Experiences in Becoming a Paramedic: A Qualitative Study Examining the Professional Socialisation of University Qualified Paramedics

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Abstract

Over the past decade, the transition of paramedicine in Australia and the United Kingdom from a vocation to a profession has invariably influenced the socialisation of paramedics. Through professional socialisation, initial preconceptions formed prior to encountering the paramedic profession undergo a transformation process whereby the reality of paramedic practice is eventually recognised. Socialisation influences how individuals learn about their chosen profession, and may even impact on the employment longevity of new professional members. To date, the professional socialisation of paramedics has been largely neglected in the literature. This study aims to explore the professional socialisation process encountered by university educated paramedics, by examining the experiences of people making the transition from being a university student to a practising paramedic.

The study applied two existing professional socialisation models to examine the socialisation of university educated paramedics and the extent to which these models explained the professional socialisation of university educated paramedics. These socialisation models are the anticipatory, formal and post-formal phases of professional socialisation (Cant & Higgs, 1999; Higgs, 2013; Lamdin, 2006; Shuval & Adler, 1977) and Kramer's reality shock model (1974). To achieve the study aims, qualitative methods appropriate to this research study were selected from the work of Charmaz (2006, 2012) and Saldana (2009) to guide the data collection and analysis the process. Further, through reflexivity, the researcher's past experiences as a paramedic, educator and academic were explored to add validity and transparency to this research study.

University students and paramedics from Australia (n=19) and the United Kingdom (n=15) were interviewed for this study. The results confirmed the presence of anticipatory, formal and post-formal

professional socialisation phases in the socialisation of university educated paramedics. However, a new phase, the 'post-internship phase', was found to be present as paramedics who participated in this study were operationally given the title of qualified paramedic (Australia) or registered paramedic (United Kingdom) only after completing an internship period or professional paid employment year with an ambulance service. Up until the end of the internship period, the participants were probationary or internship paramedics (Australia) or ambulance technicians (United Kingdom). Many professional socialisation theories relate to disciplines such as nursing where registration is obtained on graduating from a university course, and is not contingent on completing a post-qualification year of work experience.

The results confirmed the presence of marginalisation and stigmatisation during university clinical placements, and also during the transition phase to the on-road environment after graduating. Further, the presence of Kramer's (1974) honeymoon, skill and routine mastery, social integration, moral outrage and conflict resolution phases were confirmed as relevant to the socialisation of university educated paramedics.

The conclusions drawn from this study indicate the professional socialisation process for many of the participants was a challenging, and at times, difficult experience. Expectations formed during the anticipatory and formal phases were largely found to not reflect the realty of paramedic practice encountered by the participants during the post-formal and post-internship phases. Last, the socialisation process was confounded by a dissonance between the university and ambulance service cultures.

Table of Contents

Tables and Figures

Tables

Figures

Statement of Original Authorship

The work contained in this thesis has not been previously submitted to meet requirements for an award at this or any other higher education institution. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made.

Signature:

Date: 28/10/2014

Terms, Abbreviations and Assumptions

The following terms, acronyms and abbreviations have been used in this thesis.

Abbreviations	
AEC	Ambulance Education Centre
AHPRA	Australian Health Professional Registration Agency
AOTC	Ambulance Officer Training Centre
ASNSW	Ambulance Service of NSW
CAA	Council of Ambulance Authorities
CSU	Charles Sturt University
ECA	Emergency Care Assistant. An ECA "responds to emergency calls as part of an accident and emergency crew or at times as a first responder, using skills and procedures that they have been trained and directed to do. They need to help move patients safely and observe patient vital signs - reporting any changes to the qualified clinician - and provide and take relevant information from carers or others at the scene" (National Health Service, 2013).
HECS	Higher Education Contribution Scheme
HCPC	Health Care Professions Council
ICP	Intensive Care Paramedic
IHCD	Institute of Health Care Development
LAS	London Ambulance Service

SAAS	South Australian Ambulance Service
NHS	National Health System
NRES	National Research Ethics Service (UK)
NSW	New South Wales
QAS	Queensland Ambulance Service
QUT	Queensland University of Technology
RPAH	Royal Prince Alfred Hospital in Sydney Australia
TAFE	Technical and Further Education
UK	United Kingdom
UH	University of Hertfordshire
Uni	University
VAPEL	Victorian Ambulance Professional Education Lobby
VU	Victoria University
Terms	
Ambulance Technician	The term Ambulance Technician was replaced by emergency care assistant after the data were collected. Please refer to ECA in abbreviations.
(NHS) Ambulance Trust	Ambulance services in the UK are provided by NHS Ambulance Service Trusts which "exclusively supply paramedic level emergency ambulance services and provide many non-emergency patient transport services to hospitals and clinics. A number of these Trusts also provide other services, such as professional ambulance training, and more recently

	nurse-based advice telephone lines accessible to the public, as part of the NHS Direct service." (Carney, 1999 p. 575)
Attending	The paramedic responsible for patient care during the shift.
Big Job	A major case involving a patient or patients in a critical condition, such as a multiple vehicular crash.
Big Wigs	Senior ranked managerial paramedic staff.
Bollocking	To be told off by a senior paramedic officer.
Bread and Butter Jobs	Common cases such as chest pain cases, shortness of breath and elderly patients who have fallen over.
Cardiac Arrest	When a patient's heart has stopped adequately beating and the patient requires resuscitation (Considine, & Shaban, 2010).
Crewmate	The other member of a two person crew on the ambulance.
Code One Response	A code one response is the most urgent dispatch code (lights and sirens), and is assigned to cases where the patient is believed to have an immediate life threatening condition (Garza, et al., 2008)
Dispatch Centre	Communication centre which receives emergency calls and dispatches an ambulance to the scene.

Getting Posted	Reassigned to a different station or area
High Acuity	A high acuity patient may present with "abnormal breathing, cardiac arrest, major injury, unconsciousness or uncontrollable bleeding" (Clawson, Olola, Herward, & Patterson, 2008, p. 291).
Interfaculty Transfer	Transferring a patient in an ambulance from one hospital to another.
Internship Paramedic	Also known as paramedic intern, graduate paramedic and probationary paramedic. Internship paramedics in Australia are engaging in an internship or professional year under the supervision of a qualified experienced paramedic.
Job	When paramedics are sent on a case, or attend to a patient.
Low Acuity	Where the patient's condition is stable and the paramedics do not have to implement invasive treatment. Some of these patients may not require transport to hospital.
On-Road or Out On-Road	Working on an emergency ambulance, or the operational side of an ambulance service.
Prac	Clinical Placements.
A Proper Job	A high acuity case.
Qualified Paramedic	"A health professional who provides

	rapid response, emergency medical assessment, treatment and care in the out of hospital environment" (Paramedics Australasia, 2013, p. 3).
Registered Paramedic	A registered paramedic provides "specialist care and treatment to patients who are either acutely ill or injured. They can administer a range of drugs and carry out certain surgical techniques" (Health & Care Professions Council, 2013).
Rubbish Job or Crappy Job	A low acuity case where the paramedics do not need to instigate patient care.
Sandwich Year	In the third year of the University of Hertfordshire paramedic program, students complete a 12 month work block with the London Ambulance Service as Ambulance Technicians or Emergency Care Technicians.
Third Manning	Being an extra crewmember on an ambulance. Ambulances generally have two crew persons under normal circumstances.
Thrown in the Deep End	A junior paramedic being placed in the rear of the ambulance and given the responsibility of treating a critical patient while the more senior clinician drives the ambulance to hospital.
Trainee Paramedic	A paramedic being trained through the in-house vocational model.

Shock the Patient	To defibrillate a patient in cardiac arrest.
Stair Chair	A collapsible wheel chair that has also been designed to take patients down a set of stairs.
War Stories	When experienced paramedics tell stories about previous high acuity or unique cases.
Assumptions	
Cognitive Dissonance	Cognitive dissonance occurs when an individual encounters a discrepancy between previously held ideas or behaviours and justifies the discrepant ideas or behaviours to form a state of competence and morality (Stone & Cooper, 2001; Thibodeau & Aronson, 1992).
Emotional Coding	Emotional coding labels the emotions experienced by the research participants that are identified in the literature (Goleman, 1995; Prus, 1996).
Focused Coding	Focused coding searches for the most common or frequently used codes to develop a category (Charmaz, 2006; Saldana, 2013).
Holistic Coding	Holistic coding identifies the major codes, categories or issues in the data by absorbing them as a whole, and not by a line-by-line approach (Dey, 1993).
Lumping the data	Lumping the data refers to the process of analysing large segments as a

	whole, rather than through a line-by-line approach or splitting the data (Dey, 1993).

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Chapter 1 Introduction

1.1 Introduction

Professional socialisation is described as the process by which people obtain the values, attitudes, skills, knowledge and culture of a profession (Howkins & Ewens, 1999; Merton, Reader, & Kendall, 1957). It has also been asserted that the phenomenon of professional socialisation is complex as it requires an individual to develop the 'craft' of their profession, which possibly goes beyond the application of values, skills and knowledge (Conrad, 1988; Lamdin, 2006). Many authors suggest that the professional socialisation process begins in childhood and early adulthood prior to the commencement of professional studies at university (Cant & Higgs, 1999; Higgs, 2013; Kramer, 1974; Kramer, 2010; Shuval & Adler, 1977). After beginning tertiary studies, the curriculum, clinical placements and then internship programs, if any, further advance the professional socialisation process and eventually lead to the acquisition of an occupational identity (Dinmohammadi, Peyrovi, & Mehrdad, 2013; Kramer, 1974; Maclellan, Lordly, & Gingras, 2011).

Despite research dating back to the early 1960s investigating the professional socialisation of medical doctors, allied health professionals and nurses (Anderson & Bell, 1998; Becker, Hughes, Geer, & Strauss, 1961; Chipchase et al., 2006; Davis & Olesen, 1964; Dinmohammadi et al., 2013; Goode, 1960; Tradewell, 1996; Tryssenaar, 1999; Tryssenaar & Perkins, 2001), the topic of paramedic professional socialisation has been largely untouched until relatively recently (Devenish, Clark, Fleming, & Loftus, 2012; Devenish, Clark, Fleming, & Loftus, 2011; Lazarsfeld-Jensen, Bridges, & Loftus, 2011; O'Brien, Moore, Hartley, & Dawson, 2013; O'Meara, Tourle, Madigan, & Lighton, 2012; Williams, Devenish, & Stephens, 2012). Understanding the professional socialisation process encountered by paramedics is vital as more graduates enter the

workplace and paramedicine continues to transition away from a vocational occupation and emerge as a health profession. The transition towards a professional socialisation process for paramedics has implications for the individual (university paramedic graduates), university paramedic programs and the paramedic discipline.

Through this qualitative thesis, the professional socialisation of university educated paramedics from Australia and the United Kingdom is explored using existing professional socialisation models, namely the anticipatory, formal and post-formal phases of professional socialisation (Cant & Higgs, 1999; Higgs, 2013; Lamdin, 2006; Shuval & Adler, 1977) and Kramer's (1974) reality shock model. The study examines the extent to which these theories explain the professional socialisation of paramedics and develops a theoretical model specific to this discipline. To achieve these aims, qualitative methods selected from the work of Charmaz (2006, 2012) and Saldana (2009) guides the data collection and analysis process. Although the work of Charmaz (2006, 2012) is based on grounded theory (Glaser and Straus, 1965), it is important to note that this research study has been flexible in its selection of qualitative methods, and is not a grounded theory study. Further, through the process of reflexivity, the researchers past experiences as a paramedic, educator and academic have been acknowledged, and bring validity and transparency to the research process. It is anticipated that this thesis will provide future paramedics, paramedic educators and management with a better understanding of the professional socialisation process encountered by university graduates, and highlight the contributing factors that may either advance or hinder the development of a professional workplace identity.

In the context of this thesis, a paramedic is "a health professional who provides rapid response, emergency medical assessment, treatment and care (of patients) in the out of hospital environment" (Paramedics Australasia, 2013, p. 3). The nature of paramedical work combines aspects of medicine and a paramilitary hierarchy within the framework of

an emergency service. Consequently, certain aspects of the professional socialisation process of paramedics may differ when compared to medical doctors, allied health professionals and nurses. Paramedicine in the United Kingdom (UK) and Australia is still undergoing the transition towards a pre-employment tertiary qualification model which, for other health professions such as medical doctors, pharmacists and nurses, has been mandatory for quite some time. More recently, the registration of UK paramedics with the Health Care Professions Council (HCPC) was established in 2001. Australian paramedics continue to lobby State and Federal Governments to achieve national paramedic registration. Consequently the professional socialisation of paramedics is a relatively new phenomenon that to date has received little attention in the literature in contrast to what has occurred in other health professionals.

1.2 Background

Prior to 1960, paramedics in Australia and the UK had no nationally recognised qualification, and were only required to possess a driver's license and a first aid certificate to gain employment (Howie-Willis, 2009; Kilner, 2004a; McDonell, Burgess, & Williams, 2009). In 1966, UK paramedics were able to obtain an Ambulance Services Proficiency Certificate (Millar, 1966), which evolved into the in-house vocationally taught Institute of Health and Care Development (IHCD) ambulance technician program (Emms, 2010; Kilner, 2004b). In Australia, the Kangan report in the 1970s brought about the development of technical and further education (TAFE) (Fleming, 1994), which led to the development of structured in-house vocational training for paramedics in Australia (McDonell et al., 2009).

Since the mid-1990s, the education and training of paramedics commenced the transition from an in-house vocational training model to a pre-employment university model (Donaghy, 2008; Fields, 1994; Gregory, 2006; Lord, 2003). The 'academisation' of paramedicine has arguably had

an important impact on the ambulance industry (Lord, 2003). For example, the demographics of university paramedic graduates are different to the current paramedic workforce in relation to gender distribution, age and tertiary qualifications (Laing, Devenish, Lim, & Tippett, 2014; Joyce et al., 2009; Paramedics Australasia, 2012b) all of which may impact on workforce planning, including retention. After graduating from university, the time required to become a qualified paramedic has decreased to as little as nine months in Australia. Alternatively in the UK, if people follow routes to registration through higher education institutions, such as the University of Hertfordshire, then eligibility to apply for registration as a paramedic with the Health Care Professions Council is concurrent with successful completion of a paramedic degree program (Williams, 2010b, 2012a; Woollard, 2009).

At the time of writing this thesis[1], many Australian and UK ambulance services rely solely on a university pre-employment model for the initial education and training of their workforce. Therefore to gain employment with these services, an individual must first obtain a degree qualification in paramedic science. However, two of the world's largest ambulance services, the London Ambulance Service and the Ambulance Service of New South Wales (NSW), have difficulty obtaining sufficient numbers of university graduates to fill their vacancies. Therefore, these services, at the time this thesis was written, still offered a traditional in-house vocational education and training qualification as an alternative route to becoming a paramedic.

Historically, an in-house vocational training and apprenticeship model exposed recruits to the ambulance culture from the first day of their employment. Additionally ambulance service training had a strong organisational focus and in-house qualifications lacked portability between jurisdictions (Fitzgerald, 2013). In contrast, university graduates have a bachelor's degree, which is transferable between ambulance services.

[1] This research study commenced in 2008 and concluded in 2014.

Graduates are educated to use critical reasoning skills, reflective and ethical practice, and make use of the best available evidence to inform and shape their patient management decisions. University educated paramedics encounter a professional socialisation process as they progress through the academic curriculum and clinical placements while at university. This study investigates the experiences of university educated paramedics from Australia and the UK as they transition through a professional socialisation pathway to become a paramedic.

1.3 Justification for the Research Topic

Studies focusing on the professional socialisation of paramedics in Australia and the UK are sparse. However, the professional socialisation of other health professionals is well canvased in the literature. Therefore this study is timely as it fills a gap in the paramedic body of knowledge.

Paramedicine became a health profession in the UK in 2001 (Emms, 2010; Woollard, 2009), and is considered to be an emerging health profession in Australia (First, 2012; O'Meara, 2011, 2012; O'Meara & Furness, 2013; Sheather, 2009). Thus, paramedics have lagged behind other health professions in terms of university qualifications, regulation and registration (Joyce, Wainer, Piterman, Wyatt, & Archer, 2009; O'Meara, 2011, 2012; Sheather, 2009; Trede, 2009). Furthermore, registration and research are considered two of the hallmarks of being a profession. Australian university qualifications for paramedics emerged in 1994 (Battersby, 1993; Fields, 1998; Lord, 2003) and paramedic qualifications in the UK commenced in 1998 (Carney, 1999; Donaghy, 2008; Williams, 2010b). Prior to the establishment of university qualifications for paramedics, the traditional in-house vocational training of paramedics did not cover topics such as research methods and evidence based practice in the curriculum. Furthermore, paramedics have relied on pre-hospital research being completed by medical physicians, nurses and sociologists (Gurchiek, 2011). Thus, with the professionalisation of the paramedic

discipline, paramedics have begun to take accountability for research within the pre-hospital care field.

The literature focusing on paramedicine has been steadily growing as more paramedics become degree qualified. Studies have been completed that examine the integration of a pre-employment university model into the paramedic discipline that traditionally relied on a vocationally-based apprenticeship model (Boyle, Williams, Cooper, Adams, & Alford, 2008; Cooper, 2005; Fields, 1998; Lord, 2003; Raynovich, 2006; Waxman & Williams, 2006). These studies highlight challenges such as the stigmatisation of university students while on clinical placements (Boyle, Williams, Cooper, Adams, & Alford, 2008; Waxman & Williams, 2006), the initial lack of acceptance of university educated paramedics into the ambulance industry (Lord, 2003; Reynovich, 2006) and the lack of immersion training that focused on skills (Cooper, 2005; Reynovich, 2006; Fields, 1998).

The ambulance culture has been studied by several authors (Boyle, 1997; Clarke, 2008; Parker, 2008; Raynovich, 2006; Reynolds, 2008a, 2009; Wyatt, 2003). The clinical mentoring of paramedics has also been explored (Brouhard, 2007; Cox, 2006; Dawson, 2008; Donaghy, 2010; Giannini, 1991; Gurchiek, 2011; NSW Department of Premier and Cabinet, 2008; Parker & General Purpose Standing Committee No. 2., 2008; Peate, 2010; Pointer, 2001; Salzman, Dillingham, Kobersteen, Kaye, & Page, 2008; Sibson & Mursell, 2010a, 2010b, 2010c), as have the mentors' views on the work readiness of university graduates as they enter an ambulance service (Cooper, 2005; Dawson, 2008; O'Donnell, 2006). However, an area that has received little focus in the paramedic literature to date is the professional socialisation of university educated paramedics. It is noted that a small number of publications have addressed particular aspects of paramedic professional socialisation; that many of these were published since this PhD study began in 2008 (Giddens & Giddens, 2000; Gregory, 2013; Lazarsfeld-Jensen, 2010; Lazarsfeld-Jensen et al., 2011;

McDonell et al., 2009; O'Meara et al., 2012) and include the work by the author (Devenish et al., 2012; Devenish et al., 2011; Devenish & Loftus, 2010; Williams et al., 2012). However, the majority of these studies and publications report on distinct aspects of the socialisation process, such as the anticipatory formation of preconceptions of paramedicine (Devenish et al., 2011; O'Meara et al., 2012), the university curriculum (Devenish & Loftus, 2010; Williams et al., 2012) and the transition into the ambulance command and control structure (Lazarsfeld-Jensen et al., 2011; Gregory, 2013).

Most published research to date concentrates on the experiences of participants from one particular university or ambulance service. Additionally, some of these studies draw conclusions from participant numbers as small as eight (Lazarsfeld-Jensen et al., 2011). Furthermore, none of these studies have outlined a model to explain the professional socialisation of paramedics. The current study therefore, fills a notable void in the literature by adopting an overarching view of the socialisation process and recommends a model specifically to explain the professional socialisation of university educated paramedics.

1.4 Research Aims and Approach

The aims of this research study are twofold. The first aim is to employ existing professional socialisation theories to investigate the professional socialisation of university educated paramedics from Australia and the UK. The two theories used are the anticipatory, formal and post-formal models of professional socialisation (Cant & Higgs, 1999; Lamdin, 2006; Shuval & Adler, 1977) in conjunction with Kramer's (1974) reality shock (these models are discussed in Chapter 3). These theories have been previously used to examine the professional socialisation of nurses, medical doctors and physiotherapists and thus have been shown to be applicable to some health disciplines. The second aim of this thesis is to examine the extent to which these models explain or do not explain the

professional socialisation of university educated paramedics. To achieve these aims, qualitative methods drawing on the work of Charmaz (2006) and Saldana (2009) guide the data collection and analysis processes.

The anticipatory phase of professional socialisation begins during early childhood and ceases when the individual enters a professional course of study such as a university paramedic program during adulthood (Cant & Higgs, 1999; Kramer, 1974; Kramer, 2010; Van Maanen, 1976). The formal phase of professional socialisation identifies the socialisation agents active within university paramedic programs and seeks to explain what individuals learn about the profession as a result of their formal studies (Cant & Higgs, 1999; Kramer, 1974; Lamdin, 2006; Shuval & Adler, 1977). The post-formal phase of professional socialisation explores how the individual is socialised as they transition into professional practice (Cant & Higgs, 1999; Lamdin, 2006; Shuval & Adler, 1977). An additional framework appeared necessary to explore the categories arising from the post-formal phase of professional socialisation, because few studies using the anticipatory, formal and post-formal professional socialisation model adequately explore the post-formal phase of professional socialisation. The reality shock model (Kramer, 1974) provides this additional framework. Kramer's reality shock model investigates the phases of socialisation an individual encounters when transitioning into professional practice (Kramer, 1974). The phases in Kramer's (1974) model are namely: the honeymoon phase, skills and routine mastery phase; social integration phase; moral outrage phase; and the conflict resolution phase. The results and critical analysis will inform the development of a suitable model for depicting the professional socialisation of university educated paramedics.

1.5 Research Questions

The following research questions have been modified from the work of Shuval and Adler (1977) to fit the paramedic context, and will guide this

research, which investigates the professional socialisation of university educated paramedics.

Question 1

- Do the anticipatory, formal and post-formal phases of professional socialisation adequately explore how individuals, undergoing professional socialisation, learn about the role of a paramedic?
    - How does the anticipatory phase of professional socialisation contribute towards an individual's understanding of paramedicine?
    - How are the preconceptions of paramedicine formed during the anticipatory phase and altered throughout the formal phase of professional socialisation?
    - Which professional socialisation agents and events contribute to the individuals understanding of paramedicine during the formal and post-formal phases of professional socialisation?

Question 2

- Does Kramer's (1974) reality shock model adequately explain how the image of paramedicine, formed through socialisation, is transformed overtime into a structured role that eventually guides professional performance?
    - How are the images of paramedicine, developed during the anticipatory and formal phases, further transformed during the post-formal phase of professional socialisation?
    - How does the professional socialisation process influence possible professional performance outcomes?

1.6 Reflexivity and the Researchers Role in Paramedic Education and Training

Through reflexivity, the researcher's 'knowledge-marking practices' (Finlay & Brendan, 2008, p.37) are discovered by the process of self-critical

exploration (Glesne, 2011; Finlay, 2003). Researchers who reflect on their personal experiences seek to 'embrace their own humanness' (Walsh, 1995, p.335) and how it affects the research process (Maso, 2003; Williams, 2012b). Furthermore, several authors have suggested reflexivity is necessary to improve the transparency, accountability and trustworthiness of qualitative research (Gough, 2003; Coffey & Atkinson, 1996; Finlay, 2003; Bonner, 2001). Thus it is imperative to explore the ontology[2] and epistemology[3] of the researcher to explicate the reasons for this research.

I became interested in first aid while at high school. Stories told in first aid classes about paramedics were fascinating. Pursuing a career in paramedic practice was considered during the latter years of high school. However, I was advised by first aid instructors and a paramedic I knew to complete a degree in a health-related field before joining the ambulance service. In-house paramedic qualifications offered by the ASNSW at the time were not recognised by other services. Moreover tertiary studies in paramedic science were not yet in existence. Thus, the decision was made to become a registered nurse with a view to becoming a paramedic in the future.

During nursing training, I experienced marginalisation during clinical placements due to being a young male in a female dominated profession. When completing nursing clinical placements in the accident and emergency department, my interest in becoming a paramedic was fuelled by interactions with paramedics who seemed very autonomous and appeared to enjoy their jobs. The type of work paramedics spoke about I perceived to be more desirable than working on the wards as a registered nurse. After completing nursing studies, I worked as a registered nurse for a year and commenced the process to apply to the Ambulance Service

[2] The term ontology is derived from the Greek word for being, and is concerned with what exists in one's conscious state. This could include one's view of the world, or a particular phenomenon (Blackburn, 2008).

[3] The term epistemology is derived from the Greek word for knowledge and refers to the theory of knowledge, or how one forms their view of the world, or a particular phenomenon (Blackburn, 2008).

of NSW (ASNSW) to become a trainee ambulance officer. After beginning employment with the ASNSW as a trainee paramedic, I completed a 12 week in-house induction course at the ASNSW Education Centre.

By the time I joined the ASNSW, tertiary studies for paramedics had commenced at Charles Sturt University (CSU). While completing the in-house apprenticeship style training, I observed tensions between the ambulance service and the university sector. It is important to note that only 4% of NSW paramedics had a degree (not necessarily paramedic-related) in the late 1990s (Parker & General Purpose Standing Committee, 2008), meaning the vast majority of paramedics had been trained through the in-house vocational apprenticeship model. From my experience, in the late 1990s a nursing degree was more highly recognised by the paramedic discipline than a paramedic degree. After completing the induction course, a smooth transition to the on-road environment occurred, and little trouble was experienced gaining workplace acceptance.

After completing the probationary period, I was moved to a permanent station, which reportedly had staff retention problems. For example, the station was rumoured to have infighting and low morale. Unfortunately, the rumours were found to be true. Although I experienced a wide variety of cases, the station environment continued to be challenging. I decided to build upon my nursing qualification and pursue postgraduate studies in education, with a view to becoming an ambulance clinical educator. Mid-way through my master's degree, a letter was sent to the Manager of Clinical Education requesting a secondment to the ASNSW Ambulance Education Centre (AEC). Subsequently a secondment was successfully arranged, which lasted for two years. Following this, I attained full-time position as a clinical educator.

At the AEC, university graduates undergoing an orientation to the service appeared to be more comfortable performing invasive skills that they were taught towards the end of their degree. However, they were not as proficient at basic skills, taught at the beginning of their university

program. Culturally, intensive care paramedics (and not graduate or novice practitioners) performed high acuity skills such as cannulation and intubation. Furthermore, a small number of graduates appeared overly self-assured, and would ask questions and challenge cultural norms. Although this may have been encouraged at university, within a command and control paramilitary culture it was inappropriate (Lazarsfeld-Jensen, Bridges & Loftus, 2011). Circumstances such as these led to the stereotypical view of graduates being 'know it alls'. I also observed that some teaching staff had inflated expectations of graduates compared to in-house vocationally trained staff, because graduates had a university degree in paramedic science.

I taught paramedics and intensive care paramedics at the AEC for eight years. During this time a steady increase in the paramedic scope of practice was observed and a transition towards a pre-employment tertiary model for paramedics in other states of Australia such as Victoria and South Australia began to occur. That is, a greater emphasis was being placed on recruiting people with tertiary qualifications in paramedic science. After a three month break away from the paramedic discipline, I became a paramedic academic at CSU, where I experienced an initial culture shock when teaching undergraduate paramedic students. While teaching for the ambulance service, paramedics were in uniform, were punctual and acted in a professional manner. However, university students wore whatever clothes they liked, some looked at Facebook during lectures, and others either arrived late or did not attend lectures at all. It was more difficult to keep university students engaged in the classroom compared to uniformed paramedics at the AEC. The stark differences in social mores and/or behaviours intrigued the researcher and sparked his interest about how individuals become socialised into their profession.

I decided to search the available university archives to develop a deeper understanding of previous agreements signed by the ASNSW and CSU,

and the reported tensions between the two organisations. I also started to challenge his assumptions about university paramedic students being better prepared, if not superior, in terms of training compared to vocationally educated paramedics, after observing many similarities in content taught in both the AEC and university curriculums. Subsequently I developed a greater awareness about the paramedic university program, and started to challenge cultural views about university graduates that were developed while working as a paramedic. University students did not appear to understand the ambulance culture. Similarly, many paramedics were possibly unfamiliar with the university culture. I viewed these issues as a stumbling block for university students transitioning to paramedic workplace on clinical placements and when gaining employment. Thus my experiences as a paramedic, clinical educator and university academic have led to the decision to explore these issues and undertake a PhD investigating the professional socialisation of university educated paramedics.

1.7 Language, Abbreviations and Assumptions

A list of frequently used terms, abbreviations and assumptions is provided (page xi) to help the reader understand ambulance terminology. Additionally, ambulance cultural terminology differs slightly between ambulance services. Therefore, some cultural terms have been substituted for generic Australian ambulance terminology to ensure consistency and anonymity with respect to the participants' employer. There are also differences in terminology between Australian ambulance services and UK National Health System (NHS) ambulance trusts in relation to university educated paramedics. Participants were required to complete a professional employment year with an ambulance service prior to registering (UK) or qualifying (Australia), which is referred to as the internship year in this thesis. During the internship year embedded in the University of Hertfordshire (UH) paramedic program, UK participants were ambulance technicians, whereas Australian participants were probationary

or internship paramedics post-graduation from university. Thus, the term 'paramedic intern' is referred to when discussing participants during their internship (or professional employment) year be it for the UK or Australia. Furthermore, the term 'qualified paramedic' is used when discussing the Australian participants after they had completed their internship program and UK participants who had become registered paramedics.

1.8 Thesis Structure

The thesis is organised into nine chapters. Chapter 1 identified the background to this study, the justification for this research and the research aims and questions. Additionally a brief explanation of the researcher's previous experience with respect to the education and training of paramedic has been provided.

The extant literature is reviewed in Chapter 2 as it relates to paramedicine, professional socialisation and organisational socialisation. The literature review confirms that the body of knowledge on the professional socialisation of paramedics is limited. Health-related professional socialisation models and the theoretical frameworks for this thesis form the focus of Chapter 3.

The identification and justification of the methods used in this thesis are contained in Chapter 4. In particular, this chapter outlines the recruitment of participants as well as the selection of ambulance services and universities. Additionally, the ethical and research clearance process are discussed. Chapter 4 concludes with an outline of how the data were collected and analysed.

The results are presented in Chapters 5, 6, 7 and 8. Chapter 5 explores the construction of the participants' preconceptions of paramedicine during the anticipatory phase of professional socialisation. In particular, this chapter examines childhood and adulthood anticipatory socialisation. Additionally, the influence of television, the experience of working with

emergency volunteer organisations, participant information seeking and the impact of observing ambulances in the community are explored in relation to the anticipatory professional socialisation process. In this chapter, the reasons why the participants wanted to become paramedics are identified.

Chapter 6 presents the results for the formal phase of professional socialisation by examining the changes in participants' perceptions of paramedic practice while at university. It considers how the impact of socialisation agents such as peers, on-road teaching staff, academic staff and the curriculum further inform the participants' views of paramedic practice. The role of clinical placements in the formal phase of professional socialisation is addressed in this chapter, followed by a discussion of the participants' experiences as they prepared for employment with an ambulance service.

An investigation of the post-formal phase of professional socialisation, as participants transitioned from university students to internship paramedics (Australia) and ambulance technicians (UK) is described in Chapter 7. The existence of an initial culture shock created by transitioning between two divergent cultures is discussed. Finally, Kramer's (1974) reality shock professional socialisation model is used to explain the experiences of the participants as they transition to the on-road environment.

Chapter 8 is the fourth and final results chapter and explores the emergence of a new or additional phase relating to professional socialisation of university educated paramedics. The post-internship phase addresses the transition of internship paramedics to qualified paramedics within the Australian context. Within the UK context, the post-internship phase examines the transition of ambulance technicians to registered paramedics after the University Hertfordshire's 12 month work placement block (sandwich year) imbedded in the paramedic program. Kramer's (1974) model is found to be relevant for discussing the experiences of the

participants as they encountered the added complexities of being a mentor and the senior clinician in the workplace.

The overarching discussion, conclusion, and proposal for a theoretical model to explain the professional socialisation of university educated paramedics are found in Chapter 9. The study's limitations are addressed in this chapter and analytical propositions arising from this thesis are provided that will assist universities, ambulance services and students understand the professional socialisation process.

Chapter 2 Literature Review

2.1 Introduction

In this chapter, the relevant research from the diverse fields of paramedicine and professional socialisation are brought together, and a gap in the extant literature is highlighted in relation to the professional socialisation of paramedics.

The literature pertaining to paramedicine has steadily grown over previous decades, leading to the establishment of several peer reviewed paramedic journals such as the *Australasian Journal of Paramedic Practice*, and the *Journal of Paramedic Practice* (UK) in 2003 and 2008 respectively. In contrast, the literature on socialisation dates back to the 1960s with several seminal works on organisational socialisation influencing the field. Similarly, the professional socialisation of health professionals began to appear as early as 1960, and publications have grown in number, especially in the nursing discipline. Compared to the established health professions, the paramedic profession has only begun to emerge in the past decade, and the literature relating to paramedicine is still in its infancy. Thus, it is important to review the research on the professionalisation of paramedicine and other health professions to establish a theoretical background to this PhD study.

In this chapter, the search strategy is outlined. The chapter reviews the literature on the history of ambulance services and ambulance education prior to and after the transition into the tertiary sector in Australia and the UK. Research on paramedic clinical placements, paramedic internship programs (professional employment) and the ambulance culture is examined. The literature on organisational socialisation theories is discussed to provide the reader with an understanding of possible socialisation tactics used by ambulance services prior the transition of paramedic education and training into universities. Last, professional

socialisation theories relevant to other health professions are critically explored.

2.2 The Search Strategy

To establish a robust research framework, the search strategy incorporated literature from the following sources:

- journals
- books and documents recording historical accounts of paramedic training
- government reports (both federal and state)
- conference abstracts
- available industry agreements
- Ambulance Service yearly reports
- theses
- newspaper articles
- university archives (where accessible).

Two librarians independently verified in 2009 (Giuseppe Giovenco) and 2013 (Jackie Devenish) that a thorough search of the literature was conducted. The databases that were searched are identified in Table 2.1.

Table 2.1. *Databases Searched*

• CINAHL • Informit – Health Collection • Scopus • Medline/PubMed • ERIC • Library Catalogue • Google Scholar

In relation to the search strategy, the search strategy for this literature review consisted of the following key terms identified in Table 2.2. No dates were excluded and the search was limited to journal articles published in English. Further papers were located by hand searching the reference lists of relevant studies within the professional socialisation and pre-hospital care fields. Search alerts along with journal table of content alerts assisted in keeping the review of the literature up to date until mid-2014. Where gaps were found in the literature, experts in the field of pre-hospital care were consulted.

Table 2.2. *Search Strategy Key Terms*

Paramedicine	***Nursing and Allied Health***	***Generic***	***Other***
Paramedic Emergency Medical Technician Emergency Medical Services Ambulance Training Ambulance Education Industry Training Organisational Culture Professionalism Professional Socialization	Vocational nurse University nurse Nurse Education Nurse Training Professional Socialization Medicine Academisation Allied Health	Induction Internship Mentoring University Vocational Education Postgraduate experience Work-readiness Work-preparedness Work performance Communities of Practice Professional Socialization	Fire brigade Police Mortuary Workers Socialisation

2.3 In Pursuit of University Educated Paramedics

2.3.1 Paramedicine in Australia and the United Kingdom

From the available literature, it is evident that there has been a progression over the past two decades towards a pre-employment university qualification for paramedics (Balon-Rotheram, 2003; Battersby, 1993; Donaghy, 2008; Fawcett & McCall, 2008; Gregory, 2006; Kilner, 2004b; Lord, 2003; McDonell, 1994; Raynovich, 2006). In 1994, CSU was

the first Australian higher education institution to offer a degree for paramedics (Lord, 2003). In 1998 the UH in the UK established a degree in Paramedic Practice (Carney, 1999; Williams, 2010b). Since the mid-1990s many other Australian and UK universities have followed the precedent set by CSU and UH, also deciding to offer tertiary paramedic programs. The transferal of paramedic education and training from an in-house vocational apprenticeship model to the tertiary sector has been a significant contributing factor towards the professionalisation of paramedicine. Additionally, tertiary qualifications for paramedics have led to the establishment of a professional socialisation process for paramedics. The following sections expand on significant events in the history of ambulance services, and how these events have set the context for the current day pursuit of tertiary qualifications, professionalism and professional socialisation of paramedics.

In the Beginning

From an historical perspective, in the late 1800s and early 1900s the St John Ambulance Brigade took on a key role in providing the out of hospital emergency services in many Australian states and territories (Howie-Willis, 2009). Several arrangements in each state saw the establishment of many different ambulance brigades, and some private ambulance providers. To provide greater levels of regulation, funding and patient care, Acts of Parliament amalgamated these various brigades and private providers into ambulance services. For example, the ASNSW was established from brigades in 1972, the South Australian Ambulance Service was established in 1995 (Council of Ambulance Authorities, 2011; Howie-Willis, 2009).

Ambulance services in the UK have a long history that can be traced back to the Knights Templar (Hospitallers) in the Crusades (Howie-Willis, 1983). Prior to the 1890s volunteers, police, fire fighters and even taxi drivers transported sick and injured patients to the nearest hospital or physician's clinic (London Ambulance Service, 2008). In the 1890s, full-

time ambulance brigades were established to transport the sick and injured to hospital. These brigades fell under the jurisdiction of the Metropolitan Asylums Board. Major changes to local governments in England and Wales occurred in the 1930s, which saw the transferal of ambulance brigades to the local councils. In 1948, after World War II, the structure of UK ambulance services changed when the *National Health Services Act* was passed in the British Parliament, and the role of ambulance officers was expanded to treat as well as transport members of the community who required medical assistance (London Ambulance Service, 2008). In the 1960s, the Millar Report (Millar, 1966) resulted in higher levels of treatment that ambulance officers could provide such as haemorrhage control, spinal immobilisation, basic resuscitation and various drug therapies (Fisher, 2009). These clinical procedures were expanded after the Wright Report into the extended training of staff (Wright, 1984). Wright recommended skills such as intubation, infusions and defibrillation (Wright, 1984). Over time the Wright Report evolved into the current IHCD Ambulance Technician (Diploma) program. From 1996, Ambulance Services in the UK began transferring from regional Health Authorities to become National Health Trusts in their own right (London Ambulance Service, 2008). Today, there are over 30 NHS ambulance trusts in the UK providing communities with emergency and non-emergency pre-hospital care (Carney, 1999). As the regulation of ambulance services improved, changes occurred in the education and training of ambulance officers.

Prior to Tertiary Involvement

Up until the 1960s, there was no standard system or framework that governed the training of paramedics in Australia or the UK. Ambulance officers prior to 1960 were only required to be over 21 years of age, hold an unrestricted driver's license and a first aid certificate. The first aid certificate was self-funded and completed in the officers' spare time (Kilner, 2004b; McDonell et al., 2009).

In the UK in 1966, Dr ELM Millar chaired a working party into ambulance training and equipment. Millar suggested ambulance officers should not only transport patients to definitive care, they should also provide intensive first aid to their patients (Millar, 1966). Out of this report, a basic program was recommended that was to be taught over a period of eight weeks. The course had a very strong practical focus. After a period of 12 months working in the field, ambulance officers were subject to written, oral and practical examinations. On successfully completing these assessments, officers were awarded the 'Ambulance Services Proficiency Certificate', commonly referred to as the 'Millar Certificate' (Kilner, 2004b).

The Ambulance Services Proficiency Course evolved into the IHCD ambulance technician program (Emms, 2010; Kilner, 2004b). Unlike Australia's two tiered clinical system (Qualified Paramedic and Intensive Care Paramedic), paramedics in the UK are trained to a single national level outlined by the IHCD (Carney, 1999). The IHCD training course consists of a six week program, with an extra three weeks driving training (Kilner, 2004b). In the 1980s, the Wright Report outlined six training schemes to further expand the scope of practice of ambulance officers to include more advanced resuscitation techniques. The Wright Report also investigated the return on investment that would result from implementing further training and more advanced skills for paramedics relating to both monetary savings and lives saved (Wright, 1984). Additionally, the Wright Report coincided with other international trends in training such as the development of paramedics in the United States and in Belfast (Carney, 1999).

In Australia, the Federal Minister for Education and Training, Kim Beazley (Senior) under the Whitlam government, invited Myer Kangan to establish a committee to examine the development of technical and further education in Australia, now known as TAFE (Fleming, 1994). As a result, the 1970s witnessed new developments in ambulance training where

student paramedics had access to better structured training incorporating higher levels of skill (McDonell et al., 2009).

A New Era

United Kingdom In the UK, the 1980s saw the expansion of paramedic training, centralised through the National Extended Training for Ambulance Staff Scheme and launched by the National Health Services Training Authority (Carney, 1999). The ambulance staff training package was further updated in the early 1990s and became known as the Ambulance Service Paramedic Training Manual issued by the NHS Directorate (Carney, 1999). In the late 1990s, the UH and the Sheffield University launched degrees in paramedic practice in pursuit of a pre-employment degree entry model (Carney, 1999). Paramedicine became a registered health profession in 2001. As such, practising paramedics need to register with the National HCPC, and must adhere to national guidelines set out by the Joint Royal Colleges Ambulance Liaison Committee and the UK College of Paramedics (Fisher, 2009; Woollard, 2009).

Australia In the early-mid 1990s, the Australian Ambulance Services started to examine future degree programs for paramedics. In 1994, the ASNSW and CSU came to an agreement that resulted in the establishment of the CSU School of Paramedical Studies within the NSW AEC in Sydney (Fields, 1994).

While the ASNSW and CSU were debating their organisational challenges, the Victorian Ambulance Professional Education Lobby (VAPEL) submitted a proposal to the Victorian State Parliament containing a petition, signed by hundreds of Victorian paramedics, requesting the movement of ambulance education and training from a proposed TAFE model to the higher education sector. Within the proposal, it stated that "all other health professionals, such as medicine, nursing and physiotherapy undertake their education and training within the university sector … all (complete) a bachelor's degree" (McDonell, 1994, p. 7). The VAPEL

petition coincided with the decision to close the Victorian Ambulance industry-based training unit. The decision to close the Ambulance Officer Training Centre (AOTC) was due to the high cost of training ($200 per student per day), which added up to three million dollars for the AOTC per year. With a workforce of around 1119 paramedics, this figure was seen as too high (Wilde, 1999). Concerns were voiced by paramedics who saw no further benefit in aligning their training with the TAFE sector, believing that a university qualification would provide paramedics with greater professionalism and the capacity for more dialogue and articulation with other health professions, in addition to transferable qualifications (McDonell, 1994). The VAPEL's proposal shows early support within the profession for university training. However, it is noteworthy that Gregory (2006) has commented on the lack of research into whether paramedics with a tertiary degree provide enhanced patient care or increase patient satisfaction.

Further to the 1994 Victorian petition, five university courses were established to meet the needs of Ambulance Services Victoria. These are located at Monash University, Victoria University (VU), University of Ballarat, La Trobe University and Australian Catholic University. Similarly, other states such as Queensland and South Australia have undergone a transition towards paramedic university programs to reduce the ambulance services' reliance on in-house vocational education and training programs (Elks, 2005; Jess, 2010; Pointon, 2004). Authors such as Balon-Rotheram (2003), Donaghy (2008) and Pointon (2004) have claimed that paramedic university degree courses are aimed at preparing students to be professionals and to be practise ready on graduation. However, the significant amount of theory in the paramedic curriculum was initially reported to be problematic, as it diverged from the ambulance service's strong cultural emphasis on practical skills (Cooper, 2005; Pointon, 2004). Authors have claimed that a university qualification for paramedics will provide clinicians with advanced assessment and

diagnostic skills, and a greater knowledge base, enabling paramedics to fit into the multidisciplinary context of healthcare (Donaghy, 2008, p. 34; Pointon, 2004). Conversely, other paramedic academics suggest that despite university graduates having a good theoretical grounding, their practical skills may not develop for some time (Dawson, 2008; O'Brien et al., 2013; Wyatt, 2003). Although, in relation to this last point, it is important to note that both Dawson (2008) and Wyatt's (2003) research did not focus on the experiences of graduates choosing to investigate the preceptors' views, and the research of O'Brien et al. (2013) investigated the experience of university paramedic students from only one university, VU. Additionally, the idea of a university graduate being 'work-ready' essentially depends on one's definition of 'work-readiness'. For example, the Manager Education, ASNSW, in his definition describes work readiness as being prepared enough for the first shift so that the new employee is not "totally clueless" (Morrison, 2008). Furthermore, researchers from other health disciplines such as medicine and nursing indicate that new graduates are not necessarily work ready (Becker et al., 1961; Boychuk Duchscher, 2009; Boychuk Duchscher & Cowin, 2004; Conrad, 1988; Gerrish, 2000; Kramer, 1974; Lamdin, 2006; Pitkala & Mantyranta, 2003). Therefore, within a paramedic context, this thesis seeks to explore the transition from being a university student to becoming a practising intern paramedic through the lens of existing professional socialisation theories that examine the professional socialisation of other health professionals such as nurses and medical doctors.

In Australia, due to the absence of registration, paramedics were listed as well below other allied health in professional status in the 2007 Australian socioeconomic status index (McMillan, Beavis, & Jones, 2009). However, since 2009, professional societies and lobbying bodies such as Paramedics Australia and the Australian and New Zealand College of Paramedicine have initiated a public consultation process with the aim of achieving paramedic registration by mid-2015 (Australian College of Ambulance

Professionals, 2012; Bange & van Biljon, 2012; Paramedics Australasia, 2012a). Prior to the initiation of the registration consultation process, a joint paper was written by nine paramedic academics in response to the Victorian Department of Human Services discussion paper examining the regulation of health professions in Victoria. These academics voiced the view that an absence of paramedic registration and the lack of external accreditation of paramedic training programs is a clear threat to the health, safety and wellbeing of the public (Boyle et al., 2003). The rationale behind this argument is to establish professional registration for paramedics, which would provide regulation uniformity to the industry instead of the inconsistencies of the state based systems that currently exist. The existence of such national regulation would encourage universal guidelines for the education of paramedics at all clinical levels, and an emphasis on developing professional standards guiding paramedical practice (Boyle et al., 2003).

Although this view may be seen as having an academic bias, the 2008 legislative inquiry into the management and operations of the ASNSW recommended that the NSW Minister for Health liaise with the Council of Ambulance Authorities (CAA) in relation to instituting a national registration board for ambulance paramedics (Parker & General Purpose Standing Committee No. 2., 2008). Additionally, the Western Australian Coroner suggested further regulation was necessary for paramedics in Australia, as the paramedic title is not protected (Eburn, 2013). Despite the South Australian Government passing state-based legislation to protect the 'paramedic' title (Larsen, 2013), the term paramedic is not nationally protected and inadequately trained personnel working for private companies in most states of Australia are able to call themselves paramedics. Australian ambulance services appear to be well behind UK and Canadian ambulance services with regards to regulation (Gibson & Brightwell, 2006). Paramedics in the UK, for example, have been required to register with the NHS for more than a decade (Emms, 2010; Gibson &

Brightwell, 2006; Woollard, 2009). Thus, as paramedicine appears to be an emerging (Australia) or a new (UK) health profession, this research investigating the professional socialisation of university educated paramedics is a timely as it will add to the limited body of knowledge about the 'academisation' and professionalisation of paramedicine.

2.3.2 Lessons for Paramedicine from the 'Academisation' of the Health Professions

The trend of 'academisation' or moving the education of health professions to the academy is not new, being established centuries ago when other health professions moved into the universities, beginning with medicine. In more recent decades, the trend has quickened with health professions, such as physiotherapy (1960s) and nursing (1980s) making the move to the tertiary sector. Now it is the general expectation that all new entrants to these professions must begin by acquiring a university education. However, academisation is not without its problems. For example, there can be conflict between older workers trained within the traditional model and younger workers educated within the universities. The paramedicine profession in Australia is still in the midst of the academisation process. It is worthwhile looking at the history of health professional academisation, with a view to learning lessons that can inform the process for paramedics in Australia.

History of the University

Precursors of the university go back to institutions such as the Platonic Academy of ancient Greece in the 4th century BC, sometimes called the University of Athens (Cubberley 2004). The history of the university in its present format goes back to between the 8th and 13th century (Shipman & Shipman, 2006; Wilcock, 2001). Universities began to emerge in Italy, Spain, France and England. Oxford University was founded in 1167, Paris University in 1180 and both Cambridge and Bologna in 1223 (Wilcock, 2001). Most universities arose from cathedral schools and, in many ways, were a continuation of the medieval monasteries that had preserved a

love of scholarship in Europe throughout the Dark Ages (Shipman & Shipman, 2006). By the 12th century, there were 10 universities in Europe that had medicine as part of their offerings. The idea of the university being the primary site for developing new knowledge is a relatively recent idea. For a long time, many major scientific advances occurred outside the academy. For example, Leonardo da Vinci, Galileo Galilei, Charles Darwin and Sigmund Freud did their most important work outside the university as private individuals, although the latter were certainly university educated (Shipman & Shipman, 2006). It is well known that influences such as 'The Enlightenment' shaped the university into an institution where research and the development of new knowledge were highly prized (Hankins, 1985; Love, 2008; Shipman & Shipman, 2006). What is less well appreciated is the influence of social changes such as those brought about by the Industrial Revolution (More, 2000; Shipman & Shipman, 2006). Educated people were needed to manage the new industries and maintain a steady stream of innovation (More, 2000). In the mid to late 1800s, an expansion of the university system was driven by public authorities who used taxation to fund new universities as part of their pursuit of advanced education, health care and public infrastructure (Shipman & Shipman, 2006).

Universities initially educated only a small minority who were seen as privileged and elite. However, continual social change has fuelled the demand for an educated workforce in many walks of life, and participation in higher education has been steadily increasing for decades (Shipman & Shipman, 2006). Both the numbers and proportion of people enrolling in courses continue to rise and this is coupled with a rise in the range of courses offered. Since the turn of the 20th century university student numbers have increased in many countries. For example, in the UK, in 1900 there were 14 universities with 20,000 students. In 2000 the UK had 115 universities with 1.3 million full-time students and 900,000 part-time students (Shipman & Shipman, 2006). In the Australian university sector,

1996 saw 74,823 university students studying in health related fields (Department of Education Science and Training, 2005). In 2012, this figure increased to 161,117 (Department of Industry, 2013). As a whole, university student numbers in Australia increased from 634,094 in 1996 (Department of Education Science and Training, 2005) up to 1,257,722 in 2012 (Department of Industry, 2013). From the paramedic context, paramedic university students have increased from 25 enrolled at CSU in 1998 (Battersby, 1998) to an estimated 4669 students enrolled at 15 universities across Australia in 2012 (Bange, 2012).

Academisation of the Health Professions

Medicine The first health profession to move to the academy was medicine. As mentioned earlier, this occurred between the 8th and 13th century (Shipman & Shipman, 2006). Medical education through the university became the mainstream in many European countries such as Germany and Italy well before the UK, where many doctors continued to learn their trade through an apprenticeship system (Wilcock, 2001). It was the *Apothecary Act* of 1815 that was the catalyst in the UK for Medicine to move into the academy (Holloway, 1966). Prior to the *Apothecary Act*, medicine in the UK was spread among three main guilds, the College of Physicians, the College of Surgeons and the Apothecary Society. At the time of the *Apothecary Act* physicians were generally university educated and their services were very expensive (Holloway, 1966). Surgeons were considered to be of low social status and were also butchers and barbers. Surgeons also performed primitive dentistry (Hoffmann-Axthelm, 1981; Sampson, n.d.). It was not difficult for a man to become a member of the Apothecary society and practice medicine within seven miles of their residence. It is noted that there were very few females who were given the opportunity to become apothecary due to the economic and social disadvantages faced by women in the early 1800s (Wyman, 1984).

The apothecary could only charge for the potions they administered and these were concocted by the druggists (pharmacists) (Holloway, 1966). The various guilds were constantly battling each other for the power to regulate medicine, with several failed bills being put before the Parliament. The *Apothecary Bill* was controversially passed through the House of Commons late in the session on the 15 August 1815, with very few Members of the House actually present (Holloway, 1966). Although the passing of the *Apothecary Act* meant that medicine in the UK became better regulated, medical schools in hospitals continued to compete with universities well into the early 20th century. In the United States in 1910, Abraham Flexner authored the Flexner Report (Flexner, 1910), which resulted in the closure of many medical schools in the United States and the standardisation of medical training. Sir George Newman, the Chief Medical Officer to the Ministry of Health in the UK, visited the United States in 1912 and brought back to the UK and the dominions, many of the reforms resulting from the Flexner Report. These reforms were published in Newman's 'The State of Public Health Report' of 1922 (Bonner, 2000; Newman, 1923). The review of the academisation of medicine reveals that university- and hospital-based training operated concurrently in the move towards university trained doctors.

Pharmacy began to appear in the universities alongside medicine as far back as the 8th century. Similar to medicine, many European countries passed regulations in relation to the education of pharmacists in the universities long before the UK; for example, Fredrick the Great of Prussia in the late 1770s. In the UK, the medical guilds regulated the druggists. When the *Apothecary Act* was passed, pharmacists needed to look towards another body to regulate their practice. After much debate, the Royal Society of Pharmacy was established in 1841, bringing with it mandatory registration but stopping short of educational reform. Similar to medicine, private pharmacy and chemistry schools were in competition with universities. Several Bills were presented to the Parliament in the late

1800 and early 1900 to initiate educational reforms for pharmacists. However, as the majority of pharmacists and chemist were not university educated, these Bills were rejected. Pharmacy and Chemistry made a gradual transition from private pharmacy and chemistry schools to technical colleges, with the last school in the UK closing in 1949. In 1957, a university degree became the entry requirement into the profession, and in the 1967 all practising pharmacists required a university degree (Anderson, 2005; Mervyn-Madge, 1987). As with the UK, in Australia the apprenticeship model of training pharmacist also ceased in the 1960s (Low, Hattingh, & Forrester, 2010).

Dentistry Many health professions in Australia followed the British system until Federation in 1901. The first health profession to be 'academised' in Australia after Federation was dentistry. Prior to the *Dental Act* in 1901, any member of the public could establish a dental surgery and practice dentistry in Australia. The *Dental Act* was passed by the NSW Government, and Sydney University became one of the first dental schools in Australia. However, following the usual pattern of academisation in the health professions, apprenticeship training for dentists continued to be available as another training route until the late 1930s, when legislation was passed to require a mandatory university qualification for dentists in Australia (Sydney University, 2009).

Other Allied Health Physiotherapy, occupational therapy, dietetics and chiropractic moved to the academy between the 1950s and 1960s in Australia. Physiotherapy followed the path laid down by its predecessors, medicine, pharmacy and dentistry and also evolved from an apprenticeship style training model (Chipchase et al., 2006). In 1894, an association of physiotherapists was formed in the UK, and associations in the dominions, such as Australia, soon followed. The education of physiotherapists in Australia was developed by the Australian Medical Association (AMA) and approved by the Federal Council in 1906. Physiotherapy was affiliated with medical schools and always had some

link to the universities in Australia. The first physiotherapy degree (the Bachelor of Applied Science (Physiotherapy) at The University of Queensland emerged in 1951. In 1975, physiotherapy broke away from the AMA and the Australian Physiotherapists Association was formed (Chipchase et al., 2006).

The demand in Australia for occupational therapists greatly increased during and after the Second World War. Many physiotherapists were approached to complete a conversion course to become occupational therapists. Prior to the 1950s, the training of occupational therapists in Australia was the responsibility of the Australian Physiotherapy Association governed by the AMA. The training consisted of a diploma with some university study in anatomy and physiology and medical/surgical pathophysiology. The remainder of an occupational therapist's education was 'on the job training'. The transition from a three year diploma to a degree qualification in Occupational Therapy began to emerge in the 1950s, and The University of Queensland offered a four year dual qualifications in Physiotherapy and Occupational Therapy until 1958 (Anderson & Bell, 1998).

Nursing In Australia, nursing education moved to the academy in the 1980s (Levett, 2005; The College of Nursing, 2008). The pro-university argument to move nursing into the academy was "No one would consider having doctors trained on the job and the same goes for physiotherapists, radiologists, occupational therapists" (The College of Nursing, 2008, p. 4). Official reports in Australia of nurse education prior to the move to the academy suggested that nurse education was substandard. For example, Rae Chittick, a nursing pioneer, reviewed nurse education in Australia in 1968 on behalf of the World Health Organization. Chittick commented "Perhaps no other group of young people in modern society receives such narrow and restricted and unimaginative type of education" (Sax, 1978, p. 4). Even though nurse education has been in the academy for over 20 years, there is still arguably a continuing reluctance from within and

outside of the nursing profession to embrace an academic agenda (Gebbie, 2009; Hofler, 2008). The reason for this could possibly relate to the historical reliance of nursing on an in-house vocational training model, and the current day perception that new graduates are not prepared for the workplace (Andrew, Ferguson, Wilkie, Corcoran, & Simpson, 2009; Boychuk Duchscher, 2009, 2012; Boychuk Duchscher & Cowin, 2004).

Academisation and Professionalism

The academisation of health professions such as medicine, dentistry, physiotherapy and nursing has had a direct effect on the professional status of these occupations (Bradshaw & Hinton, 2002; Graham & Wealthall, 1999; McMillan et al., 2009; Wilensky, 1964). The emphasis placed by universities on academic freedom, evidence based practice and critical appraisal together with coverage of basic medical sciences, social sciences and ethics leads to a more comprehensive curriculum that reflects the diversity of practice and client groups (Thompson & Watson, 2006). The purely technical skills associated with the different health professions are contextualised and given intellectual depth, leading to the development of higher order critical thinking skills, where people are encouraged to critique their practice and its knowledge base. In turn, health professions are further prepared to take on an extended role, where they can accept responsibility for making clinical decisions and perform highly invasive procedures that have traditionally been reserved for medical doctors (Ducket, 2005; McPherson et al., 2006). Academisation can encourage interdisciplinary health education and broaden the students' outlook on the role of their profession within the wider society (Lavin et al., 2001). Further, academisation can encourage an appreciation for sound research and an ability to evaluate the evidence behind best practice (Jarvis, 1983; The College of Nursing, 2008), encouraging individuals to be lifelong learners who are also willing and able to contribute to the knowledge base of their profession. Last, academisation in allied health fields has been shown to improve career

options, work performance, career retention and job satisfaction (Rambur, McIntosh, Palumbo, & Reinier, 2005).

The paramedic profession has benefited from the academisation process as university educated paramedics are educated in areas such as mental health, chronic illnesses, professionalism, reflective practice and evidence based research (Willis et al., 2010). Conversely, the traditional in-house vocational apprenticeship model of ambulance education mainly focused on the dominant cultural emphasis of the emergency side of the occupation such as trauma and cardiac arrests, despite the reality of practice suggesting that these cases make up a small percentage of the workload (Clark, Purdie, & Fitzgerald, 2000; Cooper, 2005; Williams et al., 2012; Woollard, 2003). However, as seen in the literature about the academisation of other health professions, this pathway for paramedicine has not been without its challenges.

Most health professions have encountered challenges in the short term. For example, academisation may have created tension within the workplace culture (Bradshaw & Hinton, 2002; Lord, 2003; Stevens & Crouch, 1998). There have been many papers suggesting that the process of academisation may devalue older employees who do not possess university qualifications (Arieli, 2007; Fealy & McNamara, 2007; Rochford, Connolly, & Drennan, 2009), leading to feelings of inadequacy (Arieli, 2007) and limited options for career advancement. Additionally, vocationally trained employees who have been in the workforce for some years may encounter barriers that impact on their ability to study, such as family commitments, full-time work, the financial impact of university fees and a limited understanding of academic processes (Arieli, 2007; Davey & Robinson, 2002). Academisation has not only impacted incumbent members of staff. The traditional in-house vocational training model paid students to study (NSW Department of Premier and Cabinet, 2008), which may have been an attractive option for mature people who chose paramedic practice as a second career (Patterson, Probst, Leith, Corwin, &

Powell, 2005). However, the demographics of undergraduate paramedic students suggest that school leavers significantly outnumber mature aged students enrolled in paramedic university programs (Joyce et al., 2009; O'Meara et al., 2012). Despite the short-term disadvantages, the long term benefits of the academisation of paramedicine will likely lead to less of a reliance on a protocol-based *modus operandi* and the continued movement towards professionalisation.

2.4 Vocational Training versus Higher Education

With the transferral of the education and training of paramedics from the in-house vocational sector to universities, it is important to review the relevant research investigating both streams. At the time of writing this thesis, in addition to employing paramedic university graduates, the ASNSW and the London Ambulance Service (LAS) also continue to recruit paramedics though an in-house vocational education and training pathway. Thus both organisational and professional socialisation processes may be present. Organisational and professional socialisations are explained in Section 2.9 of this chapter.

A study into paramedic education within the UK (Cooper, 2005) focused on what paramedics thought about the in-house vocational training system. The findings of this paper suggested that there was a greater emphasis placed on practical skills in the vocational model. Thus, paramedics who had been through industry training courses believed their skills were superior to paramedic university graduates (Cooper, 2005). However, several authors maintain that paramedics who were trained via the industry pathway did not feel prepared for the work environment (Cooper, 2005; Gregory, 2013; Huot, 2013; Raynovich, 2006). Despite the work of these authors, the literature on the transition of vocationally trained paramedics to the workplace is limited. Likewise, with the exception of a small number of authors, the literature focusing on the transition of graduate paramedics into the workplace is limited

(Lazarsfeld-Jensen, 2010; Lazarsfeld-Jensen et al., 2011; Willis, Pointon, O'Meara, McCarthy, & Jensen, 2009). Within the nursing profession, comparisons between the work readiness of diploma and degree qualified nurses has been studied extensively over many years in several countries (Clinton, Murrells, & Robinson, 2005; Gerrish, 1990, 2000; Holland, 1999; Lofmark, Smide, & Wikblad, 2006; Suzuki et al., 2006; Yam, 2004). Authors suggest that nurses trained via the vocational education and training sector and university graduates felt ill-prepared for the workplace (Clinton et al., 2005; Gerrish, 1990, 2000; Lofmark et al., 2006). However, the university graduates' work performance accelerates within one to five years in comparison to those who went through an apprenticeship vocational model (Gerrish, 1990, 2000; Lofmark et al., 2006). There are various models that seek to explain the improved performance of university educated nurses and many of these take a professional socialisation approach (Benner, 2001; Boychuk Duchscher, 2008, 2012; Kramer, 1974). Other authors maintain that university educated nurses are also able to utilise scientific knowledge to better inform their problem solving ability in clinical practice (Field, 2004; Gerrish, 2000). Unlike the nursing literature, to date research relating to improvement in the workplace performance of graduate paramedics through a professional socialisation process is limited. Hence, the necessity for this research study is highlighted. An important component of the professional socialisation process is the emersion of university students in the clinical environment. The next section reviews the literature on the role of clinical placements in preparing graduates for the workplace.

2.5 Preparation for Employment: The role of clinical placements

Traditionally the vocational training model has consisted of an apprenticeship where it took approximately three years of full-time work to become a qualified paramedic. With the movement of paramedic

education to the university sector, students now complete a three year paramedic degree and then become qualified paramedics after completing an industry internship program of 9 to 12 months. As the workplace enculturation of university graduates is far less than that contained in the traditional apprenticeship model, university clinical placements have become a vital component in introducing students to the paramedic culture. Despite the importance of university clinical placements, an appropriate length of time for clinical placements has not been addressed in the paramedic literature.

Clinical placement blocks vary between universities; for example, 240 hours in the paramedic program at CSU, 500 hours at both Monash and Flinders Universities, 720 hours at Queensland University of Technology (QUT) and 1500 hours at the UH in the UK when the data were collected (Williams, 2012a). Additionally, Ambulance Victoria and the ASNSW specify that university students have observer status only, and as such should not be responsible for any patient care. However, the Queensland Ambulance Service (QAS) allows students to initiate treatment under supervision.

Due to workforce demands and workforce planning, universities such as CSU and the University of Tasmania trialled accelerated pathway agreements with the ASNSW (ASNSW, 2008). The accelerated pathway reduced the time taken to complete a university degree to as little as two years. Although CSU no longer offers an accelerated pathway, the Sydney based campus of the University of Tasmania still offers a two year accelerated program (University of Tasmania, 2013). In previous years, the QAS, unlike the ASNSW, has offered university students a paid internship period of 12 weeks in the last semester of their university studies, as well as allowing students to pursue casual employment after completing 12 months at university. QUT claimed that this would promote work readiness for the paramedic graduate (Fawcett & McCall, 2008). Additionally, this arrangement was thought to suit the QAS, since it

provided low cost labour, and enabled the service to more readily fill gaps in the rosters (Fawcett & McCall, 2008). However, with five universities in Queensland offering tertiary qualifications in paramedicine, the QAS deemed this model to be financially unsustainable and the arrangement ceased in 2010 (Jess, 2010).

Despite undertaking clinical placements, it has been argued that university educated paramedics are ill-prepared for working on-road (Devenish et al., 2012; O'Brien et al., 2013; Waxman & Williams, 2006). For example, Monash University and Victoria University paramedic students felt their studies did not adequately prepare them for the work environment (O'Brien et al., 2013; Waxman & Williams, 2006). These students feared a traumatic transition from university to the workplace, and did not believe their clinical instructors would understand the university system. Their expectation was that workplace clinical instructors would expect too much from them on their first appointments (Waxman & Williams, 2006). Multiple approaches have been suggested to improve the workplace preparation of paramedic university students that involve the classroom, hospital and on-road clinical environments (Giannini, 1991). Despite one author suggesting that paramedicine is lagging behind the nursing and medical professions in relation to preparing students for the workplace and mentoring standards (Pointer, 2001), research shows that new graduate nurses and medical doctors also feel under prepared for the workplace environment (Becker et al., 1961; Boychuk Duchscher, 2009; Boychuk Duchscher & Cowin, 2004; Boyer, 2008; Conrad, 1988; Lamdin, 2006; Owens et al., 2001; Pitkala & Mantyranta, 2003).

The few studies that focus on paramedic clinical placements examine the experiences of students in relation to how they are treated during their placement, or investigate the extent to which students are prepared to enter the workplace from the clinical mentors' point of view. What is missing from the extent literature is research on the role of clinical placements in forging a professional identity through a professional

socialisation process. Thus, this thesis seeks to explore the role of clinical placements in socialising students into the role, values and expectations of the paramedic profession.

2.6 Paramedic Internship (Professional Employment Year)

After graduating from university, Australian paramedics are required to undertake an internship program of approximately 12 months duration. Conversely, at the time of data collection, UH paramedic students had a year of employment, the sandwich year, imbedded into their university course, after which they were eligible to register as paramedics with the HCPC. From the Australian perspective, paramedics differ from a number of health professions as the status of qualified paramedic is bestowed on the graduate paramedic only after completing an industry-run internship program. From the UK perspective, paramedic graduates from the UH who took part in this study, were unique from other health professionals as they were registered health professionals with the HCPC before the completion of their paramedic degree.

Despite the requirement for the one year internship (Australia) or sandwich year (UK), there appears to be no standardised approach for supporting new graduates (McDonell et al., 2009; Sibson & Mursell, 2010a, 2010b, 2010c). There are variations between and within ambulance services on how they mentor and support new graduates. Paramedic mentors could be "chosen for the job (of training an intern paramedic) without his/her consent" and "many Officers … complain bitterly about having been given trainees or multiple trainees one after another" (Parker & General Purpose Standing Committee No. 2., 2008, p. 56). Furthermore, submissions to the NSW Legislative Council expressed concerns about interns being trained by paramedics who were still undergoing training themselves (Parker & General Purpose Standing Committee No. 2., 2008). There appears to be no standardised approach to supporting preceptors and mentors. When the data for this study were

collected, some ambulance services in Australia and the UK did not have designated preceptors. Preceptors have an important training role as they should ideally understand the university system and be skilled at giving feedback and assisting interns and mentors to resolve conflict should it occur. Authors also highlight that there is little research that examines the minimum qualifications needed to become an effective preceptor or mentor (Armitage, 2010; Brouhard, 2007). Others suggest a set application process and training course (Beaulieu O'Friel, 1993). It has been noted that conflict can arise between interns and their mentors when a breakdown in communication occurs leading to poor learning experiences for trainees (Giannini, 1991; NSW Department of Premier and Cabinet, 2008). Similarly, mentors may need support in their mentoring role and ideally preceptors should be able to provide this support.

It is thought that environmental considerations need to be taken into account to maximise the training experience of interns. Being attached to a busy metropolitan station is thought to give a newly graduated paramedic a variety of caseloads (Giannini, 1991) where they can develop and hone their clinical skills. Interestingly, current trends suggest that paramedic crews in a busy city location may have to wait up to several hours at the emergency department before transferring their patient to a hospital bed (Hitchcock et al., 2010; Temperley, 2011), and so being in a city environment does not necessarily ensure a large caseload.

There is little literature focusing on the experiences of the newly qualified university educated paramedics as they advance through their internship, with the exception of one non-peer reviewed report (Lazarsfeld-Jensen et al., 2011). A master's dissertation also examines the expediencies of Canadian community college trained paramedics transitioning into an ambulance service in Alberta (Huot, 2013). However, these paramedics were not university degree qualified. The greater part of the relevant literature focuses on issues surrounding the preceptor, for example, the preceptor's opinion of the students' work preparedness (Dawson, 2008).

Research is limited relating to how internship programs help shape a paramedic's professional identity through a professional socialisation process. Thus, the aim of this study is to fill this gap in the literature.

2.7 The Ambulance Culture

The paramedic culture is unique and complex given its military origins, its interactions with emergency and health services, and its 24-hour a day operating environment. In addition to being built on military principles, it has been reported that the culture contains medical and spiritual ideals (Reynolds, 2008). Paramedics who graduate from a university course have as little as 12 months in which to assimilate into the ambulance service culture as an employee. After this internship period, these graduates can become the lead clinician on an ambulance, when they may be required to train new employees. Within the internship period, the intern paramedic's ability to learn about and adjust to the ambulance culture arguably has an important impact on their acceptance into the workplace environment. The literature about the ambulance culture is explored in this section to provide the reader with an understanding of the experiences of paramedic interns as they encounter an enculturation process.

Spiritual Aspects

The ambulance culture of today is a result of the intermingling of many different influences. First, there is a biblical theme to paramedic practice with authors like Reynolds sighting stories of the Good Samaritan in her investigation of the ambulance culture (Reynolds, 2008, p. 38). Thus, paramedic work is thought to have a spiritual component.

Military Aspects

This spiritual theme merges with a military theme with the history of St John Ambulance stemming back to the Knights Hospitallers, (Howie-Willis, 1983) and the siege of Malta (Bell, 2009; Campbell, 2008). Ambulance services exhibit military cultural overtones such as the presence of a

hierarchical chain of command (Reynolds, 2008). The military style uniform and rank displayed on epaulets has its origins from St John Ambulance, which based their uniforms and rank structure on the Australian and British Army (Howie-Willis, 1983; Mayhew, 2011-2012).

Paramedic practice has benefited from medical advances as a result of armed conflicts from World War I to the Afghanistan War (Bell, 2009; Devenish & O'Meara, 2010). Ambulance officers were mostly men up until the late 1960s. Women became ambulance officers during World Wars I and II as men were expected to volunteer for armed service. However, most women relinquished their ambulance officer roles to returned servicemen on the cessation of these conflicts (Bell, 2009). The influence of these returned servicemen further contributed to the paramilitary structure of ambulance services such as the military style rank system for managerial staff. These ex-servicemen also had a direct influence on modernising paramedic practice, as they brought clinical skills to civilian ambulance services, which lagged behind the advancements in military medical practice (Bell, 2009; Campbell, 2008), especially during the Korean and Vietnam conflicts (Reynolds, 2008).

Boys Club

Military overtones possibly added the presence of cultural influences such as a masculine 'boys club' to the field of paramedicine (Boyle, 1997; Reynolds, 2008). The 'boys club' was reported to be evident as recently as 2008 in submissions to the Legislative Enquiry into the performance of Australia's largest ambulance service, the ASNSW (Parker & General Purpose Standing Committee No. 2., 2008). Submissions stated that members of the 'boys club' enjoyed many advantages, such as better rosters, preferential treatment in relation to overtime and promotion to management positions (Parker & General Purpose Standing Committee No. 2., 2008). As a result of managers being appointed through the 'boys club', it has been reported that many paramedics distrust management,

describing the workplace as dysfunctional with low moral (Parker & General Purpose Standing Committee No. 2., 2008).

Stressful Workplace

Paramedics have been reported to be at high risk of suffering burnout, leading to feelings of chronic fatigue, depression and negativity towards life (Hamilton, 2009; Mildenhall, 2012; Raynovich, 2006; Reynolds, 2008). Authors have suggested that paramedics have learned to cope with stressful situations by detaching themselves emotionally from their patients (Douglas, 1969), and labelling their patient according to their clinical condition (Metz, 1982). These coping mechanisms reflect the stressful nature of paramedic work. The unpredictable environment in which paramedics work can also be stressful, where long 'down times' at the station or at the hospital may be followed by a series of serious cases. Serious cases are frequently unpleasant and traumatic, and may lead to paramedics suffering stress-related disorders such as sleep disturbance (Reynolds, 2008). Paramedics use coping skills such as gallows humour to deal with traumatic circumstances (Reynolds, 2008). Additionally, paramedics may pessimistically prepare for the worst possible scenario on the way to a case and psychologically search for reasons why traumatic events occur (Hamilton, 2009; Reynolds, 2009).

High Acuity Work

Despite the stressful effects that traumatic cases can have on paramedics, Reynolds' (2008, 2009) research purports that paramedics view high acuity cases, where significant invasive interventions are required during patient care, as desirable jobs. For example, paramedics state that code one (urgent response) cases involving motor vehicle crashes, cardiac arrests, anaphylactic shock and unconscious diabetics are "good jobs" (Reynolds, 2008, p. 86). Conversely, cases or jobs where no invasive interventions were required are considered by paramedics to be "bad jobs" (Reynolds, 2008, p. 86). Therefore, the ambulance culture places an emphasis on high acuity work, despite these cases occurring infrequently.

The majority of cases paramedics attend involve routine or low acuity work (Clark et al., 2000; Devenish et al., 2012; Reynolds, 2008, 2009; Williams et al., 2012; Woollard, 2003).

It is evident from this section that the paramedic culture has military overtones, and places an emphasis on high rather than low acuity cases. The transition of graduates from a university culture to the ambulance culture described above will form a central part of this thesis. As university education prepares graduates to think and act like professionals, in the next section, the literature pertaining to the professional status of ambulance services will be reviewed.

2.8 Professionalism and Paramedicine

2.8.1 Is paramedicine in Australia a profession?

At the time of writing this thesis, paramedicine in Australia is not a registered health profession. Although paramedicine has not yet achieved formal professional status through national registration, the movement of training to university settings and the lobbying work undertaken by stakeholder organisations such as Paramedics Australasia, CAA, Australian and New Zealand College of Paramedicine are clear signals that the discipline is transitioning to professional status.

A profession is described as an occupation that is autonomous or self-directing (Trede, 2009). A profession sustains its status through the pursuit of ethical practice, knowledgeable skills and maintains the trust of its members (Lamdin, 2006; Reynolds, 2004; Trede, 2009). Additionally, a profession contains a systematic body of knowledge, authority, community sanctions, ethical codes and a professional culture (Greenwood, 1984). Two distinct components to being a profession have also been reported (Trede, 2009). These are the visible aspects that include the 'doings and sayings' and the invisible aspects that account for the values, assumptions and beliefs. In relation to the values, assumptions and beliefs, it is thought that paramedicine needs to move

away from a protocol-based *modus operandi* before it can be called a profession (Trede, 2009). It was suggested over a decade ago that paramedic professional associations need to control education, qualifications and registration (Mahony, 2003). Ambulance services in Australia and the UK have fulfilled many of the professional requirements reported in the literature (Boyle et al., 2003; Grantham, 2004; O'Meara et al., 2012; Reynolds, 2004; Sheather, 2009; Woollard, 2009). However, it has been argued that not all paramedics view themselves as professionals (Williams, Onsman, & Brown, 2010b), but rather aligned with trade or vocational occupations. From the perspective of the medical profession, Goode (1960) goes much further than Greenwood and Mahony in stating that an occupation becomes a profession when it fulfils the following 10 criteria:

1. Governs its own standards of education and training
2. Provides an extensive adult socialisation process above and beyond an occupation
3. Has a legally recognised licence to practice
4. Possesses a professional licensing board manned by members of the profession
5. Has relevant legislation shaped by members of the profession
6. Has status, income and prestige in the community
7. Has members who are free of lay evaluation and control
8. Has professional expectations that are higher than the legal requirements
9. Has members who are identified as being part of a profession not just an occupation
10. Have members who wish to stay with the profession, leading to a decrease in staff turnover rates.

Paramedics in the UK are closer to fulfilling Goode's (1960) criteria than their Australian counterparts. For example, the role of accrediting

ambulance education and training programs in Australia has been taken up by Paramedics Australia and the CAA (Council of Ambulance Authorities, 2010a), who have developed national competency standards for paramedics similar to those listed by the British Paramedics Association published by the HPCP (Health Professions Council, 2003). In the absence of a professional registering body, ambulance services in Australia provide their own framework for a certificate to practice within their state or territory's legislative framework (Convention of Ambulance Authorities, 2005; Council of Ambulance Authorities, 2009). Further, one Australian paramedic professional body (Paramedics Australasia) is seeking to protect the paramedic title through state parliaments (Larsen, 2013) while national paramedic registration is continually being sought.

2.8.2 Paramedicine as a profession in the United Kingdom and Canada

In Canada, health care comes under the jurisdiction of the provinces. Paramedic practice, like health care in general, has developed its own forms of regulation and practice at a provincial level (Bowles, 2009). A national occupational competency profile was established in 2001 by the Paramedic Association in Canada (Bowles, 2009; Gibson & Brightwell, 2006), which outlined four levels of paramedics from emergency responders through to the highly trained and educated critical care paramedics. The occupational profile has been used to licence the scope of practice for these different levels of paramedics through the Paramedic Association (Bowles, 2009).

Prior to 2000, paramedics in the UK were regulated by the NHS, which controlled educational standards and the curriculum. A change occurred in 2000 when paramedics, like other allied health professionals, were required to obtain professional registration through the HCPC (Whitmore & Furber, 2006; Woollard, 2009). In 2001, a Health Professions Order followed, which legislated the HCPC to regulate paramedics. As a result, the term 'paramedic' became protected in the UK, and it is illegal for a

person to claim to be a paramedic unless they are registered by the HCPC (Woollard, 2009). The British College of Paramedics and the Joint Royal Colleges Liaison Committee are both responsible for consulting with the HCPC to establish or review professional standards for paramedics in the UK (Woollard, 2009).

As evident in this section, which has reviewed the professional status of paramedicine, ambulance services in Australasia, the UK and Canada have either obtained, or are pursuing, registration for paramedics. In conjunction with university qualifications, it has also been identified earlier in this chapter that registration increases the professional standing of an occupation. Therefore, as an occupation's professional status increases, the socialisation processes used will likely make a shift from traditional organisational socialisation tactics and progress towards professional socialisation. As this thesis is investigating the transition of university educated paramedics into an emerging profession, it is important to highlight relevant aspects of organisational and professional socialisation in the next section.

2.9 Organisational and Professional Socialisation

The socialisation of paramedics is poorly canvassed in the literature. However, from the extant literature, it is possible to delineate two broad bodies of work-related socialisation theories that may be applicable to paramedics and their place in the workforce: professional socialisation and organisational socialisation theories. Professional socialisation is defined as the process by which "professionals learn during their education and training the values, behaviours and attitudes necessary to assume their professional role" (Howkins & Ewens, 1999, p. 41). Organisational socialisation is "the manner in which the experiences of people learning the ropes of a new organisational position, status or role are structured for them by others within the organisation" (Van Maanen, 1978, p. 19).

With the paramedic profession undergoing the transition from a vocation to a profession, both professional and organisational socialisation models may have relevance to the socialisation of university educated paramedics. On one hand, paramedic students are exposed to professionalism, reflective practice, ethics and critical thinking while at university. Conversely, after graduating paramedics encounter remnants of the traditional organisational socialisation process when joining an emergency ambulance service. Accordingly new graduates may experience discordance with the culture learned at university and the one experienced in the workplace (Devenish et al., 2011; Waxman & Williams, 2006). Therefore, to better understand the socialisation of university educated paramedics entering the ambulance culture, organisation and professional socialisation theories will be explored in this section.

2.9.1 Organisational Socialisation

While there are a number of organisational socialisation theoretical models, they all tend to explain the process of how people learn the values and attitudes necessary to fit into the organisational workplace, and which tools organisations use to facilitate this process (Kramer, 2010; Van Maanen & Schein, 1979). In the past, socialisation models have been criticised as being mainly descriptive, methodologically weak, inadequate and poorly understood (Saks & Ashforth, 1997). Of these models, the anticipatory, socialisation and metamorphosis stages of socialisation models of Van Maanen (1976) and Feldman (1976) have reportedly been the dominant models to describe the organisational socialisation process (Saks & Ashforth, 1997). Likewise, Schein and Van Maanen's six dimensions of organisational socialisation models (1979) was the "closest thing to a testable (theoretical model) of organisational socialisation" (Saks & Ashforth, 1997, p. 236) until the late 1990s. Both the anticipatory, encounter and metamorphosis phases and six dimensions of organisational socialisation models may have relevance to the socialisation of university educated paramedics as they join an ambulance service after

graduating and complete an induction course that orientates new graduates to the culture, practices and procedures valued by ambulance services.

The organisational socialisation models briefly outlined below are presented in chronological order, starting with the work of Schein (1971), then Van Maanen (1976), Feldman (1976) and finally Van Maanen and Schein (1979). Following this, the work of theorists who have added to the work by these authors will be mentioned, including, but not limited to the work of, Feldman (1981), Jones (1986), Ashforth, Saks and Lees (1998) and Ashforth, Sluss and Saks (2007).

Segments and Boundaries of Socialisation

In his theory, Schein (1971), a seminal organisational theorist, used a three dimensional spherical cone model that focused on role definition, workplace hierarchical models and inclusionary boundaries of an organisation. Schein's segments and boundaries model (see Figure 2.1) seeks to explain the roles defined by the organisation to assist newcomers in socialising into the workplace (Van Maanen & Schein, 1979). The functional aspect takes into consideration the tasks performed such as sales, marketing and production. For example, within an ambulance context this could be the functional role of a patient transport officer, as opposed to a paramedic and an intensive care paramedic. The hierarchical aspect has to do with the rank or management structure of the organisation, such as a station manager or area manager. The inclusionary aspect identifies the importance of the individual within the organisation structure; for example, the extent to which they are central or peripheral to the workings of the organisation (Schein, 1971).The segments and boundaries model investigated how an individual moves through these aspects during their career.

Figure 2.1. Schein's Segments and Boundaries Model.
The above model depicts a 3D spherical cone model that focused on role definition, workplace hierarchical models and inclusionary boundaries of an organisation adapted from Schein, E. H. (1971). "The Individual, the Organisation and the Career: A conceptual scheme." Journal of Applied Behavioural Science 7: 401-426.

The segments and boundaries model was further developed by Van Maanen and Schein (1979), who hypothetically mapped out what an organisational hierarchical structure of an organisation might look like. For example, Figure 2.2 depicts an imaginary police force that has approximately 75% of its workforce within the lower ranks. Schein's model appears to have some relevance to the ambulance service paradigm, as ambulance services are paramilitary organisations with a distinct sequential clinical and managerial hierarchy (Reynolds, 2008) including the existence of roles delineated by organisational and cultural boundaries. The segments and boundaries model may assist to explain the complex hierarchical interactions between paramedic interns, qualified paramedics and intensive care paramedics. However, Schein's (1971) model does not address the anticipatory socialisation process; that is, the formation of preconceptions prior to joining an organisation.

Figure 2.2. The Organisational Hierarchical Structural Model.
The above model depicts the hierarchal structure of a hypothetical police force, where few managers supervise the majority of workers in the lower ranks. A similar structure would be present within the paramedic paradigm. Adapted from Van Maanen, J. and E. H. Schein (1979). "Toward a theory of organizational socialization." Research in organizational behaviour 1(1): 209-264.

Schein's (1971) model may be useful for examining the experiences of university educated paramedics as they transition into a workplace where the majority of employees went through a traditional apprenticeship model.

The Anticipatory, Encounter and Metamorphosis Stages of Organisational Socialisation

Expanding on the work of Schein (1968) and Porter, Lawler and Hackman (1975), Van Maanen (1976) developed a three stage model of organisational socialisation that described the adjustment process of an individual as they encountered transitional boundaries of socialisation. In his theoretical model, Van Maanen (1976) identified an anticipatory phase, an encounter phase and a final metamorphosis stage sometimes referred to as a post socialisation phase. In the same year, Feldman (1976) also proposed a three stage model of organisational socialisation, which in essence, was very similar to Van Maanen's work.

According to several authors, the anticipatory, encounter and metamorphosis phases of organisational socialisation have been used extensively, over almost 35 years, to understand the socialisation process

(Kramer, 2010; Saks & Ashforth, 1997; Wanous, 1992). Over this period, many authors have critiqued and added to Van Maanen's (1976) work. For example, the linear nature of the anticipatory, encounter and metamorphosis stage model has been criticised (Kramer, 2010). Other authors added several variables to the encounter stage, such as managing conflict in the workplace, maintaining a work-life balance, understanding team dynamics and information seeking tactics (Feldman, 1981; Folkman & Lazarus, 1980; Morrison, 1993a; Nelson, 1987; Ostroff & Kozlowski, 1992). The anticipatory socialisation phase has been further divided into vocational anticipatory socialisation (the type of job) and organisational socialisation (which organisation to work for) (Jablin, 2001). To provide the reader with a better understanding of the anticipatory, encounter and metamorphosis phases of professional socialisation, this model is briefly explained below.

The Anticipatory Phase The anticipatory phase is where the individual fantasises about the job or role, which leads to tentative occupational choices (Mobley, Hand, Baker, & Meglino, 1979; Van Maanen, 1976; Wanous, 1977) and is thought to occur between the ages of 6 and 16 years (Jablin, 2001). Following this, there is a period where the individual builds upon these previous thoughts and experiences and engages in a more realistic career choice (Frese, 1982; Van Maanen, 1976). The anticipatory phase is influenced by family members, friends, education and learning institutions as well as cultural influences (Van Maanen & Schein, 1979).

The establishment of a vocational anticipatory socialisation sub-stage (Jablin, 2001; Kramer, 2010) was used to explain the childhood decision making process where an individual decides to pursue a certain career through informed processes such as interactions with family and friends, media portrayal and educational experience (Jablin, 2001). Conversely, the organisational anticipatory socialisation sub-stage is concerned with the selection of an organisation within a chosen occupational group. For

example, the individual may choose to become a paramedic (vocational anticipatory socialisation) and then later decide to join the ASNSW or Ambulance Victoria (organisational anticipatory socialisation). It has been suggested that organisational anticipatory socialisation occurs more rapidly than role or vocational anticipatory socialisation (Jablin, 2001; Kramer, 2010).

The encounter phase is where the individual enters the organisation as a new employee (Louis, 1980; Van Maanen, 1976). During this phase, the new employee learns the specific nature of their role within the organisation, and further develops an understanding of how to perform their job, interact with co-workers and assimilate into the culture (Ostroff & Kozlowski, 1992). It has been reported that a 'reality shock' is commonly encountered during the encounter phase (Van Maanen, 1976, 1977). The 'reality shock' is thought to be created as a result of the individual learning and amplifying unrealistic views of the nature of the job and organisation in the anticipatory phase, which do not align with the reality or lived experience in the workplace. The encounter phase can be a difficult time for the individual (Tuttle, 2002), as marketing and social media may focus on the positive aspects of the organisation and can lead to disillusionment when the individual is faced with reality (Feldman, 1976, 1981; Van Maanen, 1976). The encounter phase has also been referred to as a time of 'high uncertainty' for the newcomer (Morrison, 1995). The uncertainty can be of a cognitive and behavioural nature. For example, the newcomer may not be able to predict the motives and actions of others in the organisation (Morrison, 1995). Furthermore, Van Maanen (1976) specifies that environmental, organisational, individual and group factors may also affect the encounter phase.

Van Maanen (1976) theorised that organisations may have three different avenues for managing an individual during the encounter phase. First, the organisation may reward the new employee's behaviour if it is congruent with the organisation's values. Second, if the individual's values and

behaviour run counter to the organisation's, rewards will be withheld to discourage characteristics that are seen as undesirable. Last, the organisation can do nothing, and ignore the values and behaviours of the new member (Van Maanen, 1976). Schein (1968) and Ostroff and Kozlowski (1992) agree with Van Maanen on the significance of rewards in influencing the socialisation of a newcomer to an organisation. Other authors have outlined additional avenues. For example, the employee may voluntarily choose to exit the organisation, or they could have their employment involuntarily terminated (Kramer, 2010; Jablin, 2001).

The Metamorphosis (Change and Acquisition) Stage is the final stage of organisational socialisation is where the individual tries to come to terms with their experiences in the encounter phase and adapt to the reality of their organisational role (Folkman & Lazarus, 1980; Nelson, 1987; Van Maanen, 1976). The metamorphosis phase is largely a psychological process, where an individual no longer feels like a newcomer within the organisation (Kramer, 2010). During this phase, relevant information is gained from peers, mentors, rewards and punishments and the new employee is required to adjust their attitudes in accordance to that encouraged by the workplace (Feldman, 1976; Van Maanen, 1976).

Often an important aspect of this stage may be the transition of the new employee through an informal or formal 'rite of passage' that indicates that their membership is now fully fledged and their identity in the organisation is sealed (Van Maanen, 1978). The rite of passage may include a title, access to more information, or extra rights that were previously not offered (Van Maanen, 1977, 1978). As a result of the metamorphosis phase, the newcomer acquires a workplace identity, gains acceptance from peers and begins to make important contributions to the team (Haski-Leventhal & Bargal, 2008; Schlossberg, 1981). The metamorphosis phase may last from weeks to decades (Feldman, 1976; Kramer, 2010).

Limitations to the Anticipatory, Encounter and Metamorphosis "Stage Model" The stage model is not without criticism. A major criticism is that it relies on a linear approach (Kramer, 2010). Many authors have emphasised that the stages of socialisation are really more fluid and overlapping in nature and the newcomer may fluctuate between stages, or even repeat a given stage (Feldman, 1981; Jablin, 2001; Jones, 1986; Kramer, 2010; Morrison, 1993a). It has been suggested that the socialisation process is an individual one, which may, or may not, consist of a smooth transition (Jablin, 2001). However, despite the criticisms noted above the model does assist with gaining an understanding of socialisation process even though it may "not entirely capture the phenomenon's complexity" (Kramer, 2010, p. 192).

The anticipatory, encounter and metamorphosis stages of organisational socialisation were initially considered as a framework for this thesis. However, as the traditional in-house vocational apprenticeship style model of paramedic training has mostly been phased out, a theoretical model that allowed for the investigation of the professional socialisation that occurs at university was necessary. Such a model identifying an anticipatory, formal and post-formal phase of professional socialisation is discussed in the Chapter 3 of this thesis. What Van Maanen's (1976) and Feldman's (1976) anticipatory, encounter and metamorphosis model suggests is that paramedics who underwent an organisational socialisation process possibly encountered a reality shock when transitioning from the anticipatory phase to the encounter phase. During the encounter phase, individuals were required to complete an induction course as part of their apprenticeship style training, where new employees were introduced to the ambulance services' culture. Van Maanen and Schein (1979) developed a model that identified six different dimensions of organisational socialisation that outlined tactics organisations use to induct new employees into the workplace's culture. It is important to possess an understanding of the six dimensions of organisation

socialisation model, as university educated paramedics encounter a graduate entry course that contains aspects of organisational socialisation tactics traditionally used in apprenticeship paramedic induction courses.

Six Dimension of Organisation Socialisation

The six dimensions model draws on Schein's segments and boundaries model outlined earlier in this section. Van Maanen and Schein (1979) suggested that it was unclear which socialisation techniques could facilitate or inhibit the likelihood of an individual transitioning through the hierarchical and inclusionary aspects of Schein's (1971) segments and boundaries model. The six dimensions of organisational socialisation model addresses the process by which an organisation's values and roles are instilled in the newcomer of an organisation. However, Schein and Van Maanen never tested their propositions outlined in the six dimensions model (Tuttle, 2002). These six dimensions are briefly described below.

Collective versus Individual Socialisation Collective socialisation is where the newcomers to an organisation are put in a group, and support each other through the socialisation process. Individual socialisation occurs in isolation from other newcomers, such as an apprenticeship (Van Maanen and Schein 1979).

Formal versus Informal Socialisation Formal socialisation occurs when the newcomer is separated from the organisation's workforce and put through a socialisation program developed specifically for the new employees. This type of socialisation is commonly used in hierarchical occupations such as the police force, where new employees are often in the organisation's lower echelons. Conversely informal socialisation occurs when the new employee is not segregated, and the process involves on-the-job learning through trial and error (Van Maanen and Schein 1979).

Sequential versus Random Socialisation Sequential socialisation involves a planned process of steps that the newcomer is required to complete in a given order to reach the goals of the socialisation process. Conversely,

random socialisation may not include a specific plan for the newcomer, or the plan may constantly change (Van Maanen and Schein 1979).

Fixed versus Variable Socialisation A fixed socialisation process is where the new employee is aware of the time frame required to complete the socialisation process and obtain their organisational identity, such as a three year electrician's apprenticeship. Alternatively, variable socialisation is where the new employee has no real knowledge of how long the socialisation process will take (Van Maanen and Schein 1979).

A Serial versus Disjunctive Socialisation A new employee undergoing a serial socialisation process will be mentored by a number of more senior employees within the organisation who are experienced in the roles to be learned. For example, paramedic interns being mentored by qualified paramedics. A disjunctive socialisation process contains no organisational role models, and the individual has to learn for themselves what the organisational role entails. For example, the role could be a newly created position (Van Maanen and Schein 1979).

Investiture versus Divestiture Socialisation Investiture socialisation is where the organisation values and builds on the skills and knowledge that a new employee may bring to the workplace, such as an accounting graduate joining an accounting firm. Alternatively, a divestiture process values uniformity, and may discourage individuality, for example military boot camp (Van Maanen and Schein 1979).

Subsequent authors have added to the six dimension model. For example, Jones (1986) split the dimensions into two segments, differentiating between the institutional and individual aspects of socialisation (see Figure 2.3). Additionally, the socialisation tactics listed in the six dimensions model did not allow sufficiently for the individual's response to the socialisation process. Instead, the suggestion was made to differently configure the dimensions and create a tool for measuring organisational tactics and role responses (Jones, 1986). For example, the collective,

sequential, fixed, serial and investiture tactics arguably led newcomers to accept the current established institutional norms, acculturating newcomers into the organisation's culture (Jones, 1986). The opposite tactics, or individual, informal, random, variable, disjunctive and divestiture enabled the newcomer to question the norm and develop an

Figure 2.3. Jones' Model of Tactics, Self-Efficacy and Newcomer Adjustment
Adapted from Jones, G. R. (1986). "Socialisation Tactics, Self-Efficacy and Newcomers Adjustment to Organisations." Academy of Management Journal 29: 262-279.

individual approach to their new roles (Allen & Meyer, 1990; G. R. Jones, 1986). Another author added to the work of Van Maanen and Schein (1979), and Jones (1986) and proposed the model of 'socialisation and newcomer adjustment' (Ashforth et al., 1998).

Socialisation and Newcomer Adjustment – A structural relationship model

As demonstrated diagrammatically below, the model of socialisation and newcomer adjustment (Ashforth et al., 1998) (see Figure 2.4) further expands on the six dimensions model (Jones, 1986; Van Maanen & Schein, 1979), incorporating the theory of mechanistic organisational structures (Burns & Stalker, 1994) to explain the effects of organisation bureaucracy on socialisation tactics.

*Figure 2.*4. The model of Socialisation and Newcomer Adjustment.
The model of Socialisation and Newcomer Adjustment adapted from Ashforth, B. E., A. M. Saks, et al. (1998). "Socialization and Newcomer Adjustment: The Role of Organizational Context." Human Relations 51(7): 897-926.

Mechanistic organisations are structurally large, and contain smaller subunits. Individuals in this structure have specialised skills, workplace behaviour is more formalised and decision making is centralised with a distinct chain of command. A mechanistic structure will favour assimilation into the workplace culture through an institutionalised approach (Jones, 1986), which is less likely to lead the newcomer to question the organisational norms (Ashforth et al., 1998). The model of socialisation and newcomer adjustment suggests that individuals may be willing to put up with workplace bureaucracy during the initial socialisation process if it is essential to achieving their career goals (Ashforth et al., 1998; Burns & Stalker, 1994; Jones, 1986). For example, a soldier may put up with the harshness of boot camp to achieve their career aim of joining a certain battalion or regiment. The socialisation and newcomer adjustment model may have implications for the organisation socialisation processes used by ambulance services, as ambulance services are large bureaucratic

mechanistic organisations that possess a paramilitary structure such as a chain of command. The analysis of the experiences of university educated paramedics demonstrates the presence of an institutionalised socialisation processes, encountered during the graduate entry orientation course.

Summary of Organisational Socialisation Models

The theories presented in this section have not, to date, been used to explore organisational socialisation within the paramedic context. These theories may assist in understanding the processes used by ambulance services in the past as they socialised vocationally educated paramedics. Graduate paramedics may possibly encounter remnants of these processes as ambulance services make the transition from the traditional vocational training model to a pre-employment tertiary qualification model. Thus, some understanding of organisational socialisation is justified when interpreting how university educated paramedics are professionally socialised for practice.

Van Maanen and Schein's (1979) six dimensions of socialisation model may be of use for informing the interpretation of the experiences of new graduates as they encounter an orientation or induction with an ambulance service. The orientation marks the transition from university student to a paramedic intern. However, the six dimensions of organisational socialisation model do not explore the anticipatory and formal aspects of socialisation that university educated paramedics are expected to experience and thus its inclusion as a theoretical framework for this thesis is limited.

The anticipatory, socialisation and metamorphosis stages of organisational socialisation (Van Maanen, 1976; Feldman, 1976) do provide a framework from which to explore the transition of individuals from the anticipatory or pre-socialisation phase of socialisation through to the being socialised into the workplace. However, due to the transition of paramedic education from in-house vocational training models to the tertiary sector, Van

Maanen's (1976) and Feldman's (1976) stage models do not allow for the investigation of the participants' experiences as they become socialised into their chosen profession through studying at university. Despite this limitation, the anticipatory socialisation phase relating to organisational socialisation is theoretically similar to the anticipatory phase of professional socialisation (Cant & Higgs, 1999; Lamdin, 2006; Shuval & Adler, 1977). As such Van Maanen (1976) and Feldman's (1976) work relating to organisational anticipatory socialisation may be useful for exploring the undergraduate students' preconceptions of paramedic practice prior to studying at university.

Having discussed and examined organisational socialisation theories for their relevance to the socialisation of university educated paramedics, this thesis now turns to examine a second body of literature. This literature relates to theoretical models that have been used to explore the professional socialisation of a range of health professionals including medical doctors, nurses and allied health professionals.

2.9.2 Professional Socialisation

Professional socialisation theories have grown out of the examination of how members of particular health disciplines, such as nursing, medicine, occupational therapy and physiotherapy learn the knowledge, values and attitudes necessary to join their chosen profession (Howkins & Ewens, 1999). These theories range from investigating the socialisation of students prior to and while at university (Cant & Higgs, 1999; Higgs, 2013; Lamdin, 2006; Shuval & Adler, 1977; Thornton & Nardi, 1975), to exploring socialisation into the profession after university studies have been completed (Boychuk Duchscher, 2008, 2009, 2012; Boychuk Duchscher & Cowin, 2004; Kramer, 1974; Kramer & Schmalenberg, 1977). There is a considerable body of literature on professional socialisation within a number of disciplines such as teaching (Flores & Day, 2006; Kelchtermans & Ballet, 2002; Lacey, 2012; Schempp & Graber, 1992), business (Anderson-Gough, Grey, & Robson, 1998; Grey, 1998;

Lee, 2002; Schleef, 2006) engineering (Anderson & Swazey, 1998; Dryburgh, 1999; Nilsson, 2007) and health (Ajjawi & Higgs, 2008; Boychuk Duchscher, 2008, 2009; Cant & Higgs, 1999; Clouder, 2003; Howkins & Ewens, 1999; Kramer, 1974; Lamdin, 2006, 2010). The professional socialisation theoretical models outlined below emanate from the disciplines of allied health, medicine and nursing. As paramedicine is in the field of health, these theories may have relevance to the paramedic context. The following section begins by exploring the literature pertaining to the professional socialisation of medical doctors and then turns to investigate the professional socialisation of allied health professionals and nurses. Following this, the gaps in the research pertaining to the professional socialisation of paramedics are outlined.

Medical Doctors

The study of the professional socialisation of medical doctors has a long history, dating back to the early 1960s. Over this period, many authors have researched the experiences of medical students as they progress towards becoming doctors (Becker et al., 1961; Conrad, 1988; Coombs, 1978; Haas & Shaffir, 1987; Hafferty, 1988; Lamdin, 2006, 2010; Pitkala & Mantyranta, 2003; Radcliffe & Lester, 2003). Becker et al. (1961) in their well cited book *'Boys in White'* suggest that the professional socialisation process undertaken by medical students is stressful and even traumatising, as medical students are required to absorb large amounts of knowledge and cope with what many authors describe as a humiliating culture (Becker et al., 1961; Conrad, 1988; Radcliffe & Lester, 2003). Others liken the socialisation encountered at medical school to a form of childhood or schoolyard socialisation (Brim, 1966; Olmsted & Pacet, 1969), where a power struggle results due to the low status and high dependence of the medical students within the medical profession. Authors also argue that medical students undergo periods of disillusionment and increased cynicism (Conrad, 1988; Haas & Shaffir, 1987). They are required to normalise death (Coombs, 1978; Hafferty,

1988), and rote learn enormous amounts of information (Becker et al., 1961; Conrad, 1988; Haas & Shaffir, 1987).

Research into the professional socialisation of doctors is not without criticism. Studies have been criticised for being observational in nature, performed by sociologists and disciplines outside of the medical profession, and do not contain the inner experiences of medical students (Conrad, 1988; Pitkala & Mantyranta, 2003). Despite these claims, sociologists and non-medically trained researchers may provide unique qualitative perspectives, assisting the medical field to better understand the experiences of medical students as they are socialised into the profession at university and in the hospital environment.

Pitkala and Mantyranta (2003) and Conrad (1988) have also explored the professional socialisation of medical students as they come to terms with becoming doctors. Four specific phases were identified, such as the preclinical years, beginning an 'apprenticeship', humanistic care versus technical doctoring, and the final transformation (Conrad, 1988). In a more recent study, similar findings were discussed such as lacking credibility as medical students, beginning a 'medical apprenticeship' and high levels of stress relating to medical studies (Pitkala & Mantyranta, 2003). These phases are discussed in more detail below.

The Preclinical Years The preclinical years account for the first two years of medical education (Conrad, 1988). In this stage, the medical students are introduced to the culture of medicine. Students experience a challenging learning environment where vast amounts of information are taught in a very short time, and the dissection of human cadavers occurs (Becker et al., 1961; Conrad, 1988; Coombs, 1978; Hafferty, 1988; Pitkala & Mantyranta, 2003).

Beginning an Apprenticeship Many authors refer to an 'apprenticeship phase' for medical students, which begins when they commence hospital ward rotations (Conrad, 1988; Pitkala & Mantyranta, 2003; Radcliffe &

Lester, 2003). Students "willingly and humbly assumed the role of an apprentice" (Pitkala & Mantyranta, 2003, p. 156) as they perceived that even the patients were more grounded in the hospital culture than they were, confirming their novice position. Ward rounds, which are intended to be a learning opportunity, often left the students feeling overwhelmed due to the questions asked by the senior clinician (Conrad, 1988). Further, a small number of students used ward rounds as a tool to elevate their own status by parading their knowledge in front of supervising physicians (Conrad, 1988; Pitkala & Mantyranta, 2003). Despite this occurrence, most medical students reported having positive experiences when interacting with senior physicians on wards rounds (Pitkala & Mantyranta, 2003). Students soon began to reflect on their actions, discovering that patients trusted their opinions. As a result, students started to have more faith in their clinical ability and felt more secure and confident in exploring the role of a student doctor (Pitkala & Mantyranta, 2003).

Humanistic Care versus Technical Doctoring Many medical students appear to experience an inner confusion resulting from a perceived discrepancy between the caring aspects of being a doctor and the technical aspects of their role (Conrad, 1988), or the "disease-focused approach of medicine" (Lamdin, 2006, p. 106). Doctors on the wards spoke of the importance of humane and caring patient-doctor encounters. However, medical training appeared to concentrate more so on the "technical aspects of doctoring: diagnosis, treatment and intervention" (Conrad, 1988, p. 328), where the students learned to 'medicalise' the patient (Lamdin, 2006). Lamdin (2006) suggests that in the later stage of medical training, students began to value patient centred learning, where the patient is seen more as a unique individual when the presentation of their illness differs from the textbook cases learned while at medical school.

The Final Transformation The final transformation is where medical students develop a more realistic and cynical view of medicine (Conrad, 1988). In contrast, Pitkala and Mantyanta (2003) state that cynicism was absent from their findings. Several authors assert that students became more comfortable due to being in the hospital environment long enough to better grasp their role (Lamdin, 2006; Pitkala & Mantyranta, 2003; Radcliffe & Lester, 2003). At this stage, medical students began to fit into the medical team and gain acceptance, which provided them better access to doctors and patients, further facilitating their learning (Lamdin, 2006). Others observed students undergoing a transformation from identifying more with their patients to identifying more with their medical peers (Becker et al., 1961; Conrad, 1988). However, in contrast, Pitkala and Mantyanta (2003) and Lamdin (2006; 2010) did not find any evidence relating to the suggestion that doctors learn to identify less with their patients.

Allied Health Professions

The anticipatory, formal and post-formal phases of professional socialisation have been used to investigate the professional socialisation of physiotherapists and dieticians (Cant & Higgs, 1999; Maclellan et al., 2011). These phases of professional socialisation, which form part of the theoretical framework of this thesis, are described more fully in Chapter 3. In essence, the anticipatory, or pre-socialisation phase is where preconceptions about the profession are formed during childhood and adulthood. The formal phase encompasses the professional socialisation that occurs at university, and the post-formal phase is concerned with the socialisation that occurs during the transition to the profession (Cant & Higgs, 1999; Lamdin, 2006; Maclellan et al., 2011; Shuval & Adler, 1977). Most authors in their investigation of these phases have concentrated on the anticipatory and formal phases, and have largely neglected the post-formal phase.

The transition, euphoria and angst, reality of practice, and adaptation phases (Tryssenaar, 1999; Tryssenaar & Perkins, 2001) are part of a four phase post-formal model that investigated the transition of occupational therapists to the professional environment. During the first three months after transitioning to the workplace environment, students experienced euphoria because they had graduated and successfully found work. Euphoria was followed by angst when encountering the realities of the workplace (Tryssenaar & Perkins, 2001). A change and adaption phase was then necessary to develop strategies to adjust to the reality of occupational therapy practice (Tryssenaar & Perkins, 2001).

Nurses

Many authors have researched the professional socialisation of new graduate nurses (Boychuk Duchscher, 2008, 2009, 2012; Boychuk Duchscher & Cowin, 2004; Casey, Fink, Krugman, & Propst, 2004; du Toit, 1995; Gerrish, 1990; Kramer, 1974; Owens et al., 2001). As with the professional socialisation of allied health and medical disciplines, the anticipatory, formal and post-formal phases of professional socialisation have also been reported as relevant to nursing (du Toit, 1995; Howkins & Ewens, 1999; Simpson, 1967).

A seminal professional socialisation theoretical model investigated the reality shock and the subsequent adjustment phases experienced by newly qualified nurses making the transition to the workplace (Kramer, 1974). Many authors claim the continued relevance of this model to current day practice (Avis, Mallik, & Fraser, 2013; Cowin & Jacobsson, 2003; Edwards, Hawker, Carrier, & Rees, 2011; MacLeod-Clark, & Jones, 1996). Kramer's (1974) model is used in the theoretical framework of this thesis, and will be further discussed in Chapter 3. Others have built on Kramer's (1974) reality shock model, developing the stages of transition, transition shock and marginalisation models (Boychuk Duchscher, 2008, 2009, 2012; Boychuk Duchscher & Cowin, 2004). The novice to expert theory (Benner, 1982, 2001; Benner & Tanner, 1987) is also considered

seminal (Daley, 1999; Darbyshire, 1994; Dracup & Bryan-Brown, 2004; English, 1993) as it identifies how nurses learn their profession. Collectively, the findings of these researchers suggest that the transition from university to the profession is stressful and nurses feel neither comfortable nor confident in the workplace until they have had more than one to five years of experience.

Paramedics

Only a small number of studies have examined aspects of the professional socialisation of paramedics. These studies have focused on a particular aspect such as the reasons for becoming a paramedic (O'Meara et al., 2012), stigmatisation in the workplace (Boyle et al., 2008; Lazarsfeld-Jensen et al., 2011; Lord, 2013; Lord, McCall, & Wray, 2009; Sibson & Mursell, 2010a, 2010b, 2010c), the curriculum (Williams, Boyle, Brightwell, McCall, et al., 2012; Willis, Williams, Brightwell, O'Meara, & Pointon, 2010), work readiness (Dawson, 2008; Lazarsfeld-Jensen, 2010; O'Brien et al., 2013) and culture shock (Gregory, 2013; Lazarsfeld-Jensen et al., 2011). The experiences of university paramedic students on clinical placements have also been researched (Boyle et al., 2008; Lord, 2013).

It is unclear to what extent the results from medical, allied health or nursing professional socialisation studies apply to paramedicine. There are differences in length of training, entry requirements, status and roles that likely limit the application of many health profession socialisation theories to paramedicine. However, some similarities exist between paramedicine and other health professions. For example, in the professional socialisation of medical doctors, the pre-clinical medical years (Conrad, 1988; Pitkala & Mantyranta, 2003) may equate to paramedic university studies. The medical apprenticeship (Conrad, 1988; Pitkala & Mantyranta, 2003) may be compared to university clinical placements in the paramedical field. Humanistic versus technical doctoring (Conrad, 1988) could equate to patient-centred versus technical paramedic interventions and the final transformation (Conrad, 1988; Pitkala & Mantyranta, 2003)

could be compared to the phase when new graduates encounter the reality of paramedic practice.

Although comparisons between medicine and paramedicine can be made, Lord (2003) asserts that the university model used for paramedics appears to resemble more that of undergraduate nursing programs. Some similarities include length of training, status, pay scales and clinical placements. Prior to paramedicine, nursing was one of the more recent professions to undergo the academisation process (Andrew et al., 2009; Arieli, 2007; Chang & Daly, 2007; Taylor, Westcott, & Bartlett, 2001; The College of Nursing, 2008) such as that being encountered by paramedicine today. A university degree is now a mandatory requirement for the nursing profession, and has been since the late 1980s. Therefore, nursing professional socialisation theories may hold more relevance when investigating the professional socialisation of paramedics.

2.9.3 Summary of Organisational and Professional Socialisation

The literature addresses two forms of socialisation into the workplace, namely organisational and professional socialisation. Organisational socialisation addresses how individuals assimilate into the workplace culture (van Maanen, 1976; Kramer, 2010). Many theorists have researched organisational socialisation, and have subsequently developed models that explain how organisations induct new employees, or provide an understanding of the anticipatory, encounter and metamorphosis phases of organisational socialisation. Aspects of organisational socialisation may be relevant to understanding the professional socialisation of university educated paramedics as they gain experiences within the organisation through clinical placements, internships and work. Professional socialisation, on the other hand, explores how individuals acquire the knowledge, skills and values necessary to become a member of a professional group.

2.9.4 Gaps in the Knowledge Base

The literature shows a dearth of research about the professional socialisation of university educated paramedics. Paramedicine is undergoing a transition phase towards increased professional status, and a university education is a key milestone towards to this. Thus, it appears timely to examine the experiences of university educated paramedics as they transition from being university students to practising paramedic interns.

The few studies conducted within paramedicine examine particular or limited aspects of socialisation such as anticipatory socialisation, clinical placements, the curriculum, and enculturation post-graduation. To date, no studies have taken a comprehensive view of paramedic professional socialisation. Nor has a theoretical model been developed that attempts to explain paramedic socialisation. This thesis seeks to provide an examination of the paramedic socialisation process by using existing professional socialisation theories. The thesis examines the adequacy of existing theories to explain the professional socialisation of paramedics and seeks to develop a model for how paramedics are professionally socialised.

2.10 Conclusion

Over the past decade, paramedicine has steadily made the transition to becoming a profession. To date, no studies have comprehensively researched the professional socialisation of paramedics. However, two bodies of literature may have application for examining how paramedics attain the requisite values, skills and knowledge to be socialised into the paramedic profession. Of these, professional socialisation theories appear more relevant to the paramedic context, as they have been widely used in the examination of the professional socialisation of medical, allied health and nursing disciplines. However, organisational socialisation theories may hold some relevance as university educated paramedics intersect with,

and then join, an organisation with a unique set of cultural values, customs and practices.

Chapter 2 has explored the literature that forms the background to this study. Chapter 3 outlines the theoretical frameworks used for this thesis. The theoretical models identified and discussed in the next chapter have been taken from the medical, allied health and nursing professions. Additionally, Chapter 3 will justify the use of qualitative methods in guiding the procedural aspects of this study, such as data collection and analysis.

Chapter 3 Theoretical Framework

3.1 Introduction

The theoretical frameworks for this thesis are outlined in this chapter. The anticipatory, formal and post-formal phases of professional socialisation (Cant & Higgs, 1999; Higgs, 2013; Lamdin, 2006, 2010; Shuval & Adler, 1977) and Kramer's (1974) reality shock model are identified as most relevant to this thesis. Furthermore, the use of the reality shock model (Kramer, 1974) is justified over more recent models that expand on the original work of Kramer, such as the theory of marginalisation (Boychuk Duchscher & Cowin, 2004), the transition shock model and the stages of transitions model (Boychuk Duchscher, 2008, 2009, 2012). By using qualitative methods, this thesis seeks to investigate the professional socialisation of paramedics by using the above mentioned theoretical models with a view to developing a professional socialisation model specific to the context of university educated paramedics.

3.2 Anticipatory, Formal and Post-Formal Socialisation

The anticipatory, formal and post-formal phases of professional socialisation were introduced in Chapter 2. The linear phases of this professional socialisation model hold relevance to the nursing, allied health and medicine disciplines (Cant & Higgs, 1999; du Toit, 1995; Howkins & Ewens, 1999; Lamdin, 2006; Maclellan et al., 2011; Shuval & Adler, 1977; Simpson, 1967). To provide the reader with a better understanding of this model, the anticipatory, formal and post-formal phases are discussed in turn below.

The Pre-Socialisation Phase

The pre-socialisation or anticipatory stage encompasses the socialisation of the individual outside of the profession. Through the anticipatory phase of professional socialisation, a stereotypical preconception about the profession is developed (Lamdin, 2006; Shuval & Adler, 1977). These

stereotypical images are developed through personal observation, watching television, accessing multimedia and social media, and input from relatives and friends who are members of a given profession (Cant & Higgs, 1999; Devenish et al., 2011l; Lamdin, 2006; Shuval & Adler, 1977).

The Formal Socialisation Phase

The formal stage explores what the students learn about the profession at university. Research specifically relating to medical students (Shuval & Adler, 1977) suggests that the formal stage can be divided further into three sub-stages: pre-medical training, pre-clinical training and the internship. The formal stage is also enlightened by the formal curriculum, a hidden curriculum[1] and what students learn about the profession while on clinical placements (Cant & Higgs, 1999; Lamdin, 2006; Shuval & Adler, 1977).

In a similar model, Thornton and Nardi (1975) divide the formal phase into two sub-phases, namely the informal and personal socialisation phases. The informal phase appears to be similar to the 'hidden curriculum' outlined by Lamdin (2006). In their informal phase, students immerse themselves in the culture, observe and assimilate acceptable behaviour and develop a support group among their peers that enables them to progress through their studies easing each other's social anxiety (Thornton & Nardi, 1975). In the personal socialisation sub-phase, students begin to combine their previous preconceptions formed during the anticipatory phase with the expectations of others within the profession, and seek to take on a new professional identity (Collins, 2009; Thornton & Nardi, 1975). Students may begin to identify with the profession during this phase, consider joining relevant professional associations (Twale & Kochan, 1999) and plan for professional development activities beyond graduation (Weidman & Stein, 1990).

[1] Hidden curriculum refers to the learning that occurs outside of the formal curriculum, which is often unspoken and unexplored. This may include unintentionally educating university students as to the pressures and values of the profession's cultural norms (Cribb & Bignold, 1999).

The Post-Formal Socialisation Phase

The post-formal stage is the final period of socialisation, and continues from when the individual leaves university until they exit the profession (Shuval & Adler, 1977). Several authors refer to a post-formal phase of socialisation (Cant & Higgs, 1999; Lamdin, 2006; Shuval & Adler, 1977). However, these authors concentrate more on the anticipatory and formal socialisation phases, leaving the post-formal phase largely under-explored. Several authors have developed post-formal stage models such as the reality shock, transitional phases, transition shock and marginalisation theories, to explain the professional socialisation of nurses (Boychuk Duchscher, 2008, 2009, 2012; Boychuk Duchscher & Cowin, 2004; Kramer, 1974). These theories will now be discussed below in more detail in sections 3.3, 3.4 and 3.5.

3.3 Reality Shock Model

The reality shock (see Figure 3.1) model (Kramer, 1974) is considered to be a landmark piece of research about the professional socialisation of nurses and has been referred to by many authors (Avis et al., 2013; Boychuk Duchscher, 2008, 2009; Boychuk Duchscher & Cowin, 2004; Cowin & Jacobsson, 2003; Edwards et al., 2011; MacLeod-Clark et al., 1996).

Kramer's model (1974) investigated the professional socialisation of nurses in the United States as they integrated into the nursing profession after finishing their nursing education and training. In her model, Kramer (1974) suggests that after a brief 'honey-moon period', the new graduate nurse feels utterly unprepared for the workplace, and as such becomes focused on skills and routine mastery. The new graduate nurse perceives the established nursing staff to be judging their skills and their ability to adhere to the routine (Kramer, 1974).

Kramer (1974) then discovered that overlapping the initial emphasis on skill and routine mastery, were attempts by the new graduate to fit in at a social level within the work environment.

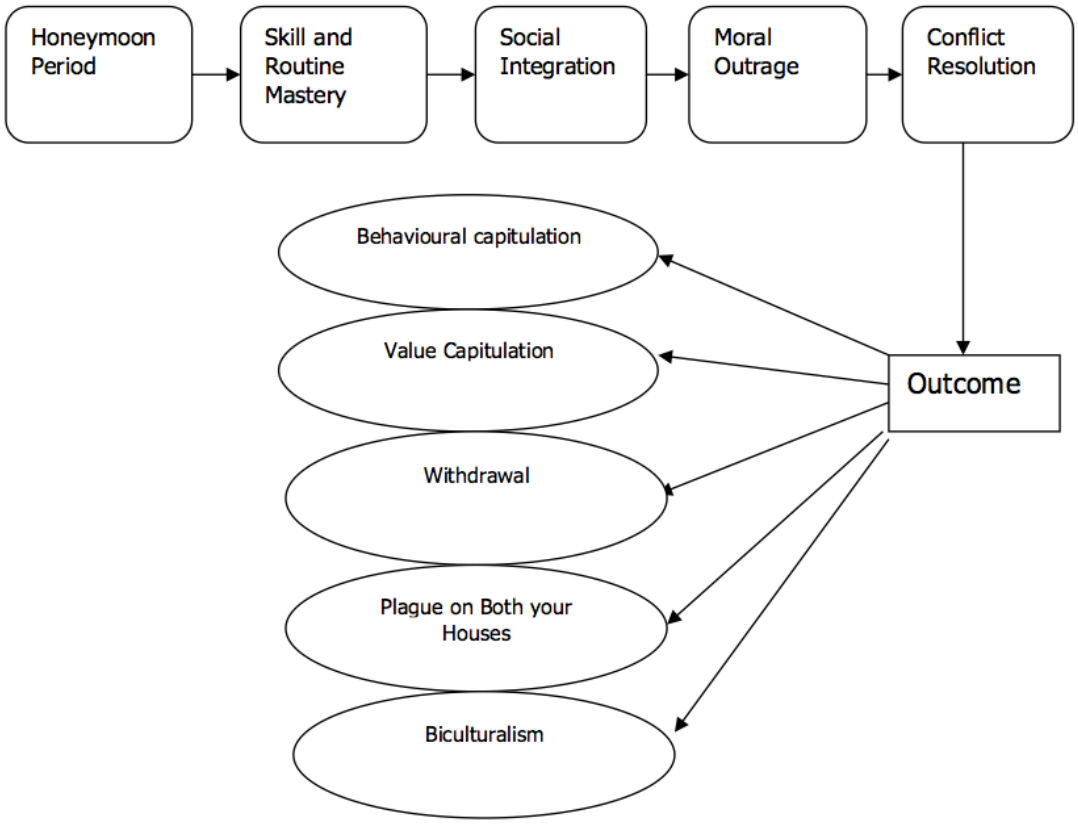


Figure 3.1. A Visual Representation of Kramer's Reality Shock Model. The above model has been adapted from Kramer, M. (1974). Reality Shock: Why nurses leave nursing. St Louis, C.V Mosby Company.

To achieve social integration, the new graduate attempts to gain acceptance by establishing relationships with co-workers and attending work functions and events (Kramer, 1974). As the reality of the work environment became apparent, the new graduate began to feel disillusioned and frustrated due to their unrealistic preconceptions, which Kramer referred to as the moral outrage phase (Kramer, 1974). As a consequence of experiencing moral outrage, the new graduate proceeds through a process of conflict resolution that led to five possible outcomes, namely: behavioural capitulation, value capitulation; withdrawal, plague

on both your houses; and biculturalism (Kramer, 1974), as shown in Figure 3.1.

Behavioural capitulation leads some new graduates to pursue a non-clinical role within nursing or to leave the profession. Value capitulation results in some new graduates immersing themselves in the workplace culture and rejecting the values taught by their nursing school. Nurses experiencing the withdrawal outcome actively pursued shifts and work locations where their interactions with other incumbent nurses would be kept to a minimum, while the plague on both your houses led new graduates to reject both the workplace culture and their school-bred values. Lastly, biculturalism occurred when new graduates merged the positive aspects of both the workplace culture and the values learned at nursing school to facilitate cultural change within the workplace (Kramer, 1974; Kramer & Schmalenberg, 1977).

Kramer's model (1974) has been instrumental in leading other authors to develop or critique the establishment of programs such as graduate programs, nurse orientation programs and structured nurse internships to counter the reality shock experienced by new graduates (Bratt & Felzer, 2012; Dyess & Parker, 2012; Edwards et al., 2011). However, determining whether these nurse graduate programs are successful in addressing reality shock has proven difficult (Edwards et al., 2011).

The reality shock model of professional socialisation (Kramer, 1974) may have relevance to the paramedic context. It has been used extensively in the nursing profession. It has also been used to research other health disciplines such as social work and occupational therapy (Hammer, Mathews, Lyons, & Johnson, 1986; Moriarty, Manthorpe, Stevens, & Hussein, 2011; Morley, 2006; Morley, Rugg, & Drew, 2007; Scott, 1990). Kramer's (1974) reality shock model may assist in the discovery of phases in the post-formal professional socialisation of paramedics. Consequently, in this research, the reality shock model (Kramer, 1974) is used to analyse

the experiences of new graduate paramedics as they transition into the ambulance culture and encounter the realities of paramedic workplace.

3.4 Theory of Marginalisation

Through the lens of critical theory[2] and postmodernism[3], the theory of marginalisation has been used to explore the professional socialisation of new graduate nurses (Boychuk Duchscher & Cowin, 2004; Hall, 1999) and social workers (Enoch, 1989). The theory of marginalisation is used by these authors to suggest that new graduates are in a 'marginal zone'. Having left the university environment, they are still building a workplace identity and trying to gain the acceptance of senior colleagues. After leaving university, new graduates may be intellectually motivated and hold high expectations of the nursing profession (Boychuk Duchscher & Cowin, 2004). However, the new graduate may not necessarily understand the historical, social and political undertones present in the workplace, as the organisation's culture may conflict with the new graduate's perceptions of reality in the workplace gained at university (Boychuk Duchscher & Cowin, 2004; Kramer, 1974). As discussed in Section 3.3, Kramer (1974) refers to this process as a 'reality shock' resulting from the values from their educational institution differing from the workplace values (Cowin & Jacobsson, 2003; Kramer, 1974). Three components of the marginal zone are presented by Boychuk Duchscher and Cowin (2004), namely: difficulties experienced with role expectations, forming a professional identity, and socialising into the role. These components will be discussed below.

Role Expectations

Several authors have purported that there may be tensions between the role expectations of the new graduate and their clinical supervisors

[2] Critical theory searches for contradictions in social arrangements, and is used in an attempt to understand the interpretation of historical social action (Blackburn, 2008).
[3] Postmodernism is the sceptical interpretation of the modern, or current, understanding of theological, aesthetic, literary and architectural work or theories (Brann, 1992).

(Boychuk Duchscher & Cowin, 2004; Bratt & Felzer, 2012; Kramer, 1974; MacLeod-Clark et al., 1996; Mayne, 2007). Research suggests that the workplace may expect the new graduate to 'hit the ground running', which could lead to significant challenges for the new graduate in the first 12 months of employment. When these unrealistic expectations are not met, new graduates have reported high stress levels resulting from being constantly observed and scrutinised (Boychuk Duchscher & Cowin, 2004). Therefore the new graduate may begin to question their ability, and experience a drop in self-confidence (Boychuk Duchscher & Cowin, 2004; Feng & Tsai, 2012).

Professional Identity

Research shows the acceptance of a new graduate nurse is directly related to their ability to assimilate into the workplace culture (Boychuk Duchscher & Cowin, 2004). If stigmatisation such as labelling occurs, a process of perceived differentiation and separation may result between the new graduate and the senior nursing staff (Boychuk Duchscher & Cowin, 2004; Kramer, 1974). Furthermore, senior staff members may appear antagonistic and unwelcoming, resulting in the perception that senior nurses have little concern for new graduates and are more preoccupied with operational issues such as staffing shortages (Boychuk Duchscher, 2009; Boychuk Duchscher & Cowin, 2004; Cowin & Jacobsson, 2003). Consequently, new graduates may experience a mismatch between how they perform as qualified beginners and expectations of the workplace around performance (Boychuk Duchscher & Cowin, 2004).

Role Socialisation

During the role socialisation, or enculturation process, new graduates found that the major stressors experienced when fitting into the workplace related to increased levels of responsibility associated with being an employee and a fear of making mistakes (Boychuk Duchscher, 2008, 2009; Boychuk Duchscher & Cowin, 2004; Kramer, 1974; Kramer & Schmalenberg, 1977). For example, the new graduates felt enormous

pressure to emulate workplace practices that prioritise ritualistic routines over interaction with patients (Boychuk Duchscher, 2001, 2008, 2012; Cowin & Jacobsson, 2003; Kelly, 1996; Kramer, 1974). New graduate nurses were apprehensive when asking for assistance, concerned that it may expose their inexperience and lead to a lack of acceptance (Boychuk Duchscher, 2009; Boychuk Duchscher & Cowin, 2004; Kramer, 1974), and felt caught between practising as taught by their educational institution, and assimilating into the modified practice encouraged in the workplace (Boychuk Duchscher & Cowin, 2004; Cowin & Jacobsson, 2003). Boychuk Duchscher and Cowin (2004) suggest the new graduate nurse may experience marginalisation in the nursing workplace for a period of up to six months.

The theory of marginalisation may have relevance in the paramedic context. Paramedic university students encounter stigmatisation in the paramedic workplace (Boyle et al., 2008; Lazarsfeld-Jensen et al., 2011; Lord, 2013; Lord et al., 2009; Sibson & Mursell, 2010a, 2010b, 2010c), and graduates are required to transition from university to the paramedic workplace and undergo an enculturation process. Thus, the theory of marginalisation will inform the theoretical framework of this thesis.

3.5 Transition Shock, and the Stages of Transition Models

Building upon Kramer's reality shock model, two theoretical models have been developed to further explain the professional socialisation of nurses in the post-formal phase. These are the transition shock model (see Figure 3.2), and the stages of transition model (see Figure 3.3) (Boychuk Duchscher, 2008, 2009, 2012). These models will be discussed below.

3.5.1 Transition Shock

The transition shock model (see Figure 3.2) looks at the experiences of nurses moving from the familiarity of their student role to the unfamiliarity of professional practice within the first four months after graduating. The

transition shock contrasts "relationships, roles, responsibilities and knowledge" (Boychuk Duchscher, 2009, p. 1105) of nursing practice learned during the academic environment compared to their experiences during the first four months of professional practice.

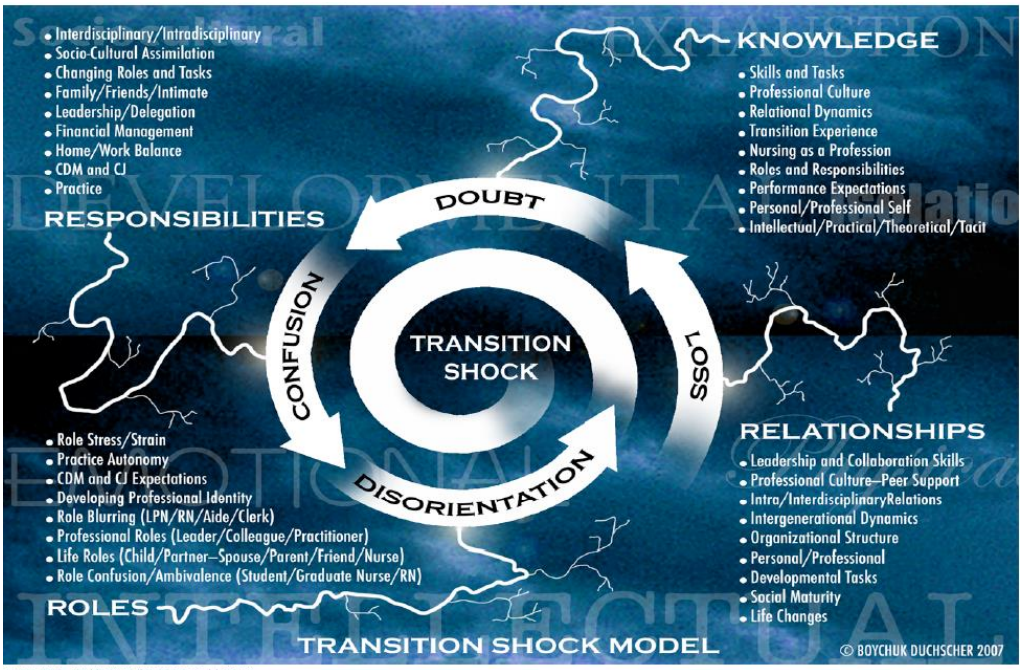


FIGURE 1. TRANSITION SHOCK MODEL

Figure 3.2. The Transition Shock Model.
The above model has been taken from Boychuk Duchscher, J. (2009). "Transition shock: The initial stage of role adaptation for newly graduated Registered Nurses." Journal of Advanced Nursing 65(5): 1103-1113.

Boychuk Duchscher (2009) maintains that when new graduates enter the workforce, they are 'emotionally terrified' and 'scared to death' due to fears of being seen as clinically incompetent, endangering their patients and unable to cope with the responsibilities of the role. Graduates are also physically exhausted as a result of trying to meet workplace expectations while at the same time encountering shift work, changes in living arrangements, challenges to existing intimate relationships and financial issues, for example, paying rent and applying for car loans (Boychuk Duchscher, 2009). Socio-culturally and developmentally, new graduate nurses observe a dissonance between the professional values taught at university and the workplace practices. Graduates begin to compare

themselves with more experienced nurses in the workplace, which leads to a lack of confidence in their own ability (Boychuk Duchscher, 2009). Intellectually, new graduates feel that they lack the required knowledge necessary to make the transition to professional practice, citing a theory-practice gap (Boychuk Duchscher, 2009). Therefore, during the transition process, new graduates are unsure of how to establish workplace relationships, and feel challenged in relation to their existing relationships. New graduates begin to doubt the knowledge they received at university and are confused over the level of responsibility in their new role, which leads to a feeling of disorientation (Boychuk Duchscher, 2009).

Boychuk Duchscher's (2009) transition shock model concentrates on the first four months of professional practice within the nursing discipline and has not been tested outside that profession. It may not provide an adequate framework to investigate how new paramedic graduates build a professional identity during the entire internship period. In contrast, Kramer's (1974) reality shock model appears to be more flexible in its design and timeframe, which might explain why it has been used by other disciplines. Thus, Kramer's model may provide a more adequate theoretical framework on which to base the post-formal socialisation of university educated paramedics.

2.5.2 Stages of Transition

The stages of transitions model outlines three transition phases: the doing, being and knowing phases (Boychuk Duchscher, 2008, 2012). These transition phases explore the 'significant adjustment' required when transitioning from a new graduate to a professional in the nursing field. A predictable process of events for graduate nurses, within the first 12 months of full-time work, are identified in this model (Boychuk Duchscher, 2008, 2012) as mapped out in Figure 3.3. The x axis maps the months when doing, being and knowing are likely to occur.

The Doing Phase The doing phase encompasses the 'transition shock'. The doing phase and the transition shock have been identified as separate experiences due to the claim by Boychuk Duchscher that the transition shock is a "foundational framework for the overall transition experience" (Boychuk Duchscher, 2012, p. 61). In the 'doing' phase, new graduate nurses are pre-occupied with their role adjustment and new responsibilities (Boychuk Duchscher, 2008, 2012). As the expectations of the new graduate do not necessarily reflect the reality of the workplace, the university system is often blamed by incumbent nursing staff for the new graduate's lack of confidence and clinical competence. The contribution of the workplace to inadequately preparing the newcomer for their roles and responsibilities is rarely acknowledged (Boychuk Duchscher, 2008, 2012; Kramer, 1974). Consequently, the new graduate may feel uncertain as to who they can trust, and suppress their emotions fearing that it may show their inadequacy (Boychuk Duchscher, 2008, 2012). New graduate nurses may also feel that their novice professional status may lead supervisors to micromanage them, resulting in the new graduate further doubting their performance (Boychuk Duchscher, 2008, 2012).

Being Phase The next phase, the being phase, lasts for four to five months as shown in Figure 3.3. During this phase, the new graduate rapidly advances in their thinking, knowledge and skills. In the being phase, the new graduate begins to doubt themselves professionally as their preconceptions are challenged, and they become aware of the faults in the health care system. The new graduate experiences an internal conflict about whether to stay or leave the profession. Nurses in this stage may find refuge in their personal lives and often disengage with colleagues at work, perceiving that they attend work only to encounter a "daily onslaught of daunting responsibility ... which leaves them feeling incompetent, inadequate, exhausted, disappointed, devalued, frustrated and powerless" (Boychuk Duchscher 2008, p.477).

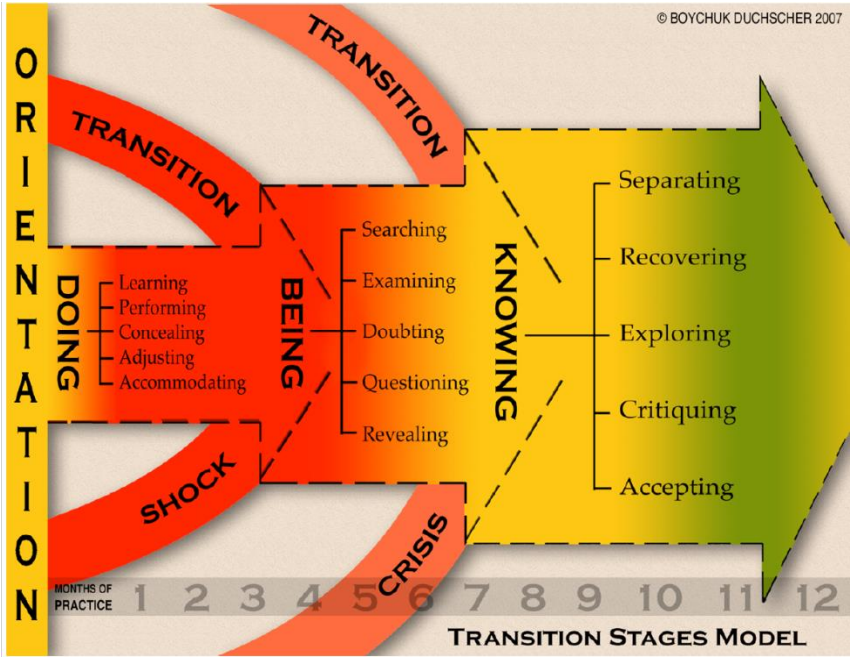


Figure 3.3. The Stages of Transition Model.
The above model has been taken from Boychuk Duchscher, J. (2008). "A process of becoming: The stages of new nursing graduate professional role transition." Journal of Continuing Education in Nursing 39(10): 441-450.

Knowing Phase The last phase, the knowing phase, lasts for around five to seven months (see Figure 7). In the 'knowing' phase, new graduates become apprehensive about their transition out of the learning role where their responsibility is greater with a narrower margin for errors. In this phase, the new graduate observes the workplace with renewed interest, taking note of the workplace political landscape in greater detail. At the end of this phase, the graduate nurse reaches a stable level of confidence in their role as they became more comfortable with their work routine, and are afforded a greater level of respect by other nurses (Boychuk Duchscher, 2008).

3.7 Summary of Professional Socialisation Theories

Selected theoretical models of health care professional socialisation have been discussed in this chapter. These models are the anticipatory, formal and post-formal professional socialisation models (Cant & Higgs, 1999;

Higgs, 2013; Lamdin, 2006; Shuval & Adler, 1977; Thornton & Nardi, 1975), the reality shock model (Kramer, 1974), the theory of marginalisation (Boychuk Duchscher & Cowin, 2004; Hall, 1999), the stages of transition model (Boychuk Duchscher, 2008) and the transition shock model (Boychuk Duchscher, 2009).

The researcher was unable to locate any professional socialisation models specifically relating to paramedicine in Australia or the UK. A notable exception was the candidate's published conference papers (see Devenish et al., 2012; Devenish et al., 2011; Williams et al., 2012), which were based on the anticipatory, formal and post-formal socialisation model outlined by Cant and Higgs (1999), Higgs (2013), Shuval and Adler (1977) and Lamdin (2006). Having investigated a number of professional socialisation theories, the next section discusses and analyses these theories for their suitability as theoretical frameworks for this thesis.

3.8 Professional Socialisation Theories Used in this Thesis

The theoretical frameworks chosen for this thesis complement the emerging professional status of paramedicine. The theories justified in this section are the anticipatory, formal and post-formal phases of professional socialisation, and Kramer's (1974) reality shock model.

The anticipatory, formal and post-formal model of professional socialisation (Cant & Higgs, 1999; Higgs, 2013; Lamdin, 2006; Shuval & Adler, 1977) has been used by authors to examine the professional socialisation of medical doctors, allied health and nursing. The model allows for the investigation of the development of preconceptions about a profession prior to the formal socialisation phase. Further, the model examines the student experience while at university, and includes a post education stage when transitioning to the workplace. However, authors, such as Lamdin (2006), Cant and Higgs, (1999) and Shuval and Adler

(1977), who have used this model have concentrated on the anticipatory and formal phases, leaving the post-formal phase largely unexplored.

The model chosen to support the exploration of post-formal socialisation is Kramer's reality shock model (Kramer, 1974). As discussed earlier, Kramer's (1974) landmark model addressed the professional socialisation of new graduate nurses as they entered the nursing workforce after the completion of their education and training. Kramer's model (1974) concentrates on the post-formal socialisation phase and proposes five phases that new graduates experience as they try to make sense of their new role and environment.

Boychuk Duchscher's more recent models were considered to be less applicable to paramedicine than Kramer's model. Additionally, it was noted that Kramer's model was written at a time when the nursing discipline was pursuing professionalisation. As noted previously, it has been used to examine the professional socialisation in several health disciplines. Boychuk Duchscher's stages of transition model was developed after the nursing discipline had achieved its professional status and examines the "impact of key personal and professional concepts within academic and practice environments on the duration and quality of role transitions" (Calhoun, 2010, p. 16). Kramer's (1974) reality shock model, on the other hand, examines the social conflicts between the education and workplace environments, and describes the effects that these social conflicts have on the experiences of newcomers (Calhoun, 2010). For multiple reasons, Kramer's (1974) reality shock model appears more applicable than the transition shock and stages of transitions models and it is used to inform the post-formal stage of professional socialisation within this thesis. Kramer's reality shock model was developed for a discipline in a transitional phase of its evolution, is flexible in its timeframe rather than prescriptive and has been used by many authors within nursing (Avis et al., 2013; Boychuk Duchscher, 2008, 2009; Boychuk Duchscher & Cowin, 2004; Cowin & Jacobsson, 2003; Edwards et al.,

2011; MacLeod-Clark et al., 1996) and in a number of disciplines outside of nursing (Hammer et al., 1986; Moriarty et al., 2011; Morley, 2006; Morley et al., 2007; Scott, 1990). As paramedicine is in the process of transitioning from a vocational occupation to a profession, Kramer's model is justified for inclusion in this thesis.

In summary, the professional socialisation models chosen to construct the theoretical framework for this thesis are the anticipatory, formal and post-formal phases of professional socialisation (Cant & Higgs, 1999; Lamdin, 2006; Shuval & Adler, 1977). Kramer's reality shock model (1974) of professional socialisation is used to inform the post-formal socialisation phase. These models are depicted in a conceptual framework (see Figure 3.4) that highlights professional socialisation stages encountered in a person's professional development prior to enrolling in paramedic studies at university through to becoming a qualified paramedic. These two theoretical models are applied in combination with qualitative methods based on the work of Charmaz (2006) and Saldana (2009).

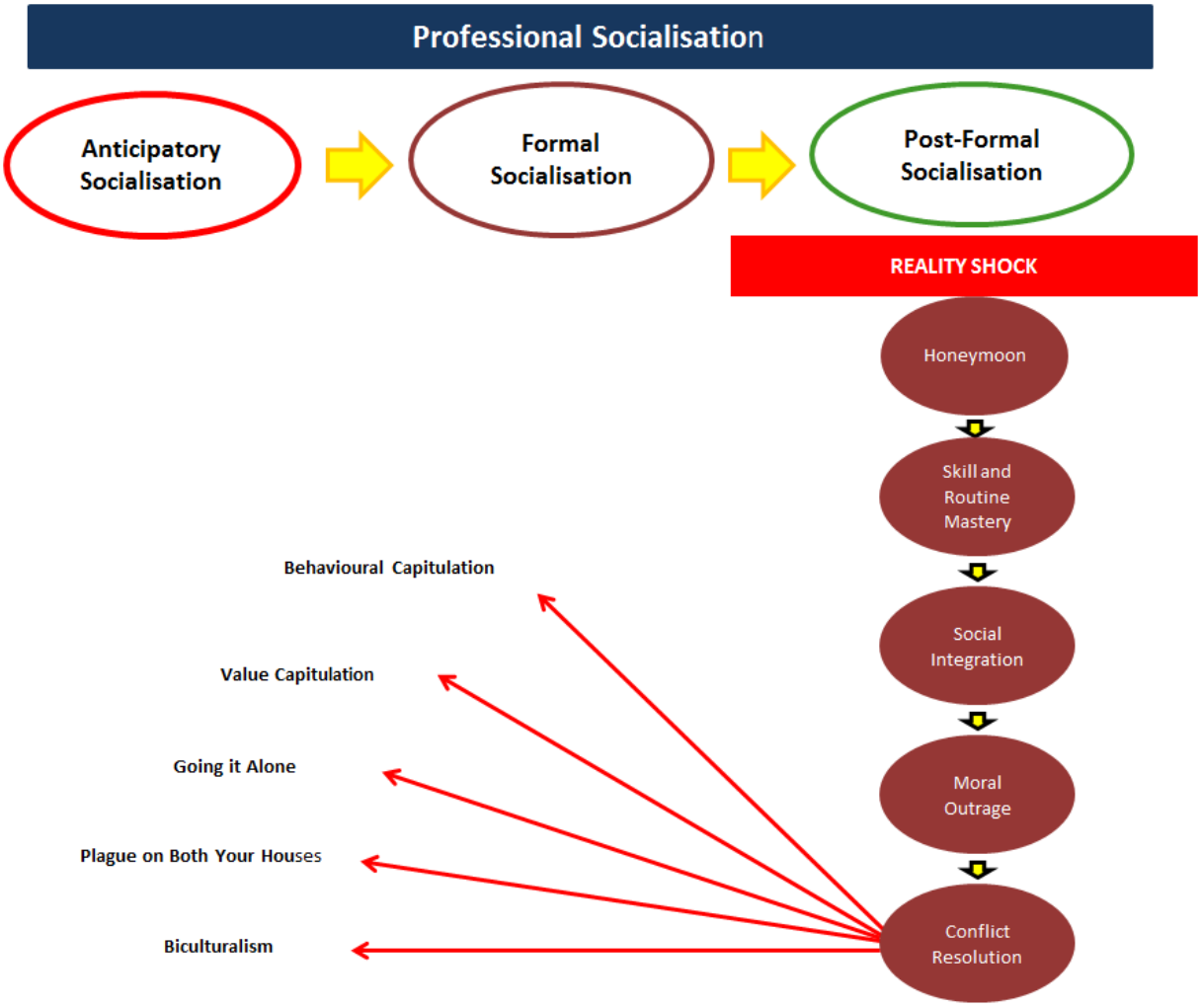


Figure 3.4. The Conceptual Framework for this Thesis.

Above is the author's own model adapted from the work of R. Cant and Higgs, J. (1999). Professional Socialisation in Educating Beginning Practitioners. Challenges for Health Professional Education. J. Higgs and H. Edwards. Melbourne, Butterworth-Heinemann, Lamdin, R. J. (2006). The professional socialisation of medical students through the preclinical to clinical transition. Auckland, The University of Auckland. Doctor of Philosophy (General Practice and Primary Health Care): 214, Shuval, J. T. and I. Adler (1977). "Processes of continuity and change during socialization for Medicine in Israel." Journal of Health and Social Behavior 18: 112-124 and Kramer, M. (1974). Reality Shock: Why nurses leave nursing. St Louis, C.V Mosby Company.

3.10 Conclusion

Chapter 3 reveals a dearth of literature examining professional socialisation of paramedics. A number of models and theories were examined, and no single model was thought to be appropriate for examining paramedic professional socialisation. Thus, a combination of two professional socialisation models forms the theoretical framework for this thesis. These models are the anticipatory formal and post-formal phases of professional socialisation and Kramer's reality shock model. These models are used to examine the professional socialisation of paramedics, leading to the development of theoretical model specific to paramedicine. Qualitative methods are used to provide the required interpretative depth needed to explore the rich nature of the data, and investigate the ontology and epistemology of new graduate paramedics as they transition though a socialisation process and become paramedics. Having chosen and justified the theoretical frameworks for this thesis in Chapter 3, Chapter 4 explores the methods used for the data collection and analysis used in this research study.

Chapter 4 Methods

4.1 Introduction

The qualitative methods used in undertaking this research are presented in Chapter 4. It discusses the recruitment of participants as well as the rationale for the selection of particular ambulance services and universities from which the participants were recruited. Chapter 4 addresses how the data were collected and analysed using qualitative methods to examine the anticipatory, formal and post-formal phases of professional socialisation, and Kramer's (1974) reality shock model. The ethical and research clearance processes are also outlined. A flow chart depicting the research study process is presented in Figure 4.1.

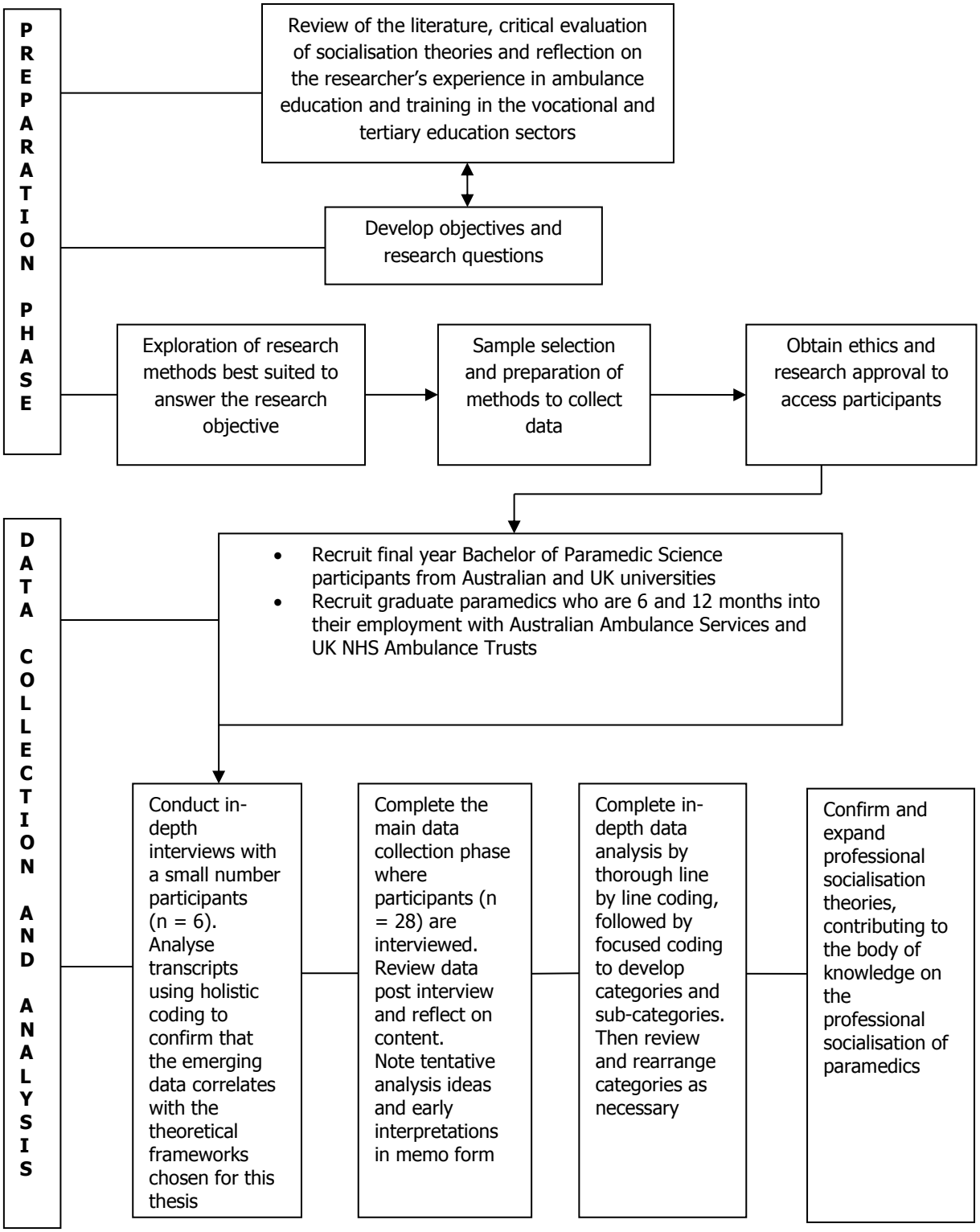


Figure 4.1. The Research Study Process.

The figure above has been adapted from the following two sources:

Charmaz, K. (2006). Constructing Grounded Theory: A Practical Guide Through the Qualitative Analysis. Los Angeles, Sage.

Brown, L. E. (2010). Role Experiences and Learning Behaviours of Health Services' Managers in Rural New South Wales: A Grounded Theory Study. Health Services Management. Bathurst, Charles Sturt University. Doctor of Philosophy

4.2 Qualitative Methods

In this thesis, qualitative methods based on the work of Charmaz (2006) and Saldana (2009) was used to guide the data collection and analysis. The work of Charmaz (2006) builds on the methodology of grounded theory, which was developed in the 1960s by Glaser and Strauss (1965). Recently, several authors have moved away from the prescriptive approach to qualitative research outlined by Glaser and Strauss (1965), preferring a more flexible approach to qualitative research (Bryant, 2002; Clarke, 2003; Charmaz, 2006, 2012). For example, Charmaz (2012) advocates the use of reflexivity and suggests that not all strategies outlined by Glaser and Strauss (1965) need to be used. Instead, researchers may choose to employ only some aspects of grounded theory to provide an 'analytical edge' to their qualitative research (Charmaz, 2012). Thus, this study does not use grounded theory as an 'off-the-shelf' inductive process for qualitative inquiry (Glaser and Strauss, 1965; Hammersley, 2012) where a stand-alone theory is built from data and where the literature review is delayed until after the data collection and analysis have occurred (Glaser and Strauss, 1965; Charmaz, 2006, 2012). Conversely, this study follows a deductive model of analysis (Brinkmann, 2014) to test theoretical frameworks, outlined in Chapter 3, against a paramedic context. Therefore, the researcher selected aspects of the work of Charmaz (2006) and Saldana (2009) to inform the research process. For example, the data were collected through one-on-one interviews. Theoretical sampling[1] was used to develop initial categories and assess the appropriateness of the theoretical frameworks to this research study (Charmaz, 2012,). Coding by gerunds[2] occurred when analysing the data, and the work of Charmaz (2006) and Saldana (2009) was used to guide the first and second round data analysis coding

[1] Theoretical sampling is the gathering of data to "develop and refine your tentative theoretical categories" (Charmaz, 2012 p.10). Theoretical sampling should not be confused with 'sampling' or developing a strategy to indicate participant numbers (Charmaz, 2012).
[2] The noun forms of verbs. Coding in gerunds involves coding for "processes, actions and meanings" (Charmaz, 2012 p.5).

techniques. Memos were created to marry the data with the categories found in the theoretical frameworks (Charmaz, 2012). Theoretical sampling, first and second round coding techniques, and memos are discussed in more detail in sections 4.7.1, 4.8.1, 4.8.2 and 4.8.4.

The qualitative methods outlined throughout this chapter provide appropriate data collection and analysis methods to fulfil the aims of this research. That is, to test the extent to which existing professional socialisation theories explain, or do not explain the professional socialisation of university educated paramedics. Having provided an introductory explanation of the qualitative methods used in this thesis, Chapter 4 now turns to explore the recruitment of the study's participants.

4.3 Research Participants

Participants in this research study were from Australia and the UK. The first group of participants involved in this research study were final year paramedic university students about to graduate from a Bachelor's Degree in Paramedic Science. Included in this first group were a small number of the students enrolled in a double degree in Nursing and Paramedicine. These final year university paramedic students were attending higher education institutions in Australia and the UK offering degrees in paramedic science.

The second and third groups of participants were both newly graduated paramedics who were 6 months (paramedic interns) and then 12 months (qualified paramedics) into their employment, having made the transition from university to the on-road work environment. These paramedics were employed by ambulance services located in Australia and the UK.

4.3.1 University Participants

In Australia, the final year of the academic program equates to the third year for the paramedic degree students, and the fourth year for the nursing and paramedic double degree. The students were enrolled at CSU, Monash University, QUT and Flinders University. These universities

were specifically chosen as they were the first universities in their states to commence paramedic university programs. Thus, these universities have contributed to the supply of graduate paramedics to the NSW, South Australian, Victorian and Queensland ambulance services for a longer period compared to other universities that have recently begun to offer university paramedic programs.

In the UK, paramedic students at the UH were invited to participate in this research. The UH offered the first paramedics degree in the UK, and has a well-established program (Donaghy, 2008; Williams, 2010a, 2010b).

CSU was the first Australian university to pursue undergraduate tertiary studies for paramedics, establishing a degree in paramedic practice in 1994 (Lord, 2003). As one of the first university programs for paramedic studies it predates university paramedic programs in the UK, Canada and New Zealand. At the time of data collection, CSU offered three streams in course progression. The standard course progression consisted of a three year full-time program with a 120 hours clinical placement block embedded in the second and third years of the program. The second stream consisted of an accelerated pathway. The accelerated pathway, negotiated between CSU and ASNSW, allowed students to complete the standard progression for the first two years of the program with two additional subjects in the summer semester of the first and second year. Therefore, after completing two years at CSU, students were eligible to apply for employment with the ASNSW, and complete the remaining four subjects over the last 12 months of their study program and graduate as qualified ambulance paramedics. Due to the demanding schedule and fewer student completions compared to the standard paramedic program, CSU ceased taking enrolments for the accelerated pathway in 2012 (Brewster, 2014). The third stream, the double degree in paramedic practice and nursing, also no longer offered at CSU, was a four year program and contained nursing and paramedic subjects as well as clinical placements. On graduating from the double degree, students were eligible

to register as a nurse with the Australian Health Practitioners Registration Authority (AHPRA). The double degree students had the option to follow a career in nursing or gain employment with an ambulance service (CSU Department of Student Administration, 2010).

Monash University has a three year university paramedic program and offers a four year double degree in paramedic practice and nursing (Monash University Faculty of Medicine Nursing and Health Sciences, 2010). However, unlike CSU, Monash University offered four observer shifts to students in Ambulance Victoria within the first year of their program, and 280 hours of clinical placements in an ambulance environment in years two and three of the program. A hospital placement was also part of the curriculum in year three of the Monash university paramedic program (Michau, Roberts, Williams, & Boyle, 2009).

Flinders University, in conjunction with the South Australian Ambulance Service, began offering a Bachelor of Science (Paramedic) course in 1999 (O'Donnell, 2006; Pointon, 2004). The paramedic course offered at Flinders is three years and was reported, in 2004, to have a total of 500 hours of clinical placements spread over the course in 2004 (Pointon, 2004). However, the current paramedic course information website indicates a possible reduction in clinical placement hours may have occurred with 36 days of clinical placements now being offered over the three year degree (Flinders University, 2014).

QUT, the first Queensland university to establish a university based paramedic degree program, requires students to complete 720 hours of ambulance clinical placements over the three year program. Until 2010, QUT students were also appointed as honorary ambulance officers. The honorary ambulance officer status enabled the students to undergo driving training and wear the QAS uniform while on clinical placements. Additionally, students received an extra 520 hours in excess of their clinical placement time on a paid internship program in the third year (second semester) of their degree. Students were also given the

opportunity to work as casual student paramedics for QAS (Fawcett & McCall, 2008). These arrangements were established when QUT offered the only degree program for paramedics in Queensland. However, with several other Queensland universities beginning to offer paramedic degrees and over 1200 paramedic university students in the state (Bange, 2012), many of these privileges, with the exception of casual employment, were noted as unsustainable by a Queensland State Government Department of Treasury review (Jess, 2010). The expense of providing these students with a uniform, driver training and a paid internship was deemed prohibitive and ceased in 2010. Consequently, students wear a clinical placement uniform designed by their respective university, and driving training is completed after securing employment as a paramedic.

The UK currently has 25 universities that offer a degree in paramedic practice (Lane, 2014). Many of these universities offer a similar three year program to Australian universities. However, at the time of this research the UH offered a four year program, where the third year consisted of a sandwich year of paid employment with the London Ambulance Service. In addition to the sandwich year, students attended ambulance clinical placements in the first, second and final year of their course, and were required to obtain 1500 hours of clinical placements per year to meet the UK College of Paramedics' curriculum requirements (Williams, 2012a, 2014). On completion of the four year program, students graduated with a Bachelor of Science (Honours) in Paramedic Science and were eligible to register with the HCPC. Since this research was performed, the UH has restructured its paramedic degree at the request of the LAS, resulting in the cessation of the sandwich year and the adoption of a postgraduate professional year. Thus, since 2013 the Hertfordshire model consists of a three year undergraduate program upon which students are registrable, but which still requires a 12 month professional internship year, post-graduation.

4.3.2 Ambulance Service Participants

Paramedics, who had graduated from university and had gained employment with an Ambulance Service (such as the Ambulance of NSW (ASNSW), Ambulance Victoria, UK NHS Trusts and the South Australian Ambulance Service (SAAS)) were approached via email to take part in this research. The emails were sent by research development staff in ambulance service clinical governance departments, and research fellows belonging to ambulance service research institutes. The paramedics who were recruited into the study fell into two groups. The first group were paramedic interns six months into their employment, and the second group were qualified paramedics and had been employed for 12 months.

The rationale for choosing participants who were employed by the ASNSW, Ambulance Victoria and NHS Trusts lies with the fact that these ambulance services claim to be amongst the largest in the world (ASNSW, 2013; LAS, 2013). These claims appear to be related to either the numbers of full-time paramedics employed, the size of the geographical area covered, or the amount of emergency ambulance responses per day. Due to the size of these services, it was hoped that obtaining adequate participant numbers would be more probable. These services also have a university entry pathway for paramedics, and they do not rely heavily on a large number of voluntary community responders. It is important to note that the ASNSW still runs an in-house vocational education and training diploma program to attract a sufficient number of recruits. Unlike ASNSW, Ambulance Victoria and SAAS recruit the majority of their new paramedic staff from universities through a graduate entry model. However, a pathway into these services for interstate and overseas qualified paramedics also exists.

In comparison to ASNSW, Ambulance Victoria and NHS Trusts, the SAAS has a smaller professional fulltime paramedic workforce and relies on volunteers in rural locations. However, the South Australian Department of Health view SAAS paramedics as health professionals. Subsequently,

this has led to a successful argument for higher rates of pay through award negotiations with the South Australian Government. Additionally, the South Australian State Parliament has approved legislation that protects the title of paramedic (Larsen, 2013). Thus, due to the absence of national professional registration for Australian paramedics at the time of this thesis, the SAAS was included in this research study because of their professional recognition by the South Australian Government. Unlike Australia, registration for paramedics in the UK has been mandatory since 2001. Therefore, the UK component of this study incorporates the views of paramedics who are registered health professionals.

Similar to the ASNSW, some UK ambulance services such as the LAS still run in-house vocational training of paramedics to generate sufficient recruitment numbers. The Former Commissioner of the LAS, Malcolm Bradley, committed to the continuation of an industry-run vocational diploma program as being the minimal acceptable qualification for a LAS paramedic. On completion of this diploma, participants are able to register as paramedics through the UK HCPC. In 2010, there were over 400 paramedics enrolled in the LAS vocational program (Williams, 2010a) to allow for increased ambulance demand during the London Olympics. Similar to CSU, the UH has to compete with an industry-run diploma program when attracting potential paramedic students.

4.4 Inclusion and Exclusion Criteria

To be eligible to participate in this study, participants needed to have progressed through the university pre-employment pathway. As outlined in Chapter 2, the education and training of paramedics in Australian and the UK is transitioning from in-house training to the tertiary sector (Joyce et al., 2009). Therefore, the rationale for focusing on graduate paramedics and not vocationally trained paramedics relates to the disparity between the two education streams. Under the vocational model, ambulance trainees could assimilate into the culture over approximately

three full-time years prior to taking on the role of senior clinician. However, university graduates have approximately 9 to 12 months after completing their three year degree to undertake an adjustment process through an internship year before becoming fully fledged qualified paramedics. Thus, the enculturation process differs significantly between the two groups.

4.4.1 Inclusion Criteria for Australian Participants

The inclusion criteria for the Australian component of this research study involved the participation of three groups namely:

1. Undergraduate paramedic students completing their university studies and about to enter paid employment (QUT, CSU, Monash, Flinders)
2. Paramedics who had completed six months of their professional or internship year post graduation (ASNSW, SAAS, Ambulance Victoria)
3. Paramedics who had completed their professional year and are now Qualified Ambulance Paramedics with the ASNSW, SAAS, Ambulance Victoria.

4.4.2 Exclusion Criteria for Australian Participants

Paramedics who progressed through an ambulance in-house vocational training model were excluded from this study. Additionally, paramedics who were employed greater than 18 months were also excluded from this study. Therefore, this study aimed to investigate the 12 month transition from university student to practising paramedic, as this is arguably one of the most significant periods in relation to the socialisation process (Berlew & Hall, 1966; Boychuk Duchscher, 2009, 2012; Chang & Hancock, 2003).

4.4.3 Inclusion Criteria for United Kingdom Participants

The inclusion criteria for the UK component of this study involved the participation of three groups, namely:

1. UH BSc Hons Paramedic Science students who had completed two years of their university studies and were about to enter their sandwich year with the LAS
2. Students who had returned to the UH after their sandwich year and had registered with the HCPC and were enrolled in the fourth year (the Honours component) of the program
3. Graduates from the UH Bachelor of Paramedic Science (Honours) who were working as registered paramedics with the NHS for less than 12 months post-graduation.

4.4.4 Exclusion Criteria for United Kingdom Participants

The exclusion criteria for the UK participants were the same as for the Australian participants. That is, paramedics who progressed through an ambulance in-house vocational training model were excluded from this study. Likewise, university educated paramedics who were employed full time by an ambulance service for greater than 18 months post-graduation were excluded from this study.

4.5 Ethics and Research Approval

This PhD study commenced at CSU in 2008. Ethical clearance was initially sought and approved through the CSU Human Research Ethics Committee (Appendix 4.1). When this study was transferred to QUT, ethical clearance was sought and approved via an abridged process though the QUT Human Research Ethics Committee (Appendix 4.2). In order to interview students from Monash and Flinders Universities, correspondence was sent to the course coordinators of these two programs seeking permission to interview final year undergraduate paramedic students (Appendix 4.3 and 4.4). As the study had been approved through the CSU Human Research Ethics Committee, approval was granted. The CSU ethics application and approval letter were forwarded to the UH, School of Allied and Emergency Professions Human Research and Ethics Committee. An abridged ethics

application was completed, and ethical approval from the UH was granted (Appendix 4.5).

The ASNSW is an area health service of the NSW Department of Health. As the ASNSW does not have an ethics committee, ethical approval is instead governed by the Royal Prince Alfred Hospital (RPAH) Human Research Ethics Committee. Thus research ethics approval was sought through the Royal Prince Alfred Hospital (RPAH) Human Research Ethics Committee. On gaining ethics approval through the Department of Health RPA Zone (Appendix 4.6), research approval was sought and granted by the Director of the Ambulance Research Institute and the Chief Executive Officer of the ASNSW (Appendix 4.7).

The CSU ethics application and approval letter were forwarded to the Ambulance Victoria Research Development Officer, who deemed that ethical clearance through Ambulance Victoria was not necessary as ethical clearance had been approved through CSU's Human Research and Ethics Committee, and the proposed study numbers were small (Appendix 4.8).

The CSU ethics application and approval letter were also forwarded to the South Australian Department of Health Human Research Ethics Committee. Ethics approval was granted on the basis that ethical clearance had been approved through CSU's Human Research and Ethics Committee (Appendix 4.9). Research approval was then obtained through the South Australian Ambulance Service Clinical Governance Department (Appendix 4.10).

The director of the Australian Centre for Pre-Hospital Research within the QAS was contacted in relation to obtaining research ethics approval to undertake this research study with QAS (Appendix 4.11). The QAS Commissioner declined the research proposal citing that there were too many research projects being conducted at that time through QAS (Appendix 4.12).

In the initial research proposal, the researcher wished to approach four large Australian ambulance services to be involved in this research study. Two of these services were to rely on a graduate pre-employment model. The other two, ASNSW and QAS had a two stream approach consisting of a vocational in-house training program and a graduate entry program. The reason for this approach was to seek to cover the cultural change the ambulance services were undergoing by employing university graduates. As QAS declined to be involved in this study, another large ambulance service was required that took both university graduates as well as ran a vocational in-house training model. Effectively, there were no other such models in Australia and thus the researcher examined overseas ambulance services.

After researching different ambulance services, it was decided to recruit participants from the UK NHS Ambulance Trusts. At the time of this research, Canada still utilised a community college model for paramedic training, and ambulance services in the United States were closely associated with the fire brigades, thus making Canadian and American training and models of education vastly different to Australian ambulance services. As UK NHS Trusts Ambulance Services are very similar to Australian Ambulance Services in organisational structure and scope of practice, the researcher decided to include UK participants in this study.

Thus, contact was made with the qualitative research representative for the UK College of Paramedics Research Committee, who was also the Research Lead and Head of Discipline for the paramedic program at the UH. Ethical approval was sought through the NHS. Since paramedics were to be interviewed on university property outside of work time, the National Research Ethics Service (NRES) decided that this qualitative study was not 'research' and was more along the lines of a service evaluation, and as such did not need NHS ethical approval (Appendix 4.13).

4.6 Recruitment of Participants

Qualitative research enables us to learn about the participant's world from their point of view and provides a method by which to develop a theory to interpret the essence of this perspective (Charmaz, 2006). The number of participants recruited for this study (n=34) from Australia and the UK is outlined in Table 4.1 below.

Table 4.2. *Number of participants recruited for this study*

Participants Recruited							
Research Stage	Male			Female			Total Number of Participants
	AUS	UK	Total	AUS	UK	Total	
Final Year at University	4	2	6	6	3	9	15
Six Months into the Internship Year or had Completed their Sandwich Year	1	5	6	4	0	4	10
Qualified / Registered Paramedics	2	3	5	2	2	4	9
Total	7	10	17	12	5	17	34

4.6.1 University student participant recruitment in Australia

Of the 34 participants recruited for this study, 10 were Australian paramedic university students who volunteered to participate. The recruitment of these participants was achieved through a 10 minute face-to-face lecture presentation delivered at CSU, Monash University and QUT. The lecture outlined the study's background, the inclusion criteria and the data collection process. Students at Flinders University were recruited via word of mouth through contacts within the university and the South Australian Ambulance Service. Each student was provided with a copy of the research information sheet and the consent form. Students

who were interested in volunteering contacted the researcher by email or mobile phone, and an interview appointment was scheduled.

4.6.2 Australian ambulance service participant recruitment

Nine Australian ambulance participants were recruited through email and word of mouth. An email containing a flyer (Appendix 4.14), the study's background, research information sheet (Appendix 4.15) and consent form (Appendix 4.16) was sent to designated contacts in ambulance service research institutes and clinical governance departments. The designated contacts forwarded this email to eligible paramedics, as per the inclusion criteria, who were identified through ambulance service personnel records. Participants who wished to volunteer contacted the researcher directly by email or telephone. Approximately 100 paramedics were invited to participate in this research study.

As a reserve measure, provision was made for recruiting participants via advertising through the *Response Magazine* and the *Journal of Emergency Primary Health Care* (now the *Australasian Journal of Paramedicine*). Both of these publications are produced by Paramedics Australasia, the peak professional body for paramedics in Australia and New Zealand. However, this recruitment strategy was not necessary as the desired number of research participants was achieved.

4.6.3 Recruitment of participants from the United Kingdom

In total, 15 UK-based participants were recruited by email. An email containing the study's background, a flyer, a participant information sheet and consent form was sent to the Head of Paramedic Research at the UH. Students who met the inclusion criteria were identified through contact databases housed at the UH. Participants wishing to volunteer contacted either the Head of Paramedic Research at the UH or the researcher by email or telephone.

4.7 Data Collection

There appears to be considerable debate in the literature in relation to achieving the required numbers of participants through the process of saturation (Caelli, Ray, & Mill, 2003; Guest, Bunce, & Johnson, 2006; Mason, 2010; O'Reilly & Parker, 2013). Charmaz (2006) and Glaser and Strauss (1967) outline the important role of saturation in achieving a sufficient sample size for qualitative studies. Other authors maintain that the concept of saturation is poorly understood (Mason, 2010), difficult to prove (Morse, 1995) and even inappropriate (Dey, 1999), as concepts within the data could potentially be limitless (Green & Thorogood, 2009). There is also an argument suggesting that saturation makes the estimated sample size difficult to defend at the research proposal and ethics application stage, prior to the commencement of the data analysis (Guest et al., 2006).

In this study, data collection was to continue to a point where the researcher was satisfied that the amount of data collected was sufficiently rich for this research project. An initial estimate of a total cohort of up to approximately 30 participants was made. The estimated number of 30 participants is close to the average sample size of 31 taken from 560 qualitative PhD studies (Mason, 2010). The estimated sample size of 30 incorporated a participant target of 15–20 subjects from Australia and 10–15 from the UK. However, the actual sample size increased to 34 because 10 Australian university students were interviewed instead of the 5 participants initially estimated. Doubling the number of Australian university participants enabled data to be collected from at least two participants for each university paramedic program invited to participate. Additionally, one participant did not attend their interview from the third group of Australian participants (qualified paramedics). Thus, the number of participants totalled 34.

4.7.1 Theoretical Sampling

Theoretical sampling is where the researcher seeks further relevant data to develop a theory, and refine the categories constituting the theory (Charmaz 2006, 2012; Glaser and Strauss 1967; Williams, 2012c). The current study employed qualitative methods based on the work of Charmaz (2006) and Saldana (2009) to inform the data collection and analysis process, and drew on existing theories of professional socialisation to examine their suitability to the emerging paramedic profession. In this study, theoretical sampling was used for the purpose of verifying the suitability of professional socialisation theoretical models chosen, and for developing broad categories or codes to further guide the main data collection and data analysis process. To achieve theoretical sampling, an initial pool of six participants, namely two university students, two intern or sandwich year paramedics and two qualified paramedics, were interviewed; the audio recordings analysed; and the interview guide validated. The six transcripts used for the theoretical sampling process were then added to the final sample of transcripts for data analysis.

4.7.2 Semi-Structured Interviews

After the initial process of theoretical sampling, the main data collection phase began. The data collection occurred through semi-structured interviews, and an interview guide (Appendix 4.17) was followed. The rationale for using interviews for the data collection is to enter "beneath the ordinary conversation and examine earlier events, views and feelings afresh" (Charmaz, 2006 p26). Thus semi-structured interviews allowed for further investigation of surrounding concepts that related to the professional socialisation process, as participants had the freedom to take the interview to areas or issues beyond the interview proforma. Participants were invited to participate in one interview, with provision for a second interview if the recording was inaudible or a category arose that required further investigation. However, the second interview was not

necessary, as the researcher was satisfied with both the interview content and the quality of the digital recording. The participants were advised that the interviews would not take longer than an hour, with most interviews taking between 35 and 50 minutes.

Following a structured interview process would not have allowed the exploration of new or surrounding concepts, and would have limited the richness of the data. Unstructured, in contrast to semi-structured interviews, may have taken the focus away from the specifics of the transitional experiences of professional socialisation (Britten, 1995; Cribb & Bignold, 1999). Thus structured and unstructured interviews were deemed as unsuitable for the current study.

4.7.3 Data Collection Locations

Funding was obtained through a research grant from the then Australasian College of Ambulance Professionals (NSW Branch). Funding was also made available through a student research allocation from QUT. These funds supported travel costs interstate and internationally to conduct the data collection. The interviews were conducted at appropriate and mutually agreeable locations, such as coffee shops, cafés and university offices. Ambulance stations were not used for the data collection, and the interviews were conducted in the paramedics' own time. A small number of interviews fell outside the designated travel times due to participant unavailability between key dates for face-to-face interviews. As a result, the data collection for these participants (n=4) was completed by telephone after the researcher had returned to QUT.

4.7.4 Consent and Data Storage

Participants signed a consent form agreeing to participate in this study. The consent form asked the permission of the participants to audio tape the interviews for transcribing purposes. A professional transcription service was used, and on the recommendation of the QUT Human Research Ethics Committee, a confidentiality agreement was signed

between the transcribers and the researcher. Digital recordings were listened to by the researcher shortly after the interview occurred, usually within 24 hours of the interview, to review the interviewing technique and initiate data analysis through the creation of memos and field notes. The memos and data were stored electronically on a university secure server, and a hard copy stored in a securely locked cabinet at QUT.

4.8 Data Analysis

Preparation for the data analysis phase included reading the transcripts and reviewing any memos created after the interview. The data analysis used a process called 'coding'. Glaser and Strauss (1967) define coding as the creation of codes and categories to describe what is happening in a certain component of the data. The data analysis followed first and second cycle coding techniques (Charmaz 2006; Saldana 2009), which will be further elaborated in sections 4.7.1 and 4.7.2 below. In summary, the first cycle coding methods consisted firstly of holistic[3] coding (Dey, 1993), followed by the more in-depth process of line-by-line coding. The line-by-line coding followed the general guidelines of initial coding (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Saldana, 2013), which was also partly informed by emotional[4] coding (Saldana, 2013). The second cycle coding methods employed focused[5] coding (Charmaz, 2006) using Nvivo software (QSR Nvivo version 9.2). Memos were created during this process, which also added further direction to the data analysis process (Charmaz, 2006). A coding system was used to keep the identity of the participant, the participant's ambulance service and country of residence anonymous. Cultural terminology or colloquialisms, specific to ambulance services of various countries (e.g. a 'blue call' or a 'Code 2'), have been removed to further protect the identity of the participant or the

[3] Holistic coding identifies the major categories or issues in the data by absorbing them as a whole, and not be a line-by-line approach (Dey, 1993)
[4] Emotional coding labels the emotions experienced by the research participants that are identified in the literature (Saldana, 2013)
[5] Focused coding searchers for the most common or frequently used codes to develop a category (Charmaz, 2006; Saldana, 2013)

ambulance service, and where this was not possible, Australian terminology has been used.

4.8.1 First Cycle Coding

The holistic coding technique involved grasping the basic codes and categories by the process of 'lumping',[6] rather than 'splitting' (Dey, 1993), or by grouping the data into broad topic areas (Bazeley, 2002). Holistic coding is a useful preparation technique prior to the more detailed process of line-by-line coding (Saldana, 2013). However, as it is not as comprehensive as other first cycle techniques such as line-by-line coding, it may provide a less detailed picture of the data (Saldana, 2013). Due to this criticism of the holistic coding approach, more specific first cycle coding techniques were also used.

The process of initial coding involves 'splitting' the data up into codes on a line-by-line basis to form a microanalysis (Charmaz, 2006; Corbin & Strauss, 2008; Saldana, 2013). Emotional coding identifies the emotions experienced by the participants as they undergo the socialisation process, and identifies the depth of the participants' insight into their experiences (Goleman, 1995; Prus, 1996). Emotional coding adds richness to the process of initial and focused coding, and enables the researcher to further understand and identify what thoughts and associated feelings the participants have experienced under challenging circumstances and helps make sense of their multiple realities. The emotions articulated by the participant, along with emotions the participant is believed to be experiencing as interpreted through their speech, body language and the written transcripts, were coded. The microanalysis was then compared and contrasted to the holistic codes identified.

4.8.2 Second Cycle Coding

In the second stage of data analysis, which used focused coding, the data was further analysed for the most significant codes that were identified

[6] Lumping the data refers to the process of analysing large segments as a whole, rather than through a line-by-line approach or splitting the data (Dey, 1993)

from the first cycle methods. These codes were further rearranged to fit under more specific code categories, and a hierarchy of codes was produced. During the focused coding process, three main parent codes or categories were taken from the literature and identified in the data. These categories form the theoretical basis for this thesis. They consisted of the pre socialisation or anticipatory phase, formal socialisation and post-formal socialisation phases (Cant & Higgs, 1999; Higgs, 2013; Lamdin, 2006; Shuval & Adler, 1977). From these parent codes, the focused coding process identified child codes made up of sub-categories and sub-sub-categories that were found in the data. These child codes are discussed in the results chapters and produce a theoretical model that maps the journey of the participants, and the changes in their epistemological and ontological views in relation to the transition phases encountered while becoming paramedics. Examples of the coding process can be seen in Table 4.2.

4.8.3 Validation of Coding

Member checking is a way of confirming the consistency of the data analysis with the participants' experiences (Charmaz, 2006; Carlson, 2010; Curtin & Fossey, 2007). However, many participants disclosed potentially sensitive information during in-depth interviews about their experiences when transitioning from the university culture to a command and control paramilitary culture. Thus, the decision was made to employ other methods to confirm the rigor and trustworthiness of the data collection and analysis process without 'forcing' participants to review their interview transcripts (Goldblatt, Karnieli-Miller & Neumann, 2011). Subsequently, six transcripts were de-identified and sent to the researcher's supervisory team for coding validation. They consisted of two transcripts, one Australian participant and one UK participant from each research group, including students about to enter a professional internship year with ASNSW, Ambulance Victoria and SAAS or commence a sandwich year with LAS; graduates who were midway through their

professional year with ASNSW, Ambulance Victoria and SAAS, and registered paramedics who had completed their sandwich year with LAS and had returned to UH; and graduate paramedics who had either finished their professional internship year with ASNSW, Ambulance Victoria and SAAS, or registered paramedics who had graduated from the Bachelor of Paramedic Science (Honours) program at UH.

Further, an outline of the category headings generated from the coding process using NVivo 9.2 was sent to the supervisory team for checking. The researcher's supervisors concurred with the coding techniques used. However, the suggestion was made to further condense and marry codes within the coding hierarchy. Therefore, some categories were condensed or collapsed within other categories. As a result, codes were rearranged to contain broader category headings with the number of sub-codes and sub-sub-codes increased (see Figure 4.2).

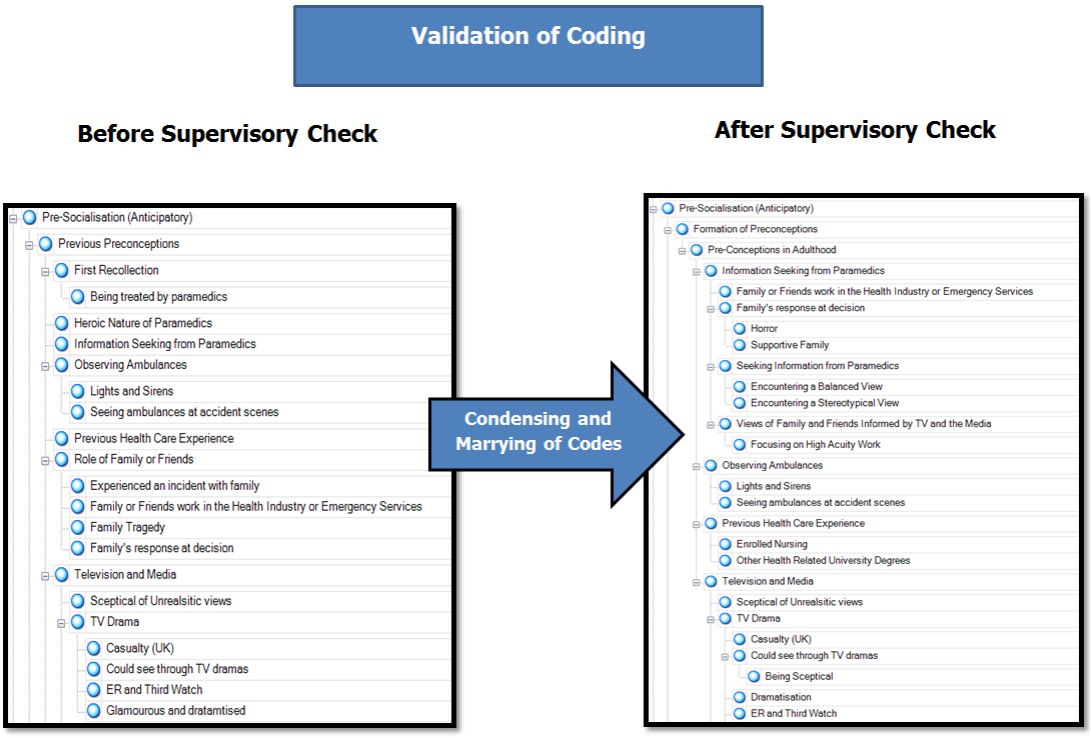


Figure 4.2. Further condensing and marrying of codes.

In the absence of member checking, the supervisory team validated the coding and data analysis. The above figure represents the changes to the data analysis and coding that resulted from this validation process.

Table 4.3. *Example of the Coding Process*

Parent Code	Focused Coding	Holistic Coding	Raw Data	Line-by-line Coding
Post-Formal Socialisation	Ambulance Culture Reality of Practice	Experiencing Stigmatisation Gaining respect Experiencing a Reality shock 'Stepping Up'	Question: How have you found joining an ambulance service, coming from a university side of things? INTERVIEWEE: Fitting in was hard, because there is a little bit of a stigma out there against uni students. That we are a bit cocky and that we don't know anything and we have got no life experience. So that side of things was hard, as soon as you got a bit of respect from people and they realise that I wasn't like that and that I was there to learn as much as everyone else was it was really good. It was a bit of a shock though, like seeing things that, oh, I didn't really expect to see some of this stuff. I think the first couple of months was difficult and a big transition. You've got to get up at 5 o'clock in the morning and get to work, and people expect you to be there on time and happy and all the rest of it and at uni if you didn't turn up no one cared. Question: So you said, you found it	Feelings of rejection Encountering stigmatisation against university students Perceiving Uni students to be cocky Lacking life experience Gaining respect Gaining acceptance Emphasis on learning Experiencing a Reality shock Seeing gruesome sights Challenging time Reality of working life Appearing happy and in control

		into Professional Practice Experiencing Reality Shock	difficult and you weren't expecting to see certain things, what kind of stuff, can you tell me, give me some examples? INTERVIEWEE: I suppose the biggest shock that I ever had was after I was posted to a low socio-economic area, and the way people live, I had no idea. I guess I sort of lived in a bubble. You know, letting kids walk around without nappies on so they could just poo on the floor and why would you bother cleaning that up? People would call you because they had a mozzie bite. I'm like; well do you understand what we do?	Experiencing Reality shock in Lower SES areas Encountering different lifestyles Protected upbringing Children involved – upsetting Dirty and unclean – disgusting? Lack of public awareness frustrating

4.8.4 Memo-Writing and Fieldnotes

Memos are an important step between the data analysis and the chapter writing process (Charmaz, 2006, 2012). A memo is the written assemblance of thoughts and ideas that come to mind during the data analysis, and allows for the comparison and connection between codes, categories and events (Charmaz, 2006, 2012). The use of memos in this study interconnected the data with the theoretical frameworks selected for this thesis, and assisted in the explication of the study's findings. That is, memos were used to assimilate the literature into the research process.

Field notes were a useful tool for observing the participant's body language and interpreting the emotions present in their voice. Through field notes, the researcher attempted to fully grasp the meaning behind the experiences identified during the participant interviews. Thus, fieldnotes informed the emotional coding process that was used as a first cycle coding technique (Saldana, 2009; Prus, 1996; Goleman, 1995).

Memos and fieldnotes were used much like keeping an academic journal, allowing the researcher to refer back to previous thoughts and events to arrive at a deeper understanding to better inform the analysis process. The researcher acknowleges that memos and fieldnotes can become part of the data (Saldana 2009). However, in this study memos and fieldnotes were used solely as data analysis tools and did not become data. An example of a memo relating to increasing confidence levels of a practising new graduate paramedic is provided below:

> *Memo - Building Confidence*
>
> "We attended a person hit by a car ... The patient actually arrested in front of us. We managed to shock the patient back into normal rhythm. And the (Intensive Care Paramedic) who backed us up has been in the job years and years, and people have a lot of respect for

him. He said to both of us, 'fantastic job, you guys did really, really well.' And, you know, I think sometimes they'll be chatting with their friends and they'll say oh yeah, I did a job with so-and-so, that grad entry paramedic, and they did a cracking job."

<u>Note:</u> Performing well at a cardiac arrest drill or a trauma case has been identified by several participants as the defining moment in their confidence levels. This fits in with Kramer's model (1974) in relation to the skills mastery component of socialisation. Interesting that the participants see these types of jobs, which make up such a small percentage of their work, as being the most desirable, and they don't seem to value the reality of practice side of their work in relation to building their confidence, such as managing a patient's pain correctly, managing a patient with an acute psychotic episode, or being able to get a good patient history. This confirms Reynolds' (2008) findings relating to what is culturally seen as a 'good job'.

Below is an example of a field note relating to the researcher's observations during an interview, where it became apparent that the interviewee clashed with the ambulance culture and encountered cultural stigmatisation:

This afternoon's interview left me feeling drained. The interviewee was in the third cohort of participants (qualified/registered paramedic). They have clashed with the ambulance culture and encountered stigmatisation. The interview was very negative towards the ambulance service and the interviewee appeared frustrated and angry when relaying (his/her) experiences about stigmatisation. I felt that I had to work hard to facilitate

the interview and keep it flowing, and not let it turn into an 'ambulance bashing' session.

I am not surprised that the interviewee intends to leave the ambulance service, as they appear to have had a really rough time. I guess this would fall under Kramer's (1974) behavioural capitulation outcome within the conflict resolution phase?

Appendix 4.18 contains additional examples of memos and field notes.

4.9 Summary of the Research Approach

The data collection and analysis processes used in this study have been informed by qualitative methods based on the work of Charmaz (2006), Saldana (2009). The participants who took part in this study were diversely located across two countries. The data collection occurred through semi-structured interviews, and the data analysis process employed captured the diversity of the experiences of paramedics located in three different Australian state based ambulances services and from UK NHS trusts.

Charmaz's (2006) and Saldana's (2009) approach to data collection was selected as it complements the theoretical frameworks used to interpret the data. This approach enables the achievement of the overall research objectives of developing a model that explains the professional socialisation of university educated paramedics. The data analysis process was not linear and required movement back and forth between coding, memo writing and analysis. Through this process, distinct categories were found that reflect the stage model of professional socialisation (Cant & Higgs, 1999; Lamdin, 2006; Shuval & Adler, 1977), and Kramer's (1974) reality shock model.

4.10 Conclusion

Chapter 4 outlined the methods used in this study, including the ethical clearance process, universities and ambulance services targeted for participant recruitment, the inclusion and exclusion criteria for participant selection, the rationale for expanding this study to involve an international approach, and the data collection process. It detailed the qualitative methods based on the work of Charmaz (2006) and Saldana (2009). The use of qualitative methods were justified in examining the relevance of existing models with a view to developing a theoretical model representing the professional socialisation of university educated paramedics as they transition from students to practising paramedics.

The process of data analysis was discussed in relation to the use of qualitative methods to extract the data and test it against the anticipatory, formal and post-formal stages of professional socialisation (Cant & Higgs, 1999; Lamdin, 2006; Shuval & Adler, 1977) and Kramer's (1974) reality shock model. The data analysis process involved several rounds of coding using well-established coding techniques such as holistic, initial, emotional and focused coding.

Having outlined the methods used to collect and analyse the data, this thesis now will examine the results arising from the data and investigate the extent to which the theoretical frameworks, and existing theories, apply to the professional socialisation of paramedics. From these results, a theoretical model specific to paramedics will be developed. The following chapters are organised around the anticipatory (Chapter 5), the formal (Chapter 6), and post-formal (Chapter 7) phases of professional socialisation.

Chapter 5 Anticipatory Socialisation

> "I think … I didn't really have a very accurate idea of what it was like to be a paramedic before I started studying at university. Probably it was mostly from television and movies ... That's where my idea of what it was like came from, but as it turns out, that wasn't super accurate."

5.1 Introduction

The previous chapter outlined the methods used in this study. This chapter presents the results and analysis of how the participants constructed their preconceptions of paramedic practice during the anticipatory phase of the professional socialisation (see red circle in Figure 5.1 below).

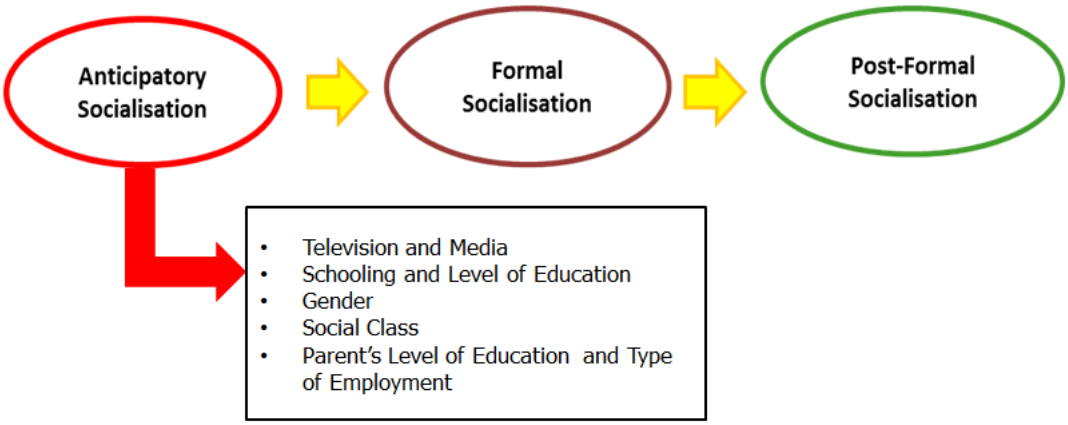


Figure 5.1. The Anticipatory Phase of Professional Socialisation

Many authors describe the anticipatory phase of professional socialisation as the period prior to the individual entering a formal socialisation phase (Cant & Higgs, 1999; Feldman, 1976; Lamdin, 2006; Shuval & Adler, 1977; Thornton & Nardi, 1975; Van Maanen, 1976). It is commonly

suggested that the anticipatory stage is where the individual develops a picture of a profession or organisation, and that this picture may not be altogether realistic (Boychuk Duchscher, 2009; Kramer, 1974; Kramer, 2010; Van Maanen, 1976). Chapter 5 seeks to explain what the participants' preconceptions of paramedic practice were, and how these preconceptions were developed during the anticipatory phase of professional socialisation.

5.2 Preconceptions of Paramedic Practice

Anticipatory preconceptions about paramedic practice are not necessarily developed from one significant event, and may result from a culmination of encounters or experiences. The development of the participants' preconceptions are multi-factorial and may result from patient-paramedic interactions after a personal or family emergency, the portrayal of paramedics in the media, family or friend role modelling, observing ambulances on an emergency case and working for volunteer organisations associated with ambulance services. The above categories are explored further, beginning with the development of childhood preconceptions.

5.2.1 Childhood Preconceptions of Paramedic Practice

The anticipatory socialisation process is thought to begin early in childhood (Kramer, 2010; Van Maanen, 1976). The most significant period in the development of preconceptions of a profession is thought to occur between the ages of 6 and 16 years (Jablin, 2001). The childhood preconceptions of the participants were formed by observing ambulances and personal encounters with paramedics; for example, being treated by paramedics after sustaining an injury, having paramedics treat a family member, or through joining a volunteer organisation such as St John's Ambulance.

Observing Ambulances

The first memory of paramedic practice the following university student could recall from childhood was of ambulances driving past their house on emergency code one lights and sirens cases. They outlined that observing ambulances aroused their curiosity about whether a critical patient was in the back of an ambulance, or whether the ambulance was responding to a case:

> "I always used to looked out of my bedroom window when an ambulance drove past the house ... I always used to wonder where the ambulance had come from, and … where it was going ... you'd see the lights and hear the siren, and I would wonder, is there somebody in there or is it going to get somebody." (X1P1F4C)

During their childhood, neither the university student nor their direct family needed an ambulance. Therefore, the childhood preconceptions were formed as a result of a fascination with watching ambulances drive past and, arguably, the accompanying explanation from their parents that ambulances only attend to really sick people.

Patient – Paramedic Interactions

In many cases, the first encounter with paramedics came about through personally requiring an ambulance after sustaining an injury. However, the experience of being treated by paramedics did not necessarily have a direct impact on the participant's desire to become a paramedic. For example:

> "I guess riding in the back of an ambulance was the first recollection (I) have ... I'd been hit in the eye with squash ball. I was 14 and I was taken (to hospital) ... I guess that's my first recollection of an ambulance ... I can't recall anything prior to that. At the time, I really thought nothing more of it." (X1P1M1C)

Likewise, the following university student injured themselves at the age of 15 years and was transported to hospital. Their encounter with paramedics did not initially influence their decision to become a

paramedic, as they were more interested in pursuing a career in engineering:

> "I got injured at school in year 10 ... it was pretty basic but I got transported to (hospital) by some (paramedics) ... I just sort of had a conversation with those guys ... it had no real bearing at the time ... to be honest I had an idea set in my head what I wanted to be, throughout school, that was something to do with engineering." (X1P1M2)

From the data, examples such as the statement above do not appear to indicate a childhood romance of paramedic practice, such as might be displayed by boys fantasising about being a fireman, policeman, soldier or doctor (Neville Nelson, 1978). Thus, the idea of becoming a paramedic was not developed through first encounters with an ambulance service.

An encounter with an emergency situation requiring an ambulance in childhood possibly influenced the development of perceptions of paramedics (Pons, Harris, & de Rosnay, 2004). As the following statement suggests, one university student did not fully understand what was occurring when they observed a parent being treated and transported to hospital by paramedics:

> "I had a few experiences with my Dad having to go to hospital and being taken away in an ambulance, but I never really understood what it was all about. I really didn't know anything about (the ambulance service) until I applied for the degree after finishing school." (X1P2F19B)

In addition to being a young child (age not specified), it may also be inferred from the above that the university student may have been shielded from the potentially bad news by a parent or the paramedics (Farrell, Ryan, & Langrick, 2001), as they 'never fully understood what it was all about' until adulthood.

A family tragedy

The tragic death of a close relative brought on an awareness of paramedics in this same participant's mind:

> "My cousin was killed in a car accident, and the first lady on the scene (before the ambulance arrived)... was a nurse ... It was really helpful for us to know that she was there with him in his final minutes ... I was only 12 at the time or just turned 13 and I thought, what would I do if I was that first person on scene? That scared me ... So for a couple of years the thought (of being a paramedic) was always in the back of my mind." (X1P2F19B)

It appears that the experience of having a close family member killed in a tragic accident developed a curiosity about paramedics and their ability to manage a medical emergency. A similar phenomenon was reported in the literature where the death of a family member or friend possibly led people to consider pursuing a career as a paramedic (O'Meara et al., 2012).

Volunteer Organisations

It was commonly reported that joining volunteer organisations during childhood strongly influenced preconceptions about paramedic practice. In the following circumstance, a university student had several family members volunteering with St John's Ambulance as first aiders, and had joined St John's Ambulance at the age of nine years:

> "I was about eight years old, and my father and my older sister joined St John's Ambulance ... that was sort of my introduction to the ambulance world. I decided to join about the age of nine. My dad was ... the light of our lives and we could get out of the house away from Mum. Yeah, so my Dad and sister were in (St John's Ambulance) and it was like a family thing to get out of the house really ... I suppose at nine years old I saw ambulances with the lights and sirens ... going to car accidents. But being involved in St John's, you know if someone got really hurt bad then you'd call an

> ambulance and they'd turn up and save the day and off they'd go." (X1P1F6A)

Likewise, another university student assisted his/her father who was a first responder in their community:

> "My Dad used to be a voluntary first responder[1] in his local community. At that time (GPS navigation systems) were not really around, so I used to go out and map read for him. I used to go into jobs, not really do anything, just more stand there and watch. That got me interested ... As soon as I was old enough I became a first aider myself. Then through meeting people in the ambulance service I found out the best ways to get involved." (X2P2M23D)

Other authors have similarly found that the influence of parents or family members is strongly associated with preconceptions that are formed during the anticipatory socialisation phase (Cahill, 1999; Feldman, 1976; Kramer, 2010; Van Maanen, 1976). Although St John's Ambulance was given the credit by many for their anticipatory view of paramedics, the portrayal of paramedics on the television appears to have strongly influenced early preconceptions of paramedic practice as well:

> "Most of my actual real ideas would have formed from St John's Ambulance. Things would have been formed from television probably as well. Not so much dramas but documentaries. But I would say generally my knowledge base developed through interactions with paramedics though St John's Ambulance." (X2P3M35D)

Additionally, preconceptions of paramedic practice were developed through working for other volunteer organisations that provided first aid

[1] Voluntary first responder, or honorary ambulance officer are members of the community, usually in country towns and isolated area who have paid employment in an non-ambulance field, for example, butchers, fire fighters, mechanics, farmers and accountants. First responders are dispatched to a medical emergency in their community, and attempt to stabilise the patient through providing basic life support and first aid whilst the professional paramedics respond to the case, in some circumstances, form the next town. A voluntary first responder will possess a certificate IV in Ambulance Studies (or equivalent)

and emergency management, such as surf lifesaving organisations:

> "My personal view of the paramedic world was through my experience as junior life guard. Whenever something went wrong (the paramedics) would be the guys that you would call and they would fix all your problems ... (paramedics) were basically problem solvers, when you didn't know what to do they would be there for you. The concepts and the way it is portrayed in the media is obviously a biased opinion that we have been exposed to in terms of trauma events and disasters and things like that. But in terms of personal experience it was through (lifesaving)." (X1P1M13C)

Others gained experience with a volunteer fire fighting and rescue association, which informed their view of paramedic practice:

> "I used to be in the volunteer fire brigade. I was only young, so I rarely got to go out to car accidents or anything. However, the few accidents I did attend ... the paramedics (would) come in and everybody (would) just kind of stand back and ... you could just see that people respected them and that was something that started clicking over in my mind to ... be a part of something like that ... Instead of being someone sitting behind a desk, and being told what to do." (X1P1F5A)

From the views above, working with volunteer organisations, along with the portrayal of paramedics in the media, provided a view that paramedics possessed a heroic status. In several of the quotations above, it seems as though paramedics would arrive on the scene of an emergency and 'save the day', and solve the rescuers' and the patients' problem. A high level of respect was also afforded to the paramedics by people who were first aid and rescue personnel.

Summary of Childhood Preconceptions

The data above indicates that between the ages of 6 and 16 years, preconceptions of being a paramedic were formed through numerous experiences. First encounters with the ambulance service were recalled,

which included being attended to by a paramedic or observing a family member being treated by paramedics. Experiencing a family tragedy also appeared to develop preconceptions about paramedic practice. Representations of paramedic practice through the media and experiences with volunteer organisations were also identified as contributing factors in forming preconceptions of paramedic practice during the anticipatory phase of professional socialisation.

During the progression towards adulthood, a deeper awareness of the role of paramedics started to develop. Many of the influencing factors that contributed to the development of preconceptions during adulthood were similar to the categories found to be pertinent during childhood. However, in late adolescence to early adulthood, a greater level of maturity and higher degree of reasoning skills became apparent, and more meaning was attached to experiences relating to paramedic practice.

Having explored the anticipatory views of paramedic practice developed during childhood, the following section begins by exploring anticipatory views in adulthood resulting from observing paramedics. The influence of encountering paramedics and the views of family members, friends and the media are then explored in relation to the formation of preconceptions about paramedicine. Finally, the reasons given for wanting to become a paramedic and the decision process undergone when choosing a paramedic university degree to study is identified.

5.2.2 Preconceptions of Paramedic Practice Formed during Early Adulthood (17-19 years of age)

During the late teens to early adulthood, preconceptions of paramedic practice were further developed though observing ambulances, from family input and the media. Early adulthood is referred to as being aged between 17–19 years, as this age bracket coincides with students' senior high school years when they start to consider career options in more detail. The anticipatory socialisation occurring during adulthood has been referred to as secondary socialisation, suggesting young adults build on

ideas developed during childhood, or primary socialisation (Cant & Higgs, 1999). During adulthood, a deeper awareness of the paramedic role was developed through experiences such as observing ambulances.

Observing ambulances

Ambulances proceeding to code one (urgent) cases were observed where the ambulance's lights were flashing and the siren wailing. Ambulances were also seen at traffic crashes and parked on the street outside of a residential address or business, with the paramedics entering the premises carrying their equipment and kit bags:

> "I formed my view of paramedics through seeing them in the community. If there was a massive accident, you know they're always there. You'd see them going into peoples' houses, I guess that's a critical time for those patients and so they're coming into someone's life at the time when someone really needs a paramedic." (X1P2F20A)

Ambulances on a code one response were observed with a sense of excitement:

> "You can't help but see them when you're out and about. If you see an ambulance going past with lights flashing and siren blaring ... it's quite exiting. It looks like they're going somewhere to save someone's life." (X2P2M25D)

While in the car with their father, the following university student refers to the great excitement they experienced when observing an ambulance on an emergency case:

> "My Dad and I were stuck (in peak hour traffic) and there was an ambulance. It was in a massive hurry and we were in the traffic jam. The ambulance went over the median strip and tore down the road. I know it sounds really bad but Dad was like … I can see you doing that!" (X1P1F0A)

It appears as though the work of paramedics was strongly associated with code one emergency responses, even though paramedics attend a significant amount of non-emergency cases (Clark et al., 2000; Morgans, Archer, & Allen, 2004; Morgans & Burgess, 2012; Thakore, McGugan, & Morrison, 2002; Williams et al., 2012; Wilson, Edwards, & Cooke, 1999; Woollard, 2003). The following sections explore the role of family, friends and the media in explaining the association between preconceptions and the 'lights and sirens' component of paramedical work.

Family and Friends

The role of family and friends appears to be significant finding in developing adult paramedic preconceptions. Views were formed from interactions with family or friends who were university paramedic students, paramedics or health care professionals. The portrayal of paramedic practice by family and friends demonstrates a variety of perspectives. The following student's preconceptions were partially informed by a friend who had an uncle who was a paramedic:

> "I lived with a mate who had an uncle that was a paramedic and (my mate) was constantly saying you know, I'd like to join the ambulance service ... you know, this is what they do and this is how they do it ... and I kept listening to him and everything he said it sort of sounded alright." (X1P1M2A)

Others built their preconceptions of paramedic practice based on comments by friends who were enrolled in a university paramedic degree, where the lights and sirens approach to ambulance work was emphasised:

> "I had a few friends who were doing a paramedic university degree. They gave me an idea of some of the jobs they'd been to on clinical placement and some of the action ... all the lights and sirens kind of stuff. So (as a result) I thought it's going to be a lot of blood and guts, rescue type of stuff." (X1P2M21A)

The role of family friends who were paramedics in the development of anticipatory preconceptions was another significant finding. The views outlined by these paramedics seemed to highlight the high acuity aspects of paramedic work. The emphasis on trauma appears to have been a deciding factor that led the following university student to enrol in university paramedic studies:

> "I thought all I was going to do was the really cool jobs, all the stabbings, shootings ... it was all the excitement that they used to talk about, that really attracted me to it. They also mentioned that you would also have to do a lot of things that were obviously not so nice, fatal accidents and deaths and stuff ... I just really liked the diversity that no day would ever be the same, always seeing different people." (X2P1F7D)

The idea of becoming a paramedic had not occurred to others until they encountered a particular life event. For example, rendering first aid to an intoxicated person who had fallen down a flight of stairs led to a conversation between the following university student and their cousin which sparked interest in the student's mind in relation to becoming a paramedic:

> "I was interested in medicine as a youngster, sort of thirteen or fourteen. Unfortunately my grades were not sufficient enough to apply for medicine. So I thought of applying for a science degree at university instead. A cousin of mine came to visit me for the weekend, and we were coming out of a restaurant and we noticed something strange. We walked over to this chap who had fallen down a flight of stairs. He was quite drunk ... I'd picked up a bit of first aid over the years playing sports. I just helped this guy out until the ambulance arrived. My cousin and I were chatting in the pub afterwards, as she was quite shaken up because there was blood everywhere. It never really bothered me. So we were just chatting and she said 'have you ever thought of doing that?' I said 'what me being a paramedic? ... Well not really'. I was a bit naive then, I still thought it was bunch of guys who drove vans and

> just took people to hospital … I did some research on the internet and I started to like what I saw." (X2P2M22D)

The role of a paramedic was not always sensationalised by parents or friends who were health professionals. For example:

> "I have family who work in (the) health care industry. From talking to them I realised it wasn't all about ... lights and sirens, blood and guts ... I understood that there was other aspects to (paramedic practice) as well." (X1P1F0A)

However, the following student was talked out of becoming a nurse by his/her mother, who was a registered nurse. In this circumstance, nursing was depicted to be a mundane profession:

> "My mum actually said to me, I don't think you would suit the nursing role because you are too active. Being a paramedic is more of a get out there and meet people all the time kind of job, whereas (with) nursing you are always stuck indoors on the (hospital) wards." (X2P1F7D)

Family and friends who worked as health professionals were also used as a means of getting in contact with paramedics to do some fact finding:

> "I knew a couple of police officers and a few emergency nurses. One of my best friends in high school, his mum was an emergency nurse down at the (Hospital), and I got talking with her towards the end (of high school) to get an idea of what (her view of paramedic practice) was like and whether she worked with the paramedics much ... So through these contacts I got to meet a few paramedics and have a chat to them and see what it was all about." (X1P1F16C)

The data above shows that most preconceptions indicated that paramedical work was predominantly high acuity cases, requiring urgent intervention and transport to an accident and emergency department.

Several authors suggest that the general community has distinct views about emergency services. These views focus on the heroic and emergency lifesaving type of work (Myers, 2005; Tracey & Scott, 2006), which is seen desirable and as a badge of honour for fire fighters (Myers, 2005) and paramedics (Reynolds, 2008).

Television and the Media

The heroic nature of paramedical work may also be reinforced by the dramatised version of paramedics portrayed on television. Of importance was the impact that television shows and the television news had on the development of anticipatory preconceptions. Television shows such as All Saints and Rescue Special Ops (Australia), Third Watch (United States) and Casualty (UK) depict a sensationalised and dramatised view of health care and paramedic practice, portraying paramedics as attending life threatening cases 24 hours a day, seven days a week (Bergman, 2006; Catterall, 2012; Mursell, 2012; O'Meara et al., 2012; Williams et al., 2012). Moreover, television news appears to focus on stories depicting ambulances attending multi-car accidents, shootings and major incidents. The following university paramedic student revealed the extent that television informed their preconception of paramedic practice:

> "To be honest I formed my views from television! Which sounds terrible ... but that is all you see (paramedics) doing on the television news. I mean I know now that helicopters don't go to the Nana that has fallen over ... so 18 years of watching the television news ... and not needing to call an ambulance for any other reason ..." (X1P1M14C)

The above view is also confirmed by another student:

> "My views arose from the generalised media ... you would read (newspaper) articles and see the (television) news. Paramedics were being called out to people in car accidents and there was flight paramedics standing in front of helicopters giving interviews on the six o'clock news. I got sort of an unrealistic version from television, movies and that sort of thing." (X1P1F15C)

On reflection, many accepted that the views represented by the media were not necessarily correct:

> "I think probably I didn't really have a very accurate idea of what it was like to be a paramedic before I started studying at university. Probably it was mostly from television and movies ... That's where my idea of what it was like came from, but as it turns out, that wasn't super accurate". (X1P1M15C)

Similarly, although fascinated with the media portrayal of paramedics, the following student could also see that television dramatised the role of a paramedic:

> "I think before you are exposed to it from a training point of view you have got a lot of media representation, like (Casualty, All Saints and Third Watch). I was sceptical enough to realise as with everything, that (television's) interpretation ... is skewed and dramatised. However, I was more interested when ambulances went past. I was curious to know what was going on in the back. On that little black box (television) there was always something exciting and groovy going on in the back (of the ambulance) ... that could be happening and you wouldn't know about it. So I was always fascinated by that sort of thing, obviously it turns out that 95% of the time nothing that exciting is going on in the back." (X2P1M10D)

Others held similar views of the way paramedic practice was portrayed through television, as demonstrated by the following participant:

> "On one hand I thought it was going to be like those emergency television shows. It's very appealing with all of that drama … well it seemed like it. But then ... I didn't think it wouldn't be like that all the time. I understood that you'd get to help people out and hopefully make a difference, even if it is only small. That sort of appealed to me." (X2P2M24D)

Summary of Preconceptions developed during early adulthood

In adulthood, anticipatory preconceptions of paramedic practice appeared to develop from a number of influences including observing ambulances on lights and sirens code one responses, from family and friends, and through the television and media. It can be noted that the influencing factors responsible for forming the preconceptions in both childhood and early adulthood were very similar. However, the young adults were able to form a deeper and more informed understanding of paramedic practice through maturity, higher levels of critical thinking and information seeking skills. The results emerging from the data about factors that influence child and adult preconceptions are discussed in the next section in relation to the professional socialisation literature.

5.2.3 Discussion of Childhood and Adult Preconceptions

The anticipatory phase of professional socialisation is when individuals develop preconceptions of a profession such as medicine, physiotherapy and nursing (Cant & Higgs, 1999; Kramer, 1974; Lamdin, 2006, 2010; Shuval & Adler, 1977). The socialisation agents that influenced the development of childhood (6–16 years) and early adulthood (17–19 years) preconceptions of paramedicine were similar. However, during early adulthood, the use critical thinking skills and independent research when forming preconceptions about of paramedic practice were apparent, confirming research identifying increased cognitive development during later adolescence (Steinberg, 2005).

Often the picture formed by people about the profession during the anticipatory phase is stereotypical (Shuval & Adler, 1977), and this stereotypical view was evident in relation to paramedic practice. Research suggests that the strongest influencing factors on the development of preconceptions during the anticipatory phase of professional socialisation come from television and schooling (Cant & Higgs, 1999; Lamdin, 2006). The findings from this study confirmed the stereotypical image of paramedic practice portrayed through the television news, television

dramas and documentaries. However, the influence of schooling was not found to be as significant as the literature would suggest. Schooling was mentioned in an indirect way, and mainly in relation to not achieving the required marks to get into particular university courses such as medicine and science.

Another influencing factor identified in the literature relates to the role modelling provided by parents (Lamdin, 2006). Role modelling can include the parent's academic achievements, professional status and even religious affiliations (Lamdin, 2006). The findings confirmed the important role played by parents in influencing the formation of perceptions about the role of paramedic practice and career choices. For example, the findings suggest parents who worked for volunteer organisations such as St John's Ambulance, or parents who worked in the health care sector and emergency services had a significant impact on the development of anticipatory views. Unlike the literature about medicine (Lamdin, 2006), firefighting (Scott & Myers, 2005), policing (Conti, 2006) and mortuary science (Cahill, 1999), none of the participants in this study had parents who were paramedics. This finding may not be an accurate reflection of the number of people who follow a parent into paramedicine. Instead, the paramedic role models were friends and relatives. Although the views portrayed by friends who were paramedic university students added to the development of a stereotypical portrayal of paramedics, the influence of family appears to lead to a more tempered perspective of paramedicine.

Research suggests that other decision making influences that can impact the anticipatory phase include the socioeconomic status and gender of the individual (Anderson & Western, 1972; Cant & Higgs, 1999; Chappell & Colwill, 1981; Richman, 1987). In relation to the historic socioeconomic status of paramedics, Howie-Willis (1985) and Fitzgerald (2013) outline

how ambulance brigade[1] members came largely from the lower middle and working classes. Fitzgerald (2013) confirms that ambulance officers were commonly recruited as honorary officers prior to becoming full-time employees. Honorary ambulance officers often possessed trade qualifications. People with professional backgrounds were frequently unable to commit to being honorary ambulance officers, and were not always located in regional locations where honorary ambulance officers were being recruited. Possessing trade qualifications enabled honorary paramedics to undertake work outside of the ambulance service while not on duty. Additionally, many ambulance officers used their trades, such as being a mechanic or carpenter, to repair or fix ambulances and maintain ambulance stations as local ambulance transport brigades were typically short of funding (Fitzgerald, 2013). The lack of funding also meant that many ambulance officers were required to collect donations from the community to purchase new equipment and supplement their income (Fitzgerald, 2013). The findings did not indicate that socioeconomic status influenced the anticipatory phase of professional socialisation. However, from the researcher's field notes, many participants stated in their interview that they grew up in average suburban areas.

The impact of gender on the anticipatory socialisation phase (Cant & Higgs, 1999) suggests that for adults, professional socialisation is built on a childhood socialisation process. Gender is thought to be a strong influence on childhood occupational preconceptions, and it has also been noted that women and men have different motivations in their career choice (Richman, 1987). For example, Palmer and Short (1994) suggest men are drawn to masculinised allied health careers and women may chose a career because it is seen as an extension to the female caring role (Adamson, Harris, Heard, & Hunt, 1996; du Toit, 1995). Historically, the ambulance service culture has been male orientated and dominated

[1] Prior to the *Queensland Ambulance Act* of 1991 (Queensland Parliamentary Counsel, 2013), ambulance services in Queensland were made up of 96 ambulance brigades. These brigades amalgamated into a single ambulance service, the QAS, in 1991.

(Reynolds, 2009), with this trend continuing up to the mid to late 2000s (New South Wales. Department of Premier and Cabinet, 2008). However, a demographic transition appears to be occurring in that women appear to constitute around 60% of paramedic university student enrolments (Joyce et al., 2009). However, gender did not appear to be a significant finding in this study relating to the anticipatory phase of the professional socialisation of paramedics. Half (n=17) of the participants in this study were females. Reynolds (2008) suggests that the caring aspect of the paramedic role may fit within a feminine nursing orientated realm, which could explain why there is an increase in females pursuing a career in paramedicine.

Of importance was an apparent association with emergency service volunteer organisations, such as St John's Ambulance, surf lifesaving organisations and volunteer fire and rescue associations, thus supporting a recent finding in the literature (O'Meara et al., 2012). The current PhD study found that those working for voluntary emergency organisations viewed paramedics with great respect and a hero-like status. The volunteers were relieved after the paramedics arrived to take over a complex case and expressed admiration of the paramedic skill set. The findings indicate that working for volunteer organisations led to less stereotypical views about the role of a paramedic compared to people who developed their preconceptions about paramedic practice from friends and the media.

The findings did not reflect the underlying ambulance culture of mistrust towards many volunteer emergency service organisations, such as St John's Ambulance, which has been reported in the literature (Reynolds, 2008; Zigmont, 2009). Historically, most Australian and UK ambulance services have origins linked with St John's Ambulance, with the Northern Territory and Western Australian Ambulance Services still being run by St John's Ambulance Australia (CAA, 2011). Additionally many paramedics still continue to volunteer to work for St John Ambulance and surf

lifesaving associations in their spare time (Fitzgerald, 2013). The animosity between ambulance services and volunteer organisations such as St John's Ambulance arose when state ambulance services replaced St John's Ambulance services in Australia (Reynolds, 2008). This animosity appears to have been exacerbated in the past through industrial action between permanent ongoing paid paramedics and Ambulance Services who appointed honorary ambulance officers that were not paid a wage. As a result of this industrial action, paid employees gradually replaced volunteer ambulance officers (Reynolds, 2008).

5.2.5 Summary of Adult and Childhood Preconceptions

In this study, childhood and early adulthood preconceptions of paramedic practice were developed by observing ambulances on lights and sirens code one responses, from family and friends, through their experience working for volunteer emergency organisations, through television and media; and as a result of personal research and information-seeking on the internet. However, the dramatised portrayal of paramedicine on television and the views of friends who were university paramedic students resulted in a more stereotypical view of paramedic work. This is in contrast to those who worked for volunteer emergency organisations, or who sought the views and opinions of family members.

Anticipatory preconceptions, in most cases, kindled some level of attraction to the idea of becoming a paramedic. Section 5.3 explores how the preconceptions of paramedicine which were gained during childhood and adulthood were further shaped and evaluated and resulted in the decision to become a paramedic.

5.3 Deciding to Become a Paramedic

The predominant finding relating to deciding to become a paramedic was a strong desire to help people and make a difference. However, as well as helping people, other reasons for becoming a paramedic included the need to be in control during an emergency, the status of wearing the

uniform, not wanting an indoor 'run of the mill' nine to five job, the desire for a challenging work environment and a desire to obtain a degree qualification.

Needing to be in Control during an Emergency

Feeling out of control or out of one's depth in an emergency situation can be a terrifying experience (Sandman, 2003). The following university paramedic student cites a need to be in control resulting from experiences with natural disasters while travelling overseas, and seeing the footage on television of the terrorist attacks in Bali, New York and London. The need for control and helping people are outlined as reasons for wanting to become a paramedic:

> "I did a lot of travel after leaving school. I encountered a couple of natural disasters such as earthquakes, large storms and floods ... So I found myself in a bit of a helpless position, I didn't like being in that position ... I'm not the kind of person that can stand being helpless ... I have to be a contributor and quite often someone who is controlling things, and I certainly wasn't in that situation, in the natural disaster sense I felt a bit inadequate, and superfluous to people that were doing things. So I wanted to address that ... I didn't want to be a paramedic, but, since that time, events like the Bali bombings, 9/11 world trade centre bombings and the London bombings ... and seeing how paramedics had come to prominence, I guess I could see that these people are attempting to help people in the community every day and you know the fact that it's not an earthquake or, or a flood or a fire, you know, that's not really the appeal, it's the helping people that's important for me and doing something that I can see that a task is done properly and there is a positive outcome." (X1P1M1C)

Status and the Uniform

A number of authors have highlighted the significance of an emergency services' uniform. It has been reported that a uniform develops conformity amongst service personnel, and portrays a level of confidence, competence, and reliability in the organisation's ability to operate

(Johnson, 2005; Johnson, 2001; Joseph & Alex, 1972; Singer & Singer, 1985). On reflection, the following university paramedic student associated the paramedic uniform with heroism prior to enrolling in university paramedic studies and assumed that wearing a paramedic uniform attracted a high level of respect from the community:

> "When you see a paramedic wearing a uniform it's like there is automatically this respect for them." (X2P1F11D)

The uniform was a significant factor in defining the identity of a paramedic for yet another student. The level of respect and attention associated with paramedic uniform were two of the reasons why they wanted to become a paramedic:

> "I wanted to wear the uniform and be known as, when someone asks me, what do you do? Reply oh ... I'm a paramedic. It was sort of like a status." (X1P1F4A)

Most ambulance services have a paramilitary culture (New South Wales. Department of Premier and Cabinet, 2008; Reynolds, 2008) which includes a distinct chain of command and rank structure. The military resemblance of emergency services uniforms is said to establish an image of authority, respect and confidence in the individual wearing the uniform and the organisation they represent (Martin, 2001).

Alternative to Medicine

University paramedic studies were also seen as a viable alternative to medicine or a good pre-medical degree. For example, the following student explains why they decided to become a paramedic instead of a doctor:

> "I wanted to do medicine but didn't quite make the cut. I saw it as a watered down version of emergency medicine ... with more autonomy than nursing. I saw it being probably far more extended in terms of scope of practice than it actually is." (X1P1F12C)

Similarly, another university paramedic student decided against medicine, as they saw paramedic practice as more challenging than medicine, with fewer years of training required. However, it was not evident that the student achieved the required grades to be accepted into medicine and through a process of cognitive dissonance[2] (Festinger, 1957; Stone & Cooper, 2001; Thibodeau & Aronson, 1992) possibly justified their decision to become a paramedic:

> "I just wanted to do something to help people. I've been quite a people's person and I used to do things like (scouts) and stuff like that. We used to go into old people's homes and I absolutely loved it, just being with people. So I always had to do a job that involved people definitely. I also wanted to do something beneficial with my life and career. I did think about medicine ... but for me the training is quite long ... also I think when you're a doctor you've got so much support and people backing you up ... if you can't do an intubation, then another anaesthetist will have a go ... and you've also got brilliant lighting ... I wanted to be challenged ... you know you wouldn't have all that when you're on road (as a paramedic) so you have really got to improvise." (X2P1F11D)

Challenging Outdoors Work Environment

Working in an outdoors environment was commonly viewed to be more desirable and challenging than being employed in an office or hospital setting. For example, the following student explains how they did not want to wear a suit, work indoors and do work which they perceive as mundane. They became attracted to the role of a paramedic after doing some personal research during a gap year:

> "The (school) I was at kind of pressured us to make decisions about what you wanted to do before you finished school and I didn't really want to do that. So as

[2] Cognitive dissonance occurs when an individual encounters a discrepancy between previously held ideas or behaviours and justifies the discrepant ideas or behaviours to form a state of competence and morality (Stone & Cooper, 2001; Thibodeau & Aronson, 1992).

> a result ... they made me go to a load of careers meetings to try and find out what I wanted to do ... I had meeting with a careers advisor and nothing was really coming up ... she said 'well how about you tell me what you don't want to do as opposed to what you do want to do?' And I said 'I don't want to wear a suit, I don't want to work nine to five and I don't want to be doing the same thing every day, I would like to be out and about, helping people, I'd like to do that possibly in some form and I would like to have something a bit more engaging than a nine to five office job'. We went through a list of things and I was pretty non-committal at the time and nothing sort of sparked. I ended up taking a gap year and in my own time I started looking up jobs on the internet and just sort of read a profile of a paramedic and thought about it further ... it sort of clicked with me." (X2P1M10D)

Several university paramedic students outlined their initial interest in becoming medical doctors. However, the thought of working indoors within a hospital environment did not appeal to them:

> "I am the kind of person who always likes to help people out ... Medicine kind of runs through the family really ... However, I wanted to be on the front line rather than being stuck in a hospital. A constantly changing environment is something that I like. I thrive on changing environments and going to work not knowing what you are going to be doing all day, I think that is quite interesting, that's why I wanted to do the job." (X2P1M9D)

The idea of a paramilitary culture and a 'structured chaos' was the determining factor to become a paramedic for others:

> "I spent a great deal of my life wanting to join the army, because I have always known that I wasn't a desk job sort of person. And being a paramedic seemed to be the perfect combination of being that militaristic, unpredictability, the structured sort of chaos, and being involved in tense situations ... quickly distilling information, which is what I love." (X1P1F12C)

As seen above, it was commonly reported that a nine-to-five office job did not have the same appeal as the paramedic role. Therefore, the decision to become a paramedic was influenced by the desire to avoid an inside desk job. For example:

> "I'd worked in a (retail shop) for two years after finishing school. I knew I didn't want to work inside. I knew I didn't want to keep on selling things and that I didn't want to work in an office. So I wanted to do something productive outside. I am not the right person to work (for the police force) ... and I'm not the right person to be a (fire fighter) ... So I decided on joining (the ambulance service)." (X2P3M25D)

Likewise, an important aspect of becoming a paramedic was the perceived freedom and autonomy associated with being mobile and outdoors:

> "What appealed to me was … caring for people, being able to help people ... do something, for people. And being out of an office, because I couldn't work sitting in an office twenty-four seven, nine to five all day long, couldn't do that. Being cooped up in a hospital or something like that, I couldn't do either. So I quite liked the idea of freedom and having the freedom in a sort of restricted way." (X2P3M34D)

Selecting and Valuing a Paramedic University Degree Program

Others wanted to pursue a career in health care. However, the idea of working in a hospital did not appeal to them. Through personal research and talking to other paramedics, the following university paramedic student recollects that they were encouraged to pursue university paramedic studies, as this was viewed from within the discipline as the best way to become a paramedic:

> "I didn't really know what I wanted to do when I left school and took a year out ... In that year I looked at my options and I knew I wanted to work with people and I was always interested in sort of health care. I looked into nursing but decided that really wasn't for me. Didn't really want to be based actually in a hospital, that's what put me off. So I looked into that for a little while and then I got chatting to a couple of paramedics back home. I decided that it would probably be quite a good career for me. I got chatting to a paramedic that told me about (the university degree). He told me that was probably the best way into it because obviously the way things were changing (with paramedic education and training). I looked into it and thought this is pretty good and I'll get a degree as well. So it'd be good to do some study ... and yeah, I applied for the course and got accepted." (X2P3F31D)

The idea of working for an emergency service was seen as desirable for the following student, as his/her father was a fire fighter. However, gaining a university degree was perceived to be equally important. Therefore it occurred to this student that they could combine the two interests and become a paramedic:

> "It wasn't really a conscious decision initially. I wanted to do a science degree ... but I didn't get the grades I needed to get into (the university degree). So I took a gap year ... and part of that year I went away on holiday. I was just sitting there and I was thinking what am I going to do ... I want to do a degree course and my dad's been a fireman for as long as I've been alive, and I fancied an emergency profession. So I thought can I do a degree and get a job and work in an emergency profession? When I came home and I had a look on the (university information website) ... sure enough there was a paramedic science degree, which was great. I thought ... that sounds interesting, I'll find out where it is and ... I was only based twenty minutes down the road. So it was a case of well that looks great … can I sort of see myself doing that? And yeah, I could see myself doing that and I thought … go for it ... I wanted to study. I wanted to learn and I really wanted to do a science degree. And this was just perfect. It was vocational. It was a science degree. And I pretty much knew I was going to get a job at the end of it. So that

> was pretty much the decision made to be honest with you." (X2P3M33D)

The decision to become a paramedic was not as intuitive for others. These students initially pursued different career pathways, and for whatever reason decided to enrol in a university paramedic degree instead. For example:

> "When I was eighteen ... I applied to (a degree unrelated to health) at university because I was kind of forced into going to university by my (high school), and I didn't want to go. So I dropped out of (the degree) before I'd started ... I'd always kind of been interested in the sort of work of paramedics. And I always thought it was something that wasn't sort of looked on as being a good career ... so I never really bothered about it. When I mentioned it to my family, they seemed sort of quite supportive, so I went down and looked at the university route. I looked at (several universities) and went to their open days. I kind of liked the idea (of being a paramedic). So I applied and I got accepted into (the university)." (X2P3M34D)

Likewise, the following university paramedic student wanted to pursue a career in physiotherapy. However, by chance they attended a session presented by a paramedic during an open day at university. The presentation in conjunction with additional research over the internet convinced the student to pursue a career as a paramedic and not in allied health:

> "Basically I was looking at university open days, first of all I was interested in doing (an allied health degree), and my mum is a GP so I have always had a sort of interest in medicine that way. So I went to a few open days and it just so happened that when I went to an open day at (university), I went to look at (the allied health course) ... They had a paramedic lecture going on there so I watched that just out of interest and I had been hearing stuff about (allied health professionals) not being guaranteed jobs at the end of their course and things like that so I was a bit sort of apprehensive. I just thought a paramedic looked really interesting and I had

> never really given it much thought because I didn't really know they did a university degree. So I did a lot of research around it when I got home and realised that (loads of universities) were starting to offer (paramedic degrees) ... I applied for a few of them and went from there really." (X2P1M9D)

5.3.1 Discussion on the Reasons Why the Participants Decided to Become Paramedics

The findings indicate that the reasons for pursuing a career in paramedic practice were diverse. The status of the paramedic uniform was strongly associated with the paramedic identity. Several authors have highlighted the rationale for an emergency service having a paramilitary uniform, citing that the uniform gives credence to both the organisation and emergency service personnel (Johnson, 2005; Johnson, 2001; Joseph & Alex, 1972; Martin, 2001; Singer & Singer, 1985). Similar findings have been reported in the professional socialisation literature about medicine and dentistry, where students associated wearing a white coat as an important component of assuming the identity of a qualified doctor or a dentist (Becker et al., 1961; Eli & Shuval, 1982).

A significant finding was that paramedic practice was viewed as an alternative to medicine. From the author's experience, a degree in paramedic practice has become a more popular choice in recent years as a pre-medical degree, with many medical degrees being graduate entry programs. The literature has also identified that qualifications and experience in paramedic practice provide a viable option when pursuing an entrance into a medical degree (Borrell, 2011; Holmes, 2002; Pipas, Audet, & Brown, 2002). Although literature investigating tertiary entrance scores of university educated paramedic students is scarce, the analysed findings from this study suggest a career in paramedic practice was chosen as an alternative to medicine due to achieving insufficient grades at school. As a result, there appeared to be an element of cognitive dissonance (Festinger, 1957; Stone & Cooper, 2001; Thibodeau & Aronson, 1992) interpreted when the decision to choose paramedicine

over medicine is justified. For example, it was suggested that the training for medicine was too long, and the hospital environment was not as challenging as paramedic practice.

Paramedic practice was also chosen for a career because anticipatory preconceptions indicated that paramedicine was an adventurous career option in the outdoors environment, and not a nine to five job. Another Australian study recently reported a similar finding (O'Meara et al., 2012). The rationale for viewing paramedic practice as an adventurous occupation is not surprising considering the influence of television dramas and the media, as well as the excitement when observing ambulances speeding to accident scenes (Catterall, 2012; Mursell, 2012; O'Meara et al., 2012; Williams et al., 2012).

Another finding was the desire to belong to a paramilitary type organisation. For some wearing a paramedic uniform was the draw card. Paramedic practice was also likened to the armed forces, with an associated 'structured chaos'. It can be interpreted that this anticipatory preconception likened paramedic practice to a war zone, where paramedics are constantly under pressure, receiving and acting on a rapidity of information to survive. A recent study reported a similar finding that undergraduates paramedic students yearned for a high stress and dangerous work environment (O'Meara et al., 2012).

The decision to become a paramedic, for some, was a last minute decision. For many, the existence of paramedic university degree was largely unknown, possibly due to the emerging professional status of paramedics and the relatively recent move of paramedic education from an in-house vocational training model to a university degree (Devenish & Loftus, 2010; O'Meara, 2012; Sheather, 2009).

The desire to pursue a career with emergency services as well as obtain a university science degree was another notable finding. In Australia, apart from degree programs in paramedic practice, policing degrees are also

emerging within Australian tertiary education institutions (Prenzler, Martin, & Sarre, 2010). The pathway to becoming a police officer in NSW is through obtaining an associate degree in policing offered through CSU's Faculty of Arts (CSU, 2012). In the UK, police officer training for new recruits occurs within the in-house vocational training environment (Association of Graduate Careers Advisory Services, 2012). Even though policing appears to be emerging within the tertiary sector, unlike paramedic practice, a bachelor's degree in policing does not appear to be mandatory for becoming a police officer. Fire brigade academies do not appear to be embedded within the university environment (Fitzgerald, 2013) despite the need for training in chemistry and related sciences.

The desire to be in control was another reason for wanting to pursue a career in paramedicine. In this study, the need to be in control related to experiences encountered during natural disasters, and was further fed by observing television news footage of terrorist attacks in London and New York. Several authors reported similar findings suggesting that paramedics in Canada and the United States possessed personality traits such as a need to be in control, a strong desire to be needed and a rescue personality (Mitchell & Bray, 1990; Patterson et al., 2005). Additionally, the anticipatory preconceptions developed through volunteering for with emergency organisations, such as St John's Ambulance or surf lifesaving clubs, were associated with high levels of respect for paramedics as they brought a level of control to complex clinical cases.

5.4 Conclusion

Chapter 5 explored the anticipatory phase of professional socialisation relating to Australian and UK paramedics (see figure 5.2). The anticipatory phase of professional socialisation was found to be relevant to the paramedic context. The anticipatory phase of paramedic professional socialisation involved the establishment of childhood and adult

preconceptions, confirming the findings in the existing professional socialisation literature.

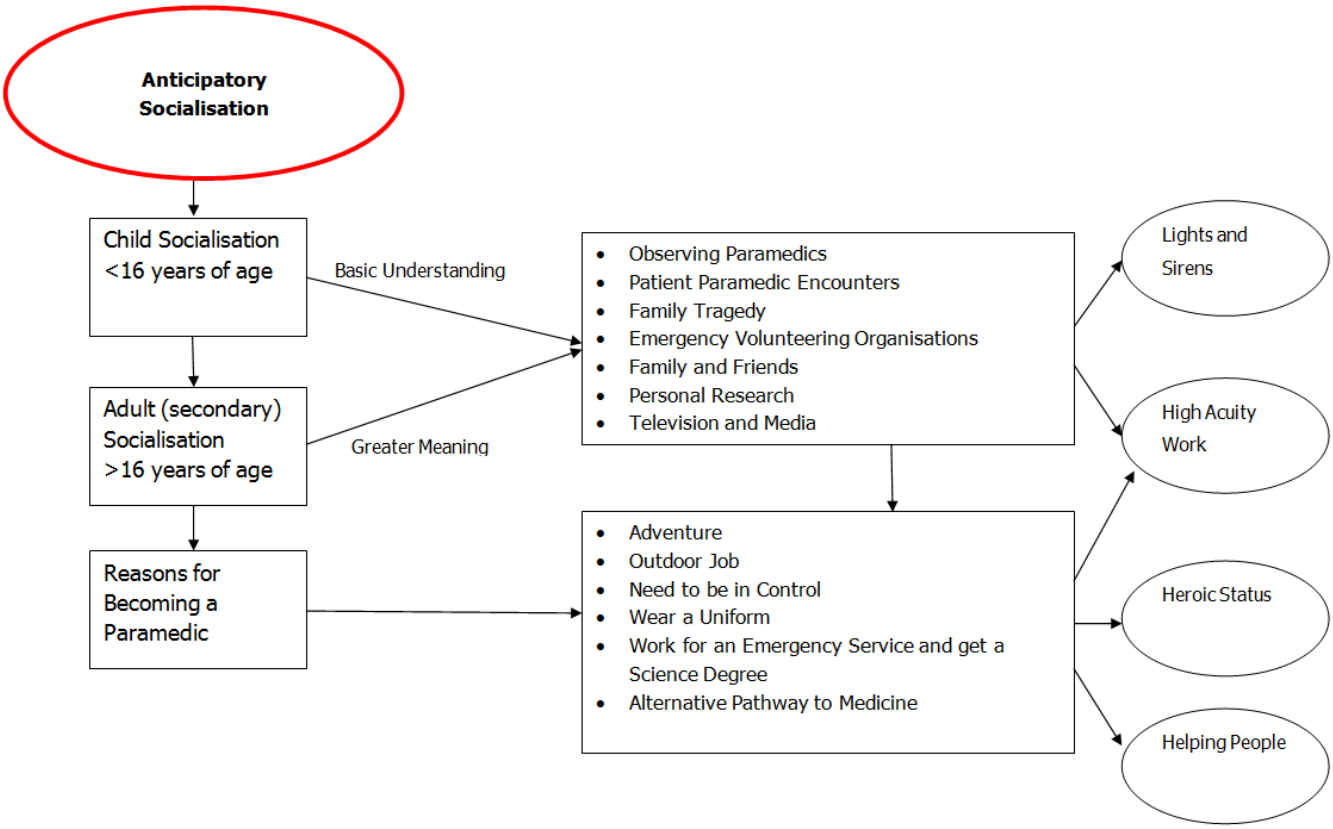


Figure 5.2. A Model of Paramedic Anticipatory Professional Socialisation Summarising the Results from Chapter 5.

Remarkably, the influencing factors that led to the development of childhood and early adulthood preconceptions were very similar. Preconceptions were developed though observing ambulances, patient-paramedic interactions, experiencing a family tragedy, working for volunteer organisations, research through the internet and university open days, the media and the influence of family and friends associated with paramedic practice, health care and emergency services. However, those participants between the ages of 17 and 19 years appeared to use critical thinking skills, independent research and the use of networks to further inform their opinions of paramedic practice. Additionally, a stereotypical

view of paramedicine appears to have been developed through the depiction of paramedics on television, and through the views presented by friends who were paramedic university students. A more tempered preconception of paramedicine was afforded by family members and through experiences gained while working for volunteer emergency organisations. Furthermore, working for volunteer emergency organisations appears to be unique finding in the anticipatory professional socialisation of university educated paramedics.

The preconceptions gained through childhood and early adulthood, in many cases, led to an interest in pursuing a career in paramedic practice. This chapter explored the reasons why people made the decision to become paramedics, and enrol in university courses to obtain qualifications in the paramedical field. The results of this study indicate that the people were influenced by their need to be in control during an emergency, the status of the paramedic uniform, paramedicine being an alternative to medicine, a need for a challenging and adventurous work environment, the desire to work outdoors in either the health care sector or emergency services and wanting to obtain a university degree. Some research findings about the professional socialisation of the medical, allied health and nursing professions were found to be different compared to this study. For example, the role of gender in pursuing a professional career choice, the influence of private or public schooling on the choice of university course and profession, and the influence of socioeconomic status and its bearing on a professional career choice were not found to be present in this study.

Having examined the anticipatory professional socialisation of Australian and UK university educated paramedics, Chapter 6 turns to investigate the formal phase of paramedic professional socialisation. The formal phase explores changes to perceptions resulting from university paramedic studies, and explores the socialisation agents present within this phase.

Chapter 6. The Formal Socialisation Phase

> "I think to a point, everybody comes (to university) thinking, oh, I get to drive fast and we are going to see lots of blood and guts and we have got to … save everybody's life … but we were shown the real world pretty quickly."

6.1 Introduction

The formal socialisation phase (see Figure 6.1) is the second stage of Cant and Higgs' (1999), Shuval and Adler's (1977) and Lamdin's (2006) model, and lies between the anticipatory and post-formal phases. The subsequent changes in perceptions during the formal socialisation phase are examined in Chapter 6.

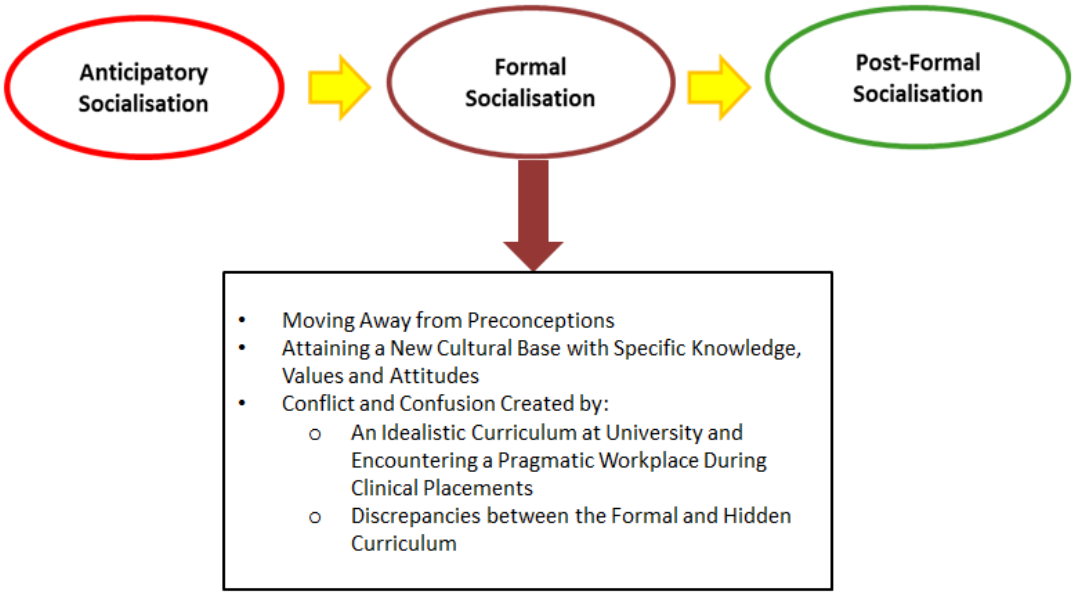


Figure 6.1. The Formal Phase of Professional Socialisation

Perceptions about the role and nature of paramedicine in the context of formal studies; contact with academic teaching staff, including

paramedics; and fieldwork experiences are examined. Other factors such as settling into university life, making sense of the curriculum and experiences while on clinical placements are discussed together, and their likely influence on the professional socialisation of paramedics are explored. Finally, the role of the university in preparing paramedic students for employment is explored.

6.2 The Role of University Orientation

As outlined in the previous chapter, initial preconceptions of paramedic practice were formed during the anticipatory phase of professional socialisation. These preconceptions led people to pursue a career in paramedic practice, and apply to a university to complete a degree with QUT, CSU, Flinders University, Monash University and the UH. After successfully being offered a place in a paramedic university degree program, participants encountered various acceptance and enrolment processes. Prior to starting university studies, attending a university orientation to program was strongly encouraged if not mandatory. During the orientation session, students met other members of their class and were given a tour of the university. Following this, an introduction to the university teaching staff and representatives from their local or state ambulance service occurred. At the beginning of the formal socialisation phase, the university staff and ambulance representatives tried to convey the reality of paramedic practice to the class:

> "The first day we had an orientation (at university) with a very experienced paramedic who had been (with the ambulance service) for quite a long time. (They) gave us a different perspective and view of the paramedic world. Although we were inspired, there were just some parts of the job that we definitely weren't familiar about, in terms of the social welfare side of it." (X1P1M13C)

It was during the orientation session, and throughout the first few weeks of university, that the stereotypic preconceptions about the paramedic roles and nature of the work held by some students were challenged by academic staff and ambulance service representatives:

> "I think to a point, everybody comes in thinking, oh, I get to drive fast and we are going to see lots of blood and guts and we have got to go and save everybody's life ... but we were shown the real world pretty quickly. It would have been in the first week of the degree that the lecturer came in and said, this is the majority of the jobs you'll get, this is what you will be faced with ... this is what your chances of employment are. From there it is a pretty big wake up call to those that come in, that there isn't going to be blood and guts and gore." (X1P3F27B)

The message from the ambulance service representative, while containing aspects of reality, also put forward the view that the ambulance culture values high acuity cases. An initiation process may serve as a mechanism to establish a particular cultural perspective that low acuity cases are a possible waste of ambulance resources:

> "To be honest they reiterated what it is really like on road from the very beginning really. They were saying right, we'll be honest with you guys, ten per cent of your work is exciting, blood and guts, you know, people dying and the type of work that you want to hear about ... The remaining 90% is made up of people wasting our time ... or elderly people who have fallen and you need to pick them up and put them back into bed. I think they made that quite obvious to us from the beginning. Whether we all took it in and actually accepted that I don't know." (X2P2M22D)

Conversely, not all students were provided with an accurate representation of the scope of paramedic practice. For example, one

ambulance service representative spoke solely about the 'blood and guts' component of a paramedics work:

> "When I first started, I thought it was all major car accidents, you know, heavy trauma and that ... and our first initial meeting day where the whole group got together, we had a representative from (the ambulance service) who showed us a quick 10 minute video of car accidents or you know, people in all sorts of interesting and deformed positions, and (the ambulance service representative) basically said 'if this isn't what you can handle, this isn't the job for you ... you're better off leaving now' ... I always remember that, because two girls that I'd been talking to got up and left." (X1P1M3A)

However, this sort of orientation appears to be the exception rather than the norm. It is clear from the findings that in the majority of cases, ambulance representatives provided a view of paramedic practice that challenged the student's preconceptions, which had been formed during the anticipatory phase of professional socialisation. There were various reactions to the different perspectives presented during orientation week. For example, the following university paramedic student observed among their classmates an air of disappointment:

> "A lot of people in my class were in it for the lights and sirens ... and that is all they wanted to do ... so a lot of people were disappointed when they found that out." (X1P1M14)

Others had difficulties accepting the view of paramedic practice outlined by university staff during orientation week, compared to the stereotypical image of paramedic practice such as that formed during childhood:

> "I think the lecturers tried to provide us with a realistic view of what being a paramedic is like, yes they definitely tried. But it's quite hard to have someone else change your opinion. I remember them saying no it's not like all the drama. But at the same time I still had my own idea of what I wanted it to be like." (X2P2M25D)

Conversely, some described the sense of relief that they experienced after finding out that paramedic practice was not all about lights, sirens and 'life and death' type of work:

> "I always worried about how I was going to handle those (big jobs) or how I would deal with it. So I think (finding out that it isn't all lights and sirens) made me feel at ease ... I felt quite relieved in knowing that. Because the reason I wanted to become a paramedic wasn't necessarily to drive fast and go to the big jobs" (X1P1M13C)

For others, the portrayal of the reality of paramedic practice, although different to their preconceptions, did not particularly shock them. On reflection the reality of practice was seen as a good thing:

> "I would say (finding out that it wasn't all lights and sirens) was different to what I expected but not shockingly different. It was more or less a lot less dramatic than I thought it might be ... which in hindsight, was actually a good thing. But I wouldn't say there was any kind of reality shock involved." (X1P1M16C)

As a result of having their views challenged during the orientation session, as classes started, many students began an information seeking process to discover more about what paramedic practice entailed:

> "It was definitely a process of thinking, at least in that first week, well what do paramedics really do? And then it was a matter of asking questions and speaking to the staff and spending time with them. And just going through and basically finding out as much as I could about the sorts of jobs that paramedics do and how these cases are handled and how the patients are treated. The lecturers basically started out saying you are solving a lot of people's problems that aren't necessarily life threatening, but to the patient on that day it is significant." (X1P1M13C)

Through information seeking processes, a new awareness of the role of a paramedic began to be developed:

> "I think I placed too much emphasis on the wrong parts of the job, and I began to draw meaning out of different parts I was learning. I began to change my emphasis in terms of my future clinical scope and expanding into those exciting areas ... I have changed my emphasis of the parts that I am interested in to make them more realistic in terms of what we are actually going to expand into." (X1P1F12C)

The diverse role of a paramedic also started to become apparent, such as dealing with mental health patients, and not just high acuity trauma cases:

> "In class when you actually start learning about the anatomy of the body and all the different diseases ... and what you might come across as a paramedic ... you get the idea that maybe once in a while you'll get an exciting job like a shooting or something like that, and the rest of the time you'll be attending to people with maybe long term illnesses or ... mental illness ... stuff I had never really thought about ... like that paramedics would actually have to deal with mental health patients ... so that was quite good." (X1P1M2A)

6.2.1 Discussion and Summary of the Role of University Orientation in the Formal Phase of Professional Socialisation

The data presented in this chapter thus far confirm the findings outlined by Cant and Higgs (1999), Shuval and Adler (1977), that the formal socialisation process involves a transition away from existing preconceptions to the attainment of a new cultural base, values and attitudes. In this study, anticipatory views were challenged through processes such as university orientation programs, reading, and contact with academic staff, on-road paramedics and other students.

The presence of an ambulance service representative in the formal professional socialisation of university educated paramedics appears to

differ from other medical, allied health and nursing degrees, and may reflect the monopolistic hold ambulance services have on the discipline. For example, 82% (n=9729) of Australian paramedics work for one of seven state or territory run ambulance services (Paramedics Australasia, 2012b). These representatives from the paramedic discipline or profession addressed the class at the beginning of their university studies. The ambulance service representative on most occasions challenged the anticipatory preconception of paramedic practice by providing a more informed, balanced view of the reality of the role. However, this was not always the case. A small number of examples were given where industry representatives focused on the value of high acuity cases. An ambulance service representative on these occasions put forward a cultural view of paramedic practice that emphasised the importance of emergency cases (Reynolds, 2008; Williams et al., 2012) and was derogatory about aged care and less acute cases. After being provided with an informed view of paramedic practice by industry representatives, subsequent reactions reported by university paramedic students include relief or disappointment, which has not been documented elsewhere in the literature.

After being informed about the role of a paramedic and the nature of paramedic work, many acknowledged that their anticipatory preconceptions had not provided them with an accurate view of paramedic practice. As a result, an adjustment process was necessary, where an information seeking process was initiated that involved getting to know university lecturers and teaching staff, asking questions, and listening to stories told about high acuity cases. Both overt and covert information seeking techniques were used, which is consistent with those outlined in the socialisation literature (Finkelstein, Kulas, & Dages, 2003; Morrison, 1993b, 1995). Mature-aged university paramedic students appeared to be more comfortable using an overt approach, and were less afraid to display their knowledge gaps. School leavers seemed to prefer

covert information seeking approaches, such as listening to stories, and observing other students. Information seeking appears to be an important step in the formal socialisation phase, confirming similar findings of many authors (Boychuk Duchscher, 2008; Kramer, 1974; Kramer & Schmalenberg, 1977; Morrison, 1993a, 1993b; Van Maanen, 1976).

Having discussed the initial experiences encountered when beginning paramedic university studies, the university culture and its role in the formal phase of paramedic, professional socialisation is explored in Section 6.3. Encounters with the academic side of university, such as attended classes and practical sessions, are described.

6.3 Adjusting to the Routine at University

As classes began, universities did not begin the study process at a rapid rate; instead, during the first week, activities were designed to settle students into the university culture. There was generally a feeling of excitement reported during this time, and many felt privileged to be accepted into their course. An appreciation of the level of work and commitment required by the university was gained. Some of the appreciation of university expectations and standards was obtained informally from returning students who had not previously passed the subject or had taken a leave of absence:

> "It was nice to mix with new people and I think there was the expectation we would straight away have our clinical side stretched and expanded. But that didn't necessarily happen. They took the time to settle us in ... They made it clear to us that this course isn't like any other course you can do at this university ... We also had some returning students who'd been knocked back from the previous year, so we were picking up bits of information from them. But I would say we were excited ... We'd been lucky enough and fortunate enough to get ourselves in a position where we had got on a course that was very sought after ... and it was definitely made clear to us how sought after (our university) course was." (X2P3M35D)

The diverse backgrounds of classmates became apparent to the paramedic university students. Although some classmates had prior experience with the military, the health care sector and volunteer organisations, there was a general consensus that they all possessed a novice status when it came to 'out of hospital' emergency care:

> "We were all in it together and it didn't matter where people had come from. On the first day ... in your own mind you identify people who you thought would do especially well or would especially struggle. We had people with (army reserve or defence force) experience in the class who I thought would do exceptionally well because I figured they would have quite transferable skills. There were also people who'd worked in hospitals and had done other volunteering and things like that ... so we were all in it together and we were all, generally speaking, starting from new regardless of where you'd come from before. So the (university paramedic staff) began to bring us all onto a par, letting us understand what the profession was about and how we interacted with other health professions." (X2P3M35D)

For others, when classes began in earnest, the workload began to appear challenging, especially when observing the proficiency displayed by students in their second or third year of study within the undergraduate paramedic program:

> "It's quite a daunting experience I think. I had just turned eighteen when I started at university ... Although the lecturers were quite good and they explained (information) in class really well ... It was quite scary when you spoke to people who were in their second year to see what stage they're at ... It's quite like, oh my God, this is going to be quite full-on, this is going to be quite intense. So … it was kind of exciting but also daunting that I had to really knuckle down and learn a lot at university ... Like, this is quite serious." (X2P2M23D)

6.3.1 Discussion and Summary of Adjusting to the University Routine

When settling into the university culture during the formal phase of professional socialisation, the diverse backgrounds of classmates who were enrolled in undergraduate paramedic university programs were identified. From the available literature, multi-institutional studies specifically relating to the backgrounds and demographics of students enrolled in paramedic university programs are sparse, with the exception of Joyce et al. (2009). Due to a perceived gap in the literature, further research is needed that explores in detail the demographics of paramedic undergraduate university students. Classmates in this study reportedly had military, volunteer organisation and health industry experience. Therefore, further studies are required to determine the impact of student backgrounds and demographics on the professional socialisation process. For example, an individual with military experience may have fewer challenges undergoing the post-formal professional socialisation phase when joining a paramilitary health discipline, but may struggle with the formal professional socialisation phase at university. In contrast, students transitioning into a paramedic course from other health degrees may find the formal professional socialisation phase easier having already adopted the university culture.

As classes and practical sessions began in earnest, the 'full on' and 'intense' nature of university studies were realised. One possible reason for this could relate to the differences between studying at high school and university. Such differences include the timetabling of classes and a greater reliance on time management skills and self-directed learning. Another reason could relate to mature-aged students possibly having been out of the study environment for some time. However, research suggests that mature-aged students from Australian universities appear to achieve higher grades than school leavers (Krause, Hartley, James, & McInnis, 2005), a finding also confirmed among paramedic students (Madigan, 2005).

Of importance was the extent to which other students influenced informal learnings about the undergraduate paramedic course. For example, information was learned from peers including those in the years ahead, and some reported learning from those who were repeating a unit or year. Several authors advocate the importance of learning through informal professional socialisation methods such as interaction with peers as part of the overall professional socialisation process (Cant & Higgs, 1999; Shuval & Adler, 1977; Thornton & Nardi, 1975).

Having explored the initial settling in phase encountered by paramedic university students, the next section explores the role of the university curriculum in the formal professional socialisation of university educated paramedics.

6.4 The Curriculum

As part of the university paramedic curriculum, the completion of subjects specific to paramedic practice were required such as the 'core fundamental sciences' including, anatomy, physiology, pathophysiology, pharmacology and clinical foundation subjects. Social science subjects such as sociology, mental health, communication, research methods, evidence based practice, law, ethics and professionalism also formed a critical component of the curriculum. Findings suggest that the relevance of social science subjects were not appreciated and learning paramedic skills was deemed to be more important:

> "The non-clinical subjects seemed a bit irrelevant, but I was trying not to look at them in this way because it's part of the curriculum, it's got to be done so you might as well just crack on with it, don't get down on it." (X2P2M25D)

Others could see the relevance of the social science units. However, they struggled to come to terms with the way some subjects were presented:

> "There was this subject (on psychology). Unfortunately … we didn't get taught a great deal. Most of it was literally sitting in a lecture theatre for an hour or two and reading off slides. As a result I'd certainly say my (knowledge) of psychology ... was very minimal. Considering we were told that mental health jobs involved so much of the work on road." (X2P2M22D)

Some units brought students together from different allied health courses to promote inter-professional learning and communication. Although the relevance of these units was acknowledged, the class activities were viewed with scepticism. For example:

> "We did quite a bit with other (health) disciplines. I think we had (allied health students like nurses, pharmacists, dieticians) ... We did a lot of communication practice, talking to each other and talking about all the things involved in the continuum of care, and then obviously doing a lot of scenarios. I think it was difficult because … when you're with friends you know them even though they're … putting on a character. It is very different compared with reality." (X2P2M22-D)

Although the relevance of the support subjects could be seen by some, others were frustrated with other aspects of the curriculum. For example, some units appeared to be taken from an 'old diploma program' and topics such as professionalism appeared to be overdone—to the perceived determent of clinical skills:

> "The first paramedic based subject was taken directly from the old diploma program so it was really more vocationally based education rather than university based education ... I figured it would get better ... However, we ended up hearing lots ... about professionalism ... it was over done because we ended up with so much on professionalism ... there is only so many times they can talk about the expansion of paramedic practise as a profession ... when really what we need to do was learn the primary assessment better." (X1P1F12C)

A small number of university paramedic students could see the relevance of the curriculum from day one:

> "In the first couple of days the university staff spoke about the curriculum and pieced the entire puzzle together ... I then understood why we needed to take all these subjects." (X1P1M14C)

However, as the course progressed, a hidden curriculum became evident and appeared within the paramedic subjects. For example, it was noticed that the stories told in class by the paramedic teaching staff would focus more on the life saving side of paramedical work:

> "We were only told about the good cases. You don't often get told war stories that aren't interesting because I guess they're not worth telling … so most of the time you would be told stories about interesting things or like really dramatic cases." (X2P2M25D)

Through 'war stories', the university paramedic student above implies a good case to be a dramatic case. Thus, the cultural overemphasis on acute cases (Reynolds, 2008) appears to be reinforced through the hidden curriculum in the university setting.

The content in the paramedic lectures was deemed to mainly centre on ambulance protocols or clinical practice guidelines, and matters relating to chronic health conditions were not made to look important:

> "I think the lecturers struggled to find reasons why they should be teaching some of the chronic health things ... They used to apologise continuously through the lecture and they say 'look don't worry we won't examine you on it because it is not part of your (Protocols or Clinical Practice guidelines)' ... They would emphasise that we were a university and not an ambulance service teaching institution, but the curriculum is essentially based on the (Protocols or Clinical Practice guidelines) and they go from there." (X1P1F12C)

Similarly, others reported that the curriculum appeared to be misaligned with the realistic nature of paramedic work, which was explained during orientation week, and instead focused on the emergency cases:

> "I think the curriculum ... definitely pitched the emergency type jobs, and on reflection that's why at the moment I feel big jobs are the easiest because they are the ones we were most drilled in at university. Not the tough jobs like where there is a communication barrier ... or when most of your time on scene is spent trying to solve an argument between a husband and wife." (X1P3F27B)

From the quote above, it could be interpreted that the reframing of what was once considered to be a complex case into what now appears to be an easy case occurred. Conversely a case that involves 'communication' now becomes a 'tough job'. That is to say a case involving a language barrier became more complex than a case involving trauma, and the social science subjects, such as communication, now appear to be more complex. The hidden curriculum conflicting with the formal curriculum resulted in a degree of confusion for many. For example:

> "The lecturers emphasised to us all the (high acuity invasive skills), but then they said that you will barely need to use them. I have spoken to paramedics who have been in the job for 30-35 years and they have rarely ever needed use them either. It all seemed strange to me." (X2P1M9D)

6.4.1. Discussion and Summary about the Role of the Curriculum in the Formal Phase of Professional Socialisation

A significant finding about the paramedic undergraduate curriculum relates to inter-professional learning and social science subjects, both of which appeared to be under-valued by the students, confirming the findings of other authors (Clark, 2009; Hallikainen, Väisänen, Rosenberg, Silfvast, & Niemi-Murola, 2007; Mallinson, 2011; Williams & Boyle, 2008; Williams, Boyle, Brightwell, McCall, et al., 2012; Williams, Brown, & Boyle, 2012; Williams, McCook, et al., 2012; Willis et al., 2010). Australian

paramedic programs teach social science subjects in isolation to core fundamental science and paramedic units, while UK paramedic programs generally imbed social science topics within paramedic units (Williams, 2010b; Willis et al., 2009). Furthermore, authors maintain that inter-professional education is often taught early in the curriculum at a time when students can least identify with the importance of the topic (Mallinson, 2011; Williams, Boyle, Brightwell, McCall, et al., 2012) and are still developing their own professional identity.

Another aspect evident in relation to the paramedic undergraduate curriculum is the presence of a hidden curriculum. Traditionally, in-house vocational training programs had a strong emphasis on skills (Cooper, 2005), with paramedics listing the three most important skills that form their identity as being intubation, defibrillation and patient assessment (Pollock, Brown, & Dunn, 1997). Due to the discipline's or profession's emphasis on clinical skills, and the added emphasis on the life saving aspects of paramedic work, a hidden curriculum became apparent. It was also reported that academic teaching staff preferred to focus on invasive skills and emergency side of paramedic practice. However, academic teaching staff would also acknowledge, almost apologetically from the perspective of the undergraduate students, that invasive skills and 'lights and sirens' type work make up a minority of cases. The formal curriculum states that routine cases involving chronic disease and minor injury make up the majority of the cases, but the stories told by academics and on-road teaching staff mostly concentrated on emergency cases and there is a strong emphasis on emergency care competencies. Professional socialisation research suggests that the socialisation process at university contains inconsistencies between information presented in textbooks and lectures and the reality of the workplace experienced during clinical placements and portrayed by sessional academics (Cant & Higgs, 1999). Thus the socialisation process is "thwart with conflicts and confusions for students to grapple with" (Cant & Higgs, 1999, p. 49; Higgs, 2013).

Students are required to synthesise conflicting information about the nature and reality of the paramedic workload, and "thread their way through the explicit messages of the visible curriculum and the implicit and often more powerful messages of the hidden curriculum" (Cant & Higgs, 1999, p. 49). Likewise, Lamdin (2006) maintains that the hidden curriculum is a powerful component in the development of students' professional attributes and values. What students are taught through the formal curriculum is not necessarily what they learn. The messages delivered to students though the informal and hidden curriculum are more important when understanding what students actually learn (Hafferty, 1998). The hidden curriculum is influenced by organisational culture, institutional policies, evaluation activities, resource-allocation decisions, and cultural jargon (Hafferty, 1998).

Another possible reason for the presence of a hidden curriculum in paramedic university programs may relate to ambulance services' organisational enculturation tactics experienced by many of the university academics, who have worked or continue to work as paramedics. It appears as though some academics simultaneously negated and promulgated the stereotypical and dominant culture embedded in the hidden curriculum. Understandably, these academics are preparing students to be able to appropriately respond to life threatening emergency cases, even though these jobs make up the minority of the caseload. Such socialisation tactics that emphasise the importance of managing high acuity cases may be a hangover from the traditional in-house apprenticeship training model, which was a major focus of the vocational curriculum. However, what is clear from this study is that further research is required to investigate the hidden curriculum present in paramedic university programs. With the exception of an article by Henderson (2012), there appears to be a dearth of literature on the hidden curriculum within the paramedical context.

Having explored the influence of the formal and informal curriculum and

their effects on the professional socialisation process, Chapter 6 now turns to examine the preparation for, and completion of, clinical placements with an ambulance service.

6.5 Clinical Placements

At the time of writing this thesis, mandatory criteria for the length or quality standards of undergraduate paramedic clinical placements do not exist throughout Australian ambulance services. Further, no standardised student paramedic clinical placement assessment tool is used within or between Australian states and territories. Consequently there are differences in the length of and requirements for clinical placements among the different universities and ambulance services in Australia. The CAA (the peak ambulance industry body in Australia, New Zealand and Papua New Guinea) has stipulated that clinical placements are an essential component of the education and training of undergraduate paramedic students. However, the CAA acknowledges that clinical placements are the responsibility of the tertiary education institutions, and universities should recognise the limited capacity of ambulance services to provide clinical placements (CAA, 2010a). Paramedicine in Australia has possibly not reached the level of professional maturity of more established health programs where there is joint ownership between universities and the relevant health sector of the challenges relating to clinical placements. As the paramedic profession continues to emerge in Australia, universities and ambulance services need to work towards developing joint responsibility for managing clinical placement in order to develop an appropriately trained workforce of sufficient numbers into the future.

The CAA also recommends that tertiary education institutions should have a contingency plan, such as the use of high fidelity simulation, to fulfil the objectives stipulated in each university's paramedic program (Council of Ambulance Authorities, 2010a). Conversely simulation should not be viewed as a replacement for clinical placements (Willis et al., 2009). At the time of writing this thesis, several bodies such as Health Workforce

Australia and the Australian Federal Office of Learning at Teaching are funding research, being completed by Paramedics Australasia (PA) and the CAA, to develop national clinical placement standards for undergraduate student paramedics in Australia and New Zealand.

In the UK, the College of Paramedics (CoP) has national clinical placement standards for paramedic university programs. When the data were collected, the CoP specified that undergraduate paramedic students must obtain 1500 hours of clinical placement to be eligible to register as a paramedic on graduation (Williams, 2012a). However, this changed in early 2014, and undergraduate students must now complete 750 hours of clinical placements per year to be eligible for registration (Williams, 2014). It is evident that Australian ambulance services lag behind UK paramedic university programs and NHS ambulance trusts in relation to the standardisation of clinical placements and professional registration. However, it is not clear from the literature whether UK NHS ambulance trusts have a standardised clinical placement assessment tool. The LAS was the first NHS trust to develop practice assessment documents, and several other NHS trusts have adopted their model (Williams, 2014).

In the context of the differences in clinical placement requirements acknowledged above, the following section explores the experiences encountered when completing clinical placements with an ambulance service. From the analysed data, the categories relating to clinical placements were: the preparation for placement while at university, the first day on station, settling into the placement, being introduced to the reality of practice, exposure to the ambulance culture and an introduction to undesirable side of the job. Each of these will be considered in turn.

6.5.1 Preparation for Clinical Placements

Australian and UK paramedic programs include clinical placements as part of their curriculum (Boyle et al., 2008; CAA, 2010a; Lord et al., 2009; Williams, 2010a, 2012a; Woollard, 2009). It appears as though an attempt was made by university paramedic programs to prepare students

for the ambulance paramilitary culture by stipulating that clinical placement uniforms were to be worn during tutorials and while out on placement. Not all students could immediately see the relevance of wearing a uniform:

> "In all honesty, I couldn't see that wearing a uniform made any difference. In actual fact, I felt a bit stupid half the time … You would see other students around in their uniform quite often, and then it was more normal. But when I first started wearing it, everyone around campus would look at you a bit funny …" (X1P3F30A)

Students were also prepared for clinical placements through theory, practical sessions and simulation. Although university staff attempted to prepare students for clinical placements, it was generally accepted that there are limitations to what universities can do to prepare students for the diversity of on-road experiences. For example:

> "I think university definitely did prepare us as much as it can, but I think … there's only so much you can do in simulations on mannequins and scenarios on each other … You could know a (clinical scenario) one hundred and ten per cent, but then you could go on a job, and you could get a family that are really upset and distressed … and just kind of throw you off a bit and then for some reason you forget a drug. Or … you forget to ask a question or listen to their chest, because you just get a bit flustered and you're new. So I think quite a lot of it is experience. But (university) does … give you quite a good insight background wise." (X2P2M23D)

Simulation formed a large component of the activities designed to prepare students for clinical placements. The simulation resources at universities range from simple advanced life support mannequins through to expensive, 3G wireless mannequins, where students can take blood pressures, pulses, breath sounds and practice invasive procedures such as cannulation and laryngeal mask airway insertion. Some universities, such as QUT and the UH have, or use, simulation centres containing simulated ambulance vehicles, emergency departments and domestic environments.

However, simulation in a classroom environment requires students to imagine their surroundings when performing a scenario. Furthermore, due to the cost of the high fidelity mannequins, they were reportedly few in number and in most cases their use is limited to the classroom when a laboratory technician or lecturer was present. When attending a self-directed learning session to practice their skills through simulated scenarios, the following student had to rely on their imagination and low fidelity simulation:

> "We have done a lot of simulation. The scenarios that we did here were mostly in a classroom, so we had to imagine a lot of things. I think at one time (during a self-directed learning session) because so many people were trying to practice at the same time the equipment was scarce ... We ended up doing a full cardiac arrest scenario with a (half torso mannequin consisting of a head and chest) and a cannulation arm ... you are trying to do CPR … and there were bits and bobs knocking about everywhere, it was quite hard to imagine really but it is all practice ... You have got to make the most of what you have, resources wise." (X2P1M9D)

Due to overuse of the equipment, another student became frustrated when many of the kits in the practical rooms were not being restocked by other students after they had completed their scenario. While on clinical placement, they learned the importance of restocking medical kits, and appear to have accepted the value attached by the paramedic discipline in relation to being prepared and pulling one's lot as a team member:

> "Half the time the kits (at university) aren't stocked. The first time I saw a kit on road, I picked it up and it was super heavy and I had a look inside of it and … I thought ... wow, I don't recognise half the things that are in this bag. So I had to take time to look through that. So when I went back after the prac I felt the need to stock the kits. Things like that made me feel more professional." (X1P2M21A)

It was acknowledged that studying at university provided students large

amount of theoretical knowledge. However, findings indicate that during clinical placements, many students realised that they had very little hands on experience with patients. The perceived lack of practical experience led to feelings of apprehension about their impending placement:

> "University definitely prepared me knowledge wise. But then going on a job (case) on my placement was a whole other story. I talked with my lecturers about my fears and they said ... 'what are you worried about ... if that did happen how would you treat the patient?' … I suppose I was not really ready or trained enough for the little things. I could take vitals and I think I could question a patient, but I didn't know how to work the stretcher very well. I didn't know what buttons to press on the (Computerised Dispatch Terminal) or those sorts of things." (X1P2M21A)

The rationale behind clinical placements was reportedly poorly understood by some undergraduate student paramedics. Instead of clinical placements providing the novice practitioner with workplace experience to consolidate and integrate their knowledge and skills into the on-road environment (Boyle, 2014), it seems as though unrealistic expectations were held, such as the assumption that university would prepare undergraduate students for all aspects of the workplace. Additionally, there was a perceived pressure to perform, created by the fear of how on-road paramedics were going to treat students on clinical placements. A view was commonly presented that indicated that academic staff at university attempted to prepare undergraduate university paramedic students for the possibility of encountering stigmatisation while out on clinical placement. For example:

> "I was terrified of going out on road because I was a university student ... I have heard horror stories about how students have been treated ... The (lecturers) said ... 'you just need one student out there (on placement) to act like an idiot and we'll all get tarred with the same brush' ... I thought they were going to crucify me just because I'm a university student." (X1P1F6A)

Discussion and Summary of the Preparation of University Students for Clinical Placement

The results indicate simulation was used by university paramedics programs to prepare students for clinical placements, which confirms the finding of several authors (Williams, et al., 2009; Williams, Brown, Scholes, French, Archer, 2010; Boyle et al., 2007). The role of uniforms in preparing university paramedic students for clinical placements has not been identified in the Australian or UK paramedic literature. However, the nursing literature indicates that clinical placement uniforms encourage the role modelling of professional behaviour (Hope, Garside & Prescott, 2011). Conversely, pre-hospital research from Sweden suggests that university students felt insecure wearing a different uniform to on-road staff because it made them 'stand out' and indicated their novice status (Wallin, Fridlund, & Thorén, 2013).

When investigating the preparation for clinical placements at university, a theory-practice gap was an important finding. It was claimed that university prepared students with clinical and theoretical knowledge, but insufficiently prepared them practically. Particular concerns were raised around operational aspects such as using stretchers and various pieces of equipment. Research shows similar findings maintaining that paramedic university students do not feel adequately prepared by university for the reality of paramedic practice (Lazarsfeld-Jensen et al., 2011; Michau et al., 2009; Ross, 2012; Sibson & Mursell, 2010b; Tanner, Knights, & Strange, 2010; Willis et al., 2009; Wyatt, 2003). The theory-practice gap is not a new concept and has been investigated within other health fields such as nursing (Benner, 2001; Gallagher, 2004; Hewison & Wildman, 1996; Rolfe, 1993; Upton, 1999), physiotherapy (Roskell, Hewison, & Wildman, 1998), occupational therapy (Welch & Dawson, 2006) and medicine (Kaufman, 2003; Weller, 2004). The increased occurrence of different disciplines providing theoretical input to professional courses at university has been highlighted by several authors as a possible contributing factor to the theory-practice gap (Roskell et al., 1998; Willis

et al., 2009). Other authors report that the extensive theoretical emphasis at university, accompanied by minimal opportunities to consolidation skills in the workplace contribute to a theory-practice gap (Lazarsfeld-Jensen et al., 2011; Michau et al., 2009). To narrow the theory-practice gap, a number of authors have suggested the development of more interactive teaching approaches, high fidelity simulation and the use of reflective practice techniques (Boyle, Williams, & Burgess, 2007; Kaufman, 2003; Williams, Brown, & Archer, 2009).

6.5.2 First Day on Station

Before clinical placements began, undergraduate student paramedics were reportedly assigned to a station and placed on the roster with a paramedic crew. In most circumstances, rosters were organised around the same crew for the entirety of the placement. While on clinical placement, university students became a third member of the crew, known colloquially as 'third manning'. On arriving at the station for the first time, the fear of stigmatisation from the on-road paramedics made the experience just that little bit more daunting:

> "I was terrified ... by my first day at station ... turning up at somewhere you don't know, trying to meet people you don't know, going out doing something you have never done before, that is scary in itself. It was quite daunting ... we were told (at university) you have two ears and one mouth so use them in that order ... it is strange sitting in the room just sort of listening to everyone bounce around. It was scary going out on the ambulance for the first time, even though you have been told that it is not all blood and guts and trauma calls, putting the lights on for the first time ended up being quite a serious adrenaline rush, even though it was someone with a nose bleed." (X2P1M10D)

Both excitement and apprehensive were reportedly experienced during the first day of the clinical placement, as most students did not really know what to expect. It was apparent that many students did not undergo a station orientation process prior to beginning their placement.

Trying to locate the ambulance station, for many, was a challenge and after arriving, they were either locked out of the premises or not expected by the crews on station. Additionally, on the first day of their clinical placement, paramedic terminology was often encountered which students did not understand, which suggests the presence of a professional language used by paramedics:

> "It was quite exciting. I didn't really know what to expect, because I'd never been on a real ambulance station before ... I didn't know whether it would be like something out of a World War II Battle of Britain film where the bell goes and everyone runs to their ambulance ... and jumps in like it's a Spitfire to rush off and save the world ... It was an utter fluke (that) I found (the station), and arrived on time because I didn't have a map or a (satellite navigation system) ... When I arrived I didn't know how to get in the building. Someone came out for a cigarette … they said 'are you third manning?' … I hadn't been part of the culture for that long I didn't know … the jargon. I just looked at them like a Muppet ... So that was my first exposure, someone saying something that I didn't understand ... I picked up that the (ambulance service) had a particular culture and I wasn't part of it, yet." (X2P3M35D)

The first code one lights and sirens case was for many an important milestone. Many university paramedic students had formed their anticipatory preconceptions about paramedicine from watching ambulances respond to emergency cases, and from the dramatised depiction of ambulance work on television. Therefore being in an ambulance with paramedics that were responding to an emergency case was an exciting experience:

> "Because you're always driving in your car and you see ambulances behind you with lights and sirens going ... you normally just move out of the way. But to actually be in the ambulance and seeing most people move out of the way for you was a real adrenaline rush ... and here I was wearing my high visibility vest. I just felt a bit

> important and like I was actually really doing this. And so, yeah, definitely got a buzz from it. (X2P1F11D)

While a large component of paramedic work is routine transfers and attending to non-emergency cases such as patients with chronic health conditions (Williams et al., 2012), the following student encountered the emergency life threatening side of paramedic practice within minutes after arriving at their station:

> "I was really anxious on my first day ... We received (a cardiac arrest case) 5 minutes after (starting the shift) … I thought 'oh my goodness what have I done'. On arrival the patient was in (Ventricular Fibrillation) and we did CPR and shocked the patient ... That was the first time I had performed CPR on a real patient and I was just like ... oh my goodness … The paramedics were excellent and talked me through everything ... I then relaxed a bit more into the placement." (X2P1F7D)

Discussion and Summary of the First Day on Station During Clinical Placement

After arriving on an ambulance station for the first time, having an outsider status in relation to the ambulance service culture was reportedly a common experience. The theory of marginalisation, within a postmodern paradigm, has been used to explore the experiences of nurses (Boychuk Duchscher & Cowin, 2004) and social workers (Enoch, 1989) transitioning from the university setting to the work environment. As seen by the experiences outlined above, feelings of marginalisation were encountered during the first day on station as students were outside of the familiarity of the university culture and not yet part of the ambulance culture. Some even reported having difficulty understanding ambulance language and terminology. Additionally, difficulties were commonly purported in relation to finding the location of the ambulance stations, or gaining entrance to the premises. It was unclear whether universities and ambulance services encouraged university paramedic students to familiarise themselves their ambulance station location prior to

commencing their placement. Providing students with entrance instructions may have lessened the intimidation felt by many as they arrived at the station for the first time.

Another finding relates to the first day on station and encountering code one lights and sirens jobs for the first time. An adrenaline rush was frequently experienced when responding to a code one emergency case. The first code one case appeared to be viewed as a rite of passage, arguably fulfilling the expectations formed during the anticipatory phase of professional socialisation and the hidden curriculum. There was also an account given of encountering a patient in cardiac arrest during the first shift. After successfully performing CPR on a real patient for the first time, positive feedback, which was provided by the paramedic clinical mentors, resulted in greater perceived levels of acceptance. Kramer (1974) in her realty shock model maintains that newcomers view skill mastery as a key component leading to acceptance in the workplace.

6.5.3 Introduction to the Reality of Practice

Cardiac arrests and trauma jobs were not commonly encountered during clinical placements. Case details often suggested that the patient was experiencing a life threatening health emergency. However, after arriving at the scene the patient's condition was often not as serious as the paramedics were led to believe by the case details sent by dispatch. For example:

> "One of the first jobs we were called to was a patient with cardiac chest pain ... and it sounded quite serious ... but when we got there ... the patient was sitting up … they could talk and they were eating their toast for breakfast ... and it was just this realisation that even when you get called to these big jobs and the person sounds like they are only minutes away from dying in fact they are sitting up and talking and can walk out to the ambulance." (X1P1M13C)

As a result of the difference between the details of the case and what was encountered on scene, feelings of frustration were reported as the reality of the situation became evident and a rapid adjustment was required. For example, the following student and their paramedic crew were dispatched code one (lights and sirens) to a person with breathing difficulties. On arrival at the scene, the paramedics met the patient, who was waiting out the front of their house, with a suitcase packed ready to go to hospital:

> "On arrival at the scene the patient was standing there waiting ... saying I am ready to go (to hospital) ... I hadn't even taken a blood pressure or put the monitor on them, to know if they really need to go to hospital. Can't they call a cab? … It was a huge adjustment ... I mean the jump from the sort of work that I thought we would be getting to what we really did get …" (X1P1M3A)

The anticipatory preconceptions that a paramedic's work is all lights and sirens were challenged for the following university paramedic student after experiencing a shift where their paramedic clinical mentors did not attend any cases for hours, as no one called for an ambulance:

> "During my prac we had a day where we went seven hours without a doing a job ... I was like what are we doing sitting down here, we should be out there doing something ... then we got a job after seven hours which was a (low acuity transfer case) from a doctor's clinic to (the hospital) ... that's when the penny dropped for me." (X1P2M21A)

Discussion and Summary of the Introduction to the Reality of Paramedic Practice During Clinical Placements

Even though numerous published papers address the reality of paramedic practice (Clark et al., 2000; Morgans et al., 2004; Morgans & Burgess, 2012; Morgans & Burgess, 2011; Snooks et al., 1998; Williams et al., 2012; Wilson et al., 1999; Woollard, 2003), the results indicate that undergraduate student paramedics often had their views that paramedic work was all about 'saving lives' challenged during their clinical placements. Considering it was commonly reported that anticipatory

preconceptions were initially challenged during university orientation week, it appears as though views relating to the reality of paramedic practice were still underdeveloped. It could also be interpreted that the hidden and informal curriculum, which emphases the lifesaving lights and sirens type of work, may have distorted the outlook held by university paramedic students relating to the reality of paramedic practice. Additionally, the results indicate that the cultural perspective about negativity towards low acuity cases was commonly accepted. Conflicting messages needed to be deciphered in terms of "personal values, the values of their patients, colleagues and mentors, and the values espoused in their curriculum" (Cant & Higgs, 1999, p. 49) while on clinical placement and during the formal phase of professional socialisation. Clinical placements provided a vehicle for developing values and attitudes for shaping professional socialisation.

6.5.4 Introduction to the Responsibility Associated with Being a Paramedic

Regardless of the type of cases attended during clinical placements, an awareness of the level of responsibility accompanying the role of a paramedic was reported. For example, due to their inexperienced status as a university student, many feared that they would not meet the expectations of the patient while on clinical placement:

> "I was pretty much terrified the whole time. Being a student I feared that I didn't know enough to be in that position ... Because when you arrive in the scene, it wasn't like the patients are recognising you by the uniform, they are recognising that you got out of that ambulance, and you're supposed to help them … I felt very underprepared … and not able to meet the expectations of the patient." (X1P2F19B)

However, in most cases, university paramedic students were eased into the treating role, and were observers during their first clinical placement, where they could watch and analyse experienced crews at work. The following student spoke in admiration about observing two paramedics

who were proficient in their practice:

> "You see the relations between the (paramedic crewmates) ... they hardly need to talk to each other, they just know what the other one is going to do … You see them (approach the patient) and they automatically start doing things and you think hang on, I've missed something here, how do they know what is going on without even talking to the patient. I thought am I ever going to understand what it going on? But then when you go out a few more times you start to see things that you wouldn't have picked up in the first place." (X1P3F27B)

After observing paramedics for several shifts, most university paramedic students were then asked to provide basic aspects of patient care, which included taking a patient history and recording clinical observations such as the patient's blood pressure, pulse rate, temperature and pain levels. After completing basic procedures, participants often found that they were then encouraged to take a greater role such as talking with the patient and giving a clinical handover at the hospital. For example:

> "For me my first placement was quite overwhelming. It was the first time I'd actually touched and talked to patients ... My clinical mentors attended to the patients at first, but they'd get me doing the observations. So I'd do the blood pressure and the pulse and … all those sort of things. Then a few shifts later (my clinical mentors) said on the way to the job 'right now you're going to do the talking' ... because they'd have a rough idea what job we're going to from (details from the dispatch centre). So on the way to jobs they'd be ... 'right, you're going to an abdominal pain, what might you be thinking of, what questions are you going to ask?'... They'd prepare me on the way to the job. ... Obviously if I looked like I was getting a bit stuck they'd step in and help. After the jobs, they'd give me a debrief and would say you did this well or you missed this ... just gradually building up to it really." (X2P3F32D)

In the latter placements, as students were getting closer to graduation,

they were encouraged to take over all aspects of patient care while under supervision:

> "In my last placement my (clinical mentor) was like ... you are in charge for today ... unless I asked him for any help ... he would just let me get on and deal with it. I then began to feel comfortable enough to say ... yeah ... I can do it by myself." (X2P1F7D)

Discussion and Summary of the Introduction to the Responsibility Associated with Being a Paramedic

Studies investigating the experiences of paramedic university students while on clinical placement are scarce apart from a few notable exceptions (Boyle et al., 2008; Lazarsfeld-Jensen et al., 2011; Lord, 2013; Lord et al., 2009; Michau et al., 2009; Wray & McCall, 2009). During clinical placements, feeling overwhelmed and uncomfortable when treating patients was frequently reported. Clinical mentors appeared to have used an apprenticeship-style approach by slowly increasing the students' involvement in the treatment of patients. The literature on the use of apprenticeship-style approaches to training within the formal phase of professional socialisation is common in the medical education literature (Becker et al., 1961; Conrad, 1988; Lamdin, 2006, 2010; Pitkala & Mantyranta, 2003). However, the clinical placements embedded in university paramedic programs are significantly shorter than the clinical exposure experienced by medical students. Further, paramedic students are supernumerary crew members. Despite these differences, there does appear to be some similarities between medical education and paramedic clinical placements with respect to easing students into the clinical environment. The use of an apprenticeship-style approach may also be cultural and linked to the previous in-house vocational training approaches historically used by ambulance services to train new recruits.

In addition to the apprenticeship style adopted by paramedic clinical mentors, clinical placements provided an opportunity to observe experienced paramedics in action. Essentially, university paramedic

students in this study possessed a novice status, and were observing experienced paramedics who had proficient or expert status (Benner, 2001). The use of reflective practice was apparent during clinical placements when combining clinical knowledge with on-road paramedic practices, and through observing, a greater awareness of how to diagnose and treat patients was gained. Similar findings have been reported in the medical and nursing literature (Benner, 2001; Lamdin, 2006; Schmidt, Norman, & Boshuizen, 1990).

6.5.5 Third Manning and Encountering Cultural Stigmatisation Against University Students

After being assigned to an ambulance crew, the analysed findings suggest that, at times, many felt like an 'intruder', or that they were in the way as they formed the third person in the team. The realisation began to occur that a third crew person presented a challenge to the supervising paramedic crew. Paramedic crews often alternate the role of driving the ambulance and providing patient care. The treating paramedic becomes the primary care provider, while the other paramedic assumes a more supportive role, which includes recording vital signs, preparing medication and facilitating the patient's extrication from the scene. Additionally, paramedics begin to anticipate the decisions and workplace practices of their crewmate. The following university paramedic student, as the third crew person, felt they were interrupting their supervising paramedics' work routine:

> "I think what is difficult is when you are a third person ... it does seem to put the crew out a bit because ... someone either has to do nothing or it's just you get in each other's way. So that affected me a little bit." (X1P2F20A)

Other students also felt some tension or awkwardness in being the third crew person:

> "I encountered some staff who just didn't want a third person on their (ambulance) because it meant that they had to look after somebody else on their (ambulance) and it meant that they had to teach me and they were just not up for that ... all they wanted to do was their job and then go home." (X1P3F27B)

A trait of the ambulance culture that stigmatised university students was commonly encountered during clinical placements. Stigmatisation led some university paramedic students to feel somewhat like an intruder or marginalised. While not all reported encountering stigmatisation, those who did believed it may have arisen from paramedics who were trained under the in-house vocational training program feeling threatened by university educated paramedics. An opinion was frequently presented that previous university students may have not acted in a respectful manner while on clinical placements, giving the university pre-employment model a bad name. For example, the following student encountered clinical supervisors who were overt about their dislike of the university pre-employment model:

> "I had a crew that were trained under the old vocational program and they were very much of the mindset that (university students) are to be seen and not heard ... don't touch that, that's ours to, you know you don't touch (the stretcher), you don't touch this equipment, you don't talk to the patient, you sit and you observe what we do and you'll learn something from that ... I was told what the problems with university students were ..." (X1P1M1C)

Other examples of stigmatisation against university students involved name-calling with one university paramedic student receiving the nickname of 'HECS[1]-debt':

[1] The Higher Education Contribution Scheme (HECS) is an Australian Government initiative, established in 1989 whereby the government pays part of the students' tuition fees to the university. After graduating, and gaining employment the individual is required to repay the loan to the government in regular small instalments on a fortnightly basis (Birch & Miller, 2006).

> "On prac one (paramedic) called me HECS-debt the entire time ... (the paramedic) could not understand why I was going to university, didn't understand it at all ..." (X1P1F5A)

Of importance was that many paramedics did not understand the university system, a finding that has been confirmed in the literature (Waxman & Williams, 2006). Some paramedics possibly had higher clinical expectations of university students compared to in-house vocational trainee paramedics. For example:

> "I have come to the understanding that some paramedics have the idea that because we have been studying at university that we should be out there practising at a higher level than what we are at ... When really what we need is to have the on-road experience …" (X1P1F5A)

Even when stigmatisation was not directly encountered, there was a general awareness of nuances or tensions around the issue of university educated paramedics. For example, the following student did not experience stigmatisation. However, they were aware that many of their peers did:

> "I worked with a lot of paramedics who had just come out of university and they were fantastic ... and then you had the paramedics who were a bit older who understood that university was going to be the way of the future and it is going to be happening everywhere whether you like it or not ... and they were quite embracing of it ... then you had the older paramedics who had been in the job for (a while) who were not accepting of university students at all. My experiences were a lot better than other students, I was never told to sit in the back of the ambulance and not do anything ... most of the people that I spoke to were quite accepting of (university students) and happy for us to help. I personally did quite well in comparison to other people, but there was definitely a stigma and it was quite confronting for some." (X1P1M14C)

Discussion and Summary of Third Manning and the Stigmatisation of University Students on Clinical Placements

The results indicate the presence of tensions between some university students and their ambulance crew during clinical placements, with feelings of marginalisation due to a supernumerary status frequently reported. Many were afforded observer status only, and discouraged from talking to or treating patients, confirming the findings of several authors (Boyle et al., 2008; Lord et al., 2009; Wray & McCall, 2009). The confusion created by a misalignment between university programs, where particular paramedic skills are taught at different stages within the curriculum, may have further exacerbated tension between university students and on-road paramedic staff. Furthermore, an apparent lack of communication between and within some universities and ambulance services may have led to students arriving for clinical placement unexpected by the services, confirming similar findings in the paramedic literature (Lord et al., 2009). Special consideration may need to be given to how to effectively communicate information about the arrival of students in 24 hour a day, 7 day a week shift work environment.

The results highlight the presence of stigmatisation and that some paramedics had unrealistic expectations of university students on clinical placements, confirming the findings of several authors (Waxman & Williams, 2006; Williams, Brown, & Winship, 2012; Wray & McCall, 2009). Others reported that stigmatisation resulted from paramedics feeling threatened by university students. Similar findings have been reported in the paramedic literature (Boyle et al., 2008; Lazarsfeld-Jensen et al., 2011; Lord et al., 2009; Willis et al., 2009; Wray & McCall, 2009). Authors have reported that stigmatisation occurs to reinforce the chain of command in a paramilitary organisation (Lazarsfeld-Jensen et al., 2011). Research also suggests that stigmatisation and bullying of health care trainees such as nursing and medical students may arise from their lack of

power in the organisation and their young age (McCormack, Djurkovic, & Casimir, 2014).

It is important to note that not all university paramedic students in this study experienced stigmatisation, with very positive experiences being reported during clinical placements, confirming similar findings in the research (Boyle et al., 2008). It was common for university students who were working with university graduates to encounter lower levels of stigmatisation during their clinical placements. However, students who reported positive experiences were still aware of tensions that occurred between other university students and their supervising paramedics.

6.5.6 Introduction to Other Aspects of the Paramedic Culture

The university and ambulance cultures are contrasting cultures with different values, schedules, expectations and administrative structures. Students are required to intersect these two different cultures during clinical placements. For example, the ambulance culture, as discussed in Chapter 2, has been influenced by biblical values (Good Samaritan), military overtones (rank, command and control uniform) and medicine (evolving treatment approaches). Universities, on the other hand, are non-hierarchical, have equitable representation of males and females among students and staff, value intellectual and other freedoms, and allow for individuality and flexibility in terms of dress code, class attendance and learning modalities. For many students, clinical placements may be the first time that they experience shift work, wear a workplace uniform, encounter strong command and control and a potentially masculine or male-dominated environment. For example, the following participant was introduced to the ambulance paramilitary rank structure and workplace politics during their first clinical placement:

> "I didn't think much of the rank structure. It's all political ... I think the stations are generally very a close knit bunch because you're all working as a team and you have to basically get along ... Some of the bigger stations you do notice the cliquey groups. But, you

> know, whatever, my placement was just for (several) weeks ...” (X1P2F20A)

The existence of an underlying division between the on-road staff, management and communication or dispatch personnel was frequently reported:

> “It’s quite political out on road … I don’t really understand it. I tried not to get too involved ... because you talk to one paramedic and they slag someone else off. You talk to another and they do the same thing … I find there’s quite a bit of bitterness towards people in management ... the higher up the manager ... the more people hate them ... And there is a massive divide between (people in the dispatch centre) and the paramedics on the road ... Someone’s got to do the (dispatch and management) jobs ... I don’t really understand the culture … it just seems a bit political really.” (X2P1F11D)

Several references in the literature refer to ambulance services being a masculine orientated, if not dominated, profession (Boyle, 1997; New South Wales. Department of Premier and Cabinet, 2008; Reynolds, 2008, 2009). The following student began to discover the ‘boys club’ was still evident on some stations, and to some degree, they felt pressure to become more macho to fit in:

> “I don’t believe in becoming more macho to fit in. But I did see that element of the sort of boys club ... Not necessarily at the stations, but just at hospital when they all sort of chat and get together. I did definitely see elements of that. I tried to keep out of it.” (X1P2F20A)

Not all university paramedic students observed the ‘boys club’. However, the need to be subdued in order to fit in did emerge from the data. While on clinical placement, the perception was developed that cultural acceptance would only be achieved after graduation after being assigned a permanent ambulance station:

> "I don't believe I had to act in a certain way to fit in except for probably being a bit more subdued. Sort of be a bit under the radar as it were. And I think ... this is my perception anyhow ... that when I do end up graduating and have a station that I can call home, that's when I can sort of be a bit more myself. So that's a bit of a louder personality." (X1P1F20A)

Conversely, others perceived that they were accepted easily enough by the paramedics on station. However, a small number of these university paramedic students received an icy reception from the Officer in Charge of the station:

> "I was accepted by the crew, definitely ... But I was not accepted by the (Officer in Charge) at (the station) I went to ... definitely not accepted. However, the crew did warn me that (the Officer in Charge) wouldn't be very friendly ... (the Officer in Charge) definitely kept a close eye on me. But the crew I was with just said 'if you're a nice enough person, and you work hard and if you're seen to be studying most of the time when you're on station then (the Officer in Charge) will accept you and they'll respect you'." (X1P2M21E)

The following student, who initially had the perception that the crews on station were not very friendly, subsequently got to know the paramedics better over the next few weeks, and discovered the complete opposite:

> "On clinical placement I think you need to be polite, friendly and be able to get on with people. Don't be too mouthy, we were always told to kind of keep our heads down and I think that's what I did ... initially I didn't find it was a friendly station ... but I think you gradually ... get to know people you're working with ... and I found them to be okay." (X2P2F35D)

From the literature on socialisation, a mature person may choose different information seeking techniques, possibly being more overt than covert in their socialisation style (Morrison, 1995, 2002). The following mature-aged

student adopted an overt approach and dealt with the ambulance culture in a more assertive fashion:

> "I guess I am a fair bit older than a lot of the students and I have worked in a lot of different places ... If I encountered workplace conflict or a disagreement ... I think I dealt with it appropriately and without necessarily getting myself into trouble or pissing anyone off ... I think I have the sensitivity to treat other people with the appropriate respect even if I disagree with what they say and I also feel that I have the assertiveness that I can stand up for myself when necessary as well. I wasn't too concerned about that." (X1P1M16C)

However, one university paramedic student who was school leaver had a different experience, initially clashing with the ambulance culture:

> "The on-road paramedics were, at first, pretty difficult to get along with. On the first clinical placement I wasn't aware of all the buttons I could push to piss people off, and I inadvertently pushed every single one of them ... So I had a lot of trouble. I have subsequently learnt how to not push the buttons ..." (X1P1F12C)

Discussion and Summary of Encountering the Ambulance Culture on Clinical Placements

Several authors have discussed the ambulance culture in some detail (Boyle, 1997; Lazarsfeld-Jensen et al., 2011; NSW Department of Premier and Cabinet, 2008; Parker & General Purpose Standing Committee No. 2., 2008; Reynolds, 2008, 2009; Wray & McCall, 2009). With the exception of Lazarsfeld-Jensen, Bridges and Loftus (2011), authors focus on the interactions between university students and their clinical mentors. This study appears to be one of the few that addresses the intersection between the university and ambulance service cultures and applies the theory of marginalisation (Boychuk Duchscher & Cowin, 2004) to ambulance clinical placements.

The presence of a 'boys club' or the male dominance of the ambulance workplace was apparent in this study, confirming the findings in the paramedic research (Boyle et al., 2008; Reynolds, 2008). However, the experiences of some female students in this research study differ to findings in the literature surrounding the 'boys club'. For example, not all females encountered gender discrimination. It was reported that males were more affected by the 'boys club' as they had to conform to the masculine image portrayed by the culture to fit in. However, both male and female students indicated that they felt unaccepted by the ambulance culture irrespective of the 'boys club', which aligns with other paramedic research (Boyle et al., 2008; Lazarsfeld-Jensen et al., 2011). Several commented that they did not feel accepted, but at the same time felt the need to be subdued, to fit in and not get embroiled in station politics. It could be interpreted that university students who took part in this study expected a greater level of acceptance from their clinical mentors even though they were not employees. The role of a student on clinical placement is to observe how their knowledge, learned at university, is put into action within the on-road pre-hospital care environment and obtain a greater contextual understanding of the paramedic role and the workplace. However, it appears as though some university students expected to be afforded almost the same level of acceptance as full-time employees. The need for a joint ambulance and university clinical placement orientation program is further highlighted with the aim of providing students with a greater awareness of their role during their clinical placement.

Another unique aspect of this study relates to interactions between university students and station officers, and other higher levels of ambulance management. For example, findings indicate instances when students were versed on how to behave in front of ambulance managers who did not like the university pre-employment pathway. There was also an unawareness of the chain of command, with some students alienating themselves from other paramedics and management staff. The need to be

quiet, polite and submissive to avoid conflict and maximise their ability to fit in while on clinical placement was a common finding in this study. Similar findings relating to tensions between being assertive and submissive to fit into the workplace have been reported (Lazarsfeld-Jensen et al., 2011). However, these findings related to university graduates during their internship year and not university students on clinical placements.

6.5.7 Introduction to the Confronting Side of Paramedic Practice

In addition to encountering the ambulance culture, being introduced to the confronting side of paramedical work was commonly reported. The confronting side of paramedic practice was not necessarily limited to the emotions of encountering situations relating to trauma, death or dying (possibly for the first time). It also included observing how people live, sometimes in less than ideal circumstances. For example, this university paramedic student was shocked when observing how some people live:

> "I've had quite a (good) upbringing ... Both my parents are together and I was brought up in an average house in a nice suburb ... So I think it was a massive culture shock to go into (lower socio-economic areas) and see … a heroin addict, because you just don't normally see people in that state ... I genuinely just sometimes found myself just wanting to stare and take it all in ... Obviously the paramedics ... had seen it so many times before that it was like normal for them ... they didn't appear to even give it a second thought really ... The paramedics I was with could walk into a house full of excrement or whatever and it didn't seem to bother them at all. It really took quite some stamina for me to go in and talk to the patient." (X2P1F11D)

It was also observed that paramedics seemed to be able to suppress their emotions when encountering a traumatic circumstance through almost a detached concern for the patient:

> "I guess depersonalising the patient is inevitable I suppose. I hope that that doesn't happen with me but I think to some extent that it is inevitable." (X1P1M16C)

Another way in which the students were introduced to undesirable aspects of the job was through the stories they were told by the more experienced paramedics on station. Through the art of storytelling, university paramedic students could gain some understanding of the complexities of the 'big job', and how to manage the situation if they encountered a similar case:

> "I think the stories you get told by the old hands are really good actually. I do like working with people who have been in the job quite a while and they do have some quite humorous stories. But then some quite informative stories about the big jobs ... it does prepare you because it makes you think about what could happen, what you could do if you were in that situation." (X2P2M24D)

Storytelling was found useful to a point. However, stories did not fully prepare students for when they encountered the real event:

> "(The paramedics) would … tell us about trauma jobs ... like (mangled people) under trains and whatever ... but obviously you don't fully grasp it until you go out there and see it for yourself." (X2P3F32D)

Discussion and Summary of the Confronting Side of Paramedic Practice Encountered on Clinical Placements

The confronting side of paramedic practice is well-documented in the literature (Halpern, Maunder, Schwartz, & Gurevich, 2012; Mildenhall, 2012; Regehr, 2005; Regehr, Goldberg, & Hughes, 2002). Teaching resilience to paramedics and paramedic students has also been discussed (Gayton & Lovell, 2012; Porter & Johnson, 2008), as has assessing empathy levels among paramedics and paramedic students (Boyle et al., 2009; Grevin, 1996; Williams, Boyle, Brightwell, Devenish, Hartley, McCall, & Webb, 2012a; Williams, Boyle, Brightwell, Devenish, Hartley, M. McCall,

& Webb, 2012b). However, the literature is limited in relation to the experiences of paramedic undergraduate students facing confronting aspects of paramedic practice while on clinical placement. Being told stories by qualified paramedics about the confronting side of paramedic practice was frequently reported, which confirms the findings of several authors about storytelling and its role in preparing paramedics for confronting cases (Charman, 2013; Mildenhall, 2012; Tangherlini, 1998, 2000). However, the results indicate that few were prepared for the scope of what they were to encounter. The results also suggest that storytelling is an important coping strategy used by paramedics as it provides a mechanism for staff to debrief about confronting cases; consistent with what has been reported in the paramedic literature (Charman, 2013; Mildenhall, 2012; Tangherlini, 1998, 2000).

Of importance was the finding that treating patients in lower-socioeconomic areas was equally as confronting as attending cases involving trauma and death. Resilience skills were learned by observing the coping styles of clinical mentors. Coping mechanisms evident in the results, which are consistent with the literature, include suppressing one's emotions (Regehr et al., 2002), avoiding or escaping the issue by choosing not to dwell on it, and by storytelling (Porter & Johnson, 2008).

It could not be determined whether resilience or empathy training was undertaken prior to clinical placements. Although the topic of resilience amongst paramedics has been researched to some extent (Gayton & Lovell, 2012; Meadows, Shreffler, & Mullins-Sweatt, 2011; Scully, 2011; Shakespeare-Finch & Savill, 2013), the development of resilience amongst undergraduate paramedic students has not been broadly canvassed in the peer-reviewed literature. Resilience is reported to increase with experience, and has been linked with the general health and wellbeing of paramedics (Gayton & Lovell, 2012). Given many of the paramedic university students being school leavers, Gayton and Lovell (2012) suggest that further research is needed to explore resilience interventions

for paramedic undergraduate university to help them avoid post-traumatic stress disorder during their career (Streb, Häller, & Michael, 2013). Findings suggest that there appeared to be a lack of awareness relating to support services available to assist university students to cope with the confronting aspects of paramedic practice despite all universities offering free counselling services to university students through the university student guild. Additionally, ambulance services provide university students on clinical placements access to peer support counselling services[2].

6.5.8 Summary of Clinical Placements and their Role in the Formal Phase of Professional Socialisation

Experiences resulting from ambulance clinical placements were explored in Section 6.5. The feelings of under-preparedness at university prior to clinical placements, and then the transition to the on-road environment were investigated. The introduction to the reality of paramedic practice, the responsibility associated with being a paramedic, the ambulance culture and the confronting aspects of paramedic practice were also examined.

In the next section, experiences encountered when preparing for and gaining employment are identified. The extent to which university paramedic students feel prepared by university for employment with an ambulance service is explored. Additionally, the decision making processes associated with choosing an employer and the job application process are discussed.

6.6 Preparing for and Gaining Employment

The findings suggest that issues surrounding seeking employment became emphasised towards the end of the undergraduate paramedic degree. In this section, views relating to work preparedness are explored. These perspectives ranged from being totally unprepared, somewhat prepared,

[2] Peer support officers are paramedics who have undergone counselling training to assist colleagues to deal with traumatic and stressful workplace incidents (Ambulance Service of NSW, n.d.; Ambulance Victoria 2012b).

and well prepared to make the transition to a professional ambulance service. Section 6.6 then turns to investigate the decision process involved with choosing an employer.

The CAA suggests that universities should produce 'work ready' graduates (CAA, 2006). The CAA has since reviewed its stance on work readiness and now suggests that graduates require an internship period of up to 12 months before being able to practice autonomously (CAA, 2010b). Several authors question the work readiness capabilities of new graduate paramedics (Gibson & Brightwell, 2006; Lazarsfeld-Jensen, 2010; O'Brien et al., 2013; O'Donnell, 2006; Willis et al., 2009), with one study suggesting that work readiness is difficult to achieve within 12 months post university graduation (Dawson, 2008).

The findings indicate that university paramedic students, towards the end of their course of study, began to realise that they had an adequate amount of clinical knowledge as evidenced by their ability to answer most of the clinical questions asked of them by their clinical mentors. However, they felt unprepared for the day-to-day work procedures and practices not covered in the university program. For example:

> "Since returning to university after my last paramedic placement, I realise how unprepared I am ... I am worried about not knowing (the ambulance service's) rules, procedures and the like. The lecturers referred to the (protocols or clinical practice guidelines) ... but we didn't go into them in great detail ... yet we are now expected to know them inside out for next year. I have looked at (other ambulance services protocols or clinical practice guidelines) for a few assignments but have never sat down and learned them. If I apply to (other ambulance services) then knowing what to do in that service is a bit daunting." (X1P1F0A)

A discontinuity between the equipment provided at university and the equipment used by the ambulance service was also discovered:

> "I think in the practical classes (at university) were pretty good. But I noticed out on clinical placement, there was different equipment in the ambulances that (the university) didn't have. Also, on my placement everything was in packets ... and you are just not used to all that at university, where the equipment is reused multiple times for practice after it has been opened ... whereas on-road once the gear has been opened and used you chuck it out." (X1P1F5A)

Due to large numbers of paramedic students at some universities, disposable equipment such as cannula bungs, syringes, fluid-giving sets and laryngeal mask airways are often placed back into the kits and re-used as the cost of constantly restocking the kits with new equipment would be prohibitive. However, sharp instruments, such as cannulas, are always disposed of appropriately as per occupational health and safety guidelines. Universities may lag behind ambulance services in relation to the equipment students are trained to use, because ambulance services frequently review and upgrade to newer versions of defibrillators, intravenous cannulas and trauma dressings.

Another interesting observation was that university lecturers were not viewed as paramedics by undergraduate paramedic students. Uniformed seconded and sessional paramedic staff were afforded a greater extent of credibility compared to academic staff. For example:

> "I had a good connection with one of the paramedics that used to come and teach us at university. If (the paramedic) had told me something about what it was like on-road I would have believed them, because (they) were an on-road paramedic and saw what was happening in the ambulance service. So I would have believed them but probably not the lecturers." (X2P2F27C)

The above view that on-road staff had more credibility than academic staff was commonly reported, even though most paramedic academic staff have extensive experience in the field of paramedicine, and continue to work on a casual basis with ambulance services. A possible reason for

viewing the on-road staff with a greater degree of credibility than the academic staff may relate to the simulated cases and 'war stories' that they told, as these were seen to promote feelings of work readiness. However, on-road staff at times openly disagreed with the curriculum and the university's way of teaching paramedic skills. For example:

> "I think that it has been good in the way that university provides the learning opportunities, like the simulation that we do ... While they are not exact to real life, they are as close as what you could expect for as a student I guess, with in a simulated environment. They try and be as realistic as possible and by having on-road paramedics which come in and take our tutorials ... and give our lectures, we are able to get their first hand experiences, so they can relate a lot of war stories and ... give us an insight into what it is really like. Some of them say in our tutorials ... this is what we are teaching you but realistically this is not how you would do it on-road."(X1P1F15C)

Tensions between the university's culture and ambulance service's culture were also cited as a reason why many reported feeling unprepared for the transition to the workplace:

> "I don't think the culture at university prepares you for being on road at all ... The culture at university is very much … we're all at the same stage and we help each other that way. Whereas when you go out on road you sort of have to deal with it yourself ... I don't think the university really prepares you for the experience. I think the (clinical placements) are very important ... as they help you put it all into context." (X1P2F20A)

A noteworthy finding was that undergraduate paramedic students found the stories from newly graduated paramedics helped them prepare for employment:

> "Some of my mates graduated last year, and I am now in my last year of study. I have been getting feedback and stories and information ... My mates have pre-

> warned me about a lot of things ... like the problems they have encountered. I get the idea it is going to be quite tough." (X2P1M10D)

From the researcher's experience, recruitment presentations given by representatives from various ambulance services are commonly held in the final year of the university paramedic programs. The aim of these presentations was to attract university students to apply for work with a particular ambulance services. Applying for employment with an ambulances service is not necessarily a straightforward process, and application procedures differ between ambulance services. However, it is common for applicants to undergo occupational suitability testing as part of the selection process (ASNSW, n.d.; Ambulance Victoria, 2012a).

When deciding on an employer, it was frequently reported that students applied to multiple ambulance services for employment. For example, the following university paramedic student applied to four different ambulance services. However, the idea of relocating away from family and friends significantly impacted their decision making process:

> "I applied to four different ambulance services … with one particular service, I didn't pass the selection tests … I then had an interview with (another ambulance service) some distance away … It was too far away ... from my boyfriend and my friends and my family. I wasn't quite ready to be entirely on my own, starting a new job, in a new part of the country, so I had to say no to that job ... So then it was just the two other Services I applied for. I always had a preference in mind ... (this ambulance service) was always number one regardless of anything … I learnt a lot about applying for paramedic jobs, about where I should go and why I should go there through those experiences ... The process cost me a bit of money but it helped me make the right decision for me, for this part in my life." (X1P2F17C)

On passing the selection testing, applicants are required to pass an interview process to get a job. During the interview, the employer is likely

looking for a good fit between the organisation and the employee. Additionally, the employer is likely to be assessing the applicant's level of maturity and ability to make the transition from university student to on-road paramedic, where interpersonal and communication skills are important. The following student was surprised when confronted about the way they spoke during the interview by the panel members:

> "I thought my interview with (the ambulance service) was going spectacularly well ... when about half way through, (the paramedic) who was interviewing me said, you are obviously very intelligent so you are going to have trouble in (this ambulance service), because your obvious intelligence is going to piss people off, how are you going to deal with that? ... I was kind of struck for words ... I enjoy reading medical textbooks and journals ... and I don't feel I should be ashamed about that." (X1P1F12C)

There are several types of intelligence referred to in the broader literature. Cognitive intelligence, or IQ, is assessed through psychometric tests and reflects a person's academic ability (Brody, 2004). On the other hand, emotional intelligence (EQ) relates to the self-regulation of emotions, and the ability to interpret the emotions of others (Bastian, Burns, & Nettelbeck, 2005; Lopes et al., 2004; Mayer & Salovey, 1995; Mayer & Salovey, 1993; Salovey & Mayer, 1989). Social intelligence is thought to be linked to emotional intelligence, and relates to a person's ability to regulate and interpret behaviour in complex social groups (Baron-Cohen et al., 1999; Bass, 2002). It would appear from the experience outlined above, that while the university paramedic student may have possessed high levels of cognitive intelligence, their social and emotional intelligence were possibly underdeveloped. Additionally, the above student's experience was cited earlier in this thesis when they described how difficult their clinical placement was as a result of being unaware of the behaviours to be avoided, which could result in the estrangement of students by on-road paramedic staff. Interestingly,

research suggests that many school leavers who enter a paramedic university degree may have a deficit of interpersonal skills and lack relational skills, which may affect their employability (Lazarsfeld-Jensen, 2010).

Among those who applied to several ambulance services, some had multiple offers of employment to consider. The subsequent process of deciding which job offer to accept became quite difficult:

> "It was a good feeling to be offered a job, However, I ended up getting job offers from more than one ambulance service and I didn't know what I wanted to do. It took me a long time, like 2 or 3 months to really decide. I just accepted them all ... I then had a big decision to make; because on signing that little piece of paper, you might need to move away from friends and family ... But I made my choice in the end and I think it was the right decision for me." (X1P3F30A)

On successfully gaining employment with an ambulance service (subject to obtaining satisfactory university results in their final semester) a common reaction reported was excitement:

> "I wasn't terrified at all. I was very excited that I was soon going to have paid employment, because university was a bit of a struggle financially ... I guess I was also really looking forward to being on the internship year because you're not that third person anymore. You make up the crew and it's almost like you mean something now." (X1P2M21A)

Feelings of apprehensive about transitioning into an ambulance service were also common as students felt they had not attended enough serious cases while on clinical placement:

> I was very apprehensive ... I mean I regard myself as a reasonably confident person, but the thing that worried me the most was that I was very inexperienced. On my clinical placements … I hadn't experienced a great deal

> of serious jobs before I graduated. So I was very apprehensive." (X2P2M22D)

Discussion and Summary of Preparing for and Gaining Employment

The findings indicate that feelings of unpreparedness for the transition to the professional workplace were common. Similar findings are reported in the paramedic, medical, allied health and nursing literature (Adamson et al., 1996; Boychuk Duchscher, 2009; Cave, Woolf, Jones, & Dacre, 2009; Dawson, 2008; DiGiacomo & Adamson, 2001; Gray et al., 2012; Lazarsfeld-Jensen et al., 2011; O'Brien et al., 2013). The literature also suggests that few are prepared for the significant amount of stress that accompanies the transition to the workplace (Boychuk Duchscher, 2009, 2012; Kramer, 1974).

The existence of a theory-practice gap appears to be evident again towards the end of the paramedic degree when preparing for employment. As previously mentioned in this thesis, the theory-practice gap experienced by paramedic university students has been acknowledged by several authors (Michau et al., 2009; Ross, 2012; Sibson & Mursell, 2010b; Tanner et al., 2010; Willis et al., 2009). The theory-practice gap appears to be linked to reflections about experiences while on clinical placements after having returned to university. For example, differences in the equipment used at university compared to that recently purchased by ambulance services were reported. These results confirm the findings of several authors who suggest that communication between ambulance services and universities should be improved (Lord et al., 2009; Willis et al., 2009).

Another noteworthy finding relates to students' perceptions that the paramedic academics at university are not paramedics. Conversely, tutoring staff, who were on-road paramedics, were afforded more credibility, even though many of the paramedic academics had more years of on-road experience. The suggestion was made that tutoring staff

were more likely to emphasise the high acuity side of paramedic work through simulations and 'war stories' than the academic staff, and not necessarily portray the reality of practice.

Another finding relates to students' preparing for employment at university through stories told by recent graduates. The paramedic literature confirms the role of storytelling as it passes on organisational knowledge to new employees and provides inexperienced clinicians with advice about how to appropriately manage complex cases (Charman, 2013; Mildenhall, 2012; Tangherlini, 1998, 2000). The current study also found that new graduates undergoing their ambulance internship may relate stories about their experiences to students still studying at university. Through storytelling, paramedic interns may possibly think they are preparing university students for the transition to employment and the ambulance culture.

When actively applying for employment, the results indicate that many final year university paramedic students applied to several different ambulance services. The literature investigating the fluidity of movement of graduates to different ambulance services is minimal. One study focused on Monash University paramedic students and reported that 48% of university students would only apply to Ambulance Victoria in relation to their proposed career options (Waxman & Williams, 2006). The authors also maintain that 11% would apply to an interstate ambulance service if their application to Ambulance Victoria was unsuccessful (Waxman & Williams, 2006). Even though the results from this thesis indicate that some students applied to four different ambulance services, it appears as though they still had a preferred service in mind, which may not have been their local service. For example, the results indicate that some students would not apply to their local ambulance service because of adverse experiences during clinical placements. Among those who were planning to seek employment with an interstate or international ambulance service, many expressed concern in relation to the different

clinical practice guidelines and pharmacology protocols used by various ambulance services.

The results in this section suggest that decisions about applying for work with an ambulance service occurred towards the end of the formal phase of professional socialisation. Choosing a professional employer appears to be influenced by experiences during clinical placements, from presentations by ambulance service recruitment personnel and the location of informal support such as family and friends. However, the organisational socialisation literature maintains that decisions pertaining to one's employer occur in the anticipatory socialisation phase (Jablin, 2001; Kramer, 2010). Thus, the results in this study suggest a shift has occurred from applying to the local ambulance service for employment and training under the vocational model to a situation where university students are prepared to apply to local, interstate and international ambulance services. It is possible that the portability afforded by a university degree and exposure to international and national teaching and research staff may be providing university graduates greater employment options and a less parochial view compared to the previous vocational education and training model.

6.7 Conclusion

Chapter 6 presented the experiences encountered during the formal phase of professional socialisation (see Figure 6.2). In this phase of professional socialisation, perceptions about paramedic practice were challenged during orientation week. Settling into the university routine occurred as students tried to make sense of the curriculum and prepared for clinical placements. The chapter explored the experiences gained while on clinical placements. These experiences included encountering the station culture for the first time, discovering the reality of practice and building a picture of the paramedic culture. Trying to fit into the

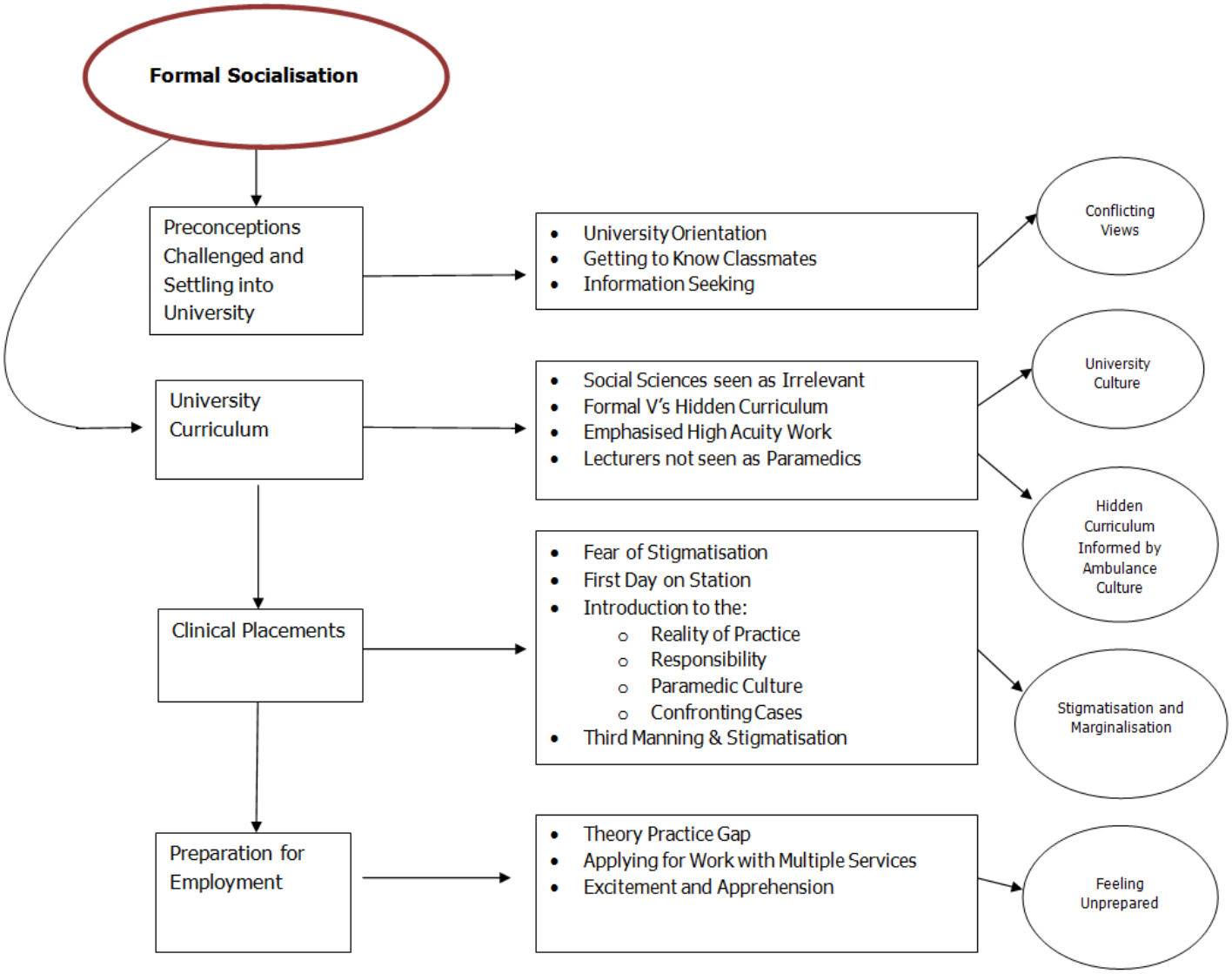


Figure 6.2. A Model of Paramedic Formal Professional Socialisation Summarising the Results from Chapter 6

ambulance culture as a university student was a challenging experience, and even required mastery of a 'new language'.

The chapter investigated experiences relating to the more confronting side of paramedic practice. It addressed the extent to which students felt prepared for employment, and explored experiences encountered while choosing an employing ambulance service. Following this, the process of applying for employment, the recruitment selection process, the process involved in deciding which job offer to accept, and the subsequent

feelings of excitement and apprehension were examined after students successfully gained an offer of employment with an ambulance service.

Chapter 6 confirmed the applicability of a formal socialisation phase in the professional socialisation of university educated paramedics. The presence of a formal and informal curriculum outlined in the professional socialisation literature (Cant & Higgs, 1999; Hafferty, 1998; Lamdin, 2010) were confirmed to be present in this study, and conflicting messages were encountered resulting from the formal and hidden curriculum. The existence of an informal socialisation process, identified in the literature (Lamdin, 2006; Thornton & Nardi, 1975), was also identified, such as students being educated by more senior students about university processes.

What appeared to be unique about the formal professional socialisation of paramedics was the presence of a senior industry representative during the orientation program. The presence of a uniformed officer exposed students to the paramilitary command and control culture of ambulance services from week one. The presence of an industry representative also indicates collaborative links between the university paramedic programs and ambulance services.

While on clinical placements, stigmatisation and marginalisation were experienced. The stigmatisation of paramedic university students has been well reported in the literature. However, this study appears to be the first to apply the theory of marginalisation (Boychuk Duchscher & Cowin, 2004; Enoch, 1989) to the paramedic context. The study highlighted the need for an integrated orientation program for university students prior to commencing clinical placements with an ambulance service. Such a program could provide the student with an orientation to the station. Furthermore, an orientation program may provide an avenue for students to be introduced to their clinical mentors and the officer in charge of the station.

This chapter explored experiences encountered when deciding which ambulance service to apply to for employment. Findings from this study differ to some extent from previous research (O'Meara et al., 2012; Waxman & Williams, 2006), which found paramedic students are more likely to apply to only one ambulance service. The current study indicates that students applied for work with multiple ambulance services. However, this study confirmed the findings of O'Meara et al. (2012), who suggest that the location of family and friends has a strong impact on the career intentions of some participants. The location of support groups, experiences from clinical placements and presentations by ambulance staff had an influence of the employment decision process during the formal professional socialisation phase of university educated paramedics.

Having discussed the formal professional socialisation process, the next chapter, Chapter 7, explores the post-formal socialisation phase of paramedic professional socialisation.

Chapter 7 Post-Formal Socialisation

> "I think the first couple of months was difficult and a big transition. You've got to get up at 5 o'clock in the morning and get to work and people expect you to be there on time and happy and all the rest of it and at (university) if you didn't turn up nobody really seemed to care."

7.1 Introduction

In this chapter, the post-formal stage of the professional socialisation of paramedics is explored (see Figure 7.1). Although there are a number of three stage theories of professional socialisation, most of the existing literature concentrates on the anticipatory and formal stages (Cant & Higgs, 1999; Lamdin, 2006; Shuval & Adler, 1977), and largely neglects the third, post-formal, stage. Alternatively, they focus solely on the final phase, the post-formal phase (Boychuk Duchscher, 2008, 2009, 2012).

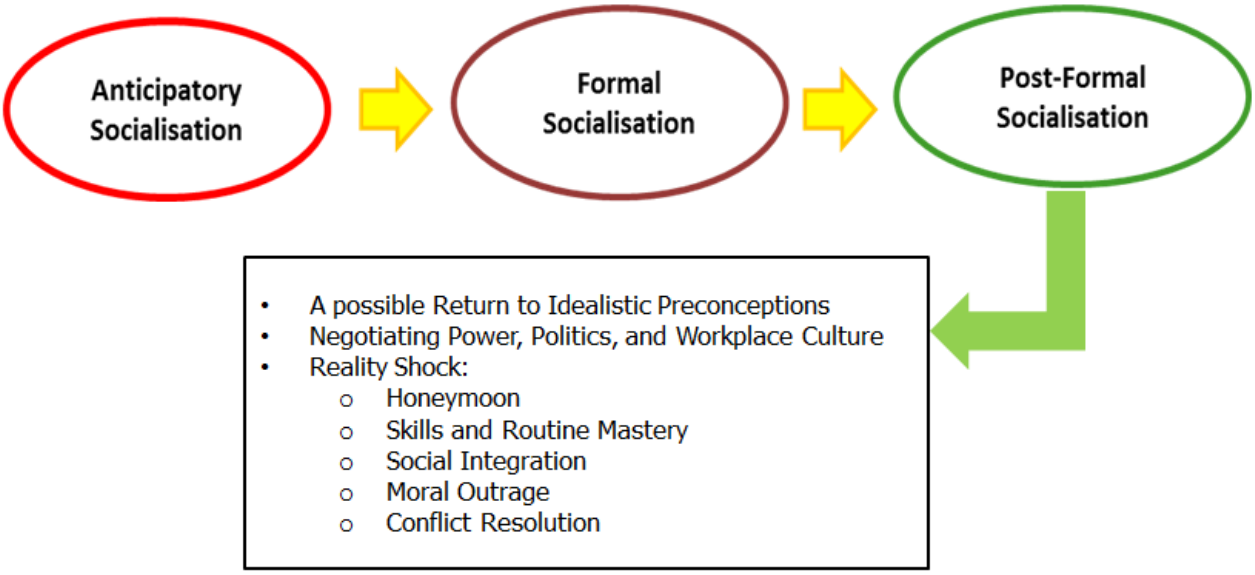


Figure 7.1. The Post-Formal Phase of Professional Socialisation

It is noted that the literature review found no published research examining the experiences of university educated paramedics after commencing employment with an ambulance service. Only one non-peer reviewed report was found (Lazarsfeld-Jensen et al., 2011), as well as an opinion piece (Gregory, 2013).

Chapter 7 focuses on the introductory graduate orientation program and the subsequent transition to an ambulance station. The chapter explores how the paramedic interns learn to cope with full-time employment, and examines how their confidence levels increased towards the end of the internship or professional year of employment.

7.2 Orientation to the Ambulance Service

The findings indicate that after successfully obtaining employment, graduate paramedics were required to attend a formal orientation program where they were welcomed to the ambulance service, and provided with an overview of policies and procedures. An organisational chart outlining the chain of command of the service was provided, and an introduction to the clinical practice guidelines or protocols authorised by the service occurred. Generally, the orientation programs covered topics such as occupational health and safety policies, timesheet procedures, patient health care records, the local area including hospital locations, radio procedures and station locations. Many orientation programs put new recruits though simulated case scenarios and assessments, which the recruits were required to pass before transitioning to the on-road environment.

On the first day of the orientation program, an initial culture shock was experienced after encountering the paramilitary nature of the ambulance culture. Many began to realise for the first time that they were no longer a university student after a paramedic supervisor made it clear to the class what the expectations of new employees were. However, one

paramedic intern acknowledges that the initial culture shock dissipated once the course got underway:

> "We got a bit of a bollocking (sic) to begin with, in hindsight I can sort of understand why. They came in and lay down the law to us about behaviour ... professionalism and sort of shock tactics to sort of make you toe the line from the beginning ... you know, punctuality and that sort of thing. I came out of the lecture thinking ... oh God! What have I got myself into? That soon dissipated as you got to know people and you got to know the educators slightly better." (X2P1M10D)

Others recalled being quite intimidated by their training officers and supervisors who arrived wearing their paramedic uniforms, which showed their senior rank on their epaulets, reflecting the command and control culture of paramedicine (Lazarsfeld-Jensen et al., 2011). Additionally, the supervisors were observed to be well-presented and appeared professional. The following paramedic intern developed the view that the education unit was well organised:

> "To be honest, when the training officers came in wearing their full uniform I thought oh ... this looks quite professional, we all sort of shied away a little bit when they first came in. They seemed well mannered and professional and organised, I got quite a good impression first of all of the ambulance service in general really." (X2P1M9D)

Of importance is that prior to the introductory orientation course, most university students had been exposed to on-road paramedic staff during clinical placement, and not paramedic managers or educators.

The paramilitary nature of ambulance services was also evident in the findings. Although initially terrified, paramedic interns began to recognise that not every ranked officer in the ambulance service was someone to be feared, and some educators made them feel comfortable and at ease very quickly:

> "It was really scary ... I think all of our hearts were pounding. What have we gotten ourselves into and what are we supposed to expect? But we were really lucky. One of our educators … had us in stitches by the first 20 minutes so it put us all at rest a lot ... but these were our tasks for the week. We had the (National and ambulance service's) flags and we were told that we were responsible for raising and lowering the flags each day. We accidently dropped one on the ground just as one of the big wigs walked past ... who knew that they weren't allowed to touch the ground ... It was all a big culture shock ... but because we knew everybody in the class, you would look around and every single person was in the same boat … it was great to be able to just turn to the person next to you and you know them well enough to … make silly comments to break the tension." (X1P3F30A)

Many felt relieved they had learned the appropriate skills and procedures at university, as the ambulance education staff hastily demonstrated the skills and procedures and then moved on to assessments.

> "I was just so happy that we got taught everything at uni because in the orientation course, nothing new clinically was really taught to us. It was just brushed through and we were quickly assessed on it … if we had just been shown the skills by the ambulance service, it probably wouldn't have been taken in so well." (X1P2F18A)

However, not all paramedic interns were fully prepared for the *modus operandi* based practice that the ambulance service enforced in relation to clinical guidelines or protocols. Additionally, the use of high fidelity simulation came as a surprise, as interns had not encountered simulation to this extent while at university:

> "They did teach us about their guidelines and drugs … this is the way we do it ... and we run by strict guidelines … We also did a lot on simulation. It was really good, (the simulation) was in a different room and there were cameras so the rest of the class could watch on the screen. The mannequin talked … they would wet

> it to simulate sweat … or they would use powder on (the mannequin) to make it look pale … it breathed and had a pulse … the mannequins probably could have done that at university but it wasn't utilised." (X1P3F30A)

The assessments, which formed part of the orientation program, were accompanied with a new degree of pressure. While at university, students are generally required to obtain an overall mark of 50% to pass a subject. Each subject can include three to four assessment items. In some circumstances, a student may perform well in two assessments, fail the third and still pass the subject. After failing a subject a student may be offered a supplementary assessment, or they may be required to repeat the subject. However, as employees of an ambulance service, the pressure to pass all assessment items was enormous, as the results could impact a paramedic intern's ongoing employment. Moreover, the pass mark for an industry-run assessment can be as high as 75% to 85%. A change in mindset away from achieving passing grades was necessary and an emphasis was placed on meeting the demanding performance expectations set out by their supervising paramedic educators:

> "Well they let us know in no uncertain terms that if we didn't pass our assessments they wouldn't let us go out on-road ... and your employment could be terminated. So I guess I felt a lot more pressure because of that." (X1P2F18A)

On the other hand, the orientation program was reported to be very supportive, and almost a continuation of the university experience. For example, on the first day of their orientation program the following paramedic intern was comforted by being surrounded by their university classmates who had also been recruited to the same ambulance service:

> "I think we were quite lucky … I was with a group of my friends. So it felt quite good … It was like an induction day. So plenty of talking about this and that (and) showing us about. Trying to tell us how things are done, which went quite well." (X2P2M22D)

Discussion and Summary of Ambulance Service Orientation Programs and their Role in the Post-Formal Professional Socialisation Process

The results indicate an initial culture shock was experienced when encountering the service's orientation program, despite having experienced aspects of the culture during university clinical placements. University paramedic students were likely buffered from parts of the ambulance culture due to the short duration of clinical placements. Others concentrated on skills development and deliberately tried to stay out of workplace politics. Similar viewpoints are confirmed in the professional socialisation literature (Cant & Higgs, 1999). Kramer (1974) defines culture shock as "a state of anxiety precipitated by loss of familiar signs, symbols and social interaction when suddenly immersed into an unfamiliar culture" (p. 4). From the experiences explored in this section, paramedic interns were introduced to paramilitary aspects of the culture outlined by Reynolds (2009), including raising and lowering flags, and respecting officers with senior rank. According to Kramer (1974), bureaucratic organisations orientate new staff specifically in relation to roles and tasks within a hierarchical authoritative structure. Conversely, professions focus on an intellectual component behind specialised competencies, and advocate the autonomous practise of these competencies (Kramer, 1974; Trede, 2009). Therefore, it appears that a bureaucratic organisational socialisation process was encountered during the orientation program, rather than a professional socialisation process.

The results indicate that organisational socialisation tactics (Ashforth et al., 1998; Jones, 1986; Van Maanen & Schein, 1979) were encountered that are designed to enculturate new employees and orientate them to acceptable workplace practices and mores. For example, paramedic interns encountered a formal and collective socialisation process, which was sequential, fixed and serial in nature, as discussed in Chapter 2 (Jones, 1986; Van Maanen & Schein, 1979). Furthermore, both investiture and divestiture socialisation processes were apparent (Jones, 1986; Van

Maanen & Schein, 1979). An investiture process occurs when people are employed for their previous knowledge and skills (Van Maanen & Schein, 1979). In this circumstance, paramedic interns are employed because they have achieved the background knowledge necessary to perform the role of a paramedic by obtaining a degree in paramedic science. Conversely, a divestiture socialisation process encourages uniformity and not individuality, moulding new employees to fit into a certain workplace identity (Van Maanen & Schein, 1979). A divestiture socialisation process can be seen when newcomers to the paramedic discipline are enculturated into a paramilitary hierarchical organisational structure and a protocol-based *modus operandi* is emphasised.

In addition to the paradox between investiture and divestiture socialisation tactics, other paradoxes also became evident from the data relating to the ambulance service orientation program. The results indicate that it is common for paramedic interns to feel intimidated when encountering the paramilitary organisational structure, where paramedics in the higher echelons of the organisation, such as educators and managers, are immaculately presented and display rank on their epaulets. However, the findings also indicate that paramedic interns felt welcomed and were put at ease by educators early in the orientation program. Despite the portrayal of a command and control paramilitary façade, a non-threatening environment was encountered by some after initially experiencing discomfort. Another paradox observed related to a fear of failing assessments resulting in the potential termination of employment. However, paramedic interns appeared to be comforted by the presence of their peers who were friends and classmates from university. Additionally, observing friends who had graduated in previous years from the same university and were now working as paramedics, was encouraging as it indicated that completing the induction process was achievable. Support networks were soon developed that assisted paramedic interns to cope with the culture shock and bureaucracy encountered during the

orientation program.

Having examined the experiences encountered during the graduate orientation program, the next section examines the transition from the education unit to an ambulance station. Furthermore, the diverse nature of ambulance work is examined, such as attending emergency cases and learning the routines associated with working for an ambulance service.

7.3 Life on an Ambulance Station: A micro culture

After completing their ambulance orientation program, paramedic interns were allocated to a station or a group of stations, where they completed their internship year. Findings suggest that there was inconsistency between ambulance services in relation to the structure of the internship year. Three ambulance services had what could be described as a structured internship program, where new graduates worked with designated clinical instructors. One of these required new graduates to work as patient transport officers[1] for several months in an attempt to orientate them to the hospitals, radio procedures and communicating with patients. A further two ambulance services offered internship programs with less structure, where graduates worked with qualified paramedics who were not designated clinical instructors. It appears as though there is little consistency amongst internship programs, although all ambulance services seemed to possess a performance review process where clinical instructors or mentors completed reports on a monthly or bimonthly basis.

Initial Encounter

The initial encounter with the crew and the ambulance station varied widely from people feeling anxious and daunted, to feeling welcomed. For example, the following paramedic intern found the whole experience 'horrible', likening it to the first day at school where everything is new and unknown:

[1] Patient transport officers do not attend emergency cases, and transport stable patients to and from medical appointments.

> "Oh the first day on station was horrible ... it was not a nice feeling. I think it's like the same as your first day of school ... It was just daunting because they're all a lot older … and they've all been there for years and years … and you're … an outsider." (X2P2M25D)

Unlike the example above, others had better experiences. For example, the following paramedic intern was rostered to work with a friend who had graduated from the same university a year prior:

> "On my first shift, I was lucky to be working with a friend of mine who graduated a year before I did. So that was quite a nice sort of integration … and I wasn't too worried." (X2P2M22D)

Unlike the results in Chapter 6, which indicated that university students did not always locate their station prior to commencing their clinical placements, as employees, they took the initiative and organised a tour of the station and 'meet and greet' session with staff the day prior to commencing work. The meet and greet session often included a briefing on what to expect from their training officers and the process to follow when restocking kits. When starting the following day, many were also introduced to the responsibility of performing a car check. For example:

> "I was shown around the station I was posted to … the day before I started so I knew how to get in. And I got told that my training officer would turn up at 6.30 on the dot the next morning to show me through the ropes ... He was lovely and he showed me where everything was … he said every day I am going to say to you where is the maternity kit, where's this and where's that and you are going to have to know exactly where it is ... because you are going to be the one checking the car everyday he said, I am not doing it, and I get that you might think that that is me not helping you out ... but it is really me helping you because you are going to know where everything is in the car, every day. So that was good too, to know where stuff is ... to be made to do that from day one." (X1P3F30A)

The findings indicate that many paramedic interns were excited to be commencing work at an ambulance station. After arriving at the station, they were introduced to the cultural expectations and norms that related to 'knowing their place' in the chain of command, including that paramedic interns are to provide patient care, and not drive the ambulance:

> "I was proud … that I'd got that far and my foot was sort of in the door ... I went down to (the station) and I found the person I was working with ... I learned that if you're new … at the station you attend and the (experienced paramedics) tend to drive … that's the culture, how it tends to be … so I attended … I was aware I was on my own, but I was also aware that I wasn't the first person to have been in this position and if anything went that wrong I'm sure the person I was working with would step in and help me. So it was quite exciting … especially because I was only nineteen." (X2P3M35D)

It was common for paramedic interns to arrive early for their first shift, and this provided an opportunity to talk to their training officer over a cup of coffee. During this informal meeting, basic rules were specified in relation to providing patient care, which once again reinforced the novice role of interns in the chain of command. Interns also felt fortunate to be eased into their first day after they became aware that other new graduates had to perform immediately on arrival at the station:

> "On my first day, luckily I had been on station for a good half an hour before we received the job (case). In that time my crewmate and I had gone and got coffee, and we had sat down and discussed things … he said … if I tell you to do something just do it and then after the job we will have a chat about it and we'll talk about what's going on. So that was really good to have that little bit of time. Whereas I've got mates that … rocked up on station twenty minutes (before the morning shift), the night crew weren't back … and dispatch asked the day

> crew to take the job (case). So they didn't even have a chance to think about what was going on." (X1P3F30A)

First Code One: A rite of passage

The first emergency case appears to be of importance. The first code one lights and sirens case was often both exciting and fear-inducing. The excitement arose from the realisation that they were a paramedic interns sitting in the front seat on their way to a case, and not sitting in the back of the ambulance as students do on clinical placement. However, the thought of having to drive an ambulance under lights and sirens during peak hour traffic was anxiety provoking:

> "I could not stop smiling. It's funny, I was sitting there going, oh my goodness, I am going to have to drive like this shortly and I don't know if I can ... My crewmate was weaving in and out of traffic because it was peak hour ... It was … the first time I have ever sat up the front when the lights and sirens are going and it's all real now." (X1P3F30A)

A paramedic intern described a code one case they attended, where a patient was complaining of back pain. The intern states that they were excited to administer analgesia for the first time. However, when prompted to take a patient history by their clinical instructor, the intern experienced a mental block which led to them feel superfluous during the remainder of the case:

> "My first job was a back pain case. We responded with lights and sirens. It was good in a way that the patient didn't have anything acutely bad with them, it was not like something had to be done right then and there. The patient had just kind of put their back out and couldn't move. They were in a lot of pain and we had to carry them out ... I was able to administer morphine for the first time. My training officer put in the cannula and I drew up the morphine ... But overall I just felt useless! My crewmate said 'you can start asking the patient questions and we will see where you're at' ... and I couldn't, and I think I said, 'how are you?' That's about

> as far as my questions went ... because my mind went totally blank." (X1P3F30A)

Interestingly, the patient's condition was viewed as not being 'acutely bad', even though the patient was complaining of severe back pain, requiring analgesia, which prevented them from walking to the ambulance.

Challenging circumstances were commonly experienced while attending an emergency case for the first time. For example, the following case involved a communication barrier where the patient did not speak English. Having to speak to the patient through a third person on the telephone was something the paramedic intern could not have foreseen while at university:

> "My first job I remember vividly. It was a (per vagina) bleed and the person didn't speak English ... So I had to ring up her sister who was (overseas) who spoke both English (and the patient's native language) ... I had to ask her sister questions on the phone and then give the phone to the patient ... I was like ... this is crazy ..." (X2P1M9D)

The findings suggest that paramedic interns can experience significant amounts of stress during their first code one lights and sirens case. For example, having the responsibility of treating a really sick patient was, for many, initially a terrifying experience. However, on reflection, the following paramedic intern found that their confidence was boosted by the case, even though at the time it was a stressful situation:

> "On my first lights and sirens job, I felt very stressed. My mentor … throwing me in the deep end, made me deal with the patient and made me send the (situation report to dispatch) on the radio. Although he was kind of speaking me through it, it was still pretty stressful because the patient was there in front of me ... apparently not very well … and my crewmate was making me do everything ... It was pretty stressful but I think it is the best way to learn how to adapt to that sort

> of situation, to be thrown in the deep end sort of thing … But at the time I was like Oh My God! What am I doing here?" (X2P1M9D)

Anticipatory stress was frequently reported in the findings while paramedic interns sat at the station awaiting their next call out. For example, paramedic interns were worried about what they would encounter on their next code one case, and had a fear of the unknown:

> "I remember sitting there on station waiting for the (phone to ring or pager to go off) … wondering what I was going to be called to ... and being scared by the fact that I had not attended many jobs (cases) before. I always wanted my partner to do the patient care, so that I could see how they did it and then adapt myself." (X1P2F19A)

Discussion and Summary of Initial Encounters on Station and to Code One Cases

The results highlight the presence of micro-cultures at station level. Various accounts of the first encounter, as employees, with paramedics on station were given. These experiences were described as being 'horrible', while a small number reported more positive experiences. Graduates were expected to step-up and be work ready from day one, which many claimed was stressful. Covert cultural norms relating to paramedic interns were evident, with the interns being informed very early about their role in the hierarchical chain of command, and about what they could and could not do in relation to patient treatment, history taking and driving the ambulance vehicle.

It was common for paramedic interns to experience pride about being a paramedic intern along with the general feeling that they had successfully made the transition from university student to the ambulance service. The professional socialisation literature refers to this stage as the honeymoon period (Boychuk Duchscher, 2009; Kramer, 1974).

As paramedic interns began to experience clinical cases, the discrepancies between university and the reality of being a paramedic intern became apparent. For example, one intern experienced a mental block when attempting to take a patient history, while another had the challenge of treating a patient who could not speak English. Taking an active involvement in the provision of patient care was encouraged and some found the experience significantly challenging. These results confirm Kramer's (1974) assertion that the honeymoon period is soon replaced by a skills and routine mastery phase, where new graduates attempt to overcome perceived discrepancy between university and on-road environments by concentrating on mastering routines such as pre-shift equipment checks, and skills such as taking a patient history, or administrating analgesia.

During the initial stages of the internship, it appears as though paramedic interns were still adjusting to the reality of paramedic practice, as their interpretation of an acute injury appears to reflect the cultural emphasis on using advanced skills during high acuity cases (Reynolds, 2008; Williams et al., 2012). For example, after attending a patient with severe back pain, the view was expressed that the patient's condition was not serious despite the patient requiring narcotic analgesia.

High levels of anxiety were described as paramedic interns sat on station expecting to be dispatched on a high acuity case, even though the reality of paramedic practice would indicate a greater chance of receiving a low acuity case or an interfaculty transfer. The emphasis placed on performing well at high acuity cases by the university hidden curriculum and ambulance culture possibly led to interns experiencing a fear of being judged on their workplace performance (M. Kramer, 1974), and may have exacerbated feelings of anxiety.

Having explored the transition from the education centre to an ambulance station, the next section examines the experiences encountered when

completing the remainder of the internship year. It was during this period of time that interns learned to normalise working full-time for an emergency service.

7.4 Settling into the Internship Year

As the internship program progressed paramedic interns became more experienced in relation to working shifts and with the policies and procedures of the workplace. For example, many interns began to recognise the diversity of work that can be encountered by paramedics, where some shifts are extremely busy, while others are very quiet:

> "How would I describe what it is like? It's forever changing; no day's the same, going from having really busy days to having very boring days ... where we don't even get one job for the entire shift ... trying to occupy yourself on station by learning your (protocols/clinical practice guidelines) or trying to find time to learn when it is really busy is always a challenge as well." (X1P2F17C)

Initially, it took time to adjust to the demanding nature of paramedic work. For instance, staff may not finish their shift on time, or have their meal during the designated meal breaks due to being dispatched to another case. However, regardless of the demands of the job, they began to realise that paramedics still somehow found time to look after their personal needs such as eating and toileting:

> "I suppose when I very first started I was very much ... oh my God, this is an emergency service, what do we do if we need to go the toilet? ... The other paramedics were like ... just go ... I suppose gradually I realised, and it surprised me, how laid back it was … (but) you don't always finish on time, or have your meal break at the same time every shift and everything else. But you're still a human being … you still need to eat. You still need to go to the toilet. You still need to drink … you need to live a normal life at the end of the day." (X2P3F32D)

Others found the transition from university student to practising paramedic intern difficult. Many had to 'step-up' and accept the responsibility of full-time work. For example, the need to arrive at work appearing happy and professional and ready for the day was recognised, despite having to wake up at five o'clock in the morning:

> "I think the first couple of months was difficult and a big transition. You've got to get up at five o'clock in the morning and get to work and people expect you to be there on time and happy and all the rest of it and at uni if you didn't turn up no one really seemed to care." (X1P3F30A)

The difference between being a university student and an employee became evident. As a university student in a large cohort, not attending lectures and tutorials may go unnoticed. However, failing to show up for work with an emergency service provider is not only inconvenient, it could also have serious consequences such as an official caution and reprimand, and most certainly cause reputational damage.

Despite struggling to get up early in the morning, once at work the analysed findings indicate that many enjoyed their paramedic intern role. However, others were introduced a busy paramedic caseload, where paramedic interns would immediately attend a case after commencing their shift and very rarely return to the ambulance station until after the shift had concluded:

> "I don't mind once I get to work but it is just the getting up early, that is something I might have to take a while coping with. Once I get to work I love it ... However, we never get back to the station." (X2P1M9D)

The increased level of responsibility also became as the internship program progressed. For example, paramedic interns experienced an added responsibility associated with making clinical decisions independently, as their training officer was driving the ambulance:

> "Well I think you have a lot more responsibility and a lot more initiative to do things because you are not the third person anymore. So you take on more responsibility and make clinical decisions. I think that's the focus on the internship year because you're in the back by yourself you can't ask your qualified paramedic to jump in because they are driving. You're basically it." (X1P2M21A)

Others experienced tension between the level of responsibility associated with being a paramedic intern while on duty, and being treated like a teenager by family and friends when off duty. The analysed findings suggest that paramedic interns greatly appreciated the level of respect afforded to them while on duty by patients who were often more than twice the interns' age:

> "It was a lot different for me being twenty-one, because, my parents and friends still treat me like a kid because I am still young. However, when I'm in uniform and you go to a forty or fifty year old man who is hurt ... he doesn't look at me as … a kid. He treats me with complete respect … (Patients) don't care that I'm a graduate entry paramedic of six months, although I'm sure some of them could tell I was reasonably new. So that respect was awesome. You just immediately get this respect and I appreciate that a lot." (X1P2M21A)

Of importance was the awareness of the paramedic interns in relation to the level of respect afforded to the ambulance service by the community. The need to be professional even when off duty became apparent, because in small communities opinions about the ambulance service may be influenced by the actions of a single paramedic. Furthermore, in the UK, registered paramedics can be deregistered if they bring the paramedic profession into disrepute:

> "How would I describe it? Well you are certainly well known through the community and people definitely remember you more than you remember them. I have

> been caught in a few situations where people randomly come up to you and thank you for what you have done and you have no clue who they are or what you helped them with. You are definitely an icon of the community, particularly being in a rural setting where it's not like being in a large city where you will probably never see that person again. The ambulance service is very well respected." (X1P2F17C)

Discussion and Summary of Adjusting to the Internship Year

Adjusting to shift work in an emergency organisation was a significant finding in this section. The unpredictable nature of emergency work needed to be normalised, where meal times and finishing times changed with the caseload. Thus mastering workplace routines within a 24 hour, 7 day a week emergency service was required. Additionally, the results indicated that interns needed to master skills such as emergency driving and providing patient interventions as the patient care paramedic. The results from this section confirm the presence of a skills and mastery phase (Kramer, 1974) and a doing phase (Boychuk Duchscher, 2008, 2012) in the post-formal professional socialisation stage.

The results in this section confirmed Kramer's (1974) findings that graduates often feel overwhelmed by the responsibility of their new roles as they realise the amount of information pertaining to the work environment that needs to be assimilated, leading to feelings of inadequacy.

A protracted honeymoon phase also appears to be evident in the results (Boychuk Duchscher, 2009, 2012; Kramer, 1974) even though interns had moved on to the skills and mastery phase. For example, the results indicate how interns continued to enjoy the admiration of the general public, which the paramedic identity appeared to attract. The protracted honeymoon phase confirms the findings of many authors who suggest that the socialisation process is not linear, and people may experience certain phases associated with the socialisation process at different rates compared to others (Ajjawi & Higgs, 2008; Cant & Higgs, 1999; Kramer,

2010; Van Maanen, 1976). However, the responsibility associated with being a paramedic in a rural location was acknowledged, where paramedics represent the ambulance service both on and off duty, and need to remain professional at all times.

Having explored the routine mastery phase of the post-formal professional socialisation stage, the next section examines how paramedic interns learn to adjust to the ambulance culture. The challenges associated with trying to fit into the culture are also discussed.

7.5 Adjusting to the Paramedic Culture

The findings suggest interns were shocked by the command and control paramilitary culture despite having experienced clinical placements. It is possible that university paramedic students may have been protected from many aspects on the workplace culture during placement, consistent with findings by researchers in other disciplines (Adamson et al., 1996; Cant & Higgs, 1999). However, after obtaining employment, new staff encountered a cultural adjustment process, which for many involved trying to gain workplace acceptance.

7.5.1 An Increase in Acceptance

The analysed data indicated various experiences were encountered when adjusting to the ambulance culture. Stigmatisation was commonly encountered while on university clinical placements. However, as employees, interns reported that their experiences were quite different:

> "Since graduating I have found it's now on a whole new level really. I feel a lot more accepted into the workplace … on my first day everyone was really accepting and showing me around a lot more, and showed more interest in myself and they are all really nice people. Everyone at the station wants to share their experiences with me a lot more compared to when I was just a student." (X1P2F18A)

Conversely others discovered that they were accepted by some paramedics on station, but not by others. For example, several paramedics still recognised the following intern as a new graduate and did not appear to be quite as welcoming:

> "For the majority of people, I don't think finishing the internship will change anything. I already feel a part of the culture as it were and accepted by a lot of them. With most of my crewmates, I can make decisions and they will kind of listen to me or want my opinion. There are a couple of people that … when I am wearing qualified epaulettes … I think it might help. Might actually show, like oh ... ok now I have to listen to you, you're not just a (paramedic intern)." (X1P2F19B)

Of importance was that paramedic interns copied both positive and negative behaviours of more experienced paramedics to gain acceptance. Experienced staff, in many ways, are role models or socialisation agents in the formal phase of professional socialisation. Interestingly, many paramedics were observed to be pessimistic about their job. Furthermore, they were pessimistic towards management and dispatch. The following paramedic intern felt the need to emulate this behaviour. They learned when to use pessimistic speech to exert maximum effect, despite being opposed to this behaviour:

> "I think to fit in … you've got to be pessimistic. You've got to find a level of pessimism that you're are comfortable with … and find … opportunities to say things that people expect you to say … Take the opportunity to criticise management, criticise (the dispatch centre), criticise getting a late job ... It is just what you need to do to fit in." (X2P3M35D)

The analysed data showed that other interns also felt pressure in relation to emulating the behaviour of other paramedics on station. For example, the following intern describes their internal conflict when deciding how much of the 'paramedic mould' they were going to fit into without compromising their prior values and beliefs:

> "Rather than just going, this is how they cope with this and that … it's learning how much of the paramedic mould you were going to fit into … you have to find … what you are comfortable with. So some people will get a certain attitude, towards patients and then you need to decide whether you are going to follow what they do, and treat the patients the same way they treat them, or whether you are going to … be true to yourself and treat them the way you want to treat them … It's a learning experience the whole time that you are doing your internship year … you get that little bit of exposure and then you have to decide for yourself how you are going to take that … when things go wrong whether you are going to take it as a personal vendetta or whether you take it as a learning experience." (X1P3F27B)

Others observed new graduates and newly qualified paramedics emulating the cultural stance on high acuity cases, placing less of an emphasis on non-emergency work in an attempt to be accepted. Conversely, some paramedics who had been in the job for a considerable time were observed to be more accepting of the reality of practice:

> "You have paramedics that just strive for the big job and then are definitely annoyed at certain people that call an ambulance for crappy jobs. But then on the other hand there are certain paramedics that don't mind. I have seen paramedics also get angry if they get sent out of their area. And you see the (newly qualified paramedics) and the students taking that attitude on to fit in … But it's the ones that have been around for a bit longer … ten to twenty years … who are very much like oh, it doesn't matter, if we have a job (case) we just go and that's your job." (X1P2M21A)

7.5.2 Male-Dominated Workplace

With ambulance services historically being a male-dominated discipline (Reynolds, 2008), or possessing a masculine work environment, female paramedic interns did encounter a 'boys club' at the station. However, there was no hostility reported towards females. For example, one female intern observed that some males were overly protective of the female paramedics, while others believed in equality. The female intern reported

fearing some aspects of paramedic practice, which could potentially threaten her safety, and viewed working with male paramedics as desirable at times:

> "I have been accepted really well. It is quite male orientated I must admit but there are a lot more females coming in (to the ambulance service)… and it's when it comes to lifting or carrying patients, some of males say to me stand back, we will do this lift for you and others will be like no you are the same as us you can do it. Usually ... I am really glad to be with a male crewmate if we go to say a drunk male on the street ... I would rather a male and a female then two female crew members ... I don't get that intimidated and if I feel intimidated (by the patient) I will just step back and just call the cops … but you do really feel safer with a male in that circumstance and I have never had any other problems with them. They are always really chatty ..." (X2P1F7D)

Another female paramedic intern found the key to being accepted on station was to have an outgoing personality. She found being a female was advantageous when fitting in, as the males had to conform to the 'boys club':

> "For me I think it's been an easy transition. I think because I have an outgoing personality. I think being a female helps a lot, I think there is kind of the stigma, that the guys have to be a bit more ego driven. I can definitely see that even from our group, the ones that succeed are the ones that are a little bit more forceful and a little bit pushy. Whereas the girls can … be themselves and slip through. It's really helped … I haven't had any issues with … fitting in and feeling comfortable ... it has been a pretty easy transition." (X1P2F19B)

The analysed findings indicate that tensions were encountered on station and were created by workplace politics. For example, one intern likened station politics to school yard bullying. Definite cliques were apparent

which may possibly have led to infighting and the alienation some employees:

> "At (the) station, it's like school yard bullying almost. Like if you are friends with a few people and if another person at that station isn't part of your little friend group then, you know, they're not in the group, they're out. It's very schoolyard kind of stuff at certain stations and, as sexist as it may sound, it's mostly the girls. All the boys are happy to like have a friendly chat or help you out in any way. But some of the girls are very cliquey against the other girls ... and if you're not in the group then you're not in the group". (X1P2M21A)

7.5.3 Stigmatisation

Some interns encountered an element of the culture that stigmatised university graduates. The reason for the stigmatisation possibly relates to previous university graduates being 'cocky' and lacking life experience. However, once the on-road staff got to know the paramedic interns, the stigmatisation often disappeared and they were accepted into the culture:

> "Fitting in was hard, because there is a little bit of a stigma out there against uni grads. That we are a bit cocky and that we don't know anything and we have got no life experience. So that side of things was hard, as soon as you got a bit of respect from people and they realise that I wasn't like that and that I was there to learn as much as everyone else was it was really good." (X1P3F30A)

Other interns also reported experiencing stigmatisation against university graduates. The rationale for this stigmatisation possibly relates to the lack of training that mentors undergo to equip them to train new graduates entering the job. For example, some mentors did not provide adequate feedback, and showed little interest in training activities on station:

> "My mentor didn't want anything to do with me … She basically said you're a university graduate you know everything … she wouldn't give me any feedback ... I never knew how I was travelling because she never

> spoke to me. … I realised that the conflict with my mentor wasn't due to her paramedical ability, it was because she didn't know how to be a teacher." (X1P2F17C)

The lack of constructive feedback was a common finding. Many paramedic interns observed that they never heard anything if they were doing well. However, paramedics and management were quick to criticise someone when something went wrong. The findings indicate that graduates were pre-warned before leaving university about the cultural norm of lack of feedback, which generally meant you were performing well. The findings also suggest that paramedic interns found this cultural norm frustrating. For example:

> "They are quick to have a go if you did something wrong rather than congratulate you if you did something right. One of the lecturers always used to say to us if you don't hear anything about yourself then you've done a good job. If you've done something bad you'll hear about it … I find this quite frustrating. I've always been an advocate of the happier people are at work, the better they work." (X2P2M22D)

A noteworthy finding was interns experience difficulty when trying to maintain a good reputation. For example, culturally, paramedics only seem to remember the mistakes other paramedics have made. It was acknowledged that first impressions are very important. Paramedic interns spoke of the need to 'keep their heads down' and avoid developing a poor reputation:

> "You can get a good name for yourself (but) if you do something wrong, (your good reputation) can be easily forgotten about. So yeah, I think definitely people do say that to you when you start out and you're new. People say keep your head down, make sure you don't give yourself a bad name because it will stick with you and I think probably it's true … But you never really hear what people say about you, so you never really know." (X2P3F31D)

7.5.4 Micro-Cultures and Tensions

At Station Level

The findings suggest that some interns were not able to work at one particular station on a regular basis, but rather were designated to an area covering several stations on a relief or pool roster. They experienced different micro-cultures present at multiple stations, and did not have the stability of working with only one crewmate. To fit in, the following paramedic intern felt the need to be quiet and subdued, and to take on the treating role allowing the other paramedic to do the easier job of driving. Proving oneself in relation to the clinical side of work was another means of gaining acceptance in the workplace:

> "It depends where you work. You can work at a station one day and potentially be at another the next day. Every station is different and acceptable behaviour is different ... At first I would just be quiet and keep my head down. Even now, the first time I work with someone I'll always attend. And then once I've attended, if I've proved myself as an attendant I can have a much better relationship … You go to some stations you enthusiastically get up and answer the phone and you can be right … (but) at other stations you know not to do it. And people will warn you about these things and you'll hear about it through the grape vine. So to fit in, I keep my mouth shut and my head down." (X2P3M35D)

It became evident from the findings that micro-cultures existed within the ambulance culture. For example, an ambulance station may have a reputation of being accepting of interns who were university graduates, and be rumoured to be a progressive and friendly place. However, other stations within the same area or sector could have the opposite reputation, due to reports of high levels of conflict between employees on the station, and being known as unfriendly towards new graduates. Some interns reported that they were prepared during their orientation program for an encounter with a station culture that showed animosity towards new graduates. In the following example, an intern was allocated a

station that was rumoured to have had a questionable reputation, but had subsequently changed over time, possibly due to an increase in the critical mass of university graduates in the workforce. However, the station's reputation had not changed, and had become part of ambulance culture folklore. After arriving at the station, the paramedic intern was relieved to find that people on the station were accepting and very supportive towards new employees. When recalling their experiences as a university student, where they did not feel accepted by paramedics during their clinical placements, the intern asserts that as an employee it was totally different:

> When we were at the service's training facility, the staff said that the area I was posted to was a horrible place. That everyone is really horrible there ... and that there are a lot of intensive care paramedics that have been in the job for years and they don't like uni grads. When I got there I thought wow, where did that rumour come from because I didn't experience that at all. I was really nervous starting there, because I was told I was going to have a horrible time but it's not like that at all, total the opposite." (X1P2F18A)

Others also encountered micro-cultures present within a station. For example, the station environment was often found to be confrontational. The reasons behind the tensions possibly relate to the ambulance culture having two distinct hierarchies, these being a managerial and an 'on-road' hierarchy (Reynolds, 2008, 2009). In the managerial hierarchy, paramedics wear military style rank on their epaulets. The on-road hierarchy relates to the clinical capacity of the paramedic, and is also indicated on a paramedic's epaulets. The two main clinical levels in Australia are a qualified paramedic and an intensive care paramedic (ICPs). In the UK, ambulance technicians and paramedics make up the two clinical levels. A complex interaction may result between the two hierarchies, especially when a paramedic manager's clinical level is less than the paramedics they are supervising on scene. For example, a

supervising manager may be a qualified paramedic, while the treating paramedics may hold intensive care qualifications. Thus, the treating paramedics may overrule a manager on clinical grounds in relation to patient care. At the following paramedic intern's ambulance station, ambulance managers, ICPs and qualified paramedics were constantly clashing with each other. Some of the most experienced clinicians (ICPs) on station would refuse to speak to less experienced staff members. Ironically, part of the rationale of the ICPs position was to focus on mentoring and nurturing new employees entering the service. The analogy was given likening the station culture to walking through a minefield:

> "Well my first station was like the biggest ambulance station in my area, so it had all the managers there. Then you had intensive care paramedics (ICPs), and then you had qualified paramedics and so there was this huge kind of clash between everybody. If you were a paramedic then you wouldn't talk to an intensive care paramedic (ICP), and you had to learn which ICP would talk to you and which ICP wouldn't. Oh the first couple of weeks were just like walking into a minefield." (X1P3F30A)

Encountering Ambulance Managers

When it came to ambulance managers, the findings suggest many interns were initially intimidated by the rank displayed on epaulets, and had to work out how to behave around paramedics in certain managerial positions. It is also apparent that paramedic managers were initially viewed as being pretentious. However, after transitioning to the on-road environment, it was generally discovered how informal some of the managers were, and interns could see the reason for wearing rank, as it was easy to identify the senior officer while on the scene of a 'big job':

> "We were told during our (orientation course) that if you see someone with a stars or crowns on the shoulders you better be looking smart and be nice to them. One or two of them tried a little bit to pull rank … but the rest

> of them said look, just because I am (a manager) doesn't mean I am any better … then you so you treat me with respect and I'll treat you with respect and that's how we'll go ... But now, I quite like the fact that I can turn up at a big scene and I can go ... ok, who is in charge ... and you just look at their shoulders and you just find the next senior person and that's good as well." (X1P3F30A)

Others reported that managers were supportive and proactive, even when the interactions with managers were not necessarily in ideal circumstances. The following paramedic intern acknowledged the presence of a paramilitary chain of command structure, although unlike the military, the ambulance managers did not issue orders:

> "Yes there is a rank structure with a chain of command. I've had quite a bit of experience with my direct supervisors and even those above them … not that I have wanted to on occasions … through incidents that have occurred, However, I found them really approachable and really helpful. And I've got no problem with ringing up the supervisors or team leaders and … just having a chat … So there is a chain of command structure in place but … it's more of a collaborative thing." (X1P2F19B)

Them versus Us Micro-Culture

Unlike the examples above, other findings indicated the presence of a 'them versus us' component of the paramedic culture. It was described as being the paramedics versus the patient, when paramedics should be focusing on the needs of the patient. The analysed findings also indicate a level of bitterness being expressed by the on-road staff towards ambulance management and dispatch:

> "I think the culture is us against them, when it's the ambulance service versus your patients. Like, why can't they leave us alone? … What are we going to get next? … The culture seems to be on-road paramedic staff versus the patients and then it's the on-road staff versus the management … and on-road staff versus dispatch." (X1P2M21A)

Despite encountering a 'them versus us' culture towards management, some interns tried to make sense of the situation by admitting that ambulance managers were acting on directives and key performance indicators put forward by ambulance senior executives:

> "There is definitely a 'them and us' sort of feel. I think it is hard for management because obviously they've got the people above them telling them what to do and they're trying to accommodate for everyone. And I think, especially at the moment it seems, I think we've come in at a bad time, because people would say it didn't used to be as bad as this. It seems quite a lot of people are annoyed and a lot of change going on." (X2P2M24D)

A 'them versus us' culture was also perceived to exist between vocationally trained paramedics and university graduates. Tension arising from vocationally educated paramedic possibly feeling threatened by university graduates appears to have led to some interns feeling marginalised by the culture:

> "I did come across people who I felt were threatened by university graduates. We will be qualified paramedics after twelve months, and it took them years to qualify." (X1P3M29A)

The Old Guard

The presence of workplace politics within the ambulance service was commonly reported. For example, older employees on the station appeared to be disgruntled with many aspects of the job, and would disagree with ambulance management as a matter of principle, regardless of whether the decision was appropriate. These older staff may have possibly formed their view of ambulance management through individual differences, past experiences and change in the ambulance culture over time:

> "You see a lot more politics that go on with the service. You meet the old disgruntled employees who have got an issue with absolutely everything, particularly management. So even if a brilliant idea comes out of management and I guess us as the new degree students coming out, we can see why they are doing it, you know it is all part of it becoming a profession ... And they can't see it, they just go, nup (sic) its management." (X1P3F27B)

7.5.5 Discussion and Summary of Adjusting to the Ambulance Culture

When adjusting to the ambulance culture, pressure to emulate the cultural norms displayed by other paramedics was experienced. Nurses and firefighters have also reported similar occurrences (Boychuk Duchscher & Cowin, 2004; Kramer, 1974; Myers, 2005). For example, new firefighters (Booters) willingly make the meals for the other firefighters and clean the station, because completing these tasks formed part of the initiation into the fire service leading to cultural acceptance. In this study, interns were pressured to emphasise the high acuity side of the job, adopt a pessimistic view, and adopt a 'them versus us' attitude towards management, dispatch and patients to fit in. Inner conflict was also reported when deciding which parts of the culture to emulate and which aspects to reject, while achieving acceptance in the workplace.

After the honeymoon, skills and mastery phases comes the social integration phase (Kramer, 1974). The presence of the social integration phase in the post-formal phase was confirmed to be present in the results as interns worked towards gaining acceptance in the workplace. However, it is possible for the initial skills and routine mastery phase to overlap with the pursuit of social integration (Kramer, 1974). The model suggests that new graduates may view skills and routine mastery as the key to obtaining workplace acceptance (Kramer, 1974, p. 157). The lack of positive feedback relating to job performance, reported in the results, may have negatively influenced the transition from the skills and routine

mastery phase to the social integration phase. That is, the absence of feedback about how interns were progressing with their clinical skills appears to have stalled the extent to which the interns felt accepted. Social integration is concerned with gaining the acceptance of co-workers, forming interpersonal relationships and gaining participation rights within and outside of the workplace (Kramer, 1974).

Of importance were the attempts to gain the acceptance of ambulance management. During their orientation, some paramedic interns maintained that ambulance managers were pretentious; ambulance managers appeared to parade their rank and exhibit high opinions of themselves. After transferring to the operational environment, some managers were viewed as being down to earth and approachable, even though interns felt pressure from their peers to ostracise management to gain acceptance at the station level.

Although the results suggest that some interns appeared to have little difficulty in achieving acceptance, others encountered barriers. For example, interns who were placed on a pooled roster were required to work at multiple ambulance stations in their assigned area. Experiencing changes between station micro-cultures, on-road personnel and work practices made the process of gaining acceptance difficult as these interns had less opportunity to form a strong attachment with colleagues at a station. They did not have the feeling of belonging to a particular station and perceived themselves as being an outsider. The presence of marginalisation (Boychuk Duchscher & Cowin, 2004) was also apprent and led to a lack of cultural acceptance from co-workers on station due to the stigmatisation of new graduates. Other examples of marginalisation were present; for example, the results indicated that some interns perceived that they would not be fully accepted on their station until they were wearing qualified paramedic epaulets, which appeared to be a 'rite of passage'. Other aspects of the culture, such as a 'boys club' (Reynolds, 2008), were perceived as a being both a barrier, and an advantage as

discussed previously.

Interestingly, a contrast was noted when comparing how paramedic interns were received as students on clinical placement with the level of acceptance they encountered as employees, as many university paramedics students reported experiencing cultural stigmatisation while on clinical placements (Boyle et al., 2008; Lazarsfeld-Jensen et al., 2011; Lord et al., 2009). However, the results indicate that stigmatisation often continued during the post-formal phase. An important finding in this section relates to the stereotypical portrayal of new graduate paramedics by the ambulance culture. The dominant group within a culture often create stereotypes, forming assumptions and beliefs about another social group and their interactions with the culture (Stangor & Schaller, 1996). Therefore, stereotypes may result as the dominant group attempts to maintain their control over the culture (Fiske, 1993; Oakes, Haslam, & Turner, 1994; Osland, Bird, Delano, & Jacob, 2000). Stereotypes, which are often not based on reality, are then reinforced and assimilated into the culture and are used to perceive, interpret and remember the behaviour of a less dominant group (Schneider, 2005; Stangor & Schaller, 1996). The results in this chapter show that interns can experience stigmatisation by incumbent staff who are threatened by tertiary educated paramedics.

Having explored how interns endeavoured to achieve acceptance or social integration into the ambulance culture, the chapter now examines the presence of workplace conflict in the internship year including the extent to which it happens and how people manage it. Kramer's (1974) professional socialisation model, in particular the moral outrage phase, is used to identify the underlying causes of the workplace conflict.

7.6 Encountering Workplace Conflict and Moral Outrage

While on clinical placements, university paramedic students may have been shielded from workplace conflict (Adamson, Harris, & Hunt, 1997;

Cant & Higgs, 1999), because the placement duration was often short and there was possibly a limited exposure to internal politics at the station. Alternatively, students may have been focusing on skills mastery rather than the politics of the organisation. When fully immersed in the ambulance culture as a full-time, paid employee, interns discovered discrepancies between their preconceptions of paramedic practice and reality. Kramer (1974) refers to this in her professional socialisation model as the moral outrage phase. Moral outrage is characterised by "anger, frustration and intense discomfort" for the new graduate (Kramer, 1974, p. 158).

Moral outrage often arose as a result of working with vocationally trained paramedics, who were responsible for mentoring the interns. Differences in opinion relating to patient management were the main reason behind the conflict experienced by the paramedic interns. For example, being the junior staff member, the following intern felt the need to overrule their paramedic clinical mentor in front of the patient. The decision to use the stair chair to wheel a patient out to the ambulance was based on the patient's clinical condition. Conversely, the clinical instructor wanted the patient to walk. Due to experiencing cardiac chest pain, the patient's condition could potentially have deteriorated as a result of walking to the ambulance. Following the advice of their clinical mentor could have had negative ramifications for both the patient's condition and the intern's employment:

> "An old school paramedic would just walk a patient to the ambulance when I would prefer them to be in a stair chair … I would verbally say in front of the patient … 'get the chair' … Afterwards he said I don't think we should have got the chair for that patient they would have been fine, I went well I don't think they were fine because of ... (the patient's observations were not within normal limits) ... it was the best thing for the patient and I am not going to risk my (registration or employment). I would rather do things properly." (X2P1F7D)

Workplace conflict was not necessarily the result of verbal communication. For example, clinical training officers could indicate through their body language that they disagreed with an interns' course of action. For example, a lack of verbal communication led the following paramedic intern to second guess their mentor's expectations:

> "I could get a feel just from my mentor's body language whether she wanted me to take the patient to hospital or not or whether she wanted me to do something particular. So it took me a little while to get some courage to make decisions on my own. She was very quick to make conclusions ... quick to tell me what I was doing wrong. I had to feel my way around them. I could get a feel from their body language that I was not doing what they expected me to do." (X1P2F19D)

When encountering a situation where conflict could occur, findings suggest that interns were concerned about avoiding it and maintaining a good reputation. Interns would consciously 'bite their tongue' so as not to escalate the situation further or become embroiled in conflict. For example, the following paramedic intern coped with workplace conflict by being professional and courteous towards the other paramedic:

> "If I didn't get on with the person I was working with … I'd try and get on with my job … (and) be as professional as possible and carry on really … I tried never to rise to it (although) I did on some occasions find myself sort of biting my tongue to not say anything … I thought I'm not going to say anything to wind them up or irritate them ... you know keep under the radar as it were and not make a name for myself." (X2P2M22D)

A noteworthy finding was that interns felt the need to 'bite their tongues', avoid conflict and do whatever it took to avoid negative attention to themselves to reach the goal of completing their internship year and receiving their qualified epaulets. This finding aligns with the work of several authors in the professional socialisation literature, where intern

doctors would take on a subservient role to fit in (Becker et al., 1961; Conrad, 1988). It also aligns with the literature in the organisational socialisation field where staff will tolerate bureaucracy to achieve their desired role in the workplace (Burns & Stalker, 1994; Jones, 1986; Scott & Myers, 2005).

7.6.1 Discussion and Summary of Encountering Workplace Conflict and Moral Outrage

Following the social integration phase of professional socialisation, Kramer (1974) outlines a third stage known as the moral outrage stage (see Figure 3.4). Moral outrage arises when the new graduate realises that some of what they were taught at university, differs from what they observe occurring on-road. For example, conflict arose from disagreements between vocationally trained mentors and paramedic interns over patient management. Moral outrage was also apparent when an intern maintained that their employment could have been jeopardised if they had not insisted that the appropriate equipment and procedures were to be used. Graduate paramedics have contemporary academic knowledge and skills but little clinical experience. Paramedics who have progressed via the vocational education pathway may have an abundance of clinical experience but little contemporary academic knowledge and skills such as evidence based practice, critical appraisal and literature searching skills. This paradox was perceived to be a trigger for workplace conflict as vocationally trained staff appeared to be threatened by new graduates, which aligns with the findings of several authors from the paramedic and nursing disciplines (Buckenham, 1994; Gerrish, 1990, 2000; Jasper, 1996; Kramer, 1974; Lazarsfeld-Jensen, 2010; Lazarsfeld-Jensen et al., 2011; Maben, Latter, & Clark, 2006; Parker & General Purpose Standing Committee No. 2., 2008; Willis et al., 2009).

Another example or moral outrage is given in the results when clinical mentors disagreed with the treatment decisions made by paramedic interns and showed non-verbal signs of disapproval. Several authors

confirm that during the moral outrage stage of professional socialisation the new graduate is likely at their most vulnerable point as they confront the discordance between what they have learned at university and how things are done in the field (Boychuk Duchscher, 2009; Kramer, 1974). Additionally, the moral outrage stage is a pivotal stage in determining the long-term outcomes of the socialisation process because it is at this point that new staff begin to either resolve their inner conflict and move on to the next phase, or else consider alternative career options (Kramer, 1974).

The importance of interpersonal skills such as communication is evident in the results with respect to the strategies used by paramedic interns to cope with moral outrage and workplace conflict. The results suggest that interpersonal skills such as communication were taught in the social sciences component of their paramedic curriculums. However, as confirmed in the literature (Lazarsfeld-Jensen, 2010, 2013; Willis et al., 2010), many paramedic interns in this study also questioned the relevance of the interpersonal and inter-professional skills taught in social science subjects at university. One author maintains that the ability of new graduates to develop appropriate face to face communication, negotiation and conflict resolution skills may be impacted by an isolated and depersonalised youth culture created by social networking and the digital age (Lazarsfeld-Jensen, 2013). Consequently, new graduates may not be prepared for the complexity of the on-road environment, even though they have to complete subjects that focus on workplace communication and organisational awareness while at university. A similar phenomenon was reported long before the creation of social networks and the digital age, stating that new graduate nurses were "interpersonally incompetent ... (and) not able to either resolve their own conflict or influence others in the organisation to make changes efficaciously to improve patient care" (Kramer, 1974, p. 159).

Instead of resolving their conflict, it was found that paramedic interns

took a non-confrontationist approach to workplace conflict to maintain the perception of a good reputation. Maintaining a good reputation was seen as important, and paramedic interns were willing to be subservient, avoid conflict and conform to maximise their chances of fitting in and completing their internship. Similar findings have been described in the literature relating to medical doctors and American firefighters (Becker et al., 1961; Conrad, 1988; Myers, 2005).

Having confirmed the existence of Kramer's (1974) moral outrage phase in the post-formal professional socialisation of paramedics, the chapter moves to investigate the confronting nature of paramedical work. The confronting side of paramedic practice includes dealing with traumatic injuries, which can often result in patient death. However, other confronting aspects include responding to cases in lower socioeconomic areas and patients experiencing mental health crisis. Kramer's (1974) skills and routine mastery phase is referred to in the next section while examining how paramedic interns learn to develop resilience skills to cope with confronting cases.

7.7 Coping with the Confronting Side of the Job: Building Resilience

In addition to adjusting to the ambulance culture and dealing with workplace conflict, paramedic interns were also required to contend with the confronting side of the job, such as observing traumatic cases and death. Confronting cases may have been encountered during clinical placements. However, the exposure to these cases at that stage was most likely limited due to the short duration of university clinical placements and the significant proportion of paramedic work being low acuity related cases. Moreover, as employees, interns were now required to accept greater responsibilities, because they were no longer supernumerary observers completing university clinical placements.

7.7.1 Resilience Techniques

Gallows Humour

The analysed results suggest that the type of cases which interns considered to be confronting differed. Some struggled to deal with traumatic situations such as fatal motor vehicle accidents, while others found treating patients in cardiac arrest equally confronting. Resilience techniques were developed by observing other paramedics and learning how experienced staff managed confronting cases. A significant finding related to the use of gallows humour as a coping mechanism. For example, the following paramedic intern was surprised at how paramedics would joke about distressing sights, and maintained that if the general public heard some of the jokes they might think that paramedics were callous, uncaring people:

> "I think (gallows) humour is a coping mechanisms that quite a few paramedics tend to adopt, because if you are serious about it all the time that's just really depressing. But if you turn bad ugly situations into jokes then it is not so bad, but ... particularly for the public to hear about it … it sounds horrible. We sound like really horrible people that don't care … but we do." (X1P2F17C)

Depersonalisation

Depersonalisation of some patients, and role definition at the scene was significant. For example, an intern cites a cardiac arrest case they had recently attended. During the case, the resuscitation of the patient was viewed as a clinical puzzle that needed to be solved. To cope, the intern avoided acknowledging the patient's family, as they did not want to confront the raw emotions of those who had just experienced the death of a loved one:

> "We went to a cardiac arrest last night and straight away I was just thinking of clinically what to do … I was walking into the house, I saw the family out the front crying, screaming and everything. I purposely just

> walked straight passed them. I didn't stop there ... I had to get to the patient but also because I didn't want to get involved with the emotions or any of those sorts of things … If (the case) is intense … I look at the clinical side of things and detach myself I guess." (X1P2F18A)

Others assert that they coped with serious cases through a problem solving process, finding it more difficult to deal with confronting or distressing cases if they are not directly involved in the provision of patient care. It could be interpreted that some paramedics cope with confronting cases though the mental distraction of performing their role, concentrating on clinical tasks:

> "It definitely depends on the job, if I am attending and the person is what we call sick ... then definitely, you concentrate on the task at hand ... this is what the patient's problem is ... I'm taking them to hospital ... then step back from it and that's fine ... If it's like a time critical type thing, that's easy, I can just go in do it. If I'm driving or I'm not directly involved in the clinical stuff, it can be a little bit difficult ... as you have time for a bit of a look around the situation or have to talk to family members on scene ... I've found that a little bit difficult, but yeah, I've come to deal with it." (X1P2F19B)

Establishing an Emotional Bank Account

Concentrating on the positive aspects of being a paramedic when attending distressing and confronting cases was another noteworthy finding. By doing this, the negative aspects of paramedic practice were balanced with the positive characteristics of the job:

> "I guess we are exposed more to the negative things and so a lot of people talk about the big bad jobs, but I think you've got to build on the good jobs. And I think that's what I focus on the most ... building on the good jobs … like a simple transport of a ninety-nine year old and she gives you a hug ... I think to me ... that's an awesome feeling. So I suppose that helps me build or take away from the negative." (X1P2M21A)

Developing Support Networks

Developing support networks was another finding related to developing coping strategies. For example, it was observed that many paramedics deal with the confronting aspects of the job by talking about it at the hospital or a cafe while having a cup of coffee. It was maintained, with some frustration, that politicians and members of the community often complain when paramedics are seen at coffee shops and cafes, because paramedics should be dealing with emergencies. However, politicians and members of the public may not realise that the paramedics are actually accessing their support network and debriefing after a difficult case, or possibly having their meal break:

> "There is a lot of talking, you get the politicians looking and saying these crews spend so much at this hospital or you go to a small country town and you will see the crews sitting at a cafe or something, and to the public that just looks lazy, but doing that every day you have got that support network to go to when the big job does happen. Or, when you see something that doesn't affect other people but you have got that history and it does affect you, then you can go to your mates and say let's grab a coffee (and) can we have a chat?" (X1P3F27B)

Emotional Release

Some paramedic interns, after a distressing case, would feel better after the release of emotions by crying once the case was complete. After a distressing case, paramedics are still required to carry on performing their role in a professional manner for the remainder of the shift:

> "I've had jobs where I've cried ... like sobbed after the job. We had a job (case) a couple of weeks ago ... we attended a (case) where a female patient (premature gestation) miscarried ... We were doing CPR on (the premature) the baby ... We were unable to (successfully resuscitate) the baby ... so the baby died ... it was a horrible job ... every single one of us … 5 paramedics who attended the case in total ... at end of that job (case) … just walked out of the hospital and broke

> down. And I don't know what it was about that job (case) compared to other jobs (cases), I've attended other paediatric cardiac arrests and have not been that affected, but every single one of us was just drained after that job. We all walked outside, had a cry … we then got back … on with the job and kind of that was it. So, yeah, I suppose you just go, well life's a bitch sometimes, but we have to move on ... these things happen." (X1P3F30A)

Unhealthy Coping Strategies

Another finding relates to negative coping mechanisms. For example, paramedics were observed to use alcohol and cigarettes as a way of dealing with stressful cases:

> "Actually now that I think about it, there are a quite few paramedics that I have worked with that drink a fair bit. Also a couple of people I have worked with need to have a smoke after the big job." (X1P3M29A)

7.7.3 Lower Socioeconomic Cases

Encountering cases in lower socioeconomic areas could be just as 'shocking' as trauma and death. For example, having noted their own limited life experience, the following intern outlines their initial fears of interacting with people in lower socioeconomic areas that they would not normally converse with. They admit that gaining more experience with cases in lower socioeconomic areas has led to the development of tolerance, and an awareness of the associated health-related issues. However, the intern found encountering patients of a similar age experiencing distressing circumstances to be upsetting:

> "Initially aspects of the job were very shocking to me. I have been really insulated in a way; very naïve ... Didn't have very many life experiences myself. I came straight from school to university and then to work ... I work in a lower socioeconomic area and there are lots of the related problems linked that. So at first it was pretty scary, just even going into houses and talking to these people that I wouldn't ordinarily be around ... but I think

> it is just something that you do each day. The more you see it, the more you get used to it … Sometimes it's upsetting when you can see somebody in a situation that they really can't get out of and you feel that they are a victim of that situation. It gets a bit difficult for me sometimes especially seeing girls my own age, and looking at, wow, you're my age and that's where you've ended up and this is where I am … that sort of thing's hard." (X1P2F19B)

Although the findings suggest that treating patients in lower socioeconomic areas could be difficult, the processes available to paramedics for referring the patient to other allied health professional and authorities was also described. The process involves completing forms or referral documentation. However, some interns appeared to be frustrated by people who continue to live in less than desirable circumstances:

> "It seems to be, from my experiences, that some people just live in those conditions … you do your best to fill out the forms, try and get them some help and things like that. You can get very upset. But … it's their choice, they can live like that and you sort of have to get on with it." (X2P2M22D)

The findings indicate that some interns could not help but be judgmental towards patients in lower socioeconomic areas. Their ability to deal with these patients also depended on the time of day. For example, at the beginning of the shift they were less judgemental compared to four o'clock in the morning on a night shift:

> "Unfortunately sometimes you can't help being a little bit judgmental. You know, possibly treating people differently just based on first impressions of them really. I think it does happen but then I think you've got to take into consideration the situation you're put in. If it's your first shift in the morning and you're quite spritely and you're awake you might treat them differently than if it's four o'clock in the morning." (X2P2M22D)

7.7.4 Discussion and Summary of Learning to Cope with Confronting Cases

Because paramedics are often first on scene, they experience sights, sounds, smells and environmental issues, that other health professionals are often not privy to (De La Garza, 2011; Revicki & Gershon, 1996; Reynolds, 2008). For example paramedics may attend murder scenes, domestic violence, people threatening suicide and acutely ill patients (Regehr, 2005). Due to the potential for developing post-traumatic stress disorder, it is important for paramedics to develop resilience when confronting scenes such as trauma and death (Regehr et al., 2002; Regehr, Hill, & Glancey, 2000; Reynolds, 2008). The development of emotional management techniques are possibly an important aspect of the professional socialisation process, which appears not to be covered in the university curriculum.

The results suggest paramedic interns observed the emotional management techniques used by their mentors when developing their own resilience skills. Certain resilience techniques, such as gallows humour, also appear to be culturally reinforced (Reynolds, 2008). The results in this study confirm findings in the paramedic literature, which suggest that there are possibly tensions surrounding the use of gallows humour. Gallows humour was acknowledged as sick and morbid in nature, and interns needed to remind themselves not to use the technique outside of the work environment, with similar findings being reported in the paramedic literature (Reynolds, 2008; Rosenberg, 1991). However, the use of gallows humour appears to be encouraged in the work environment because it enables paramedics to "gain a manageable perspective of a particular incident" (Reynolds, 2008, p. 46). Gallows humour has also been referred to as being a normalising or reframing tool (Myers, 2005), replacing a disturbing perspective with one that is more organisationally acceptable. The use of resilience techniques, such as gallows humour, may form part of the skills and routine mastery phase of professional socialisation, as these resilience techniques are learned and

culturally encouraged. Thus, emulating these techniques possibly led to greater acceptance in the workplace.

Depersonalisation was another coping mechanism. The results suggest that paramedic interns would concentrate on the task of treating the patient to detach themselves from the difficult emotions of the case. Treating paramedics could cope better with confronting cases because they were concentrating on a task. Depersonalisation and distraction processes reportedly fall under the emotional management techniques known as buffering (Scott & Myers, 2005). The use of alcohol and cigarettes as a coping mechanism was another noteworthy finding. Several authors link increased cigarette and alcohol intake with high levels of stress (Joseph et al., 2012; Kouvonen, Kivimäki, Virtanen, Pentti, & Vahtera, 2005; McKee et al., 2011; Murphy, Beaton, Pike, & Johnson, 1999; Siegrist & Rödel, 2006). However, the literature on smoking and alcohol consumption among paramedics is limited (De La Garza, 2011; Mildenhall, 2012).

Choosing not to dwell on the confronting aspects of a case on its completion was reported to be another coping mechanism, with paramedic interns maintaining that they would rather forget the case and move on. The compartmentalisation of emotions, also a form of buffering, is a common emotional management technique reported in the literature (Scott & Myers, 2005). However, several authors suggest that buffering is not the healthiest emotional management technique and is more likely to have long-term personal mental health consequences (Halpern et al., 2012; Regehr, 2005; Regehr et al., 2002).

The development of emotional bank account (Smith, 1995) was another finding, which research suggests is common in male-orientated occupations (Scott & Myers, 2005) that have traditionally discouraged the showing of emotions. However, another coping mechanism found in the results was the release of emotions after a difficult case. Researchers

maintain that many paramedics express difficulties in describing and showing their emotions and suggest that "educating paramedics about identifying emotions may offer a new approach to preventing adverse effects of occupational stress" (Halpern et al., 2012, p. 113).

Of importance was the finding that cases in lower socioeconomic areas appear to be as stressful as managing cases involving traumatic death. Abhorrent scenes were described as interns entered peoples' homes. Several authors maintain that paramedics may be required to deliver emergency care to people in dirty and cluttered environments, with poor lighting and ventilation (Reynolds, 2008; Spitzer & Neely, 1993). Feeling sorry for patients living in lower socioeconomic areas was a common finding. However, the results indicate that this was often replaced by frustration as these patients apparently chose to live in less than desirable conditions, because they would not accept any assistance. The moral outrage phase of Kramer's model may explain why interns experienced frustration when managing patients living in lower socioeconomic areas, as a discrepancy possibly exists between the cultural emphases placed on high acuity cases compared to managing patients living in poverty. The results also suggest a small number of interns became judgemental towards some people in lower socioeconomic areas, although they stressed that they still maintained a professional approach towards these patients. These findings do not necessarily reflect the results reported by Williams, Onsman, Brown (2010a) and Kilner (2004a), who found that paramedic academics and educators considered a non-judgemental and non-discriminatory approach as important and desirable attributes for paramedics. However, the importance of communication skills were referred to when managing patients in lower socioeconomic areas, which was a similar finding to Williams, Onsman and Brown (2010a) and Kilner (2004a).

Having examined the confronting side of paramedical work, the next section explores the varying degrees of confidence levels experienced by

interns towards the end of their internship year. Improvements in confidence levels are explained using Kramer's (1974) reality shock model of professional socialisation.

7.8 Building Confidence

Towards the latter part of the paramedic internship program the analysed data indicates many interns began to feel more confident in their ability to perform their role. The reasons given for the improvement in confidence levels include having a greater exposure to different jobs during the internship program, consolidating knowledge accumulated while at university and having to take responsibility as interns could not rely on their crewmate:

> "I've just been talking about this recently ... I definitely don't feel like I'm at the point where I've made it ... but within the last couple of weeks, I've actually been really excited to go to work and can't wait for the pager to go off ... and I can't wait for them to say it's the big job that you're always scared of ... I'm looking forward to it now as opposed to what I was saying before when I was ... terrified and didn't want the big job … I think that it has definitely come down to the exposure I've had, and building up that experience. I've been to lots of cases now … and I have the general idea … I think specifically for me, (over) last two months, I've had a partner that I can't rely on and that has shaped me, hugely. I've grown exponentially as a practitioner because of my lack of confidence in (my crewmate)." (X1P2F19B)

Others admitted to having compiled a mental list of high acuity cases that they were fearful of attending. As they progressed though their internship program, they began to encounter the cases on their mental list and self-assessed as having responded appropriately. Consequently, their confidence levels began to increase. Most of these lists included 'attend a cardiac arrest'. Receiving positive feedback and being referred to as a knowledgeable paramedic also led to improved confidence, especially

when the ambulance culture is reportedly more likely to provide criticism than positive feedback:

> "I started off with a list of jobs in my head which starts with I can't wait to do my first ... or I'm not looking forward to doing my first ... so it would be a (cardiac arrest) ... people hit by trains … a big car crash, a case requiring the helicopter and a murder. And then when you slowly start to tick things off the list and you haven't got sacked and haven't got too upset ... you realise yeah, I'm working through this list … When it got to the point where people started to ask my opinion, genuinely ask my opinion about things. Not because I was a (university graduate), but because they wanted to know the answer. That's when I thought yeah, I could have my foot in the door here." (X2P3M35D)

Performing well at a cardiac arrest was an important step in improving confidence levels, and was a noteworthy finding of this research.

Also of importance was that positive feedback, particularly from highly regarded staff, was identified as a reason for experiencing increased levels in confidence. Furthermore, the importance of forging a good reputation was highlighted:

> "Word of mouth does help. We attended a person hit by a car. We recognised quite a serious head injury and the patient actually arrested in front of us. We managed to shock the patient back into (a normal cardiac rhythm). The (intensive care paramedic) who backed us up has been in the job years and years, and people have a lot of respect of him. He said to both of us, 'fantastic job, you guys did really, really well' ... and, you know, I think sometimes they'll be chatting with their friends and they'll say oh yeah, I did a job with so-and-so that (grad entry paramedic) and they did a cracking job." (X2P2M22D)

However, the same paramedic intern went on to describe how critical they were of themselves after missing what they considered to be an obvious

clinical sign or symptom. Some interns placed enormous pressure on themselves to perform, even though, as internship paramedics, they were considered to be inexperienced within the field of paramedicine:

> "I'd say my confidence is improving; however, at the same time my confidence has certainly been knocked on certain things. You know, if I've missed something that was really obvious. You know, sometimes I've gone home and kicked myself for a couple days, gone home in a really foul mood. Sitting there and I've just thought … how on earth did I miss that it was so obvious. Or I've done something wrong and I'm just really disappointed in myself. That certainly happens as well. So it sort of can happen both ways I think. But I usually managed to bounce back relatively quickly." (X2P2M22D)

7.8.1 Discussion and Summary of Building Confidence Levels During the Internship Year

The results indicate that increased confidence levels were primarily experienced towards the end of the internship year. By this stage, a diverse range of work had been encountered, and interns had become familiar with their equipment and the ambulance culture. These findings are consistent with similar findings reported in the literature (Lazarsfeld-Jensen et al., 2011).

The results in this section align with Kramer's model about the emphasis on achieving the skills and routine mastery (Kramer, 1974), and the knowing stage of the 'stages of transition' model (Boychuk Duchscher, 2012). The ability to successfully perform clinical skills and procedures within the workplace was also linked with maintaining a good reputation. Interns were aware that an error could significantly impact confidence levels and workplace acceptance. The results in this section confirm Kramer's (1974) reality shock model of professional socialisation, as interns perceived the skills and routine mastery phase to be an important link to achieving workplace acceptance.

7.9 Conclusion

In this chapter, the transition from university student to paramedic intern was explored (see Figure 7.2). Chapter 7 began by investigating the formal ambulance service orientation program. The orientation program appeared to be built on organisational socialisation principles, and an initial culture shock was encountered by interns on joining a paramilitary organisation. Paradoxically, supervising officers made interns feel at ease and were down to earth in their approach. During the orientation, the service's procedures, protocols and clinical practice guidelines were introduced. The ambulance service expected interns to have obtained adequate background knowledge and competencies relating to paramedic procedures and skills prior to commencement, because little clinical information was taught during the orientation program. High fidelity simulation activities were encountered, and assessments were completed before transitioning to the on-road environment. Enormous pressure accompanied assessments, as failure may have led to the termination of employment.

Following the orientation program, various accounts were given about the transition to the on-road environment and first encounters with paramedics on the ambulance station. Initially, a honeymoon period was experienced after the transfer to the station. However, this was soon replaced by a perceived theory-practice gap and feeling out of one's depth. As outlined by Kramer (1974), building skills and routine mastery was used to overcome the perceived theory-practice gap.

The continuation of skills and routine mastery throughout the internship year and the differences in ambulance internship programs were discussed. Becoming 'work ready', including getting up early in the morning to attend work on time and completing shift work, was identified as challenging by interns. An added responsibility was encountered in regional areas associated with representing the ambulance service in the

community, whether on or off duty. An extended honeymoon period was also found, confirming the socialisation process is not linear.

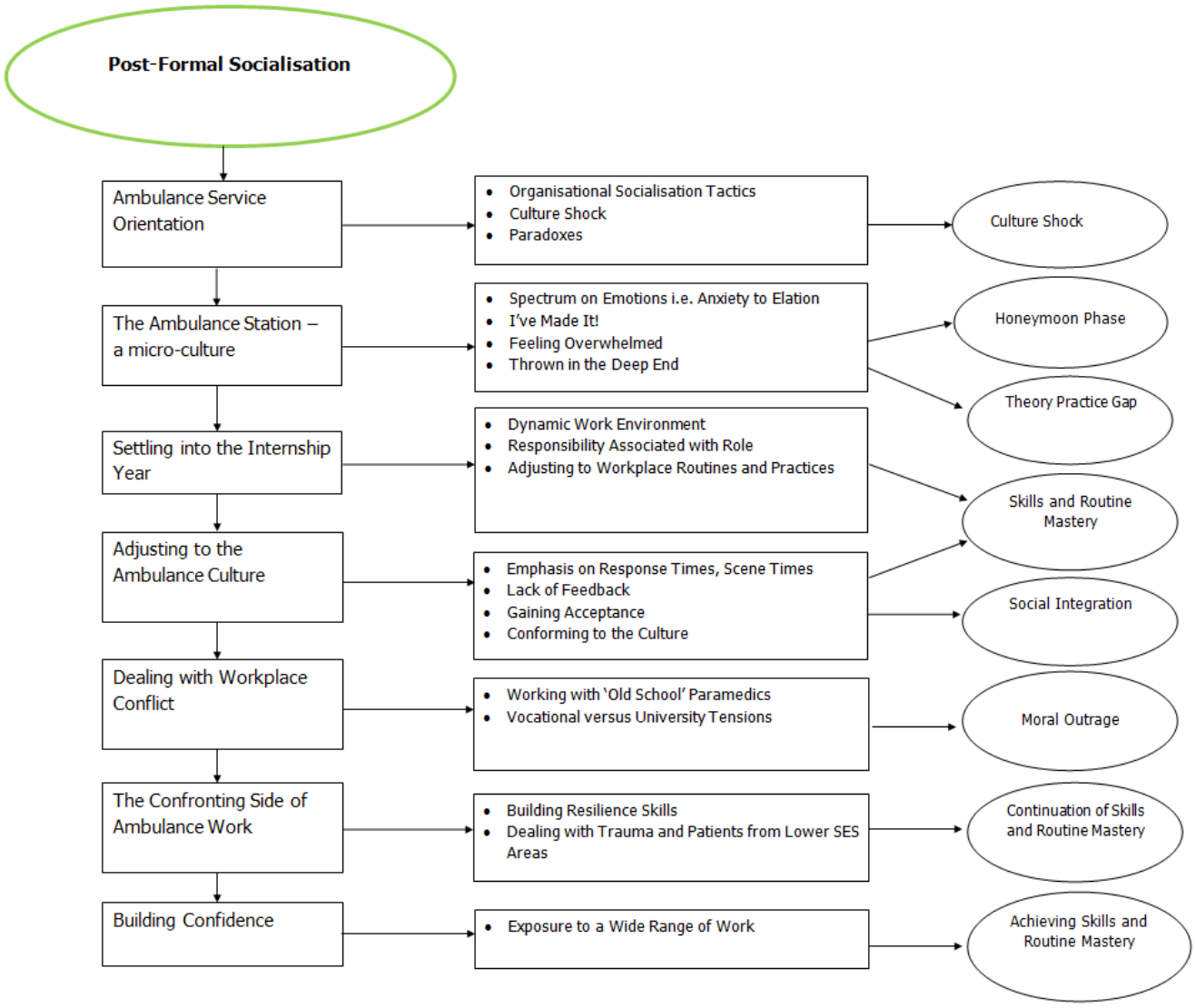


Figure 7.2. A Model of Paramedic Post-Formal Professional Socialisation Summarising the Results from Chapter 7

An adjustment to the ambulance culture was required as interns attempted to gain acceptance from co-workers. In general, a greater level of respect and acceptance was encountered as employees compared to that experienced on clinical placements. However, the results continued to point towards the presence of marginalisation. A 'them versus us' component to the ambulance culture was encountered, which tended to

view dispatch staff, ambulance management and, to a certain extent patients, with aversion. Conversely, others viewed ambulance management to be down to earth and quite supportive. The results indicate that internal conflict was experienced when deciding on how much of the culture to emulate or reject while still maintaining acceptance in the workplace.

Workplace conflict was encountered, often resulting from disagreements with clinical mentors who were vocationally trained. The presence of Kramer's (1974) moral outrage phase was confirmed, as idealistic view of paramedic practice differed from reality. Interpersonal skills were used to develop strategies to cope with clinical mentors who would overrule clinical decisions made by interns and impose shortcuts. Interns felt the need to be subdued and quiet to avoid exacerbating workplace tensions and maintain a good reputation within what was perceived as an unforgiving ambulance culture.

Chapter 7 then turned to investigate experiences when encountering the confronting aspects of paramedic work. Resilience skills used by clinical mentors, such as gallows humour, were observed and copied. Other coping mechanisms were also outlined, including buffering techniques (e.g., depersonalisation and distraction strategies). Additionally, some paramedics were observed to use alcohol and cigarettes as a coping mechanism. Another coping mechanism involved using emotional compartmentalisation techniques such as choosing not to dwell on confronting cases. The literature suggests such an approach may not represent the healthiest emotional management strategy (Halpern et al., 2012; Regehr, 2005; Regehr et al., 2002).

The results suggest managing cases in lower socioeconomic areas could be very stressful. Feeling sorry for patients was followed by frustration and judgemental feelings when people were perceived to have chosen to live in abhorrent conditions. However, a professional approach to these

patients was reportedly always upheld. Communication skills were seen as vital to working with patients living in lower socioeconomic areas. Developing resilience strategies arguably forms part of the skills and routine mastery phase outlined by Kramer (1974).

Chapter 7 explored possible reasons for experiencing increased confidence levels towards the end of the internship year. A variety of cases were managed successfully and interns were able to demonstrate to other paramedics their competence when dealing with challenging cases. Consequently, a progression towards achieving skills and routine mastery was evident, which led to a perceived sense of workplace acceptance. However, confidence levels appeared to be fragile and mistakes were deemed by interns to have a negative impact on both acceptance and reputation in the workplace.

This chapter has confirmed the relevance of aspects of Kramer's (1974) model to the professional socialisation of university educated paramedics in the post-formal phase. Kramer maintains that a honeymoon period, an emphasis on the development of skills and routine mastery, a desire for social acceptance and experiencing frustration resulting from the reality of the workplace are transitional phases encountered by new employees undergoing a post-formal professional socialisation process. These aspects were confirmed to be present in the post-formal phase of paramedic professional socialisation. The current study also confirms professional socialisation to be a non-linear process, as interns transitioned through the various phases differently.

Remnants of organisational socialisation processes were encountered, as the new recruits were orientated to and began employment with their respective ambulance service, consistent with that outlined by several authors (Ashforth et al., 1998; Jones, 1986; Van Maanen & Schein, 1979). Furthermore, transferring from the orientation course to the station

environment was not necessarily an easy process due to the cultural marginalisation and stigmatisation of new graduates.

Having investigated the transition from university student to practicing paramedic intern, the next chapter identifies a new post-internship phase of professional socialisation. The post-internship phase examines the transition from intern to qualified paramedic.

Chapter 8. The Post-Internship Phase

> "It's amazing, now I've got (qualified) paramedic on my shoulder (epaulets) … I can walk onto a station and people definitely treat me differently. Even at the hospital … people want to talk to me now. It's like you're sort of in now, if you know what I mean … you've lost that (paramedic intern) stigma."

8.1 Introduction

University educated paramedics in Australia are required to complete their university studies, graduate and then undertake a year-long internship program before they are recognised by the discipline as qualified paramedics. In the UK, there are no standardised internship programs across NHS ambulance trusts (Williams, 2014). At the time the data were collected in the UK and Australia, all the paramedic interns were required to do a professional year to become fully qualified. Although this professional year varies between the UK and Australia in relation to when it occurs, it is argued in this study that an additional phase of professional socialisation is required to more comprehensively examine professional socialisation in paramedicine.

Unlike other health professions such as nursing, physiotherapy, podiatry and dentistry where registration is gained after graduating from tertiary studies, university educated paramedics in Australia and UH paramedic students in the UK needed to complete an internship program prior to qualifying.

Existing three phase models of professional socialisation seem more applicable in professions where the students are registrable at the end of their university studies, because at that point these graduates would then

be entering the post-formal phase. Consequently a fourth stage, the post-internship phase (see Figure 8.1), is proposed as being more suitable to the paramedic discipline because the participants were neither students nor fully qualified paramedics during the internship programs. Chapter 8 investigates the post-internship phase, which marks the transition from being a paramedic intern to a qualified paramedic. No studies were found in the peer reviewed paramedic literature relating to a post-internship phase, or this transition.

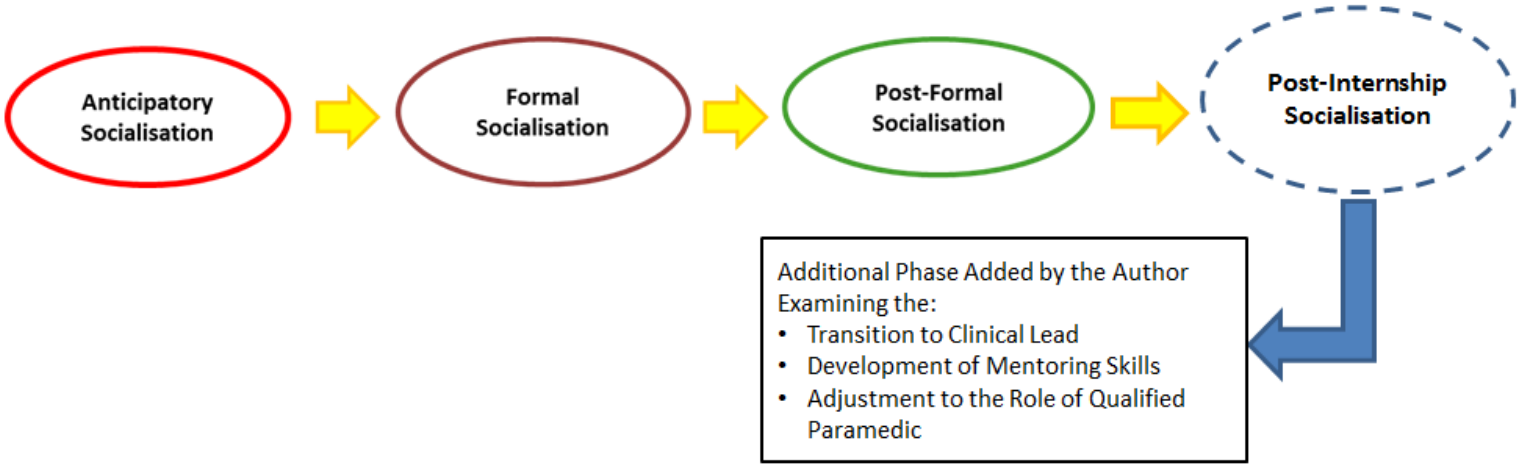


Figure 8.1. The Post-Internship Phase of Paramedic Professional Socialisation

This chapter presents the case for a post-internship stage and argues that the professional socialisation process for graduate paramedics is not complete until they have finished their internship year and assumed the role of a qualified paramedic. It investigates the experiences of the qualified paramedics as they began to mentor new graduates. It explores the components of the image of paramedic practice, which the qualified paramedics chose to portray to new staff and members of the general public. The chapter continues to investigate the relevance of Kramer's (1974) reality shock model to the professional socialisation of paramedics.

For example, the last of Kramer's phases, the conflict resolution phase, is used to examine how paramedics attempt to make sense of the reality of paramedic work and ambulance culture.

8.3 Transition to Clinical Lead

During the internship year, epaulets were worn by paramedic interns who identified their beginner status to other qualified paramedics. After completing the internship year, qualified paramedic epaulets were able to be worn. The analysed findings indicate that wearing qualified paramedic epaulets instantly led to a greater level of respect and acceptance amongst other paramedics. For example, wearing qualified paramedic epaulets was associated with greater workplace acceptance and a transition away from marginalisation and stigmatisation:

> "It's amazing, now I've got (qualified) paramedic on my shoulder (epaulets) … I can walk onto a station and people definitely treat me differently. Even at the hospital … people want to talk to me now. It's like you're sort of in now, if you know what I mean … you've lost that (paramedic intern) stigma." (X2P3M33D)

The need to accept the new level of responsibility associated with being a qualified paramedic was another important finding. The added responsibility, along with working with less qualified staff, confirmed in the following qualified paramedic's mind that they could do the job, and subsequently their confidence began to improve:

> "It was at the point when I started working with people who were new and I was more experienced and qualified than them that I realised that I had no one to fall back on and it was me in charge. And that's when I really started building my confidence and realising I could do the job ... After that, I worked with quite a few people who are less qualified than me and I had to lead the way." (X2P3F32D)

An important part of being a qualified paramedic is the requirement to maintain a certificate to practice (Australia) or paramedic registration (UK). The realisation of the ongoing requirements necessary to remain qualified as a paramedic became a point of concern for the following qualified paramedic:

> "It's a bit of a double-edged sword really because in a way you think oh gosh, something could so easily go wrong and … you could be struck off (deregistered) and it really may not be your fault. And then on the other hand you realise I'm answerable to the HCPC. I'm answerable to my HCPC and I'm answerable to my service. … If (the HCPC and Ambulance Service) haven't got a problem with me then nobody else should necessarily have a problem with me as a clinician ... However, it does play on your mind ... you've got your registration to look after." (X2P3M35D)

In addition to accepting the responsibility of being a qualified paramedic, complexities associated with the role were discovered. For example, supervising a crewmate with a lower scope of practice, who may have been employed with the ambulance service for over 25 years, was deemed to be confronting. Difficulties with respect to communication, created between a 20 year old newly qualified paramedic and a 50 year old with 25 years of experience as an ambulance technician, were identified:

> "I think the main difference for me was that you're in charge most of the time. I think that was hard, because on my first day I was with a guy who'd been working twenty-five years and was a lower clinical level. But my second day I was with someone who'd been working in the job for only a week." (X2P2M25D)

Being the senior clinician also meant backing up other crews who possessed a lower scope of practice. For example, qualified paramedics are able to administer more advanced drugs and perform more advanced life support skills than technicians and trainee paramedics. Some were

transferred to new areas after qualifying, and had to respond to emergency cases despite being unfamiliar with their new surroundings. Wearing qualified paramedic epaulets also meant that local crews would expect the newly qualified paramedic to take charge. The following qualified paramedic gives an account of the complexities encountered when working in an unfamiliar area and supervising another staff member who was twice their age:

> "After I qualified I moved area ... I'd get to jobs (cases) and the (ambulance personnel) didn't know me, they would start asking me questions … and you know people see on your epaulets and suddenly think, oh, well they can take charge of this one. And getting called for backup, because (vocational in-house) trainee paramedics needs additional pain relief for their patient ... or someone is fitting and they need (an anticonvulsant) ... I still find it quite a bit of an adrenaline rush ... oh my goodness, I am the senior clinician on site, I have to make some serious clinical decisions. And I still find that difficult because I am only in my early 20's … and you go out to jobs and there is like 40 or 50 year olds there asking you what to do … I find that quite intimidating, but I am getting better at it." (X1P3F30A)

Findings indicate that the extra level of responsibility was daunting. For example, newly qualified paramedics were still learning their new roles and consolidating their experience, while at the same time supervising ambulance technicians, ambulance officers[1], new graduate paramedics and trainee paramedics undergoing in-house vocational training:

> "I think it was quite daunting because you've done your training ... with a supervisor and that obviously was quite good preparation. But then you're out ... working

[1] An ambulance officer is a uniformed service employee that obtained an in-house vocational certificate or diploma prior to the late 1990s, and can perform basic life support skills only. Ambulance services have since up skilled most ambulance officers to paramedics. However, for various reasons, a small number of these officers elected not to up-skill to paramedic. For example, ambulance officers are referred to as 'Level C' (Charlie) and 'level 3' ambulance officers by two of Australia's largest ambulance service.

> with people who were less experienced than yourself. So that was quite daunting. That was tough, because it's kind of all on you and ... you're the lead clinician … That was the tough bit. But the actual going out there and doing the job, you're still learning ... every day is different." (X2P3F31D)

Many of the UK qualified paramedics wished to consolidate their experience, having gained their registration at the end of their sandwich year. Instead, they returned to university to compete their studies. Despite undertaking casual work as paramedics with LAS during their final year at university, feelings of frustration were commonly reported as a result of not able to work fulltime and consolidate their experience as a paramedic for another 12 months:

> "That transition (back to university) was tough … I learnt a lot from my year out … and it was strange becoming a student again. I was (a casual paramedic) so I could still go out and work the occasional shift … to keep up my experience because although we had become registered paramedics ... we hadn't really practiced as paramedics. So I was going back to university at a point in my career where I felt like I actually wanted to get out and actually work as a paramedic. So it was kind of difficult juggling wanting to be a paramedic with my university studies." (X2P3F31D)

Initial feelings of apprehension and frustration began to subside after experiencing a large number of clinically similar cases. Confidence levels improved after qualified paramedics became accustomed to greater levels of responsibility and were required to provide clinical leadership to intern paramedics or trainee paramedics they were working with:

> "My confidence began to grow, I think because I had begun to settle down and, it's once you start seeing jobs that you've already seen before you can obviously learn off those and then you build up that knowledge yourself, and you become more comfortable. At times it was hard because sometimes you're working with (in-house

> vocational trainee paramedics), or new graduates like in terms of you have to … really keep on the ball. Whereas in the past obviously there wasn't this big injection of new people so you would always be new person working with an old hand so you'd be fine. But I think, yeah, you begin to settle into it". (X2P2M24D)

Discussion and Summary of the Transition to Clinical Lead during the Post- Internship Phase of Professional Socialisation

An additional honeymoon period was initially experienced and a new level of acceptance and respect was discovered after becoming a qualified paramedic. Kramer (1974) reported a honeymoon period for new graduate nurses whereas the current study found two honeymoon phases, one at start of the internship phase (post-formal phase) and another in the post-internship phase. The finding of a second honeymoon phase would appear to justify the development of an additional phase in a profession that requires a professional employment year prior to qualifying. The findings presented a paradox, in that although qualified paramedics were enamoured with the role during the second honeymoon period, their feelings were tempered by an unpreparedness or hesitancy to take on the role of lead clinician.

An additional moral outrage phase was also encountered after becoming qualified paramedics. However, the causes were different from the initial moral outrage phase that occurred in the post-formal phase. In the second moral outrage phase, the results indicate that frustration was experienced due to taking up a training role for which new qualified paramedics felt ill-prepared. Conversely in the first phase, interns were frustrated due to factors such as their preconceptions of paramedic practice differing to reality. Unlike the current study, Kramer (1974) found only one moral outrage phase that occurred in the post-formal phase. The finding of a second moral outrage phase provides further justification for a fourth phase. The results maintain that new qualified paramedics felt ill-equipped for the complexities of their new role. For example, a 20 year

old qualified paramedic experienced difficulties working with a 50 year old employee who was less clinically qualified, then the next day worked with a new employee. Thus a doing, being and becoming finding (Fidler & Fidler, 1978; Wilcock, 1999) was evident as qualified paramedics were possibly still undergoing an adjustment and learning process (doing), required to accept extra responsibility and deal with workplace complexities (being), and perform their new role despite self-doubt (becoming). The results also indicate that inadequate mentor training possibly disadvantaged qualified paramedics with respect to mentoring new graduate or vocationally trained paramedics.

The results outlined another example of moral outrage when UK qualified paramedics experienced feelings of frustration at having to return to university after their sandwich year. Paramedic registration was achieved at the end of their sandwich year for this cohort. Returning to university studies to complete the paramedic degree possibly led to a decrease in the consolidation of their experience. Kramer's (1974) moral outrage phase applied to the UK qualified paramedics due to their inability to consolidate their new roles as registered paramedics after returning to university to complete their studies.

Having explored the transition to the lead clinician on the ambulance, the next section examines experiences encountered when beginning to mentor new graduate and vocationally trained paramedics. The mentoring styles adopted are identified, and range from copying the mentoring techniques their own mentors used, through to developing reassuring and supportive mentoring techniques. The lack of mentor training and standards for paramedic mentors is also discussed.

8.4 Mentoring New Paramedic Graduates and Vocational Trainee Paramedics

Senior clinicians with the responsibility of working with new staff need to develop training skills and mentoring techniques. While there are

qualifications available to assist qualified paramedics to develop their training and mentoring abilities (Sibson & Mursell, 2010a), these qualifications are not mandatory, and there are no prescribed mentoring standards for qualified paramedics (Armitage, 2010). This research study found that paramedic interns did not report undertaking mentor training prior to becoming qualified paramedics. The lack of mentor training and standards could have possibly led to difficulties being experienced when supervising new graduate paramedics entering the ambulance service. Adjusting to the new role of qualified paramedic while simultaneously mentoring a new staff member may have negatively influenced the mentoring ability of some qualified paramedics, as they were still learning to make critical clinical decisions:

> "My internship was in (a regional area) and it was slow … because we didn't do much work … After qualifying … I got posted to (the city) and I got put with a new graduate who had just started with (the ambulance service), who had no confidence in themselves either, and as the senior officer all of a sudden I had no choice but to learn to be confident, so (being a mentor) was thrust upon me." (X1P3M29A)

When mentoring many qualified paramedics, new graduate paramedics decided to adopt the same high expectations required of them while they were progressing through their internship year. For example, some qualified paramedics indicated how they disliked the high expectations that were forced upon them during their internship. However, as clinical mentors, in retrospect they could see the advantage of adopting such a strategy:

> "I try to use a style similar to one of my training officers ... (who) said I can't hold your hand. You're halfway through (your internship) and you are going to be out there doing what I am doing, so you have to act like a qualified paramedic … I hated him at the time ... I just wanted to cruise for a little bit longer as an intern paramedic ... I was happy behind my defence of not

> knowing everything. He said 'I expect you to be the level of a qualified paramedic … I am going to push you and unless I push you, you are not going to get there.' Which was so true ... With less than 12 months experience I had to mentor a new graduate on their first day on-road ... So, it was really good (that my training officer) pushed me really hard ... I take that stance with interns and I say you are going to be a qualified so start acting like it. I am not going to hold your hand. If you have a question, just ask me ... We will talk about the job (case) afterwards, but if you are treating, you are treating, I am not saying a word ... and I don't. I stand back and I let them do everything. Then when they get a bit stuck … I step in. But being pushed like that when I was an intern was the best thing that ever happened to me." (X1P3F30A)

Conversely, remembering how difficult the internship process was, others outlined how their experiences influenced their approach to mentoring new graduates. For example, the following paramedic describes their mentoring style as being sympathetic towards new graduates. They also report that they believe their style is supportive and not overpowering, enabling new graduates to build their confidence by only stepping in when there is a perceived threat to patient safety:

> "I think having gone through (a new grad year) ... you're a bit more sympathetic ... it can be pretty tough. I just give them a bit of advice. I've worked with a couple of people who are just coming to the end of their internship year ... having just finished … you know what it's like to have done all the training ... I think just be sympathetic and give them a bit more support. I've worked with a few (in-house vocational) students who have only been on the road a few weeks and I think it's being a bit patient as well, knowing that they're coming out with not a lot of experience and maybe not a lot of knowledge. You just have to step back, let them attend if they're attending for the shift … but sort of step in when you feel the need to … but not in a way that's sort of putting them down." (X2P3M31D)

Of importance was the supportive and encouraging mentoring style

adopted by some qualified paramedics as a result of their intern experiences. One such approach was to assist new graduates to implement a reflective practice process especially after cases where the new graduate's confidence had been negatively impacted. The following paramedic used a supportive approach and also maintains that they are careful when deciding to step in and assist their crewmates. When deciding to interject, they maintain it is in a reassuring manner that is supportive of the new graduate's ability to develop their critical thinking skills:

> "I think sometimes you can tell just by the way that they give you a look, or in their history taking when they're not sure of what questions to ask. (I) gently step in and giving them a few questions and then talking to the patient a little bit as well ... You know what it's like to be new and you know what it's like to sort of second guess everything … When you're new you haven't got that experience base … It is quite hard, but I think you can talk to them and you can relate to what they've been through … give them a bit of encouragement as well." (X2P3M32D)

When working with new staff members, many qualified paramedics developed an understanding about the differences between the in-house vocationally trained paramedics and university educated paramedics. Some indicated they could even recognise the difference between new graduates from different universities. For example, the following paramedic observed that university educated paramedics usually become better practitioners. However, they concede that the type of education and training a paramedic receives does not necessarily establish whether they are a 'good' practitioner. It is possible that as the pre-employment university model becomes the standard point of entry that a new form of stigmatisation may occur based on which university a person graduated from:

> "I will consciously treat students from different universities differently ... But that's just because I know how the university I went to works and I am not as confident on how the other ones work. On top of that there's the (in-house vocational student paramedic program) ... I expect different things of university students than I do from in-house student paramedics … You can you spot the difference generally speaking … However, I think you need to take everyone at face value ... I think it is quite difficult to say this person went to university so will be necessarily any better than anybody else." (X2P3M35D)

Discussion and Summary of Mentoring New Paramedic Staff during the Post-Internship Phase of Professional Socialisation

From the results it can be seen that some qualified paramedics emulated the mentoring style used by their clinical instructors during their internship year. Conversely, others developed their own approach after reflecting on their internship experiences. Similar examples can be drawn from the literature, which suggest that the supervisor's preferred style is informed by their own experiences as a higher degree student, and may not reflect the needs of their students (Gurr, 2001; Mainhard, van der Rijst, van Tartwijk, & Wubbels, 2009). The literature suggests supervisory styles are either *laissez-faire* style, pastoral, contractual or directorial in approach (Deuchar, 2008; Moses, 1984; Taylor & Beasley, 2005). The nursing literature outlines the importance of ensuring compatibility between mentors and newcomers (Barker, 2006; Darling, 1985; Lockwood-Rayermann, 2003). From a paramedic context, a small number of authors, primarily from the UK, have addressed preceptorship programs and the mentoring of new graduate and vocationally trained paramedics (Armitage, 2010; Dawson, 2008; Donaghy, 2010; Edwards, 2011; Jones, 2012; Peate, 2010; Sibson & Mursell, 2010a, 2010b, 2010c; Lane, 2014).

In this study, three ambulance services provided rostered blocks with designated clinical instructors or preceptors. Conversely, other ambulance services did not designate preceptors to work with paramedic interns, and

the minimum requirement necessary to mentor new staff was being a qualified paramedic (Armitage, 2010; Lane, 2014). The literature suggests that several paramedic programs, ambulance services and health departments offer some degree of mentoring training for paramedics and paramedic graduates (Armitage, 2010; Jones, 2012; Sibson & Mursell, 2010a, 2010c). However, these mentoring models appear to be generic in origin, and not specifically designed for paramedics.

Having examined experiences encountered when learning to mentor new staff members, the next section turns to explore discrepancies, if any, encountered during the anticipatory, formal and post-formal professional socialisation phases. For example, discordances were observed between the reality of practice and the emphasis on high acuity work encountered during the anticipatory socialisation phase, through the universities' hidden curriculum and from the ambulance culture. Kramer (1974) refers to a conflict resolution phase, where the newcomer tries to make sense of their experiences throughout the socialisation process in an attempt to move forward. The next section identifies how conflicting messages, developed during the socialisation phases, may have long-term ramifications on the future career decisions of university educated paramedics.

8.5 Inner Conflict Resolution and the Outcomes of the Professional Socialisation Process

During the post-formal and post-internship phases of professional socialisation, two honeymoon periods were identified. Furthermore, several phases involving the mastery of skills and routines, a social integration phase and two moral outrage phases were encountered. After the moral outrage phase, the next phase in Kramer's (1974) reality shock model is the conflict resolution phase. Kramer's model holds that a conflict resolution phase is entered, where experiences during the socialisation process are evaluated and choices made about long-term career goals (Kramer, 1974; Kramer & Schmalenberg, 1977). Chapter 8 now turns to

examine the applicability of Kramer's (1974) model to the paramedic context by exploring the experiences of newly qualified paramedics.

8.5.1 Portrayal of Paramedic Practice

During the anticipatory phase of professional socialisation, in many cases, a stereotypical image of paramedic practice was developed though the dramatisation of paramedics depicted on television and talking to friends who were studying to become paramedics at university. Furthermore during the formal professional socialisation phase at university, the paramedic culture and the hidden curriculum emphasised the high acuity component of paramedic practice over non-emergency cases. An acceptance of the reality of paramedic practice was apparent after graduation, as some chose to portray to the general public a viewpoint that did not just focus on high acuity components of paramedic practice. However, describing the reality of paramedic practice to the general public was reportedly challenging, especially when the public have the preconception of paramedic work that focuses on the high acuity cases:

> "When asked what it's like to be a paramedic I dish up the reality ... and often they are surprised as they've got the movie conception (sic) of it. I don't tell them stories. I just say oh, you know, it's not really something you can describe. I brush it off. I don't tend to brag about some of the things I've seen because I don't think that's appropriate." (X1P2F20A)

Similarly, the following qualified paramedic encountered the preconception, expressed by the public, that paramedics mainly attend high acuity cases. Portraying the reality of practice to members of the public, with an emphasis on communication and unpredictable aspects of the job, appears to have challenged some people's preconceptions that paramedic practice is not just about attending lifesaving emergencies:

> "I think they usually ask what's the worst thing you've ever seen or something like that. So sometimes I suppose you kind of go along the lines of I really enjoy

> my job in terms of I get to meet people I wouldn't normally meet and you get to see things that you wouldn't normally see. They always want to know about interesting jobs like bad car accident or something like that. I would never go into great detail about it and I sort of try and say that it's not all like that, you know. And I think people do begin to kind of understand that you do some quite routine stuff." (X2P2M24D)

8.5.2 Disillusionment with the Reality of Practice

Not all qualified paramedics were as accepting of the reality of paramedic practice. Some appear to have maintained the view that paramedic practice was a 'Hollywood kind of job', where the role of a paramedic was to attend high acuity cases. Throughout the internship year, these paramedics may have encountered what Kramer (1974) refers to as moral outrage because they admit to becoming frustrated with the reality of paramedic practice, which then subsequently turned into cynicism. The cynicism can be observed when qualified paramedics refer to non-emergency cases as 'rubbish jobs', and suggest that it takes an 'interesting job' to improve their morale. An apparent struggle with inner conflicting views of paramedic practice is also evident. For example, after experiencing several serious cases in one shift, some paramedics maintained that if their job consisted of only high acuity cases they would not be able to cope, despite admitting that they continue to complain about the mundane side of the job. There appears to be a paradox in that these paramedics value attending acute cases *vis-à-vis* routine cases, and continue to desire to treat complex cases despite an awareness that they could not cope if all cases were at the acute end of the care spectrum. The frustration and cynicism towards the reality of practice appears to have led some to consider choosing another career:

> "I still thought it was this Hollywood kind of job ... life and death kind of (cases). I must admit over the last twelve months I have got very frustrated at times about how we can do all these wondrous things clinically, and you'd tell somebody what you can do and they're like oh

> wow, it must be amazing. And then you don't have the heart to tell them well actually I spend ninety-five per cent of my time picking up a drunk person off the street or picking up somebody with a bit of stomach pain. It takes quite an interesting job to really bounce me back up again. Unfortunately the gap between a lot of rubbish and a good job is a while. I'll never moan about the proper job … However, I've had a couple of shifts where the proverbial has hit the fan … and you come home and you think I could not do that every day. But I still complain a bit about the other stuff. I'd certainly say my ideas of what a paramedic is all about has definitely changed over the last twelve months … I don't necessarily fancy a job on the road for the next thirty years." (X2P2M22D)

A dichotomy between the cultural emphasis relating to attending high acuity cases and the mental exhaustion experienced after responding to high acuity work was found:

> "Maybe once a year and you get to the end of the day and you think yeah, that's like it probably would have been presented on TV. And then you realise how mentally exhausting six jobs, six proper jobs, have been. And then you get to the end of the day and you think ... God, I couldn't do that every day." (X2P3M35D)

While others could see that all cases were interesting to an extent, they observed some paramedics becoming less interested in their role, possibly due to frustration with the reality of practice as well as the lack of career progression. There was an expectation that more career pathways would be present in ambulance services other than the two-tiered system in place in Australian and UK ambulance services. The potential for ambulance services to offer new clinical pathways seems to be an incentive for some to continue working as paramedics:

> "I now realise how many frustrated people there are in the ambulance service. I now realise how many people there are who don't seem to enjoy doing what they do and don't seem to enjoy the opportunity to do things that I think are the interesting parts of the job … I think

> in a way I expected ... the pathways for career progression to be a lot more developed then they are in reality ... I hear pathways are rapidly developing ... they're not there yet but they are tangible and it is quite an exciting time to come into the service." (X2P3M35D)

8.5.3 Developing a Deeper Understanding of the Paramedic Role:

While some paramedics experienced frustration with the reality of practice during the conflict resolution phase, others began to develop a deeper understanding and acceptance of their role. For example, the following paramedic exhibits pride in their ability to provide a high quality care to their patients as a result of their university education and on-road experience:

> "Now I feel like I know a lot more about what a paramedic can do. You know, I didn't realise how much they could do, how much they could benefit a patient. So, you know, now, you know, as a paramedic I think wow ... I've got a lot more knowledge, and lot more drugs at hand than I thought I could ever have." (X2P2M23D)

Others also developed a deeper understanding of the role of a paramedic, explaining how passionate they have become about their role, and outlined their plans to contribute towards the profession into the future. Despite admitting that the role of a paramedic is more 'routine' than they initially anticipated, their adjustment into the ambulance culture can be observed when they refer to the occasional high acuity case as 'decent work':

> "My view of being a paramedic has definitely changed I think. I understand it a lot more now and I would still say that I am very passionate about it and it's a job that I definitely think I could carry on doing for a while … I think it is very good having an internship year, so you get out and actually do the job. And in terms of whether my perception is different now than to what it was, I

> think I do know it's a lot more routine. It's almost bread and butter jobs most of the time and you get that one decent job maybe a shift or in a week, that you can really think ... I made a difference." (X2P2M24D)

Another paramedic, in reflection, partially attributes their university studies with assisting them to develop a deeper understanding of the paramedic role. Additionally, they appear to be content being a qualified paramedic, referring to a desire to build a career as a paramedic and possibly pursue further advancement after consolidating their experience:

> "University has taken me from not having any knowledge base at all in terms of the (ambulance service), trained me up, and it has given me a professional outlook, the knowledge base and the ability to feel I could do the job. At the moment I wish to settle down as a paramedic. I think in the future I'll maybe take on a more clinically advanced role … but for now I … want to stay with the (ambulance service) and work as a paramedic." (X2P3F31D)

8.4.5 Discussion and Summary of Experiencing Inner Conflict and the Outcomes of the Professional Socialisation Process

In relation to Kramer's conflict resolution phase, confusion resulting from the dichotomy between the cultural emphasis on high acuity work and the reality of practice was reported. A similar phenomenon is outlined in the medical literature (Becker et al., 1961; Gray, Moody, & Newman, 1965), where doctors appeared to return to their idealistic preconceptions after graduating from medical school. In the current study, paramedics were seen to complain about the mundane nature of paramedic work, wishing for a greater number of high acuity cases. However, after experiencing several high acuity cases in one shift, along with the added complexity of mentoring new employees, it was acknowledged how mentally and physically onerous managing critical patients can be.

Difficulties were reportedly faced when trying to explain the reality of paramedic practice to family members and the general public. The

preconceptions of the general public may have additionally contributed to the creation of the inner conflict apparent in some paramedics, as emergency service personnel often view the lifesaving component of their work as a badge of honour and their reason for existing (Scott & Myers, 2005; Tracey & Scott, 2006).

The reality shock model proposed by Kramer (1974) indicates several possible outcomes that may occur as a result of the conflict resolution phase. One pathway pursued by new graduates to resolve their inner conflict relates to behavioural capitulation (Kramer, 1974). Behavioural capitulation is where the new graduate "holds on to their (nursing) school-bred values but compromises (their) behaviour" (Kramer, 1974, p. 159). For example, a new graduate may resolve their inner conflict by "running away from it" (Kramer, 1974, p. 159), that is by leaving the profession. However, they retain their 'school-bred' values. Behavioural capitulation was found in this section when several paramedics revealed their intentions to quit and pursue further studies at university in allied health fields. Studies specific to the attrition rate of university educated paramedics are limited, although the CAA (2009) reports on the attrition rates for Australian ambulance services. The Australian ambulance services involved in this research have relatively low attrition rates (1.1% to 4.4%). However, these figures were taken up to two years prior to the data collection for this thesis. From the UK perspective, the largest NHS Ambulance Trust, the LAS, reported a 7% attrition rate in 2011. Paramedics threatening to terminate their employment with an ambulance service may also be seen as a temporary measure to "psychologically justify less involvement, commitment and need for change" (Kramer, 1974, p. 9). Conversely, instead of leaving the profession, Kramer suggests that behavioural capitulation may lead new staff to pursue other positions within the organisation such as education or training roles, where "they can enact behaviours more consistent with the values they hold" (Kramer, 1974, p. 159).

Value capitulation may be another possible outcome of the conflict resolution phase (Kramer, 1974). Value capitulation is where a new staff member forms the view that the workplace values are more desirable than the values which they were taught at university. Value capitulation may immediately reduce the level of tension experienced by new staff, and has the added advantage of being culturally rewarding (Kramer, 1974). An example of value capitulation is where a qualified paramedic emulates the mentoring approach used by his or her own mentor, viewing such an approach as a desirable method for training an intern despite experiencing a personal dislike for it themselves. Interestingly, Chapter 7 also referred to an example of value capitulation: paramedic interns were observed to stigmatise university students on clinical placements after graduating and joining an ambulance service. These graduate paramedics possibly emulated perceived culturally acceptable behaviours in order to fit in. Thus, the results in this thesis confirm Kramer's (1974) findings relating to the existence of value capitulation.

Another conflict resolution technique outlined in Kramer's model is called "the plague on both your houses solution" (Kramer, 1974, p. 161). Plague on both your houses is where the new graduate's preconceptions are not met by either the university or the workplace. Consequently the newcomer rejects both sets of values. Kramer suggests that these individuals will display "behaviour that is just conforming enough to hold onto their job" (Kramer, 1974, p. 161). In other words, new graduates may observe significant differences between their university's values and the reality of paramedic practice in the workplace, choosing to reject the ideals of both parties, and become complacent. The plague on both your houses solution was not observed in this study. However, examples were given of their encounters with other paramedics in the workplace that have possibly chosen this pathway, especially in Chapter 6 during clinical placements, when mentors were observed by students to be contemptuous about both the university system and the ambulance

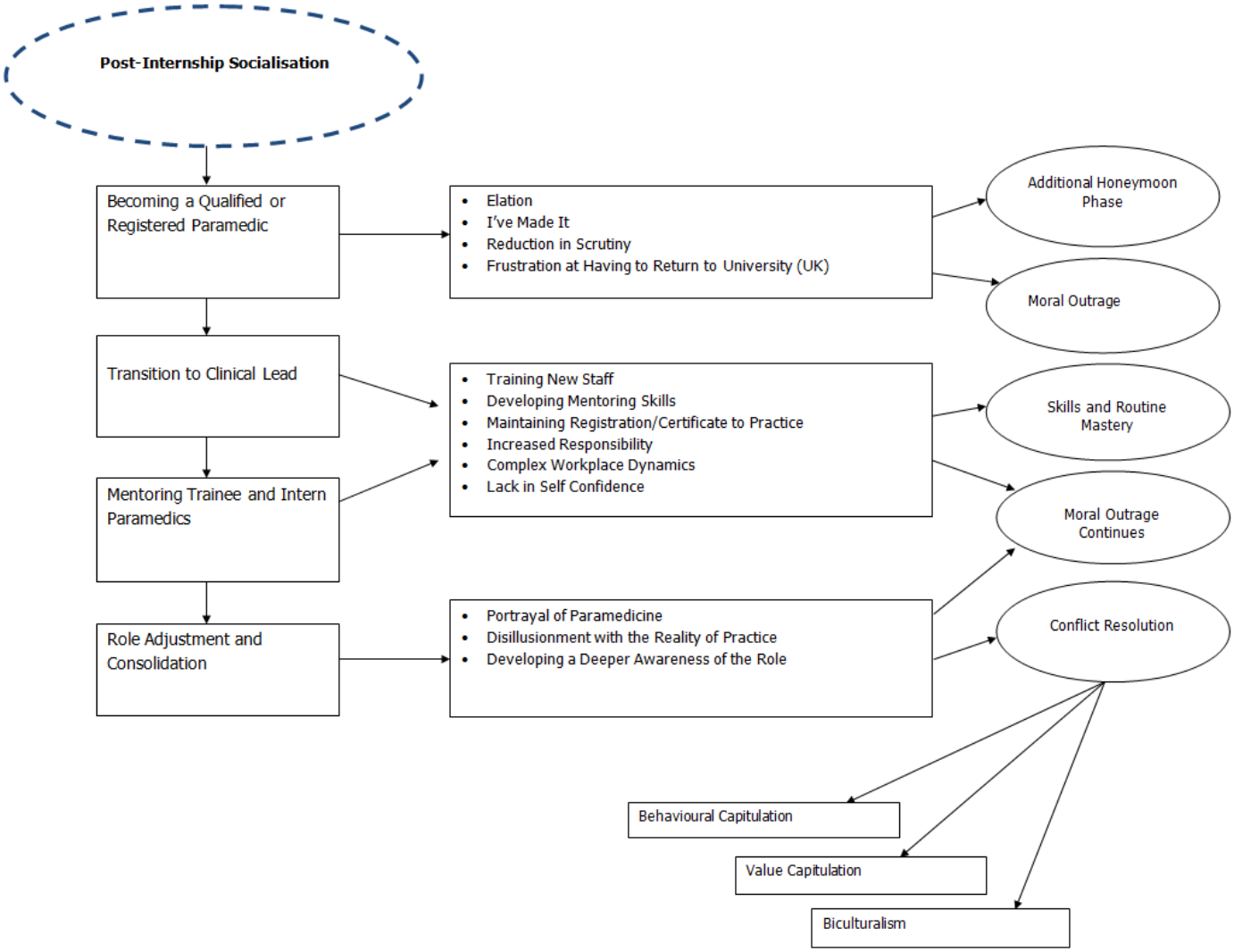
service.

Another conflict resolution technique that was not found in this study relates to what Kramer refers to as "going it alone" (Kramer, 1974, p. 161). Going it alone involves seeking protective isolation by pursuing geographically isolated stations or isolated shifts. By choosing this option, new graduates may "isolate (themselves) psychologically from conflicting value messages" (Kramer, 1974, p. 161).

The most desirable outcome from the conflict resolution phase, for the emerging paramedic profession, is biculturalism. Biculturalism occurs when the new graduate chooses to merge positive aspects of both university and ambulance service cultures in an attempt to add positively to the system (Kramer, 1974; Kramer & Schmalenberg, 1977). In Chapter 7, paramedic interns reported experiencing inner conflict when deciding which aspects of the culture to accept or reject according to their values and ethics. Biculturalism was observed in the post-internship phase where qualified paramedics were able to give credit to their university studies for preparing them for the workplace, as well as accept the reality of practice and maintain their passion for paramedical work.

8.6 Conclusion

In conclusion, the processes involved in the transition from being a paramedic intern to a qualified paramedic have been identified (see Figure 8.2). On completion of the internship year in Australia, the transition from internship paramedic to qualified paramedic occurred rapidly. Experiences encountered when learning to mentor new paramedic staff were investigated. Mentoring activities included imitating techniques used mentors when training new paramedic staff, despite expressing dislike for those techniques used during their own internship period. Others chose to develop mentoring styles that were supportive, reassuring and encouraged the new paramedic staff member to progress their critical thinking skills.



In the post-internship phase, difficulties were faced when attempting to

Figure 8.2. A Conceptual Model of Paramedic Post-Internship Professional Socialisation Summarising the Results from Chapter 9

explain the reality of practice to family members and the general public. These difficulties appear to have arisen from the general public's preconceptions, associating the paramedic's role with high acuity work. Some qualified paramedics reported becoming disillusioned with the realty of paramedic practice. Possible reasons for this disillusionment can be attributed to the ambulance culture and the university hidden curriculum,

which appear to emphasise the high acuity component of paramedic practice. However, others reported being more accepting of the reality of paramedic practice due to the values, knowledge and skills they were taught at university. Several possible reasons for the identified reactions to the reality of paramedic practice are outlined in Kramer's (1974) conflict resolution phase of professional socialisation. Frustration and disillusionment were exhibited, and plans to leave the ambulance service were identified. These reactions were explained using Kramer's (1974) behavioural capitulation outcome. Value capitulation was also experienced, as paramedics chose to emulate cultural behaviour such as mentoring techniques that stigmatised university students on clinical placement. Those who valued their university studies and accepted the reality of paramedic practice appeared to embody biculturalism as described by Kramer.

Finally, this chapter justified the addition of a post-internship phase, which appears to be unique to this study. The anticipatory and formal professional socialisation phases both adequately explained the formation of preconceptions prior to encountering the paramedic profession and how these preconceptions changed throughout their university studies. The post-formal phase, using aspects of Kramer's (1974) model as the framework, adequately explained the transition from university student to practising paramedic intern. However, as the paramedic interns were not qualified paramedics until the completion of their sandwich year (UK) and internship year (Australia), another phase was necessary to investigate the experiences of qualified paramedics as they continued to undergo a paramedic professional socialisation process. Therefore, the inclusion of a post-internship appears warranted and extends Kramer's (1974) reality shock model and the anticipatory, formal and post-formal phases of professional socialisation (Cant & Higgs, 1999; Lamdin, 2006; Shuval & Adler, 1977). In the post-internship phase, the moral outrage and conflict resolution phases of Kramer's (1974) professional socialisation model

were confirmed by this study. However, two outcomes associated with the conflict resolution phase, namely the withdrawal and plague on both your houses phases, were not present in the results. Further research is necessary to determine whether these two phases appears in university educated paramedics up to five years post-graduation.

Differences between the post-formal professional socialisation of paramedics and Kramer's (1974) reality shock model were apparent in the results. For example, an additional honeymoon phase was experienced after becoming a qualified paramedic. Further, another moral outrage phase was experienced after becoming a qualified paramedic that was different from the one experienced during the internship year. For example, the UK cohort experienced frustration at having to return to their university studies after becoming registered for practice, and Australian paramedics expressed frustration at having to mentor new staff members despite having low self-confidence and self-doubt. Moreover, in both cohorts moral outrage was evident because initial anticipatory views, the hidden university curriculum and the ambulance culture were different to the reality of practice.

Having investigated the transition from intern to qualified paramedic, Chapter 9 provides a discussion of the professional socialisation of university educated paramedics from Australia and the UK. Chapter 9 provides a summary of the paramedic professional socialisation process highlighted in this research study. An amended, four phase professional socialisation model is proposed specific to the professional socialisation of university educated paramedics, and a new model of paramedic socialisation is presented. Several analytical propositions are suggested to assist universities, ambulance services and students to understand the paramedic professional socialisation process.

Chapter 9. Discussion, A Theoretical Model, Significance of this Research, Limitations, Analytical Propositions and Conclusion

9.1 Introduction

This chapter revisits the research questions and explores the applicability of the anticipatory, formal, post-formal phases of professional socialisation and Kramer's reality shock model to the professional socialisation of paramedics. A fourth phase, the post-internship phase, is proposed. A model of paramedic socialisation is presented (see Figure 9.2), the significance of this research and the study's limitations are explored, and analytical propositions are outlined. Chapter 9 closes with the conclusions arising from the results.

9.1 Review of Research Aims and Research Questions

9.1.1 Research Aims

The aims of this PhD study were two-fold. The first aim was to employ existing professional socialisation theories to explore the professional socialisation of university educated paramedics from Australia and the UK. The second aim was to examine the extent to which these theories explain, or do not explain, the professional socialisation of university educated paramedics. Examining the professional socialisation of paramedics using the anticipatory, formal and post-formal phases of professional socialisation (Cant & Higgs, 1999; Higgs, 2013; Lamdin, 2006; Shuval & Adler, 1977) and Kramer's (1974) reality shock model achieved the first aim. The discussion of the results has addressed the second aim by demonstrating the suitability of these theories to the paramedic context, as well as proposing further amendments to these

models specific to the professional socialisation of university educated paramedics.

9.1.2 Research Questions

There were two main research questions, highlighted in Chapter 1, which guided the research task.

Question 1

The first question asked whether:

> The anticipatory, formal and post-formal phases of professional socialisation adequately explain how individuals, undergoing professional socialisation, learn about the role of a paramedic?

Chapter 5 highlighted and discussed the factors responsible for the formation of paramedic preconceptions in the anticipatory phase of professional socialisation. Many of these anticipatory socialisation agents confirmed similar findings in the literature pertaining to the role of television and media in developing stereotypical images of an occupation or profession. However, several unique anticipatory socialisation agents specific to the paramedic context were found, such as working for emergency volunteer organisations.

Chapter 6 identified how the preconceptions formed during the anticipatory phase were challenged during the formal phase of professional socialisation. The professional socialisation agents that assisted in the development of more credible perceptions of paramedicine included on-road paramedics, academic and teaching staff, the formal and informal curriculum, and university clinical placements.

Chapter 7 identified the professional socialisation agents and events that contributed to the formation of a deeper understanding of paramedicine. These events included university clinical placements, ambulance introductory orientation programs, and the transition to the on-road environment and internship programs. The socialisation agents included

education staff, other paramedics, clinical mentors and preceptors, ambulance management and the ambulance culture. However, the three phase model of professional socialisation was found to insufficient when exploring the transition of paramedic interns to qualified paramedics. Paramedics do not attain the full paramedic identity until the completion of the internship year, when they gain qualified paramedic status. Thus, the addition of a post-internship phase was introduced and discussed in Chapter 8.

Question 2

The second question asked:

> Does Kramer's reality shock model adequately explain how the image of paramedicine, formed through socialisation, is transformed overtime into a structured role that eventually guides professional performance?

By using Kramer's (1974) reality shock model to investigate the transformation of a university paramedic student through to being a paramedic intern then a qualified paramedic, five phases of importance in Chapters 7 and 8 are pertinent to the paramedic context. These phases are the honeymoon phase, skills and routine mastery phase, social integration phase, moral outrage phase and conflict resolution phase. These phases identified how new graduates adjust to the professional workplace and how they adapt to the reality of the workplace. New graduates are required to resolve tensions existing between their preconceptions and the reality of paramedic practice. Chapter 8 indicated that new graduates chose one of three pathways to resolve these tensions, namely: behavioural capitulation, value capitulation, and biculturalism. These pathways influenced the new graduates' professional performance, as they referred to their desire to quit the profession (behavioural capitulation); decided to reject aspects of their university bred professional values to fit in to the workplace (value capitulation); or

managed to merge their university values with the discipline's culture and add positively to the system (biculturalism).

The following section discusses in greater detail the professional socialisation models highlighted in the theoretical framework chapter, and how their applicability to the paramedic context is demonstrated through the results chapters.

9.2 Professional Socialisation Models and their Applicability to Paramedic Practice

This thesis investigated the applicability of the anticipatory, formal and post-formal phases of professional socialisation to the field of paramedicine. In summary, the anticipatory socialisation phase begins in early childhood and ends when the individual begins a program of study at university (Cant & Higgs, 1999; Lamdin, 2006; Shuval & Adler, 1977). The formal phase of socialisation spans the time it takes the individual to complete their university program (Cant & Higgs, 1999; Lamdin, 2006; Shuval & Adler, 1977). The post-formal phase of professional socialisation begins when the individual completes their tertiary studies and makes the transition to the workplace (Cant & Higgs, 1999; Lamdin, 2006; Shuval & Adler, 1977). Although Lamdin (2006), Shuval and Adler (1977), and Cant and Higgs (1999) allude to the presence of a post socialisation phase, in most cases these authors have chosen to concentrate on the anticipatory and formal phases of professional socialisation in their respective studies. Therefore Kramer's (1974) reality shock model was used to provide the framework for investigating the post-formal phase.

9.2.1 Anticipatory Socialisation

The presence of an anticipatory phase of professional socialisation was identified in this research. The concept of anticipatory socialisation is applicable to both organisational and professional socialisation (Cant & Higgs, 1999; Feldman, 1976; Kramer, 2010; Lamdin, 2006; Shuval & Adler, 1977; Van Maanen, 1976). It is during the anticipatory socialisation

phase that preconceptions of paramedic practice are formed, which are often unrealistic if not stereotypical (Shuval & Adler, 1977; Van Maanen, 1976). The findings in Chapter 5 confirmed Cant and Higgs' (1999) summation with respect to the segregation of the anticipatory socialisation into childhood (6–16 years) and adult (17–19 years) socialisation. In essence, the influencing factors, which helped build the anticipatory preconceptions during both childhood and early adulthood, were similar since secondary (adult) socialisation is built on resynthesised childhood preconceptions (Cant & Higgs, 1999). However, in this research there was a qualitative difference in the depth of consideration about the paramedic role and a more active and critical exploration during secondary socialisation. In other words, during adulthood, various socialisation agents, such as the media or patient-paramedic interactions were viewed with a greater degree of awareness, reflection and critique. To date, the qualitative differences between childhood and adult paramedic socialisation have not been a major focus of attention in the literature.

Television and the media were found to have a major impact on the formation of preconceptions during the anticipatory phase of socialisation, confirming a small body of previous literature (Cant & Higgs, 1999; Jablin, 2001; O'Meara et al., 2012). Additionally, the reported influence of family, friends and peers in forming the anticipatory views of paramedic practice align with similar findings in the literature (Jablin, 2001; Lamdin, 2006). The extent of information seeking and research during the anticipatory phase such as accessing networks during early adulthood also confirms previous research (Flanagin & Waldeck, 2004; Holton & Russell, 1997; Moschis & Moore, 1979).

Anticipatory views about paramedic practice were also formed from previous work with emergency volunteer organisations. Previous exposure to a range of tasks paramedics undertake, as well as an interface between paramedical services and volunteer organisations, assisted in the

formation of less stereotypical preconceptions about paramedic practice. One study identified that working for volunteer organisations was a reason for some students wanting to enrol in undergraduate studies in paramedicine (O'Meara et al., 2012). However, these authors did not analyse in detail how volunteer organisations assisted in the development of preconceptions about paramedicine. The findings in this thesis have outlined a greater level of complexity relating to the development of the preconceptions of paramedic practice, by linking volunteer work with emergency organisations and the portrayal of paramedics in the media, which subsequently led many to pursue a career as a paramedic. The role of volunteering with emergency organisations within a professional socialisation paradigm also appears to be unique to the paramedical and emergency health related fields, as it was not found to be present in literature about other health professional groups.

Events such as a family tragedy and being treated by paramedics also led to the formation of preconceptions about paramedic practice. These findings also appear to be specific to the paramedical context.

9.2.2 Formal Socialisation Phase

A formal professional socialisation phase (Cant & Higgs, 1999; Higgs, 2013; Lamdin, 2006; Shuval & Adler, 1977) was found to be relevant to paramedic practice. A transition from anticipatory preconceptions to a more informed view occurred during the formal phase of professional socialisation, confirming the findings of other authors (Cant & Higgs, 1999; Shuval & Adler, 1977). However, within the paramedic context, unique findings were evident, which related to the formal phase. The representation made to students by senior officers from various ambulance services during university orientation week does not appear to occur with other health-related disciplines. Industry representation could be interpreted variously as a possible marketing exercise for the ambulance service and providing credence for the universities' paramedic

program, as it demonstrates a close working relationship between the two institutions. Certainly, it gives early exposure to a paramilitary culture.

During the formal professional socialisation phase, what Kramer (1974) refers to as socialisation agents were found in the results. Socialisation agents included, but were not limited to, university staff, on-road teaching staff, peers and the curriculum. In relation to the curriculum, the dislike for aspects of the curriculum pertaining to the social sciences such as communication, inter-professional education, psychology and sociology were commonly asserted, confirming similar findings reported by other authors (Williams, Boyle, Brightwell, Devenish, Hartley, M. McCall, & Webb, 2012; Williams, Boyle, Brightwell, McCall, et al., 2012; Willis et al., 2010). The presence and influence of a hidden curriculum could assist to explain the reasons behind a perceived dislike of social science subjects. The hidden curriculum identified in this study emphasised the paramedic cultural viewpoint and high value placed on the importance of attending high acuity cases. Reynolds (2008) addresses the cultural emphasis on high acuity work by maintaining that a 'good job' is where paramedics use invasive skills and administer pharmacological agents, while a 'bad job' is where the patient receives limited intervention. The results indicate that the hidden curriculum could be more influential than the formal curriculum, confirming the findings of other authors (Cant & Higgs, 1999; Hafferty, 1998; Lamdin, 2006).

Another unique finding from this study indicates that university paramedic students do not recognise paramedic academic staff as 'paramedics'; instead, more credibility is given to sessional or tutoring staff who are uniformed paramedics. The sessional staff may have contributed to the hidden curriculum by telling 'war' stories and designing high acuity simulation activities which portrayed the dominant ambulance culture, despite these cases forming a small proportion of the paramedic caseload (Clark et al., 2000; Morgans et al., 2004; Morgans & Burgess, 2012;

Morgans & Burgess, 2011; Snooks et al., 1998; Williams et al., 2012; Wilson et al., 1999; Woollard, 2003).

A perceived theory-practice gap became evident during the formal phase of professional socialisation, as the results indicate that feeling underprepared for the on-road environment during clinical placements commonly occurred. Similar findings have been reported in the medical literature (Prince, Boshuizen, Van Der Vleuten, & Scherpbier, 2005). In the current study, reasons given for being underprepared appear to be relatively minor such as the equipment located at university differing to the on-road environment, and being used to the university culture where disposable equipment is reused when safe to do so. These examples reinforce the difference between the university and on-road environments, where the investment in and turnover of equipment differs. It was also apparent that an orientation program or even visiting the station prior to commencing their clinical placement was not undertaken by many university paramedic students. These factors made the transition to the on-road environment more challenging. Many ambulance services now issue clinical placement booklets instead of running orientation programs (Lord, 2013). Similarly, many universities have assumed the responsibility of preparing students for clinical placements within the university curriculum (Lord, 2013). However, despite the measures employed by ambulance services and universities, some students continue to be poorly prepared for the commencement of their clinical placement, including not being able to locate the station and even its entrance.

From experiences encountered during clinical placements, it was evident that there are a number of triggers for tension with on-road paramedics supervising students. One important trigger occurred when on-road staff were confused because of disparities between university paramedic programs. Due to the absence of a national curriculum, students from various university programs may learn skills and procedures at different points throughout their studies. Thus, tensions occurred because clinical

mentors sometimes had higher expectations of undergraduate paramedic students, expecting them to perform beyond the scope of practice that had been stipulated by the university and the ambulance service. Similar findings have been noted in the paramedic literature by a small number of other authors (Boyle et al., 2008; Lazarsfeld-Jensen et al., 2011; Lord, 2013).

Another finding of importance related to the stigmatisation of university students during clinical placements. Clashes between vocationally trained and university educated paramedics reportedly led to the stigmatisation of university paramedic students on clinical placement, confirming the findings of other studies (Boyle et al., 2008; Lazarsfeld-Jensen et al., 2011; Lord, 2013). What became apparent from the findings is that while on clinical placements, university paramedic students expected to gain a similar level of respect from on-road paramedics compared to that afforded to vocational trainee paramedic staff who are on the payroll. It could be interpreted that university students on clinical placements may have viewed themselves as superior to vocational trainee paramedics, when in fact their credibility within the workplace was much reduced. Tensions between university students and vocational trainee paramedics may have added further to the presence of stigmatisation. Future clinical placement orientation programs should clearly prepare students for their super-nummary status. Notably, many students reported that they did not directly encounter any stigmatisation while on placement, which may indicate a cultural change due to the growing critical mass of university graduates now in the workplace.

As well as encountering stigmatisation, university students may experience marginalisation while on clinical placements (Boychuk Duchscher & Cowin, 2004) as a result of the intersection of two divergent cultures. A possible reason for this relates to the unfamiliar paramilitary command and control structure within ambulance services (Lazarsfeld-Jensen et al., 2011; Reynolds, 2008), which differs significantly from the

university environment. Similar findings have been reported in literature about the professional socialisation of medical students. Hospital placements were described as traumatic and humiliating experiences and medical students adopted a subservient approach to senior doctors on ward rounds (Becker et al., 1961; Conrad, 1988; Radcliffe & Lester, 2003). Similarly, the need to be polite and subdued was identified in this study to avoid exacerbating tensions with on-road staff, while others preferred to take an observational approach to the ambulance culture. The students felt the need to fit in and not 'rock the boat' and do virtually whatever it took to pass their clinical placement.

Towards the end of the paramedic degree, seeking employment with an ambulance service became a major focus. Previously, under the traditional vocational education and training model, the majority of recruits applied to become paramedics with their local- or state-based ambulance service (Fitzgerald, 2013). Under the traditional organisational socialisation model, deciding on an employer occurred during the anticipatory phase of socialisation (Jablin, 2001; Kramer, 2010). The results in this research study indicate that the decision in relation to which ambulance service to apply for employment was made towards the end of the formal phase of professional socialisation. The findings in this study also suggest that a number of university graduates applied for work with several ambulance services, and not just their local ambulance provider. Thus graduates may be willing to consider moving to different states or NHS Trusts because their university qualifications offer a greater extent of portability compared to vocational qualifications. These results differ from a small number of studies which examine potential employment destinations (O'Meara et al., 2012; Waxman & Williams, 2006).

After being provided with offers of employment, subject to satisfactory final grades, the extent of preparedness for the workplace became the main focus. Many expressed the view that university prepared them well academically but not practically, confirming the findings of several other

authors (Dawson, 2008; Lazarsfeld-Jensen, 2010; Lazarsfeld-Jensen et al., 2011; O'Brien et al., 2013). The results from this study also indicate that stories told by newly employed paramedic graduates about their experiences transitioning into a command and control culture might have negatively influenced the work preparedness preconceptions of final year university students.

9.2.3 Post-Formal Socialisation

A post-formal phase of professional socialisation, as outlined by a number of authors (Cant & Higgs, 1999; Lamdin, 2006; Shuval & Adler, 1977), was found to be present in this research study. The formal orientation programs run by many ambulance services appear to be influenced by organisational socialisation tactics (Ashforth et al., 1998; Jones, 1983; Van Maanen & Schein, 1979) previously utilised under the traditional apprenticeship vocational training model. An initial culture shock was experienced when encountering the paramedic hierarchical paramilitary structure for the first time as an employee, which aligns with a small body of research examining the structure of ambulance services (Lazarsfeld-Jensen et al., 2011). Although having had clinical placement experience as students, they were most likely shielded from the hierarchy as they had very junior student status and operated at the field level. Orientation exposed new graduates to upper echelons of the organisation such as senior managers and educators.

As the transition from the formal orientation program to the on-road environment occurred, the presence of an initial honeymoon period was found, which confirmed the work of Kramer (1974) and Boychuk Duchscher (2008, 2009, 2012). As uniformed employees, a greater degree of acceptance by colleagues was encountered compared to clinical placement experiences, which aligns with the observation that university students may have an unrealistic expectation about their acceptance into the workplace while on placement. After a short honeymoon period, a skills and routine mastery phase occurred, confirming Kramer's (1974)

work. The skills and routine mastery category arose repeatedly during the formal professional socialisation phase, as a workplace culture was encountered where paramedics judged each other on skills proficiency, most notably during high acuity cases. Consequently, the importance of managing cardiac arrests and trauma cases was emphasised. The new graduates' adherence to workplace routines was also scrutinised. For example, paramedics are required to arrive at work before the shift begins to perform an ambulance pre-shift check, correctly sign out schedule 8[1] drugs, take rest breaks and complete timesheets. A perception occurred that a paramedic's reputation could possibly be enhanced or reduced as a result of their skills and routine proficiency.

A divergence between the university and ambulance service environments became apparent during the post-formal phase. At university, the culture values 'academic freedom' and diversity of view, while the ambulance service values conformity, a hierarchical chain of command and a protocol based *modus operandi*. A period of marginalisation (Boychuk Duchscher & Cowin, 2004; Enoch, 1989) occurred as new graduates had moved out of the university culture and had not yet adjusted to the dominant ambulance culture.

The variation in internship models used by ambulance services was apparent. Some services provided structured and supportive internship programs, while others retained an internship program similar in structure to the traditional in-house vocational apprenticeship model. These results confirm similar findings in the literature suggesting that graduate internship programs need to move away from traditional vocational models (Willis et al., 2009), where interns are treated as 'roster fodder' to

[1] Schedule 8 drugs are drugs of addiction, such as morphine and fentanyl. These drugs are required by law in Australia to be kept in a double locked safe when not signed out by a qualified paramedic, and if not administered to a patient the drugs must be sign back in at the conclusion of a shift. Audits are regularly carried out by an ambulance managers to ensure that these drugs are correctly accounted for.

an approach that is better tailored to university graduates. The need for further research on paramedic internship programs arises from this study.

According to Kramer's (1974) reality shock model, the skills and routine mastery phase is simultaneously associated with a social integration phase. The presence of a social integration phase was verified as relevant in this study as interns sought acceptance into the ambulance culture. Social integration appeared to be significantly influenced by micro-cultures at the ambulance station level. For example, social integration was easy to obtain at stations where regular social events such as barbeques occurred, while personality clashes between management and on-road staff could result in a hostile or confrontational work environment. To gain acceptance, pressure was felt by many to emulate the cultural behaviour of paramedics on station, confirming findings outlined by several other authors (Boychuk Duchscher & Cowin, 2004; Kramer, 1974; Scott & Myers, 2005; Tracey & Scott, 2006). Cultural behaviour such as promoting a 'boys club' and a 'them versus us' attitude towards management and dispatch were also highlighted, confirming the results outlined by Reynolds (2008) in her pivotal work investigating the ambulance culture.

A culture where there is a lack of positive feedback was identified in the results. Feedback was mostly provided after paramedics made mistakes. The lack of positive feedback may be the result of a command and control culture where "concepts of rank and authority" need to be preserved (Lazarsfeld-Jensen et al., 2011, p. 34). Research suggests that a "side effect of a command culture is that everyone wants an opportunity to pressure someone a rank below them", which may lead the lower ranked paramedic interns to feel victimised (Lazarsfeld-Jensen et al., 2011, p. 34). At university, students are used to receiving and giving feedback, which possibly makes the transition into a command and control environment difficult (Lazarsfeld-Jensen et al., 2011).

The results also confirmed the presence of Kramer's (1974) moral outrage phase. The moral outrage phase was evident as new graduate paramedics became aware of their inability to practice paramedicine as it was portrayed at university. Examples given included being over-ruled by clinical mentors, who may have felt threatened by working with degree qualified paramedics. Several authors (Lazarsfeld-Jensen et al., 2011; Parker & General Purpose Standing Committee No. 2., 2008; Willis et al., 2009) have reported similar findings. The importance of interpersonal skills, such as good communication, was especially evident with respect to managing workplace conflict. With the benefit of hindsight, interns could see the relevance of the inclusion of communication skills in the curriculum. A non-confrontationist approach was taken to avoid developing a bad workplace reputation, aligning with the findings of other authors (Burns & Stalker, 1994; Jones, 1986; Lazarsfeld-Jensen et al., 2011; Scott & Myers, 2005; Tracey & Scott, 2006; Willis et al., 2009). Conflict resolution training in the paramedic university curriculum may be a way of dealing with such issues.

Another strong finding indicated the need to develop resilience strategies to manage the confronting side of paramedic practice. The confronting nature of paramedic work has been well documented in the literature (De La Garza, 2011; Revicki & Gershon, 1996; Reynolds, 2008). The results of the current study indicate that new graduates are likely to observe and emulate their clinical instructor's resilience strategies, which may not always reflect best practice. Developing resilience strategies appears to be relevant to the skills and routine mastery, and social interaction phases. Common resilience mechanisms that were adopted by the interns included the use of gallows humour, storytelling, buffering techniques such as depersonalisation, emotional compartmentalisation and the formation of an emotional bank account. These resilience mechanisms are consistent with the literature on emotional intelligence (De La Garza, 2011; Regehr et al., 2002; Regehr et al., 2000; Reynolds, 2008; Rosenberg, 1991; Scott

& Myers, 2005; Smith, 1995). It was not clear from the results as to whether resilience training was undertaken at university. It can be noted that other confronting occupations, such as military personnel with the United States Defence Force, have adopted resilience training as part of their basic curriculum (Reivich, Seligman, & McBride, 2011).

A finding that has not been widely reported in the literature related to responding to cases in lower socioeconomic areas as this was as confronting as encountering traumatic death. Feeling powerless to change the socioeconomic status of some patient groups was also reported, which led to cynicism and judgemental thoughts towards these patients. However, the new graduate paramedics who took part in this study stressed that despite experiencing judgemental thoughts, professionalism was always displayed.

Increased confidence levels were reported towards the end of the internship or sandwich year. This may result from encountering a variety of clinical cases and growing accustomed to the apprenticeship like structure of the internship program (Lazarsfeld-Jensen et al., 2011). Improved confidence levels may indicate that interns, by the second half of the year, had developed their skills and routine mastery to a sufficient level that would enable them to achieve social integration (Kramer, 1974).

9.2.4 The Post-Internship Phase

A new professional socialisation phase, called the post-internship phase, was deemed necessary, as the current professional socialisation model outlined by several authors (Cant & Higgs, 1999; Higgs, 2013; Lamdin, 2006; Shuval & Adler, 1977) did not sufficiently explain the professional socialisation of paramedics. The post-internship phase has been created because Australian paramedics, after graduating, have to complete an internship year prior to being awarded the title of qualified paramedic. A new level of cultural credence is associated with becoming a qualified paramedic. Many allied health, nursing and medical graduates are

required to undertake a mentor or internship year. However, these professionals are eligible to register as health professionals after graduating from university. As paramedicine is not a registered profession in Australia, the employer provides a graduate paramedic's authority to practice as a qualified clinician.

The post-internship phase was also relevant to the UK context, because after the sandwich year, UH students fulfilled the criteria for registration as a paramedic. Similar to the Australian context, UK registered paramedics possess a higher cultural credence than ambulance technicians. However, unlike other health professionals, after registering, the UK participants interviewed in 2010 returned to university for 12 months to complete their Paramedic Science Degree. Their feelings of frustration due to having to return to university after registering were interpreted using Kramer's (1974) moral outrage phase.

After graduating and securing fulltime employment with a UK NHS Ambulance Trusts, the experiences of UK paramedics were similar to their Australian counterparts who had become qualified paramedics. For example, both cohorts made the transition to the senior clinician on the ambulance and were required to mentor new employees. The results indicated that another honeymoon phase was experienced after qualifying, adding to Kramer's (1974) reality shock model. After experiencing stigmatisation and marginalisation as university students, internship paramedics (Australia) and ambulance technicians (UK), the workplace identity associated with being a fully qualified paramedic was gained which was met with both relief and excitement.

The brief honeymoon period appeared to give way to an additional moral outrage phase (see Figure 9.1) due to a perceived unpreparedness to undertake the role of a senior clinician and clinical mentor.

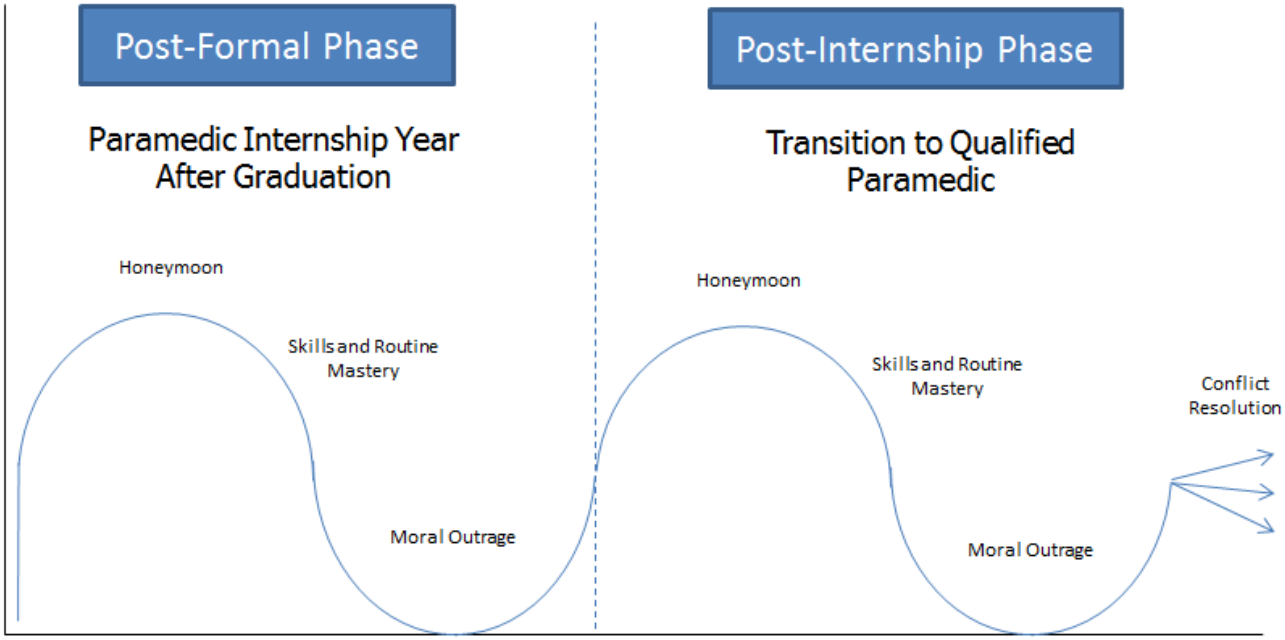


Figure 9.1. A Conceptual Model of Kramer's Phases during the Post-Formal and Post-Internship Phases.

In the above model the post-formal and post-internship phases are presented. The left hand side shows the post-formal phase outlined by several authors (Cant & Higgs, 1999; Higgs, 2013; Lamdin, 2006; Shuval & Adler, 1977). On the right hand side the new post-internship phase of professional socialisation is depicted. Figure 9.1 shows how paramedics go through two cycles of the honeymoon, skills and routine mastery and moral outrage phases during and after undertaking a professional employment year.

From the results, it appears that ambulance services did not adequately prepare qualified paramedics for the added complexity of being a clinical mentor. In addition to managing potentially difficult cases, newly qualified paramedics were required to supervise less qualified ambulance staff, some of whom were twice their age. Furthermore, Australian and UK ambulance services need to provide standards and role descriptions for clinical mentors beyond being a qualified paramedic. For example, some Canadian ambulance services require clinical mentors to be respected senior paramedics, who have completed specialist mentor training (Mutchmor, 2013; Slade, 2007). Due to a lack of mentor training, some newly qualified paramedics appear to have emulated the demanding

mentoring style of their clinical instructors. It was unclear whether the instructors' mentoring style was emulated due to micro-cultural pressure, or due to a lack of information on mentoring techniques. Others appeared to use reflective practice when developing their mentoring styles, and developed a more supportive approach. Developing supervisory and mentoring skills as the senior clinician on the ambulance possibly led to the commencement of another skills and routine mastery phase (Kramer, 1974) as depicted in Figure 9.1. Having the additional tasks, for which they felt neither prepared nor trained for, on top of usual clinical work led newly qualified paramedics to experience a further moral outrage phase (see Figure 9.1).

In addition to the skills and routine mastery, social integration and moral outrage phases, this study also confirmed that Kramer's (1974) conflict resolution phase is relevant to the professional socialisation of university educated paramedics. An attempt to make sense of the reality of paramedic practice occurred during the conflict resolution phase (Kramer, 1974). A dichotomy between the reality of practice and the idealistic portrayal of paramedic work by the ambulance culture became evident during the conflict resolution phase. For example, numerous high acuity cases in one shift could lead to mental and physical fatigue, despite the culture emphasising the importance of these cases. However, describing the reality of paramedic practice to the general public was often challenging. A similar phenomenon has been reported in the literature where criminal justice workers and firefighters tend to talk about the heroic components of their jobs, placing less of an emphasis on the mundane or less desirable aspects of their work (Tracey & Scott, 2006). Likewise, trauma and cardiac arrest cases can form a 'badge of honour' (Tracey & Scott, 2006) for paramedics.

Kramer (1974) maintains that the conflict resolution phase may result in several possible socialisation outcomes. The outcomes discussed in the results component of this thesis confirm the relevance of some of these

outcomes. The conflict resolution outcomes specifically identified in this thesis are behavioural capitulation, values capitulation and biculturalism (Kramer, 1974). However, not all of Kramer's outcomes were found or confirmed by this research. For example, the plague on both your houses and going it alone (withdrawal) outcomes were not observed. Although not observed, these outcomes may exist in the paramedic context, and newly qualified paramedics who have chosen these pathways possibly did not volunteer for this study. A three to five year longitudinal study of university educated paramedics, after they complete their internship year and become qualified, may possibly confirm the presence of the plague on both your houses and the going it alone outcomes discussed by Kramer.

Intentions to leave paramedicine and select an alternative career confirmed the presence of the behavioural capitulation outcome (Kramer, 1974). However, not all the components of behavioural capitulation were observed. For example, a desire to move into an education or management role to escape the discomfort of the conflict resolution phase was not reported. Ideally new graduates need to gain several years of experience as a paramedic before taking on an educator's role (Ruple et al., 2005).

The value capitulation outcome was observed in this study when new graduate paramedics began to stigmatise university students on clinical placements, and qualified paramedics adopted harsh mentoring styles when supervising paramedic interns. Emulating these negative aspects of the ambulance culture may lead to greater acceptance in some micro-cultures and rapidly reduce tensions in the workplace, confirming Kramer's (1974) findings. In effect, some paramedics 'sold their souls' in order to fit into a particular micro-culture. A similar finding is reported in the literature investigating gang theory, which addresses issues such as membership to a group with specific rules enforced by the person in charge. A postmodern interpretation of gang theory may further assist in

understanding the reasons why some university educated paramedics choose to pursue the value capitulation outcome.

The theory of cultural transmission (Thrasher, 1936; Wood & Alleyne, 2010) proposes that cultural behaviour is learned and not biologically inherent. Thus, when placed in an environment where gang culture is the norm, people will assimilate into this culture. The theory of differential association (Sutherland & Cressey, 1960; Wood & Alleyne, 2010) explores how cultural assimilation is reinforced by observing and participating in gang activity, resulting in the normalisation of such behaviour (Akers, 1997). Within the paramedic context, graduates may be exposed to a micro-culture where some paramedics stigmatise university students, promote a management versus the rank and file culture and view low acuity cases as undesirable. Consequently new staff members may normalise these views and digress from their pre-employment values.

Not all newly qualified paramedics choose to pursue the value capitulation outcome. Similarly, not all youths who live in communities with deteriorating social structures join gangs. The control or social bond theory (Gottfredson & Hirschi, 1990; Wood & Alleyne, 2010) investigates the reasons why people choose not to join gangs. Youths from families with positive value systems, and who possess a strong family bond are less likely to join gangs (Gottfredson & Hirschi, 1990; Wood & Alleyne, 2010). Many people join gangs for the short-term benefits, such as acceptance or belonging, while others abstain from immediate gratification and see the long-term social benefits resulting from keeping away from gangs (Wood & Alleyne, 2010). Likewise, in the context of this study, most did not encounter Kramer's (1974) value capitulation outcome, possibly due to observing the long-term effects of emulating certain micro-cultural behaviours, which may lead to pessimism and cynicism. Instead, they decided to keep their established bonds elsewhere in the organisation.

The final outcome observed in this thesis was biculturalism (Kramer, 1974; Kramer & Schmalenberg, 1977). Through the process of biculturalism, there was a merging of the desirable aspects of both the university and the ambulance service cultures, with a focus on adding positively to the system through achieving cultural change (Kramer, 1974). For example, the importance of having a university education was emphasised, and value placed on the reality of paramedic practice. New graduates who pursue the biculturalism outcome appear to have developed the ability to interpret the underpinning reason for the cultural behaviour of incumbent staff within the organisation. Therefore, participants who pursue biculturalism may "possess a value orientation that is perhaps different from the dominant one in the work organisation" (Kramer, 1974, p. 162).

Although Kramer's (1974) reality shock model is confirmed in this study as relevant to the paramedic context, it is limited in its ability to address how individuals impact on an organisation and the two-way collaboration between the university sector and the paramedic discipline, all of which may influence professional socialisation. In effect, Kramer (1974) emphasises the role of the profession and the organisation in influencing socialisation but largely neglects the role of the individual in influencing the organisation. Similarly, Kramer pays scant attention to university and professional interactions and the role these play in shaping both organisations. For example, universities and ambulance services collaborate through industry and professional organisations, such as the CAA, Paramedics Australasia, and the UK CoP.

The CAA Education Committee consists of representatives from both ambulance service education departments and the university sector. The education committee discusses curriculum issues, clinical placements, and future directions for ambulance education (CAA, 2010b). The accreditation of university programs in Australia is provided jointly by the CAA and PA,

and has both academics and industry representatives on accrediting panels.

In Australia, a student paramedic association (SPA) exists as a sub-group of PA, and provides university paramedic students with professional development and networking activities within the paramedic discipline (SPA, n.d.). Networking, mentoring and advocacy for university academics and paramedics involved in ambulance education is provided by the Network of Australasian Paramedic Academics, another sub-group of PA (Network of Australasian Paramedic Academics, 2014).

In the UK, universities and ambulance trusts collaborate with the CoP through committees such as the Higher Education Ambulance Development Group (HEADG), Joint Royal College Ambulance Liaison Committee (JRCALC) and the National Ambulance Education and Development Forum (College of Paramedics, 2009). Although the UK College of Paramedics has a student membership category, a student paramedic association does not appear to form part of the association's structure (CoP, n.d.). However, university paramedic students are able to interact with paramedics through professional development activities, which may influence the formation of preconceptions relating to paramedicine during the anticipatory and formal phases of professional socialisation.

Kramer's (1974) theory also does not address attempts by university paramedic programs to introduce aspects of the ambulance culture within the university environment, which may prepare students for a paramilitary culture. For example, university paramedic students are required to wear a uniform during practical sessions and while on clinical placements (see Section 6.5.1).

Having discussed the findings from this thesis, a model of paramedic professional socialisation is proposed in Section 9.2.5 (see Figure 9.2). The model of paramedic professional socialisation is built on two existing

professional socialisation models, namely the three phase professional model outlined by Cant and Higgs (1999), Higgs (2013), Lamdin (2006) and Shuval and Adler (1977), and Kramer's (1974) reality shock model.

9.2.5 A Theoretical Model Depicting Paramedic Professional Socialisation

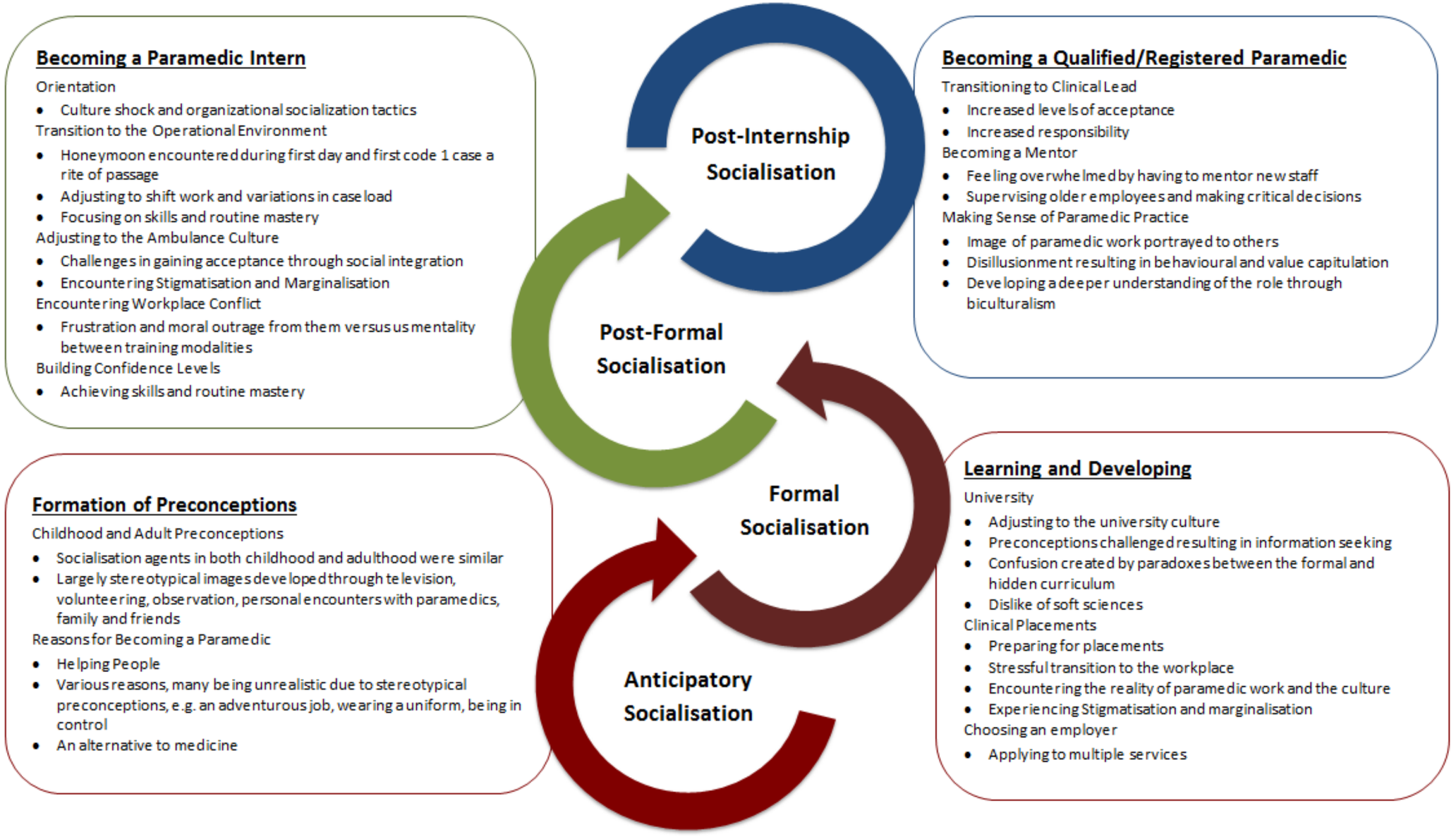


Figure 9.2. A Theoretical Model of Paramedic Professional Socialisation.

The above paramedic professional socialisation model reflects the main findings from the results and is informed by the work of Kramer, M. (1974). Reality Shock: Why nurses leave nursing. St Louis, C.V Mosby Company, R. Cant and Higgs, J. (1999), Professional Socialisation in Educating Beginning Practitioners. Challenges for Health Professional Education. J. Higgs and H. Edwards. Melbourne, Butterworth-Heinemann, and Boychuk Duchscher, J. E. and L. S. Cowin (2004). "The experience of marginalization in new nursing graduates." Nursing Outlook **52**(6): 289-296.

9.2.6 Summary of the Professional Socialisation of Paramedics

Four phases of professional socialisation were identified in this thesis. The first three phases, the anticipatory, formal and post-formal phases of paramedic professional socialisation largely conformed to professional socialisation theories outlined by Cant and Higgs (1999), Lamdin (2006) and Shuval and Adler (1977). A fourth phase, the post-internship phase was added to existing models, and explains the professional socialisation of paramedics transitioning from interns to qualified practitioners.

The presence of a honeymoon phase and a skills and routine mastery phase were confirmed as per Kramer's (1974) reality shock model. Social integration and moral outrage phases were also confirmed to be relevant to this research. Furthermore, the theory of marginalisation was found to be evident as paramedic interns attempted to fit into the ambulance culture.

In the post-internship phase, a second honeymoon phase was present as the identity of a qualified paramedic was finally achieved. An additional skills and mastery phase and moral outrage phase were encountered, which differed to Kramer's (1974) original theoretical model. For example, qualified paramedics had to develop mentoring skills and learn to negotiate the role of the senior clinician.

The conflict resolution phase was confirmed and found to be consistent with Kramer's (1974) reality shock professional socialisation model. The conflict resolution phase resulted in identification of several possible outcomes to the socialisation process. The intention to leave the paramedic profession identifies the presence of behavioural capitulation. However, not all aspects of behavioural capitulation were observed, such as moving into an education or management role to avoid frustration caused by the reality of paramedic practice. Value capitulation was confirmed to be present when university educated paramedics emulated the cultural practice of stereotyping new graduates in an attempt to fit in.

A postmodern view of gang theory, such as cultural transmission and differential association, was utilised to further explain Kramer's (1974) value capitulation outcome. The last of Kramer's outcomes to be confirmed in this study was biculturalism as paramedics merged the best aspects of the values of both universities and ambulance services to add positively to the system. Kramer's plague on both your houses and going it alone outcomes were not observed in this thesis.

Finally, a model outlining the professional socialisation process experienced by university educated paramedics was presented, which incorporates two models of professional socialisation. These models are the anticipatory, formal, post-formal phases (Cant & Higgs, 1999; Higgs, 2013; Lamdin, 2006; Shuval & Adler, 1977), with an additional post-internship phase added by the author. An amended version of Kramer's reality shock model (Kramer, 1974) informed by the postmodern theory of marginalisation (Boychuk Duchscher & Cowin, 2004) is also represented in the proposed model of paramedic professional socialisation.

9.3 The Significance of this Research

This research is significant because it has created new knowledge about the professional socialisation of university educated paramedics. To date, no studies have examined this topic comprehensively from the time of enrolment at university through to the impact of clinical placements, internship programs and the transition to fully qualified paramedic. While professional socialisation theories within health disciplines are not new, the researcher developed the first theoretical model of professional socialisation reflecting a paramedical paradigm.

The information presented in this thesis may help university students prepare for clinical practice. For example, it provides valuable information on processes such as fitting into the ambulance culture and practical issues that can facilitate good first impressions such as reconnoitring the station prior to commencing clinical placement. Furthermore, the findings

can assist students prior to undertaking their clinical placement to enter their placement with realistic expectations, where students will not be attending multi-vehicle traumas on a daily basis, but rather are more likely to be spending much of their time working with relatively low acuity patients, and spending large amounts of time at the emergency department waiting for the patient to be transferred to an emergency bed. In many ways, the reality of ambulance practice can compare to the military, where the work has been described as 95% boredom and 5% terror (Hancock & Krueger, 2010). The thesis also highlights tensions between the university and ambulance cultures, and identifies the presence of stigmatisation and marginalisation in relation to university students entering the paramedic workplace as visitors.

The results from this research highlight the different phases a paramedic intern is likely to encounter as he/she transitions into full-time employment with an ambulance service. These phases are the honeymoon period, skills and mastery phase and the moral outrage phase. In the honeymoon phase, interns can expect to be enamoured with the uniform, the status of being in the workforce, working in their chosen career as well as getting paid. It would be very valuable for interns to know ahead of time that the culture will judge them on their ability to perform clinically, and their clinical performance can either positively or negatively impact their acceptance in the workplace environment. The benefit of this knowledge may assist interns to avoid cementing a poor workplace reputation. It may also be beneficial for interns to be cognisant of the moral outrage phase, where they have to reconcile the values of two different institutions, namely the university and the ambulance service. Interns may encounter discrepancies in relation to their expectations and the reality of paramedic practice. For example, interns may be overruled by more senior staff who may not be aware of best practice.

Newly qualified paramedics may also benefit from this research as it identifies the presence of further phases that may be encountered such as an additional honeymoon phase and moral outrage phase as well as a conflict resolution phase. As paramedics become mentors, this research provides insights into how they might want to develop their mentoring styles and techniques, as well as the complexities of consolidating their skills while being expected to supervise new staff members. Furthermore, this research is beneficial for paramedics as it provides an awareness of strategies, such as behavioural capitulation, value capitulation and biculturalism, which are used by people as they adjust to the reality of the workplace.

The research has significance for universities. For example, the important influence of the hidden curriculum is highlighted, and consequently universities may consider appropriate briefing of sessional on-road teaching staff to ensure that a realistic picture of paramedicine is portrayed. The research may also assist universities as they prepare students for the transition to clinical placements and employment. For example, universities may want to more overtly brief the students about the potential for some stigmatisation and marginalisation to occur due to their university student status. The findings presented in this study may also assist ambulance services to understand the enculturation process undergone by university educated paramedics as they encounter a discipline transitioning from a vocational occupation to a profession. Finally, this research may provide additional learnings for ambulance services as it identified that the professional socialisation process undergone by university educated paramedics may influence the workplace attitudes, performance and retention of graduate entry paramedics. This research suggests more structured internship programs are necessary and the treatment of graduate entry paramedics as 'roster fodder' should be discouraged by the service.

9.4 Limitations

A number of limitations are present in this study. For example, the selection of a convenience sample of participants could be viewed as a limitation. As participants volunteered to take part in this study, the researcher was unable to implement selection impartiality outside of the inclusion criteria. As such there was no formula which required set numbers of participants to be males, females, mature aged students or school leavers. The results explored in this study present the experiences of the participants. Further research could build on the findings of the current study to examine the experiences of a larger sample of graduate paramedics in Australia and the UK. As very little research exists on the professional socialisation of paramedics, a qualitative research approach was appropriate for building a model and for testing the extent to which existing models developed in the cognate disciplines of medicine, allied health and nursing could be applied to paramedicine.

The cultural differences between Australia and the UK may be considered by some as a limitation. From a paramedical context, it is common for paramedics and paramedic managers to move between the two countries for work. For example, in 2014 LAS opened a recruitment campaign for Australian paramedics to address shortages in the UK paramedic workforce (Keast, 2014). Furthermore, from his exposure to the ambulance culture in the UK through ride outs with LAS and conversing with UK paramedics and paramedic academics, the researcher has identified the UK and Australian ambulance cultures to be very similar.

The cross-sectional nature of this study may have been a limitation as different participants shared their experiences at various time points. A longitudinal approach would have been useful for following the experience of the same people over time. However, a longitudinal approach was not possible due to the time and other resource constraints.

The data collection method of one-on-one semi-structured interviews may have seen some participants exaggerating aspects of their stories to the researcher in an attempt to make their experiences appear favourable. Participants may also have manipulated aspects of their stories to protect their identity. To minimise this limitation, the researcher referred to Minichiello, Aroni and Neville-Hays (2008) and Charmaz (2006) when developing the interview guide and techniques. Member validation was not sought because the interviews were digitally recorded and two supervisors assisted with validating the data analysis techniques used. Participants were aware that they could withdraw from the study at any time, including after the interviews.

The researcher's prior experience and preconceptions formed when in the roles of paramedic, ambulance clinical educator and a paramedic academic could also be viewed as a limitation. Qualitative research has been criticised for being unscientific, and representing an assembly of the researcher's impressions which are subject to bias (Mays & Pope, 1995). The literature focusing on the rigour and objectiveness of qualitative research is said to lack consensus (Williams, 2012b). For example, the qualitative methodology literature outlines several processes to maintain objectivity such as bracketing[1] (Smith, Flowers, & Larkin, 2009; Tufford & Newman, 2010). However, the notion of bracketing has been challenged by the suggestion that researchers are unable to totally detach themselves from their preconceptions (Gough, 2008; Coffey & Atkinson, 1996; Finlay, 2008; Bonner, 2001; LeVasseur, 2003; Mantzoukas, 2005). The researcher demonstrated that his previous experience has added valuable insights in relation to this study, and reflexivity was used to demonstrate the transparency, accountability and trustworthiness of this qualitative research (Gough, 2008; Coffey & Atkinson, 1996; Finlay, 2008; Bonner, 2001).

[1] "Bracketing is a method used by some researchers to mitigate the potential deleterious effects of unacknowledged preconceptions related to the research and thereby to increase the rigor of the project" (Tufford & Newman, 2010, p. 81).

In this study, the researcher used well documented data analysis procedures based on qualitative methods (Charmaz, 2006; Saldana, 2009). However, the use of these qualitative methods is not necessarily considered to be a verification method (Charmaz, 2006; Glaser, 2003). The researcher maintains the trustworthiness and quality of this research study has been established through both transferability and reliability checks (Lincoln & Guba, 1985). Many of findings from this study have confirmed the transferability of the results to similar findings found in peer reviewed publications and reports in the paramedic literature published since this research began in 2008 (Boyle et al., 2008; Boyle, 1997; Lazarsfeld-Jensen, 2010, 2013; Lazarsfeld-Jensen et al., 2011; Lord, 2013; Lord et al., 2009; Michau et al., 2009; O'Brien et al., 2013; O'Meara et al., 2012; Willis et al., 2009; Willis et al., 2010). Further, as outlined in Chapter 4, in the absence of member checking, the coding and data analysis underwent supervisor reliability checks and the process was deemed to be valid.

The linear nature of the socialisation model chosen to explore the anticipatory, formal and post-formal socialisation phases may be viewed as a limitation. The linear progression of socialisation models has been criticised by many authors (Jablin, 2001; Kramer, 2010; Morrison, 2002), as individuals can move through the various phases at different rates. Additionally, individuals may not encounter all phases of socialisation; for example, Kramer (1974) maintains that some individuals do not progress beyond the skills and mastery phase. The rationale for choosing linear socialisation models is that they provide a "convenient metaphor or visual representation that assist in the understanding" of the socialisation process (Kramer, 2010, p. 194). However, it has been acknowledged that reflecting the entire complexities of the professional socialisation process is beyond the scope of any theoretical model (Kramer, 2010).

The seminal work of Kramer (1974) was used in this study to analyse the professional socialisation of paramedics. The use of a theoretical model

published in the 1970s may be seen as a limitation to this study, given Boychuk Duchshcher (2008, 2009, 2012) has more recently built on Kramer's model to develop the stages of transition and transition shock theories. Kramer's (1974) reality shock model was used because it was developed for a discipline in a transitional phase of its evolution, and is flexible in its timeframe (rather than prescriptive). It is noted that Boychuk Duchscher's (2008, 2009, 2012) work is highly prescriptive—to the point of outlining the socialisation of nurses on a month by month basis making it specific to the nursing profession. Kramer's (1974) reality shock model is more applicable than the stages of transitions theories to inform the post-formal stage of professional socialisation in this research.

The creation of a fourth, or post-internship, phase instead of creating a subclass to the third, or formal professional socialisation, phase may be criticised. The rationale for creating a fourth phase relates to the presence of a period where the participants were viewed as qualified by the university, having graduated with a degree, but were not seen as qualified practitioners by the paramedic discipline. A distinct transition phase occurs when paramedic interns become qualified paramedics and are exposed to new experiences, such as mentoring new staff and being the senior clinician on the ambulance.

Having addressed the limitations of the study, the next section outlines a number of analytical propositions resulting from the research.

9.5 Analytical Propositions

A number of analytical propositions have been identified from this research that can inform the professional socialisation process encountered by university educated paramedics.

Analytical Proposition 1

Representing the reality of practice during the anticipatory phase of professional socialisation is an important factor in reducing the severity of the reality shock experienced by new graduates (Kramer, 1974). Future documents, web pages and marketing activities utilised by peak ambulance authorities, ambulance services and ambulance professional bodies need to include photographs that are more representative of the reality of paramedic practice.

Analytical Proposition 2

University paramedic programs should question the need to invite industry representatives to attend and address the undergraduate paramedic cohort during orientation week. If universities are going to continue to seek industry representation during orientation week, course coordinators need to clearly brief the speaker on the need to represent the reality of practice and avoid an emphasis on high acuity cases. Content needs to be of an appropriate welcoming nature, and should not be viewed as an opportunity to potentially traumatise, dissuade or present unrealistic representations to university students aspiring to join the paramedic profession.

Analytical Proposition 3

Further research needs to be undertaken in relation to social science subjects such as inter-professional learning and the timing of these topics in the curriculum. For example, research could investigate if it is best practice for social science subjects to be transferred from the first year of the paramedic program to the final year of study, where students may have a greater ability to recognise the relevance of these subjects to paramedic practice (Mallinson, 2011). Additionally, clearer links or synthesising tutorials need to be provided between the social and core fundamental sciences, enabling university students to learn important

aspects of paramedic practice through an integrated approach. An example would be combining psychology with the management of acute mental health emergencies. Furthermore, paramedic academics should be more involved in topics such as anatomy, physiology and pharmacology in an attempt to address the theory-practice gap. For example, paramedic academics could assist with the synthesis of tutorial content by directly relating the context back to the field of paramedicine. Moreover, a robust process needs to exist for the selection, recruitment and training of sessional academics to address the hidden curriculum which emphasises the high acuity side of paramedic work.

From the results, it was noted that equipment differed in the classroom compared to the on-road environment. Although this appeared to be the exception and not the rule, some universities need to strive to keep up to date with ambulance services with respect to currency of equipment.

Analytical Proposition 4

The results of this study suggest that resilience and preceptorship techniques were not adequately addressed in the undergraduate paramedic curriculum. It is recommended that universities and ambulance services discuss these important areas and decide where these skills are best taught, be it at universities, within ambulance services or possibly by both.

Analytical Proposition 5

Universities and ambulance services need to communicate more effectively in relation to clinical placements. Formal clinical placement orientation programs should be instigated for both university students and on-road clinical mentors. Students should be informed that it is necessary to reconnoitre their placement station prior to the commencement of their clinical placement to minimise the possibility of arriving late on the first day. Additionally, on-road staff need to be better

informed about the scope of clinical practice of students from different universities according to year/level of their programs. Ambulance services and universities need to jointly work on a process for placing students with clinical mentors who are adequately trained and have positive attitudes towards university students.

Analytical Proposition 6

Further research investigating best practice internship year models is required, as the data in this study indicates that internship programs vary widely in both structure and support. Currently, there is a dearth of literature investigating best practice models with respect to the design and implementation of internship programs. Ambulance services should consider implementing more rigorous standards and credentialing to be met by paramedics prior to becoming clinical mentors. After qualifying or registering, paramedics should also be afforded a further consolidation phase with more advanced internship paramedics or paramedic technicians prior to mentoring newly employed graduate paramedics and vocational trainee paramedics. A consolidation period would align paramedicine with other health professions such as physiotherapy and occupational therapy where clinical supervisors are expected to have least one year of experience as a qualified practitioner before they can supervise new staff members.

Analytical Proposition 7

The final recommendation arising from this thesis relates to the creation of various specialities for paramedics. At the time of writing this thesis, paramedics in Australia and the UK are limited with respect to career progression options within the clinical environment. Paramedics have the option of becoming intensive care or critical care paramedics. Alternatively, some Australian ambulance services and UK NHS Trusts have adopted an extended care or paramedic practitioner model. Many

university paramedic programs require high tertiary entrance scores, resulting in the recruitment of intelligent, highly motivated and professionally minded individuals into ambulance services that have previously relied on a vocational education and training models. Thus, there may be a mismatch between the aspirations of university educated paramedics and possible career development options. Further clinical specialities coupled with cultural change are necessary to keep new graduates engaged in the paramedic profession for the longer term and provide opportunities for career advancement and renewal within the service.

9.6 Conclusion

By using existing professional socialisation models and qualitative methods selected from the work of Charmaz (2006, 2012) and Saldana (2009), this thesis has investigated the professional socialisation of university educated paramedics from Australia and the UK. The anticipatory, formal and post-formal model of professional socialisation (Cant & Higgs, 1999; Higgs, 2013; Lamdin, 2006; Shuval & Adler, 1977) in conjunction with Kramer's (1974) reality shock professional socialisation model were used as the frameworks for this thesis. Additionally, postmodern views of marginalisation and gang culture were used when discussing the results of this thesis.

The study has confirmed the presence of the anticipatory formal and post-formal phases, and extended the model to develop a fourth phase to more adequately explain the professional socialisation of university educated paramedics. Additionally, Kramer's reality shock model was expanded when investigating the paramedic context.

The models that have been created from the results will contribute to the overall body of knowledge on the professional socialisation of paramedics and other emerging professions. The results of this study may be of use

in curriculum and policy development with respect to university programs and ambulance services in Australia and the UK. Finally, the experiences of the participants in this study may provide an insight into the professional socialisation process for individuals wishing to pursue careers in paramedicine.

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11. Appendices

Appendix 4.1 Ethical Clearance, Charles Sturt University

CHARLES STURT
UNIVERSITY

OFFICE OF ACADEMIC GOVERNANCE
Private Mail Bag 29
Panorama Avenue
Bathurst NSW 2795
Australia
Tel: +61 2 6338 4185
Fax: +61 2 6338 4194
www.csu.edu.au
ABN: 83 878 708 551

12 June 2009

Mr Anthony Devenish
School of Biomedical Sciences
N8
BATHURST CAMPUS

Dear Mr Devenish,

Thank you for the additional information forwarded in response to a request from the Human Research Ethics Committee.

The Committee has now approved your proposal entitled ***"Experiences in Becoming a Paramedic; A narrative hermeneutic phenomenological study into the experiences of university qualified paramedics in relation to how cultural, educational and political occurrences in their internship period influence the professional socialisation process"*** for a twelve month period beginning 12/06/2009. The protocol number issued with respect to the project is **2009/089**. Please be sure to quote this number when responding to any request made by the Committee.

You must notify the Committee immediately should your research differ in any way from that proposed.

You are also required to complete a Progress Report form, which can be downloaded from **www.csu.edu.au/research/forms/ehrc_annrep.doc**, and return it on completion of your research or by 12/06/2010 if your research has not been completed by that date.

Please don't hesitate to contact the Executive Officer telephone (02) 6338 4628 or email ethics@csu.edu.au if you have any enquiries about this matter.

Yours sincerely,

Julie Hicks
Executive Officer
Human Research Ethics Committee

Cc Professor Joy Higgs Professor Stephen Loftus

Appendix 4.2 Ethical Clearance, Queensland University of Technology

University Human Research Ethics Committee

HUMAN ETHICS APPROVAL CERTIFICATE

NHMRC Registered Committee Number EC00171

Date of Issue: 10/6/10 (supersedes all previously issued certificates)

Dear Mr Scott Devenish

A UHREC should clearly communicate its decisions about a research proposal to the researcher and the final decision to approve or reject a proposal should be communicated to the researcher in writing. This Approval Certificate serves as your written notice that the proposal has met the requirements of the *National Statement on Research involving Human Participation* and has been approved on that basis. You are therefore authorised to commence activities as outlined in your proposal application, subject to any specific and standard conditions detailed in this document.

Within this Approval Certificate are:

* Project Details
* Participant Details
* Conditions of Approval (Specific and Standard)

Researchers should report to the UHREC, via the Research Ethics Coordinator, events that might affect continued ethical acceptability of the project, including, but not limited to:

(a) serious or unexpected adverse effects on participants; and
(b) proposed significant changes in the conduct, the participant profile or the risks of the proposed research.

Further information regarding your ongoing obligations regarding human based research can be found via the Research Ethics website http://www.research.qut.edu.au/ethics/ or by contacting the Research Ethics Coordinator on 07 3138 2091 or ethicscontact@qut.edu.au

If any details within this Approval Certificate are incorrect please advise the Research Ethics Unit within 10 days of receipt of this certificate.

Project Details

Category of Approval: Administrative Review

Approved From: 10/06/2010 **Approved Until:** 10/06/2013 (subject to annual reports)

Approval Number: 1000000500

Project Title: Experiences of becoming a paramedic: a narrative hermeneutic phenomenological study into the experiences of university qualified paramedics in relation to how cultural, educational and political occurrences in their internship period influence the professional socialisation process

Chief Investigator: Mr Scott Devenish

Other Staff/Students: Prof Michele Clark , Prof MaryLou Fleming

Experiment Summary:
The purpose of this project is to research the experiences of people making the transition from university graduate to practising ambulance paramedic.

Participant Details

Participants:
University graduates entering into paid employment with an ambulance service

Location/s of the Work:
Charles Sturt University NSW Department of Health SA Department of Health Ambulance Victoria

Appendix 4.3 Research Approval through Monash University

CHARLES STURT UNIVERSITY

School of Biomedical Sciences

Panorama Avenue
Bathurst NSW 2795
Australia

Int: +61 2 6338 4512
Fax: (02) 6338 4993
Int: +61 2 6338 4993
www.csu.edu.au/faculty/science/biomed
ABN: 83 878 708 551

6 October, 2009

Bill Lord
Head, Undergraduate Program
Senior Lecturer
Department of Community Emergency Health and Paramedic Practice
Monash University

Dear Bill,

Frank Archer suggested I contact you in relation to interviewing three Monash University paramedic students approaching the end of their degree. I am investigating the lived experience of university qualified paramedics as they leave the tertiary sector, gain employment with an Australian ambulance service and progress to qualified paramedic status. The title of my PhD is as follows:

"Experiences in Becoming a Paramedic"

A narrative hermeneutic phenomenological study into the experiences of university qualified paramedics in relation to how cultural, educational and political occurrences in their internship period influence the professional socialisation process.

By professional socialisation, I am referring to the process where attitudes, behaviour, and knowledge are gained by newcomers in order to participate as an organisational member, or put simply, the organisational moulding of new employees.

I understand your third year students are away on clinical placement at the moment, however, could you please pass on the attached information sheet to your final year students, and hopefully I may attract some volunteers. In addition to the CSU students I have already interviewed, I am also hoping to interview students from Flinders University, as well as graduate paramedics from Ambulance Victoria, SAAS, QAAS and the ASNSW.

In addition to the Information sheet, I have also attached, for your information, further supporting documents relating to my PhD:

1. Information sheet and Consent form
2. Letter of ethics approval from the Charles Sturt University Human Research Ethics Committee
3. Letter of ethics approval from the South Australian Department of Health
4. CSU Ethics application form
5. Research proposal

Yours sincerely,

Scott Devenish *MVEdT, B.Nur, Dip.Para Sc, RN, MACAP*
Lecturer,
Bachelor of Clinical Practice (Paramedic)
Bachelor of Nursing/Clinical Practice (Paramedic)

Appendix 4.4 Research Approval through Flinders University

Queensland University of Technology
Faculty of Health School of
Public Health

Victoria Park Road
Kelvin Grove Qld 4059 Australia
Phone +61 7 3138 5879 Fax +61 7 3138 3369
www.hlth.qut.edu.au/ph

10 June, 2010

Tim Pointon
Head Paramedic
Faculty of Health Sciences
Flinders University

Dear Tim,

Further to our telephone conversation on the 9th of June, I wish to interview 2 or 3 voluntary participants from the final year cohort of your paramedic program for my PhD.

This PhD study is investigating, via qualitative methods, the lived experience of university qualified paramedics as they leave the tertiary sector, gain employment with an Australian ambulance service and progress to qualified paramedic status. The title of my PhD is as follows:

"Experiences in Becoming a Paramedic"

A narrative hermeneutic phenomenological study into the experiences of university qualified paramedics in relation to how cultural, educational and political occurrences in their internship period influence the professional socialisation process.

By professional socialisation, I am referring to the process where attitudes, behaviour, and knowledge are gained by newcomers in order to participate as a professional in their chosen career.

The data collection process will be by semi-structured interviews conducted by me, either by face to face or by telephone. Interviews are not expected to take more than an hour in length.

I am planning to be in Adelaide to interview qualified paramedics from SAAS in mid July. It would be fantastic to be able to interview some final year paramedic students on Wednesday the 14th of July whilst I am over in Adelaide as well.

For your information, please find attached supporting evidence and documentation relating to my PhD request:

1. Information sheet and Consent form
2. Letter of ethics approval from the Charles Sturt University Human Research Ethics Committee
3. Letter of ethics approval from the South Australian Department of Health

Yours sincerely,

Scott Devenish *MVEdT, B.Nur, Dip.Para Sc, RN, MACAP*
Lecturer,
Bachelor of Health Sciences (Paramedic)
Queensland University of Technology

Appendix 4.5 Ethics Approval and Research Approval through the University of Hertfordshire

UNIVERSITY OF HERTFORDSHIRE
FACULTY OF HEALTH AND HUMAN SCIENCES
ETHICS COMMITTEE FOR HEALTH AND EMERGENCY PROFESSIONS

Protocol Number:	HEPEC/09/10/1
Name of Investigator:	Scott Devenish
Name of UH Link:	Dr Julia Williams
Programme:	PhD
Title of Study:	Experiences in becoming a paramedic: A narrative hermeneutic phenomenological study into the experiences of university qualified paramedics in relation to how cultural, educational and political occurrences in their internship period influence the professional socialisation process

Following Chair's review of the protocol and documentation which obtained Ethical Approval from QUT University Human Research Ethics Committee, Australia, I am pleased to confirm that it is consistent with the protocol and documentation standards for the University of Hertfordshire's Health and Emergency Professions Ethics Committee. Your protocol is, therefore, approved for this institution.

The general conditions of Ethics Protocol approval are that:

- you do not deviate from the approved protocol without further ethical approval, which can be obtained by completing a Minor Modifications form and submitting for consideration via Chair's Action.

Please cite the HEPEC Protocol Number given above on all participant material relating to participants from the University of Hertfordshire.

On behalf of the Committee, I would like to wish you all the best with your study.

Jane Smith
Chair of Ethics Committee

Cc Dr Julia Williams, UH Link Date: September 2010

Approval by HEPEC Committee — September 2010

Appendix 4.6 Ethical Clearance NSW Department of Health

SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

ADDRESS FOR ALL CORRESPONDENCE
RESEARCH DEVELOPMENT OFFICE
LEVEL 3, BUILDING 92
ROYAL PRINCE ALFRED HOSPITAL
CAMPERDOWN NSW 2050

TELEPHONE: (02) 9515 6766
FACSIMILE: (02) 9515 7176
EMAIL: lesley.townsend@email.cs.nsw.gov.au
REFERENCE: X09-0362 & HREC/09/RPAH/614

29 January 2010

Mr S Devenish
PO Box 8092
CSU LPO
BATHURST NSW 2795

Dear Mr Devenish,

Re: Protocol No X09-0362 & HREC/09/RPAH/614 - "Experiences in becoming a paramedic: A narrative hermeneutic phenomenological study into the experiences of university qualified paramedics in relation to how cultural, educational and political occurrences in their internship period influence the professional socialisation process"

The Executive of the Ethics Review Committee, at its meeting of 28 January 2010, considered your correspondence of 17 December 2009. In accordance with the decision made by the Ethics Review Committee, at its meeting of 9 December 2009, ethical approval is now granted.

This approval includes the following:

- Research Proposal (Version 1, 24 March 2009)
- Timeline for Research Activities (Version 1, 24 March 2009)
- Information for Participants (Master Version 2, 17 December 2009)
- Participant Consent Form (Master Version 2, 17 December 2009)
- Interview Guide (Version 1, 24 March 2009)
- Recruitment Advertisement (Version 1, 10 November 2009)

You are asked to note the following:

- This approval is valid for four years, and the Committee requires that you furnish it with annual reports on the study's progress beginning in February 2011.
- This human research ethics committee (HREC) has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review and is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* and the *CPMP/ICH Note for Guidance on Good Clinical Practice*.
- You must immediately report anything which might warrant review of ethical approval of the project in the specified format, including unforeseen events that might affect continued ethical acceptability of the project.
- You must notify the HREC of proposed changes to the research protocol or conduct of the research in the specified format.
- You must notify the HREC, giving reasons, if the project is discontinued at a site before the expected date of completion.
- Where appropriate, the Committee recommends that you consult with your Medical Defence Union to ensure that you are adequately covered for the purposes of conducting this study.

Should you have any queries about the Committee's consideration of your project, please contact me. The Committee's Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the Sydney South West Area Health Service website.

You are reminded that this letter constitutes ethical approval only. You must NOT commence this research project at ANY site until you have submitted a Site Specific Assessment Form to the Research Governance Officer and received separate authorisation from the Chief Executive or delegate of that site.

A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

The Ethics Review Committee wishes you every success in your research.

Yours sincerely,

Lesley Townsend

Lesley Townsend
Executive Officer
Ethics Review Committee (RPAH Zone)

HERC\EXECOR/10-01

Appendix 4.7 Research Approval from the Ambulance Service of NSW

ambulance research institute

29 April 2010

Locked Mail Bag 105
Rozelle NSW 2039
Direct Tel: (02) 9320 7605
Direct Fax: (02) 9320 3890

TRIM file no: 10/397
TRIM doc no: D10/3678

Scott Devenish
Lecturer, Paramedic Practice
School of Public Health
Queensland University of Technology
Victoria Park Rd
Kelvin Grove QLD 4059

Re': Protocol No X09-0362 & HREC/09/RPAH/614 'Experiences in becoming a paramedic: A narrative hermeneutic phenomenological study into the experiences of university qualified paramedics in relation to how cultural, educational and political occurrences in their internship period influence the Professionalisation socialization process.'

Dear Mr Devenish,

Thank you for submitting a Site Specific Assessment Form for this study. I am pleased to inform you that authorisation has been granted for it to be undertaken at The Ambulance Service of NSW.

The following conditions apply to this research study. These are additional to those conditions imposed by the human research ethics committee (HREC) that granted ethical approval:

1. Proposed amendments to the research protocol or conduct of the research, which may affect the ethical acceptability of the study and which are submitted to the lead HREC for review, must be copied to me.
2. Proposed amendments to the research protocol or conduct of the research, which may affect the ongoing site acceptability of the study, must be submitted to me.
3. Any research findings must be submitted to the Ambulance Service of NSW for information prior to publication.
4. The research must be conducted in accordance with the ASNSW Guidelines for approving Research Applications, which is enclosed for reference. Any research outcomes submitted for peer reviewed publication or presentation should include ASNSW co-authorship and, therefore, identify the ASNSW as a named collaborating institution. This recognition should conform to the guidelines set down by the Confederation of Medical Editors for Co-authorship.

I wish you every success in your research.

Yours sincerely

Associate Professor Middleton
Director of Research/ Research Governance Officer
Ambulance Service of NSW

Cc Mr Paul Simpson, Ambulance Research Institute

Ambulance Service of New South Wales

Appendix 4.8 Research Approval from Ambulance Victoria

CHARLES STURT
UNIVERSITY

FACULTY OF SCIENCE
School of Biomedical Sciences
Panorama Avenue
Bathurst NSW 2795
Australia
Tel: (02) 6338 4512
Int: +61 2 6338 4512
Fax: (02) 6338 4993
Int: +61 2 6338 4993
ABN: 83 878 708 551

25 August, 2009

Dr Linton Harriss
Research Development Officer
Ambulance Victoria

Dr Harriss,

RE: Ambulance Victoria Ethics and Research Approval.

Further to our telephone conversation on Monday the 24th of August, I am investigating the lived experience of university qualified paramedics as they leave the tertiary sector, gain employment with an Australian ambulance service and progress to qualified paramedic status. The title of my PhD is as follows:

"Experiences in Becoming a Paramedic"

A narrative hermeneutic phenomenological study into the experiences of university qualified paramedics in relation to how cultural, educational and political occurrences in their internship period influence the professional socialisation process.

Hermeneutics is defined as the study of literature and speech in order to discover underlying meaning and themes, where as phenomenology is the study of lived experiences. A narrative (or story telling) approach will also used when writing about these experiences.

By professional socialisation, I am referring to the process where attitudes, behaviour, and knowledge are gained by newcomers in order to participate as an organisational member, or put simply, the organisational moulding of new employees.

The data collection will be through semi-structured interviews, and I am hoping to achieve 30 participants in total from Australia's four largest ambulance services. Participation in this study will be voluntary.

I have a strong interest in interviewing a small number of new graduate paramedic employees from Ambulance Victoria, as I believe your new graduate employees will provide a rich source of data for my Doctorate.

The participants from Ambulance Victoria will have progressed through a pre-employment university model and will fit into one of the following three distinct groups:

- Group one will be about to graduate from university, and will have recently entered paid employment.
- Group two will have completed six months of their probationary/internship period
- Group three will have recently completed their probationary/internship program, achieving the position of Qualified Ambulance Paramedic

Ideally, the aim is to obtain around three participants in each group from Ambulance Victoria.

CHARLES STURT
UNIVERSITY

FACULTY OF SCIENCE
School of Biomedical Sciences
Panorama Avenue
Bathurst NSW 2795
Australia
Tel: (02) 6338 4512
Int: +61 2 6338 4512
Fax: (02) 6338 4993
Int: +61 2 6338 4993
ABN: 83 878 708 551

I have obtained ethics approval through the Charles Sturt University Human Research Ethics Committee. By way of supporting evidence, please find attached copies of the following documents relating to my PhD:

1. Letter of ethics approval from the Charles Sturt University Human Research Ethics Committee
2. Information sheet and Consent form
3. Ethics application form
4. Research proposal

Please don't hesitate to contact me if further clarification is required.

Kind Regards,

Scott Devenish *MVEdT, B.Nur, Dip.Para Sc, RN, MACAP*
Lecturer,
Bachelor of Clinical Practice (Paramedic)
Bachelor of Nursing/Clinical Practice (Paramedic)
School of Biomedical Sciences
Charles Sturt University

From: Harriss, Linton [Linton.Harriss@ambulance.vic.gov.au]

Sent: Tuesday, 1 September 2009 12:50 PM

To: Devenish, Anthony

Subject:RE: Ethics and Research Approval - Experiences in Becoming a Paramedic

Hi Scott,

You do not need to submit this project via the AV Research Committee for the following reasons:

1. the small number of expected participants (up to 7 for Victoria)

2. most, if not all participants will be undergraduates (this doesn't fall under the jurisdiction of Ambulance

Victoria)

If your project changes in regard to these two points and/or in a way that requires greater participation of

AV paramedics please contact me to discuss.

Regards

Linton

Dr Linton Harriss

Research Development Manager

Strategic Planning

Ambulance Victoria | 375 Manningham Road, Doncaster, Victoria 3108

Tel: +61 3 9840 3746 | Fx: + 61 3 9840 3618

Email: linton.harriss@ambulance.vic.gov.au

Web: www.ambulance.vic.gov.au

Appendix 4.9 Ethics Approval from the South Australian Department of Health

Government of South Australia
SA Health

Human Research Ethics Committee

ABN 97 643 356 590

Level 10, CitiCentre
11 Hindmarsh Square
Adelaide SA 5000

PO Box 287
Rundle Mall
Adelaide 5000
Telephone (08) 8226 6064
Facsimile (08) 8226 7088

Mr Scott Devenish
School of Biomedical Sciences
Charles Sturt University
Panorama Avenue
BATHURST NSW 2795

Dear Mr Devenish

Re: Experiences in becoming a paramedic

HREC PROTOCOL NO: 315/09/2012

Thank you for responding to the issues raised by the Department of Health Human Research Ethics Committee. The Committee reviewed your response out-of-session.

I am pleased to advise that ethics approval has been granted to your project, subject to the following conditions:

- The research being conducted in accordance with the 'National Statement on Ethical Conduct in Human Research.'
- Provision of a final report when the project is completed.
- Immediate notification to HREC of any complaints by or adverse events involving participants.
- Immediate notification of any unforeseen events that might affect continued ethical acceptability of the project.
- Submission of any significant changes to the original proposal. Such changes should be approved by the HREC before they are implemented.
- Immediate advice, giving reasons, if the project is discontinued before its completion.

Approval is given for a period of three (3) years only, and if the research is more prolonged than this, a new submission will be required.

Should you have any questions or concerns, please contact Sarah Lawson, Executive Officer of the HREC, Tel 8226 6367 or E-mail hrec@health.sa.gov.au

We wish you well with your project.

Yours sincerely,

Andrew Stanley
CHAIRPERSON
HUMAN RESEARCH ETHICS COMMITTEE

14/09/2009

Appendix 4.10 Research Approval from the South Australian Ambulance Service

From: Mullins, June (Health) [mailto:June.Mullins@health.sa.gov.au]
Sent: Wednesday, 9 December 2009 9:15 AM
To: Devenish, Anthony
Subject: Research application

Dear Mr Devenish

Thankyou for your research application submitted to SAAS. I advise that your proposed research project has been approved by the SAAS Research Review Committee.

It is a current requirement that all approved research projects commence within 6 months of approval and that the researcher forward a brief research progress update to the Committee every 6 months after the commencement date.

Should you require further information regarding the facilitation of your project, please contact Cindy Hein, Manager Clinical Governance â€“ cindy2.hein@health.sa.gov.au

Yours faithfully

June Mullins (B A, B H Sc (Hons))
Research Officer
Clinical Services
SA Ambulance Service
Government of South Australia
Tel: (08) 8274 0730
Fax: (08) 8271 0599

Email: june.mullins@health.sa.gov.au
Website: www.saambulance.com.au

Appendix 4.11 Request for Research Approval through the Queensland Ambulance Service

CHARLES STURT UNIVERSITY

School of Biomedical Sciences

Panorama Avenue
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Australia

Int: +61 2 6338 4912
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www.csu.edu.au/faculty/science/biomed
ABN: 83 878 708 551

Vivienne Tippett
Director ACPHR
GPO Box 1425
Brisbane QLD 4001

Vivienne,

RE: Queensland Ambulance Service Ethics and Research Approval.

My name is Scott Devenish, and I am a Paramedic Academic and a PhD Candidate at Charles Sturt University (CSU), I am investigating the lived experience of university qualified paramedics as they leave the tertiary sector, gain employment with an Australian ambulance service and progress to qualified paramedic status. The title of my PhD is as follows:

"Experiences in Becoming a Paramedic"

A narrative hermeneutic phenomenological study into the experiences of university qualified paramedics in relation to how cultural, educational and political occurrences in their internship period influence the professional socialisation process.

By professional socialisation, I am referring to the process where attitudes, behaviour, and knowledge are gained by newcomers in order to participate as an organisational member, or put simply, the organisational moulding of new employees.

The data collection will be through semi-structured interviews, and I am hoping to achieve 30 participants in total from Australia's four largest ambulance services. Participation in this study will be voluntary.

I have a strong interest in interviewing a small number of new graduate paramedic employees from the Queensland Ambulance Service (QAS), as I believe QAS new graduate employees will provide a rich source of data for my Doctorate.

By way of supporting evidence, please find attached copies of the following documents relating to my PhD:

1. Letter of ethics approval from the Charles Sturt University Human Research Ethics Committee
2. Information sheet and Consent form
3. Ethics application form
4. Research proposal

Yours sincerely,

Scott Devenish *MVEdT, B.Nur, Dip.Para Sc, RN, MACAP*
Lecturer,
Bachelor of Clinical Practice (Paramedic)
Bachelor of Nursing/Clinical Practice (Paramedic)

Appendix 4.12 Request for Research Approval through the Queensland Ambulance Service Declined

REQUEST FOR ACCESS TO QAS STAFF

Vivienne Tippett [Vivienne.Tippett@dcs.qld.gov.au]

Sent: Tuesday, 20 October 2009 11:24 AM

To: Devenish, Anthony

Cc: Jamie Quinn [Jamie.Quinn@dcs.qld.gov.au]

Importance: High

Dear Scott,

Apologies for the phone-tag over the last couple of days and delay in response to your letter. Unfortunately it corresponded with my annual leave and OS trips for work.

I have discussed your request with the Commissioner and on this occasion we're unable to support your application due to a combination of operational pressures and the large number of existing research projects currently seeking similar access to staff.

I'm happy to discuss this with you further if you wish (numbers below)

Regards

A/Prof Vivienne Tippett

DIRECTOR

Australian Centre for Prehospital Research

Queensland Ambulance Service

Ph: +61 7 36351995; Fx: +61 7 3131 6688

Mob: 0407 174 248

Appendix 4.13 National Health System Ethics Clearance

From: NRES Queries Line [mailto:queries@nres.npsa.nhs.uk]
Sent: Wednesday, 18 August 2010 12:56 AM
To: Scott Devenish
Cc: Williams, Julia
Subject: RE: Ethics enquiry

Thank you for your enquiry.

Your query was reviewed by our Queries Line Advisers.

Our leaflet "Defining Research", which explains how we differentiate research from other activities, is published at:

http://www.nres.npsa.nhs.uk/rec-community/guidance/#researchoraudit

Based on the information you provided, our advice is that the project is not considered to be research according to this guidance.

Therefore it does not require ethical review by a NHS Research Ethics Committee.

Given that these paramedics are being recruited from the University of Hertford, I do not consider NHS REC review is needed.

If you are undertaking the project within the NHS, you should check with the relevant NHS care organisation(s) what other review arrangements or sources of advice apply to projects of this type.

Guidance may be available from the clinical governance office.

Although ethical review by a NHS REC is not necessary in this case, all types of study involving human participants should be conducted in accordance with basic ethical principles such as informed consent and respect for the confidentiality of participants. When processing identifiable data there are also legal requirements under the Data Protection Act 2000. When undertaking an audit or service/therapy evaluation, the investigator and his/her team are responsible for considering the ethics of their project with advice from within their organisation. University projects may require approval by the university ethics committee.

This response should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements.

However, if you, your sponsor/funder or any NHS organisation feel that the project should be managed as research and/or that ethical review by a NHS REC is essential, please write setting out your reasons and we will be pleased to consider further.

Where NHS organisations have clarified that a project is not to be managed as research, the Research Governance Framework states that it should not be presented as research within the NHS.

If you have received advice on the same or a similar matter from a different source (for example directly from a Research Ethics Committee (REC) or from an NHS R&D department), it would be helpful if you could share the initial query and response received if then seeking additional advice through the NRES Queries service.

However, if you have been asked to follow a particular course of action by a REC as part of a provisional or conditional opinion, then the REC requirements are mandatory to the opinion, unless

specifically revised by that REC. Should you wish to query the REC requirements, this should either be through contacting the REC direct or, alternatively, the relevant local operational manager.

Regards

Queries Line
National Research Ethics Service
National Patient Safety Agency
4-8 Maple Street
London
W1T 5HD

The NRES Queries Line is an email based service that provides advice from NRES senior management including operations managers based in our regional offices throughout England. Providing your query in an email helps us to quickly direct your enquiry to the most appropriate member of our team who can provide you with accurate written response. It also enables us to monitor the quality and timeliness of the advice given by NRES to ensure we can give you the best service possible, as well as use queries to continue to improve and to develop our processes.

Website: www.nres.npsa.nhs.uk
Email: queries@nres.npsa.nhs.uk

Ref: 04/31

Streamline your research application process with IRAS (Integrated Research Application System). To view IRAS and for further information visit: www.myresearchproject.org.uk

Appendix 4.14 Participant Flyer

Are You a University Educated Paramedic?

Are you interested in sharing your experiences on what it is like joining and working for an ambulance service?

Scott Devenish, a Lecturer in Paramedic Practice and PhD Candidate at Queensland University of Technology, is researching the experiences of people making the transition from university student to practising ambulance officer. Scott wishes to hear the stories people can tell about this experience.

In particular, Scott is interested in university educated paramedics who:

1. Are about to make the transition from university to an operational ambulance service
2. Are mid way through their professional year
3. Have just completed their professional year and are now qualified paramedics

If you wish to participate in this research study, or would like further information, please contact Scott Devenish on +61 7 3138 3581, +61 0433903670 or email scott.devenish@qut.edu.au

Participants will be asked to take part in up to two interviews with Scott, either by telephone or face to face. No interview is expected to take more than an hour. The interviews will be audio taped for transcription purposes; however any identifying information will be kept strictly confidential.

This research has ethics approval through Queensland University of Technology (Ref No 1000000500), NSW Department of Health (RPA Zone Ref No X09-0362), the South Australian Department of Health (Ref No 315/09/2012) and Ambulance Victoria.

Appendix 4.15 Participant Information Sheet

QUT PARTICIPANT INFORMATION for QUT RESEARCH PROJECT

"Experiences in Becoming a Paramedic"

Research Team Contacts

Scott Devenish,
Lecturer, Paramedic Practice
PhD Candidate,
School of Public Health,
Queensland University of Technology
+61 07 31383581
scott.devenish@qut.edu.au

Professor Michele Clark
Director for Research
School of Public Health
Queensland University of Technology
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mj.clark@qut.edu.au

Description

This project is being undertaken as part of PhD for Scott Devenish. The project is funded by Queensland University of Technology. The funding body will not have access to the data obtained during the project.

The purpose of this project is to research the experiences of people making the transition from university graduate to practising ambulance officer. Scott wishes to hear the stories people can tell about this experience.

The research team requests your assistance because you are a university educated paramedic who is either:

1. About to make the transition from university into the ambulance industry
2. Midway through a professional year of employment or an internship program
3. Now a qualified paramedic and have recently completed a professional year of employment or internship period

Participation

Your participation in this project is voluntary. If you do agree to participate, you can withdraw from participation at any time during the project without comment or penalty. Your decision to participate will in no way impact upon your current or future relationship with QUT or the chief investigator.

Participants will be asked to participate in primarily one interview with Scott either by telephone, or face to face in a mutual location. A second interview maybe requested at a later date to further explore themes highlighted in the first interview. A time and date for the second interview, if required, will be negotiated between the participant and the chief investigator on a needs basis. It is not expected that an interview will take longer than an hour.

Example interview questions are as follows:

- Since leaving university, how have your expectations on what it is like to work as a paramedic changed?
- How would you describe the culture of the ambulance service you work in?
- You will most likely have seen things that the average person in society will never see. What have you observed in other paramedics in relation to their coping mechanisms?

Expected benefits

It is expected that this project will not benefit you directly; however, the project may benefit:

- People wishing to pursue a career as a paramedic,
- The paramedic industry,
- The higher education sector.

Risks

There are no anticipated risks in taking part in this project beyond your normal activities as a paramedic. However, you may experience some anxiety when recalling trauma and death as part of your training. In this event the interview will be discontinued and arrangements made for you to receive counselling if you wish through your ambulance service's employee assistance program. However if you are about to make the transition from university student to practising ambulance paramedic, QUT provides for limited free counselling for research participants of QUT projects who may experience anxiety as a result of their participation in the research. Should you wish to access the service, please contact the Clinic Receptionist of the QUT Psychology Clinic on (07) 3138 4578. Please indicate to the receptionist that you are a research participant.

Confidentiality

All comments and responses are anonymous and will be treated confidentially. The names of individual persons are not required in any of the responses. The ambulance service and station you are employed by will not be identified to maintain your confidentiality

The methodology used for this project requires a written transcript of the interview for the purposes of a thematic analysis. Therefore audio recording of interviews is necessary. The audio recording will be:

- Transcribed by a professional transcription service not directly involved in this research project,
- Accessible only by the chief investigator, Scott Devenish, and a professional transcriber,
- Destroyed after transcription of the interview has been completed.

A copy of the transcript can be made available to you on request.

Consent to Participate

We would like to ask you to sign a written consent form (enclosed) to confirm your agreement to participate.

Questions / further information about the project

Please contact the researcher team members named above to have any questions answered or if you require further information about the project.

Concerns / complaints regarding the conduct of the project

QUT is committed to researcher integrity and the ethical conduct of research projects. However, if you do have any concerns or complaints about the ethical conduct of the project you may contact the QUT Research Ethics Officer on 3138 5123 or ethicscontact@qut.edu.au. The Research Ethics Officer is not connected with the research project and can facilitate a resolution to your concern in an impartial manner.

Appendix 4.16 Consent Form

CONSENT FORM for QUT RESEARCH PROJECT

"Experiences in Becoming a Paramedic"

Statement of consent

By signing below, you are indicating that you:

- have read and understood the information document regarding this project
- have had any questions answered to your satisfaction
- understand that if you have any additional questions you can contact the research team
- understand that you are free to withdraw at any time, without comment or penalty
- understand that you can contact the Research Ethics Officer on 3138 5123 or ethicscontact@qut.edu.au if you have concerns about the ethical conduct of the project
- agree to participate in the project
- understand that the project will include audio recording

Name _____

Signature _____

Date _____ / _____ / _____

Appendix 4.17 Interview Guide

Scott Devenish
Experiences in Becoming a Paramedic
sdevenis@csu.edu.au

CHARLES STURT
UNIVERSITY

Interview Guide

Example Interview Questions to be used in a Semi-Structured Interview

1. Pre-employment questions
    - What is your first recollection of the ambulance world?
    - What initially convinced you to become a paramedic?
    - How has your view of paramedicine changed since coming going to university?
    - What do you perceive working as a paramedic will be like?
    - How do you think you will cope with the 'big job'?
    - Do you feel prepared to work in the paramedic industry?
    - How have you enjoyed your university course?
        - What are some highlights
        - What are some low points?

2. Questions for the cohort who are six months into a paramedic internship period
    - Since leaving university, how have your expectations on what it is like to work as a paramedic changed?
        - Can you give me some examples?
    - What is it like to be a paramedic?
        - What experiences have shaped this opinion?

- You will most likely have seen things that the average person in society will never see. What have you observed in other paramedics in relation to their coping mechanism? DO you also employ these coping strategies yourself?
- How has university prepared you for what you are experiencing now in your internship period?
    - Any suggested improvements?
    - What has been the advantage of completing a university degree?
- In six months or so you will be working as a qualified paramedic. How do you feel about this?
- What have been some of the attitudes of your training officers, other senior colleagues and managers to you as a university graduate?

3. Questions for paramedics who are about to complete their internship period, and become qualified paramedics:
    - How has your perception of being a paramedic changed since leaving university?
        - Can you give me some examples of events that have led to this change?
    - How would you describe the culture of the ambulance service you work in?
    - Have you felt adequately supported throughout your internship period?
        - Can you give me some examples of what has led you to feel this way?
    - How have your co-workers attitudes towards you, and workplace treatment you have received changed over your internship period?
    - If you had any advice for university students who are about to join an Australian ambulance service, what would it be?
    - What have been the most challenging aspects in relation to fitting into the paramedic mold?

- You will most likely have seen things that the average person in society will never see.

  What have you observed in other paramedics in relation to their coping mechanism? DO

  you also employ these coping strategies yourself?

Appendix 4.18 Example Memos and Field Notes

Memo:

Paramedics being heroes:

- *I suppose at nine years old I saw ambulances with the lights and sirens ... going to car accidents. But being involved in St John's, you know if someone got really hurt bad then you'd call an ambulance and they'd turn up and save the day and off they'd go."* (X1P1F6A)
- *Whenever something went wrong (the paramedics) would be the guys that you would call and they would fix all your problems.* (X1P1M13C)
- *However the few accidents I did attend ... the paramedics (would) come in and everybody just kinds of stands back and, you could just see that people respected them and that was something that started clicking over in my mind to ... be a part of something like that.* (X1P1F5A)

Participants who have worked for volunteer organisations appear to have placed paramedics up on a pedestal. However they seemed to have a better understanding of the role of a paramedic then others that relied on television and media. The role of volunteer organisations in building the anticipatory preconceptions of paramedic practice appears to be unique to the paramedic field. Nevertheless, these participants still recalled seeing the trauma and life saving side of the paramedic's role. If they had of seen the mundane side of the job, would they have been just as interested? As roughly 7% of the job is as these participants would have perceived it to be like (Clark, Purdie, & Fitzgerald, 2000; Cooper, 2005; Williams et al., 2012; Woollard, 2003).

Memo:

Preconceptions during Early childhood – Being too young to understand what the paramedics do

"I had a few experiences with my Dad having to go to hospital and being taken away in the ambulance, but I never really understood what it was all about. I really didn't know all that much about (the ambulance service) until I applied for the degree after finishing school."(X1P2F19B)

In this example, the participants, being a child, appears to have been too young to understand why the ambulance was coming to treat her father, or why he was being transported to hospital. No actual diagnosis was give, so we are not clear as to what the health issue was. Was it a mental health? The participant did not wish to specify.

Was this participant shielded from the situation by a parent who did not want the child to become upset? Research suggests parents commonly shield young children from traumatic events (Farrell, Ryan & Langrick, 2001). However it is clear preconceptions in adulthood are built upon childhood experiences (Cant & Higgs, 1999, Jablin, 2001, Kramer, 2010).

Memo:

Family tragedy increased the awareness of paramedics

"My cousin was killed in a car accident, and the first lady on scene ... was a nurse ... I was only 12 at the time or just turned 13 and I thought what would I do if I was that first person on scene. That scared me. So for a couple of years the thought (of being a paramedic) was always in the back of my mind." (X1P2F19B)

In this quote, the participant appears have fantasised about what to do in a crisis. The death of a family member who they were arguably close to was obviously a significant memory for this participant whilst growing up. The thoughts of possibly:

- Could I have save them?
- Would I have known what to do if I was there?

Almost a feeling of helplessness appears to be present, leading the participant to trying to come to terms with why and how their cousin died.

Similar findings have been reported in the literature (O'Meara et al., 2012). However these findings relate to peoples decision to become paramedics and did not focus on anticipatory preconceptions as such.

Memo:

Memo – Lack of childhood romance in relation to the paramedic profession.

"I guess riding in the back of an ambulance was the first recollection, recollection (I) have … I'd been hit in the eye with squash ball. I was 14 and I was taken (to hospital) … I guess that's my first recollection of an ambulance … I can't recall anything prior to that. At the time, I really thought nothing more of it." (X1P1M1C)

From the data, examples such as the statement above do not appear to indicate that the participant's had a childhood romantic view of paramedic practice, such as boys fantasising about being a fireman, policeman, soldier or doctor (Neville Nelson, 1978).

It appears as though the participants did not necessarily fall in love with the idea of being a paramedic from their first encounter with an ambulance service. Thus other meaning making was involved in the preconceptions about paramedic practice

Field Note:

Met the participant at (a local café) 1430 in the afternoon.

The participant had previously signed the consent form. The participant was slightly late.

The interview started with a general chat. They were quite interested in my background and appeared relaxed and quite chatty. They were quite young and were of Caucasian background.

The interview was more like a conversation and lasted around 45 minutes.

From their experience, the participant did not seem happy with the university degree they had completed. They gave the university little credibility in preparing them for the workplace. Most of the learning apparently occurred during the internship year. They were quite scathing of the university model really.

I wonder if this participant had encountered what Kramer (1974) refers to as value capitulation. Maybe other paramedics in the workplace look sceptically at the university model and highlight its inability to prepare new graduates for the reality of paramedic practice? Possibly this behaviour was emulated to achieve social integration (Kramer, 1974) and fit in to the workplace?

Field Note:

During today's interview, the interviewee appeared young and seemed quite intelligent – almost a bit intense.

I think they expected paramedics to be a watered down version of medicine. They stated that they didn't get the grades for medicine. This is turning out to be a commonality between some participants.

From what the participant said, they managed to alienate the paramedics on placement. Could this possibly be due to a lack of cultural awareness as well as flaunting their intelligence? Similar findings have been reported by Boychuk Duchscher (2008, 2009, 2012) about new graduate burses being unaware on the cultural sensitivities as they transfer to fulltime employment.

This finding also fits in with the differences between IQ and EQ (Bastian, Burns & Nettelbeck, 2005; Lopes, et al., 2004; Mayer and Salovey, 1989, 1993, 1995; Baron-Cohen et al., 1999; Bass, 2002). They might have had an above average IQ, but their EQ dies not appear to have been as well developed.

Field Note:

Met the participant at a local café. They were a mature aged university paramedic student. During the interview they appeared to be quite reserved.

The interview began with a general conversation over a coffee. I explained the interview process and the participant signed the consent form.

The participant would have been in the 25 – 30 age group, and was of Caucasian background.

It turns out that the paramedic degree was their second degree, as they had completed another degree in another health related filed. They also had quite a bit of work experience with St Johns ambulance.

When talking about clinical placements, the participant appeared to become slightly agitated, as it appears they had encountered stigmatisation. They stated that the ambulance culture is very different to the culture in their previous health related occupation, and it took quite some getting used to the paramilitary structure. The participant's experience confirms the work of Reynolds (2008) in relation to the unique paramilitary culture of paramedicine. However what is interesting is that the paramilitar6y culture is modelled of St John's ambulance, which whom the participant had quite a bit of experience.

Encountering stigmatisation during clinical placements also confirms findings in the literature (Boyle et al. 2008; Lazarsfeld-Jensen et al., 2011; Lord et al., 2009; Willis et al., 2009; Wray & McCall, 2009). The cultural differences between their previous health related occupation and the ambulance service may have contributed to the stigmatisation. However, stigmatisation may also have resulted from experiences encountered by the on-road paramedics in relation to previous mature aged university paramedic students while on placement, and the participant was subjected to this stereotypical image.

Note to self – after listening to recording, must not cut participant off. Wait for them to finish.