2008).

Reflexivity in the conduct of my study has been facilitated through the use of analytical realism, the completion of a reflective fieldwork diary in addition to and separate to my fieldnotes, which allowed exploration of my feelings and thoughts about my fieldwork experiences. I frequently engaged in cognitive dialogue with myself and critical discussion with my supervisors (particularly MC), and their constructive feedback and occasional reminders of the importance of 'critical distance' helped to enhance my reflexivity and positioning.

1.6 The organisation and content of my thesis

In chapter 2 I discuss, critically analyse and synthesise the findings of my review of the various literatures pertinent to my study. I make clear the process used to effectively search and retrieve literature relevant to my area of interest, my approach to the critical analysis and appraisal of the literature and the organisation and presentation of my review findings in a chosen narrative format.

The search strategy including selected search terms, electronic databases searched, the limits applied to my search and the nature and quantities of literature I retrieved and selected for inclusion in my review are presented. My review of the literature is organised under themed headings pertaining to the historical development of the ambulance service in the UK, theoretical underpinnings of emotional labour, emotional labour in the EMS context, categorisation and appraisal of emergency work and the implications for emotional labour and emotion work, public interpretation of need for the EMS and the coping strategies to help deal with the challenges of EMS work.

In this chapter, based on my analysis of this literature, I will argue that emotional labour and emotion work have applicability to the context of emergency pre-hospital care, through the interaction and interpersonal exchange between the professional and patient and in the presentation of an appropriate professional display and the processing of emotion afterwards (Boyle, 1997, 2005; Williams, 2013a). However overall, the research on this aspect of emergency practice is limited and warrants further research investigation.

My analysis of the literature highlights the valuing of particular types of work in the emergency pre-hospital care setting which reinforces traditional roles and perceptions of emergency work. Appraisals and categorisations of work have the potential to instigate differing emotions and emotional labour. However, although these are hinted at there are no clear and specific links to the implications of types and valuing of work to emotional labour and emotion work. The current paucity of research serves to warrant and justify my research investigation.

In chapter 3 I present a detailed explanation and discussion of the ethnographic methodological design and approach to my study. The chapter is organised and presented in two detailed sections. In the first section I reiterate the focus of my study and situate this within a critical exploration of the nature of qualitative inquiry and specifically ethnography, to furnish a clear rationale for my choice. The nature and philosophical and theoretical underpinnings of ethnography are explored. I give attention to critics of ethnography, both traditional and postmodern and the attempts made to address these in past decades. I then provide a critical discussion of the use and application of ethnographic methods in my study. My specific attention is given to how I accessed the setting, my sampling, how I undertook participant observation and interviewing, documentary evidence I used, how I analysed my data and the ethical considerations incumbent in the conduct of my study.

In chapter 4 I will focus my description on the setting of my study: Bryn Ambulance Station the base and foundation for my research. I will offer an overview of the history of Bryn Station, its physical features and layout, its fabric and decor, its organisational role in service provision, its structure, the people and their roles and positions. I describe the regular checking and preparation of vehicles and equipment at the changeover of shifts, the organisation of roles and responsibilities between crews and the routine elements of a shift in the EMS. Bryn Station and its crew room are features of the backstage context of the EMS which I share to show its physical features, social context and organisation. This chapter foregrounds my ethnography and furnishes detail of the fabric of this setting as a base for emotional labour and emotion work.

In chapter 5 based on participant observation and in-depth interviews, I present my analysis of the backstage behaviours and interactions of EMS crews in Bryn station, with particular focus on the crew room and on other occasions when they were not undertaking their frontline duties in view of a front stage audience. This backstage environment was my first encounter with the EMS at Bryn Station and my observations and analysis of this context addressed two of my study objectives; how and in what circumstances are the emotional demands perceived and handled by social actors in the cultural and professional context of emergency pre-hospital care and what rules and expectations influence it and how it is managed within this organisational, cultural work setting? Bryn Station and its EMS crew room constituted part of the entirety of their work context; a regular social gathering and meeting point for crews in which their frontline role and its frustrations and challenges could find expression amongst colleagues who understand and are trusted. Crew' behaviours and activities involved periodic moaning and complaining about calls and callers, particularly those they considered to not necessitate an emergency ambulance. Some crews described the crew room as a setting in which they could talk through calls they found difficult or challenging. Humour and teasing were common features of crew room gatherings, particularly of new recruits but also of established crew members. The EMS crew room in Bryn Station and the opportunities for backstage interaction were not universally valued or engaged in by all crew members, however, were perceived as important to some in enabling them to cope with the challenges of EMS work. In this chapter I make the case for this backstage location having a part to play in the emotional handling, processing and management of EMS work.

In chapter 6 I present my analysis of data extracts that I suggest communicate aspects of the EMS role in frontline service provision. I bring attention to the role adopted by crews in responding to emergency calls and focus on what I detect as informal positive call categorisation in the accounts of workers. I suggest these call categorisations have implications for crew' emotions and emotional labour and present attempts to position their role and their understanding of it amidst threats to their professional identity.

My analysis indicates that interpretive resources are used in identifying positive call categorisations which are often classed as 'making a difference'. 'Making a difference' is a locally produced signifier in evaluations of the value and effect of the EMS role in emergency situations. Attention is given to life threatening emergencies wherein there is a need for an emergency ambulance, where crews can demonstrate their technical skills, clinically manage medical emergencies and save lives. My analysis also suggests that interpretation of calls constituting positive call categorisation are associated with evaluation of what is positioned as genuine need for the emergency ambulance service. 'Genuine' and 'they really need us' were locally ascribed descriptors in evaluations of calls which included features of serious physical, medical and mental health needs and help needed to get to A&E.

Interpretations of calls categorised positively instigate crews' perceptions of their understanding of what they consider to be appropriate use of the emergency ambulance service and are positioned in accounts as the kind of calls they perceive they should be dealing with.

Chapter 6 serves to communicate the basis for the appraisal, valuing and categorisation of EMS work in positive ways which reinforce traditional emergency roles and role fulfilment. These reflect a cultural valuing of particular types of work and occur alongside positive signifiers such as 'making a difference'. These appraisals and categorisations establish a contrast to 'others' which I show in chapter 7.

In chapter 7 I will present my findings relating to how some EMS crews negatively appraise and position their work. My analysis suggests that calls in which crews' question what they perceive to be the legitimate need for the EMS can lead to negative appraisal. Crew' interpretation and positioning of calls focus specifically on whether they consider an emergency ambulance was needed for transport to hospital and the perceived severity of the medical problem. My analysis suggests crews' appraisal of calls draw on their interpretations of what is considered to warrant an emergency ambulance response and reflect discrepancies between their professional perception and the public perception of need. Crew' interpretation and negative appraisal of their work are situated amidst frustrations which have to be 'managed'; disguised and suppressed in their front stage performance and as such call for particular forms of emotional labour (Hochschild, 1983, 2003).

Chapters 6 and 7 collectively, address two of my study objectives; how frontline emergency pre-hospital practitioners perceive and describe the emotional demands of their role and how and in what circumstances are the emotional demands perceived and handled by social actors in the cultural and professional context of emergency pre-hospital care?

In chapter 8 I will explore and critically discuss the key issues which have arisen from my field observations and interviews with EMS crews in Bryn Station and the conclusions I draw from them. I will examine these issues in detail, discuss the links with relevant literatures and clarify how my study contributes to understandings of emotional labour and emotion work in the emergency, pre-hospital

care setting. My attention will be given to the setting of my study, to its organisational features, to the behaviours and interactions of crews in the entirety and complexity of this work-related social context.

I will discuss my observations and interpretations of crew room behaviours and activities and the implications these have. I will discuss how crews interpret, categorise and position their work in positive and negative ways and explore the potential implications these may have for their interactions with service users their emotional labour and emotion work.

In chapter 8 I will discuss the unique contributions of my study to the theory of emotional labour and emotion work in the emergency pre-hospital care context, to EMS work, to learning and education and to research. I will discuss the limitations of my study which relate to my focus on one EMS setting, my novice status as an ethnographer and to the methodological issues which arise in ethnographic research. I will present an overall conclusion to my thesis and clarify what I have learnt about emotional labour and emotion work in the emergency context and what I have gained as a researcher from undertaking an ethnography.

1.7 Conclusion

In this chapter I have provided an overview of the aim and focus of my thesis and have highlighted the place of emotional labour and emotion work in the role of the emergency ambulance service. I have critically appraised the underpinning theory of emotional labour, summarised existing literature from the EMS context and highlighted the need for further research.

I have clarified my aim and objectives for further study and have articulated the choice of an ethnographic approach using participant observation, documentary evidence and in-depth interviews with frontline EMS crews in the setting of a busy, urban, inner city ambulance station in the UK. I have outlined the structure and organisation of my thesis with a description of the focus and content of each subsequent chapter.

In the next chapter I present detail on the process used to effectively search, retrieve and critically appraise existing literatures considered pertinent to my topic of interest. I present my review of literature in a narrative format through the identification of themes which reflect issues of collective attention and research focus. I include an overview of the history and development of the ambulance service as an important contextual backdrop and my review includes the critical appraisal of theoretical contributions to the concept of emotional labour, emotion work in the context of the EMS, work appraisal as a basis for emotional labour and strategies for dealing with the emotional demands of emergency work.

Chapter 2

Literature review on emotional labour and emotion work

2.1 Introduction

In this chapter I discuss, critically analyse and synthesise the findings of my review of the various literatures which I considered pertinent to the aim and subject matter of my research study of emotional labour and emotion work in the context of the emergency ambulance service.

I have presented and organised my literature review in a narrative format which places my study within the context of existing literatures pertinent to my research questions and which support the need for further investigation (Harvey & Land, 2017). I have chosen a narrative review as opposed to others such as a systematic review to enable inclusivity of pertinent wider sources of literature to create a background of existing understandings on the subject of my study. An inclusive review is appropriate and sympathetic to the nature and intentions of an ethnography such as mine. I have combined a narrative format with a thematic, critical discussion of the literature in which pertinent issues are synthesised.

My review draws on key theoretical, seminal and classic literature (such as Boyle, 1997, 2005; Goffman, 1959; Hochschild, 1983, 2003; James, 1989; 1992; Smith, 1992) which were considered relevant to my study and some which have been recommended by my supervisors (such as Becker et al; 1961; Dingwall & Murray, 1983; Mulvey, 1975; O'Neill, 2001; Roth, 1972). This has been supplemented with a structured, transparent search, retrieval, generation, and inclusion of literature pertinent to the key concepts and ideas used in my thesis. (See Appendix 1 – Record of literature search, retrieval & selection). Collectively, these sources constitute an eclectic mix of traditional and contemporary contributions to understandings of the concepts central to my study.

Drawing on key, foundational theoretical literature on the concept of emotional labour in the commercial context of the American airline industry it was argued that emotion was commodified and manipulated for economic gain (Hochschild, 1983, 2003). Emotional labour is a central feature of frontline, public service work involving interpersonal interaction, attention to the emotions of others through the manipulation of one's own emotions, in the pursuit of positive outcomes (Hochschild, 1983, 2003).

The concept of emotional labour as a feature of public service work has been investigated in health care contexts from the perspective of student nurses (Smith, 1992) and those providing end of life, palliative care (James, 1989, 1992) initially. These studies provided early contributions to the recognition of work involving emotions; the work of providing emotional care for others and the management of one's own emotions.

Emotional labour and emotion work have been examined in the context of emergency pre-hospital care, through the interaction and interpersonal exchange between the professional and patient, in the maintenance of an appropriate professional display (Boyle, 1997, 2005; Williams, 2013a) and against traditional stereotypical, hegemonic views of masculinity which discourage the expression of emotion (Boyle, 1989, 2005). This literature provides a foundation for further research into this comparatively neglected aspect of emergency pre-hospital care.

My analysis of the literature from the pre-hospital care setting highlights the historical backdrop and traditional identity of the emergency ambulance service, the emphasis on life-saving resuscitation and trauma. These lay the foundations for role identity and the valuing of types of work in the emergency pre-hospital care setting, which reinforce traditional roles and perceptions of 'real' emergency work. Differing appraisals and categorisations of work amongst EMS crews have the potential to instigate differing emotions and emotional labour. However, although these are hinted at there appears to be a paucity of research which explores the implications of work appraisal and valuing on emotional labour and emotion work and justifies the need for further research study.

My review of the literature highlights various coping strategies used in the context of the EMS to deal with the emotional challenges of this type of work; and a key approach is reported to involve a reliance on informal colleague support through talking and listening and to a lesser extent humour is suggested to be helpful.

My review analyses theoretical contributions to the concepts of emotional labour and emotion work and existing knowledge on the applicability of this to health care contexts, including the EMS. The paucity of attention to this topic area however, particularly in the EMS accentuates the need for further research investigation into the emotional labour and emotion work which accompanies frontline emergency pre-hospital care and how this is handled by those who deliver it.

2.2 My search strategy

My search of the literature focused on electronic databases including EBSCO Medline, EBSCO Cumulative Index for Nursing and Allied Health (CINAHL) and EBSCO psycINFO, EBSCO ASSIA (Applied Social Science Index & Abstracts), Scopus and Web of Science collection which were recommended by subject specialist librarians. Broad search terms were selected based on knowledge of titles and discussion with a subject specialist librarian to identify the population of interest which were indicated by full role titles and abbreviations (EMTs, Emergency Medical Technicians, paramedics) and included other signifiers such as 'ambulance' and 'pre-hospital'. The specific search terms included were separated by the Boolean operator 'OR' to expand the search through the retrieval of alternative terms and was collectively constructed as 'EMTs OR emergency medical technicians OR prehospital OR pre-hospital OR ambulance OR paramedic OR paramedics'.

Search terms for the subject of interest in my study included 'emotion', 'feelings', 'frustrat' and 'stress'. However, the term 'stress' resulted in the retrieval of a significant quantity of literature which focused on the physiological and biological effects of stress and the implications for post-traumatic stress disorder (PTSD) and burnout which were not topics that I was specifically interested in. To resolve this and retrieve literature relevant to my research topic Medical Subject Headings (or MeSH headings) were suggested and explored for alternatives, more appropriate nomenclature and consequently 'stress, psychological' was selected and added to my search terms. The specific search terms were separated by 'OR' and were combined as emotion* OR feel* OR MH "stress, psychological" OR frustrat*. I was advised to truncate or shorten some terms and utilise an asterisk to facilitate the inclusion of all the words starting with the same letters to enable retrieval of as much pertinent literature as possible. For example, I used emotion* to retrieve emotions, emotional, emotional labour.

Further terms were added to my search to also include ways of coping with the emotional challenges of emergency pre-hospital work, using 'OR' and following discussion with a subject specialist librarian were again combined as coping OR talk* OR debrief* OR humour.

I applied limits of English Language, literature published in the last 4-5 years and humans only. Three searches were undertaken during my study covering a date range of 2010 - 2020; the first in 2016 (date range 2010-2016), the second in 2019 (date range 2015-2019) and third in 2020 (date range 2019 – 2020) (See appendix 1 – Record of literature search, retrieval & selection). This was done to facilitate my capture of pertinent literature over the period of my study. The terms, configurations and limits were utilised to search the electronic databases. My selection of appropriate literature was guided by reference to the inclusion criteria of literature relating to emotional labour, emotion work or emotions in the context of emergency pre-hospital care and exclusion criteria were literature or research on specific mental health issues such as burnout and Post Traumatic Stress Disorder (PTSD). My initial analysis of the retrieved literature suggested a significant emphasis on these topics with various literatures assessing and predicting its incidence amongst the EMS and other emergency service responders (examples include Navarro, Carrasco & Hoz, 2017; Oginska-Bulik & Kobylarczyk, 2015). Whilst this is valuable literature it was not of specific relevance to me and my research questions and was therefore excluded.

My first search (2016) produced a total of 1835 hits across all databases; the title and abstracts were screened in relation to the inclusion and exclusion criteria, duplicates were removed leading to the provisional inclusion of 31 sources. My second search (2019) utilised the same process, produced 763 hits and 26 pertinent sources of literature. Finally, my third search (2020) produced 206 hits which after screening led to the inclusion of an additional 3 sources (See appendix 1 – Record of literature search, retrieval & selection).

A total of 60 sources of pertinent literature were included from my literature searches. These have been scanned and those considered to be irrelevant have been removed and saved in a separate folder. From the above searches a total of 32 sources have been considered relevant to my study and have been included in my literature review.

The literature from all searches were combined, read and organised into themes (for example 'theory of emotional labour', emotional labour in the EMS', 'humour'). The reference lists of papers located offered me a further fruitful source of additional literature to follow up and expand my review (for example Henckes and Nurok (2015) included a reference to "Interaction rituals" by Collins (2004) which I sourced and read). As indicated above, I have also included additional theoretical and in some cases seminal contributions to the topic of emotion and emotional labour (Boyle, 1997, 2005; Hochschild, 1983, 2003; James, 1989, 1992; Smith, 1992) and some which have been recommended by my supervisors (such as Becker et al; 1961; Dingwall & Murray, 1983; Mulvey, 1975; O'Neill, 2001; Roth, 1972).

Pertinent grey literature has been included in the form of paramedic educational curricula (British Paramedic Association, (BPA) 2006; College of Paramedics, 2019; Institute of Health Care Development, (IHCD) 1999) professional policy and clinical guidelines in the pre-hospital care context (Joint Royal Colleges Ambulance Liaison Committee, (JRCALC) 2019; WAST NHS Trust, 2013a).

My appraisal of the literature has been guided and informed by the critical appraisal frameworks with which I am familiar (Critical Appraisal Skills Programme, (2018) CASP Checklists (online). Available at: https://casp-uk-net). For example, the qualitative checklist – 10 questions to help you make sense of a qualitative research. I have also undertaken a methodological critique of the literature which is included in a tabulated format (See appendix 2 – Methodological critique of the literature).

I have organised my narrative review to start with an overview of the history of the emergency ambulance service in the UK to describe this professional group and the changes and developments which have taken place over time. I present a detailed, critical portrayal of the theories of emotional labour; a significant framework underpinning my study, and the complex, contextual nuances of this concept and its interpretation in health care contexts. I then focus on the EMS setting and the appraisal, valuing, categorisation and legitimacy of the work and the implications for emotional labour and emotion work. My review of the literature also includes discussion of coping strategies used in the EMS context.

2.3.1 The UK emergency ambulance service; its history, development and current focus

The ambulance service has a long and established history which can be traced to its original conception in the battlefields of the Napoleonic War (starting 1799) and the need to quickly remove and transport

the injured men (Craggs & Blaber, 2008; Traverse & Locker-Freeman, 1997) a pragmatic response to need and the brainchild of Baron Dominique Jean Larrey. Pierre Francois-Percy, a French surgeon is said to have combined transport with expert medical treatment on route to a field hospital (Marx et al; 2002). However, this wartime, battlefield initiative was not developed further until the 1950s. Early civilian ambulances took the form of hearses and developments in pre-hospital care provision in some areas like London were hampered by the nickname "body snatchers" (Donald, 1996, p.451) which discouraged support by the medical profession.

The ambulance service although closely aligned to the health service has been peripheral and somewhat independent of it. Despite its development para medicine has not historically been included in the realms of established health care professional groups like medicine, nursing, physiotherapy and social work. Historically, entry to this type of emergency health service work was often secured through young cadet routes and internal mechanisms for promotion through the various ranks and levels for those with the most experience (Wankhade, 2016). A training-based approach with short periods of teaching and learning in ambulance training schools, complemented by apprentice style, on the job learning have traditionally been considered appropriate preparation for these roles (IHCD, 1999). Educational preparation has centred on skills acquisition in various types of trauma and medical emergencies including resuscitation (Craggs & Blaber, 2008; IHCD, 1999).

Despite its comparatively slow start as a health care professional group the ambulance service has developed considerably in the past century with significant developments in its contribution to health provision, its educational preparation and professional development (Givati, Markham & Street, 2017; Wankhade, 2016). The emergency ambulance service has developed from a rather simple recovery, first aid and transport system to an educated, technically skilled service to meet the increasing challenges of health care demand (Givati et al; 2017).

The redesign of health care provision in the 21st century has placed the ambulance service and in particular the role of the paramedic in a key position with emphasis on 'front door clinical screening' (NICE, 2020). The ongoing political, economic and social landscape of health care provision has fuelled developments in the nature and role of the emergency ambulance service in recent decades (Givati et al; 2017; Wankhade, 2016) and the educational preparation (Givati et al; 2017).

In past decades changes in service delivery have ensued for the EMS with a sustained move away from treatment and transport to hospital, to alternative models involving clinical assessment, treatment at scene and referral to community services where appropriate (WAST NHS Trust, 2013a). These alternative models of care however place greater responsibility and accountability for clinical decision-making and treatment on these emergency care providers (Wankhade, 2016). Clinical decision-making on issues of alternative patient disposition (rather than treatment and transport to ED) are supported through various algorithms for care. Established pathways for example relate to situations involving

falls without injury, epileptic seizures (in diagnosed epileptics) and low blood glucose levels (in diagnosed diabetes mellitus), which can be medically stabilised and referred to primary care services (WAST NHS Trust, 2013a).

Commensurate with developments in service delivery have been significant changes to the educational preparation for the paramedic role which has moved into higher education institutions (BPA, 2006) and offers Masters and PhD levels of study. Career pathways have also expanded to include Advanced Paramedic Practitioner and Consultant Paramedic (BPA, 2006, 2008).

Against the backdrop of increasing demand for healthcare services the emergency ambulance service provides individualised contact, assessment and treatment of the public which involves interpersonal interaction, management of emotion and emotional care for those who may be frightened, anxious and distressed (Boyle, 2005). Emotional labour is a key feature of emergency care work (Boyle, 2005; Williams, 2013a & b).

2.3.2 The theory of emotional labour

The initial conceptualisation and theory of emotional labour is attributed to Hochschild (1983, 2003) an American sociologist whose interest in the subject began as a child when her father's work as a diplomat prompted her questioning of the authenticity of the emotional exchange she often witnessed between visiting diplomats. She questioned to what extent these expressions were theirs or part of their role. Against this background Hochschild began testing and exploring her ideas on the manipulation of emotion and feeling through the distribution of questionnaires to 261 students in the University of California. She began to unearth the private emotional system in which feelings can be changed to suit the situation or the situation changed to fit the feelings. Emotional labour was brought into play to address the dissonance between what is felt and what is expected and to comply with 'feeling rules', socially situated norms of feeling and expression. These could constitute for instance being sad at a funeral or happy at a celebration. She uncovered a sense of 'will' in relation to feelings and examples of where feelings had been wilfully induced or suppressed to coincide with expected feelings. Hochschild said that in personal interaction there is a "gift exchange" in which "we bow to each other not only from the waist but from the heart" (Hochschild, 2003, p.76).

Hochschild (1983, 2003) proposed that emotional labour involved the induction or suppression of feeling to create in those around a desired feeling such as gratitude, fear and comfort. Hochschild (Ibid) described processes for feeling management involving two strategies she terms surface acting and deep acting. The former is confined to changing the external display whilst leaving true internal feelings unchanged. The latter, deep acting however necessitates efforts to change and alter what is felt internally through strategies such as empathy, imagination and emotion memories. Emotional labour involves the

work and effort needed to hide or change feelings at the personal level to meet externally imposed expectations for feeling.

Hochschild (1983, 2003) is best known for her efforts to extend her initial theory of emotional labour beyond the private emotional system and into the public, commercial setting of the airline industry and specifically Delta airlines. She focused her efforts on the emotional labour undertaken by flight attendants and debt collectors to create differing feelings at different points amongst airline passengers and company debtors. For flight attendants it was gratitude and pleasure and for company debtors it was fear and humiliation.

Much of her research attention focused on flight attendants and their work. Hochschild (1983, 2003) spent time interviewing flight attendants in the course of their work and observed the company's initial and recurrent annual training aimed at inducing flight attendants to 'smile', irrespective of how the passenger behaved and how they felt about it. The flight attendants were encouraged to apply the private emotional system to the public setting and to imagine that the cabin setting was their living room in which they were entertaining friends and family.

Deep acting was encouraged when dealing with rude, demanding and demeaning behaviour by passengers, with flight attendants advised by trainers to use empathy and to view the passenger as a child. Hochschild (1983, 2003) draws on Darwinian and Freudian conceptualisations of the signal function of emotion in creating anxiety and protecting and alerting individuals. She argues that "from feeling we discover our own viewpoint on the world" (Hochschild, Ibid, p.17). Hochschild (1983, 2003) argues that through deep acting strategies Delta training interfered with the important signal function of emotion. Flight attendants were encouraged in training to reappraise the stressor and to override their instinct. Utilising a Marxist view of worker exploitation at the hands of capitalism and the goals of financial profit, Hochschild (1983, 2003) argued that this manipulation of feeling would lead to the estrangement between the worker and their true feelings and raises questions concerning the degree of influence work should have over its workers.

In providing a personalised service to the customer who was taken to be not "...always right but he's never wrong" (Hochschild 1983, 2003, p.108), flight attendants were encouraged to be submissive, tolerant and selfless in endless pursuit of keeping the passenger happy. Flight attendants were in effect if taken to its completion emotionally defenceless against the 'irates'; the term used for a difficult or abusive passenger. Hochschild (1983, 2003) undertook her study of Delta airlines in the early 1980s and against a backdrop of significant changes to the economic landscape of the industry from the 1930s heyday of growth, wealth, small passenger numbers, good staff customer ratios and a particular type of passenger, to the 1960s and 70s. Economic recession and deregulation saw increased competition, greater passenger numbers and workload without a concomitant increase in staff. This is captured in her use of metaphor for the change from "…a cruise ship to a Greyhound bus" (p.124).

Hochschild (1983, 2003) highlights the implications of these changes for emotional labour of the flight attendant and the quest to maintain the promise of a personalised service with a genuine smile. She describes the reality of a "smile war" and the more frequent use of surface acting where a "thin crust of display is offered" in which "their smiles were on them but not of them" (p.8). Hochschild (1983, 2003) provides an insightful theory of emotion as part of workplace labour; the first of its kind to publicly recognise this less known component of work. She asserts that emotional labour is "a dimension of work that is seldom recognised, rarely honoured, and almost never taken into account by employers as a source of on-the-job stress" (p.153). She makes a case for the effective manipulation of workers' emotion in the pursuit of commercial gain and financial profit. Hochschild's (Ibid) argument is fuelled by the concept of Marxist exploitation and the subordinate and powerless worker and questions the right to interfere with emotion and the potential cost of this to the worker. Hochschild's (1983, 2003) theory of emotional labour is as such seated within the context of a particular social and commercial backdrop with associated expectations and demands on the workers. This offers a basis for comparison and potential transferability and applicability to other contexts however, this needs careful consideration.

Delta airlines was a company specifically chosen to exemplify the point Hochschild (1983, 2003) was trying to make and the case for the deliberate manipulation, commodification and commercialisation of human emotion in the interests of company profit. Delta airlines were a family-owned company with a long and reputable history in the airline industry in which they were renowned for quality and attention to customer service for which they had received awards. This context and expectation create a particular set of circumstances which acts as a benchmark rather than a specific fit for other comparative public service settings. When comparing differing contexts of emotional labour, it is necessary to recognise differing expectations and requirements of emotional display and feeling rules. It is also necessary to consider the wider infrastructure and organisational culture which instructs, monitors, rewards and punishes staff on emotional display rules. Delta instigated a range of strategies from initial and recurrent training, 'suggestions' for anger expression to instil and maintain these company expectations. The idealised flight attendant is informed by the "male gaze" (Mulvey, 1975), whereby the female is viewed (in this case metaphorically), through the lens of the heterosexual male with accompanying emphasis on sexualised physical features, female passivity and subordination. Stereotypical gendered traits appear to have been capitalised on in a commercial context in which passengers were often wealthy businessmen and flight attendants were young, physically attractive females (Hochschild, 1983, 2003). James (1992) also highlights the gendered underpinnings of emotion work as the domain of women, an extension of the caring domestic role, unskilled and subordinate to men's external, workplace skills and role.

Hochschild (1983, 2003) regales us with the details of company influence and rules for emotional display and the occupational socialisation which upholds and maintains it at Delta airlines. The details of context are crucial to the story and our conceptualisation of the whole picture and also serve as a

basis for determining similarity or dissonance to other contexts and roles and the implications this may have for the specifics of emotional labour within them.

It could be said that Hochschild (1983, 2003) had chosen an exceptional setting for her research study, one which she says herself "gives a sharper point to the general case about emotion work in public life" (p.13) and "an exaggerated case" (p.14) in which there was a high demand for the "trained management of feeling" (p.14). Indeed, she recognises and asserts this as part of the justification for selection of the setting; she states Delta airlines with its ethos, the absence of a workers' union offers a suitable example to illustrate and perhaps more, to underpin and support the exploitation and its potentially damaging effects, the very point she is keen to make.

Hochschild (1983, 2003) draws on a variety of theories to inform and support her conceptualisation of emotional labour and in some areas to fuel her concerns about the emotional exploitation of the worker and their emotional sequelae. The impact of an underlying Marxist philosophy of exploitation and the outcome of estrangement from the true self is the point Hochschild is keen to make and is one perhaps overly laboured. She highlights that when the private emotional system is transmuted into the public sphere and is put to commercial use it poses a greater risk to the dissonance between the true self and the public self. She repeats this assertion at points but fails to really convince as to why the threat in a commercial setting is so great and to strongly evidence the dissonance she foretells.

Hochschild (1983, 2003) offers a theory of emotional labour, albeit in a particular context and commercial culture which begins to shed light on a hitherto invisible though crucial dimension of public service work. Whether the point she is at pains to make on estrangement is as valid as she argues is a point to make, however she postulates the potential costs of this work to the worker and the integrity of the self. In other professional work contexts without the perhaps heavily instructive recipe for feeling rules in Delta airlines, there is as Hochschild (1983, 2003) says a reliance on self-management and the adherence to professional codes to guide emotional display.

The setting for Hochschild's (1983, 2003) study has a clear focus on service and how this is manipulated for commercial enterprise. In a health care context, the service is a part of care giving and the three criteria for work requiring emotional labour; face to face or voice contact with the public, expectation to create a particular response in another like gratitude and training in emotional display (Hochschild Ibid), resonate with the demands of the public health service. Emotional labour has received research attention in the health care literatures (for examples Bolton, 2000; James, 1989, 1992; Maunder, 2013; Riley &Weiss, 2015; Smith, 1992).

Smith (1992) explored the emotional culture of nursing from the perspective of student nurses and utilised Hochschild's theory to interpret her findings of the emotional labour of nursing, serving to expand its applicability to health care service. Smith (Ibid) describes the emotional challenges of human

caring in the face of illness and death, particularly demanding patients and a harsh work setting in which students were at times shouted at and unsupported by ward sisters, necessitating the suppression and induction of feelings to create an appropriate emotional display.

James (1989), in the palliative and end of life care setting described emotional labour as the complex, interactional and interpersonal work of responding to the emotional needs of patients. She used descriptors such as sad, lonely and difficult to convey this type of work which was predominantly performed by auxiliaries who had more time and closer personal relationships with patients. James (1989, 1992) concluded that despite its invisibility emotional labour; the work of caring for others' emotions is a key component of what nursing is. Similarly, other nursing conceptualisations of emotional labour have portrayed the caring efforts to meet the emotional needs of patients and sometimes families. For example, Bolton (2000) describes "gifts" (p.580) offered by nurses to bereaved parents after miscarriage and late termination of pregnancy. Gifts included making handprints and footprints and humour. These nursing conceptualisations reflect professional and contextual nuances in emotional labour as part of a caring, authentic response to human suffering and hard work on the emotions of self and others. These nursing conceptualisations suggest emotional labour is hard, skilful, interactive, personal caring and purposeful authentic exchange.

The complexity of emotional labour is captured in a review of literature in health care contexts (including nursing, midwifery, para medicine and medicine), where various dimensions of this complex concept emerged (Riley & Weiss, 2015) including professional, gender, organisational and cultural elements. Other key aspects relate to the management of personal emotions and the importance of support and supervision for staff (Riley & Weiss, 2015).

Emotional labour and emotion work in the pre-hospital care context has in recent decades, received research attention (Boyle, 1997, 2005; Henckes & Nurok, 2015; Williams, 2013a & b), this will be explored in the next section.

2.3.3 Emotional labour and emotion work in the EMS

Emergency pre-hospital care exposes practitioners to a range of challenging and traumatic experiences which can evoke a myriad of emotions in themselves and their patients. For example, practitioners report frustration, empathy and compassion (Clompus & Albarran, 2016) and must deal with anxiety, fear and panic in patients who are suddenly ill (Togher, O'Cathain, Phung, Turner, & Siriwardena, 2014). Emergency pre-hospital practitioners are central to the frontline health care service. Emotional labour and the maintenance of an appropriate emotional display or 'front' is an important matter in emergency practice (O'Neill, 2001). The work of the EMS is often undertaken in public settings under the public gaze (O'Neill, 2001) and emotional control and display are considered prerequisites to its performance. However, despite its importance there is a paucity of research on emotion work in

emergency pre-hospital care specifically and what is available is diverse, often small scale and from differing geographical settings such as Australia, Norway and the UK (Boyle, 1997; Henckes & Nurok, 2015; Filstad, 2010; Steen, Naess & Steen, 1997; Williams, 2013a & b), which may suggest it is taken for granted. Nevertheless, these studies show aspects of emotional labour in responding to the emotional needs of patients, the need for the control and suppression of emotion and emotional distancing and the challenges of this amidst an organisational male dominated culture characterised by traditional hegemonic masculinity which may deter the expression of emotion (Boyle, 1997; Steen et al; 1997).

One of the most comprehensive insights into the emotional culture of the ambulance service is offered by Boyle (1997), who used an ethnographic approach and Hochschild's (1983) concept of emotional labour to explore emotionality across seven ambulance regions in Queensland, Australia. Boyle (1997) undertook 500 hours of participant observation with emergency crews across the regions and 30 in-depth interviews. Emotional labour was perceived as the management of the emotional interaction between the patient and paramedic in the provision of care. However, Boyle (1997) also emphasised the emotion management needed after the interaction which she argued is crucial to emotional performance in the frontline interaction. Goffman's (1959) front stage, backstage and off-stage regions were used by Boyle as a framework on which to base her study and its findings.

Boyle (1997) reported that paramedics considered emotional labour and putting on a display to cover their true feelings to be a positive and important part of the job, which they frequently used. Surface and deep acting strategies were often employed by paramedics to manage their own emotions and to maintain an appropriate professional demeanour. Surface acting emerged with disgruntled patients and the elderly when negative feelings were suppressed, and positive feelings expressed. Smiling, teasing and light humour were used to disguise the negative feelings which emerged after the interaction. Boyle (1997) thus found that surface acting was as a key feature of paramedic emotion work as public service work, implicating the relevance of Hochschild's theory (1983) to the EMS context.

However, Boyle (1997) found the need for a greater amount of deep acting in paramedic practice. Deep acting strategies unlike surface acting focus on changing feelings towards a situation or person through reappraisal (Hochschild, 1983). Paramedics highlighted the need to maintain an emotional distance between them and the patient which enabled them to cope, and Boyle (Ibid) suggested deep acting strategies included viewing the patient as a thing or object rather than a person. They described the use of a "veneer" (p.177) to allow the suppression and denial of emotions and the presentation of an affectively neutral, professional appearance. The objectification of the person served to prevent emotional attachment and was precipitated by high levels of stress and emotional exhaustion which may also be indicative of occupational burnout (World Health Organisation, 2019), although Boyle (1997) does not discuss this possibility. Deep acting was threatened when there was a resemblance to family

members or someone close which could be a reminder that this is a person and threaten their ability to manage their personal emotion.

Drawing on Thoits (1985) concept of emotion processing work, Boyle (1997) also captured the work needed after the face- to-face interaction, where emotions are processed by the professional. Back stage regions include base stations or truck stops or wherever the paramedic is not involved in frontline interaction. Boyle (1997) described the use of rapid speech patterns, the telling of "war stories" and the use of black humour but could also include formal education on the signs of post-traumatic stress disorder. She set the study within and against the organisational and cultural backdrop of the EMS; the prevalence of a traditional hegemonic masculinity which she said proscribed the expression of emotions in the work context, particularly the backstage setting and as such effectively deferred these to the offstage setting of the family and home.

The cultural, professional and geographical setting of Boyle's (1997) study collectively contributes understanding of emotion work, gender and masculinity in an Australian context which may resonate with a UK context. She reports a male dominated workforce (90%) which has also been a tradition in the UK ambulance service (Craggs & Blaber, 2008; NHS The Information Centre for Health and Social Care, 2011; WAST NHS Trust, 2009). Latest figures indicate an increasing number of newly qualified females in EMS work although overall the greater proportion is still male (WAST, 2019). The implications of these gender differences for emotionality and emotion work in the EMS context would necessitate further research in a UK setting.

Further understanding of emotion work in the EMS and the organisational culture was provided by Steen et al. (1997) in a study of 33 paramedics in Oslo, Norway who in interviews about decision making surrounding resuscitation spontaneously described important aspects of their work the most important being the care of relatives. 24 of the 33 paramedics described spending time, listening and talking to relatives. However, despite the importance and value of the caring role, Steen et al. (1997) also found that these paramedics did not share or discuss this aspect of their role with each other. Caring was therefore presented as a basic but also tacit assumption, which Steen et al.' (1997) attribute to features of the organisational culture. They highlight the lack of explicit and external valuing of caring manifest by its absence in paramedic educational curricula and in paramedic literature and the existence of a "male coping culture" (p.60). Steen et al. (1997) suggest the expectation to be a coping male is learnt at an early stage through the process of occupational socialisation and thus becomes a basic assumption. Consequently, interaction between these professionals remains superficial and comfortable. Whilst interesting, it is however important to note that the explanations offered by Steen et al. (1997) are not directly or explicitly drawn from the paramedics themselves nor have they emerged from a comprehensive ethnographic study of organisational culture. Nevertheless, Steen et al. (1997) contribute further evidence of features of the organisational culture within the ambulance service and

the existence of a dominant, stereotypical masculine image characterised by stoicism and self-control. The existence of traditional male gender stereotypes was mirrored in Boyle's study (1997) who argued that organisational recognition of emotion work would necessitate acceptance of multiple masculinities and a challenge to the normative hegemonic masculinity prevalent in paramedical service.

The importance of emotional control in frontline emergency time critical situations was reported by Williams (2013a), in a study involving interviews with 8 undergraduate paramedic science students in a Higher Education Institution in the UK. Getting on with the job emerged as a priority and emotions had to be suppressed and controlled through surface acting strategies. Students portrayed their mentors as important role models in managing and hiding emotion effectively which the students perceived as essential to do the job. Deep acting and depersonalisation were also evident, where the patient was seen as a job or task rather than a person. These findings reflect the nature of emergency paramedic practice and the need to suppress and control emotion highlighted previously (Boyle, 1997; Filstad, 2010). Emotional labour also arose in responding to the emotions of patients and relatives and the students reported difficulty and uncertainty in how to respond to others' distress. The students described having to suppress their own emotions at times, particularly where there was a personal link to them like a resemblance to a family member and as such implicate the challenges of dealing with both personal emotions and the emotions of others.

The students also described the strategies they used to deal with the emotional demands of practice after the event which included talking and humour (Williams, 2013b). Talking involved partners, family, work colleagues and the clinical mentor, however the focus during these interactions was different. Talking with close family and partners was more likely to involve emotions and feelings. Students also valued talking through the experience with their clinical mentor, which although focused on the technical aspects of care, did impact on their feelings. The students reported feeling reassured that they had done the right thing and their best in the situation despite the clinical outcome (Williams, 2013b). The study is small scale and confined to one educational institution in the UK which limits transferability beyond the context of the study. However, it offers insights into the nature of emotional labour and the emotion work undertaken by students in managing their own and others' emotions in frontline paramedic practice. Evidence of the backstage and off-stage emotion work is also revealed through the strategies involving talking and humour. However, the study also yields some further tentative insight into the cultural and professional attitudes towards emotional expression in the ambulance service and the need to control emotion highlighted previously (Boyle, 1997; Steen et al; 1997).

The above studies into emotional labour in the context of the EMS offer understandings of the challenges inherent in frontline care delivery and the needs of patients, their relatives and the work needed to provide this. There is also evidence of the need to manage and suppress emotion and the

added challenges of these demands in a cultural context which has been traditionally male dominated, with particular views of masculinity and the control of emotion.

Emotional labour in health care arises from the interaction and interpersonal exchange between the professional and service recipient which may be impacted by how the former perceives and appraises the latter and the perceived legitimacy of their need for care and the nature of work required. Little attention has been given to the potential effects of the specific nature of work and work appraisal and the implications for emotional labour and emotion work in the EMS context. These will be explored in the next section of my review.

2.3.4 Work appraisal and categorisation in healthcare contexts

The concepts of appraisal and categorisation of work by health care professionals in the context of health care services are by no means new phenomena. On the contrary these are well established with research attention developing and refining understanding of the complexity and features of its application and implications (Becker, et al; 1961; Dingwall & Murray, 1983; Hillman, 2013; Roth, 1972).

One of the earliest understandings was offered by Becker et al. (1961), who in a study of the occupational socialisation of medical students showed how they categorised patients in differing ways based on an eclectic mix of professional, social and personal values. Attitudes from student culture and evaluation indicated a valuing of 'interesting cases' which contributed to their learning about disease pathology. This was in direct comparison to "crooks" (p.137) who were patients not perceived to be physically ill, who did not need medical care and were not regarded as worthwhile to the students. Patients were subject to judgements based on social class and the more desirable patients to have and comments made about those who could not pay for their care and were perceived to not deserve treatment. The study shows a concoction of values drawn from social, moral and professional sources which potentially impact on how patients may be appraised and viewed by health care professionals. Although these sources are speculative and set against American health care culture and systems at a particular time, they nevertheless offer understandings of how patients are positioned by these professionals and the influences on their valuing, appraisal and categorisation of their work.

Labelling and categorisation of those who access the health service were also identified by Roth (1972) in a study of health care professionals in the accident and emergency setting; the gateway to the health service and a significant point for this to commence. Roth (Ibid) begins with the assertion that professional health care education does little to reduce the tendency of service providers to judge, categorise and label those seeking to use the service; an assertion he endeavours to justify. He describes processes involved in the assessment and labelling of patients by different levels of staff including receptionists and clerks and the strategies employed by them to control access to health care services.

He like others (such as Hillman, 2013) however, also describe the patient categorisation process to be a complex, non- linear and negotiated one based on assessment, interaction and self-presentation between staff and patients themselves.

Hillman (2013) contributed a more contemporary understanding of the process of patient categorisation in an ethnographic study in an A&E setting of a large university teaching hospital in the UK over a 4-year period of observation and informal and formal interviewing of staff, patients and relatives. Thematic analysis is reported with reflexivity and respondent validation to enhance trustworthiness in the study. Her study describes and exemplifies the process by which A&E staff, elderly patients and their relatives negotiate their allocation into staff constituted categories which have positive and negative associations, and which influence access and treatment in the emergency setting. Hillman (Ibid) applies theoretical contributions on determining deviance (specifically McHugh's theory 1970) involving conventionality (appropriateness of something) and theoreticity (whether the person knows what they are doing), in her interpretation of how patients are categorised. Hillman (2013) describes the process by which A&E attendees whose legitimacy may be questioned, negotiate through self-presentation, a favourable staff appraisal which will secure their treatment.

Hillman (2013) also highlights social expectations on individuals to take responsibility for their health and well-being and the wider political changes from government to individual level (McDonald et al; 2007). She examines the fragile concept of legitimacy which she says is never assumed and one which increasingly must be demonstrated by service users. She highlights the key role of A&E staff and other 'gatekeepers' to the health service and how organisational demands, costs, rationing and appropriateness of use are integral aspects of staff' clinical processes and decision making. She also in her discussion reflects on the wider health care context and rationalisation of treatment in A&E to acute illness and the underpinning change from the traditional values of the NHS (Russell & Greenhalgh, 2012) of "universality and comprehensiveness" to "affordability and rationing" (p.12). Against this background patients she argues, may be increasingly expected to not simply expect treatment but to have to justify their need and legitimacy for it.

Although focused specifically on the elderly and one A&E setting, which limits transferability, Hillman (2013) furthers understanding of the interactive and negotiated process by which elderly patients contribute to their categorisation by A&E staff and ultimately determination of legitimacy and access to care and treatment. She sets her interpretation within the wider economic stringency of health care service, changing social expectations and increased demand and the implications for those who are at the forefront of determining access to finite resources. She makes transparent the wider factors which help to comprehend the origin and motives behind staff determination and categorisation of patients as legitimate and not legitimate and the role patients play in negotiating the decision making of health care professionals.

The concepts of the categorisation of health care work and legitimacy are applicable to the context of pre-hospital care and to these emergency health care workers as veritable gatekeepers to the health service. This will be examined in the next section of my review.

2.3.5 Call appraisal, valuing, categorisation and legitimacy and the implications for emotional labour in the EMS context

The concepts of call appraisal, valuing, categorisation and legitimacy are features of emergency pre-hospital health care culture (Hutchinson, 1983; Mannon, 1992; Metz, 1982; Nurok & Henckes, 2009; Palmer, 1983).

Hutchinson (1983), in a study of American rescue workers including fire and emergency ambulance service described how they managed the uncertainties of their work through clinical decision making and social processes of "casing out", "categorising" and "disposing" (p.xiv). She collectively described the process of "covering" (xi); an attempt to avoid potential negative consequences. Through her fieldwork and participant observation with emergency crews, she unearthed features of categorisations involving those perceived to be legitimately ill as opposed to those considered malingerers. Hutchinson (Ibid) reports emergency workers must be "attuned to real emergencies" (p.68) and as such are involved in the differentiation and categorisation of "emergency or non-emergency, self-induced or accidental, legitimate or non-legitimate" (p.68). She also describes the valuing of types of typical emergency work that these professionals are trained to respond to. Hutchinson (Ibid) asserts that "emergencies supply the exciting, dramatic and heroic part of their work" (p.68), recognition and praise from others and offers testament of skills and the ability to deal with stress by these workers. As such her research adds further to the historical nature and process of emergency rescue work, how it is managed, the differentiation of calls and some explanation for the underpinning valuing of medical emergencies which offer opportunities to apply their skills and gain sought after recognition from others for "snatching another victim from the jaws of death" (p.68). As such Hutchinson touches on the emotional impacts and rewards of what is considered 'real' emergency work.

The historical valuing of emergency work amongst the EMS is further endorsed by Palmer (1983), who using an ethnographic approach explored the work-related concerns of paramedics and EMTs in an EMS organisation in the USA. Himself an EMT, using participant observation, interviewing and documentary analysis Palmer (Ibid) describes the demarcations and categorisation of EMS work into "211s" and "pukes" (p.167). 211s are calls which require two ambulances where there may be multiple traumas and the need for technical and lifesaving skills and "pukes" are calls to minor health problems, where there may be pretence of illness, exaggeration and no need for an ambulance. 'Puke' is a local descriptor relating to the call and the caller which imputes a negative appraisal. Puke calls evoke frustration amongst EMS crews and may be subject to rougher handling, quick handover and negative appraisal reflected in comments such as "let's hurry and wash our hands of this guy and get clear"

(available for another call) (Palmer, 1983, p.170). These calls are perceived to prevent crews responding to "real" calls (p.162), the "211s" conceptualised as exciting, important, offering crews the opportunity to use their skills and experience positive psychological and physiological effects. These are positively categorised by crews as "the good runs" (p.163). The researcher is an EMT and reports that some data were collected as part of certification for this role, however the potential impact of his close positioning (or 'insider' status) to the subject matter of the study, its context and culture are not considered or addressed, creating a potential blind spot. Palmer (Ibid) also uses the terms EMS, EMTs and paramedics interchangeably without clear differentiation even though these have differing meanings and roles.

Despite these potential limitations of the study, Palmer (1983) sets the scene for the historical valuing of types of work amongst EMS staff. Those which are associated with "advanced lifesaving, rescue, and medical skills" (p.162) are highly valued, validate their role and are thus sought after fuelling his description of EMS crews as "trauma junkies" (p.162). Their role has historically and typically been focused on life-saving interventions and is validated through exposure to this type of work. Their role perception therefore shapes their valuing and pursuit of types of work and what may be considered legitimate or "real" work (p.162) which serves to "maintain positive occupational self-images" (p.164).

The EMS' valuing of certain types of work has implications for their perception and appraisal of work which is other or not of the typical 'emergency' calibre where their advanced skills can be put to good effect. One such type of work involves dealing with those with mental health and behavioural problems such as substance abuse. Prener and Lincoln (2015) examined the experiences and attitudes of EMS staff to calls involving mental health problems and substance misuse which were collectively described by them as "psych calls" (p.612). The study was set in one busy, urban, private EMS agency in the USA using participant observation (one of the researchers is an EMT) and semi-structured interviews and produced four themes relating to types of calls, system abuse, structural factors and consequences of abuse. EMS crews (20 in total) described difficulties in responding to calls for mental health problems due to lack of knowledge and skills and related frustrations in undertaking transfers of patients between health care facilities which required transportation only. Whilst differing views were reported amongst the EMS, some perceived these calls as abuse of the system (particularly from the homeless who were perceived to simply want to be inside when the weather gets bad). Crews expressed the view that mental illness was not the responsibility of the EMS and some considered it not serious and not worthy of the provider's time (p.617). Conversely attention was given to physical illness and sick people as legitimate emergency work, reflecting the educational process and narrow view of emergency care.

Some crews questioned the legitimacy of "psych" calls further in portraying this work as a barrier to dealing with calls they perceive as "real emergencies" like sick children and cardiac arrests. Prener and Lincoln (2015) also hint at the implications this may have for the interaction and care offered by the EMS in these differing situations but stops short of asserting what this might be. However, one

paramedic questioned why they had to be "nice" to the homeless when they were perceived to be abusing the system and other crews expressed difficulty in managing their demeanour when faced with what they considered to be abuse of the emergency service, hinting at the need for emotional labour. Crew' responses to these types of calls and callers are suggested to be tools of socialisation aimed at discouraging use of the service. However, the backdrop of increased health care need and expansive models of service necessitate understanding of how this type of work is perceived and understood by EMS professionals (Prener & Lincoln, 2015) and the implications this can have for the quality of care they offer.

The study (Prener & Lincoln, 2015) includes little explicit attention to the positioning of one of the researchers as an EMT, the implications for the research process and its findings and the measures taken to minimise these. This presents a potential limitation of the study in representing the views of participants, a feature of trustworthiness (Lincoln & Guba, 1994). The collective local labelling of these calls as 'psych' which includes mental health problems and substance abuse creates difficulty in differentiating attitudes towards these individually. The study is small scale and centred on one American EMS setting which limits transferability to other settings, however it does highlight the differing valuing of certain types of EMS work and hints at the implications this may have for interaction with users of the service.

From a metasynthesis of existing qualitative research on professional perceptions of dealing with self-harm, Rees, Rapport and Snooks (2015) reported the influence of a number of factors involving paramedic' role perception, their perceived skill set, the effectiveness of interventions and their priorities of care, amongst other things. Higher value was given to medical need in comparison to mental illness which influenced judgements of legitimacy and non-legitimacy. They highlighted further evidence of the specific culture and valuing of paramedics towards life threatening technical interventions which they see as their priority. In relation to self-harm, it was reported that paramedics see their role as one which involves technical interventions that save and sustain life, but the underlying psychiatric interventions are perceived to be "outside of their skill level" (p.533). This is a secondary analysis of others' research which can invite criticisms of biased selection and inclusion of literature (Harvey & Land, 2017). However, Rees et al. (2015) utilise a systematic and transparent approach to the selection, retrieval and inclusion of pertinent literature based on identified criteria.

Rolfe, Pope and Crouch (2020) provide further, contemporary understanding of EMS work, their changing frontline role, the challenges this creates when dealing specifically with patients with mental health problems and how these are managed. 240 hours of observation and interviews with 21 paramedics were undertaken in one English ambulance trust. Trustworthiness was reported using reflexivity, member checking and researcher triangulation. Goffman's (1959) dramaturgical framework involving front stage and backstage contexts and impression management were used to analyse and

present how paramedics handled these types of calls. Front stage performance included the value of 'props' such as uniform, humour and stereotyping as ways of coping with the challenges of this work, their uncertainties and frustrations influenced by lack of preparation for dealing with these types of need. Rolfe et al. (2020) highlight the frustrations amongst this professional group fuelled by a lack of educational preparation to deal with mental health problems and a traditional historical emphasis on biological, physical health as "true emergency calls" (p.3). Backstage contexts involved the use of nostalgia and emotional expression without the public audience however the long-term efficacy of this as a coping mechanism is questionable.

Against the backdrop of the changing role of the EMS, the lack of educational preparation in dealing with people with mental health problems, these researchers highlight the implications for the management of emotion and "impression management" (Goffman, 1959, cited in Rolfe et al; 2020, p.4) in front stage performance to an audience. However, the study hints at but stops short of evidencing the specifics of the emotional labour which appears to be increasingly needed in this public service work when dealing with those with mental health problems.

Valuing of certain types of emergency work is also reported by Nurok and Henckes (2009), drawing on fieldwork with EMS crews in Paris and New York. They suggest that valuing of types of work is influenced by a range of complex factors related to the professional and what the call my offer them. They propose that valuing has temporal and evolutionary features to it which they capture in the terms "fluctuating economy" (p.505). However, amidst these fluctuations they say valuing is attributed to work which requires technical skills and the heroism which is associated with resuscitation and that 'real' emergencies are rare and are sought after. Nurok and Henckes (2009) refer to "technical value; the priority of action" (p.506) and the emphasis and value associated with doing something and demonstrating expertise in this context. Alternatively, situations where advice or transport is needed deny professionals these opportunities to do. Work which draws on their technical skills also have emotional sequelae, they are "the cases that they remember most vividly and which they recall in order to valorize their skill" (p.507). There are similarities with technical work and resuscitation work where the latter offers the opportunity to save a life, to demonstrate mastery and to gain external praise and recognition from others. Nurok & Henckes (Ibid) describe this as "directly attributable to the visible action of the emergency services" (p.508).

Nurok and Henckes (2009) investigate two health care systems of EMS provision which are different in their levels of autonomy and expertise and in the roles each of these can potentially adopt. In Paris the service is physician led and the model of care much wider with opportunities to deliver more on-site interventions and in New York it is staffed by paramedics only, where speedy transport is the model of care, the latter being more akin to the UK system. However, despite these role differences and the

potential implications there is no explicit consideration given to this and the sample and findings are presented in a homogenous fashion. The study lacks detail on the specific approach to the analysis of data and the coding and there is no discussion of the impact of the researcher's presence in the field or actions aimed at demonstrating trustworthiness, which raise questions about its rigour. This is of particular significance given that the researcher, Nurok is a physician. Nurok and Henckes (2009) however offer insights into the professionally sourced factors which impact on how work is valued by the EMS and the varied contingencies which are brought to bear in a particular situation at a particular time. Contingencies relate to social, technical, medical or surgical, intellectual value, heroic and competence features, meaning for example that work may be valued because it offers opportunity to develop competence. They propose a more complex pattern to work appraisal and the potential nuances of this. It offers further support for the valuing of certain types of work which are mirrored by other studies of the EMS and its culture above and suggest that the "case-based values" in the context of EMS collectively are reflective of the "emergency medical mentality" (p.509). As such although the basis of call appraisal is suggested to be a "fluctuating" one the core value appears to centre on the use and mastery of technical skills including lifesaving and resuscitation.

More contemporary literature (Wankhade, 2016) also reflects the traditional valuing of certain types of emergency work in the EMS and the challenges it faces in changing and developing to meet the current and future demands of emergency health care. Wankhade (Ibid) highlights the current challenges and 'turbulence' experienced by the emergency ambulance service in the UK attributed to a composite of role changes, complex and increased service demands, imposed target times and significant educational developments including moves towards an all-graduate profession in the context of its historical and cultural origin. Through an ethnographic approach Wankhade (2016) explores perceptions of staff to the above changes, including frontline, middle and top management within one ambulance service setting the England. The implications for patient safety associated with alternative models of care and for the stress and well -being of staff are also examined against the evidence of higher-than-average levels of staff sickness and attrition. Wankhade (Ibid) reflects on the historical values of this occupational group which have traditionally been associated with the emergency response and transport to typical emergencies where their technical skills can be used to one which increasingly requires complex decision making and alternative patient disposition than speedy transport to ED. He summarises the transition in service from "... being seen as an emergency service wearing uniforms and driving with lights and sirens (fast response) against the emerging role and expectation of being a clinical efficient pre-hospital care provider" (p.128).

Wankhade's (2016) findings highlight aspects of role valuing within the emergency ambulance service wherein staff report not valuing attending calls for minor health problems and leaving patients at home. Contrasts are made between the increasing reality of the EMS role and the expectations of those entering

the profession and the attractiveness of media portrayals of exciting emergency ambulance work and the implications for staff disillusionment on realisation of its reality. The study also draws attention to the current approaches to the assessment and triage of calls by staff with no clinical expertise and the implications of this for the calls to which the EMS respond. Examples are given from Wankade's non-participant observation with EMS crews involving an elderly man who was frightened and did not want to be on his own and another call to someone who needed a replacement respiratory inhaler. These suggest problems at an organisational and operational level within the EMS which were said to create "a notable source of strain on staff and organisation" (Wankhade, 2016, p.136).

Methodologically there is a lack of clarity and detail on the numbers of staff involved in the study, how these were selected, and the process of data analysis used by Wankhade (2016). In addition, there is little detail on attempts to enhance trustworthiness and there is no mention of reflexivity by the researcher which can impact on confirmability and credibility of the findings. The findings are rather diffusely presented with no clear themes and only a small amount of data used to exemplify and support the points raised which is disappointing for a qualitative research paper. The study is situated in one ambulance service trust in the UK which may limit transferability to other contexts. However, the wider contextual backdrop of increased demand, role development, the nature of health care need, role expectations, historical influences and traditional models of pre-hospital care are to some extent generic and as such the findings and implications have applicability beyond the study setting.

The above literatures show the traditional valuing of certain types of emergency work and touch rather lightly on the emotional implications for those who deliver the service, however there is little specific and explicit detail on the emotional labour which may be instigated by differing role demands and changes to an alternative model of emergency care. There appear to be suggestions that role changes pose a challenge for the emergency ambulance service which may imply the need for emotional labour as an accepted part of this.

Public use of the emergency ambulance service and questions regarding legitimate use, particularly given traditional models of care delivery and the implications for professional identity, are a potential source of frustration for EMS crews which may impact on the need for emotional labour. However, insights into the process of decision making to call an emergency ambulance have the potential to furnish EMS professionals with alternative interpretation and appraisal of some aspects of their role and the emotional labour needed to deliver it.

2.3.6 Public perception of need for an emergency ambulance

The public use and perceived misuse of the emergency ambulance service has sparked research interest in recent times amidst increasing demands for health care provision (Kirby & Roberts, 2012). Kirby and Roberts (2012) highlighted the problems with the inappropriate use of the EMS and the implications

this may have for the safety and response to other emergency calls. An online survey received 150 responses to a questionnaire containing 12 vignettes of different health related situations such as stroke, chest pain and labour with a question as to whether an emergency ambulance was needed. The testing instrument used implicates commonly understood and non-contested facts about when to call an emergency ambulance which itself predicates commonality and oversimplifies the complexity of health care need. More correct responses were made in situations of clear emergency such as sudden chest pain than those which were for non-life-threatening conditions such as abdominal pain. There were more errors in responses to situations considered to not require an ambulance, perhaps suggesting the differentiation may be more difficult in these complex areas of decision making without healthcare knowledge and experience. Those with first aid training in the sample were more able to correctly identify when an ambulance was not needed. The findings of this study also draw attention to the variations which accompany health issues and how these may alter or influence a course of action. For example, someone who is intoxicated which would not necessitate an emergency ambulance however, accompanied by a state of unconsciousness it would. These exemplify the potential complexity of decision making in situations of sudden illness, what knowledge can be reasonably expected of the public and the importance of clarity in the information and education of those who use the emergency ambulance service. The study tests knowledge in a hypothetical context without the potential complexity of this process and the individual factors which may impact at a time of potential panic, stress and anxiety. In addition, the online survey draws on a convenience sample of family, friends and others via a snowballing technique which although readily accessible, accompanies poor representation and prohibits generalisation beyond the sample (Harvey & Land, 2017).

Insights into the public use of the emergency 999 ambulance service have been examined from the perspective of those calling and offer rationales which reflect alternative interpretations of need and individual appraisals of challenging situations for patients, carers, relatives and the primary health care team (Ahlenius, Lindstrom & Vicente, 2017; Booker, Purdy, Barnes & Shaw, 2019; Rantala, Ekwall & Forsberg, 2016).

Booker et al. (2019) used an ethnographic approach to explore the factors which influence the decisions to call for a 999 ambulance in one ambulance setting in the UK. The study focused on cases or examples of calls to situations in which the health issue could have been resolved in the primary care setting of the community without the need for an emergency ambulance. The data consisted of 50 cases which were deemed to constitute examples of PCSC or "primary care sensitive conditions" (p.11); those relating to social problems and mental health problems and prompting what were considered "less efficient use of the EMS" (p.1). The cases were selected based on clear, set criteria which were formulated by one of the authors with experience in primary care. The study draws from a range of data sources from each case including observation, interviewing and fieldnotes of cases selected and involving patients, relatives, carers and health care professionals to gather their perspectives, offering a

wide perspective. Thematic analysis led to the identification of three issues which were apparent across the cases and include "triggers" (p.1), the urgency to call an ambulance for someone else and conflict for health care professionals in increasing demand on the EMS. Individual factors were described including a timeline for seeking help which may have been exceeded, red flags or significant changes in medical condition, a feeling of being overwhelmed by the demands of the situation and feelings of social isolation. Advice from others and a change in the care provided were also suggested to prompt calls for help.

Requesting an emergency ambulance for someone else was suggested to generate a sense of urgency to call 999 and was initiated by professionals and carers for different reasons, with the former influenced by responsibility and accountability and the latter by motivation to do the best for the person (Booker et al; 2019). Professional advice was said to be vague at times, whilst some professionals were said to be advising the use of an emergency ambulance by the broad phrase "if any further problems' call 999" (Booker et al; Ibid, p.7). The findings show the complexity of factors which may come to bear on and influence a decision to call 999 and request emergency medical help. The data also presents a multifaceted framework which incorporates the individual appraisal and how individual situations are interpreted, rationalised and responded to in deciding to make the call. The impact of calling for another and the motivations and intentions of both professional and lay carers and family add another dimension to this issue and the implications for health care professionals such as GPs who are conflicted by patient demands and the pressure on the EMS. This research begins to show the complexity of decision making and the subjective appraisal and reasoning in individual situations used by the public and health care professionals. Contrary to some professional perspectives of such calls the process of public decision making appears to be informed by rational thought and interpretation of the situation by those closely involved. EMS professionals involved in the delivery of the service may not appreciate the subjective interpretation of health events and the significance these have for those who are directly and personally affected by them. This study offers a detailed 'picture' of factors which may impact on decisions to call an emergency ambulance and is presented with clarity however, it is limited to one setting and more detail could have been included on measures to enhance trustworthiness.

The experience of sudden illness, its impact on the individual and their subjective appraisal is also highlighted by Rantala et al. (2016) in a phenomenological study exploring the lived experience of patients who had called the emergency ambulance service but were considered to not necessitate care in an accident and emergency department and were downgraded to alternative care and services. Telephone interviews with 12 patients in Sweden who have received care showed the importance of how these were treated and the significance of being considered genuinely ill by the health professional involved. The study highlights the vulnerability patients experience when they are suddenly ill and need help and contemplate the decision to call for an emergency ambulance. Patients reported feeling insecure, vulnerable because they were unsure what was wrong with them. Some were isolated and

lonely without the reassurance of a companion with whom to share their concerns and relieve anxieties. When the situation could no longer be managed by the person themselves the only option was perceived to be to call for an ambulance. Attention is given to the need for the confirmation of illness from others and hence the vulnerability and powerlessness of the patient and the potentially powerful position of the professional in this encounter. The study is small scale and set in one setting in Sweden which limits transferability. However, the study highlights the subjective appraisal and need in calling for emergency help and the need for reassurance. An appreciation and understanding of the complexity, difficulty and challenge experienced by the public among EMS providers, may enable alternative appraisal of this type of emergency work.

Rantala et al. (2016) and Booker et al. (2019) highlight the subjective appraisal of the situation, the complex emotional issues which arise in sudden illness and the influence of social factors such as isolation and lack of support which collectively contribute to the decision to call an emergency ambulance. These complex factors and the emotional challenges of sudden illness are also reported by Ahlenius et al. (2017) who investigated so called "deviations" (p.25) or complaints made by patients who had received poor care from the EMS in Sweden. A total of 32 examples were drawn from three ambulance services operating in the city of Stockholm, adding some diversity to the sample. Analysis by three researchers using a framework approach enhanced the confirmability of the findings and yielded detail on the patients' experience of becoming acutely unwell; what this was like and their subsequent treatment from the ambulance staff and their attitudes. Patients vividly described the onset of acute illness and the symptoms of pain and weakness, trying to cope, feeling unable to cope, feeling ill and weak and eventually feeling there is no other option but to call an ambulance. However, against this background they reported not being taken seriously by the EMS staff, discrepancies between what they felt and how professionals perceived their illness and the absence of care. Patients reported feeling they were "objectified" (p.28) by EMS staff. The impact of this response on the individual who is dependent, powerless and vulnerable and needs the care and help of EMS professionals is collectively described as "suffering from care" (p.26). This research contributes awareness of the nature of human experience and suffering associated with sudden illness and the effects of this on the individual and the sometimes-tortuous process they endure before eventually calling for help from emergency health care professionals. The study draws on public experiences and expectations of care; to be believed and treated as human beings in a caring, empathetic and humanistic way and the consequences of this for additional suffering when these basic human needs are not met. However, the study is based in one city in Sweden and transferability to other settings is limited. The findings of the study are also dependent on accurate memory and recall of the event and the detail included in the written complaint.

Ahlenius et al. (2017) and others (Booker et al; 2016; Rantala et al; 2019) offer understanding of the vulnerability and dependency which may accompany illness, the effects on the individual and their needs. They are sobering and concerning and are reminders of the central role emergency health care

professionals play in the care and response to these patients and in the quality of care they receive. Appreciation of these factors amongst EMS professionals has the potential to enable more informed, empathetic and caring responses from them.

An issue characterising patient experience of health deterioration is their uncertainty about what is wrong and how serious it is and the concomitant need for reassurance from health care professionals (Rantala et al; 2019; Togher et al; 2014). Reassurance from EMS professionals was reported to be the most important and valued aspect of the care that was provided to patients and their relatives in response to emergency health care problems (Togher et al; 2014). This exploratory study sought the views of service users in one large ambulance service trust (East Midlands Ambulance Service) in the UK who had recently received services from the EMS and included 22 patients and 8 spouses who were involved in the call to 999. Semi-structured interviews, face to face or via telephone using a critical incident technique showed a consensus on the valuing and importance of reassurance from interactions and communication with EMS staff when patients were anxious about their condition. Reassurance was linked and attributed to features of care offered by the EMS such as communication, confidence in care, professionalism, continuity of care and a speedy response. The sample for the study (Togher et al; Ibid), included a range of medical, physical health issues and different models of response such as 'hear & treat', 'see & treat', 'see & convey', which added diversity. The sample however constituted those mostly 55 years and over and did not include those with mental health problems which limits the transferability to these groups and those of a younger age range, who are frequent users of the EMS. However, the study draws attention to the anxiety, panic and stress which accompanies sudden illness and the importance and value the public place on having an opportunity to talk to a health care professional and receive their reassurance. Some respondents also reported feeling "guilty" (p.2954) about calling an ambulance and perceiving it to be for others in greater need than them and sought the reassurance from EMS that they had made the right decision.

The study (Togher et al; 2014) contributes the perspective of the service user to the service that is expected and that is most valued and draws attention to aspects of care which include the non-technical interventions and their importance as part of the care experience. Importantly the study implicates the anxiety and panic which can accompany serious illness, the subjective experience of this situation and the need for interaction with EMS and the reassurance they offer. These aspects of care however are not those which the ambulance service have focused on or seemingly valued in their evaluations of service historically which have been target response times (McClelland, 2013).

Research literatures like the above have sought to highlight and examine the issue of perceived misuse of the EMS and some have mentioned the implications of increased stress and pressure on the emergency services at a time of unprecedented demand (Wankhade, 2016), however little attention has

been specifically given to the effect this may have on the staff themselves and what these demand in relation to front stage emotional labour and emotion work.

EMS professionals are exposed to a range of challenges as they deliver frontline emergency care and against the background of this "emotion laden" (Boyle, 2005, p.46) context attention has been given to coping strategies and sources of support for this professional group (Bohström, Carlström & Sjöström 2017; Boyle, 1997, 2005; Williams, 2013a & b). In the next section I present analysis of papers located for this review that show the sources of support and the coping strategies; the emotion work needed in this social context.

2.3.7 Dealing with the emotional demands of EMS work; support and coping strategies

The EMS frontline work can be difficult and frustrating, where workers are confronted with challenges as they deliver care which requires the use of emotional labour (Boyle, 1997; Williams, 2013a & b). Coupled with this are the cumulative and ongoing effects of these experiences, requiring sustained emotional labour and opportunities to process emotions afterwards (Thoits, 1985) through support and coping strategies.

The support of colleagues in the EMS and opportunities to share experiences with each other are highlighted as important in how crews deal with the challenges associated with their work (Bohström et al; 2017; Halpern, Maunder, Schwartz & Gurevich, 2014). Opportunities to talk to colleagues about everyday events (Bohström et al; 2017; Setti, Lourel & Argentero, 2016) and critical incidents were highly valued (Avraham, Goldblatt &Yafe, 2014; Bohström et al; 2017; Gouweloos-Trines et al; 2017). In addition to talking, humour is also reported to be a helpful strategy in some literatures (Hutchinson, 1983; Sliter, Kale & Yuan, 2014).

2.3.7.1 Colleague support

The support of colleagues in the EMS is a cross cutting feature of the literature, reported to be important in providing opportunities to talk and share difficult calls and work-related issues with those who are perceived to know and understand the nature of EMS work, the demands and can be trusted (Bohström et al; 2017; Halpern et al; 2014).

Some of this research has focused on colleague support specifically following critical incidents which evoked high levels of emotional response (Avraham et al; 2014; Bohström et al; 2017; Gouweloos-Trines et al; 2017). Bohström et al. (2017) explored the stress experienced by ambulance nurses; what caused stress and what reduced stress based on critical incident analysis. A sample of 15 nurses from four ambulance stations in Sweden, male and female were interviewed, some face to face and some via telephone and asked about experiences which were stressful, handled well or not and what could help

deal with stress. The causes of stress related to insufficiency including concerns about ability, competence and resources, lack of information relating to the severity of the health problem and calls involving sick children. Helpful strategies in dealing with stress were informal discussions with colleagues who were involved with the call immediately after. Crews reported discussing with each other what was done and the value of this with those who knew, understood, that were present in the incident and were trusted. This was in preference to professional help from psychologists or specialists. Regular interaction between crews at the changeover of shifts was also suggested as valuable, when staff could have a cup of tea and informally debrief about cases they had attended during the shift with each other. The study is small scale, with ambulance nurses, is not UK based and includes little specific detail on the process used to analyse and enhance trustworthiness, which introduce limitations. However, the study offers tentative support for the value of colleague support; colleagues who are involved and understand the nature of the work of EMS in dealing with work related stress and challenges. This was linked to knowledge, understanding and trust between crews and to the availability of immediate support.

Colleague support through debriefing after significant events was regarded as important by ambulance nurse graduates during their first year of service in Sweden (Hörberg, Kalén, Jirwe, Scheja & Lindström, 2018). A cross- sectional survey with statements drawn from a Delphi technique were received from 230 ambulance nurse graduates (qualified nurses who undertake a year specialist study in EMS work), from 11 universities highlighted the importance of colleague peer debriefing after significant events, having a trustworthy colleague, being accepted and respected by colleagues and having an experienced colleague. The limitations of self- report measure such as comprehension of questions, self-awareness and self- assessment my impact on the validity of the findings (Moule, Aveyard & Goodman, 2017). Also, the study focuses on ambulance nurses in the first year after graduation which may impact on transferability beyond this, to other settings and other roles in the EMS context. However, from a broader perspective and in relation to its work setting it has wider applicability and does appear to contribute further support to the value of colleague support in the EMS context particularly in the first year.

Colleague support after critical incidents was also highlighted as important in a phenomenological study involving semi-structured interviews with 15 paramedics in one emergency setting in Israel (Avraham et al; 2017). A qualitative, phenomenological approach was used and two key themes were identified on continuums of varying degrees which included emotional connection and detachment on the one hand and control and loss of control on the other. The paramedics in the study also mentioned the value of discussing what had happened with colleagues after the incident, even if they were not themselves directly involved in it, saying it was a learning opportunity for all and could help them maintain control in future situations. Measures to enhance trustworthiness including reflexivity, an audit trail and

credibility were reported and although small scale and confined to one, albeit large organisation, the findings may have transferability to other, similar emergency contexts.

The importance of colleague support and opportunities to talk to colleagues after emotionally difficult calls are mirrored across various roles within the EMS context. For example, Drury et al. (2013) using a Delphi technique examined the perspectives of first responders on psychosocial needs of patients, their importance and their educational and support needs to deliver this type of care. Six focus groups were used to generate key statements from various emergency response services (for example HEMS – Helicopter Emergency Medical Service and general EMS – deemed to have a good understanding of the subject) in two settings in the UK (London and the North West ambulance service), which was formulated into a questionnaire. The questionnaire was subject to three rounds of further questioning, refinement and consensus. One area of consensus in all three rounds was that talking about emotionally difficult calls with their colleagues helped them. The study utilises a self-selecting sample who may have had experiences and views on the topic, which may not have been typical and representative of the population. This limits the ability to generalise beyond the sample. However, the study provides further evidence of the use and importance of colleague support within the EMS, specifically with what was described as "emotionally difficult jobs" (Drury et al; 2013, p.834).

A portion of this literature has proceeded further to determine the impact of critical incident debriefing with colleagues on reducing distress (Gouweloos-Trines et al; 2017) and depressive symptoms (Halpern et al; 2014) amongst EMS professionals. Colleague support after the experience of critical incidents had a statistically significant effect on reducing distress in a sample of 813 pre-hospital care providers in a variety of geographical and cross-cultural settings (Gouweloos-Trines et al; 2017). Gouweloos-Trines et al. (2017) investigated pre-hospital care providers' levels of distress associated with critical incidents and the impact of work-related social support using an online survey of 813 staff in the USA, Canada, Australia, UK, Austria, Germany, Switzerland and New Zealand. A variety of valid tools were used to measure variables of gender, age, colleague and managerial support, formal peer support and professional support, time off after the critical incident and the effects on distress were included in the questionnaire. The limitations of self-report measure such as the likelihood of socially desirable answers, comprehension of questions and ability to accurately self-assess, can impact on the validity of responses and require consideration (Moule et al; 2017). The findings revealed a statistically significant relationship between informal colleague support and lower levels of distress. Attempts were made through further analysis and indirect links to determine the effects of formal peer support groups on levels of distress, which were small but suggested to be associated with the perception of the support being colleague centred. Specific detail on the exact nature of colleague support and what is perceived to be most helpful is not captured in the study using generalised questions and consequently inferences beyond colleague support cannot be made. The study (Gouweloos-Trines et al; 2017) is however a

broad and cross-sectional one which lends evidence of the value and importance of 'perceived' support from colleagues and the impact on levels of distress associated with critical incidents in eight different geographical and cultural settings which provide pre-hospital emergency care. As such the study adds further to the overall value of colleague support in this working context in chorus with others.

The support of a colleague who was directly involved and the opportunity of receiving 'downtime' (time off work after a critical incident or difficult call) were found to have a statistically significant impact on reducing the development of long-term depressive symptoms (Halpern et al; 2014) in a sample of 201 frontline staff (paramedics and EMT's) and their supervisors. The study was part of a larger investigation into risk and resilience in ambulance workers in a large urban ambulance organisation in Canada. The sample was recruited from those who were attending mandatory continuing education, reflecting and representing those who were in attendance and using an incentive of entry into a monthly prize draw, both of which impact on who might be inclined to participate, the representativeness of the sample and the ability to generalise beyond it (Moule et al; 2017). An online or paper survey was offered to participants, which can facilitate participation, however the limitations of self-report such as accurate recall and self- assessment are important considerations which can impact on the validity of responses (Moule et al; 2017). The specifics of what downtime involved aside from time not undertaking work, was not part of the research aim, however it is implied that this time could be spent reflecting on the incident with others, discussing what happened and sharing views. Although the reasons for the links between depression and downtime are only postulated by the authors, for example that this offers an opportunity for reflection and recognition of what has been done well, there does appear to be some tentative support for the beneficial effects of facilitating time after critical incidents with colleague support for EMS crews.

Further evidence of the importance of colleague support is provided by Setti et al; (2016) who investigated the role of affective commitment to the organisation and perceived social support from superiors and colleagues as protective strategies against burnout and vicarious traumatisation (VT) amongst a sample of rescue workers in Italy. A large sample of 782 various rescue workers including police, ambulance and firefighters were used. The majority were ambulance operators (over 70%) who were asked to complete a paper questionnaire about social support, their commitment to the organisation, burnout and VT using a variety of measurement tools. Respondents were asked questions about social support based on an appraisal inventory tool (Lawrence, Gardner & Callan, 2007 cited in Setti et al; 2016), however there is no discussion of the tool's validity or reliability. Questions asked included for example "I can rely on my colleagues to help me feel better when I experience work related problems" (p.263), which can lead and influence respondents towards particular responses and in this case particular sources of support. The limitations of self-report measure such as social desirability, the accuracy and ability to self-assess and comprehension of questions may impact on the validity of the

findings (Harvey & Land, 2017). The self-selecting sample used also limits generalisation beyond the group (Moule et al; 2017). Despite the potential limitations of the study, the findings offer evidence in support of the positive effects of affective commitment as a buffer which when combined with high levels of perceived social support from colleagues significantly impacted on rescue workers' (predominantly ambulance) well-being.

Colleague support has also been positively linked to staff resilience in the EMS context. Clompus and Albarram (2016) explored paramedics' experiences of work-related emotional challenges and how they developed their resilience to these. The research was centred on one service setting in the South of England where 7 paramedics were interviewed firstly about their individual biographies. These were based on Free Association Narrative Interviewing (Holloway & Jefferson 2013, cited in Clompus & Albarran, 2016), an approach to psycho-social studies and secondly to expand on issues raised in the first interview. Thematic analysis, member checking, and researcher triangulation were described which enhance trustworthiness and credibility of the findings. Four core themes were found; motivation to become a paramedic, workload pressures, coping and resilience and external support. Coping and resilience was achieved through different ways such as managerial support, informal peer support and humour and external support included family for some and professional referrals. Peer support from colleagues was regarded as important to share their work-related concerns and as opportunities to discuss actions and receive "constructive guidance" (p.5). Paramedics reported having doubts about whether they could have done better which could be resolved with the help of colleagues and in this context, one respondent said ambulance staff rely particularly on their work colleagues who understand. The study is confined to one setting and used a self-selecting sample recruited through a paramedic bulletin, which the researchers acknowledge can introduce a bias towards those who had problems and were keen to express these and as such may not have been 'typical'. However, the study offers understanding of the challenges of EMS work and strategies to support their coping and resilience.

Colleague support was regarded as important to other professional first responders including the military, police and emergency medical physicians (Nilsson et al; 2015). Nilsson (Ibid) used a grounded theory approach to the analysis of interview data from 37 first responders from the military, police and treatment room in Norway & Sweden to explore "daily hassles" (p.3) experienced and situations causing moral dilemmas. They highlighted the attention given to problems such as PTSD in these groups but also recognised the lack of attention given to everyday issues and their cumulative effect, acute stress, their antecedents and the favourable and unfavourable formal and informal support available. The findings led to the formulation of a model capturing the key concepts; the causes, cumulative nature of stressors, individual factors such as personality type and experience, appraisal and the preferred support.

Formal and informal sources of favourable support included colleague support where there were debriefing after difficult events. Attention was also given to informal opportunities to talk to colleagues about difficult moral decisions and to share actions taken in situations. The medical professionals reported the beneficial effects of receiving reassurance from others that they would have done the same thing and one respondent reported the alternative of having to carry this around like a "rucksack" (Nilsson et al; 2015, p.4), reflecting the potential impact on the individual. The study draws on a variety of professional groups and presents data reflecting all of these, some relating to warfare, criminal activity and violence and complex medical dilemmas. The snowball sampling technique used generates a mix of levels within these organisations, which collectively creates an eclectic sample, adding to its diversity but also reducing its level of specificity. The medical section of the sample is confined to doctor's aside from one nurse and do not include members of the emergency ambulance service specifically, which limit transferability directly to this professional group. Nevertheless, the study does draw attention to the moral dilemmas and cumulative everyday challenges experienced by these frontline professionals and the importance of informal support from colleagues in dealing with them.

The above literatures relate to the emotional challenges of EMS work and the implications for ongoing support and coping strategies in this context. There is a significant emphasis on colleague support and opportunities to talk and debrief with each other after critical incidents (Avraham et al; 2014; Bohström et al; 2017; Gouweloos-Trines et al; 2017) and when dealing with everyday challenges associated with their frontline role (Bohström et al; 2017; Setti et al; 2016). Trust in colleagues who are perceived to know and understand the role (Bohström et al; 2017; Halpern et al; 2014) suggest reliance on internal, informal support mechanisms. The quality of the sources reviewed are varied; there is reliance on self-report measures, small samples which are not representative, lack of clarity and data collection instruments which are prescriptive and leading rather than open and exploratory, all of which can impact on the quality of the findings.

Humour is another feature of support, coping and emotion work in the EMS context as a way of dealing with the difficulties of their frontline role (Sliter et al; 2014; Williams, 2013a). In the next section I present literature relating to the use of humour.

2.3.7.2 Humour as a coping strategy

Humour is a feature of the culture of emergency service professionals (Sliter et al; 2014), particularly the emergency ambulance service (Hutchinson, 1983) as a way of dealing with the harsh realities of their frontline role and what they experience (Williams, 2013a). Williams (2013a) investigated the emotional challenges experienced by a small sample (n=8) of student paramedics and the strategies used to deal with these in one higher education institution in the UK. In individual, semi-structured interviews students highlighted the importance of humour; particularly 'black' humour as a strategy

which helped them deal with potentially difficult experiences. Although small scale and localised to one institution participants drew on their experiences during the first year of their educational programme from a variety of clinical settings, expanding the scope of the study. Students described humour as part of how difficult experiences were dealt with which suggests its place in emergency ambulance service culture.

The potentially protective, buffering effects of humour use amongst other emergency service professionals are tentatively supported by other studies (Bochantin, 2017; Sliter et al; 2014). Sliter et al. (2014) examined the effects of traumatic stressors in a sample of 179 firefighters in Indianapolis, USA. In a two phased study, 6 hypotheses were tested by means of a questionnaire to determine the relationships between traumatic stressors and PTSD symptoms, burnout and work absenteeism and the buffering effects of "coping humor" (p.259) on the development of these health issues and their implications. The findings supported the predicted hypotheses of the positive relationship between traumatic stressors, PTSD, burnout and absenteeism and the buffering effect of humour reducing the incidence of PTSD and burnout. However, the predicted impact of humour on absenteeism was not supported. The nature of the humour and the exact way in which it helped to reduce the impact of traumatic stressors is not the subject of the study and can thus only be speculated. Limitations associated with self-report such as social desirability, accurate recall and ability to self-assess may have impacted on the validity of responses (Moule et al; 2017) and the sample is confined to firefighters which limits applicability and transferability to ambulance workers. Nevertheless, the study lends tentative support to the value of workplace humour as a coping strategy in dealing with some work-related problems such as PTSD and burnout. However, the failure to impact significantly on absenteeism suggests there are limits to the effects of humour which is unlikely to be sufficient on its own.

Bochantin (2017) examined the use of humour by other public safety employees (PSEs), these being police officers and firefighters and their family's perception of these through individual interviews with 36 PSEs and 8 focus groups with family members including children (59 in total). Findings suggested the use of humour and humorous story telling by PSEs to protect both them and their family from the realities of their work and the dangers involved. Bochantin refers to this as "humorous bilateral emotional labor" (p278); whereby efforts are made through humour to detract from the emotional reality of emergency work for both parties. However, the humour was reported to have positive and negative effects. Black humour or gallows humour was reported to overspill into family communications, but this was ill received by them. This highlights differences in what may be defined as humorous, particularly outside of the immediate context and the perceived appropriateness and as such the limits to black humour. The study draws on a mixture of purposive and snowball sampling and includes little detail on the settings which limits transferability to other contexts.

These studies (Bochantin, 2017; Sliter et al; 2014) focus on police and firefighters which limits their direct transferability to other emergency settings such as the emergency ambulance service and the effects of humour use are tentatively implicated rather than convincingly demonstrated. The perception of black humour outside the context of emergency workers hints at its limited utility beyond this group. Whilst there is some tentative support for the use of humour as a coping strategy further research is needed to clearly evidence its' impact.

2.4 Conclusion

In this chapter I have presented my critical review of existing literature pertinent to my chosen topic of emotional labour and emotion work in the context of the emergency pre-hospital care setting.

My search strategy led to the retrieval of a variety of literature, some of which were pertinent to my research questions. Scanning of retrieved literature and the application of inclusion and exclusion criteria led to the inclusion of 32 relevant sources of literature. My methodological critique of sources included in the review implicates the varied quality of existing literatures on this subject and reinforce the need for further research.

My review reveals the theoretical and research origin of emotional labour (Hochschild 1983, 2003) and emotion work and their applicability to the context of emergency pre-hospital care, through the interaction and interpersonal exchange between the professional and patient and in the presentation of an appropriate professional display (Boyle, 1989, 2005; Williams, 2013a). However overall, the research on this aspect of emergency pre-hospital care is limited, small scale and lacks currency, which collectively supports the need for further research investigation.

My analysis of the literature highlights the valuing of certain types of work in the emergency pre-hospital care setting which reinforces traditional roles and perceptions of emergency work (Hutchinson, 1983; Nurok & Henckes, 2009; Palmer, 1983; Rolfe et al; 2020). Appraisals and categorisations of work amongst these workers have the potential to instigate differing emotions and emotional labour however, there are no clear and specific links to these, which warrant and justify my research investigation.

Emotion work includes the work done after the face-to-face interaction (Boyle, 1997, 2005), where emotions can be processed (Thoits, 1985). My review suggests value associated with colleague support through opportunities to talk about difficult calls (Avraham et al; 2014; Bohström et al; 2017; Gouweloos-Trines et al; 2017) and everyday frustrations with each other (Bohström et al; 2017; Setti et al; 2016). There are also tentative suggestions that humour may help in dealing with emotionally difficult experiences (Bochantin, 2017; Sliter et al; 2014; Williams, 2013a), however these studies are small scale and do not specifically involve the emergency ambulance service, limiting transferability to other contexts. These findings warrant the need for further research study.

Methodologically, the studies reflect an eclectic mix of approaches and methods used, in their geographical and cultural settings and in their quality. Many are small scale and limited to specific individual settings and some draw on convenience samples which limit transferability to other contexts. Some studies lack transparency and clarity in approaches to data analysis and the potential impact of the researcher on the setting and the findings of the study. Some quantitative studies have utilised self-report measures which accompany the potential limitations of accurate recall, self-awareness and the ability to self-assess on the validity of the findings. However, they do offer understandings of how EMS crews appraise and value different types of emergency work and some hint at the implications these have for interaction and emotional labour.

My review of the literature pertaining to my research question has provided useful insights into existing understandings of emotional labour and emotion work within the pre-hospital care context, although this is limited, with small pockets of research in previous decades from differing geographical contexts.

Against the backdrop of significant changes to health care provision and the increased demands on the EMS there is a need for contemporary research which explores how these professionals appraise their day-to-day work, the emotional challenges associated with their frontline role and the discrepancies between their role expectations and their role reality. The implications for emotional labour and emotion work need to be explored from the perspective of those directly involved and their cultural and professional standpoint together with appropriate ways of dealing with these challenges.

My review has served to foreground and inform my research aim and objectives to explore emotional labour and emotion work in the emergency ambulance service, how it is handled and its meaning and significance to the social actors involved and within this organisational cultural context. In the next chapter I detail the methodological approach, philosophical underpinnings and methods which I have used to guide and direct my study.

Chapter 3

The methodology and methods of my study

3.1 Introduction

Ethnography is an umbrella term which refers to research methodology, its philosophical underpinnings and particular methods of inquiry (Brewer, 2000; Hammersley & Atkinson, 2019). In my study ethnography has been used in both its senses, as methodology and method. This chapter is organised and presented in two detailed sections. In the first section I will reiterate the focus of my study and will situate this within a critical exploration of the nature of qualitative inquiry and specifically ethnography, to furnish a clear rationale for this choice of approach. The nature and philosophical underpinnings of ethnography will be explored. Attention will be given to the sources of criticism, both traditional and postmodern and the attempts made to address these in past decades. I will then move on to provide a critical discussion of the use and application of ethnographic methods in my study. My specific attention will be given to describing my approach to accessing the setting, sampling, participant observation, interviewing, documentary evidence, data analysis and ethical considerations.

3.2 Focus of inquiry

My study is concerned with the exploration of emotional labour and emotion work within the specific organisational cultural context of emergency pre-hospital care. Organisational culture is a complex phenomenon which received significant interest in the 1980s, when American corporate managers in competing with Japanese business sought to manipulate and augment it in the promulgation of organisational values and the pursuit of organisational goals (Parker, 2000). Parker (2000) summarises the genre of some of these literary contributions as "chatty and anecdotal…to be read by people who would like to be too busy to have their time wasted on academic sophistry" (p.15). However, such simplistic, positivist, functionalist interpretations have been challenged by interpretations of organisational cultures as "fragmented unities", with features of commonality and variation, comprising individual and collective interpretations, illustrated through existing organisational exemplars (Parker, 2000, p.1). Organisational culture has also received ethnographic attention, contributing crucial inductive and interpretive insights. For example, Van Maanen (1992), in his study of Disney parks illuminated the complexity, reality and disparity of workplace culture and questioned the apparent "flow of culture" across continents (p.5). Despite the universal, corporate positive emotional image of Disney and the offer of delight and happiness, there existed a clear and explicit hierarchy amongst workers and internal conflicts.

The place of emotion; its role and significance within workplace culture has been theoretically and empirically neglected (Boyle, 1997) and perhaps underestimated. However, attention to "emotionality"

(Boyle, Ibid, p.1) in the organisational context of the emergency ambulance service has offered some fruitful insights (Boyle, 1997; Steen et al; 1997; Williams, 2013a & b). My study aims to illuminate the contemporary place of emotional labour and emotion work (Boyle, 1997), within the organisational, cultural context of emergency pre-hospital care in the UK. I have used the concept of 'emotional labour' (Hochschild, 1983, 2003) and the term 'emotion work'; the latter to include the work done after the face-to-face interaction. Thoits (1985) described 'emotion process work' as central to the face-to-face interactional work. Consequently, emotional labour and emotion work will be used as the theoretical foreground to my ethnographic investigation.

The preceding literature review has revealed insights into workplace culture and emotionality as a feature of this (Hochschild, 1983, 2003). Hochschild (Ibid), drawing on Marxist theory, highlighted the organisational commodification and manipulation of worker' feelings and emotion as paid labour in the pursuit of airline passenger satisfaction. The concept of emotional labour has also resonated with health care work (Smith, 1992) and with clinical specialities (Bolton, 2000; James, 1992; Maunder, 2013).

These concepts have been examined in the specific context of emergency pre-hospital care and have begun to illuminate the hitherto neglected notion of emotion work in this setting (Boyle 1997; Steen et al; 1997; Williams, 2013a & b). Whilst collectively these represent an eclectic mix of geographical, cultural and professional settings, they show insights into the organisational cultural context of pre-hospital care. Interesting features of organisational culture such as hegemonic masculinity and specific feeling rules including the management and suppression of emotion have emerged (Boyle, 1997; Steen et al; 1997; Williams, 2012) which tempt further contemporary study. The rudimentary, though complex historical background and origins of this nascent professional group have suggested precursors and contributors to the persistent dominant valuing system that favours and recognises "saving lives through technical wizardry" (Boyle, 1997, p.164) but is ambivalent on the significance of emotionality in emergency care. The ambulance service has strong paramilitary origins, a strong historical focus on the manual labour of transport, and an explicit valuing of technical competence but offers little recognition of the emotional demands of emergency work (Boyle, 1997; Williams, 2012). Despite the lack of formal recognition, emergency pre-hospital practice is described as "emotion-laden" (Boyle, 2005, p.46).

My particular interest in the emotional challenges of care work and previous insights derived from my experience and own research (Williams, 2013a & b) and others, specifically James (1989, 1992) and Boyle (1997) led me to design and embark on this research. Collectively these stimulated my interest in expanding and developing insight into emotion as a feature of pre-hospital care work, within its organisational culture, through the behaviour, meanings and performance of these social actors.

3.3 Study Aim

My study aims to explore emotional labour and emotion work in the cultural and professional context of frontline emergency pre-hospital care from the perspective of those who deliver it.

3.4 Research objectives

My study objectives focus on,

- How frontline emergency pre-hospital practitioners perceive and describe the emotional demands of their role.
- How and in what circumstances are the emotional demands perceived and handled by social actors in the cultural and professional context of emergency pre-hospital care.
- What rules and expectations influence it and how it is managed within this organisational, cultural work setting?

3.5 The research process

3.5.1 Qualitative approach

My study aims to capture and illuminate the nature of emotional labour and emotion work in the social context of emergency pre-hospital care. I was keen to understand the perspectives of individual practitioners; the meanings and social context in which emotional work takes place, which is congruent with the philosophical underpinnings of qualitative research (Bryman, 1988, 2004; Hammersley & Atkinson, 2019).

Qualitative research incorporates a number of individual methodological approaches including grounded theory, phenomenology and ethnography, which reflect variations in purpose, focus and differing theoretical and philosophical backgrounds. Despite its eclectic patterning of intellectual and philosophical influence, qualitative research shares common features including an interest in the social world as an interpreted one, socially sensitive and flexible methods of data generation; and data analysis which captures the complexity of the social context (Mason, 2002). Ethnography is the strand of qualitative research selected for my research study which centres its interest on the culture of a group within their naturally occurring setting through their behaviours, actions and their meaning to those involved (Hammersley & Atkinson, 2019).

The aforementioned features of qualitative inquiry contrast sharply with the traditional and historically dominant tenets of positivism which underpin and guide quantitative research (Bryman, 1988). Positivism incorporates the traditional natural science model characterised by experimentation, a deductive approach to the formulation and testing of covering, universal laws and an intrinsic valuing

of directly observable and thus measurable phenomena (Hammersley & Atkinson, 2019). These major tenets validate structured, controlled, objective, measurable and uniform methods of inquiry to produce valid and reliable data that test theory and constitute 'true' scientific research (Bryman, 1988). The control and manipulation of variables and the implementation of standardised procedures are crucial to its power of predictability.

Qualitative research stands in opposition to the scientific ideals of positivism and instead draws on naturalism as an underpinning philosophy for its scientific approach and methods of inquiry (Hammersley & Atkinson, 2019). Fidelity and sensitivity to the subject of inquiry are the cornerstone features of naturalism which manifest in a commitment to the study of phenomena in their natural environment incorporating the context, behaviours and views of individuals as they occur (Hammersley & Atkinson, 2019). Naturalism is a key feature of my study and is operationalized in my intention to explore emotional labour and emotion work as they are played out within its natural social context of the emergency pre-hospital care setting.

Both naturalism and positivism share a view that physical phenomena exist independent of individual perception, a concept referred to as realism (Hammersley & Atkinson, 2019). However, naturalists view social phenomena differently and reject the simple cause and effect explanations for human behaviour in the social world derived from the study of physics. Infused with philosophical and sociological ideas including symbolic interactionism, hermeneutics and phenomenology, naturalists argue individuals interpret, make sense of and give meaning to external stimuli which serve to shape human behaviour in responses and actions. Human behaviour itself is complex and underpinned by social meanings including values, beliefs, rules and motives. The concept of universal, explanatory laws to explain and unify human perception and behaviour are thus firmly rejected in favour of multiple realities, perceptions and meanings for social behaviours. Hammersley & Atkinson (1995) capture the subjective, complex and dynamic nature of human behaviour by arguing that it is, "…continually constructed and reconstructed, on the basis of people's interpretations of the situations they are in" (p.8)

Anti-realist, postmodern critiques favour multiple realities based on individual perception (Brewer, 2000) and as such serve to stimulate and inform research which seeks to explore and understand the social world through the eyes of the social actors; a defining characteristic of qualitative research (Bryman, 1988). These views were consistent with my own fundamental beliefs and valuing of individual perception and reality which have subsequently underpinned my choice of approach to my study.

Naturalism draws on the natural science model and as such pursues a quest to understand and render an objective view of social phenomena as external to and independent of the researcher. However, the concept and achievement of this enterprise has ignited criticism from sources both intrinsic and extrinsic

to ethnographic study and has created a double crisis; one of representation and the other of legitimation (Brewer, 2000).

Underpinning realist beliefs in an objective reality and the ability to capture and render this in an unproblematic way has prompted criticism and accusations of naïve realism from anti-realists. Anti-realists have challenged the realist ethnographers' authoritative claims to a privileged position which allows access to an independent reality or truth using the argument that there is not one reality and the view presented is a partial one. Brewer (2000, p.43) captures the challenges in the intention to tell it like it is, when there is more than one "telling' and more than one is".

These more contemporary challenges and critiques of traditional ethnographic assumptions threaten claims to authenticity and knowledge and present thorny issues which prompt responses, one of which has been the growing use of reflexivity (Hammersley & Atkinson, 2019). Rather than eliminating the effects of the ethnographer, it is advocated that there is recognition of the impact of the researcher as part of the social setting under investigation. Accepting that there is no neutral way of presenting the social world, reflexivity provides the tool to enable researchers to bring forth and make transparent the factors which influence their perceptions and presentations of what is seen (Brewer, 2000). Consequentially what is presented is recognised to be a "partial, selective and personal version" (Brewer Ibid, p.44). A critical awareness of my impact on both the process and product of this research study has presented an almost constant concern and has been assisted through critical reflexivity and the completion of a fieldwork reflective diary.

Responses to criticisms have not however been confined to the problem of representation and the promulgation of reflexivity in ethnographic writing. For example, Brewer (2000) describes methodological and theoretical infrastructures such as subtle realism, critical realism, analytical realism and the "ethnographic imagination" (p.53) as features of postmodern ethnography. These propose alternative philosophical and theoretical foundations and systematic and disciplined methodologies on which to build contemporary ethnographic research and appease some of its critics.

Following closer scrutiny analytical realism (Altheide & Johnson, 1998) appealed particularly to my own philosophical beliefs, my concerns and my intentions for the conduct of my study. Analytical realism incorporates the view that the social world is an interpreted one, constantly under construction and revision by both the researcher and the researched. The ethnographer aims to capture and present the differing perspectives offered and to draw on an approach to validity which involves substantiating findings with a reflexive awareness of themselves and the process of their research, which is referred to as "validity-as-reflexive-accounting" (p.489). The intention to authentically present the social world simultaneously addresses the issues of representation and legitimation. Operationalising analytical realism necessitates a holistic presentation involving consideration of behaviours within their wider cultural and organisational contexts; the relationship between the researcher and researched; the

perspectives of both; the contribution of the reader in the product, and the style used to communicate the interpretation (Altheide & Johnson, 1998).

The pre-hospital care context and priorities are different to my own and I have a career history as a nurse and educator and an established professional, theoretical and perhaps 'ideal' lens which are inescapable aspects of my biography which I bring to my research study. A critical and analytical awareness of these factors and their potential impact was crucial in the conduct of my study.

The principles of analytical realism offer a systematic, robust, transparent approach reflective of my philosophical views, addressed my concerns for transparency and offered a critical guide to the study of a professional group different, though close to my own and a subject matter with which I am familiar.

3.6 Methodology

As indicated, ethnography is a term which can be used to denote both methodology and method. In a generic sense ethnography is characterised by the notion of fieldwork observation as a method of data collection, sometimes referred to as 'big' ethnography (Brewer, 2000). However, ethnography can also combine the theoretical and philosophical foundation and the prescriptive and pragmatic methods of application and inquiry (Hammersley & Atkinson, 2019). It is as both methodology and method that ethnography has been used in my research study.

My initial knowledge and interest in ethnography arose from studies of early anthropological work as part of my study of sociology. These early contributions (Mead, 1928; Whyte, 1943) demonstrated the application of research methods and provided what I considered to be fascinating insights into human cultures, behaviours and their social meaning within that context. My interest in ethnography has continued through its use and contribution to understandings of healthcare culture and contexts through the decades (Examples include Hillman, 2013; Philpin, 2004; Savage, 1995; Swanson-Kauffman, 1986).

In a challenge to rather negative perceptions of nursing routines and rituals in the literature at the time, Philpin (2004) explored their use and symbolic meaning to nurses in an intensive care setting. She uncovered their meaning as important expressions of caring, protection and guardianship by these nurses. More recently Hillman (2013), developing previous work on patient categorisation in Emergency Departments (Hughes, 1980; Roth, 1972), described the interactive and negotiated process by which legitimacy and subsequent access is determined. Savage's (1995) ethnography of intimacy within the nurse-patient relationship and how this was demonstrated on two wards has impacted particularly on my earlier research by offering a conceptual framework for the physical and psychological expression and manifestation of closeness (Williams, 2001). Savage (Ibid) describes the contrasting contextual and cultural setting of Smith and Jones wards and the influence on expressions

of intimacy between patients and nurses. These ethnographic contributions have the power to enlighten our understandings of the nature of health care contexts and culture through sustained study and close interaction with individuals; what they say and do and their articulations of their subjective interpretations.

My intentions are to explore emotional labour and emotion work in the context of the pre-hospital care setting; how it is described and interpreted by those who are at its centre, how and in what circumstances it is handled by social actors, what rules and expectations influence it and how it is managed within this organisational, cultural work setting.

The emergency ambulance service involves regular confrontation and skilled management of highly stressful situations involving trauma, human suffering, death, threats of violence and aggression and the perceived misuse of the service (Regehr, Goldberg & Hughes, 2002). Much of this work is also undertaken in the public arena under public gaze (Sterud, Ekerberg & Hem, 2006) and as such necessitates the maintenance of a calm, controlled and professional exterior (Avraham et al; 2014). The presentation of a 'front' by these emergency professionals has been highlighted across the literature (Boyle, 1997; O'Neill, 2001) and implicates the somewhat hidden emotional dimensions accompanying their work. Previous literatures have also commented on the traditional cultural paramilitary origins, stereotypical hegemonic masculinity and expectations of emotional stoicism which characterise the emergency ambulance service (Boyle, 1997; Steen et al; 1997) and the implications these have for emotion work in both its frontline delivery (Williams, 2013a & b) and its backstage context (Boyle, 1997).

Rather ironically, the success of emotional labour is its invisibility in the provision of the service which, including aspects of organisational culture are not visible through a fleeting, superficial, external lens. Ethnography offers the fundamental philosophical valuing of subjective interpretations and implicit meanings accompanied by the tools of sustained interaction with key individuals providing the service to capture and present their perspectives of the emotional challenges of their work and how they handle these in the context of the organisational culture. I anticipated that ethnography incorporating methodology and method would enable me to experience this social group and setting to furnish understanding of the behaviours, practices and their meanings to these actors through direct participation in their work and its social context.

3.6.1 Ethnography; its history and nature

Ethnography has a long and established history in the social sciences and has emerged from the disciplines of social anthropology and sociology (Hammersley & Atkinson, 2019). Primitive examples include centuries old tales written by travellers seeking, often poorly to represent a particular culture, group or country (Brewer, 2000).

Early anthropological exemplars include Malinowski (1922) who undertook a two-year, immersion into the lives of the Trobriand Islanders of New Guinea and set the standard for future fieldwork studies. Significant contributions also include Brown (1922) and his study of the Andaman Islands in India and Evans-Pritchard (1937) who, influenced by Malinowski, studied the Azande people from the upper region of the Nile. These anthropological studies share the characteristics of prolonged immersion in a social setting, with the aim of making explicit what is implicit in social behaviours and their meanings.

Expansion in ethnographic research also occurred slightly later in the twentieth century from the Chicago School of Sociology in North America under the auspices of Robert Park and fellow educators. Park linked real research with first-hand observation (Brewer, 2000) and ethnography was subsequently utilised to study sub-cultural and professional groups and organisations on the domestic front. These included groups on the periphery of industrial society in the USA and frequently incorporated deviant subgroups such as street gangs, drug dealers and prostitutes. One of the most well-known examples was Whyte's (1943) study of a 1930s inner city, American slum district inhabited by Italian immigrants. Whyte named this 'Cornerville' to reflect what he found to be the centre of interaction for the young gang members he became part of. Whyte proposed that to those outside of Cornerville it is chaotic, unruly and disorganised, a view he challenged through his sustained presence and experience of the complex social structure within.

In essence, ethnography is characterised by an interest in the culture of a particular group in their naturally existing environment; their behaviour and social meanings (Brewer, 2000; Hammersley & Atkinson, 1995, 2019). Brewer (2000) described ethnography as,

> ...the study of people in naturally occurring settings or 'fields' by methods of data collection which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting, if not also the activities, in order to collect data in a systematic manner but without meaning being imposed on them externally (p.6).

Ethnography is based on the fundamental philosophical belief in the subjectivity of human experience, perception and meaning and is therefore dedicated to exploring, capturing and understanding these through the perspective of individuals concerned.

Ethnography seeks to understand culture and meanings through the subjective interpretations of those within it as those who attribute it. Geertz (1973) explicates the relationship between culture and meaning through the articulations of Max Weber, "that man is an animal suspended in webs of significance he himself has spun" (cited in Geertz, Ibid, p.5). He proceeds to perceive culture as these webs and the analysis of them an attempt to interpret meaning. Ethnography is therefore underpinned by fundamental philosophical and consequential epistemological perspectives, which explicitly synchronise methodology and method. Ethnography draws on the human ability to experience differing human cultures, to experience their world and access the internal meanings which guide behaviour, whilst also

maintaining a degree of objectivity sufficient to enable recognition of accepted patterns of behaviour. It is characterised by field study and active involvement in a setting for the purpose of capturing internal social meanings within a particular cultural context and is predicated on the value of engaging with first-hand accounts to gain perspectives on a particular phenomenon from those directly involved (Brewer, 2000; Hammersley & Atkinson, 2019). Ethnographers therefore participate in people's everyday life for a prolonged period; listening, watching and asking, for the purpose of gaining understanding of the topic of interest (Emmerson, Fretz & Shaw, 1995; Hammersley & Atkinson, 1995, 2019).

Geertz (1973) argues that what signifies the essence of ethnographic endeavour is not to be found in its methods nor the simple reporting of what is experienced but rather in the degree of "intellectual effort" required (p.6) to fathom out the meanings. To exemplify his point Geertz draws on Gilbert Ryle's (1929-1968) concept of "thick description" (p.6), combined with the metaphor of two boys contracting their eyelids. He explains that although physically and externally these are identical actions, they may constitute a wink or a twitch, with two vastly different functions and meanings. Geertz (1973) progresses to suggest that thick description is necessary to effectively capture and communicate what exactly is being done, winking or twitching and that it is this very differentiation between the two which is the *raison d'être* of the ethnographer. Thick description would provide the ideal place from which the researcher lets us in and brings us close to the lives of those being studied and what specifically they are doing. Ethnography is thus underpinned and justified by a quest not just to tell of the mere existence of behaviour but instead to grasp and then render what this behaviour means and achieves in a social context.

An ethnographic approach to my study will therefore enable me understanding of emotional labour and emotion work crucially from the perspective of individual practitioners, their behaviours, practices, processes and their social meaning within the context of emergency pre-hospital care.

3.7 Methods

In this section I will detail how ethnography and ethnographic methods were specifically used in my research study. More specifically I will address the processes I used in accessing the setting, sampling, participant observation, interviewing, documentary evidence, data analysis and ethical considerations.

This ethnography focused on one large, inner city ambulance station, where over a period of 10 months for at least one shift a week I responded to and attended calls with emergency crews in both rapid response vehicles and ambulances. Fieldwork involved directly observing and participating in the frontline work and care delivery of ambulance staff and in the interim periods between calls, waiting with the patient, restocking equipment, hanging around, before shifts and mealtimes. The locations of this work varied from the station crew room, Emergency Department staff rooms, Rapid Response

Vehicles (RRVs), ambulances to hospital corridors and departments. I recorded jottings and short phrases or statements wherever I could in a small pocket-sized note pad to aid my memory and recall and for later write up.

Following this period of immersion in the field I conducted in-depth research interviews with key participants from a range of roles within the setting and documentary sources from the setting were also included in my endeavour to provide a complete picture of this social group.

3.7.1 Ethnography as method

As I have indicated above ethnography aims to gather insight and understanding of a social context, the behaviours and their meanings from the perspective of those directly involved in the setting (Hammersley & Atkinson, 2019). To this end ethnography typically and purposefully utilises a range of data collection tools to furnish understanding of the topic under study in its everyday setting from the perspective of those who experience it and attribute it meaning (Brewer, 2000; Hammersley & Atkinson, 2019; Lofland, Snow, Anderson & Lofland, 2006).

In this study I have used participant observation, research interviews with key participants and analysis of documentary sources. In this section I examine the theoretical underpinnings of these methods alongside their specific application to my research study.

3.7.2 Fieldwork; gaining access to the field

Gaining access to the field of study is crucial to a successful ethnography and must be considered early on (Hammersley and Atkinson, 1995, 2019; Lofland et al; 2006). Lofland et al. (2006) explain that successful entry or "getting in" to the setting (p.33) is reliant on connections, accounts, knowledge and courtesy. Connections with people from within the setting or organisation can facilitate entry, coupled with articulate accounts of oneself and one's areas of interest and intention as a researcher. Knowledge of the setting or social group and the extension of courtesy in communications and negotiations both informal and formal with them, are likely to evoke a willingness to allow entry (Lofland et al; Ibid).

Establishing or using existing connections with those within the group under study are important in gaining access (Lofland et al; 2006). I began early informal access negotiations to the emergency ambulance service in 2012. I discussed my ideas for a research project on the emotional challenges of pre-hospital care with two experienced paramedics who held leadership positions in research and development within a local Ambulance Service NHS Trust. This gave me the opportunity to assess their interest in my ideas for the study and their views on its feasibility. I was also foregrounding their future support, their knowledge of the organisation and their established connections within it, on which I fully intended to draw. My interactions were favoured by familiarity, previous professional relations (I had contributed to paramedic education with them) and connections with these key, influential people on

the inside of this organisation which served to expedite my early access negotiations (Lofland et al; 2006). My early endeavours were fruitful and reassuring; they gave me a verbal agreement that I would receive support to undertake my study in the local ambulance service trust. I was reassured that my study was now a feasible one and that I had made the first important step to realising my plan.

During this meeting I did raise the issue of the specific setting or station for my study and had in anticipation given this some consideration. Bryn Station, I knew to be the largest and most conveniently located for early morning shift starts. I noticed however that there was some reticence towards my suggestion of this as a setting for my study with brief mention of 'an investigation' which was ongoing there.

The agreement to support my study was formally confirmed in January 2014 following review of my research proposal by the Research Risk Review Group, a subgroup of the Pre-hospital Emergency Research Unit (PERU) for the chosen trust.

Following this on request from the Lead for PERU I prepared a shortened research proposal which was disseminated to heads of service in possible locations within the regional ambulance service. Feedback from this was encouraging, although some clarification was requested on the procedure for consent from patients and staff that were not within the chosen station, prompting minor amendments to my research proposal. I was informed that all heads of service were willing to accommodate and support my research study and particular interest was shown by the station manager at Bryn Station.

Prior to commencing field work I was required by the regional ambulance service to comply with certain requirements (Protocol for non-clinical observer applications WAST 2013b – see appendix 3), including violence and aggression training; a Disclosure and Barring Scheme (DBS) assessment; a current signed curriculum vitae; confirmation of professional nursing registration and occupational health clearance. I therefore arranged for all the requirements to be met.

On the 21st of January 2015, I received a letter from the regional ambulance service trust confirming access to undertake my research study (See appendix 4 - Confirmation of access to Welsh Ambulance Service NHS Trust), and that this would be in the largest ambulance station within the region, Bryn Station. Following this and utilising my connections with initial contacts, I arranged two meetings with the station manager; the first to introduce myself and discuss my plans for fieldwork and the second closer to the start of fieldwork, to clarify practical arrangements for me to start such as suitable clothes, shoes, shift patterns, confidentiality, my role in the setting and what I should do on my first day. On that first day the station manager had arranged for me to accompany a paramedic and an emergency medical technician who would expect me to arrive no later than 6.45am on the 2nd of March 2015.

The willingness of staff to allow participation and observation can be problematic in fieldwork, may necessitate negotiation and re-negotiation but is central to its success (Hammersley & Atkinson, 1995, 2019; Lofland et al; 2006). Suspicions about the real purpose of the research and perceptions of the researcher as a critic or expert may be roused (Hammersley & Atkinson, 1995, 2019). Previous ethnographic research within the ambulance service suggests some challenges in getting into the field. For example, Douglas (1969), a nurse reported initial reticence from crews in allowing her to ride out with them, however with time her acceptance and access to the field increased. Other studies however have not detailed problems regarding access to the field (Hutchinson, 1983; Mannon, 1994; O'Neill 2001).

I perceived early on that access and acceptance in this setting could not be assumed and would take time, sensitivity, perseverance, determination, discomfort and resilience at differing times (Lofland et al; 2006). I found access to be a significant part of my field 'work' experience and found this to be fickle, anxiety provoking and uncomfortable at times. Some crews welcomed me, involved me and looked out for me whilst others appeared quietly suspicious and a few (fortunately a few) it seemed avoided me at all costs. My success at getting in and staying in was hampered by regular, though nevertheless episodic opportunities for participant observation which I often reflected on (See appendix 5 – Fieldwork reflective diary).

The station manager at Bryn Station proved invaluable in the initial stages of my access to the setting in organising and allocating me to a particular crew and thereafter at the start of the shift the clinical team leaders would sometimes organise my allocation to a crew. However, I wanted to vary my sample of crews as much as possible which necessitated me negotiating with and choosing between different crews and different opportunities at times. I found that my access to the field and its opportunities grew as time passed and seemed to benefit from some crews' experience of taking me along with them and their finding that I was in fact no trouble and could be helpful. At times, I felt in no doubt that my acceptance by some crew members and my relationships with them were noted by others. The endorsement of a significant insider in the setting is a powerful tool not to be underestimated in achieving access and group acceptance (for example 'Doc' in Whyte, 1943).

Physical access and acceptance in the setting can be enhanced with suitable, sympathetic attire and in some cases 'props', which serve to help define and create an appropriate stage (Goffman, 1959). I was issued with a high visibility jacket with the ambulance service logo and the inscription 'AMBIWLANS' (Welsh for 'ambulance') in large letters across the back and recall the station manager advising me to wear it so that other professionals such as the police, fire service and hospital staff would not question my presence with the crews, particularly in public places. Initially however I neglected to wear it at times, however I quickly realised that this was an important and essential 'prop' which linked me to the ambulance service against the backdrop of the public and varied context of pre-hospital care,

particularly busy public roads and town centre shops. This jacket signalled to the public, patients, relatives and hospital staff that I was with the crews and had a legitimate right to be there. On a few occasions some crews from other stations asked who I was to which the crews would say 'that's Ang she's from the college and she's with us'. My acceptance by crews within Bryn Station was not achieved by the simple donning of an ambulance service jacket; it was not assumed, required time, negotiation and resilience at times from me. Negotiating access to the field and my continuous efforts at this were a constant feature of my reflective diary entries. I will expand further on this in my description of the setting of my study in chapter 4.

3.7.3 Setting and sampling

Ethnography typically centres on the study of people and their behaviour in naturally occurring social settings through direct involvement and participation (Brewer, 2000). Sample selection has a purposive nature in ethnographic study (Bryman, 1988), whereby a setting and sample are consciously and deliberately chosen to allow access and insight into the phenomena of interest (Silverman, 2000). Ethnographic studies historically and currently are characterised by a focus on a single setting as a basis for investigation (Mead, 1928; Philpin, 2004; Whyte, 1943). Such focus enables the sought-after immersion and deep understanding of the specific culture under study; the nuances and idiosyncrasies of behaviour and their meanings to those central to it (Geertz, 1973).

The focus on a single setting raises concerns amongst researchers regarding the representativeness and thus generality of the findings beyond the specific setting chosen. Indeed Bryman (1988) argues, "the concern that findings may be untypical is understandable when a subject is keen to develop a modicum of empirical generalisation and possibly to make a contribution to wider theoretical developments" (p.88).

Concerns about the generalisation of findings are however more appropriately seated in the context of positivism and the hallowed ideals and purposes of the traditional scientific model of research (Brewer, 2000) than in qualitative research and as such are rejected by some ethnographers. Additionally, misguided perceptions of a single setting as offering one example can be challenged and effectively subverted by exposure to the variance and complexity of actors and their activities in a social setting (Bryman, 1988). Also, analysis in making what happens recognisable as an instance of things that happen in such settings, are a basis from which readers can see what knowledge is unique to that setting or what is transferable to similar settings.

My study centred on an ambulance service trust serving an extensive geographical area within the United Kingdom and on one ambulance station within the trust. The station serves a large inner-city area, which reflects the 'typical' demands of current, urban pre-hospital emergency care and the adjunct of a sample rich in both actors and activities as a fruitful basis for exploring my interest in emotional

labour and emotion work. These were factors I was aware of at the very beginning of my study when I contemplated the possibilities and the most suitable context in which to do it and which prompted me to suggest Bryn Station in my initial meetings with ambulance service representatives. Bryn Station I thought would be a good base and platform from which I could gain access and entry to the ambulance service within this region. I also considered important practical issues including the numbers of emergency vehicles particularly ambulances which run from the station at any given time. At Bryn Station this was two, whilst at other smaller stations this could be just one and could affect my opportunities to accompany crews on emergency calls. Many of the stations including Bryn Station also offer opportunities for student learning and for emergency department staff to accompany crews, increasing demand. My decisions about the setting of my study were motivated by my determination to have regular, guaranteed access to the field of emergency ambulance care. Bryn Station was also easy for me to access quickly and frequently from my home, particularly in the early morning.

Participant observation incorporates selection of and access to a social situation which includes places; actors and their activities (Spradley, 2016). The specific configurations of these differ and are dependent on the purpose and thus focus of the study. My purposive sample included the staff directly involved in the EMS provision within the station chosen who as such had experience of and thus understandings of the emotional demands of this work (See appendix 6 – Details of sample). The staff predominantly consisted of Paramedics, Emergency Medical Technicians and Clinical Team Leaders but also on occasion Urgent Care Service staff who support the emergency service. The station had an eclectic mix of EMS staff in the sense of varying age, gender, experience and educational route. Some staff were close to retirement whilst others were recent entrants to the ambulance service from either the Higher Education Institution as paramedics or the traditional training programme as EMTs. Many of those who have undertaken the 12-week residential EMT local training course have gained clinical experience within Urgent Care Services (non-emergency calls which need transport, some interventions and monitoring), Patient Care Service (transport for routine hospital appointments and treatments) or the Clinical Contact Centre (known as ‘control’ amongst crews and where calls are received and vehicles dispatched). The sample is a naturally occurring one and as such fits with the underpinning philosophy of naturalism (Hammersley and Atkinson, 1995, 2019) and a commitment to the authenticity of the setting. It is a typical UK ambulance service setting and as such my aim was to provide an ethnographic account that would yield insights of relevance to this and similar services. The sample included a total of 28 participants who were involved in the provision of emergency care in the station; paramedics, CTLs and EMTs, with varying years of service from 5-35 years (mean = 8yrs) and with differing educational preparation; many traditional in-service developmental routes and a smaller number who had undertaken a Diploma in Paramedic Science in Higher Education Institutions (See appendix 6 – Details of sample).

The role of EMS provision within the ambulance service was naturally framed around an integrated set of social situations; whereby the same actors undertake the same activities in similar or the same locations (Spradley, 2016). In my fieldwork with crews, I noticed a general structuring and organisation to their role in each call which involves the performance of routinised activities such as initial assessment and information gathering through specific questioning, a standard set of clinical recordings of for example blood pressure and body temperature and the provision of treatments such as oxygen. There were more subtle forms of structuring of roles within the service which I will discuss in chapter 4. The locations were often in the patient's home in their living room, bedroom or kitchen and less commonly in public places such as shops and busy roads. My fieldwork across these locations furnished access to the nature and demands of their role in its entirety including its temporal, processual and physical dimensions.

3.7.4 Participant observation

Ethnography involves a crucial and deliberate synchronicity between methodology and method, whereby fieldwork is undertaken requiring direct involvement in the social setting (Brewer, 2000); watching, listening, asking questions and sometimes doing, to enable access to behaviours and their meaning. Fieldwork is therefore predicated on the belief that to understand the perspective of participants it is necessary to work closely with and participate in their varied activities over time (Brewer, 2000; Emmerson et al; 1995).

Prolonged immersion and participation within a setting draws on naturalistic tenets and serves to furnish the sought-after closeness and intimacy; enabling the capture of rich data which facilitates understanding of the behaviours of actors, their meanings and significance within the particular social context (Lofland et al; 2006). Some of the early classic, anthropological studies from which ethnography has emerged (Brown, 1922; Malinowski, 1922; Mead, 1928; Whyte, 1943), were characterised by lengthy periods of continuous time spent physically, psychologically and socially immersed in the cultures under study.

Broadly speaking, participant observation is a process whereby an appropriate relationship is adopted between the researcher and the researched which enables the researcher understanding of the latter (Lofland et al; 2006). However, more specifically participant observation denotes the active participation of the researcher in the daily activities and lives of those being studied; watching, listening and talking to them, as opposed to watching them from a distance (Brewer, 2000). Participant observation combines the capture of natural behaviour and their meanings though the researcher's personal experience and contact with it; its autobiographical nature expanding the spectrum of perception (Brewer, 2000).

Observation periods were undertaken on a regular, weekly basis for a period of 10 months between March and December 2015, involving part of a 12-hour shift accompanying EMS crews on an ambulance or rapid response vehicle. Observation periods varied in duration from 4 hours (minimum) to 12 hours (maximum) and were often undertaken during weekdays and included one night shift. (See record of observation periods – Appendix 7). Periods of participant observation were arranged alongside my role as a full-time Lecturer and associated commitments of teaching, supervision, personal tutoring, marking, module management and clinical support. Participant observation was at times curtailed to enable me time to return home and write up fieldnotes before the end of the day. Although I often wanted to stay longer with the crews in the hope of seeing more, I reminded myself that having some data was better than none. I was also mindful that crews might often have to work beyond their 12-hour shift and had to wait for an incoming crew to relieve them. I had been advised at the start of my fieldwork by the station manager, that if I wanted to return before the crew, I would have to organise my own transport back to the station. These practical considerations influenced my decisions regarding the duration of fieldwork episodes.

Calls attended during fieldwork were varied and included those categorised as emergency red calls which were life threatening, trauma, road traffic collisions, falls, bleeding, collapse, stroke, infections, confusion, self-harm and attempted suicide, intoxication and drug overdose, fractures, pain, labour and on some occasions when the reason for the call was not clear to the crews. (See record of calls attended – Appendix 8). These were representative of the calls EMS crews typically attend.

During observation periods I accompanied a one or two-person crew with a variety of skills ranging from assessment, monitoring, drug administration and advanced resuscitation. I shadowed the crew for the duration of the observation period and went wherever they went. Typically, crews would leave the station early and could be out attending calls until official break periods. After the patient's care had been transferred to hospital staff (known as 'handover') and whilst waiting for the next call enabled me opportunities to hang around talking, listening and waiting with the crew and included backstage contexts such as ambulances, ambulance stations, crew rooms, hospital corridors and less frequently hospital canteens and hospital coffee shops. I also had opportunities to interact with crews from different stations in and around Accident and Emergency departments as they arrived, offloaded their patients and waited around, talking, laughing and at times teasing each other.

Participant observation provided me direct access to the nature of the roles and work demands and their activities and behaviours when not giving care. In this sense the context of my observation was holistic, incorporating both front stage and backstage activities within the whole context of their work environment and cultural setting. These contexts enabled me to observe how emotional labour and emotion work occurred in situ.

Observation is suggested to implicitly favour that which is seen and, in my study, attention was largely given to what was seen and heard. Watching activities and listening to interactions took the focus of my attention and included my efforts to make some brief notes of them to recall and write up later.

Questioning of participants is often incorporated as part of participant observation and information gathering in the field (Lofland et al; 2006) and in my study this was confined to periods when the patient was not present and more often during periods between calls. The appropriateness of questioning is an important consideration in differing cultural contexts, necessitating an awareness of how this may be perceived (Hammersley & Atkinson, 1995, 2019). At times as a newcomer, guest and stranger in the setting, especially in the crew room, I felt it more appropriate to listen and watch what was being said. On some occasions when dominant characters were telling stories the social expectation appeared to be that I should listen and laugh; not question. I also felt more generally that a careful assessment and balance was important to maintain between inquisitiveness and sensitivity. Frequent questioning can be perceived as threatening (Hammersley & Atkinson, 1995, 2019) and could have damaged the delicate relations in the field. Questioning can be perceived as intrusive and carries the risk of undoing my work of fitting in by immediately setting myself apart again.

Fieldwork observation can involve the adoption of differing roles including complete-participant, participant-as-observer, observer-as-participant and complete-observer (Junker, 1960 cited in Hammersley & Atkinson, 1995), which lend to varying degrees of involvement and detachment and subjectivity and objectivity. At the outset of the study, I had anticipated undertaking an observation role only; a decision informed by my concern to focus on the researcher role, combined with a lack of recent clinical health care practice and a requirement from the ambulance trust as part of their ride out policy.

However, I found a purely observational role impossible to maintain for a number of reasons and a moderate level of participation was undertaken. This required me to weigh up and achieve a careful balance between insider and outsider with some participation in activities in the field but not complete membership (Spradley, 2016). My level of participation varied across differing periods of observation depending on the nature of the calls and the crews. However, I wanted to help and automatically; often without thinking, would assist with manual handling and moving patients, immobilising for head and neck injuries, carrying equipment and supporting and comforting patients and relatives. Many of these activities drew on the skills I acquired as a nurse and as such came as second nature to me. Early into fieldwork, an occasion arose where my clinical involvement was significant, and I contributed to the active resuscitation of a patient who was in cardiac arrest. In this unpredictable, emergency where there was no time, I did not stop to analyse the pros and cons but acted instinctively based on my training and practice as a nurse. This experience led to my abrupt confrontation with personal, ethical and professional responsibilities in the field and the observational role I had perhaps naïvely agreed prior to fieldwork.

Ethical dilemmas are an inevitable aspect of research investigation and ethnographic fieldwork (Brewer, 2000; Lofland et al; 2006) and present challenges within the context of insider research (Allen, 2004). Indeed Allen (2004) highlights the ethical dilemmas which arise from combined practitioner/researcher roles where a situational approach may conflict with a duty based one typical of nursing. As a qualified and registered nurse, I possess the knowledge, skills and experience to assist in resuscitation and am bound by a code of conduct to help in situations of emergency (Nursing and Midwifery Council, 2018).

A highly participatory and active role in the field is endorsed in contemporary ethnography as a valuable conduit to the life of the native whereby personal exposure enhances insight into their social world and the challenges and processes involved (Emmerson et al; 1995). From a pragmatic standpoint participation in activities can lead to acceptance which is a matter crucial to the success of an ethnographic study (Brewer, 2000) and has indeed facilitated acceptance in the pre-hospital care setting (Douglas, 1969; O'Neill, 2001). O'Neill (2001), who had previously been an Emergency Medical Technician, carried equipment for staff and found himself participating in resuscitation. My active role in the field was fuelled to varying degrees by my awareness of the culture and persistent valuing system in healthcare practice which favours physical work and doing (Melia, 1987), this was further reinforced by negative comments of some crews regarding students' non participative behaviour in practice. It is fair to say that my involvement to a significant extent also assuaged my sense of gratitude to the crews for allowing me to go with them and helping was my way of reciprocating.

The advocated closeness and 'ethnographic immersion' in the field of study (Emmerson et al; 1995 p. 2) is however not without its challenges, one of which is the need to maintain an appropriate professional distance and avoid the ever-present possibility of over-rapport (Brewer, 2000). Given the central role of the researcher in participant observation, the careful balance between insider and outsider is essential (Brewer, 2000); being 'in' enough to see and 'out' enough to recognise what is happening. A delicate balance between familiarity and crucial relations on the one hand and retaining critical distance is a constant consideration to maintain "critical faculties" (Brewer, 2000 p.60). In this sense the ethnographer should endeavour to be "…intellectually poised between familiarity and strangeness" (Hammersley and Atkinson, 1995 p.112)

The possibility of 'going native' is a real one, indeed Whyte's (1943) degree of involvement and sought after 'intimate familiarity' (Lofland et al; 2006) with the Norton gang was such that it compromised his research role at points, exemplifying the risk here. Appropriate positioning requires work and creates a constant tension for the researcher, the presence of which is to be expected and serves as a reassuring reminder (Hammersley & Atkinson, 1995; Lofland et al; 2006).

In my study being able to sympathise and empathise with the crews was essential to understand their perspective and their world as they see it; a central and traditional aim of ethnographic study (Brewer, 2000). These were heightened by my own biography and experience of the challenges of frontline health

care delivery. However, a level of detachment was also possible and achievable by my outsider status in respect of current healthcare delivery which enabled me to listen to them and to think about their perspectives without being directly involved with them as a regular part of my work. I also frequently engaged in private reflexive episodes in which my own personal identity, values and sense of self were brought to mind as a basis from which to see their perspectives and how these may differ from my own. These opportunities to reflect helped me to create and importantly maintain my sense and awareness of self and where I was positioned in relation to the crews I was studying. At times they were a useful reminder to me of my role and my purpose in undertaking my study and that as close as I may have got to the crews, I was nevertheless not one of them and had no desire to be.

3.7.5 Fieldnotes

The construction and maintenance of fieldnotes is a central component of ethnographic research which enables the capture and recording of insights gained from immersion and participation in the field (Emmerson et al; 1995). Whilst Emmerson et al. (1995) acknowledge significant variation in the nature and recording of fieldnotes they highlight the integrated relationship between the method and the findings, the importance of participant's indigenous meanings, the maintenance of contemporaneous fieldnotes to build upon; and the focus on social and interactional processes. These essential components served to guide the focus and content of my fieldnotes.

The recording of fieldnotes close to the event is widely advocated to facilitate accurate recall and to capture the rich detail of contemporary experience (Brewer, 2000; Fetterman, 1998; Lofland et al; 2006; Spradley, 2016). In my study specifically, extensive records were made of what was experienced during each observation period often immediately after or very occasionally the following day. A careful balance between observation of the setting and the recording of experiences within it is crucial (Lofland et al; 2006) and prompted me to monitor and limit the periods of time spent in the field. I would decide what time to leave during each episode of observation in a conscious attempt to ensure I had enough time to get back home and write up my notes as fully as I possibly could. I was often tempted to stay longer with the crews in case I missed something. However, I realised that my completion of fieldnotes immediately after observation periods was as important as the experience itself. If I could not capture it and describe it, I would have no findings.

My fieldnotes took a chronological, report-like format and describe what had happened during the period of observation; in this sense they represent a literal account, referred to as "substantive field notes" (Brewer, 2000, p.88). This chronological approach was consciously chosen incorporating a detailed narrative starting with my journey to the station; my arrival, the anticipation of the awaiting crew room, my re-negotiation into this setting with the crews, my allocation, the calls attended and what was done and said. This autobiographical lens served to locate me within the research journey, my relations and the responses to my presence and as such operationalized the philosophical principles of

analytical realism I described earlier (Altheide & Johnson, 1998). On a pragmatic level, I found the narrative, chronological format to my fieldnotes helped me to remember details of what had happened during an observation period; to recall and mentally revisit the events and interactions in as much detail as I could muster.

At the outset, my detailed fieldnotes were necessarily broad to capture the usual patterns of behaviour in the field; a more selective approach I thought may have led to an overly restricted focus at an early stage. Ethnographic research is characterised by the adoption of open, naturalistic approaches which avoid the imposition of externally situated, preconceived theoretical ideas on the setting (Brewer, 2000) and prize emergent theory generation instead. My broad approach to fieldnotes was an attempt to describe what was happening and to allow patterns to become apparent from within the field itself.

My record keeping during fieldwork also included the maintenance of a reflective diary which I wrote in tandem with my fieldnotes. This enabled the expression and recording of my perceptions, feelings, emotions, relations and challenges in the field which combine to give crucial context to the factual data (Brewer, 2000; Spradley, 2016) and communicate the researcher's experience of doing the research and the factors which were brought to bear on it. This level of transparency transports readers into the context of the setting and the process of naturalistic inquiry and serves to implement the "ethnographic ethic" of analytical realism (Altheide & Johnson, 1998, p.489). My reflective diary offered me a crucial milieu for analysis and critical thought about what was going on in the field and importantly what these might mean and what they were possibly achieving and communicating; issues explored were significant, interesting and patterned. My interpretative notes clarified and captured my thoughts about key issues at the time and served as a valuable reminder and basis for future analytical discussion.

In formulating an "ethnographic record" the inclusion of the specific language, verbatim statements and concrete details is advocated to capture and communicate a complete picture of the field; its culture and context (Spradley, 2016 p.33). In my study I attempted to record as much detail as possible including the spoken word. However, I found the nature of the setting; its' fast pace, my intention to interact with the crews as much as possible and minimal opportunities for privacy and time out, collectively rendered note taking in the field particularly difficult and heightened my reliance on memory. Emmerson et al. (1995) recommend the use of jottings as brief statements or words quickly scribbled to help jog the memory and facilitate recall and the writing up of full field notes after the observation. They advocate the recording of key components of events and interactions which can include direct speech and significant statements and a suggestion of what these might mean. They also advocate recording of concrete sensory details such as words and non-verbal behaviours and the description of these as they are seen; the focus being on what is being expressed.

In my study, as recommended a small discreet, pocket-sized notebook was used to record jottings (Emmerson et al; 1995) and was specifically chosen for ease of transport and storage. The notebook

fitted into my jacket pocket and could be easily retrieved to make notes while out with the crews. The practical challenges of detailed note taking mentioned above, led to the frequent use of jottings such as key points and occasional statements or phrases that I was able to commit to paper and expand on later. These were sometimes a brief note of calls attended which served later as an aide memoire from which I could recall and retrace the events and experiences of a few hours earlier.

Careful consideration is accorded to the visibility of note taking in the field and the implications for the relationship with participants (Emmerson et al; 1995). Note taking can be overt or covert; with the former offering the potential for greater flexibility and capture of rich detailed experiences but with possible risks to delicate relations central to the ethnographic endeavour (Emmerson et al; 1995). Note taking is an explicit reminder of the researcher's role in the setting and can be perceived as threatening. O'Neill (2001), a former Emergency Medical Technician found overt note taking to be negatively perceived by his participants and he resorted to taking notes in the back of the ambulance when it was not in use. Participants became accustomed to him regularly taking time away for note taking which led him to conclude 'out of sight' was 'out of mind'. Emmerson et al. (1995) suggests the use of toilet facilities, store cupboards, stairwells or rest rooms to make notes and Philpin (2004) sought the space and privacy of toilets for note taking during field work in an intensive care setting.

In my study note taking was at times overt and covert, although as my observation progressed it became more overt. At the outset of fieldwork when I was starting to become familiar with and gain the trust of the crews, I felt reluctant to overtly take notes however, as time progressed, I trialled note taking in their presence a few times and beyond the initial visual recognition from them I found no objection.

3.7.6 Interviewing key participants

Individual in-depth research interviews are the typical accompaniment of participant observation in fieldwork studies, which collectively serve up a comprehensive insight into the setting under study (Brewer, 2000). The relationship between these methods and the data produced is varied and complex and has been subject to progressive thinking and development (Atkinson, Coffey & Delamont, 2003).

Historically, participant observation has been granted supremacy from some significant and influential quarters (Becker & Geer, 1957) as the preferred method of verifying events in the social world; in opposition to reliance on individual's retrospective accounts that may be subject to distortion. Underpinned by philosophical and epistemological views, observation offers a confident, privileged seat for viewing in the pursuit of an independent, objective reality. Alternative perspectives such as methodological triangulation (Denzin, 1978) proffer a more egalitarian relationship between observation and interviewing however persist in perpetuating an overly simplistic and naïve relationship between problems, methods and the data generated (Atkinson et al; 2003).

Alternative views however challenge the somewhat restricted perception of social action and argue for a symmetrical perspective wherein interviews equate to social action and become appropriate ways of reflecting cultural understanding and interpretations of the social world (Holstein & Gubrium, 1995).

In juxtapose to traditional views and harnessing philosophical perspectives on truth as a subjective phenomenon, Holstein and Gubrium (1995) perceive respondents as active interpreters, creators and constructors of knowledge and meaning. Interviews rather than liberating human vessels of a generic body of knowledge from their passive occupants, are conversely seen as opportunities for action whereby accounts are constructed, communicated and presented in particular ways to achieve ends (Holstein & Gubrium, Ibid). The active interview offers an opportunity to stimulate and illuminate individual's interpretive capabilities in the process and product of the interview, forming the basis for analysis and understanding.

Edwards and Potter (1992) present a convincing argument for the creative, active and purposeful nature of account giving. Carefully constructed and functional, accounts are described by these authors as "contextualised and variable productions that perform pragmatic and rhetorical work" (p.54). Descriptions and accounts are perceived as socially purposeful and attribution orientated, possibly used as defence or mitigation. Collectively these theoretical perspectives present individuals as active, creative, meaning giving and purposeful constructors of knowledge through both the content and process of communication. Viewed in this way interviews become a rich and fruitful resource for analysis as to what is being done, for what purpose (for example see Baruch, 1981 & Coffey, 2012) and importantly why.

In my study, these philosophical views were operationalized through my use of in-depth ethnographic research interviews with key participants drawn from the field with various key roles within EMS provision. Many of these crew members I had accompanied; observed and spent time with during the fieldwork period, which served as a basis and broad guide for questioning. The interview guide and specific questions were based around sources of 'puzzlement' and interest (Lofland et al; 2006) that had come to my attention during fieldwork that I wanted to know more about and explore further; I wanted to know what they were doing and why. Existing theoretical constructs of emotional labour (Hochschild, 1983, 2003) and emotion process work (Boyle, 1997; Thoits, 1985) were used as a broad framework as opposed to a prescriptive tool to reassert their existence, in congruence with the philosophical and epistemological ideals of inductive theory generation and discovery. From a pragmatic perspective I was constantly mindful of the potential impact of my existing theoretical understandings of emotional labour and emotion work and possible imposition of these through overly prescriptive and leading questions. To this end, I formulated open questions to enable the exploration of perspectives from actors within the field, their roles, experiences, challenges and responses. Research interviews were undertaken with 25 staff from within the EMS at Bryn Station; 18 frontline EMS crews

consisting 12 paramedics and six EMTs, six CTL's (who hold management roles) and one administrative staff member (See appendix 6 – Details of sample).

The interviews incorporated a recommended developmental structure and "global organisation" format (Lofland et al; 2006, p.100); beginning with broad introductory questions about them, their role (For example 'How long have you been working in the ambulance service?' 'Tell me about your current role here?'). Broad, neutral questions to start the interview offer a gentle pathway to accessing specific areas of questioning (Lofland et al; 2006) and enabled my key participants to relax and ease into the interview process with me. My questions progressed to more specific areas I wanted to explore with them relating to the use of the emergency ambulance service, the challenges of their role and how they deal with these. The interviews ended with a final, open question which gave participants an opportunity to add to what they had said.

18 in-depth research interviews were conducted with frontline EMS crews using an interview schedule with 14 open questions which were informed by my participant observations with them and areas I wanted to explore further. For example, 'Who do you find uses the emergency ambulance service?' 'Tell me about the challenges of your role?'). (See appendix 9 – Participant interview schedule-frontline staff).

I conducted in–depth research interviews with six CTLs; staff with leadership and management roles combined with frontline clinical work, to furnish a comprehensive picture of the differing roles and perspectives within the field. 12 open, exploratory questions were formulated to capture perspectives on the challenges of emergency pre-hospital care and the support available for staff. As indicated above, I used a developmental structure beginning with broad, introductory questions about duration of service and progressing to more specific questions on the changes seen within the service (For example 'Tell me about the changes you have seen in the ambulance service since you started?'); the challenges of emergency care provision; how these are dealt with by staff; what support is available and whether staff use the support systems (For example 'What do staff do to deal with the challenging aspects of their role?'. (See appendix 10 – Participant interview schedule – organisational management staff).

I also conducted an interview with one administrative staff member at Bryn Station, who held the position of secretary to the station manager and had regular contact with the EMS crews for the purposes of arranging time off in lieu and ordering of uniforms. For this purpose, an interview schedule was developed using nine open questions exploring their role in the station, their involvement with EMS crews and what they perceive to be the challenges they experience and how they deal with these. (See appendix 11 – Participant interview schedule – Administrative Staff).

The terms 'interview schedule' have been used in my study which may suggest an inflexible and heavily structured approach (Brewer, 2000; Lofland et al; 2006), however during interviewing these were used

in a flexible and facilitative rather than restrictive way. In congruence with philosophical perspectives (Holstein & Gubrium, 1995), I was keen to encourage and enable individual account giving crafted in "character and contour" by the informant (Lofland et al; 2006 p. 102). A balanced and flexible approach was taken whereby participants were encouraged to talk in a flowing, natural way and during which I found issues were often spontaneously raised by them, sometimes obviating the need for me to pose a question about it.

Probes were identified for each area of questioning which included possible issues to explore that had been experienced during fieldwork (Lofland et al; 2006); for example, crew room banter and humour. I found participants would often mention the crew room banter and humour without my prompting and would refer to my experience of it as support. Probes were also used when participants raised issues which I thought needed clarification or further exploration and included questions such as 'is it?', 'tell me more about that?', 'what do you mean by rubbish calls? I also used non–verbal prompts such as head nods, smiles and sympathetic facial gestures as participants on occasions recalled experiences we had shared during my fieldwork and particularly in situations where they sought my agreement with their perspective. I consciously adopted an informal, conversational and relaxed style to interviewing to encourage participants to feel comfortable and to facilitate expression of their individual views and perspectives.

I undertook and electronically recorded the interviews within the ambulance station in a small, private office during mutually convenient times when crews were on days off or before the start of a shift. Interviews with those in leadership and management roles were usually done when they were undertaking administrative and management duties.

3.7.7 Documentary and visual sources

Ethnographic investigation can incorporate analysis of relevant documentary and visual sources to provide insight into the culture of the setting under study (Brewer, 2000; Lofland et al; 2006; Mason, 2002, Prior, 2003). Indeed "conscientious naturalistic investigators" expand their data net beyond talk and action to incorporate potentially valuable supplementary information which may cross their path (Lofland et al; 2006 p.88). Documents are a potential source of valuable data and can serve dual purposes as containers of information or instruction and as an agent, whereby they can be used and manipulated towards particular ends (Prior, 2003), such as authenticity and defence. Indeed, documents are accorded a high level of value as confirmatory evidence, which can supersede the spoken word. In both senses, documents represent actions and are creative, expressive and potentially active phenomena (Prior, 2003), which have the potential to 'speak' to the researcher. These can include existing documents created by the setting such as charts and records or can be generic official documents that have relevance to the topic of investigation. Documentary data can also be generated as part of the research process through for example diaries, biographies and pictures. The inclusion of documentary

sources is contingent on their relevance and significance to the phenomenon under study. For example, Philpin (2004) included patients' clinical charts in her ethnographic study in intensive care which were a significant manifestation of symbolism and ritual, her topic of interest, in this context.

The inclusion of documents and visual data is also contingent on epistemological and ontological positions which hold these as natural and meaningful aspects of social reality that individually and independently represent the social world (Mason, 2002). More specifically, visual phenomena can be perceived as "material culture" that serves to express features which are complex, multi-sensory and not confined to language (Mason, 2002, p.107). In essence, "things perform work in the world in a way that words cannot" (Tilley, 1999, p.259).

In my study, the world of pre-hospital care was both strange and unfamiliar to me and as such I was struck by the contextual and physical features of the settings, the station and the emergency vehicles. I was mindful of their fabric; curious as to what this said and its place in the overall cultural picture and have thus included detailed descriptions within my fieldnotes as a basis for analysis. I also include detailed descriptions of the setting of my study, Bryn Station in chapter 4.

I was drawn to the visible, contextual documentary sources displayed within the station in and around the crew room on notice boards for and sometimes by crew members as potential offerings into the patterns and practices of this social setting. Collectively displayed, these were of a formal and informal nature. The formal included occasional organisational memoranda from management sources circulated downwards, periodic admonishments following feedback, training opportunities, initiatives and developments in practice, research projects and information on health, well-being and sources of support for stress. These provided insights into the organisational priorities, responsibilities and their communication with those in the frontline of care delivery. I was also curious about the informal material displayed on the notice board by crews which included details of social events including parties, celebrations and invitations; with details of arrangements, costs and contacts and the names of those wishing to attend. These reflected the social nature of this setting; of the work done by crew members to retain and perpetuate this and the pursuit of enjoyment and recreation as a collective phenomenon. I collected this data in the form of jottings in my notebook during fieldwork which I later wrote up in my fieldnotes. In some instances, I was able to collect physical copies such as the Patient Care Record and some organisational memos, which I filed in the pages of my notebook for later analysis.

Collectively, this detailed, holistic and contextual backdrop offered a complete picture as a basis for transparency and "validity-as-reflexive accounting", operationalising the principles of analytical realism (Altheide and Johnson, 1998, p.46).

3.7.8 Data analysis and interpretation

Historically qualitative researchers have paid little attention to explicating the process of data analysis promoting attempts to instigate a more systematic and transparent approach (Miles & Huberman, 1994). Data analysis, interpretation and presentation are the key, broad components of ethnographic inquiry (Brewer, 2000). Analysis involves careful organisation of the data to form patterns, categories and units and their potential relationships. Interpretation requires the explication of these patterns and relationships and their meanings, drawing on deeper levels of analysis, skill, creativity and the imagination of the researcher (Brewer, 2000). The presentation is the formulation of findings in written text as the product of ethnography.

Despite various philosophical perspectives amongst ethnographers, there is consensus on the use of an inductive approach to analysis which enables authenticity to the data and the generation rather than imposition of existing theory (Braun & Clarke, 2006; Brewer, 2000). Thematic analysis incorporates an inductive approach to data analysis enabling identification and recognition of patterns through familiarity with the data, generation of codes, search; review and definition of themes and production of the report (Braun & Clarke, 2006). This approach was used to guide the foundation of data analysis in my study. My analysis of data began and continued with my detailed fieldnotes of events and experiences of attending various calls with crews and interactions both in the front stage and backstage contexts. During my observations in the field and through the writing and reading of my fieldnotes I noticed how crews appraised calls in differing ways, the patterning of their appraisals, their interpretations of 'real' emergency work and how this impacted on their emotions and behaviours at the time and after as they shared their experiences with each other in backstage contexts such as the crew room. I began to organise my extensive fieldnotes into types or examples of crew' responses to differing situations and calls, what they had said to me about these and the behaviours I had observed and noted. Examples of my early 'types' of calls included 'good' calls, 'rubbish' calls and misuse of the EMS.

My early field observations of how crews appraised their work in differing ways guided me in structuring my interview questions to offer opportunities for them to tell me more about these. I did not want to 'lead' them towards issues or responses but wanted to offer them an opportunity to tell me in their own words and from their own perspective how they saw their role, the role of the emergency ambulance service, types of calls they attend and how they appraise these and their emotions within this specific cultural context.

Each interview was electronically recorded and later transcribed by a recommended professional and confidential transcription service over a period of a month. My decision to use this service was prompted by consideration of available time, my lack of expertise and speed in the skill of transcription and my time-consuming attempts at this in the past. I decided to use my time to focus on the analysis and interpretation of my data findings once the research interview recordings were transcribed.

Following transcription, I checked each interview transcript against the interview recordings and noticed there were errors in parts of the transcripts and some missing text with question marks (such as '...?'). In these instances, I went back over the recording slowly and with the volume level at its maximum so that I could decipher what had been said and where possible add this to the transcript. Instances of missing text occurred when participants used rapid speech patterns, were particularly quiet, when colloquialisms were used and medically technical terms such as 'NOFF' (which is an abbreviation for the fracture of the neck of the femur bone). This process took a fair amount of my time however, it served to remind me again of what my participants had told me when I had interviewed them. Once this was completed I read and re-read each interview transcript and began to code sections of data. From the codes I compiled a list of key issues or themes from what was said. This for example included frustrations with calls, moaning, crew room banter, humour and talking with colleagues. I colour coded each interview transcript so that I could immediately see the variation of informant extracts I had used to represent the perspectives. I created a selection of folders on my personal computer which I labelled with each theme and transferred the relevant text data into each file for further analysis and organisation.

I returned to the folders and started to read each data extract in detail and to organise my analysis and write up of my themes and sub-themes and integrate my data. In my first attempts to analyse and write up my findings I felt the need to include all the data I had to reassure myself and those reading it that this really was there in my data. However, I soon realised following feedback from my supervisor (MC) that this was not necessary and that one example to support a point was sufficient. I selected exemplars which best communicated and illustrated the phenomenon. I also linked my interview analysis with my earlier analysis and organisation of my fieldnotes and through this process located case examples of calls I had observed which illustrated what participants were telling me about in the interviews. I then combined cases from my fieldnotes with my interview analysis and integrated the data as a whole picture or representation of what was going on and participants' interpretation of it.

My analysis of the data took time, close attention to detail; to what was said and done and how, and in what context. My analysis included the language and terms used and continuous attention to possible meanings and to what was being done by my participants which added a deeper level to my understanding.

3.7.9 Trustworthiness

Undertaking ethnographic research and in particular fieldwork, presents challenges and considerations for the researcher (Brewer, 2000; Hammersley & Atkinson, 1995, 2019). Fieldwork and observation whilst offering crucial access to the behaviours and social meanings within a particular group, also encounter the challenge of the potential impact of the researcher on the researched and the possibility that behaviour may change, thus impacting on the degree of typicality and authenticity of data. However, spending prolonged time in the setting is a characteristic of ethnography and is perceived to

facilitate acceptance and 'typical' behaviour (Brewer, 2000; Bryman, 1988). In my study I undertook consecutive periods of participant observation for 280 hours with the emergency crews for a continuous period of 10 months which enhanced our familiarity, their acceptance and trust in me and which ultimately enabled authenticity.

Geertz (1973) highlights the importance of understanding the significance of behaviour and meanings in their context through the capture of rich, thick description rather than superficial frequencies of occurrence. In my study attention has been given to the inclusion of detailed description particularly in my field notes as a basis for capturing behaviours and their meanings within context.

Interpretation presents another challenge in the conduct of qualitative research (Bryman, 1988, 2004; Freshwater, 2011) and indeed in ethnographic research, which as discussed earlier has prompted some researchers to incorporate greater transparency and rigour (Altheide & Johnson, 1998; Bhasker, 1989; Hammersley, 1990). In my study interpretive validity has been enhanced by the adoption of analytical realism and "validity-as-reflexive-accounting" (Altheide & Johnson, 1998, p.489), which offers a window into the cultural and social context of pre-hospital care and the experience of the researcher as a transparent basis for interpretation.

My analysis of the findings of my study has been subjected to the close scrutiny of my supervisors throughout which has served to expand, enhance and verify my interpretation. Their constructive feedback on occasions proved valuable reminders of the importance of critical distance in my understandings and presentation of the viewpoints expressed and in the positioning of myself within it.

Reflexivity is considered a feature of good research practice and is a complex concept with differing interpretations and perspectives (Buscatto, 2021; Keuhner, Ploder, & Langer 2016). Reflexivity involves reflection and critical consideration of the data and the social processes which impact on and affect data (Aull Davies, 2008; Brewer, 2000). Factors to consider may include the preconceptions of the researcher, the sensitivity of the issue, location of the setting, power relations and the interaction between the researcher and participants (Brewer, 2000). Reflexivity involves a critical introspection of self; ones' lens and its' potential impact on the research (Mason, 2002); is derived from the partial and selective nature of representations and offers a response to this. Stanley (1996) differentiates between descriptive and analytical reflexivity. Descriptive reflexivity centres on describing factors and their impact on the outcome of the research. However analytical reflexivity requires a deeper level of reflection which examines theoretical and methodological issues and the researcher's particular perspective on the topic. In my study analytical reflexivity has been maintained throughout by the adoption of a constant critical and questioning approach to my perceptions and interpretations, often through internal thinking processes and dialogue with my supervisors (particularly MC).

My fieldwork reflective diary (See appendix 5) afforded me critical space to identify key issues and to critically consider their implications and meanings and my own response to them, as part of the process of doing research. I felt that my reflective diary was a crucial accompaniment to my fieldwork which facilitated attention to myself, the placing of me at the centre of my study and the process by which I make sense of it and communicate it.

Keuhner et al. (2016) argue and exemplify differing, epistemologically situated perspectives on subjectivity and reflexivity in research discourses, whereby subjectivity is embraced and actively harnessed to enhance understandings of the subject. They contrast this view with powerful "hegemonic discourses" on the threat of subjectivity (p.699), in quantitative research traditions, which see it as problematic, to be controlled, minimised and otherwise accounted for in research findings. They view these endeavours to constitute 'weak' reflexivity and juxtapose it with 'strong' reflexivity which embraces subjectivity as a strength which can be harnessed as part of interpreting the social world. However, they highlight the dilemma and potential risk for researchers who relinquish the "authoritative position of the sovereign researcher" and accept "her decentredness" (p.700), which can be seen to undermine assertions of validity and truth.

Buscatto (2021, p.150), proposes that a "reflexive approach" challenges the researcher to maintain a careful balance between involvement and detachment. The latter involves a critical questioning of the researcher's perspectives and the situations through which data are produced. As indicated above, the maintenance of a reflective diary (See appendix 5) has enabled a reflexive awareness of myself, my preconceptions, perspectives and expectations and their potential impact. The "social conditions" (p.150) through which my study has been conducted and their potential implications are explored at pertinent points within the chapters of this thesis. (For example, chapters 3 & 4). Examples include the different responses of crew members towards me and their willingness to allow me to observe their work, some welcomed me whilst others avoided me (See pages 56, 79 & 80). Also, as time passed, I found that my participatory role, helping crews, engendered a positive attitude towards me and enhanced their willingness to allow me to accompany them (See page 80).

Reflexivity in the conduct of research investigation necessitates a critical awareness of self and the potential impact of this, so that the perspectives of those who are central to it, who give it meaning are authentically presented. It has been my intention in this study to achieve this.

3.8 Ethical considerations

Ethical issues and considerations are a crucial component of any research investigation and no less ethnography (Hammersley & Atkinson, 2019), which involves the up-close involvement in the everyday lives of people, their behaviours and meanings in their natural context.

Research ethics are concerned with fundamental theoretical and philosophical beliefs and values which serve to guide and instruct on the appropriate conduct and behaviour of researchers in the business of research activity (Biggs, 2010). Key ethical principles include autonomy, beneficence, non-maleficence and justice (Beauchamp & Childress, 2001) and also fidelity, veracity and confidentiality. Ethical codes represent these fundamental beliefs and as such facilitate their application and fulfilment in the practice of research through attention to informed consent, the right to withdraw from the study, anonymity and confidentiality; and the potential benefits and harm (Offredy & Vickers, 2010).

Ethical approval is a key requirement in research investigation whereby proposed research is assessed and benchmarked against established ethical standards to determine ethical rigour (Biggs, 2010). In my study ethical review and approval was requested from the National Research Ethics Committee via the online electronic Integrated Research Application System (IRAS) in September 2014. I requested a proportionate review as the study did not require patient identifiable information and as such generated no significant patient-relevant ethical issues and this was undertaken by the East of Scotland Research Ethics Committee (See appendix 12 – confirmation of request for ethical approval). A few minor additions were required (See appendix 13 – Research ethics initial opinion letter) including clarification on the participant's right to withdraw from the study at any time on the participant information sheet, the inclusion of a witness signature on the participant consent form, the use of formal headed paper on the participant information sheets and consent forms; and details of the specific ethics committee. Following these additions, a favourable opinion was received on the 17th of October 2014. (See appendix 14 – confirmation of favourable opinion and ethical approval).

3.8.1 Informed consent

Respect for autonomy and choice is upheld through information giving, informed consent, avoidance of coercion and the right to withdraw from the study (Offredy & Vickers, 2010). In my study staff who were directly involved in emergency care delivery within the ambulance station were initially informed of my research study through a recruitment poster which was displayed on the main notice board in the crew mess room. (See appendix 15 – Participant recruitment poster). This is the central area where the emergency crews converge, typically at the changeover of shifts, between calls and for breaks during shift periods and as such proved to be an appropriate place. My anticipated opportunities to speak to staff about the study before fieldwork proved difficult to achieve as the station was extremely busy and the crews were often out on calls for long periods during a 12-hour shift. The poster included a broad statement about the nature and aim of my study and requested that staff contact me should they not wish to participate or have any queries about the study. A week elapsed between the poster displays and the commencement of my fieldwork so that any queries or concerns could be raised. I did not however receive any queries during this period.

At times during fieldwork crews asked what I was specifically interested in which proved initially challenging in that I did not want to deliberately deceive them, nor did I want to influence their natural behaviour. Also, importantly, I was keen to just see what emerged about them, their roles, and their challenges and how they managed these which I reiterated through a general, inquisitive and non-threatening response. Contrary to simplistic perspectives on overt and covert research as distinctive opposites, variation and complexity exists even when the researcher is known (Lofland et al; 2006). Roth (1972) highlights the secretive nature of research and the lack of complete transparency for a number of practical and indeed legitimate reasons including my own, the impact on the research and its emergent rather than pre-determined nature.

The majority of my time was spent with crews from Bryn Station however, I did often interact with crews from other stations as they naturally converged in areas like Accident and Emergency. These included staff that had little or no knowledge of me or my study. On these occasions I found crews would sometimes introduce me and on others I would say that I was a nurse from the university doing research on their role and the challenges involved.

Informed consent was gained from key participants before undertaking individual research interviews, which included staff involved in frontline care delivery and those with additional managerial responsibilities within the station. For all interviews I adopted a particular format to avoid any omissions whereby I initially thanked them for agreeing to do the interview; gave them a copy of the participant information sheet to read (See appendix 16 – Participant information sheet – frontline staff, appendix 17 – Participant information sheet – Organisational management staff and appendix 18 – Participant information sheet – administrative staff) and verbally summarised the content areas. I reassured participants that anonymity and confidentiality would be maintained; that they would not be identified in any description of the findings and that they were not required to participate and could withdraw from the study at any time. I offered to answer any questions and asked participants to sign the consent form if they were willing to participate in my study. (See appendix 19 - Participant consent form – frontline staff, appendix 20 – Participant consent form – Organisational management staff and appendix 21 – Participant consent form - Administrative staff).

The nature of my study and its fieldwork granted me necessary access to the emergency care and treatment of patients, the privacy of their physical, social, psychological and spiritual world. I was particularly mindful of the potential intrusiveness of this and was keen to limit it and protect their welfare. Wherever possible and practicable the crews would automatically introduce me to the patient and their relatives as part of their introductions. These introductions varied depending on the crew; some would name us all individually as the crew which included me, some would say ‘this is Ang she’s a nurse’ and others would say ‘this is Ang she’s a nurse doing research on us’. On one occasion one of the crew Arthur introduced me as ‘Blodwen’. I was a little surprised by this but smiled and did not

contradict what he had said. I was aware that some crews could be sarcastic and humorous at times. As mentioned earlier, my acceptance in the field particularly by patients and relatives, was aided by the use of a high visibility jacket with the ambulance service logo which served my purpose well in conferring an identity and legitimacy in this context whilst not communicating a specific clinical role.

In some clinical situations introductions and consent from patients were not possible or appropriate, for example in emergency resuscitations or trauma cases; here the priority was to get in, assess and respond to the casualty as quickly as possible. In these situations, if there was no objection from the crew I remained often to assist and help where I could. Merrell and Williams (1994) highlight the practical challenges of gaining and maintaining informed consent when undertaking participant observation and the need for tactical decision-making based on the individual situation.

3.8.2 Confidentiality and anonymity

Anonymity is a central feature of field research implemented through the researcher's promise and duty to maintain confidentiality and the deliberate masking of identity and context (Loftland et al; 2006). Although a "cardinal principle of naturalistic fieldwork"; in practice confidentiality cannot be guaranteed especially with particular groups or communities where identity may be suspected or guessed (Lofland et al; 2006. p.51).

Anonymity and confidentiality are nevertheless crucial research responsibilities which impact on access, trust and the authenticity of participants and as such have been addressed in my study through a variety of actions. All data gathered including my detailed field notes, interview transcripts and documentary sources were rendered anonymous by me; data have been coded, names of people or places have either not been recorded or have been removed to protect informant identity. All data collected have been kept securely and safely throughout the study and stored on a password protected computer at the university to which only I have access. Any printed or hard copy transcripts and field notes have been kept in a locked cupboard in my office. All data generated have been analysed by me in the university and in my private study at my home. Access to my data and analysis has been confined to me and my supervisors. In accordance with Swansea University recommendations at this time, data will be retained for a period of 5 years after the study completion.

The data gathered on patients has been minimal, relating only to the nature of the call, the problem and a brief record of the care given. I have used fictitious names in all record keeping and any patient information gathered during the study has been treated in a strictly confidential manner in accordance with the professional protocol (WAST, 2013b) and my own Code of Professional Conduct (NMC, 2018).

3.8.3 Harm/benefit

Beneficence and non-maleficence; doing good and the avoidance of harm respectively, represent important responsibilities for the researcher requiring careful assessment and consideration (Offredy & Vickers, 2010). Although it was considered unlikely that my participants would experience harm as a result of involvement in the research, I was mindful that experiencing and recalling challenging emotional experiences could prove distressing. During fieldwork, some crew members spontaneously and graphically described experiences which were significant to them and had remained vividly within their memory. These were often tragic, sad and emotionally difficult. At times I found myself emotionally drawn into their recollections, though their vivid recall of events and the minutiae of their descriptions. On these occasions I listened intently to their stories and tried to communicate my genuine empathy for what they had experienced and felt and what this meant to them.

3.9 Conclusion

In this chapter I have set out the methodological underpinnings of my study through a critical exploration of ethnography as methodology and method. I have reiterated my aim and research objectives and situated this within the philosophical and epistemological backdrop of the qualitative tradition and specifically ethnography.

I have explored the anthropological origins, nature and characteristics of ethnography amidst recognition of important contributions from classic studies both in the UK and from across the Atlantic. I have highlighted the challenges and critics of ethnography from within its ranks and amidst the background of postmodernism juxtaposed to the powerful insight that this approach to research can give and importantly, its suitability to my study.

I have dedicated the remainder of this chapter of my thesis to the specific methods I have used in my study. I have centred my attention to explicating the processes I used to access the setting, my selection of setting and sample, my approach to participant observation and in-depth research interviewing, the documentary sources around me, and how I analysed my rich data within the broader framework of analytical realism. I have completed this chapter with discussion of important ethical principles as part of good research practice and how these have been specifically addressed in my study.

The next chapters of my thesis (Chapters 4, 5, 6 and 7) will focus on my detailed findings, my interpretation and analysis of them and their meanings to those at the centre of the setting and my study, the EMS. The first chapter of my study findings focuses on the specific setting of Bryn Station; its location, physical features, staff and their roles and positions within the organisation and the routine features of a typical shift within the EMS.

Chapter 4

Bryn Station; the setting of my study

4.1 Introduction

In this chapter I describe the setting of my study, Bryn Ambulance Station which was the base for my research. Ethnography typically centres on human actions, perceptions and interpretations amidst natural, everyday contexts (Hammersley & Atkinson, 2019). The physical, contextual backdrop is central to the nature and purpose of ethnographic inquiry, in capturing and portraying a holistic view of a specific social setting; of what is being done by people, with what purpose and meaning to them. Ethnographers are tasked with metaphorically taking the reader into the world of those being studied to facilitate an understanding and appreciation of that world; contextual detail and usual patterns of behaviour and structure are its core framework (Brewer, 2000).

In keeping with ethnographic tradition, I provide a description of the history of Bryn Station, its physical features and layout, its fabric and decor, its organisational role in service provision, its structure, the people and their roles and positions. I also show the regular checking and preparation of vehicles and equipment at the changeover of shifts, the organisation of roles and responsibilities between crews and the routine elements of a shift in the EMS. My purpose in doing so is to share the context and background of my study; to show its physical features, social context and organisation.

4.2 Study setting

My study centred on one ambulance service Trust serving an extensive geographical area within the United Kingdom. The study had its base in one ambulance station within the Trust which serves a large urban, inner city area. The geographical area incorporates two large general hospitals, the largest of which is located on the northern side of the city. Prior to and during my study this hospital has undergone extensive and continued expansion and currently incorporates a range of medical and surgical, general and specialist services, together with cardiac and burns and plastics specialities. This hospital houses the major Accident and Emergency Department and its geographical location has enabled it's recognition as the major trauma centre for the city and for an extensive area covering the south west of the country.

4.2.1 Bryn station

The ambulance station is 1.6 miles from the city centre, has easy access to the motorway and to the two main, large acute hospitals. It is the main and largest station within the regional area and unlike the smaller stations does not share premises with the Fire and Rescue Service. The station is a base for three distinct sections of the service. The Emergency Medical Services (EMS) responds to emergency 999 and urgent GP calls and is supported by the Urgent Care Service (UCS); the latter respond to urgent

calls and transport patients who have additional needs such as oxygen therapy and monitoring between hospitals. The third section is Patient Care Services (PCS) providing non-emergency care and transport for those with a medical need such as for clinic appointments or day centres and on occasions transport between hospitals.

The station is a well-established one with a long history dating back to the late 1960's when it was first opened by the then Mayor of the town. The geographical location of the station on the close periphery of the city reflected the 'typical' demands of current, urban pre-hospital emergency care and offered a setting rich in quantity and variation of calls as a basis for exploring the emotional demands and challenges of this work. I considered Bryn Station to be an ideal platform from which I could gain access to the ambulance service within this region. However, during the research planning the Chairman of the Pre-hospital Emergency Research Unit suggested the station was unsuitable. The reason given was that a crew member had recently been suspended from duty and was under investigation. Nevertheless, a short time later when the study proposal was discussed with the Heads of the Service within the area, the station manager of Bryn Station was particularly interested and keen for me to do my study there.

I was made aware through various comments from those who knew the station that it had something of a reputation for having long serving crews with 'strong personalities' and viewpoints. During my first episode of participant observation in Bryn Station (2.3.15), whilst the crew I was with were cleaning the floor of an ambulance after a patient had been sick, one crew member Mike who was telling me about the station said 'we are quite militant here, we won't let management walk all over us'. I interpreted this as a possible indication of some underlying conflict between service management and the frontline workers. Mike's statement hinted strongly at this and used it to present an image to me of the frontline workers as those who can be resistant, strong and powerful. This assertive portrayal of him and his EMS colleagues served as a message, perhaps even warning, to me as a researcher.

Many of the EMS crews were welcoming and helpful to me during my participant observation and were willing to take me with them, but this was by no means universal and some crews were suspicious of me from the outset and this didn't change. One crew member said to me at the start 'I can't teach you anything' and despite my assurances that I did not need to be taught he only ever acknowledged me with a brief hello and nothing more. He appeared to effectively close down the option of allowing me to observe his work by constructing my presence as akin to that of a student who might observe to learn something. His declarative statement worked to imply that I have knowledge and expertise beyond his. This appeared as an outwardly socially acceptable rationale for denying me the opportunity to observe his work and his meaning and delivery of this line in closing down the option was made abundantly clear. I took from this to mean that I would not be able to attend calls with him.

Another crew member appeared to particularly avoid me and one morning shift three months into my fieldwork (15.6.15), after it was agreed that I would accompany him and another crew member, they subsequently left the station without me (when they had a call, they would usually call me but didn't). It was a painful reminder of my vulnerability as a researcher and the fragility of my acceptance by the crews, of my dependency on their willingness to take me with them on which so much rested. It was a sharp contrast to the support I received from others, two of whom saw me sitting in the crew room and took me with them instead. At a point during the shift whilst the crew (Gail and Alex) were waiting outside the hospital in reference to me being left at the station Alex said to me 'don't worry about it, it's just him, the reason he wouldn't want to take you is because he wouldn't want you to see what his care is like'. I toughened up about it afterwards but a few weeks later one of the crews Tom (who I had got to know), offered to take me with him for the shift (the crew had to take an RRV to the hospital to relieve a crew already there), however when we went out into the garage to get into the RRV the other crew member said there was no room for me. I stood in the station garage and looked at the other crew member (who was one of the crew who had gone without me a few weeks before) and waited bemused. I had been in the RRVs and knew there was room in the back for me. I refused to go back in the station because Tom had said I could spend the shift with him. Eventually after a pause I said to Tom 'it's okay I will go with the other crew', who had offered to take me. I felt better that I had faced this head on.

I had come to realise from first-hand that undertaking an ethnography was not at all an easy feat. I found that I had to renegotiate my access to the crews every shift to some extent; at times this was easy if I were familiar with them but on other occasions it was more challenging and I would get anxious and a little panicky until it was agreed who I would accompany for the shift. Initially I felt I needed to work to earn the crews' trust and acceptance of me and to this end I would always offer to help carry equipment or to help them with the patient in ways I could and as time passed, I gradually got to know some of them the more time I spent with them which helped. Some crews looked out for me and went out of their way to help me, some crews not from the station already knew me from my educational role and this familiarity helped me at least gain some acceptance.

When my period of fieldwork was coming to an end, I attempted to arrange research interviews with the crews before I left and some agreed immediately. In some cases, however despite initial promises from them and my efforts to follow up they did not get back to me and my focus turned to alternative accessible sources instead.

These are examples of the challenges I experienced regarding access to sources and data for my study and the reality of negotiating, achieving and maintaining this. My experiences highlight the issues arising from socially sensitive research (Lee, 1993), where there may be perceptions of threat or risk by potential participants from involvement in the research. The individuals in my study felt threatened in some way which is perhaps understandable given what seems to be a fractious relationship with

management and the previous issues with a staff member suspended from work. In retrospect, this may have explained the initial reticence I perceived during early access negotiations specifically to Bryn Station. My endorsement from management to undertake the study implicitly aligned me with them and perhaps generated a sense of suspicion and mistrust of me by some of the crews. Lee (Ibid) makes the point that sensitivity is context dependent and cannot be known or predicted before entry into the setting. However, researchers must be aware of the potential, sensitive to the possibilities and knowledgeable of ways to deal with this.

This covert control has unavoidable implications for what and who I was able to access during my study, which limits what is observed and may as such limit my claims to seeing a complete picture of the natural order of things. However, research like mine, in a natural social setting is inevitably impacted by situated complexities which necessitate recognition, but which should not discourage research on valuable albeit, socially sensitive issues (Lee, 1993).

Bryn Station is situated within a densely populated, residential housing area and has within its vicinity a few public amenities including a supermarket and public house. Access to the station is through an exterior parking area, where staff would leave their private vehicles during shift periods. The exterior parking is small, often full and also houses vans which provide the courier service. The exterior parking area leads into a large, covered parking bay much like a large bus garage and has two opposite rows of twelve individual parking bays which are frequently occupied by ambulance vehicles. The first two parking bays on the right nearest the entrance are designated for the two emergency ambulances which cover each shift. All vehicles have a 3-digit number to enable their identification. Opposite and to the left houses the rapid response vehicles (RRVs) which include cars, some of which are 4x4 vehicles. On the wall of the first parking bay is a large white marker board which includes details of the weekly staff allocation to each of the RRVs. Immediately below the marker board are some chairs and a small table with tea making facilities used by some crews who work permanently on the RRVs. A smaller number of crew members are allocated to work on the RRVs on an occasional basis, dictated by need. The RRVs are driven if necessary, at high speed by paramedics as lone workers and are designed to enable fast response to immediate, life threatening emergency calls.

The station itself is a large, single floored brick building accessed directly from the ambulance parking bay, through a door in the right-hand corner. The door immediately to the left of this opens into a sluice room containing cleaning equipment including a mop and bucket. The entrance to the station is an old, wooden door with a small window and a coded entry pad to the left-hand side, which was disused. The wooden entrance door is easily pushed open and gives immediate access and entry to a corridor. Immediately to the left is an equipment storeroom and straight ahead through a short corridor opens directly into the EMS crew room. To the right on entry to the station is a long corridor with various rooms leading off, including store cupboards, a small computer room for staff, male and female toilets

and shower facilities. Towards the end of this corridor to the right a door leads into a small office with two desks and this leads directly into a large office occupied by the station manager.

The station although generally clean, is dated, old fashioned and well-worn in appearance. The décor still reflects the 1960s, with for example the iconic avocado green wash hand basin and shower cubicle in the toilets and does not appear to have been modernised since its construction.

The station is frequented by two cats, one of each gender, Tom and Poppy. Tom is station owned and the other wanders in from the surrounding neighbourhood. Some staff encourage, call and smooth the cats and both are well fed, with bowls of food and water placed along the main corridor of the station. The cats are frequently seen around the parking bay and typically on warm days will lay out on the bonnet of the stationary RRVs, reluctant to move.

4.2.2 EMS in Bryn Station

A key and central function of this station is EMS provision for the surrounding area and beyond if needed and for this purpose the station has Paramedics, Emergency Medical Technicians, Clinical Team Leaders and a station manager at its disposal. The locality station manager holds overall authority and responsibility for the EMS provision within Bryn Station. The station has six Clinical Team Leaders (CTLs) who make sure the crews are allocated to the emergency vehicles at the start of a shift and get equipment if necessary. They were responsible for the training and development of the crews and their periodic performance reviews. CTLs would also undertake clinical duties as Paramedics on the ambulance or RRVs and I noticed would help the crews deal with serious calls and major incidents when they arose too.

There are a variety of roles undertaken within EMS frontline service; paramedics are professionally registered and have responsibility to clinically assess all patients, to recognise, treat and manage immediate health problems to prevent deterioration and to transport to appropriate follow on care. Paramedics can undertake complex clinical skills such as endotracheal intubation, advanced cardiopulmonary resuscitation, venous cannulation, oxygen administration, intravenous fluid replacement, phlebotomy and can administer an increasing range of emergency drugs via different routes. Drug therapy includes those used in emergency cardiopulmonary resuscitation such as adrenaline and atropine; analgesics such as morphine and specialised drug therapy such as insulin (JRCALC, 2019).

Emergency Medical Technicians (EMTs) work closely with paramedics as clinical partners in the delivery of EMS provision. They too undertake the clinical assessment of patients and many of the clinical skills performed by the paramedic such as basic and advanced life support, trauma immobilisation and the administration of some intramuscular injections. EMTs however are not trained

to perform and interpret 12 lead electrocardiograph recordings, administer such a wide range of medication and cannot refer patients to other services unless this is checked and agreed by a paramedic. Their options for alternative patient disposition are more restricted and unless the patient refuses hospital admission they have little option other than to transport them to the Accident and Emergency Department.

The skill mixes on the emergency ambulances did vary and were impacted by available staff, however the frequent configurations I noticed were paramedic and EMT crew and on occasions a crew of two paramedics or two EMTs. The crews had regular partners for at least some of the shifts. Once allocated the two crew members remained with an ambulance vehicle responding to calls for the duration of the shift. Each emergency vehicle had a phone assigned to it which the crew would carry with them enabling them to be contacted.

Shift periods for EMS ambulance crews are 12 hours; 7am-7pm day shift and 7pm-7am night shift. Crews would work a weekly pattern of four shifts on duty followed by three shifts off duty. Although the shifts were lengthy the crews said they preferred these to shorter work patterns as this gave them a longer continuous period off duty between blocks of shifts. The station operates two emergency ambulances for each shift. For the day shift there are two break periods; the first is 30 minutes taken when convenient between 11.30am and 2pm and the second 20 minutes taken between 4.30 and 6pm. At night, the first break is again when convenient between 11.30pm and 2am and the second 20 minutes between 4.30 and 6am. Break times are taken from the time the crew and vehicle arrive back at the station (often referred to as ‘base’ by the crews). During busy periods crews would find themselves waiting with patients outside A&E Departments, unable to handover patients to hospital care due to lack of space inside. At such times fluid refreshments were made available within A&E and for mealtimes crews were offered vouchers to use in the hospital canteen or were given sandwiches. Some crews complained about this arrangement and preferred to return to the station where they could relax, eat their prepared and chosen food away from public view. In addition to the ambulance crews there would be two RRVs at any given time providing 24-hour speedy emergency response.

Following the period of fieldwork with EMS crews, I was able to visit The Clinical Contact Centre (commonly referred to as ‘Control’) which is responsible for the geographical area served by Bryn Station. The Clinical Contact Centres are a less visible, though crucial part of the NHS ambulance service (WAST NHS Trust, 2020). These are geographically placed service settings not usually in or near the site of frontline service provision which receive emergency, urgent and non-urgent calls within a given area of the country and whose staff allocate appropriate response and transport resources. These settings have staff dedicated to the differing nature of calls such as non-urgent, urgent and emergency and within the EMS section staff respond to calls within smaller geographical areas and communicate with specific ambulance stations and crews. Collectively EMS Clinical Contact Centre staff receive,

respond, assess, prioritise, advise, communicate and allocate an appropriate emergency response vehicle and crew to calls received. I was able to spend time with staff responsible for call taking, assessing and advising and those responsible for the allocation and dispatching of emergency vehicles from Bryn Station. Each of the two dedicated emergency dispatch staff had in front of them three large computer screens detailing each call, when received, the complaint, the categorisation of the call and where possible the allocation of a response vehicle. Calls were initially prioritised and responded to, and if waiting were periodically reviewed and if necessary re-prioritised. I was told that some of the non-urgent calls could be waiting until late that night or the early hours of the following day before receiving an ambulance due to the need to prioritise more urgent and emergency calls. The location and activity of each emergency vehicle and its crews were continuously tracked, monitored and updated on computer screens. During break periods the vehicles were static and when responding to calls would be located and traced on a map whilst proceeding to a particular destination.

4.2.3 The shift routine at Bryn Station

At the start of the shift incoming and outgoing crews would congregate in the EMS crew room. The station had a 'gentleman's agreement' that crews would come in 15 minutes before the start of the shift to take handover and relieve the outgoing crew. Most crews seemed to acquiesce with this, creating an opportunity for regular social interaction. The station manager had informed me of this agreement prior to starting fieldwork and I was reminded of it again later when the crews referred to a crew member as 'Tracy five to'. I was bemused by this and asked why the description only to be told that Tracy regularly comes in at five minutes to the hour. Although said in jest and not outright criticism, this was a reminder to the crew member of informal though perhaps important unwritten rules.

The shift crossover period was an opportunity for outgoing crews to handover keys for the ambulance, phones, a key for the controlled drugs cupboard (containing morphine) and to give a verbal account of what clinical equipment may be needed, such as drugs, intravenous fluids, needles and oxygen cylinders. Informally this was an opportunity for crews to talk about the previous shift, to catch up on interesting news, gossip, stories and reminders of planned social events. Occasionally these were opportunities for humour, teasing, banter, moaning and horseplay.

The outgoing crews would eventually leave and for the new crews the shift would start. Typically, the crews would ascertain what vehicle they were working on and with whom and would jointly go out to the parking bay and into the ambulance and check the clinical equipment within the vehicle. This was a chance for the crew to chat and again catch up whilst both checking the controlled drug stock and signing a small book, checking the drawers for needles, syringes and alcohol wipes for the skin. Oxygen tubing and suction were checked, intravenous fluids, the response bag (a smaller bag designed to carry emergency equipment into a setting) and blankets stored in a small overhead cupboard. Rubbish bags were removed and tied off and the sharps box for needles was checked and replaced if necessary. The

checking and restocking would usually only take five to ten minutes and if calls were received before or during this time the crews would respond immediately and postpone this. An example occurred one early morning when a call for a cardiac arrest came through; the crew (and me) left the station immediately and returned afterwards and resumed the checking and restocking.

Once the checking was complete the crews would input their Personal Identification Number (PIN) details on to the computer screen at the centre of the front cab as confirmation and communication to Control. Crews referred to this as 'booking on' the vehicle and from this point they were ready to receive and respond to calls. The crew were allocated to work together as a small team with complementary roles and responsibilities on each call. At the start of the shift the crew would agree who would undertake the clinical lead or the driver role in the first call and throughout the shift these two roles would be alternated between the two crew members. The practice at Bryn Station was for the crew member most recently in work to perform the clinical role in the first call, whilst the other crew member would undertake the driving role. The crews explained that this practice was to ensure the 'freshest and most rested' crew member would have the driving role to start. I thought this a curious phenomenon having seen these roles and responsibilities played out. The clinical role seemed to me to be a more demanding and intensive one involving assessment skills, documentation and handover. I took an opportunity to ask the station manager (Jack) about the origin and rationale for this practice which he confirmed as the crews had that this was done so that the most rested crew member would drive. Jack said that this was a long-established practice in Bryn Station related to previous shift patterns of shorter but more frequent shifts with less rest time between.

Once the crew had confirmed with 'Control' that they were ready they would await the calls usually in the crew room. Emergency 999 calls from the public would be received, assessed, categorised (using the Manchester Triage System), prioritised and given a colour code by staff in 'Control'. Call categorisation is a long-established practice in the ambulance service, derived from the initial assessment of the call and used as a way of allocating and communicating the level of threat to life and the level of urgency with which a response is needed. The calls are categorised on the basis of seriousness and immediacy into colour codes ranging from red, amber and green, and are subdivided further into red 1 and 2, amber 1 and 2 and green 2 and 3. Red calls are the highest level of threat to life such as a cardiac arrest, choking or chest pain and receive the highest priority with an 8-minute target response time. Response vehicles; both the ambulance and the RRVs travel at very high speed, with sirens and blue flashing lights to red calls. Amber 1 calls are those with a high level of patient acuity such as strokes which require an urgent response and amber 2 calls are less urgent and include road traffic collisions and falls. Green calls are non-urgent but require hospitalisation such as GP referrals and these can be allocated a 4-hour waiting time.

Calls were assessed and categorised by staff in the control centre and were allocated to crew members through a phone they use as part of their equipment, often suddenly alerting crews who would gather their jackets, keys and head out to the ambulance to set off in response as quickly as possible. Emergency vehicles have a central screen at the front which they use to communicate with Control. Control would communicate on screen the address or location of the caller and a brief description of the age, gender and nature of the problem. So, for example the screen might say '84-year-old female with shortness of breath'.

The emergency vehicles have inbuilt satellite navigators which display the route and progress of the vehicle to the call and the estimated time of arrival. The other crew member would take the second seat in the front cab of the ambulance next to the driver and would help locate the exact address and sometimes suggest where to park the vehicle. On arrival the crews would quickly get any necessary equipment from the back of the ambulance; often this was the response bag which could be carried on the shoulder and back and contained such things as a small oxygen cylinder, medication, needles, syringes and alcohol wipes. A cardiac monitor was also taken for some calls if crews considered this necessary; for example, if there the problem was chest pain. Each crew member would also get a pair of rubber gloves and if I were with them, they would ask me to pass these through to the front cab. Once they arrived at the scene the crews would be out of the ambulance quickly and would walk swiftly into the property or scene and get straight to the patient.

The crew member who was performing the clinical role would introduce the crews briefly using their first names and would immediately start to ask questions about the reason for the call, the history of it, past medical history and medication currently being taken and would record this on a Patient Care Record (PCR) (See appendix 22). It has areas for the four separate clinical assessments using ABCDE (airway, breathing, circulation, disability and exposure), culminating in a National Early Warning Score (abbreviated to NEWS). Crews would also complete an open text section on the PCR to record a brief history and summary of the presenting problem and treatment given.

The PCR is a heavily structured, prescriptive, standardised form for the clinical assessment, monitoring and treatment given in each call attended. It communicates the requisite structure and nature of the clinical assessment, monitoring and management of the patient and is a tool to record and evidence the response of the attending crew. The PCR is to a large extent oriented towards and reflective of the medical model of care; the focus is on physiological recordings and parameters and their implications (for example the NEWS score). As such these mirror the nature, the focus and clinical priorities of the work of the EMS. The PCR is prescriptive and protocol driven, which reflects the military origin of the ambulance service and its risk-averse culture (Wankhade, 2016).

Whilst one crew member was completing the PCR the other would undertake various clinical assessments and measurements of the patient such as blood pressure, pulse rate, temperature and oxygen

levels and would say what these were for the other to record. On completion of assessment and initial treatment the crew would decide the most appropriate course of action for the patient. Historically the emergency ambulance service has operated almost entirely as a treatment and speedy transport service to hospital A&E departments, a care delivery model referred to as 'scoop and run' (Blaber, 2008). However, in recent years increasingly, the paramedic role has developed to incorporate options other than transport to hospital A&E. Alternative options are based on and guided by initial assessment of the patient, social circumstances and medical condition and can involve for example referral to the GP, Community Falls Team or Community Mental Health Team. Pathways of care are available in cases of fall, epileptic seizure and hypoglycaemia where if appropriate these patients if medically stable can be treated where they are, referred to their GP and left at home (WAST NHS Trust, 2013a). The Patient Pathways Guidelines (WAST NHS Trust, 2013a) are a written document that was available in every emergency vehicle with guidance for crews on situations where alternative options than transport to hospital may be appropriate and was also on the PCR document. These are indicative of the changing role of the EMS from its tradition of emergency treatment and transport to hospital, to one which requires the management of various health problems and the implementation of alternative patient disposition.

In situations where the patient was already deceased or in failed cardiopulmonary resuscitation (for official recording purposes this was a ROLE, Recognition of Life Extinct), the crew would inform the police and Coroner and would then remain until the Coroner arrived but would not take the deceased to hospital. If alternative options were inappropriate, following assessment and immediate treatment crews would be ready to transport the patient to an appropriate hospital facility which would vary depending on the nature of the health problem, frequently this would be the Accident and Emergency department of the nearest hospital, but could if necessary be an assessment unit, cardiac catheterisation laboratory ('cath lab') or maternity unit. In cases where the patient was critically ill and requiring immediate or ongoing resuscitation the crews would phone the receiving Accident and Emergency (known as a pre-alert), enabling staff preparation and on entry to hospital the crews would take the patient straight into the resuscitation area to awaiting medical and nursing staff.

The clinical lead crew member would remain with the patient in the back of the ambulance during transport, often continuing the completion of the PCR and monitoring ongoing vital signs and treatment and on arrival to hospital would provide the detailed verbal handover of the patient to receiving nursing and sometimes medical staff. This handover involved an introduction of the patient, their name, a brief history of the reason for the call, past medical history and current medication, the assessments and findings, any treatment given and the outcome. The hard copy of the PCR would be given to the receiving staff. The PCRs were completed with a digital recording pen allocated to each crew member. At the end of the shift the pens would have to be docked at a point in the station allowing the recorded information to be downloaded and retained by the ambulance service. The digital pens were introduced

during the early part of my fieldwork and replaced the use of individually coloured duplicate PCR forms; the top white copy of which would be given to the receiving staff after clinical handover of the patient. The bottom yellow copy was retained by the crews, often removed before entering A&E, stored around the cab of the ambulance and returned to the station.

Crews would use a 15-minute allotted time from arrival at the hospital in which to give handover, to physically move the patient from the chair or stretcher onto the hospital trolley, remove the stretcher sheet and pillowcase and place in the laundry, wipe down the stretcher, replace the sheet, return the stretcher to the vehicle, briefly clean surfaces in the ambulance, dispose of used equipment and restock equipment for the next call. Toilet breaks were also taken during this time. The crews returned to the ambulance and informed Control they had completed the call and were ready for the next. The crews referred to this as 'clearing the call with control'.

Calls would continue to be received and responded to in the same format until an opportunity arose within the window of the designated break period for the crew to return to the station to have their break. The break period would be recorded from the time the crew arrived back at the station or 'base'. The crews referred to this as 'being stood down for break'. Following this period, the crews were again available to respond to calls until the second break, and eventually would complete the shift and return to the station and handover to the incoming crews.

4.2.4 EMS crew room

Within Bryn Station, the EMS crew room is the central point and frequent, regular hub of meeting and interaction for the EMS (including UCS) crews. The crew room is located on entry through the station door, immediately straight ahead through a short corridor which opens into it. The crew room is a large oblong shape, which at a glance looks like a sitting room one might have at home. Much of the room is organised into a large open seating area with 7 well worn, though comfortable, dark brown leather sofas; five with two seats and two with one seat, arranged in an incomplete oblong shape facing each other. In the middle are coffee tables, which frequently contain full and used cups, magazines and occasional pieces of information on policies and procedures or updates passed down to crews from the station manager and the head of the ambulance service. A large proportion of the magazines were 'Auto Trader', a large site for buying and selling of cars and some focused on male fitness equipment. These reflected and mimicked the male and stereotypical masculine context of Bryn Station and its physical fabric of dowdy colours and hard, functional feel. Occasionally memoranda from service management were left on the central coffee table for crews' cursory attention. An example of this was one which reminded crews that a special 'taxi' service could be used where appropriate to transport patients to A&E who did not require clinical treatment on route. This appeared as a directive to the crews, revealing mechanisms of communication within this organisation between those making decisions and those at the forefront of its delivery.

To the far right of the crew room where the sofas end is a long table with 4 chairs, which is used much like a dining room table at times where crews eat breakfast, lunch and sit to drink tea. Immediately behind this table is a large cork notice board and to the right of this is a white marker board, with a wall mounted telephone alongside. The notice board was always covered by a range of information for staff, both formal and informal. For example, there were details of social events arranged such as a day out at the local racecourse or the Christmas staff party on which crews wanting to attend would add their names, jokes, news and at one point an evening wedding invitation of two crew members to all crews. Further to the right of the notice board, in the corner was a door into a small and rather cramped office type room which contained individual named pigeonholes for each crew member to receive mail and some small lockers for crew use.

The crew room was a busy, central gathering point for EMS crews and was an area which all staff would pass through to get to the station kitchen. It is the area where EMS crews converge regularly at the changeover of shifts, when not attending calls and during designated break periods. At times when full I felt the crew room was quite intimidating, particularly on entry when attention and teasing would often focus on the newcomer. However, this is where crews can relax, talk, joke, laugh, complain, tell stories and tease each other, away from public view, in the "backstage region" (Goffman, 1959, p.114).

Much less frequently the crew room was used for training purposes, for example one of the CTLs on one occasion demonstrated the use of a new chair for patient transport to and from the ambulance. The crews were encouraged and given opportunities to try out the chair in the middle of the room and some crews took the chairs outside into the garage area to practise their use on the steps.

The station as indicated, houses different and separate services which constitute parts of the NHS ambulance service. Although not mentioned explicitly I noticed that EMS and PCS crews had different spaces or crew rooms within the station. Although adjacent to each other crews never used each other's crew room. PCS crews frequently passed through the EMS crew room as a practical necessity to access their own crew room and would interact positively with EMS crews but never sat down. Unlike the EMS crew room, the PCS crews have a comparatively small area in which they congregated located on route to the large communal station kitchen. The PCS area has a small table, a few dining table type upright chairs and television on one side and on the other a large glass fronted drink and snack dispenser for the use of all staff. The PCS crews would typically start their day shifts at 9am so would start to come in after 8am and would pass through the periphery of the EMS crew room regularly.

PCS have dedicated staff who deliver patient transport services such as collecting patients for regular hospital appointments such as radiotherapy, renal therapy, outpatient appointments. Patients are collected in small minibus type transport vehicles from home or nursing home settings and taken to nearby hospitals and departments and are collected and taken home. These crews do not require clinical skills and are not involved in the treatment of patients; their role is predominantly one of transport to

and from treatment NHS treatment and consultation facilities. Despite being part of the ambulance service, the EMS and PCS are separately staffed and their work independently organised and undertaken. However, although distinct these aspects of the ambulance service are hierarchically separated too. The EMS is the frontline emergency service which holds prestige in saving lives and in the treatment and management of complex trauma. These crews are awarded higher grades and salaries with more intense training and educational preparation for their roles. In addition, historically and to some extent currently, the PCS serves as a typical entry point to the ambulance service, from which staff can gain experience and progress into EMS roles. Prior to the introduction of the Higher Education route into the paramedic role in 2005 the PCS route was the one typically and commonly taken. Indeed, most of the EMS crews within Bryn Station started their career within the PCS (then known as the Patient Transport Service) and progressed into EMS. This reflects the developmental and progressive relationship between these sections of the ambulance service and the historical and current hierarchical set up between them. EMS have a larger space and comfortable furnishings for their crew room in comparison to the PCS which could reflect differential nature of roles, service boundaries and the hierarchical positioning of these parts of the service.

4.3 Conclusion

In this chapter I have described the setting and context of Bryn Station, the focal point of my study. I have revealed the history of the station, its physical features, its organisation, structure, staff and their roles. I have given specific attention to my experience of EMS working routines, a typical shift pattern in Bryn Station, the organisation of roles and responsibilities between crews, the formal categorisation and prioritisation of calls and the processing of an individual call.

Bryn Station and its crew room constitute features of “backstage” (Goffman, 1959, p.114), wherein crews are not undertaking their frontline professional roles. In the next chapter I describe my experience of the behaviours and interactions of the crews and their functions in this context of their work setting. My analysis includes attention to features I observed as part of my fieldwork which included frequent moaning and complaining, teasing, talking and humour in the crew room and the function and significance of these to the crews.

Chapter 5

EMS crew room; observing and analysing backstage interactions and behaviours

5.1 Introduction

In this chapter I describe my experience of observing and analysing the backstage behaviours and interactions of EMS crews in Bryn station, with particular focus on the crew room and on other occasions when they were not undertaking their frontline duties in view of a front stage audience (Goffman, 1959). Bryn Station and its EMS crew room constituted part of the entirety of their work context; a regular social gathering and meeting point for crews in which their frontline role and its frustrations and challenges could find expression amongst colleagues who understand. I was able to observe what manifested as a mixture of behaviours and activities such as periodic moaning and complaining about calls and callers, opportunities to talk through calls crews found difficult or challenging, and humour and teasing particularly of new recruits but also of established crew members. The EMS crew room in Bryn Station and the opportunities for backstage interaction was considered important to some of the crews in enabling them to cope with the challenges of EMS work. In this chapter I will use my analysis to make the case for this backstage location having its part to play in the emotional handling, processing and management of EMS work.

The backstage interactions I describe are drawn from my accounts of fieldwork participation and involvement with them; from what I observed and heard and what crews told me. They offer examples of interactions and activities within the setting and its' backstage.

5.2 Backstage; complaining and moaning

In this section I will describe and analyse how during my fieldwork observation in Bryn Station, I found that crews shared their experiences with each other and expressed the challenges and frustrations that arose from their frontline role during regular gatherings in the crew room. The crew room (a component of the backstage) offers a setting and opportunity for emotion processing work (Boyle, 2005; Thoits, 1985); where crews could voice and share their frustrations; 'get it off their chest', with their colleagues who they said understand their experiences. The source of their frustrations varied and included the quantity of calls, delays in getting patients into A&E departments, lengthy periods waiting outside A&E, types of calls they had attended and those which crews considered not to need a 999-emergency response.

5.2.1 'Well when we got there, he said he was tired and wanted to go to hospital'

A source of complaint frequently related to calls considered to not necessitate an emergency ambulance and one early morning in the crew room a month into my field work, Pete an EMT, described to the crews one such call he had attended the previous weekend,

> We (two-day crews (4) and a few remaining night crews) were gathered in the crew room as usual this morning sitting around waiting for the shift to start and Pete (an EMT who had been working night shift) started telling us about a call he went to on the previous Sunday night. Pete said the man had called for a 999 ambulance from a telephone box on the sea front. We all listened in anticipation of what was to come next and Pete said, 'well when we got there he said he was tired and wanted to go to hospital'. Pete said nothing else but gave us all this incredulous look. I was keen to hear how Pete responded to this reason for calling 999 and said to him 'what did you say?' and he said 'well, I walked away in case I said something I shouldn't'. Pete shook his head and said to us all 'can you believe it?'
>
> *(Fieldnote, 'complaining about calls', 15.4.15, 7.20am)*

On this occasion Pete related a call he had attended where the patient had a minor complaint of tiredness and a wish to go to hospital. In the telling of the story and his facial expression, Pete displayed a sense of frustration and incredulity. The reason for the call was related by Pete as tiredness and a wish to go to hospital which can be perceived as vague, non-medical problems which on the surface do not necessitate an emergency ambulance and as such support his narrative and justify his complaint about the call. He describes how he prevented the expression of his feelings by walking away from the patient, so that he did not say or show something he shouldn't, which I interpreted to be his frustration. In so doing there is a degree of emotional labour in his suppression of emotion and evidence of superficial, surface acting where internal feelings remain unchanged but are not physically displayed (Hochschild, 1983, 2003). As such in his description of the call Pete intimates at the emotional labour needed in front stage work. Pete's self-removal from interaction indicates his struggle to hide his emotions and his concern that he would otherwise communicate these to the caller.

Another example of talk about calls that some crews thought did not need an emergency ambulance occurred in the crew room approximately 2 months into my field work one early morning whilst they were gathered as they usually did. The night shift crews were getting ready to go home and the day shift crews were preparing to start the shift. There was often a short period of time, about 15 minutes where crews sat and talked. Arthur, a paramedic who had been working the night shift contributed his own experience to the ongoing discussion.

> I parked up quickly this morning, went into the station and the crew room was quite full, there were night and day crews in, all sitting around. I glanced around, said hi and quickly found myself a seat amongst the crews and listened in to what was happening. The crews as usual were talking and laughing and telling stories about patients and calls they had been to. There was talk about calls crews thought they shouldn't be getting and Arthur who was standing up started to tell us about a call and patient he had gone to during the previous night shift, he said 'we got there and the woman was crying and I said what's the problem, why are you crying and she said the carer hasn't come. So, I said what time does the carer come and she said 7 o'clock and I said well its only 6'. Arthur did not say anything more but looked bemused and shrugged his shoulders.
>
> *(Fieldnote, 'complaining about calls', 6.5.15, 6.55am)*

Arthur's story was relayed amid crew room talk that morning which centred on discussion and complaints about calls which the crews see as not needing an emergency ambulance response and as such those the EMS should not be receiving. Arthur contributed his story amidst the context of complaints, in sympathy and congruence with the sentiments expressed by the crews, showing his solidarity and agreement. The background offered an opportunity and licence for Arthur to contribute in what was a supportive environment. Arthur outlined some key aspects of the call which served to iterate the point he and the crews were making and shrugged his shoulders, hinting at familiarity and a shared understanding and experience. His account is brief, suggesting that he did not feel the need to strongly convince his audience. He appears to be offering another candidate example, a supportive layer in sympathy with the group discussion and the shared experiences.

EMS backstage talk and complaints about the nature of their work and the types of calls they attend may serve differing functions. The crew room and other backstage opportunities offer a platform for attention, display and performance by crews. The accounts given can be crafted by the presenter both verbally and non-verbally to achieve certain ends such as to convince the audience of a particular interpretation. Performances can be influential and persuasive to their audience. Account givers are not simply retelling the story or the 'facts of the case' but are active, constructors of knowledge in the execution, delivery and content of what is chosen and communicated (Coffey, 2012; Edwards & Potter, 1992; Holstein & Gubrium, 1995). Constructed and functional, accounts are described as "contextualised and variable productions that perform pragmatic and rhetorical work" (Edwards & Potter, 1992, p.54).

In the above field note extracts purposeful verbal and non-verbal devices are being used by the account givers in their accounts. In the first extract Pete provided little detail of the call, verbally communicating some specific aspects of it deemed to be significant in the 'account' and its purposes. Pete is constructing the account by way of the content and its delivery (Coffey, 2012; Edwards & Potter, 1992; Holstein & Gubrium, 1995), to question the legitimacy of the call and caller and to furnish his point. In the build up to the story Pete mentioned that the call had been made from a public telephone box indicating that the caller was outside and on the sea front. Although not explicit the suggestion here appears to be that ill people do not call ambulances from public telephone boxes and would not be expected to be outside. The inclusion of these observations by Pete, contribute to and inform his conclusion that the caller in his opinion, was not in legitimate need of an emergency ambulance. The account is developed and epitomised with the reason given for requesting a 999 ambulance; a vague feeling of tiredness and a wish to go to hospital. Pete's silence at points in the account assumes that a full explanation and justification is unnecessary and suggests his confidence in the groups' concordance. He ends his narrative with further non-verbal gestures like a shake of the head which communicate his disagreement and finally with a rhetorical question which draws the audience in through a persuasive question without necessitating a confirmatory response from them (Koshik, 2005). Koshik (2005, p.2)

refers to rhetorical questions as "reversed polarity questions", where a negative or positive statement is made to emphasise the point being made. For example, Pete says, 'can you believe it', this suggests that you would not believe it. Positioning opposites in this way enables these questions to perform "specific kinds of social actions" (Koshik, Ibid, p.2).

Arthur in his story above, amid crew' complaints about calls in the early morning crew room, contributes his own account in support. He selects and relates a few facts of a call and caller who had summoned help because her carer had not arrived only to be told it was too early. Arthur relays his account in a simple, factual, objective manner with sarcasm and a hint of humour to elicit audience interest and support. He is confident; a well-established and long-time crew member in Bryn Station, influential and not likely to be openly challenged by the assembled audience.

These performances by crew members call on linguistic devices which help to convince and persuade the audience towards a particular interpretation and perspective (Potter & Edwards, 1992). For example, rhetorical questions are persuasive tools (Koshik, 2005), used by Pete and Arthur and both accounts though limited in their content, include sufficient detail to help craft and convince the audience. Crew room and backstage complaints and call interpretations offer perspectives and make points; they are opinionated, persuasive and convincing, crafted to communicate viewpoints and agendas which can be difficult to challenge. They reflect and perpetuate a way of interpreting calls and callers and determining their legitimacy in this work context. There is a taken for granted quality to them which reflect normative ideas and expectations, and what can be understood to hold in a particular setting and in this setting. Anderton, Elfert and Lai (1989) examine normative ideologies in health care and the complex array of economic, historical, social and political motives which drive them. Importantly, they highlight how ideologies are "unwittingly" mobilised by health professionals who, in their positions of dominance "act to sanction, legitimise and reinforce them" (p.259).

Garfinkel (1967) describes the nuances of everyday interactions; the features and structures of it which are taken to be "background expectancies" (p.37) and often overlooked in sociological investigation. He refers to "common understandings" (p.38) exemplified in patterns of talk between individuals in which some things are accepted and understood without absolute clarity and specificity. So, there is no need to explain fully. Patterns of talk suggest inferences from what is said and not said, audience' understanding that is developmental and temporal in nature and to listeners who are willing to wait for it. Garfinkel (Ibid) says "thus many expressions had the property of being progressively realized and realizable through the further course of the conversation" (p.41). These features are identifiable in both Arthur and Pete's accounts with minimal detail and a staged, orderly, delayed revelation of what happened to an audience who were assumed to be familiar with the issue at hand and the significance of time needed for it to be told. This may also reflect issues of sequencing in interaction, where what is said came in the context of previous talk along similar lines and was understood by listeners as another

candidate example of what was already taken to be known and regularly heard by them. For example, Pete describes the reason for calling an ambulance but says nothing more for a time until he is prompted by me (someone who was not party to the 'common understandings' of other audience members). In the conduct of everyday matters individuals refuse to allow others to fully understand what is being talked about though means of "sanctioned properties of common discourse" (Garfinkel, 1967, p.41) which are implicitly known but are often imperceptible. This may also work as a way of distinguishing between in-group and out-group within the context of group interactions (Becker, 1963).

Complaining and moaning about calls and their legitimacy couples judgement and evaluation. Shotter (1984) notes the social processes and interactions through which public behaviours are described, discussed, scrutinised and evaluated. The criteria for evaluation can be personally and professionally sourced and are revealed in the talk. Complaints are a form of expressive response to dissatisfaction which can be levelled directly at the perpetrators or can be raised indirectly when for example behaviours can be complained 'about' and to another person (Laforest, 2002). They are a response to what is judged to be unsatisfactory behaviour and signify the failure to meet expectations of the complainer (Goffman, 1971). Complaints communicate a response to transgressions; a reaction to perceived injustice or wrongdoing, which as such reveal expectations of others and which may be shared with others to bolster and justify them. The EMS crews refer to their service as one designed to respond to emergency, life threatening situations involving sudden medical emergencies and trauma. Calls which are perceived as 'non-legitimate' and the inappropriate use of the 999-emergency ambulance service conflict with service ideals and role identity, evoking frustration amongst crews (Kirby & Roberts, 2011; Prener & Lincoln, 2015). Frustrations arise when there is conflict between their role expectations and the reality of their work.

The above accounts by crew members in their content present 'an interpretation' by them of the call and caller. The content is sparse with no detail on the background of the caller, consideration of individual contributory circumstances, rationales or precursors and individual subjectivities. The accounts as such portray a surface, superficial assessment which serves to justify and warrant the complaint and appraisal of the call. For example, Arthur does not in his account acknowledge that the individual is elderly, perhaps confused, disorientated and frightened and for these reasons sought help. Recognition of these potential contributors and explanations could undermine the basis of this complaint. Accounts in their content, packaging and delivery are crafted towards a given purpose and are as such important in their powers of persuasiveness towards a particular perspective. Group interactions like those which frequently occur in the crew room setting offer a platform for sharing of interpretations, values and beliefs which may serve to garner solidarity and group membership (Collins, 2004). In this sense the complaints in the context of the crew room may function to create a sense of belonging and identity as those who complain about such matters and hold such views. By fitting in and

being part of the group, they gain access to the benefits of group membership such as supportive others (Collins, 2004) that may help them to manage the frustrations of their work.

5.2.2 'It's just the way of getting it off your chest'

Backstage and crew room accounts and complaints like the above are described by some of the crews as valuable opportunities to share and express their work-related frustrations with their colleagues. For example, in a research interview with Tracy, a paramedic, she explained this to me,

AW: How do you deal with the kind of frustrations of your work?

Tracy: Coming back here and having a whinge

AW: Tell me about having a whinge then?

Tracy: Just coming back and saying, 'I've just been to this bloody patient and dud dud dud dud dud' and everyone is like 'yes, I know, I went to one last week'. It is just the way of getting it off your chest. Especially with the guys in here...and you're just getting the support of these guys...When you come back and you have a bit of rant and 'oh they bloody rung us for this and rung us for this', 'oh we've had to wait four hours for backup today' and things like this and one of the other guys says 'oh we had to wait six hours the other day' and you think it could have been worse. The situation could have been worse. It is nice with just these guys in here. I think we all just pull everybody through.

(Tracy, Paramedic, Office Bryn Station, Interview, 9.3 .16, 'having a whinge' in crew room)

Tracy describes dealing with frustrations by coming back to the station and 'having a whinge' with colleagues. She uses the more informal term 'whinge' which is a form of complaining in an annoying way about something unimportant (Collins Dictionary, 2020) and exemplifies this with reference to a generic class of patients who might be commonly agreed within the EMS to cause frustration. She implicates a shared, commonality of experiences amongst the crews and the realisation that others are dealing with the same or more frustrating issues. Tracy refers to whinging to get it off your chest, allowing the expression of pent-up frustrations originating from the front stage work setting. Tracy reiterates the value of the support offered by colleagues who in this way she says help each other to deal with frustrations and emphasises the camaraderie of the backstage.

The value of crew room colleague support as a way of dealing with work related frustrations is a pattern described by other staff at Bryn Station such as Miriam, an administrator and secretary. Miriam was popular and familiar with the crews and in regular contact with them for booking time off in lieu and uniform ordering and some of the crews would spend time talking to her. She describes the challenges crews experience, the sharing and support of each other who know the challenges, which she suggests enables them to enjoy their home life,

AW:..what do they do to deal with some of the frustrations, the pressures of work, what do you see that they do?

Miriam: They come in and they'll have a rant to me, *[laughs]* they do and that's fine... but I think they just sort of talk to each other to deal with it because, you know, 'I've been outside [hospital] or [hospital] for seven hours', 'well I've been there for eight and I didn't get a cup of tea, did you manage to get a cup?', do you know what I mean? So, they sort of, they try and have a bit of banter and work it out for themselves with each other, because they all know what they've been going through and they're dealing with, so yeah, that's, yeah, and then they go home to their families and, you know, enjoy their time there, that's really all they can do, isn't it?

(Miriam, secretary, Office Bryn Station, Interview, 1.8.16, 'talk to each other')

When asked about the challenges and pressures of EMS work Miriam highlighted various sources of complaint by crews such as long waits, lack of time, long periods without a break and she sheds light on the significance of backstage and the station, the crews and the opportunity they provide each other to vent, talk and share experiences and frustrations. She mimics the crews' interaction; their complaints and comparisons with each other and what they say to each other. Miriam describes the value of being able to talk to colleagues who she says know and understand the pressures of the work and she hints that this offers a way to deal with frustrations, to contain them as part of work and enable crews to enjoy their time away from work with their families. The suggestion that opportunities to moan and complain enable crews to move on from them was developed further by other crews in the next section.

5.2.3 '…have a bit of a moan with colleagues…let it go then': Handling the emotional burden of emergency work

Several of the EMS crew articulated a view that the expression of frustrations enabled them to move on from them. For example, when discussing the frustrations and challenges of EMS work and how these are dealt with, Tom describes having 'a bit of a moan' with his colleagues who understand and then letting it go and getting on with work and his personal life,

AW: ...You mentioned about frustrations, how do you deal with frustrations like that from work?

Tom: Generally, have a bit of a moan with colleagues, someone else who knows where you're coming from and has been there themselves and let it go then, you know. I mean I *[sighs]*, you can't let it, um, you can't let it just sort of stay on your chest so to speak because the next shift there will be another frustration and the next shift there will be another frustration and before you know it, you know, you've got a whole load of them and I can only imagine you'll burn out. So, for me it's either talk it through myself in my own head and then throw it away, talk through it... with colleagues, shuffle it away, move on, and go home and get on with your life.

(Tom, EMT, Office Bryn Station, Interview, 11.4.16, 'having a moan – let it go – move on')

Tom describes something of a process whereby he will 'moan' with colleagues who know and understand the frustrations from their own experience and he will let it go. He explains his rationale based on being able to express frustrations and avoid the cumulative effect. Tom relates the frequency of frustrations which can build and his approach to either think it through individually and discard it or share it with colleagues and move on from them. Tom seems to offer a more sophisticated rationale that

moaning is an effective coping strategy, a way of moving the burden to enable him to continue and deal with the frustrations arising from work.

Mike, another crew member describes the frustrations evoked by the nature and demands of frontline EMS work, the practice of relying on opportunities for interaction with colleagues to share and express them and move on from them. However, he adds that older crew members like him are more likely to use opportunities for interaction, intimating that this practice whilst popular amongst some EMS crews is not a universal one.

> Mike:. Going to people with life-threatening problems is about one in every ten-twelve jobs now, run of the mill is going to elderly fallers or to middle-aged people with very minor complaints or can't see a Doctor
>
> AW: And how does that affect you?
>
> Mike: Winds you up...Big time, yeah. Because as I've said, you've got to treat everyone the same you can't go in and throw off a bit of steam just because someone's got a headache for two days now, they haven't taken any pain relief and now they've rung NHS Direct and they've dialled 999 simply because they think there's something more sinister going on...and there's just nowhere where you can, where the frustration is, you can't get rid of that until the patients gone and then you can get on top of it with some of your colleagues and unwind that way...Some of, it's the older ones and we don't mind getting together and having a good laugh and a good chat about and just throwing them off but some of the younger people coming in now don't, they tend to take these frustrations a little bit more and keep them a little bit longer. The first opportunity we get we just try and throw them off, look forward to the next job...Eventually you've got to explode if you just keep doing job after job and getting wound up after it.
>
> *(Mike, paramedic, Office Bryn Station, Interview, 26.2.16, 'throw them off')*

Mike describes the frustrations arising from frontline work and implicates the need for the suppression and disguise of emotions (Hochschild, 1983, 2003) until the patient has been transferred on. He says there is nowhere for these frustrations to go and describes 'unwinding' with colleagues and 'throwing them off' at the earliest opportunity and moving on to focus on the next call. Mike, however, describes differences amongst EMS crews in their practice of engaging in opportunities to deal with frustrations in this way. He indicates variations in how crews may perceive and value such opportunities.

Indeed, an alternative view is proposed by Rhys who described the backdrop of the high work pressures, long waits outside A&E, the role impact and the effects on crew morale and staff retention but on a personal level he questioned the value of backstage 'moaning' and 'whinging',

> Rhys: Again, lowers morale. It's, it's, it's a big drag on morale. People are coming out of the profession, you know. That's, that's a big thing, you know. That never used to happen, used to be a job for life, you know. But people will come out and that'll be because they just feel so flat, yeah, that's the thing, just seem flat.
>
> AW: How do you deal with this on a day-to-day basis, how you feel?

Rhys: I deal with it by removing myself from it. So, I, I try very much not to get involved in the moaning. I could say the politics but what I mean is the moaning, and I completely understand why people moan but generally I find that doesn't help anything. Moaning only puts you in a lower frame of mind, it doesn't make you feel better. It's not like, "Oh I'll have a whinge now and I'll feel better," it's not that, that's a falsehood. If you have a whinge you're only encouraging more whinging, and if you have a whinge at somebody else who justifies your whinging, then that increases your sense of injustice and it shouldn't be and makes it worse. So, I just try my best to avoid it.

AW: So, you don't find that relieves anything?

Rhys: Not at all, no, absolutely not. It's much better to be around positive people, you know, that's a known thing, so I try to be one of those positive people.....

AW: Do you, what do you see people doing as a way of dealing with this?

Rhys: Well, what I see people do is perpetually moaning and then somebody else saying, "Yeah, you're right and this happened to me as well," and, "Oh yeah, well that happened to me last week," and it just creates this merry-go-round of bad feeling and intensifying of emotions...

(Rhys, Paramedic, AW' working setting, Interview, 23.3.16, 'moaning not helpful')

Rhys describes the pressures of EMS work, the effect on staff morale and mood and highlights the impact on the retention of staff and the mood of crews which he describes as 'flat'. He describes the practice of 'moaning' and 'whinging' amongst crews but offers his own different interpretation and view of it which challenge the beneficial effects reported by other crews. Rhys is offering his version or what Garfinkel (1967) refers to as his display of understanding. Rather than joining the collective behaviours Rhys describes consciously avoiding them on the basis that rather than helping this can worsen feelings. He challenges the belief that moaning helps describing this as a 'falsehood' and instead offering his interpretation that being with 'positive people' is better, something he refers to as a 'known thing'. Rhys intimates at some existing information or perhaps experience of positive workplace cultures, alternative to what he is describing in Bryn Station.

Rhys describes aspects of the established EMS culture of moaning, whinging and complaining in Bryn Station; he challenges the purportedly positive effects and questions what is achieved by engaging in it and proposes an alternative strategy of interacting with those who are 'positive' instead. Rhys thus challenges and questions the culture and practice of backstage and crew room moaning and complaining and the rationale and benefits perceived by other crew members some of whom have been in Bryn Station for a long period of time. Crew room complaining and moaning may be perceived as a relatively benign and vacuous activity which whilst temporarily relieving tension does little if anything to address or change the root of the issue. Rhys is a relative newcomer to Bryn Station, who offers a differing interpretation and positioning of some established practices and their efficacy and describes an alternative approach of affiliating with those who are more positive instead.

In summary the crew room in Bryn Station appears for some EMS crews, to offer a valuable backdrop for interaction with colleagues; where the frustrations and challenges emanating from their work in the front region can be shared, discussed, vented and compared. Functions of this talk appear to be varied and include communicating views on specific types of calls and particularly those which do not necessitate an emergency ambulance and may also function to create a sense of solidarity, group membership and support (Collins, 2004), in dealing with the frustrations of frontline work. Opportunities to interact and complain were perceived as valuable by crews in enabling them to cope with their work-related frustrations, although this view was not shared by all crews.

Other regular features of crew room and other backstage settings were interaction, humour, laughter and teasing amongst crews. Humour was perceived by some EMS crews as important relief from the pressures of their role which enabled them to cope. Humour was perceived as entertaining and enjoyable however, the teasing and mockery were also interpreted by some crew members as 'going too far'. In the next section I present my observations, analysis and interpretations of humour in the EMS context as a feature of their backstage culture.

5.3 Backstage humour

In this section I will describe and provide analysis of the key features I observed about Bryn Station namely the interaction, humour and laughter amongst the crews whenever and wherever they gathered and the emotional impact this appeared to have on those involved. Humour was perceived as important by many of the EMS crews as a way of coping with the challenges of their work and some referred to the use of 'black' humour specifically. Humour was derived at the expense of patients and from colleagues at times. However, whilst some crews referred to humour in a positive way, at times I observed that humour was generated through teasing of individual crew members who were present and, on some occasions, when they were not which appeared to test loyalties amongst the group and implicate wider effects of humour use in this setting.

5.3.1 Humour derived from patients; what to do when patients call an ambulance when they don't need one

Backstage humour was a regular feature of my fieldwork experience at Bryn Station which enthused and entertained the crews at times. I also found these entertaining and inclusive to me as a researcher and outsider; they hinted at my inclusion, my acceptance and their potential trust in me. However, they also served to question my position, my perspectives and me as a professional and prompted my reflection and self-analysis (See fieldwork reflective diary – Appendix 5). The crew room context offered a readily available opportunity and audience for humour, laughter and teasing and some crew members I noticed adopted a central role engaging, encouraging and leading their colleagues through group interaction, storytelling and humour. One such person was Nick, who I noted in the following

field note (approximately 6 weeks into my field work), early morning in the crew room proposed and demonstrated to the assembled crews a way of dealing with calls which from their perspective do not require an emergency ambulance,

> In the crew room this morning it was quite full, it was early, just getting light outside, the start of the day shift and we were all sitting around, there was the usual banter, talking and laughing between crews. Nick was as usual leading a lot of this and was the centre of the crew room's attention this morning. He was upbeat and jovial and keen to make us laugh. Nick started to announce to the crews that he knew what could be done about patients who call an ambulance when they don't need one. Everyone was listening. He said we could go in and say, 'why have you called for a 999 ambulance? and we could give them a minute to tell us and if they've got it wrong we could shoot um'. Nick mimicked the holding of a gun and the firing of it. I was not at all sure what to make of this, I thought this was inappropriate and felt uncomfortable about being party to it, but felt it was difficult to express my objection. The crews laughed and some got excited and joined in and added to Nick's idea. They seemed to like the absurdity of it. I sat, listened and laughed at points with the crews, despite feeling uncertain about whether I should. Nick, encouraged by the crews continued enthusiastically with his story and said 'can you imagine how it would be? A&E would be empty, there'd be loads of pillows and they'd have duvet covers for the beds'. The crew room again responded well to this and these possibilities and was filled with laughter and agreement. I laughed myself even though I felt that perhaps I shouldn't have. It felt almost impossible not to. The laughter and joking were light-hearted, it created a kind of buzz and positive atmosphere in the crew room, which continued as crews slowly left to check their trucks (ambulances) ready for the day shift.
>
> *(Fieldnote, 30.4.15, 6.40am 'humour – what to do about calls')*

Nick, a popular and influential character in Bryn Station used the opportunity of the crew room early morning assembly to instigate interaction and humour amongst the crews. He chose and raised an issue which appeared to resonate with crews' experience; the perceived inappropriate use of the 999-emergency service and was encouraged by their response to continue and suggest a solution to this and to propose what some of the positive outcomes might be. The solution offered by Nick is an extreme, untenable, absurd and potentially alarming one, though used and told in jest and for the entertainment and amusement of the crews. The mimicry of the gun use seemed to entertain crews who were present and the consequential effects of his suggestion were followed with imagery in the A&E setting which stimulated further laughter. Although this is backstage; away from front stage performance, there appeared to be a 'performance' offered by Nick in entertaining, encouraging and leading the interaction.

Humour is inclusive to those involved in it (Collins, 2004), is enjoyable and entertaining, enhancing one's popularity and influence within the group. However, humour may also enable frustrations to be aired and shared in a benign and non-confrontational way. Nick chose the issue of perceived service misuse; one which he anticipates will be a common experience amongst crews and one to effectively gain attention and interest. Nick's proposal though humorous and apparently benign also communicates his underlying perspective that accords some degree of blame and responsibility on the public for the unnecessary use of the 999-ambulance service and may suggest that there is a 'right' and correct use of the service and that crews are able to judge this. Through humour Nick shared his frustrations and views with the group and used the humour and engagement of others to influence their thinking perhaps

subtly on the issue of service use. The group interaction, with laughter and "emotional entrainment" resonates with interaction rituals (Collins, 2004, p.104) which can be used to garner support for certain views and perspectives, to influence these and serve to reaffirm values, norms and beliefs of a given group, enhancing group solidarity (Collins, 2004).

Humour in its nature and source can be absurd, illogical and preposterous which is what may constitute its efficacy as a basis for backstage entertainment. Humour in its 'ridiculousness' and absurdity enable expression of views, thoughts and frustrations in a what may be perceived as a safe way and perhaps context, without repercussion and consequence. The backstage, away from front stage audience provides a suitable context for such humour to be employed; it is private, shrouded from public view, where behaviour may be somewhat unbecoming. Hutchinson (1983) in her study of the emergency ambulance service, suggests that behaviour in the backstage region is usually only seen by and revealed to a few, the few being insiders or people who are considered safe or "in the know" (p.16). Revealing backstage behaviours could be incriminating for individuals and could be perceived negatively by those who are outside of these groups.

In this sense backstage behaviour may be risky for those involved and could reflect negatively on this professional group. From a research standpoint these reflect the challenges of doing participant observation; of the careful balance of being allowed into the setting to see and experience what is going on and the implications and expectations that accompany this. I felt there was an expectation from the assembled crews that I too would find this humorous. These experiences also create dilemmas for the researcher in what is shared and the potential implications and the balancing of this with a responsibility to reflect the culture and behaviours of those under study (Lee, 1993). There were issues I frequently reflected on, debated and analysed, particularly as I got to know the crews and realised their trust in me.

Several of the EMS crews described the humour and laughter in the backstage as important relief from their work which enabled them to cope. For example, in a research interview with Alex he referred to crew room humour and laughter and their significance,

> Alex: I think they're coping mechanisms, definitely. You know, cos that's a big part of it. You've got release, you've got to have a laugh otherwise people just, your head would fry if you were here all the time and you couldn't let your hair down and have a bit of fun.
>
> *(Alex, Clinical Team Leader, Office Bryn Station, Interview, 18.5.16, 'humour & laughter – coping mechanism')*

The importance of backstage and the associated characteristics of humour, laughter and relaxation and the potential implications for crews' well-being are highlighted by Alex. He relates the importance of humour and to be able to 'let your hair down' and the alternative that 'your head would fry', utilising colloquial idioms to assist his expression. Idioms are literary expressions which are not meant to be taken literally, though can reflect colloquial language and speech (Drew & Holt, 1988). They are also

attributed a "special robustness" (Drew & Holt, 1988, p.409), and ability to communicate a point in the absence of empirical evidence. In the above extract the humorous and somewhat flippant idioms reflect colloquial and informal speech patterns but nevertheless manage to communicate the importance of humour and the opportunity to 'let your hair down' or behave in a freer and less inhibited manner. These expressions are used by Alex to convince and perhaps justify the use of crew room humour against an undesirable alternative for crews. However, his endorsement is a generalised, blanket one, which implies no threshold or boundaries of what may be acceptable to appropriate. Alex is in a leadership position and has the potential to influence crew' behaviour which may be significant here. The crew room humour was at times derived from mockery and teasing of some crew members and was suggested by some to 'go too far', as described in the next section.

5.3.2 Use of humour on colleagues: 'A patient thought he was only 14 years old and kept calling him Kim'

Whilst crews described the use of humour in a positive way implicating its impact on their ability to cope and the feelings generated; I noticed too that at times the humour arose from teasing of some crew members. As such the humour was at the expense of some crews and could be challenging for them against the backdrop of a packed crew room. A typical example was directed at a new young Technician Jim, who had recently joined the station (around the same time as I started fieldwork) from another area and had started working shifts with the crews. It was one usual early morning crew room gathering about two months into my fieldwork after Jim had done the night shift,

> I wandered in behind Tracy and Mary and noticed the crew room was quite full this morning with night crews and the day crews sitting around. I sat down and said hello to the faces I knew and had got to know. There were some characters I knew well, a few who are known for their humour, Mickey taking, story- telling and general banter. Nick is the best at this, I'd been out on calls with him before. The crews' attention and humour suddenly focused on Jim; a new Technician recently transferred from another station. Jim had been on the night shift with Nick. Jim is currently the youngest member of the EMS crews (20) and is very young looking too I thought. Nick said to the crew room 'a patient thought he was 14 years old and kept calling him Kim', there was great laughter at this. I had to laugh too but looked at Jim to see his response to this banter and teasing; he was smiling too and seemed to be taking it all in good spirits. Nick then moved attention to Catrin another female crew member who was in the crew room and also young. Nick said, 'what must people think when you two come down the drive?…they are taking them straight from school', someone else said '6th form now' and Nick quickly mimicked this and everyone laughed.
>
> *(Fieldnote, 13.5.15, 6.45 am 'teasing in crew room')*

The above crew room gathering offered an opportunity for a popular and influential crew member Nick, to engage crews in interaction, humour, teasing at the expense of Jim, a young, newcomer to Bryn Station. Nick drew crews' attention to Jim's youth and expanded with a story of a patient who thought he was only 14 years old and called Kim, as such Nick is using assumed public perception of Jim to support and bolster his point. Nick expands his focus on humour at the expense of youth to Catrin a similarly young female crew member and suggested how this may be negatively perceived by the public

they attend. Nick used a rhetorical question to query how their youth may be interpreted. Rhetorical questions are linguistic devices which make a claim or assertion, although technically a question they do not intend a response (Koshik, 2005), the response may therefore be assumed and taken by the speaker as a given. In a group context rhetorical questions may be particularly powerful and as such unlikely to be challenged (Collins, 2004). In this case Nick used a rhetorical question to make a statement about 'what the public might think'; as such he implicates that they would think and perhaps question the appropriateness of crews so apparently young in coming to their aid in an emergency situation.

Nick uses a supposed example of a member of the public making a criticism of youth to effectively disguise his own evaluation and suspicion. Locating the criticism with the public is safe to do and deflects the source of complaint away from him. Draping his complaint in humour provides him social sanction to air this in the crew room and disguises his attempts to target youth and by implication inexperience to undermine others and to gather those present to laugh at the target of his jest. Humour in this sense aimed at individuals can question their credibility and test their response and willingness to accept it.

The focus on Jim, a newcomer and recruit may be particularly significant in demonstrating his acceptance in the station and to the crew room culture. Inclusion in humour can indicate acceptance (Collins, 2004) and can be used by groups to assess and 'test' a newcomer's perception and response, in this situation Jim's ability to tolerate being made fun of and laughed at within a communal social setting. Although I sensed the pressure to join in the laughter, I was conscious and uncertain how Jim might be feeling about being the focus of ridicule and I watched his outward response carefully.

Both crew members appeared to smile along without any outward objections, although they may have felt under pressure to do so. As such the teasing and humour at their expense may create additional emotional labour and emotion work in managing and disguising their emotions. Their positioning within the group, as young, inexperienced newcomers make it difficult for them to outwardly oppose and object to it. Humour use is suggested to reflect hierarchical positions; used by those with power on those who are powerless (Collinson, 1992; Goffman, 1961). Despite the potentially negative effects of mockery, some crews appeared to suggest this was to be expected as described in the next section.

5.3.3 In defence of humour: 'They've just got to let it go over the top of their heads'

Although some crew members described humour as important in helping them deal with the challenges of their work, the examples above highlight the potentially difficult and uncomfortable effects this may have on individuals. In a research interview extract below, Alex makes direct reference to the crew room humour and teasing in Bryn Station, he hints at the potentially challenging nature of the teasing

and how it may be perceived by those 'from outside' and offers a solution to 'let it go over the top of their heads',

> Alex:…Banter, taking the Mickey out of each other, big style, there's constant Mickey taking and ranging from practical jokes to sort of, just general winding each other up and taking the Mickey out of each other, and that's a big part of it...they don't bite. Some people do, but that's after, a lot of people, they bite and they get the Mickey taken out of them worse then if they bite. They've just got to let it go over the top of their heads, and I think it's difficult for some people coming in from outside to see it, who are not within that environment, that's bullying, or it's sort of, could be, "oh that's a bit harsh," why they, you know, but it's not, cos they'll each give as good as they get. And they each wind each, you know, they wind each other up and that's what they do, it's natural, you know, they swear at each other. You know what it's like here, you've seen that...
>
> *(Alex, Clinical Team Leader, Office Bryn Station, Interview, 18.5.16, 'Mickey taking – let it go over the top of their heads')*

Alex describes the culture of crew room behaviours in Bryn Station, typical antics of teasing and 'Mickey taking' between crews and the responses to it. He initially says crews 'don't bite', suggesting they don't respond to it, minimalising its' impact, however he immediately acknowledges that some do which he says may increase its frequency. Alex hints at the testing nature of the teasing and advises crews don't respond and 'let it go over their heads'. He uses an idiom here of colloquial speech rather than literal meaning to communicate what is needed to deal with this aspect of crew room culture. Alex recognises the difficult nature of the teasing and the potential emotional labour and emotion work this may necessitate; however, his recommendation appears to be toleration. His account works to defend, justify and excuse what he admits may be perceived as 'bullying' to those outside, such as me. He uses the reciprocity of the teasing as justification and describes it as 'natural'; normalising it to further bolster its acceptance. Accounts are a response to and an attempt to excuse or justify questionable behaviour through what Scott and Lyman (1968, p.46) call "socially approved vocabularies".

His explanation works to convince me of his interpretation and justification for allowing this to continue seemingly without check and to this end he draws on my experience of crew room behaviour to support his account, perhaps to verify his 'version' of it and to further persuade me of its 'acceptability' as a feature of EMS culture. Accounts are necessary when a shared cultural understanding and acceptance of behaviour is not assumed and as consequence, they represent an attempt to address this (Scott & Lyman, 1968); to bridge the gap.

Alex's account, in its content and structure is augmented to justify, convince and defend the continued use of teasing amongst crews, despite the potential implications this may have for the emotional labour and emotion work of those involved. His recommendation of tolerance suggests that he may consider the potentially deleterious emotional impacts of the teasing to be outweighed by the value of the humour generated for the rest of the crews and their opportunity to relax and 'have fun'. Alternatively, handling difficult and frustrating elements of work could be made harder if crews have to also deal with

colleagues who may potentially cause further distress under the guise of banter. Humour for some based on the mockery of others can create additional demands for emotional labour as described in the next section.

5.3.4 When humour generates emotional labour: 'It can go too far at times'

Some crews perceived that the humour and teasing could also at times 'go too far'. For example, a month into my fieldwork experience, during an episode of participant observation with Stu and Grant and after the first patient had been taken to Accident and Emergency, we were going back to the ambulance ready for the next call,

> When we got back into the ambulance, I mentioned to Stu that there was a lot of humour and banter between crews. Stu nodded and said but 'it can go too far at times'. I nodded and listened to what else he might have to say about this. Stu told me that he had recently completed some further education and training in his role as an EMT and that he had been given the title 'TWAT' by one of his colleagues. I continued to listen and Stu said 'I don't mind because I'm married, happy and settled' but he said others may not have felt the same about it.
>
> *(Fieldnote, 8.4.15, 10.45 am 'Making fun of…go too far at times')*

In the above Stu offered a different interpretation of the humour and teasing within Bryn Station, he said it can 'go too far at times' suggesting that he may not have found the humour acceptable or appropriate. Stu expanded and qualified his perception with an example of his experience of humour and teasing at his expense. He appears to minimise and offset the impact of the mockery on himself by saying that he doesn't mind because of the nature of his personal life. Here Stu appears to suggest that these aspects of personal life may serve to support, cushion and help him tolerate the mockery from others which implicates his attempts at emotional labour and emotion work. Stu now has to manage another set of emotions related to his work that are excused or allowed for by the supposed necessity of humour. Stu also raises the issue of his colleagues who, unlike him may not have been able to balance and manage the potentially collective though emotionally divergent impact of humour and mockery.

Stu highlighted the negative interpretations and effects of mockery and humour as part of the backstage culture at Bryn Station. I noticed that some crews were reluctant to join in the humour at the expense of colleagues and at times communicated this through not participating and verbally objecting to it. An example of this occurred one morning 3 months into my field work, in the busy crew room and on this occasion involved a student paramedic,

> It was early morning, and we were all sitting in the crew room at the start of the shift. The night crews were getting ready to go home and some of the day crews were asking what needed to be restocked in the ambulances, there was some exchange and banter about this. A student paramedic who had been on night shift came into the crew room; I recognised him and smiled. He said he was going home and Gail, one of the paramedics who had worked the night shift with him said 'where do you live, do you want a lift home?' The student said, 'thanks but I'll be fine'. Nothing was said in the crew room, but immediately after the student left, Arthur one of the paramedics came into the

crew room and said to everyone 'where did that voice come from?' and mimicked it. Some laughed at this and some didn't. Gail said to Arthur 'don't, he's a nice student'. I voiced my agreement with her. The others continued to laugh. I felt pressure to join the laughing but didn't.

(Fieldnote, 6.5.15, 7.00 am 'Making fun - student')

The description shows the opportunistic nature of crew room humour derived from mockery and its focus at times on specific individuals; their features, behaviours and actions which could be used as a source of amusement in their absence, creating laughter and amusement for some. Arthur an influential and dominant personality with a long history in the station had used the student's voice as a basis for mockery and derision in a performance for the gathered crews. Some laughed at Arthur's attempt through child-like, schoolboy mockery to deride the student on the basis of his voice. However, the reluctance and objection to this by Gail, the paramedic who knew the student suggests the disparity between crews' appetite for this behaviour and their tolerance of it. Gail's plea and endorsement of the student as 'nice' is a direct appeal to the perpetrator Arthur, in support of the student. The patchy response and engagement of the crews suggested disparity and divided loyalties amongst them and further undermined the notion of the universal perception of humour and mockery as an acceptable way to help manage the emotional challenges of their work. On the contrary, the response from some crews may have signalled unwanted implications for their emotional labour and emotion work.

The extract shows the dominance and influence of some characters and their attempts to use others for amusement and mockery and highlights the potentially negative features of crew room humour and behaviour in Bryn Station. Some crew members (like Arthur) took up positions of initiating and leading the attempts at humour often in crew room gathering and others appeared to respond and participate. Participation in group humour can generate feelings of solidarity, membership and identity among those involved (Collins, 2004). However, my analysis suggests that humour generated from mockery of individuals is not perceived or experienced in a universally positive way.

The backstage context was also one in which I observed what appeared to be the use of 'black' humour by crews at times as described in the next section.

5.3.5 Black humour: 'our way' of dealing with emotions in difficult situations

In their talk some of the crews referred to black humour as an important way to deal with the emotional challenges they experienced in their frontline work and referred to it as 'our way of dealing with it' and 'how we deal with it', suggesting affinity, ownership and perhaps some anticipatory defensiveness of this type of humour and its place in their culture.

In my fieldwork too some humour occurred in situations involving their frontline work which were sad and depressing and which as such constituted 'black' humour (Cambridge Dictionary, 2019). In this

section I present my observations, interpretation and analysis of socially situated events which appeared to me as a research observer as examples of this type of humour.

One such occasion arose during my fieldwork observation, when the crew (and me) were returning to the station for lunch but on route received a call to attend a sudden death,

> It was lunchtime and we were on our way back to the station when a call came through on the radio to attend a sudden cardiac arrest. We immediately set off at speed with lights and sirens on and headed to the call in the town centre. I got gloves on in the back. It was not long and we were at the address. We got out and a crew were already there, we could see the ambulance parked down the road. We went quickly into a dark ground floor flat and were guided by a relative into a bedroom. There were bedclothes on the bed but no one in the bed and we couldn't see anyone at first; the patient was lying on the floor at the other side of the bed with her head back. She was an absolutely shocking sight and frightening to see. She was extremely thin and her chest bones were prominent and visibly protruding through her nightdress; it was like a large cage. She was stiff and her skin was a mixture of blue and grey. The personal, human sadness of the whole scene hit me; the idea of her dying here alone was hard for me to imagine. One of the crews who was already there said 'the blood is pooling in her hands; she's been gone awhile'. The crew attached the stickers to her chest, the cardiac monitor showed a straight line and he pressed the button on the monitor which produced a recording of it. One of the crews said, 'you couldn't do compressions on that chest anyway you'd go straight through' and there was some laughter. We lifted her onto the bed and covered her up and one of the crews said, 'It's sad'.
>
> Pete and one of the other crews Dave started laughing and teasing each other. Pete said, 'watch him, he's bad luck, here we go, he put 3 in the mortuary in one night'. We laughed at this. Pete and Arthur said to me 'come on we're off now' and we left shortly after and returned to the station for lunch.
>
> *(Fieldnote, 19.11.15, 'sudden death - black humour')*

In the field note extract the crews were responding to an emergency call potentially needing immediate resuscitation and in which death ensued. The situation was sad, depressing and shocking against the backdrop of a personal and human home and family context. Amidst this context and work crews introduced humour and made light in a sad and challenging situation, lifting the atmosphere. My field experiences with EMS crews showed the nature of emergency ambulance work, the sudden exposure to life threatening situations, death and physical disfigurement, the human impact and reality of it and the roles they perform in responding to and managing these, both technically and emotionally.

The humour could be considered crass and insensitive particularly viewed outside of the individual context. Front stage work settings like that above show the close relationship between front and backstage and the fluidity of backstage and reflect Goffman's (1959) conceptualisation of backstage as one defined by behaviour not physical setting. It is the absence of front stage audience which can give vent to behaviours which are backstage in their nature; relaxed, informal and oriented to by participants as humorous. Backstage behaviour was displayed in the temporary backstage of the bedroom, where crews conduct their work as a team, in private and without external audience. Against this private

context and the sadness of the situation this was an attempt at humour which was responded to by others and which is a form of emotional handling of a difficult and distressing scene.

5.3.5.1 Black humour: 'that's our way of dealing with it'

When talking about the challenges of EMS work and how they deal with these, James says black humour is their way of dealing with what is seen and experienced in their frontline work and suggests it offers 'easier' emotional response,

> James: ...unfortunately you get quite blasé, you laugh and you joke about it but I suppose that's our way of dealing with it. You get like a dark sense of humour, a sick sense of humour, you find things funny that you're not supposed to, but it's hard not to because it's the old saying, you're either gonna laugh or you're gonna cry, so it's easier to laugh about some stuff...You go to some pretty grotesque sights, you see some awful things... and it just becomes, I don't know, part and parcel of your mind I suppose, it's, you just tend to not think about things unless it actually concerns you, so you tend to make a dark humour about things as well without realising.
>
> *(James, EMT, Office Bryn Station, Interview, 11.4.16, 'Dark humour – our way of dealing with it')*

James offers his explanation of the use of black humour; how and why this develops and becomes part of crews' accepted response and behaviour. He refers to the nature of their work and what they may be exposed to, anticipating how this humour might be perceived and interpreted and thereby offering justification. He attempts to justify its use as an alternative to being emotionally affected employing a phrase 'you're gonna laugh or you're gonna cry', implying a level of resolution and acceptance of the situation and the emotional options available to them. He suggests that they become able to 'not think about things' unless it affects them, hinting at detachment and desensitisation which he appears to suggest may enable their use of black humour. Black humour is suggested to be part of how crews emotionally deal with what they experience, it becomes part of how they detach, distance and shield themselves from the challenging reality of their work and becomes a way they endeavour to manage it. James refers to black humour as 'our way of dealing with it', suggesting ownership and a 'specialness' about them, the nature of their work, what they witness and how they deal with it. He may be making a case for the specialness of their work as justification and necessity for generating black humour.

Louise, an EMT, justifies the use of what constitutes black humour as a means of handling difficult emotions associated with challenging situations crews experience,

> AW: It's one of the things that I've noticed here coming out with you it's that people come back and talk and laugh about things.
>
> Louise: Yes, and I think everybody has got a very good sense of humour which other people that don't do this job probably wouldn't appreciate. I mean we can laugh about things that people would think that you really shouldn't laugh about that, but we don't mean it personal to anybody, it's just that is our humour and that's how we deal with it, you know, because, you know, we might have seen something terrible ten times and to us that might be a little bit funny, to other people they might think

'gosh, you can't laugh about that', but I think you've got to be a certain type of person to do this job and if you don't find humour I think you'll just go mad. I think you need to have a laugh because I think it's not good for you if you don't...

(Louise, EMT, Office Bryn Station, Interview, 12.5.16, 'humour – how we deal with it')

Louise makes the case above for the importance of black humour by EMS crews as a means by which they handle and manage the emotions which may arise from the challenging aspects of frontline emergency work and the potential emotional labour needed. She refers to what is seen and experienced, sometimes repeatedly by crews and the importance of having a 'good sense of humour' as a way to deal with this work. Louise recognises that humour is not a generically defined phenomenon and may not be perceived as such by everyone; particularly those who don't do emergency work. Louise makes the case that humour is context, situation and people dependent and she refers to the particular contingencies of their work; it's nature and 'specialness' as justification for what may be considered by them as humorous. Louise continues in her quest to augment her case for the specialness of the EMS by suggesting the need to be a 'certain type of person' to do emergency work, again differentiating it and elevating it to a position of special, which justifies what is perceived as humorous to those who may not necessarily agree. Louise is offering an account of what is perceived as humorous within the context of emergency work. Accounts are verbal attempts to "neutralise an act or its consequences" (Scott & Lyman, 1968, p.46), when these are called into question.

Louise presents her account to justify perceptions of what is humorous and the importance of this as a way of handling the emotional challenges of EMS work. Alongside opportunities to moan and complain and to laugh and tease each other, the backstage crew room context in Bryn Station was also described by some EMS crews as one in which they could talk to their colleagues about calls that bothered them, question their actions and whether these were the right ones. This appeared to be an informal peer supervision system which helped crews deal with their emotions after difficult calls. In the next section I present my analysis of the value of talking to colleagues in the EMS context as a way of handling the emotional demands of their work.

5.4 Handling difficult work: Talking through 'jobs' with each other

The crew room in Bryn Station was perceived by some EMS crews as one in which they could share difficult or challenging work experiences with each other and receive feedback on the actions they had taken. In this section I will present my analysis of what crews said about these crew room opportunities to talk through difficult calls with their colleagues.

EMS crews described the crew room as a setting in which they could talk to each other about particular calls (they referred to these as 'jobs') they had attended which bothered them; prompting them to think about the call, to analyse it, question whether their actions were the 'right' ones and if there was anything else they could have done. Some of the crews described a process of questioning what was done, what else could have been done, learning from the experience and moving on. Crews referred to the importance of talking through the job; 'not bottling it up', venting it, sharing it, with their colleagues who understand the role and how it can affect them. Crews explained their reliance on each other on the basis of a shared understanding, experience and appreciation of their work, what was involved and the feelings this may evoke and sought the reassurance and validation from their colleagues that they had done the right thing. These opportunities for interaction with colleagues about challenging calls are perceived by crews as important in how they handle and manage the emotional issues which arise from and accompany their frontline work.

5.4.1 Handling difficult jobs: 'You've got to resolve it... it's not easy to do...colleagues are the best way'

For example, in a research interview, Mike, a paramedic describes a call he attended some ten years previously which he said 'was in his mind for days' afterwards but which he said is best 'resolved' through talking to colleagues who understand,

> Mike: I remember jobs I did ten years ago. I can walk you through one particular job I went to. I just qualified as a paramedic so that's ten years ago, I can take you through practically every second of that job because it was a job that I hadn't a clue what was going on. I couldn't understand what was going on. All I had to do was take the person into hospital. Took her into hospital and stood in the resus and watched her die, and we left her husband and two kids at home, not knowing what was going to happen...That was something that was in my mind for days but I was able to resolve it because there was nothing else I could have done...It's when you don't do that, it's when you're waking up every day or every night and just think, oh no that's a bad experience. You've got to resolve it... it's not easy to do...colleagues are the best way.
>
> AW: Are they?
>
> Mike: Oh yeah, because they understand. They know what you're going through. You can't take it home to your wife or your husband because they haven't got a clue what you do. It's even difficult taking it to somebody like within the well-being...because they don't understand. Very few people understand what paramedics do, and what our role involves, and what we see, what we do, how we influence people's lives and if we think that we haven't done it properly, how much that can influence us as well...you've obviously been in the rest room when we've been talking about jobs and we've been throwing it around different people and different people will say well yeah fine, it looks like, yeah its fine, we did that, and usually you find that everybody is in agreement. Yeah, you've done exactly the right thing, and that's probably the most helpful thing that we get, is our peers listening to what we have to say about a particular job and then discussing it amongst ourselves...I know now ok I find this time I'm going to do it slightly different or we'll say well there's nothing else you could have done, but that's the one way of getting rid of that stress. That 'pent-up' feeling that maybe you didn't do everything right, but it needs somebody else that does your job to look at it...

(Mike, paramedic, Office Bryn Station, Interview, 26.2.16, 'discussing it amongst ourselves – the best way')

In the above interview data extract Mike describes and exemplifies the highly emotive and challenging aspects of EMS work, of calls they may attend and the possible psychological and emotional sequelae whereby crews question their actions and whether they were 'right' and that all that could be done was done. To furnish his point Mike draws on his own experience of a call he had attended some years previously which he says led him to question his actions and what was going on. He advocates the best way of dealing with this is through talking about it with colleagues, who he says understand the role and how this can impact on how crews feel.

Mike positions those outside of the work setting, such as family members and professionals from 'well-being'; a service available to crews to help them deal with health issues arising from their work as not being able to understand the role. Mike says, 'very few people know what paramedics do', which suggests a uniqueness, a complexity and obscurity to the role, which he uses to bolster his point that therefore those outside it would not understand. Mike creates an otherness to the work of the EMS and uses this difference to support his argument that his colleagues are the best way to deal with the realities and challenges of EMS work. Talking through the call with colleagues as described by Mike involves attention to what actions and clinical interventions were undertaken and the outcomes of these. He suggests opportunities to talk with colleagues as a way of dealing with what he says are 'pent up' feelings of self-doubt crews experience and which can accompany their work. Mike is describing and advocating opportunities to talk with colleagues about difficult calls as a way of handling the emotional labour and emotion work associated with their work.

Mike presents his account through the use of instructions and recommendations for what he proposes is the 'best way' of dealing with calls but refrains from actually saying this is what he did in the situation he describes. He is making a case to try to convince and advocate that this is the best way and, in this quest, says me as a researcher in the course of my fieldwork in Bryn Station crew room would have witnessed the discussion of such calls between crews. He draws me into his point, as assumed experience and support of it. In so doing Mike uses my experience to metaphorically bring me on side with his recommendation in a way which offered me little if any opportunity to confirm or refute it. As such my confirmation of his positioning is accorded cursory attention and is paid lip service rather than being actually sought.

As such Mike offers his understanding and experience of the role of these emergency professionals, of the complexity and uncertainty of circumstances they face and their outcomes and their perceived responsibility for the care they deliver and its outcomes. He describes his experience and perspective of the psychological and emotional effect this can have and the process of resolving it by thinking it through, talking and receiving feedback from trusted colleagues who he says know and understand the

role and how it can affect them. Mike implicates trust in colleagues and recommends resolving such matters internally rather than seeking external support and verification.

Mike is making a case for the 'special' nature of their work in EMS that only they know and understand and correspondingly only they can evaluate and validate. As such Mike is perpetuating what he perceives is an appropriate and purportedly effective coping strategy for dealing with difficult calls and the emotions which these may create, one which prescribes self and colleague' analysis and simultaneously avoids external disclosure and scrutiny. He describes a process of seeking the views of colleagues on the actions taken during a call and their reassurance and agreement in doing the 'right thing', highlighting a need for validation from colleagues which is raised by other crews too.

Mike presents his positioning of the value of talking it through with colleagues in a singularly positive, unproblematic and rather simplistic way. He omits to consider the potential pitfalls of reliance on close colleagues and the implications this may have on the nature, content and possible outcomes of these encounters. For example, he does not consider the potential effect of group or collective thinking which may serve to perpetuate similar perspectives rather than alternative understandings. The social element of sharing and disclosure itself may influence what is disclosed in an effort to avoid negative commentary from others and may also impact on the nature of feedback given by the crews, who may be reluctant to criticise or even upset their colleagues. A sufficient degree of distancing may not be easily afforded by those who work closely together.

The possible limitations of colleague' feedback when talking about difficult calls is touched on in a research interview with Alex, in which he suggests crews may be inclined to give reassurances to each other even when they would not have done the same thing.

> AW: ...you just mentioned that they come in and they talk here (station). How does that help them?
>
> Alex: I think a lot of times they just talk about a job, a lot of them need sort of validation that they did everything right. A lot of the time they think, oh, right, they talk about it, say, "oh I'd have done the same thing." "Oh right, okay." Or if something did go wrong, you'd say, "well, why did it go wrong?" And they talk, and talk, and talk, and they say, "well, yeah well, I can understand why that happened, and it wasn't your fault." So, a lot of the time, the more they talk, they just want somebody to say, "yeah, you've done alright there," even if they think it went wrong. They just need a bit of support, say, "yeah well, I'd have done the same thing." You know, even if you think well, perhaps I wouldn't have in that occasion perhaps. "well, what if you'd done this?" "Yeah, I could have, but I did it this way because X, Y, Z." "Well fair enough, I can see why you've done that".
>
> *(Alex, Clinical Team Leader, Office Bryn Station, Interview, 18.5.16, 'Talk about a job, need support- even if wouldn't have')*

Alex describes crews' reliance on each other to talk through 'jobs', he perceives this as a 'release valve' where they share and discuss their actions and seek the reassurance from colleagues that they did the right thing and that others would have done the same thing. As such his account describes the use of

talk with colleagues as a way of handling the emotional challenges of EMS work. However, Alex also says crews might be inclined to agree and support colleagues even if they think they would not have done the same thing. Alex exemplifies and replicates the dialogue and discussion where crews may offer explanations for their actions in particular circumstances to each other. He describes possible responses from listening crews and highlights the potential pitfalls of reliance on feedback from close colleagues.

The crew room however as an 'internal' setting for crew' exchange is one which is self-sought and is perpetuated and endorsed by some crews as a way of dealing with the questioning and self-doubt arising from their work but is apparently one in which actions are likely to be supported and perhaps unchallenged. As such the backstage crew room may be a 'comfortable' one, which helps to meet the emotional and psychological sequelae of their work in a relatively low risk way with colleagues they are familiar with and who understand the challenges arising from their role. There are suggestions here that crews appreciate the challenges of their work and the emotional labour and emotion work that accompany this and that they rely on each other to help them handle and deal with it.

The above interview data extracts from EMS crews show experiences and perspectives of the emotional and psychological challenges of frontline emergency pre-hospital care and the historically established and for some, culturally acceptable ways of dealing with these, with colleagues in the backstage context of the crew room. They describe a way of dealing with calls or jobs they find difficult and troublesome to them which involves a process in which they 'talk it through, 'they discuss what was done and if anything else could have been done in the situation and receive feedback and suggestions. They seek the views and perspectives of their colleagues who know the job and understand their feelings; seeking the reassurance that their actions were agreed by colleagues as the right ones and enabling them to resolve it; that they had done all they could.

This offers awareness of the complexity and the challenges of front stage emergency ambulance work and the psychological and emotional effects this can have on crews after a call, in the backstage where it is discussed and examined, and emotion work undertaken to address worries and reshape how crews feel. The complex and unpredictable nature of this work is described, and the accompanying moral and professional duty of care felt by the crews, their concerns and needs for validation and reassurance from each other that they did the right thing.

Although crews related their experiences and perspectives on the process and importance of talking about calls they had attended with each other in the backstage settings such as the crew room in my interviews with them, during my fieldwork I did not personally experience this interaction. Despite attending a variety of calls with differing levels of urgency and complexity crews did not discuss these in settings which included me. This may be attributed to my role as a researcher, nurse educator and 'outsider' and their reticence in displaying their uncertainties and need for validation and approval of

their colleagues. This may have placed them in an exposed position, undermining their skill and exposing them to external scrutiny. Hutchinson (1983) in her study of emergency rescue workers in America noted that behaviour in the backstage region is usually only seen by and revealed to a few, the few being 'insiders' or people who are considered 'safe' or "in the know" (p.16). She comments that "behaviours express, among other things, people's frailties, fantasies and desires" (p.16), which they may not want 'outsiders' such as me to witness.

The lack of empirical incidents of 'talking through jobs'; could also be attributed to the infrequency of calls which may necessitate this interaction and discussion with their colleagues.

5.5 Conclusion

In this chapter I have described my experience and analysis of the backstage behaviours and interactions of EMS crews in Bryn station, with particular focus on the crew room and on other occasions when they were not undertaking their frontline duties. My fieldwork experiences in Bryn Station have positioned the backstage, particularly the crew room as a permanent, convenient and physical backstage for EMS crews to meet, interact and engage with each other in moaning and complaining about their work, creating humour through teasing and on occasions talking about calls they had found difficult. Some of the crews described the crew room as a valuable source of support and reassurance that they had done their best and the right thing in challenging situations where there was uncertainty.

I have shown how crews use the crew room to complain and moan to their colleagues about the frustrations and challenges of their frontline work, particular calls and more specifically those they consider to not need an emergency 999 ambulance response. Opportunities to moan and complain in the crew room were not however universally valued and some crew members described this as unhelpful. Some quieter crew members I noticed spent minimal time sitting in the crew room.

I have shown how humour, laughter and teasing amongst EMS crews was an almost constant accompaniment of backstage interactions in Bryn Station, which some crews said was helpful in enabling them to cope with the emotional challenges of their work However, at times I noticed the humour was generated from teasing, particularly newcomers and also established crew members and was perceived by some as 'going too far'; potentially creating the need for additional emotional labour and emotion work. The humour on occasions could be considered 'black' in nature and was perceived by some crews to help them cope with the realities of their frontline work.

I have described how some crews perceived the crew room as offering them a valuable opportunity to talk to their colleagues about particular calls that bothered them, where they questioned and doubted their actions and sought the reassurance of colleagues who they said know and understand the role and how it can affect them. My analysis indicates that opportunities to talk to colleagues enabled the

expression of ‘pent up’ emotions and the resolution of doubts and concerns; as such they are ways some EMS crews handle the emotional accompaniments of their role. They are aspects of emotion work in this context.

My analysis suggests that for some EMS crews the crew room was perceived to play a valuable role in enabling them to express and share frustrating and challenging aspects of their frontline work. To express their frustrations with particular types of calls and the impact on their role and identity, calls which raise self-doubt and those which may be shocking, sad and depressing to witness. Some EMS crews in their talk made a case for the specialness and uniqueness of their work, only they know and understand it and they seek the support of colleagues who they perceive share this understanding. My analysis however also suggests that crew room interactions were not perceived by all crew in a universally positive and helpful way and could necessitate additional demands for emotional labour.

In the next chapter I will focus on my experiences of the frontline work of the EMS, how they interpret and position their work in differing ways and the underlying cultural and historical backdrop which shape and give meaning to their work. I will begin with attention to the features which give rise to and constitute positive work and call appraisal by EMS crews and the implications these have for their response and the care given by them.

Chapter 6

Positive call categorisations; their implications for emotions and emotional labour

6.1 Introduction

In this third findings chapter I present my analysis of data extracts that I suggest communicate aspects of the EMS role in frontline service provision. I bring attention to the role adopted by crews in responding to emergency calls and focus on what I detect as informal positive call categorisation in the accounts of workers. I suggest these call categorisations have implications for crew' emotions and emotional labour and incite attempts to position their role and their understanding of it amidst threats to their professional identity.

My analysis suggests that it is the interpretation of calls as candidates for a positive categorisation that prompt evaluations centred on 'making a difference'. 'Making a difference' is a locally produced signifier in evaluations of the value and effect of the EMS role in emergency situations. Attention is given by crews to life threatening incidents, allowing them to demonstrate their technical skills and save lives. My analysis also suggests that interpretation of calls constituting positive call categorisation are associated with evaluation of what is positioned as genuine need for the emergency ambulance service. 'Genuine' and 'they really need us' were locally ascribed descriptors in evaluations of calls which included features of serious physical, medical and mental health needs and help needed to get to A&E.

Interpretations of calls categorised positively instigate crews' perceptions of what they consider to be the appropriate use of the emergency ambulance service. Calls evaluated positively by crews are artfully positioned in accounts supporting their argument that these are the kind of calls they should be dealing with based in claims of genuine need. These contrast with 'others' considered not genuine, which impute a discrepancy between the public and professional perception of need which I will show in chapter 7.

Goffman (1959) refers to front stage or front region as that in which the performance occurs and is presented and displayed to the audience. This is where actors undertake their role in the midst and backdrop of "props" and a setting conducive and sympathetic to the purpose and delivery of the performance. This is where actors are keen to provide a display which is convincing to the audience. The front stage of the emergency ambulance service is where crews respond to and interact with the public and perform their skills of history taking, assessment, treatment and management of the person and their presenting condition. Unlike other healthcare professional groups this service is delivered in a potential myriad of constantly changeable settings located and dictated by medical and public need (Hutchinson, 1983). The pre-hospital context can include private, personal contexts and some of the most public contexts. Private contexts include home environments such as the living room, kitchen, bathrooms, bedrooms and frequently the inside of the ambulance. External public settings include the

busy observable roadside or shopping centres and any public or private establishment. The audience for front stage performance is thus a potentially extensive and constantly changing one.

In this chapter I will present analysis that shows how calls are interpreted and categorised positively by crews, the emotions incited and the emotional implications of their frontline work, crews' understanding of their role and their efforts in asserting its 'specialness' and uniqueness.

6.2 The Emergency Medical Service role, call evaluation, categorisation and emotional impact

My analysis of the data collected for my thesis suggests that the EMS crews describe their role as one which deals with a complex and vast range of calls with varying levels of medical speciality and need across the lifespan and the requisite skills to meet these. They describe their role as responding to 'anything and everything', including emergencies such as chest pain, cardiac arrest, falls, stroke and road traffic collisions. Their role is complex and varied in dealing with serious medical emergencies and unique in its demands. My period of participant observation with the crews and a day I spent at the Clinical Contact Centre where calls are received, assessed, categorised and responded to highlight the complexity of demand and the formal systems in place to respond to these. The EMS crews in their talk and in their practice reveal the existence of additional, informal, other means of call evaluation and categorisation. I will show how their call evaluations showed commonalities and variations which reflect their understandings of the role of EMS and their concepts of legitimate need for the service and implicate the specialist skills and role of the crew.

In the following sections I show how call evaluation impacts on EMS crews in fulfilling their role expectations and enabling role fulfillment, role identity and job satisfaction and the accompanying psychological and emotional benefits. I argue that call evaluation, positive images and interpretations amongst crews incite different emotions; excitement and frustration and thus have implications for emotional labour. My study has suggested that crews negatively appraise calls using local descriptors such as 'rubbish' (discussed further in chapter 5 and chapter 7), and which occur alongside frustrations; positive call appraisal is the reverse side of the central phenomenon of work appraisal.

Crew' appraisal and positioning of calls in these two different ways indicate identity relevant talk and show how they do identity work. The calls and their evaluations of them impute particular versions of what it is to be an EMS worker. This identity work has relevance to their emotions and emotion work, in a sense they are interlinked and interdependent.

I have chosen to focus on examples of positive call appraisal because of the emphasis crews placed on these calls, the emotions evoked and the impact on emotional labour. These examples suggest a patterning of emotional response and interaction within the work of EMS crews that is central to my interest in the emotional labour of this category of work. During my fieldwork with EMS crews, I

noticed their positive evaluation of calls in which their emergency skills were put into action; generating excitement and a sense of achievement through what they described as 'making a difference' as described in the next section.

6.2.1 'Exciting calls', using skills and 'making a difference'

During 280 hours in 10 months of participant observation in the field with EMS crews I witnessed their informal assessment, evaluation and appraisal of the calls they attended. My analysis indicates that positive features of call appraisal included those described by crews as 'exciting', in which they were able to do something, put their skills to the test and make a difference, prompting feelings of satisfaction, role fulfillment and emotional well-being.

Some of the calls perceived as most exciting were to individuals who were in cardiac arrest where crews would immediately react and respond, instigating coordinated resuscitation. On occasions during fieldwork, I witnessed the crews' excitement of responding to a cardiac arrest call. This raised emotional state was obvious to me as someone socially situated in the same wider culture, first from the behaviours I observed and then from what they said to me during these episodes. One such occasion arose in the second call of a day shift three months into fieldwork,

> We got back in the ambulance and Lucy (a Paramedic who was covering in Bryn Station for the shift) radioed Control to clear the call. We got ready to go and a call came through to a cardiac arrest in a 91-year-old female. We went quickly with blue flashing lights and sirens to this. This was sudden and everyone was going quickly. We got to the house, parked up outside just off the road and went straight up the stairs and into the front bedroom of the house. Roy was already there and was sent first in the RRV, the woman was unconscious in bed, not breathing and was in cardiac arrest and Roy was trying to move her onto the floor. Lucy, Tom and I got either side of the bed and together on the count of 3 slid the woman down the bed and onto the floor at the bottom of the bed; she was small and not heavy to move and so this was done quickly and easily. It was as if everyone got into action and worked together. There was very little space at the end of the bed though. Roy quickly put a tube into her mouth and down into the lungs. I quickly attached the oxygen and started to compress the bag (ambu bag). Tom started chest compressions and counted and we did 30 chest compressions to 2 lung inflations for 3 cycles. I was pleased to have something to do in this emergency situation and pleased to be able to help. These were situations I dreaded and feared in my position as a researcher because I didn't feel certain of where equipment was kept or what if any my role would be. Also, these skills are not part of my current role which made me feel less confident than I had previously been. Lucy put a small tube into a vein and gave fluid into this. Heart monitoring continued as we continued. Lucy gave adrenaline and shock treatment to restart the heart. We continued resuscitation which was physically hard work in a very confined space, kneeling at the end of the bed with the radiator and the bed close by either side of us.
>
> The crew were totally focused on the resuscitation and didn't look up. Family members were at the house and periodically came to the door of the bedroom to look in; one woman came by the door crying and said to us 'thank you for all you are doing'. I felt so sorry for them, they were clearly distressed.
>
> After a while, the patient was showing some improvement and her heart had restarted and it was decided by the crew that we would go quickly whilst she was stable. The crew said we would 'run with her as quickly as we could'. Together we lifted her onto a chair, I held her head, and continued

to help carry equipment. I struggled to get her feet onto the step of the chair quickly and panicked a little; Roy said it's okay. We went down the stairs together and out quickly to the ambulance.

A&E were contacted about the call coming in. On route to the hospital the ambulance went at speed and the crew continued to focus on monitoring her closely and giving oxygen. She had started to breathe independently, and her circulation had returned. When we got to A&E we took the trolley straight into the resuscitation area, moved her over on to the trolley and left after handover.

There was a positive feeling amongst the crew afterwards with lots of talk about what we had done. As Tom and I cleaned down the stretcher in the corridor outside the resuscitation area I could see Lucy's excitement; she couldn't keep still. As we wheeled the stretcher out of A&E and into the ambulance I said, 'how do you feel about a call like that?' and she said 'that's a good job. That's what happens when there is a witnessed arrest we worked together as a team'.

(Fieldnote, red call - cardiac arrest, 9.6.15, 8.30am)

The above field note extract describes my observations of the actions and interventions of an EMS crew in the resuscitation of an elderly lady who had suffered a sudden cardiac arrest. The co-ordinated efforts, skills and interventions of airway management, chest compressions, defibrillation and drug administration were impressive to see and be a part of and the positive effect of the return of circulation and respiration were the rewards for all, the patient, her family and the crew. The sense of achievement, satisfaction and excitement was palpable after the call as the crew relived their role with each other. Lucy who had co-ordinated the resuscitation was visibly excited by the success and later confirmed when asked that this was indeed a 'good job'; 'a witnessed arrest' and one in which there was effective teamwork, with a positive outcome.

Lucy categorised the call as a 'good job' and qualified this further with the objective and subjective attributes about the call; that it was a cardiac arrest immediately seen and quickly responded to forging a much greater chance of success and adding the context specific features of teamwork and the coordinated crew response. The call was also a success in relation to the objective restoration of life. A cardiac arrest and successful resuscitation is a call which draws on and utilises the skills and interventions of the EMS and is typically and traditionally what their role is designed, prepared and equipped for; quick response, skilled interventions and transport to hospital (College of Paramedics, 2019). Their role and contribution in this type of call is crucial, the effects are visible and real, and the outcome is theirs to claim and enjoy. They have made a clear difference to the patient and saved a life. The crews were quick and keen in their response to the call; they were focused and determined in their actions in resuscitation and their talk and behaviours after the call suggested positive feelings. The crews hung around outside the resuscitation area of A&E and continued to talk about the call and what had happened.

I interpreted the actions and behaviours I witnessed to suggest positive emotion and feelings of excitement and satisfaction amongst the crew. Behavioural reactions accompanying emotion have an agreed and well-established history which includes, "actions, attitudes, and perceptible physical

manifestations, both voluntary and involuntary", which can be identified by others successfully using the senses (Jacob-Dazarola et al; 2016, p.105). These actions and behaviours are recognisable and familiar to me as someone who is socialised in the same social milieu and as such sensitised to social cues for particular types of emotion states. As an observer, whilst I am separate from the work world that the crews inhabit, at the same time I am part of the same wider social world and therefore familiar with the expressions of emotion that may be found there. My intellectual interest in emotional labour and emotions in work settings also rendered me alert for examples of these when they arose.

There was a general feeling of positivity among the crew going back to the station too, the mood was upbeat and there appeared to be sense of achievement; they had done their job. The positive mood continued, suggesting that there may be longer term emotional effects for crews; later in my analysis I show how crews say this type of work sustains them over periods when they have to deal with less exciting, mundane or what they refer to as 'rubbish calls'.

Crews used the descriptor 'exciting', which suggests the emotions which may accompany this type of emergency work. For example, in a research interview data extract, Stu, a paramedic, describes the excitement of saving a person's life.

6.2.2 '... exciting stuff when you can actually do stuff to people that will either bring them back to life or save their life'

In the following data extract Stu makes a case for the importance of having an impact on the outcome of a call, he appraises different calls and crews' impact and perceives a cardiac arrest as one in which his actions can make a difference and save a life. These he concludes to be 'the exciting stuff'.

AW: Would you say these are jobs that you do things in?

> Stu: Certainly, you are affecting the outcome of that job. I'm affecting the outcome of a granny who's on the floor, or an abdo pain, you can't do actually anything there, can we really affect the outcome? we can't. With an abdo pain you need to see a doctor and if you need surgery, well we're not going to do it. The overdose, you may need medical help, you probably need psychiatric help – we're not going to do that. Where you got a cardiac arrest, then if we don't do stuff, you're dead. Well, you're dead already, but we can bring them back to life with CPR and shocks and drugs. I'm not able to give the drugs but CPR and shocks are more important anyway and getting them to a hospital. That I suppose is the exciting stuff when you can actually do stuff to people that will either bring them back to life or save their life.

(Stu, EMT, Office Bryn Station, Interview, 2.12.16, cardiac arrest – 'exciting')

Stu refers to calls which he perceives crews can impact the outcome of; he offers examples and indicates the degree of role impact, at points contradicting himself and employing rhetorical questions which are persuasive tools to facilitate his argument (Koshik, 2005). He places and supports his argument amidst a work context which he says does not enable clear impact on the outcome. Stu displays his thinking, he draws on different types of call and medical need and for each he questions the impact of his role,

deferring to other professionals who have the ultimate expertise and professional autonomy to address the underlying health problem. He questions the crew' ability to affect the outcome, making a case for his argument and compares these with cardiac arrests where EMS interventions and skills and his own specific interventions make a significant difference to the outcome, as such his valuing of calls appears to be influenced by what he can do and the impact on the patient and himself.

Stu implicates a valuing of calls where EMS role and intervention is clear, distinct, skilful and demonstrable and where the accompanying feeling is excitement. He is articulating a specific and confined perception of role and role impact; the nature and degree of it, implicating his role in it. Medical and technical impacts are accorded recognition and supremacy in Stu's appraisal of calls. A feature of this call valuing and categorisation may also relate to role autonomy; a role which EMS can claim ownership of discreet responsibility for and specialism in. Cardiac arrests serve to utilise their specialist skills, accentuate their unique role, their contribution and the rewards of positive emotional sequelae.

Stu shares the nature and basis of his appraisal of calls privileging those in which his particular skills are needed, are discharged, have a clear impact and make a difference. Making a difference through the use of technical skills was perceived as important to other crews too, who also related the challenge of trying to achieve this and how they had reconciled their role expectation with the reality of their practice.

Crews also suggested that there are longer term positive emotional effects of work which offers opportunity to 'make a difference'. In the research interview data extract below, Mike, a paramedic explains this.

6.2.3 '...if I make a difference then the next ten jobs are just water off a duck's back'

In the next data extract below Mike refers to making a difference and the difficulty crews' face in achieving this within the context of the dissonance between role preparation and expectation and role reality. Mike aligns these role expectations and conflicts with younger crews and their training, from which he distances himself. Instead, he casts himself as one of another group 'the older ones' whose role expectations are different,

> Mike:...people like myself, I just go and get on with the job. I just look forward to the job where I make a difference, and that one job in ten, if I make a difference then the next ten jobs are just water off a duck's back, but there's a lot of people, especially the younger ones that find that difficult to do because they've done so much training to get to where they are then suddenly find it's not like Casualty. They find they're going to the alcoholic that's drunk too much and find out that they can't really leave them at home the way he is, they take him in and then they got to put up with verbal abuse, or the threatening behaviour or they go to Granny Smith who's fallen twenty times in the last month, never hurts herself but it means they got to pick her up off the floor because she's twenty stone so they then got to go and get bits of equipment and blow it up and get her off the floor then go through all the paperwork and they think to themselves well does this, is this the job I've actually signed up for? I've signed up to go to cardiac arrests, to major trauma, major RTC's, people having

> heart attacks, people having CVA's, people I can make a difference to, but as I say, the older ones, as long as we get one now and again, keeps us happy just to make a difference, once a week and it helps with the job but there's youngsters now that can't see it that way. They remember the jobs that frustrated them rather than the jobs where they make a difference because the ratio's quite high, one against the other.
>
> (*Mike, paramedic, Bryn Station office, Interview, 26.2.16, 'making a difference')*

Mike is presenting a view of frontline EMS work; he is making a case for the dissonance between some crews' expectations of the role and the contrast with the reality of their role. He creates and crafts his account in both content and organisation to facilitate and communicate his point. He selects and employs extreme examples to communicate a particular 'picture' of EMS work; of the unpleasant, the physically and emotionally difficult aspects of it to contrast sharply and effectively to secure his argument. Mike describes the examples of calls starkly and vividly with fervor and engagement, using rather extreme descriptions which may reflect his own experience and frustration with them. He presents these examples in quick succession which cumulatively builds the foundations to his argument.

Mike's account also has a resolute, accepting stance to it, employing an idiom to communicate and express the effect of less rewarding jobs which he says is like 'water off a duck's back'. Idioms are verbal expressions not meant to be taken literally and reflect local language (Drew & Holt, 1988). However, they are creative devices which can be put to good effect in succinctly communicating the desired meaning. 'Water off a duck's back' communicates an unaffected, resilient response enabled through a protective cover around oneself. The image forged by the idiom is a persuasive, convincing one which suggests his successful role reconciliation and one which although not literal and colloquial, imputes a "special robustness" to his point (Drew & Holt, 1988, p.406), not necessitating empirical evidence and unlikely to be challenged.

Mike suggests that the opportunity to make a difference; albeit infrequently enables him to deal with work which is less rewarding. The implication is that opportunities to make a difference may have longer term emotional effects which help with the emotional management of their work.

At points within his account Mike attaches and aligns himself with some groups in the EMS and conversely detaches himself from others, as such he is doing "identity work" (Snow & Anderson, 1987, p.1336), using his talk through "distancing" and "embracement" (ibid) to craft, create and communicate an identity which he chooses, and which supports his personal identity and self-concept. At both ends of his account Mike presents himself as one of a group within the EMS who have different role expectations for calls in which they can make a difference in technical, emergency and medically sophisticated ways. Mike refers to 'people like myself'; which describes him as one of a group of people who get on with what the job involves and have differing and more realistic role expectations; he is creating his identity here through embracing the identity of 'older' crews; more experienced and cognisant of the realities of the EMS role. Having asserted his identify and affiliation to one group he

compares and separates himself and his older colleagues from another group: the 'younger ones' and their role expectations. Mike separates and detaches himself from the role expectations and perceptions of these newcomers to the EMS; he refers to their educational preparation and 'training', implicating their difference to his own and using this as explanation and contributory to their role expectations. He assigns himself to a position of other in relation to these perceptions, he is 'looking on', distancing himself from them, from a self-positioned different stance that appears to know better. Mike suggests he has the experience to know that role expectations are one thing, and the reality of practice is another, one he himself and his older colleagues know and have learnt to accept. Mike creates his identity as one who is experienced, is wise to the realities of EMS work and the ways of resolving expectation and reality. He also intimates that he has developed ways to emotionally manage the realities of EMS work and balance the positive, exciting work with the more frequent, mundane aspects of it. He suggests that he 'just gets on with the job', which implicates emotional labour in the effort to suppress emotions which are perhaps generated by the routinised, less exciting and rewarding types of emergency work.

Identity is a generic feature of personhood which is transient, malleable and influenced by time and the perceived desirability or undesirability of particular identities (Snow & Anderson, 1987). My analysis indicates that Mike's account displays evidence of 'identity talk'. He is constructing his identity through detachment from one, younger group of EMS crews; their training and role expectation and aligning himself with another; experienced group who know the reality of the EMS role. Mike suggests he and his colleagues have ways of reconciling these between role expectation and their need to make a difference and the emotional management of this.

Some crews suggested other ways of dealing with the reality of their role and the frustrations this may create, through alternative appraisal of their role. For example, Tracy, a paramedic, in the research interview extract below refers to making a difference in a different way; a way which involves a reappraisal of what may constitute 'making a difference'.

6.2.4 '...she's given me a hug and kiss and I've left her there and its things like that that make a difference

Despite the dissonance between role preparation, expectation and the reality of their practice role some crews interpreted making a difference in alternative ways. Tracy is one of the 'younger' crew members in Bryn Station, who refers to her role preparation and training, wanting to use her technical skills to make a difference and the difficulties of achieving this. She describes her interventions to organise referral for appropriate care and uses the appreciation shown by the patient as evidence of 'making a difference'.

> Tracy: I've done loads of training and extra courses; I just want to be able to use my skills. Even like for elderly people who fall, if they've got a NOF (fractured neck of femur) you get there,

cannulate, give them some pain relief, give them some entonox and try and make them as comfortable as you can on the car but you can make a difference...

AW: It's making a difference

Tracy: Yes, it's making a difference and sometimes you go home and think I've made no difference today at all to anybody and then sometimes you go home and think I've made a difference today. As I said that mental health lady last week, she gave me a hug and kiss when I left her and the things like that make a difference. You think I haven't got her to the right place, I've tried my best but I haven't got her to the right place, but I've made a difference to her. She smiled on the way up, and I took her in the car. She smiled on the way up to the hospital, she's given me a hug and kiss and I've left her there and its things like that that make a difference, and you go home and think the job hadn't gone how I wanted it to go but I've made a difference to her.

(*Tracy, paramedic, Office Bryn Station, Interview, 9.3.16, 'making a difference')*

Tracy highlights the training and skills she has accrued and is eager to use; she refers to particular technical skills and ways of making a difference which reflect a medical, physical and scientific orientation to her role. One which has been (IHCD, 1999) and continues to be a significant feature of the preparation for emergency ambulance service work (College of Paramedics, 2019). Tracy refers to the challenge of being able to feel she has made a difference and the positive feelings this engenders. She describes different types of EMS work and calls and assesses her potential to make a difference in them; often through the use of technical skills such as giving pain killing medication for a joint fracture. As such Tracy is showing how she perceives 'making a difference' and what qualifies this. However, she proceeds in her account to use an example of patient referral and the patient's response to qualify and justify her role impact. In so doing Tracy is presenting an interpretation of making a difference that is broader than technical and medical skills and their physical impact. It is one which in her account has emotional and human caring and is subjectively felt and appreciated by the recipient. This interpretation of care is holistic, subjective and broad and utilises the human experience as an indicator of its effectiveness and impact. As such this is an alternative to the objective, instrumental goal of effective patient referral which Tracy reports she was unable in this instance to achieve. Subjective patient experience is however not traditionally and historically an evaluative indicator and priority of the EMS amidst a service context which privileges measurable, objective time targets for calls and response times over the quality of care or outcome of the call (McClelland Review, 2013). An anecdotally used illustration of this valuing I heard crews say was that if an EMS crew took more than eight minutes to respond to a cardiac arrest it would be considered as a failure irrespective of the outcome of their efforts (*For example Sarah, EMT, fieldnotes, 16.12.15*). Such organisational valuing systems may have implications for EMS crews in their understanding of role, role fulfilment and their perception of what constitutes 'making a difference'.

Tracy refers to her best efforts to assist her patient to get the most appropriate help with their health problem; a pragmatic and instrumental intervention that proved difficult to achieve in this instance.

In the absence of her achievement of appropriate patient placement Tracy reports the patient's appreciation of her efforts nevertheless; she counteracts role failure is one aspect using a substitute of patient perception and gratitude, retrieving and demonstrating role effectiveness and satisfying her subjective need to make a difference. In her account Tracy is making a case for the importance of her role and its value using the patient's appreciation as a bolster in the absence of alternative, objective measures of its success. Like her colleagues Tracy values the opportunity to make a difference in her role and to experience the positive emotional effects of this. However, in the midst of a paucity of opportunity to make a difference in traditional, technical ways, she appears to reappraise and redefine what may constitute this and as a consequence to receive the positive emotional effects of her work. Tracy shows how the emotional challenges of EMS work are handled, in this case through a reappraisal of making a difference and role fulfilment.

In the above section I have presented my analysis of data extracts that I suggest communicate aspects of the EMS role in frontline service provision. I have focused on what I detect as positive call categorisation and my analysis proposes that calls interpreted as such draw on evaluations on the role of EMS in 'making a difference'. Crews describe role conflict arising from the dissonance between education and training, role expectation and the reality of their practice role and their ability to make a difference in particular lifesaving and medically technical ways. My analysis relates how crews purport to reconcile their role expectations over time through realignment with the reality of their role, through suppressing their emotions and getting on with the job and utilising the long-term emotional impacts of a call in which they were able to 'make a difference'. Crews also described their use of creative, broader and subjective interpretations of what constitutes 'making a difference'. This reappraisal of 'making a difference' enable crews to receive the positive effects associated with achieving this. Collectively, these represent ways of handling the emotional challenges of EMS work; the frustrations which accompany it and the means by which they are managed in this setting.

6.3 Genuine calls

My analysis suggests that crews' perception of authentic and genuine need for emergency help instigated positive evaluations from them and the categorisation of these calls in a favourable way. 'Genuine' was a locally used descriptor in some evaluations of calls which included features of serious physical, medical and mental health need and assistance to get to A&E. Crews appeared to interpret a genuine need for help and to perceive the vulnerability of the caller in their evaluation and categorisation of genuine. Crews described being caring and compassionate, making more time and being empathic towards those they perceived to have a genuine need for emergency intervention and help. These opportunities enable crews to achieve their intentions to help those in need and fulfill their role and receive the positive emotional impact of this. There were plentiful incidences of this in my field work

experience and I have selected the two examples below to help me to show how crews' positioned these particular types of calls and the implications for emotional labour.

6.3.1'...this is the type of call that needs an ambulance'

The field note extract below was a call which occurred two months into my fieldwork to an elderly man 'Harry', who lived alone and following an accident one early morning at home had fallen and dislocated his shoulder. The data extract presents a situation in which crews evaluated the call as constituting a genuine need for an emergency ambulance; where there was perception and recognition of need for help confirmed by the crews. We were returning to the station after the first call of the shift, I was in my usual place in the back looking through to the front cab when the call came from Control. One of the crew James who was in the passenger seat read the information out on the call and Roy who was driving began to follow the route to the address on the screen. Roy parked the ambulance outside the house and we went in. James called out 'ambulance' as we went down a short hallway and into the living room where Harry was kneeling on the floor unable to get up, in severe pain and alone.

> Harry's right arm was hanging down limply at this side and his right shoulder looked to have slumped down. He could not get up from the floor because he told us he couldn't put any weight on this right shoulder. Harry was groaning slightly to himself at times and looked to me to be in severe pain. Roy immediately introduced us all, asked Harry his name and what had happened. Harry told us he had been doing work in the house and had fallen over on his shoulder early that morning. Roy got a chair from the kitchen and put this next to Harry and said, 'we will help you up and onto this chair'. On the count of three we supported Harry to get up from the floor and onto the chair. Roy said, 'rest there for a bit now'. After a short while we were able to help Harry up and to walk out to the ambulance with us. Roy said, 'there's no rush, we can take our time'. I held Harry's arm up and supported it as we slowly walked out to the ambulance. Roy asked if they needed to call anyone for Harry and James checked the back door of the house was locked before we left and that Harry had his keys ready for his return. We got Harry into the back of the ambulance and his observations were taken, a heart tracing done and a small tube put into his vein. Roy put a splint on Harry's arm and he was given some paracetamol into his vein to relieve his pain. Roy said to Harry 'we want to make you as comfortable as possible and get you to hospital'. We arrived at A&E and took Harry straight in. The staff came out, Roy gave handover and we left. When we got back in the ambulance Roy said, 'it was good that we were free, if another more urgent call had come in we would have been diverted to that and he would have been left there in pain for much longer'. Roy said, 'this is the type of call that needs an ambulance', James agreed and I nodded.
>
> *(Fieldnote, 'Call that needs an ambulance', 30.4.15, 8.10am)*

Roy refers to this call as one which needs an ambulance, in so doing he communicates and confers a categorisation system and implies simultaneously that there are other calls which do not. Roy provides this account that works to position a candidate example of real need and therefore by association a requirement for an ambulance. His perception of need is used to furnish and justify the use of the EMS and reinforces their role. Roy, James and I agreed and supported the appraisal of 'legitimate' need which enables role fulfilment for the crews and the positive emotions of meeting that need.

Another example of crew' appraisal of genuine need is offered by Mike, a paramedic in the field note description below.

6.3.2 '...this was a genuine case'

Crew' interpretation and categorisation of a 'genuine case' was brought suddenly and explicitly into focus six months into my fieldwork when I attended a call with an EMS crew to a young man. After the call, the crew shared their perception of the situation, their reasoning and basis for evaluating the call as 'a genuine case', differentiating and categorising it from others considered to be not genuine.

> This was a red call- the most serious and we got there quickly and went straight into the house. We tried to avoid the broken glass scattered over the floor by the front door where the police had got in through a smashed window. I followed the crew quickly up the stairs and I could sense the urgency of the situation from their focus and speed. A young man, Matt was lying on his side on the landing at the top of the stairs where the police had placed him. I noticed the attic door was open above us and a rope was hanging down. The police said they had got there just in time and had 'caught him' just as he swung off the step ladder which was below. I was shocked by the scene. Mike immediately got down to Matt's side and level and started assessing and asking questions. Mike examined Matt's neck and assessed for any symptoms of injury to his spine and explained what was happening and what the crew were planning to do. The crew needed to immobilise Matt's neck and spine in case of an injury and I held his head carefully while the crew got 'the scoop' (which turned out to be a long plastic and metal stretcher divided into two detachable halves levered in each side of the patient and fastened together at the top, bottom and middle). Matt was strapped carefully to the board across the whole of his body and the crew and police worked together to lift Matt up and over the banister and down the stairs and out into the ambulance. As we moved the stretcher over the banister, we could see a sealed envelope lying on the top addressed to 'Mum'. Once observations had been completed on Matt, I offered to go and call his friend who was waiting in the house. I knocked the ambulance door as the crews do to alert them that we were outside and as I opened the door and got back into the ambulance I could see Mike bending over Matt and trying to reassure him and comfort him, I could see Matt was crying. Mike seemed to sympathise with Matt; he seemed to appreciate the seriousness of the situation and the desperation and he said to Matt 'you need to have help with this'.
>
> Once in the ambulance, Mike spoke to Matt's friend and emphasised that they must ask for help, he said 'this is a call for help and you must make sure that he gets help'. He said to Matt 'you don't have to deal with this on your own' and Matt listened and was crying at points again. Mike rang A&E to alert them of our imminent arrival. We went quickly and took Matt straight in and handed him over. I helped to transfer him across onto the trolley in resuscitation and after Mike handed over we left.
>
> When we got back in the ambulance I spoke to Mike about the call, I was keen to know what he thought. He said, 'this was a genuine case', I asked him how he knew and he said, 'if you attempt hanging it's genuine, it's serious and he nearly did it'. He said, 'he was relying on a lot of things and was very lucky to be alive'. We talked about 'genuine cases' and he said others self- harm for attention. He said these were often unemployed and doing nothing all day so this was excitement for them. He said he felt this situation was different. I said he had become cynical and he said 'I've seen it too many times'. I said he was very caring towards Matt and he said, 'I give care to them all but give more when it's a genuine case like this one'. We put all the equipment back and sat in the ambulance and waited for the next call.
>
> *(Field note – 'genuine case' 16.9.15, 9pm)*

The sudden emergency to an attempted suicide by hanging was a shocking experience; fast paced and necessitating an emergency response amidst the unmistakable backdrop of personal, sad and desperate human need and suffering. The call, the response of the crews and their accounts show their evaluation, interpretation and categorisation of a call as 'genuine' and the contrast and differentiation from those considered to be not genuine. Mike offers his rationale for perception and categorisation of this as a 'genuine case', which he justifies with reference to the nature of what was attempted and combines with specific features of the call; the planning, the risks and the near success of it. As such Mike is furnishing and justifying his evaluation and categorisation articulating what he perceives to be significant factors to support his interpretation. He rewards the patient who is 'genuine' with what he says is 'more care', reflecting his agency in his role. His care and attentiveness is prefaced, justified and warranted by his perception and interpretation of 'genuine' and is augmented as such to convince the listener.

Mike compares and contrasts this with other 'cases' of self-harm from which he distinguishes this call, (he said he felt this situation was different). He is identifying categories for direct comparison and distinction and qualifying the basis for evaluative inferences between genuine and those considered not. Mike describes features he associates with the latter; unemployment and inactivity, evaluative, stereotypical descriptors which combine to constitute the category of 'other', who he says self-harm for 'attention'. In his account Mike shows how he categorises, organises and differentiates calls he considers genuine and not genuine. Sacks (1992) refers to membership categorisation devices used in conversations which he says tell us some of the informal ways in which people categorise and the knowledge they use to do this (he calls these "lay theories" p.42). Categorisations in conversation Sacks (ibid) suggests include attention to membership, inference and representation and being "inference rich" (p.41) can tell much about the person and the knowledge stored. Mike tells us how he positions what he sees and how he organises these into groups using his 'lay theories'. Sacks describes membership categorisation devices as "central machinery of social organisation" (p.40) which are important to understand. Mike's account shows how he appraises and categorises his work; what criteria he uses to differentiate and decide genuine need for the EMS and how this may influence the care given.

Mike's categorisation of genuine need is associated with displays of empathy, compassion and 'more care', which he uses to justify, explain and warrant his attentiveness to the patient. Mike responded with attentiveness, close interpersonal exchange and comforting, reassuring interaction, gestures and words. He was keen to advocate and communicate Matt's needs and ensure he received the help he needed. There was effort and labour to meet the emotional needs of the patient through interpersonal exchange, caring and attention, reflecting some conceptualisations of emotional labour (James, 1989, 1992).

Hochschild (1983, 2003) conceptualised emotional labour as the work required to deal with others' emotions; to create a desired emotional state in another like gratitude or fear, characteristic though not confined to frontline public service work. Emotional labour was brought to play when the worker did

not feel the desired emotion and had to create it for the audience, through superficial or deep acting techniques. Hochschild's (ibid) conceptualisations of emotional labour are drawn from and as such impacted by the particular period and contextual commercial backdrop of the competitive airline industry and differing interpretations have been proffered from health care contexts (Bolton, 2000; James, 1989, 1992). James (1992) interpreted emotional labour as interpersonal exchange and interaction between nurses and dying patients in a hospice, where emotional and psychological care was given. She portrayed the emotional labour as hard, sad, lonely, difficult and skilled; most often provided by workers with more frequent contact with patients. Bolton (2000) also described emotional labour as the interactions between nurses and parents who had lost children through miscarriage; the support and comfort work to create memories. Such professional conceptualisations of caring may overly romanticise the work of nurses and serve an agenda to elevate its positioning and contribution. However, these interpretations of emotional labour share similarities to the interpersonal exchange described between Mike and Matt. They share some of Hochschild's (1983, 2003) theory; the focus on the emotions of others and interpersonal interaction as caring but differ in the specific nature of the work needed to do this. Hochschild (ibid) suggests the emotional labour is in the emotional display of the worker and what is needed to create this persona when it is not felt.

In the example above Mike's appraisal and categorisation of genuine need is associated with efforts to provide personalised, empathetic and sensitive care. Mike described his perception of genuine need for help, which appeared to preface his efforts at emotional labour through his care and attention to Matt and how he was feeling.

The perception of genuine need and the implications for emotional labour are highlighted in a research interview extract below with Gail, a paramedic.

6.3.3 'I try and make time for the genuine people, the genuine people who need us'

Categorisations used by workers within accounts tell us how they interpret, make sense of and position what they see in the context of their everyday work. They tell us the features workers invoke to populate their categorisations and their perceptions of those that exemplify them. In my research interview about calls Gail uses the terms 'genuine people' for which she shares her criteria and she differentiates and contrasts these with others considered to not be genuine. Those who are perceived to need the EMS are categorised as genuine,

> Gail:...I do like to think I try and make time for the genuine people, the genuine people who need us
>
> AW: And you know you say genuine, who do you mean by genuine then?
>
> Gail: It, you know, little old Doris on the floor needs us, she's genuine, you know, she needs us, people who can't get hold of their doctor with a genuine chest infection, and then you've got the,

you know, people who, you know, are having the heart attack, the stroke, and are unable to do without us

AW: Yeah, so who wouldn't be genuine then?

Gail: Well yes, someone who's stubbed their toe! [Laughs]...or fallen over and hurt themselves that can get up and can get themselves to A&E, people who can actually do something about it, you know, if I phoned an ambulance I'm not, you know, it'd have to be genuine, you know...someone who needs us is a genuine person…

(Gail, Paramedic, Office Bryn Station, Interview, 16.3.16,'genuine people')

Gail communicates her categorisation of 'genuine' calls and the attributes she deems to constitute this and those considered not to. She begins with a general descriptor of 'genuine people' without explanation and qualification. She deals with genuine as though it is a universal phenomenon; a given. She implies a certain type of background knowledge and expectancy about what is genuine and furthers this when on invitation from me, she prefaces her example with 'it, you know…'. The 'you know' suggesting that this is knowledge I and possibly everyone has. Gail uses a stereotypical example to reinforce her point. Her depiction of 'little old Doris' creates an image of a frail elderly lady universally considered to be vulnerable if in need and which as such effectively supports her categorisation and her point. Gail expands her categorisation of genuine further, drawing on serious medical conditions, utilising empirical medical diagnoses and their accompanying external legitimacy to bolster her interpretation.

In her categorisation of what she perceives to be genuine, Gail creates a distinction and simultaneously suggests the existence of 'other' from which genuine is different. On invitation from me Gail populates her categorisation of other, not genuine with minor ailments; a stubbed toe, chosen to augment and facilitate her point. She couples this with a laugh, perhaps to further trivialise and undermine the complaint. She is also possibly showing awareness that her example here is an extreme and somewhat ridiculous one which she provides to emphasise her point and her laugh shows this. In laughing she frees herself from the possible effect of a criticism that this is not a realistic example. However, Gail follows it by showing some other criteria for her non-genuine category. She may also be showing caution by not displaying personal prejudices in the research interview; she doesn't wish to label particular conditions, so she chooses an example that is non-stigmatising. As such Gail is showing her awareness of the implications of what she is saying and being careful in not going too far with her categorisations. She also says that 'genuine' people who are able should make their own way to hospital and not rely on the emergency services. Her descriptor of genuine people here serves as a kind of social marker for the type of person you are or can be considered to be as understood by some emergency ambulance crews.

Gail applies her own categorisation of 'genuine' to herself and her own behaviour as a benchmark, as a standard and example of what 'one should do' and more specifically when one should call an emergency ambulance. In her talk she is expressing her concordance with her categorisation, aligning herself with the genuine and presenting herself in a positive light (Shotter, 1984).

In her final comments Gail attaches genuineness to personhood, to the core of the individual and what she considers to be someone who needs the emergency ambulance service. She says, 'someone who needs us is a genuine person', by implication those who use the service outside of her boundaries is not a genuine person. Gail is instigating value judgements of those who use the emergency ambulance service based on what she considers to constitute genuine need. Like her colleagues Gail implies a valuing of 'genuine' calls as those she 'makes time for'; as such she is favouring these calls and callers and suggesting particular responses. 'Making time' suggests giving time and attentiveness to another who is considered in justifiable need of it. The implications of the appraisal of genuine need suggest efforts at emotional labour, through the attentiveness to another's emotions and situation through attention to one's own.

Calls which are appraised and evaluated in a positive way by crews link to a perceived genuine need for emergency help and can evoke feelings of empathy, caring and concern and prompt action tendencies (Coppin & Sander, 2016), which they communicated in their verbal expressions and observed actions in these situations. Behavioural responses, although not absolute measures, are a key dimension of emotion and can be used as reliable cues by observers in understanding the emotions of others (Jacob-Dazarola et al; 2016). Collectively, these were interpreted by me to reflect their emotion and feelings towards these types of calls and callers.

Categorisations used by workers within accounts tell us how they interpret, make sense of and position what they see in the context of their everyday work. They tell us the criteria workers invoke to populate their categorisations and their perceptions of those that exemplify them. Importantly they also foreground particular implications for how these emergency professionals respond and their efforts at emotional labour.

6.4 Conclusion

In this chapter I have shown how EMS crews interpret, appraise and categorise their work and those who use the emergency ambulance service. The above categorisations and evaluations of calls by EMS crews tell us how they perceive, interpret and position their work and those who use the service. They show features of calls crews utilise to constitute their categorisations. I have shown how calls evaluated positively by crews evoke excitement and the satisfaction of making a difference and those perceived to be 'genuine' generate compassion, caring, sensitivity and engagement. Crews implicate a particular quality of care and interpersonal exchange which is reminiscent of conceptualisations of emotional

labour as genuine, skilled interactive, interpersonal work (James 1989, 1992) offered in caring contexts of perceived need such as end of life care (James, 1992) and miscarriage (Bolton, 2000). My analysis suggests the relationship between call evaluation, interpretation, perceived genuine need and types of work and the potential implications for the response and care given by EMS crews and their emotional labour.

In instigating one categorisation another is automatically constructed as that from which it differs and contrasts. The 'other' are those who are seen as not genuine and which as such represent the alternative case. These calls characterise discrepancies between the crews' and public' perception of need and implicate crews' assumptions of a universal knowledge of when to call an emergency ambulance. These assumptions form a basis and justification for criticism of those who are considered to know. In the next chapter I will describe the features which give rise to and constitute negative work and call appraisal by EMS crews and the implications these have for their response and the care given by them.

Chapter 7

Discrepancy between professional and public perception of need for the EMS; implications for emotions and emotional labour

7.1 Introduction

In this chapter I present my findings relating to how some EMS crews negatively appraise and position calls and the implications these have for emotional labour in the front stage context of their work. My analysis suggests that calls in which crews question what they perceive to be the legitimate need for the EMS can lead to negative appraisal. As I have shown in the previous chapter crews' interpretation and positioning of calls focus specifically on whether they consider an emergency ambulance was needed for transport to hospital and the perceived severity of the medical problem. My analysis suggests crews' appraisal of calls draw on their interpretations of what is considered to warrant an emergency ambulance response and reflect discrepancies between their professional perception and the public perception of need.

In chapter 5 I presented analysis of how the backstage area served an important function to allow crews to air their frustrations. In this current chapter I extend that analysis to examine how this plays out in front stage performance and show some further legitimisation attempts by crews to explain their positioning.

Crew' interpretation and negative appraisal of their work have the potential to create frustrations amongst them which have to be 'managed'; disguised and suppressed in their front stage performance and as such call for particular forms of emotional labour (Hochschild, 1983, 2003).

Discrepancies between crew and what they saw as public interpretations of need for the EMS was a phenomenon I often experienced during my fieldwork whilst attending calls, in talking and listening to crews and in their interactions in the backstage context of the crew room. My data contains numerous examples from my fieldwork with the crews; those I present here best exemplify the crew' interpretation and response, the emotions and behaviours evoked and the implications for emotional labour.

Crew' interpretation and positioning of calls at times centred on the public use of an emergency ambulance as a means of transport to hospital and to what extent they considered this to be necessary. The next section focuses on examples of this and my analysis of the implications of work appraisal for their interaction with service users, demands for their emotional labour and front stage performance.

7.2 Need for an emergency ambulance

Crew' positioning and interpretation of calls sometimes focused on the extent to which there was a perceived need to utilise an emergency ambulance to access hospital care. Crews would assess and appraise callers' ability to make their own way to A&E where possible thus, avoiding the use of an

emergency ambulance. Crew' interpretations again suggested discrepancies between what they expected patients and sometimes their relatives to do and what the public appear to expect. Crews would at times question the public rationale for waiting for and using an emergency ambulance and what they saw as its skilled crew, particularly in situations where their skills were not needed.

7.2.1 Questions of perceived legitimacy: 'This is close, it's in walking distance'

One such occasion arose at an early stage in my fieldwork, the second episode with the crews (Nick and Arthur), when after completing the first call of a day shift and whilst waiting in the ambulance outside A&E a call came through to respond to a male (Keith) complaining of abdominal pain. Nick who was in the driving seat started up the ambulance ready to leave.

> Nick looked at the address and said, 'this is close, it's in walking distance'. He drove out of the hospital and immediately into a nearby housing estate. Within two minutes we were there. I was in the back of the ambulance, looking through into the front cab and I listened but said nothing. I thought to myself if you are in pain it doesn't matter how close you are, you still need help to get to hospital. The ambulance pulled up outside the house and before we got out Arthur said, 'there's two cars in the drive'. I wondered what the significance of this was but nothing further was said and we got out quickly. I followed behind Arthur into the house. There was a middle-aged man lying on the sofa, holding his upper abdomen and slightly crouched up. He looked at us but clearly could not communicate or understand us, he just looked at us. Arthur introduced us all and discovered quickly that Keith could speak only very little English. His daughter helped translate and communicate for her parents. Arthur asked about the history of the pain and was told Keith had had pain for 4 days. Arthur asked if he had taken any treatment for the pain and was told no; he noted the responses but said nothing. Shortly afterwards we helped Keith into the ambulance, Arthur continued to make notes on the PCR (Patient Care Record) on the short journey to A&E and when we arrived we took Keith into an assessment area and left.
>
> After putting the stretcher back Arthur confirmed the call was completed ('cleared the call with control') and we sat and waited for the next. Nick said, 'going to calls like that makes you question humanity'. Arthur agreed. Nick went on, 'his wife got there before us, she could have taken him in'. He said, 'you don't need an emergency ambulance for pain for 4 days and he hasn't taken anything for it either'. I listened but said nothing. I wanted to say he is in pain so it doesn't matter how close he is to the hospital. We left shortly after to another call.
>
> *(Fieldnote, 'in walking distance', 'emergency ambulance not needed', 12.3.15, 11am)*

The above field note data extract shows how this crew interpreted this call; how they appear to mobilise their expectations and understandings about what constitutes an emergency and the need for an emergency ambulance in their positioning of calls. Immediately, Nick noted that the address was in close proximity and his early comment that this was 'in walking distance' served to question the call. The use of 'walking distance' implies that the distance is short and can be easily accessed on foot which was confirmed by our speedy arrival at the address. Arthur noted that there were two cars in the drive which although not immediately expanded on, drew our attention to their presence and availability in an obtuse and subtle way.

The verbal comments by both crew members before and after the call suggested their frustration and annoyance with the nature of the call and the dissonance between their expectations and the reality of the situation. Emotion is conjoined with behavioural expression such as vocalisations (Coppin & Sander, 2016) and this helped to support my interpretation of their feelings at this time.

During the interactions with the patient and his family Arthur and Nick focused on the assessment, history taking and documentation without expression or display of thoughts or feelings they may have had about the call which suggested their use of emotional labour to suppress and disguise these. However, these were expressed and shared after the call in the privacy of the ambulance cab, where Nick said 'going to calls like that makes you question humanity'; in so doing he brings into question humanity and how humans behave. His reference to humanity is a general one which avoids overt and direct criticism of the individual which is nevertheless implied here. He may be concerned to avoid the display of undesirable and perhaps even racist views. His questioning is directed towards a large, faceless, indiscernible entity and avoids culpability and criticism at the individual level. However, he then directs his attention to individual issues and the situation specifically. Nick said Keith's wife was able to get to A&E before the ambulance and that she therefore could have taken him; the implication here is that she got there speedily and quickly, which Nick draws on to support his questioning of the use of an emergency ambulance. Nick moves from the general to the specific features of the individual situation to qualify his interpretation. In questioning aspects of the individual situation Nick makes these individuals part of 'humanity' and the source of his questioning. Nick also questions the use of an emergency ambulance for pain which has lasted 4 days. Nick is referring to informal criteria for pain duration and the use of an emergency ambulance, suggesting a personal interpretation that the period of time pain is experienced is a factor which he perceives to influence whether emergency help should be sought. Finally, he adds to his interpretation of the call that Keith had not taken anything to relieve his pain; his comment here suggests an expectation that Keith should have done this and apportions responsibility to self-administer pain relief.

The comments of both crew members show their understandings of the role of the EMS and their expectations of the public use of the service. In their interpretation and evaluation of calls, crews mobilise their perspectives which appear to contrast with the public interpretation. When confronted with discrepancies between their interpretation and the public interpretation, crews call into question the latter; generally, as in the reference to 'humanity' and specifically and individually in reference to the individual situation. Their accounts forge and secure a convincing argument which can serve to reinforce their interpretation and perspective.

The discrepancies between crews' and patient interpretation of legitimate need create a potential for emotional labour in which frustrations have to be disguised and suppressed to provide an appropriate performance in the front stage setting.

The demand for emotional labour was described in a research interview extract below, by Stu, an EMT.

7.2.2 'Rubbish calls' - 'We are a three hundred pound or whatever taxi at that point'

During my field work crews often expressed their frustration and complained to me about what they perceived to be the misuse of an emergency ambulance. In one research interview, when talking about calls, Stu labels 'rubbish' those where he perceives public own transport would have been appropriate and he shares what he thinks and feels but cannot show in these situations. I noticed that crews at times implied an expectation that the public use their judgement and initiative and try to get themselves or take their relative to A&E when this is appropriate.

> Stu: I consider myself a bit of a shit magnet. Not that I get dirty jobs, as in physically dirty jobs, just rubbish calls...
>
> AW: I was just wondering really, when you said rubbish calls, what made them rubbish?
>
> Stu: The overdoses, they can make their own way to hospital I feel. We went to one yesterday. They waited four hours for an ambulance. She was fully mobile. She was cwtched up in bed. Can you walk down the stairs? fine yes, I can walk down the stairs. Well, if she can walk down the stairs fine, then she can get her own way to hospital. All her friends, 'oh she needs to go to hospital, she's not right', right ok, I take her full history, I do a full set of obs, we take her to hospital. She could make her own way to hospital. We are a three hundred pound or whatever taxi at that point...You have got people who will only phone up when they are unable to move or it is the last resort and they phone us up because it is an emergency but unfortunately there is a large slice of the population that just phone us up because we are the easiest thing to do…then you got the people 'oh I got a bit of a chest infection, I tried to phone the GP and they got no appointment until next week'. Oh, right ok, who's this here then? That's my boyfriend, he's going to follow up in the car, is that ok? And what are you supposed to say? 'No, that's not ok, its bloody ridiculous'.
>
> *(Stu, EMT, Interview office Bryn Station, 10.2.16, 'rubbish calls')*

Stu describes what he calls 'rubbish' calls, drawing on examples from his experience which work to qualify and convince the listener of his argument. He retraces calls, their features and his questions used to assess need such as 'can you walk down the stairs?' which rationalise and support his interpretation. Stu asserts his view that 'she could make her own way to hospital' and refers to the ambulance as a 'three-hundred-pound taxi'; he makes direct reference to the cost and the transport role with which he appears to take umbrage. His reference to a 'taxi' suggests the role of transport only, wherein the clinical skills of crews would not be utilised.

He creates a categorisation of those who have overdosed who he says can make their own way to hospital. Stu relays his assessment and determination of whether there is need for an emergency ambulance, he talks in a confident, knowledgeable way using his professional insight and his account suggests this is easy, simple and obvious for all to see. He mimics his interaction; 'Can you walk down the stairs? fine yes, I can walk down the stairs. Well, if she can walk down the stairs fine, then she can get her own way to hospital'. His rather simplistic portrayal of assessment and determination of need

suggests its' ease, undermines the thinking of and actions of the friends who didn't do this and justifies criticism of them. In his account Stu appears to assume the friends are able to do this assessment and to know when an emergency ambulance is needed or indeed not. Recognition of the requisite professional knowledge and assessment skills would seriously weaken his argument.

Stu contrasts his categorisations of those 'who could make their own way' to hospital with others who he says only phone when it is an emergency. In his account he relays these as only phoning in situations where they are unable to move or have no other option, the 'last resort' category; in so doing Stu presents what he sees as appropriate criteria to justify calling an ambulance. His selection of these implies his preference and endorsement of their actions as the right ones. His use of contrast serves to support his argument and comparisons of behaviour justify his criticism of one group through direct reference to another.

Stu continues to categorise some who call because he says it's the 'easiest thing to do' and others who are unable to get a timely appointment with their GP and call an emergency ambulance to get to A&E instead. He mimics the questioning between himself and the patient to communicate the situation and his argument. He relays the patient's question about her boyfriend following up behind the ambulance and answers the question with a rhetorical one which asks, 'what are you supposed to say?' His use of a rhetorical question 'what are you supposed to say?' suggests that there is nothing that can be said (Koshik, 2005). Stu's account creates the scene and backdrop of the call and circumstances, is structured, builds and leads to the rhetorical question which communicates his frustration. Stu answers his own question and expresses what he feels like saying but can't, 'No, that's not okay, its bloody ridiculous', suggesting that these feelings have had to be disguised and suppressed through emotional labour. I interpreted what Stu said in the above interview transcript to indicate his frustration and annoyance during the call he describes. As highlighted earlier, vocalisations are an accepted and reliable expression of emotion (Coppin & Sander, 2016; Lachlan Mackenzie, 2019). Expletives in particular, (such as 'bloody'), although superfluous to the basic meaning of the sentence are cathartic and "…'fill out' the clause with an expression of emotion" (Lachlan MacKenzie, 2019, p.55), such as anger and frustration.

Sacks (1992) suggests that categorisations assist in organising and making sense of experiences and communicate meanings imputed in particular interactional contexts. How categorisations are formed and the criteria used to populate them can offer awareness of the person, their knowledge and how this may influence their work. Stu's descriptions show how he interprets and categorises those who use the EMS, how he differentiates between those who he considers needing the service and those who don't and the implications for the use of his emotional labour.

In their accounts crews drew on social expectations and normative ideology (Anderton et al; 1989) to support their interpretations. In a research interview extract below with Sarah, an EMT, she offers a rationale for her positioning of particular calls.

7.2.3 'I wouldn't dream of ringing an ambulance for that, would you?'

In the next data extract, Sarah shows how she compares, differentiates and categorises calls on the basis of her perception of when an emergency ambulance is needed. Discrepancies between how these professionals interpret need and how the public perceives their need are raised and their right to the use of publicly funded health services is called into question.

> Sarah: And there's the ones, little old ladies that, "I don't want to bother you, but I've had chest pain for a week now," and you get there, and she has a heart attack. Those are the ones that really need us rather than the ones who are, "I've just fallen over, cut my finger." ...pathetic calls we get, as I said, "I've fallen over, I've hurt my ankle, I've hurt my arm." Well, if it, you know, back in the, when I was, my mother's day she wouldn't dream of ringing, you and I wouldn't dream of ringing an ambulance for that, would you? You'd just get a taxi, get a friend, get a relative to take you. This day and age, "Oh, it's free, we'll ring for an ambulance," and if there's not one available and it's low acuity then NHS Direct or clinical desk will arrange for a taxi. Well, then they've figured out then that this gets paid for and it's a free lift to the hospital, isn't it? At the moment it takes the crap away from us...
>
> AW: When you say crap, what do you mean by crap then?
>
> Sarah: The crappy calls like that.
>
> AW: Right and what makes a crappy call then?
>
> Sarah: Well, someone's fallen over and hurt their ankle, unless it's obviously hanging at a different angle, it's just a sprain and they're walking on it most of the night, why do you need an ambulance for that? Why don't you take two paracetamol, two ibuprofen and get a lift or a taxi to hospital or go to a minor injury unit where you'd be seen quicker. Why do you need an ambulance?…and that's so frustrating...Sometimes I can't hold back my attitude which I know is wrong, but I feel like they need to be told because they're not going to learn otherwise, are they?
>
> *(Sarah EMT, Interview Bryn Station, 1.4.16, 'crappy calls')*

At points in the above interview excerpt Sarah describes her categorisation of calls where an emergency ambulance is needed and particularly when it is not needed. She relays examples of the latter with reference to a fall, cut finger, arm injury, apparently minor health problems as criteria for her categorisation. Alternatively, and in contrast she describes those who 'really need' an ambulance as those who are reluctant to call for emergency help, the 'little old ladies' who are found to have a serious medical problem. Sarah's account of calls shows her organisation, membership categories and criteria. They exemplify and support her interpretation and her argument and show the informal ways she categorises those who use the EMS, their behaviours and her knowledge; being as Sacks (1992) says

"inference rich" (p.41). Membership categorisation devices like those used by Sarah show her monitoring and categorisation of users of the EMS and how she positions these. As Sacks suggests, descriptions perform important 'membership' business.

Sarah supports her argument further with examples of minor injuries and in her talk appeals to the past; her mother and me the interviewer who she deems would not consider calling an ambulance. As such Sarah is phrasing her talk to justify her point and drawing on influences on her like her mother and the past as 'significant' supports. She extends this further to me as the interviewer; including me brings me into the circle of those who wouldn't do such a thing. Bringing me into the group that 'wouldn't dream of...' works to gain my support and my agreement for her argument; it places me with others like her and confers on me the identity of someone who wouldn't inappropriately use the emergency ambulance service. Including me is a form of flattery which could make me less inclined to disagree with her perspective. Through her talk Sarah is communicating her identity as someone who she says wouldn't call an emergency ambulance in circumstances she perceives to not need one. She is identifying particular standards and expectations for service use and aligning herself with them, forging an identity for herself as a particular type of person. Identity work is interwoven in regular interaction and is functional (Antaki & Widdicombe, 1998). Sarah is constructing a collective identity of people who would not abuse the resource of an emergency ambulance. In a sense she is constructing the moral versus the proposed amoral and positioning herself in the former.

Shotter (1984) proposes a more active interpretation of identity work which can be employed in the pursuit of moral ends; essentially in presenting oneself as a particular kind of human being. The somewhat abstract nature of what it is to be human Shotter (ibid) suggests is understood, articulated and demonstrated in our ways of being and interacting with others in everyday social interactions in our talk. He suggests that "what we believe ourselves to be determines how we treat one another (and ourselves) in our practical everyday affairs" (Ibid, p. ix), through a phenomenon he calls the "ecology of everyday life" (p. ix). Our social accounting in all with which we can be involved offers a valuable conduit to understanding what it is to be human and more specifically what constitutes an autonomous, responsible person, required by society. The knowing is tacit but is enabled in the talk and common agreement between individuals which make visible the invisible social expectations. Sarah through her talk makes visible what she has come to expect from herself and what she extends to users of the ambulance service.

Shotter (1984) seats his "ecology of everyday life" within socially constructed institutions in which values are reproduced through accountable activities and 'joint action', though which "…people produce the institutions within which they make sense of their activities to one another" (p. x). So, people between them create a common sense and common ways of making sense of whatever occurs

to, in or around them, on a micro level and amidst the background of wider social processes. Accounting practices are learnt through "developmental practices"; crucial in learning to become the kind of person required in society and importantly able to reproduce its social order (p. xi). In the above account Sarah refers to her 'mother' as one who has been influential in the process of her learning to be a 'kind of person' and to behave in a 'kind of way'. Therefore, such accounting and accounting activities and the learning of them are facets of socialisation; they serve to recreate, maintain and reproduce desired values and behaviours. They may also function as forms of social control in shaping and perpetuating desired societal norms and values and in responding to deviance.

The social processes of reproduction and social accounting serves the account giver too in demonstrating they are "the kind of person required in society" (p. xi); Sarah in her talk presents herself as 'the kind of person'. This reveals interesting insights into how individuals themselves in the "ecology of everyday life" become the tools or instruments of social control and social judgement. These social accounting practices work to cast judgement on users of the service, their legitimacy and simultaneously serve to reinforce the moral standing of the account giver as one who commands and indeed fulfils a morally accountable role. The stance taken above by Sarah is one of moral righteousness and is potentially a powerful tool in the hands of gate keepers to the health service. Shotter (ibid) refers to the use of accounting to enable individuals to actively craft and present themselves and be helped by others to perfect this. In our talk we are inadvertent collaborators in forming, reforming and reasserting institutional values and expectations. However, talkers in so doing, affiliate with the dominant group as a trade-off for their moral inclusion and verification. Sarah is positioning herself as one who affiliates with the perspectives and behaviours of those who 'appropriately' use the emergency ambulance service and the moral status this accords her. Sarah's account of her experience reflects her professional role and the context of her interactions; Orbuch (1997) suggests "people must account for their experiences in ways that are intelligible and legitimate in their current social context" (p.460).

Sarah's talk centres attention and responsibility for health and appropriate access to healthcare services at the individual level and presents a simplistic and unproblematic interpretation. As such this ignores wider political, economic and social policy and the impacts on healthcare services. More specifically this has meant the resurgence of Neo-liberalism characterised by the detraction of 'big government' and promulgation of deregulation of business, the market and individualism (Rose, 2000). The consequences include greater austerity and economic stringency affecting the provision and access to healthcare services (Pollack, 2010). Popular normative ideologies can be "unwittingly" mobilised by health care professionals in their expectations and categorisations of those who use the health service (Anderton et al; 1989, p.259).

Armed with a perception of 'the right kind of person' and against the background of perceived misuse of the emergency services, Sarah says she finds difficulty disguising how she feels; she refers to difficulty 'holding back my attitude' and suggesting that these may find expression in her interactions. Sarah refers here to the front stage performance and the emotional labour needed to maintain an appropriate display when faced with what she sees as inappropriate use. She refers explicitly to her feelings of frustration, which she admits she can't disguise, allowing them to escape and failing to labour emotionally, she communicates them to her audience. Sarah acknowledges that this may be inappropriate; anticipating how her behaviour may be perceived, however she goes on to justify the need to tell them so that they learn; 'them' she does not specifically define although by implication she appears to be referring to those who she perceives to misuse the service. Sarah positions herself in a somewhat parental and paternalistic type role of one who knows better and indeed behaves better than those she is referring to and, on this basis, she adopts a position of telling people so that they 'will learn' as she has done. She appears to adopt a role of "moral entrepreneur"; monitoring and policing the boundaries of what is acceptable (Becker, 1963).

Crew' interpretation and evaluation of calls they attended would also at times involve attention to the nature of the health problem and their perceived seriousness of it as a basis for requesting emergency help. In the next section I will present examples of this and the implications for their emotional labour. My analysis shows how crews utilise these opportunities to argue their moral positioning and worth as a basis for the judgement and evaluation of those who 'inappropriately' use the emergency ambulance service.

7.3 Minor health problems

During my fieldwork I noticed that crews' interpretation and evaluation of calls centred on the nature of the health problem and more specifically its' perceived severity or seriousness. Crews interpreted and positioned some calls they were responding to as being for minor health problems which they perceived were not appropriate for the emergency ambulance service. The frustrations arising from their interpretation of the reason for the request for help and the consequent demands for emotional labour by the crews was a feature of my fieldwork with them. Although crews' interpretations of the call and callers were often not explicitly expressed at the time, I was able through my observation of their non-verbal behaviours and the atmosphere and interactions during the call to perceive these at times and their interpretations were frequently shared with me afterwards.

7.3.1 '...only food poisoning'

One such example arose when I accompanied a crew (Len and Grant) on a call to a man (John) who was complaining of abdominal pains and had been vomiting. It was six weeks into my fieldwork and

after the first call of a day shift, we were sitting in the ambulance outside A&E when a call came through which was outside of the area usually covered by Bryn Station and we had to travel some distance to get there.

> We got to the address and there was an RRV already there, another crew member came out to meet us and gave handover to Len, we went into the house and I stood in the doorway to the living room. The patient (John) was sitting in the living room on a large sofa, complaining and saying he was ill and felt terrible. He had had diarrhoea and vomiting and at times was trying to make himself sick. He was grey in colour. It was unclear if he had abdominal pain and the crews were discussing amongst themselves outside which hospital to take John to. After a short time, a decision was made, and John was encouraged to get up and walk out into the ambulance with us accompanied by his wife. He lay down on the stretcher, his observations were done, I did his temperature and then sat down opposite John and next to his wife. During the journey John rolled around the stretcher repeatedly, pulled the blanket up, at times he got up, moaned and complained and repeatedly knocked his vomit bowl on to the floor of the ambulance. Fortunately, this was empty, and I retrieved it from the floor and replaced it on the stretcher. Len sat in the seat at the head of the stretcher, behind John. He concentrated on completing the PCR form. He didn't look up or appear to physically notice what John was doing and he didn't respond in any visible way, he seemed disengaged from John. It was interesting to watch this, but I was not totally sure what was going on and started to feel annoyed with Len. Len said nothing and did not display any emotion, he just sat there, his disengagement was clear to me. We got to the hospital relatively quickly and pulled up outside the local A&E; I was relieved by this, the atmosphere felt strained in the back of the ambulance. Immediately Len got up from his seat and was out of the ambulance and straight into A&E. We waited a few minutes and Len came out and said we could go in and he got a wheelchair and took John into A&E. When we got back in the ambulance, Len said to me 'I don't know whether you noticed but I didn't take any notice of him'. I nodded that I had, and Len said, 'he's a faggot, making a fuss about nothing, this is D&V' (diarrhoea and vomiting'). He said the family had said they had eaten a kebab the day before and that this was 'only food poisoning'. Len started to talk about the public expectation of the health service and public demand. He said, 'we as a society have created a public expectation and demand and now people can't do anything for themselves and expect us to be there for everything'.
>
> *(Fieldnote, 'only food poisoning', 15.4.15, 11.15am)*

The above field note extract shows how Len interpreted and positioned the nature of this call and the particular patient. He offered his interpretation of the call immediately on return to the ambulance, wherein he initiated a discussion and explanation with me for his lack of attention to John. In his account Len minimised John's complaint, he recalled the family's report of having eaten a kebab the day before which he used to support his interpretation of the problem and its cause. Len's account culminated in his reference to the problem as 'only food poisoning'; 'only' serving as an adjunct to shrink and minimise the significance of the problem. He described John as a 'faggot' using a derogatory and slang term which can be used for a homosexual man (Cambridge Dictionary, 2019). The adjective of 'faggot' has non-masculinised implications of weakness, lack of fortitude and resilience to which Len appears to take umbrage. Len's use of 'faggot' for John confers a weaker and inferior position; it differentiates John as that, as other from himself which he is not. Connell (2005) suggests terms such as faggot and others such as "wimp, milksop, nerd, turkey, sissy, lily liver, jellyfish, yellowbelly" (p.79) are used by

heterosexual men in reference to homosexual men and assert the positioning of one 'superior' group in relation to another. John did not appear to be homosexual however the use of the term 'faggot' may confer a perception of inferiority and weakness. These views reflect a particular culturally hegemonic view of masculinity; what is perceived as the dominant one in this set of relations (Connell, 2005). In so doing Len uses culturally dominant interpretations of masculinity to place himself in a socially advantageous and superior position to John, who he positions as weak.

John was clearly unwell if not immediately arousing sympathy for his plight and this was largely ignored or passed over by Len. Whilst Len is likely to feel some concern for John he may be conflicted when he weighs up the cost versus benefit of using the ambulance service for calls such as this. Len's irritation appears to impact on his response to John. This bypassing of usual concern for the suffering of another may serve as a way for handling conflicting emotions.

Len initially focused his attention and criticism at the level of the individual, John, drawing on his subjective, gendered behavioural expectations for illness behaviour and implied expectations of stoicism. However, as he talked further, he brought into play the issue of public expectancy and demand for care; a feature he attributed to a societal creation of expectation. As such Len broadens and expands the issue to 'society' as a whole. He is positioning his interpretation and understanding of the issue as one which he now attributes to a wider 'expectation'. He offers what he sees as the cause, that being 'society'; a carefully chosen non-specific and generic noun for a large and diffuse group. As such the use of 'society' avoids casting blame at the individual level of those who are sick and vulnerable; an action which may be perceived as morally reprehensible and unbecoming of a health care professional. 'Society' instead serves to scatter blame and culpability over a potentially vast, faceless, indiscernible quantity of accepted power and responsibility, diverting it from the individual and out of their reach and reform. Len began with criticism at the individual level, specifically of John and progressed to attribute this to 'society', detracting and apportioning it elsewhere.

Len positioned 'public expectation' as a societal creation, as causative and problematic. He implicates his particular interpretation of it as an unreasonable burden and demand. Expectation implies a strong belief that something will happen and can be said to derive from a perceived right to the receipt of something. This is the public expectation of the National Health Service as that into which public tax is paid to fund health care when they need it. Len's positioning of 'public expectation' as problematic questions the validity of it and could be perceived to undermine the fundamental ideas on which the UK health service is based.

Len's interpretation and positioning of the situation above is reflective of wider political and socio-cultural views of health and where responsibility for this lies (Lupton, 1995). Foucault (1991) maps changing perspectives on governmentality and a pluralist approach which includes both self-government and state or external responsibility for health. Self-government places responsibility on

individuals and as such has the potential to direct criticism at this level when there is a failure to conform. Lupton (Ibid) describes the implications of self-surveillance whereby "gaze" (p.11) is focused on oneself and through the "admonitions of their nearest and dearest for "letting themselves go or inviting illness" (p.11). This highlights the strategies by which health behaviours are controlled and shaped through self and others. Anderton et al. (1989) highlight the historical, economic, social and political factors which shape normative ideologies of health and how these are mobilised by healthcare professionals in their categorisations of patients as compliant and non-compliant. The emergency ambulance services are frontline health providers who are likely to experience a mismatch between social and political health expectations and public behaviour frequently. As such they react to it as part of the culture in which they operate, they are unwitting instruments of wider social and political culture. Their responses show their attempts to grapple with these expectations when confronted with non-compliance and the demands they place on their emotional labour.

Increasing demand for health care services necessitates prioritisation and public expectation can be unreasonable too. Whilst John was unwell and perhaps anxious about what was wrong with him it was not unreasonable that he expected care, however the issue here for the crew appears to be whether the emergency ambulance service is the appropriate service or route to receive this care. Such situations may serve to conflict with how emergency workers perceive their roles and may also implicate a wider social understanding of what the service is for and how it ought to be used. These have potential implications for emotional labour in how crews handle and respond to such situations.

Len's actions and behaviours during the call suggested his disengagement from John and his attempts at emotional labour which I observed and suspected though could not confirm immediately. Efforts to disguise and supress emotion, if successful, can render detection of true, inner emotion difficult for observers. However, I suspected and interpreted Len's disengagement to indicate his annoyance and frustration with John. Behavioural observation is suggested to be "a natural and intuitive human approach to identify others' subjective experiences" (Jacob-Dazarola et al., 2016, p.108). Len also seemed to have suppressed any caring or compassion towards a man who was unwell; he had withdrawn his caring. His explanation after the call supported my initial perception and interpretation that he was annoyed with John; his use of the term 'faggot' and his spontaneous self-description of conscious disengagement confirmed his feelings of frustration and annoyance which he appeared to be attempting to disguise, with little success. My interpretation of this is that Len was attempting emotional labour but had not quite managed it in the way Hochschild (1983, 2003) describes it as "the induction or suppression of feeling to create an external appearance which makes others feel cared for in a convivial, safe place" (p.7). His disengagement from interaction and attention to John may have served to lessen the degree of emotional labour which would accompany more frequent and closer interpersonal exchange. Len's efforts at emotional labour present a professional if somewhat disengaged front which was augmented through authentic, contextual props to furnish the performance. The Patient Care

Record (PCR) was afforded an unusually high degree of focus and attention by Len which exemplifies how documents can be manipulated in a given context (Prior, 2003); put to use in a pragmatic way as legitimate source of attention and as a 'prop' to help maintain the performance and disguise of underlying feeling. The PCR coupled with the speedy, enthusiastic efforts to secure a quick handover to A&E lessened the need for protracted interaction and emotional labour and served as authentic props to assist a somewhat convincing professional performance.

Len was nevertheless engaged in much emotional labour because he wanted to hide how he really felt. The atmosphere in the back of the ambulance appeared to be quite tense and strained and the emotional display from Len was thin, superficial and tolerant and emotional labour was needed. Hochschild (1983, 2003) noted the challenges of emotional labour and the "thin display" offered by Delta's staff in her study. However, Len was not prepared to face up to the demands and to smile through it. He chose to busy himself with something else that was ostensibly about patient care but was a prop used for the purpose of not engaging with the person and thereby reducing the emotional effort.

My analysis of the above field extract makes visible some of the beliefs and values which influence how crews evaluate and position calls perceived negatively. There appears to be a mix of personal, professional and social values which implicate expectations for health behaviours and public responsibility. These values are a platform for judgement and evaluation of calls and callers and reflect discrepancies between professional and public understandings. They appear to create frustrations for EMS crews and necessitate emotional labour in the disguise and management of emotion to facilitate an appropriate 'emotional display'. True feelings are suppressed, disguised and hidden through processes of surface acting to create a desired performance but remain unchanged (Hochschild, 1983, 2003). However, as highlighted in the above examples, emotional labour can be performed with varying degrees of success or failure.

Calls which evoke negative interpretations also involve differing amounts of interaction from the crews, limiting their efforts at disguise through physical disengagement and the social withdrawal from those in receipt of the service. These may offer crews ways to register their response and disapproval whilst performing their role. However, crews' frustration and annoyance focus their efforts on their own emotions and detract from the care and compassion for the patient.

Crews suggested they appraised calls in differing ways which involved an awareness of public perception and definition of need for emergency help and that this may differ to their professional opinion. Some crews expressed empathy towards the public which reflected their efforts at emotional labour. For example, Roy, a paramedic, describes this in the research interview extract below.

7.3.2 Alternative appraisal of call: 'Sometimes they feel they are having a heart attack'

Although some EMS crews interpreted and positioned calls which they considered to be minor health issues, these were not shared by all crews. Some members of the EMS I spent time with expressed differing perspectives, somewhat more appreciative and sympathetic to the positioning of the caller and their subjective perception of need. When talking to me about his role and what he deals with, Roy described the variation of emergency calls, he showed awareness of the public perception of their situations and need and how this may be different to the professional one.

> Roy: We go to anything and everything from a cardiac arrest to delivering a baby, falls, chest pains, strokes, abdominal pains, road traffic accidents, whatever the public sees as an emergency. Now sometimes it's not an emergency to us but it is to that person who is phoning at that time...obviously at that time when that person has put that call in, they have panicked. Sometimes they feel they are having a heart attack, they are panicking, sometimes it's just a panic attack, sometimes it's just indigestion but until we turn up and tell them that you're not having a heart attack they are convinced that because it is a pain in the chest, they got visions that they are having a heart attack.
>
> *(Roy Paramedic, Office Bryn Station, Interview, 5.2.16, 'what public sees as an emergency')*

Roy describes the variety of calls to the EMS and furnishes this with a range of medically serious health issues requiring emergency help of which there could be little dispute, however he adds to this list 'whatever the public sees as an emergency'. Although Roy offers a list of health problems such as chest pains and strokes, he attaches to these an open statement which introduces the place of public perception of need. As such Roy opens up the potential for others not included in his list and not one of the objectively verified medically serious or traumatic conditions. He implies an awareness of the publics' subjective interpretation of need. In saying 'whatever the public sees as an emergency', Roy gives credence to the public interpretation of need and places the public in a significant position; perhaps one which is in receipt of a service for which it has a right and for which it pays. Roy's positioning of the public suggests the right and power of a service user, and himself as one who provides the service. He says that crews may not perceive the situation as an emergency; as such he refers to the differing interpretation and assessment of need by the crews of which he himself is a member. His reference to 'us' situates him as part of the crews and as such in a position to appreciate how calls may be perceived and interpreted by them. However, he also shows an awareness of how this may differ from the patient's perception. Roy makes a case for the importance of the public in defining and determining what constitutes an emergency and furthers his point by the use of chest pain as an example. He furnishes his description with the potential for panic and the need for reassurance which collectively serves to convince the listener. The situation chosen by Roy is one where the perceived need would be difficult to dispute. He describes the potential panic as a place from which to appreciate and justify the public perception of need. Roy offers a perspective which is different to other crews who may not appreciate

the significance of the patient's interpretation and he crafts himself an identity of one who holds a different perspective which enables him to be caring and empathetic.

In appraising calls in a somewhat sympathetic and more permissive way, Roy is engaging in deep acting (Hochschild, 1983, 2003); a form of emotional labour which involves trying, through imagination and empathy to perceive patients differently. Feelings are manipulated internally to help create an appropriate professional display. Roy communicates an equitable and permissive stance that enables him to be less judgemental in responding to calls and allows him to process his emotion work in specific sets of ways that might be more sustainable. An example of this occurred during a call I attended with Roy, working on an RRV, 5 months into my field work, to a complaint of chest pain.

> The first call was sudden and at speed to a man with chest pains who was in a church garden just off a busy road in the centre of the city. Roy parked the car, we both got out, he collected the heart monitor and clipboard from the boot and I followed him through a small gate at the side of the main entrance to the church. As we walked through we could immediately see a man sitting on a bench to the right of the path, around him were a number of empty discarded cans of lager that he told us he had been drinking. It was a cold and windy day and the weather was getting worse; we could feel the cold and wind coming off the sea on the opposite side of the road.
>
> Roy introduced us, shook the man's hand and explained what we were going to do and then went through the PCR form. The man said he knew Roy from before and that he was a 'good bloke'. He explained to Roy that he was homeless and said he had been here since the previous night. He told us he was not from the city but had travelled here.
>
> He was cold and florid in complexion and after assessment Roy told the man that he may have a chest infection and that because he didn't have a GP he would call for a back-up ambulance to take him to A&E. The back- up crew came shortly after, Roy gave handover to them, he thanked us both and the crew took the man into the ambulance.
>
> In the car on the way back to the station Roy talked about the call. He said the man was homeless, had chest pain, was smoking and drinking whilst we were with him. Roy said, 'he may want to go in' (to hospital), he said 'it's cold, he's probably hungry and the weather's getting bad'. Roy said, 'I know all about this but I'm not going to create a problem out of it'. He said, 'why would I want to argue with him, he was pleasant with us'. I nodded. Roy said 'something has happened in his life to make him become like this'. He explained that he had got to know lots of homeless people in a previous job and that they would often ask him for cigarettes but never money. Roy seemed to sympathise with this man and not be judgemental of him.
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> *(Fieldnote, 'something has happened in his life to make him become like this', 25.8.15, 9.15am)*

The above field note extract shows how in his assessment of a call, Roy displays an awareness of the complexity of situations which may lead someone to request an emergency ambulance. In his account after the call, he drew my attention to key issues and how these influenced his actions, his approach and his decisions. Roy highlighted possible motivations in making the call such as homelessness, the inclement weather and basic human needs for shelter, which are not perceived as 'legitimate' reasons for requesting an emergency ambulance. In so doing he shows recognition of these possible factors but does not interpret them as problematic and suggests these did not influence his decision to arrange

transport to A&E. Roy displays sensitivity and empathy towards the man's plight; he attributes his situation to 'something' that has happened to him, which places the cause external to him and not therefore of his own volition. Roy describes his previous experience in dealing with the homeless which he interprets in a positive way and which appear to influence his current appraisal.

Roy appraises the call and situation in a way that avoids blame and criticism of the individual and their possible motives in calling an ambulance. He is using deep acting; where he empathises with the man, appreciates the difficulties of his situation and is able to labour emotionally and remain caring, sensitive and compassionate towards him.

In his account above, Roy suggests public knowledge is potentially limited in relation to judging the critical nature of physical symptoms. In the next section I provide an example of just this and the implications for emotional labour, caring, sensitivity and compassion.

7.3.3 Crew expectations of patients: 'Why didn't you ring us last night?

During my participant observation with crews, I noticed that the discrepancy between the professional and patient perception of need at times also arose in situations where it was thought by crews that patients should have called for emergency help sooner than they had. This was an interesting observation which perhaps suggests the difficulties at times for the lay person to judge when things are okay or worse than they think. Crew' interpretation and positioning of these calls created frustration amongst them and had implications for their emotional labour and at times their care and compassion for patients. The following field note is an example of this when at the start of an unusually quiet morning, two months into my fieldwork, with a crew, Arthur and Jim, we went to a call to a woman (Julie) who was complaining of numbness down her right side which began the previous night. The screen in the ambulance cab read 'query CVA' (cerebrovascular accident or stroke); it was categorised as a green 1call (meaning urgent) and the crew used blue flashing lights to get there quickly.

> The ambulance went swiftly through the built-up traffic through the city centre and on to the address. It was early morning, and the town centre was busy and the call was a distance to the outskirts of the city. I was in the back of the ambulance, looking through to the front cab and holding on tightly at times. Arthur was driving and Jim who was new to the station sat in the seat opposite. Arthur said, 'she should have called last night, not waited until now', Jim said yeah and nodded. I didn't comment. I felt sick in the back with the movement and jolting of the ambulance, but I tried to breathe deeply and focus on the road signs as the ambulance struggled to move quickly but awkwardly. As we got to the street, we could see Julie's husband out on the drive waiting. Arthur parked the ambulance outside and I got out with the crew. We all said hello and Julie's husband led us into the house and upstairs to one of the bedrooms. We went in and could see Julie lying down in bed. Jim took the lead and I stood slightly behind him, he introduced us all and started to ask Julie what had happened. He took a history of events since the previous night and past medical and medication history briefly.

> Arthur was also listening a little further away in the bedroom and suddenly said to Julie 'why didn't you ring us last night when these symptoms all started?' and Julie said, 'I thought it would get better overnight after some sleep'. Arthur said, 'have you got a pillow that is therapeutic in some way then?' At this point I thought to myself why would you say that? It is not at all helpful. I felt so sorry for her. Julie didn't answer him and looked away. This seemed to create a feeling of tension between Julie and Arthur but neither said anything more. After a short time, me and Jim helped Julie to get up, downstairs and into the ambulance. I could see that Julie was dragging her right foot. Arthur returned to the driving seat for the journey to A&E and we looked after Julie in the back of the ambulance.
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> *(Fieldnote – 'should have called last night', 6.5.15, 9.00am)*

My observation of this event showed the difference between the patient' or public' understanding and perception of need for emergency help in some situations. In this case Julie, the patient is perceived by the crew to have underestimated or delayed the request for emergency help despite what appeared to them to be a clear need. Arthur had openly questioned Julie's perception and response to the symptoms the previous night in the ambulance on route to the call. He said, 'she should have called us last night, not waited until now'. In so doing he is presenting his perception and interpretation of the situation; he says what she 'should' have done and in doing so undermines what she actually did do. In making this statement Arthur positioned his interpretation and shared it with Jim and myself, gaining agreement from Jim and support for his perspective.

Arthur's interpretation and positioning of the situation was brought suddenly and rather abruptly and directly to the surface, showing itself in interaction with Julie when he said, 'why didn't you ring us last night when these symptoms started?' Julie's offer of an explanation shows the difference in her interpretation and response; her perception of its seriousness and significance wherein she thought rest and sleep would suffice. Arthur's retort was in the form of a rhetorical question to Julie as to whether her pillow was therapeutic. The question posed here is rhetorical in the sense that it is intended to question without courting a response and in itself may imply that an explanation as a response is not easy to provide, nor is it expected (Koshik, 2005). It serves to question and challenge Julie's actions the night before in a direct and powerful way through the mockery of satire, sarcasm and humour at her expense. The suggestion of a pillow being therapeutic is framed as a ridiculous one by Arthur who appears confident in his objective interpretation and positioning of the situation and what he thinks should have been done. His questioning of Julie had a somewhat authoritarian, paternalistic and unequal stance to it, placing her under scrutiny and inferior to him who knows best.

His direct questioning exposed and confronted the issue, seemingly requesting an explanation for it. Arthur failed to labour emotionally; his question and comment on a 'therapeutic pillow' communicated his frustration to Julie. By airing his frustration openly, he created a barrier with Julie and her husband which impacted an opportunity for him to facilitate their care in this situation.

I did not take the opportunity to question Arthur during the journey to the call when he expressed his view that Julie should have called an ambulance the night before, partly because of my nausea and because my knowledge led me to consider I knew his reasoning already. The information the crew was given and the possibility of a stroke is highly likely to be accompanied by their knowledge of the significance of acting quickly at the first signs of the condition to minimise the long-term effects, which in this circumstance they were unable to do. This is part of Arthur's professional knowledge and understanding of the medical condition of stroke, its signs and symptoms and the importance of speedy diagnosis and treatment. Patients and the public cannot be expected to possess the level of knowledge and expertise of emergency healthcare professionals and the expectation of this may be an unreasonable one. The need for immediate emergency help may also not have been realised or sought for a variety of reasons by this patient. The professional' perspective is not necessarily how the patient understands, interprets or positions it, perhaps contributing to the discrepancy between them. In addition to this, public concerns about overly busy emergency services might instigate reticence to request help.

Arthur appeared to be frustrated that Julie had not called for help the night before and he had raised this in the ambulance on the way to the call. His rather direct and inappropriate questioning of Julie's actions the night before and his satirical and sarcastic comment of having a 'pillow that was therapeutic in some way', I interpreted as an expression of his frustrations and views, which were unexpected and took me by surprise. As highlighted earlier, expression is a significant component of emotion and vocalisations considered an accepted and reliable indicator (Coppin & Sander, 2016), which I used in my interpretation and analysis of this event.

The call showed how crews' appraisal of need for the EMS can be impacted by their professional knowledge and interpretation which can be different from the patient's. Importantly, this potential discrepancy can have implications for emotional labour and how some crews respond to and interact with vulnerable patients. In this situation efforts at emotional labour and the maintenance of a professional display, described by Hochschild (1983, 2003), were denied the patient. Feelings of frustration were expressed and felt by those around and appeared to impact negatively on the potential for a caring, empathetic and compassionate encounter.

7.4 Conclusion

In this chapter I have shown how at times crews appraise, interpret and position their work in negative ways. Closer analysis and observation have led me to see that negative appraisal is associated with situations in which crews question the legitimacy of need for their emergency help involving focus on specifically whether emergency transport was needed and the nature or perceived seriousness of the health problem. In their appraisal crews have mobilised their perception and interpretation of what they see as appropriate and legitimate need for the EMS and its role and contrasted this with public use of

the service. Crews have drawn on categorisation devices which show how they organise and categorise their work and the criteria they use to populate these.

Discrepancies between crews' and public perception of legitimate need for emergency transport and care appear to have implications for emotional labour in the suppression and disguise of internal feelings and frustrations of crews. Failures to labour emotionally can lead to the communication of frustrations and have the potential to interfere with care and compassion for vulnerable patients in times of most need.

In the next chapter I will explore and discuss the key findings of my study, the conclusions I draw from them, how they interface with existing literatures and the implications they have for understandings of emotional labour and emotion work in the pre-hospital care context. I will examine the contributions of my study to the theory of emotional labour and emotion work, to understanding of EMS work, to learning and education, and to research. I will consider the limitations which derive from my study and the overall conclusions to my thesis.

Chapter 8

Discussion and conclusions

8.1 Introduction

In this chapter I explore and critically discuss the key issues which have arisen from my study with EMS crews in Bryn Station, the conclusions I draw from them, how they relate to existing literatures and the implications for emotional labour and emotion work in this context. I discuss the unique contribution of my study, its' limitations and the overall conclusion to my thesis.

My discussion is framed within the contexts of this work setting and includes attention to the setting of my study, its organisational features, and to the behaviours and interactions of crews in the backstage and front stage regions. I discuss the regular activities I observed in the EMS crew room; how crews complain and moan about particular types of calls with each other, how they use humour and at times talk about calls they found difficult and challenging. I discuss the significance of the crew room to the crews in the emotional handling, processing and management of EMS work. I also examine the implications of backstage humour and teasing amongst crews for creating additional forms of emotional labour.

I focus my discussion on the front stage challenges of EMS work and the features crews instigate in their interpretation, positioning and categorisation of calls to which they respond. The perceived legitimacy of calls, crew' complaints and the underlying discrepancies between the crews' and the public interpretation of need for emergency help are discussed. The background of personal and wider, currently popular political perspectives on health and the public use of the NHS are discussed alongside professional judgement, social accountability and self.

I discuss how work appraisal appears to evoke emotions and feelings amongst crews and occur alongside behaviours, interactions and as such different kinds of emotional labour. The implications for emotional labour in the suppression of emotion, interpersonal interaction and exchange and their importance are explored and discussed.

I will make clear the unique contribution of my thesis to the knowledge about the theory of emotional labour and emotion work, to understanding of EMS work, to learning and education, and to research.

Finally, I discuss the limitations of my study and the potential implications of these and present an overall conclusion to my thesis.

8.2 Discussion of my findings

8.2.1 Bryn Station, the EMS crew room and their place in this social setting

I begin my analysis for this chapter in the setting of my study, Bryn station and the EMS crew room. This was my first introduction to the social setting of my study, where I initially met the crews and joined and re-joined them at the start of my frequent episodes of participant observation.

The backstage context, particularly the EMS crew room at Bryn Station offered a regular opportunity for some crew members to meet, talk and share the frontline challenges and frustrations of their role with each other. The significance of their work appraisal and the emotions evoked appear from my analysis to have implications for the backstage, particularly the crew room wherein the challenges of their frontline work are handled, processed and managed by crews.

The EMS crew room I noticed was a larger, more comfortable, physically separate space from other crew rooms and was exclusively used by EMS crews. Other ambulance service workers at the station (known as patient courier service or PCS) congregated in a separate area. During my participant observation when I asked why crews congregated in different areas, Pete (one of the crews) laughed and said 'that's the way it is' (Fieldnote, 24.6.15, 7.30am). I interpreted this response to suggest that these were established patterns and contexts for social gathering and interaction for different staff, which were accepted. These patterns of workplace organisation appear to reflect differing roles and distinguish groups of individuals within this organisation and their role boundaries and as such constitute features of "negotiated order" (Strauss, Schatzman, Ehrlich, Bucher, & Sabshin, 1963, p. 147). Negotiated order is a theoretical interpretation of the nature of social order drawn from symbolic interactionism, which proposes a fluid-like dynamic through which individuals within and across professional and lay groups function effectively. Strauss et al. (1963) drawing on a research study of 2 North American psychiatric hospitals, downplayed the role of formalised rules and laws and exemplified how social order was achieved through a process of negotiation involving "the processes of give-and-take, of diplomacy, of bargaining which characterises organisational life" (p.148).

The physical differences between these settings may also reflect and to some extent reinforce the hierarchical positioning of these parts of the ambulance service. The EMS is the frontline emergency service which holds prestige in saving lives and in the treatment and management of complex trauma. These crews are awarded higher grades and salaries with more intense training and educational preparation for their roles.

Diefenbach (2013) highlights hierarchies as persistent and pervasive features of human existence and social organisations, constituting a complex interplay of key structural elements, individual subjective

mindsets and social action, which offer possible explanations for their continuation, despite their deleterious impacts for many. He refers to physical space and land (historically) as a basis for and representation of superiority and social dominance which was "not only in a physical/spatial sense but also in a socio-cultural sense – and it becomes even more protected" (Diefenbach, Ibid, p.62). He says hierarchies are part of the mind and are protected and preserved through adherence to norms, values and behaviours in a given social setting. Collinson (1992), in a study of heavy vehicle manufacturing described the hierarchical organisation of white collar and shop floor workers, physically and aesthetically represented in the "fully tarmacademed" car park and waitress canteen service of the former and the "pot-holed wasteland of soil and shale" (p.7) and the small, self-service food services of the latter. Organisational hierarchies and structures have physical, organic features which communicate and reinforce the positioning of those within them.

8.2.2 Backstage - Moaning and complaining to each other in the crew room

The EMS crew room was a setting in which some crews would regularly moan and complain to each other about aspects of their work role including calls they had attended where questions were raised regarding the legitimacy of need for the emergency ambulance service (See examples on pages 93 & 94). My analysis of crews' accounts in the crew room focused on features of both their content and structure and the function these may have. Their accounts of calls were characterised by limited specific detail, broad, generalised statements of the situations and employed linguistic devices such as rhetorical questions which can be persuasive and convincing (Edwards & Potter, 1992). People's accounts are not narrative productions of fact simply told; on the contrary they are the product of active construction, organisation and delivery (Coffey, 2012; Edwards & Potter, 1992; Holstein & Gubrium, 1995). Edwards and Potter (1992) suggest accounts are complex creations, impacted by their context and which are put to practical and persuasive ends. This conceptualisation of accounts offers the prospect of levels of analysis which may extend far beyond what is said, to include how these are constructed, the particular context in which they occur and what this shows about what may be deemed appropriate within a particular social setting.

On closer analysis crews' accounts described above had features of minimal detail, a staged sharing of information, an assumption of common understanding of the issue at hand and how this is to be told. Garfinkel (1967) suggests that everyday interactions have a taken for granted aspect to them which he says is often subtle and imperceptible; extending beyond reading what is said. He describes "common understandings" (p.38) in patterns of interactions in which inferences are made, there is little specific detail offered and the information shared is revealed in a developmental manner to an audience who know it is coming and expect to wait for it. These are agreed patterns of social interaction (Garfinkel, Ibid), played out and which, on closer inspection show us what holds in a particular setting. Garfinkel

(1967) centres attention on "common sense knowledge and common-sense activities" (p.75), which constitute social interaction and interpretation, and which draw on assumptions which are tacit and only made visible through attempts to unmask them. He experiments to deliberately unveil and expose the "background expectancies" (p.37) and assumptions on which individuals rely. The accounts presented in this thesis provide many examples of crew' perceived misuse of the EMS, incorporate assumptions and judgements of the callers and the legitimacy of their need for emergency help. They reflect 'common understandings' amongst crews and expectations of these sets of social circumstances. In summary crew room accounts offered by crews in both the nature of their delivery and in the assumptions on which they rely, when examined closely show the culturally acceptable common understandings at play in this social setting. These include that full detail and explanation is not necessary amongst those who already know and have experience of the issue raised and that there appear to be shared views amongst some of them about what constitutes inappropriate use of the EMS.

Crews' accounts of calls also take the form of complaints which suggest their dissatisfaction, in this case with what they consider to be the inappropriate use of the emergency ambulance service. Complaints represent a response to perceived unsatisfactory behaviour and the failure to meet expectations (Goffman, 1971). My analysis suggests that crews interpret the role of the EMS as one which responds to emergency, life threatening situations including medical emergencies and trauma. Calls which are perceived as 'non-legitimate' and perceptions of inappropriate use of the 999-emergency ambulance service conflict with service ideals and role identity, creating frustration amongst crews (Kirby & Roberts, 2011; Prener & Lincoln, 2015).

The set up and organisation of the backstage and EMS crews' interactions with each other about the nature of their work and how this is categorised, offer further examples of "negotiated order" (Strauss et al; 1963, p.147). In addition, more broadly, the interactional, interdisciplinary nature of ambulance service work involve negotiation with an array of professionals, patients, and relatives and as such constitute opportunities for negotiated ordering of the layered social context in which they work.

The crew room itself is an important focal point for ambulance crews to gather and discuss the challenges and generate shared understandings of what the job involves. My analysis suggests that some crews value the opportunities of crew room interaction to express and share the frustrations arising from their front stage role including types of calls they have responded to. Crews suggest opportunities to moan and complain to each other are important in enabling them to deal with frustrations arising from their work, to 'let off steam', to process their emotions and to potentially avoid the negative, cumulative effects. In summary, crews' complaints express and communicate their frustrations with discrepancies between their role expectations and the reality of their practice; and as such they implicate the need for emotional labour. The crew room offers a regular opportunity to express frustrations with colleagues and to do important emotion work arising from their frontline role.

Complaints about the nature of calls reflect the sources of frustration crews experience in the frontline areas of their work and suggest the link between the front stage and backstage contexts of their work environment. They hint at the relationship between these areas of their work and indicate the crews' reliance on each other as sources of sympathy and support with the frustrations and challenges of their frontline role and the place of the backstage context of the crew room in the processing and management of the emotional challenges of their work. It is recognised that emergency health care professionals can experience a variety of difficulties and that sources of support are a crucial consideration (Bohström et al; 2017; Clompus & Albarram, 2016). Colleague support involving opportunities to share experiences with others has been suggested to be important in enabling coping with work associated stress (Bohström et al; 2017; Clompus & Albarram, 2016; Williams, 2013b). Some research interest has centred on the perceived value of debriefing with colleagues specifically following critical incidents (Bohström et al; 2017; Gouweloos-Trines et al; 2017).

Less attention has been given to the significance of colleague support in dealing with 'everyday' frustrations EMS crews might experience as a way of preventing the cumulative effects of stress. However, in a study investigating paramedics' experiences of work-related emotional challenges and the various coping strategies, Clompus and Albarram (2016) reported the value of informal peer support. Respondents described frustrations arising from increased workloads and targets, calls to sick children, suicide and also to calls which were considered a waste of time causing anger from some. One source of frustration was attributed to changes in the health and social care system which resulted in crews attending calls which they perceived as "wasting all our time" (p.4). This was described as an uncomplicated fall where there is no injury. The study offers some understanding of sources of frustration and stress in the EMS and helpful strategies to assist their resilience and coping through informal discussion with colleagues.

Despite the frequency and popularity of crew room 'moaning' and 'whinging' about work related frustrations amongst EMS crews, I was aware that not all crews engaged in these opportunities in equal measure and some hardly ever did. Some crews suggested this was something 'older' crews do to 'throw off a bit of steam' and different perspectives were offered by other crew members who perceived these as not helpful and even worsening feelings (see page 98 & 99). My analysis suggests variance in crew' perspectives and indicate that the handling of frustrations by complaining openly in the crew room is not a strategy that all workers see as helpful in handling the emotions generated by their work. As such some crew members offered their display of understanding of crew room moaning and complaining and its place in the expression and processing of work-related frustrations (Garfinkel, 1967), however these were varied and not in unison.

8.2.3 Backstage - humour

The backstage context of EMS work, including the crew room and other opportunities when they were not involved in their frontline roles (Goffman, 1959), were characterised by frequent interactions positioned by them as humour, laughter and teasing, to which I became accustomed during my participant observation with them. The crew room humour in Bryn Station was at times entertaining and some crews appeared to listen, join in with the laughter and even contribute to it. Their verbal and non-verbal behaviours in some crew room interactions I interpreted as suggestive of crews' enjoyment and excitement. Some crews suggested the humour and teasing enabled them to relax and 'let off steam' and to manage the challenges of their work.

My observations of backstage humour in this context suggest features of its particular culture and what may be considered by some to constitute 'humorous'. In the example I have used (see page 101), suggestions proposed by Nick appear to be consciously preposterous and ridiculous, not meant to be taken literally and are behaviours characteristic of what constitutes backstage environs (Goffman, 1959). The EMS crew room is a physical backstage setting where crews congregate when not working or performing their role in the front stage arena. Front stage, backstage and off-stage regions as areas distinguishable by the behaviours typically displayed by actors in a social setting (Goffman, 1959). The backstage Goffman says may be a physical one, often adjacent to the front stage, easily accessible to actors and may constitute a corridor. However, backstage need not have a specific physical context to it and as such is defined instead by the behaviours of actors when not involved in frontline performance. As such backstage has the potential to be fluid like and varied in its context. The EMS crews have professional expectations to perform in the frontline provision of emergency care in view of a public audience; this is what Goffman (1959) refers to as front stage or "front region" (p.109). However, juxtaposed to this context is backstage or "back region" (p.114); wherein behaviours are those characterised by their informality and shaped by the presumption that they will not be seen by an external audience.

Differences in behaviours and demeanour between front stage and backstage are evident during actors' movement between these areas and by the "impression management" employed (Goffman, 1959, p.123). Goffman draws on Orwell's account of hotel waiters and their backstage behaviours, particularly one; the assistant Maître D'hôtel, who vociferously curses and scolds the kitchen apprentice for smashing a bottle of wine at the entrance to the dining room but as he moves through the revolving doors from one region (the kitchen and backstage) to another (the dining room and front stage), his whole presentation changes in synchrony with the door movements. As he moves out to the front stage, he changes immediately in sympathy with the setting to display a calm, pleasant and gracious

appearance to his audience; likened to a swan. He displays the desirable traits, and the front stage performance is in full swing.

Goffman (1959) describes how backstage is awarded privacy from front stage and the audience for the benefit of the performance and the desired ambience. However, despite its' somewhat invisibility he recognises the positioning of backstage as a central part of workplace settings and organisations. He describes typical behaviours and actions of actors therein and hints at its role and function. Backstage or "back region" is described by Goffman (1959) as a setting in which the image created by the front stage performance is contradicted and undermined and where "suppressed facts make an appearance" (p.114). In the backstage the performer can relax, change his persona and move out of character. Goffman says behaviour in this region might be considered by psychologists to have a "regressive character" to it (p.129). Backstage is suggested to play a significant role in the process of "work control whereby individuals attempt to buffer themselves from the deterministic demands that surround them" (Goffman, p.116). In my study these are the front stage demands of emotional labour.

Regular crew room gatherings, interactions, behaviours and humour were entertaining and were suggested by crews to help them relax and cope with their work, having positive emotional impacts and sequelae. Crew room interactions I observed during my participant observation at Bryn Station resonated with those described by Collins (2004) in the context of "interaction ritual theory" (p.3) and interaction rituals. Collins (Ibid) emphasises the significance of face-to-face social interaction, its complexity and potential source for understanding and investigating human interaction and behaviour. Against the theoretical background of situational theory and influences of Goffman and Durkheim, Collins (2004) argues that "incidents shape their incumbents, however momentary they may be; encounters make their encountees" (p.5). In such encounters Collins proposes a "mutual focus/emotional entrainment model" (p.47); informed by empirical studies of human interaction, which proffers an explanatory and descriptive configuration of behaviours in a social gathering. Key structural elements are two or more people, a common mood, boundaries and a central focus of attention. Emotions are a crucial component; being brought to the interaction, whipped up in it and an outcome of it. Collins (2004) outlines the macro and micro interactional processes which propel the overall process; emotional entrainment, collective effervescence and turn taking, rhythmicity and gaps, respectively. The process of emotional entrainment means emotions are swirled and raised and group members can be taken along through rhythmic entrainment and are physiologically "caught in the swing of things" (p.108). These processes appeared to me to be at play for some crews in the regular meetings and crew' interactions in the context of the crew room at Bryn Station.

Interaction rituals have significant outcomes for those who are party to them such as high emotional energy (Collins, 2004). Emotions are central ingredients for interaction rituals and central outcomes of

them, with high emotional energy leading to confidence and enthusiasm for future social interaction. Interaction rituals in the crew room may therefore perform an important function in offering opportunities for participants to vent emotions (like frustrations with those who inappropriately use the 999-emergency service) and deal with them collectively, to create emotional energy both in the short term as part of the process (with laughter) and in the long term in the residual mood of the crews as they depart the gathering and engage in further interaction. Humour can generate positive feelings and may be accompanied by laughter, hilarity and jocularity (Collins, 2004). Laughter has organic physical features to it and is associated with biochemical changes and hormonal outputs which can enhance the positive effects (Tortora & Derrickson, 2017). Humour and laughter are suggested to have positive effects on health and well-being (Moran & Massam, 1997) and are a pleasurable part of life. The interaction rituals, humour and emotional energy created may have important impacts on the emotional well-being of emergency ambulance crews in Bryn Station and some of the crews described crew room humour as a 'coping mechanism' (See Alex, page 104), 'good humour' and makes it 'good to be here' (Roger, a CTL and paramedic).

Humour is a phenomenon frequently associated with emergency health service personnel and their backstage culture (Boyle, 2005; Scott, 2007); and the emergency ambulance service is no exception to this (Boyle, 2005; Hutchinson, 1983; Williams, 2013b). Hutchinson (1983) described crew room activities involving practical jokes and humour in the emergency ambulance and fire service which included storytelling of blood and guts, incompetence of staff and ignorance of patients. She suggests these meet their purpose of enhancing group cohesiveness and "killing time" between responding to calls (p.29) and offer opportunities for crews to relax and let their hair down. Workplace humour has been perceived to allow workers to 'let off steam' amidst repetitive, monotonous work (Giddens, 1979).

My analysis suggests that the crew room in Bryn Station, its characters and humour whilst providing a regular backdrop for crew interaction and engagement could also be potentially challenging, creating a communal environment for individuals to draw attention to others and to use these in a performance and as entertainment. At times, the humour and teasing centred on established crew members like Catrin and on other newcomers like Jim (See page 103). The humour was generated from the teasing and mockery of crew members and drew attention to particulars such as youth and inexperience. As such these were subtle attempts to undermine individuals using devices such as humour to 'soften' the point and rhetorical questions to divert attention from the perpetrator through reference in some cases to assumed public perception (see page 103 & 104). The collective audience may have created a context in which this mockery would be difficult to challenge and as such is likely to have generated a need for additional emotional labour by crews in their disguise of how they may have felt. My findings suggest that some crews perceived the crew room teasing to at times 'go too far'; generating emotion labour by crews in how they handled their feelings and the potential impact this may have had on them (See Stu's perspective see page 106).

Whilst some crews appeared to recognise the potentially deleterious effects of this teasing and mockery (for example see Alex, page 107 who said it could be seen as 'harsh' and 'bullying' by those outside the setting – such as myself perhaps), there were attempts made to defend, justify and accept this by reference to the assumed reciprocal nature of the 'banter' and a lack of appreciation of the culture. As such this interpretation of backstage humour and mockery implicated toleration of it, a willingness to excuse and accept it. However, this failure to check and monitor the use of humour and mockery, the emotional implications of its use, both in a positive and potentially negative way, fostered and enabled its continuation and the additional demands this placed on crews' emotional labour.

As a human behaviour, humour is an active phenomenon which is not without other functions and roles beyond and above the immediate enjoyment of self and others party to it (Collinson, 1992). At Bryn Station there were particular crew members who frequently adopted a central role in initiating and directing the interaction and humour in the crew room. Humour can place some group members, especially those initiating and directing it in a powerful, dominant and influential position within the group (Collins, 2004; Goffman, 1961). Goffman (1961) reported humour to be the prerogative of those in authority and denotes positioning of the dominant and simultaneously the less powerful (Kehily & Nayak, 1997). Teasing and humour can have a hierarchical element to them and are suggested to possibly reinforce these positions further (Collinson, 1992).

Collinson (1992) investigated humour and "joking practices" (p.107) amongst shop floor workers in heavy vehicle manufacturing in Lancashire in the 1980s. Amidst a male dominated backdrop he suggested humour to be the means and result of cultural forms of "resistance, conformity, control and self- differentiation on the shopfloor" (p.107). He suggested shop floor humour served to characterise, separate and distinguish the workers from management (and white-collar workers); to create an identity of a "group of comedians" (p.107) and names reflecting individual features of its members. He also described practices relating to conformity to a 'masculine culture' involving teasing, mockery and practical jokes initiated by established group members on newcomers (apprentices) with the purpose of teaching them the culture and assessing their willingness to be part of the group. Newcomers had to demonstrate an ability to be ridiculed, to take a joke and "be a man" (p.111), implicating that this could be difficult and challenging (it could hurt), had to be tolerated and was a test. Humour at others expense in a group situation has the potential to be particularly challenging for individuals, puts them at a significant disadvantage, removes their power and places it with the group who then judge if they have been a good sport or not according to group norms (Collinson, 1992). Humour can as such have its victims.

Goffman (1959) argues that teasing represents unofficial test of individual ability to take a joke in good spirit, despite internal feelings, as a foundation for trust. The features and implications of traditional

masculine culture are reported in a study of 20 ex-military servicemen (Green et al; 2010), wherein "laddish banter" (p.1483), teasing and the ability to tolerate it were closely associated with soldier identity and hegemonic masculinity. Despite some reports of the distressing effects of this banter respondents described it as "fair" (p.1483), suggesting their acceptance and perhaps toleration of it as a feature of this culture. These interpretations may resonate with the ambulance service which has military origins, is historically and currently male dominated and has been characterised by a traditional view of hegemonic masculinity (Boyle, 1997; Steen et al; 1997).

Humour has a variety of potential functions to which it can be put (Collinson, 1992; Goffman, 1959; Green et al; 2010), and there are suggestions that it can be uncomfortable for individuals, it can test their willingness to tolerate it and takes the power and authority of those who use it over those it is used on (Collinson, 1992). As a feature of traditional masculine culture humour is tolerated and accepted (Green et al; 2010); it is positioned as untouchable by some and those who may take umbrage with it run the risk of being seen as problematic.

However, whilst the above offer insights into the traditional, male dominated, masculine culture of the emergency services, these are likely to be challenged by a more gender balanced workforce and increasing numbers of university educated recruits, who don't fit the blue-collar versions described above (Collinson, 1992) or the traditional entrants to the ambulance service. As such these newcomers are likely to have different sets of expectations and perspectives which may oppose and challenge traditionally accepted behaviours. My findings suggest this type of humour was not engaged in by all crews in Bryn Station.

My study suggests that crew room humour, teasing and mockery appear to have differing implications and effects on emotional labour and emotion work in the context of the EMS. For some crews these were positioned as entertaining and amusing opportunities for interaction which help them relax and cope with the nature and challenges of their frontline work. However, my findings also suggest there are potential pitfalls and negative effects of teasing and mockery for individuals, which may render objection to it difficult or impossible. As such it is likely to necessitate emotional labour by crews in their efforts to disguise and suppress what they feel, inadvertently adding to the demands for work on their emotions. An uncritical acceptance of humour and mockery, as traditional and benign features of backstage culture run the risk of offering amusement and stress relief for some at the expense of others and their emotional labour.

The potentially deleterious effects of humour and mockery, particularly as a feature of crew room, group interaction in the context of the emergency ambulance service has received little specific research attention. However, this is an area which could be explored further as a feature of backstage culture amongst emergency ambulance health care workers.

8.2.4 Humour in sad contexts

At times during my participant observation the humour in the backstage contexts of their work could be described as 'black' in the sense that it involved situations which were sad, awful and horrific (Cambridge Dictionary, 2019). The effect of the humour used appeared to lift the atmosphere somewhat and EMS crews referred to black humour as 'how we deal with it' (see page 109) suggesting their ownership of it and perhaps a hint of defensiveness and justification of it.

Black humour is a recognised feature of emergency personnel interaction, particularly in backstage regions (Hutchinson, 1983) and is one associated with the emergency ambulance service (Christopher, 2015; Daubney, 2019; Scott, 2007; Williams, 2013b). As such it has a typical, normative element to it and is described as a feature of "ambulance service culture" (Christopher, 2015, p.610). Black humour serves important functions in enabling crews to deal with the challenging experiences and events they witness and manage (Christopher, 2015) and with the incongruities (Moran & Massam, 1997). Black humour therefore has an important protective function which some of the crews in Bryn Station show awareness of. Black humour introduces a differing 'version' or coating to the event which detracts and protects the person from the stark reality of the experience (Moran & Massam, 1997; Scott, 2007). The reality of frontline emergency care has the potential for confrontation with the harsh aspects of life, death, human suffering and disfigurement and the emotional and psychological impact and sequelae. Against this working terrain, black humour is a way of making light of it; of responding to and dealing with it in a manageable way that offers some emotional protection for crews (Williams, 2013b).

Black humour in detracting attention from the reality of the event may also serve to enable crews to deal with what is experienced and to demonstrate and maintain stoicism; one of this professions' historically valued ideals (Boyle, 1997, 2005; Steen et al; 1997). The ambulance service has its origins in the military, recovering the victims of war from the battlefield and transporting speedily to expert medical attention (Jean Paul Larre cited in Blaber, 2008); and likewise, in modern times takes its place in responding and immediately managing a myriad of trauma, fatality and medical emergency (Caroline, 2012). As such the service at times deals with the dark, disturbing, disgusting and frightening realities of human life (Mannon, 1992), much of which is hidden from the general public. Against this backdrop stoicism is a pragmatic and valued professional ideal in managing this harsh working context combined with hegemonic masculinity, historically characteristic of the ambulance service (Boyle, 1997; Steen et al; 1997). Stereotypical masculine traits are demonstrated in crews being able to deal with this work and handle it (Connell, 2005). Black humour demonstrates their stoicism and ability to do the job effectively without showing repulsion or weakness and may also serve to highlight and reinforce internal hierarchies.

Crews described black humour as ‘our way’ of dealing with it, claiming ownership and perhaps carving out a case for their ‘specialness’; their uniqueness and their way of managing their work. Their talk accords their work a distinctiveness, appreciated fully by themselves and serves to position those who don’t do the work as ‘outsiders’, who by their ‘otherness’ would not understand the work and the black humour which arises from it. Such talk serves to render the work as ‘special’ and defends black humour against external sources which may appraise it differently.

The reality of frontline EMS work is that only just over 5% of calls received are immediately life threatening which includes severe trauma (Welsh Government, 2019), leaving the vast majority beset with routine, mundane and non-emergency, non-life-threatening situations, which somewhat contradicts the emphasis placed on black humour as a strategy to manage these comparative rarities. However, as some of the crews told me, events which were difficult and highly emotive, although comparatively infrequent could remain with them indefinitely and as such explain their emphasis on black humour as a coping and protective strategy. On one occasion at the start of my fieldwork one of the crews, Mike, told me in detail about a call he attended a number of years earlier to a young schoolteacher who had taken her own life and had prepared everything, including her clothes and a letter to be read to her class. His recall and detail were both astonishing and concerning to me and on reflection are a reminder of the emotional impact of this type of work and the importance of strategies which help these professional to cope with the likely burden.

My analysis leads me to the conclusion that the use of black humour continues to serve an important function for individuals in emergency services in helping distract from sometimes very difficult situations. There is an artful element in producing these displays and a careful and sensitive timing to their production in what could otherwise be a crass response to clearly emotionally burdensome circumstances. This is a difficult line to tread and sometimes they appear to get it wrong.

8.2.5 Talking through difficult calls

The crew room interaction in Bryn Station was also described by crews as somewhere they could talk to each other about calls (or ‘jobs’) they found difficult and challenging, where they experienced doubts about what they had done or the decisions they had made in particular situations. Some of the crews reported wondering if they had done the right things and all they could have done in their frontline work in some calls. Crew room interactions crews said offered opportunities for them to talk to their colleagues about these calls, who they said understood and provided feedback and reassurance that they had done the right thing. Crew members described the importance of ‘not bottling it up’ (See pages 111 & 112) and sharing it with other crews who they said ‘understand’. As such crews implicate their reliance on each other as sources of support in processing difficult aspects of their frontline work and the uncertainties and emotions this can potentially generate.

Crews sought the views and perspectives of their colleagues on what was done, what could have been done and ultimately the reassurance and satisfaction that they have done the right thing, the best or most appropriate in the circumstance. 'Talking through the job' with colleagues can offer professional, 'insider knowledge' as a legitimate base to offer constructive comment and feedback. Crews' emphasised their reliance on each other on the basis of understanding of the role. However, it was also said that crews might be inclined to agree with colleagues even if privately they did not. This suggests that the crew room may provide a setting for the processing of the challenging aspects of their frontline work and the accompanying emotions. However, it was also suggested that whilst this informal support strategy amongst crews may offer the reassurance they seek, in doing so it may not offer a critically evaluative one.

Crews also referred to their reliance on each other as the 'way we deal with things'; suggesting this as historical and common practice within the station and hinting at a cultural normative persuasion towards internal processes and mechanisms of resolution. Whilst crews told me they would talk to each other about calls they found difficult I did not personally witness them doing this during my participant observation with them. This does not however suggest that this practice did not happen in Bryn Station and one simple explanation could have been that an incidence or opportunity for this type of interaction between crews did not arise or coincide with my presence for fieldwork. It is possible too that some crews may have been reluctant to share what could be considered uncertainties and weaknesses of their practice, which to someone such as me, an outsider to the group and the profession, could be perceived negatively.

These internal processes of reliance and resolution may reflect its military origins; historical influences and practices characterised by closed, internal structures and processes, resistant to external influences and scrutiny (Green et al; 2010). These established patterns are perpetuated by their acceptance and promulgation through claims of ownership such as 'the way we deal with things'. Crews my feel their professional image and performance may be at risk if these issues are shared outside the work context and by keeping these within the station and colleagues, the front stage performance is protected, untainted and unquestioned and the professional image intact.

The potential psychological and emotional impact of health care work is explored by Strauss et al. (1982); who through their focus on medical work, show its potentially emotionally disruptive effects attributed to its uncertain and unpredictable nature, the challenge of attaining the desired outcome for the patient (which may be recovery) and the professional's personal involvement in it. The combination of this working terrain can create challenges for frontline practitioners to manage and resolve. Henckes and Nurok (2015) used a typology of emotional work developed by Strauss et al. (Ibid), to discuss the emotionally disruptive nature of emergency pre-hospital care work in cardiac resuscitation and unearth the use of colleague' emotional support. The collective emotion work between crews after successful

cardiac arrest resuscitation and the crews' rehearsal of their actions and "congratulatory" talk (Henckes & Nurok, 2015, p.1035) are described in real time situations and hint at its normative nature in this context.

The support of colleagues through opportunities to talk about difficult calls or situations and what are referred to as 'critical incidents' are viewed as valuable coping strategies in the pre-hospital care context (Avraham et al 2014; Bohström et al; 2017; Clompus & Albarran, 2016; Drury et al; 2013; Gouweloos-Trines et al; 2017; Williams, 2013b).

Clompus and Albarram (2016) reported the value of peer support in dealing with challenges arising from paramedic work and more specifically opportunities to discuss their actions and receive "constructive guidance" (p.5) from each other. Paramedics described uncertainties they had about whether they could have done better which they could resolve with colleagues who they said understand. Peer support was considered an important strategy to enhance their coping and resilience. Nilsson et al. (2015) in a study of a variety of first responders including military, police and emergency medical physicians and support strategies for dealing with "daily hassles" (p.3) reported that the medical professionals valued opportunities to receive assurances from colleagues that they would have done the same thing. The sense of responsibility for appropriate action and the potential impact on these professionals of uncertainty was graphically described as being like a "rucksack" (p.4). Although small scale, the study highlights the role of emergency health care professionals, the challenges, uncertainties and emotions arising from their work and what helps them to manage these.

The perceived value of debriefing with colleagues has also focused on 'critical incidents' specifically (Bohström et al; 2017; Hörberg et al; 2018), and has been attributed to knowledge, understanding, trust and the provision of immediate support (Bohström et al; Ibid). Avraham et al. (2017) reported that paramedics value opportunities to discuss critical incidents with colleagues even when not personally involved with them as the incident was perceived as a potential learning opportunity for future situations. This suggests its function may extend to enhance the learning of others. Some attention has also been given to the effects of colleague debriefing after critical incidents on stress reduction (Gouweloos-Trines et al; 2017) and depressive symptoms (Halpern et al; 2014) amongst EMS professionals, with positive outcomes.

My analysis leads me to conclude that EMS crews value opportunities to talk to each other about calls they find difficult and challenging; where there may be residual concerns about what had been done and efforts to seek the reassurance of trusted colleagues who understand the role. As such these informal support strategies have the potential to enable the processing and expression of emotions which accompany emergency work and the uncertainties of it. My study findings offer insights into the

potential of informal colleague support and the implications this may have in helping crews handle and deal with the emotionally challenging aspects of their role.

8.2.6 Front stage – call interpretation, appraisal and categorisation and the implications for emotional labour

My analysis of observations with EMS crews and their accounts in the context of frontline service provision suggested their engagement in interpreting, appraising, categorising and valuing of their work in differing ways. My analysis suggests crews' valuing of different types of calls is linked to what they see is the role of the EMS, what they perceive their role to be and their ability to fulfil this role and as such have implications for emotional labour and emotion work.

In appraising, organising and labelling their work in differing ways crews are creating membership categorisation devices, which are "inference rich" (Sacks, 1992, p.41), and have the potential to show how individuals do organisational work and what may influence it. Sacks (Ibid) suggests these devices are the tools of social organisation, as such important to understand and which function as means of social expectation and social control. Categorisations used by EMS crews' show how they value different types of work, how they constitute these and what may inform and influence their positioning.

EMS crews used locally generated criteria such as 'good calls' and 'rubbish calls' as descriptive labels to populate their categorisations and communicate their evaluations of their work. More specifically criteria prompting a positive call appraisal involved crews being able to 'make a difference' to the patient. Making a difference was a local signifier used by crews to communicate this criterion and was exemplified by participants as arising in situations such as emergency calls needing resuscitation, where their technical, life-saving skills were put to use with good effect and excitement generated. My observation of crew' response to and successful resuscitation of a patient who was in cardiac arrest exemplifies their positive appraisal of this type of work (See pages 119, 120 & 121). Whilst the positive appraisal may be attributed in some part to the success of the resuscitation attempt, such calls provide opportunities for EMS crew to utilise their technical skills and fulfil their expectations of an emergency role.

Some crews referred to their educational preparation for the role, their assumptions of emergency work and their expectation to be responding to '…cardiac arrests, to major trauma, major RTC's, people having heart attacks, people having CVA's, people I can make a difference to...' (see page 122).

Crew' interpretation, positioning and valuing of calls which demand their technical skills of resuscitation and medical interventions may be influenced by their role perception as a service which deals with life threatening emergencies and the increasing emphasis on technical and medical expertise (JRCALC, 2019). The emergency ambulance service boasts a long history of providing a crucial and

immediate direct response to the public in situations of life-threatening emergencies and traumatic injuries. Historically the service and role focused on speedy transport to ongoing health care facilities (Blaber, 2008) however significant developments in the role of the Paramedic and Emergency Medical Technician have led to service expansion with increasing levels of medical and technological sophistication in the pre-hospital care context. These include advanced life support, endotracheal intubation, venous cannulation, intravenous fluid replacement, oxygenation, trauma immobilisation and the administration of a range of drugs such as analgesics, antiemetics and more recently thrombolytics (JRCALC, 2019). These developments have led this neophyte professional group towards increasing levels of medical expertise and skill.

In tangent with these developments, pre-registration paramedic educational preparation, now established within Higher Education Institutions has dedicated a significant proportion of curriculum content to skills in life saving and emergency care (BPA, 2006; College of Paramedics, 2019), further endorsing the importance, mastery and valuing of this type of work. Ambulance crew' educational preparation reflects a keen and comprehensive focus on biological science and pathophysiology preparing them for the performance of technical sophistication if needed. Pre-hospital care professionals are thus well prepared and equipped to deal with acute medical conditions, major trauma and threat to life (College of Paramedics, 2019) and may understandably expect to put their skills to use in their role.

The historical and current preference for and valuing of technical skills and traditional emergency work by EMS workers is reported in the literature (Hutchinson, 1983; Nurok & Henckes, 2009; Palmer, 1983; Wankhade, 2016). In a study of American rescue workers including ambulance staff, Hutchinson (1983) described how work was categorised into emergency and non-emergency types and she highlights the valuing of emergencies which offer excitement, drama and heroism. She adds the potential for this work to enable the application of skills, to manage stress and to court the recognition and praise from others for saving lives. Hutchinson shows the emotional rewards of emergency work and possible explanations for its valuing. Palmer (1983) also describes patterns of work categorisation amongst paramedics and EMTs into "211s" and "pukes" (p.167). '211s' are calls to trauma and threat to life, described by crews as "real" calls (p.162) and perceived by crews as exciting. They utilise skills and have positive emotional outcomes for crews and are referred to as "the good runs" (p.163). Palmer (Ibid) highlights the valuing of lifesaving and medical skills and reports how some of the EMS actively sought out calls needing these skills and the emotional and psychological sequelae hence his descriptor of them as "trauma junkies" (p.162). My analysis suggests that positive call appraisal in which crews can 'make a difference' often through their use of technical skills such as lifesaving, create positive feelings of satisfaction and in some situations excitement. The emotional sequelae of some types of EMS work are reflected in the value crews' associate with them and their attempts to seek out this type of work. My analysis also suggests that some crews perceived these experiences to see them through the more

mundane, more frequent elements of their work and to lessen their frustrations. As such these calls may have longer term positive impacts for crews.

Nurok and Henckes (2009) report a more varied and complex basis for the appraisal and valuing of types of emergency work which they describe as a "fluctuating economy" (p.505); wherein a multitude of factors including though not confined to medical seriousness may impact on how a given call is perceived and appraised by crews. Some of these were individual factors such as the level of experience of the crew member; meaning a call could be perceived as valuable in providing the sought-after experience needed. However, they report the valuing of technical skills and action in the EMS which demonstrates these abilities and is clearly visible and attributable to them.

My analysis suggests that in the absence of work which meets the aim of 'making a difference' though traditional technical, emergency and life-saving ways, some crews 'get on with the job', intimating their acceptance of it and perhaps emotional labour in suppressing their frustrations. Others however appear to utilise broader definitions of how they can make a difference. This differing appraisal of work and what constitutes making a difference enables EMS crews to appreciate the value of what they do and to continue to reap the emotional rewards of role fulfilment.

My study findings add further understanding of how EMS crews appraise, categorise and value particular types of emergency work. In this case positive appraisal of calls necessitating their technical skills may reflect their traditional role, skills and reinforce and uphold their role identity as they see it. They reflect the role they are educated to perform and their expectations of the role of the EMS and create positive emotional outcomes associated with role fulfilment (Metz, 1982; Palmer, 1983). However, my analysis also shows how some crews manage the realities of their work, through alternative appraisal which enables them to value, appreciate and fulfil their role.

Positive call appraisal was also populated with locally devised signifiers such as 'genuine' and 'they really need us', which served to denote what they perceived to be legitimate need for an emergency ambulance. Crews drew on established medical diagnoses such as heart attack and stroke as examples to populate and support their interpretations of legitimacy. Crews' appraisals which focus on genuine and 'real' need for the EMS appear to reinforce their perceptions of the role of the emergency ambulance service and those who they perceive to legitimately need it. Crews' accounts showed how they populated these; with calls to the elderly, frail and vulnerable like 'little old Doris' (see page 130 & 131). The imagery used offers a convincing picture of vulnerability which justifies sympathy, is unlikely to be challenged and exemplifies the creative nature of accounts and their use towards persuasive ends (Edwards & Potter, 1992).

My analysis suggests that crews' interpretations of genuine need are associated with efforts at particular types of emotional labour and caring. Some crews mobilised their perceptions of genuine need to justify giving 'more care' and showed their empathy and compassion towards the patient. As such there appear to be more emotional labour through caring 'rewards' associated with this type of work appraisal. The implication here is that because it is perceived to be 'genuine' the patient is given 'more care', alluding to the particular types of attentiveness and caring offered. These suggest particular rewards for those categorised in positive, legitimate ways. My observations of crews' communication and interaction with patients resonate with interpretations of emotional labour characterised as skilled, caring interpersonal exchange and effort by the worker to meet the emotional needs of those who are distressed (James, 1989, 1992). Hochschild (1983, 2003) defines emotional labour as the work focused on the emotions of others; namely "…which makes others feel cared for in a convivial, safe place" (p.7), in this case through the use of deep acting strategies, which enable a particular appraisal of the call and caller.

My findings and analysis however also expand the theory of emotional labour further to show the other side, when crews don't do it, reject it or can't achieve it and the implications this may have for the interactions between those involved. As a contrast to positive work appraisal, EMS crews interpreted, appraised and categorised some of their work and calls in negative ways, which my analysis suggests was associated with particular types of emotional labour and emotion work. Crews appeared to draw on their perceptions of legitimacy, what they see as the role of the EMS and social expectations of the public to inform and justify their interpretations. My analysis suggests that there were discrepancies between the crews' and the publics' interpretation of need for the emergency ambulance service and constituted differing expectations (See pages 135, 136 & 137). Some of these discrepancies focused on the need for an emergency ambulance with crews suggesting that alternative transport to hospital such as by family and friends would have been more appropriate. Some crews articulated their assessment and determination of need for an ambulance in an apparently straightforward manner and from their professional perspective. The crews' accounts and explanations may be predicated on a number of issues such as morality and whether this use of the service is morally acceptable. Some crews drew explicit attention to the economic implications for a health service with high demand and finite resources.

Questions of perceived legitimacy of calls were also centred on the specific nature of the health problem and whether this was considered by crews to necessitate an emergency response. Crews described the specific features of calls and their labelling and categorisations showing how they were constituted and formulated (Sacks, 1992). In this case crew' categorisations reflect negative interpretations which question need and minimise their significance. These accounts utilise negative descriptors and language to categorise their work which denote crews' inferior positioning of it and dissatisfaction with the type of work they are being deployed to do and the implications this may have for their personal and professional identity of doing valuable, technically skilled work. As a contrast to positive work appraisal

which reinforces perceptions of 'real' emergency work, negative appraisal appears to accompany work which undermines their traditional identity and denies them opportunities to 'make a difference' in ways they expect and are able to do.

Crews' accounts show their frustrations and draw on specific individuals whose actions are called into question by them and implicate their assumption and expectation of a common knowledge and understanding by the public of what constitutes an emergency, what to do in such circumstances and when the use of the publics' own transport to hospital is appropriate. In their accounts crews drew on normative devices in which appeal is made to a commonality of knowledge; arguments used such as 'to everybody ...' linguistically create a large group of 'everybody' and are effective ways of suggesting that there is a generalised knowledge on when to call an emergency ambulance.

In their interpretation and categorisation of calls, crews are also doing identity work in presenting themselves as different from those they were describing (Antaki & Widdicombe, 1998) and who would not inappropriately use the emergency service. As such crews present themselves as particular types of people, different to those they are describing. Shotter (1984) suggests identity work can be used for moral purposes in presenting oneself as a particular kind of human being. He refers to the process of social accounting as part of the "ecology of everyday life" (Ibid p. x), whereby individuals engage with others in presenting themselves in particular, morally acceptable ways. Interaction Shotter (Ibid) says provides a platform and opportunities through which individuals can present themselves as those who know what is appropriate and abide by this in their own actions and behaviours. In the process of doing identity work, crews are presenting themselves as particular types of people; crafting their identity and simultaneously creating other types which are less favourable. Identity work can also create a justification and foundation from which to question the actions of others. Crews' construction and population of categories also display identity work in denoting what they perceive to be the role of the EMS and the kind of work they should be doing. They are thus doing moral work and identity work in distinguishing between what they consider to be appropriate and inappropriate and positioning themselves and others within these groupings. They are displaying features of what Becker (1963) calls 'moral entrepreneurs'. Crews' appraisal and categorisation of their frontline work in positive and negative ways suggest the interactive ways by which they 'negotiate' and reconstitute the social order of their work (Strauss et al; 1963) drawing on notions of identity, morality and normative ideology.

The concept of judgement and categorisation of patients by health care professionals is a well evidenced phenomenon (Becker et al 1961; Dingwall & Murray, 1983; Hillman, 2013; Hughes, 1980; Roth, 1972) with Accident and Emergency settings at the forefront of this (Hillman, 2013). Indeed Roth (1972) asserts there is no evidence that a professional education eliminates this tendency with the reverse more akin to the reality. Becker et al. (1961) highlighted the categorisation and judgement of patients by

medical students; reflecting both professional and personal values and in some cases, comment was made by students on a given patient's right and 'entitlement' to the use of the NHS. Health care professionals in their positioning within health care service provision cast themselves in positions of assessment and judgement of those who use the service and their perceived right to its use. Professionals' values and beliefs about the NHS; its' perceived right of access and entitlement and popular normative ideologies surfaced as features of some crew's interpretation of calls they attended. For example, in a call to what one crew member Len referred to as 'only food poisoning', (See pages 142, 143 & 144) he questions society and the public' expectation of the NHS as he put it 'to be there for everything'. Other crews likewise suggested an expectation that individuals perform some levels of self-care for what were perceived to be minor ailments and utilise their own transport to get to hospital. Also, during my participant observation crews would often complain to me about what they considered to be the inappropriate use of the EMS. Although I wasn't overtly asked for a response to their complaints these linguistic patterns vicariously draw on (imagined) support from everybody and me specifically to make the argument defensible, rational and significant and implicate their understanding of how this is to be convincingly communicated in this social context.

Crews' expectations of the public to undertake self-care and to access appropriate health care services independently in particular circumstances are recognisable in current, popular political views of neo-liberalism (Rose, 2000). The disfavour of 'big government' is coupled with deregulation, individualism and greater individual responsibility for health care (Pollack, 2010). Increased levels of responsibility however are predicated on assumptions and are accompanied by expectations of individuals (Lupton, 1995). The assumptions are that individuals have the requisite knowledge to make appropriate choices, have available resources and access to do this and on this premise can face blame and criticism when these are considered inappropriate by others including health care professionals (Anderton et al; 1989).

However, assumptions of a universal and equal socioeconomic, educational and health standpoint is not the reality and presupposes certain levels of knowledge, education and general health that users of the emergency ambulance service don't necessarily have. In an analysis of 'avoidable' emergency admissions in England over a 3-year period and the variables impacting on these, the most significant was deprivation related to unemployment and low income (O'Cathain et al; 2014). The researchers concluded that whilst other factors may be at play reductions in unnecessary emergency admissions necessitate a focus on deprived communities and how services can best support their needs as opposed to viewing deprivation as "nuisance" (p.54). The specific reasons for these differences require further investigation, although were suggested to be more than the higher incidence of morbidity and co-morbidities in these groups, with challenges in getting access to services a factor amongst deprived groups (Dixon-Woods et al; 2006).

My analysis suggests that in their interpretation and appraisal of calls some crews implicated an assumption of a common and universal knowledge and understanding of what an emergency is, how to determine it and what to do (See pages 139 & 140). However, these assumptions and the rather simplistic interpretations of legitimate need are questionable amidst research which highlights the difficulty and complexity of public' decision making in situations of illness (Ahlenius et al; 2017; Booker et al; 2019; Kirby & Roberts, 2012; Rantala et al; 2016).

Utilising an online survey, Kirby and Roberts (2012) reported that clear emergencies were easier to recognise in comparison with those not necessitating an emergency ambulance, which hints at the complexity the public may face without healthcare knowledge. In addition, studies focusing on the public' experience of decision making during sudden illness, provide understanding and what one calls "nuanced insights" (Booker et al; 2019, p.1) into the challenges and subjective factors which influence decisions to call for emergency help (Ahlenius et al; 2017; Booker et al; 2019; Rantala et al; 2016). These include a potential array of physical, social, emotional and psychological factors (See for example Booker et al; 2019) of which, EMS professionals may not be cognisant. This foregrounds potential differences between professional and public interpretation of legitimate need for the EMS.

In creating and populating the category of 'genuine', crews are simultaneously establishing another from which this differs (Sacks, 1992); that which is considered not genuine. My analysis suggests that crews' negative work appraisal was associated with particular types of emotional labour and emotion work. The degree and nature of interpersonal interaction (emotional labour) in what was perceived to be a 'genuine case' contrasted sharply at times with other calls in which crews questioned the legitimacy of the call. My observations and analysis suggest that such that the latter seem to evoke frustrations in crews which call for emotional labour in the form of surface acting (Hochschild, 1983, 2003), whereby emotions are superficially and temporarily suppressed and disguised to create and maintain an appropriate, professional display and perform the job at hand. Deeper feelings however remain intact and unchanged and as Hochschild (2003, p.37) says, "the body not the soul is the main tool of the trade". Crews attempted to 'disengage' from the patient, to avoid or reduce the frequency of interaction through the use of 'props'; in this case the PCR document (Prior, 2003), as a valid source of alternative attention. These actions are likely to have helped to minimise, though not eradicate the effort at emotional labour.

Discrepancies between crews' and the public' perception of need for emergency help also arose in calls where it was thought that the patient should have called for help sooner than they had and in some situations my analysis showed that crews failed in their attempts at emotional labour and the effective disguise and suppression of emotion. These failures at emotional labour appeared to create barriers to crews' their full engagement with the patient thereafter. These were a clear reminder to me of the importance of emotional labour in frontline service provision and particularly the care of vulnerable people. In highlighting the value of emotional labour, Hochschild (2003) argues no one appreciates an

ill-tempered manner and failures although common are stark reminders of the delicacy of human civility, "...what the social carpet actually consists of and what it requires of those who are who are supposed to keep it beautiful" (p.9). My study develops the theory of emotional labour through the implications of its successful performance in the EMS context but also highlights the failures and reluctance of some crews to deliver it and the potential implications for those in need of the service.

My study findings and analysis indicate however that variations exist in how the crews perceive and interpret calls, which has implications for emotional labour in differing sorts of ways. Whilst some crews appeared to assume a universal knowledge of when to call and what to do in particular circumstances, this was not the case for all of them. Some EMS crews showed an awareness of the patient's subjective interpretation of their situation and the anxiety and uncertainty which may accompany sudden illness. Empathy is used which enables appreciation of the patient's interpretation of their situation and allows a framing of the call, which is more permissive, less judgemental and problematic. Negative feelings are avoided or dissipated, obviating the need for emotional labour to disguise and suppress. These alternative appraisals of individuals who call the EMS unnecessarily enable crews to deal with them professionally and present a rationalisation for their behaviour that allows provision of a service in the way that aligns with their professional identity. These are examples of deep acting strategies (Hochschild, 1983, 2003), whereby internal feelings are altered and changed through manipulation and which results in a differing appraisal of the issue. Hochschild (Ibid) reported the use of deep acting in the recurrent training of flight attendants who were encouraged to reappraise difficult passengers through for example empathy, imagery and emotional memories to facilitate the delivery of a positive passenger experience. Hochschild (Ibid) draws on Marxist and Darwinian theories to critically question the use of these and the implications for the individual; for example, manipulation of feeling interferes with the 'signal function of emotion' which represents our positioning and response to external threats and issues. Hochschild (Ibid) suggests this can lead to alienation between true self and feelings however, her evidence of this is lacking.

Hochschild (Ibid) presents a somewhat deterministic and negative view of deep acting, perhaps informed by the particular context of her study and theoretical influences. However, my findings add further to the theory of emotional labour by suggesting that deep acting; a reappraisal and perspective of the issue at hand offers public service workers a strategy to effectively deal with and diffuse the frustrations which can accompany their work and enable them to remain engaged and professional.

In the next section I will clarify and consolidate the unique contribution of my thesis to theory, to the work of the EMS, to education and research.

8.3 The unique contribution of my thesis

The knowledge and understanding gained from my thesis have offered unique contributions to the theory of emotional labour and emotion work in the emergency pre-hospital care context, to EMS work, to learning and education, and to research.

8.3.1 Contributions to the theory of emotional labour and emotion work in the EMS

My study builds and expands on earlier theory on emotional labour and emotion work (Hochschild, 1983, 2003) and examines its' applicability to the particular context of the emergency ambulance service and the specific emotional challenges of this work.

My study locates the sources of emotional labour and emotion work within the nature and type of EMS work and suggests these are closely linked to perceptions of the role of the emergency ambulance service, perceptions of work they think they should be doing, to expectations of the public in managing and maintaining health and knowing when to call 999.

My study highlights the use of surface acting; wherein feelings are disguised through the alteration of external expression in the context of frontline work and contributes further to understandings of how emotions are managed. However, as highlighted in the examples, emotional labour can have various degrees of success or failure. Demands for emotional labour were in some instances met with disengagement which was facilitated through the use of 'props' as plausible distractions and diversions to patient interaction. As such these develop the theory of emotional labour to illustrate failures to undertake and deliver it and the implications this may have for the interactions between those who provide and those in receipt of the service. My findings suggest that whilst strategies such as disengagement work to reduce face-to-face interaction and thus efforts to disguise and suppress unwanted emotions, in doing so they have implications for the care that is offered and available. Emotional labour is important in overcoming, dealing with and managing emotions which arise from work and enable the provision of a caring, professional approach in spite of these.

Deep acting, the manipulation of internal feelings through reappraisal and imaginative methods such as empathy were alternative strategies used autonomously and successfully by some crews. Hochschild (1983, 2003), set her interpretation of deep acting within the backdrop of the airline industry and Delta airlines specifically, who through 'recurrent training' embedded its use, with potentially negative consequences for the workers. However, my study suggests the use of deep acting by crews of their volition importantly, with good effect. The reappraisal and reframing of work was accompanied by permissiveness and tolerance and enabled a caring, professional, sensitive and engaged response. This offers an effective strategy to help these professionals deal with and manage the emotional challenges and frustrations which can accompany their public service-facing work.

My study highlights and reinforces the value of emotional labour in the context of the emergency ambulance service and the strategies which may assist and enable the provision of it.

8.3.2 Contributions to understanding of EMS work

My study has provided unique, contemporary understandings of frontline EMS work and the potential implications of these for emotional labour and emotion work, which have not been previously explored.

The demands for emergency health care provision are reportedly on the increase (Ambulance Services, 2015) and there are significant challenges in meeting this need and implications for service providers and the roles they are expected to undertake. My research has begun to highlight some of the challenges faced by this neophyte professional group in maintaining its professional identity, its historical and traditional role amidst changes in health care provision and increased public demand and expectation of this service. Whilst changes and adaptations may be seen as expedient and justifiable in meeting immediate health care need, they implicate significant role changes for this professional group. My research findings suggest the implications of role changes and role demands that conflict with role expectations and hint at the effects of these on the emotional demands of this work, including emotional labour and emotion work. My study suggests links between role expectation, role identity and role fulfilment and the implications for emotional labour, which have hitherto been given minimal attention.

My study has also offered unique understandings of how the emotional demands of contemporary EMS work are handled and managed, in differing ways, using differing types of emotional labour with differing implications for caring and interaction, in their frontline work.

The concepts of appraisal and categorisation in healthcare work are not new phenomena (Dingwall & Murray, 1983; Hillman, 2013; Roth, 1972), including emergency ambulance work (Henckes & Nurok, 2015; Hutchinson, 1983; Palmer, 1983), however my study offers unique contributions to the implications these have for emotional labour, caring and emotion work. My study offers links between work appraisal, categorisations and valuing and underpinning normative, ideological beliefs regarding health and their mobilisation by this professional group.

The emotional demands of contemporary emergency ambulance work have implications for staff welfare and wellbeing and place responsibility on the organisation to offer sources of support. My study has suggested the use of informal colleague support mechanisms through crew room interaction and talking to express work-related frustrations and difficult experiences. These may reflect the valuing of traditional sources of support; however, my study suggests that these may not be acceptable and appropriate for all and necessitate other strategies.

Humour is a feature of the culture of emergency health care practice which may offer positive outcomes for these professionals. However, my study suggests that humour which is generated through mockery

of individuals can necessitate additional demands for emotional labour which need to be considered against the perceived benefits for a few. A professional culture which places humour and mockery as an accepted and expected part of it fails to appreciate the potential deleterious effects this may have for those involved and to protect its members.

8.3.3 Contributions to the learning and education of EMS staff

The findings of my study offer unique contributions to the learning and education of emergency pre-hospital care professionals in preparation for the emotional challenges of their contemporary frontline role.

My study suggests that the educational preparation for a role in the EMS needs careful consideration and development to reflect the contemporary demands of pre-hospital service provision. The emergency ambulance service has a historical identity characterised by emergency trauma, resuscitation, medical emergencies and the use of technical skills (Blaber, 2008), which continue to dominate the focus and nature of pre-registration paramedic educational curricula (College of Paramedics, 2019). Emergency skill acquisition and clinical competence are crucial elements for this role however, they need to be combined with attention to the assessment and management of wider mental and social health problems, clinical decision making, alternative pathways of care, referral and the complexities of multidisciplinary team working to enable role competence and fulfilment. These health care professionals need to be appropriately prepared and equipped to manage the complexity of what is increasingly the nature of frontline need. Educational preparation which reflects, informs and underpins the nature of health care need can enable a wider role and appreciation of alternative ways of 'making a difference' and achieving role fulfilment.

My study shows the potential feelings and emotions which accompany frontline emergency care work and public service interaction where emotional labour is needed to disguise and suppress emotion, through superficial and deep acting to maintain an appropriate professional demeanour. My study findings highlight the importance of emotional labour to enable professionals to handle emotions in ways which enable their continued engagement in interaction and care giving. My study suggests that the initial and continuing educational preparation for a role in the emergency ambulance service must include attention to the potential emotional challenges of the role and to the value of emotional labour. Self-awareness and recognition of personal values, beliefs and expectations and the implications of these for judgement, responses and the care given are important components of professionalism. The responses of emergency health care professionals to those who are vulnerable have the potential to impact the experience in both positive and negative ways and may influence appraisal of the service and its future use by those who need it (Prener & Lincoln, 2015; Rees et al; 2015). EMS professionals operate at a level of immediate access to health care services and the National Health Service, and their role and its potential impact must be part of their educational preparation.

My experience of participant observation with the EMS highlighted the diversity and complex nature of calls to which they respond and the circumstances which impact on the decision to make a call for help. Educational preparation for a role in the emergency ambulance service would benefit from recognition of the complexity, subjectivity and difficulty of decision making when calling for emergency help, particularly in situations where there is not a clear medical emergency. Booker et al. (2019), suggests such calls may be attributed the generic labelling of 'inappropriate'. The findings offer what the authors call "nuanced insights" (p.1) into factors which influence help seeking behaviours and serve to challenge the uncomplicated perception and categorisation of these calls as simply inappropriate and abusive of the service and the callers problematic. The term 'inappropriate' has negative connotations which suggest something is not suitable or is improper (Collins Dictionary, 2020) and intimate at wrongdoing. Inappropriate also whilst a functional descriptor which serves to differentiate, categorise and label calls, also obscures the underpinning factors which may influence decisions to call an emergency ambulance when alternative options are considered more suitable. Understanding of the significance of the person's subjective appraisal and perception of their situation and an appreciation of the difficulty of public judgement as part of the educational preparation for the EMS can support alternative interpretations and responses from them. Professional appreciation of the challenges for the public can facilitate the use of deep acting, enable a more sympathetic response and reduce levels of frustration and concomitant superficial emotional disguise and suppression.

My study findings suggest discrepancies between the role expectations of the EMS and the reality of service provision and the potential impact on role satisfaction and staff retention in the emergency ambulance service. Amidst demands for emergency health care provision and for the development and expansion of this professional group, recruitment and retention of staff are essential considerations. Recruitment to the emergency ambulance service should be carefully augmented to attract and invite suitable candidates through a realistic portrayal of the role and the work involved and the value associated with it.

The findings of my study also draw attention to the role of the ambulance service in the education of the public as users of its service. The provision of clear information on its role and situations which constitute its appropriate use, alongside alternative sources of health care support and advice have the potential to enhance the emergency ambulance service. An active role and clear communication strategy to enhance public knowledge and understanding of the role of the EMS would enable appropriate choices to be made. This education could extend to include other health care professionals such as doctors, general practitioners, nurses, social workers and home care managers who utilise the emergency ambulance service.

8.3.4 Contributions to research

Despite the significance of emotional labour and emotion work as part of emergency ambulance work, it remains a comparatively under researched and neglected aspect of this work. My research study has contributed unique understandings of the emotional challenges which accompany contemporary, frontline emergency pre-hospital care and the links these have to the nature of work and their perceptions of their role and the role of the EMS. My research has expanded on the use of categorisations in healthcare work, including the emergency ambulance service and the implications these may have for emotional labour and emotion work and how this work is handled in this cultural context. These are tentative associations and suggestions which should be developed through further research investigation.

Further research into the emotional demands of emergency ambulance work should develop and expand knowledge and understanding from wider perspectives and differing geographical, frontline service settings in the UK and international locations. These may build on my findings here and offer further and perhaps alternative perspectives on emotional labour and emotion work and how it is perceived and handled. Collectively, further research into the subject of emotional labour in the emergency pre-hospital care setting can contribute to the development of a body of knowledge and understanding about the emotional dimension of this working environment.

My research has contributed unique understandings of the place of backstage activities in this context and the potential of these in enabling the processing of emotions arising from frontline work. My findings suggest that whilst helpful for some, these strategies are not beneficial or suitable for all. Further research should explore the views expressed by participants in my study and examine the place opportunities for crew room interaction hold in supporting the processing of emotions accompanying frontline roles.

8.4 The limitations of my study

There are limitations associated with my research study which have arisen from my performance as a researcher and from the specific methodological approach I used to underpin and guide it.

My study focuses on one emergency ambulance station and the EMS crews within it and as a consequence my findings can only be perceived to reflect those involved. They cannot be considered to reflect and represent the perspectives and views of other EMS crews in differing settings and are not necessarily transferable.

Despite my efforts to engage with crews I found that some were reluctant to allow me to participate in and observe their role which inevitably impacted on who and what I have been able to include in my

study. This limitation has been a concern to me as a researcher which is important to acknowledge. However, I appreciate that this is a potential aspect of undertaking an ethnographic study.

My experience of ethnographic research is limited and my lack of adeptness at participant observation and interviewing techniques may have, at times, affected the quality of my research and its findings. More specifically on reflection my questioning techniques during individual interviews with participants could have been more direct in parts and perhaps more directly focused on how participants felt, particularly given the nature and intention of the study. I attribute my reluctance to my concern to avoid leading or suggesting concepts to participants. I have been keen to allow participants to tell their story and for this to develop naturally from their perspective. Having now undertaken my study and analysed my findings I appreciate that this is a fine balance when conducting ethnographic enquiry; so that pertinent areas are explored whilst also allowing sufficient scope to enable and to capture the individual perspective.

My efforts at participant observation in the field of emergency health care were a persistent challenge and concern for me as a nurse. I found myself automatically taking a role in helping and on some occasions adopting a role alongside the crews, particularly in emergency resuscitation and situations needing an urgent response. My active involvement and participation whilst helping me to integrate into the setting and be less obvious as a researcher, also diverted my attention away from the role of researcher and the perspective of the observer and may have impacted on what I was able to recall and write up in my fieldnotes. However, as time progressed I learnt to remind myself of my role and intention in being in this context.

My periods of participant observation were regular, although as a whole necessarily fragmented, which impacted on the continuity of my relationships, familiarity with crews and their acceptance of me. Also, the duration of my episodes of participant observation were influenced by the time available to me as a part-time student with a full-time academic job and the time needed to fully record the details of what I had experienced, what had been done and said and to record my reflective interpretations of these. These practical contingencies may have impacted on the quality of my findings.

Ethnography focuses on people in their natural environment, using unstructured methods and the active involvement of the researcher to ultimately uncover human behaviours and their social meanings (Brewer, 2000). These methods of inquiry, with close sustained involvement with people of interest to the researcher have the potential to influence the setting and subjects and impact on the authenticity of what is seen (Aull Davies, 2008). This is a challenge and possible limitation which is difficult to predict and ascertain, however its potential is important to acknowledge.

Ethnography necessitates and prescribes a central place for the researcher in the capture, interpretation, analysis and presentation of data and findings (Bryman, 1988), which create challenges for the researcher in the representation and legitimation of what is reported. These challenges of ethnographic investigation have the potential to introduce methodological limitations and considerations for the researcher in the conduct of the research. As a registered nurse and nurse educator my positioning and the potential impact of this have been a constant companion throughout my study. My attempts to assuage these possibilities have included the use of an analytical realist approach (Altheide & Johnson, 1998), in which I have maintained a critical awareness of myself as researcher in the setting, my views, beliefs and perspectives and importantly their potential impact on both the process and the products of my study.

8.5 Conclusion

In this chapter I have discussed my analysis and interpretation of the findings of my study and the conclusions drawn from them. These have been linked to existing, pertinent literature and theories of emotional labour and emotion work. Attention has been given to the specific contribution of my study findings to the theory of emotional labour and emotion work, to the work of the EMS, to education and research. The limitations arising from my study have also been examined.

My discussion began in the backstage context of Bryn Station, the base of my study and my first point of contact with the setting. This showed the organisational structure, the routines and patterns of work and the usual gathering points for EMS crew members; in particular, a large crew room, exclusive to them. This signified the positioning of the EMS, within the wider structure of the ambulance service and features of "negotiated order" (Strauss et al; 1963, p.147).

The EMS crew room was a central area for regular crew gatherings and interactions; it was where crews complained, moaned and expressed the frustrations arising from their frontline work with each other. My analysis suggests, however that not all crews engaged in this and some perceived moaning and complaining to not help at all.

Humour, teasing and mockery were frequent features of crew room interaction, described by some crews as valuable in enabling them to relax and handle the challenges of their work. However, this was not a universally held view. My fieldwork observations and analysis led me to conclude that the mockery of some crew members was perceived to 'go too far' and as such may have necessitated the use of emotional labour in the disguise and suppression of feelings (Hochschild,1983, 2003). Humour is suggested to have functions of enhancing group cohesiveness, camaraderie and inclusivity (Hutchinson, 1983), however can also reflect and reinforce hierarchies (Collinson, 1992; Goffman,

1971) and can be difficult to handle (Collinson, 1992; Green et al; 2010). My findings suggest that humour, mockery and teasing, whilst beneficial for some, may necessitate additional emotional labour for others.

The crew room was also perceived to offer valuable opportunity for EMS crews to talk to their colleagues about the 'difficult' calls they had attended, to share their concerns and receive the reassurance they sought from those who they said understand. Reliance on internal sources of support from colleagues is a reported feature of the context and culture of the EMS context (Bohström et al; 2017; Clompus & Albarram, 2016; Williams, 2013b). The suggested reticence crews may have in challenging each other may be a limitation of this informal support strategy but also recognition of the complexity and difficulty of their work and their support of colleagues.

My analysis shows how EMS crews interpret, appraise and categorise calls in positive and negative ways, using locally produced signifiers and categories and the implications these have for differing forms of emotional labour. Differing work appraisal is linked to crews' perception of the EMS, of their role and social expectations of the public. Positive call appraisal was linked to perceptions of 'making a difference' through the use of emergency life-saving skills and 'genuine' need for the EMS. These reinforced their identity and enabled role fulfilment and the positive emotional sequelae. EMS appraisals and categorisation of their work reflect the valuing of traditional roles of the emergency ambulance service (Hutchinson, 1983; Nurok & Henckes, 2009; Palmer, 1983; Wankhade, 2016) and work which is visible, technically skilled and which evokes positive emotions. Categorisations created by crews perform identity work in denoting what they consider to be the legitimate work of the EMS, what they should be dealing with and what upholds the professional identity they value, amidst threats to it. My analysis suggests that crews handle the paucity of opportunities to make a difference in traditional ways through the long-term emotional effects of these situations. Some crews worked to reappraise, redefine and broaden their perception of making a difference to enable access to the positive emotional outcomes. Perceptions of 'genuine' need for the EMS were associated with crews' efforts to undertake emotional labour, though empathy, caring and compassion.

Crew' appraisals of work in negative ways were linked to questions of their perceived legitimacy of need for the EMS and their role and my analysis suggests that these necessitated emotional labour in the disguise and suppression of frustration and the presentation of an appropriate professional display (Hochschild, 1983, 2003). However, as highlighted in the examples, emotional labour can have various degrees of success or failure. Crews drew on available 'props' to divert attention and interaction from the patient and as such reduced the demands for emotional labour. My study also highlights the failures in emotional labour and the implications for those involved. My analysis however suggests that some

crews perceived calls in differing ways which enabled them to labour emotionally through deep acting (Hochschild, 1983, 2003) and provide care to vulnerable patients.

My discussion has highlighted that categorisations are an established phenomenon of healthcare work (Becker et al; 1961; Dingwall & Murray, 1983; Hillman, 2013; Hughes, 1980; Roth, 1972). However, the specific implications for emotional labour and emotion work are less clear. My analysis suggests that popular normative ideologies in health care appear to influence positive and negative categorisations, create emotions and feelings amongst crews and coexist with differing kinds of emotional labour, behaviours and interactions from them.

The opportunity to examine and discuss my study findings has enabled me to revisit the totality and complexity of what I have found and to synthesise key issues in a meaningful way which communicates my interpretation and understanding of the emotional challenges of EMS work, how these are perceived by the crews and the ways in which they are processed and handled by them. The findings of my study have made unique contributions to the theory of emotional labour and emotion work, particularly in the context of emergency pre-hospital care. They have also contributed to understandings of contemporary EMS work and to the educational preparation for the role. Educational preparation for roles within the EMS should reflect the complexity and include the knowledge and skills needed to instigate alternative pathways of care, through team working, clinical decision making and effective communication. Educational preparation should include attention to the emotional demands of emergency work and the performance of emotional labour and appreciation of the difficulty of public decision making in situations of potential panic and uncertainty.

Recruitment to the EMS should include realistic portrayal of the practice and role involved and attention should be given to the provision of clear information to the public on the role of the emergency ambulance and alternative sources of help and support.

Organisationally the ambulance service needs to show recognition of the implications and demands of role changes within the EMS and the frustrations which may arise for crews and ensure appropriate and acceptable support strategies are in place. Whilst humour is a recognised feature of emergency care culture (Christopher, 2015), organisational and leadership consideration should be given to the potentially negative perceptions of humour and mockery for some crews.

My unique contributions to research include understandings of emotional labour and emotion work in the context of contemporary emergency pre-hospital care and to how this is handled. Opportunities arise for further research on the emotional labour and emotion work which accompanies the work of the

emergency ambulance service, the implications this may have for care and interaction and the role of crew room and other backstage support in the processing of emotions which arise.

I have considered the limitations of my study which relate to my performance as a researcher and novice ethnographer and to the particular methodological approach I have used. Limitations have arisen from my focus on one ambulance station and EMS site, my skills in participant observation and interviewing techniques and the willingness of those in the setting to participate, which may have impacted on the quality of my data.

Limitations emanate from the challenges I experienced as a nurse in mastering a balance in the level of participation and observation effectively in a setting where I could and felt a duty at times to contribute. In doing so my attention and role moved away from researcher to participant. Limitations to my study also relate to the episodic nature of field work which impacted on the continuity of my relations within the field and with my involvement and acceptance within it. I felt tasked with the need to re-establish and reintegrate into the field at the start of each episode of participation. The periods of time I was able to dedicate to participant observation were necessarily circumscribed due to my position as a part-time student and full-time educator, which impacted on what I was able to see, hear and witness.

Limitations can arise from the methodological approach of ethnography which utilises the close involvement of the researcher in the setting, collection of data and the analysis and presentation of findings and the challenges these create. I have been mindful of these issues throughout and have utilised a critical, reflective approach to enhance my awareness of my positioning and impact on the context of my study and my attempts to authentically present the views of those who are central to it.

8.6 Conclusion to my thesis

My intention in undertaking this study has been to explore the emotional aspects of the work of the emergency ambulance service, how this work is described, handled and managed from the perspective of those who deliver it. My aim has provided an opportunity to undertake an ethnographic study, situated within the cultural organisational context of the emergency ambulance service; its frontline work and backstage crew room setting.

Bryn Station, a large inner city, urban ambulance station in the UK has been the focal point and base from which I observed and participated in the work of EMS crews in their response to emergency calls. Individual, in-depth research interviews were conducted with various EMS crew members on their role, their perceptions of the challenges of their work and how they deal with these and some context dependent, documentary sources have been integrated into my portrayal of this cultural work setting.

My experience of involvement and participation with this professional group has enabled me access to the front stage and backstage contexts of their work, their perceptions of the challenges and frustrations

which accompany their role, how they perceive their role and the role of the EMS and how they respond to the threats to it through categorisation devices, account giving, moral work and features of "negotiated order" (Strauss et al; 1963, p.147). In later work, Strauss (1978) intimated at the complex nature of social order and the potential for negotiation which he says needs to be ascertained,

> not everything is either equally negotiable or—at any given time or period of time—negotiable at all. One of the researcher's main tasks, as it is that of the negotiating parties themselves, is to discover just what is negotiable at any given time (p.252).

The complex, interactional interface of ambulance service work, both internally and externally offer opportunities for negotiation work and crews' interactions with each other, with other ambulance service members (such as patient courier service and urgent care services), patients, relatives, the public and other health care professional groups such as nurses and doctors exemplify negotiation and contain both explicit and implicit ordering of the social sphere in which they operate.

My analysis has highlighted the crews' appraisal and categorisations of work in positive and negative ways and has suggested the implications of these for emotional labour and emotion work.

Against this frontline context of their work, the station and crew room offer crews opportunities to moan, complain and talk about the 'difficult' calls to each other and to process their emotions. Humour derived from teasing and mockery were regular features of crew room interaction which some crews regarded favourably whilst others did not. My findings collectively suggest the interrelationship of front stage and backstage work contexts and hint at the complementary relationship between them in the emotional labour of the former and the emotion processing work of the latter.

My aim and objectives in undertaking this study have been met through my presentation and discussion of findings on emotional labour and emotion work as aspects of emergency pre-hospital care, a central component of frontline service work and importantly the cultural meaning and significance to this group of emergency professionals. My findings contribute unique understandings of emotional labour and emotion work in this work setting which have implications for the educational preparation for this role and provide a foundation for further research on this topic.

The opportunity to undertake and complete my study has contributed to my learning and development in a number of aspects. My study has enhanced my understandings of the theory of emotional labour and emotion work and to the ways these are handled and managed in emergency settings. I have developed understanding of how different types of work are valued by these emergency frontline workers and how this differs to my own perspective as a nurse. Through my analysis I have been able to appreciate the nuances of emotional labour and its value in the context of emergency ambulance work, when interacting with the public, particularly when dealing with vulnerable patients.

Undertaking my study has developed my initial, limited understanding of ethnography and of the philosophical and epistemological underpinnings which guide and inform it. I have developed my knowledge of research methods, data capture and recording, data analysis and the concept of the "active interview" (Holstein & Gubrium, 1995). Doing an ethnographic study has enabled my understanding and appreciation of the challenges of entering a different cultural setting, of the physical, emotional, social and psychological demands which can accompany this. I had no real concept of these before starting my study. Indeed, many of these cannot be reliably predicted or anticipated before starting a study and getting into the field. I had not, for example, been used to shift work and early starts for some time or limited, set break periods, limited opportunities to use toilet facilities and regular experiences of motion sickness. As a nurse I constantly felt the urge to help whenever I could in the care of patients, and this often concerned me and the impact this may have had on my study.

I have found doing an ethnographic study can be emotionally demanding in relation to the maintenance of interpersonal relations and interactions with those in the setting, the effort to socialise, to interact, to gently probe and at times to remain quiet rather than say what is thought and felt. In this sense doing ethnography has placed demands on my emotional labour in differing ways.

I have come to appreciate that the success of ethnographic endeavour is greatly dependent on the possession of social skills, of willingness to be 'uncomfortable', vulnerable, an outsider to the social group under investigation, constantly vigilant and reflexive, resilient and determined. I have learnt that ethnography requires a delicate balance of social relations for the purpose of doing research and finding out what is going on in a social setting from the perspective of those who are embedded within it. These areas of learning about doing research are complementary to the knowledge and understanding gained about the topic under study. In undertaking my research study, I have gained knowledge of both.

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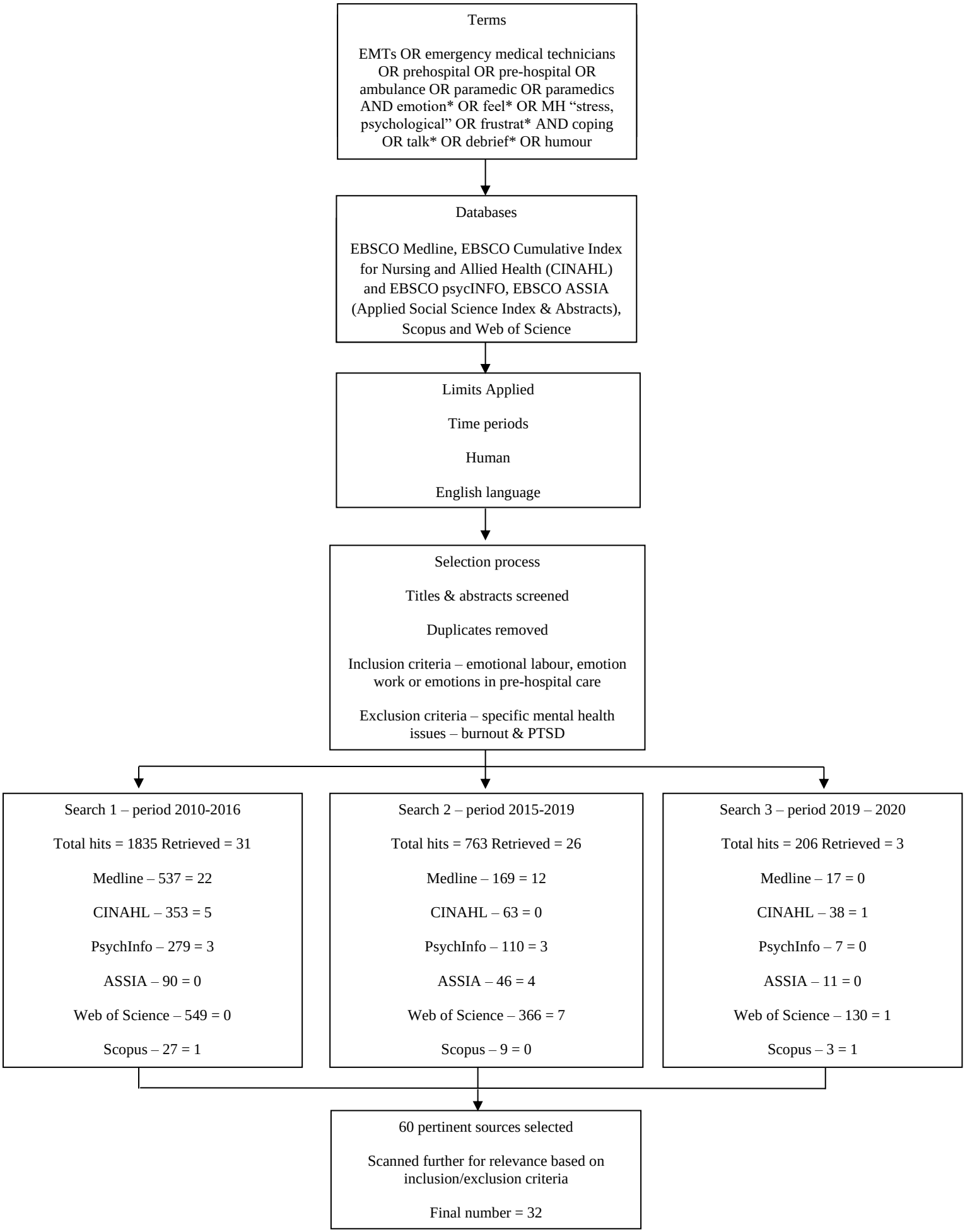
Appendix 1

Record of literature search, retrieval & selection

Record of literature search, retrieval & selection



Appendix 2

Methodological critique of the literature

Methodological critique of the literature

Study	Sample & setting	Aim, design & analysis	Limitations
Ahlenius, Lindstrom & Vicente (2017)	32 written complaints from patients based on identified criteria selected from 3 ambulance stations in Stockholm.	Investigation of patients' experience of poor treatment from ambulance service/qualitative/review of written complaints/framework method of analysis by 3 researchers.	Confined to one city. Based on memory and recall of events. Relies on patients' perception only. Relies on accuracy and detail of written complaint.
Avraham, Goldblatt & Yafe (2014)	15 paramedics in one emergency organisation in Israel. Selection based on age, gender & experience.	Explore paramedics' experience of critical incidents and coping strategies/qualitative/phenomenological study/semi-structured interviews/thematic analysis/bracketing, reflexivity, audit trail and credibility measures included.	Based in Israel – transferability to UK may be limited. Small scale.
Bochantin (2017)	36 Public safety employees (PSEs) – 18 police officers and 18 firemen. 59 family members. In USA.	Explored the use of humour among PSEs and their families/qualitative/Semi- structured interviews with employees & focus groups & interviews with family members/thematic analysis/member checking reported to enhance credibility of findings.	Focused on police and fire service not ambulance service – limits transferability to other emergency contexts.
Bohström, Carlström, & Sjöström (2017)	15 ambulance nurses across 4 ambulance stations in Sweden.	Explored perceptions of stress and coping strategies among ambulance nurses/qualitative, descriptive design/face-to-face & telephone interview/ used critical incident technique/structural analysis mentioned/not detail on measures to enhance trustworthiness.	Focused on ambulance nurses which may limit applicability to paramedics and EMTs. Small sample. Based in Sweden – transferability to the UK may be limited. Little detail on process of data analysis and trustworthiness.

Booker et al (2019)	50 cases selected based on clear, transparent inclusion criteria. Drawn from one ambulance setting in the UK.	Explored the factors influencing a decision to call 999 ambulance in primary care sensitive conditions/qualitative, ethnographic study/observation/interviews/fieldnotes/documentary sources/patient/professional/family/carer perspectives/thematic analysis used across cases/clear & transparent coding presented/reflective diary used.	Drawn from one ambulance setting which limits transferability. Limited detail on measures to enhance trustworthiness.
Boyle (1997)	Emergency ambulance service staff in one large geographical setting covering Queensland, Australia.	An investigation of emotionality, organisational culture and masculinity in emergency pre-hospital care/qualitative/ethnography/500 hrs participant observation/30 in-depth interviews/little specific detail on data analysis/reflexivity evident in thesis.	Based in EMS setting in Australia – may limit transferability to UK context.
Clompus & Albarran (2016)	7 paramedics in one ambulance setting in the UK. Self- selected sample using paramedic bulletin.	Explored paramedics' experiences of work-related emotional challenges and how they developed their resilience/qualitative study/ 2 individual interviews with each paramedic/ thematic analysis/credibility enhanced through member checking and researcher triangulation.	One setting in the UK which limits transferability. Self-selecting sample recruited from a paramedic bulletin can introduce bias.
Drury et al (2013)	102 emergency pre-hospital care providers – some with specialist skills. Drawn from 2 ambulance services in the UK. Self-selecting sample.	Investigation of the psychosocial care needed by those affected by major incidents and emergencies/quantitative/online survey method/Delphi technique/3 rounds/SPSS used to analyse levels of consensus.	Self-selecting sample may not be typical and representative of the population – limits generalisation.
Gouweloos-Trines et al (2017)	813 pre-hospital care providers in 8 western countries – UK, USA, Germany, Austria, Australia, Canada , Switzerland & New Zealand.	Investigation of levels of distress following critical incidents and what work-related social support helps to reduce this/quantitative/cross- sectional online survey/questionnaire included various measurement tools/statistical analysis using SPSS.	Limitations of self-report measures – social desirability, ability to self-assess, accuracy of recall & comprehension of questions – affects validity.

Halpern, Maunder, Schwartz & Gurevich (2014)	201 paramedics, EMTs & their supervisors in one ambulance organisation in Canada.	An investigation of the effects of downtime after critical incidents in emergency ambulance workers and effects on emotional outcomes/quantitative/online or paper survey of staff attending mandatory study/questionnaire included valid measurement tools/statistical analysis/SPSS.	Convenience sample used which limits generalisation. Limitations of self-report – social desirability, accuracy of self-assessment and recall – affects validity.
Henckes & Nurok (2015)	Two EMS settings; one in Paris and one in New York	Examines emotion work in pre-hospital care context by emergency teams/based on earlier study (Nurok 2007)/fieldwork/observation/informal discussion/fieldnotes/secondary analysis of data/recoding of data/little detail on measures to enhance trustworthiness.	Little detail on measures to enhance trustworthiness.
Hillman (2013)	One A&E dept in UK.	An examination of the process of negotiation, categorisation and treatment of elderly patients in A&E/qualitative ethnography/observation/fieldnotes/interviewing of patients, staff & relatives/ 4-year period/250 hours/50 patients/15 patients interviewed/thematic analysis/reflexivity/respondent validation sought.	Based on one setting – limits transferability to other settings. Focused on the elderly specifically – limits transferability to other age groups.
Hochschild (1983)	Flight attendants, supervisors & debt collectors at Delta Airlines, America.	A study of the commercialisation of human emotion in the airline industry/based on previous study of emotional manipulation in survey of 261 college students/qualitative/observation/interviews.	Specific context of airline industry – limits applicability to other public service settings. Influenced by Marxist views on exploitation of the worker & predictions of negative outcomes of emotional labour.
Hörberg, Kalén, Jirwe, Scheja & Lindström (2018)	230 ambulance nurses from 11 universities in Sweden.	Most important sources of support for graduate ambulance nurses in the first year/quantitative/survey/postal or online questionnaire/statements drawn from a Delphi study/statistical analysis using SPSS.	Specific to ambulance nurses in the first year after graduation – limits

			applicability to other groups. Limitations of self-report measures – comprehension, social desirability, self-awareness and ability to self-assess.
Hutchinson (1983)	Ambulance & fire rescue workers in one service station in America.	An investigation of the challenges of rescue work and coping strategies/qualitative/grounded theory/participant observation/interviewing/little detail on data analysis/reflexivity evident.	Focused on one setting limits transferability. Sample not specific to ambulance workers only. Historical views which may not reflect current perspectives.
Kirby & Roberts (2012)	150 members of the public – convenience sample of family, friends & colleagues.	Determine ability to correctly decide when an emergency ambulance is necessary and who may not/quantitative/online survey/questionnaire including 12 vignettes/statistical/SPSS.	Convenience & snowball sampling – biased sample – not representative & not generalisable.
Nilsson et al (2015)	37 emergency service responders from the military, police and treatment room in Norway & Sweden.	Investigate reactions of emergency responders to acute situations of moral concern & cumulative stress /qualitative/semi- structured interviews/grounded theory approach to data analysis/no discussion of measures to enhance trustworthiness.	Uses a mixed sample of professionals with different issues. Sample does not include emergency ambulance workers – limits transferability. Snowball sampling limits transferability beyond the sample.
Nurok & Henckes (2009)	Two EMS settings; one in Paris and one in New York.	Examines emotion work in pre-hospital care context by emergency teams/based on earlier study (Nurok 2007)/fieldwork/observation/informal discussion/fieldnotes/secondary analysis of data/recoding of data/little detail on measures to enhance trustworthiness.	Little detail on measures to enhance trustworthiness.

Palmer (1983)	One EMS setting in America.	An investigation into the work-related concerns of paramedics and EMTs/qualitative/ethnography/observation/interviews/documentary sources/ little detail on process of data analysis/no discussion of impact of 'insider' status of researcher as an EMT.	Focused on one setting which limits transferability. Little attention to potential impact of 'insider' status of researcher on process & findings of the study – can affect credibility. Historical views which may not reflect current perspectives.
Prener and Lincoln (2015)	One urban, EMS agency in America.	Explored experiences and attitudes of EMS staff in dealing with patients with mental health and substance abuse problems/qualitative/observation/interviews/thematic analysis/measures to enhance trustworthiness reported/researcher triangulation.	Small scale and confined to one setting – limits transferability to other contexts.
Rantala, Ekwall & Forsberg (2016)	12 patients in one A&E department in Sweden.	Explored experience of patients who had called the emergency ambulance service but were considered to not necessitate A&E care/qualitative/phenomenological/telephone interviews/thematic analysis/reflexivity & researcher triangulation used to enhance trustworthiness.	Small scale and confined to one setting – limits transferability to other contexts.
Rolfe, Pope & Crouch (2020)	21 paramedics & 20 patients/family & carers in one English ambulance service trust.	An investigation into how paramedics respond to and manage patients with mental health problems /qualitative/240 hrs observation & 11 interviews with paramedics/data analysed using frameworks/trustworthiness reported through reflexivity, member checking, researcher triangulation.	Confined to one ambulance setting in the UK – limits transferability.
Setti, Lourel & Argentero (2016)	782 rescue workers (over 70% ambulance workers) in Italy.	An investigation of the impact of affective commitment and perceived social support as a protective strategy against burnout and vicarious traumatisation/quantitative cross-sectional survey/questionnaire & measurement tools/validity & reliability of tools not discussed for all/statistical analysis/SPSS.	Limitations of self-report measures – social desirability, ability to self-assess, accuracy of recall & comprehension of questions – affects validity. Self-selecting sample limits

			generalisation .
Sliter, Kale & Yuan (2014)	179 firefighters in USA.	Investigation into traumatic stressors and PTSD symptoms, burnout and work absenteeism and the buffering effects of humour/quantitative/questionnaire/postal and online/survey/statistical analysis.	Limitations of self-report measures – social desirability, ability to self -assess, accuracy of recall & comprehension of questions – affects validity. Sample focused on firefighters which limits applicability and transferability to other emergency workers.
Steen, Naess & Steen (1997)	33 paramedics in Oslo, Norway.	An investigation of paramedics' decision making in cases of cardiac arrest and resuscitation/qualitative/interviews/little detail on data analysis & trustworthiness.	Limited to one setting. Based in Norway – limits transferability to UK content.
Togher, O'Cathain, Phung, Turner & Siriwardena (2014)	Sample of 30; 22 patients & 8 spouses received EMS care. One large ambulance service trust in UK.	Investigate aspects of care most important to emergency callers/qualitative/semi-structured interviews/telephone & face-to-face/using critical incident technique/thematic analysis/data saturation included/researcher triangulation used to enhance trustworthiness.	Small sample & one setting limits transferability to other contexts. Sample includes mostly over 55yrs (24/30) – limits findings to this age group.
Wankhade (2016)	Management & frontline staff in one ambulance setting in the UK.	Investigation into staff perception of increased demands of service, different models of care and educational changes in the emergency ambulance/service/qualitative/ethnography/100 hrs observation/ 70 interviews/limited detail on data analysis/measures to enhance trustworthiness not presented/little data presented to support the study findings.	Limited to one ambulance setting in the UK – limits transferability . Little detail on data analysis & trustworthiness.

Williams (2013a)	8 paramedic students in one university in the UK.	An investigation of emotion work in student paramedic practice and the strategies used to deal with it/qualitative/exploratory design/individual semi-structured interviews/thematic analysis/reflexivity/audit trail/independent verification.	Small scale and in one UK university – limits transferability . Saturation of data not mentioned.
Williams (2013b)	8 paramedic students in one university in the UK.	Second paper based on above study (Williams 2013a) – presentation of additional findings – strategies used to deal with emotion work.	As above – based on same study.

Appendix 3

Protocol for Non-Clinical Observer Applications – Welsh Ambulance Service NHS Trust

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services NHS Trust

Protocol for Non-clinical observer applications

on

Welsh Ambulance Services NHS Trust Ambulances

Appendix 4

Confirmation of access to Welsh Ambulance Service NHS Trust

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

GIG
NHS

Pencadlys Rhanbarthol Ambiwlans a Chanolfan Cyfathrebu Clinigol
Regional Ambulance Headquarters and Clinical Contact Centre
Tŷ Vantage Point / Vantage Point House, Tŷ Coch Way, Cwmbran NP44 7HF
Tel/Ffôn 01633 626262 Fax/Ffacs 01633 626299
www.ambulance.wales.nhs.uk

21st January 2015

Angela Williams
Senior Lecturer, Department of Nursing
College of Human & Health Sciences
Swansea University
Singleton Park
SWANSEA
SA2 8PP

Dear Ms Williams

Letter of access for research – Angela Williams

This letter should be presented to each participating organisation before you commence your research at that site. The participating organisation is: Welsh Ambulance Services NHS Trust.

In accepting this letter, the Welsh Ambulance Services NHS Trust confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on 1st February 2015 and ends on 31 January 2018 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from the Welsh Ambulance Services NHS Trust. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving confirmation from the individual organisation of their agreement to conduct the research.

The information supplied about your role in research at the organisation has been reviewed and you do not require an honorary research contract with the organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out. Evidence of checks should be available on request to the organisation.

You are considered to be a legal visitor to the organisations premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and the organisation, in particular that of an employee.

Appendix 5

Fieldwork reflective diary – excerpts

Fieldwork Reflective diary

Examples

Labelling/being judgemental of patients

30.4.15

After the crew had handed over the first patient to A&E today we went back out to the truck and started to make our way back to the station, however we received a call to a house where a woman was queried to have suffered a stroke. We arrived fairly quickly to the house and just as we entered the street one of the crew said, 'oh no, I have been here before to a very fat man and his wife'. He said they call 999 and ask for an ambulance but refuse to go to hospital. As we got closer both crews said they recognised the house.

I have noticed that before we attend calls the crew will tell me if they recognise or already know the caller or have been to the caller before. This seems like a preparation before entry. They seem keen to make sure I have the lowdown on the patient and details of their previous experiences with them. Often they tell me stories about these patients and negative aspects such as repeated calls, unnecessary calls, time wasting, drug abuse and refusal of treatment. I usually listen but say nothing to the crews and I think about what the purpose of this information giving is. The crews may want to bring me onside, to get my agreement with their perspective and view of things, to appreciate and sympathise with their interpretation.

I feel this affects my view, my perspective of the caller even before I have seen them, I feel this almost obliges me to accept this view and to not see things differently to the crews, like this is how it is and there is no other explanation or way of seeing it. Openly challenging their view, I feel could be difficult and could compromise my acceptance and support from them. I know I have to handle this carefully to avoid creating barriers with the crews. I am aware of this though; I can see it and recognise what is going on and I know this is important for me to keep in mind. I am aware of my positioning, my view and my perspective as a nurse, as an educator and now as a researcher, an outsider and how these aspects of myself influence what I make of what I see and hear and how this may be different to the crews. I am also mindful that they experience these issues frequently as part of their role and am cognisant of the potential effect this may have on their perception.

I feel my instinct as a nurse is to feel sympathy for people and to believe what they say and that they are genuine. I find that I tend to take what patients report at face value, whereas crews at times do not. I notice that crews can be quite judgemental and at times critical of callers and I need to keep an open mind to all of this.

'Therapeutic pillow'; failure in emotional labour

6.5.15

Today we went to a woman who had shown signs of stroke the night before but had waited until the next day to call an ambulance. On the way to the call Arthur said she should have called last night. When we got there Jim took the clinical lead and was taking a history and when the patient said she had decided to go to bed and wait the night before, Arthur asked if she had a pillow that was therapeutic. The patient said nothing in response and looked away. I said nothing but wanted to say why did you say that? It didn't help and wouldn't help in this situation. The comment seemed cruel, harsh and insensitive to me. I felt sorry for the patient, as she gave the history of feeling unwell with a sudden headache the night before and explained that she thought it best to take some pain killers and go to bed early. I could understand her reasoning, I felt empathy and sensed her fear and worry now as the symptoms had worsened. Even though I knew she should have called the night before to get treatment and speed is of the essence in the case of a stroke to minimise the damage, there's no point in saying it afterwards.

I felt annoyed at Arthur for judging the patient and communicating this in a sarcastic and insensitive comment at the time of vulnerability and need for reassurance. I realised the importance of empathy and sensitivity despite what we may think and feel. We did our best to help her.

My first shift – getting in

2.3.15

This was my first shift with the crews. I am really out of my comfort zone, going in I kept thinking why am I doing this and then telling myself I must be brave and this is what I want to do. The first is also the worst and it will be okay. When I got in on my first shift I felt overwhelmed and intimidated by the crew room, people sitting around, I didn't know any of them. This was their space and I felt like I was an intruder, a stranger invading their crew room. I felt like I needed to be respectful of this. The crew room was full of mostly men in their uniforms and boots sitting in dark brown leather seats, arranged round two large tables in the middle, I saw some look up as I entered and I smiled and looked desperately for a spare seat to sit down and hide. It took all of my strength, courage and personality to overcome this and get in. I tried hard to come across as friendly, matter of fact, in control and confident, but not overly so. I tried to appear relaxed.

The environment of the station is male orientated, has masculine features to it and is functional. The station looks dated with old wooden doors and dark furniture. It's not dirty but is drab. The colours are neutral or dark. There is little if anything feminine about this environment. A bit rough and hard, it seems to me. The female toilet is old and shabby too.

Getting in and staying in

10.6.15

Yesterday I went in for a second shift this week and was expecting to go with a crew, a paramedic I know and have been out with before and was willing to take me and another crew member. I waited as usual in the crew room but when a call came in somehow the crew went without me. I hadn't realised until they had gone and another crew member asked why I was still waiting. Until now I had been feeling okay. That I had made progress in getting to know the crews and they had been willing to take me.

I felt lots of things when I realised – annoyed, upset, embarrassed, stupid, vulnerable, frustrated, all came and went. I felt like going home, what a waste of time I thought. Thankfully though another crew said I could go with them for the shift which helped me recover and get something done today.

What happened yesterday was difficult and upsetting. It feels like a lesson on the difficulties of fieldwork and people and their willingness to let you in, the vulnerability and dependency of a being a researcher and doing fieldwork. I realise I can't take their participation for granted and can't assume it. With some crews I am comfortable and feel 'accepted' sort of speak but with others I am out and they perceive me and my presence differently.

I know that negotiating and maintaining my access to the crews and their role is part of my fieldwork. The situation of access and acceptance to the field is fluid-like, changeable and varied. I have read about all of these issues and the experiences and advice of other ethnographers. However, the feelings and emotions they create in me are hard and difficult and are impossible to predict beforehand.

Later in the shift Alex said don't worry about the other crew not wanting to take you, he told me it was because one of the crew is renowned for being lazy and not performing well and may not want me to see this. I felt better and appreciated these crews' efforts to help me. It made me consider how some

crews may perceive me and my purpose as a researcher and the risks to them of taking me along with them.

I didn't realise how demanding and difficult fieldwork could be. My own emotions change frequently and this necessitates emotional labour from me in how I manage and process the feelings which accompany doing research with and on others.

Crew room: Making fun of the student

6.5.15

I sat and listened to the conversations between the crews this morning. At these times I felt on the periphery and an outsider, not really able to contribute. Not in enough to be able to do this and not thinking that this was appropriate. I don't want to be overly familiar with them as I know this would not be appropriate and I fear being rejected by them and want to avoid this.

The night crews got up to go and some of the day staff asked what needed to be restocked in the trucks, there was some exchange and banter about this. George, a paramedic student who had been on nights came into the crew room and Gail who had been working with him asked where he lived and offered him a lift home. George answered in a slightly high-pitched tone of voice, that he already had a lift. Immediately after he left, Arthur, one of the other crew members came in and said, 'where did that voice come from?' and mimicked it. Some of the crews laughed at this but Gail said 'don't, he's a nice student'. I agreed with Gail and said I know him as a student, he is great. The others continued to laugh.

This mockery I felt was rather childish and silly, aimed at the student, George who was not present or aware of it and seemed like an attempt to undermine him, in the face of others. It made me feel like I had to say something in defence and support of George, like Gail had done. I sensed from her response that Gail wanted to support him.

I notice that the mockery and humour in the crew room is often created by particular crew members (Arthur is one of these), who seem to initiate it and influence others, some of whom appear to go along with it. It may be easier for some crew members to show loyalty to the group or key individuals like Arthur and join in the hilarity and the derision than to challenge or question it. There seems for some, including myself at times, pressure to join in with this.

Crew room: Nick said 'we could shoot um'

30.4.15

In the crew room early this morning Nick started joking and making everyone laugh. He came up with a way of dealing with patients who call for an ambulance but in his opinion don't need one. The crew room was busy first thing, the day crews were in and night crews were getting ready to go home. We were all sitting around, Alex the CTL was there too. Nick said they could go to the calls and give the patient a minute to say why they have called 999 and if they have got it wrong, they could shoot them. The crews listened and laughed at Nick's suggestion and some joined in and added further comments. Nick went on further to say that A&E would be empty, there would be plenty of pillows and duvets on the beds. I felt uncertain how to respond to it, it seemed inappropriate to me and perhaps a step too far. It was difficult not join in the laughter and amusement though. I felt some pressure from the crews to appreciate the humour, to understand it and to not object to it, at least not openly.

I find these situations difficult at times where there are conflicts with my personal and professional views and how I handle these.

I am a visitor, a guest in what is their private backstage setting of the crew room, they are sharing this with me. This is how they spend their time, what they find amusing and funny, what they do to relax and as a researcher I want to show this. Also, as a nurse I do appreciate some of their humour and their challenges and frustrations.

I am aware that this humour may appear crass, inappropriate, unprofessional and not at all amusing to those outside the setting and context but it is what I have observed them doing.

Appendix 6

Details of sample

Details of sample

Pseudonym	Role	Years in service	Education
Roy	Paramedic	15	Traditional (T)
Pete	EMT	12	T
Stu	EMT	11	T
Mike	Paramedic	22	T
Tracy	Paramedic	7	Higher Education Diploma (HED)
Gail	Paramedic	7	HED
Rhys	Paramedic	6	HED
Simon	Paramedic/CTL	23	T
Sarah	EMT	11	T
Tom	EMT	6	T
Trevor	Paramedic/CTL	28	T
Arthur	Paramedic	35	T
Louise	EMT	10	T
Roger	Paramedic/CTL	30	T
Alex	Paramedic/CTL	27	T
Laura	Paramedic/CTL	5	T
Paul	Paramedic	30	T
Ann	Paramedic/CTL	23	T
Rhian	Paramedic	17	T
Ashley	Paramedic	22	T
Carl	Paramedic	18	T
Grant	Paramedic	7	HED
James	EMT	14	T
Nick	Paramedic	14	T
Miriam	Station secretary	16	N/A

Additional crews from fieldwork

Pseudonym	Role	Education
Rod	EMT	T
Terry	EMT	T
Glyn	Paramedic	T
Jim	EMT	T

Appendix 7

Record of observation periods

Record of observation periods

Date	Time Period	Crews
2.3.15	7am - 5.30pm = 10.5 hours	Paramedic (Mike) & EMT (Malcolm)
12.3.15	7am- 3pm = 8 hours	Paramedics (Arthur) & (Nick)
18.3.15	7am – 2.30pm = 7.5 hours	Clinical Team Leader (Alex) & EMT (Pete)
26.3.15	7am-4pm = 9 hours	Clinical Team Leader (Alex) & EMT (Pete)
2.4.15	7am- 2pm = 7 hours	Paramedic (Gail) & EMT (Malcolm)
8.4.15	7am-2.30pm = 6.5 hours	Paramedic (Grant) & EMT (Stu)
15.4.15	7am- 1.30pm = 4.5 hours	Paramedic (Grant) & EMT (Len)
24.4.15	7am- 11am= 4 hours	EMTs (Pete & (Len)
30.4.15	7am – 2.30pm = 7.5 hours	Paramedic (Roy) & EMT (James)
6.5.15	7am – 3.30pm = 8.5 hours	Paramedic (Arthur) & EMT (Jim)
13.5.15	7am – 3pm = 8 hours	Paramedic (Roy) RRV
20.5.15	7am-1.30pm = 6.5 hours	Paramedic (Mike) & EMT (Sarah)
26.5.15	8am- 2.30pm = 6.5 hours	Paramedic (Grant) & EMT (Len)
1.6.15	7am – 1.30pm = 6.5 hours	Paramedic (Roy) & EMT (Tom)
9.5.15	7am – 2pm = 7 hours	Paramedic (Lucy) & EMT (Tom)
10.6.15	7am – 2pm = 7 hours	Paramedic (Gail) & CTL (Alex)
17.6.15	7am- 5.45pm = 10.45 hours	EMTs (Len) & (Sarah)
24.6.15	7am – 2.30pm = 6.5 hours	Paramedic (Sam) & EMT (Pete)
	Break for 2 weeks annual leave	
16.7.15	7am- 1.30pm = 6.5 hours	Paramedic (Roy & EMT (Tom)
22.7.15	7am – 2pm = 7 hours	EMTs (Sarah) & (Louise)
28.7.15	7am – 2pm = 7 hours	Paramedic (Roy on RRV
4.8.15	7am – 2.30pm = 7.5 hours	Paramedic (Roy on RRV
11.8.15	7am – 2pm = 7 hours	Paramedic (Evan) & EMT (Louise)
8.8.15	7am- 1.30pm = 6.5 hours	EMT (Pete) & EMT (Henry)
25.8.15	7am – 2pm = 7 hours	Paramedic (Roy) on RRV
2.9.15	7am-2.30 = 7.5 hours	Paramedic (Paul) & EMT (Alistair)
9.9.15	7am-2pm = 8 hours	Paramedics (Nick) & (Arthur)
12.9.15	7pm – 5.30 am = 10.5 hours – Night shift	Paramedic (Mike) & EMT (Len)
24.9.15	7am – 2pm = 7 hours	Paramedic (Mary) & EMT (Pete)
7.10.15	7am – 2pm = 7 hours	Paramedic – (Tracy) on RRV
22.10.15	7am – 2pm = 7 hours	EMTs (Stu) & (Andrew)

28.10.15	7am – 2pm = 7 hours	Paramedic (Annie) & EMT (Stu)
4.11.15	7am-12pm = 6 hours	Paramedic (Gail) & EMT (Malcolm)
11.11.15	7am – 6pm = 11 hours	Paramedic (Annie) & EMT (Pete)
19.11.15	7 am – 2pm = 7 hours	Paramedic (Arthur) & EMT Pete)
25.11.15	7am – 3pm = 8 hours	Paramedic (Paul) on RRV
2.12.15	7am – 3pm = 8 hours	EMTs (Len) & (Henry)
7.12.15	7am – 1pm = 6 hours	Paramedic (Gail) & EMT (Sarah)
16.12.15	7am – 3.30pm = 8.5 hours	EMTs (Sarah) & (Henry)

Appendix 8

Record of calls attended

Record of calls attended

Patient	Problem	Notes
Mr H	Vomiting\abdominal pain	Repeat caller\well known to crews & A&E staff House unkempt Old man, living alone, colostomy Took to A&E Curt with him\said they wouldn't have been so nice if I hadn't been there.
Mr J	83, fallen - ? fractured neck of femur	Obvious fracture, leg shortened and rotated out, on the floor with wife and neighbours. Been waiting a while for us. Lovely old man Taken out to ambulance, obs done, BP good, given morphine and metoclopramide, settled pain relieved from left hip, pain still 3 in right hip though. Took to A& E with his wife. Waited a while, took him in for x-rays and bloods, would be going to theatre later today.
Mr A	Chest pain and small laceration on arm due self-harm	Friend was waiting outside for us and guided us in to the flat. Man was slurring and coughing and complaining of chest pain on both sides. Both occupants were taking drugs and were arguing about a prescription. Took to A&E, didn't wait long and took him in.
Mrs T	Cellulitis and dehydration	The crew took over this lady from another crew who hadn't had a lunch break. So, she was

		moved across on to our cot and wheeled into our ambulance. Obs done, bloods taken. She was taken into A&E for bloods and then brought back out. Shortly after this she was taken into A&E.
Mr F	Chest pain	Suffered with sleep apnoea Complaining of central chest pain- Seen by G.P- ? angina, given GTN, aspirin. Been having chest pain on rest Crew pleasant, spent time talking with and listening to the patient, finding out about the problem, taking a history. ECG, obs done and taken to A&E, no delays
Mr D	Abdominal pain	Polish, little English spoken, wife little too Daughter helped translate Complaining of pain for 4 days. Seen for pain previously, has inflammation of gall bladder so on waiting list. Took onto ambulance, obs done, ECG, history, details from daughter, no analgesia given, close to hospital, few minutes. Taken into A&E trolley bay.
Mrs J	Fall/twisted leg and ankle	Fell in cattle grid, entrance to work, twisted her left knee, both legs got stuck, Knee very swollen. Already got up and taken into work, waiting for us. Lots of joking, she was in pain and shocked though.

		Took her onto ambulance, obs done, pain assessed as 7.5/10 offered morphine but accepted paracetamol x2, took without water. Took her to A&E - waited a short while and after handover came back to station.
Mr R & his wife	Generally unwell, unsteady on his feet.	Mr R looked very pale, deaf in both ears, in bed. Wife very breathless, very distressed, chronic bronchial asthma. Both needed help. Very chaotic at the start. Hearing aid found and inserted. Observations done on both. ECG done on Mr R, blood sugar. Dressed and taken to hospital. I took wife downstairs to find daughter's phone number and we sat and talked, her breathing settled down and she could be left at the house.
Mr W	Paranoid Schizophrenia	Patient escort to MH secure Unit. Settled and quiet most of the journey and crew took him in and handed over to the staff.
Mr E	Shortness of breath.	In nursing home. Known to have lung cancer, very pale, breathing very rapid and on oxygen. Obs done, chest examined, fluid on right side. Had a do not attempt resuscitation order and we had a copy. Taken into A&E
Mrs T	Fall in kitchen/possible injury to upper spine/loss of sensation in hands	At home, fell in kitchen, tripped up and hit head on cooker, fell down, injured neck, loss of sensation initially from neck down but regained. Both hands and arms burning sensation on touch, hypersensitive. Pain left side of C spine. Spine immobilised. Few minor lacerations to face and arms. Back up called to

		help move and get out of property (on a steep slope, steep steps down. I helped with neck immobilisation and support. Got in ambulance after a while, obs done, venflon in, bloods taken, BM low - given glucose by me. A&E pre alerted. Continued to monitor. Took her into A& E and waited for a while with her.
Mr H	Carer had not arrived.	Called for an emergency ambulance as the carers were late but did not answer the call back and so emergency ambulance sent. Well known to the crews, repeat caller they said. We got there the same time as the carers; patient opened the door but said he did not ring for an ambulance. The crew clarified this with the patient, contacted control and we left.
Mr T	Fall off scooter in town centre	Arrived at a bank in the centre of the city. Man in a motorised scooter with a large egg-shaped contusion to the right of his forehead. He had fallen off his scooter on the pavement outside. He had grazed his right hand too. Took into ambulance, did obs, blood sugar, checked pupil reaction. Took to A&E.
Mrs W	Fast heart rate, shortness of breath, feeling faint.	Arrived in M&S food hall, very busy, woman, very pale and sweaty sitting down with staff around her. Had a heart attack 2 weeks ago and stent inserted. In checkout queue and suddenly felt faint. Heart rate high, 150-160 bts\min, blood pressure low 90\60mmhg- symptomatic. Pale, sweating ++ around eyes.

		Obs done on site and then taken into ambulance. ECG done, obs continued, Bm done, venflon sited, bloods taken, o2 sats monitored. Taken to A&E and monitoring continued. Very busy, 12 ambulances outside couldn't off load, had to wait.
Mr S	Angina/chest pain	Complaining of chest pain (had 3 MIs previously and stents) took GTN spray. Paramedic on RRV already there and obs done and ECG. Still in pain. Taken into ambulance. Pain resolved, details taken but patient refused admission and signed self-discharge.
Mr P	Stroke/TIA/? Urinary tract infection/ Generally unwell	Went into elderly care complex. Individual flats. Paramedic and RRV already there doing obs and monitoring. Obs continued, details taken and patient taken into ambulance, BP taken and transferred to A&E and handed over.
Ms R	Bowel infection/diarrhoea/collapse	Took over from night crew in station, very weak, pale elderly lady and her sister. Had diarrhoea, went to toilet and felt weak. Continued monitoring and obs and took to A&E.
Mr T	Fall	Found him in the bathroom, had fallen at the side of the toilet. Very ill man, complex medical history, kidney failure, transplant, temp 40, very hot to touch and delirious. House very unkempt, smell very offensive. Treated at scene, obs done, venflon, BM, IV fluids started, IV paracetamol given. Given 02.

		BP low, quite distressed. NEWS score 14, A&E pre-alerted. Monitoring continued. Wife very anxious too, I tried to reassure her as best I could and collected information from her. St Johns ambulance attended too – first responder at the scene, helped with chair. Took straight into A&E and into resus, handed over and left.
Mr S	Chest pain/heart attack/Angina	Called to GP surgery. Patient had chest pain over weekend but had not called anyone. History of heart disease and type 2 diabetes. GP had done ECG, changes seen? heart attack. Slight pain, but reluctant to say, didn't want to go to hospital. ECG done, obs, blood sugar done. GP had already spoken to Cardiologist and arranged an admission to local Assessment Unit. Took him in and handed over.
Mrs D	Diarrhoea &Vomiting/ high temperature	Nursing home resident. Observations done, very hot to touch, abdomen rigid. Hadn't passed urine. Very dehydrated. History of D&V Venflon sited, IV paracetamol given. Monitored. Taken to A&E.

Mr E	Abdominal pain/diarrhoea and vomiting\had a kebab night before - ? Food poisoning.	Call from out of crews' usual area. RRV already there, done assessment and handed over to crew. Walked out to ambulance, monitored on route. Little interaction though with crews, very tense in the back of the ambulance. Handed over to A&E quickly.
Mrs F	39 weeks pregnant and in labour	Polish, spoke little English. In labour in bed. Took a while to make a clinical decision. Gave entonox, encouraged slow breathing. Crew anxious. Midwife came and assessed; crew took to hospital quickly. Handed over patient to midwives.
Tommy	Drug overdose/unconscious	Unresponsive, unconscious male (looked very young to me), in wooded area, taken unknown substance. Airway opened, airway inserted, paramedic crew arrived, gave treatment. Came round quickly. Took down into paramedic ambulance, obs done, PCR completed. Patient signed refusal to go to hospital and left.
Mr A	Fall, dislocated shoulder	Elderly man had fallen early morning, injury to his shoulder, kneeling on the floor, couldn't get up, looked in severe pain but didn't say it. Crew helped him up. Into ambulance, ECG, obs done, sling applied. Venflon sited and given IV paracetamol. Took into A&E handed over.
Mrs M	Call from District nurse, possible stroke/weakness down one side.	Went into the house, woman in bed, district nurse and student present to do leg dressing. Patient morbidly obese in bed and did not want to go to hospital. Assessed for

		weakness but not evident. ECG done, obs, temp. Paramedic spoke to GP practice to arrange GP house call and this confirmed, already been made. Crew said not clear why they had been called. Patient signed refusal to go to hospital. Crew left.
Mr L	Collapse in bathroom - unknown cause	Crew went in, patient laying down on his back at side of toilet, conscious and very pale. Crew asked what had happened, sat him up slowly, got him up, immediately vomited in the sink. Cleaned him up and took out to sit down. Did ECG, obs, BM, had bump on back of head and contusions on his back from the fall. Took in ambulance, obs continued, vomited on route once. Took him into A&E and handed over.
Mrs B	? Stroke/transient ischaemic attack	Went into house, woman in bed, complaining of numbness down left side, particularly her left hand, loss of strength but could move both limbs and walk with help. Had a headache previous night but went to bed and hoped it would get better. One of the crew said, 'do you have a therapeutic pillow'. Assessed and taken out to ambulance with our help. ECG, obs, blood sugar done. Taken to A&E, waited for while in ambulance as no beds available. Dr came out to assess. Crew took patient in, for chest x-ray and for scan of head. Brought her back to A&E and transferred onto trolley and left.
Mickey	Paracetamol overdose	Went to upstairs flat to find young man. Taken 25 paracetamol tablets. Said he felt down this morning.

		Took him in ambulance, ECG done, obs but didn't want to allow this first because of self-harm marks on right arm. Taken to A&E and handed over.
Mr C	Abdominal pain, weakness, dizziness	On RRV today. Went into house, man described by wife as very ill. Sitting up in living room, pale. Obs, blood sugar, ECG done - all normal limits. Had bowel investigations done recently and waiting results. Crew gave options of hospital or GP, rang GP, did standing BP- postural drop. Advised stop blood pressure tablets and District Nurse would call following day. Referral done and crew left.
Mr Z	Fall/fitting	On RRV today. Went into house, patient was conscious, mouth bleeding, obs done and blood sugar, history of alcoholism which had been reduced, not epileptic, alcohol induced withdrawal fitting. Wife was there and said husband had been violent to her and next time she would be gone. She seemed upset. Another crew came and took patient to A&E.
Mr Q	Cardiac arrest	On RRV today. Went to area out of town, quite remote, a man had suddenly collapsed at home with his wife. In cardiac arrest, I had to help Roy with CPR. Air ambulance came after and another local crew. Resuscitation continued 40 minutes. We supported his wife after time was called. Coroner came and we left.
Mr T	Overdose of medication	Went on red lights to flats near town centre. Elderly man not

		responsive, breathing, low pulse rate and blood pressure. ECG, obs, temp, blood sugar done, venflon sited, given IV fluids. Responsive to pain only. Still very flaccid, crew pre-alerted A&E. Crew took to resuscitation area and handed over.
Mrs H	Fall, ? stroke/ confusion	Patient sitting up beside bed downstairs, complaining of pain in hips, slow and unable to walk. Got into wheelchair, took in ambulance, ECG, obs, blood sugar done. Took into A&E and handed over.
Mrs C	Fall/ head injury	Elderly woman had slipped and fallen on to her back and was lying on the bathroom floor. Large amount of blood under her head from injury. Crew applied pressure bandage and helped get her up. Superficial lacerations to right arm and graze to knee. Observations done and taken to A&E.
Mr G	Chest pain/heart attack	Man complaining of chest pain at GP practice. With GP when got there, ECG done, given aspirin, GTN and morphine IV. Took to coronary care unit and handed over.
Mr M	Fit – known epileptic	First call of the day. Went with crew to man who was outside shops in city centre. Reported to have fitted by friends who were from homeless community. Took into ambulance, obs and blood sugar done, patient said he just wanted to sleep. Took to A&E, delays today, no beds available in hospital, had to wait outside in ambulance. Patient slept, eventually handed over to A&E.

Miss B	Collapsed/? Faint	Went with crew to school where member of staff had collapsed. On floor when we got there, on side, fainted, given 02, helped to sit up and taken into ambulance, obs, blood sugar & ECG done. Took to A&E, waited a little but off loaded and handed over.
Mr R	Chest pain	This came through as a Red call and was outside usual area. Crew went quickly. Crew said repeat caller – control said 80 calls to address in the last few months. Went in, man said he had had enough and wanted to die. Crew explained that we had to take him to A&E. Took out to ambulance, obs, ECG and blood sugar done. Took to A&E, staff knew him well, handed over and left.
Mr P	Falls - two in short period	The crew took over from night crew on way to A&E. Handed over to A&E and left.
Mrs F	Cardiac arrest	Red call early morning to sudden cardiac arrest. Ambulance went at high speed. RRV already there, together crews got her onto the floor at bottom of bed. Started resuscitation, I helped. Given shock treatment & adrenaline. Got a pulse, crew said we would 'run with it'. Got into ambulance, lung inflations continued, pre-alerted A&E and went straight in. Lucy very excited said 'this is a good call'.
Mr N	Pressed his lifeline by accident-automatic response from police.	Patient was having breakfast when the crew git there. Crew said not sure why they were called.

		Patient was assessed, obs, blood sugar and ECG done, his carer was present. Lucy contacted GP - happy for patient to stay at home. Crew left.
Mrs P, Mrs S & baby Lily	Minor RTC, no apparent injuries	Went quickly to report of road traffic collision. Two cars involved. All occupants out at side of road. Crews assessed all, no injuries. Car driver upset and shocked. Police present too. Crews gave information and advice and left. Lucy said there was nothing for us to do here.
Mrs J	? Epileptic fit	Call to woman in her car at a road junction. Very disorientated, agitated and confused, sweating profusely. Looked ill. The crew got her into ambulance straight away and on stretcher. Obs, ECG and blood sugar done, given oxygen. Very agitated at times. I sat close to her and tried to calm her down and keep her oxygen on and venflon running. Crew pre-alerted A&E and took patient straight in and handed over.
Mrs J	Chest pain	Call to a nursing home to an elderly lady. Looked very pale and grey in colour when got there. Sitting in chair, RRV already there and paramedic doing assessment. Crew helped her up and she fainted suddenly. Got her onto the stretcher and crew said we will run with her – go quickly. Got into ambulance, she came around suddenly and vomited. IVI and fluids given, obs done, monitoring continued and went straight to A&E.
Mrs B	Chest pain/shortness of breath	Call for chest pain and shortness of breath. Patient was Indian, did not speak much

		English. Family present, very upset and anxious, worried about her. Obs, ECG, blood sugar done. Took in ambulance, assessed, monitored. Daughter came with us, very protective. Took to A&E, handed over.
Mrs T	Confusion & agitation	Call to elderly lady at home. Obs, ECG, blood sugar done. Temperature raised, agitated and confused. Taken to A&E and handed over.
Mr O	Sprained ankle	Call to man who had twisted his ankle, complaining of pain on movement. Hobbled into ambulance with crew help. Assessed by crew, given paracetamol, taken to A&E, taken to waiting area.
Mr D	Shortness of breath	Called to an elderly man and his family with complaint of shortness of breath. When crew got there patient was sitting quietly and was not short of breath. Took into ambulance, assessed, all obs done and no abnormalities. Crew were annoyed – said this is not a medical problem. Took to A&E and handed over.
Mrs W	Chest pain/Shortness of breath/unsteady	Carer called for ambulance. Crew went in, patient sitting down, no chest pain, not short of breath, but shaking. Assessed, history taken, obs, ECG and blood sugar taken. Taken to A&E, long delays today so had to wait outside in ambulance. Eventually gave handover and left.
Baby Jessica	Cough, high temperature, ? chest infection	Call from GP surgery, already arranged for admission to Children's Assessment Unit.

		Obs done, given treatment to ease breathing and oxygen – worked well, baby fell asleep on her mum. Took to A&E, transferred straight to children's unit by the crew and left.
Mr M	Upper back pain/neck pain for 1 week	Call to man, living alone and complaining of pain in his upper back and neck. Had pain a week ago but did not want to call an ambulance then. Got there, man was sitting, but bending forward and complaining of severe pain, his colour was grey. Started to vomit. Took out to ambulance, assessed, obs done, ECG showed heart attack, given morphine, GTN, Aspirin, 02 and taken at speed to Cardiac catheterisation laboratory, crew stayed with him until he went in for stenting.
Stephan	Bleeding after a Tonsillectomy	Call for sudden heavy bleeding from throat after tonsillectomy. Crew went straight in, upstairs to toilet, patient spitting up large amounts of fresh blood. Looked very pale, feeling faint. Assessed quickly and taken into ambulance. Obs done, venflon sited, A&E pre-alerted. Went on lights straight into resuscitation.
Mr X	Stroke	Call to house not far from the station. Elderly man, in bed, right sided facial droop, unable to communicate verbally, dazed, incontinent of urine, wife distressed. Assessment done, got into ambulance, CTL came to give a hand. Wife came in too. Took to A&E on lights and handed over quickly.

Mr S	RTC, - ? spinal injury	Call to multi vehicle RTC on busy dual carriageway, we were second ambulance there. RRV & paramedic already there organising and assessing. Crew allocated male in car with possible spinal injury. Assessed by crew, placed on stretcher and spine immobilised and taken into ambulance. Observations done and taken to A&E..
Mrs G	Confusion	Call to an elderly lady, lives alone, found wondering and confused by daughter. Has bladder cancer and repeated urine infections. Daughter present. Long term problems, given antibiotics. Not new issues. Obs and blood sugar done. Crew rang GP, who gave more antibiotics and we left shortly afterwards.
Mrs T	Fall, ? stroke	Called to residential home for elderly. RRV already there, woman on floor, head bruises to right side caused by fall. Possible stroke, not responsive verbally but blinked. Helped to get onto scoop and stretcher. Took onto ambulance, assessed and took to A&E, with Son and handed over.
Mr R	Breathless, cough, dehydrated	Crew took handover of this patient out of station. Student, Paramedic and EMT on board. Venflon, fluids up already, monitoring on and obs done. Took to A&E and into trolley bay. Handed over and left.
Mr P	Fall on steps outside	Crew went to call for elderly man who was attending an event and fell outside on the steps. Lying on side, conscious and breathing, assessed for head injury, helped up and into chair and taken in ambulance for assessment. ECG done, obs and blood sugar. Taken to A&E for assessment.

Ms L	Possible ectopic pregnancy	Call to house, been to see GP referred to gynaecology ward for assessment. Taken into ambulance, assessed for pain, paracetamol given, reassurance. Taken straight to gynaecology ward.
Mrs M	Stroke	On RRV today, went to call for possible stroke. Patient conscious, sitting up, talking, daughter and husband present. Assessments done. Back up crew came and transported patient to hospital.
Mr E	Drowsy/unresponsive	On RRV, call to elderly man, pale, drowsy. Wife very anxious, recently out of hospital and husband in respite until day before. ECG, obs, blood sugar done. Back up came, took out to ambulance assessed and decided not to transport – social problems more than medical. Wife very upset. GP contacted and arranged referral back to respite care later that day.
Mrs W	Blocked catheter	On RRV, on route to call but diverted to urgent call.
Mr H	Short of breath	On RRV, carer present, elderly man with difficulty breathing, obs done, given nebuliser, 02

		sats monitor, coughing, been in hospital recently for chest infection. Back up crew came and transferred to hospital.
Mr S	Short of breath, cough	On RRV, went to patient in residential home. Obs done, 02 sats done, ECG, blood sugar - all normal. Chest palpated decision made to take to hospital. GP at the home at the time, saw patient, said no need for admission. Back up crew arrived to transport, but all left.
Miss F	Faint/fit	Sudden collapse in shop in town centre. Crew assessed, taken in chair out to ambulance. Obs done, blood sugar, post faint. Took to A&E, waited, handed over and left.
Mrs B	Labour pains	Went to flat, partner present, pain since 5am, waters broken, in labour. Took in ambulance, obs done, given entonox. Taken to hospital and handed over.
Mr H	Fall, pain in right leg, fallen outside house.	Call to patient well known to crews for repeatedly calling 999. Patient lying outside his house on the floor. Members of public stopped to help. Crew helped him up and assessed. Taken into ambulance for assessment, observations done. Able to walk as usual. Crew rang GP and A&E, advised to leave at home.
Mr E	Motorbike accident	Minor collision, minor injuries to legs, graze to forehead. Crew assessed and took to A&E
Mr K	Fall/possible faint	Patient assessed, obs done, ECG & blood sugar, taken to A&E.

Mrs T	Nosebleed	In nursing home, history of epistaxis. RRV there, assessment done by paramedic. Taken to A&E.
Mr Y	Chest pain, cough	On RRV, went to elderly man, of no fixed abode, outside in church yard off main road. Had been coughing up sputum. Obs done, blood sugar and ECG. Taken by back- up paramedic crew to A&E.
Mr S	Fall at home/abdominal pain/diarrhoea/vomiting	On RRV, call started as red 1 call- not breathing then changed to red 2. Elderly man on floor in bathroom, first responders present. Assessed, obs and blood sugar done. Back up crew arrived, taken out in chair into ambulance, obs and ECG. Taken to A&E.
Mr Q	Chest pain	On RRV, ECG, obs and blood sugar done. Taken to A&E in RRV.
Mrs R	Nosebleed	On RRV, went to nursing home. Elderly lady had nosebleed, 3rd nosebleed in 3 weeks. Assessed, bleeding stopped, taken out, obs, ECG and blood sugar done. Taken to A&E and handed over.
Tina	Intoxicated, aggressive, violent behaviour	Call to young woman who was distressed. Very difficult for crew to assess. Woman was very intoxicated, aggressive, shouting, kicking and punching. Took into ambulance, police called, took to A&E, with police present.
Rosie	Abdominal pain	Went to work setting, young woman complaining of pain shooting into groin, assessed, taken into ambulance, obs, blood sugar, ECG done. Taken to A&E and handed over.
Mrs T	Stroke	Crew took handover from team leader and Dr already at scene in nursing home. Too out to

		ambulance, monitored on route and taken to A&E.
Tommy	Burns	Doing night shift with crew. Went straight to A&E – took over from day crews outside A&E. Young man who was living in a tent, trying to light cigarette, and tent ignited and burnt. Face and hands burnt. Given entonox, obs continued. Taken into A&E and handed over.
Matt	Attempted hanging/possible spinal injury	Went quickly to call to hanging. Police there, broke in just in time, man jumped off ladder, police just caught him in time. Assessed and immobilised at scene, taken into ambulance, obs and blood sugar done. A&E pre-alerted and taken straight in.
Mr E	Abdominal distension, constipation. Transfer to acute hospital	Elderly man in mental health setting, with constipation. Obs done in ambulance and taken to acute hospital and admitted to surgical assessment unit.
Mrs W	Vomiting. Referral by GP arranged admission	Elderly lady, seen by GP earlier and assessed for vomiting. Arranged admission to hospital. Assessed, observations done and taken to assessment unit and handed over.
Mr C	Abdominal pain, nausea	Took over from night staff at A&E, monitoring continued, given analgesia. Been waiting 3 hours for admission. Taken into A&E and handed over.
Mr V	Chest pain – Shortness of breath	Call from GP surgery, chest pain, ECG done, taken into ambulance. Venflon sited, monitored, 12 lead ECG done, pre-altered and taken to A&E to resuscitation area and handed over.
Mrs P	Transfer to another hospital	Whilst in A&E, crew agreed to take a patient from one of ward in hospital to another hospital. Collected patient from ward,

		taken onto ambu, obs done, transferred to another hospital. Taken to ward, handed over and left.
Mrs H	Left sided abdominal pain	On RRV, woman complaining of pain, obs, ECG and blood sugar done. Given analgesia. Back up ambulance came, took patient out to ambulance and left.
Mr Z	Right sided abdominal pain	On RRV, went to man having spasms of abdominal pain. Obs, ECG, blood sugar done. Waited for back up ambulance to come. Took in RRV to A&E, waited, gave handover and left.
Mr F	Intoxicated/fall/head injury	On RRV, went to call outside local shops, man drinking heavily, small cut to head. Police present. Waited for back up crew to come. Taken into ambulance obs, ECG, blood sugar done. Taken to A&E and handed over.
Mrs A	Chest pain on breathing/chest infection	Went to call to elderly woman complaining of chest pain and difficulty breathing. Took in ambulance, assessed, given oxygen, monitored. Spent long time in ambulance as no beds available. Took into hospital for chest x-ray and assessments and back out to ambulance. After some time took into A&E and handed over and left.
Mr G	Collapse/back pain	Call to man, lying in the street after a fall, supported by colleagues. Got into ambulance, assessed, obs, ECG, blood sugar done. Took to A&E and handed over.
Mrs B	Fall/? Hip fracture	Went to elderly lady living in residential care, unable to weight bear, in pain. Took into ambulance, assessed, obs, ECG, blood sugar done. Given analgesia. Took into

		A&E, to x-ray, waited with patient and her daughter. Then transferred onto a trolley and handed over.
Mrs D	Asthma, difficulty breathing.	Woman, in house, in bed, very distressed and upset. Complaining of pain in chest when breathing, known asthmatic. Short of breath. Taken out into ambu, ECG, obs and blood sugar done. Taken to local hospital and handed over.
Mr A	Rectal pain	Went quickly on lights and sirens to this call. Patient in pain, assessed, history taken. Taken out to ambulance, obs, ECG, blood sugar done. Given analgesia. Taken to A&E, handed over and left.
Mrs E	Difficulty breathing	Elderly lady in nursing home, very pale, breathing rapidly. Taken out in chair to ambulance. ECG, obs, blood sugar done, given oxygen. Taken to A&E and handed over.
Mr K	Dizziness, vertigo, nausea	Call to elderly man, with dizziness. Assessed, concern might fall, taken into ambulance, obs, ECG and blood sugar done. Taken to A&E and handed over.
Mrs D	Chest pain	Call to an elderly lady with chest pain, first responder present. Assessed taken into ambulance, ECG, obs, blood sugar done. Given paracetamol, GTN, aspirin. Taken to A&E, had to wait outside as no beds available. After some time took into A&E and handed over and left.
Mrs L	Fall	Elderly lady, found on the floor of bedroom. Assessed and helped up, no injuries noted. Patient signed paperwork to

		not go to hospital. Crew left when daughter in law arrived.
Mrs C	Cardiac arrest	Crew backed up other crew already there. Elderly lady on bedroom floor, already deceased for some time, limbs stiff, blood pooling in hands. ECG showed no activity, not resuscitated. We helped lift her up onto the bed and left.
Mr F	Short of breath & anxious	Elderly man in bed, assessed by crew, complaining of headache, tired, feeling depressed. Assessed, ECG, obs and blood sugar done. Taken into ambulance, given paracetamol, waited a while in ambulance as no room in A&E. Took into A&E and handed over, went back to the station for lunch..
Ellie	Vomiting blood/mental health problems	On RRV, went to young woman. Distressed, hiding under quilt, would not talk to crew. After some time came out, obs done, advised to go to hospital, backup by another crew who took to A&E.
Mr G	Fall/? head injury	On RRV, went to call to man who had slipped and fallen. Assessed, obs, ECG and blood sugar done. Patient refused admission, given information.
Mr T	Fall	On RRV, elderly man fallen over at home. Assessed, no injury, obs, ECG and blood sugar done. Patient referred to falls team.
Mr T	Head injury/violent and abusive	On RRV, went to call with police escort/known patient/history of violence. Patient refused to go to hospital and told crew to leave.
Mrs F	Cardiac arrest	Went to call early morning at start of shift. Elderly lady in bedroom on floor, family present. Resuscitated for 30

		minutes with little effect. Crew informed coroner, cleaned up and left.
Mr K	Vomiting blood	Went to elderly man in nursing home, took into ambulance, obs, ECG, blood sugar done. Took to A&E, handed over and left.
Mr D	Collapse, pain in legs	Went to man complaining of pain in left leg, unable to stand up and walk unaided. Assessed took to A&E, waited, outside as no room in A&E. After time, taken back in and handed over.
Mrs E	Shortness of breath, chest pain	Crew got to house, patient very short of breath, pale, given nebuliser, oxygen, obs, blood sugar done. Taken out to ambulance. ECG done, monitored, given treatment and oxygen. Crew pre alerted A&E. Daughter came with us. Took straight into A&E, handed over and left.
Mr O	Fit	Went to house, early morning, RRV there, male upstairs, came out to ambulance, obs already done, sat in the back, assessed, taken to A&E, waited a while, handed over and left.
Dylan	Breathing problems/chest infection	This was a transfer from one unit to another for paediatric care. Went in, Mum and baby already been seen. Took out to ambulance, assessed, obs done, very difficult, baby very fractious, gave nebulisers, settled on route, relaxed. Took into A&E - seen straightaway. Handed over and left.
Mrs G	Chest infection	Short of breath, on oxygen constantly. Assessed, taken out to ambulance, obs, ECG and blood sugar done. Patient kept apologising for being a

		nuisance. Taken into A&E, handed over and left.
Poppy	Faint	Went to call to a school, young girl in gym, lying on the floor, on her back, staff with her. Assessed, response checked, eyes fluttering, airway inserted but immediately spat out. Looked like coming round, got into chair, taken out to ambulance. In ambulance, assessed, obs and blood sugar done. Mother came with us. Taken to A&E, handed over and left.
Mr L	Fall, head injury	Crew went to elderly man who had fallen in a shop in town centre. Went in, lying on the floor, bleeding laceration to right eyebrow. Crew got down and assessed, checked for head and neck injury. Helped him up and into chair. Taken out, assessed, obs, ECG and blood sugar done. Dressing applied to laceration and bandage over the top. Took into A&E, handed over and left.

Appendix 9

Participant interview schedule

Frontline staff

Participant Interview schedule

Frontline staff

Welcome and thank you for agreeing to be interviewed.

Introductory questions

- How long have you been working for the ambulance service?
- How long have you been in your current role?

Main questions

- Tell me about your role here, what does it involve?
- What kinds of calls do you attend?
- Tell me about your role in these calls?
- What kinds of calls would you say that you mostly attend?
- What is your role in these calls?
- Who do you find uses the emergency ambulance service?
- Tell me about how this affects your role?
- Tell me about the challenges of your role?
- How do you feel about the challenges of your role?
- What helps you deal with these challenges?
- In what ways do these help?

Closing question

- Is there anything else that you would like to add to what you have said?

Thank you again for agreeing to be interviewed.

Appendix 10

Participant interview schedule – Organisational management staff

Participant Interview Schedule

Organisational Management Staff

Welcome and thank you for agreeing to be interviewed.

Introductory questions

- How long have you been working for the ambulance service?
- How long have you been in your current role?

Main questions

- What does your current role involve?
- Tell me about the changes you have seen in the service since you started?
- What do you think about the changes?
- As you know I have had the chance to spend time with the ambulance crews and to experience their work and the challenges they face. I am really interested to hear your thoughts and views on the challenging aspects of their job?
- What do staff do to deal with the challenging aspects of their role?
- What support is available for staff to help them deal with these challenges?
- What are your views about these support systems?
- How do you find staff view the support available to them?

Closing question

- Is there anything else that you would like to add to what you have said?

Thank you again for agreeing to be interviewed.

Appendix 11

Participant interview schedule – Administrative staff

Participant Interview Schedule

Administrative Staff

Welcome and thank you for agreeing to be interviewed.

Introductory questions

- How long have you been working for the ambulance service?
- How long have you been in your current role?

Main questions

- Tell me about your current role and what this involves?
- Tell me about your involvement with the emergency crews in the station?
- What changes have you seen here since you started?
- How do these changes affect the crews?
- What do you see are the challenges they experience in their work?
- What do they do that helps them deal with these challenges?

Closing question

- Is there anything else that you would like to add to what you have said?

Thank you again for agreeing to be interviewed.

Appendix 12

Confirmation of request for ethical approval

EoSRES

NHS SCOTLAND
Research Ethics Service

East of Scotland Research Ethics Service (EoSRES) REC 1
Tayside Medical Sciences Centre (TASC)
Residency Block C, Level 3
Ninewells Hospital & Medical School
George Pirie Way
Dundee DD1 9SY

Mrs Angela Williams
Senior Lecturer
Swansea University
Swansea University
Singleton Park
Swansea, SA2 8PP

Date: 08 October 2014
Your Ref:
Our Ref: DL/14/ES/1090
Enquiries to: Mrs Diane Leonard
Extension: Ninewells extension: 83871
Direct Line: 01382 383871
Email: eosres.tayside@nhs.net

Dear Mrs Williams

Study title: **An ethnographic study of emotion work in emergency pre-hospital care**
REC reference: **14/ES/1090**
Protocol number: **RIO 016-14**
IRAS project ID: **159996**

Thank you for your application for ethical review, which was received on 07 October 2014. I can confirm that the application is valid and will be reviewed by the Proportionate Review Sub-Committee on 13 October 2014. To enable the Proportionate Review Sub Committee to provide you with a final opinion within 10 working days your application documentation will be sent by email to Committee members.

One of the REC members is appointed as the lead reviewer for each application reviewed by the Sub-Committee. Dr Graham Cormack is the Lead Reviewer for your application.

Please note that the lead reviewer may wish to contact you by phone or email between 08 October 2014 and 13 October 2014 to clarify any points that might be raised by members and assist the Sub-Committee in reaching a decision.

If you will not be available between these dates, you are welcome to nominate another key investigator or a representative of the study sponsor who would be able to respond to the lead reviewer's queries on your behalf. If this is your preferred option, please identify this person to us and ensure we have their contact details.

You are not required to attend a meeting of the Proportionate Review Sub-Committee.

Please do not send any further documentation or revised documentation prior to the review unless requested.

Documents received

The documents to be reviewed are as follows:

Appendix 13

Research ethics committee initial opinion letter

EoSRES

NHS SCOTLAND
Research Ethics Service

East of Scotland Research Ethics Service (EoSRES) REC 1
Tayside Medical Sciences Centre (TASC)
Residency Block C, Level 3
Ninewells Hospital & Medical School
George Pirie Way
Dundee DD1 9SY

Mrs Angela Williams
Senior Lecturer
Swansea University
Swansea University
Singleton Park
Swansea
SA2 8PP

Date: 15th October 2014
Your Ref:
Our Ref: LR/14/ES/1090
Enquiries to: Mrs Lorraine Reilly
Extension: Ninewells extension: 83878
Direct Line: 01382 383878
Email: eosres.tayside@nhs.net

Dear Mrs Williams

Study title:	**An ethnographic study of emotion work in emergency pre-hospital care**
REC reference:	**14/ES/1090**
Protocol number:	**RIO 016-14**
IRAS project ID:	**159996**

The Proportionate Review Sub-Committee of the East of Scotland Research Ethics Service REC 1 reviewed the above application on 13 October 2014.

Provisional opinion

The Sub-Committee would be content to give a favourable ethical opinion of the research, subject to clarification of the following issues and/or the following changes being made to the documentation for study participants:

1. Regarding the application form:

   - The Sub-Committee requested that an opt-in slip be attached to the Participant Information Sheet for participants to send/email back if they were interested in taking part in the study.

2. Regarding the Participant Information Sheet:

   - The Participant Information Sheet should be printed on appropriate departmental headed paper.
   - There should be information for participants explaining that they could withdraw from the study at any time and what would happen with the information collected if they withdrew.
   - The researcher was asked to adapt and insert the appropriate paragraph below under 'Who has reviewed the study?'

Appendix 14

Confirmation of favourable opinion & ethical approval

East of Scotland Research Ethics Service *(EoSRES)*

NHS SCOTLAND
Research Ethics Service

TAyside medical Science Centre
Residency Block Level 3
George Pirie Way
Ninewells Hospital and Medical School
Dundee DD1 9SY

Mrs Angela Williams
Senior Lecturer
Swansea University
Swansea University
Singleton Park
Swansea
SA2 8PP

Date: 17th October 2014
Your Ref: LR/14/ES/1090
Our Ref: Mrs Lorraine Reilly
Enquiries to: Ninewells extension: 83878
Direct Line: 01382 383878
Email: eosres.tayside@nhs.net

Dear Mrs Williams

Study title:	**An ethnographic study of emotion work in emergency pre-hospital care**
REC reference:	**14/ES/1090**
Protocol number:	**RIO 016-14**
IRAS project ID:	**159996**

Thank you for your correspondence of 17th October 2014, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Mrs Lorraine Reilly, eosres.tayside@nhs.net.

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.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Appendix 15

Participant recruitment poster

Swansea University
Prifysgol Abertawe

RESEARCH STUDY

Learning more about pre-hospital care

A PHD student from Swansea University will be based at this station over the next 12 months or so to learn about pre-hospital care and the challenges faced by workers in this environment.

The study is ethnographic which means the student will spend time with operational staff observing them as they perform their duties in order to learn as much as possible about what they do. Later there will be a chance for staff to participate in research interviews about their work.

Approval to conduct this study has been given by the National Research Ethics Committee and the Welsh

Ambulance Service (NHS) Trust.

If you have any concerns about this research or you would just like some more information then please contact Angela Williams on
01792 518549
Or email at [redacted]

Appendix 16

Participant information sheet – Frontline staff

PARTICIPANT INFORMATION SHEET

Frontline staff

Title of Project: A study of emotion work in emergency pre-hospital care
Chief Investigator: Angela Williams
REC No…… Version PartInfoFsV2 Date: 16.10.2014

Introduction
I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you.

What is the purpose of the research?
The purpose of the research is to learn more about the emotional demands of emergency pre-hospital care and to explore how practitioners deal with these demands. Central to this purpose is the need to gain insight into these demands from your perspective as the emergency practitioner.

Who is conducting this study?
The study is being conducted by me, Angela Williams, a Senior Lecturer at Swansea University, who is undertaking a part- time PhD study. I am being supervised by Dr Michael Coffey and Professor David Hughes at Swansea University.

Why have I been invited?
I am keen to gather the views and perspectives of the staff directly involved in emergency care delivery in the pre-hospital care setting and your particular ambulance station has been chosen as a setting for this study.

Do I have to take part?
It is up to you to decide if you would like to participate in the study. **You are not obliged to participate and can withdraw from the study at any time, without giving a reason. Any information collected from you will be removed from the study.**
Your decision will not affect your role in any way.

What will I have to do if I take part?

Participation in the study will involve you being interviewed by me at a mutually convenient time and place. The interview will be audio recorded so that I don't miss anything you tell me and should take no longer than 1 hour to complete.

Are there any risks or inconveniences?
I do not think there will be any risks involved in the study. However the interview may touch on experiences that were emotionally challenging and the recall of events may be upsetting to you. Should this happen I will offer to stop the interview. I will advise you of sources of professional support which will be available to help you such as occupational health and the counselling service. You are reminded that your participation is entirely optional and you are free to stop the interview at any time.

What benefits are there for me?
Whilst I am unable to guarantee specific benefits for you, it is hoped that the research findings will serve to enhance understanding and appreciation of the emotional demands of emergency care provision and the support needed by those who deliver it.

Who has reviewed this research?
'The East of Scotland Research Ethics Committee REC 1, which has responsibility for scrutinising all proposals for medical research on humans in Tayside, has examined the proposal and has raised no objections from the point of view of medical ethics. It is a requirement that your records in this research, together with any relevant records, be made available for scrutiny by monitors from the <<sponsor>> and NHS <<organisation/Trust/Healthboard>>, whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.'

What if there is a problem?
If you have a concern about any aspect of this study, you are free to speak to the researcher who will do their best to answer your questions. The researcher as indicated above is Angela Williams. She can be contacted by telephone on [redacted] or by email on: [redacted] between the hours of 9am and 5pm weekdays.

How will you keep information about me confidential?
Any information gathered whilst conducting the study will be treated in confidence. I will do this in several ways.

1) All information collected during the course of the research will be kept strictly confidential, and any information gathered will not include any identifying information so that you cannot be recognised.
2) Tape recordings of interviews will not include your name and once transcribed (typed) the recordings will be destroyed.
3) All data collected will be stored safely and securely on password-protected computers or in locked cabinets in secure University premises.
4) At no time will you be identified in reports, publications or presentations. We will also remove any identifying information and use codes and pseudonyms to ensure you are not identified.
5) Data collected for this research study will be stored securely for up to 5 years and then destroyed.
6) This study focuses on staff and will not involve the collection of data from or about patients or relatives receiving care in the pre-hospital setting.

Finally, anything you tell me will be treated in confidence unless I am concerned about your safety or the safety of someone else or if I become aware of professional malpractice, in which case I would have to discuss my concerns with you.

What will happen if I don't want to continue with the study?
You may withdraw from the study at any time. However, if you withdraw from the study I would like to use the information I have already collected unless you ask me not to.

Are you insured if anything goes wrong?
In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against Swansea University but you may have to pay your legal costs.

What will happen to the results of the study?
The findings of the research study will be written up in the form of a thesis which will be submitted to Swansea University for the award of a Doctor of Philosophy. It is also anticipated that the findings of the study will be published in a variety of professional journals, will be presented at the researcher's college and at suitable conferences. I would reiterate however that you or your station will not be identified in any publication or presentation.

What do I do now?

If you have any questions or concerns please do not hesitate to ask. **If you have fully understood the information and agree to be interviewed please complete the attached consent form and return this to the researcher within 2 days.**
Alternatively you can email me at [redacted] if you are interested in participating in the study.

Thank you very much for your time and interest.
Angela Williams
Principal Investigator
Further information and contact details
For more information or any concerns about this research project please contact:
Angela Williams – Senior Lecturer/Researcher (Swansea University)
Tel: [redacted] Email: [redacted]

Appendix 17

Participant information sheet – Organisational management staff

PARTICIPANT INFORMATION SHEET

Organisational Management Representative

Title of Project: A study of emotion work in emergency pre-hospital care
Chief Investigator: Angela Williams
REC No…… Version PartInfoMgtV2 Date: 16.10.2014

Introduction
I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you.

What is the purpose of the research?
The purpose of the research is to identify the emotional demands of emergency pre-hospital care and to explore how practitioners deal with these demands in this particular setting. As part of this understanding, I am interested in the perspectives of management staff within the ambulance service trust and the support available.

Who is conducting this study?
The study is being conducted by myself Angela Williams, a Senior Lecturer at Swansea University, who is undertaking a part- time PhD study. I am being supervised by Dr Michael Coffey and Professor David Hughes at Swansea University.

Why have I been invited?
I am keen to gather the views and perspectives of both frontline staff and those in a managerial capacity within the particular trust, to gain an holistic picture.

Do I have to take part?
It is up to you to decide if you would like to participate in the study. **You are not obliged to participate and can withdraw from the study at any time, without giving a reason. Any information collected from you will be removed from the study.**
Your decision will not affect your role in any way.

What will I have to do if I take part?
Participation in the study will involve you allowing me to interview you at a mutually convenient time and place. The interview will be tape recorded so that I don't miss anything you tell me and should take no longer than 1 hour to complete.

Are there any risks or inconveniences?
I do not think there will be any risks involved in the study.

What benefits are there for me?
Whilst I am unable to guarantee specific benefits for you, it is hoped that the research findings will serve to enhance understanding and appreciation of the emotional demands of emergency care provision and the support needed by those who deliver it.

Who has reviewed this research?
'The East of Scotland Research Ethics Committee REC 1, which has responsibility for scrutinising all proposals for medical research on humans in Tayside, has examined the proposal and has raised no objections from the point of view of medical ethics. It is a requirement that your records in this research, together with any relevant records, be made available for scrutiny by monitors from the <<sponsor>> and NHS <<organisation/Trust/Healthboard>>, whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.'

What if there is a problem?
If you have a concern about any aspect of this study, you are free to speak to the researcher who will do their best to answer your questions. The researcher as indicated above is Angela Williams. She can be contacted by telephone on [redacted] or by email on: [redacted] between the hours of 9am and 5pm weekdays.

How will you keep information about me confidential?
Any information gathered whilst conducting the study will be treated in confidence. I will do this in several ways.

1) All information collected during the course of the research will be kept strictly confidential, and any information gathered will not include any identifying information so that you cannot be recognised.
2) Tape recordings of interviews will not include your name and once transcribed (typed) the recordings will be destroyed.
3) All data collected will be stored safely and securely on password-protected computers or in locked cabinets in secure University premises.

4) At no time will you be identified in reports, publications or presentations. We will also remove any identifying information and use codes and pseudonyms to ensure you are not identified.

5) Data collected for this research study will be stored securely for up to 5 years and then destroyed.

6) This study focuses on staff and will not involve the collection of data from or about patients or relatives receiving care in the pre-hospital setting.

Finally, anything you tell me will be treated in confidence unless I am concerned about your safety or the safety of someone else or if I become aware of professional malpractice, in which case I would have to discuss my concerns with you.

What will happen if I don't want to continue with the study?

You may withdraw from the study at any time. However, if you withdraw from the study I would like to use the information I have already collected unless you ask me not to.

Are you insured if anything goes wrong?

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against Swansea University but you may have to pay your legal costs.

What will happen to the results of the study?

The findings of the research study will be written up in the form of a large thesis which will be submitted to Swansea University for the award of a Doctor of Philosophy. It is also anticipated that the findings of the study will be published in a variety of professional journals, will be presented at the researcher's college and at suitable conferences. I would reiterate however that you or your station will not be identified in any publication or presentation.

What do I do now?

If you have any questions or concerns please do not hesitate to ask. **If you have fully understood the information and agree to be interviewed please complete the attached consent form and return this to the researcher within 2 days.**

Alternatively you can email me at [redacted] if you are interested in participating in the study.

Thank you very much for your time and interest.

Angela Williams

Principal Investigator

Further information and contact details

For more information or any concerns about this research project please contact:

Angela Williams – Senior Lecturer/Researcher (Swansea University)

Tel: [redacted] Email: [redacted]

Appendix 18

Participant information sheet - Administrative staff

PARTICIPANT INFORMATION SHEET

Administrative staff

Title of Project: A study of emotion work in emergency pre-hospital care
Chief Investigator: Angela Williams
REC No…… Version PartInfoAdminV2 Date: 16.10.2014

Introduction
I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you.

What is the purpose of the research?
The purpose of the research is to identify the emotional demands of emergency pre-hospital care and to explore how practitioners deal with these demands in this particular setting. As part of this understanding, I am interested in the perspectives of management staff within the ambulance service trust and the support available.

Who is conducting this study?
The study is being conducted by myself Angela Williams, a Senior Lecturer at Swansea University, who is undertaking a part- time PhD study. I am being supervised by Dr Michael Coffey and Professor David Hughes at Swansea University.

Why have I been invited?
I am keen to gather the views and perspectives of both frontline staff and those in a managerial capacity within the particular trust, to gain an holistic picture.

Do I have to take part?
It is up to you to decide if you would like to participate in the study. **You are not obliged to participate and can withdraw from the study at any time, without giving a reason. Any information collected from you will be removed from the study.**
Your decision will not affect your role in any way.

What will I have to do if I take part?
Participation in the study will involve you allowing me to interview you at a mutually convenient time and place. The interview will be tape recorded so that I don't miss anything you tell me and should take no longer than 1 hour to complete.

Are there any risks or inconveniences?
I do not think there will be any risks involved in the study.

What benefits are there for me?
Whilst I am unable to guarantee specific benefits for you, it is hoped that the research findings will serve to enhance understanding and appreciation of the emotional demands of emergency care provision and the support needed by those who deliver it.

Who has reviewed this research?
'The East of Scotland Research Ethics Committee REC 1, which has responsibility for scrutinising all proposals for medical research on humans in Tayside, has examined the proposal and has raised no objections from the point of view of medical ethics. It is a requirement that your records in this research, together with any relevant records, be made available for scrutiny by monitors from the <<sponsor>> and NHS <<organisation/Trust/Healthboard>>, whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.'

What if there is a problem?
If you have a concern about any aspect of this study, you are free to speak to the researcher who will do their best to answer your questions. The researcher as indicated above is Angela Williams. She can be contacted by telephone on [redacted] or by email on: [redacted] between the hours of 9am and 5pm weekdays.

How will you keep information about me confidential?
Any information gathered whilst conducting the study will be treated in confidence. I will do this in several ways.

1) All information collected during the course of the research will be kept strictly confidential, and any information gathered will not include any identifying information so that you cannot be recognised.
2) Tape recordings of interviews will not include your name and once transcribed (typed) the recordings will be destroyed.
3) All data collected will be stored safely and securely on password-protected computers or in locked cabinets in secure University premises.

4) At no time will you be identified in reports, publications or presentations. We will also remove any identifying information and use codes and pseudonyms to ensure you are not identified.

5) Data collected for this research study will be stored securely for up to 5 years and then destroyed.

6) This study focuses on staff and will not involve the collection of data from or about patients or relatives receiving care in the pre-hospital setting.

Finally, anything you tell me will be treated in confidence unless I am concerned about your safety or the safety of someone else or if I become aware of professional malpractice, in which case I would have to discuss my concerns with you.

What will happen if I don't want to continue with the study?

You may withdraw from the study at any time. However, if you withdraw from the study I would like to use the information I have already collected unless you ask me not to.

Are you insured if anything goes wrong?

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against Swansea University but you may have to pay your legal costs.

What will happen to the results of the study?

The findings of the research study will be written up in the form of a large thesis which will be submitted to Swansea University for the award of a Doctor of Philosophy. It is also anticipated that the findings of the study will be published in a variety of professional journals, will be presented at the researcher's college and at suitable conferences. I would reiterate however that you or your station will not be identified in any publication or presentation.

What do I do now?

If you have any questions or concerns please do not hesitate to ask. **If you have fully understood the information and agree to be interviewed please complete the attached consent form and return this to the researcher within 2 days.**

Alternatively you can email me at [redacted]k if you are interested in participating in the study.

Thank you very much for your time and interest.

Angela Williams

Principal Investigator

Further information and contact details

For more information or any concerns about this research project please contact:

Angela Williams – Senior Lecturer/Researcher (Swansea University)

Tel: [redacted] Email: [redacted]

Appendix 19

Participant consent form – Frontline staff

PARTICIPANT CONSENT FORM

Frontline staff

Title of Project: A study of emotion work in emergency pre-hospital care

Chief Investigator: Angela Williams

REC No…… Version PartInfoFsConsV2 Date: 16.10.2014

Please initial box to indicate agreement

1.	I confirm that I have read and understood the information sheet (Version PartInfoFsV2 Date: 16.10.2014, Participant Information Sheet) for the study. I have had time 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 a reason and without my legal rights being affected in any way.	
3.	I agree for the researcher to collect data directly from me, for the data to be held for 5 years, and for the data to be used in presentations, reports, other publications, teaching, and for secondary analysis. This is on the understanding that I will not be identifiable in any of these materials.	
4.	I consent to the use of the audio-recording of interviews with possible use of anonymous verbatim quotations in reports and publications.	
5.	I agree to take part in the above study.	

……..	……	…….
Name of Participant	Date	Signature
……..	……	…….
Name of witness	Date	Signature

Appendix 20

Participant consent form – Organisational management staff

PARTICIPANT CONSENT FORM

Organisational Management Representative

Title of Project: A study of emotion work in emergency pre-hospital care

Chief Investigator: Angela Williams

REC No…… Version PartInfo/MgtConsV2 Date: 16.10.2014

Please initial box to indicate agreement

1.	I confirm that I have read and understood the information sheet (Version PartInfoMgtV2 Date: 16.10.2014, Participant Information Sheet - management representative) for the study. I have had time 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 a reason and without my legal rights being affected in any way.	
3.	I agree for the researcher to collect data directly from me, for the data to be held for 5 years, and for the data to be used in presentations, reports, other publications, teaching, and for secondary analysis. This is on the understanding that I will not be identifiable in any of these materials.	
4.	I consent to the use of the audio-recording of interviews with possible use of anonymous verbatim quotations in reports and publications.	
5.	I agree to take part in the above study.	

.....	.....	.....
Name of Participant	Date	Signature
.....	.....	.....
Name of witness	Date	Signature

Appendix 21

Participant consent form - Administrative staff

PARTICIPANT CONSENT FORM

Administrative staff

Title of Project: A study of emotion work in emergency pre-hospital care

Chief Investigator: Angela Williams

REC No…… Version PartInfoFsConsV2 Date: 16.10.2014

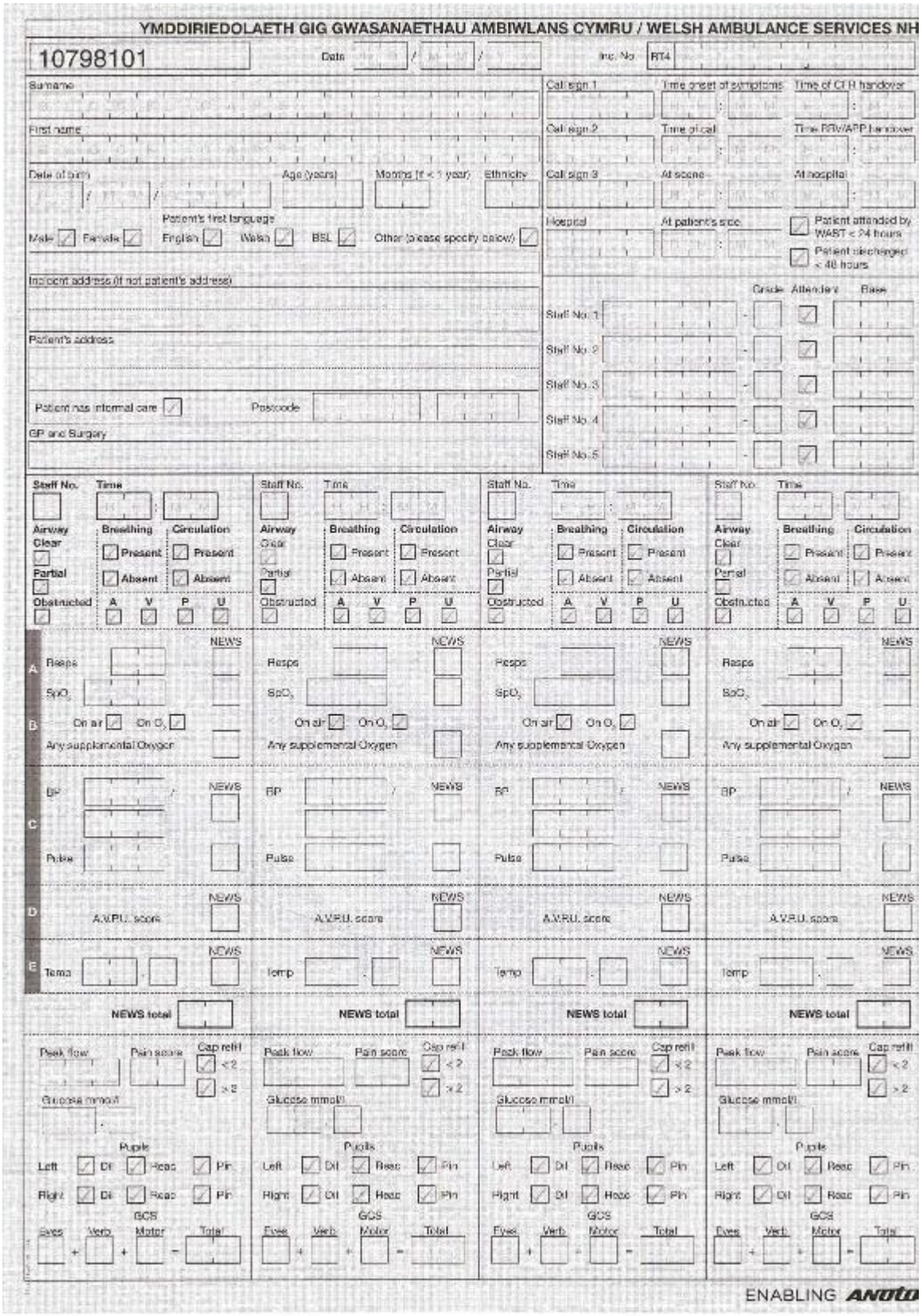
Please initial box to indicate agreement

1.	I confirm that I have read and understood the information sheet (Version PartInfoAsV2 Date: 16.10.2014, Participant Information Sheet) for the study. I have had time 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 a reason and without my legal rights being affected in any way.	
3.	I agree for the researcher to collect data directly from me, for the data to be held for 5 years, and for the data to be used in presentations, reports, other publications, teaching, and for secondary analysis. This is on the understanding that I will not be identifiable in any of these materials.	
4.	I consent to the use of the audio-recording of interviews with possible use of anonymous verbatim quotations in reports and publications.	
5.	I agree to take part in the above study.	

……..	……	…….
Name of Participant	Date	Signature
……..	……	…….
Name of witness	Date	Signature

Appendix 22

Patient Care Record (PCR)



YMDDIRIEDOLAETH GIG GWASANAETHAU AMBIWLANS CYMRU / WELSH AMBULANCE SERVICES NH

10798101

Date / /

Inc No RT4

Surname

First name

Date of birth / /

Age (years)

Months (if < 1 year)

Ethnicity

Patient's first language

Male ☑ Female ☑ English ☑ Welsh ☑ BSL ☑ Other (please specify below) ☑

Incident address (if not patient's address)

Patient's address

Patient has informal care ☑ Postcode

GP and Surgery

Call sign 1 Time onset of symptoms Time of CTR handover

Call sign 2 Time of call Time RRV/APP handover

Call sign 3 At scene At hospital

Hospital At patient's side ☑ Patient attended by WAST < 24 hours ☑ Patient discharged < 48 hours

	Grade	Attended	Base
Staff No. 1		☑	
Staff No. 2		☑	
Staff No. 3		☑	
Staff No. 4		☑	
Staff No. 5		☑	

Staff No.				
Time	:	:	:	:
Airway				
Clear ☑				
Partial ☑				
Obstructed ☑				
Breathing				
Present ☑				
Absent ☑				
A ☑				
V ☑				
P ☑				
U ☑				
Circulation				
Present ☑				
Absent ☑				
A ☑				
V ☑				
P ☑				
U ☑				
A				
Resps				
NEWS				
B				
SpO_2				
On air ☑				
On O_2 ☑				
Any supplemental Oxygen				
NEWS				
C				
BP /	/	/	/	
NEWS				
Pulse				
D				
A.V.P.U. score				
NEWS				
E				
Temp .	.	.	.	
NEWS				
NEWS total				
Peak flow				
Pain score				
Cap refill < 2 ☑				
Cap refill > 2 ☑				
Glucose mmol/l .	.	.	.	
Pupils				
Left ☑ Dil ☑ Reac ☑ Fix				
Right ☑ Dil ☑ Reac ☑ Fix				
GCS				
Eyes + Verb + Motor = Total				

ENABLING ANOTO

UST CLINICAL RECORD IN CONFIDENCE

Airway and Breathing (in Cardiac Arrest use A + B section overleaf)

OPA | NPA | SGA (Staff No.) | ETT (Staff No.) | NCRIC (Staff No.) | NCD (Staff No.)

Oxygen

Nasal cannula | Simple face mask | Non-rebreathing mask | Tracheostomy mask | Assisted ventilation

SGA/ETT checked by Auscultation | ET CO_2 | CO_2 mmHg

Cannulation (successful)

Cannulation site | Staff No. | Cannulation site | Staff No. | IV | IO | ANTT

Stroke/TIA FAST (deficit)

Face: L | R | None — Arm: L | R | None — Speech: Y | N — Time of onset HH : MM

Referred to Stroke Unit | Referred to TIA Clinic | ABCD² score

ECG

3 lead | 12 lead | NSR | AF | STEMI | PPCI referral | PIT with informed consent

ST elevation

I	AVR	V1	V4
II	AVL	V2	V5
III	AVF	V3	V6

Burns %

Flame | Scald | Electrical | Chemical | Other (details in narrative)

Trauma

Penetrating trauma | Fall < own height | Fall > own height | Blunt trauma | Assault | Firearms | Electrocution | Blast | Other (details in narrative)

Obstetrics

Time delivered HH : MM

Cord cut HH : MM

Placenta delivered HH : MM

Gest age (weeks)

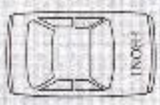
Delivered: On scene | En route

Spinal immobilisation

Collar | Longboard/scoop | Extric dev e.g. KED | Vacuum mattress

RTC

Minutes trapped



➡ = Point of impact

● = Position of patient

✚ = Position of fatality

Seat belt / crash helmet worn | Air bag activated | Ejected | Self extricated

Pedestrian | Cyclist | Motorcyclist | Vehicle occupant

Speed of impact in mph < 10 | 10 - 30 | > 30

Routine inquiry

H | I | T | S | Negative | Not undertaken (detail in narrative)

Safeguarding referral

Safeguarding referral form No. | Child | Adult | Staff No.

Condition codes Main | Other | Other

Next PCR number (Or previous if this is the last PCR)

Upgrade to hot response (details in narrative)

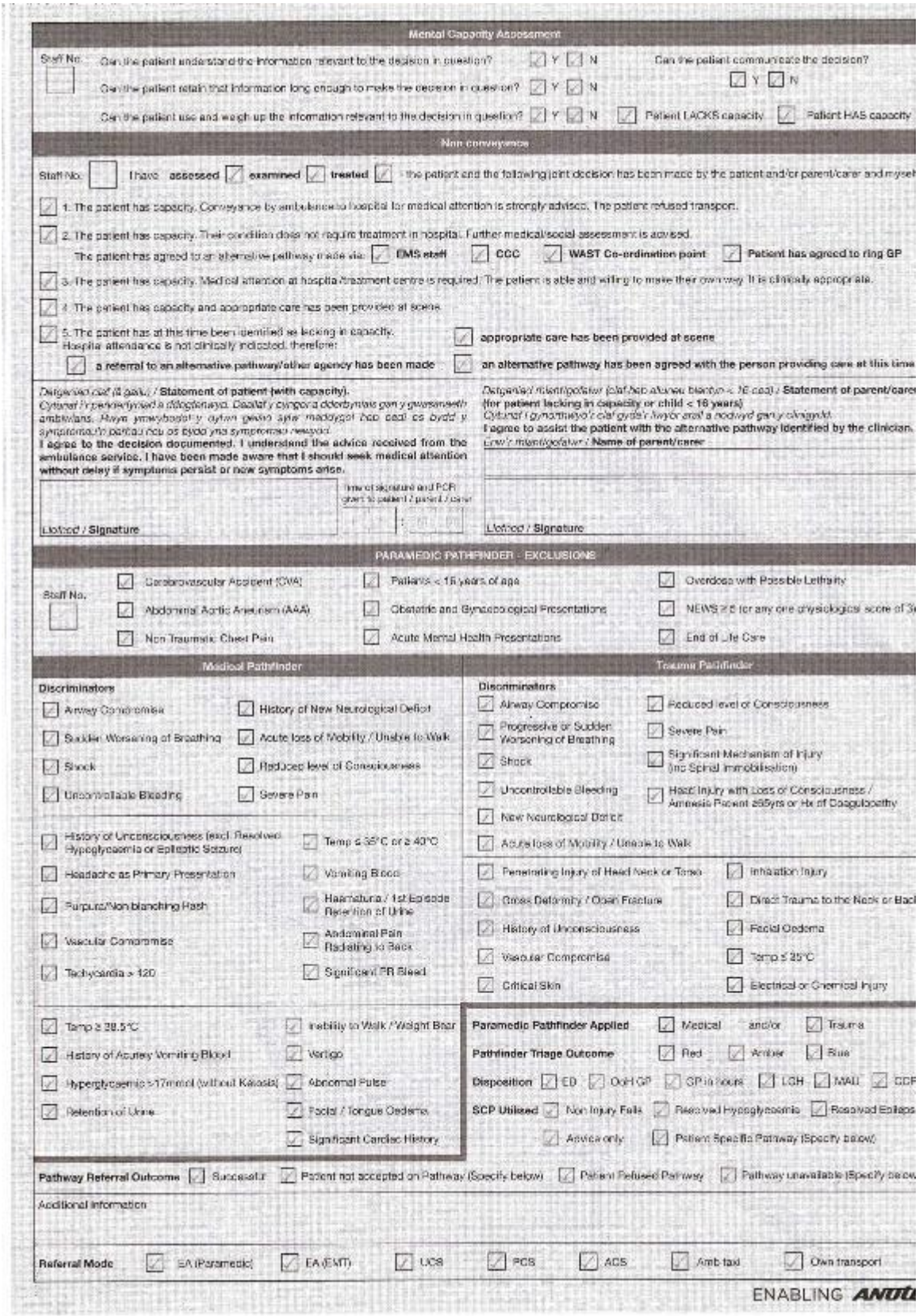
Non immediate transport requested | Pre-alert given

R&I code | R5 additional information

Medicines (including post Cardiac Arrest/ROSC medicines) Entonox

Time	Medicine	Code	Dose	Unit	Route	Staff No.
HH : MM			.			
HH : MM			.			
HH : MM			.			
HH : MM			.			
HH : MM			.			
HH : MM			.			
HH : MM			.			
HH : MM			.			

VE FUNCTIONALITY



Mental Capacity Assessment

Staff No:

Can the patient understand the information relevant to the decision in question? ☑ Y ☑ N

Can the patient retain that information long enough to make the decision in question? ☑ Y ☑ N

Can the patient use and weigh up the information relevant to the decision in question? ☑ Y ☑ N

Can the patient communicate the decision? ☑ Y ☑ N

☑ Patient LACKS capacity ☑ Patient HAS capacity

Non conveyance

Staff No: I have: **assessed** ☑ **examined** ☑ **treated** ☑ the patient and the following joint decision has been made by the patient and/or parent/carer and myself

☑ 1. The patient has capacity. Conveyance by ambulance to hospital for medical attention is strongly advised. The patient refused transport.

☑ 2. The patient has capacity. Their condition does not require treatment in hospital. Further medical/social assessment is advised.

The patient has agreed to an alternative pathway made via: ☑ **EMS staff** ☑ **CCC** ☑ **WAST Co-ordination point** ☑ **Patient has agreed to ring GP**

☑ 3. The patient has capacity. Medical attention at hospital/treatment centre is required. The patient is able and willing to make their own way. It is clinically appropriate.

☑ 4. The patient has capacity and appropriate care has been provided at scene.

☑ 5. The patient has at this time been identified as lacking in capacity. Hospital attendance is not clinically indicated, therefore:

☑ **appropriate care has been provided at scene**

☑ **a referral to an alternative pathway/other agency has been made**

☑ **an alternative pathway has been agreed with the person providing care at this time**

Datganiad cleif (i gleifion sydd â gallu) / **Statement of patient (with capacity).**
Cytuno i'r penderfyniad a ddogfennwyd. Deallaf y cynghorir ddarparwr gofal gwasanaeth ambiwlans. Rwyn ymwybodol y dylwn geisio sylw meddygol heb oedi os bydd y symptomau'n parhau neu os bydd yna symptomau newydd.
I agree to the decision documented. I understand the advice received from the ambulance service. I have been made aware that I should seek medical attention without delay if symptoms persist or new symptoms arise.

Llofnod / **Signature**

Amser llofnodi a PCR a roddwyd i'r claf / gofalwr / *Time of signature and PCR given to patient / parent / carer*

Datganiad rhiant/gofalwr (claf heb allu i gydsynio, blwydd < 16 oed) / **Statement of parent/carer (for patient lacking in capacity or child < 16 years)**
Cytuno i gymryd rhan yn y penderfyniad a ddogfennwyd gan y clinigydd.
I agree to assist the patient with the alternative pathway identified by the clinician.
Enw'r rhiant/gofalwr / **Name of parent/carer**

Llofnod / **Signature**

PARAMEDIC PATHFINDER - EXCLUSIONS

Staff No.

☑ Cerebrovascular Accident (CVA)
☑ Abdominal Aortic Aneurysm (AAA)
☑ Non Traumatic Chest Pain
☑ Patients < 16 years of age
☑ Obstetric and Gynaecological Presentations
☑ Acute Mental Health Presentations
☑ Overdose with Possible Lethality
☑ NEWS ≥ 5 for any one physiological score of 3
☑ End of Life Care

Medical Pathfinder

Discriminators

☑ Airway Compromise
☑ Sudden Worsening of Breathing
☑ Shock
☑ Uncontrollable Bleeding
☑ History of New Neurological Deficit
☑ Acute loss of Mobility / Unable to Walk
☑ Reduced level of Consciousness
☑ Severe Pain

☑ History of Unconsciousness (excl. Resolved Hypoglycaemia or Epileptic Seizure)
☑ Headache as Primary Presentation
☑ Purpuric/Non blanching Rash
☑ Vascular Compromise
☑ Tachycardia > 120
☑ Temp ≤ 35°C or ≥ 40°C
☑ Vomiting Blood
☑ Haematuria / 1st Episode Retention of Urine
☑ Abdominal Pain Radiating to Back
☑ Significant PR Bleed

☑ Temp ≥ 38.5°C
☑ History of Acutley Vomiting Blood
☑ Hyperglycaemic >17mmol (without Ketosis)
☑ Retention of Urine
☑ Inability to Walk / Weight Bear
☑ Vertigo
☑ Abnormal Pulse
☑ Facial / Tongue Oedema
☑ Significant Cardiac History

Trauma Pathfinder

Discriminators

☑ Airway Compromise
☑ Progressive or Sudden Worsening of Breathing
☑ Shock
☑ Uncontrollable Bleeding
☑ New Neurological Deficit
☑ Acute loss of Mobility / Unable to Walk
☑ Reduced level of Consciousness
☑ Severe Pain
☑ Significant Mechanism of Injury (inc Spinal Immobilisation)
☑ Head Injury with Loss of Consciousness / Amnesia Patient ≥65yrs or Hx of Coagulopathy

☑ Penetrating Injury of Head Neck or Torso
☑ Gross Deformity / Open Fracture
☑ History of Unconsciousness
☑ Vascular Compromise
☑ Critical Skin
☑ Inhalation Injury
☑ Direct Trauma to the Neck or Back
☑ Facial Oedema
☑ Temp ≤ 25°C
☑ Electrical or Chemical Injury

Paramedic Pathfinder Applied ☑ Medical and/or ☑ Trauma

Pathfinder Triage Outcome ☑ Red ☑ Amber ☑ Blue

Disposition ☑ ED ☑ OoH GP ☑ GP in hours ☑ LGH ☑ MAU ☑ CCP

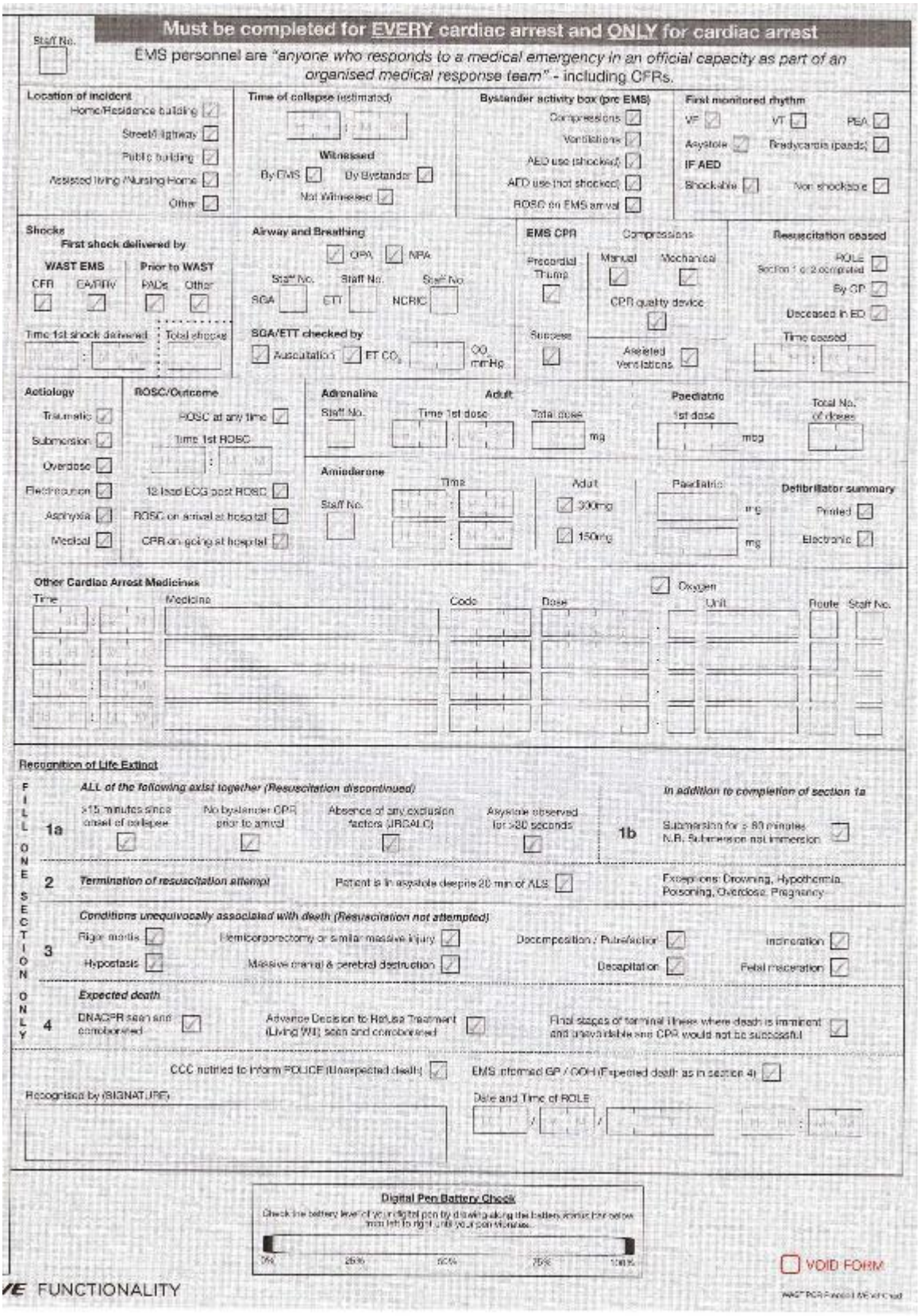
SCP Utilised ☑ Non Injury Falls ☑ Resolved Hypoglycaemia ☑ Resolved Epilepsy
☑ Advice only ☑ Patient Specific Pathway (Specify below)

Pathway Referral Outcome ☑ Successful ☑ Patient not accepted on Pathway (Specify below) ☑ Patient Refused Pathway ☑ Pathway unavailable (Specify below)

Additional Information

Referral Mode ☑ EA (Paramedic) ☑ EA (EMT) ☑ UCS ☑ PCS ☑ ACS ☑ Amb taxi ☑ Own transport

ENABLING ANOTU



Staff No.

Must be completed for EVERY cardiac arrest and ONLY for cardiac arrest

EMS personnel are *"anyone who responds to a medical emergency in an official capacity as part of an organised medical response team"* - including CFRs.

Location of incident
Home/Residence building
Street/Highway
Public building
Assisted living /Nursing Home
Other

Time of collapse (estimated)

Witnessed
By EMS
By Bystander
Not Witnessed

Bystander activity box (pre EMS)
Compressions
Ventilations
AED use (shocked)
AED use (not shocked)
ROSC on EMS arrival

First monitored rhythm
VF
VT
PEA
Asystole
Bradycardia (paeds)
IF AED
Shockable
Non shockable

Shocks
First shock delivered by
WAST EMS: CFR, EA/PBV
Prior to WAST: PADs, Other
Time 1st shock delivered
Total shocks

Airway and Breathing
OPA
NPA
SGA (Staff No.)
ETT (Staff No.)
NCRIC (Staff No.)
SGA/ETT checked by
Auscultation
ET CO_2
CO_2 mmHg

EMS CPR
Precordial Thump
Success
Compressions: Manual, Mechanical
CPR quality device
Assisted Ventilations

Resuscitation ceased
ROLE
Section 1 or 2 completed
By GP
Deceased in ED
Time ceased

Aetiology
Traumatic
Submersion
Overdose
Electrocution
Asphyxia
Medical

ROSC/Outcome
ROSC at any time
Time 1st ROSC
12 lead ECG post ROSC
ROSC on arrival at hospital
CPR on going at hospital

Adrenaline
Staff No.
Time 1st dose
Adult: Total dose (mg)
Paediatric: 1st dose (mcg)
Total No. of doses

Amiodarone
Staff No.
Time
Adult: 300mg, 150mg
Paediatric (mg, mg)

Defibrillator summary
Printed
Electronic

Other Cardiac Arrest Medicines
Oxygen

Time	Medicine	Code	Dose	Unit	Route	Staff No.

Recognition of Life Extinct

FILL ONE SECTION ONLY

1a *ALL of the following exist together (Resuscitation discontinued)*
>15 minutes since onset of collapse
No bystander CPR prior to arrival
Absence of any exclusion factors (URGALC)
Asystole observed for >30 seconds

1b *In addition to completion of section 1a*
Submersion for > 60 minutes
N.B. Submersion not immersion

2 *Termination of resuscitation attempt* — Patient is in asystole despite 20 min of ALS
Exceptions: Drowning, Hypothermia, Poisoning, Overdose, Pregnancy

3 *Conditions unequivocally associated with death (Resuscitation not attempted)*
Rigor mortis
Hypostasis
Hemicorporectomy or similar massive injury
Massive cranial & cerebral destruction
Decomposition / Putrefaction
Decapitation
Incineration
Fetal maceration

4 *Expected death*
DNACPR seen and corroborated
Advance Decision to Refuse Treatment (Living Will) seen and corroborated
Final stages of terminal illness where death is imminent and unavoidable and CPR would not be successful

CCC notified to inform POLICE (Unexpected death)
EMS informed GP / CDH (Expected death as in section 4)

Recognised by (SIGNATURE)

Date and Time of ROLE

Digital Pen Battery Check
Check the battery level of your digital pen by drawing along the battery status bar below from left to right until your pen vibrates.
0% 25% 50% 75% 100%

VOID FORM

FUNCTIONALITY