This is the published version of a paper published in *IMPACT Journal*. 2016 Nov; 2.

Citation for the original published paper (version of record):

Hedman, K. (2016)
Managing Emotions in Swedish Medical Emergency Calls.
*IMPACT Journal*. 2016 Nov; 2, 2: 1-12

Access to the published version may require subscription.

N.B. When citing this work, cite the original published paper.

Permanent link to this version:
http://urn.kb.se/resolve?urn=urn:nbn:se:hj:diva-34571
Managing Emotions in Swedish Medical Emergency Calls

Hedman, K.

1. Ph.D., University Lecturer in Nursing and Assistant Professor in Social Work at School of Health and Welfare, Jönköping University.

Mail correspondence: karl.hedman@ju.se

Abstract

This study is a conversation analytic and ethnographic examination of recurrent emotion management practices of interaction in Swedish medical emergency calls. The study expands the analytical focus in past research on emergency calls between emergency call operators and callers to pre-hospital emergency care interaction on the phone between nurses, physicians and callers. The investigation is based on ethnographic fieldwork in an emergency control centre in a Swedish metropolitan area. The data used for the study consists of audio recordings of medical emergency calls and ethnographic fieldnotes, observations and interviews in the emergency control centre. The analysis reveals four fundamental types of emotion management practices that emergency call-takers use to help people in crisis: (1) call-takers keep themselves calm when managing callers’ social displays of emotions; (2) promising ambulance assistance or other types of assistance; (3) providing problem solving presentations including emergency response measures to concerns of callers, and (4) emphasising the positive to create and maintain hope for callers. The findings generated from this study will be useful in emergency call-taker training in carrying out emotion management procedures in medical emergency calls and add to the larger research programmes on on-telephone interaction between healthcare professionals and citizen callers.

Key words: Conversation Analysis; Emotion management; Ethnography; Medical emergency calls; Nurse; Physician; Swedish.
Introduction

This article examines emotion management practices of emergency call-takers in Swedish medical emergency calls. When faced with medical emergencies, crises and unknown risks, as when patients’ conditions change rapidly it is common for callers to react emotionally. These emotions may be viewed as expressions of that people’s lives are at stake and that callers do not have control over their emotions and what is going on. Call-takers use varying methods to manage the emotional turmoil and psychological stress of callers. The methods include call-takers being calm and responding empathetically to callers’ social displays of emotions and actively calming down anxious, angry, frustrated, frightened and shocked callers. In the interviews, call-takers state that central norms in emergency calls are for call-takers to first empathize with callers’ emotions and second to initiate and maintain a calm call environment throughout the calls. The term emergency call-takers refers here to emergency call operators, nurses and physicians, and is used in this article when I discuss emergency call operators, nurses and physicians as a call taking team.

I share the view of interactive practice with Heritage and Stivers (2014:665) that define a practice as “any aspect of action that (a) has a distinctive character, (b) has a specific location within a turn or sequence, and (c) is distinctive in its consequences for the nature of meaning of the action in which it is implemented”. CA builds spoken interaction theory empirically. Actions in medical emergency calls are achieved and oriented to by call participants using interactive procedures through which acute telephone contacts are shaped and re-shaped. Medical emergency call practices refer to how call-takers in social interaction with callers handle an unanticipated variety of conditions that calls for direct action, routinely with life-threatening consequences, such as unconsciousness, heart and respiratory related emergencies and suicide attempts. Each unique emergency is shaped by patients, callers, bystanders and emergency call-takers who encounter it. When participants in medical emergency calls are unable to accomplish particular actions in emergency response operations persons may die or their conditions may worsen.

Several types of feelings have the potential to create challenges, problems and concerns for call-takers and callers in the emergency response operations. Frustration, anger and anxiety are three emotional responses that may obstruct call-takers when conducting the medical interview in medical emergency calls. The emergency control centre has therefore developed detailed operational plans and practices that manage callers’ emotions. Anger may threaten emergency call norms and lead to a conflict between the call-taker and the caller and is rare in the emergency call data. Caller anxiety, on the other hand, is encountered by call-takers as a routine part of medical emergency calls. Anxious callers are upset, nervous, distracted, and uncomfortable. For that reason, are callers not always able to hear or remember what call-takers say. The anxiety may interfere with the medical interview that call-takers carry out in interaction with callers. Anxious callers may need reassurances about what can be expected about the emergency response operations decreasing caller confusion in the heat of the moment making medical interviewing more efficient. In response to crisis situations, call-takers routinely restore callers’ confidence in believing in their abilities and capacities to handle emergencies. Callers may feel lost, confused, worried and can thus experience difficulties in taking in what is going on and describing events when acting in emotion.

This study will demonstrate that power asymmetries and hierarchical differences are exhibited in emotion management practices of medical emergency calls. They are related to, for instance, the participants’ interactive and institutional knowledge, task and competence asymmetries, and asymmetries of participation as emergency management experts or novices. Emotion management practices display the epistemic asymmetry between the call-taker as the knowledgeable expert and the caller and/or patient as the recipient of emotion management
actions as its fundamental feature. Call-takers in emergency calls carry out emotion management with an “institutional mandate”. Callers in medical emergency calls routinely expect call-takers to manage emotions, and calm and reassure callers in relation to diverse needs and concerns.

When comparing call-takers and callers, emotion management skills of physicians, nurses and emergency call operators are incomparably much deeper and most of all more professional experience anchored than emotion management competencies of callers. Call-takers are institutionally responsible for patients in emergencies. Callers do not have any patient responsibility. When looking at asymmetries from the point of view of callers then callers have direct knowledge of and access to ongoing emergencies when they respond to questions, information and instructions of call-takers. Consequently, callers may have knowledge about current situations, symptoms and conditions, past illness history and life circumstances of patients. They may also be vulnerable and afraid because emergencies may be about life and death issues of persons and many times it is about persons that they have close relationships to which may make them worry. Emergency events for callers are usually new situations. In contrast, emotion management practices in medical emergency calls is a routine activity for call-takers. The participants have for that reason different outlooks and norms in emotion management procedures in medical calls for help.

A distinction can be made in the analysis of medical emergency calls in that callers express emotions or risk expressing emotions, for instance, anxiety or anger. The analysis will demonstrate how call-takers orient to this distinction. Callers may be the person that is directly affected in the emergency. In most medical emergency calls callers are predominantly immediate family members, extended family, close friends, acquaintances and bystanders and not the actual patients. They are through their relations to the acutely ill or injured persons often emotionally involved in the ongoing events. We can also assume that they are emotionally affected by the situation which can result in that they display emotions in the call interactions. In performing their routine work tasks of the emergency control centre, call-takers are not directly emotionally involved in each of the ongoing emergencies. They are not at the sites of the emergencies and can therefore not see and hear what is going on. In this regard they are limited by what they can do and what type of data they can collect from callers about patient symptoms, past medical histories and emergency events. Call-takers engage in emotion management in order to gather data and assess and make decisions about emergencies.

Emotions may run high in medical emergency calls and emotional displays may be consequential for interaction. The emotion management process is characteristically prompted by the orientation of call-takers that callers are facing problematic situations and are in need of being calmed, reassured and other types of emotional support. Emotion management practices in medical emergency calls carried out by call-takers are emergency organisational responses aiming to calm and support callers in order to immediately or in the near future handle emergency situations and patient symptoms.

In the beginning of medical emergency calls callers regularly inform call-takers what relationships they have to the acutely ill or injured persons. Call-takers can if the caller is a friend, acquaintance or relative of the patient assume that the caller is emotionally involved and affected. Professionals can also hear on the voices of the callers if they are emotionally affected by the emergency events. It thus requires great sensitivity and empathy in the interaction of call-takers to understand and assess patient symptoms and emergency events. Callers may not always be susceptible to emotion management practices because of the ongoing emergency situations which may make them feel anxious and stressed out when talking to call-takers.

Call-takers regulate their own and the callers’ emotions and observe what is going on in emergencies. They organise their emotion management practices in medical emergency calls in order for the participants to orient to overall
call goals that are not emotionally regulated such as the dispatch of ambulance assistance. Call-takers work to reduce strong emotions of callers that may obstruct and delay emergency response operations.

In CA studies, emotion and affect are often employed interchangeably (Ruusuvuori 2014:331-332). Ruusuvuori (2014:347) argues that conversation analytic research on emotion and affectivity views “emotion as social display that is co-constructed and thus emerges as observable in specific situations in talk-in-interaction”. Ruusuvuori (2014) presents different ways emotions emerge in conversation: (1) Emotion displays as consequential for interaction; (2) emotion as a co-constructed interactional resource; (3) emotion as a vehicle in performing institutional tasks; and (4) displays of emotion as an interplay of different modalities using the case of facial expression in relation to spoken interaction. Ruusuvuori (2014:332) states that emotional dimensions of interaction including laugh tokens, emotional tones of voice, affective lexical choices or facial expressions, are interwoven with talk and create a significant resource for understanding actions as emotional in human social interaction. In my conversation analytic understanding of emotion management, I am mainly interested in social displays of emotions, how emotions arise in medical emergency calls and how call-takers manage callers’ emotions and not emotions as individual experience. The analytic focus in this article is on the ways emotional displays are initiated and used by callers and how call-taker respond to these emotional expressions.

Tracy and Tracy (1998) carried out an ethnographic study based on participant observations and interviews of the different ways human feelings are understood, expressed and managed in an emergency control centre. The investigation is a description of the emotional landscape of the centre, the emotion rules of the organisation, and the communicative methods call-takers use to handle their own emotions while channelling callers’ emotions (anger, hysteria and other types of feelings) in order to keep callers on the phone to collect relevant emergency details. They use the term “double-faced emotional management” to refer to the emotion work of call-takers when they calm themselves and at the same time calm callers. Call-takers are expected to be calm and professional according to the call-taker training manuals which presents rules such as not getting emotionally involved, angry or excited. Instead they should show interest and care through tone of voice when talking to callers. Tracy and Tracy emphasise the significance of a working environment for call-takers that allows practices such as evaluative talk off the phone, joking and sharing experiences, in order to release stress, anger and anxiety.

**Methods**

In this study, medical emergency calls are approached through a Conversation Analysis (CA) of human social interaction in naturally occurring calls examining interactive practices of medical emergency calls and how these are implicated in local medical emergency situations. I perform an inductive, qualitative and data-driven data analysis to examine interactive patterns in medical emergency calls by repeated listening to and observing the medical emergency calls with the objective of identifying and collecting instances and collections of a phenomenon or a practice by describing and explaining recurring interactive practices of interaction between call-takers and callers, call participant orientations and commonalities in contexts of use (Sidnell and Stivers 2014:2). Reviewing the medical emergency calls in my data corpus, I selected and gave a detailed account of what was going on in the calls. In analysing each of the interactive procedures individually, I observed general and specific functions. Maynard (2014:19) states that “In the CA view, analysts need to discover participants’ orientations rather than impose their own”. Sidnell (2014:79-80) claims that interaction participants’ orientations are demonstrated in their own talk and in the “next-turn proof procedure”. Next-turn proof procedure means that we can see in the recipient’s response how this person understood the prior turn. We can also use
this foundation to our own analysis of what a participant meant to be doing by achieving that turn. Based on the analysis, the researchers formulate interactive phenomena to describe the occurrence of social practices. In the ethnographic analysis, I seek to locate and interpret the ethnographically local meanings, functions, and implications of human actions and organisational practices, and contextualise modes of organisation and organising principles of the culturally defined setting of the emergency control centre within a broader societal framework.

I have followed ethical principles discussed in past ethnographic, pre-hospital emergency care and social science research (Israel 2015; Atkinson 2015). Medical emergency calls with patients and callers in complex and distressing events and at a time of heightened vulnerability for patients have resulted in that a number of ethical decisions have been made in the project. In the pre-field work preparation, I contacted a Swedish emergency control centre and introduced the study. Ethical approval was sought and granted by the emergency control centre that I co-listen to and make copies of all telephone calls and radio communications made to and from the centre. Permission to collect and use the audio recordings of the calls and radio communications for research purposes was given by the chief of operations in this emergency control centre. At the time of this data collection there was no other required ethical review.

I signed secrecy contracts with the emergency response organisation SOS Alarm agreeing to that no caller, patient or call-taker identifiable details were going to be revealed. Participation by the emergency call-takers in the study was voluntary and consent was given after both verbal and written information about the research project was provided. None of the call-takers in the emergency control centre opposed to the fieldwork and data collection. An ethical problem in this study is that patients and callers in the medical emergency calls were not informed that they were being researched. In order to have respect for and protect persons involved in this study and for them to remain anonymous I have changed names, places and other identifying features of call participants in the transcripts.

The range of data for this article was prepared with the main objective of acquiring a demonstration of emotion management practices in Swedish medical emergency calls in which persons seek ambulance assistance. The study involved 483 hours of observing in the emergency control centre and 60 hours of audio recordings of telephone calls and radio communication contacts to and from the emergency control centre. In 82 of these audio recorded emergency calls callers requested ambulance assistance and described medical emergencies. All 82 medical emergency calls have been examined in a CA and ethnographic data analysis for this article.

A central analytical criterion in CA is procedural consequentiality (Schegloff 1992:111) which refers to that conversation analysts must be able to demonstrate how social context such as an identity, setting or other contextual details have determinate consequences for the participants in conversations. In analysing emotion management from a CA perspective, it is vital to show that participants of interaction orient to some features of interaction as affective (Local and Walker 2008).

Results

Emergency call-takers identify particular emotions, problems, options and possible emotion management practices, choose one or several emotion management methods, consider consequences for each method, plan to carry out emotion management methods and perform emotion management procedures. The call-takers use four main types of emotion management procedures:

1. Call-takers keep themselves calm and manage callers’ social displays of emotions
2. Granting ambulance assistance or other types of assistance
3. Providing problem solving presentations to concerns of callers
4. Emphasising the positive to create and maintain hope for callers

A distinction in regards to calmness can be made here in the way call-takers interact when performing emotion management in medical emergency calls. First, it is the practice of being calm as an emergency call-taker by maintaining a calm state, calm voice, avoiding going up into emotions of callers, follow action sequences and staying on topic even if callers are screaming or challenging the emotional order of medical emergency calls. Second, it is the practice of doing calming through active efforts to calm down callers and manage their emotions by delivering decisions about emergency responses, problem solving, underlining the positive of the event and working to create hope for callers.

According to the professional calmness norm of the emergency organisation, call-takers are expected to be empathetic, listen with full focus and remain calm in the midst of emergencies and crises independent of if the callers are expressing emotions or not. Callers may convey pain in their voices, be distressed, panicky or have fearful thoughts which may impede their talking and may cause them to scream, talk too fast, too loud or too slow and show a temporary loss of control over their emotions. A basic institutional task and interactive norm and practice of call-takers used throughout medical emergency calls is to stay calm and avoid going up into callers’ social display of emotions through a calm conversational tone of voice and choice of words, not raising the volume of the voice and not reacting to emotions of callers.

The emotion management practices of maintaining a calm state and managing emotions of callers are performed by call-takers throughout the calls. Ambulance promises are routinely positioned in the end of medical emergency calls. Problem solving is placed in the questioning phase and in the end of the calls. Engaging callers through future, hypothetical measure oriented problem solving is habitually located in the end of the calls as a method to prepare callers to encounter and respond to possible upcoming, acute situations. Positive messages are usually positioned in the end of the calls and also occasionally in the questioning phase. Most of the emotion management practices are thus placed in the end or in the questioning phase of emergency calls. With these emotion management practices call-takers stay calm, reassure callers with positive messages, solve problems and make decisions about how needs and concerns of patients and callers should be met regarding emergency response efforts.

When call-takers maintain a calm state by using a calm tone of voice and appear secure they work to construct a calm call environment. Callers are then more likely to feel safe and less worried. Call-takers listen to callers to see what types of reassurances and emotion management callers may need. Call-takers’ calm and reassuring manner may convince callers that they have little to fear. The voices of call-takers may be viewed as projecting authority and knowledge, backed up by a certainty of what they are telling callers. In this recipient designed emotion management practice, call-takers create calm call environments using a calm tone of voice, information and reassurances relevant to the concerns and needs of each individual caller. Presenting emergency response decisions and more specifically promising an ambulance is a routinized measure delivered by call-takers securing the organisational decisions of granting ambulance assistance to callers which also functions as a type of emotional management in medical emergency calls and as an emotion management method to avoid the risk that callers would express emotions later in the call such as anger or worry.

Call-takers routinely manage callers’ emotions by explaining that the ambulance is sent or that the caller will receive help while the parties are talking. This type of emotion management practice has a decision making dimension in that it presents a forward plan and strategic route process of the emergency. This is a granting of the caller’s emergency response request through an ambulance promise which meets the callers’ needs of ambulance assistance. The ambulance granting is usually placed in the middle of a medical call for help or in the end as a response to the ambulance assistance request made by the caller in the beginning of the call. In Extract 1,
the nurse responds to a suicide emergency when a self-harming person has swallowed tablets and alcohol. The daughter of the patient reports about the incident. Cases of self-harm present special challenges for callers and call-takers. This instance of self-harm requires urgent ambulance assistance. Here the nurse grants ambulance service and instructs the caller to look out for the ambulance (46-47) and keeping the gate open (54-55) thus engaging the caller in the problem solving process which the caller recognises (48). The nurse gives reassurance by alternative action preparedness instructions about either keeping the door open or to look out for the ambulance crew which is followed by the granting of ambulance assistance (54-55).

**Extract 1 [Suicide attempt by tablet overdose and acute alcohol intoxication] (8A344 98)**

44 N Hon har blandat sprit å tabletter då? She has mixed alcohol and tablets then?

45 C Ja, Yes,

46 N–Mm om vi skickar- <vi skickar ambulans direkt å Mmhm if we send- <we send ambulance directly and

47 du kan väl hålla utkik efter den.> you can surely keep a lookout for it.>

48 C Ja.

Yes.

49 N <Det finns väl ingen portkod eller nåt sånt där <There is surely no gate code or something like that

50 däruppe eller?> up there or?>

51 C Nå det är stängd port hh No it’s closed gate hh

52 N <Ja just det.> <Yes that’s correct.>

53 C .hhja .hh yes

54 N– <Du kan väl ställa nätting emellan ( ) eller

<You can surely put something in between ( ) or

55 hålla utkik lite så ska vi komma direkt där.> keep a lookout a little so are we going to come directly there.>

The nurse is oriented to that the caller is willing to help in the emergency response operation because the incident is about the caller’s mother. Consequently, the call participants share responsibility for the safety and health of the patient which demonstrates that they are in agreement in saving the life of the self-harming woman. The turns with the lexical item “surely” (47, 54) are delivered in a question format as an instruction. The format “Then it is just to make sure” does not even include a person anticipating that the participants cooperate. The reassurances (47, 54-55) concern significant details before the ambulance crew arrives in keeping a look after the ambulance and making sure that the gate is open.

A central aspect of the ambulance granting practice is reassurance. Based on their emergency response expertise call-takers calm emotionally upset callers by providing and enabling support through the use of caring, gentle and reinforcing words and tone of voice demonstrating an understanding of patient pain, symptoms, events, callers’ situations and emergency accounts. An emotion management calming technique that call-takers use to maintain a calm call environment in medical emergency calls is to present emergency response measures that will be carried out in the near future exampled in the expressions “just make sure” and “we’ll arrange that someone”. The usage of the word “just” is presenting emergency response measures as an easy practice to perform. In order to solve problems when managing emergencies and crises call-takers give callers self-motivating messages to enhance caller engagement.

Extract 2 is taken from a medical emergency call about a man with a diagnosed kidney disease. The physician engages the caller by providing him with measure oriented instructions about future, hypothetical conditions which are confirmed and negotiated by the caller. In the physician evaluation of the patient the doctor makes acuity judgements and determines what aspects the caller needs to think about in the emergency
situation which is transferred in the measure oriented instructions to the caller.

**Extract 2 [Kidney disease] (1A17:111)**

91D—En ambulans ä en akutbil
An ambulance and an emergency vehicle

92 är på väg å de är snart
is on the way and they are soon

93 framme eh då är det bara att se till
there eh then it is just to make sure

94 att andningsvägarna är så fria
that the airways are as open

95 som de kan å samtidigt framstupa læge.
as they can and at the same time recovery position.

96 C Vänta lite jag ska titta bara.
Wait a moment I will just have a look.

This agenda-setting exchange guides the caller what to think about and to follow the treatment instruction by the physician by leaving the phone in order to initiate the treatment procedure in two steps ensuring that the airways of the patient are open and that the patient is placed in a recovery position. The physician prepares the caller to save the life of his father by adopting a joint treatment-orientation with the physician.

In light of this point, it is noteworthy to state that treatment options for patients increase if callers stay calm and become involved and take on a treatment-giver identity and responsibility in the emergency response process while they wait for the ambulance crew to arrive. In this case above, the preparation for the acceleration of the treatment initiation from pre-hospital to family handling of the emergency situation occurs because of the emergency context. The caller has in the kidney patient emergency been informed that the ambulance and the emergency vehicle teams are on their way to the patient but the patient may die in the interim.

Call-takers habitually emphasise the positive to construct a calm call atmosphere in medical emergency calls example in “now it’s life in him anyway”. This emotion management practice expresses optimism for callers. Positive messages are usually positioned in the end of medical emergency calls. In Excerpt 3, the physician points to the two positive tendencies of a fast response time (185) and an improved condition of the patient (187).

**Extract 3 [Kidney problem] (1A17:111)**

91D—En ambulans ä en akutbil
An ambulance and an emergency vehicle

92 är på väg å de är snart
is on the way and they are soon

93 framme eh då är det bara att se till
there eh then it is just to make sure

94 att andningsvägarna är så fria
that the airways are as open

95 som de kan å samtidigt framstupa læge.
as they can and at the same time recovery position.

96 C Vänta lite jag ska titta bara.
Wait a moment I will just have a look.

To provide positive messages as a call-taker may both have calming and cooling effects on callers in medical emergency calls.

**Conclusions**

Emotion management in medical emergency calls is a professional social sensitivity and specialised telephone call support activity initiated and carried out by call-takers when interacting with callers. An overall strategy of call-takers in medical emergency calls includes performing a number of emotion management practices simultaneously. Emotion management interaction in medical emergency calls is distinctive in relation to emotion management practices in other forms of interaction by being acute, brief and goal oriented because of the emergency character of patient symptoms and events.

The findings demonstrate that call-takers manage callers’ emotions as direct responses to social displays of emotions by callers, for instance, when call-takers promise an ambulance instead of
responding with frustration in the call in which the caller delivers a frustrated protest to the suggested choice of hospital destination by the call-taker. More specific places that cause emotion management interaction in medical emergency calls are characterised by situations when callers express anxiety and insecurity with their words and voices of what they should do next, when callers state that they lack abilities to handle emergency events or explicitly articulate that they need support.

Emotion management procedures in medical emergency calls are asymmetric in character. Call-takers have knowledge about emergency response routines and when ambulances are sent. Asymmetries between call participants are exhibited by, for instance, in that call-takers have a decision and interpretative prerogative in medical emergency calls and perform emotion management practices based on emergency response organisational expertise, norms and guidelines. However, call-takers orient to understanding emergency situations, expectations and needs of callers with the consequence that calming interaction sequences may end in consensus between call-takers and callers. When comparing the emotion management methods the findings demonstrate differences in levels of interactional asymmetry of participation between call-takers and callers. Asymmetries of tasks include that call-takers calm callers to engage them in assisting patients. Knowledge-based asymmetries are expressed in dissimilar epistemic domains between call-takers and callers in that professional call-takers have expertise in emotion and emergency management. By engaging callers in the emergency response work call-takers ask callers to carry out first aid measures on patients or prepare for the arrival of ambulance services when both call-takers and callers share the strong commitment to save lives of patients. Asymmetries between call-takers and callers are minimised when they cooperate to assist patients in a shared emergency response operation.

Call-takers usually respond sensitively to callers’ emotions through specific and recipient designed emotion management. By orienting to see emergency events from the eyes of callers call-takers use their emergency response expertise when performing emotion management in medical emergency calls. Call-takers are routinely able to stay calm and collected and organise their conduct so that the calls are moving towards to overall goals of the medical emergency call of making an informed ambulance assistance decision and preparing for the arrival of the ambulance services. These overall goals are not emotionally steered but driven by the emergency control centre and the societal mandate of the emergency control centre to respond to medical emergencies in cooperation with ambulance services.

When callers become worried and agitated it will usually make the call environment worse. As a response call-takers maintain their professional emotional neutrality, stay calm and reassure callers that they have emergency response operations under control. Emotion management through calming practices will usually lead to a decrease in callers’ anxiety. Anxious callers will generally benefit from extra emphasis on supportive calming statements by call-takers.

Emotion management techniques are used by call-takers to meet the requirements and functions of medical emergency calls and the emergency control centre. The results suggest that emotion management methods used by call-takers keep callers as information sources and active participants in managing emergencies. Call-takers’ emotion management practices are supported by the institutional mandate with operational implications of what call-takers are required to do according to the protocols of the emergency control centre.

Another dimension of emotion management practices is to perform tangible strategic route planning in regards to the emergency response. Creating an emergency strategic route in medical emergency calls is a social structure that has been built by the emergency control centre and call-takers in order to calm and help callers to overview emergency situations. By giving strategic route messages call-takers can support callers to calm down, handle stress, worry and other strains.
Call-takers use the medical index to calm and direct callers to adhere to the social normative order of medical emergency calls in case they challenge it or do any other actions that may risk the expected acute flow of the emergency call order. A related practice in medical emergency calls on the topic of calming is what I term acute flow maintaining instructions exampled in, for instance, “if you calm down a little bit now” which is a caller compliance procedure in which call-takers make total strangers comply with the social normative order of medical emergency calls by requiring the assistance of callers. Callers are expected to calm down and help emergency response authorities and therefore submit to call-takers who have expertise over emergency response procedures. Callers have limited emergency response options. Relinquishing their free will and going with the emergency call order is part of the emergency response process for callers. When call-takers direct callers to calm down and perform emergency measures on acutely ill patients callers routinely comply with the procedure.

Call-takers need three main capacities to perform emotion management in medical emergency calls: (1) self-control to stay calm and focus on what patients and/or callers account for; (2) interactive skills in empathetically reassuring, calming and positively motivating callers; and (3) emotional awareness and critical reflection skills in analysing and understanding contacts between call-takers and callers and the decision process that from professional emergency response knowledge choose relevant emotion management methods in varying emergencies. The emotional awareness and moral responsibility of call-takers precedes emotion identification and management efforts, and decision making decisions about emergencies and crises. Other important dimensions of emotion management in medical emergency calls are the guiding principles of establishing credibility and mutual trust between call-takers and callers.

The interactive phenomenon of emotion management practices in medical emergency calls may change in the coming years. The rapid globalization, migration due to wars, disasters, starvation, totalitarian regimes, terror attacks and the transformation of Swedish society including innovative social technologies and the ageing population of Swedish society may create new requirements for emergency control centre resources and call-taker competences to handle the complexities of emotion management practices in medical emergencies. A possible consequence would be an even higher demand for advanced emotion management capabilities of call-takers and emotion management routines in medical emergency calls.

Call-takers may need to improve their emotion management knowledge and skills in relation to mainly two groups of callers where comprehension and hearing problems are frequent in medical emergency calls. The first group is elderly persons and the second is non-native callers. Non-native callers may experience linguistic barriers and cultural differences when talking to call-takers at the emergency control centre which may create risks that call participants do not understand each other in ambulance emergencies. Emotion management interaction in medical emergency calls is a complex work task for call-takers. They will continue to experience increasing demands, both demographically and societally driven by an ageing population with vulnerable elderly including patients with symptoms and conditions such as Alzheimer’s or dementia, and disabled patients who rely upon reassurances and support for their care in emergencies.

**Source of funding, acknowledgements, conflict of interest**

I want to acknowledge the funding from Stiftelsen Lars Hiertas Minne that has provided financial support to this project. Great appreciation is extended to the Swedish emergency response organisation SOS Alarm and its personnel especially the outstanding workforce of the emergency control centre where I conducted ethnographic fieldwork for participating in this research project and for giving me consent to co-listen to medical emergency calls, use audio recorded calls and emergency control centre manuals which provide data for this article. I greatly appreciate the medical emergency call...
expertise and the efforts of my key contacts at SOS Alarm Andreas Leviné, Katarina Bohm and Hans Granløf. I certify that no actual or potential conflict of interest in relation to this article exists.

**Key Points**

Emotion management in medical emergency calls is a relevant social problem to analyse because when call-takers in medical emergency calls are unable to handle callers’ emotions in emergency response operations persons may die or their conditions may worsen. The call-takers use four main types of emotion management procedures: (1) Call-takers keep themselves calm and manage callers’ social displays of emotions; (2) Granting ambulance assistance or other types of assistance; (3) Providing problem solving presentations to concerns of callers, and (4) Emphasising the positive to create and maintain hope for callers.

The activity of emotion management in medical emergency calls is shaped by patient symptoms and emergency events and also by the emergency response requirements of society and the emergency organisation. Call-takers manage callers’ emotions as reactions to the varying local circumstances of medical emergency calls. The analysis in this article contributes to the emotion management literature by discussing the interactional consequences on social displays of emotion by callers when call-takers grant ambulance assistance, present solutions to problems of callers, and emphasise the positive to create and maintain hope for callers.

**References**