Journal of Paramedic Practice

Emotional Labour Amidst COVID-19: Focus on Paramedic Practice'

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Response to Reviewers:	
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Question	**Response**
Please enter the word count of your manuscript **excluding references and tables**	2145

Title page

‘Emotional Labour Amidst Covid 19: Focus on Paramedic Practice’

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Author Responses Commentary Box:

We have highlighted all of our responses in the resubmitted article in turquoise so that it is clear where amendments have been inserted. We would like to sincerely thank the reviewers for their constructive commentaries, it was a huge help in the final iteration of the article.

Reviewer One Commentaries	Author Responses
The introduction could be better worded to give you a strong opening, to draw the reader further into your article	Thanks so much, we agree absolutely and have reworded this introduction so that hopefully it is far more accessible than it was in the original version.
A few sweeping statements which would benefit from being referenced- such as the psycho-emotional effects which are anticipated for the long-term. Several academics have published papers from which this point could be referenced.	Thanks, we have added some additional authors, around the psycho-emotional impact of long term effects. These have been cited and referenced as: Bergen-Cico, D., Kilaru, P., Rizzo, R., & Buore, P. (2020). Stress and well-being of first responders. In *Handbook of Research on Stress and Well-Being in the Public Sector*. Edward Elgar Publishing. Kent, J., Thornton, M., Fong, A., Hall, E., Fitzgibbons, S., & Sava, J. (2020). Acute provider stress in high stakes medical care: Implications for trauma surgeons. *Journal of Trauma and Acute Care Surgery*, *88*(3), 440-445. Roser, M,. Ritchie, H,. Ortiz-Ospina E and Hasell, J (2020) - "Coronavirus Pandemic (COVID-19)". *Published online at OurWorldInData.org.* Retrieved from: 'https://ourworldindata.org/coronavirus' [Online Resource – Accessed 22.05.20] Schmidt, K. H., & Diestel, S. (2014). Are emotional labour strategies by nurses associated with psychological costs? A cross-sectional survey. International Journal of Nursing Studies, 51, 1450–1461. doi: 10.1016/j.ijnurstu.2014.03.003

	Theodosius, C. (2008). Emotional Labour in Healthcare: The Unmanaged Heart of Nursing. New York, NY: Routledge.
The paragraph relating to the aim of the article, followed by 'these two issues...' but I was confused as to which two issues you felt were often overlooked...?	Thank you, we agree and have removed this in its entirety.
It's great that you have made reference to Hochschild. I wonder if you can make links to deep and surface acting where you go on to discuss emotional response and emotional labour. This would help to connect Hochschild's theory with your own work, and its application to paramedic practice	Thanks, this was a really constructive suggestion, within which we also incorporated another citation and reference: Msiska, G., Smith, P., Fawcett, T., & Nyasulu, B. M. (2014). Emotional labour and compassionate care: What's the relationship?. *Nurse education today*, *34*(9), 1246-1252.
It would also help the reader by giving a short, clear definition of what emotional labour and associated terms mean.	Thanks, we have also incorporated this into the section above.
First paragraph of the 'Emotional regularity' section is confusing too. Are you saying that as a result of critical world events, emotions in the workplace have become more relevant to understand, and since these world events, our approach to emotional regulation and critical reflection has changed? If so, I think your article could be enhanced by rewording this.	Many thanks for this suggestion, we hope the reviewers will agree this has made things much clearer in terms of articulation.
The section on paramedic practice is a useful one but it is quite difficult to read and make sense of. It doesn't really relate to practice specifically, and I think you need to link the text with paramedic's work more explicitly. I understand that you're talking of how it used to be part of the professionalisation process for healthcare workers to develop a detachment from their emotions - but how does this link to a paramedic's work? Then link this to covid-19, as you have done	Thanks, we agreed with this and with hindsight thought this section was best removed, since the additional lengthy insert earlier in the manuscript and also the discussion of organisational hierarchies at the conclusion, negated the need for its overall inclusion.
The last paragraph prior to the conclusion - you make an important point about hierarchy and detachment of emotions. It would be great if you could expand on this within your article. Perhaps it would be helpful here, to draw upon professional examples - such as Dr's/	Thanks, this was a sound suggestion and we feel our change to this section makes it much stronger.

Consultants, bedside manner in terms of emotions etc. Also, expand on how hierarchy and detachment relates to covid-19. For example - Ambulance managers and the strategic response to the pandemic, or ambulance staff detaching from emotions when dealing with covid patients.	

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Response to Reviewers:	Please see the attached table we have provided, detailing all of our changes.
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Introduction

Emotional preparedness is no new phenomenon for paramedic and emergency service healthcare personnel across the world (Buick et al, 2020; Kent et al, 2020). The emergence and rapid spread of COVID-19 globally, in the pandemic we now face, though, has ensured an impact on human emotion, suffering and loss of the greatest resonance since World War Two. As a consequence, the lived experiences of front line healthcare staff, of which paramedics are an integral and invaluable part, have been irrevocably changed in terms of their usual everyday clinical and professional practice.

The impact of the pandemic has had a tangible resonance across all health and social care professional groups, but the context specificity of providing acute emergency care provision for COVID-19 patients is nowhere more evident than in paramedic practice (Bergen-Cico, et al, 2020). High volumes of COVID-19 patients present as severely oxygen deprived and in need of urgent hospitalisation, which sadly has become a new norm for paramedic and front line healthcare personnel. Added to the fact that the disease state they present with being highly contagious and potentially deadly (as evidenced by the recorded mortality figures of medical, allied health and carers) the pressure that currently faces paramedic staff in providing care and often the final opportunity of families to say goodbye to loved ones as they are transported away for oxygen therapy and sometimes ventilation is immeasurable.

The temporal impact of COVID-19 has been dramatic; over the initial eight-week period of lockdown, the, the United Kingdom has witnessed over 35,000 deaths directly attributable to the condition, many of which have occurred in community based settings (Roser et al. 2020). The ripple effect upon those who have lost loved ones, in addition to the front-line personnel caring for COVD-19 patients is something so tangible and raw on a human level to those affected, that the impact of this will be felt for generations yet to come. In the midst of human suffering and the human impact of this condition are paramedics, whose psychological wellbeing is imperative to their role, and perhaps most importantly their own capacity to cope, in dealing with patients and their families and carers, for whom death may be imminent, unexpected and under difficult circumstances, without loved ones present because of the necessity of enforced and very stringent social distancing measures. The emotional cost of such scenarios has long been documented within the existing published l healthcare professional literature base from parallel disciplinary fields such as nursing practice (Schmidt and Diestel, 2014; Theodosius, 2008)

The aim of this article is to raise awareness of the concept of emotional labour that underpins the role of paramedics at the front line of patient care. The concept of emotional labour is often overlooked in relation to the personal cost of having to cope, particularly amidst the intensity of this pandemic, which is a new scenario and rapidly changing, fraught with uncertainty and unexpected outcomes.

Emotional Regularity for First Line Healthcare Responders

As a result of critical world events, emotions in the workplace have become more relevant to understand, and since these world events, our approach to emotional regulation and critical reflection has changed (Peate, 2020; Steele et al, 2019). Two key events in recent history of usefulness, in comparison, are the Ebola pandemic across the Democratic Republic of Congo and to a lesser extent, and contextually different, the accounts of how 9/11 responders' lives were irrevocably changed by the experiences they had at the time (Peate, 2020; Smith and Burkle, 2019). Despite being separated by culture, context and geography, alongside different causes necessitating emergency response, emphasis was placed on the clear separation of emotions on a personal level and emotions at a professional level, where there was an engendered sense of separation from the true self in the workplace, rather than an acknowledgement of how that essentially underpinned everything (Schultz, Koenig and Alassaf, 2015; Matthew, 2020). Theorists have explored this phenomenon in detail – Hochschild (1979 and 1983), as outlined earlier in this article, emphasised the concept of regularity in practice and operationally defined zones of emotional response and engagement, termed emotional labour and emotional work, where the two are equated to deep and superficial processes of acting. Acting in itself implies a sense of disingenuity in 21st Century healthcare, where authenticity is a keystone, central to the foundation and building of genuine compassionate care.

Framing Emotional Response

Emotive response can appear insincere when it is acted or faked or actively modified to accommodate an organisational societal norm (Grandey, 2003). Within the context of paramedic practice, it is wholly necessary for personnel to ensure certain human emotions stay concealed, e.g. revulsion at a horrific injury. In the conceptualisation of the term emotional labour, this constitutes the effort that paramedics have to, by necessity, apply to their expressed behaviour, rather than managing the feelings that underpin them with something, in terms of organisational psychology, that is constructed without any degree of authentic feeling. One of the key areas of consideration in affective response for paramedic practice over recent years, has been the concept of emotional intelligence. The delineation between this and the concept of emotional labour under the present circumstances of COVID-19 has been placed into the limelight. Essentially they belong to the same psychological parameters, but whereas emotional intelligence is about the processing of complex information about an emotive response, emotional labour refers to the fact that in paid employment, personnel are expected, by virtue of their professional contracts to behave in a particular manner (McCann and Granter, 2019). As such, emotional labour is a consequence of the capacity for emotional intelligence, necessitating the application to practice of specific skills associated with mental resilience. These skills

are more commonly identified as the capacity to work amidst complex ambiguity, the capacity to resolve conflict and to work collaboratively in team based settings (Guy and Lee, 2015). All of these characterise the professional role of the paramedic at the front line of patient care.

Emotional Labour in Practice

Across parallel disciplines of healthcare provision, for example in emergency nursing practice and care, Hayward and Tuckey (2011) identified that possessing specific expertise and authority in the choice and manner in which to interact and connect emotively with patients and their families and carers facilitates them in feeling positively valued for the work they do. Alongside this, it drives their motivation to engage and take control of their contributions to working practice.

This article does not seek to engage with the deep philosophical debates around performativity that Lyotard perfected, but what is worthy of note is how this links directly to the concepts of what are termed 'deep and surface acting' at the front line of care. Both contribute directly to strategic mechanisms of performing and articulating emotional labour. Most straightforwardly operationally defined and for the purposes of this article, emotional labour is what is used to "induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others" (Hochschild, 1983). Within the context of emotional labour, it is important to distinguish clearly between both the concepts of deep and surface acting. Both have distinctly different purposes in practice, which can largely depend on the patient's level of consciousness and as a direct consequence of this, actually how aware they are in the context of any caring interaction. Within the context of paramedic practice specifically, acting is how emotional labour is performed with patients. In surface acting contexts, for example where reassurance of people is needed in the face of a situation, which might be terrifying for a patient, for example being taken away in an ambulance with the prospect of being placed on a ventilator and not knowing whether they will ever see their family again, emotions might be simulated, which are the exact opposite of what are being experienced. Reassurance for someone, for example who is of a BME background is uttered through the stark lens of awareness of the latest research that details quite starkly that actually that might not be the case at all, if they are found to have a positive diagnosis of Covid-19 (Chakravorty, 2020). At the opposite end of the continuum, is deep acting, when the paramedic may consciously alter their inner experience, inducing genuine emotions (Msiska et al, 2014). This is where a consideration of the altruistic care of paramedics is best considered through the lens of Bolton (2000), who stated that the concept of emotional labour might actually be oversimplified because of personal choice, rather than any degree of organisational expectation. It is also indisputable that since emotion is socially constructed and consequently embedded within personhood, that it remains possible to learn mechanisms of engagement with emotion rather than being constrained by those emotions which have somehow framed our existence to date (Goffman, 1959).

Within the context of everyday practical work at the front line of patient care is an acknowledgement of emotional labour and what it means in the sense of self-giving by paramedics at every shift, regardless of their own personal circumstances or individual mindset. Alongside and influencing this

perspective, are the cultural and situated aspects of meaning making from experience that characterise all work and frame all interactions that are undertaken in the healthcare workplace. There are clear gaps in the difference between theoretical thinking about being able to separate rational thought processes and approaches to emotional response in practice. This is particularly relevant when paramedics have to make very functional decisions in emergency situations, are often reliant on tacit knowledge, amidst the expression and intuitive understanding of human need, in relation to the needs of patients and their families and carers (Crinson, 2018).

Multi-Disciplinary Teamwork

Mutual repricocity is often overlooked within the context of emotional interaction at the front line of healthcare, particularly in relation to the interactive dialogue that takes place between interdisciplinary and multi-disciplinary, as well as multi-agency working (Takhom et al, 2019). A key example of this is at the point of paramedic handover to secondary care, when paramedics leave the patients they have transported from outside of the hospital setting with their colleagues from other healthcare professions, such as consultants and nurses whose care and expertise moves the patient along the next stage of their journey (Fitzpatrick et al, 2018). We define mutual repricocity in this instance as the symbiotic relationship between various partner agencies working together at the forefront of patient centred care. This is particularly evident in the care of COVID-19 patients for whom decision making and ownership of it can be life changing and in some instances even influence chances of surviving the condition. This is particularly true in the context of critical incidents where there is a power imbalance created by the vulnerability of a patient and / or perhaps the extent of injury or illness they are currently experiencing. It is the gap between these, which is the focus of meaning or sense making for those working with COVID-19.

Parameters of Physical Care Provision

Social distancing in the context of medical and healthcare provision is the very antithesis of what we associate with care (Ransing et al, 2020). Care is characterised by touch, warmth and human contact at the heart of interaction. Where masks are worn over the face, this serves not only as a necessary part of personal protective equipment but also to further distance the patient from their carer at an already frightening time for most people, amidst separation from their families for an unknown length of time in the knowledge that they have contracted a disease that the public media report every day, kills without first clearly delineating who is next. With COVID-19 physical detachment is everything in the preservation of the lives of others and the reduction of rates of infection caused by the virus.

The contextual and temporal significance of Covid 19, also provides a means of using Bolton's (2005) theory of being able to clearly delineate between four fundamental work based emotional responses in practice. These are highly relevant to paramedics working in practice, whose work ultimately incorporates each, on a daily basis.

- Adhering to social expectation of the presentation of an emotional response.

- ❖ Emotional response consistent with prescribed and professional conduct rules and parameters.
- ❖ Performing an emotive response for financial reward, as a paid employee.
- ❖ The sacrificial giving of emotion in the sense of a philanthropic or charitable gift.

Establishing what Drives Emotional Response in Practice

It is easily recognisable from the context of clinical paramedic practice that feelings can drive emotion in the context of patient centred care. As humans with empathy and compassion for others, we accept this as a social norm in work, where death and injury become everyday norms of reference (Clompus and Albarran, 2016). Dirkx' work emphasised that if this was used to drive emotive response rather than to become a product of it, that this was how transformation in practice, via learned experience could occur (Dirkx, 2006). In the context of paramedic practice, this is of utmost importance in being able to make sense of what are often horrific scenes, which in terms of an everyday context would be regarded as being in complete abstraction to everyday life, for most clinicians. It lies at the heart of why processes of reflection and critical reflexivity, alongside the everyday coping mechanisms of paramedics are so important in practice (Howlett, 2019). It is the cultural mediation of work that Jarret and Vinc (2017) describe as mediating the energisation and disempowering of emotion in practice. Nowhere is this more evident than in the paired professional clinical working of paramedic teams in practice. Their shared experiences as well as individual capacity to make meaning of them, lie at the heart of what will become memorialised as the time of COVID 19.

In the context of clinical professional practice, a legacy of pyramidal hierarchical structures of organisation, means that detachment of emotion from care was relative in relation to the functional capacity of the person administering it. It was highlighted by Lewis (2005) that there ought to be a clear assumption that detachment of emotion is not associated with competence. Traditionally and historically, prior to the days of patient-centric models of care, those who treated and cared for people, were delineated by the infrastructure of an organisational hierarchy that created division and separation between those who worked interprofessionally. The typical pyramidal structure, with consultants at the top, followed by medics and with allied health and nursing staff positioned at the bottom, was not as conducive to either patient empowerment or optimal communication pathways. It can be argued that COVID-19 has served to functionalise roles at the height of clinical emergency and then sentimentalise care at its foundation. This is largely attributable to the need for PPE and social distancing. Care is directly associated with acts of human emotion, which are not separated by plastic sheeting, the anonymising of facial features and the homogenising of appearance in human interaction via the absolute necessity for PPE. The complex ambiguity with which the paramedic is faced on a daily basis serves to highlight not only their competence but their authentic compassion for dealing with patients and their families and carers with abject professionalism, whilst simultaneously never losing sight of the 'human touch' of compassion and care.

Conclusion

The pandemic we face as a global society has brought the concept of emotional labour to the fore of the healthcare workforce like nothing contemporary society has ever experienced before. Whilst we can allude to similarities in historical contexts, our own cultures and contexts, frame what these mean to us and the feelings that we regard them with. Paramedics working in the midst of COVID-19, need to be supported in the acknowledgement of their invaluable contributions but also acknowledge the extent of the emotional labour they contribute, above and beyond, what is usually required of them. Where they are now also accompanying patients, without other family members being present, the context of their care, in the midst of social distancing has never been more important, yet fundamentally more difficult. Whilst considering theoretical perspectives on emotional labour is useful, seeing this actively applied in praxis is an invaluable part of the legacy this global pandemic will leave us to learn from across the context of clinical healthcare provision.

Dedication

We would like to dedicate this article to the memory of Adekunle Enitan, a nurse who served in the ICU of the William Harvey Hospital in Kent, where on 24th April 2020, he also lost his battle with Covid-19. Ade was undertaking his doctorate at the University of Sunderland and will never be forgotten by his friends and colleagues. We were privileged to know him for only a short time but memories of his passion and enthusiasm to drive positive change in ICU care will stay with us forever. Our thoughts are with his family at this sad time.

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Author Responses Commentary Box:

We have highlighted all of our responses in the resubmitted article in turquoise so that it is clear where amendments have been inserted. We would like to sincerely thank the reviewers for their constructive commentaries, it was a huge help in the final iteration of the article.

Reviewer One Commentaries	Author Responses
The introduction could be better worded to give you a strong opening, to draw the reader further into your article	Thanks so much, we agree absolutely and have reworded this introduction so that hopefully it is far more accessible than it was in the original version.
A few sweeping statements which would benefit from being referenced- such as the psychoemotional effects which are anticipated for the long-term. Several academics have published papers from which this point could be referenced.	Thanks, we have added some additional authors, around the psycho-emotional impact of long term effects. These have been cited and referenced as: Bergen-Cico, D., Kilaru, P., Rizzo, R., & Buore, P. (2020). Stress and well-being of first responders. In *Handbook of Research on Stress and Well-Being in the Public Sector*. Edward Elgar Publishing. Kent, J., Thornton, M., Fong, A., Hall, E., Fitzgibbons, S., & Sava, J. (2020). Acute provider stress in high stakes medical care: Implications for trauma surgeons. *Journal of Trauma and Acute Care Surgery*, *88*(3), 440445. Roser, M,. Ritchie, H,. Ortiz-Ospina E and Hasell, J (2020) - "Coronavirus Pandemic (COVID-19)". *Published online at OurWorldInData.org.* Retrieved from: 'https://ourworldindata.org/coronavirus' [Online Resource – Accessed 22.05.20] Schmidt, K. H., & Diestel, S. (2014). Are emotional labour strategies by nurses associated with psychological costs? A crosssectional survey. International Journal of Nursing Studies, 51, 1450–1461. doi: 10.1016/j.ijnurstu.2014.03.003

	Theodosius, C. (2008). Emotional Labour in Healthcare: The Unmanaged Heart of Nursing. New York, NY: Routledge.
The paragraph relating to the aim of the article, followed by 'these two issues...' but I was confused as to which two issues you felt were often overlooked...?	Thank you, we agree and have removed this in its entirety.
It's great that you have made reference to Hochschild. I wonder if you can make links to deep and surface acting where you go on to discuss emotional response and emotional labour. This would help to connect Hochschild's theory with your own work, and its application to paramedic practice	Thanks, this was a really constructive suggestion, within which we also incorporated another citation and reference: Msiska, G., Smith, P., Fawcett, T., & Nyasulu, B. M. (2014). Emotional labour and compassionate care: What's the relationship?. *Nurse education today*, *34*(9), 1246-1252.
It would also help the reader by giving a short, clear definition of what emotional labour and associated terms mean.	Thanks, we have also incorporated this into the section above.
First paragraph of the 'Emotional regularity' section is confusing too. Are you saying that as a result of critical world events, emotions in the workplace have become more relevant to understand, and since these world events, our approach to emotional regulation and critical reflection has changed? If so, I think your article could be enhanced by rewording this.	Many thanks for this suggestion, we hope the reviewers will agree this has made things much clearer in terms of articulation.
The section on paramedic practice is a useful one but it is quite difficult to read and make sense of. It doesn't really relate to practice specifically, and I think you need to link the text with paramedic's work more explicitly. I understand that you're talking of how it used to be part of the professionalisation process for healthcare workers to develop a detachment from their emotions - but how does this link to a paramedic's work? Then link this to covid-19, as you have done	Thanks, we agreed with this and with hindsight thought this section was best removed, since the additional lengthy insert earlier in the manuscript and also the discussion of organisational hierarchies at the conclusion, negated the need for its overall inclusion.
The last paragraph prior to the conclusion - you make an important point about hierarchy and detachment of emotions. It would be great if you could expand on this within your article. Perhaps it would be helpful here, to draw upon professional examples - such as Dr's/	Thanks, this was a sound suggestion and we feel our change to this section makes it much stronger.

Consultants, bedside manner in terms of emotions etc. Also, expand on how hierarchy and detachment relates to covid-19. For example - Ambulance managers and the strategic response to the pandemic, or ambulance staff detaching from emotions when dealing with covid patients.	