An Examination of
University Paramedic Students' Enculturation into the
Ambulance Service

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Abstract
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Service.

This study explores student paramedics' enculturation into a traditional NHS ambulance service trust. The research illustrates the many challenges and dichotomies which face neophyte paramedics as they go from a University classroom setting into their day-to-day clinical work placements. The challenges they face are not the result of individuals alone, rather they result from an inherent subculture ingrained within the organisational structures of the ambulance service and paramedic profession. This ethnography contributes to the social science literature on health and social care by presenting a sociological perspective of student enculturation, from the university classroom into an often chaotic working environment of the ambulance service.

In this research, the way cultural meanings, institutionalised rules, professional identity and working practices determine the working behaviours in the subculture of paramedic practice are uncovered, as individual situations and experiences are contextualised. Drawing on the work of seminal authors and experts in the field, this research explores the subculture along with the hidden curriculum which gives rise to it, as it seeks to understand how and why this appears to hamper and impede the pedagogy experienced by students. This is not the pedagogy taught and encouraged in university, rather a pedagogy which arises out from the intricacies and nuances of the traditional working environment of the paramedic.

The research steers the reader through a complex interplay of subcultural integration between experienced paramedics and students. The work draws on the peculiarity of the language, behaviours, values and working practices of paramedics and students to illustrate the subculture and hidden curriculum which is inherent in their day-to-day working practices. How students transpose what they learn in the university classroom setting to their clinical work placements is examined and unpacked to help illuminate how students

contextualise the knowledge formally taught in the university learning environment, to that of the practice setting.

Supported by a plethora of fieldnotes and interviews with students and paramedics, along with my reflective and reflexive accounts collected over a period of eighteen months, this research informs and contributes to the unfolding developments within the paramedic profession. The work acquaints the reader with a rich meaningful insight into the working customs and practices not seen by members of the public or portrayed by media representations.

Acknowledgements

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Table of Contents:

List of Figures:

List of Tables:

Glossary of Terms:

AACE	Association of Ambulance Chief Executives
A&E	Accident and Emergency
AFC	Agenda for Change
AP	Advanced Practitioner
BBC	British Broadcasting Corporation
CCP	Critical Care Paramedic
COD	Council of Deans for Health
COP	College of Paramedics
EMT	Emergency Medical Technician
GP	General Practitioner
HART	Hazardous Area Response Team
HCPC	Health and Care Professions Council
HEE	Health Education England
HEMS	Helicopter Emergency Medical Service
HMSO	Her Majesty's Stationary Office
ITU	Intensive Care Unit
JRCALC	Joint Royal Colleges Ambulance Liaison Committee
NHS	National Health Service
NHSTA	National Health Service Ambulance Training Authority
NHSTD	National Health Service Ambulance Training Directorate
NMC	Nursing Midwifery Council
MAXQDA	Qualitative research supporting software
NIHR	National Institute of Health Research
NQP	Newley Qualified Paramedic
OSCE	Objective Structured Clinical Examination
PAD	Practice Assessment Document
PPED	Paramedic Practice Educator
QAA	Quality Assurance Agency
QAP	Qualified Ambulance Person
REF	Research Excellence Framework
UPR	University Policies and Procedures

Chapter One: Introduction

1.1 Aims of the research:

The aim of this research is to establish how and why, following a period of formal university education, student paramedics become enculturated, 'the processes whereby newcomers come to participate in the normative practices of a cultural community' (Kirshner & Meng, 2012: 65), into a National Health Service (NHS), Ambulance Service Trust. I explore and critically analyse the students' enculturation away from the university, to understand the relationship between two different cultures. I suggest the culture which neophyte paramedics experience in the clinical practice setting, is different from the culture nurtured and experienced by students in university. I argue that the culture experienced in the workplace is a subculture drawn from the traditional practices and processes embedded within the ambulance service. I further argue this subculture creates a hidden curriculum which students are exposed to. This hidden curriculum gives rise to a form of pedagogy which, in part, inhibits and impedes the students' ability to influence and change the subculture which they become accustomed to. To help understand this I used an ethnographic approach to explore, interpret and illustrate the traditional workplace practices, cultural norms and hidden curriculum which neophyte paramedics experience in the clinical workplace.

1.2 Rationale for the Study:

The rationale for this study followed my initial interest in students returning to university after attending their clinical practice placements. I noticed distinct differences in the students' behaviours, attitudes and working practices to that previously seen in the university. I wondered why this was occurring after a relatively short period of time in clinical practice. In addition, I was aware of the high number of reported fitness to practice (FTP) cases (complaints), being referred to the UK regulator, The Health and Care Professions Council (HCPC, 2019), concerning both experienced and novice paramedics. I was also mindful of the growing number of adverse events taking place in healthcare, such as those identified in the Francis (2010) report and subsequent Keogh (2013) report. Both Francis and Keogh highlight significant areas of concern, such as poor care, unprofessional behaviours and attitudes which were evident in the North

Staffordshire Healthcare NHS Trust. They consider this type of poor practice could be widespread.

1.3 The Research Questions:

In answering the research question - How and why do university students become enculturated into the Ambulance Service? - Several sub-questions emerged which I have listed below:

- Why do student paramedics, returning from clinical practice, appear to take on a different form of identity to that previously seen in university?
- How do student paramedics function in the clinical practice-based environment?
- How do students contextualise their academic studies into real-life practice-based situations and experiences?
- What are the working relationships between the students and their colleagues (crewmates)?
- What are the working relationships between the students and managers?
- What are the working relationships between the students and patients/public and wider healthcare community?
- What is the changing agency of a specific form of learning, which shapes the students' ways of working?

These were all questions which I needed to understand. To fulfil these objectives ethnography provided a suitable research approach. I decided to observe a group of university student paramedics over a prolonged period of eighteen months; as they attended their day-to-day clinical work placements. This allowed me to witness the students' real-life experiences, along with the intricacies and nuances of their day-to-day work. As in the research, I used observational fieldnotes, audio recordings and my recorded reflective notes to capture the day-to-day practices of both the students and experienced paramedics. I was able to reflect on my observations and clarify my fieldnotes with follow-up interviews and conversations with the students and paramedics. Riemann (2012) suggests the written work is a synthesis of the researcher's impressions which are recorded as fieldnotes, observations or interview data. In collecting my fieldnotes several

issues arose from my data. For example, students mimicked their paramedic colleagues' behaviours and attitudes, they made derogatory comments about patients and at times students were coerced into avoiding emergency calls along with occasionally damaging ambulances, such as kicking and damaging the dashboard. These issues are explored in more detail in the findings and discussion chapters. Students internalise and interpret the placement setting differently to that previously taught in university and which further adds to the dichotomies experienced by students. How they are influenced by and interact with the traditional cultures of the workplace and their perception of themselves within the paramedic environment, are explored. I needed to understand the various cultural meanings which students came to interpret as normal practice, such as those identified by (Devenish, Clark & Fleming 2016; Becker et al. 1961 and O'Meara, 2011), as these are essential components of the socialisation process. At times I use the terms enculturation and socialisation interchangeably. However, it is important that I define the two terms and their respective differences at the outset. Therefore, I very simply define these terms as – socialisation as a process of learning to behave in a way that is acceptable to society, whereas enculturation is the process of being socialised in a certain culture.

Within the research I argue that students, when on placement, are drawn into a different form of practice. This form of practice influences and impedes the pedagogy to that experienced in the university. Metz (1981) work supports this, suggesting it is as a consequence of the traditions and practices embedded within the very fabric of the ambulance service workplace.

1.4 Structure of the study:

In chapter two I layout a brief description of the recent history of the NHS ambulance service and paramedic profession. I map some of the traditional processes and events which have influenced and impacted on the development of the ambulance service and paramedic profession. By doing this, I provide a degree of insight and understanding to help contextualise the traditional working practices and customs associated with the UK ambulance service. The degree to which these traditions have become an integral and inseparable part of the

ambulance service gives rise to the very essence of enculturation. I reflect on my own knowledge as an experienced paramedic to help identify key milestones in the development of the paramedic profession. Lastly, I draw on a reflexive stance to help position these developments within today's practices.

In chapter three I explore the literature. The culture, subculture and the hidden curriculum associated with student paramedics' enculturation are reviewed and interrogated. This will help identify and understand the resulting pedagogy. The stringent organisational structures of the NHS ambulance service, to that of the day-to-day work of student paramedics and experienced paramedics, is further explored to possibly help identify the two competing cultures, which Schein's (1985) model of organisational culture illustrates. The notion of professionalisation and the professional identity of paramedics are examined as I illustrate how paramedic storytelling becomes an integral part of the day-to-day narrative of paramedics and student paramedics. Finally, I explore Lave & Wenger's (1991) work on Communities of Practice to help bring the work together to provide meaning and understanding of how and why students become enculturated into the ambulance service.

In chapter four I focus on the methodology and the research processes. I discuss how a constructivist paradigm was used in the research and how ethnography became the primary methodology for the study. The research methods used to obtain the data are identified to help reveal the students' experiences, as Becker et al. (1961: 133) believes, 'the most complete form of sociological datum, after all, is the form in which the participant observer gathers it, this rich data gives more information about the event under study, than data gathered by any other sociological method'. I discuss where the research was conducted, along with the details of the participants and the duration of the study. Lastly, the initial pilot study is reviewed prior to setting out how the thematic analyses and management of the data was carried out, along with the supporting software which helped me to review and revise various themes and trends emerging from the initial analysis of the data.

Chapter five provides a comprehensive look at the research findings. The challenges and opportunities of riding out in the ambulance with students and experienced paramedics are illuminated. A key theme drawn from the data revolves around the work experiences of both students and experienced paramedics. How tensions developed in the clinical practice setting between crew staff, students and mentors, with managers and at times with patients and the public, are exposed. Issues such as harassment and bullying are further drawn out of the fieldnotes and represented in the narrative of the findings. The institutionalisation of the ambulance service along with its relationship to the paramedics working environment is discussed, as these also became key themes which emerged from the data. Finally, the relationship of black humour, which Scott (2007) suggests is an essential component of the paramedics' day-to-day work, is discussed.

Chapter six is the discussion chapter where I contextualise my findings by drawing on their relationship to the literature. I illustrate how the three dominant constructs: work experience, professional identity and organisational culture, are woven throughout the narrative of my work. I show that my findings reveal forms of student enculturation which influences and impacts upon the student learning. I argue that the pedagogy emerging from the practice placement experience is not reflective of the pedagogy which students experience in the university classroom setting.

In chapter seven I look at the implications for practice and put forward some recommendations for long-term change. I unravel the initial research question as I summarise the basis of my study. I highlight the strengths and limitations of my study. Finally, I argue that there is limited published literature around the socialisation of student paramedics into the UK ambulance service. Much of the published literature focuses on patient care and the patient's clinical presentations, diagnosis and treatment. I draw my work to a conclusion and present my contribution to practice by depicting how my study adds to the limited published research on the workplace socialisation of student paramedics in the UK.

This chapter has provided an outline of the research. The next chapter provides an historical overview of the developments of the paramedic profession over the past fifty years.

Chapter Two: Historical context

2.1 Introduction.

In this section I provide a brief chronological narrative of several key events which have shaped and influenced today's representation of the modern-day NHS ambulance service. Case et al. (2014) believes, ethnography provides an historical, deeply contextual and in-depth understanding of communities which I use in my study. I briefly explore the past, so as to shed light on the future role of the paramedic.

To help understand student paramedics' enculturation into the ambulance service, I provide an overview of historical content to help contextualise the paramedic journey over the past 50 years. I illustrate how the embryonic nature of paramedic development provides insight into the rapid growth of knowledge which paramedics are now expected to obtain, both in terms of psychomotor practical skills, such as inserting a cannula (needle) into a patient's vein and correctly applying a cervical collar to a patient who has a suspected spinal injury, along with the cognitive clinical knowledge and application of care, such as anatomy and physiology, pathophysiology and pharmacology. By highlighting the trajectory of the ambulance service, along with the development of the paramedic profession over this period of time, I provide an historical overview in which to distinguish between the traditional working conditions and practices of the 1970s, with that of the modern-day ambulance service and paramedic profession.

2.2 The Millar Report

I start with a summary of the National Health Service Act (1948), which called for local authorities to provide ambulances, as and when necessary, to the public. This provided a basic system of transportation for the sick or injured to hospital as noted by the (Joint Royal Colleges Ambulance Liaison Committee, 2018). This basic form of transportation remained for many years against a backdrop of post war austerity and deprivation. In 1966, in the midst of seeking improved pre-hospital care, Dr E Millar reported to the Minister of Health on the standard of equipment and training requirements for National Health Service (NHS) ambulance staff. The report, known as the Millar report (Millar, 1966), became instrumental in enhancing the standards of training for ambulance crews.

However, this training mainly consisted of psychomotor skills to help aid the introduction of new pieces of ambulance equipment, such as splints, oxygen and dressings, along with some limited technology, such as radios. The Millar standard remained as a recognised component of ambulance training for a number of years, only to be superseded in the 1980s by the introduction of the National Health Service Ambulance Training Authority (NHSTA), later to become the National Health Service Ambulance Training Directorate (NHSTD). The NHSTD standardised training (Kilner, 2004) and provided the syllabus for advanced ambulance training into the 1980/1990s, although this did not completely replace Millar, rather it complemented the Millar standard.

2.3 Cultural Boundaries

To help provide an indication of the level of trained ambulance staff of the 1970s and illustrate the cultural community in which staff worked at that time, I provide an extract taken from Morris's (1970) Handbook for Professional Ambulance Personnel, figure 1, to help shed light of the gender gap in the 1970s ambulance workforce. The discrepancy between male and female workers, along with their expected roles and limitations within the ambulance service, is clear to see and provides an indicator of the culture of that time. Current data depicts a different picture, suggesting the total number of registered paramedics in 2019, was 27,747 of which 16,916 were males and 10,916 were females, see table 1 below. It is reasonable to assume that the culture of the present-day ambulance service, should therefore be very different from that of the 1970s.

Figure 1:

Complete Handbook for Professional Ambulance Personnel 1970.

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CHAPTER 67

The Role of the Ambulance Woman.

Female ambulance attendants are employed by some ambulance Authorities, but obviously the duties which they can perform normally have to be of a limited nature. Their true value comes in the daily transportation of the more mobile out-patients, using the sitting-car type vehicle, and in dealing with old people and children.

I would not in any way decry the worth of female ambulance attendants, because they do most certainly ease the out-patient workload, allowing more double (male) crews to be available for emergency work.

The female ambulance attendant would be advised to undergo a period of training similar to that of her male counterpart, especially, *comprehensive first aid, kinetics, the handling of the elderly, and good road-craft.* But perhaps some special emphasis might be placed on more sedentary aspects of the service, i.e., work in Control, preparation of work etc., in case relief should be required in that department.

(Morris, 1970)

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Table 1: **Legend Males = Blue. Red = Females. Yellow = Unknown.**

Registrant gender and age for selected profession - Register wide. Calculated Report date

13/05/2019

Male
Female

Volume

		20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+	Total
PA	F	678	1,736	1,690	1,395	1,854	1,694	1,108	541	191	24	4	1	10,916
	M	462	1,651	2,033	1,781	2,315	2,776	2,480	2,093	941	233	57	8	16,830
	U	0	0	0	0	0	0	0	1	0	0	0	0	1
	Total	1,140	3,387	3,723	3,176	4,169	4,470	3,588	2,635	1,132	257	61	9	27,747
Total		1,140	3,387	3,723	3,176	4,169	4,470	3,588	2,635	1,132	257	61	9	27,747

Data taken from: The Health and Care Professions Council 2019.

2.4 The Institute of Healthcare Development (IHCD) awards

By the 1980s, as part of the Institute of Healthcare and Development (IHCD), technician and paramedic-training award, a National standard for ambulance/paramedic training was mirrored across the UK. The curricula predominantly focused on the anatomy and physiology of the respiratory, cardiovascular and neurological systems of the body, with little context to other anatomical body systems. The curricula were limited in terms of theoretical content in areas such as, professional behaviours, healthcare economy, communication strategies, law and ethics, continuous professional development (CPD) and reflective practice. It was for all intents and purposes, an in-house skills-based approach to advanced training (Brooks et al. 2015). In 1998 an influential report – *Life in the Fast lane* (The National Audit Office, 1998), highlighted a number of recommendations for the UK NHS Ambulance Service, regarding vehicles, patient treatment, equipment and more importantly, targets, such as response times and so on.

2.5 National Ambulance Service Dispute

In the latter part of 1980, negotiations commenced between ambulance workers and employers. The aim was to agree a national formula which would ensure improved pay and working conditions, such as additional annual leave, negotiated shift rosters and general improvements in the working terms and conditions of ambulance workers. The collapse of lengthy negotiations between the National Union of Public Employees (NUPE), the National Union of General Municipal Workers (GMB), The Confederation of Health Service Employees (COHES) and the then Secretary of State for Health, the Right Honourable Kenneth Clarke MP, led to a nationwide ambulance service dispute.

The dispute became a bitter and difficult fight between the Conservative Government of Margaret Thatcher and the unions which lasted for six months from September 1989 till February 1990. It could now be argued however, that as a consequence of the dispute, substantial changes emerged in relation to the development of ambulance staff which paved the way in shaping the future direction of the ambulance service, to that of today's ambulance/paramedic provision. The dispute eventually ended in a perceived victory by 'driving a coach

and horses through the Government's pay policy' (Poole, 1990: 3). This victory was however contested by many ambulance workers who considered they had been let down by their union representatives. To give a sense of the camaraderie of the ambulance staff throughout the dispute, figure 2 below depicts a lapel badge worn by ambulance personnel during that time, whilst figure 3 provides a photograph of ambulance staff gathered around a brazier whilst on a picket line outside the ambulance station.

Figure 2: **Lapel Badge**

Image taken from: The British Ambulance Preservation Society.

Figure 3: **Picket Line**

Image taken from: COHSE - Union

Because of the dispute, pay and conditions improved for staff, whilst the creation of the Joint Royal Colleges of Ambulance Liaison Committees (JRCALC), provided both clinical guidance and advice to ambulance services. Made up of various medical experts and specialists in pre-hospital emergency care, the group established a set of clinical procedures and governance standards to support ambulance staff in their day-to-day work. These guidelines became known as the National Clinical Guidelines (NCG) and are still used today by UK paramedics. The NCG provide paramedics with a set of clinical procedures to follow, such as drug doses, clinical algorithms and clinical advice, which can be referred to in supporting clinical decision making. The JRCALC, along with the then, newly formed professional body, the British Paramedic Association (BPA, 2001) provided a national platform of support and guidance to the UK ambulance service.

2.6 The Move to Higher Education

Before I examine any impact, higher education may have had on paramedic development, I outline how paramedics initially became registered with the Council for Professions Supplementary to Medicine (CPSM) in 1998, along with Clinical Scientists and Speech and Language Therapists. These three made up the 12 professions allowed to be regulated under the CPSM Act of (1960). The first paramedic university programme began in 1996 and the Paramedic Board only formed just before the Health Act of 2000 which replaced the CPSM and created the Health Professions Council (HPC) – a multi professional regulator. As most of the other CPSM professions had been regulated since 1961 and had developed university degree programmes which already had strong professional bodies supporting them, paramedics were in a vulnerable place having to get used to being regulated so quickly when they had barely formed any form of professional identity. This is relevant for the argument in this thesis around professional identity and professionalism, which is why I illustrate this.

The shift in paramedic development into higher education became the catalyst of the gradual decline of the traditional model of in-house training provided by ambulance services and other external agencies. In light of this, the number of universities developing paramedic Diploma programmes, Foundation degree programmes and Honours Degree programmes increased substantially. However, this shift in paramedic development into universities spanned several years and faced strong opposition from several stakeholders, such as trade unions, some ambulance crew staff and some ambulance Chief Executives. Without the continuous drive from organisations such as, the British Paramedic Association (BPA), now the College of Paramedics (COP), along with prominent individuals, such as Furber, Newton, Woolard, Williams, Hunt, Dean, Fellows and Whitmore, in helping to secure the transition into higher education, it might be argued that the move into higher education may not have taken place.

Having established the transition of paramedic development into higher education and following a public consultation in 2018, the education threshold entry level for paramedics onto the HCPC register was raised from a certificate of higher education or equivalent, to degree level education. This means

paramedic programmes carried out in-house by ambulance services or other external agencies, would no longer be valid after September 2021. In light of this, existing paramedic programmes which are delivered below the new threshold Degree entry level qualification in universities, will no longer be available after September 2021 (HCPC, 2020). Existing paramedics working without a degree level qualification but registered on the HCPC register, can continue to operate as usual under the auspices of grandparenting rights. The term 'grandparenting' allows those paramedics registered through previous educational routes to continue to practice as paramedics.

2.7 Influential Policy Documents

In this section I examine various government policies and reports which impact and contribute to the paramedics working environment. These reports depict and imply both the role and scope of paramedic practice, paramedic development and the role of the paramedic in an evolving NHS. This provides a sense of how these reports contribute and influence the working environment of paramedics and student paramedics.

I identify a number of key reports, such as – 'Taking healthcare to the patient' – which advocated a model of pre-hospital care involving patients being treated more effectively within their home environment, avoiding unnecessary admission to hospital (Bradley, 2005). This influential report, supports the need for an all graduate profession, suggesting this would adequately equip paramedic students with the necessary knowledge, skills and attributes required to make accurate informed clinical diagnostic and management decisions. Darzi's (2008) report, inevitably supports an all graduate pathway by outlining a vision of care which is both, accessible and acceptable to patients. This would allow a standardised level of care, regardless of demographics. Newton (2012) provides evidence of the strong research base which is contributing to a higher level of education within the profession, as it equips the paramedic with enhanced knowledge and skills to perform their role. Despite this, the report entitled Paramedic Evidence Based Education Project (Lovgrove, 2013), found models of paramedic education within the UK paramedic profession somewhat diverse, at times lacking structure and continuity in some areas. Similar observations were also made by the

Commission on Human Medicines (2015). These publications are important as they are, in part responsible for the development of paramedic practice (Donaghy, 2008; Copper 2005; Woollard 2006) often set against a position of fiscal austerity across all public sector funding streams (Stevens, 2004), along with an uncertain political landscape Valderas et al. (2009). National policy documents inevitably influence working practices by establishing targets and creating standards, for example, time targets, quality control standards, clinical governance and so on.

As a result of the discussion above, I was drawn to Kilner's (2004) Delphi study which illustrates how various attributes which experts regarded sufficient for a range of ambulance personnel, including emergency medical technicians (EMTs), paramedics and supervisors (mentors), informs and questions paramedic development. Kilner's (2004) study drew on a panel of experts with specific knowledge of the demands of contemporary pre-hospital emergency care, including ambulance medical directors, members of the Royal Joint Colleges Ambulance Liaison Committee (JRCALC), the Royal College of Surgeons-Edinburgh and various advisors of NHS Ambulance Service Trusts. The study categorised 25 broad statements elicited from an original 3,403 initial responses to individual statements. The results revealed that many of the desirable areas of learning identified within the study were not embedded within the traditional training curriculum at that time. Areas such as, reflective practice, ethics and law, advanced practice, enhanced skills, communication skills, inter-professional working, human factors, resilience and research were absent from the curriculum. These results indicate that the basic model of in-house training proposed by Millar, was predominantly a skill's orientated model, 'as is its modern manifestation of Ambulance Basic and Paramedic training, which places emphasis on technical skills procedures' (Kilner, 2004: 374). Effectively, the results of the study helped bring the original paramedic training paradigm, identified in Kilner's study, consisting of elements of the original Institute for Health and Care Development (IHCD) training award to an end.

These stringent formal policies and rules, which contribute to advancing clinical practice, can also create barriers to autonomous practice by restricting, restraining and impeding practice. McCann et al. (2015) argue that, some of these

policies and reports lead to stringent and often unrealistic demands and targets being placed on the workforce. Bradley (2005) lays out the relationship between the expected delivery of ambulance services with the actual delivery of service. The report claims practitioners must obtain additional diagnostic and clinical reasoning skills enabling greater autonomy for paramedics and subsequently improved care pathways for patients. Yet, establishing a system whereby healthcare professionals, such as paramedics explore different care options, for example, leaving patients at home if it is safe to do so, contacting social services for patient support instead of leaving vulnerable patients at home, making arrangements for a General Practitioner (GP) to attend the patient or some other form of care rather than attending the Accident and Emergency (A&E) department, are versions of alternative care pathways. In contrast, these alternative care pathways are often perceived by ambulance crews as wholly inadequate since many of these pathways are not necessarily available to the healthcare practitioner or patients. This can cause frustration, anxiety and sometimes tension amongst paramedic practitioners and graduating paramedic students, as the lack of access to these facilities can lead to a rigid adherence to more traditional ways of working, such as taking all patients to hospital as opposed to using alternative care pathways thus avoiding particular treatment options and advanced clinical care. I argue this can restrict and dictate the healthcare landscape, rather than support autonomous clinical practice proposed by the College of Paramedics (2015) and supported by Health Education England (2013).

2.8 Today's Healthcare Professional

The notion of professionalisation of the paramedic profession remains an embryonic development. Bledsoe et al. (2005) considers certain qualities are needed by the practitioner to be a professional, offering the notion that paramedics fall within this, as they contribute to the continuum of care and therefore posses certain qualities to undertake this role, see table 2. To fulfil the requirements of professional registration paramedics are expected to underpin their day-to-day practice by adhering to professional standards, such as those prescribed by the (HCPC Standards of Proficiency for Paramedics, 2014) and Standards of Conduct, Performance & Ethics (2016). However, as also seen in

the work of (van der Gaag & Donaghy, 2013) these concepts are not always fully understood by some paramedics. Bledsoe et al. (2005) illustrates below some of the qualities they believe are required of a professional paramedic and include such attributes as, honesty, evidence-based medicine, responsible and autonomous practitioners. I will argue that the notion of paramedic professionalisation, is still unclear and undefined. This is discussed in more detail in the discussion chapter.

Table 2: **Qualities and conduct of a professional practitioner.**

> *A confident leader faces up to challenges*
> *Accept responsibility*
> *Have excellent judgment skills*
> *Be able to prioritize decisions*
> *Act quickly in the interest of the patient/client*
> *Develop a rapport with a wide variety of people*
> *Communicate with diverse cultural groups and ages*
> *Be evidence-based*
> *Be an autonomous practitioner*
>
> Bledsoe et al. 2005: 35

2.9 Professional Body

The introduction of the professional body, the College of Paramedics (COP), provides direction in moving the profession to the next stage of its development Cooper (2005), offering professional guidance and opportunities for paramedics to help maintain and enhance individuals' professional profiles. For example, continued professional development (CPD), conferences, outstanding achievement awards and presentations. The chair of the COP stating:

> Perhaps the single biggest prize that we still need to seize, is unlocking the full potential of our profession and this means making paramedics ever more relevant and effective in meeting emerging patient needs, through the development of scope of practice.
>
> (Newton, 2011: 58)

Whilst collecting my data however, I found that there was often confusion and misunderstanding from both students and paramedics as to the role and nature of the various professional, regulatory, advisory, mandatory and statutory bodies. I provide an example of this below to illustrate the various organisations involved in the development and management of the UK ambulance service and

paramedic profession: The Ambulance Service Association (ASA)—now The Association of Ambulance Chief Executives (AACE), The Institute of Health Care and Development (IHCD), The Joint Royal Colleges Ambulance Liaison Committee (JRCALC), The Health and Care Professions Council (HCPC), The College of Paramedics (COP), Health Education England (HEE) and, The Council of Deans of Health (COD), along with the various Trade unions which paramedics may become members of. These organisations all have different functions and activities which were often unclear, confusing and not deemed to be important for many students and experienced paramedics.

2.9.1 Summary of Chapter

Over the past 50 years the development of paramedics has seen a substantial shift from the Institute of Health Care and Development (IHCD) training award, predominantly delivered in-house by local and regional ambulance training centres, towards an academic award. This change of delivery is in keeping with the professional body, the College of Paramedics (CoP), Curriculum Guidance Framework (COP, 2019), which acts as an educational basis for future paramedic education. However, this framework is not isolated and is therefore shaped by the Health and Care Professions Council's (HCPC's) Standards of Proficiency for paramedics (2014) and Standards of Education and Training (2017), Standards of Conduct, Performance and Ethics (2016) and the Quality Assurance Agency (QAA) Benchmarking Statements (2016). Collectively these organisations support and enhance both paramedic education and the future development of the profession through rigorous frameworks. As Donaghy (2008: 31) suggests, 'these frameworks represent new ways of working for paramedics as front-line practitioners'.

The professional body, along with stakeholders such as the UK Department of Health and Social Care (DHSC), endorses the current shift from a traditional training paradigm, to one of Higher Education. The move implies students will graduate with a higher degree of knowledge, skills and professional accountability (Woollard, 2009), which will enhance the profession, along with patient care (Donaghy, 2010). As universities continue to establish paramedic programmes to meet the educational needs of the paramedic profession, it is

unclear how this will impact on the national shortage of paramedics, which has increased exponentially over a number of years, see NHS Employers (2018). For example, new apprenticeship schemes, increased student numbers on university programmes and so on. The chaotic and relentless ebb and flow of paramedics moving across from the public sector into the private sector and other healthcare settings, such as private ambulance companies, private healthcare clinics, industry, accident and emergency (A&E) departments and general practitioner (GP) surgeries, is unprecedented in the UK ambulance services (AACE, 2016).

This chapter has provided a brief insight into the paramedic journey over the past 50 years. Key events and milestones in the development of the ambulance service and paramedic profession have been identified and contextualised within the paramedic journey. The relationship between indicative policies and current paramedic professional development has been discussed, although it could be argued that some of the key influential reports run counter to the autonomy and degree of clinical decision making expected of the practitioner, see Lovegrove (2013) and Newton (2012). In this summary, I provide insight into the training and culture associated with the ambulance service in the 1970s, to that expected of today's paramedics. The next chapter explores the literature underpinning this research.

Chapter Three: Exploring the Literature

3.1 Introduction:

Literature pertaining to paramedic practice has grown steadily over the past few years. This has led to several peer reviewed paramedic journals such as the Journal of Paramedic Practice (UK), the British Paramedic Journal, the Emergency Medical Journal (EMJ) and the Australasian Journal of Paramedic Practice. In contrast, literature on the socialisation of ambulance workers dates back to the 1980s with several seminal works influencing the field, such as (Metz, 1981; Palmer, 1983; Mannon, 1992; Reynolds, 2007; McCann et al. 2013; Devenish, 2014; Wankhade & Mackway-Jones, 2015 and Corman, 2017). Compared to the established health professions such as nursing, physiotherapy and so on, paramedic practice has only recently emerged to reveal new insights into how and why paramedics function in a demanding and challenging working environment. It is important to review the research on areas such as, culture, curriculum, pedagogy, communities of practice, enculturation and professionalism of student paramedics and experienced paramedics to establish a theoretical background to this EdD study.

The chapter explores, reviews and interrogates the literature. The principal constructs or discourses arising out of the literature shape the interpretation of subculture, since the context of the study lies within a stringent authoritarian organisation comprised of an inner-city National Health Service (NHS) Ambulance Service Trust, along with a large University, delivering Undergraduate Paramedic Science Degree programmes. These two opposing settings present subcultures which have a strong influence on paramedic development. To help shed light on the processes and experiences which face neophyte paramedics, which comprises of the formal structured paramedic university setting, with an opposing busy, unpredictable and often chaotic working environment, provides the context for the literature search. In light of this, I needed to unearth the existing literature and drill down on the concepts and how they have been used in the workplace practice. To do this, I drew on the work of, (Corman, 2017; Mannon, 1992; Palmer, 1983; McCann et al. 2013; Metz, 1981; Devenish, 2014 and Wankhade & Mackway-Jones, 2015) to help understand the concept of

enculturation on the ambulance and paramedic services. The enculturation I am proposing is the interaction between paramedic students, with that of the experienced paramedics, found in their clinical workplace setting. The work of authors such as, (Hammersley, 1993; O'Reilly, 2009; Madden, 2017; Brewer, 2000; van Maanen, 2011; Becker et al. 1961; Delamont 2008 and Mead, 1936) subsequently add to the literature to illuminate the wider aspects of ethnography within society and helps to illustrate the relationship between the formal and informal learning environments. Not surprisingly, the literature search has concentrated on identifying relationships between the university classroom setting and ambulance/paramedic setting. Opposing arguments within the literature are examined, as also seen in the work of Donaghy (2010) and Devenish (2014), to help unpack and critique the possibility of student paramedics becoming enculturated into a very different traditional working environment, to that cultivated in university.

In the next section, I provide a short summary of the various components of the chapter and offer some key points from each section.

In section 3.2, I begin by exploring culture and subculture, this is important as these terms can be used in different ways, and in order to understand the practices of the paramedic students, a framework is required to adequately describe what could be going on between their practice and the university. A key finding from this section has been that practices disseminate values in a hidden way, whether that be in the university or on placement, this led to further research on the hidden curriculum.

In section 3.3, organisational culture is explored, as this gives rise to a form of culture often unseen by those outside the organisation of the ambulance service. Schein's (2004) model of organisational culture acts as a scaffold to help unpack and understand how these concepts influence and inform student culture. By drawing on Schein's three stage approach to organisational culture, it can reveal how students get drawn into a very different culture to that seen in university. A key finding emerging from this section has been that the organisational model highlights how the culture changes depending upon perceptions.

In section 3.4, I argue that subculture and its underlying hidden curriculum, contributes to and inhibits student learning in the clinical practice setting. This is also supported by (Alsubaic, 2015). I draw on the seminal work of (Jackson, 1968; Hafferty and O'Donnell, 2014; Becker et al. 1961; and Lave and Wenger, 1991) to provide clarity that the hidden curriculum is not the learning expected or planned in the formally structured university curriculum; it is learning which is shaped by the very basis of the workplace and working environment. This phenomenon has been observed by other studies which have found students being exposed to a very different pedagogy in the clinical setting from that which they expected, as also seen in the work of Becker (1961) and Hafferty & O'Donnell (2014). An understanding of why students and experienced paramedics appear to work within the boundaries set by a hidden curriculum is important, as the tension between the two conflicting curricula are an unexamined consequence. I will refer to these curricular as, the 'formal university curriculum' and 'hidden workplace curriculum'. A key finding here is that the underlying subculture, is not unique to paramedic students, as also seen in the work of Boychuck Duchscher & Cowin, (2004) on newly qualified nurses.

In section 3.5, professional identity and professionalisation are examined. The work of Devenish (2014), helps to discuss the concept of paramedic professionalism and professional identity, as he describes how concerns were raised within the Australian ambulance service and general Australian healthcare community as paramedics transferred from an in-service training model, to one which is taught in universities. Devenish found a belief existed which anticipated that graduate status would provide paramedics with greater professionalism and autonomy. Coster et al. (2008) study identifies the extent to which students learn together and how they 'perceive' professional identity is very different. Whilst Reynolds (2007), also studying paramedic professionalism, illustrates different discourses of inter-professionalism and how these impact on professionals and service users. Reynolds (2004), reported that multiple professional identities, cloaked within the concept of professionalism maybe experienced by student paramedics as well as experienced paramedics as they become exposed to the working environment. I was however reminded of the work of O'Meara (2011)

who suggests that this is systematic within the paramedic profession. Although Burford et al. (2014), on the other hand, consider the concept of professionalism of paramedics in the United Kingdom (UK) to be too abstract to define. A key finding from this section has been that the professional identity of student paramedics and experienced paramedics is not unique. This was also seen in the work of (Devenish, 2014) on student paramedics in Australia.

In section 3.6, the use of paramedic storytelling is explored, something which Tangherlini (2000) aligns with the broader aspects of paramedic identity. Forms of storytelling often run counter to the dominant media representation of the paramedic field which is so often presented in many fictional and documentary representations of the working 'reality' of paramedics. These fictional representations depict very positive and harmonious relationships between crew members, ambulance managers (officers), the public, patients and other healthcare and emergency service professionals. The often jovial and unassuming banter between crews and trainee (student) paramedics are positively portrayed. A key finding from this section revealed this form of storytelling is unique to particular groups, such as paramedics, firefighters and police officers.

In section 3.7, the interpretation of pedagogy in practice, rather than skills acquisition alone, is decisive and can inform an understanding of the practice environment. By this I mean students get to learn how and when to use their newly taught skills, they are able to contextualise and implement these skills at the appropriate time, although this can distract them from the knowledge which they have received at university and sets the tone for the clinical workplace. Lave and Wenger (1991) argue that the relationship between the pedagogy experienced in the clinical workplace setting is important, as both concepts have different meanings, yet both appear inseparable for the students once they are in the workplace. I needed to drill down, to understand the relationship between both concepts. The extent to which this can influence student paramedic pedagogy can give rise to a particular form of student enculturation into the working environment. A key finding here is that the underlying subculture is not

unique to paramedic students, as already noted in the work of (Boychuck Duchscher & Cowin, 2004) on newly qualified nurses.

In section 3.8, I illustrate how various components of the workplace environment can cause forms of tension and anxiety for students and paramedics. These issues are often entwined within the nuances and intricacies of the day-to-day work and not necessarily related to the traumatic events which could reasonably be expected to impact on paramedics' anxiety and stress levels. Considering this, it was important for me to understand the issues which result from this dichotomy. A key finding from this section has highlighted the working practices which students were expected to conform to, stifled and confused students as they became caught up in a chaotic working environment.

In section 3.9, I begin by defining enculturation. This is important as this term lies at the very essence of this thesis and is influenced by, and on, the subculture, hidden curriculum and resulting pedagogy, as noted by Choy & Delahaye (2011), students contextualise the formal taught elements of study within the socio-cultural and functional environment of the workplace. Enculturation draws on established and accepted norms and values of a particular culture or society, where accepted members fulfil the functions and roles of the group. This is also seen in the work of Gibson & Brightwell (2006) as boundaries and accepted behaviours are established, which dictates both, acceptable and unacceptable, standards of the group or society.

In section 3.9.1, I summarise the chapter by highlighting the various National and International literature pertaining to paramedic culture in order to, encapsulate, compare and contrast the various models of student paramedic enculturation. The similarities between the various types of ambulance cultures, with that of the day-to-day working subculture which students become exposed to, are depicted within the relevant literature. Associated concepts, such as, subculture, hidden curriculum and pedagogy, are further explored within the literature, to unearth the ramification for practice and illustrate the relationship between these concepts and enculturation. In understanding these concepts, the work draws together

developments of the paramedic profession both within and outside the UK to help contextualise the paramedic landscape within the recognised body of literature.

This introduction has provided an overview of the chapters. The next section looks at culture and subculture.

3.2 Culture and subculture:

It is important here to define culture, as this is a dominant construct of this thesis as it revolves around a form of culture. I draw on Geertz (1973: 89) who defines culture as, 'inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate and develop their knowledge about and attitudes toward life'. Having defined culture, subculture may be defined as, arising from and as a sub-set of culture. A small group with their norms, symbols, interaction and language which are specific to them. Stevenson, Elliott & Jones (2002: 701) define this as, 'The distinct culture of a group existing within a larger culture'.

Initially recognised and accepted in the Chicago School of Sociology, Agnew & Kaufman (2010) and Lewis (1933), describe how a particular subculture emerged in a group of young men to form of deviant group whose potential menace on social and racial welfare formed part of their behaviours. Burt's (1925: 39-40) early work, also describes young deviants as 'defective, a typical street-Arab, dull, mongo's, cretins and subnormal'. The racial overtones depicted here by Burt, is at the limit of the researcher's world view. Likewise, Bell (2010) claims that early literature depicts the notion of subculture and subculturalist as having theoretical lineage with deviance. Early depiction of subculture situates the term alongside words such as, deviance, defective and non-conformist. Blackman (2014), however, describes subculture in light of the modern reincarnation of the term, suggesting, subcultural theory has now been adapted to reflect the various sociological paradigms. In short, what Blackman is suggesting is that the term deviance is no longer used in this context. Furthermore, subculture is linked to fashion, such as changes within contemporary society, making the term an indicator of social and cultural measurement across centuries of change in society.

Parson's (1942) claim, that subcultural theory is a complex and pragmatic concept in relation to sociology, however remains true. This is because what Blackman (2014) considers is that the concept has since been constructed through the use of academic and accepted usage, suggesting subculture is about different ways in which people behave and perform. Becker (1963) and Clinard (1974) for example, found that subcultures have discrete values and cultural practices which are shared and form different cultures to that of the mainstream. Studies of Emergency Medical Technicians (EMTs) and paramedics have found characteristic values and cultural practices were shared between the groups, which were different from the mainstream culture, such as those identified by (Palmer, 1983; Mannon, 1992; Metz, 1981 & Corman, 2017). Subcultures recognise society and culture as being distinct from, but also resistant to, the dominant culture found by (Blackman, 2014). For example: Metz (1981) and Mannon (1992) found a culture existed between paramedics and emergency medical technicians which was distinctive to them. They imply that crews would 'run-hot' (meaning using the ambulance's audible and visual warning lights and sirens), as if on route to an emergency call, when in fact, they were returning to the ambulance station for breaks. Thornton (1995: 510) referring to the work of Bourdieu, describes subculture as, 'the cultural knowledge and commodities acquired by members of a group, raising their status and helping to differentiate themselves from members of other groups'.

Paramedic students returning to university following a short period of clinical placement lasting two to three weeks, can be seen to adopt different attitudes and behaviours from that previously seen, as also recognised in Devenish's (2014) work. I provide an extract from my original fieldnotes taken from the pilot study as an example, as students returned to university following a short period of time (three weeks) in the workplace. I recall from my notes that I questioned two female students enquiring as to how they had enjoyed their time in clinical practice. I was shocked and disappointed by the reaction of the students as a torrent of foul language and distasteful remarks followed. The quotation below taken from my fieldnotes illustrates this. For the sake of authenticity, I have kept the language used by the students (Claire & Gill).

> Question: "*so how was your time in clinical placement-what station did you go to?*"
>
> Answer: "*it was all a fucking waste of time; we were at sunny side ambulance station and all we dealt with was a load of old shit*".
>
> Extract taken from my original fieldnotes (Claire & Gill 4/3/2013).

Similarly, Becker et al's. (1961) work on medical students, illustrates how year groups became insular within their own unique working group.

> *Becker was speaking to Jim Hampton and asked Jim about a recent examination he had sat. Jim was answering the question and Becker asked him to explain what he meant, but Jim seemed unwilling to explain or unable to, Becker thinks this was probably, in part, due to the presence of two other students who were not part of Jim's group arriving and joining the conversation (Becker et al. 1961: 123).*

To help contextualise the two very different environments, university and workplace, the additional example below taken from my pilot interview with a student, helps illustrate the relationship between this particular paramedic student's expectations of the workplace culture, to that which she actually experienced.

> *I was speaking to Jennie in the classroom after she had recently returned to university following her clinical practice placement. She seemed different, despondent, and fed-up. I asked her what was wrong. She spoke about the workplace culture and how we (students) must fit into this dodgy culture. She told me of working practices that she had to do, which were not taught at university. "It's a different world out there to what we do at university" she proclaimed.* Extract taken from my initial small-scale pilot study on the (22/04/2013).

As Devenish (2014) found, whether students are aware of it or not, a subculture can influence and shape their workplace experience. Metz (1981) found that a form of subculture existed in his early seminal ethnography of Emergency Medical Technicians (EMT) and Paramedics, although it is worth noting here that in Metz's early work, there were more EMTs than paramedics, so he focuses his

study predominantly on EMTs. He found that they worked in a vacuum, often contrary to formal policy, by doing their own thing. This meant that experienced EMTs, paramedics and trainees would revert to the traditional taken for granted ways of working. To enable student paramedics to fit into the cultural context of the workplace setting, I looked at the literature pertaining to paramedics in Canada and the work of Corman (2017) who found experienced paramedics, 'old-timers', would encourage students to follow the taken for granted traditional practices and procedures which were then carried out by the students. Becker et al's. (1961) work on medical students further assisted my understanding as he also discusses the distinct form of subculture which existed amongst medical students as they worked within the formal processes of the medical faculty. For example, they found students had a perceived idea of what they were about to learn in medical school and clinical practice did not coincide with those of their teachers. The example below provides an extract from Becker's work as it describes how, in orientation week the medical fraternity hint at the workload which follows:

> *"You start work immediately because there will be no time to catch up. Perhaps for some of you, even if you caught up, there will not be time enough. We want to keep the tension down for you. Doctors are always anxious. There are 5,000 names of parts of the body you will have to learn"* (Extract from Becker et al's. 1961: 89-90 work).

I later provide examples in my discussion chapter to help illustrate how Becker et al. (1961), sheds light on the different subcultures fostered within the medical faculty and wider medical fraternity as students described not knowing what to do at the start of clinical practice. They were unaware of the unwritten rules, such as being guided by nursing colleagues, not sitting around idle and not getting involved in areas that one is unfamiliar with. Metz's (1981) ethnography helps to illustrate the very fabric of the EMT and Paramedic environment by depicting the day-to-day work of the ambulance crew. He illuminates the collegiate relationships between crews, the dark humour displayed by crews and the trauma of the job. In trying to understand the student paramedic clinical practice experience, I used both Becker's and Metz's work to help illustrate this point further, as Metz (1981), found EMTs and paramedics became drawn into a very

traditional orthodoxy of established cultural practices, such as, not stepping out of line with the more experienced crew members by just doing what they were told to do. I revisited Lave and Wenger's (1991) work, who argue that new groups are formed within the workplace setting, as opposed to the groups formed outside the work setting, such as the university. I found communities of practice contribute to an understanding of how students become drawn into the workplace setting, as various cultural groups are formulated and structured. Mead's work offers some insight into the individual's self-concept arising from the social experiences which can influence and shape their behaviour. The literature indicates that there is a potential clash of cultures between the practice and curriculum of the university and those within the ambulance services where students train. The context in which students learn is fundamental (Blackman, 2014), as Kelly (2006) suggests, the classroom setting and the practice setting have significant differences. Jackson (1968) implies that two opposing settings exist, the formal and informal, which prepare students with knowledge of hierarchical power relations. Students unknowingly became exposed to the existence of a hidden curriculum as a result of the workplace culture which leads students to unwittingly depict a form of behaviour very different from that taught in the classroom setting. This is further depicted by Taylor & Wendland (2014) and Kramsch (1999: 111) who describes, individuals as 'having difficulty relinquishing already taken for granted cultural perceptions, beliefs and behaviours when attempting to adapt to a new culture'. I looked at the work of Schein, to try and help figure out what was happening here, as Schein (1985) highlights the subcultures which can exist in social interactions, suggesting that the very nature of the workplace creates a different set of values to that prescribed by the organisation, see figure 4. Wankhade, (2015), affords additional insight of an inner-city NHS Ambulance Service Trust by highlighting how a subtle yet powerful workplace subculture existed within the ambulance service. This was very different from the culture proclaimed by senior managers of the ambulance service and academic staff. Examples of these can be found in the findings chapter.

In the process of understanding student paramedics' enculturation into the ambulance service I referred to (Agnew & Kaufman, 2010; Lewis, 1933 and Burt, 1925) who indicate that the subculture is defined by the concepts synonymous

with deviancy, such as deviant (subversive) behaviours, exclusive of small group behaviours, symbols, interactions and language, although as previously discussed, (Blackman, 2014) describes deviance in contemporary society as a form of social behaviour, indicating that its etymological roots are no longer in the realm of deviancy. Building on this, I now set out a theoretical framework for addressing enculturation as it applies to a particular group of students' socialisations into the reality of the workplace culture of becoming paramedics. Here, both the formal and hidden curriculum become intensely problematic, as it can both assist and impede paramedic pedagogy. In light of the discussions above, in the next section, I draw on Schein's (1985) model of organisational culture, to help unpack the ingrained subculture which I am arguing exists within the ambulance service.

3.3 Organisational culture:

Schein's (1985) model of organisational culture helps illustrate and positions this work within a theoretical framework, as he depicts three distinct constructs, to illustrate this. These constructs consist of, shared values, beliefs, and various assumptions. His model illustrates how people within the organisation behave and interact with colleagues, the public and others, how decisions are made and how work activities are carried out, see figure 4. Flamholtz & Randle (2011: 6) suggest, 'organisational' corresponds to corporate personality, which implies that, every organisation-regardless of size-has a culture that influences how people behave. I went back to Schein's (1985) model to help understand the observable aspects of culture, because his model of culture, infers that individual behaviours change. Whilst recognising the complexity of culture, this study acknowledges that the construction of individual professional identities may be subject to a specific cultural context, such as the culture depicted by paramedics as superheroes, such as those found in (Tangherlini's, 2000) work.

Figure 4: **Illustrates an adaptation of Schein's (1985) model of Organisational Culture**
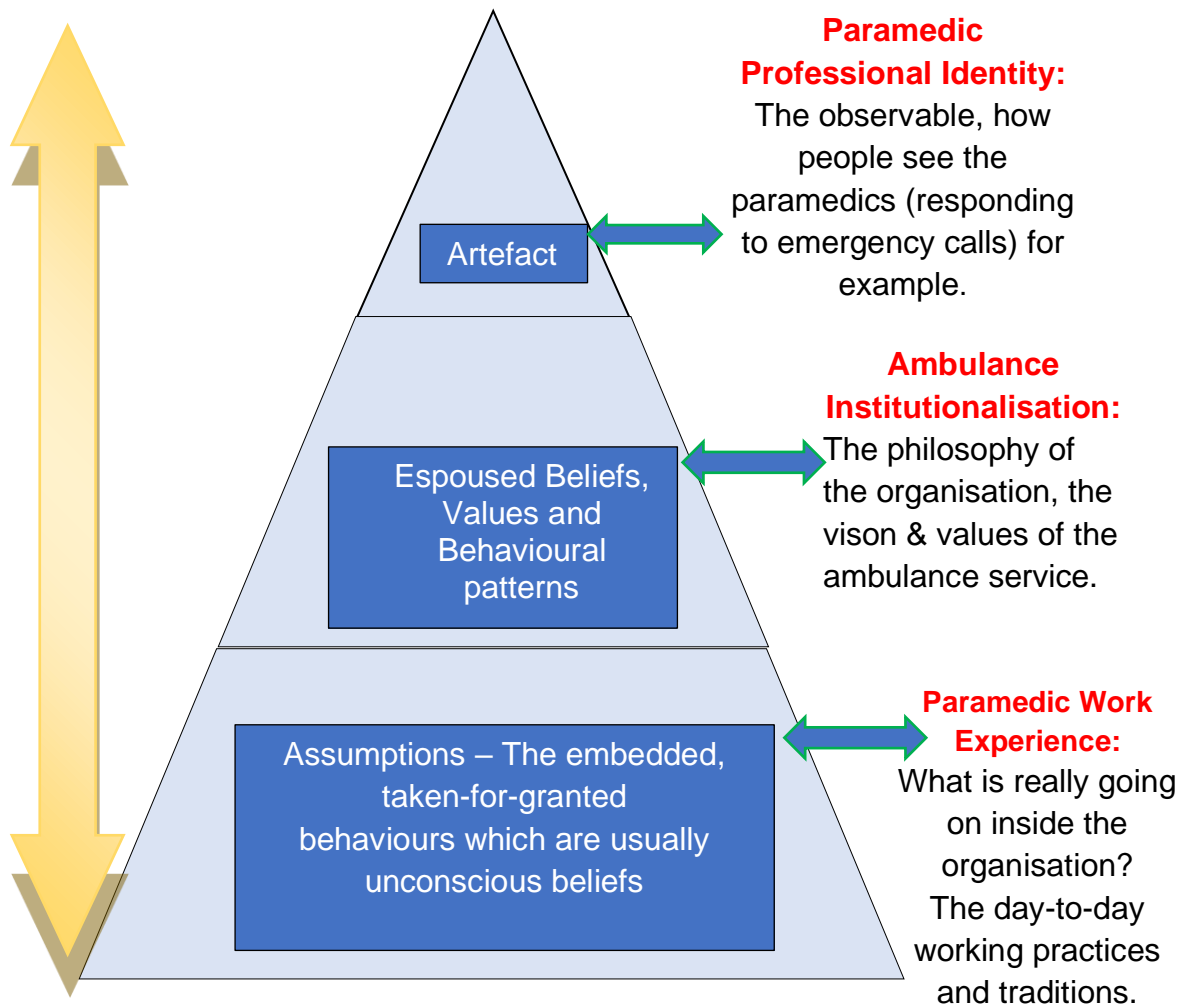
Schein's model symbolises three distinct components, whereby the culture of an organisation or institution is portrayed and provides a unique lens in which to depict the organisational culture. The first construct, artefacts, describes how people within the organisation are seen by others outside the organisation, through their observable appearances, behaviours, communication and workplace. In the context of this study, this portrays how members of the public may visualise the ambulance service. For example, the blue flashing lights and sirens as the ambulance rushes through the streets as paramedic lifesavers respond to a life-threatening emergency. Similarly, McCann et al. (2013) describe organisational culture as posing the corporate values and behaviours that are

expected of the organisation. Schein's second construct, espoused beliefs, consist of the values and behavioural patterns embedded within an organisation. This is how organisations carry out their functions, such as the way in which 999 emergency calls are responded to, how patients are treated, how the patients' clinical conditions are managed and patients are transported safely to hospital within the prescribed policies, procedures and philosophy of the ambulance service. These are all fundamental values of the ambulance service and the paramedics' role within it. Schein's third construct offers an alternative view, one steeped in the day-to-day work of the people within the organisation, such as those of front-line paramedics. This comprises of basic underlying assumptions; which Schein acknowledges as being what *really goes on in the organisation*. A specific type of organisational culture exists here, one that forms a subculture, unseen by those outside the organisation. This subculture comprises of forms of behaviour, such as language, values, attitudes and customs, not seen or expected by members of the public, academics or senior managers of the ambulance service. For example, derogatory language directed at certain types of patients common throughout the workplace, sexism, homophobia and inappropriate comments and innuendos to staff, students and the public. These contribute to Schein's (1985) third construct, examples of which can be seen in my findings.

Palmer's (1989) study of paramedics typifies how crews would pre-judge callers prior to arriving at the scene of an incident (call). She suggests this may be because of a particular location of the call, for example, attending calls to squalid downtown, shabby areas of the city, areas consisting predominantly of social (council) housing, such as tenement blocks, high-rise apartments and areas of social deprivation. Metz (1981) and Mannon (1992) found crews would talk about 'shit-calls', such as patients presenting with flu like symptoms, whilst Wankhade & Mackway-Jones (2015) and Corman (2017) found crews wanting emergency calls to be potentially about excitement and, 'blood and guts'. They found a degree of resentment and stereotyping of patients existed. For example, crews would often volunteer for emergency calls which sounded exciting and serious when ambulance control broadcasted outstanding emergency calls over the radio system, such as, a Road Traffic Accident (RTA) a person knocked down and

unconscious with a suspected head injury, or a person fallen from height, an expected fatality and so on. Wankhade & Mackway-Jones (2015) and Corman (2017), believe these types of calls are more appealing to crews as opposed to the more mundane calls, such as an elderly person collapsed or suffering from abdominal (abdo) pains etc. These examples provide an authentic insight into what really goes on in the organisation and which helpfully depicts Schein's third construct. To further contextualise this, I went back to (McCann et al. 2013), who found the organisational culture embedded within the NHS Ambulance Service Trust where their study was conducted, as authoritative and bureaucratic. This is explored in more detail later in the discussion chapter.

In this section of the chapter, literature pertaining to subculture has been investigated. I summarise the pertinent points from this section as the relationships between organisational culture, culture and subculture are important in understanding the potential similarities between the cultural constructs depicted by Schein (1985), to that which applies to the workplace.

In the next section of the chapter, the entrenched subculture and hidden curriculum, which I will argue is inherent within the workplace is explored. In so doing, I offer an understanding of how and why experienced paramedics and student paramedics resort to a form of workplace culture which is far removed from that cultivated and encouraged in university. Becker et al. (1968) provides a useful representation of cultural context by referring to terms such as 'latent', which resides in the individual or within a group or society and means dormant, not yet developed and currently hidden or concealed, as opposed to 'manifest', which means obvious, apparent, plain and more identifiable within a group. These concepts reveal how student paramedics display these tenancies in the workplace setting. For example, some students in my study very early on in the investigation displayed an open and transparent acceptance of the type of culture they found themselves in. They became an integral part of the workplace culture, quickly adopting the slangy informal language and behaviours of their more experienced paramedics, whilst other students were not so open and transparent. For example, these students did not openly and enthusiastically engage in the banter and rituals which formed part of the working practices of paramedic life,

although Cox (2005) would argue, they were an integral part of that culture, they had just not recognised it.

3.4 Hidden curriculum:

To understand how and why a subtle, yet dominant hidden curriculum appears to form part of the paramedic students' workplace experience, I looked at Matheson (2019) work, as a variety of social interactions are experienced by paramedics and student paramedics in the practice setting. These comprise working relationships forged between experienced paramedics, mentors, ambulance service managers, services users (patients), carers, other emergency service personnel, nursing staff, hospital staff and members of the public, which students sometimes find challenging. I was interested in Carlson et al. (2010) who noted that professional socialisation may have a negative impact, as observational forms of learning can lead students to internalise poor practice. Similarly, Henderson's (2002) study of nursing, provides insight to what is really going on here. Both Carlson and Henderson found nurses, in part, developed their social identity through the influences of senior role models, such as mentors and experienced staff which they conclude was particularly evident in the way experienced staff provided care, even if this contradicted what had been taught to the students in the classroom setting. Similar findings are reported by Greenwood (1984) and Mackintosh (2006) who describes how student nurses' views and attitudes became negative after increasing exposure to clinical practice. For example:

> Nurses were more negative once they had spent time in clinical practice, citing negative examples of care or incidents where participants felt that care was missing or less than ideal by giving examples of staff who appeared to have less then caring attitudes.

> (Mackintosh 2006: 957)

Campeau's (2008: 286) work on paramedics suggests, 'what sets paramedics apart from nursing colleagues, is the setting in which they practice'. Campeau (2008) further argues that paramedics adapt their clinical practice into their work context; subsequently, paramedics often practice a distinctive type of care, which is that of the street, meaning paramedic work is unpredictable, not necessarily set in sterile clinical conditions or within planned procedures but rather

unpredictable and chaotic. Nelson (1997: 162) found paramedic clinical skills are often performed in a, 'context rife with chaotic, dangerous, and often uncontrollable elements with which hospital-based practitioners need not contend'. Although, some accident and emergency (A&E) front line workers, such as hospital staff, might contest this view as similar chaotic, unpredictable and dangerous circumstances can occur within hospitals.

Whilst Nelson (1997) illustrates the unpredictable nature of paramedic work, I was also reminded of (Lipsky's, 2010) ethnography of police officers in the United States of America (USA). Lipsky (2010), puts forward a similar account of the unpredictable and often challenging environments which contribute to the comradery he found in his study. An example could be, riding out on shift with a police officer, whilst chasing a motor vehicle (car), which was eventually stopped. The apprehension and insecurity of the police officer, who, after stopping the stolen vehicle, must approach and confront the driver. Lipsky (2010) recalls the unpredictable nature of this type of emergency work, whilst Metz (1981) seminal work also observed how, at that time, EMTs and paramedics point of view became integral to the success of new trainees. Metz (1981: 93) illustrates the fragile nature of success or failure new recruits were afforded by their experienced established colleagues, stating that the 'measure of a man or woman doing paramedic work is decided at the scene of an incident'. Back at the ambulance station, Metz recalls how the result of the trainee's performance would be discussed by the traditional old-timers. This contributed to the working practices experienced by trainees in the workplace culture which I would argue, is still evident to some degree and is different, from that taught in the university classroom setting. Jackson (1968) implies, student learning is influenced by aspects of the hidden curriculum. I was reminded of (Bourdieu, 1990) work, linking subculture with forms of deviance, a phenomenon already discussed, although (Blackman, 2014) further suggests this notion is outdated, prejudiced and fundamentally wrong in today's society. Furthermore, (Blackman, 2014) believes the concept of subculture is now less associated with such negative aspects of society. If this is true, then the subculture which I am proposing exists, characterised by paramedics avoiding meal breaks, avoiding finishing shifts late,

avoiding certain emergency calls, causing unnecessary damage to ambulances, along with the nuances and intricacies of the working environment, results from a sustained and familiar workplace subculture. It could be argued that context specific types of deviant behaviours are going on here which have become part of the paramedic subculture, such as institutional deviance.

I argue that the diverse nature of paramedic work, noted by Palmer (1989) and Corman (2017), accompanied with the desire for students to fit-in to the established culture identified by (Becker et al. 1961) manifests from past practices and traditions which results in a particular type of pedagogy. This pedagogy is complex and integral to the hidden curriculum which students experience and which is shaped by the prevailing subculture. As Devenish (2014) argues, this form of pedagogy influences student paramedics' enculturation. Lave & Wenger (1991) suggest workplace practice is contextual to the practice environment in which it is situated, whilst Strauss & Quinn (1997) argue that, cultural influences contribute to the learning environment which are based on recurring common experiences, mediated by learned practices in the practice setting. Students become enculturated into a complex web of workplace practices which they struggle to understand. The unfamiliar educational process which confronts them in the clinical workplace setting is challenging. Devenish's (2014: 13) findings, in part, act as a foundation to my claim, as he found students, 'did not appear to understand the ambulance culture, similarly, many paramedics were not familiar with university culture'. Significant numbers of experienced paramedics in the UK and Australian workforce may not necessarily possess a university education because the ambulance services were previously formed from a very traditional manual working environment, as identified by McCann et al (2013). This leads to a hidden curriculum formed from established and taken for granted ways of working and traditions. Hafferty (1998) and O'Donnell (2014) consider these ways of working as being responsible for the learning which occurs outside the formal curriculum, which Hafferty (2014: 7) suggests is, 'The place one learns, often tacitly, how things work around here'. What I take from this, is that the day-to-day pedagogy which students are exposed to, is far removed from that envisaged by the academic community, professional and

regulatory bodies, and ambulance service managers. Similar findings are seen in (McCann et al's. 2013; Wankhade & Mackway-Jones, 2015 and Reynolds, 2004) work, who found the structure and culture of the ambulance service became grounded in a very ridged, authoritarian organisation. This suggests that a paradox exists between front line ambulance crews and managers, resulting in little understanding and appreciation of each other's roles and responsibilities.

Student paramedics are exposed to a very formal structured taught curriculum, whilst attending university, as also seen in (Woolard, 2009) work. Kelly (2006) and Stenhouse (1975), discussing the same issue in schools, identify this curriculum as, one that is set out by formally agreed syllabi, prospectuses, course outlines and assessment strategies. The curriculum found outside the formal processes, however is also what pupils' actually experience. What Kelly (2006) and Stenhouse (1975) infer here, is that student experiences outside the formal institution, such as the school playground or workplace, can be very different from the curriculum taught within the institution. This suggests that the hidden curriculum which students are exposed to forms part of the socialisation process, which in turn results in the enculturation into the ambulance service. I needed to understand how this hidden curriculum is experienced in the workplace and drawn from a subculture. To do this I was particularly drawn to the work (Metz, 1981; Mannon, 1992; Devenish, 2014 and Corman, 2017), who found that paramedics and EMT's are unwittingly drawn into a subculture and subsequently a hidden curriculum. I thought about my initial findings from my pilot study to help contextualise these claims. I provide an example from my pilot study to help illustrate this point below:

> *James, the student paramedic, and I were on a nightshift together. Jim, the experienced paramedic was running late for work so James and I were in the crew room waiting for Jim to arrive. I was interested in how James was reluctant to talk about university in front of other paramedics in the crew room, instead wanting to engage with their conversation which was around nuisance callers, and callers that were a waste of time. It felt as though I was embarrassing James by talking about university. I thought this was reflective of a subculture which harnessed a form of a hidden curriculum which James just had to be part off. Observation from fieldnotes 12/06/13.*

Corman (2017: 26), also recalls a time when he entered the building (ambulance station), he says hello to Julie, who is reclining in the armchair polishing her boots. She says, "It's going to be a good day today; someone is going to die". She explains, that whenever she polishes her boots, someone dies. Corman explains that perhaps she wanted him to see a good call. He illustrates how he found paramedics orientate to different social characteristics depending on the patient they are attending. He recalls how they would prejudge the work:

> Hanna (paramedic) guessed a patient was a heavy drinker, as she explains how "She's uh, she's um, she's poor hygiene, she stays at the drop-in centre, and just from, well not that everybody who has those things is a heavy drinker but just from experience with this kind of clientele that I can guess" Hannah claims.
>
> (Corman 2017: 65)

Mannon (1992: 132), reminds us how he found EMTs and Paramedics in the USA often displayed a sense of frustration and tension when they attended certain calls, he explains, 'all the bullshit you see in the districts, in part, the taxi service function'. Here Mannon is referring to how crews would perceive certain calls which they have attended, as a free taxi service. A view often shared by ambulance crews in the UK (See findings chapter). Whilst Metz (1981), found EMTs and paramedics had widespread agreement among themselves about how patients should be classified and how the various classifications should be treated. Metz (1981: 113) explains, '.... in other words, the EMTs and paramedics stereotype the patients and pass these attitudes along to trainees, with the result that the stereotypes become institutionalised'. This is an important claim, which further reinforces the argument that the relationship between the concepts of subculture and hidden curriculum, allows them to gain specific types of informal learning, as also noted by (Jackson, 1968). This learning impacts on their enculturation into the workplace setting. The similarity of the students' observed behaviours, noted by Palmer (1989) and Metz (1981), may explain how and why student paramedics get drawn into the role of actor, depicting a calm, confident, controlled individual at the scene of an incident, whilst other members of public around them are in crisis and despair. This is a very different depiction from that portrayed by students and paramedics once they are alone in the rig (ambulance). Palmer (1989), further describes how paramedics, strut their stuff, by acting out the role of their more experienced colleagues. To try and answer

this, I went back to Schein's (1985) model of organisational culture to help signal the very different cultures which exist. This can be one which depicts a somewhat improper, tasteless display, brought about in the confines of the ambulance or the ambulance station or other private areas, to that displayed and recognised by the public. These types of behaviours, presented by paramedics are further seen in the works of other researchers, such as; (Lipsky, 2010; Metz, 1981; Corman, 2016; Mannon, 1992; Palmer, 1989; Tangherlini, 2000 and McCann, 2013). To help illustrate this, I provide two examples below extracted from my early exploratory fieldnotes to highlight how these behaviours manifest themselves through the paramedic subculture.

> *Whilst I was riding out with Ben, the student paramedic, we were talking about his work at university, where I was one of his tutors. Ben is a keen, hardworking and conscientious student at university, always willing to help his peers and staff alike. Yet I was surprised by Ben's behaviour and attitude in the practice setting. I watched Ben, mimic his mentor, (experienced paramedic), not wanting to appear keen, or enthusiastic but settled to adopt a no-do culture. Such as mimicking and moaning about certain calls (jobs) derogatory comments regarding break times and finishing times and a general dismissive attitude toward ambulance control. I spoke to Ben a couple of times about his university studies whilst we were driving back to station. Ben's response was 'yeah they're okay I suppose, I do what I need to do, you know'. He then smiled at his mentor followed by a quiet giggle of laughter.*
>
> *Observation from fieldnotes 14/01/13*

> *This particular shift, I was riding out with Julie, the student paramedic and Joe, the experienced paramedic. We arrived on scene at the next call, and whilst we are waiting to gain access into the premises via an intercom system on the communal door of a care home, I noticed Julie, constantly texting via her mobile phone, expressing little if any concept of her surroundings or the voice which answered the intercom. I nudged Julie to draw her attention to the fact that someone was answering the intercom system and was trying to let us in. Her colleague (Joe) was bringing the carry chair from the ambulance and as such wasn't with us at that point. This was such a different behaviour to that witnessed by the student back in university.*
>
> *Observation from fieldnotes 05/05/13*

The subculture which I am arguing exists within the ambulance workplace, is pragmatic, insular and untenable for the future development of the modern paramedic practitioner. I was mindful of Hafferty & O'Donnell's (2014: 18) suggestion that, 'distinct differences exist from the curriculum presented by the educational institutions, to the curriculum which actually takes place on the shop floor'. Tindall, also referring to curricula, offers an alternative reflective interpretation of the hidden curriculum, one rooted in the distinction between one's intention and one's actions, which he illustrates as, 'A lesson in how to behave which is neither planned nor discussed' (Tindall, 1975: 2-28). For Becker et al. (1961), the lineage is more direct, claiming:

> The influence of social stratification, social class, social status and the role of place on student education and learning, contributes to a subsequent latent culture and the existence of a student culture in medical school.
>
> (Becker et al. 1961: 304–313)

A further two examples are provided below from Becker's work which I have summarised to help reinforce this point and depict the behaviour and tensions which he witnessed whilst researching medical students' workplace practice curricula and their already taken for granted groups or communities. Becker found that the students would finally co-operate together to avoid making a bad impression on the faculty. Becker (1961: 307) also illustrates how, 'they (medical students) will do another man's work for him, when circumstances make it impossible for him to do it himself; in this way they protect him from the adverse judgment the faculty would otherwise make'. Becker recalls how, students received their information regarding their clinical placements, he found they became apprehensive, anxious and defensive of their potential separation from the group which had been shaped during their time together in medical school. The main point I draw from this, highlights how students had become enculturated into the very fabric of the academic medical fraternity, how they became communities of their own practice (Lave & Wenger, 1991) forming and shaping a coherent group, who then found it challenging and unsettling to leave the group, as students go from formal academic studies into a challenging, unpredictable and often, hostile working environment. Lave & Wenger's suggest:

> On the one hand, newcomers need to engage in existing practices in order to understand, participate and to become full members of the community. On the other hand, they have a stake in the development of their communities as they begin to establish their identity.
>
> (Lave & Wenger, 1991: 36)

I was further drawn to the work of Lipsky (2010) on this matter, who highlights how public sector workers in the United States of America (USA), such as public housing officers, police officers, prison officers and hospital staff, often felt restricted by formal reports, policies and rules. Workers formed collegiate groups and would circumnavigate and bypass formal rules which they felt restricted and somewhat prohibited their working day. He notes how the traditional working customs and practices of the day-to-day work of police officers were conducted, finding this to be in sharp contrast to that laid down by formal rules and expectations from the police service managers. I provide an extract from his example below whilst he was riding out with a police patrolman (Jim) to help illustrate this point:

> Jim would often disregard what he felt were mundane calls, such as domestic disputes, for more unusual and potentially interesting and exciting calls, such as a person stabbed, or shootings etc. Lipsky illustrates how Jim would get frustrated and angry when once on scene of an interesting call, senior members of the squad, such as their police sergeant, or senior police officer, would arrive and take control of the situation, meaning Jim would have to return to normal (mundane) duties.
>
> (Lipsky 2010: 67).

The extract above taken from Lipsky (2010), gives an indication of the subculture, along with the hidden curriculum which gives rise to it. Notwithstanding this, I found educationalists, such as (Cottingham et al. 2008) refer to various terms to describe the hidden curriculum, such as informal curriculum, tacit curriculum, unintentional curriculum and unwritten curriculum. It has also been suggested that these curricula result in working practices and traditions far removed from that taught in the formal curriculum often found in the classroom setting (Hafferty, 1998; Cowell, 1972; O'Donnell, 2014). Doja et al. (2016) found several themes which medical students identified within the hidden curriculum, such as a culture of tolerance towards unprofessional behaviours and the importance of role modelling in professional identity were common. Wilkinson (2016) considers this

represents a powerful and influential component to the students' educational development. Graduate paramedic students enter an established tradition of working customs and practices which often consist of behaviours not expected nor planned for by the student. I illustrate some of these practices to contextualise the impact these practices can have on the ambulance service and student pedagogy. These practices include behaviours such as avoiding emergency calls where possible, excessive down time (unavailability for calls) whilst at hospitals and avoiding late finishes and meal breaks. Occasionally this includes more sinister behaviours, such as damaging ambulance vehicles (See findings chapter). Students find these practices and traditions difficult to understand, in part, as these components of practices are not shared, nor spoken of, whilst students are in the university.

Mead (1936) found people can adapt and adjust to the social structure and behaviours. These can consist of copying or falling in line with other people's behaviours – such as the more experienced paramedics (old timers), suggesting student paramedics have little control over the social structure of the workplace as this has previously been mapped out by the existing behaviours, customs and norms of the traditional working practices. Becker et al. (1961), describing medical students' induction into medical school, found students expected a scripted formal form of pedagogy, although this was not what students found in their practice sessions. Hafferty & O'Donnel (2014) describes the type of behaviour found in the healthcare setting as being common practice throughout the workforce.

I reviewed (Jackson, 1968; Dreeben, 1968 and Vallance, 1986) work to gain a deeper understanding of the emergence of the hidden curriculum. They suggest it is implicit in many guises, that the curricula outside these parameters becomes the unwritten curriculum or hidden curriculum. They further suggest that any formal curriculum is often accompanied by an opposing curriculum which sits outside of formal control. In this case, the hidden curriculum provides a form of pedagogy which is neither planned, nor spoken of in the students' formal university studies. This, it would seem, knowingly or unknowingly, exposes students, to a form of pedagogy which is scripted within the traditional ways,

customs and norms of the working environment, as set out by the experienced traditional workforce.

The examples below depict the formal university curricula, taught to paramedic students, in one University, along with an example of the statutory regulatory requirements expected of paramedics. In addition, an early sample of data taken from my exploratory fieldnotes offers a contextualisation of the fragmented environment in which paramedics operate.

Extract taken from the University Paramedic Curriculum (2020)

> *'This module has been designed to provide you (*students*) with insight into the current role of the paramedic and associated disciplines, along with the future of the Paramedic profession. It relates to other modules on your course as it threads through all areas of the paramedic role and furthermore has been designed to support you to think beyond tradition and consider the pathway your own career may take. The module hopes to inspire Paramedic students to continue into postgraduate study and play an active role in the development of the Paramedic profession'*
>
> (University Module Content-The Professional Role of the Paramedic 2020).

Extract taken from the Health and Care Professions Council's Standards of Proficiency.

> *1.4 be able to work safely in challenging and unpredictable environments, including being able to take appropriate action to assess and manage risk*
> *2.3 understand the need to respect and uphold the rights, dignity, values, and autonomy of service users including their role in the diagnostic and therapeutic process and in maintaining health and wellbeing*
> *3.1 understand the need to maintain high standards of personal and professional conduct*
> *5.2 understand the need to demonstrate sensitivity to the factors which shape lifestyle that may affect the individual's health and the interaction between the service user and paramedic*
> *6.0 Be able to practice in a non-discriminatory manner*
>
> (Standards of Proficiency for Paramedics 2019).

Sample from my early exploratory fieldnotes:

> *"We arrived at hospital and handed over our patient, whilst Julian (Paramedic) completed the paperwork in the front cab of the ambulance. I noticed he leant back in his seat and put his feet up on the dashboard deliberately kicking the air vent until it was shattered in pieces, before kicking it again and breaking the last remaining piece of plastic. He seemed unconcerned by the amount of damage he was causing and just continued to get comfortable and push his feet into the air vent causing even more damage"* (extract from my early exploratory fieldnotes 13/04/2013)

Sample from my early exploratory fieldnotes:

> *(Q) 'Is there anything you want to tell me that would assist me in my research'* (Last Question).
>
> *(A) 'Yeah, well its different out there (clinical practice), I think a lot of us* (students*) when we get in practice are okay but sometimes it just takes time to know where you need to be, you know to fit in, as opposed to you are just in it like that. I think they (*experienced paramedics*) are generally okay but do things different from what we have been taught, err you know short cuts and stuff like that'.* (Extract from early exploratory student interview with Charles 03/10/2013).

I argue that these perspectives of recurrent behaviours, like those highlighted in the two examples above, become endemic throughout the workplace and act as the students' customary approach to the workplace setting, as also experienced by Becker's (1961) ethnography of medical students, Metz's (1981) ethnography of emergency medical technicians (EMTs) and paramedics, Mannon's (1992) work of EMTs and paramedics, along with Devenish's (2014) work on student paramedics in Australia. In addition, Corman's (2017) ethnography of Canadian paramedics provides a degree of confidence that these practices and behaviours, are also to be found in their seminal works. Hundert et al. (1996) also raises concerns that the hidden curricula may be found in many levels of organisations or institutions, such as education establishments, commerce and Industry, arguing that this is a consequence of rigid structures and formal rules and policies which subsequently influence behaviours and working practices. The policies and rules which (Hundert et al,1996) refer to, are not conducive of the day-to-day work

found in the ambulance service or that which (Lipsky, 2010) highlights in his study of housing officers, police officers and prison officers.

Bray et al's. (2017) work, examining the hidden curriculum in schooling, believes the hidden curriculum may now have reached a point at which it is no longer hidden. The two juxtapositions, formal and informal (hidden curriculum), become evident, as students are drawn into a silo of fitting into the traditional orthodoxy of working practices and behaviours. The powerful and influential nature of the hidden curriculum means that some students become detached from their future professional aspirations and developments. For example, I found very early in my investigations, that students were not necessarily concerned about becoming an Advanced Paramedic, Specialist Paramedic, Primary Care Practitioner, Flight Paramedic or Critical Care Paramedic (COP, 2019). Instead, some students continued to work in the confines of the unintentional hidden curriculum as students become focused on fitting-in with their experienced colleagues. This is how students start to become drawn into a community of practice which (Lave & Wenger's, 1991) work clearly depicts. I then looked at the work of O'Donnell (2014) who examines the impact of student behaviour, believing the knowledge and experience expected of students exposed to the practice setting, is often limited and aligned to the subculture, suggesting that this is implicit within the clinical setting of medical education. Anyon (1981), Giroux (2001) and Vallance (1973) also believe this remains consistent throughout education, indicating the hidden curriculum orchestrates many sociocultural aspects of society. Paramedic students are restricted, restrained and unable to use their newly taught theories, knowledge and skills in the practice setting. This is an unintended and negative consequence of the hidden curriculum which Ball (2005), goes some way to help illustrate below:

> *'Holistic ways of working which take a far wider approach to service provision are the long-term goal therefore and, as such, must impact upon the future training of the paramedic. Paramedic training must move its focus away from the acquisition of clinical skills (no matter how wide ranging), towards fostering the ability to think and practice autonomously. In the short term, paramedics must be taught to appropriately diagnose and manage a wider range of patients, practically those who present with hidden conditions, minor illnesses, and minor*

trauma. In the longer term, and more importantly however, they must learn to work together to take ownership of the basic philosophies of their practice, which are solidly grounded in the methodologically valid and reliable research, and therefore truly evidence based' (Ball, 2005: 899).

Ball (2005), advocates for an advanced curriculum to support the concept of paramedic development, which the hidden curriculum and corresponding subculture, impedes and hampers. The report on the, Pre-Registration Education and Funding for Paramedics (DH, 2008)*,* helps to provide a sense of the move to Higher Education, suggesting this is crucial if the paramedic profession is to meet the future demands and requirements of the employer and increasing public expectations. An extract of this is illustrated below.

Health Education England's (HEE) major piece of work stemming from the 2014 publication of the Paramedic Evidence Based Education Project, which recommended the introduction of a single point of education entry at degree level for paramedic training. The Paramedic Education and Training Steering Group was established to review the potential benefits of up skilling and training paramedics to enable them to deliver more treatment in the community, as well as better delivery of on-site triage and treatment in emergencies, where clinically appropriate
(DH, 2008).

However, it is unclear and difficult to quantify from the evidence just how successful and influential the introduction of an all graduate profession has been in shaping and changing current behaviours, values and practice of the paramedic profession. It is envisaged that this research will help contribute to the literature on paramedic enculturation.

In this section of the chapter, I have reviewed the literature on culture and education to gain an understanding of the relationship these two paradigms may have on student paramedics as they enter into the workplace. The emphasis has been on the balance between the cultural and educational needs of student paramedics, with that which they experience in the workplace, whereby students mirror the behaviour of the experienced traditional workforce. This appears endemic throughout the student community, as a failure to do so results in rejection from the practice community, likened by (Lave & Wenger, 1991) to,

communities of practice. To sum up the pertinent points in this section, along with their implication for practice, many of the points raised have negative connotations for practice, although at this stage of my work, it is unclear whether all aspects of the student journey in the workplace setting are necessarily negative.

To summarise this section of the chapter, I propose that an established traditional way of working, rather than one which has been shaped and developed over time, is borne out by the work of (Metz, 1981; Mannon, 1992; Devenish, 2014; Palmer, 1989 and Corman, 2017). The implications for practice would suggest the profession remains restricted, stagnant and static in its professional development, whilst a hidden curriculum is drawn out of the subculture, as also highlighted by (Anyon, 1981; Giroux, 2001; Vallance, 1973; O'Donnell, 2014; and Hafferty, 2014). This can produce student paramedics who replicate the traditional ways and behaviour of previous years producing a pedagogy which is steeped in the traditional, taken for granted, ways of working, as the two opposing curriculums are formed. The implications for practice stem from inconsistencies which students may experience in both their clinical practice experience and educational experience. The formal university curriculum does not accurately reflect the hidden curriculum which students become exposed to in the practice setting, as students are drawn into a different social group when they attend clinical practice, to that experienced in university. They form a different, community of practice to that of the university, which is also seen in the work of (Becker et al. 1961; Lave & Wenger, 1991; Lipsky, 2010 and Hafferty & O'Donnell, 2014) and can have a positive or negative consequence for the student population.

In the next section of this chapter, literature pertaining to professional identity and professionalism within the ambulance service are discussed. This is important and adds to this research, as the notion of professionalism can have a significant influence over the traditional behaviours and customs embedded within the traditional workplace environment.

3.5 Paramedic Professionalism and Professional Identity:

In this section, I will argue that professionalism and paramedic professional identity is, to an extent, an abstract concept in the context of paramedics, as often mooted and debated within the literature. To do this, I draw on the work of Burford (2012); Donaghy (2010); McCann (2013); Devenish (2014); Williams's et al. (2015); Lovegrove, (2013) and van der Gaag & Donaghy (2013), to illustrate the abstract notion of professional identity on paramedic practice. Firstly, I refer back to Becker et al's. (1961) study of medical students to provide a helpful example of why this appears to be the case, as they found freshman students entering the medical profession became somewhat disillusioned with the medical practices which were being taught to them, viewing them as anything but professional. Williams et al. (2015), and Kell & Owen (2008), propose that a somewhat vague, confused understanding of the terms professional and professionalism exists. They suggest, contemporary society has seen the term,' professional', as a vocational structure emerging, which they believe, are deeply contested and which varies across geographical, cultural and historical context. In short, as (Kell and Owen, 2008) have pointed out, the term professionalism has become a commonly accepted term which can be influenced by historical content, social practices, demographics and context. At the same time, Evetts (2003: 407) suggests, 'the examination of the role of HEIs in shaping paramedics' professional identity reflects the increasingly ambiguous nature of professionalism in Allied Health professions (AHPs) practice'. The meaning of professionalism is not fixed as various connotations of professionalism are required to understand the role of universities in facilitating change. Burford et al's. (2012), study of professionalism of paramedics and social workers, provides a context in which to illustrate the notion of professionalisation within the UK paramedic profession, suggesting the locus of professionalism as a construct is an abstract concept to which individuals subscribe. Burford et al. (2012) imply that the notion of professionalism remains attached to the individual despite the environment or social status. A degree of confusion and ambiguity exists amongst both students and experienced paramedics as they grapple to contextualise the concept of professionalism. Paramedic professionalisation is embryonic and continually changing and developing, due in part, to the introduction of university degree programmes, as seen in the work of (Devenish, 2014), statutory

regulation and membership of a professional body. The examples below, helps illustrate this point:

> *Extract taken from initial exploratory student interviews (pilot study with Tom 08/01/2013)*
>
> *(Q) "How professional did you feel the clinical practice experience was"*
>
> *(A) "Oh fuck, oops sorry John (researcher), not at all. Christ, crews didn't give a toss about that, they just wanted to do as little as possible for the most money available (*overtime*) and get off work and get home. I don't think it is very professional at all if you ask me".*

> *Extract taken from initial pilot study (10/01/2013)*
>
> *I was riding out with Tony, an experienced paramedic and mentor, when I asked him what he thought of the British Paramedic Association (BPA), now the College of Paramedics* (professional body) *and the Health Professions Council (HPC), now the HCPC* (the regulatory body). *Tony wasn't able to distinguish between the two of them and was unaware of each other's roles, responsibilities and functions, as he thought they were both: "a bit of a waste of time I think". Tony had little if any insight into the roles and functions of these two organisations, although as a paramedic he has a mandatory annual subscription for registration with the HCPC.*

William's et al. (2015), Lovegrove (2013), McCann (2013), Burford et al. (2012) and van der Gaag & Donaghy (2013), consider the evidence around professionalism on the paramedic discipline, which they suggest remains unclear. A key component of their findings, relies on data regarding paramedics Fitness to Practice (FTP) referrals (Illing et al. 2017) (complaints against paramedics), submitted to the regulatory body, the Health and Care Professions Council (HCPC), which increases exponentially year-on-year. This would indicate that paramedics are, what McCann et al. (2013) calls, *'blue collar professionals'*, a term to describe semi-professional attitudes and behaviours. The extract taken from the HCPC protecting the public, promoting professionalism, fitness to practice annual report 2018, helps highlight his point:

Paramedics have the second largest number of concerns raised and are the fifth largest profession overall (Fitness to Practise annual report, 2018).

However, 47% of cases received by the HCPC concerning paramedics FTP referrals in 2018, originate from self-referral cases. For example, a paramedic maybe reported to their employer (an NHS ambulance service) by a member of the public or patient, complaining about the paramedics, behaviour, attitude, clinical care and so on. The paramedic then reports him/herself to the HCPC prior to any internal investigation being carried out by the ambulance service, although any internal ambulance investigation may conclude that there is no case to answer. What this means, is that the paramedic has already reported themselves to the regulator, prior to internal formal process of investigation taking place by the ambulance service. A decisive point which requires noting as this may infer the percentage of FTP referrals are artificially high. This happens because of defensive practice – paramedics wanted to get in early before someone else does. Some of this is due to a misunderstanding of the role of the HCPC which is, to protect the public and service users (patients), not to punish or make punitive restrictions on paramedics' practice.

In light of the discussion above, I looked at the Paramedic Evidence Based Education Project (Lovegrove, 2013) report, which argues that paramedic development is a key component of the professionalisation agenda. I was mindful that the PEEP report lays the professionalisation agenda firmly at university education. The report suggests that once students graduate and become paramedics, they are autonomous practitioners and able to deliver effective care. Lovegrove & Davis (2013: 7) suggesting 'for this situation to be realised, a more robust education and training system needs to be in place'. I looked at Newton's work to help understand this a little more. Newton (2012: 12) believes, 'what is needed for the modern ambulance service is a new guiding principle based on a more clinical decision focused approach'. Drawing on a professionalised paramedic workforce, consisting of additional clinical capabilities. Newton goes on to add, 'It is recognised that education of this workforce is essential for lasting change and is the core enabler for changing clinical behaviour' (Newton (2012: 8). This implies that, paramedic professional identity is dependent on individual

perceptions and agency, such as public perception or organisational image, which (Burford et al. 2014; McCann et al. 2013; and Lovegrove, 2013) infer. Glimpses are gained of various forms of identity, as seen from the patients, public or managers differing perceptions.

Furthermore, Burford et al. (2014) found variations of expectations existed between paramedic students, their university lecturers and their workplace colleagues, such as experienced staff. Becker et al. (1961), also illustrates how freshman students had different expectations from that of the faculty. These differences are recursive and connote attitudes towards professionalism which Burford et al. (2014) suggests, remain blurred. Furthermore, Lovegrove (2013) found paramedics, and student paramedics, orientate towards a strong workplace identity. These workplace identities are formed within the complexity of social, demographic locational or situational factors, as Corman (2016), found these identities were changed or modified dependent on the social setting. Looking at the professional values of emergency services, Nurok & Henckes (2009: 9), found social categories, such as 'age, sex, race and socio-economic statues' influenced and potentially mediated the care provided to patients. Whilst Pratt et al. (2006) offers an alternative concept, by reiterating the importance of knowing what people do, will help galvanise a richer appreciation of who they are in the identity construction of professionals. For example, providing feedback and role models which (Pratt et al, 2006) claim serves to improve and understand professional identity which is not the same as that fostered and nurtured in university. Metz (1981) found Emergency Medical Technicians (EMTs) and paramedics' identity was an essential component of their working day. Not surprisingly, students and paramedics construct their identity through the various forms of day-to-day work, such as discursive conversations, the insignia worn on their uniforms, symbols and personalised utility belts, (these are large belts used by crews to add a number of utility pouches and tools such as torches, scissors and forceps). This, in part, constructs the group's identity and helps consolidate their unique community of practice, which is also seen in the work of Lave & Wenger (1991).

As the discussions above suggest, the difficulty is that paramedics continue to enact subtle forms of institutional work, meaning they continue to work as they

have done for many years. An example of this can be seen in crews responding to 999 emergency calls in rotation, as opposed to decisions about who should attend being based on the clinical significance of the incident or event. For instance, when two or three ambulances are in the ambulance station and a 999-emergency call is received from ambulance control, the first ambulance on station from the previous call responds to the next call. This is regardless of the skill set of the crew i.e., EMT or Paramedic. The consequence of this traditional way of working can lead to a less experienced and clinically qualified ambulance crew attending a serious clinical situation, whilst the more experienced and clinically competent paramedic, remains on station. I provide this example to help depict one of the traditions embedded within an often stagnant, inactive and arguably passive workforce, which Givati, Markham and Street (2018: 353) suggest, in part, is 'responsible for the complex nature of the relationship between the university and professional practice'.

I argue that this traditional workplace culture remains inherently notable throughout practice and serves to maintain a form of institutionalisation as identified by McCann et al. (2013) and further supported by Corman (2017). Paramedics and student paramedics are unclear, unsure and unknowing of their professional identity, which Ginsburg el al. (2000), further supports, suggesting, professionalism remains an emerging contextualised interaction of individuals. Burford et al. (2014: 3) example helps illustrate this, as they observed that: 'values may occasionally come into conflict, and the ultimate choice the student makes will depend on the specifics of the situation'. Paramedic workplace culture is extensively incumbent on individual agency, whereby individuals may display a form of professional behaviour in one situation, yet not in another. Aultman, Williams-Johnson & Schutz (2009) and Kell & Owen (2008), depict this kind of professional behaviour as being inherently linked to social agency, a mishmash of understanding becomes prevalent as students and experienced paramedics seek assurance of their professional identity. I reminded myself of Burford et al. (2014) work, who consider that this underlying complexity is what challenges professionalism as a practical concept. Boundaries between professionalism and non-professionalism remain blurred and unclear, as also identified by (Burford et al, 2014; van der Gaag et al. 2017 and Martimianakis & Maniate, 2009).

I conclude this section of the chapter by suggesting professionalism, within paramedic practice remains an abstract concept. As Burford et al. (2014 7) claims, 'Professionalism remains conceptually unclear'. I argue that to define the notion of professionalism as an embedded construct within paramedic practice is limited, as recognised in the literature. It is embryonic in its development, evolution and augmentation. Furthermore, as suggested by (Kell & Owen, 2008) it is influenced by many factors, such as the social situation, demographics, location and situational circumstances.

In the next section of this chapter, the notion of storytelling as a means of communication between student paramedics and experienced paramedics, along with other emergency services is explored. The literature on paramedic storytelling is focused on the day-to-day communication which is widespread across the profession. The language used is often derogatory and seemingly callous, yet it is embedded within paramedic practice. This has been observed by several studies, such as those of (Metz, 1981; Corman, 2016; McCann, 2013; Mannon, 1992; Palmer, 1989; Tangherlini, 2000 & Scott, 2007), which I discuss within this section.

3.6 Paramedic storytelling:

Tangherlini's (2000) work - *Heroes and Lies- Storytelling Tactics among Paramedics,* depicts an entrenched and cynical self-deprecatory storytelling tradition which is prevalent within the practice setting of paramedics. This storytelling often runs counter to media representations of paramedics so often presented in many fictional and documentary broadcasts. For example, television fictional broadcasts such as, (*Casualty,* 1986), (*Holby City,* 1999), (*Chicago Fire,* 2012) along with representations such as, (*Rescue 911,* 1989) featuring re-enactments and occasionally real footage of emergencies which are dramatised and represented as being exciting dramatic events, whereby paramedics heroically arrive on scene in their gleaming shinning rig (ambulance) along with their smartly pressed paramedic uniforms. Other examples include, (*Inside the Ambulance*, 2020) illustrating the work of paramedics in an often, busy, caring and unpredictable environment. Another example of this is the television broadcast, (*Junior Paramedics*, 2014), whereby a depiction of very

content, happy and enthusiastic group of student paramedics go about their day-to-day work in emergency ambulances, dealing with various incidents in a supportive and friendly working environment. This is in addition to media coverage of real-life situations, such as major incidents, large scale terrorist incidents and assaults on high profile individuals. Paramedics, along with other emergency service personnel are often featured and represented by the media as heroic lifesaving professionals, which in many cases they are. However, the literature would suggest another version of the 'truth' exists, despite media coverage. Both Tangherlini (2000) and Reynolds (2007) depict paramedics as a more belligerent group of individuals who often use unscrupulous and at times offensive storytelling as part of their day-to-day activities whilst working together in the rig (ambulance). The example below by Tangherlini gives an indication of the type of storytelling used by paramedics:

> ……. deeply cynical and self-deprecatory storytelling tradition, one that countermands the media representations of their field so neatly presented in globally popular television programmes'. Rather than depicting the paramedic as silent heroes just doing our job, highlighted in media representations……
>
> (Tangherlini 2000: 43)

Tangherlini (2000: 449) found that paramedics tended to present themselves through their stories as anti-heroes. Suggesting 'they were always ready with a sardonic quip in even the most horrific situations' believing this, 'is a result of the tactical resistance to the various groups with whom they come into contact with on a daily basis. This is also seen in the work of Young (1995: 151) on policing, who reveals the 'complexity of one small area of police culture which is often hidden from the outsider; for the stories about 'bad' deaths and the savage black humour these generate'. To try and understand this, I first went back to Lave & Wenger (1991), who highlight the context in which groups of individuals are potentially drawn together within the workplace and are identified to offer some interpretation of the paramedics' storytelling. I found that the relationship between Lave and Wenger's (1991) model of communities of practice, to some extent, became a catalyst for the various stories which paramedics used in their day-to-day work. Tangherlini's (2000) study of paramedics in the USA found there was a

cultural ideology which influences the behaviours and interactions of paramedics. An example of which is below:

> The medic's tactical resistance to the various groups of patients with whom they come into contact on a daily basis, are qualitatively different from their relationships with medical personnel, managers and other emergency providers. Many patients and members of the public have expectations derived from 'reality television' and are often angered when medics do not behave like their television counterparts.
>
> (Tangherlini 2000: 59)

Tangherlini (1998: 86) further states, that 'In the course of this storytelling, paramedics often resort to strong language, vying against each other to tell the best story'. Furthermore, Corman (2016) found this style of storytelling pervasive and suggests that this occurred mostly at the ambulance station, or in the rig (ambulance), which may suggest this type of storytelling is used as a way of coping with the stress and angst which paramedics experience in their day-to-day work. Corman (2016), explains this storytelling by trying to understand what paramedics actually do and why, by suggesting this is a characteristic of the paramedics' working environment which is unseen and unknown by their patients and the wider public. The use of slang, abbreviations, antidotes, colloquialisms, and discursive terms are identified. Terms such as, truck, instead of ambulance, brown-bread, referring to dead, punter instead of patient, sickie meaning unwell patient (often a child) and purple-plus referring to a deceased patient who would be beyond resuscitation, are commonly used in the clinical practice setting. This provides a realistic and authentic insight into the traditional workplace culture experienced by students. As referred to previously, McCann et al's. (2013) study of paramedics in an inner-city NHS ambulance service illustrates how the tension between middle ranking managers (officers) of the ambulance service and front-line paramedics and student paramedics became deeply precarious, which also leads to additional forms of dialog between the fragile relationship between crew staff and managers. I provide an example below from my pilot study.

> *'Whilst a paramedic crew were completing their essential patient report form at the hospital. I recall from my early pilot study fieldnotes, how the crew were then subsequently instructed by an ambulance officer to contact ambulance*

In light of the discussions and the example provided above, I drew on the work of Boychuck Duchscher & Cowin's (2004), study of nurses in North America to help provide some insight into the conflict which they found between nurses and managers. They found that nurses became disadvantaged and discriminated against when in clinical practice, because senior staff bullied and intimidated newly qualified and trainee nurses. Boychuck Duchscher & Cowin's (2004) findings provide some comparisons between student nurses with those of student paramedics in my study. I was then drawn to Mulder, et, al. (2018) study, who explore how nurses become drawn into a hidden curriculum, whilst Kramer (1974), found nurses are 'shocked' into the realities of the workplace. I refer back McCann et al's. (2013) work, to reiterate the distinctive and unhelpful relationship they found existed between senior members of the ambulance service with that of the frontline paramedic workforce. At the same time, the Care Quality Commission (2015), the regulator of health and adult social services in England, found a lack of support from management within the NHS ambulance service trust where my study was conducted.

To try and understand why the paramedic workplace proved so challenging, I reviewed the literature on cultural identity and was drawn to the work of Geertz (1973) to help illustrate the relationship between work-cultures and work identity. Geertz argues that people create for themselves a cultural identity and ideology which governs their behaviours and interactions within an organisation, since human actions can mean many different things and one needs to understand this in the context of the work setting. Tangherlini's (2000) work provides an explanation as to why the storytelling appears prevalent within the paramedic profession, as he postulates that paramedics potentially become exposed to hostile and challenging situations and environments. These sometimes, unpredictable situations can foster a relationship between storytelling and folklore which Tangherlini identifies with the day-to-day rhythms of the work and their environment. By demystifying the concept of storytelling and folklore, I was

reminded of Schein (2004) to draw together a collection of beliefs, values and behaviours which go some way to help understand the relationship between storytelling and culture. The characteristics of certain societies, organisations and institutions, where individuals have certain basic assumptions, ratify membership into a group. This means that various nuances and subculture within the ambulance workforce reveal a discrete storytelling which is prevalent amongst individual paramedics whilst in the confines of the ambulance or ambulance station.

I was mindful of the term 'black humour', a form of humour sometimes used by emergency personnel as a relief mechanism after dealing with traumatic situations, as also seen in the work of Christopher (2015). I wanted to assure myself that the 'storytelling' which I am proposing exists is not a form of black humour used by the emergency services, instead it is a different kind of humour. Scott (2007: 350) claims, paramedics and police officers use a form of humour after witnessing horrific sights or when faced with incidents such as mutilated bodies. Scott's work found a number of themes existed which contained examples of how humour helped in everyday practice, which she concludes 'authenticates the value of humour as a stress reducing mechanism and is a normalizing characteristic of emergency care culture'. Rosenberg (1991) found that dealing with the physical exhaustion, emotional stresses and at times challenging and dangerous situations, whilst responding rapidly to life-or-death situations, exposes individuals to high levels of personal anxiety. Humour can generate a feeling of personal accomplishment among emergency workers. Mc Creaddie & Wiggin's (2008) review of the literature associated with death and humour identified the use of humour as both challenging and revealing, particularly with regard to self-deprecating humour. Scott (2007), advocates that this style of humour lies with people's values and the culture of the working environment. Despite Scott's explanation of emergency service personnel using black humour as a coping mechanism, Metz (1981) and Corman (2016) provide examples below which illustrate a type of behaviour that at times is somewhat bizarre:

> There seems to be a widespread agreement amongst them (EMTs) about how patients should be classified and about how the various classifications should be treated. In other words, the EMTs stereotype the patients and pass these attitudes along to trainees.
>
> (Metz 1981: 113)

Whilst Corman recalls how:

> …..Jake goes on to explain how the call might impact his initial reaction to the call; if the call was an Echo (this is the call code indicating a critical incident), he might 'get excited'; however, if it was an Alpha call, (this is the call code indicating a non-critical incident) he thinks to himself, 'This [call] might suck'.
>
> Corman (2016: 34)

In comparing the back humour which (Scott, 2007) claims is an essential coping mechanism for paramedics' day-to-day work as they become hardened to the sights they get to see. Corman (2017: 29) claims that 'they see things that are unfamiliar in everyday settings and interact with individuals who are in a backstage mode, whose defences are down, whose normal politeness has been shattered by crisis'. He found multiple professional identities are a consequence of the paramedics' role and the environment in which they work. I would argue, that Tangherlini's (2000) work is quite clear, that the storytelling he identifies is not black humour, but a form of storytelling which is steeped within the traditional working practices and traditions 'banter' of the ambulance service and paramedic profession. Student paramedics' behaviour may be somewhat different when alone or with colleagues in the ambulance or the ambulance station, to that experienced in the classroom at university. This, Lave & Wenger (1991) believe, is because students want to fit-into the accepted norms of the paramedics working environment.

In this section, literature on the use of paramedic storytelling has been explored, along with its influence and impact on the student paramedics' professional identity and working practices. The work of Geertz's (1973) helps to contextualise cultural identities and Tangherlini's (2000) work around folklore offers some understanding of storytelling. How and when paramedic storytelling occurs is sporadic and situational in the clinical practice setting. The next section

of the chapter explores the concept of pedagogy and communities of practice (Lave & Wenger, 1991), which seeks to understand and establish how this concept forms part of the enculturation of student paramedics in their clinical practice setting.

3.7 Pedagogy and Community of Practice:

There is a need to recognise and demonstrate that situational learning enables the application of knowledge depicted within the practice setting. Benner's (2015: 3) work on nurses helps explain this, as she suggests the 'signature pedagogy in nursing is designing experimental learning'. This would suggest that the nursing model of education revolves around clinical practice, whilst Lave & Wenger's (1991) seminal work positions learning in the practice setting as situated learning. This would mean the practice setting provides the platform for learning which Boychuck Duchscher (2012) identifies, is not necessarily the learning that is prescribed for the clinical setting. It has been suggested, that this is another research setting from which to explore the relationship between the students' detachment from the formal classroom setting, as they take on a very different identity in their working environment (Wenger, 1998). Becker et al. (1961) found trainees were drawn into the working environment as they strived to complete their fresher's year, accepting poor working conditions and long working hours to achieve what was expected of them. Work-readiness of student paramedics may not necessarily be evident in the clinical placement setting, as paramedic students form part of a traditional workforce, taking on the established ways of working, such as undertaking minimal basic patient assessment and examination rather than the in-depth detailed assessment procedures taught at university, which Devenish (2014) also implies. Willis et al. (2010), describes how the university community is a very different community from that experienced by students in the workplace, as Lave & Wenger (1991) also imply, the social setting forms a prominent part of the learners' community and formulates a dimension of social practice viewed as situated activity. Greenland (1977) suggests, the curriculum becomes adopted as the practice setting exposes students to the nuances and traditions set within it. It is 'how things are done around here', rather than following the formal structured curriculum delivered at universities.

I was drawn again to Benner's (2015) work, who considers the theories taught to the students in the classroom to that of the workplace. Lipsky (2010) illustrates how the day-to-day work of housing officers would pick and choose their clients on the basis of ease, such as non-confrontational and quick wins, as opposed to lengthy complex cases. This is despite a formal selection policy and procedure which frontline housing staff were required to implement by their managers.

Palmer (1989), Metz (1981) & Corman (2017) found the traditional working practices of paramedics remained consistent throughout their individual studies and Becker et al. (1961) provides an example below of the demands placed on medical students within the authoritarian autocratic faculty.

> *A faculty member had done something the students resented very much, something that emphasised his power over them. I (Becker) sat and listened to a discussion of what they could do about this. One of the students said, "One thing you have to understand is that most of us here will put up with just about anything if we really have to in order to get through. We spent too much time getting this far to start being crusaders about something like that. Whether you like it or not, we have to put up with it and we do". (Extract from Becker et al's. 1961 work: 281).*

I found Unwin et al. (2007), contextualises the nature of pedagogy within the workplace setting, referring to the symbolic relationship between workplace learning and operational demands, whilst Fuller et al. (2011) highlights a complex relationship between learning and workplace, as both have competing demands and outcomes. What this means is that multiple modes of learning can have commonly occurring consequences for students, as suggested by (Hafferty & O'Donnell, 2014), these forms of learning, whether by choice or coercion, can significantly influence student learning

To understand the impact this can have on student paramedics, I looked at the work of Willis et, al, (2010) who draw on the work of Benner (1984) to pose two arguments. Firstly, that the Australian paramedic industry's expectations of an experienced practitioner does not necessarily reflect educational theory, and secondly, that the degree of knowledge and skills required to move beyond the novice stage originates from literature associated with sociology, law, ethics,

psychology and communication. This can indicate that the traditional in-house ambulance training model, familiar to both the UK and Australian ambulance services, is not sufficient to reflect the supporting sciences of sociology. Willis (2010) suggests, the introduction of degree level education leading to registration, provides an opportunity to address these issues. This is significant, as developments in paramedic education become more educationally (university) based, there is an expectation by the regulatory and professional bodies that this will drive change within the paramedic profession. I would argue, however, this has yet to be achieved, as students go into the workplace setting with a set of competencies in which to perform mechanistic practical skills, such as inserting a breathing tube into a patient's mouth, or inserting a needle into the patient's vein. Yet the higher-level cognitive knowledge and social awareness required for the role of paramedics remain somewhat absent, as the more traditional behaviours and practices drive the student learning. To address these issues, Willis et al. (2010) also argues that, an educated reflexive and advanced practitioner with the growth of knowledge and understanding within the social sciences, which may be difficult to teach in the classroom setting, is required. I went back to Benner (1982) to help illustrate how nurses develop in clinical practice, suggesting:

> The heart of the difficulty that the novice faces is the inability to use discretionary judgment. Since novices have no experience with the situation they face, they must use these context-free rules to guide their task performance. But following rules legislates against successful task performance because no rule can tell a novice which tasks are most relevant in a real situation or when an exception to the rule is in order.
>
> (Benner, 1982: 128).

The sociological interpretation of pedagogy in practice rather than skills acquisition alone, is decisive and can inform an understanding of the practice environment. The pedagogy which occurs because of the hidden curriculum, Fuller et al. (2011) believe, are significant and dependent upon the political, institutional and social landscape in which students learn. In short, Fuller et al. (2011) argue, students possess a desire to form part of their workplace community, which Lave & Wenger (1991), Lipsky (2010) and Corman (2016) also note. Metz (1981) highlights the social solidarity of crews (communities) when unrealistic demands were placed on them from various sources, such as

workload, shift patterns, reduced breaks and downtime. Wenger (1998) argues that students are drawn into a form of community of practice which is based on a recognised traditional, established workplace community, which 'becomes the property of a kind of community created over time by the sustained pursuit of a shared enterprise' Wenger (1998: 45). What Wenger is suggesting here, are that communities are formed from a shared purpose. This shared purpose is formed over a period of time, similar to paramedic students spending blocks of time in the workplace. Students become forged within a shared purpose as they become drawn into a particular community.

Members of these communities are formed by joining in common activities. This, Wenger (1998) suggests, leads to either formal or informal communities being formed and stems from their mutual engagement in these activities. Pedagogy in practice, remains fluid, tacit and unstructured. Specific examples are woven throughout the findings chapter to help elicit pedagogical behaviour of students. Connections are drawn between the practice setting and that of pedagogy. A dissonance exists between what is taught in the formal setting of the university with that of the practice setting.

The theoretical knowledge taught in university can enable student paramedics to rationalise and identify best practice. However, these practices are stifled and confused as students become inevitably caught up in a chaotic working environment. Consequently, tension and anxiety exist as students go into the clinical practice setting (Jones, Slater & Griffiths, 2010) unsure of their roles and responsibilities. In the next section of the chapter, I explore the literature to offer further explanation of why these tensions exist.

3.8 Tension:

Wallis's (2009) work illustrate that a number of tensions exist between generations of nurses in the workplace as different decades of nurses' work alongside each other. She argues that 'each generation holds different values which differs from others in the way they make sense of the world, and in what they expect from work' (Wallis, 2009: 62), whilst Putnam, Myers & Gailliard, (2014) believe tension in the context of the workplace possesses an overarching

dilemma in implementing workplace flexibility, suggesting friction exists between the flexibility to work autonomously, with that of a rigid, controlling environment which (Givati et, al. 2018) also illustrate in their work.

In light of the above discussion, I reviewed the work of Sarros, et, al. (2002) who found tensions existed in their work on a bureaucratic, quasi-military style, US Eastern seaboard fire department, suggesting the style of leadership was a significant factor in this, as also seen in McCann, el al. (2013) and Wankhade & Mackway-Jones (2015) studies. I turned to Metz (1981), who expresses the often taken for granted assumption that EMTs and paramedics' work, offers variety in the workplace. For example, Metz highlights how experienced EMTs/paramedics bracket certain incidents (jobs), such as calls involving minor injuries or trivial ailments, false alarms and regular callers. The perceived inappropriateness of these calls causes low morale and tension between crews, as both students and experienced paramedics find these tensions cause unhappiness and dissatisfaction after working long hours, often without official breaks. Other influences include, the time of day or night; nearing the completion of the shift; and calls early in the shifts (whilst the crew are checking their equipment and ambulance), these all add to the tensions associated with the work of paramedics. An example below taken from my early fieldnotes helps illustrate this:

I was riding out on an early shift with Charlie the student and Jim the paramedic. It was early morning (07-00 to 19-00) day shift. Whilst we were checking the ambulance equipment, stocking the paramedic drugs and checking the road worthiness of the vehicle (Ambulance), and at the same time having a cup of morning tea. A call was received from ambulance control at (07-01) for a male with head pains. The time of origin of the call (when the 999 call was first received by ambulance control was 05.30am), one and half hours prior to the call being despatched to us. Both Charlie and Jim were fuming at such an outrageous position to be in. We did not get back to station that day till 19-20. (Extract from my fieldnotes 05/05/14)*.*

It can be argued that there remains rigid managerial influence over ambulance work. Managerial control is exercised over crews which includes electronic positioning location monitors (data track devises) in the rig or truck (ambulance),

which McCann et al. (2013) suggests, causes additional tension amongst crews, as they witnessed direct control over crew staff (both paramedics and students). For example, they found managers physically hurrying crews out of hospitals in an attempt to exercise explicit and direct control over their working environment. They recall the lack of direction witnessed by one of the researchers during a particularly busy period of the day, as ambulance managers put pressure on paramedics to leave hospitals where they were waiting to hand over patients in order to get them back into commission and available for calls, McCann el al. (2013). Crew staff (paramedics and students) develop and implement their own style of working practices, which Lipsky (2010) explains, is a form of survival within the workplace. Paramedics and students display a constant vigilance (lookout*)* for ambulance officers (managers), as any unnecessary downtime (unable to attend a call) is frowned upon by managers. This can occur at hospitals whilst crews create a little downtime or at the scene of incidents and back on station. The desire to experience freedom from direct supervision within the ambulance service is not new, as patient handover at hospitals, along with the necessary cleaning of ambulances and completing of documentation that follows, were often being neglected due to managerial pressure which Givati, et, al. (2018), Wankhade & Mackway-Jones (2015) and McCann et al. (2013) conclude are conflictual restrictions that are present in ambulance services.

Authors such as, (Bass, 2010; Judge, & Piccolo, 2004; Avolio, & Bass, 2001) argue, that, as a result of deconstructing the institutionalisation of the ambulance organisation, a less bureaucratic management regime which normalises and orientates the workforce to a more encompassing organisation, could be a more effective model of management. Swain (2019) however, urges caution here, suggesting that workers are familiar now with leaders and managers talking nonsense about leadership and employee autonomy. Swain (2019) make a valid contribution here, concluding that this type of rhetoric is often used by managers to get their own way as ambulance services continue to function and operate as quasi-military style organisations, something which (Sarros et al. 2002) has already identified and which I would argue impacts significantly on the operation of the ambulance service.

In this section, literature pertaining to tensions associated with the institutionalisation of the ambulance service have been discussed. I highlight this as it serves to illustrate the subtle, often hidden forms of behaviour and working customs entrenched within ambulance work which forms part of the wider makeup of the hidden curriculum and subculture. This contributes in shaping and influencing student enculturation of the practice environment. I summarise this section below with key points which emerged from the literature.

The literature implies that the impact of these tensions on the behaviour and workplace subculture of paramedic socialisation is important and can, in part, be summarised by Schein's (1985) model of organisational culture along with the behaviours and intricacies within the day-to-day working of paramedics and students. Using Schein's three-layer approach to culture, it is easy to see how different expectations are formed. For example, artefacts - the observable aspect of how people see the paramedics (responding to emergency calls). Espoused beliefs, values and behavioural patterns – how the philosophy of the organisation operate, the vison & values of the ambulance service. Thirdly, assumptions – the embedded, taken-for-granted behaviours which are usually unconscious beliefs. What is really going on inside the organisation, such as the day-to-day working practices and traditions. McCann et al. (2013) illustrates how ambulance services operate as a quasi-military style fashion, whilst Metz (1981) and Mannon (1992) highlight the tensions created by the perceived mundane nature of the emergency calls which emergency medical technicians and paramedics attend. These are sources of frustration and tension between students and paramedics which aggravates the tensions already experienced by crews. In the next section of the chapter, I explore how these experiences result in the enculturation of student paramedics in the workplace.

3.9 Enculturation:

Reviewing the literature on enculturation, I was reminded of the affiliation with socialisation, so for the purpose of clarity, I recap on the definition of the two terms to help focus my search. Gibson & Brightwell (2006) believe enculturation draws on established and accepted norms and values of a particular culture or society, where accepted members fulfil the functions and roles of the group.

Whilst Kottak (2010: 23) describes enculturation as 'the process whereby individuals establish a context of boundaries and accepted behaviour that dictates what is acceptable and not acceptable within the framework of that society'. McPherson & Brown, (1988: 267) define socialisation as 'the process whereby individuals learn skills, traits, values, attitudes, norms, and knowledge associated with the performance of present or anticipated social roles.

Now that I had reminded myself of enculturation, I looked at Choy & Delahaye (2011) work, who found students contextualised the formal taught elements of study within the socio-cultural and functional environment of the workplace, suggesting students become enculturated into the workplace, before even experiencing it, whilst Willis et al. (2010) suggest graduates were not ready for the experience of clinical placements, as the relationship between work experience, institutionalisation and professional identity, are interwoven and is a consequence of an entrenched subculture and subsequent hidden curriculum.

Working practices influence the students' experience and learning environment, thereby enculturating the student into the traditional ways of working. This gives rise to a working environment which Brewer & Whiteside (2012) depict as an unfavourable, adverse and often hostile way of working, whereupon unprofessional and unscrupulous practices can occur, such as, bullying, sexism, racism, homophobia and in some instance's criminal behaviour, which may be prevalent within the day-to-day work of paramedics and student paramedics (See appendix A). Lewis (2017: 7) reports the alleged misconduct at one NHS ambulance service trust, revealing a 'culture of bullying, harassment and alleged sexual predation at an ambulance trust that managers failed to address, leaving employees bereft of both confidence and direction'. Lewis's findings reveal a behaviour far removed from the formal process expected. Subsequently, contradictory definitions, terminological and conceptual confusion can result, as the relationship between what happens in the practice environment, to that expected by the university is, and remains, polarised. This poses confusion and uncertainty for students as they enter the ambulance workplace.

I reminded myself of Kramsch (1999), who highlights the importance of recognising an individual's difficulty in abandoning already constructed cultural demeanour, behaviours and values, when trying to customise to a new culture. Students are drawn into an unexpected, unintentional, unwarranted and unhelpful practices when they attend clinical placements, as Corman (2017) found deep entrenched ways of working existed within the ambulance service which is further supported by McCann et al's. (2013) work with a UK, inner city NHS ambulance service trust. The enculturation of student paramedics enables them to function as members of a particular group or community. Its influences, amongst other things, include behaviours, expectations, rituals, symbols and morale values, which students share with peers and newcomers. It has also been suggested (Becker et al. 1961) work, identifies forms of behaviour which leads to a continuous cycle of enculturation taking place:

> A type of culture which forms a pattern of thought, emotions and behaviours which are learnt, not necessarily innate or inter-connected or shared within a group. Instead, it characterises each group, to what their relationships are with the environment and people. (Hofstede & Bond, 1984: 81).

Tuohy et al. (2008) remarks that culture itself is not static nor a single entity, rather, there are multiple facets which change as one evolves through different environments and interactions.

In this section, I reviewed the literature associated with enculturation. Comprising of a subculture which inadvertently produces a hidden curriculum. This hidden curriculum impacts and impinges on student learning and their subsequent enculturation into a formidable, established, traditional culture, which leads to a form of pedagogy not experienced in university or envisaged by the students.

In the last section of the chapter, I summarise the interpretation of the literature whilst exploring the conceptual framework for this study. This provides an underpinning theoretical context and helps illustrate how and why paramedic students become enculturated into the traditional working ways and customs of the ambulance service.

3.9.1 Overview of chapter:

This chapter has reviewed both National and International literature pertaining to paramedic culture in order to, encapsulate, compare and contrast the various models of student paramedic enculturation. It was also necessary to explore how tension existed between individuals, with managers and crews, with students and paramedics and with each other. In doing so it became necessary to explore how similarities existed between the various types of ambulance cultures, such as the culture depicting paramedics as lifesaving heroes, as opposed to the expectations of the ambulance organisation, with that of the day-to-day working subculture which students become exposed to.

In order to explore, examine and interpret the findings associated with the concepts of subculture, hidden curriculum and pedagogy, evidence integral to these concepts have been discussed. In understanding these concepts, the work draws together developments of the paramedic profession both within and outside the UK to help contextualise the paramedic landscape.

The extent to which student paramedics' learning is influenced by pedagogy within the classroom setting has been shown to be limited. Whilst literature pertaining to pedagogy in practice, provides meaning and context to this research. Associated literature relating to social integration, behaviour, tension and work experience, has been discussed to help provide further context. Various sections of seminal works have been used which directly relate to paramedic practice, whilst other seminal work complements and supports the wider body of knowledge which include other professions such as: the fire service, nursing, medical students, police officers and housing officers. These are drawn from the prevailing literature to help provide support and agency to this thesis. Both I, and participants of the study have been influenced by this work. My personal engagement has been compelling and significant in highlighting the issues raised by this research. The issues identified from my literature review, challenges and highlights significant expectations and potential differences in paramedic students' learning and learning environment, which ultimately impacts on their professional values and pedagogic understanding. Based on this, the question

then is, to what extent students are drawn into the traditional taken for granted ways of working in the clinical practice environment of paramedic practice and what is the impact on their learning? The methodology used to explore these concepts for this study is discussed in the next chapter and an attempt is made to address this important question.

Chapter Four: The Research Approach

4.1 Introduction:

In this chapter the research methodology is laid out. It starts by discussing the research paradigm and goes on to describes the methods used in the study, which comprise of ethnographic observations accounting for most of the data and a small number of interviews to disclose student perspectives and the lived experiences, revealing processes of enculturation. Finally, the chapter concludes how the chosen methodology influences and shapes the study. The next section of this chapter discusses the research paradigm. Table 3 below provides an illustration of the research process to help illuminate the various stages of the research process.

Table 3: **Overview of Research project:**

Research Title	An examination of University Paramedic students' Enculturation into the Ambulance Service
Study	Explored student paramedics' understanding and experience of their practice placements. Focusing on their integration with their more experienced paramedic
Methods	Ethnography Revealed the real life, day-to-day events which students experience in their clinical work placements.
Ethics	Institutional, ambulance service and NHS ethics clearance
Pilot study	Tested fieldnote data collection and interview schedule with students.
Paradigm	Constructivist Paradigm
Main study	Explore students' experiences
	Institution, National Institute of Health Research (NIHR), NHS Ambulance Service Trust Ethics
Design	Ethnography: Data was obtained over eighteen months, using observational fieldnotes, and interviews
Methodology	Qualitative
Methods	Interviews Fieldnotes
	Sample interviews based on accounts of fieldnotes (n=8)
Pilot study	Explored social integration into the community of practice and that of the paramedic
Main study	**Total Sample:** Key participants n=8. Other participating participants n=30 **Time Period:** Between 2013 and 2014 eighteen-month period. **Area:** Predominantly inner-city Metropolitan, along with leafy suburban rural areas **Research Tool:** Ethnographic field notes supported with semi-structured interviews **Qualitative Analysis:** thematic coding by hand, supported with MAXQDA supporting software.
Pre-defined Key areas	Professional Identity, Institutionalisation. Pedagogy woven throughout the three themes. Embedded within communities of Practice
Emergent Sub-themes	Traditional ways of working, bullying, meal breaks, stress, uniforms, late finishes, management support, working colleagues, training, ambulance control, vehicles, management spies, whistle blowing, workload, university curriculum, superheroes, Pre-judgement, patients, racism, sexism.
	How students became enculturated into the community of practice (Ambulance Service)

4.2 Research Paradigm:

Stevenson, Elliot & Jones, (2002: 498), define a paradigm as 'a model underlying the theories and practice of a scientific subject'. A Constructivist paradigm consists of the learner having previous experience and knowledge which is usually determined by their cultural and social environment. Seifert et al. (2008: 33-37) believes, 'learning is therefore done by students constructing knowledge out of their experiences'. This is illustrated by Kuhn (1996: 10) who believes that: 'a paradigm implies a set of concepts and practices that define a scientific discipline at any particular period'. Exploring a notion, such as culture within the paramedic workplace required a methodology which enabled me to tease out detailed intricacies and nuances, which are often unseen by those who may be outside the research specific subject, as illustrated by Madden (2017: 20) who suggests that, 'many characterisations of ethnography will stress the emic or insider perspective over the etic outsider perspective to understand the folk or native insider point of view'. I was mindful of Madden's words and never lost sight of my own perspective of being both an insider and, at times, an outsider researcher, along with the driving question as to why student paramedics appear to change their behaviour when they attend the clinical practice setting. Qualitative research allows the exploration necessary to study the experiences and voices of a group or population, sometimes making it possible to hear silenced voices, as seen in the work of Creswell (2007). Creswell refers to observational studies, in particular hearing the silent voice. Drawing on observational studies in the latter part of the investigation enabled me to tease out a detailed understanding of the subject matter as well as the voices of the paramedic students.

The paradigm was identified by the research aim, which is to explore student paramedics' enculturation into the ambulance service. I was interested in the process of how, and why, student paramedics appear to engage with certain values and ways of working. Of particular interest, is the socialisation which appears to take place between the established traditional workforce and new recruits; the central aim of ethnography is, as (Spradley, 1979: 3) points out 'to understand another way of life from the native point of view'.

Individual students perceive their experience differently, as they interpret or make sense of the situation within the context of their points of reference. In turn, the researchers' individuality inevitably contextualises and affects the research. Crotty & Crotty (2004) refers to this as, multiple constructed realities. Therefore, the texts produced during observations are, as (Mann 1992: 273) describes: 'never an objective record of what happened, rather, an expression and interpretation'. Consequently, an interpretivist paradigm allows the researcher to elicit, engage and connect with participants, uncovering aspects of the individual, such as their feelings, thoughts and behaviours, along with the individuals' expectations. Within this process, certain interests, assumptions and the researcher's perspectives may be different to the issues being researched. This can potentially influence the research and must be identified and acknowledged. However, caution is required as Madden (2017: 25) suggests that: 'The influences of subjectivity on ethnography and the lack of control over field settings are the sorts of conditions that are mentioned when people make a claim that the ethnography is not scientific or reliable'. I was always mindful and never lost sight of the fact that the relationship between the researcher and participants is pertinent and essential to the ethnography. Both have a different construction of social realities, making the method of data collection a key component in drawing out rich insights into the study's context (Brewer, 2000). In using an interpretive position, I attempt to reflect on the realities of the findings, (Denzin & Lincoln, 2002), produce judgements about the data and translate this to the reader. By choosing this paradigm, a number of assumptions were imposed, namely that the application of theoretical classroom knowledge into the clinical practice setting is complex, made up of conscious and subconscious processes which are contextually constrained. This allowed for the opportunity to reveal and illuminate the nuances, intricacies and subtleties, of the paramedic practice setting. The next section of this chapter considers ethnography in more depth.

4.3 Ethnographic principles:

Guba, believes a set of guiding beliefs form the infrastructure of the research paradigm, which Guba (1990: 18) expresses as an inquiry which asks: 'What is the nature of knowledge or reality (ontology)? what is the relationship between

the researcher and knowledge (epistemology)? and how the inquirer should go about finding out knowledge (methodology)?'.

Bradshaw and Stratford (2010) illustrate, how a research design can help form a meaningful strategy of the investigation. This strategy supports the theoretical perspectives and aims of the research. In my research, I particularly wanted an approach which explored the interaction between the often knowledgeable but inexperienced neophyte paramedic students, with that of the authoritative stance of the experienced paramedics (Givati et al. 2018) highlights. To facilitate this, an insider's (emic) view of the realities of the workplace, as opposed to an outsider's (etic) understanding, was identified (Pike, 1967). According to Madden (2017: 6), 'ethnography is ultimately a story that is backed up by reliable qualitative data and the authority that comes from active ethnographic engagement'. This is further supported by Spradley (1979: 5) who believes that, 'ethnography is concerned with illustrating meanings of actions and events of people, through observation and interviewing key informants', whilst O'Reilly (2009: 3) claims that, 'ethnography is a theory, or set of ideas, about research that rests on a number of fundamental criteria', that it is iterative-inductive research; and evolves in design through the study'. I was mindful however, that ethnography is not without critics who may view this kind of data collection as subversive and non-scientific. For example, Hammersley (2018) found critics argue that ethnographers can fail to examine the processes through which the phenomena studied have been constituted, suggesting there is an absence of rigour due to unexplicated common-sense knowledge. In my view, this criticism is subjective which only becomes problematic if due processes and procedures have not been followed regarding the ethnography, for example, following good practice, such as accurate note taking, recording events and situations as they are seen through the researcher's lens and respecting participants anonymity. Draper (2015) believes, these all contribute to ethnographic principles.

My background as a UK registered paramedic, provides considerable expertise and experience in identifying the subtleties and complexities this research captures. The ethnography is used to explore and gather insight into the realities of the participants' experiential viewpoints based on details of what occurred,

which Brewer's (2000) work helps to reveal, what is said (Koch, 1996), between the lines (Kvale, 1996) and silences (van Maanen, 2011). The individuals' perspective of their experience is considered in relation to the context in which it is positioned. This illuminates the participants' cultural and social experiences. My reflexive interpretation of the participants' experiences could then be taken back to the participants in follow-up interviews. This revealed an exploratory lens based on shared experience which helped to uncover participants' reality as it was experienced and interpreted by them. Hammersley & Atkinson (2006) express the importance of ethnographic enquiry in uncovering the emerging issues which they believe, can be found by the ethnographer as:

> Researchers participating, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, and/or asking questions through informal and formal interviews, collecting documents and artefacts – in fact, gathering whatever data are available to throw light on the issues that are the emerging focus of inquiry.
> (Hammersley & Atkinson 2006: 3)

Geertz (1973) found that participants act and behave differently and voice their opinions openly, depending on the relationship with the ethnographer. The participant's voice is influenced by the ethnographer's insider or outsider status. Notwithstanding the researcher's emic or etic stance, participants often express their rationale and meaning about individuals, their environment and the way of illustrating this to the researcher. Walford (2008) believes that:

> Ethnography is the art and science of describing a group or culture. The description may be of a small group in an exotic land or a classroom in middle-class suburbia. The task is to interview relevant people, review records, weigh the credibility of one person's opinion against another and look for ties to special interests and organisations.
> (Walford, 2008: 272)

Recognising Walford's (2008) description, I needed to identify the ties to any specific community or group which occurred in the practice setting; how and why students became part of the workplace culture of the ambulance service. Creswell (2007) helps identify how to investigate such a phenomenon, as he believes qualitative research supports exploration, especially the need to identify

a group or community, illuminate specific irregularities which can then be measured, or to listen to silent voices. Creswell speaks of the 'silent voice', referring to the intricacies of nonverbal communication and body language. Observations will allow the opportunity to elicit various trends which maybe explicit in a participant observation. Schwandt, (2007: 96) reminds us that, 'Ethnography is a particular kind of qualitative inquiry distinguishable from case study research, descriptive studies and naturalistic inquiry by the fact that it is the process and product of describing and interpreting cultural behaviour'. My focus was to unpick and understand the subculture which, I am arguing exists. I needed to understand how a subculture may impact on the students' learning and enculturation into the paramedic profession and the subsequent hidden curriculum which gives rise to it.

In light of the discussion above, drawing on an emic perspective, enabled a more nuanced insider interpretation and understanding of the experiences and shared meaning of participants (van Maanen, 2011) as they react to, and within, a culture. This provides a clear description of social meaning. The ethnographic principle of cultural interpretation locates the researcher as an integral part of the research process, as also seen in the work of (Madden, 2017; O'Reilly, 2009; Brewer, 2000; Walford, 2008; and van Maanen, 2011). Ethnographers engage with their research, exploring the perspectives of participants and assimilating the researchers own views to help aid the research. Denzin & Lincoln (2008) describe interpretivism as mutual patterns of impressions encapsulated in the participants' experience. O'Reilly (2009: 122) suggests, interpretivism is to 'understand shared meanings, cultures, and individual motives that lead to action'. These are articulated by the researcher through a rich, explicit depiction of the individual, societal and cultural aspect of the situation being investigated. Savin-Baden (2004) believes a reflexive researcher provides the reader with insight and understanding of the relationship between the research study and the researcher's position within the study. This enables the researcher's background to be disclosed, decisions made and the strategies formed for the readers to see.

The next section of the chapter looks at the data collection methods used.

4.4 Methods:

To ascertain which data collection tools I would use, I firstly considered the conceptual framework employed for this study, as the purpose of data collection is to elicit information and understanding from participants, Brewer, (2000). Although my work eventually ended up as an ethnography, I did initially explore Kelly's (1955) Personal Construct Psychology's (PCP) Reparatory Grid (RG) as part of a small-scale study. This introduced me to my research journey and provided an indication that after their first clinical practice placement, the expectations of the paramedic students, about the workplace, appeared to have changed. For details of this small-scale study, (See Appendix B). This early work provided the foundation from which to draw comparisons, between first year university students going into the workplace and those returning from the workplace environment. This illustrated the fact that some cultural influences which were embedded within the structure of the ambulance service were affecting students. I found student perceptions altered, after workplace exposure, compared with their perceptions prior to the workplace; this puzzled me and I wondered what was going on.

Data generated in this process illustrated the need for further investigation to determine the phenomenon of student enculturation. Furthermore, it became evident from the initial dataset that an in-depth understanding of the complexities may best be achieved from an insider's perspective of the phenomenon through the use of field observations as an insider to the profession. Consequently, the concept of utilising an ethnographic approach in order to establish why this phenomenon appeared to be prevalent within the paramedic profession was undertaken. Adler & Adler (1987), Lipsky (2010), Palmer (1989) and Metz (1981), draw on the richness and in-depth analyses of ethnography in examining the inner workings of emergency service personnel. It also became clear, through reflecting on the initial experiments with PCP that, exploring culture within the workplace can require more than one method within the researchers' armament if one is to gain a deep and meaningful experience from the data collection, Denzin (2017).

4.5 What method to employ:

The use of an ethnographic approach meant I could identify an appropriate data collection tool. Both interviews and focus groups have a long traditional standing in the data collection of qualitative research methods, Creswell (2007). These were supplementary methods to my fieldnotes. However, Patton (2002) believes participants may amend or change their behaviour and react differently in focus groups or interviews, as these methods can sometimes provide socially suitable answers. By this Patton suggests interviews and focus groups can lead students to provide answers which they believe the researcher want to hear. My aim was to understand how and why university paramedic students become socialised into a very different workplace culture, to that cultivated at university. In order to do this, I needed to hear, see and experience what was really going on in the workplace setting, to hear the voices and probe questions in the attempt to gain insight into the students' perspectives of the workplace environment. I acknowledged that some students and experienced paramedics may know me, both as an academic and/or paramedic practitioner and therefore may not wish to voice their opinion or express their views openly to me. In interviews and focus groups, this may have led to participants acting differently or expressing opinions which they may believe I wanted to hear and see from them and limiting confession. Although there is a risk of the researcher's observations affecting behaviour, I become immersed in their day-to-day work. I remembered Atkinson et al's. (2007) work suggesting that ethnography limits and restricts these possibilities, as students become immersed in the day-to-day working practices. Following my critique of the literature, along with my desire to really understand what was happening in the workplace, I referred to Becker et al's. (1961: 133) work, who believed that, 'the most complete form of sociological datum, after all, is the form in which the participant observer gathers it; this rich data gives more information about the event under study than data gathered by any other sociological method'. O' Reilly, (2009) concludes:

> Being with people (or more precisely, being ethnographic with people), in their time and space, in all their strangeness and in their mundane and quotidian flow, is still one of the most valued ways to build a qualitative understanding of the particularities and generalities of the human condition (O' Reilly, 2009: 143).

Here, I am not suggesting that other forms of enquiry are not valued and valid. They are more than adequate to provide a different lens in which to illustrate enculturation of student paramedics into the workplace setting. However, I am indicating how, for me, participant observation was an appropriate, yet challenging, method with which to explore, uncover, identify and illustrate the intricacies and behaviors often unseen and unknown to those outside the practice setting. Diamond (2008) provides an ethnographic account of patients in long-term care facilities in the USA, and Rankin & Campball (2006), give an ethnographic explanation of nursing. These studies depict the use of ethnography to help illustrate the social interactions of people in the healthcare setting and provide reassurance to me that my approach is both workable and valid. These two studies are particularly helpful as the subjects being explored were patients and nurses who found themselves in challenging and at times distressful situations. Some comparisons can be drawn from theses ethnographies with that of paramedics who often work in hostile and challenging situations and environments. The seminal work of authors such as: (Corman, 2017; McCann et al. 2013; Palmer, 1983 and Metz, 1981) helps to understand the complexity of both the challenging working environments of paramedics' work, along with the cultural discourses which are displayed by those who work in the organisations. Metz's (1981) work is particularly helpful in providing an historical account and understanding of how the ambulance crew's behaviour, customs and unwritten rules, became a prominent feature in their day-to-day operational working practice. Madden's (2017) work expresses how ethnography synthesises the information gathered by the ethnographer by contextualising the fieldnotes (data), into a narrative, suitably structured as to illustrate the ethnographer's journey. Metz's study spanned a period of several years, two years employed as an Emergency Medical Technician (EMT) in America working alongside other EMTs and Paramedics, whilst undertaking an extensive ethnography as a researcher. His work affords recognition and provides authority and realism to this unique working environment. His study recognised the cultural meanings, institutional rules, and rituals of the EMTs and paramedics within a competitive socioeconomic backdrop of austerity. He determines and illuminates the human activities of this working environment (Metz, 1981) and galvanises the historical past with the 1980s, to provide a sociological perspective of ambulance culture. More recently,

Corman's (2016), work on Canadian paramedics, suggests the research often assumes an operational perspective rather than empirically exploring what paramedics actually do in their day-to-day work. Authors such as (Creswell, 2009; Brewer, 2000; Walford, 2008; van Maanen, 1988; and Hammersley, 1993) describe the richness and depth of thick description which is attributed to ethnography as a sociological form of enquiry.

Drawing on the work of Brewer (2000), I generated my fieldnotes from the observational placements, audio-recordings, interviews and the occasional report to help draw out meaning from the data and clarify my findings. Burgess (1985) suggest this overtly engages the researcher with the participants and their communities of practice, which Lave & Wenger (1991) also identifies. Burgess (1985) stresses the positive impact he believes insider researchers have, arguing they can achieve full participant status as someone that already belongs to the group being researched. Hammersley (1993) however, suggests there are no overwhelming advantages to being an insider or an outsider researcher. I kept in mind both Burgess's and Hammersley's advice and was very cognisant of the professional boundaries which I, and students, may experience in the day-to-day clinical practice environment. To address this, I very early on in the data collection phase of the research, joined in with the banter and culture of the workplace. I tried to give an illusion of being a paramedic, being one of them, although I never lost sight of Walford's (2008) views, which highlights the danger of the insider researcher going 'native' arguing that this infers the researcher is trying to be the person he/she is researching, rather than as a researcher. Labaree (2002) argues that one can simultaneously be to some extent an insider and to some extent an outsider, of qualitative research, as the research may have elements of insiderness, along with outsiderness attached to it. I am a registered paramedic and was not trying to become native, instead I wanted to get a real appreciation for what I was seeing, hearing, experiencing and recording. As is suggested by (Madden, 2017) I was trying to make the familiar, unfamiliar. Walford (2008) also points out that the position of insider/outsider research is endorsed by one's reflexivity. Kielmann's (2012) ethnography focuses on practitioners and their professional socialisation within healthcare as being reflexive. In undertaking this research, I had to balance the dichotomy of insider/outsider relationships. I

became reflexive and reflected on the research and participants relationship to help understand and position myself within the role of researcher.

Establishing the relationships between the researcher, student paramedic and experienced paramedic became somewhat tested in the field. As seen in the work of Creswell (2009), research participants view the researcher through multiple lenses. I attended operational shifts both in ambulance uniform and non-uniform. When I attended operational shifts without my uniform however, it appeared to cause some anxiety for both students and experienced staff. I continued to test this by wearing my ambulance uniform for many of the shifts, then occasionally I would arrive for the shift in my normal clothing, except for my protective footwear (steel toe caped boots) and high visibility fluorescent jacket, which is mandatory for ridding out on ambulances. I thought of Burgess (1985) who believes, a fundamental part of being an ethnographer, is to become accustomed and accepted into the social context of the community being observed. Brewer (2000) suggests, as an ethnographer it is essential to immerse oneself into a community to gain deeper insight of the intricacies and nuances which may not be so clearly obtained from literature or methods where information could be second-hand. Ethnography, obtains insight into the participants lives (O'Reilly, 2009), the customs, traditions, intricacies and nuances of their day-to-day environment, which may not be attainable through narrative discourse alone. Here the researcher has a relationship with the participants, the community activities and the wider research environment. Extensive and elaborate notes are recorded of the experience. This enables the researcher to engage with the culture without imposing one's own social reality (Searle, 1995) on that culture (Walford et al. 2008). Craft & Jeffrey (2008: 141) proposes that, 'ethnographic research includes involvement, immersion and empathy on the one hand and distance, scientific appraisal and objectivity on the other'. I never lost sight of their view.

4.6 The research study:

The study consisted of a number of paramedics from a traditional inner-city NHS ambulance service trust, many of which were long serving members of staff who had trained as paramedics through the traditional in-house, Institute of Healthcare and Development (IHCD) award some years previous, before

university paramedic degree programmes existed. In addition to the paramedics, 8 university paramedic students offered their time to help in the study. Numerous other students became involved in the study along with other consenting paramedics as I came across staff and students at various locations, such as hospitals and ambulance stations and at times on scene of incidents. These participants knew of my data collection due to information circulated via the internal ambulance service network and through word and mouth. In addition, students from the university where I worked were aware of the research project. Consequently, I carried a supply of information sheets (See Appendix C) and consent forms (See Appendix D) which were circulated to participants to ensure I remained within the ethical boundaries of the research project. O'Reilly (2009: 63) suggests, 'Ethical issues are best resolved via an ongoing reflexive dialog between the researcher and research participants within the field context'.

The 8 student paramedics selected for the study were observed over a period of twelve to eighteen months, often on twelve-hour shifts, consisting of a student paramedic along with an experienced paramedic or recently newly qualified IHCD paramedic (NQP). Semi-structured interviews were used to support and supplement the observational fieldnotes, (See Appendix E). The purpose of these interviews was to gain a deeper understanding and clarification of my observational findings, Brewer (2000) and Burgess (1985). This helped to compliment and contextualise the data and facilitate exploration of the student's own views of the phenomenon under investigation.

Table 4 below, provides an example of my time collecting data. The matrix identifies whether data was collected from students, newly qualified paramedics (NQP), experienced paramedics or other members of ambulance staff or emergency service personnel. This example gives an indication of when and where the data was collected, such as hospitals, on the scene of an incident, in the ambulance station or in the ambulance vehicle and highlights the total time accrued collecting fieldnotes (602 hours) and the total number of interview hours (10 hours). Table 5 provides examples of short biographies of participants involved in the study. I have used pseudonyms to protect the individual identity of participants.

Table 4: **Provides an example of data collection matrix. From 2013 to 2014**

Date of Data Collection	Data Collection Method	Fieldnote Duration	Interview Duration	Student Pseudonyms Names	Paramedic/EMT Pseudonyms Names	Other e.g. Firefighter, Nurse, Police officer, Pseudonyms Names	Location of data Collection
12/03/2013	Fieldnotes	12 Hour shift	N/A	Janet	Asher	Other Ambulance personnel	Ambulance Station
12/04/2013	Fieldnotes	12 Hour shift	N/A	Tony	Time	N/A	At the Hospital
13/04/2013	Fieldnotes	12 Hour Shift	N/A	Tom	Bill	N/A	Ambulance Station
22/04/2013	N/A	N/A	1 Hour	Jennie	N/A	N/A	At University
01/03/2014	Fieldnotes	12 Hour shift	N/A	James	Bruce	N/A	In the Ambulance
08/06/2014	Fieldnotes & Interviews	12 Hour shift	1 Hour	Amy	Tina	Other Ambulance personnel	On-Scene
05/09/2014	Fieldnotes	10 Hour shift	N/A	N/A	N/A	N/A	In the Ambulance
21/09/2014	Fieldnotes & Interviews	8 Hour Shift	45 Minutes	Ben	Joe	N/A	In the Ambulance

Table 5: **Provides brief biographies of the eight key participants involved in the study, along with their working colleagues for the shift.**

Date of Data Collection	Participants Name	Approximate Age	Gender	Ethnicity	Biographies
14/01/2013	Ben	18	Male	White	3rd year BSc Hons students + 150 hours clinical experience
25/02/2013	Peter	26	Male	Mediterra-nean	2nd year part-time Foundation degree student who is employed by the ambulance service
25/02/2013	Paul	58	Male	White	An experienced paramedic with over 28 years ambulance service experience
04/03/2013	Claire	22	Female	White	3rd year BSc Hons students + 150 hours clinical experience
10/03/2013	Tom	20	Male	White	1st year part-time Foundation degree student who is employed by the ambulance service
13/04/2013	Julian	26	Male	European	A Newley Qualified Paramedic (NQP) with 2 years operational experience
22/04/2013	Jennie	17	Female	White	2nd year BSc Hons student + 70 hours clinical experience
05/05/2013	Julie	20	Female	White	2nd year BSc Hons student + 70 hours clinical experience
05/05/2013	Joe	55	Male	White	An experienced Paramedic with 21 years operational experience
08/05/2013	Tim	33	Male	White	An experienced paramedic
08/05/2013	Caroline	17	Female	White	1st year BSc Hons student + 20 hours clinical experience
12/06/2013	James	17	Male	White	1st year BSc Hons student + 20 hours clinical experience
20/08/2013	Mark	22	Male	European	A comparatively new paramedic training via the traditional IHCD training route
03/10/2013	Lee	32	Male	Black	1st year part-time Foundation degree student who is employed by the ambulance service
07/12/2014	Richard	60	Male	White	An experienced paramedic with over 20 years ambulance service experience

4.7 Study site:

I sought clarification to undertake the research from the university's research and ethics unit where I was a student, the NHS ambulance service trust, where my study was going to be conducted and the National Institute for Health Research (NIHR). This process proved to be complex and lengthy, before I received the permission required to access the study-sites (See Appendix F) I was mindful that the ambulance service was a type of regimented organisation which I recognised may take some time for approval. Brewer's (1991) ethnography of policing in Northern Ireland offers an understanding of the relationship between a structured authoritarian militaristic organisation, such as the Irish police authority, and the researcher. It was not plausible or realistic to proceed with my research study if negotiations between myself and the organisation's gatekeeper(s) involved in the study were not established and agreed prior to data collection, Madden (2017). I liaised closely with the ambulance service trust and was personally grateful for the opportunity to start data collection and looked forward to involving participants in their daily working lives for an extended period of time. I was keen to explore what was really happening to paramedic students in the workplace. I cite Hammersley and Atkinson as a reflection of my feelings and excitement of starting data collection: 'Watching what happens, listening to what is said, asking questions - in fact, collecting whatever data are available to throw light on the issues that are the focus of the research will contribute to the understanding' (Hammersley & Atkinson, 2006: 1).

I identified three specific ambulance complexes for the research. Each complex comprised of two to three individual ambulance stations, known as satellite stations. This meant I could collect data from eight different ambulance stations, comprising of various working conditions and a mix of busy urban ambulance stations, along with some rural leafy, suburban ambulance stations. It was important to encompass and investigate both urban and rural areas if I were to truly engage in forging the strange and the unknown elements of enquiry. (van Maanen (2015: 44) is of the opinion that it is 'both dynamic and recursive but the encounter with the 'foreign' or 'unknown' or 'strange' is the very essence of ethnography'. The ambulance stations selected also supported several university students in their clinical work placements from other universities. This was

acknowledged early within the research process and identified as a risk as the site-specific ambulance locations could become saturated with students. I had identified additional site-specific ambulance complexes to reassure myself that sufficient site-specific stations were available. However, these additional facilities were not required as my concerns proved unfounded and participants in my study were accommodated within the eight original ambulance stations initially identified. These ambulance stations were where students had become allocated for their work placements. At times though, students were relocated to other ambulance stations at short notice due to the operational demands of the ambulance service. A number of these ambulance stations were some considerable distance away from where the student was initially meant to be attending. I too as researcher sometimes had the unenviable task of chasing around a particular area trying to locate where students had been sent to work. As access to these research sites is through gatekeepers, in this case the local ambulance station managers and local ambulance officers. As a result, Burgess (1983) highlights the importance of communication through which the researcher should exercise skill in building relationships and building rapport. Madden (2017: 52) believes that, 'the ethnographic field represents part geographic location, part social and part mental construct, suggesting the conceptualisation of the interrogative boundary forms part of the ethnographic field of enquiry'.

Some local ambulance mangers became suspicious and sceptical of my purpose in their ambulance stations. In order to facilitate the manager's uncertainty and concerns, I carried copies of my research aims, along with the approval and consent documents, which I had previously received from the ambulance service, the NIHR and university. This helped to inform and reassure the ambulance managers (officers).

4.8 Participants:
The selection of participants for the study was, in part, driven by the students' work rotas. My thoughts were clear, I wanted to investigate the process of student enculturation in the workplace. To help illustrate and clarify the selection criteria, I provide some understanding of the process. I selected participants who were either employees of the ambulance service or paramedic degree students from

the university, or a combination of both, as some students were studying a paramedic foundation degree programme. This meant that these particular students were also employed by the ambulance service trust on a short-term contract for a period of one year, as well as university students who attended university for one-week blocks. The participants' shift patterns were challenging and raised a number of additional issues for me as researcher. The day-to-day demands placed on me by fulltime employment in a large, busy university was challenging. I often conducted my observational fieldwork after a day's work at the university. I would leave work and attend late shifts or night shifts at nearby ambulance stations. I attended weekend shifts and took annual leave to attend additional shifts on ambulances. I raise this, not as a limitation of the study, but as a consequence of data collection in the field of ethnography and a real understanding of the demands and challenges this brings. To quote van Maanen (2015: 41) 'Nothing much can prepare you for intensive field-work'.

4.9 Sample size & study duration:

I took guidance from Patton (2002) and adopted purposeful sampling as the means of participant selection to the study. I selected students for their relevancy to the research and consent to study.

The students studying on the Bachelor of Science (BSc Hons) degree programme in Paramedic Science attended between two to four-week practice placement blocks throughout the year. Students studying on the Foundation Degree programme, attended clinical placement for one full year as employees of the ambulance service. I argue, these practice placements became the basis by which students become conditioned and cemented into the cultural and social aspects of the workplace environment. I drew on Lave & Wenger's (1991) work to help illustrate some similarity, as they refer to groups or communities, eventually having full legitimacy to contribute and engage within a profession.

To obtain the rich meaningful data, I initially struggled and pondered on the size and number of participating students. I eventually took comfort from both Schwandt's (2007) and Hammersley's (1993) work who suggest that the size of

the sample depends on the study and the research questions and concepts under investigation. Hammersley (1993), believes issues of adequacy of sample size in qualitative research are determined by several factors, including the phenomenon of data saturation. Hammersley's view, suggested data saturation can become problematic. However, I also acknowledged that the data extrapolated from the students and experienced paramedics, along with secondary data, would produce a significant degree of data, suggesting generalisability of the data findings maybe pertinent to other paramedic workgroups, along with academic institutions offering paramedic education programmes in the future. I was also reminded of Brabbie (1989) who suggests, saturation of data in ethnographic fieldwork means that no additional data is found, the ethnographer can develop themes from the categories.

All participants of the study were informed of the type of study being undertaken. This was conducted through the dissemination of information, such as email correspondence, posters, information leaflets and flyers, disseminated throughout the ambulance service trust, (See Appendix G). Other dissemination methods included word-of-mouth and a detailed information letter, (See Appendix H), which was issued to those participants who expressed an initial interest in participating in the study.

4.9.1 Ethics:

It was imperative to my professional accountability and personal integrity, that ethical approval was gained prior to carrying out any data collection. Madden (2017) illustrates the importance of gaining ethical approval by, 'first, do no harm', whilst Higginbottom (2004: 4) talks of, 'leaving ethical footprints which future researchers may follow, in the knowledge the research was conducted ethically'. Cohen et al. (1981) believes the researcher should have a moral compass which ensures the reliability and validity of the research. Informed consent was gained as an important and inseparable component of the research process (Creswell, 2007) which adds accountability and sensitivity to the work. Creswell (2007) further suggests, assigning aliases to participants, thereby protecting their privacy. Outlining the purpose and process of the research, along with participant anonymity are essential components of the researcher's role prior to data

collection. Participants were advised that involvement in this study was entirely voluntary. Participants could withdraw from the study at any time, resulting in their data being destroyed. Assurance was also given that at no time would dialogue between the researcher and participants take place within the presence of any critically ill or injured patient, if this would impede or disrupt the care provided to the patient. This was an important element to the study and one which was highlighted within the ethics application and subsequent approval of the study. It was essential that students, along with other participants of the study, such as the experienced paramedics, of whom students worked alongside, were able to consent to the research freely and informatively. This required participants to be fully informed of the study. This task proved challenging at times as individual (crew members) who may have initially been identified to work with the student for a particular shift (a task which was the responsibility of the Ambulance Divisional Resource Centre, (DRC)), had sometimes been changed, swapped or cancelled at short notice due to operational demands. This would result in other individual paramedics being drafted in at short notice as replacements. In these instances, I also carried with me an abridged résumé of the study which provided these paramedics with an outline of the study prior to the start of shift (See Appendix C). In addition, all participants were provided with consent forms for both the pilot study and main study. Participants had the opportunity to ask questions about any aspect of the research. I gave assurance and guaranteed that any recordings and fieldnotes would remain in a secure and locked unit for the duration of the research. Once this information had been passed to the participants, ethical consent was signed for by the participants. I was able to assure participants that their identity, ethnicity and their university/employment organisation would be concealed. Cohen & Golan (2007) believe participant's rights, welfare and dignity must be protected. Over the period of time, I was collecting data, just one experienced paramedic refused to participate in the study. His/her actions were fully understood and appreciated, I returned home instead of riding out and collecting data on the ambulance that day.

The interpretive nature of my research meant that the ethical aspects of the research emerged slowly, although some were identified early in the research process, others appeared throughout the fieldwork and, as documented below,

had aspects that went much deeper than formal procedures covered, such as understanding my role as researcher and practitioner should I need to assist with the treatment of a patient along with the ethical consequences. The University's Policies and Regulations (UPR) require research projects involving human beings to have Ethical Approval prior to the start of the research process (University UPRs). Identifiable data uploaded onto electronic resources, such as MAXQDA supporting software, complied with the Data Protection Act (1998) requirements (Her Majesty's Stationery Office (HMSO). The research proposal was to undertake full participant observations within the clinical practice setting of an inner-City NHS Ambulance Service Trust. I received formal approval from the University Research Ethics Committee, along with the NHS ethics approval from the Research Ethics Committees (REC), of the National Institute of Health Research and Audit (NIHRA) proportionate review process. This detailed application process proved to be lengthy, eventually accumulating in a favourable opinion from the REC and NIHRA, and approval to undertake the study. Drawing on the key principles depicted by the Equality Act (2010), I was cognisant that individuals were respected and their dignity maintained throughout the research process. I took due regard of participant's views and moral values, regardless of gender, age, ethnicity, nationality, sexuality, faith, race, cultural identity, class, disability, partnership status, political belief, or any other significant difference.

I was reminded of Madden (2017: 35) who suggests that, 'ethnography is a 'whole body experience' and ethical commitment from the very outset, and through all phases of ethnographic research and writing is important'. I was also mindful that ethical commitment forms an integral and ongoing component of the research process. I wanted student paramedics, along with experienced paramedics and paramedic mentors, to participate in open and frank dialogue in quite detailed and, at times, emotive discussions around their perceptions of the day-to-day working environment. I was aware throughout the data collection that certain aspect of my fieldwork maybe particularly sensitive to some participants. It was essential therefore that informed consent, along with a participant's autonomy and right to withdraw be assured from the outset of the study. This adhered to Burgess's (1983) views that informed consent must be obtained from

participants prior to any data collection methods are employed (See Appendix F).

Ethical approval is recognised within the literature as an essential component of the research process (Patton, 2002; Atkinson et al. 2007; O'Reilly, 2009). As noted above, gaining consent for this study was complex and prolonged. Issues were raised, such as patient involvement and identification in the research. Due to the unpredictable nature of paramedic work this meant this interaction would sometimes occur whist the student and paramedic were dealing with patients. Subsequently, patients were present during periods of the data collection, although they were not the primary focus of the study. I was able to ensure anonymity for the project throughout the research process- no individuals are identifiable within the research findings. Should any emotional or physical distress been caused to any participants either as a result of my research or from their day-to-day work, they would have been supported by the appropriate NHS ambulance service trust's counselling services and/or university counselling services.

As a registered paramedic I also have a duty of care. Prior to data collection, I recognised that there was a realistic prospect that occasions may arises whereby a patient's medical condition(s) or severity of an injury, could became compromised, if for some reason, I decided not to intervene as a registered paramedic in the interest of patient safety. I grappled with the notion of the insider/outsider relationship in relation to this. Madden (2017) suggests, Insider/outsider relationships are not incompatible, rather they are simultaneously created and sustained as part of ethnographic fieldwork. The realistic potential of becoming involved, along with my ability to withdraw myself from the study as the researcher, should I be required to attend to a patient, could not be guaranteed. I took my strategy for managing and coping with any such eventuality from the HCPC Standards of Conduct Performance and Ethic (2014) which states:

> 'you must take all reasonable steps to reduce the risk of harm
> to service users, carers and colleagues as far as possible'.
> And that you must not 'do anything, or allow someone else to

> do anything, which could put the health or safety of a service
> user, carer or colleague at unacceptable'
>
> (HCPC, 2014: 6.1 & 6.2).

I was conscious that the ethics approval application had to be realistic, timely, yet a pragmatic representation which recognised the possibility of allowing me the opportunity to gather data, whilst being mindful of my duty of care as a paramedic. Schwandt (2007: 89), refers to ethics as 'the justification of human actions, especially as those actions affect others'. On two occasions, whilst collecting data, I had to intervene as a paramedic. This first occurred whilst the crew and I were responding in the ambulance to a 999-emergency call for a road traffic collision (RTC). As we arrived on scene, I could see that a number of patients required medical attention, some of them urgently as they were in a critical condition. As we were the only ambulance crew on scene at that time, consisting of a paramedic, a student paramedic and myself as researcher, we quickly requested assistance via the ambulance radio transmitter through to ambulance control, asking for urgent back-up. I recognised I had a duty of care and ceased being a researcher to take on the role of paramedic. I putdown my pen and notepad and assisted with the care and treatment of the patients. On the second occasion, I assisted an experienced (old timer) paramedic with a clinical drug calculation, as I became drawn into helping an elderly male who had collapsed and was in Cardiac Arrest. I again put my notepad in my pocket and assisted with the treatment and management of the patient. My notepad remained in my pocket for the duration of the patient care. Yet despite our best efforts, we were unsuccessful in resuscitating this patient.

4.9.2 Pilot testing:

According to van Teijlingen & Hundley (2002: 33-36), 'pilot studies are a crucial element of good study design'. I carried out the pilot study so I could be reasonably assured that the practicalities of data collection, such as travelling, to and from the ambulance stations, resting between fulltime university work and data collection, on site car parking facilities, public transport facilities to and from the data collection sites (ambulance stations), working around data collection, family life and writing up findings, proved realistic. This also allowed me to test the quality of the data collection instruments, such as recording fieldnotes and

my personal notes, as we sped through the busy inner-city traffic, undertaking one-to-one interviews, along with the quality of recordings. Brewer (2000) notes that, pilot studies should be completed before the topic is pursued properly. Walford (2003: 76-77) helpfully illustrates this in his ethnography on elementary schools, when he states that: 'He firstly conducted a pilot study in two elementary schools in a rural part of the prefecture, observing classes, interviewing teachers, and fine-tuning data collection instruments'.

I attended a number of ambulance shifts, known as ride-outs, as part of my pilot study. I recruited four students, along with four experienced paramedics, for the pilot study prior to my main ethnography. These eight (4 student paramedics and 4 experienced paramedics) participants had been informed about the aims of my study' along with their rights as participants in the study and the protection of their autonomy in the findings, prior to the start of the pilot study. Ambulance shifts were arranged so I was able to attend two-night shifts on Friday and Saturday nights between the times of 19:00 to 07:00 hours, along with two day shifts, on alternative Saturdays and Sundays between the times of 07:00 to 19:00 hours. The shifts were repeated to ensure I had a spread of initial primary data from the eight individual participants over a period of ten weeks (eight twelve-hour shifts in total). By undertaking these shifts over a period of weekends, I was able to continue with my fulltime employment at university throughout the week (Monday to Friday). Lynn, Howells & Stein (2018) found field-based research offers an exceptional opportunity for in-depth research. However, the requirements of carrying out research away from home creates challenges which are not necessarily always fully understood.

4.9.3 Initial stage of data collection:
At the initial stage of my study, I faced some unanticipated issues. I had to be assured my fieldnotes were recorded accurately, a true representation of what I had seen through the researcher's lens (Hammersly, 2018) at the end of each shift. I would use short follow up interviews to check and verify my data, in the form of fieldnotes, rather than present a narrative of events. This process proved difficult however, as both the experienced paramedics and students were keen

to leave work at the end of an often, very busy twelve-hour shift. I have to say, I too was also keen to get home on occasions.

As an inexperienced researcher, I was aware that a component of my data collection strategy had been halted. I set in place plans to deal with this untoward eventuality. The majority of the shifts in the pilot study were extremely busy, unrelenting, non-stop working. It was clear from the pilot study that the idea of reviewing and checking my fieldnotes with participants after each shift would be challenging and not a realistic proposition. I found a way around this problem as I decided to clarify any uncertainty in my fieldnotes at the time of writing them, or at the earliest opportunity within the field. This appeared to work well. I also used this strategy in the pilot study when in the presence of patients. I thought it unreasonable and rude to take extensive fieldnotes at the patient's side, although I needed to capture the dialogue which took place between both the paramedic and student whilst they were with the patient. This data was important as it had the potential to highlight any prejudices and nuances which manifested between the student and paramedic whilst treating the patient. Therein glimpses were gained that may not have necessarily been evident to me if I had left the room. In these circumstances my fieldnotes were documented as soon as practically possible after the patient had been cared for because I was mindful not to disrupt or delay any clinical intervention that may have been required for the patients. I also used any downtime (between calls) to write up my notes, such as free time when no emergency calls were pending. I used my fieldnotes to structure the interview process, to elicit data and to reiterate my understanding of events and clarify situations. I was again reminded of Madden (2017: 71) who suggests, 'the ethnographer should express cultural ignorance when undertaking ethnographic interviews with participants, by using expressions such as: 'I never knew that', or, I didn't realise that you were so….'. This keeps the information flowing as a form of corrective knowledge as participants clarify misunderstandings or perceived ignorance of the researcher. This system appeared to work well and proved helpful in understanding and clarifying certain aspects of the findings. These reflections I considered invaluable in helping to understand how and why students became enculturated into the working environment of the ambulance service Schon (1983). O'Reilly's (2009) assertions that pilot studies are useful in

identifying issues that may arise from fieldwork were welcomed. Therefore, pre-testing of the observational data collection and interview process helped refine and clarify my fieldnotes into a more orderly and comprehensive set of records and reflections. For example, they provided additional insight and clarification of what I was experiencing. Conflicting views and understanding of events became visible as students and paramedics helped to clarify the plausibility of my interpretation.

The preliminary data source of my ethnography was fieldnotes which provided a snapshot of the day-to-day nuances and intricacies of the paramedics working practices. It was pertinent that the qualitative nature of the ethnography revealed the representativeness of participants' interaction and socialisation into the working environment. Firstly, I was aware that due to my status as a paramedic and academic, students and practitioners may have been reluctant to work and act as they would if I was absent. Secondly, despite emphasising that they should express themselves as they normally would on a day-to-day working shift, I was aware that this could be challenging and may take some time. Thirdly, participants may have feared being perceived as negative with negative consequences for their programme of study or employment. Gagliardi et al. (2009) suggests participants may be unwilling to fully engage due to repercussions, or influence on professional relationships which remain after the research has been concluded. To address this early within the data (pilot) collection exercise, as an insider researcher, I used my experience as a paramedic to fit-in to the relationships. I was mindful of Abdullah's (1992: 8) observation about the use of 'verbal seduction, to encourage participants to share and depict their experiences'. I used a language which suited the workplace environment, the intricacies and nuances, colloquialisms and behaviours, commonly used throughout the shift. I provide an example below to help illustrate how the day-to-day language was used within ambulance service interactions.

> *Whilst I was in the watch room I said to Robert, the Paramedic that I was going into the yard (ambulance station) to help Tony, the student with checking the truck (ambulance) and to just let us know if a job comes in down the line. By this I refer to us receiving an emergency call from ambulance control. Robert*

> *gave a smile as to approve my stance! (Taken from my fieldnotes 18-07-13).*

I was to some degree a native to the culture being studied. Madden (2017) suggests being native in an investigation can be problematic, as the researcher can become a form of 'participant' rather than researcher. I was mindful of this as I found participants became more relaxed and comfortable to have me around them and increasingly animated in both their dialogue and openness. The pilot study helped refine the data collection process, along with my position within the field as I started to become drawn away from the native stance. It enabled an initial practice of ethnographic field studies. I felt more comfortable that the tool was not just adequate but appropriate in eliciting the information and insights, I wanted to experience from this study in relation to the research question.

4.9.4 Personal and analytical notes:

I recorded in my fieldnotes various events, behaviours, language, dialogue, intricacies, nuances, subtleties, and discriminations which took place between students, paramedics, mentors and patients, along with other key individuals. It is the ethnographer's duty to 'watch what happens, listen to what is said, ask questions, and produce a richly written account' (O'Reilly, 2004: 3). In addition to the accounts recorded in my fieldnotes, van Maneen, (1990) believes ideas, impressions and memories of the experiences are recorded in a journal to help decisions or create an audit trail which would assist during interpretation of data. Madden (2017: 139) believes ethnographers 'go to a great deal of effort to record good fieldnotes; they experiment with various styles, formats and jottings whilst wrestling with the reactivity notebooks can sometimes cause'. An observation also supported by (Atkinson et al. 2007).

During my time in the field collecting data, I drew on reflection to understand and critique my thoughts and views of what I had seen, heard and experienced. I used my reflexive values to help relay my position as an emic, although at times, etic researcher. I allowed time whilst I collected my fieldnotes to record my insights and emerging ideas of what I was experiencing through a reflexive lens. At times I was exhausted so it became challenging to accurately record my thoughts and

feelings as footnotes to my data. Where this was the case, I wrote short notes and symbols which would help me revisit these later to prompt my memory. I was aware that my interpretation of what I had seen and recorded may have multiple meanings in different situations which I was keen to clarify with participants through the use of short interviews (van Maanen, 2011) as and when I could.

4.9.5 Data analyses and management:

Analysis of the research consisted of a process of constructing data by examining various trends, themes and the connection between them. My study used a qualitative ethnographic approach to address the enculturation of a group of university paramedic students into the clinical workplace of an ambulance service. The ethnography enabled me to facilitate in-depth observational data through the collection of fieldnotes. I reflected on my actions during my observations in the field. This helped me to construct shared meanings to assist me in making sense of the observations which I had recorded in my fieldnotes and galvanised the perspectives of the participants. I describe how my influence on the research process helped draw out situational meaning which contributed to some contextual understanding of student paramedic enculturation. O'Reilly (2004) believes, the ethnographic principles of cultural interpretation, which underpins this research, recognised that ethnography is not a prescribed set of methods, but rather a process which recognises the complexity of the human experience and human behaviour.

I drew on my personal insight, on literature from previous studies of the paramedic profession, both nationally and internationally. I immersed myself in the data, recapping and reflecting on my notes. By adopting a reflexive stance, I was able to draw on my experience to help understand and examine the data. I took van Maanen's (2011) guidance, figuring out realist tales, to authentically represent the cultural depiction of the text of the fieldnotes. I familiarised myself with the data, thoroughly examining and interpreting my fieldnotes to dwell on the situation I had recorded. I firstly separated the data into three main work-streams, consisting of, data recorded as fieldnotes, this comprised most of the data. Data recorded from face-to-face interviews with participants, which helped clarify certain observations, and thirdly, my reflections. I was drawn to O'Reilly's (2009:

70) interpretation of fieldnotes which is more focused on 'observations, jottings, full notes, intellectual ideas, and emotional reflections'. To enable meaning to be extracted from the raw fieldnotes, the researcher moves back and forth between data and recordings. My data produced three main streams, consisting of work experience, institutionalisation and professional identity. At the center, lies pedagogy. I then sub-divided the themes into more manageable reasoned thematic trends, which van Maanen (1990) suggests is a process of isolating the thematic statements into detailed understanding and experiences of participants. He advises then selecting the appropriate data which reveals the participants experiences and lastly, holistic phases which captures the actual meaning to the data. Each element of data was coded as I drew various themes and trends together. Coffey and Atkinson (1996) suggest that coding separates and divides the data into manageable sections which can then be formulated into different interpretations. Key words, phrases, situations and experiences of the data were searched to help elicit and capture the context of the ethnography. This process was undertaken by hand and recorded into text from the original hand-written fieldnotes and transcriptions of audio recordings. Once these had been transcribed onto electronic data using MAXQDA supporting software, it allowed me to draw various themes together more succinctly, alter or amend the data into various components and scrutinise the findings more clearly. I took Le Compte & Schensul's (1999: 2) guidance that, 'ethnographers create ethnography in a sometimes tedious and often exhilarating two-step process of analyses of raw data and interpretation of analysed data' (See Appendix I). My fieldnotes were structured so I was able to record significant concepts emerging from the data, such as ideas, interpretive thoughts, views and areas requiring clarification. I also attached my notes obtained from the face-to-face interviews between students and paramedics. This helped complement and enhance the data. I ensured that I was able to identify which dataset corresponded with each component of the data collection method. I attached a section whereby I was able to record my personal thoughts and reactions annotated in my fieldnotes, an example of which can be seen in (Appendix J). Once I had the initial data separated into more manageable sections, I was then able to draw out detailed themes. This process began by initially selecting and considering events, statements, situations, language, environments, with the public or without the public in private, also other

work colleagues and students, nursing and medical staff and lastly patients. These statements were then highlighted so key words, phrases, people or situations, were colour coded and categorised. This process continued as I refined the data drawn out of my fieldnotes and interviews. Patton (2002) believes that this is an essential process for qualitative data. Table 6 below provides some early categorisation of my data to help illustrate the processes. This helped me make sense of my fieldnotes and interviews.

Table 6: **Provides an example of the early categorisation of data in date order.**

Colour categorisation of data clusters	Example of my fieldnote and interview dataset.	Date of Data Collection
Work Experience	*Tony, the student, gave a number of examples of events where there had been problems. Each event has a student paramedic at the heart of the incident. We spoke about 'dangerous Jim', a paramedic, whom I had worked with just a few weeks previously with another student whilst collecting data. Tony referred to dangerous Jim as 'fucking Coco the clown'. I asked why Coco the clown? Jim answered, 'he is a fucking menace and difficult to work with. He's just a clown'.*	12/04/2013
Professional Identity	*Although (Roy) is a newly qualified paramedic (NQP), he is very territorial and overrides students or constantly appears to question the decisions with patients while the student is questioning the patient at the time. Rebecca, the student, appeared to stop talking, not challenge Roy, but rather accepts his authority as an NQP and just works under his instructions.* This did not appear to be mentorship, but a form of power.	12/04/2013
Work Experience	*As soon as I started the shift it was apparent that there were tensions between the crew. When I had the opportunity, I spoke with the student (Tom), I asked him why such hostility between them both (him and his crewmate) the paramedic (Bill). Tom threw his eyes to the back of his head and said, 'John, he is a knob, Bill doesn't want to be here and he takes it out on us (students) although he is okay with his old stooges' (I took this to mean the experienced old hands) 'and he seems okay with you John, but that's because you are a visitor'.*	13/04/2013
Work Experience	*I could see the student (Chris) struggling to cope with the enormity of dealing with a very sick patient whilst getting very little support or direction from his colleague. Chris was working with an experienced paramedic (Jim) but had received little encouragement all shift. We have just attended an incident with a sick patient, gosh I felt sorry for Chris, as he couldn't do a thing right. Tempers are now fraught with tension between them both. I was tempted to step in but didn't. Another insider outsider dilemma!*	21/06/2013
Professional Identity	*Whilst on route to the second call of the shift, Jim who was driving the ambulance, promptly turns the radio volume on full. We then continued to drive to the call with both the ambulance cab side window fully open whilst music (Meat Loaf's-Bat out-of-Hell) pounded the surrounding area as we sped through the streets. Whilst Alan and Jim accompanied the music by singing as loud as possible.*	18/08/2013
Institutionalisation	*Throughout my observational shifts as a researcher, I recognised experienced members of the ambulance service (paramedics) insignia (wearing badges) on their uniforms. These badges were new to me and I needed to understand what they represented. I subsequently discovered, they represented a period of long service, such as 10, 20, & 30 years' service of the individual to the ambulance service. As an 'insider' researcher this was of interest to me.*	05/11/2013
Professional Identity	*Members of the public appeared to expect and accept some kind of order to be restored, to an often-chaotic scene, as we (ambulance crew) arrived at the emergency call.*	02/03/2014
Institutionalisation	*It was very evident from the beginning of the shift that (Tina), the paramedic, wasn't comfortable having a student with her, I spoke with (Amy) the student who hadn't worked with Tina before. It was clear that it wasn't going to be an easy shift and I felt sorry for (Amy) as the shift progressed, as she often found herself in challenging and unsupportive situations. I had time to speak with (Amy) at the end of shift and it was of no surprise that she hated the shift, stating: "How do you (the university) expect us (students) to work like this, you know we had some sick patients this evening and I got no support from her (Tina the paramedic). I feel like just giving the lot up".*	08/06/2014
Institutionalisation	*I observed students returning to university and discussing their practice placement experience back in the classroom setting. This was free time for students to share their practice experiences. I was struck by the sense of excitement and their sense of community within their discussions. There was a distinct sense of being 'street wise' and authoritative, as they discussed their role as paramedics, not necessarily as students. There were areas of elitism demonstrated within their discussion, often in connection with their mentor or station complex or at times themselves.*	22/09/2014

I wanted to illustrate shared and conflicting phenomena of what I was investigating, to extrapolate meaning from what the data was telling me. Consequently, I re-categorised elements of data, re-ordered it into clusters before tabulating and sieving the data between themes, which (van Maanen, 1990) suggests in his work. Once the data had been rearranged into similar categories, I spent two months revisiting, re-ordering and re-shaping the data that were similar or different. I was obtaining meaning from the data by refining and clarifying the interactions of participants, Patton (2002). To help accommodate and manage the patterns formed from the thematic analyses, I initially identified recurring concepts. The ethnographic data obtained from the face-to-face interviews, observational fieldnotes and reflections, were subsequently managed utilising a blend of both manual and computer techniques. Data from my observational fieldnotes, along with data voice recordings from interviews and my reflections, were supported with electronic software (MAXQDA) to assist in managing the data, (See Appendix K). The supporting software helps to enhance and enrich the data through electronic management of the data set, noted by (Schonfelder, 2011). The supporting software is not there to replace, alter or compensate the data analyses, as this takes place manually by the researcher through the use of thematic analysis and identifying themes which maybe common through the data set, Hammersley (1993). It is only then that, the supporting software assists in the management of data, as it helps to sort and manage the data from the various themes already identified and appropriately coded by the researcher (Adler & Adler, 2008) systematically and thematically. Several software packages are available to support qualitative data analyses. However, I found this particular software provided the required flexibility, storage capacity, coding ability and user friendliness, making it an ideal platform to use. My electronic data is stored securely and protected by a password. In addition, password protected memory devices are used as back up, should the main storage device become corrupted or contaminated.

I drew on van Maanen's (1990) narrative tales, to portray and elicit the ethnographer's journey. The data is viewed through the lens of a researcher, rather than a paramedic, although I balanced my interpretation with the participants' explanations of events and my experience as a paramedic. I drew

comfort from the literature along with my knowledge and understanding of the clinical workplace. The analysis of my data was such that it was difficult to ascertain what I had initially seen. I was then able to interpret this and offer an illustration and description of enculturation into the ambulance service workplace, as I was eventually able to understand my observations and recording, as I moved beyond the shallow aspect of the research to an in-depth position, allowing me to assimilate any discordancy to the overall meaning within a larger context. By keeping in mind, the notion of enculturation, as a central premise of my study, I was able to forge together elements of data to help make sense and unravel meanings of my fieldnotes. I was aware of Savin-Baden's (2004) example, that there are multiple meanings in many situations which may differ for both the participant and researcher. I was able to draw together various patterns, trends, experiences, situations and behaviours, to help weave together and illuminate glimpses of enculturation which revealed something authentic and significant.

To undertake an 'ethnography requires at a minimum, some understanding of the language, concepts, categories, practices, rules, and beliefs, used by members of the group being observed' (van Maanen, 2011: 13). I had jurisdiction over the translation of my data, yet I also had to acknowledge the various interviews and dialogue which took place throughout the research. This, to a degree, authenticated the data, as I interwove various elements of literature with that of my findings. I was able to ensure a resemblance with other earlier forms of studies and ethnographies carried out in previous work on paramedics. For example, the work of Metz (1981) and his findings that crews would speculate on the type of patient they were attending whilst on route to the emergency call, and McCann et al's. (2013) work highlighting how they found one of his researcher's being hurried-out of the hospital by an ambulance manager, along with the ambulance crew, illustrates some of the frustrations and tensions experienced by crews. Any suspicion of my personal experiences as a paramedic corrupting or altering the integrity of the data were minimalised and if possible, excluded from various elements of transcribed data. I did this by comparing and checking my fieldnotes with student interview data wherever possible. The remaining components of data collectively formed a comprehensive illustration of

enculturation found within the NHS ambulance service trust where I conducted my ethnography.

4.9.6 Conclusions:

In conclusion, the ethnography used in this study provides a rich, meaningful insight into an area of student paramedic education, as they move from a position of university studies, to become enculturated into the pre-hospital emergency care environment of the paramedic workplace. By undertaking an ethnographic approach, I was able to delve into an area of interest, often unseen and neglected by some studies. The ethnography has provided a method of enquiry which explores both student paramedics and experienced paramedics, along with a framework which provides 'an interpretive and exploratory story about a group of people and their sociality, cultural and behavioural accounts' (Madden, 2017: 16). Concepts which integrate a conceptual framework and support one another, express their corresponding phenomena, and as suggested by (Jabareen, 2009). create a framework-specific philosophy. The ontological, epistemological, and methodological assumptions are drawn out from the study as knowledge of the way things have become apparent to the researcher (Guba & Lincoln, 1994) illuminating the real-world experience.

I knew what I was trying to achieve and needed a starting point as the premise of my work. The literature provides accounts of paramedics and emergency medical technicians (EMTs) being investigated and studied, often in the USA, Canada and Australia. To help provide a starting point, I needed a comparative study, a way of measuring the extent of the problem, (See Appendix B) for more detail. O'Reilly (2009: 189) argues that: 'The ethnographer, considers the politics of representation; to reclaim some authority for the academic ethnographer, whilst retaining what was beneficial, intelligent, and insightful from the reflexive turn'. As a researcher I wanted a stringent research process. I thought about O'Reilly's views and how this may impact on data collection and how she interprets this. I needed to understand from my research the complexities of multiple situations. Brewer (2000: 17) initially alerted me to ethnography, as a descriptive account of 'telling it like it is from the inside'. Whilst Becker (1970) reaffirmed the use of ethnography from his seminal works. Significant factors drawn from the literature

guided me to adopt observational field studies embedded within ethnographic principles as the predominant methodological approach for the research. Hammersley & Atkinson (2006) reminded me of the importance to approach the subject with a clear understanding of the theoretical underpinning of ethnography. Therefore, I focused my readings on ethnography and ethnographic principles to gain a deeper and more meaningful understanding of the subject. This was further enhanced as I attended and presented my initial research findings, at a number of conferences including: the 2011 Ethnography in Education conference Oxford, UK, (Donaghy, 2011); the University of Alberta, International Institute for Qualitative Research, Qualitative Methods conference in Glasgow (Donaghy, 2016); the Paramedic Students' conference in Cambridge (Donaghy, 2018); the 27th International Networking for Education in Healthcare (NET) conference in Cambridge (Donaghy, 2016) and the Open Space Seminar at the School of Education, University of Hertfordshire (Donaghy, 2020) (See Appendix L). The peer reviews and critical feedback I received from these conferences proved to be invaluable in helping to strengthen my confidence and appreciation of ethnography and develop the skills required to defend my position and argument, Clifford (1986).

It was important to reflect, with a degree of accurately and authentically what really goes on in the ambulance service, as students attend their clinical work placements. This approach, Brewer (2000) calls, analytical realism. Altheide and Johnson (1998) argue that analytical realism is situated and that the social world is an interpreted world, rather than a literal one, suggesting constructs are drawn from a world view rather than accepts it for what it is. Therefore, the ethnographer focuses on obtaining various perspectives on the participants social realities, analytical realisms and acknowledges that most fields have multiple perspectives, voices and lenses in which to view the activity, reaffirming (Altheide and Johnson's, 2011) suggestion, that the ethnographer reports this and identifies his/her own voice within this.

4.9.7 Overview of the chapter:
In this chapter, I have identified and critically reviewed my use of ethnographic methods. The advantages and prevalence of studying the lived experiences of

participants becomes evident, as the often taken for granted assumptions and understandings are challenged, as the everyday nuances, intricacies, unseen, unheard and unknown aspects of the workplace are exposed. I provided and justified details of the research process which included recruitment of participants, along with some of the challenges associated with this process, ethical considerations, data collecting tools, pilot study, along with the structure and credibility of data analysis.

The chapter concluded with a discussion on ethnography which served to highlight my position as a healthcare professional and academic researcher along with my personal position, which uncovered various beliefs, values, ethical dilemmas and experiences. These contributed and influenced the research process which subsequently shaped the interpretation of my observations to contextualise the situated meaning and an in-depth understanding of ethnography.

The next chapter will explore findings from the data.

Chapter Five: Findings

5.1 Introduction:

In this chapter, my findings are categorised into three broad emerging themes. These themes consist of: Student work experience; Paramedic professional Identity; and Institutionalisation. These themes sit within, and are influenced by a subculture, along with a hidden curriculum which it gives rise to. The themes weave through the work as both discrete and overt forms of data. They provide ways of understanding many of the intricacies and nuances emerging out of the research, Breen (2007). The transition of paramedic students, from the classroom to the workplace, is illustrated by examining this change from a framework of enculturation as both a concept and through the lived experience of the paramedic students, as also seen in the work of (Grusec & Hastings, 2007) on socialisation.

The chapter starts with a section which describes the environment which sets the scene of a typical shift for a paramedic. The aspects of data which make up the three themes and contribute to student enculturation are then discussed. These are work experience, paramedic professional identity and institutionalisation, each of which is illustrated using the data collected from my fieldnotes, interviews, reflections and occasional reports. Working practices are described through extracts from fieldnotes and interview transcripts used throughout the chapter. In the course of collecting the data, experienced paramedics and students sometimes resorted to strong language, jargon and anecdotes. For the sake of authenticity, these have been retained in the transcripts in this chapter. I have used pseudonyms and fictitious details to disguise the NHS Ambulance Service Trust where the study took place, along with those individuals involved in the study and the university where students are studying. The chapter concludes with a summary of findings.

5.2 Setting the scene:

In the course of collecting data, paramedics commonly worked in traditional ambulances, known as doubled crewed vehicles. These doubled crewed ambulances consisted of two people which form the ambulance crew. In addition,

some paramedics worked on alternative forms of response units. These consisted of motor cycles, bicycles, and fast response cars. These alternative forms of response are designed to reach the scene of life-threatening incidents quickly, allowing the paramedic to initiate life support and immediate care to the patient whilst waiting for the doubled crewed ambulance to arrive. Only traditional doubled crewed ambulances have the capacity to convey patients to hospital. In addition, paramedics have the support of pre-hospital emergency care physicians if required. These physicians are traditionally attached to air ambulances (helicopters) or fast response units and can support the paramedic with additional critical care interventions, such as anaesthetic agents (drugs), pre-hospital surgical procedures and advanced primary care assessment and treatments, such as antibiotics. However, it should be recognised that recent developments, such as Independent prescribing for paramedics 2019 and the new threshold for paramedic registration 2018 - now allow some advanced paramedics and specialist paramedics to undertake various advanced techniques and interventions.

Paramedics also work in multiple sites and situations. This work tended to be chaotic, often unpredictable and at times threatening and dangerous, whilst illustrating a uniqueness of its own, as no two incidents (999 emergency calls) were the same. These characteristics of paramedic practice are illustrated in the work of Metz, 1981; Mannon, 1992; Corman, 2017; McCann et al. 2013 and Palmer 1989. Consequently, the unpredictable nature of Paramedic work can be challenging as each incident is different and can range from critical lifesaving interventions to dealing with minor incidents. However, the majority of the day-to-day work of paramedics lies within the ambulance setting, or *truck, bus or van* as crews refer to it. Corman (2017) illustrates how Canadian paramedics, refer to the ambulance as the *rig*. This is important, as students are immediately drawn to using these insider terms as they provide an indication of acceptance into the community of practice, Lave & Wenger (1991). Subsequently the ambulance becomes the paramedics' office (Corman, 2017) for the shift. This comprises the driver's cab, which forms the front of the vehicle where the crew will spend most of the day together when not conveying patients to hospital. The illustration below

(Figure 5) is a photograph of a standard layout of the interior (saloon) of an ambulance.

Figure 5: **Standard layout of the interior (saloon) of an ambulance**

Image taken from: https://www.istockphoto.com/photos/inside-ambulance

The rear of the ambulance, known as the saloon, comprises of a treatment centre, consisting of a trolley bed (stretcher) which is detachable from the interior of the ambulance and removed via the use of a tail lift at the rear of the ambulance, allowing the trolley bed to be taken to the patient if necessary. The remainder of the saloon consists of three small seats, one positioned at the head of the trolley bed facing backward and used by the paramedic to manage the patient's airway, the other two seats are perpendicular to the trolley bed but can be rotated forward facing. These seats allow the paramedic to carryout general clinical observations on the patient whilst obtaining patient details.

The saloon of the ambulance also consists of numerous cupboards and shelves containing various pieces of ambulance equipment and kitbags used by the crew depending on the situation they are faced with. For example, maternity kit, burns kit, splinting devices, defibrillator, airway suction unit, advance life support (ALS) equipment, paediatric kit, infection control kit, various dressings and intravenous fluids, also sealed bags containing therapeutic and controlled drugs along with the paramedic's immediate response bag, consisting of life support equipment, some prescription and controlled medications (drugs) and intravenous fluids.

There is also an assortment of lifting devices, such as a carry-chair, folding stretcher and other lifting aids securely stored in the ambulance saloon.

In addition to the ambulance, there are a number of other factors which influence the paramedic's daily work: these comprise the various geographic locations of the incident, such as the street, the patient's home, workplace, sports facility, police custody suites, offices, prisons, shopping malls and transport networks. Their work is also influenced by the people involved in the incident and comprises of casualties, relatives, bystanders, prisoners, first aiders, social workers and other emergency service personnel and so on. The environment also impacts on their work, (Burgess, 2010) such as whether it is a rural or urban area, the weather conditions, time of day or night and lastly, the length of their shift. This normally lasts twelve hours, although crews often incur late calls, resulting in thirteen to fourteen-hour shifts. There is little legislation which restricts the paramedic's hours of operational duty and what legislation is available is weak. Therefore, crews are obligated by their contract of employment not to refuse an emergency call during their allocated shift times, regardless of how many hours they have already worked. The location of each incident varies, although the familiar day-to-day setting of the ambulance remains the same. To exemplify this, a typical twelve-hour shift is described below:

5.3 A typical twelve-hour shift:

On any one day, the student is attached to a large ambulance complex, comprising of two to three smaller ambulance stations, known as satellite stations (satellites) which are situated in relatively close proximity to the main ambulance complex, within a few miles or so. The student works closely with his/her colleague or mentor, although this can often change from day-to-day resulting in the student not necessarily meeting his/her assigned mentor on a shift rotation. Boychuck Duchscher & Cowin (2004) found similarities with student nurses who enter clinical practice and rotate through various departments and mentors.

The commencement of the paramedic shift consists of checking the equipment stored within the ambulance whilst waiting for the first emergency call. However, the first call is often received within the first few minutes of starting the shift

allowing minimal, if any time, to carry out these essential checks which also include the road worthiness of the vehicle. If an emergency call was not assigned after a short period of time, normally ten to fifteen minutes, the crew would most probably be mobilised out on standby. Standbys consists of dispatching an ambulance to a specific geographic location which is determined by the central ambulance control dispatch centre. This procedure is used when an area of high call volume is received in central ambulance control, who themselves have limited, if any, local resources (ambulances) to send to the scene of the incident. An example could be an area consisting of busy transportation hubs, such as railway stations, shopping malls or sporting venues.

The crew would set off in the ambulance which often comprises a rather cramped, overheated, stuffy and scruffy ambulance cab, often with an aroma of stale food and perspiration as a result of the previous crew's twelve plus hours working together in the front of the vehicle (the cab). In stark contrast is the more clinical setting of the rear of the ambulance (the saloon), where I was seated as researcher (on the airway seat) for the majority of the time whilst travelling to emergency calls. The saloon afforded a more tranquil environment with adjustable lighting and heating/air-conditioning, as opposed to the noisy cab of the ambulance, which constantly echoed the broken voices of distant radio messages between various ambulance crews and ambulance control centre. The relentless sound of the siren and constant electronic alerts (bleeps and buzzers) arising out of the mobile computer data terminal (MDT) alerting the crew of an incoming emergency call, a cancellation, an update or urgent information concerning the incident, was an ongoing distraction. In addition, there was the commercial radio station, playing popular music, which the majority of crews liked to play (extract from my fieldnotes below helps to illustrate this). At the same time, the data-track navigation system periodically bellowed electronic voice recordings, instructing the driver to turn left, turn right, ahead at the roundabout, or that we had arrived at our destination. This incursion of noise impacts upon the student and paramedic who need to construct a plan of action for when arriving at scene. Corman (2017) refers to the activity and noise generated in the (ambulance) cab as they speedily respond to emergency calls. This makes up the environment in which the majority of the day-to-day activities take place. It is

the crew's mobile office, treatment centre, canteen, patient transport facility, and often playground, as crews become playful and restless, for example teasing each other, throwing paper cups and waste lunch wrappers and so on. Observational fieldnotes (18-08-13).

> *Whilst on route to the second call of the shift, Jim who was driving the ambulance, promptly turns the radio volume on full. We then continued to drive to the call with both the ambulance cab side window fully open whilst music (Meat Loaf's-Bat out-of-Hell) pounded the surrounding area as we sped through the streets. Whilst Alan and Jim accompanied the music by singing as loud as possible (18-08-13).*

In the paragraphs above, I have tried to encapsulate the close community which the student, paramedic and myself as researcher occupied for the duration of our time together whilst collecting data. This provides a sense of the paramedic environment and coincides with the ethnographic studies of (Metz, 1981; Mannon, 1992; Corman, 2017; McCann et al. 2013; Palmer's, 1989). The next section contextualises the current situation of UK paramedics.

5.4 Context:

As discussed in chapter two. The transition and development of the paramedic profession, along with the growing shortage of paramedic practitioners, has led to an exceptionally high increase of inexperienced paramedics entering the workplace (AACE, 2016; COPs, 2015; Lovegrove, 2013) which has resulted in a diverse workforce, comprising of International, European and UK paramedics joining the ambulance service from University or previously, through direct entry into the ambulance service. I was often struck by the diversity of experience, skill mix and knowledge of many paramedic practitioners which I observed whilst undertaking my field studies. Such a diverse workforce has the potential to offer significant opportunities, both culturally and socially within the development of the growing profession (AACE, 2016; Nabib, Razaq & Wilhelm, 2017). This brings a variety of skills and prior knowledge, along with differing practical experiences and educational grounding to the practice setting, Public Health England (2020). Such opportunities consist of inter-professional working between cultural groups, allowing paramedics to share experiences of their country with that of the UK.

Furthermore, the social interaction between practitioners and students can be enhanced by the multi-professional workforce. An example of this is illustrated in my observational fieldnotes below. The fieldnotes also illustrates the high regard students can have for experienced paramedics.

> *Whilst travelling back to station, I was interested in the conversation between (James) the student and (Bruce) the paramedic. Bruce was talking about his experience in Australia, compared to that in the UK. It seemed that James was inspired by Bruce's experience, as he continually asked more questions of Bruce whilst we drove back to station. I wondered if this is helping to shape the future workforce. Back on station as we finished our shift, I witnessed James speaking with other Australian paramedics as I drove out the station on route home (01-03-14).*

So far, this chapter has provided contextual details of the working environment of the paramedic. The chapter will now explore data from my findings. In so doing it will place the findings under the three predominant themes which I have previously identified but reiterate in this chapter.

5.5 Work experience:

I found little evidence in my data of any international cohort of practitioners which impacted on the established subculture already present within the ambulance service. Many of the international paramedics originated from Australia and were predominantly newly graduated Australian paramedic students, HCPC (2016). There were demonstrable similarities between both new recruits and students with that of the traditional workforce. The similarities which O'Meara, Devenish, Willis et al. and Reynolds depict within the Australian transition from a traditional paramedic training paradigm to one of higher education, is synonymous with that of the UK model (O'Meara, 2011; Devenish, 2014; 2006; Reynolds, 2004). However, there were tensions between both international new recruits and UK students and the established traditional paramedic workforce.

5.6 Tensions:

The tensions found in my data are important as they provide insight and interplay with the working practices inherent throughout the subculture of the ambulance service. The traditional in-house training route, which provided training through

the Institute of Healthcare and Development (IHCD) training award, formed the established entry route for paramedics prior to graduate entry. The demise of the IHCD training award has become a contentious issue amongst many experienced staff (old timers). Previously, training for the experienced old timers consisted of a period of eight to twelve weeks and lacked much of the scientific and educational models used in today's graduate programmes, as also seen in the work of (Donaghy, 2010; Devenish, 2014; O'Mera, 2011). This disparity of knowledge results in tensions between experienced staff and recruits. I encountered tangible and deeply pragmatic issues whilst collecting data. Students were often unable to defend their position within the practice setting. Experienced staff would not, or did not, recognise or accept graduate paramedics, therefore students were required to comply with traditional norms and practices. These sometimes consisted of deviant, ethical and moral dilemmas, not conducive with that expected by the professional body, health services, regulator and the academic community. The introduction of a graduate degree was seen as a catalyst for change, based on the belief that professionalisation would inevitably follow. This is expressed in various reports and academic publications. Examples of which are provided below.

Extract from the Paramedic Evidence Based Education Project (PEEP):

> *'The role of paramedics has become increasingly important over recent years, with growing expectation for ambulance services to deliver the right care in the right place first time. As early as 2005, it was recognised that investing in the clinical development of the frontline ambulance staff would yield significant benefits for patient outcomes and to the health economy'*
> *(Lovegrove, 2013: 13).*

Extract from College of Paramedics:

> *'The transition from a training paradigm into the world of further and higher education has already moved us to the next era of preparing the profession to fulfil its role in a modern health service' (Furber, 2008: 2).*

Journal of Paramedic Practice:

> *'Regulation should act as a driver to quality improvement, as well as taking action against those who do not meet accepted standards. This is the litmus test – are we as regulators concerned with quality – our own and those regulated by us – or*

not? Regulatory bodies must be constantly self-critical, reflective, emulating the high standards of professionalism of those they regulate' (van der Gaag & Donaghy, 2013: 10).

Journal of Paramedic Practice:

'Over the past 15 years, the training and education of technicians and paramedics has seen a shift from the more traditional approach initiated by the Institute of Healthcare Development (IHCD) towards an academic route, developed in association with Higher Education Institutions (HEIs). This shift reflects the curriculum framework put forward by the British Paramedic Association (BPA), now the College of Paramedics (COP), which acts as an educational basis for future paramedic education. The essential transition from training to education is viewed as key for the future of ambulance service delivery' (Donaghy, 2010: 528).

There was little evidence to support this notion expressed by the professional bodies, the regulator and academic institutions, as also expressed by (McCann et al. 2013; Wankhade, 2018; Devenish, 2014). Early recognition and development of the professional body, along with the transition into higher education was meant to create a professional group of practitioners, although it is unclear that this had taken place. This abstract concept has not yet been fully understood or embraced within the profession. The aspirations expressed above were somewhat disconnected with the realities of practice. I provide examples below taken from my fieldnotes to help illustrate this.

Observational fieldnotes (12-04-2013)

Tony, the student, gave a number of examples of events where there had been problems. Each event has a student paramedic at the heart of the incident. We spoke about 'dangerous Jim', a paramedic, whom I had rode out with just a few weeks previously with another student whilst collecting data. Tony referred to dangerous Jim as 'fucking Coco the clown'. I asked why Coco the clown? Jim answered, 'he is a fucking menace and difficult to work with. He's just a clown' (12-04-2013).

Observational fieldnotes (05-09-14)

> *I am on a Saturday nightshift with Liz (student). Liz is not sure who her colleague (crew mate) will be tonight. In the meantime, Liz and I go to check the vehicle (ambulance) which has been allocated to us for the shift. Halfway through the checks, two experienced paramedics (old timers) approach us and demand that they use this vehicle tonight (the vehicle was new). In the absence of Liz's crewmate, I tried to explain that this vehicle had been allocated to us and we are halfway through the checks. This had no impression on the two 'old timers' experienced paramedics, so Liz and I changed vehicles! (05-09-14).*

The next two examples below help illustrate the subtle pedagogy emerging from the data. The salience of the subtle aspects of subculture drew the students into traditional working processes and practices, which were not taught in the formal university classroom. The first student was unable to address the situation in which he found himself and accepted the perverse and hostile situation for the duration of the twelve-hour shift. The second example provides a paradox. Here the student was allowed to treat a very sick patient whilst the experienced paramedic (old timer) shows little, if any, interest in either the patient's clinical condition or the student paramedic's inability and lack of experience to manage the complex clinical presentation.

Observation fieldnotes (13-04-13)

> *As soon as I started the shift it was apparent that there were tensions between the crew. When I had the opportunity, I spoke with the student (Tom), I asked him why such hostility between them both (him and his crewmate) the paramedic (Bill). Tom threw his eyes to the back of his head and said, 'John (researcher), he is a knob, Bill doesn't want to be here, and he takes it out on us (students) although he is okay with his old stooges' (I took this to mean the experienced old hands) 'and he seems okay with you John (researcher), but that's because you are a visitor' (13-04-13).*

Observational fieldnotes on (17-05-13).

> *I could see the student (Chris) struggling to cope with the enormity of dealing with a very sick patient whilst getting very little support or direction from his colleague. Chris was working with an experienced paramedic (Jim) but had received little*

> *encouragement all shift. We have just attended an incident with a sick patient, gosh I felt sorry for Chris, as he couldn't do a thing right. Tempers are now fraught with tension between them both. I was tempted to step in but didn't. Another insider outsider dilemma! (21-06-13).*

This unprofessional and often disparate behaviour remained evident. There was hostility towards students who did not conform. By not challenging some of the taken for granted behaviours displayed by the experienced staff, students were provided with a degree of acceptance into the community of practice, which Lave & Wenger, (1991) subscribes to. Notwithstanding this, nonconformity resulted in students being ostracised from the ambulance station banter and subsequent community. Another extract from my fieldnotes provides examples of this below.

Observational fieldnotes (18-05-13)

> *On route to hospital, I asked the student (Mark) if he had experienced any resentment when he started as a student, some three years ago. His response was: "Man, you can't believe it, I was ridiculed and abused when I started and I had to learn to live with it, you can't change the 'die-hards' you really can't". I asked him if he could give any specific examples. He referred to an incident in the crew room (watch-room) where he was challenged by two 'old hands' not to make trouble or else! I asked Mark what he thought they meant by this, he said, "They would have taken me round the back of station and knocked the living shit out of me probably" (18-05-13).*

I experienced some hostility and an uneasy atmosphere when I arrived at an ambulance station for my observational shift. The extract below gives an illustration of this.

Observational fieldnotes (12-04-13)

> *As I entered the watch room, my reception appeared somewhat frosty, old-timers not really encouraging me to 'feel welcome' or allow for any introductions, there was tension and I felt very much an outsider within an organisation which I had worked in for the past 30+ years (12-04-13).*

I also found tension between crews, between stations and paramedics on fast response vehicles (first responders). An example of which is illustrated below taken from my fieldnotes.

Observational fieldnotes (12-04-2013)

> *The next call involved a first responder arriving on scene prior to our arrival; the responder appeared a little agitated, had little to say to us and was quite rude to the crew. I wondered why this might have been, clearly, we were all trying our best for the patient! Why such hostility? I offered to assist the first responder with carrying his equipment to his car but he refused. There appeared to be no apparent reason for this negative response to the crew or myself (12-04-13).*

Tensions between students and paramedics became somewhat normalised. By normalised I draw on Armitage (2010) to help illustrate this as a means in which students became accepting of the behaviour and culture of the workplace. I found students were exposed to numerous and various degrees of interaction with colleagues, mentors, managers and other healthcare professionals when attending practice placements, some of which resulted in negative experiences, as illustrated in the observations below.

> *It was very evident from the beginning of the shift that (Tina), the paramedic, wasn't comfortable having a student with her, I spoke with (Amy) the student who hadn't worked with Tina before. It was clear that it wasn't going to be an easy shift and I felt sorry for (Amy) as the shift progressed, as she often found herself in challenging and unsupportive situations. I had time to speak with (Amy) at the end of shift and it was of no surprise that she hated the shift, stating:*
>
> *"How do you (the university) expect us (students) to work like this, you know we had some sick patients this evening and I got no support from her (Tina the paramedic). I feel like just giving the lot up" (08-06-14).*

There were limited number of mentors, given the number of students attending clinical practice placements and requiring mentorship. Mentors that were available were not always keen to accommodate students for the shift. I found this situation difficult to understand. The partnership agreement between the NHS ambulance service and university requires the ambulance trusts to provide both a positive and meaningful student experience. Therefore, the agreement

stipulates the standards required by both parties to ensure students received a positive educational practice experience, HCPC (2019). This is an example of where policy and bureaucracy does not reflect the reality of the practice setting, similar to that which Lipsky (2010) found in his work on housing officers and police officers. I found there were tensions and resentment within the organisation which spanned all aspects of the student experience and working environment. The next section of this chapter highlights the more serious forms of tension that were uncovered throughout my data.

5.7 Harassment, inequality and bullying:

I found a hidden curriculum exists which produces a pedagogy far removed from that of university education and professional expectations. The type of behaviour associated with harassment and equality depicted within my research was often covert and has similarities with other uniformed, authoritarian services seen in the work of (Coyne et al. 2004; Boychuck Duchscher & Cowin's, 2004 and Zapf, Einarsen & Hoel's, 2003). I found claims of bullying and harassment of staff and students by peers, middle managers and senior managers. Boychuck Duchscher & Cowin (2024) found that senior nursing staff displayed contempt for newly qualified staff at best and bullying at worse.

A subsequent visit by the Care Quality Commission (CQC, 2015: 39) into the NHS Ambulance Service Trust where my study was conducted, reported 'Significant concerns about a reported culture of bullying and harassment in parts of the Ambulance Trust'. There were episodes where harassment and bullying were evident throughout a number of transcripts which provides some context in which bullying took place. There was also evidence of racism. I provide an example below to help illustrate this.

> *Whilst the student (Janet) and her crew mate, (Asher) were in the watch-room with colleagues, an experienced (old-timer, Tom) paramedic asked who would like a cup of tea. A number of colleagues within the watch room replied and said they would like a cup of tea. The experienced paramedic then specifically asked if Asher would also like tea. Asher refused tea, stating "he was observing Ramadan and that he would not be taking any food or drinks (other than water) whilst at work today". I observed how the experienced paramedic then*

> *focused in on Asher's response. The experienced paramedic continued to mock Asher's views and beliefs and jested to his colleagues, to get Asher a huge cake as "Asher was observing fucking Ramadan, so get him a big fuck off cake". Although this rant appeared to be taken in good humour and in a jovial manner by Asher, and other members of staff, as they all appeared to accept the so-called banter. After dealing with the first patient and whilst on route to hospital, I was able to talk to Asher about the previous events which had occurred on the station. I asked Asher how he felt about the so-called banter within the watch-room, and especially about Ramadan. Asher gave a little laugh and said that he has to accept it, "I wear a green uniform like other colleagues" he said, "it doesn't really matter, although Ramadan is clearly very important to me, I just have to accept this kind of banter, there is no other way". Asher again gave a little nervous laugh and continued to drive to hospital* (Observational fieldnotes 12-04-13).*

In the next example below, I provide an example to demonstrates unprofessional behaviour bordering on sexism and depicts the hidden subculture inherent throughout my study. The example can be explored under the heading of harassment, equality and bullying or professional identity, as this exhibits what Tangherlini (2000: 46) describes in his study as, 'interacting with a cast of characters so utterly diverse that no Hollywood scriptwriter could ever do justice to'.

> *Whilst in the watch-room (crew room) beginning our shift, there was a mixture of males and females present. One female asked her colleague if she had watched a particular TV programme the previous night and the conversation soon turned to the subject of sex. One particular male, who was rostered onto the adjacent ambulance to ours, stated that, 'he hadn't watched that particular programme on the television the previous night, unlike his colleagues, as he was too busy fucking xxxxxxx' (masturbating). He then went on to talk about how far he could xxx (ejaculate). My student, (Sarah) was in the watch-room and appeared to give a nervous laugh whilst others laughed at the young man's gesture. I found it uncomfortable and disconcerting, listening to this young man talking about this and wondered how other colleagues may have thought. This was interesting and bizarre at the same time, as various crews in the watch-room had no idea who I was, I was not in ambulance service uniform that day, although I had an ambulance identification (ID) card worn around my neck, that would have been difficult to read unless in very close proximity to me. It struck me that I could have been anybody*

> *from the ambulance service, yet no regard was given to whom I may be. On the contrary, it appeared that at least three members of the watch-room banter drew on the assumption that they could impress me with their bizarre and outrageous conversations (13-05-14).*

What appeared to be happening here, was that the established relationship forged between the experienced paramedic and other crew members was somewhat threatened by my presence in the crew-room, which Devenish (2014) also relates to. A form of authority was being tested, something (McLaughlin et al. 2012) illustrate in their work, as does (Martimianakis & Maniate, 2009). There was a perceived threat that the paramedic's status and authority was being challenged by my presence which illustrates how his behaviour and professional identity became an inherent aspect of the data. Here I will summarise the working practices which students found themselves involved in - racism, sexism, forms of bullying, hostility and tension between ambulance control and management. I will now continue this section under the sub-heading of Paramedic Professional Identity.

5.8 Paramedic Professional Identity:

The nature of paramedic work often means both student paramedics and paramedics arrive at the incident in a backdrop of hope and relief from those who require their assistance (patients and bystanders). The high visibility of the ambulance, the flashing blue lights and sirens, alerts people of the paramedics' impending arrival. The distinctive green uniform of the paramedic (Lovegrove, 2013) and other ambulance personnel, such as emergency medical technicians (EMTs) and emergency care assistance (ECAs), along with the calm, calculated manner in which paramedics operated whist collecting my data, gave them a distinctive identity, which Lovegrove (2013) believes is symbolic in their workplace. This symbol or status appeared to manifest itself as a form of perceived authority and power whilst dealing with emergency calls. Although theorising these concepts in this thesis would be challenging, as it is argued by McNamee & Glasser (1987: 79) that 'Numerous definitions and conceptualisations of power have been identified', perhaps the most effective means of understanding the power concept of the paramedic for this thesis, is from Corman's (2017) study on Canadian paramedics, who also found that the

public appeared to want and expect the paramedics to take charge, control and supervise the situation once they arrive on scene. I found that some experienced paramedics and students metaphorically drew on characters within film and media to express their perceived position within the social structure of the paramedic role, as the extract below helps to illustrate.

Extract from my data.

> *I am with Harry the student and Dave the paramedic for this shift. I had no sooner started the shift with them when we received a call to a road traffic collision (RTC), a person knocked down. Both Harry & Dave appeared excited and glad to get a 'good' job. As we started our journey with the blue lights and sirens on, Harry promptly stuck his arm and hand out straight towards the top of the ambulance windscreen and shouted 'don't worry, superman is on his way', whilst Dave the paramedic corrected his student (Harry) by informing him that it was more like Batman and Robin (14-05-14).*

Their obsession of the role typically reflected their behaviour on station and whilst in the ambulance, as Tangherlini (2000) also notes in his study, as paramedics and students compared themselves to larger than life superheroes.

5.9 Authority and Power:

A form of power relations was inherent within the bureaucratic, quasi–military style organisation of the ambulance service which (McCann et al. 2013; Corman, 2017 and Wankhade, 2015) also experienced, as they studied the organisational culture of the ambulance service. This was replicated throughout my data. One example depicts how long serving paramedics proudly displayed their long service emblems (badges), whilst at the same time, other elements of their uniform remained unkempt and scruffy.

Observational fieldnotes (05-04-13)

> *Throughout my observational shifts as a researcher, I recognised experienced members of the ambulance service (paramedics) insignia (wearing badges) on their uniforms. These badges were new to me and I needed to understand what they represented. I subsequently discovered, they represented a period of long service, such as 10-, 20-, & 30- years' service of the individual to the ambulance service. As an 'insider' researcher this was of interest to me (05-11-13).*

When asking one old timer why he wore this insignia his reply was:

> *'Well, you get nothing from this setup, so at least I have a badge for my 20 years' service'* (05-11-13 Steve).

The insignia represented the length of service of the practitioners and therefore highlights their established position within the community. This form of status initiated a degree of authority to students. This was a defining characteristic of many old timers who curtailed established policies and procedures for traditional ways of working. Lave and Wenger (1991) refer to the work of Becker (1970) as recognising the disastrous consequences and structural constraints which work practices may have for participants. Lipsky (2010) found students were caught between local practices and traditional norms and bureaucratic infrastructure. The subculture exposes the vulnerability of students and new comers into these communities of practice. This appears throughout the data and shows how the hidden curriculum manifests and draws university educated paramedic degree student, into the traditional working ways and established practices inherent within the practice environment.

5.9.1 Examples of perceived elitism:

I found evidence within the hidden curriculum of what appeared to be a form of professional elitism. I use the term professional elitism in the particular context of the ambulance and paramedic environment. This was important data which emerged from my findings which needs to be understood. The elitism spanned all sectors of the profession and was evident in a number of areas of practice, such as certain ambulance stations where specialist teams of paramedics are situated, and where air ambulance providers operate. For example, the extract taken from my observational fieldnotes below displays this behaviour:

> *This is the second of three consecutive shifts, in which I am riding out with crews. I am feeling rather weary after working at the university, prior to undertaking the shift. This particular night I am riding out with a comparatively new crew, clearly the student is new and her colleague for the shift has recently finished university and qualified as a newly qualified paramedic (NQP). It is interesting though to see and hear from the onset of the shift, how they appear to have become conditioned into*

> *the service jargon and subculture. I was surprised by the response I received when I ask about the Hazardous Area Response Teams (HART). This is a comparatively new concept for the UK ambulance service whereby specialist crews with specialist equipment and vehicles, respond to incidents involving hazardous environments, such as working at height, confined spaces and hazardous materials. Whilst talking about the HART teams I am met with negativity and verbal innuendos, such as "they are all lazy sods (Amber), they do nothing and it's a waste of time……. (Paul)"* This was from both the student and experienced paramedic (11-10-13).

Observational fieldnotes (09-05-14)

> *Whilst on my ride out this particular night with (Sharon) the paramedic and (Julie) the student, we attended quite a serious road traffic collision (RTC). Both Sharon and Julie were excited by the call as we sped off using both our visual and audible warning lights and sirens (commonly known as, blues and two's). I could understand the excitement, this was different from the mundane calls, such as falls, collapses and abdominal (abdo) pains which we had been dealing with most of the night. As we arrived on scene, we could see both HART and HEMS (in a response car) along with the Fire Service were already on scene. The frustration from Sharon and Julie was very evident, both verbally and behaviourally. After the incident they both expressed their 'negative' views about these specialist teams (09-05-14).* HEMS is the Helicopter Emergency Medical Service

The dissatisfaction here is because they were denied the interesting cases owing to the presence of the HEMS service which takes supremacy in these types of serious incidents.

Observational fieldnotes (21-09-14)

> Extract from interview with paramedic Ben: *'I have no idea what the fuck these teams do (referring to the Hazardous Area Response Team (HARTs), they hardly go out and when they do, they want to take over the poxy job, there're just a waste of fucking time if you ask me' (18-09-14).* Extract from student Joe: *'Well I haven't really had any dealings with the hazardous area response teams (HART) as such, but I can't really see the point of them, you know, what they do, I never see them. No one really likes them John' (researcher) (21-09-14).*

The tension expressed here was based on a lack of respect for roles or differing cultures in the ambulance and fire services. There was a distinct sense of resentment, frustration, rejection and perceived elitism. Paramedics and students would often depict specialist teams as elitists, or a demonstration of elitist behaviours when working together. To try and understand this perception, this section is reflective in nature, as I draw on my own experience in order to shed light on certain aspects of interpersonal and interagency working. The anatomy of an accident or emergency, by definition, is an unplanned and unknown event, as seen in the work of (Metz, 1981). Many of these events, or incidents require either a multiple response, such as additional ambulances, fast response vehicles or specialist teams, or they require a multiagency response, such as the attendance of the fire service, the police service and the ambulance service. In addition, other services may also be required, for example, lifeboats, coastguard, local authority and the utility companies, such as those responsible for electricity, water and gas. Tangherlini (2000) also found similar tensions existed between paramedics and fire fighters, or the plugs as paramedics derisively referred to them, in his study. The accumulation of the emergency and essential services arriving at an incident at different times adds to the confusion and often chaotic situation, as everyone goes about their distinct specialist roles. This can sometimes cause tension within individual services and across services, as individuals are not necessarily aware of each other's roles and responsibilities. This can lead to individuals perceiving other roles as elitist and an unwelcoming distraction from their own unique role and responsibility. I draw on Mowforth (1999) to help illustrate this as she implies elitism existed in nursing, as various disciplines perceive each other as elitist, for example, Intensive Care Nurses (ITU), as opposed to Accident and Emergency (A&E) nurses, or care of the elderly nursing staff and general nursing. I reviewed the work of Weber (1968) to try and unpack this perception, as he believed alliances were formed within groups, on the understanding of social position and authority. Weber argued that groups have the exclusionary tools in the admission criteria to a particular group. I wondered if this is what was happening here, as many of the ambulance service's 'specialisms', such as the Hazardous Area Response Teams (HART), the Helicopter Emergency Medical Service (HEMS), Advanced Paramedics (AP), Primary Care Paramedics (PCP) and Critical Care Paramedics (CCP), require

certain unique entry criteria into the group. This results in the group becoming illusive, out of the reach of some paramedics and generally regarded with a degree of contempt and sometimes elitism. Weber describes these restrictions as a process which is often seen in certain developing professions by raising the educational qualifications for applicants. Therefore, the introduction of degree level education for paramedics, in some respect, may present barriers for some of the experienced *old-timer's* individual development.

Observational fieldnotes (15-02-14)

Lisa the paramedic and Julie the student was excited to receive a fire call 'persons reported'. The term '*Persons reported'* relates to fire calls whereby the fire has been reported to have potential people inside the building or that people have already been identified as injured from the fire. *We made great haste and arrived on scene to see two adult male patients receiving oxygen from the fire and rescue service. Both Lisa and Julie jumped out of the cab of the ambulance and approached the fire fighter and patients. As I was climbing out from the rear of the ambulance, I could see and hear some disagreement taking place with the fire fighter and crew (Lisa & Julie). There was disagreement about the volume of oxygen the patient should be receiving. I watched from a distance and could see and hear how the fire service were claiming seniority over this clinical procedure which was causing such tension for Lisa & Julia (15-02-14).*

The extract below provides a further example.

Observational fieldnotes (22-09-13)

I observed students returning to university and discussing their practice placement experience back in the classroom setting. This was free time for students to share their practice experiences. I was struck by the sense of excitement and their sense of community within their discussions. There was a distinct sense of being 'street wise' and authoritative, as they discussed their role as paramedics, not necessarily as students. There were areas of elitism demonstrated within their discussion, often in connection with their mentor or station complex or at times them selves
(22-09-14).

Students were keen to assume the identity of paramedics, rather than students. I observed Billy, the student below, exercise a degree of power and authority at an incident. Lave & Wenger (1991) depicts this as full legitimate participation, although this particular paramedic student was still quite new.

Observational fieldnotes (12-12-13)

> *The student (Billy) is a very capable and confident student (one may argue verging on cocky and arrogant) Billy, wants to get his point across. He isn't that enthralled with the university, so I stayed clear of mentioning this. We received a call to a Road Traffic Collision (RTC) which appeared to excite Billy; the paramedic (Jimmy) appeared calm and continued to drive to the scene. Upon arrival there were three casualties, although two of them had received very minor injuries. Whilst the other one had sustained whiplash and bruising to the chest, sustained from the seat belt/airbag deployment (a common occurrence following a collisions). I witnessed Billy dealing with the minor injured patients and bystanders, his whole demeanour and body language appeared to be one of authority and control. Directing people, assuming control of the incident, stating his intentions to the police officer and so on (12-12-13).*

Students related to the traditional practices and norms of day-to-day front-line emergency work which (Mannon, 1992; Metz, 1981) identify with. The hidden curriculum equipped students with the necessary understanding and confidence to operate in practice, such as that seen in the work of (Corman, 2017). The traditional working practices and behaviours of experienced paramedics were mirrored in many aspects, as students became increasingly confident and authoritative in many areas of their practice.

Below I provide further examples from my observational fieldnotes (12-04-13)

> *Although communication with the patient was positive, the student (Brian) was very assertive and, at times, his mentor (Charles) was unable to interject into either the communication or patient treatment (12-04-13).*

Observational fieldnotes (10-03-13)

It is interesting watching and listening to these three students at Global City NHS Ambulance Station. I am surprised at the rivalry between them, as they talk about and illustrate the types of calls, they have attended and how they highlight their paramedic colleagues as the 'best', or the 'worst'. They appear to measure both the call they attended on the severity or unusual nature of the incident, which they rate highly. There is competition between their mentors as the students speak of their own mentors' experience and the traumatic discourse of the incident. The conversation draws on the traditional language associated with front-line paramedic work (10-03-13).

5.9.2: Deviant Behaviour

I use this sub-heading to help depict some of the unorthodox practices which I witnessed whilst collecting my fieldnotes. There was a clear disparity between the formal classroom learning situated in university, with that of practice learning, which has been suggested by (Williams, 2005). In order to understand this knowledge and the influence this had on the students' pedagogy, I found students were drawn into an oppressive, cognitively restrictive working environment. To provide an indication of this dissonance in the experience highlighted in my fieldnotes, I provide two examples of the discourse. One illustrates the damage, resulting from vandalism which was apparent in the vehicles (ambulances) I rode out on, see figure 8. The second example is a narrative (below) taken from an official ambulance bulletin which provides an example of unprofessional and offensive behaviours by some staff. The full bulletin is available in (Appendix A), whilst I illustrate the contents of the bulletin below.

Extract taken from internal ambulance circular.

'*There have been several occasions recently where the trust (ambulance service) has been brought into disrepute due to drawings of penises as well as scrawling of words, some of which have been interpreted as homophobic slurs on documents around Cowley Cross ambulance station. One occasion, someone had drawn a picture of a penis on an ECG strip and put it back in the lifepack (fig 6 & 7). When an ECG was printed it had a large penis along the patient's heart rhythm. This now forms part of the legal record of the patient's care and was picked up by the consultant in the* Accident & Emergency (A&E) department at Cowley Cross hospital. *In*

addition, we have had several internal and external visitors who have commented on the amount of penis drawings, as well as other graffiti, including words intending to cause offence (particularly the word 'bender' which was taken to be a homophobic slur) on documents around the mess-room and in particular the male locker room' (See Appendix A).

Figure 6 below, is an image of an Electrocardiographs (ECG) rhythm strip – this is the Electrocardiographs paper which prints an electric representation of the patients' heart rhythm. By examining the rhythm against the values of the graph paper, paramedics are able to diagnoses various heart deformities and heart attacks. Figure 7 below, is a pictorial example of a Lifepak defibrillator – this consists of the manufactures trade name of the ECG/defibrillator used to monitor and print the ECG rhythm. The Illustrations below help visualise the pieces of equipment referred to above.

Figure 6: **ECG rhythm strip**   Figure 7: **Lifepak 12 Defibrillator**

Image taken from: https://ecglibrary.com/ecghome.php

Image taken from: https://www.direct365.co.uk/
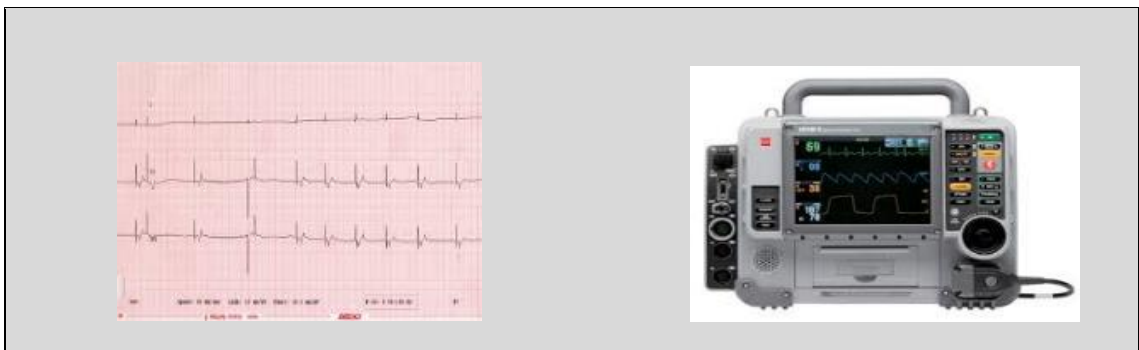
On many of my observational placements I noticed a number of exposed electrical wires hanging down in the ambulance cab, situated just by the driver's sun visor, see Figure 8 below.

Figure 8: **Exposed Damaged Wires situated in the driver's cab of the ambulance.**
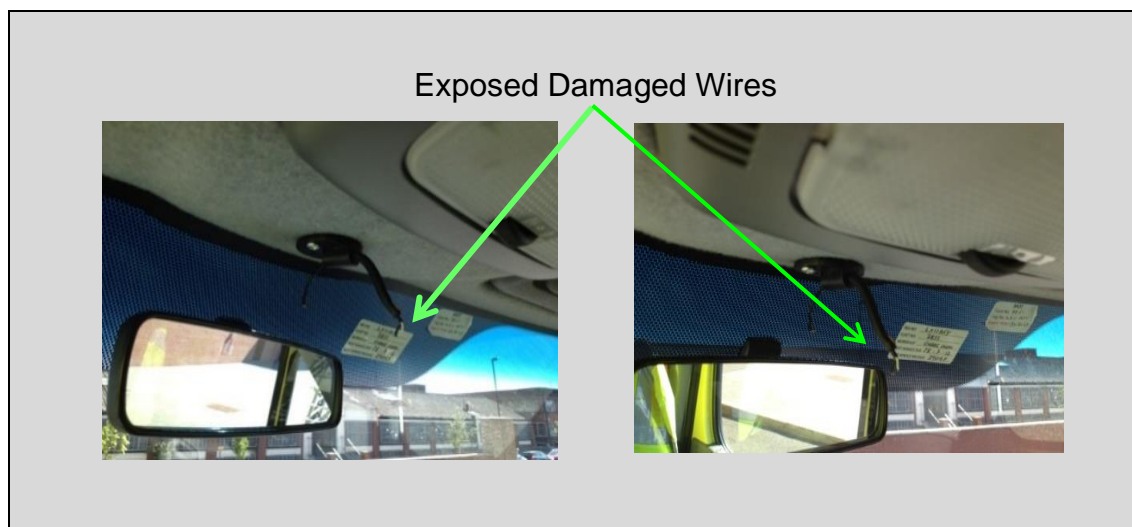

Exposed Damaged Wires

Image courtesy of: J. Donaghy

My initial enquiry into the exposed wires found hanging in the ambulance cab were one of joyous laughter from crews, followed by an explanation which is illustrated below:

Example from my fieldnotes (12-04-14).

> *'…….we (the crews) cut the wires, Len the paramedic tells me. Management had installed small microphones in the cabs of the ambulance, a so-called safety feature management claimed! However, we (crews) cut the wires leaving them hanging. It is a common sight' Len tells me; 'you won't find a vehicle with any of these working he says. They are just spies in the cab', I am told!*
> (12-05-14). Len was correct, I never did see any of the actual microphones, just exposed 'bare' wires as highlighted above.

This form of deviance, bordering on criminal activity, Shprakh, Gorbacheva & Golubchikova, (2019) suggest, typically highlights how both paramedics and students work in a backdrop of accepted subcultural expectations of non-conformity. These norms laid out the recognised behaviour expected within the workplace and community of practice, which Lave & Wenger (1991) imply, are forms of acceptance within groups or communities. Becker's (1963) studies into the sociology of deviance, concludes that these types of behaviour form a collective action, which he illustrates in his later work as being replicated both

within and across the social group or community (Becker, 1964). This suggests that a failure to conform to these deviant behaviours, places one outside of the social group, expelled from that particular community. This is also illustrated by Burt's (1925) and Bell's (2010) early work. This is different from the formal rules and procedures which the ambulance managers expect and crews find tiresome to follow, especially against a backdrop of a busy working environment, which (Lipsky, 2010) found in his work. Sharar (2016) suggest people have to be drawn into using these formal rules, policed by social agents within society. Here I clarify what I mean by formal rules, as these are not to be confused with that of the accepted norms and behaviour found throughout my data collection. I refer to formal rules as those imposed on crews by either legislation or internal ambulance service policies and procedures, for example, a patient conveyance policy and procedure or uniform policy. This is different from the day-to-day working practices and norms of behaviours so ingrained in the workplace and evident throughout my data. These taken for granted assumptions and behaviours spanned many aspects of the subculture of the ambulance service. The observation from my fieldnotes below help to illustrate this.

Observations from my fieldnotes (22-10-2014).

> *Tim the paramedic was very vocal about the volume of formal documentation that has to be completed each and every day. "The job has become more of an administration role than a caring role", he tells me. "You near enough need a form to have a shit these days" he tells me! (22-10-14).*

In this section of the chapter, I have illustrated some of the behaviours and practices often not seen through media representation of the ambulance service and paramedic profession, yet they were practices and behaviours which were very prominent and widespread throughout my data in the field. The next section of this chapter highlights other areas where traditional working practices were an essential part of working which influenced both experienced staff and students alike.

5.9.3 Meal break avoidance and finishing shifts on time:

Another feature of a subcultural form of practice which fostered accepted norms of behaviour, was the prevalence of meal break avoidance among both

experienced paramedics and students. For example, crews would often go out their way to avoid being sent back to their designated ambulance station and stood down for a meal break. The rationale for this behaviour lay in the receipt of a reward for not taking a break. Here crews that were not allocated a meal break would receive a monetary reward of ten pounds in addition to finishing their rostered shift thirty minutes earlier than their planned finishing time. I observed crews driving away from hospitals in the opposite direction to their ambulance station so they became too far away to be sent back to station for a meal break. The example below from my fieldnotes provides examples of this widespread practice.

Observational fieldnotes (12-08-13)

> *It is 23-00 hours and we are completing the paperwork at Treetop University Hospital. The discussion soon leads to meal breaks and meal break time. The latest opportunity for our break is 00-15 hours, and already plans start to be developed and implemented between the paramedic (Charlotte) & student (Terry) regarding avoidance of the meal break, commonly known within the service as 'meal break avoidance'. According to Charlotte it is vital we (Charlotte) & (Terry) avoid the break so as to finish the shift 30 minutes early (05:30 hours), in addition to receiving £10 for each meal break that is not taken on each shift. Terry & Charlotte seem to think that while they are in the North West geographical area of the city, they would not receive a meal break. This appears to please them and results in a perceived victory (12-08-13).*

Observational fieldnotes (18-08-13)

> *After the next call, we were at the hospital waiting to become 'green' and available* (green denotes the colour coding used by this particular NHS ambulance service to inform ambulance control that the crew are available for the next call), whereby *(Ricky), the paramedic activated the mobile data terminal (MDT) to acknowledge that we were green and available for another call. Ambulance control acknowledged us and requested that we return to station for a meal break. Ricky appeared annoyed at this suggestion and said to the student (Tracy), "there is no way we are fucking going back and get a break this time of night". Ricky then proceeded to drive in the opposite direction from the hospital, which was some distance away from the ambulance station. Tracy gave a nervous laugh and asked if this was okay to do, Ricky was adamant that*

> *everyone does this to avoid breaks so I don't see why we shouldn't, he then continued to proceed in the opposite direction to where the ambulance station was situated. There was no challenge or questions from ambulance control and I wondered why they (control) hadn't challenged and questioned us, as they were able to follow the movement of the vehicle via the data tracking device installed within the vehicle. I asked the crew what about control, would they not notice us going in the opposite direction? Ricky suggested that they (ambulance control) are always too busy to notice (18-08-13).*

Observational fieldnotes (25-05-13)

> *I was shocked and surprised to see that there was a definite reluctance to take their meal break (25-05-13).*

As crews neared the end of their rostered shift a parallel situation to meal break avoidance occurred. Here I found crews were very keen to finish their shift on time and not receive a late call. Often referred to as the, *off job* (the last call within the scheduled shift time). Crews would plan, organise, facilitate and conspire to finish their rostered shift on time. This process begins quite early, normally within two to three hours of the end of a crew's shift. Subsequently crews try to work out busy areas known as hot spots to help inform and influence their decisions, such as which hospital to take a patient to, or create a mechanical issue relating to the vehicle or claim that their uniform is damaged or soiled. Consequently, crews tended to want to be in close proximity of their ambulance station if possible, as they neared the end of their shift rather than being some considerable distance from the station. This allowed crews the opportunity to receive the last call of their shift (off job) which they hoped would be in their local area and therefore allowing them to finish their shift on, or near, their scheduled finishing time. Crews vigorously tried to plan their geographic location in the latter stages of their shift, as 999 Emergency calls are categorised, depending on the urgency of the clinical situation as described by the person making the 999 call. These calls are then subsequently triaged (arranged in order of clinical priority) in central ambulance control with the aid of computer software programmes to help denote the category of call, such as the category known as a red-1 for cardiac arrest and life-threatening emergencies through to green-2 suggesting the patient has no immediate medical life-threatening problems and therefore can receive a delayed

response. I found crews would refer to the practice of *off job* with anecdotes. These anecdotes would suggest that the most urgent call you will ever receive is the '*off job*', (last call of the shift). Indicating that the call would be dealt with quickly so as to finish the shift, thus suggesting this would be the fastest the ambulance would be driven all shift. The observations below go some way to highlight this:

Observational fieldnotes (23-06-14) gives an example:

> *I was part of a conversation between Mike the paramedic and Tim the student, referring to urgent calls which they had attended. Mike was referring to calls he had received when nearing his finishing time, suggesting there is no more an urgent call than that one. Here "the ambulance goes faster back to station from the hospital than it ever did going to the emergency call on blue lights and sirens" proclaimed Mike. Both Tim and I laugh at this image (23-06-14).*

Observational fieldnotes (27-06-14) gives an example:

> *We spent time 'sitting it out'* (waiting at the hospital) *whilst we try to gauge our last call (off job). The crew believe they have it sorted and activate the Mobile Data Terminal (MDT) which acknowledges the crew's availability to ambulance control. As the crew activate the MDT a call is received which is some distance away from our current position, this will not assist the crew to finish on time, they are both questioning the call with ambulance control, calling them on the radio. They have to continue with the call for the moment, as no other nearer ambulance is available at this time. Eventually, and to the delight of the crew, the call is cancelled, concurrently an additional call is received immediately, although this is to a closer location which the crew are very content with (27-06-14).*

I found experienced paramedics and students had become habituated to this way of working; it appeared to be a kind of survival mechanism, designed to allow crews to finish their shift on time, or with as little dissatisfaction as possible. I found deviant and at times fraudulent practices were taking place in order to escape the grasp of ambulance control and a possible late call. The observations below help to illustrate some of the practices I witnessed whilst collecting data in the field.

The observational fieldnotes below on (18-06-13) gives reference to the degree of knowledge required when implementing such strategies.

> *(Jim) the student turned to speak to me, as (Bill), the paramedic and driver for the day, activated the radio in preparation to speak with control. "Okay John (researcher), what we do now is think about getting off on time, you must know about this John, we don't want a late job" Jim tells me. Once ambulance control had acknowledged us, Bill told them of a bogus vehicle fault which he claimed had suddenly developed (18-06-13).*
>
> *On our way back to station, in the knowledge that we would not receive another call, both Jim and Bill spoke about the procedure. It was clear that this is a detailed strategy that crews are aware off. "Which particular vehicle fault will get us sent back to station is important", Bill said. "If you get it wrong John, it might mean the vehicle is un-roadworthy (illegal) such as a brake problem for example. Then you are stuck, as they (ambulance control) won't allow you to move the vehicle and that's a right pain in the arse, as you have to then wait for a low loader (breakdown recovery vehicle) to arrive and move it back to station for you. This can get you off shift later than the late call itself" (18-06-13).*

> *Whilst we were driving back to station, Bill (the experienced paramedic) continued to talk about strategies that were used previously, although not so much now due to "too many poxy close circuit television (CCTV) cameras everywhere", Bill informs me. Bill continued to explain how he would pretend they (the crew) had come across someone in the street (a collapse) and call it into control via the radio. Bill continued to explain, that ambulance control would have to cancel the original call you were going on.* I couldn't quite workout where Bill was going with this, I asked him to expand, how would this help? *He then explained that "once they (the crew) had passed their finishing time he would call control and explain that this (phantom) patient had refused treatment and 'walked off'. They (ambulance control) can't give you another call once you have past your scheduled finishing time".* (a degree of laughter and innuendoes about ambulance control then proceeded to entertain them) *for the rest of the journey back to station*
>
> *(18-06-13).*

The enthusiasm and energy to which crews allocated to meal break avoidance and finishing their shift on time (off job) was significant. These somewhat deviant practices create a firmer foundation for students to be drawn into the subculture of the ambulance service. To a degree, this type of practice can also be seen in

the work of: (Metz, 1981; Mannon, 1992; Corman, 2017; Palmer, 1989) and to some extent, in the work of McCann et al. (2013); and Wankhade & Macway-Jones (2015). I found little, if any, evidence of change, as this practice was deeply embedded in the ambulance crews I was working with. I needed to understand how and why students were so readily drawn into this way of working. This is examined further in the discussion chapter.

The final section in this chapter on paramedic professional identity, explores the notion of black humour. The concept of black humour is often used by emergency personnel as a form of stress relief. There is a plethora of literature supporting the notion. Scott's (2007) work suggests, that emergency personnel need black humour to escape from the horrors of distressing and horrific incidents. In the course of obtaining my fieldnotes, I was often surprised by the use of the term black humour by students and experienced paramedics. Although black humour is often used by the emergency service personnel to express their feelings following horrific sights and situations through the use of jokes and innuendo - see Poole (1990). I found little, if any, use of black humour in response to horrific or tragic events. My findings suggest that the notion of black humour was used more commonly as a means to justify and accord with more mundane non-traumatic events. The next section of this chapter examines this phenomenon and seeks to understand how and where black humour potentially fits within my data.

5.9.4 Black Humour:

At times, the notion of black humour, a concept sometimes used by emergency service personnel to defuse very stressful and traumatic events, became substituted for what could be perceived as cynical unprofessional behaviour or misconduct (HCPC, 2016). Somewhere in the midst of all the formal university classroom development, student paramedics learn about the diverse group of individuals whom students will meet and treat, along with the social phenomena and cultures that the diverse group of people represent. The use of humour by healthcare professionals is acknowledged within the literature (Mc Creaddie & Wiggins, 2008), although this is in the context of traumatic events, as already identified. My data however, found both experienced paramedics and student

paramedics would sometimes use derogatory and offensive language when referring to patients or members of the public. When challenged, the response from paramedics and students would often bracket these types of remarks as black humour, as a substitute for what I believe was often a form of racism and to justify the use of strong language, or simply as a purposeful illustration of unprofessional behaviour. I provide an example taken from my fieldnotes below to help highlight this.

Observational fieldnotes taken on 20-08-13.

> *I was surprised and disappointed how Jane, the student appeared to agree with Mark, the paramedic when Mark voiced his opinion of the call we were attending. Both Jane and Mark agreed that we were going to a call that would be a 'load of old shit'. This will be some old 'alcoh' (alcoholic) depicting the call as a waste of fucking time. Then continuing to imply that paramedics should be able to undertake euthanasia!* (although I took this to be a figure of speech, rather than a literal intent) (20-08-13)!

Rowe & Regehr (2010: 1) suggest, where stressful life-and-death situations occur, 'individuals would use black humour as a method of venting their feelings, eliciting social support through the development of group cohesion, and distancing themselves from a situation, ensuring that they can act effectively'. The following two observations on 14-02-13 and 08-05-13 provide an indication of where perceived black humour was exhibited by crews, which may not conform to the accepted understanding of the term. Observational field data (25-02-13)

> *I am with the student (Peter) and a very experienced paramedic (Paul). I understand from Peter that Paul is perceived to be a 'dinosaur' (old timer), although Peter tells me he is okay! We attended a call to a collapse and on arrival found a large obese female patient who had fallen off the commode. Both Peter and Paul worked well treating the patient and we, (I assisted), got the patient back into bed, as she had no apparent injuries. Although both Peter and Paul were very polite and kind to the patient. The post event conversation in the ambulance was very different, often referring to the patient as a smelly Lardy, (slang for someone who is obese), and claiming that she had eaten too many pies (football slang for obese people) (25-*

> *02-13).* I could not comprehend how this could be presented as black humour!

Observational field data (08-05-13)

> *Whilst returning from our last call Tim, the paramedic spoke about how these people (the last patient) are a pain in the arse, referring to them as 'rag heads'* a term I had heard whilst collecting data in the ambulance service when referring to people from either the Sikh or Asian community (The patient was of Indian origin). *Although fortunately Caroline, the student didn't appear to engage with this dialogue (08-05-13).*

The following quotation taken from Mizrahi (1986) of an interview with a medical student, helps lay out how the cynical views of other healthcare professionals may change over time:

> When I was a brand-new third year medical student, I saw residents and interns joking about patients and I said I'll never do that…' I'm more cynical now…. I've definitely changed…. It's common for us to sit around clinic at the end of the day and ask, 'Well how many 'pounds' did you see today?' and you talk about a two-ton and a four-ton clinic because I have at least two dozen women that weigh over 3000 pounds apiece.
>
> (Mizrahi, 1986: 228)

I would argue that this is not black humour, but a way in which practitioners became conditioned to talk about patients (punters) with other colleagues. Observational fieldnotes taken on 10-03-13

> *Whilst out on a night shift with the student (Tom) and paramedic (Sonia), I asked them both about their experiences of the 'watch-room' banter. I was trying to understand what they experienced and how they perceived the language and actions often associated with the watch-room environment. Both Tom and Sonia spoke about black humour, as a way of de-stressing, although often there was little if any evidence of correlation to actual events with that of subsequent behaviour. I challenged them on various racial and sexual comments, which were so often heard in this environment, both agreed this was unacceptable, yet believed it was still part of black humour (10-03-13).*

Palmer (1983) highlights the unique and colourful use of terms described by crews when confronted with such devastating and grotesque and distressing events. Terms such as 'crispy critter' to describe someone who has burned to death, 'veggie' for an individual who has sustained a severe head injury (brain injury) and 'greenie' for a decomposing body. Scott's (2007) work makes reference to these although a subtle change in linguistics by UK paramedics, who use terms such as 'stiff', denoting a person who has been deceased for some considerable time, or 'goner' for someone who has recently died. I was reminded of Charman (2013), who suggests, there is clearly a place to be found for black humour in emergency services work, to aid the de-stressing process, coping with the enormity of the situation, forming bonds between one and other as well as to reinforce the group's values. This allows them to continue with their often demanding and unpredictable work. I accept that there may be a time when it becomes necessary to suspend professional behaviour in order to cope with the difficulties of dealing with discomforting events, as identified in the work of (Scott, 2007). However, this is not black humour but a way in which both experienced paramedics and students deal with day-to-day events. Also found in the work of: Tangherlini (2000); Metz (1981); Palmer (1989); and Mannon, (1992). This is a form of behaviour not expected nor warranted from healthcare professionals. The use of perverse and at times foul language used to depict certain categories of people (patients) should not be confused with the accepted concept of black humour as a coping mechanism. Paramedics have a duty, responsibility and an expectation to act with dignity and respect to patients (HCPC, 2019; COP, 2015). This was not always apparent from my findings.

Weaving a fabric of moral meaning into the day-to-day work of paramedics is somewhat challenging, as the paramedics' role is often multi-faceted, at times acting like a social worker, police officer, support worker, teacher and ultimately carer, COP (2019). The literature refers to black humour as being associated with the notion of death and dying and not superficial events which paramedics deal with on a daily basis, such as homeless people, the elderly, the obese patient, alcohol dependant patent, drug addicted patient and mentally ill patient. These categories of patients are amongst the most fragile and disparate group within society, which make up the majority of paramedics' workload. They require a

caring and empathic approach to manage their often-complex medical needs. This is an important point which is highlighted within my data and examined further in the discussion chapter, as the practice of using black humour to disguise poor behaviour of vulnerable distressed patients appeared widespread across many sections of data, both as discreet and overt presentations within the subculture, which I claim is unacceptable in today's modern NHS ambulance services.

This section of the chapter has explored issues which I have bracketed under the theme of Paramedic Professional Identity, a strong and credible characteristic merging from the data. I will summarise professional identity as that of, meal break avoidance, off job, black humour, vandalism and misconduct. The next section of this paragraph looks at institutionalisation and where this theme fits within the plethora of data. I use the term institutionalisation as a means to capture both the rigidity of university curricula, along with the bureaucratic nature of ambulance services. In so doing I draw on my data to explore the relationship between university education and paramedic practice in helping to inform and understand the student paramedic practice experience.

5.9.5 Institutionalisation-socio-political influences:

The reference to politics here is to describe formal organisations and institutions, such as higher education institutions, the NHS, the paramedic profession, along with other healthcare professions who have agency and, in a number of cases, hierarchical power structures and relations, which (Lipsky, 2010) relates to street level bureaucracy, whilst institutionalisation refers to the 'action of establishing something as a convention or norm in an organisation or culture' (Stevenson, Elliott & Jones, 2002: 364). My work explores the relationship embedded within the organisational culture of the ambulance service and provides examples of the mistrust and interplay between managers and crew staff. This is an important fundamental tenant of the practice setting as it provides a backdrop in order to inform the theme of institutionalisation. There were tensions between crew staff and students directed at the management of the organisation which needed to be understood. Wankhade, McCann & Murphy (2018) believe there are striking similarities between the management style of all three emergency services,

police, fire and ambulance. The extracts below provide an indication of the distrust and resentment between front-line paramedic crew staff and managers.

Observational fieldnotes (25-05-13)

> *This was my first of two weekend shifts and straightaway Pat, the experienced paramedic, not the student, stated why she thinks management are 'crap', (25-05-13).*

This was subsequently followed:

> *Within the first 30 minutes of the shift, while the student and I were checking the vehicle, Pat constantly complained about the management of the Global City Ambulance Service, stating that: "they are only interested in response times and 'running you''.* (placing you on a disciplinary hearing) (25-05-13).

The following section illustrates how this debate continued to be enacted out.

Observational fieldnotes (25-05-13)

> *Pat again spoke about the attitude of management and of the regulator, the Health Professions Council (HPC),* now the Health and Care Professions Council (HCPC), *suggesting they only want to report paramedics and to discipline those who do wrong. "Response times and complaints are all they are interested in" (25-05-13).*

These sentiments were echoed by the student who subsequently voiced his concerns (25-5-13).

> *The student (Mark), suggested that we (paramedics) shouldn't be regulated, seeking some reassurance from his paramedic colleague Pat, Mark added "the poxy ambulance service always want to report you to the HPC, and they only want to strike you off the register, you know, get rid of you for the slightest thing, like complaining about how you spoke to someone, regardless of the person being a fucking pain the arse" (25-05-13).*

Marks and Pat's views are interesting as they want to find agreement with each other's viewpoint. I needed to understand what was happening here. Lave & Wenger (1991) liken this kind of behaviour in the practice setting as a desire to belong to the community. This interaction supports previous examples of the

fieldnotes where students are drawn into friendships with co-workers and mentors, regardless of the relationship being positive or negative. As Jordon (1989) claims, It's all about acceptance into the community. The role of the paramedic is to attend, treat and generally assist patients, many who may be difficult to help for a variety of reasons, such as physical discomfort and/or pain, psychiatric conditions, some medical conditions such as a diabetic hypoglycaemic episode or fitting due to epilepsy, intoxication or drug use, all of which can initiate sometimes aggressive and/or abusive behaviour from the patient (Moukaddam, Aufder-Heide, Flores, & Tucci, 2015). The frustration from both the practitioner and student, along with the distrust of the ambulance service, depicts a sense of despair and frustration, a catalyst for debate amongst practitioners, as this position appears endemic within the service, as also seen in the work of (Wankhade, 2018). Arguably, the perceived unfairness in pay and conditions adds to the resentment and lack of trust with management by crew staff. This was evident in my observational fieldnotes taken on 02-05-13 and illustrated below.

> *After our first call, whilst at the hospital, we spoke about the amount of overtime being paid currently by the ambulance service (double time at weekends in addition to £120 attendance money). Although this attendance money would be withdrawn if the person (paramedic) was off sick within the same month. This caused much debate between (Mick) the student and (Andy) the paramedic, as Andy felt he was being discriminated against, as he worked reduced hours and was not entitled to this money. Both Mick and Andy continued to debate the 'perceived' unfairness of the pay-outs, both thought it unfair that the attendance allowance should be withdrawn if the person has any sickness within that month (02-05-13).*

Observational fieldnotes (14-04-14)

> *Talking with (Sam) the paramedic, who added "…the pay is okay when overtime payments are there, but that's not guaranteed and we work our balls off for what we get. I can't believe we (paramedics) are still on band five" (14-04-12).* (Band five refers to the National Agenda for Change (AFC), National NHS pay banding which equates to pay in the region of £20,000 to £30,000 per annum. To give some context to the banding, Nurses are generally paid a band six, or above, as are Physiotherapists which equates to a pay banding around 30,000 to 40,000. (14-04-14).

At the same time NHS ambulance services are working in a resource starved environment, where the requirement to deliver prompt, appropriate, proportionate care to those who require their services (patients) is limited and stretched. (as a footnote, it should be acknowledged that since the collection of data, many experienced paramedics are now receiving a band six AFC pay banding).

Below is an example taken from my observational fieldnotes (13-05-13)

> *"To be quite honest John (researcher), I am sick and tired of it. They (ambulance service) want us to work for them when we graduate but treat us like shit as students. I won't be applying to this shower; I am going back home to Andover and work for them. They can't be any worse than this bunch".*
> *(13-05-13 student William).* (The term 'shower' is used as jargon to illustrate the student's dissatisfaction and disappointment of the ambulance service).

There was a deep-rooted mistrust and dislike of ambulance control from experienced crews and students alike. Ambulance control have the responsibility of dispatching the response to the call as prescribed by the nature and extent of the 999-emergency call received within the control centre. This can consist of a, fast response motorcar, motor cycle unit, cycle unit, air ambulance and double crewed ambulance. This is how crews receive their calls from the ambulance dispatch centre. Consequently, it is central ambulance control who dictate the crews' workload, meal breaks, and to a degree, their finishing times. This is important as it forms another key component of the subtle hidden curriculum in which students learn for themselves. In order to understand this, Lipsky, McCall, Wray & Lord and Lave & Wenger offer some insight. Lipsky (2010) found, people who work within these rigid intentional structures, have a desire to 'fit in' to the organisation, not wanting to encounter negative attention, rather give a positive image. Lave & Wenger's (1991) work explores the relationship between the Master, with that of the trainee apprentice, not wishing to upset the Master, but to do as they are told. Students mimic their role as full participants of the community rather than novices or peripheral participants. Students want to be central to their community of practice, rather than be peripheral in the practice setting, which (McCall, Wray & Lord, 2009) work also illustrates. This has significant implications, both for the student and the profession. These tensions are explored

later in the discussion chapter to help contextualise the emerging themes. The examples below help provide some initial context to this.

Observational fieldnotes (06-04-13)

> *Already within the conversation there appeared to be distrust and disappointment with ambulance control, especially when ambulance control called the station to ask whether the ambulance from the previous night shift had returned as they (ambulance control) were holding an emergency call for us (the early turn) (06-04-13).*

Observational fieldnotes (12-04-13)

> *Our first call is at 15:02 hours, just 2 min after starting duty, both student (Rees) and paramedic (Nigel) then complain about receiving the call whilst they are still checking the ambulance, I can sense their frustration as we have only just started the shift and need to get the vehicle ready and prepared. There appears to be general moans and groans about the control centre and the problems in allocating calls (12-04-13).*

I was able to sympathise with ambulance control, as they were also pressurised in meeting their targets. The extract below from a 2017 media broadcast gives an indication of the volume of work received by ambulance control and the enormity of the task whilst working within a fragile infrastructure:

> …..ambulance system failure 'might have led to patient death'. The London Ambulance Service are investigating whether computer failure early on New Year's Day may have contributed to the death of a patient. A Crew member remarks, "we went from running a service to running a shamble's, people couldn't get ambulances. People couldn't get help". They were waiting and waiting and waiting. For five hours, call-takers had to process every incident with pen and paper, and control room staff were limited to using radios to track and assign response units (ambulances).
>
> (Ironmonger, 2017*).*

The extent to which the theme of institutionalisation informs this work, depicts a restricted authoritarian organisation. Ambulance crews and students are working within bureaucratic and often antiquated management systems. Modern

technology has helped assist the operational arm of the ambulance service to deliver better healthcare. However, the day-to-day management of the organisation remains static and stagnant. For any significant change to occur, McCann et al. (2013) suggest, the cultural position of the organisation needs to change. This is further explored in the discussion chapter.

This section of the chapter has illustrated how the quasi-military nature of the ambulance service can influence and impact how people working within the organisation perceive those charged with managing and running the organisation. I found a deep mistrust and dislike from those on the front-line (paramedics) responsible for delivering the face-to-face service, with that of the bureaucratic organisational control placed over the paramedics by managers, which is similar to that of McCann et al. (2013) findings.

5.9.6 Summary:

To summarise this chapter, my findings show three coexistent themes, consisting of paramedic work experience, institutionalisation and paramedic professional identity. Each of these themes gave rise to certain working practices in which the students found themselves involved. As a result, a degree of enculturation took place which was informed by a hidden curriculum, which Andarvazh et al. (2017) infer are, the unofficial, the unwritten and often unintended lessons, values, and perspectives which students learn whilst in the practice setting. Furthermore, these practices lead to a form of pedagogy which students are neither informed of, nor aware of and therefore, contribute to the students' learning and development as paramedics.

The findings have drawn on various sources of evidence to help position and expose some of this hidden curriculum embedded within the subculture of an inner-city Metropolitan NHS ambulance service trust. This illustrates how these findings are an integral part of a professional social structure within a working environment which spans formal authoritarian (quasi-military) control, with a constrained (front-line) workforce. The proceeding chapter will explore the implications for the role of paramedics. It will argue how the subculture of the ambulance service contributes to the student's epistemological development in

identifying the precise nature of student enculturation and their journey, from classroom learning to situational understandings and the hidden curriculum which informs their pedagogic understanding. It will argue that for any significant change to occur, work experiences and professional identity, along with the stringent structurally confined organisation, such as the ambulance service (Devenish, 2014; Donaghy, 2011; Wankhade & Brinkman, 2014; Reynolds, 2004; O'Meara, 2011; Gray & Harrison 2007 and Givati et al. 2018), requires significant change at both the macro, professional level and micro, individual level.

Chapter Six: Discussion

6.1 Introduction

In this chapter, I outline the theoretical framework I use to structure this discussion. This draws on the concepts of the formal and in-formal phases of paramedic education, sub-culture and subsequent hidden curriculum which gives rise to it. Furthermore, (Jackson's 1968; Brewer's, 2000; McCann's et al. 2013; Wankhade & Macway-Jones's, 2015) models of enculturation are identified as most relevant to this thesis, whilst Schein's (1985) model of organisational culture along with (Lave & Wenger's, 1991; Wenger's, 1998) use of Communities of Practice is justified over more recent models that expand on the original work of Lave & Wenger, such as the theory of marginalisation (Boychuk Duchscher & Cowin, 2004).

By using an ethnography, this thesis investigated the enculturation of student paramedics by drawing on the above mentioned theoretical models with a view to identifying the processes by which students experience the clinical workplace in the context of university paramedic education. The formal and informal phases of student education were introduced in chapter three. I recognise the aspects of enculturation are relevant to teaching, nursing and medicine, as also seen in the work of (Jackson, 1968; Henderson, 2011; Rankin & Campbell, 2006; Cant & Higgs, 1999; Becker et al. 1961). I draw on relevant research literature in paramedic training, school teaching, medical socialisation and nurse education to support my findings.

The findings found in chapter five, sit within an overarching organisational (parent) culture which is depicted within the ambulance service. Yet my findings also illustrate the existence of an entrenched subculture, embedded within the National Health Service (NHS) ambulance trust where my study was conducted. This subculture shaped and informed a hidden curriculum which gave rise to a specific type of student learning. Overall, my data illustrated culturally different ideas and expectations of the working environment to that expected by the academic community, along with the professional and regulatory bodies. There were differences in the pedagogic and professional context of the workplace

setting which paramedic students struggled to adapt to and which impinged on the application of learning and impeded workplace pedagogy.

I discuss how the three dominate themes drawn out of my data provide a scaffold to help explore the paramedic students' enculturation into the working environment of the ambulance service which gives rise to the cultural norms and traditions ingrained within a very structured and autocratic institution, as also found in the work of (McCann et al. 2013). I also set out to understand how and why this ingrained subculture and subsequent hidden curriculum, became so prominent and dominant throughout my findings.

In the next section of the chapter, I discuss the relationship between my findings and the wider theoretical concepts which help strengthen and underpin this work. Furthermore, the chapter defines the process of enculturation into the working environment. It concludes with the research findings while drawing out implications for practice then conclusions.

6.2 The relationship of data to a conceptual framework:

I was initially drawn to Jackson's (1968) study on school children which popularised the term hidden curriculum. Conducting intensive observations of school children in the classroom, Jackson noted that the day-to-day conduct of schooling appeared to be a strong influence on children's values and beliefs which Bain (1985: 145), reviewing Jackson's work, found that 'students learned patience, acceptance of impersonal prescriptive authority and distinctions between work and play'. In addition, students leaned to conform to institutional expectations. The work highlights the impact of the hidden curriculum and questions whether the patterns and customs of schooling are functional or dysfunctional, harmful, or harmless. I needed to understand the hidden curriculum, as this is a key finding drawn from my data. To do this I looked at the work of Giroux & Penna (2012: ii) who state that the hidden curriculum's 'covert patterns of socialisation, may prepare students to function in the existing workplace and in other political spheres'. They argue that social processes of school provide specific meaning to the term 'hidden curriculum'. I was also reminded of the work of Hafferty (1998) who found a deep-rooted hidden curriculum is evident in medical education, suggesting that what is often taught

in the formal setting of the classroom, has little resemblance to what occurs in the busy turbulent clinical setting. They contextualise the concept in medical education by arguing that connections exist between group membership, socialisation, institutional authority and patterns of perception, which they also argue resonate with the hidden curriculum in medical education. What this means is that students are drawn into a very different form of learning in the workplace, to that which is taught in the university.

Becker et al. (1961) found medical students grouped together to form their own communities. These communities were subversive and aimed to survive the established rules and regulations of medical training and excessive workloads. Lave & Wenger (1991) claim that learning is situated within the social context of the workplace, claiming that knowledge is drawn from the workplace experience. This drew me to the work of Devenish (2014) who discusses organisational socialisation theories to understand the possible socialisation of ambulance staff prior to undertaking paramedic education and training into universities. Consisting of three stages, the socialisation theory separates the pre-socialisation phase, the formal socialisation phase, and the post-formal socialisation phase. Devenish (2014) also found that academisation is not without its problems and concludes that:

> 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.

(Devenish, 2014: 27)

I was drawn back to Schein's theory of organisational culture to reveal a structure which identifies the preconceptions of the public outside of the organisation, the taken for granted assumptions of the organisation and universities, and lastly, what really goes on in the workplace. Schein's (1985) model highlights the discord found between these three areas and provides an understanding to what I have unearthed in my findings. I then looked at Kramer's (1974) work, who found the assimilation of post qualified (new) nurses into the profession, went through a short 'honey-moon period', as nurses felt wholly unready for the workplace,

suggesting that they become focused solely on skills and routine mastery which Lave & Wenger's (1991) identify with their work on apprenticeships, whilst Whitehead (2001) suggests, newly qualified nurses have a different perspective of their role. This helped me to identify what I had found in my findings, whilst also assimilating the relationship found in the skills-based approach to the learning situation.

To address the subculture and hidden curriculum and to understand the social aspects in which this specific subculture is situated, I needed to understand social integration as students attempt to gain acceptance into the community by forming relationships with their paramedic colleagues, sometimes attending work functions and events, Kramer (1974). Although just creating these relationships does not ensure students become comfortable, as students become suspicious and frustrated due to their unrealistic expectations based on their university training, which depicts a different form of learning, to that experienced in the workplace. Kramer (1974) refers to this as being the 'moral outrage' phase, as students experience a paradox between the two learning environment. In light of this, I looked at Lave & Wenger's (1991) communities of practice. This enabled me to illustrate how and why paramedic students unwittingly become an integral and inseparable part of the community in which they were exposed to in the ambulance workplace. See figure 9 below, which illustrates the various components of the learning process, as depicted by Lave & Wenger's (1991) model of Communities of Practice. In the centre lies the integral involvement of practice and the experienced practitioners (old-timers), whilst the middle circle represents the various forms of learning, such as learning through engagement with other members of the workplace community, such as interaction with colleagues, collaboration with other members of the learning environment, for example, hospital staff, nurses, doctors and other emergency service personnel. These help to shape and inform the learning, knowledge and skills which the student acquires through this form of social interaction. As a result of this, students move from a position of being peripheral participants of the practice community, to one of full legitimate participants as they learn the social practices and situated learning which is integral to the workplace practice. The student has now become a mature experienced practitioner (old-timers) through the concept

of communities of practice. The interrelating arrows help depict the student journey, from newcomers to legitimate participants and depicts the social practice and situated learning which influences and shapes workplace learning.

Figure 9:
Lave & Wenger's (1991) model depicting Communities of Practice
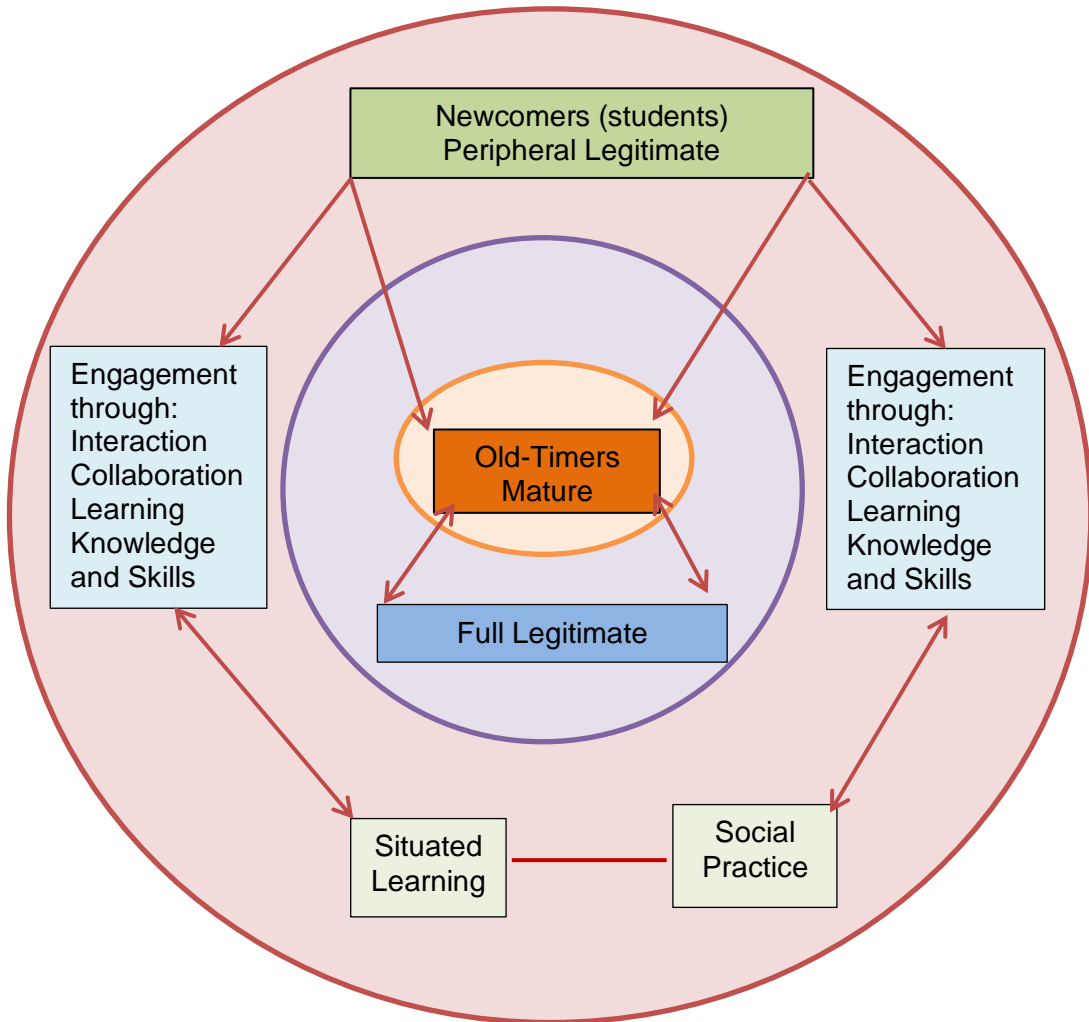
In light of the discussion above, an appreciation of how students become enculturated into the cultural surroundings is apparent as they engage in the complex relationships between the workplace culture, as opposed to the culture prescribed within the university setting. I needed to understand what is involved in the movement from the newcomer's position to the old-timers position. The behaviours and cultural norms that the students move through to get to the centre. How the wider aspects of culture associated with the concepts of enculturation emerged as students went about their day-to-day work placements.

To answer this dichotomy, I looked at Schein's (1985) model of organisational culture along with its relationship to Lave & Wenger's (1991) communities of practice. By doing so I was able to unearth the comparisons found in my study between the cultural differences identified by Schien (1985) with that of studies on work placements. In chapter three, figure 4, I illustrate Schein's model to help identify the three components of his model as this forms an essential component of the study as it depicts the day-to-day 'goings on' of the workplace. The dichotomy between the theory-based aspects of the university programme, and the ability of students to enact these aspects of practice in the 'real world' clinical environment, was at best challenging and at worst impossible, Devenish (2014) and Corman (2017). I provide an example to help illustrate this below taken from my fieldnotes.

After our first call, on route to hospital, (Jim) the student, was speaking to me about returning to university for his last final year, next year. He was looking forward to it, he told me that he has had enough of the ambulance 'world'. Jim said how much he loved the job (ambulance work) at first, but as he has been treated so badly by the Ambulance Service, such as poor rotas, being messed around by the resource centre and finishing shifts late, that he now hates the "stinking job". He told me how much he likes dealing with patients, stating that, "I still enjoy that side of the job very much, but being messed around so much is just crazy". He spoke about the University students being placed onto 'X' relief rota which he states- "is a fucking nightmare". (X relief incorporates an additional number of unsocial and weekend working). He appeared so angry of the position (student paramedic), which he was once so proud of being accepted onto, proved to be so poor, due to the way the staff, especially students, were being treated. I asked if he felt that maybe the University could do something to support students, for example, speaking with the Ambulance Service. Jim replied, "Well you know John, nothing will ever change that, the ambulance service has no career structure for staff or students and it appears that they really don't care about you, as long as you meet their targets". (Observational fieldnotes recorded on the 7/12/2014 whilst in the ambulance travelling to hospital).

Students who dared to challenge the traditional accepted norms and banter of the day-to-day work were ostracised by the more experienced paramedics from the working environment, which (Kramer's, 1974) work shows startling

similarities. Drawing on the students' experiences, I argue that the subculture is identified from the three key themes which Schein's (1985) pluralistic dimension of culture define as:

> Schein (1985) proposes a model of organisational culture where the basic assumptions shape values and the values shape practices and behaviour, which is the visible part of culture.
>
> Schein's (1985: 17)

The work of McCann et al. (2013) helps illustrate the Institutional culture within the ambulance service. Based on the formal institutionalisation of a structured, regimented, quasi-military style NHS ambulance service trust. McCann et al. (2013) found a rigid form of organisational culture existed. This consisted of an authoritarian, quasi-military style service which restricts and detracts from the day-to-day operational demands experienced by those on the front-line, such as the experienced paramedics and student paramedics. To cope with this, as my data shows, paramedics develop their own unique observable patterns of behaviours, beliefs and values which become implicit in shaping and reinforcing the subculture. These types of behaviour inform and shape the hidden curriculum, recognised by Kelly (2006); Corman (2016); Wankhade & Mackway-Jones (2015), and further supported by Hafferty's (1998) and Becker et al's. (1961) work on the hidden curriculum in medical education. Hafferty and O'Donnell's (2014) findings have some similarities with my findings, as they found students were following the largely unconscious beliefs and expectations which formed a deep and largely hidden subculture. Hafferty & O'Donnell (2014: 18) argue, that 'faculties feel more comfortable reengineering the formal curriculum than they do redesigning the learning environments that make up, in this case medical school experiences'. Similar issues present themselves within the harsh, totalitarian, structure of the ambulance service, which Wankhade & Mackway-Jones 2015; McCann et al. 2013, also identify, as opposed to the relative academic freedom of university. An example of the rigid, formal quasi-military style of the ambulance service, is provided below taken from my findings.

> *After one incident whist we were at the hospital handing over our patient, we were asked by an ambulance officer to try and call control as quickly as possible as they (ambulance control)*

> *were holding emergency calls and there were no other resources available. Both the experienced paramedic and student paramedic subsequently thought up a fictitious reason to return to station, rather than conform to the officer's instructions (Observational fieldnotes recorded on the 5/12/2014 whilst waiting to handover patient at treetop hospital).*

> *Whilst riding out with Paul the student and Tim the paramedic, I watched how Paul tried to listen to an elderly female's abdomen with his stethoscope (this would be normal practice that is taught at university for listening to bowel sounds etc). I was not overly surprised to hear Tim, the paramedic, announce that, "we don't do all that old tosh around here Paul, just let's get the chair and go to hospital". Paul, obliged and put his stethoscope back in his trouser pocket, whilst they put the patient in the carry chair (Observational fieldnotes recorded on the 23/4/2014 whilst in the patient's house).*

Similarly, Lipsky's (2010) work on public sector workers in the United States of America (USA), found that public housing officers and police officers formed their own unique working subcultures, as opposed to the autocratic culture imposed by their perspective organisations. Lipsky's work identifies the organisational subcultures which exist independently to that of their (parent) organisational culture and which can lead to small work groups forming their own set of values, beliefs, and attributes, which are also reflected in the work of (Brown, 2002; Martin & Siehl, 1983; Schneider, 1990; Sackman, 1991; Trice & Beyer, 1993). Brewer (1991) claims, that if the parent culture is not sufficiently strong the subculture becomes predominant. This is how students in my study became rooted into the day-to-day working practices. I link this back to how Paul, the student paramedic tried to listen to an elderly female's abdominal (bowel) sounds yet was prevented from doing so by the more experienced (old-timer) paramedic. Lok & Crawford (2004) conclude from their study, that the organisational subculture had a larger effect on organisational engagement than did the organisational (parent) culture. Boychuck Duchscher (2009) believe students are 'emotionally terrified' and 'scared to death' when they go into the workplace of fears of being incompetent. Students become physically and mentally exhausted because of trying to meet the workplace expectations.

In this section I unearth the relationship between Schein (1985) model of organisational culture with that of my findings. I examine how Lave & Wenger's (1991) communities of practice offers an understanding of how and why students form unique, often subversive, communities of practice, whilst at the same time, I acknowledge other theoretical concepts which relate to similar aspects that have been identified in my findings. In the next section of the chapter, I focus on enculturation and illustrate how, because of forming unique communities of practice, students become enculturated into a specific subculture and hidden curriculum.

6.3 Enculturation:

This ethnography draws on participant's interaction with the experienced paramedics, other medical staff and patients/public. It is an ethnographic study, albeit one that took place at sporadic intervals between fulltime work, homelife and occasional periods of leisure (holidays), rather than a continuous field study. The study involved working with the students over many months to facilitate describing and interpreting the shared patterns of culture experienced by participants, Moore (2000). This ethnography is not based on an institutional ethnography specifically (Campbell et al. 2015), although the very essence of observing people in the workplace over a prolonged period of time creates data which identifies and illustrates the real-life working practices and behaviours of student paramedics and experienced paramedics, such as that found in the work of (Crawford & Lox, 1999). This is a central feature of ethnographic research whereby a variety of cultures may arise from the working environment.

My ethnography gave rise to certain working practices in which the students found themselves drawn into. This process operated as a hidden curriculum, where the knowledge learned is historically, culturally, and situationally constituted within the practice setting, such as that supported by (Lave & Wenger, 1991). A hidden curriculum draws on the concept of curricula as a series of experiences which students go through. 'Lessons which are learned but not openly intended' (Martin & Siehl, 1983: 122) and which Kelly (2006) implies, are responsible for some of the social roles which are learnt in this way, such as aspects of living and working. O'Donnell (2014) further suggests that, learning in

medical education takes place, to some degree, outside of the formal curriculum. Hafferty (1998) also suggests, that subcultures need particular exploration if we are to uncover the institutions and workplace hidden curricula. Although ill-defined, Jackson (1968) found the hidden curriculum is associated with the unintentional learning which occurs in the practice setting which is in addition to any formal structured curriculum, such as that delivered at university, which van Maanen (2011) and Freire (1978) infer. I found that this unintentional learning became evident in the workplace which informed and shaped students' pedagogy, as they became drawn into a subculture far removed from that envisaged by the university curriculum (Andarvazh et al. 2017). I referred to Billett (2002) to remind myself that participatory practices are however mutually constructed, as individuals decide if and how to enlist in and learn from these workplace practices. Considering Billett's argument, I would argue that students had little, if any choice in these workplace practices, because failure to engage in them resulted in hostility and rejection from their community of practitioners.

Mulder et al. (2018) study looks at the hidden curriculum in the clinical workplace of a hospital and provides striking similarities to the paramedics' clinical workplace experiences. Mulder et al's. (2018) paper, presents a practical method to facilitate reflection and consider the hidden curriculum by all those involved. Using a non-judgmental conceptual framework, they suggest early experiences of addressing the hidden curriculum can be beneficial. The extract below helps illustrate this:

> That much of what happens in the clinical environment is not prescribed nor foreseen in curriculum documents. Medical education literature uses the term hidden curriculum to refer to the set of implicit messages about values, norms and attitudes that learners infer from the behaviour of individual role models as well as from group dynamics, processes, rituals and structure
> (Mulder et al. 2018: 1).

I then reviewed McCann et al's. (2013) work and found a deep distrust and resentment in the ambulance service between management and front-line crew staff, which they believe originates from the institutional context. Policy makers at both the macro (Governmental) and micro (Institutional) level become far removed from the realities of delivery and the often unrealistic and arbitrary

restrictions and targets which drive the institutional processes, as my results have illustrated. I reverted back to Lipsky's (2010) study who, refers to front line practitioners, as *street level bureaucrats*, working face-to-face in public service. These street level bureaucrats form their own unique working practices and behaviours as a response to unreasonable and unrealistic targets and delivery of service. A consequence of which results in workers forming their own systems and traditions of working. I provide some examples below where these forms of working practices and behaviours, highlighted by Lipsky (2010), are evident in my findings:

- Paramedics and students were constantly avoiding their official meal breaks so as to finish their rostered shift early and receive monetary remuneration (as depicted in my fieldnotes and recorded whilst riding out with Tim, experienced paramedic and Paul, student paramedic, (06/04/2013).

- Crews would often report, or create, various vehicle (ambulance) defects to avoid a late emergency call when they were nearing the end of their shift (as depicted in my fieldnotes whilst riding out with Trevor, experienced paramedic, on (13/04/2013).

- Crews would generally try to manipulate their day-to-day work so as to remain local to their geographic location nearer to their ambulance station (as depicted in my fieldnotes whilst riding out with Tony, experienced paramedic, and Sally, student paramedic on (12/04/2013).

These working practices gives rise to a complex web of sociocultural conditions which formed the very fabric of the placement setting. In a similar model to that of Lipsky (2010), Thornton and Nardi (1975) divide the informal and personal socialisation phases by defining roles as behavioural, attitudinal, and cognitive expectations. The passive phase appears to be reflective of the 'hidden curriculum' outlined by Hafferty & O'Donnell (2014), whilst the formal phase, involves students immersing themselves in the culture. They observe and assimilate behaviours that supports their progression, easing each other's social anxiety. In the personal socialisation phase, students begin to combine their

previous preconceptions with the expectations of others within the profession They seek to take on a new identity, which (Collins, 2009; Thornton & Nardi, 1975) work, also demonstrates. Students identify with the work culture during this phase, as they begin to engage with the banter and accepted norms and workplace practices which can comprise of a demanding, unpredictable and challenging working environment. This can result in confusion and resentment by the students as they come to terms with the complexities of the paramedic workplace. I provide an illustration below, Figure 10, to help acknowledge the complex structure in which students adapt in the practice setting.

The illustration shows, the interrelating themes of pedagogy in the field. The large circle stands for the communities of practice which became a common thread throughout my research, as students became exposed to, and an integral part of, the practice community. The three smaller coloured circles represent the three themes, consisting of work experience, institutionalisation and professional identity, which sit within the communities of practice and influence, and are influenced by tensions, represented by the yellow arrows. Pedagogy is represented by the red circle positioned within the central orange triangle, which is influenced by a hidden curriculum emerging from the entrenched subculture of the paramedic working environment.

Figure 10: **Model of Student Enculturation**
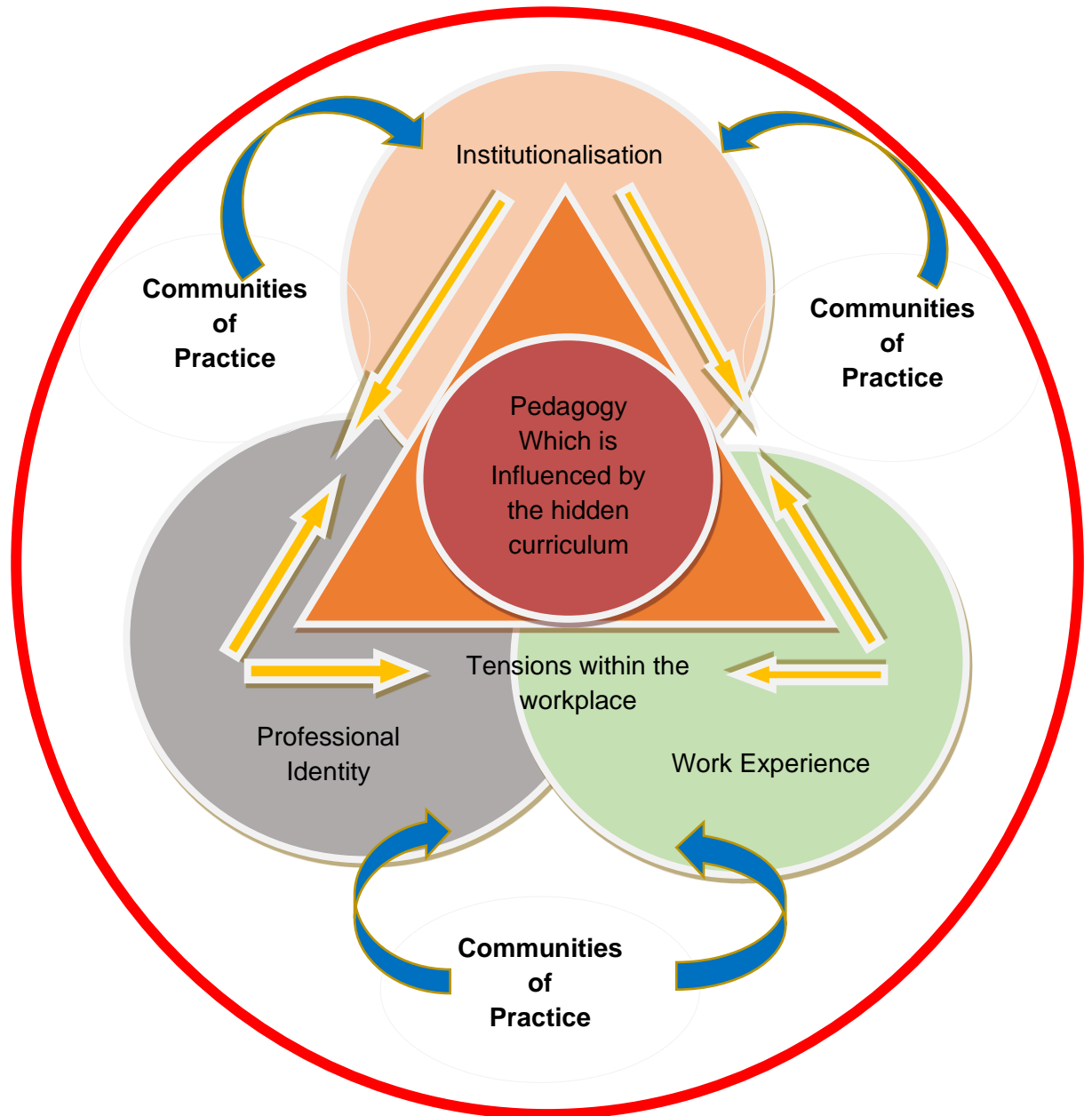
During the enculturation process, students became anxious as a result of the work-based responsibilities (work experiences), combined with being a student (professional identity) and fear of making mistakes and getting into trouble with their mentor or ambulance managers (institutionalisation). Kramer (1974) found that the new nurses regard the experienced nurses, to be judging them. Similarly (Boychuck Duchscher, 2008) found students became under pressure to emulate work practices which prioritised ritualistic routines, as opposed to clinical interaction with patients. Students were concerned that their inexperience and lack of acceptance in the practice setting was compromised whilst trying to

practice what they were taught by their educational institution whilst assimilating the practices carried out in clinical practice. Corman (2017) and Reynolds (2007). I went back to Boychuck Duchscher and Cowin's (2004) work to shed light on this process. They found that newly qualified nurses can experience a form of marginalisation in the workplace for some time. I then looked at marginalisation for any relevance in the context of paramedics. I found (Devenish's, 2014) study of particular interest, as university paramedic students encountered similar isolation and hostility in the paramedic workplace as also identified by (Boyle et al. 2008) and (Lord et al. 2009), as they transition from their academic studies to their workplace communities of practice. This can create a form of marginalisation as students undergo the enculturation process.

In this section, I have illustrated how student enculturation emerged from the various components of my 602 hours of observational fieldnotes, 10 hours of interviews and 50 hours of reflexive accounts. These interact with the theoretical literature such as Lave & Wenger's (1991) communities of practice which contribute to the theoretical framework of this thesis. In the next section, a particular form of pedagogy which occurred in the workplace is explored. This is one of the fundamental tenants of the thesis and one which gives rise to the enculturation of students due to the relationship on workplace learning.

6.4 Pedagogy:
The emerging subtle pedagogy identified in this thesis often manifested itself as a discrete, yet powerful learning experience whereby students became drawn into the traditional subculture of the working practices which subsequently enculturated them into the practice setting, which (Hafferty & O'Donnell, 2014; Burns, 2002; Lave & Wenger 1991; Devenish 2014) suggest, is part of the socialisation process, as also seen in the work of (van Maanen, & Schein, (1979) (Freire, 1985), who claim this results in a subtle form of pedagogy. This identifies with Lave & Wenger's (1991) position, that students are drawn into a specific community of practice. The extent to which this emergent pedagogy affects student enculturation is important and provides a particular epistemological stance, in that it is a particular and unpredicted type of knowledge that students are learning which is interwoven throughout the three themes which (O'Brien et

al. 2013) believe are integral to workplace learning. I provide three examples below to highlight the three interrelated themes identified in my study:

- **Work Experience** - Students would enact behaviours of the experienced paramedics and mentors whilst working in the practice setting (as depicted in my fieldnotes (06/04/2013).

- **Institutionalisation** - There was a constant mistrust and resentment by experienced paramedics and students of managers and control staff (as depicted in my fieldnotes (20/05/2014).

- **Professional Identity** - Experienced paramedics (old timers) and students would display a sense of authority and power once they were wearing their green ambulance service uniform (as depicted in my fieldnotes (02/08/2013).

Tensions existed between what had been taught in university, with what was learnt in the practice setting. This was due to the perceptions and values of stakeholders involved in the practice environment, for example student paramedics whose perceptions and values in part, emerged from the formal taught curriculum and processes experienced whilst in university, Donaghy, (2010). Whilst experienced paramedic practitioners, displayed a very different perception of students (Devenish, 2014), who were often depicted as, 'newbies', an additional burden, who needed to be watched, thus adding to the complexity and responsibility of the paramedics' already, busy shift. There was little, if any, understanding of the student's role. Some paramedic mentors took an interest in trying to understand the students' university course to help support the students and sympathise with the challenges they faced in the practice setting, whilst others showed little, if any interest in helping them. I provide a further example below taken from my fieldnotes to help illustrate this point.

> *Whilst waiting for the student to arrive for his shift, I was speaking with Andrew (Andy), an experienced paramedic with 12 years operational experience. We were discussing university students and I quickly gained a sense that Andy was*

> *not that keen with having a student attached to him for the shift. He was derogatory about the process, stating that he was "fed up with it, having students with me all the time, looking after them, pampering them and trying to teach them, it grinds you down, you know gets on your tits".* (taken form my observational fieldnotes 14-04-2014).

I again went back to Boychuck Duchscher & Cowin (2004) to see if there were any similarities with that of student nurses which could offer insight into the relationship between various healthcare professionals and students. They reiterate the concept of marginalisation to help illustrate how nurses in North America became disadvantaged and discriminated against when in the clinical workplace setting, for example by stigmatisation and labelling of newly qualified nurses in their first year by senior staff. This resulted in frequent references to the newly qualified nurses as, 'new graduates, kids, young nurses, novices, as distinct from seasoned, senior, or expert nurses' (Boychuck Duchscher & Cowin, 2004: 291). I found Cowin & Hengstberger-Sims (2004), challenge the way the education system prepares student nurses for the workplace, offering a view that it is essentially at odds with nursing care philosophy. I then looked at Paramedic students in my study and how they had to learn the hidden curriculum drawn from the entrenched subculture of the workplace. I thought about the ritualistic routines of day-to-day work, since failure to understand this meant students would not be accepted by the experienced paramedics and subsequent community of practice Lave & Wanger (1991). I provide an example below, taken from my data, to help illustrate this.

> *Whilst I was riding out with Thomas the student, and Rachel the paramedic, I was surprised to learn that two students from the previous year's university cohort had failed their practice placements. Rachel explained: "They were nice enough kids but just didn't fit in, you know, wanted to do their own thing rather than accept the way things are done around here". (Observational fieldnotes recorded on the 12/04/2013 whilst riding returning to station with Thomas and Rachel).*

Some forms of knowledge, however are being absorbed by students during their engagement in the processes of their work experience, institutionalisation, and development of professional identity. Students began to doubt the knowledge they received at university, as anything more than an abstract concept and were

confused as to their responsibilities in their new role, which can also be seen in the work of (Boychuck Duchscher, 2009), These feelings and experiences served to form students' ontological position in the real world (Sharar, 2016) and how students became integral to, and formed part of, the community of experienced practitioners, which (Lave & Wenger, 1991: 65) also illustrate in their 'work on Yucatec midwives, Vai and Gola tailors, naval quartermasters and meat cutters'.

My findings illustrate that this matters deeply with regards to students who want to identify with the experienced paramedic community as it sees itself. The way in which the paramedics see themselves was not always the same as the professional body, regulatory authority, health education England and universities envisage. The relationship between the classroom and situated clinical practice highlighted a lack of coherence between that taught in university, (McLaughlin et al, 2012) with the reality of the practice environment. Mulder et al. (2018) found a great deal of what occurs in the workplace context is not prescribed nor foreseen in curriculum documents. For example, students were taught in the university classroom how regulation, professional accountability and formal processes govern graduate paramedic development, which includes professional standards of conduct performance and ethics (Health & Care Professions Council, 2016 and the Quality Assurance Agency, 2016) as essential attributes for graduates. The values and behaviours of graduate paramedics, whilst working alongside other healthcare professionals, such as doctors, nurses and allied health professionals, also contribute to the essential criteria for graduate paramedics in meeting the expectations of patients, the professional body and UK regulator. Yet, my findings were not necessarily conducive to this notion. To shed light on this, I was reminded of Burford et al. (2014) who imply that students develop in a vacuum of moral dilemma and professional integrity. van der Gaag & Donaghy (2013: 8) found that 'analysis over the last eight years that the majority of complaints about HPC registered health professionals concerned conduct, not competence'. This implies that the behaviours and experiences of paramedics may go beyond the workplace in some instances which may be as a result of the cultural norms extending into private as well as work domains, as offered by (Newton, 2012; Burford et al. 2014; Gallagher et al. 2018). Students became isolated, at times marginalised and unsure once in

clinical practice, as the experienced paramedics did not always display professional behaviour to one another, towards the students and other healthcare professionals. This is because some of the learning which occurs in the practice setting is about cultural norms, behaviours and values of the practitioner which is partly due to the hidden curriculum and is recognised in a number of different studies, such as those of: (Lempp & Seale 2004, 1994; Kramer, 1974; Metz, 1981; Corman, 2017; Palmer, 1983; Mannon, 1992). The theory of a hidden curriculum forms part of the theorisation of this thesis, as I needed to understand why students have little control of their learning experience once they are enculturated into the day-to-day practices, customs, and traditions of the ambulance service workplace. I went back to the literature to remind myself of Becker et al's. (1961) work, on medical students in the USA, who found the challenges, misconceptions and relationship between the students and faculty proved difficult and unexpected, such as working extremely long hours, the volume and detail of information they were expected to absorb each day and the poor working conditions experienced in their practical anatomy laboratory (labs) became a form of debate amongst the students at every opportunity. This helped shed light on student paramedics and the often hostile and challenging environment they become exposed to in their clinical workplace. I used Lave & Wenger's (1991) work, to help further understand what was happening here, as they liken practice learning as a way new comer's move from being peripheral participants, working under instruction from their mentor or master as a novice, through to becoming fully legitimate participants, working as experienced autonomous practitioners (expert), as students become enculturated into the practice community. I then wondered if this was an inevitable part of the enculturation process which students must go through. I reviewed Benner's (1984) model of learning to provide a useful reminder of how students move through the learning process from novice to expert (See Appendix M) and Geertz's (1973) work, of how people experience life and the cultural ideologies of behaviour within organisations. I propose that it is reasonable to surmise from my findings that some student paramedics became marginalised (Boychuck Duchscher, & Cowin's, 2004) within the working culture of seasoned paramedic practitioners, as Lave and Wenger hypothesise, that learning theories are positioned on underlying assumptions about the person, the world, and their

relations, which they argue formulates social practice, which in turn generates situated activity, often treated separately from that of formal classroom education, (Lave & Wenger, 1991) as opposed to that which takes place in the workplace. My work depicts learning as a social process, occurring within the communities of the workplace. Little common ground existed between the university classroom learning and that of the workplace. Some of the taught elements of classroom education provided at university conflicted with the busy, pressured, practical workplace setting of the ambulance service as depicted in (McCann et al. 2013 and Corman, 2017) work.

So far, this chapter has depicted a form of learning which student paramedics are exposed. This learning is often covert and subtle in nature. It is a form of learning experience which is drawn from the hidden curriculum of the paramedics' working environment, as students become enculturated into a very different community. In light of the discussions above, the next section of the chapter illustrates how students form an integral part of the community of practice. The unwitting and implicit part of their learning which many students were not consciously aware of, are unpacked and examined.

6.5 Communities of Practice and Storytelling:

Students embarked on a journey whilst in the practice setting, which Lave & Wenger (1991) regard as, learners going from a state of being on the peripheral of their working community, to one of full membership. This was not a conscious act; instead, it was a covert process which took place over weeks and months. Sometimes, a significant incident, such as taking charge of looking after a patient, would help build student confidence. An example of this, taken from my observational fieldnotes illustrates this below.

> *Once again, I witnessed the eagerness of the student to please the paramedic mentor. Here Tony (student) was really getting involved in helping to treat and manage a very sick person, Jim (experienced paramedic and mentor) appeared pleased with Tony's performance and congratulated him after the incident at the hospital (Observational fieldnotes recorded on the 14/11/2014 whilst ridding out with Tony and Jim).*

These events were significant, increasing student confidence and promoting the legitimacy of their position within the team. The impact of this positive feedback gave students a sense of belonging as they became an integral part of the team. Students were expected to understand the various practices and roles they were to perform. Membership to these teams or communities gave students a form of identity, which Tangherlini (2000) identifies as being anti-heroes, confiding only within their own unique communities and engaging in storytelling as a predominant factor within their cultural environment, as also found in the work of (Mannon, 1992 and Mezt, 1981). I found that the storytelling consisted of the paramedic's own unique working experiences, pertaining to incidents they had attended during the shift (See findings chapter). For example:

> *We arrived back at the ambulance station after a busy late turn shift. Jennie, the student, went straight into the watch-room. As I arrived at the watch-room, some short time afterwards, Jennie was reiterating to two other students how we had struggled to extricate a large elderly female from her flat earlier that day. There was a great deal of laughter and jovial comments and actions as Jennie gave explicit detail of the patient's poor personal hygiene and infected ulcerated legs (Observational fieldnotes recorded back on station on the 19/03/2014 whilst riding out with Jennie, the student paramedic).*

> *Whist at Giddins general hospital, I met up with several university students from various ambulances who had just handed over their patients to the Accident and Emergency (A&E) department staff. They informed me of various incidents (jobs) they had attended that day. One student expressing how he had dealt with 'time wasters' all day. I asked him what he meant by 'time wasters', he replied, "you know the druggies and piss artists" (Observational fieldnotes recorded on the 11/08/2014 whilst the crew were handing over the patient to the nursing staff at hospital).*

Tangherlini (2000) found these types of conversations were often drawn out, as other crew members would interject with similar tales of their own unique stories, and what Tangherlini refers to as, *war stories*. I was mindful of Mannon's (1992) work and the appetite he found when the emergency medical technicians and paramedics returned to quarters (ambulance station). Here, they were able to express their feelings whilst they interacted within their unique ambulance station community. To situate this work (Corman, 2017; McCann et al. 2013; Lovegrove,

2013; Tangherlini, 2000; Mannon, 1992; Metz, 1981; Palmer, 1983), found unique work-based communities formed the very fabric of the paramedics' shift. As my findings reveal, these stories (Tangherlini, 2000) had a sense of companionship as various stories were discussed, whilst jovial behaviour was played out. Students became complicit in accepting the various stories and tales afforded them by the experienced paramedics and which Palmer (1983) found with rookies (new paramedics) who were initiated into the workplace by the old timers' 'blood & guts' stories. These stories helped cement the foundations of becoming accepted into the community, as students deciphered and learned to accept these often lengthy and at times outrageous stories. Palmer, (1983) Corman (2017) and Metz (1981), also show how rookies would be drawn into storytelling as a means of acceptance into their working environment. I provide an illustration below taken from my fieldnotes to help highlight this:

Observational fieldnotes (07-12-14).

I was on a night shift with Ann the student and Richard the experienced paramedic. I recall sitting in the back of the ambulance (Saloon) at 03-30 in the morning whilst Richard was recalling an incident, he had attended about 15 years ago.

Richard was explicitly and graphically, explaining to Ann, who was sitting in the ambulance cab next to Richard, about a patient who he had attended in the city and who had been struck by a train (a person being struck or fallen under a train, is commonly known to paramedics as a 'one under'). *Although some 15 years previously, I remember how Richard was still able to recall all the gory graphic details of the incident* (job). *I looked at Ann, whilst Richard continued to explain, how he had to crawl under the train to reach the patient. Using only a touch light for visibility as he wriggled along the track under the train, before stumbling across a severed leg. He explains how there were bits of bone and body parts scattered along the track until he finally reached the main torso and part of the patient's head. Ann looked shocked but was keen to hear more, asking Richard, how they moved the body etc. (Observational fieldnotes taken whilst I was riding out with Richard, the experienced paramedic, and Ann, the student paramedic on 07-12-2014 whist travelling in the ambulance on-route back to the ambulance station).*

The work of Moskos (2008) Corman (2017) Mannon (1992) and Palmer (1983) illustrate similar forms of storytelling which further notes the essential components of the practice setting, along with the cultural inferences which develop. They give rise to a form of community in which outsiders, such as members of the public, other healthcare workers and even some other emergency services, form little if any part of, and therefore are unable to understand the uniqueness in which this community operates, as identified by (Lave & Wenger, 1991). Palmer (1983) illustrate the uniqueness of paramedics, along with their own area of practice, which includes the location of their ambulance station and their practice environment. The example below taken from my fieldnotes helps to illustrate this.

Observational fieldnotes (03-08-2014).

> *Whilst I was riding out with the experienced paramedic and student paramedic, it was clear that they did not want to move away from their local working area. This was an area, often depicted by the geographic location of their ambulance station and local hospitals to that of the next ambulance station, often situated in another area of town (Observational fieldnotes taken whilst I was riding out on an ambulance in the Eastern area of the city, on 03-08-14).*

The forms of storytelling revealed common values and understanding of when and to whom these integrate 'blood & guts' stories could be told. A type of membership that the students were now part of. That students now understand the unwritten, unheard and unspoken rules of 'engagement'. In this section I have focused on Tangherlini's storytelling, as it provides a form of behaviour, often unseen and unknown by those outside the paramedic community. In the next section, I illustrate the tensions experienced by students in the workplace, as I uncover the relationship between crew staff and managers which are evident within my findings.

6.6 Tensions:
Students experienced a form of tension that was in part, due to the behaviours of experienced paramedics, which students later confirmed to me, were often difficult to manage or challenge. I was reminded of Becker et al's. (1961) work,

who found tensions existed between medical students and the university faculty. The sense of community amongst medical students had become a powerful experience for students. Becker et al. (1961) found camaraderie existed amongst year groups, as opposed to those of authority within the faculty. Pratt et al. (2006) depicts a different example, suggesting different identities exists between medical communities, for example, between surgeons, anaesthetists, radiologists and so on. This is due to their status within society, along with the presence of their learned society's, such as the British Medical Association (BMA), the Royal College of Anaesthetists, and the Royal College of Radiologists. They consider this as a central premise of the medical community. To try and make sense of this, I went back to Lipsky's (2010) concept of street level bureaucracy to gauge his ethnographic observations of the day-to-day vicissitudes of front-line public servants, such as police officers, medical staff, housing officers, probation officers and teachers, (See findings chapter) to help understand the wider landscape, along with the comparativeness of these workplace communities.

Having acknowledged that various forms of tension are evident in my data, I now set out to show how this weaved through the narrative of the data which consisted of tensions between experienced staff, such as the, old timers and student paramedics. I found students struggling to manage these tensions, as many experienced paramedics, (old timers) often appeared disinterested, demoralised and demotivated, which was evident in their day-to-day work such as, taking an ambulance out of commission (not able to attend an emergency call) or claiming that they had a soiled (dirty) uniform, meaning they would need to go back to the ambulance station to change and so on. This may be due to what Wankhade & Mackway-Jones (2015) suggests, are the experienced old timers feeling the new cadre of paramedics (students) have developed at a pace which is not reflective of the realities of the road (doing the job). This kind of tension is what Tuckman (1965) and Belbin (1981) attribute to the *forming and storming* processes referring to how the construction of teams or groups are formed and emerge in particular patterns, see also Spataro (2019). Tensions can emerge as groups are formed and constructed, such tensions are expressed by students and paramedics as they became an integral aspect of the data collection and which was a key finding. Further explanation is required as it impacted on student

engagement in the learning process, as there was a reluctance and apparent inability by students to challenge poor behaviour of experienced members of staff whilst in the practice setting. This can be answered in part, as crew-staff and managers, left students' little opportunity to raise concerns with the higher levels of authority. McCann (2015) work suggests, the risk of being ostracised from their (student) cultural group was not an option.

In light of the discussions above, Blaber (2015) suggests that an essential premise of student development, is a safe, secure and supportive practice placement and an essential component of student learning, something which Jones et, al. (2010) did not find in their research on first responders, as they explored the emotional and mental strain that first responders became exposed to, affected the mental wellbeing of the individuals. This poses a unique and contentious issue because the learning process became stifled and entrenched within the hidden curriculum to which students were being exposed, so the student's health and wellbeing became difficult to measure (Boyle et al. 2008), as they were unable to challenge the experienced staff or gain support within the organisation. I was reminded of McCall, Wray & Lord (2009) work, who found deficits existed in the relationship which impeded the fostering of quality clinical paramedic education in a UK ambulance service. Students were unprepared, there was little, if any, preparation to adequately communicate the learning they were about to experience in the clinical placement setting. Identification of problems early, particularly in relation to student support, are essential elements of care. McCall, Wray & Lord (2009) found good supervisor/mentor relationships were key components of the students' learning, whilst Devenish (2014), found some socialisation of student paramedics occurred in the university setting prior to their clinical practice placements. He refers to the work of Cant & Higgs (1999) in recognising the juxtaposition of formal textbook descriptions of the paramedic curriculum, as opposed to that portrayed in practice. Cant & Higgs (1999:49) suggest this is 'fraught with conflicts and confusions for students to grapple with'. The example below illustrates where a student learned that academic study was frowned upon in the practice setting:

Observational fieldnotes (22-09-2015).

> *Whilst sitting in the ambulance outside the hospital, (Jim) the student, started to read a paramedic journal. Whilst we were discussing several articles in the journal, I asked him if he reads this journal back at the ambulance station in the watch-room. Jim replied, "no way, I normally have something with me to read relating to the job (paramedic profession) but I only get that out of my bag once I have established who I am working with and no way would I read it on station, I get enough grief as it is, without encouraging it" (Observational fieldnotes taken whilst I was riding out on an ambulance with Jim, the student paramedic, these notes were recorded as we were at the hospital and the paramedic had gone off to the canteen 22/09/2015).*

The example above, is an example of the conflict this student experienced between university and work experience. It provides an outline of what really happens in practice and it gets to the heart of how sharply the cultural inclinations of the students clashed with the guys on the road with consequent negative implications for pedagogy and best practice. Students' learning became influenced by a deep-rooted sense of negativity, which was frequently displayed by the more experienced paramedics. Devenish (2014) found conflict existed between the older traditionally, trained workforce, with that of the younger university workforce. The example below provides insight into the traditional culture experienced by the students in my study.

> *Although (Roy) is a newly qualified paramedic (NQP), he is very territorial and overrides students or constantly appears to question the decisions with patients while the student is questioning the patient at the time. Rebecca, the student, appeared to stop talking, not challenging Roy, but rather accepts his authority as a NQP and just works under his instructions.* This did not appear to be mentorship, but a form of power. *(Observational fieldnotes recorded on the 12/04/2013 whilst I was riding out with the crew).*

The example above, illustrates a common thread which weaved throughout my data. It is significant, because the Newley Qualified Paramedics (NQP) themselves were likely to be paramedic graduates, yet still behaved in ways that might be more associated with the old timers. This observation is examined further in the next section of this chapter as the notion of professional identity is explored.

6.7 Professional identity or blue-collar workers:

Professional identity emerged out of my data as a discrete, yet powerful theme and one which needs further understanding to help position this theme within the context of the subculture. However, Pillen, Beijaard & Brok (2013) imply the concept of professionalism, along with professional identity, is varied and difficult to define. Freidson (2004) argues, that professionalism consists of, knowledge that is esoteric not because it is mysterious, but because it is unique and takes time and effort to acquire. I looked at Goltz & Smith (2014), to provide a useful and helpful understanding of professional identity as, 'A form of social identification that individuals have within, and of, a profession, such as medicine, law, nursing etc'. They go on to suggest:

> The degree in which individuals define themselves as members of a profession, and thereon their professional identity, consists of the individual's alignment of various roles, responsibilities, values and ethical standards which are consistent with practices accepted by the specific profession
>
> (Goltz & Smith 2014: 785–789).

As my findings illustrate, professional Identity is an inherent component of the data. Issues such as the paramedic distinctive, idiosyncratic green uniforms, which Tangherlini (2000) and Lovegrove (2013) claim, is the influence and importance that the paramedic uniforms provide, both for the public and paramedics themselves. The paramedics' identity became an integral part of the behaviours and customs which reinforced the social context in which this work is positioned (See findings chapter). The green paramedic uniform acted as a conduit which illustrated a sense of authority, identity and professional status. Displayed throughout the data collection, this formed a visual symbol of authority and expertise, Lazarsfeld-Jensen (2014). This identity was relevant, both internally, within the organisational rank structure of the ambulance service, as well as externally by the immediately recognisable uniform of paramedic expertise.

I argue however, that crews lacked a sense of autonomy, restricted by formal processes and controls. McCann et al. (2013) found that crews are tethered and leashed and have little autonomy, as crews become governed and therefore

dependent upon delivery of various targets, deadlines and schedules. For example, whilst I was riding out collecting data, I saw how every aspect of our working day was monitored. Such as, the time it took to attend a call, the time spent at the scene of a call, the time taken to drive to hospital and more importantly, down time (time not available to attend calls), whilst at the hospital. These were all electronically monitored and recorded by the mobile data tracking (MDT) system. These all illustrate how paramedic crews are controlled, monitored and restricted in their day-to-day working practices, which I further argue, are not necessarily conducive with autonomy. McCann et al. (2013) along with Wankhade and Mackway-Jones (2015), found paramedic crews and students are governed by theses electronic tags, albeit from the mobile data terminal in the ambulance, the phone and computer on station, the radio from ambulance control, which is positioned in the ambulance cab and the portable radio carried at all times by the paramedic crews. Furthermore, crew members attending the bathroom were still subject to receiving an emergency call, as identified by (McCann et al. 2013). Hafler et al. (2011) suggests these practices and processes are not helpful when decoding the learning environment, whilst Cribb (2008) suggests that these types of practice form part of organisational control. I was drawn back to the work of Corman (2017) and McCann et al. (2013) who found paramedics personally interpret these restrictions and then construct their own occupational professional identity, similar to those which Lipsky (2010) identifies. Just as paramedics in my study, would turn their portable radio off when using the bathroom in defiance to alleviate this pressure. This does not convey a sense of professionalism, although my findings reveal, both students and experienced paramedics had a strong sense of professional identity which was explicit and striking. As discussed previously, there was a sense of power, authority, status, purpose and community. Examples of these are provided below taken from my fieldnotes.

> *Student paramedics and experienced paramedics would often act like police officers to gain control of situations, such as domestic disputes which had resulted in an injury to one of the parties (Observational fieldnotes recorded on the 11/05/2015 whilst I was riding out with the crew).*

> *Members of the public appeared to expect and accept some kind of order to be restored, to an often-chaotic scene, as we (ambulance crew) arrived at the emergency call (Observational fieldnotes recorded on the 02/03/2014 whilst I was riding out with the crew).*

Sarros et al. (2002) liken this style of control illustrated above, to a bureaucratic, quasi-military type organisation. I was reminded of O'Meara (2009) who provides deeper understanding of paramedic identity, whilst Reynolds (2004), helps illustrate this phenomenon. O'Meara suggests, registration and regulation are components of professional identity, both of which are synonymous with UK paramedics, whilst Donaghy (2012) believes, registration and regulation are essential components in enhancing the professionalisation of paramedics to the next level. Lipsky (2010) refers to the realities of street level practice, suggesting the work becomes far removed from abstract ideologies, such as professionalisation, as also seen in the work of (Burford, 2012). This is not the professional identity seen by those who promote the development of the profession, such as the, College of Paramedics (COP), Health Education England (HEE), Council of Deans for Health (CODs), the Health and Care Professions Council (HCPC) and the Association of Ambulance Chief Executives (AACE). Instead, these are aspects of professional identity that grow out of the realities of the working practices, reiterating the hidden curriculum that I am arguing exists. O'Meara (2009) suggests that:

> The evolving professionalism of paramedics needs to be confirmed through professional behaviours that incorporate adherence to professional codes of conduct, reflective practice and commitment to continuing professional development.
>
> (O'Meara, 2009: 2)

Reynold's (2004) review of professional development of paramedics in Australia, suggests progress has been slow. The sense of what is understood by professionalisation, as evidenced in the paramedics' workplace, appeared somewhat limited. Freidson (1988) and Goltz & Smith (2014) previously noted the disparities that may exist between participants' behaviours and perceived values. Accordingly, I found student observations of practice led to a form of confusion regarding the expectations of professionalism, (Zubin, Simpson & reynen, 2005) as students sometimes encountered disruption and conflict, as a

result of the use of varying forms of racism, sexism and bullying whilst on the road (See findings chapter). Students were expected to participate in the traditional working practices and processes inherent within the workplace setting, these sometimes included, meal break avoidance, off jobs (finishing their shifts on time), writing graffiti on the walls of ambulance stations, bullying and vehicle sabotage (cutting and exposing electrical wires). I found cultural integration into the paramedics' community of practice (Lave & Wenger, 1991) was often associated with bullying and stereotyping, as documented in the findings (See findings chapter). Students became aware of the possible consequences of non-conformity that is, they became rejected, abandoned and according to (Boychuck Duchscher, (2009) became marginalised. They often acted as larger than life characters, super-heroes and authoritative in their distinctive green uniforms (Lovegrove, 2013; Tangherlini, 2000) to make an impression as they grappled with their perceived professional identity. They formulated cynical views and assumptions about patients, which they would often claim to be examples of black humour (See findings chapter). However, I argue, this did not correspond to black humour, but a reflection of the intricacies and nuances of observed behaviour that weaved through the students' day-to-day practices. This formed part of the subculture which existed. These are all examples of the disparity between the formal university classroom learning and that of the practice setting, which operate as a hidden curriculum, unplanned and unintended by policy makers and university programmes.

Selected theoretical models of enculturation have been discussed in this chapter. These models rely on the work of Lave & Wenger's (1991), communities of practice, Becker et al's. (1961) study of medical students and Schein's (1985) model of organisational culture. In formulating these theoretical concepts, I was remined of the work of many other authors who have contributed to this section of my thesis. Drawing on my findings, I found that students become enculturated into a subculture comprised of experienced 'old-timer' paramedics, whose traditions and working practices formed a workplace community and subsequent hidden curriculum which students were unaware of and unable to resist, as to do so would exclude them from the day-to-day working relationships. I have illustrated this in my findings along with the often challenging, demanding and at

times hostile working environment students found themselves. My findings also reveal this workplace culture is often unchallenged and uncritically accepted. The following section of this chapter sets out the implications for practice on student enculturation.

6.8 Implications for practice:

The implications for practice stemming from my findings, serves to strengthen the need for this research. I argue for any significant change to occur within the profession, the work experiences, professional identity and the stringent structurally confined organisation needs to be addressed. My findings reveal that accumulatively this can inhibit and detract from any significant change at all levels (Givati et al. 2018), to include both the micro, individual level and the macro, organisational, institutional and professional level. I am reminded of the work of Devenish (2014) Brinkman (2014) and Currie et al (2010) that these issues are not necessarily limited or unique to one NHS ambulance service. In this section, I address the implications for practice before offering suggestions for change in the next chapter (chapter seven) and suggest potential solutions in tackling the subculture and hidden curriculum depicted within the NHS ambulance service trust.

This work lays claim that learning styles are contextually linked to the cultural setting. For example, Lave & Wenger (1991) express how learners or new trainees, contextualise their learning experiences to their situational participation, such as those of their experienced paramedic colleagues and mentors. This raises a key question arising from my study, which is, what is taught in the university classroom is not necessarily sufficient to equip students for the culturally based practices embedded within the ambulance and paramedic working environment. The university curriculum focuses on the award of a degree, Ball (2005). This is not always reflective or necessarily aligned to current trends and working practices carried out in the workplace, which (Hafferty, 1998; O'Donnell, 2014) suggest. In addressing these issues, I argue, a structurally work based approach is required to accurately reflect the realities of the practice setting, without diluting the key components of knowledge, skills and practice, required to produce paramedic practitioners, who are fit for purpose, fit for the

award of degree and fit for practice. Nevertheless, any kind of meaningful and tangible development or adjustment to the paramedic programme would require a multi-faceted approach, involving the inclusion of the professional body, ambulance managers, educationalists, academic tutors (institutionalisation), experienced paramedics, paramedic mentors, paramedic students, service users and trade unionists (professional identity) in the course design, development and delivery of service. A multifaceted partnership which draws together knowledge, experience, standards and governance, to produce a curriculum, suitable and workable, for both the academic components of paramedic professional practice, together with the practicalities and 'real life' issues which can taint and distort that found in the working environment of clinical practice. It could be argued that the requirements for this are already in all the relevant standards. However, it is unclear if important voices or perspectives are lost in the process of involving and engaging these different groups.

6.9 Conclusion:

To help contextualise how and why these findings became so relevant to this piece of work, I have illustrated how the notion of enculturation and the subsequent hidden curriculum became embedded within work cultures (Guufberg et al. 2010) in similar organisations, to that of the ambulance service, such as Sarros et al (2002) work with the fire service in the USA and Lipsky's (2010) work with American police officers. I provide an ethnographic account of how I found students in my study, became shaped and conditioned into a hidden curriculum. I explore how this hidden curriculum was not that expected or planned within the wider aspects of paramedic development, situated in University education, rather a hidden curriculum drawn from the subculture which revealed a form of pedagogy unknown, and unseen by students, as supported by the work of (Mulder et al. 2018; O'Donnell, 2014; Hafferty and Franks, 1994). Furthermore, the work addresses the subculture and hidden curriculum, along with the fragmentation of communities of practice which became evident. Dewey (1963) offers a degree of insight by suggesting that competencies, as a system of knowledge, skills and attitudes, may not necessarily be covered in the classroom setting. Lave (2010) suggests that learning does not begin with goals and objectives it begins with experience and reflection on the experience, suggesting

that learning is situated and therefore is influenced and informed by the practice environment. Dreyfus (2001) claim, that students firstly learn the rules of the discipline (novice), before applying the rules in certain context (advanced beginner) and then accepting the responsibility (competent) of their practice, also see Benner (1984) model of *novice to expert* (See appendix M).

I have illustrated how the data drawn out of my ethnography interacts with the empirical evidence based and pre-existing concepts such as communities of practice, workplace culture and institutionalisation. The chapter has extracted, reviewed, critiqued and analysed key elements of the findings within the study and selected theoretical models of enculturation have been discussed. These models consist of the formal and in-formal education, seen in the work of (Hafferty & O'Donnell, 2014; Benner, 1984; Lave & Wenger, 1991; Boychuck Duchscher, 2008), along with the hidden curriculum and resulting pedagogy, as seen in (Hafferty & O'Donnell 2014; Cant & Higgs, 1999; O'Mera, 2009; Reynolds, 2004; Devenish, 2014; Becker et al. 1961) work and the theory of communities of practice of (Lave & Wenger 1991; Wenger 1998). This community of practice is steeped in traditional practices and behaviours of experienced paramedics, which students are expected to mirror. I was able to witness the intricate subtleties of practices and nuances of the workplace through the lens of an ethnographer which allowed me to understand the enculturation processes which were evident as students attended their work placements with the ambulance service.

The next chapter looks at the future directions and recommendations for policy and practice, along with the student assessment process, strengths and limitations of the study, and insider/outsider roles, before summarising and drawing this work to a conclusion.

Chapter Seven: Reflections, Recommendations and Conclusions

7.1 Introduction

In this chapter, I summarise the findings of my thesis and illustrate how the student assessment processes are carried out, both in university and the clinical workplace. I illustrate how the insider/outsider research perspectives impacted and informed my research, before reflecting on the study. I then offer some thoughts on the strengths and limitations of the study before suggesting some potential future research for paramedic education, offering recommendations for policy and practice, prior to concluding this thesis and offering my original contribution to practice.

This research is significant because it has created new knowledge about the enculturation of university student paramedics and experienced paramedics. To date, few studies have explored this topic thoroughly drawing on an ethnographic position, from university through to the impact of work-based placements. While the theories of enculturation within healthcare are not new, this work generates a theoretical model of UK student paramedic enculturation through an ethnographic perspective, reflecting a paramedic paradigm.

Unravelling the student paramedic perspectives using observational fieldnotes, interviews and reports, this work has captured their unique and often challenging practice experiences, which (O'Reilly, 2009) suggests is one of the advantages of ethnographic study. Their behaviours, situations, attitudes, and voice became key to my research as I interpreted and analysed the findings. The relationship between their practice experiences with that of their university experience became evident (McCann et al. 2013; Wankhade & Mackway-Jones, 2015), as the subculture emerged (Hafferty & O'Donnell, 2014) through the research process to reveal a very different curriculum to that which students had been taught at university.

7.2 Summary of Findings

The student paramedics' experiences of university contrasted with that of their workplace practice experience. This highlighted a void between the elements formally taught in university and that experienced and embraced by students in the workplace, along with behaviours and attitudes. Often conflicting sets of professional values and clinical practice became evident, as students worked alongside more senior paramedic mentors and experienced staff. The differences between the formal (university) and informal workplace (hidden) curriculums were evident, as one type of pedagogy occurred in the university classroom and the other, on the job, dealing with patients in real life situations of ill health, injury, mental health crises and so on, as also seen in the work of (Corman, 2017; Metz, 1981; Palmer, 1983; O'Meara, 2001; Mannon, 1992 and Reynolds, 2007).

My findings are supported by Devenish's (2014) work on socialisation, along with Kramer's (1974) work on newly graduated nurses which found similar issues and concerns. For example, some experienced paramedics did not recognise students as novice practitioners in need of further training or support, because some experienced paramedics were set in their traditional ways and working practices. Lave & Wenger (1991) suggest that this forms part of the continuum of the students' community of practice, which Wenger (1991) claims, is the way in which social structures are formed giving rise to socio-cognitive activities we normally view as purely cognitive. What Wenger (1991) is referring to here, is that cognition, is situated within the social structures around us. Suggesting that the social structure shapes and informs our knowledge. The consideration of learning as a process of becoming a member of a sustained community of practice aligns with my findings, since the students in my research were unable to challenge the recognised established ways and customs engrained within the workplace and paramedic subculture, which is in line with the studies of (McCann et al. 2013; Givati, et el, 2018; Corman, 2016 and Cooper, 2005). Shortcomings in the teaching and learning environment of the practice setting, along with the application of pedagogy in clinical practice, led some students to question the value of the workplace experience. Students reported how the practice experience offered limited value to their theoretical knowledge as they felt unable to display their newly taught knowledge and skills in the clinical practice setting.

At times, their practice placement experiences were a painful and challenging process which they felt they had to accept or risk hostility from the experienced paramedics, which Boychuck Duchscher's (2009) study on newly graduated nurses, describes as marginalisation. In light of these discussions, it is of concern to learn that a recent media report highlights 'thirteen counts of sexual misconduct have been reported to the police at one NHS ambulance service trust where bullying was "normalised" which it is alleged by paramedics and other employees of the ambulance service', a recent (*Look East,* 2020) report claim. I was reminded of the students in my study, who confessed that the desire to succeed and become registered paramedics constrained them to adapt to the contradictions and difficulties they experienced in the workplace. An example of the extreme conditions of practice experienced by one student in my study is illustrated below:

> *I was riding out with Susan, a third-year student paramedic. I was talking with Susan alone in the ambulance cab whilst we were at Sunnymead hospital. We were discussing the university degree programme and practice experience when suddenly and unexpectedly, Susan became tearful, and upset. Once Susan had settled down, I asked her "what was wrong", and why she was so upset. I was shocked and amazed at her response, which highlighted a catalogue of sexual innuendos. Such as, forms of bullying and at times allegations of inappropriate touching throughout her three years practice placements. I was clearly in a difficult position as these events should have been reported and investigated at the time. However, Susan was adamant that she shared this information with me in confidence, as someone who she could trust. Her reasoning was this, she explains: "John, (researcher) I only have a few weeks left on placement then my three years are completed and I will finally be able to register as a paramedic and go and work elsewhere, away from this awful organisation". I was stunned at such a claim! (Observational fieldnotes recorded on the 17/06/2014 whilst in the ambulance at the hospital).*

However, despite their often poor and problematic practice experiences, most students continued to complete the course to become registered healthcare professionals. 90% of the students who started the paramedic programme successfully completed the three-year degree programme. (University, 2020).

It remains to be seen how students, once they become qualified paramedics, will apply their learning in the clinical placement setting, as students have been exposed to various forms of poor practice and learned some bad habits, although Reynolds (2004) suggest that they will not necessarily entirely jettison the knowledge, values and ethical principles that they have been taught at university when they become newly qualified paramedics (NQP). I was mindful of this, although there is a realistic prospect that students, once they become newly qualified paramedics, may become conditioned into the traditional ways of working, as suggested in the work of (Devenish, 2014). Therefore, the traditional workplace culture depicted in my findings would not become challenged, denounced, altered, or fully addressed as newly qualified paramedics (ex-students) may take on the traditional, taken for granted customs and practices of the experienced paramedics (old-timers). Metz's (1981) ethnography of paramedics and emergency medical technicians (EMTs) in the USA, found little evidence to support the fact that new recruits changed or influenced the already established ways of working. This also matches the findings of (Reynolds, 2004 and McCann et, al. 2013) who found the clinical workplace environment has a defined and lasting impact on students and their relationship with aspects of paramedic pedagogy.

In the section above, I have summarised the experiences of students in the workplace; this is important as these lie at the foundation of my thesis. To understand how students are assessed and deemed to be successfully qualified paramedics, despite their problematic and conflictual workplace training experience, will add further clarity and objectivity to my research. The next section illustrates the assessment structure, both in terms of the clinical workplace and the university. This provides a contextualisation of the two assessment processes, which further helps understand how students are expected to meet the standards required by the HCPC.

7.3 Assessment Processes

Students' knowledge and skills are assessed throughout the course by several methods, these include on-going assessment of the students' clinical placement experiences by a continuous record of ongoing progress, along with their

academic work situated in university. This section of the chapter illustrates the two processes, workplace and university, whilst highlighting some of the challenges these processes present.

In the clinical workplace setting, students are provided with an individual Practice Assessment Document (PAD). This is a record of the skills and competencies which students are expected to achieve throughout their time in the clinical workplace. These competencies are divided into year groups, such as year one, year two and year three. Year one consists of students having to achieve a set of basic clinical competencies, such as scene safety, communication skills, the use of basic ambulance aid equipment and basic patient assessment. This is followed in year two and three by the need for students to demonstrate a higher level of competency in advanced clinical knowledge and skills, such as advanced patient assessment and management (treatment), advanced clinical interventions, for example, the administration of intravenous fluids (IV) and drug calculations. There is an expectation and requirement that these competencies be assessed by a trained and qualified paramedic practice placement educator (PPEDs) or paramedic mentor, although I found many incidences whereby students had difficulty obtaining ratification of these competencies due to the low number of appropriately trained and qualified PPEDs or mentors. This is an important limitation of the practice assessment process, as other 'experienced' paramedics, who were not trained mentors or PPEDS would often sign the students PADs in the absence of a qualified PPED or mentor. This undermines the fundamental principle of the practice placement document in ensuring that the defined and agreed standards and competencies are met (HCPC, 2020). It also renders the workplace assessment process highly problematic in terms of meeting both academic and professional standards, as well as the national quality assurance agency (QAA) standards (QAA, 2019).

Students returning to university are also assessed through several different methods. For example, formal written examinations in topics such as, pharmacology and pathophysiology. Poster presentations and verbal presentations are used for topics such as reflective practice and communication skills, whilst written assignments are used for topics such as, anatomy and

physiology (A&P), leadership and management, crew-resource management and professionalisation. In addition, practical assessments, known as OSCES (Objective Structured Clinical Examinations) are undertaken for the assessment of practical skills, such as, patient assessment, the use of ambulance equipment and clinical interventions, for example, inserting a needle and administering appropriate drugs or placing a plastic tube into the patient's airway (trachea) These combined assessment processes are designed to contextualise the learning taught in the university, which replicates that of the workplace.

The validation processes undertaken by the university's internal academic validation panel, along with the Health and Care Professions Council's external approval panel, forms part of the initial development and approval processes of the programme. These processes are designed to ensure both validity and rigour of assessments are adhered to. However, questions are raised whether this is consistent throughout the students' clinical workplace, as I found worrying examples of poor practice which was evident on several occasions whilst I was collecting my observational fieldnotes. For example, I found paramedics with no formal mentorship training or qualifications, 'signing off' student work, assessing their clinical skills and grading their patient assessment in the workplace. I provide an example of this from my fieldnotes below to help illustrate these practices.

> *Whilst I was riding out with Amy the student paramedic, she was talking with Tony, the paramedic about her PAD document and getting it signed off by a mentor. Clearly Amy was keen to get her PAD signed and up to date. Without hesitation, Tony took her PAD and asked Amy where she needs it signed, stating "I will sign this for you love, you are a nice kid and I don't mind helping you out". Amy jumped at the chance to get her PAD completed for other outstanding entries, she seemed pleased with Tony's response.   (Observational fieldnotes taken whilst I was riding out on an ambulance in the West End of the city on 13-09-2014).*

The implications of these practices on the veracity of academic standards, particularly in assessment practices, as my findings indicate, are significant and as I speculate this is something which maybe endemic throughout the students' clinical placements. Eaton (2019) found that:

> Whilst the ability to mentor paramedic students is a requirement of paramedic registration, unlike the national education requirements for teaching in higher education, there is no nationally accepted education process for practice educators to work within this role. Since the practice placements constitute approximately one-half of the paramedic curriculum, it is surprising that there is no requirement for formal training or education of the clinicians who will support students during this phase of their studies.
>
> <div align="right">(Eaton, 2019: 1095)</div>

My findings also indicate that the students' epistemology formed within the structure of university education, is not necessarily fully transferred to the workplace. McCall, Wray & Lord (2009) and O'Meara et al's. (2009) work found shortfalls in the practice learning of paramedic students, suggesting a partnership between the university, ambulance service and student, is required in order to assure the national quality and standards of clinical education. McCall Wray & Lord. (2009) suggests that each party needs to communicate and prepare for quality learning to occur. Often, ambulance service managers are more focused on meeting operational deadlines and targets, than on student education, whilst students are usually focussed solely on the award of their degree, as (Suchman et al. 2004) highlight similar implications from their work. This can result in experienced paramedics continuing their day-to-day working practices and procedures which could be outdated, antiquated, obsolete and at times fundamentally at odds with the pedagogy and practice taught in the university setting. I argue that these have serious implications, not only in clinical placement pedagogy but in the assessment processes as well. I make some recommendations later in this chapter to help address these shortfalls.

Throughout my data collection, the notion of being an insider or outsider researcher was at the forefront of my mind, as Brewer (2000) points out, this can have implications for the researcher's data. The next section of this chapter explores the relationship between my insider and outsider position as a paramedic and as a researcher.

7.4 Insider-Outsider Researcher

The ethnography allowed me to really engage and witness first hand how and why students became so reliant on the subculture and hidden curriculum which (O'Reilly, 2009; Brewer, 2000; Emerson, Fretz & Shaw, 2011; Burgess, 1984; Walford, 2008 and Jeffrey, 2014) also highlight in their work, claiming that ethnography can provide forms of in-depth data. It provided me with the opportunity to work with participants, to see and be part of their community of practice, (Lave & Wenger, 1991), to share in their frustrations, anxieties, disappointments and at times sadness which confronted them in their challenging day-to-day work. The intricacies, nuances, colloquialisms, attitudes, and behaviours, become exposed, whilst I grappled with the emic position of researcher as I became one of them, Brewer (2000). I took Burgess's (1984) advice, that the emic position provides the researcher with full participant observation status who already belongs to the group being researched. At the same time, I was reminded of Walford (2008) whose opinion highlights the danger of the emic researcher going native as I was keen that my position would not compromise my research findings. Considering the dichotomy between the emic and etic researcher and the potential influence on my study, I use this section of the chapter to illustrate how this dichotomy was managed in the field.

My insider observations helped guide me to slip between insider (emic) and outsider (etic) roles, to create a persona that encouraged and cajoled participants to disclose and illuminate more confidential and detailed accounts of their day-to-day practices, which (Merleau-Ponty, 1962) work demonstartes. I was also aware that my research evolved through a reflexive stance related to my personal practice experience throughout the research. I took Hunt & Sampson's (2006) and van-Maanen's (2011) advice to use reflexivity to examine the self and voice to help harness and understand the responsibility of the researcher within the research. I combined a meaningful personal, professional and researcher self, to the research (van Maanen, 2011), as I became an integral part of the participants community. I worked with them, I copied their language, their slangy terms, their anecdotes and at times their offensive language, to help cement my place within the community. Developments of social research and in particular ethnography,

have stimulated discussion on the advantages and disadvantages of 'insider' and 'outsider' researcher. For example, Allen (2004) believes:

> Advocates of the 'insider' view argue that it is only those who are closely immersed in the field of study who can ensure an authentic account. Others make the counterclaim, that the 'outsider' position is a preferable stance as it is free from the potential for bias that arises from too close an affiliation with the research subjects or 'going native'.
>
> (Allen, 2004: 15)

Burgess (1984) suggests, situations are neither totally familiar nor totally strange, and the researcher's insider–outsider status changes at different points in a research project. I was also cognisant of O'Reilly's (2009) words that:

> The goal of ethnography, is to gain the perspective of the insider and to render it meaningful, raises special issues for ethnographers who are also members of the group they study.
>
> (O'Reilly, 2009: 109)

There were occasions, such as when I was required to treat patients as a paramedic, whereby I removed myself from the research process, then slipped back into the emic role as soon as I had cared for the patient (See chapter four). There were dichotomies within the discourse, as students releveled startling accounts of inappropriate behaviour, or I witnessed criminal damage to the ambulance (See findings chapter). These actions often required me to switch between the emic to etic researcher as I continued with the ambulance shift. I questioned myself, at times not really knowing what to do, whether to speak up, or remain silent and ensure my acceptance into their workplace community. I provide two difficult and challenging examples below, which stretched and tested my professional and moral compass.

> *I was riding out with Rupert, a second year Foundation Degree student. This meant that Rupert was employed by the ambulance service as a student paramedic, who returned to university in blocks to commence his academic studies. This also meant that Rupert was working one-to-one with his crewmate (working partner), an experienced (old-timer) called Albert. The shift was due to start at 15-00 hours and finish at 23-00 hours at Newmoon ambulance station situated in the*

> *outskirts of the city. Albert arrived for the shift ten minutes late, although we had not received any emergency calls, so ambulance control was unaware of the situation. At 15-10 Albert arrived and parked his car on the station. I had not met the paramedic (Albert) before, but Rupert had been working with him for a while now and appeared to get on well with him. It was not long within the shift, after attending our second emergency call, that whilst sitting in the ambulance that I could smell alcohol on Albert's breath as we were talking. Albert was the driver of the ambulance that day and it soon became apparent that Albert had been drinking alcohol prior to starting the shift and driving the ambulance. I found a moment to speak with Rupert privately about my suspicions and to my surprise Rupert was aware of the situation, stating: "Oh don't worry John (researcher) he often has a little drink before the shift, he only has a couple of pints at lunchtime, everyone knows him around here, it's okay it's just something he does".* Taken from my fieldnotes on (12/12/2014).*

> *On this occasion I was riding out with Jenny, a foundation degree student. Jenny was driving the ambulance whilst we had a patient in the back of the vehicle taking them to hospital. I sat in the front of the cab so I could talk to Jenny on route to hospital. The patient was in a stable condition, suffering just minor abdominal discomfort. Suddenly, jenny miscalculated the distance between a passing car and a parked motor vehicle (van) causing us to strike the parked van. I could see from looking through the ambulance wing mirror that we had shattered the van's right-hand side mirror, which was hanging from the vehicle with shattered glass and debris on the road as we continued passing various vehicles. I looked at Jenny who promptly said: "pretend you didn't see that John (researcher)" and laughed as we continued on-route to hospital.* Taken from my fieldnotes on the (06/08/2013).*

The two accounts above taken from my fieldnotes illustrate the dichotomy of my insider/outsider relationship which had formed over time with the participants. O'Reilly (2009: 110) claims that it is the, 'insiders' explicit goal to gain an insider perspective and to collect insider accounts'. It was therefore important for me to have their trust, assurance and be part of their community if I were to witness and experience their real-life working relationships and behaviours. These were real and challenging dichotomies and ethical tensions which I had to grapple with as I spent time in the field as researcher. Other accounts of my insider/outsider relationship can be found in my findings chapter.

In the next section of the chapter, I briefly reflect on my work and my experience as a novice researcher going into the research field to collect data. This section provides a summary of my feelings and experiences of the data collection within the field of ethnography.

7.5 Reflecting on the study

The title, 'An Examination of University Paramedic Students Enculturation into the Ambulance Service', was chosen for my research, firstly because of the unique opportunity I had to investigate what was really going on in the clinical practice setting and secondly, it allowed me to witness the stagnant, sometimes hostile and difficult practice environment which students can become exposed to. When students spoke to me in my role as a university lecturer, rather than researcher, they often wanted to know why they were unable to demonstrate and disseminate the newly taught knowledge and skills formed within the university, into the workplace. Why they had to work with experienced paramedics who were often negative about teaching them and why these paramedics were opposed to university students. Furthermore, they asked me why I am giving up my time to be out with them 'on this wet and cold night shift?' (Jane, university student, 2014). I found myself unable to provide a satisfactory response, as I was left wondering and reflecting on my experiences as a novice ambulance man forty years ago and asking myself why things had not fundamentally changed. This challenged my expectations as I confronted their reality. Thus, when students returned to university and reported that their "time in clinical practice was poor", I was able to understand, empathise and agree with them. I was able to offer an apology on behalf of the university teaching team. Wankhade (2018) found that discrimination remains a concern between ambulance colleagues, patients, students and the public. He further suggests that 'meaningful partnerships with Higher Education Institutions (HEIs) and Ambulance Services should be welcomed' (Wankhade, 2018: 7).

As with any form of data collection, various strength and limitations emerge from the research process. In the next section, I highlight some of the strengths and limitation which my research offers.

7.6 Strengths and Limitations of the study

Hammersley and Atkinson (2006) suggest the researcher makes these transparent within the narrative of the findings. In this section, I firstly highlight the strengths of this thesis before discussing some of the potential limitations of the research.

My research addresses a void within the literature on the paramedic student's enculturation into the working practice of the ambulance service. The data which I have collected over weeks and months of riding-out with student paramedics in the ambulance, provides an insightful and meaningful account of the experiences of eight university paramedic students, along with many other consenting students and paramedics (participants), of whom I came into contact with whilst collecting data in the field. This work contributes to the body of knowledge around paramedic socialisation, as it depicts a paradox between the students' university studies and clinical workplace experience. These are important accounts which illustrate the fundamental premise of this thesis.

However, I acknowledge that there are some potential limitations of the study which need to be considered. For example, the convenience sample of participants became limited as participants volunteered to take part in the study. This meant that the selection process utilised purposeful sampling, as I had to rely on my own judgment when selecting participants to participate in the study, although one key purpose of this is to 'ensure that all criteria of relevance are included' (O'Reilly, 2009: 197). The nature of operational shift work, also meant that I was restricted to who the participant (student) was crewed with (crewmate) on each shift. I was not able to impartially select who the student would be working with, as this was decided for me by the ambulance service rotas. Therefore, issues such as, ethnicity, gender and age of participants were random. At times limited contact was made with the student's crewmate (paramedic) prior to arriving at the ambulance station to undertake the shift.

The sample size of the study could also be considered a limitation, although I refer to the matrix found in (Appendix N) to illustrate the very compelling, rich meaningful data and close encounter which I experienced with participants on

numinous 'ride-outs' over a prolonged period of time, resulting in 602 hours of fieldnotes, over 10 hours of interviews, along with numerous personal reflective and reflexive accounts.

My data collection method, consisting of observations, fieldnotes and interviews, became a lengthy and demanding process. This had the potential to impact on my intellectual resilience and physical stamina to record accurate data at times of tiredness and exhaustion. I managed this potential hazard by recognising my limitations, by having chocolate bars and sweets in my rucksack, along with a flask of coffee whilst in the field. This was particularly important whilst riding out on night shift after a day's work, as my resilience and personal stamina suffered in the early hours of the morning, especially on those shifts in the dark winter nights. I was also mindful of the possibility that participants, both students and experienced paramedics, may have acted in a style that favoured the researcher's expectations, along with my own prior experience and knowledge of the paramedic profession and NHS ambulance services, which Willis et al. (2010) suggests could be viewed as a limitation but also a strength. I suggest, my knowledge and experience of the ambulance service and paramedic profession became a strength of this research. My insider perspective allowed me the opportunity to see the subtleties, nuances and hidden aspects (Creswell, 2009) of the workplace, which may not have been visible to those outsider perspectives.

I argue that my critical reflective and reflexive approaches to my data collection, data analysis, interpretation and representation of my findings, provides a transparency, accountability and honesty to this ethnographic account which (Coffey & Atkinson, 1996; O'Reilly, 2009), believe are the ethnographers goals, as many of the findings from this research could confirm the transferability of findings to similar studies seen in peer reviewed publications and reports associated with paramedic training and socialisation. My rationale for choosing ethnography was, as Kramer (2010) suggests, to present a realistic representation that would assist in understanding the enculturation process, whilst also acknowledging the complexities of the socialisation process. As limited research exists on the enculturation of student paramedics, I drew on a qualitative research approach to provide a voice and offer a degree of insight into

this area of research. Ethnography therefore provided an appropriate methodology for this thesis.

In the next section of this chapter, I offer some future direction and recommendations for policy and practice. I review my findings to offer potential solutions and recommendations which would add to the body of knowledge and contribute to practice.

7.7 Future Direction and Recommendations for Policy and Practice

The results drawn from my findings raise serious questions about some of the current practices carried out in the ambulance service. The future direction of paramedic development remains unclear and uncertain. Out-of-hospital emergency and urgent care continues to evolve and expand, whilst attrition of paramedics from the NHS ambulance service continues to be problematic and remains a priority for ambulance services to confront and address (ACCE, 2020). I was drawn to the 2015 NHS pay review body to remind myself of the degree of attrition in the NHS ambulance service, as they seuggest: 'The retention of staff is an issue, but in the case of paramedics the related recruitment problems are making retaining paramedics a crucial issue' (NHS Pay Review Body, 2015: 8).

My work is situated within social constructivism, as I draw on the work Lave & Wenger (1991) and Palincsar (1998) who looked at the social constructivist perspective on teaching, whilst Lave & Wenger (1991) situate learning as being socially constructed. They suggest that learning occurs in a social constructed environment such as the workplace. Their work on Yucatec Mayn midwives in Mexico and Gola tailors in Liberia, along with U.S. navy quartermasters, helps to understand the relationship between socially constructed ideas and knowledge. For example, how daughters of the Mexican midwives undertook no formal training but followed and watched their mothers as they went to village after villages undertaking their midwifery work as the young daughters learnt the knowledge and skills required to emanate their mothers as midwives in the socially constructed pedagogy. Similarly, how the Gola tailors learnt their trade by watching, learning and developing as master tailors within the small community of practitioners. The environment influences and shapes the learning

which occurs, such as that of the organisation (ambulance service), the work colleagues in the environment (paramedics) and the various groups of practitioners who form bonds, such as those formed by paramedics in the watch-room or between students and paramedics. These all contribute to a form of learning, different from that which is taught in the university environment. Both these environments have different socially constructed ideas and assumptions, meaning the learning environment impacts on the learning experience, Wenger (1998). This can hinder and curtail the type of pedagogy experienced in the workplace in the context of the informal workplace curriculum, as opposed to the formally prescribed university curriculum which can be significantly different, which is also seen in the work of (Becker et al. 1961; Boychuck Duchscher, 2009; Lave & Wenger, 1991). This poses pedagogical challenges for paramedic students (Devenish, 2014), as both the design and delivery of the formal curriculum fails to recognise and adequately address the real-life issues which face paramedic students in the clinical workplace setting. Barret & Hafferty (2013: 388) try and address this by examining how a hidden curriculum may influence medical education, suggesting it 'influences and impedes medicine's push for professionalism'. The pedagogy experienced in the paramedic workplace can restrict the potential for the future development of paramedics and the professionalisation of the paramedic profession. This is significant and can challenge the experiences of neophyte students as depicted in my findings chapter. I am arguing therefore, that a radical overall of policy and practice be at the forefront of future paramedic development. I offer analytical propositions later in this section to address these issues.

In the light of the discussion above, I am proposing that the information presented in this thesis may assist university paramedic students to better prepare for their clinical workplace. For example, it gives an indication of the processes which will confront paramedic students, such as the intrenched subculture which forms part of the student journey. This will provide students with a realistic expectation of the real-life working environment, rather than any perceived expectations drawn from media coverage or taken for granted assumptions. The thesis also highlights the various tensions which exist between the university and ambulance cultures which identifies the processes of enculturation as students enter the paramedic

workplace (Devenish, 2014) and the likely encounters, he/she faces as they transition into a registered paramedic. Newly qualified and experienced paramedics may also benefit from this research, as it identifies the subculture and subsequent hidden curriculum which results from it. As paramedics become mentors, this research provides a deeper and detailed insight into the student learning experience and how experienced paramedics might develop their mentoring styles and techniques to help support students, whilst dealing with the complexities of being expected to supervise new staff members. Furthermore, this research can be beneficial for paramedics as it identifies the forms of behaviour, storytelling, language and identity, which fosters a deep-rooted cultural identity within the workplace.

Analytical propositions have been identified from this research which informs the enculturation process encountered by university students. I provide my analytical propositions below which I propose in order to address the concerns raised in this thesis:

1. A particular subculture exists within the ambulance service which students unexpectedly get drawn into as they attend their clinical practice placements. This subculture consists of forms of racism, homophobic and sexist behaviours, along with criminal damage and cultural practices which are archaic and unacceptable in the current workplace environment. However, this appears ubiquitous and, to a degree, tolerated within the ambulance service, as my findings have depicted and also found in the work of McCann et al's. (2013) and Wankhade & Mackway-Jones (2015), as well as being highlighted in recent media reports, such as the (BBC, 2020) report identifying a culture of sexism. To eradicate these archaic behaviours, which are often targeted towards other staff members, students and the public, I argue that a radical change to the current workplace culture is required. This would address the taken for granted, primitive, old-fashioned, and offensive practices evident in the ambulance service, if the paramedic profession is to strive for professional status, as expected by the (COP, 2019). My findings

suggests that resilience to these challenging and unacceptable behaviours were not sufficiently addressed in the undergraduate paramedic curriculum. University paramedic programmes should question the need to invite ambulance service representatives to attend and address the university programme ensuring content reflects the reality of the practice placement setting. A radical overall of the cultural practices and behaviours, so evident in the findings of this study, is recommended. This would go some way in addressing these issues. By drawing on the findings of this thesis, the deep rooted, traditional subcultures which exist, can be drawn out whilst engaging staff, students, public and patient forums, offering a degree of understanding of the challenges associated with these practices. Furthermore, by empowering educators of ambulance trusts to actively promote equality, diversity and inclusion, through clear expectations of behaviour, would go some way to address these concerns. Students deserve to feel safe and secure when attending clinical placements, and to be able to challenge and report unacceptable behaviours when they occur, which currently is not necessarily the case.

2. My findings indicate that a patchwork of standards exist regarding paramedic mentorship and Practice Placement Educators (PPEDs). The role and responsibilities of qualified paramedic practitioners is of concern. The public expect a speedy response when they need paramedics. An empathic knowledgeable and skilful practitioner who has been assessed to the highest standard, who can confidently and competently address the patients presenting clinical complaint and concerns. Patients are often in their greatest need, the most vulnerable in society, those who have suffered significant physical injury or complex physical illness or mental health issues, people who are at their lowest ebb and people who just need help. However, my findings reveal that the current model of mentorship training does not provide this assurance (Givati et, al, 2018), as obsolete, outdated and inconsistent

standards of mentorship training and education appear common throughout the findings, as can also be seen in the findings of (McCann et al. 2013). Some ambulance services fully engage with universities who offer post-graduate studies in mentorship related subjects, whilst other ambulance services offer their staff a one or two day in-house (ambulance service) mentorship training course and other ambulance services have no formal structure and expect paramedics to take on the role of mentor, as highlighted by (Eaton, 2019). The diverse forms of mentorship education and training are considerably different, both in their expectations, knowledge and standards. This approach to paramedic mentorship is broken and does not work. It is inconsistent, erratic, conflicting and inconceivable in today's modern NHS ambulance service.

My findings indicate that there is a strong case for an agreed nationally recognised paramedic mentorship programme, similar to those of the Nursing and Midwifery Council (NMC, 2020) and the Department of Education's Academic Mentor Programme (National Association of School-Based Teacher Trainers, 2020) to bring paramedic mentorship in line with similar professional organisations. To achieve this, 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. Agreement between the various bodies who have oversight for paramedic development would be required. These consist of, The Association of Ambulance Chief Executives, The Health and Care Professions Council, The College of Paramedics, The Council of Deans for Health and Health Education England. Therefore, 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. It is envisaged that a national recognised standard would supersede the arbitrary, add-hock in-house mentorship

programmes, currently offered by many NHS ambulance service trusts. This is a justifiable suggestion for future policy and practice which might ameliorate the current disjunctions and tensions identified in my findings between university and clinical placements. This has the potential not only to enhance the student paramedic workplace learning experiences, but go some way to tackle the hidden curriculum, found in my data and subsequently address the resulting workplace pedagogy depicted in other areas of work, similar to those found in Teaching (Jackson, 1968), Nursing (Boychuck Duchscher, 2009) Paramedicine in Australia (Devenish, 2014) and Medicine (Becker et al. 1961). Michau et al. (2009) identify the challenges associated with the theory-practice gap.

3. The final recommendation arising from this thesis relates to the existing paramedic workforce, who qualified prior to the introduction of paramedic degree level qualifications. These experienced paramedics, often referred to throughout my findings as 'old-timers' (Lave & Wenger, 1991), require updating in areas such as patient assessment and management, ethics and law and behavioural studies. Further development and training would ensure this group of practitioners become and remain current and knowledgeable in the educational developments occurring within the profession as taught to student paramedics at university. As my data suggests, many experienced paramedics (old timers), felt isolated from the current knowledge afforded to the new cadre of students and newly graduated paramedics. This development could be carried out over a number of weeks and months through a university development programme.

7.8 Conclusion

My work offers unique insight into the day-to-day realities of traditional working practices to which student paramedics become exposed. Devenish's (2014) work helps to illustrate this by exploring the transition from being a university student to becoming a practising intern paramedic in Australia through the lens of existing

professional socialisation theories. Schein (1985) provides a framework to help understand the three distinguishable components of organisational culture, whilst Lave and Wenger's (1991) theoretical model of communities of practice gives substance and theoretical underpinning to this work. The paramedic student journey is an unsettled and often uneven pathway which students are expected to navigate, often under challenging and difficult conditions, at times with little if any support and or encouragement. Therefore, this research is a timely contribution to the limited literature on the enculturation of UK paramedic students, as they go from university into the workplace.

This thesis has considered the expectations of student paramedics as they become exposed to the unexpected reality of the workplace. The formal and informal models of curriculum (Jackson, 1968; Hafferty & O'Donnell, 2014; Lave & Wenger, 1991; Cant & Higgs, 1999) have been discussed and issues around subculture, and marginalisation have been alluded to when discussing this thesis. Notwithstanding this, I believe these results will contribute to the overall body of knowledge on the enculturation of student paramedics' curriculum development and policy and practice, with regards to the UK NHS ambulance service and paramedic profession. Finally, the experiences of the participants within this study offers a rich and detailed ethnographic insight into the ambulance service for individuals wishing to pursue a career in the paramedic profession. I refer to the work of Givati et al. (2018) to conclude my work:

> Over the past two decades, paramedic education has undergone a process of academisation and a shift from in-house, occupational training, to university-based undergraduate programs. While the professional regulation and standardisation of Allied Health Professionals' education has captured scholarly attention, the study of paramedic practice is still in its infancy and there is a need to explore its evolvement in relation to the fluid societal–political circumstances affecting its provision and demand.
>
> (Givati, et a, 2018: 353)

The illustration below, figure 11, provides an overview of the student paramedic journey, as they go from student (novice) through to becoming registered healthcare professionals (expert). I illustrate the various stages which students go through, from novice to expert, whilst highlighting some of the influencing

factors which impact on these. Connecting arrows link the student journey whilst the blue broken (dotted) line captures the whole journey, incorporating students' legitimate peripheral participation through to full legitimate participation into the community of practice (Lave & Wenger, 1991).

Figure 11: **The Student Paramedic Journey**
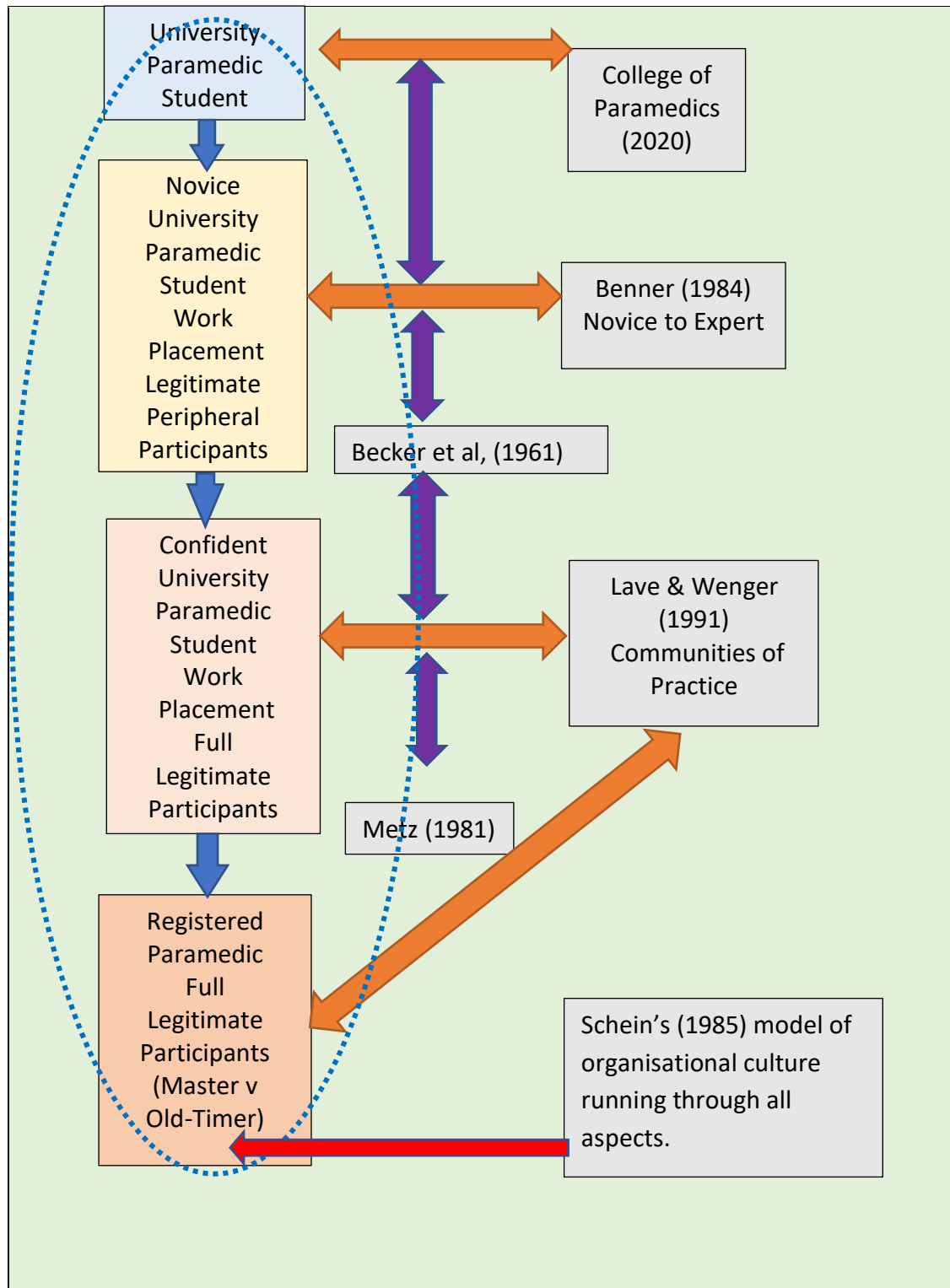
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Chapter Nine: Appendices

Appendix A: Ambulance Station Information Bulletin

Graphic drawings and other graffiti

There have been several occasions recently where the Trust has been brought into disrepute due to drawings of penises, as well as the scrawling of words some of which have been interpreted as homophobic slurs on documents around Whipps Cross Ambulance Station.

On one particular occasion, someone had drawn a picture of a penis on an ECG strip and put it back in the Lifepak. When an ECG was printed it had had a large penis along with the patient's heart rhythm. This now forms part of the legal record of that patient's care, and was picked up by the consultant at A&E – we await his formal complaint.

This will now form part of that doctor's view of the London Ambulance Service, and all of us individually, and is completely unacceptable.

In addition, we have had several internal and external visitors who have commented on the amount of penis drawings, as well as other graffiti including words intended to cause offence (particularly the word "bender" which was taken to be a homophobic slur) on documents around the messroom and in particular the male locker room.

Again, this now forms part of those visitors' view of the London Ambulance Service and in particular staff at Whipps Cross that we allow it to happen.

Today, all penis drawings located were covered up or removed, as were any other visual representations which could cause offence. This matter will be the subject of ongoing investigation until the culprit(s) is/are found.

Colleagues are reminded that whilst they may wish to add decoration to their locker, the locker remains the property of the Trust and any decoration should be non-permanent, and should not cause offence. Colleagues are also reminded that all employees have a right to work in an environment free of discrimination or harassment, in particular that which relates to gender or sexuality.

Anyone who wishes to provide any information regarding this please get in touch with one of the GSMs or a Clinical Team Leader in confidence.

Information

My investigation explores the relationship between the traditional ambulance/paramedic culture to that of the student paramedics, as they embark upon their work placements with the ambulance service. How the culture impacted on their practice experience, how students internalised and interpret the placement setting, how they made sense of the culture and become influenced by and interact with, the culture. Qualitative and quantitative research methodologies, identify, position and question the understanding of the world, the qualities and intellectual capacity of the researcher and the purpose and nature of the research study in question are tested (Creswell, 2009). Both qualitative and quantitative procedures demonstrate differing approaches to scholarly inquiry (Bryman, 1984). Quantitative research is driven by an explicit process of enquiry, which Cormack (1991) believes forms an objective and systematic process with numerical data used to obtain information about the world (Cormack, 1991: 140). Objectivity, numerical data generally underpins the impersonal position of the researcher in highlighting the knowledge presented from the research. 'Quantitative methodology therefore, offers an adjective, indicating that something is expressible in terms of quantity, thus it is accurate to talk of quantitative measures and quantitative data' (Schwandt 2015: 259). In comparison, qualitative research asserts, an investigative process, whereby the researcher gradually makes sense of a social phenomenon by contrasting, comparing, replicating, cataloguing and classifying the object of study (Creswell, 1994: 161). This occurs within the interpersonal space of the researcher, as inference is drawn from the data to construct knowledge. The reader, subsequently focuses on the narrative to understand the phenomena. Therefore, qualitative inquiry employs different philosophical assumptions; strategies of enquiry; and methods of data collection, analysis, and interpretation (Creswell, 2009: 173).

I initially explored the relationship between the traditional ambulance/paramedic culture, with that of the student paramedics culture as they embark upon their work placements with the ambulance service, through the use of Kelly's (1955a) Reparatory Grid. How the culture impacted on their practice experience, how students internalised and interpret the placement setting, how they made sense

of the culture and become influenced by and interact with, the culture were key questions I needed to know.

After detailed review, investigation and interpretation, of this concept, however, I became convinced this form of data collection represented a coherent, comprehensive psychology of personality, which concentrated on the special relevance to psychotherapy. Although illuminating, it occludes the phenomena being studied by detaching the researcher's valuable insights from the reality of workplace culture. Therefore, it soon became clear that this method of data collection would not necessarily provide an in-depth analyses and interpretation of the intricacies, nuances, customs and interactions I was trying to uncover between students and experienced staff. Although my initial use of the reparatory grid (RG), did provide a detailed diagrammatical comparison of two sets of data. These data sets are helpful and influenced the main piece of research, as the results revealed comparison data.

Creswell (2002) suggests, a comparison of the two narrative approaches, problem-solution and three-dimensional space, shows several common features and distinctions. Such as, narrative researchers decide which approach to use, they look at the broader holistic sketch to narrow the structure of the problem-solution. What is implied here, is the impact on the student practice experience one year later, is of particular interests and provides a lens to view the data. Additional testing and validating of the data (Denzin & Lincoln, 2012) through observations and interviews can help contextualise the findings. This clarifies Creswell's argument, that the data is thus representing a broader aspect of findings.

The following table below (2&3) gives a diagrammatical representation of my results, plotted against the reparatory grid, following the student's workplace experience. The data illustrates the relationship between both the first and second year placements and allows comparison to be drawn between the data received from first year students, prior to exposure into the practice setting, with that of the second year practice setting (Kelly, 1955a) & (Schwandt, 2015a), following one year.

Purposeful sampling was adopted to select students, as I wanted students who had no pre-existing experience and knowledge of the ambulance service. Students were required to have no pre-existing personal experience of the ambulance service, either as a service user, in a voluntary capacity, as a carer for a service user or any such experience. This ensures comparability between the six students selected to participate in this section of the study. Schwandt (2015b) refers to purposeful sampling as being appropriate, providing an explanation as to why this method was chosen is explicit within the narrative of the study. I provide clarity here, as it is important to have students who wished to participate in the study, with no previous experience or understanding of the context of the practice setting. Therefore, justifying the use of purposeful sampling to provide clarity and consistency to the findings. I initially undertook a scoping of the student cohort which identified six first year university paramedic students who were able to participate in the study, should they wish to. These students had no previous experience of the ambulance service or been exposed to any practice placements at that time. Following ethical approval and consent from the students I undertook the study. Using supporting electronic software (Ideio-Grid 2.4), participant responses (constructs) to the questions (elements) were collected, collated and analysed. Questions are referred to as 'elements', whilst responses, or answers are referred to as 'constructs' (Kelly, 1955b) and forms a fundamental premise of Kelly's reparatory grid. The software proved central in illustrating diagrammatical representation of the findings (table 2&3). The results from the reparative grid, indicate how university students' perceptions of the ambulance service were portrayed. The study was repeated as students returned from their clinical practice setting, one year later, supporting a comparative element to the work. The RG became an initial component of the study and as such requires some recognition and understanding of the context in which it was utilised. Kelly's notion of Personal Construct Physiology, or Personal Construct Theory (PCT), positions the concept within the literature, describing the capacity of the living thing to represent its environment, which Kelly (1955c) describes as: "This is especially true of man, who builds construction systems through which to view the real world" (Kelly 1955c: 43).

Personal Construct Theory (PCT) explored the perceptions of how, if at all, students became influenced by workplace culture. Drawing on participant's pre and post perceived thoughts and views of their working environment, highlighting how paramedic students, studying at university, thought about their working

environment, before experiencing it for real. This provided an initial 'exploratory' component of the study (comparative study). A deeper understanding of why the chosen methodology for the study draws on ethnography to help draw out more in-depth and meaningful data to elicit the underpinning components not found or identified from the RG process.

Table 2.

Student 300 data prior to practice placement

Table 3.

Student 300 data post to practice placement
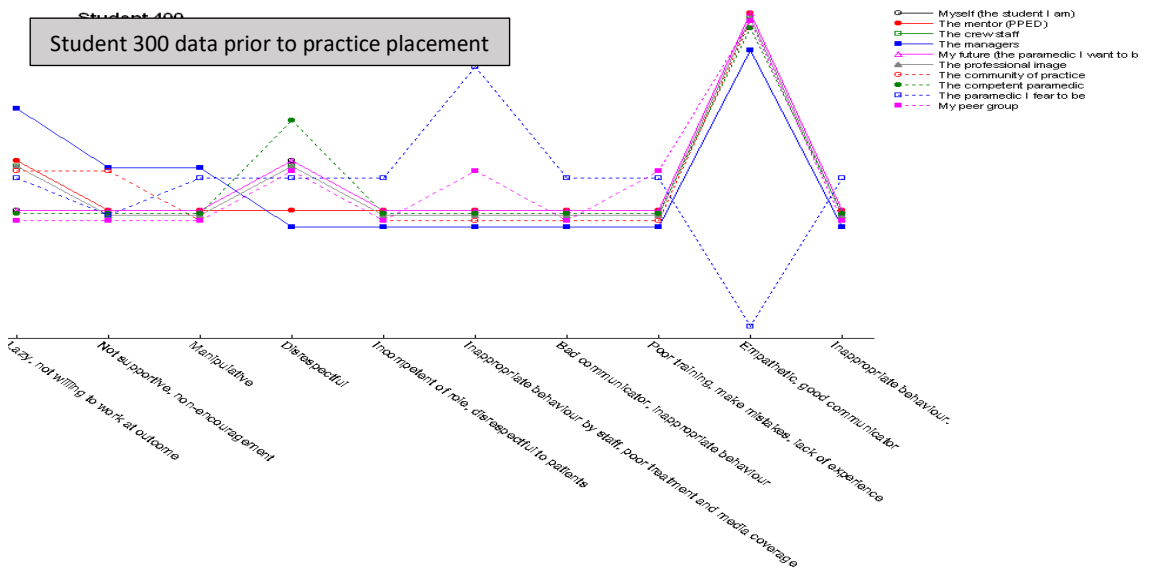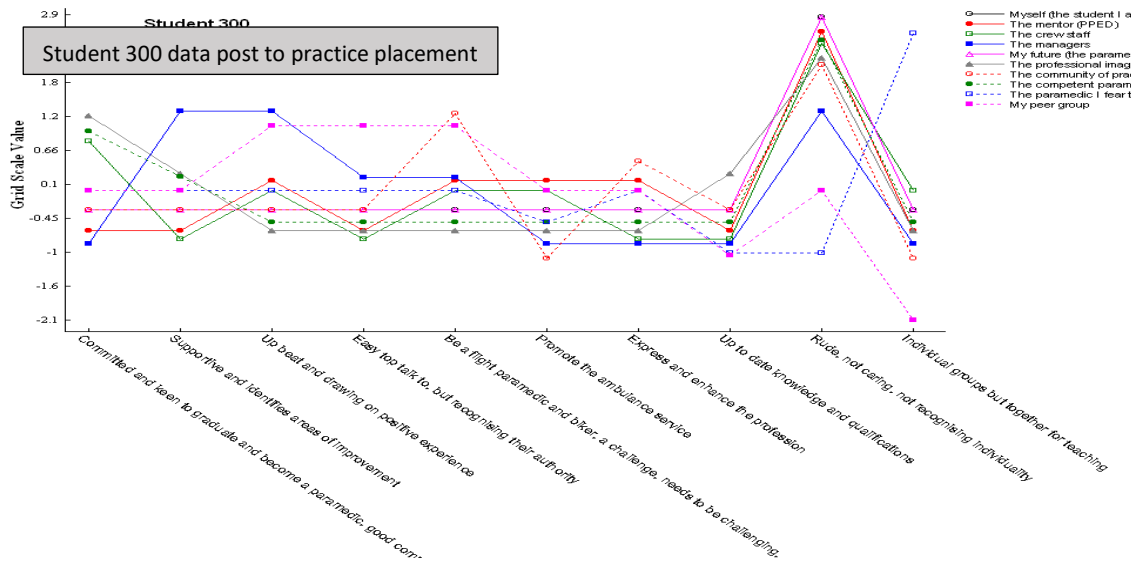
The findings from the RG, reveals a disparity as student perceptions change and altered, after workplace exposure, with that experienced by students prior to exposure of the workplace. To help illustrate this, there is consistency identified concerning areas such as, *managerial support, paramedics' attitudes and unsupported students,* and a *different culture to that of university*. Many of these areas were perceived by students prior to their workplace exposure, as being essential components of the clinical placement, although returning students identified their surprise and disappointment of paramedics' views and attitudes towards them, although some highlighted a positive experience, whilst many others a negative experience. All students thought paramedics would be professional and attentive, prior to their (students) exposure to the workplace, although some areas of the findings outline poor outcomes (Kelly, 1955d). Table two highlights the limited empathy and communication found in the workplace as being an essential component of the practice setting. This is illustrated by the downward spike (-2.1) in table three. Although students returning to university, following a one year period at university, found this to be mediocre and similar to many of their initial perceptions, illustrated in table three (+2.5). In his work, Kelly suggests a richer and fuller investigation of the elements (questions) can be found by engaging participants in the construction of the elements (questions). This he argues, is carried out through dialog from focus groups (Kelly, 1955e). The practicalities of identifying students, selecting students and consenting students, whilst they were undertaking their university studies, along with their work placements and leisure time, proved to be a limitation of this component of the research, nevertheless the use of focus groups may have enhanced response to the RG. Patton (2002) speaks of the demands and practicalities of carrying out research, suggesting one has to be pragmatic and recognize the limitations when collecting data.

The use of questionnaires, either through an electronic medium, such as Bristol Online Survey (BOS) Questionnaire, or paper based open ended questions can help provide data, although I was keen to gain a more insightful degree of data which represented the realism of what was really going on in the workplace (Brewer 2000). Not denying, focus groups can be helpful in providing particular issues, such as, disputed opinions, thoughts and impressions of individual group members in a group, reflecting shared reflections of social realities of a particular cultural group (Kitzinger, 1995). They can release forgotten experiences and inhibitions which may otherwise dampen participants disclosing further

information. I chose ethnography as the prominent methodology. This would allow me to delve into the real day-to-day issues both student paramedics and paramedics encounter.

I have provided further examples below, one depicting the raw data, the other diagrammatical representation of the data in graph format.

Raw date from my initial Rep Grid investigation.

Blank Grid (page 1)

Myself (the student I am)
. The mentor (PPED)
. . The crew staff
. . . The managers
. . . . My future (the paramedic I want to be)
. . . . . The professional image
. . . . . . The community of practice
. . . . The competent paramedic
. . . . The paramedic I fear to be
. . . . My peer group

Left construct	1	2	3	4	5	6	7	8	9	10	Right construct
Willing to learn and explore subject area	1	2	3	4	1	2	2	1	5	2	Unwilling to achieve
Willing to explain mistakes, enhance learning	1	1	2	3	1	1	2	2	5	2	Unapproachable
De-brief after incidents, engage with student	2	1	2	2	1	1	1	1	5	2	Unhelpful, not engaging with you
Willing to help, but firm. The ability to work with you, two way interaction	2	1	2	3	1	1	3	2	5	2	Inability to manage, superior attitude
Autonomous practitioners, utilising best evidence	3	3	2	3	1	1	1	3	3	2	Following guidelines, not challenging and not continuing with education
Having accountability to other health professionals and working in a team	3	2	3	2	2	1	1	5	5	5	Not able to increase and enhance their role (stagnate)
Must be able to work with other health professional	1	2	2	1	1	1	1	3	4	3	Poor communication with other health professionals
Recognising ones limitations	1	1	1	2	1	1	1	1	3	1	Not recognising ones limitations
Not enjoying the job, becoming 'blasé'	5	5	4	3	5	4	4	2	1	2	Developing ones knowledge and understanding
Degree educated, enhancing the paramedic profession	1	2	3	2	1	1	2	4	5	2	Various standards

Student 200
Constructs: 10   # Elements: 10.
Grid Type: Binary   Scale Range: 0.00 to   1.00.

Examples of the diagrammatical data from my initial Rep Grid investigation.

Profile Plot for Blank Grid

Student 300

Profile Plot for Blank Grid

Student 400
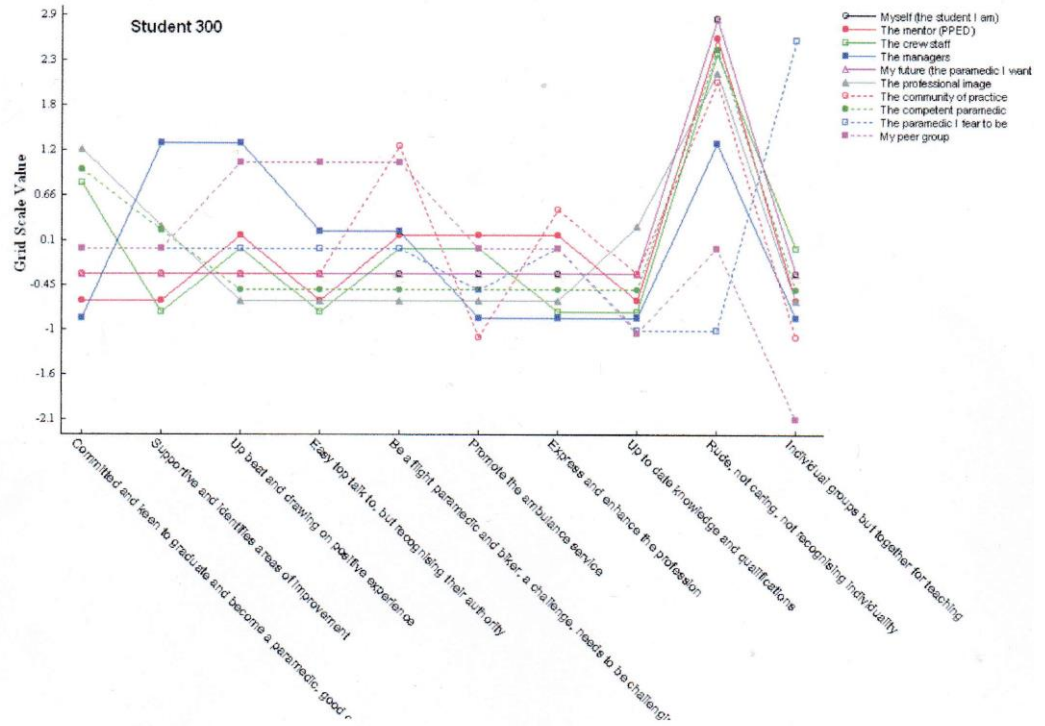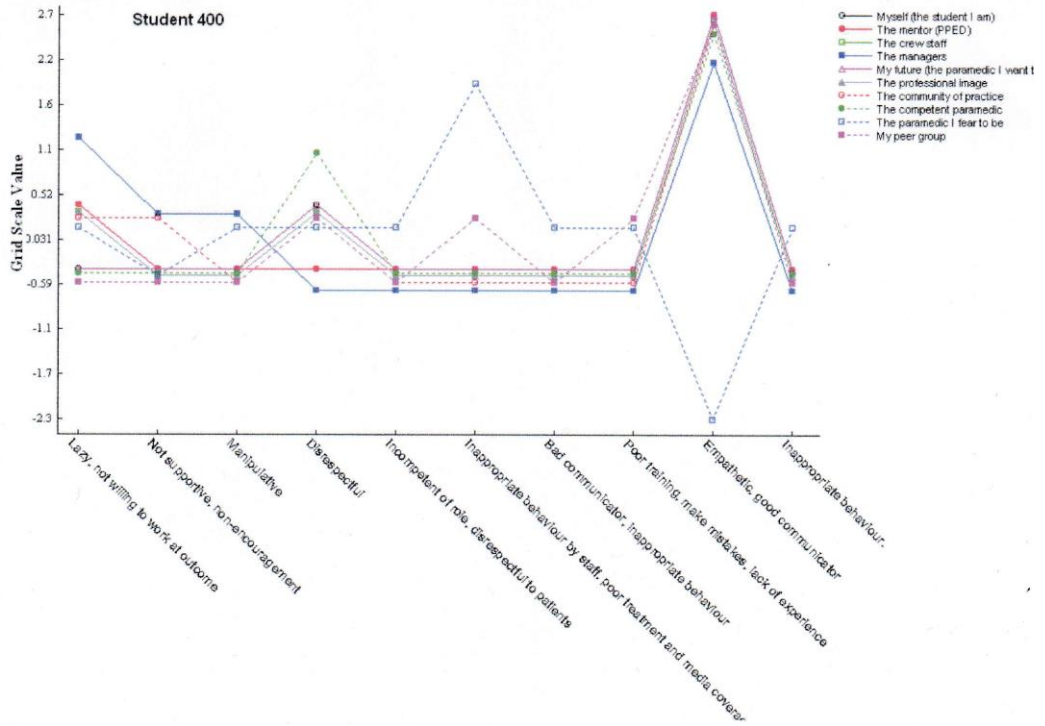
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Appendix C: Abridged version of information letter

Abridged Version of Information Letter

Dear Colleague

I would like to take invite you to participate in this small scale research as part of my Doctorate of Education (EdD).

All information will be confidential and will not be identifiable to anyone. The data gathered will be analysed, and although various trends and themes maybe identified, there will be no correlation with student identity. You will not be required to supply your name or any other form of identification.

This project has had ethical approval from the School of Education's Ethics Committee at the University of xxxxxxxx. Your participation in the project is purely voluntary and there is no commitment for you to participate in this work, you can withdraw from the process at any time.

I would like to take this opportunity to thank you for your assistance and support.

Yours sincerely

xxxxxxxxxxxxxx

EdD Research Student (1st year)

Appendix D: Consent letter
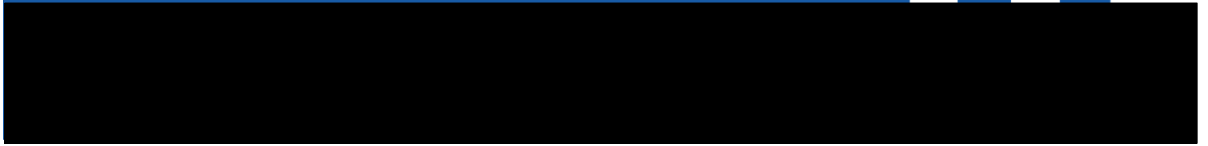
University of

xxxxxxxxx

Dear John Donaghy

This is to confirm that I have previously received information regarding this research exercise and have been fully informed as to the purpose and structure of the research. I am also aware that all information will be confidential and will not be identifiable to any one student.

The data gathered will be analysed, and although various trends and themes maybe identified, there will be no correlation with student identity. My name or any other form of identification will not be identifiable and will be anonymous. I also fully understand that I can withdraw from the process at anytime without reason or prejudice.

I give my full consent to participate in this exercise:

Name:..

Signature:..

Date:..

Appendix E: Examples of semi-structured interviews

1	**Questionnaire**
2	**Candidate No: 003 Date:15th July 2012... Stn:………**
3	**(Q) How have you found your sandwich year experience?**
4	(A) It started very good at September interested enjoyable, but as the year has gone on being set all over the place mean the job itself is okay and it has definitely been an experience, one that I have learnt many things from.
5	**(Q) What do you think of the 'X' Rota, has it influenced your experience?**
6	(A) Well, it was part of it was the be Rota, lots of nights, lates, ummm weekends few days off in between, you do like lo then a couple of days off then you start early again is not ideal, this should definitely be improved and would imp experience
7	(A)There is no separation between student paramedics from university and those from XXXXXXXX , there's no differen we (students) have to do much more, we have done all the theory and practice such as incubation so if we were paramedic we could do calculation and things like that but they look at you as a 2 and think ohh, so you are a 2 and so things.
8	**(Q) So, do you think that the crews look at you then decide what you can do?**
9	(A) as soon as you walk into the watch-room they look at you (crews) an
10	look what's on your shoulders, and think ohh, his only a two. This is something I have noticed over the last year or so to see who they are, what's on the shoulders before you really notice the or even noticed your patients if this team sent first you look at the shoulders it is how the ambulance service works.
11	**(Q) Generally, how have the more experienced 'paramedics' responded to you, and how have you found them. Any ma**
12	(A) Ummmm, one or two issues (a nervous laugh) at certain stations complexes not always the paramedics sometimes i ummmmm but as for XXXXXX XXXXXX ambulance station goes they always invite me out at social events that type of t generally okay. I think every station has problems, but I have now it more this year it's been more with the tec paramedics
13	**(Q) Do you use/read your textbooks in the watch room on station, if not why not?**
14	(A) I do, at XXXXXX XXXXXX ambulance station, a few weeks ago we got a break, and I got the JRCALC manual out and I up, ummmm I am happy to do this although I wouldn't feel happy doing this off complex. I wouldn't do it at certain sta definitely do it complex, yer.
15	**(Q)How do you perceive the management structure?**
16	(A) I found them okay personally, if I ever needed anything I would obviously go up and well you hear stories about ummmm but as I say I have always found them okay I've never had any problems with any of them team leaders main seen the ambulance operations manager (AOM). I've had a few jobs with duty station officers (DSO) and team leaders (been fine.
17	**(Q) Is there anything you want to tell me that would assist my research?**
18	(A) Well only that it has been an interesting year and I think by getting rid of the year is not a good thing I think you prepare yourself so it's going to be a shame to see it go. The five weeks PPED blocks were ideal. Sometimes we must wo because we are working with a lower grade or equal grade.
19	**(Q) what do you think of that?**
20	(A) personally, I don't mind although it is a little worrying because we still go to quite serious calls and patients and tha what you can and can't do skill wise you know. They (control) sent us to somebody in a lot of pain and was not sure if we or not, so we called the clinical support desk (CSB) and they said work within your skills limit that was not helpful.
21	**(Q) so, with blame, do you think there is a culture of blame within the ambulance service?**
22	(A) we had our introduction to the XXXX sector and they said if you leave somebody at home for example, and they have done everything correctly they will support you 100% and they stood by that the whole time, and then come ba people that the necessary new people the old school and they say don't believe that everyone has a go hospital can't home and they don't think you would be supported they say everyone needs to go to hospital or you'll get the sack if t

Appendix F: Ethics consent
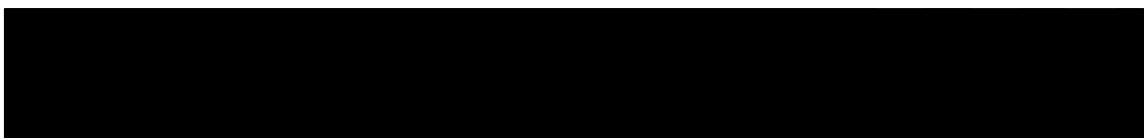
Appendix 3

CONSENT
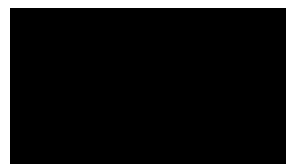
Centre Number: ▮
Study Number: ▮
Recipient Identification Number for this trial: ....

CONSENT FORM

Title of Project: The students' understanding of university paramedic education/training-from classroom learning to situational understanding

Name of Researcher: John Donaghy

Please initial Box

1	I confirm that I have read and understand the information sheet dated ▮ ▮or the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my studies/employment, or legal rights being affected.	☐
3	I understand that I may be audio recorded at times throughout the study and data collected during the study, will not be identified within the transcripts to any one individual. No patient/client information will be identifiable.	☐
4	I understand that this will require the researcher to 'shadow' me whilst on duty	☐
5	I agree to take part in the above study.	☐

Name of Recipient   Date   Signature

_____   _____   _____

Name of Person taking consent   Date   Signature
(if different from researcher)

_____ _____   _____ _____
Researcher   Date   Signature

Research

Do you want to assist in the future development of your profession, if yes why not think about how you maybe able to influence this.

You maybe aware that there is a piece of research about to take place, which may ultimately, benefit the paramedic profession and paramedics.

What will it involve?

The research will be undertaken at the ▮▮▮▮▮▮▮▮▮▮▮▮▮ and will comprise of the researcher ridding out as a fourth person on the ambulance with you for 4 x12 hour shifts, over a period of three to four months. The researcher is very familiar with the ambulance service and attending calls.

How can I get involved?

The Chief/Principal Investigator (CI/PI) will be visiting the complex shortly with additional information and guidance as to getting involved, alternatively, if you would like to contact the CI/PI you can do so on the contact details below.

Appendix H: Participant information sheet

[BLACK REDACTED AREA]

Participant's information sheet:

The student experience of university paramedic education/training - from classroom learning to situational understanding.

You are being invited to take part in a research study. Before you decide whether to take part or not it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss with others if you wish. Ask the principal researcher anything that is not clear or if you would like further information.

What is the purpose of the study?
To explore the professional and working relationship between both experienced traditional ambulance staff with that of newly qualified paramedics and those undertaking higher educational studies as student paramedics.

Why have I been asked to take part?
You are being asked to take part as either a qualified experienced Paramedic registered with the Health Professions Council (HPC), a newly qualified Paramedic registered with the HPC or a Student Paramedic undertaking either a Foundation Degree or Bachelor of Science Degree. As such, you would have undoubtedly have had to work with either one or all these groups of ambulance staff.

Do I have to take part?
It is up to you to decide whether or not to take part in the study. If you decide to take part, you are still free to withdraw at anytime and without giving a reason. A decision to withdraw at any time or a decision not to take part, can be taken without fear of any reprisals.

What will happen to me if I take part?
Your views and experience of working with a number of different people within your day-to-day working environment will be explored using observations [REDACTED] in addition to a semi-structured interview, either at mid point and conclusion of the study, or just at the conclusion of the study.

If you would like to take part in this study, you will need to confirm to the Chief/Principal Investigator (CI/PI) that this is your wish. Once this has been confirmed, you will see the CI/PI on the station complex from time to time speaking to various members of staff including yourself. The CI/PI may ask you some questions and have some informal discussions about your role within the ambulance service and your experiences working with various people. In addition, you may see the CI/PI making notes of activities that maybe observed whilst on station complex. Some of the conversations the CI/PI has with you maybe audio recorded. If so, your individual permission will be sought each time, prior to this activity being carried out.

Will my expenses be met for taking part?
It is envisaged that any research undertaken with you will be conducted whilst you are undertaking your normal duties.

[BLACK REDACTED AREA]

234

What are the possible disadvantages of taking part?

The CI/PI and research supervisors cannot think of any disadvantages of taking part in this study. It would be very useful to the CI/PI and the paramedic profession, to get your views and hear of your experiences working with various people within the ambulance service.

What are the possible benefits from taking part?

It is hoped that the findings from the research will inform and benefit both the current and future educational models of paramedic education and the paramedic profession.

What if something goes wrong?

If you have a complaint about how you feel you have been treated ███████████████████ y or how any aspect of it was carried out, this will be addressed within the ███████████████ policies and procedures.

Will my taking part in this study be kept confidential?

All information collected from you during the course of this research will be kept strictly confidential. The information you provide will be made anonymous by removing any personal details from any documentation, so that you cannot be recognised from it. All data will be secured in a locked filling cabinet and on password protected computer.

What will happen to the results of the study?

The results of the research will be published in a dissertation and in academic papers and pr███████████ If you would like a copy of the dissertation this can be obtained once finalised from the University of ██████

Who is organising and funding the research?

███
███

Who has reviewed the study?

The study has been reviewed by [Name] NHS Research Ethics Committee.

Contact for further information:

John Donaghy, Principal Researcher

Appendix I: Sample of my raw field-notes.

MUCH DEBATE BETWEEN BEN & DAVE WHO THOUGHT CREW WERE DISCRIMINATED AGAINST IF THEY HAD A GENERINE ILLNESS.

THERE CERTAINLY IS HIGHER STANDING OF THE EXPERIENCED CREW'S, AT HOSPITALS CREW ARE OFTEN SPOKEN OFF AS BEING EXPERIENCED, OFTEN TALKING ABOUT VARIOUS CALLS THAT THEY HAVE UNDERTAKEN DURING THEIR TIME ON THE AMBULANCE SERVICE.

I NOTICE THAT BEN LOOKS AT DAVE WITH SOME TREPIDATION AS HE HAS BECOME KNOWN AS C9, C9 THE CLOWN OR DANGEROUS DAVE! ALTHOUGH IT APPEARS THAT DAVE DOESN'T STOP TALKING.

PILOT

1ST SHIFT, ALAN HACK 12-02-12 & AMY COLMAN 19-00 TO 07-00 13 STN

MY FIRST RESEARCH OBSERVATION NIGHT SHIFT, I SIT IN THE WATCH ROOM WAITING, APPREHENSIVE OF MY FIRST OBSERVATIONAL SHIFT.

THE SHIFT CONSTITUTES OF 18-30 START TO 06-30 THE FOLLOWING DAY I SIT AND REFLECT HOW LONG AGO IT WAS I UNDERTOOK A 12th NIGHT SHIFT WITH THE AMBULANCE SERVICE.

MY CREW SHOULD CONSIST OF A 2nd YEAR FOUNDATION DEGREE STUDENT & AN EXPERIENCED PARAMEDIC WHOME I HAVE KNOWN FOR SOME CONSIDERABLE TIME AS A WORK COLLEAGUE BUT NOT IN MY CAPACITY AS RESEARCHER.

(4)

MY OTHER GENERAL OBSERVATION IS THAT MANY STUDENTS & NEW PARAMEDICS DO NOT SEE THE AMBULANCE SERVICE AS A CAREER, MANY BELIVE THEY WILL DO A FEW YEAR (3-5) THEN MOVE ON, NONE OF THEM THAT I SPOKE WITH HAD A CAREER PLAN, RATHER SAW IT AS A WAY OF MAYBE MOVING TO ANOTHER SERVICE OR MAYBE GOING TO MEDICAL SCHOOL, OR SOMETHING ELES, NON OF THE PEOPLE I SPOKE WITH SAW THEMSELVES STAYING IN LONDON, AND OFTEN REFERED TO EITHER THE "B" RELIFE ROTA, OR POOR CONDITIONS AND MANAGEMENT A THERE AS BEING

(5)

WHEN I WAS ON EDMONTON STATION, I WAS TAKEN BACK BY THE ~~GENERAL~~ "FLIPANT" CONVERSATION THAT WAS OCCURING ON STATION, THEY HAD NO IDEA WHO I WAS YET CONTINUED WITH THE SOMETIMES RACIST, & ABUSIVE CONVERSATION, I THOUGHT THIS WAS A THING OF THE PAST YET WAS STILL VERY PROMINANT ALTHOUGH THE INEXPERIENCE AND STUDENT PARAMEDICS APPEAR TO HAVE TO GO ALONG WITH THE "BANTER" TO BE ACEPTED. I WONDER, WHAT ABOUT IF I HAD BEEN A SENIOR MEMBER OF THE MANAGEMENT TEAM, THEY WOULDN'T HAVE KNOWN IF I WERE OR NOT.

OBSERVATIONS FROM OTHER AREAS

(1)

WHILST THE CHIEF EXECUTIVE WAS ADDRESSING ALL STUDENT AT UNIVERSITY, AS HE DOES EVERY YEAR, HE TOUCHED UPON THE SERIOUS NATURE OF SENSITIVE PEICES OF EQUIPMENT BEING VANDALISED BY CREWS, CLEARLY THIS IS A SERIOUS OFFANCE AND ONE WHICH HE TAKES EXTREMELY SERIOUSLY, ONCE IT WAS INTRODUCED ALONG WITH PHOTOS OF THE DAMAGE ON POWER POINT, A SMALL NUMBER OF STUDENT IN THE AUDIENCE FELT IT WAS FUNNEY AND LAUGHED, CLEARLY THE CHIEF EXECUTIVE WAS NOT IMPRESSED WITH THIS RESPONSE.

(2)

WHILST TEACHING OUR 2ND YEAR STUDENT I APPROACHED THE SUBJECT OF THE HAZARDOUS AREA RESPONSE TEAM (HART) THIS IS A SPECALIST TEAM WHICH DEALS WITH CHEMICAL INCIDENT AND OTHER SUCH INCIDENT. THE MAJORITY OF THE CLASS HAD AN IMPRESSION OF THESE TEAM AS BEING LAZEY, AND A WASTE OF TIME, OFTEN THE VIEWS AND THOUGHTS OF REGULAR CREWS.

PERSONAL REFLECTION

I wonder what was happening here, with Jennifer & the experienced crews. As I reflect on my initial observations I am kind of wondering if I am missing something!

I will explain further on the next shift.

I think to myself how nice it is to see students out here, working, showing empathy and care to there patients, but I can't help to think about the socialisation into this very busy service, where they have to plan there shift to survive.

My student (009) I believe is generally a quite and introvert student anyway, and it will be interesting to see how she deals with other more experienced crews. I have three more shifts with Jennifer (009) so I will be interested to observe the next few shifts. Our last call seem to be sufficient to get us finished on time, so all happy.

PERSONAL REFLECTION

I had to understand if and how students separate their social "uni" life with the strict, authoritarian structure of the ambulance station.

Interestingly a reference was made of smoking an illicit substance, and implied that this is something everyone does (student)

This was indeed a busy shift, which saw no time to take a break, or have a standdown, the crew and I were out from station from 18-30 to 06-30.

Throughout this time my observations were such that I believe the student had settled into the practice environment, she often looked to her colleague for reassurance, I suspect this is normal, although I felt the student wouldn't challenge

Appendix K: Sample of MAXQDA managed data

Sample of my data into MAXQDA data management software

NET 2016 Conference 6th - 8th September 2016 Cambridge, UK:

Education in clinical practice and practice development 1
In the Club room

Group 2

Convenor: Jan Draper, Professor of Nursing, The Open University, UK

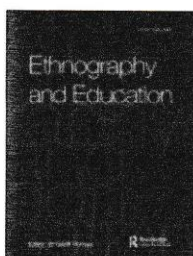| Wednesday 7 September 2016	
10.55	Welcome and introduction to theme session
	Core presenter
11.10 G2ECP1-C1	*Supporting healthcare students to raise concerns with the quality of care: Applying the findings of a systematic literature review*
	Frank Milligan, Senior Lecturer in Patient Safety; **Mark Wareing**, Director of Practice Learning, University of Bedfordshire, UK
	Theme presenters
11.55 G2ECP1-T1	*Shaping professional development for registered nurses in aged residential care*
	Molly Page, Lecturer; **Leanne Pool**, Lecturer; **Shelly Crick**, Lecturer, Whitireia New Zealand, Porirua, New Zealand
12.25 G2ECP1-T2 First-time presenter	*The impact of introducing clinical skills drop-in sessions for first year student nurses on placement in the Whittington Trust*
	Alison Dexter, Professional Development Nurse for Student Nurses, Whittington Hospital; Georgina Cox, Senior Lecturer Adult Health, Middlesex University, UK
12.50	Lunch break
13.50 G2ECP1-T3	*Developing a standardised evaluation survey: Challenges in undertaking evaluative research in practice*
	Kath Sharples, Nurse Manager Clinical Practice and Innovation; **Kim Da Silva**, Nurse Educator; **Carrie Alvaro**, Nurse Educator, Western Sydney Local Health District, Australia
14.20 G2ECP1-T4	*Made in my image: A grounded theory of the work of supervising mentors as they support student mentors in practice*
	Claire McGuinness, Lecturer; **Kay Currie**, Reader in Applied Health Research and Assistant Head of Department (Research); **Nicola Andrew**, Senior Lecturer, Glasgow Caledonian University, UK
14.50 G2ECP1-T5	*The student experience of university paramedic education and training: From classroom learning to situational understanding*
	John Donaghy, ▮▮▮▮▮▮▮▮
15.15	Refreshment break
15.40 G2ECP1-T6	*Barriers and facilitators to implementing a communication skills model in practice: Bridging the theory practice gap*
	Jane Griffiths, Senior Lecturer; **Lucie Byrne-Davis**, Lecturer; **Gunn Grande**, Professor; **Nicky Lamb**, Clinical Educator, St James' Hospital, Leeds, UK
16.05	Discussion time
16.25	Close of session

Qualitative Methods Conference 3rd - 5th May 2016, Glasgow:

Qualitative Methods Conference 3rd - 5th May 2016, Glasgow. Conference Presentations:

QM Oral Presentation Schedule - Tuesday, May 3, 2016

Session A4: Data Collection — 11:15 am - 1:00 pm

Room: Clyde			Session Chair: Amanda Kenny
11:15 am - 11:45 am	i	Can you tell me about...? The pros and cons of telephone interviews and Leximancer analysis for experiential data collected with people living with severe mental illness	Victoria Palmer, Kali Godbee, Wayne Weavell, Rosemary Callander, Jane Gunn
11:50 am - 12:20 pm	ii	The 'absent' researcher: reflections on using real-time observational methods to explore young peoples' online behaviours	Susan Martin, Lisa McDaid, Shona Hilton
12:25 pm - 12:55 pm	iii	A Queer Critical Approach to Exploring Trans* Male Identity Construction Using Mixed Qualitative Methods Research	Andre Grace, Michel L'vesque

Session A5: Identity: Who are we? — 11:15 am - 1:00 pm

Room: Dee			Session Chair: Mary Butler
11:15 am - 11:45 am	i	Re-discovering the power of participant observation: Walking the Talk	Mary Butler
11:50 am - 12:20 pm	ii	The evolution of self in the presence of illness and injury: using narrative inquiry to facilitate our understanding	Charlotte Whiffin
12:25 pm - 12:55 pm	iii	An exploration of the student paramedic experience of cultural integration-from University classroom learning, to a contrasting ambulance service culture and subsequent relationship of insider/outsider researcher	John Donaghy

Session A6: Longitudinal Research — 11:15 am - 1:00 pm

Room: Don			Session Chair: Virginia Dickson-Swift
11:15 am - 11:45 am	i	It makes me feel humble': exploring the potential value of applying social network research to longitudinal qualitative research	Fiona Dobbie, Gerda Reith, Susan McConville
11:50 am - 12:20 pm	ii	Exploring Service Innovation Practices through a Longitudinal Ethnographic Case Study	Vessela Warren
12:25 pm - 12:55 pm	iii	Thinking collaboratively over time: collaboration in, and across, qualitative longitudinal research practice	Emma Davidson, Susie Weller

Session A7: IPA — 11:15 am - 1:00 pm

Room: Ballroom 1 & 2			Session Chair: Aileen Grant
11:15 am - 11:45 am	i	Perceptions of Personhood and the Early Onset Dementia Experience: I'm Still Here	Mariko Sakamoto
11:50 am - 12:20 pm	ii	Interpretive phenomenology in research on knowledge sharing among global business leaders: collaboration or conflict?	Gill Maxwell, P. Lang
12:25 pm - 12:55 pm	iii	Perception of physical ageing: An interpretative phenomenological analysis study exploring the views of older adults	Carol Duguid

23

The Oxford Ethnography Conference: a place in history?

Geoffrey Walford

School of Education seminar series

Tuesday 21ˢᵗ January
4.30 – 5.30

John Donaghy
Anglia Ruskin University

The Hidden Curriculum of the Workplace

An ethnography to understand how and why University paramedic students become enculturated into the workplace

The study examines how student paramedics became drawn into a very different culture from th[e]

formed at university, as students became exposed to the working environment of the ambulan[ce]

service. Associated concepts of culture, subculture, curriculum and pedagogy, are examined [in]

order to shed light on the processes and experiences which faced neophyte paramedics in th[e]

clinical placements. Literature to help understand the two environments, comprising of a form[al]

structured paramedic university setting, with an opposing, busy, unpredictable and often chaot[ic]

working environment, provides context for this research.

The discussion will set out to provide an understanding for the study of enculturation as it appli[es]

to a particular group of paramedics' socialisation into the reality of the workplace culture [of]

becoming paramedics. Both the formal and informal/hidden curriculum maybe intens[ely]

problematic in that it can both influences and impede paramedic pedagogy.

All staff and students welcome
Please do join us; we look forward to seeing you there.

EXPERT

PROFICIENT

COMPETENT

BEGINNER

NOVICE

Has intuitive grasp of t[h]e situation and zeros in [o]n the accurate region o[f] the problem

Perceives situations as wholes, rather than in terms of aspects

Begins to understand actions in terms of long-range goals

Can note recurrent meaningful situational components, but not prioritize between them

Has no professional experience

Dr. Patricia Benner is a nursing theorist who first developed a model for the stages of clinical competence in her classic book "From Novice to Expert: Excellence and Power in Clinical Nursing Practice". Her model is one of the most useful frameworks for assessing nurses' needs at different stages of professional growth. This nursing theory proposes that expert nurses develop skills and understanding of patient care over time through a proper educational background as well as a multitude of experiences. Dr. Benner's theory is not focused on how to be a nurse, rather on how nurses acquire nursing knowledge – one could gain knowledge and skills ("knowing how"), without ever learning the theory ("knowing that"). She used the Dreyfus Model of Skill Acquisition as a foundation for her work. The Dreyfus model, described by brothers Stuart and Hubert Dreyfus, is a model based on observations of chess players, Air Force pilots, army commanders and tank drivers. The Dreyfus brothers believed learning was experiential (learning through experience) as well as situation-based, and that a student had to pass through five very distinct stages in learning, from novice to expert.

Extract taken from: Nursing Theory 2020.

https://nursing-theory.org/theories-and-models/from-novice-to-expert.php

Appendix N: Sample of field data

Date	Data Collection Method	Participant numbers	Fieldnote Duration	Interview Duration	Pseudonyms Student	Pseudonyms Newly Qualified Paramedic (NQP)	Pseudonyms Experienced Paramedic	Other, such as Police, Fire, Nurse etc.	Context, such as ambulance, on-scene, ambulance station etc.	Pilot Study	Bibliography
04/03/2013	Interview	2	0	15min	Claire				University	Yes	A 3rd year BSc Hons students + 150 hours clinical experience
04/03/2013	Interview	2	0	10min	Gill				University	Yes	A 3rd year BSc Hons students + 150 hours clinical experience
22/04/2013	Interview	1	0	20min	Jennie				University	Yes	A 2nd year BSc Hons student + 70 hours clinical experience
12/06/2013	Fieldnotes	1	8hrs		James				Amb Stn	No	A 1st year BSc Hons student + 20 hours clinical experience
14/01/2013	Fieldnotes & Interviews	1	12hrs	15min	Ben				Ambulance	No	A 3rd year BSc Hons students + 150 hours clinical experience
05/05/2013	Fieldnotes	2	12hrs		Julie				On-Scene	No	A 2nd year BSc Hons student + 70 hours clinical experience
05/05/2013							Joe				An experienced Paramedic with 21 years operational experience
13/04/2013	Fieldnotes	1	10hrs			Julian			Hospital	No	A NQP with 2 years operational experience
03/10/2013	Interview	1		30min	Lee				Ambulance	Yes	A 1st year part-time Foundation degree student who is employed by the ambulance s...
08/01/2013	Interview	1		20min	Tom				Amb Stun	Yes	A 1st year BSc Hons student + 20 hours clinical experience
10/01/2013	Fieldnotes	1	8hrs				Tony		Ambulance	Yes	An experienced Paramedic with 11 years operational experience
05/06/2014	Fieldnotes	2	12hrs		Charles				Ambulance	No	A 2nd year BSc Hons student + 70 hours clinical experience
05/06/2014							Jim				An experienced paramedic with around 13 years ambulance service
18/07/2013	Fieldnotes	2	12hrs		Tony				Amb Stun	No	A 2nd year part-time Foundation degree student who is employed by the ambulance...
18/07/2013							Robert				An experienced paramedic with 5 years ambulance service
18/08/2013	Fieldnotes	2	12hrs			Jim			Ambulance	No	A NQP with 18 months operational experience
18/08/2013					Alan						A 1st year BSc Hons student + 20 hours clinical experience
01/04/2014	Fieldnotes	2	12hrs		James				Ambulance	No	A 2nd year part-time Foundation degree student who is employed by the ambulance...
01/04/2014						Bruce					A NQP from Australia with just over 12 months employment with the ambulance serv...
12/04/2013	Fieldnotes & Interviews		10hrs	40min	Tony				Hospital	No	A 3rd year BSc Hons students + 150 hours clinical experience
12/04/2013							Jim				Known as Dangerous Jim. trained through the traditional IHCD routes to Paramedic...
05/09/2014	Fieldnotes	1	8hrs		Liz				Ambulance	No	A 1st year BSc Hons student + 20 hours clinical experience
13/07/2013	Fieldnotes & Interviews	2	12hrs	10min					Ambulance	No	A 3rd year BSc Hons students + 150 hours clinical experience
13/07/2013							Bill				An experienced Emergency Medical Technician (EMT) with over 27 years ambulan...
21/06/2013	Fieldnotes	2	12hrs		Chris				On-scene	No	A 2nd year BSc Hons student + 70 hours clinical experience
21/06/2013							Jim				An experienced paramedic with 8 years ambulance service
18/05/2013	Fieldnotes & Interviews	1	12hrs	30min					Ambulance	No	A 3rd year BSc Hons students + 150 hours clinical experience
12/04/2013	Fieldnotes	N/A	10hrs							Yes	Myself as researcher with over 35 years experience as a paramedic
12/04/2013	Fieldnotes	1	N/A					Eric	On-scene	Yes	Not sure about this paramedics length of service
08/06/2014	Fieldnotes & Interviews	2	12hrs	25min	Amy				Amb Stn	No	A 2nd year BSc Hons student + 70 hours clinical experience
08/06/2014							Tina				An experienced paramedic
12/03/2013	Fieldnotes	3	12hrs		Janet				Amb Stn	No	A 1st year BSc Hons student + 8 hours clinical experience
12/03/2013						Asher					A NQP with 1 year of operational experience
12/03/2013							Tom				An experienced paramedic with 18 years ambulance service experience and union...
13/05/2014	Fieldnotes	1	10hrs		Sarah				Amb Stn	No	A 2nd year BSc Hons student + 70 hours clinical experience
14/05/2014	Fieldnotes	2	12hrs		Harry				Ambulance	No	A 2nd year BSc Hons student + 70 hours clinical experience
14/05/2014							Dave				An experienced paramedic with 3 years ambulance service
05/11/2013	Fieldnotes	N/A	8hrs				Steve		Amb Stn	No	An experienced paramedic with around 20 years ambulance service
11/10/2013	Fieldnotes & Interviews	2	12hrs	10min	Paul				Ambulance	No	A 1st year part-time Foundation degree student who is employed by the ambulance s...
11/10/2013						Amber					A NQP with 2 years of operational experience
09/05/2014	Fieldnotes	2	12hrs				Sharon		Ambulance	No	An experienced paramedic with around 5 years ambulance service experience
09/05/2014					Julie						A 1st year BSc Hons student + 20 hours clinical experience
21/09/2014	Interviews	2	10hrs	60min		Ben			Hospital	No	A NQP with 2 years of operational experience
21/09/2014						Joe					A 3rd year BSc Hons students + 150 hours clinical experience
05/02/2014	Fieldnotes	3	12hrs		Julie				On-Scene	No	A 3rd year BSc Hons students + 150 hours clinical experience
05/02/2014							Lisa				An experienced paramedic with around 6-7 years ambulance service experience
05/02/2014								Firefighter			Firefighter engaging in conversation/argument
22/09/2014	Fieldnotes	N/A							University	No	I witnessed students returning to university after becoming 'street wise'
12/12/2013	Fieldnotes	2	12hrs		Billy				On-Scene	No	A 3rd year BSc Hons students + 150 hours clinical experience
12/12/2013							Jimmy				An experienced paramedic
12/04/2013	Fieldnotes	2	10hrs		Brian				On-Scene	No	A 3rd year BSc Hons students + 150 hours clinical experience
12/04/2013							Charles				Experienced paramedic mentor
10/03/2013	Fieldnotes	N/A	8hrs						Amb Stn	No	A general conversation between students and their practice placement experience
12/05/2014	Fieldnotes	1					Len		Ambulance	No	An experienced paramedic with many years operational experience.
22/10/2013	Fieldnotes & Interviews	1	12hrs	40min	Tim				Hospital	No	A 2nd year part-time Foundation degree student who is employed by the ambulance...
12/08/2013	Fieldnotes & Interviews	2	12hrs	20min	Terry				Hospital	No	A 1st year BSc Hons student + 20 hours clinical experience
12/08/2013				10min		Charlotte					A NQP with around 18 months of operational experience
18/08/2013	Fieldnotes	2	12hrs				Ricky		Hospital	No	An experienced paramedic with around 10 years ambulance service experience
18/08/2013					Tracey						A 2nd year part-time Foundation degree student who is employed by the ambulance...
25/05/2013	Fieldnotes	N/A								No	I was surprised to see that crews were reluctant to take their meal breaks
23/06/2014	Fieldnotes & Interviews	2	10hrs		Tim				Ambulance	No	A 1st year part-time Foundation degree student who is employed by the ambulance...
23/06/2014						Mike					A NQP with around 9 months of operational experience
27/06/2014	Fieldnotes	2	12hrs						Ambulance	No	An experienced paramedic and 2nd year student
18/06/2013	Fieldnotes	2	10hrs		Jim				Ambulance	No	A 3rd year BSc Hons students + 150 hours clinical experience
18/06/2013							Bill				An experienced paramedic with 11 years ambulance service experience
20/08/2013	Fieldnotes	2	12hrs		Jane				Ambulance	No	A 1st year BSc Hons student + 20 hours clinical experience
20/08/2013							Mark				A comparatively new paramedic training via the traditional IHCD training route
25/02/2013	Fieldnotes	2	12hrs		Peter				On-Scene	No	A 2nd year part-time Foundation degree student who is employed by the ambulance...
25/02/2013							Paul				An experienced paramedic with over 28 years ambulance service experience
08/05/2013	Fieldnotes	2	12hrs				Tim		Ambulance	No	An experienced paramedic
08/05/2013					Caroline						A 1st year BSc Hons student + 20 hours clinical experience
10/03/2013	Fieldnotes & Interviews	2	12hrs	55min	Tom				Hospital	No	A 1st year part-time Foundation degree student who is employed by the ambulance...
10/03/2013						Sonia					A NQP with around 18 months of operational experience
25/05/2013	Fieldnotes	2	10hrs				Pat		Amb Stn	No	An experienced paramedic with a reputation of being despondent and negative
25/05/2013					Mark						A 2nd year BSc Hons student + 70 hours clinical experience
02/05/2013	Fieldnotes & Interviews	2	6hrs	30min		Mick			Hospital	No	A NQP with 2 years operational experience
02/05/2013					Andy						A 2nd year BSc Hons student + 70 hours clinical experience
14/04/2014	Fieldnotes & Interviews	1	10hrs	20min	Sam				Amb Stn	No	A 3rd year BSc Hons students + 150 hours clinical experience
13/05/2013	Interview	1	8hrs	90min	William				On-Scene	No	A 3rd year BSc Hons students + 150 hours clinical experience
06/04/2013	Fieldnotes	2	12hrs						Amb Stn	No	A foundation degree student and experienced paramedic
12/04/2013	Fieldnotes	2	8hrs		Rees				Amb Stn	No	A 1st year BSc Hons student + 20 hours clinical experience
12/04/2013						Nigel					A NQP with nearly 2 years operational experience
12/07/2014	Fieldnotes & Interviews	1	12hrs	45min	Jim				Ambulance	No	A 3rd year BSc Hons students + 150 hours clinical experience in final stage of his de...
05/12/2014	Fieldnotes	3	12hrs		Sophia				Hospital	No	A 2nd year part-time Foundation degree student who is employed by the ambulance...
05/12/2014							Leigh				An experienced paramedic and union representative
05/12/2014								Amb Officer			Experienced ambulance duty officer (responsible for the operations in a specific are...
23/04/2014	Fieldnotes	2	12hrs		John				On-Scene	No	A 1st year BSc Hons student + 20 hours clinical experience
23/04/2014							Tim				An experienced paramedic with over 28 years ambulance service experience
12/04/2013	Fieldnotes	2	12hrs		Thomas				On-Scene	No	A 1st year part-time Foundation degree student who is employed by the ambulance...
12/04/2013						Rachel					A NQP with 2 years operational experience (was previously a university paramedic s...
14/11/2014	Fieldnotes	2	10hrs		Tony				On-Scene	No	A 2nd year BSc Hons student + 70 hours clinical experience
14/11/2014							Ashley				An experienced paramedic and Mentor
19/03/2013	Fieldnotes	1	12hrs		Jennie				Amb Stn	No	A 2nd year BSc Hons student + 70 hours clinical experience
11/08/2014	Fieldnotes		8hrs						Hospital	No	A number of paramedic students recapping on their practice experiences to each o...
07/12/2014	Fieldnotes				Ann				Ambulance	No	A 1st year BSc Hons student + 20 hours clinical experience
07/12/2014							Richard				An experienced paramedic with over 20 years ambulance service experience
03/08/2014	Fieldnotes	2	12hrs		Justin				Ambulance	No	A 1st year part-time Foundation degree student who is employed by the ambulance...
03/08/2014						Burt					A NQP Australian paramedic with around 15 months of operational experience
22/09/2014	Fieldnotes & Interviews	1	6hrs	30min	Grant				Hospital	No	A 1st year BSc Hons student + 20 hours clinical experience
12/10/2013	Fieldnotes	2	12hrs			Roy			On-Scene	No	A NQP with just over 1 years experience
12/10/2013					Rebecca						A 2nd year BSc Hons student + 70 hours clinical experience
11/05/2014	Fieldnotes	N/A	10hrs						On-Scene	No	I noted that crews would often often act with authority. This was both paramedics an...