How are paramedic student notions of ‘self-identity’ formed/negotiated as part of the enculturation process within professional clinical practice?

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How are paramedic student notions of ‘self-identity’ formed/negotiated as part of the enculturation process within professional clinical practice?

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It is normal here to say that I am also grateful for the support of my wife Jane and our children, Lauren, and James – about how they demonstrated patience in sacrificing time with me and did not get too offended when I became distracted by the whole doctorate thing.... However, I do have a special reason to mention them.

On the 15th of January 2020 I was found collapsed and unconscious at home by my son who was just about to leave for school. He saved my life by placing me in the recovery position (my airway was partially blocked) and calling an ambulance. I was rushed to hospital where it was discovered that I was suffering from a sub-arachnoid brain haemorrhage secondary to an aneurysm. Thanks to Jane’s ‘show-down’ with the consultant in charge of my initial care, and her insistence that I be conveyed immediately for surgery (rather than being delayed to the following day) my life was saved for the second time in one day. Just prior to surgery I began to deteriorate, and it is not believed that I would have lasted much longer – certainly not until the following day. After being in a coma on ITU for a week and a period of rehabilitation on a Neuro ward I began to make a painstaking return to normal functioning. During all of this time my family never left my side. I know that without their love, support, quick-thinking, and perseverance I would not be alive, never mind able to complete this project.

I am sorry for the emotional trauma I put you all through last year. When you needed me the most, I couldn’t help.

## Abstract

This study explores how undergraduate paramedic students at one UK University develop and/or negotiate their sense of professional identity within the emergency pre-hospital workplace.

A subjective ontology with a qualitative interpretive methodology has been adopted which encompasses some of the theories of seminal phenomenologist Martin Heidegger. This includes the concept of ‘Dasein’ and the temporal nature of an individual’s sense of ‘self’. Twelve university paramedic students were recruited via non-probability purposive sampling, and face-to-face semi-structured interviews undertaken. Data analysis follows the Miles and Huberman (1994) model, with initial descriptive codes being followed by more inferential pattern codes. A-priori codes were based upon an exploration of the literature, with additional codes arising inductively from the data.

Key findings include the possible presence of a ‘hidden curriculum’ which may be detrimental to the preparedness of students for the workplace. Students are also likely to be drawn towards the cultural values synonymous with the pre-hospital workplace and are more likely to thrive if they have sponsorship from established staff. When experiencing stress, they are likely to seek solace with ambulance staff and their peers rather than external others. Social media messaging platforms also seem to be ubiquitously used for accessing peer support. There are suggestions of positive cultural change in relation ambulance staff and students who are female or who have BME backgrounds.

Recommendations incorporate the need to better prepare students for learning within the pre-hospital workplace. This includes investigating the presence/impact of a ‘hidden curriculum’, acknowledging that their supernumerary status may affect perceptions of inclusion, being flexible in relation to how and where students undertake clinical learning, and providing guidance on how best to ensure equality of inclusion within informal support networks. Paramedic education providers, policymakers and employers could also explore the implementation of a Reverse Mentoring programme for paramedic students from BME backgrounds.

## List of tables

Table 1: Key social theorists; their cited work, and location within this review…………11

Table 2: WRES 2020 data for BME clinical staff…………………………………………..50

Table 3: Houston’s (2015, p.252) ‘social domains’…….………………………………….65

Table 4: Sampling plan……………………………………………………………………….80

Table 5. Final sample…………………………………………………………………………82

Table 6. Participant attributes………………………………………………………………..82

Table 7. Superordinate themes and subordinate sections……..…………………………97

Table 8. Participant pseudonyms and other details……………………………………….98

Table 9. Chapter topics areas………………………………………………………………149

Table 10. Concluding review and summarised content…….……………………………183

Table 11. Areas of originality and details of contribution………………………………...191

## List of figures

Figure 1: Critical review structure with sub-ordinate areas………………………………..12

Figure 2: Heidegger’s (1927) underpinning ‘Care’ structure………………………………93

Contents

[Acknowledgements iii](#_Toc96587932)

[Abstract iv](#_Toc96587933)

[List of tables vi](#_Toc96587934)

[List of figures vii](#_Toc96587935)

[CHAPTER 1 1](#_Toc96587936)

[Introduction 2](#_Toc96587937)

[Overview 2](#_Toc96587938)

[The overarching research question and objectives 2](#_Toc96587939)

[Personal and Professional context and rationale 4](#_Toc96587940)

[University and employer policy context 7](#_Toc96587941)

[CHAPTER 2 9](#_Toc96587942)

[Critical review of the literature 10](#_Toc96587943)

[Approach to the review 10](#_Toc96587944)

[An exploration of social theory: The Structural Field of Practice 14](#_Toc96587945)

[i. Workplace and cultural environment 17](#_Toc96587946)

[ii. ‘Blue-collar professionalism’ 20](#_Toc96587947)

[iii. Attitudes towards university students 23](#_Toc96587948)

[iv. Workplace socialisation and ‘community’ affiliation 27](#_Toc96587949)

[v. Support from peers 31](#_Toc96587950)

[vi. Use of humour and ‘Banter’ 34](#_Toc96587951)

[vii. The influence of the university 36](#_Toc96587952)

[Individual passive influences 38](#_Toc96587953)

[i. Socio-economic background and habitus in the pre-hospital workplace 40](#_Toc96587954)

[ii. Pre-conceptions and personality 42](#_Toc96587955)

[iii. Age and life experience 45](#_Toc96587956)

[iv. Gender 47](#_Toc96587957)

[v. Ethnicity 48](#_Toc96587958)

[Individual agency 51](#_Toc96587959)

[i. Experiential learning 51](#_Toc96587960)

[ii. Choosing who and what to emulate 53](#_Toc96587961)

[Chapter summary 54](#_Toc96587962)

[CHAPTER 3 56](#_Toc96587963)

[Research methodology and design 57](#_Toc96587964)

[Overview 57](#_Toc96587965)

[The Paradigm of enquiry 57](#_Toc96587966)

[Ontology 58](#_Toc96587967)

[Epistemology 59](#_Toc96587968)

[Methodology 61](#_Toc96587969)

[Reflexivity 62](#_Toc96587970)

[Reflexivity: Psychobiology 65](#_Toc96587971)

[Reflexivity: Situated activity 67](#_Toc96587972)

[Reflexivity: Social settings 68](#_Toc96587973)

[Reflexivity: Culture 68](#_Toc96587974)

[Reflexivity: Politico-economy 69](#_Toc96587975)

[Method of enquiry 69](#_Toc96587976)

[The creation of research instruments 71](#_Toc96587977)

[Piloting the method of enquiry and the research instruments 73](#_Toc96587978)

[Ethical considerations 75](#_Toc96587979)

[Sampling 77](#_Toc96587980)

[Gathering the data 84](#_Toc96587981)

[Data analysis 86](#_Toc96587982)

[Heidegger’s philosophy: an overarching phenomenological theory 89](#_Toc96587983)

[The concept of Thrownness 90](#_Toc96587984)

[The concept of ‘Fallenness’ 91](#_Toc96587985)

[The concept of ‘Projection’ 92](#_Toc96587986)

[Chapter summary 94](#_Toc96587987)

[CHAPTER 4 95](#_Toc96587988)

[Findings 96](#_Toc96587989)

[Introduction 96](#_Toc96587990)

[Participants 98](#_Toc96587991)

[Thrownness 99](#_Toc96587992)

[Being equipped for the context of the working environment 99](#_Toc96587993)

[i. The establishment of ‘capital’ relevant to the working environment 100](#_Toc96587994)

[ii. Understanding the cultural ‘rules of the game’ 102](#_Toc96587995)

[iii. Being surprised or frustrated by the nature of the role 104](#_Toc96587996)

[iv. Being surprised by the living conditions of service users and patients 107](#_Toc96587997)

[Perspective: ‘thrown’ prior experience 109](#_Toc96587998)

[Impact of gender and ethnicity 111](#_Toc96587999)

[i. Gender 111](#_Toc96588000)

[ii. Ethnicity 113](#_Toc96588001)

[A confident or extroverted disposition 115](#_Toc96588002)

[Fallenness 118](#_Toc96588003)

[Commonly witnessed behaviour of ‘Das Man’ 119](#_Toc96588004)

[i. Witnessing control over the allocation and pace of work 119](#_Toc96588005)

[ii. ‘Dark’ humour and banter 120](#_Toc96588006)

[iii. Taking liberties during the working day 122](#_Toc96588007)

[Remembered instances of admiration or respect. 123](#_Toc96588008)

[Factors or circumstances which may promote a sense of integration 126](#_Toc96588009)

[Factors or circumstances which may create feelings of dissociation or discomfort……………………………………………………………………………….131](#_Toc96588010)

[Feeling 'at one' with ‘Das Man’ 135](#_Toc96588011)

[Projection 141](#_Toc96588012)

[Evidence of shorter-term projection 141](#_Toc96588013)

[Evidence of longer-term projection 143](#_Toc96588014)

[Chapter summary 146](#_Toc96588015)

[CHAPTER 5 147](#_Toc96588016)

[Discussion 148](#_Toc96588017)

[Experiences of the pre-hospital workplace 150](#_Toc96588018)

[i. Student perceptions of the pervading pre-hospital workplace and culture 150](#_Toc96588019)

[ii. Suggestions of change: attitudes relating to gender within the workplace 154](#_Toc96588020)

[iii. Suggestions of change: attitudes towards BME groups in the workplace 156](#_Toc96588021)

[Suggestions of cultural immersion and evidence of ‘authenticity’ 158](#_Toc96588022)

[i. Alignment (or not) with the pervading attitudes of ambulance staff 159](#_Toc96588023)

[ii. Inclusion with ‘dark humour’ and ‘banter’ 161](#_Toc96588024)

[iii. Use of profession-specific language 163](#_Toc96588025)

[Overarching motivations on placement 164](#_Toc96588026)

[i. Passing placement (and the avoidance of ‘risk’ in this area) 164](#_Toc96588027)

[ii. Deciding upon what sort of clinician students aspire to become 166](#_Toc96588028)

[A perceived lack of preparation 168](#_Toc96588029)

[i. The potential influence of a ‘hidden curriculum’ 169](#_Toc96588030)

[ii. A confident disposition and the potential of ‘cognitive flexibility’ 171](#_Toc96588031)

[Integrating and supporting factors 173](#_Toc96588032)

[i. Informal peer support and smartphone tech’ 173](#_Toc96588033)

[ii. Utilising the coping strategies of ambulance staff 175](#_Toc96588034)

[Chapter summary 176](#_Toc96588035)

[CHAPTER 6 178](#_Toc96588036)

[Conclusion and Recommendations 179](#_Toc96588037)

[Aim and conceptual underpinnings 179](#_Toc96588038)

[Research question and objectives 181](#_Toc96588039)

[Review of findings, analysis, and discussion 182](#_Toc96588040)

[Occupying a unique position within a unique professional culture 183](#_Toc96588041)

[Suggestions of change 187](#_Toc96588042)

[The need for better student preparation 189](#_Toc96588043)

[Limitations 194](#_Toc96588044)

[Recommendations 196](#_Toc96588045)

[Greater cognisance of a potential ‘hidden curriculum’ by university paramedic educators………………………………………………………………………………..196](#_Toc96588046)

[The implementation of a reverse mentoring programme within ambulance service organisations 197](#_Toc96588047)

[Greater cognisance of the importance of informal peer networks and ensuring that no students are excluded 198](#_Toc96588048)

[Acknowledging the pre-hospital cultural context within the curriculum 198](#_Toc96588049)

[The value of observing alternative learning environments and role-models 199](#_Toc96588050)

[Recommendations for further research 200](#_Toc96588051)

[Further research into the findings relating to positive change for student paramedics and staff from BME backgrounds 200](#_Toc96588052)

[Further research into the findings relating to positive change for Female students/paramedics 200](#_Toc96588053)

[Mentors as ‘socialisation agents’ and gender congruence 201](#_Toc96588054)

[Acknowledging the unique position occupied by university paramedic students within the prehospital workplace in relation to their management of stress 202](#_Toc96588055)

[Transferability 203](#_Toc96588056)

[Concluding commentary 204](#_Toc96588057)

[Reference list: 206](#_Toc96588058)

[Appendix 1 226](#_Toc96588059)

[Appendix 2 227](#_Toc96588060)

[Appendix 3 229](#_Toc96588061)

[Appendix 4 230](#_Toc96588062)

[Appendix 5 231](#_Toc96588063)

[Appendix 6 232](#_Toc96588064)

[Appendix 7 234](#_Toc96588065)

[Appendix 8 235](#_Toc96588066)

[Appendix 9 236](#_Toc96588067)

[Appendix 10 237](#_Toc96588068)

[Appendix 11 238](#_Toc96588069)

[Appendix 12 239](#_Toc96588070)

# CHAPTER 1

Introduction

## Introduction

### Overview

This introductory chapter will outline the aim, the general research question, and the objectives of this study. It will explore the academic and professional context, as well as the rationale, and my own personal justification for undertaking it. A review of the relevant supporting literature and underpinning theoretical concepts is also included.

### The overarching research question and objectives

Through the adoption of a qualitative hermeneutic approach based upon the philosophy of seminal phenomenologist Martin Heidegger (1927), this thesis will explore the [professional identity formation](file:///C:\Users\garra\Desktop\EdD\Thesis%20chapters\Chapter%201\PID%20notes.docx) and enculturation experiences of university paramedic students during the compulsory pre-hospital clinical practice elements of their degree programme. Underpinning this approach, the overarching research question is:

*How are paramedic student notions of ‘self-identity’ formed/negotiated as part of the enculturation process within professional clinical practice?*

In accordance with both Punch (2010, p.58) and Savin-Baden (2013), this question has been deductively derived from the initial identification of a ‘research area’ which is reflective of my background and professional expertise. This was then refined to a more specific ‘research topic’ concerning an area of deficiency within the literature and my own personal and professional interest. It was then distilled further into a ‘general research question’, which is considered by Punch (2010, p.60) to be essential for organising and directing the study. The significance of deriving an overarching question in this manner is suggested by Kennedy *et al.* (2015), who stress the importance of cultural integration and the adoption of key values and norms as part of the enculturation process for student paramedics. For this professional group, this is complicated by the still ‘emerging’ nature of Paramedic Science as a profession, reports of dissonance with what is learned at university and what is experienced on placement, and potential factors such as ‘blue-collar professionalism’ - a suggested behavioural feature of emergency service workers encompassing a moral devotion to duty and a focus upon self-preservation within the workplace (McCann *et al.,* 2013, p.754).

In support of the overarching research question, the key objectives are:

1. To explore the development and/or negotiation of paramedic professional identity from the perspective of the university student
2. To explore the role played by the university in the professional enculturation of paramedic students

These objectives are predicated upon the understanding that each healthcare profession has a unique and defining cultural heritage with bespoke knowledge, skills, attitudes, beliefs, behaviour patterns, customs, and public expectations. Alignment with these elements is considered to underpin the development of professional self-identity, and this process of enculturation is reinforced by educational and socialisation processes; with the acquisition and application of learning restricted by the social boundaries which regulate behaviour within a specific field of practice (McMurty *et al.*, 2015; Hall, 2005; Higgs, 1993). For individuals, the acquisition of professional and cultural perceptions is thought to enable ‘feelings of personal adequacy and satisfaction’ (Ewan, 1988, p.85) and provide a particular lens through which the world may be viewed (Pettifer and Clouder, 2008; Schein, 1978). Due to this socio-cultural and experiential context, the development of self-identity is thus considered to be an individual negotiation which takes place within the mind of the learner as they align new ways of perceiving the world (as their sense of professional identity develops) with their pre-existing schemata of perceptions and experiential understandings (Monrouxe, 2009; Hunter *et al.,* 2007). Of significance for the current study, is the assertion of McMurty *et al.* (2015) that health profession educators should acknowledge and tailor their provision in accordance with these experiential and cultural factors.

## Personal and Professional context and rationale

Although I am an early career researcher, I have been a qualified paramedic within the UK since 1997, and a university educator for student paramedics since 2007. I am employed by the UK university at which all twelve participants for the current study were enrolled as student paramedics. In this capacity, I have a professional and academic investment in facilitating a positive work-place enculturation experience for student paramedics, and in ensuring that the university plays a constructive role in this area. My own unfavourable pre-hospital workplace and enculturation experiences underpin this research, as well as anecdotal reports of difficulty from my own students. In acknowledgement of such potential problems, Kennedy *et al.* (2015, p.1042) assert that in this respect, universities may leave some students, ‘ill prepared for the rigors of transition into the workplace’ with consequent risks to their mental health.

The participants were enrolled upon an undergraduate university paramedic programme which - along with other equivalent paramedic programmes within the UK - meets the educational benchmark standards of the Quality Assurance Agency (QAA), the curriculum guidance set by the College of Paramedics (CoP) and all the relevant standards required by the registering body for the paramedic profession, the Health and Care Professions Council (HCPC) (QAA, 2016; HCPC, 2017; HCPC, 2014; CoP, 2019). Completing the course and achieving professional registration requires that the participants undertake pre-hospital clinical practice placements which are principally spent with a local Ambulance Service NHS Trust.

For the programme upon which the participants are enrolled, the first of these placements was undertaken after an initial five months of classroom and skills-lab tuition at university. This initial ‘block’ of placement lasted for approximately three months before they were scheduled for more university-based tuition. During their second year, the schedule included two placement ‘blocks’ of three months at the beginning and end of the academic year (with university-based tuition between). Due to a change in university provision for Paramedic Science, which saw a move from a two-year Foundation Degree to a three-year Batchelors Degree, none of the participants had undertaken a third year at university at the time of their interviews.

The placement ‘blocks’ are where participants were exposed to the pre-hospital emergency ambulance workplace environment and culture. Although they were issued with a green uniform by the university, it is a noticeably different uniform to that worn by ambulance staff within the placement location, and the participants were present in a purely supernumerary learning capacity. In terms of their programme requirements, they are expected to achieve certain skills-based clinical competencies under the guidance of a paramedic mentor (employed by the host ambulance service). Beyond these summative conditions however, the workplace setting is also considered to be where students are more broadly considered to develop the informal attitudes, behaviours, values, and perspectives synonymous with the development of professional identity. These characteristics are suggested to be a vital part of ‘fitting in’ and being accepted by established staff; something considered important in developing a ‘sense of belonging’, obtaining further experience, and the establishment of a sympathetic and ‘healthy positive workplace’ (Ewan, 1988, p.85; Paterson *et al.,* 2002; Kelly and McAllister, 2013).

For the paramedic profession, this process of enculturation is likely to be confounded by its ‘emerging’ nature in terms of having to negotiate a place alongside more established professions such as nursing and medicine (McCann *et al.*, 2013, p.753). This perception is important for the professional identity formation of paramedics as according to Friedson (1979), a profession is an occupational group which may adopt certain attitudes and behaviours synonymous with higher levels of discretion and autonomy. It is also suggested that individuals in a professional group understand that their skills and knowledge are exclusive to them and that this is supported by their own abstract body of knowledge which is learned within a HEI environment (Freidson, 2004). Members of a profession are thus considered to have greater prestige, unique rights and freedoms, and the support of the community to practice within their field. They have profession specific journals and a representative professional body with codes of conduct, proficiency, and ethics for the regulation of their members (Greenwood, 1957; Giddens, 2010; Abbott, 1988).

Broader theories on professional identity development include how individuals develop role-specific attitudes, beliefs, and standards commensurate with their professional position and consistent with society’s expectations; including the creation of a ‘self-image which permits feelings of personal adequacy and satisfaction’, the critical self-evaluation of practice, and the ability to exercise self-directed learning (Paterson *et al.,* 2002, p.7; Higgs, 1993; Ewan, 1988). The contextual significance of this is highlighted by Kennedy *et al.* (2015), who stress the importance of cultural integration and the adoption of key values and norms as part of the enculturation process, something which is likely to be complicated by the ‘emerging’ nature of the paramedic profession, and reports of dissonance with what is learned at university and what is experienced on placement.

The nebulous and changing nature of paramedic professional identity represents an area for which it is suggested that HEI curricula be adjusted to ensure that students are appropriately prepared for the workplace (Bauman, 2009). For Hunter *et al.* (2007), Bramming (2007), and Paterson *et al.* (2002) the overriding role of universities in this area is to maintain high professional standards and to create conditions which facilitate student participation. I am invested in exploring the phenomena of Paramedic professional identity development and enculturation from the student’s perspective, and in exploring ways in which they may be better supported at university. With cognisance that this area of research has been suggested to require much further investigation (Kennedy *et al.*, 2015), this thesis will contribute towards addressing an identified gap in our knowledge and understanding.

## University and employer policy context

Through the integration of academic and work-based learning and close collaboration with employers, the university paramedic science programme aligns with the conception of vocational degrees introduced by the Department for Education and Skills (DfES, 2003) as a means of enhancing employability through the acquisition of work-related skills and qualifications. The programme reflects the educational response to the Dearing Report (1997) which outlines the contribution universities should make to the envisioned ‘learning society’ and falls within the remit of government strategies pertaining to social mobility, lifelong learning, and widening-participation; which represents a commitment to encourage applications from diverse groups, and from those who may not have considered a more traditional course of study (QAA, 2010; Hayton and Tang, 2016). According to some however, the neo-liberal policy relating to the setting of university tuition fees has led to a reduction in student applications from those who may be considered socially deprived (Hayton and Tang, 2016; Chitty, 2014; DfEE,1998). In the context of the current study, this drive to increase the diversity of student applicants set against the potential narrowing of application criteria (towards the more socially advantaged) may thus affect the enculturation and professional identity development experiences of student paramedics. Some applicants may thus be drawn by such a skills-orientated programme which has a clear employability focus, whilst others from lower socio-economic groups may be excluded from entering the profession via a university pathway for financial reasons (Kaehne *et al.,* 2014).

The policy which underpins undergraduate paramedic students undertaking pre-hospital workplace placements supports the enablement of a highly skilled and diverse workforce in accordance with the aspirations of vocational learning and the political narrative that skills-based learning leads to broader economic success (Dearing,1997; Humes,1997; Leitch, 2006). However, Bellinger (2010, p.602) suggests that university representatives have argued against such an emphasis upon workplace learning due to concerns that students may ‘uncritically’ embrace the ‘culture of the organisation in which they are placed’. Whilst this is contrary to Domakin’s (2013) finding that students undertaking workplace experience may experience a beneficial blurring of boundaries between education and practice, Walton (2005) suggests that students usually view their periods of placement exposure and university teaching as separate entities. In accordance with exploring these suggestions, this study has sought to gain an insight into how the student paramedic participants experience and relate to the pre-hospital workplace culture they encounter during the practice placement elements of their programme.

The next chapter will seek to critically review the literature with the aid of some key social theory frameworks.

## 

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# CHAPTER 2

Critical review of the literature

## Critical review of the literature

### Approach to the review

According to Murphy (2013), social theory frameworks are a powerful aid for interpretation in that they facilitate the extraction of meaning and the exploration of social relations of power, behaviour, educational processes, and the relationship between individuals and society. Due to the social and cultural hermeneutic nature of this enquiry, I have adopted an approach which is structured around some key social theory frameworks (as detailed within Table 1 below). I believe this approach has merit as professions such as paramedic science have been described as ‘vitally important social actors’ (McCann et al., 2013, p.752), and because some authors assert that ‘ambulance work has received scant attention from sociology’ (Granter *et al*., 2018, p.2). Whilst offering a potentially unique perspective, this approach also allows me to utilise some relevant aspects of seminal social theory as an interpretive lens through which to evaluate some of the more profession-specific literature, and to help ensure that this review is based upon recognised and accepted theory (Grant and Osanloo, 2014; Simon and Goes, 2011).

Table 1 references the key social theorists included within this review, and their place within its structure. Figure 1 outlines the approach that I have taken for this review and the additional subordinate areas which have been derived from my interpretation of key social theory frameworks and the profession specific literature. This interpretation is refined here in terms of an overarching ‘Structural ‘field’ of Practice’, within which I have located a section entitled ‘Individual Passive Influences’, and a subsequent sub-section called ‘Individual Agency and the Conscious Role of the Individual’. These key terms are defined within their own areas of evaluation below, after my rationale for approaching the critical review in this manner.

**Table 1**: Key social theorists; their cited work, and location within this review.

|  |  |  |
| --- | --- | --- |
| Author(s) | Cited work | Positioning within review structure |
| Foucault (1979) | Conceptions of discipline and surveillance | ‘Structural field of practice’ |
| Lave and Wenger (1988) | Legitimate peripheral participation within a Community of Practice (CoPr) (1998) | ‘Structural field of practice’ |
| Goffman (1959) | Concepts of ‘self’ and ‘performance’ | ‘Structural field of practice’ |
| Bourdieu (1986) | Conceptions of ‘capital’, ‘habitus’, and ‘practice’ | ‘Individual passive influences’ |
| Kolb (1984) | Experiential learning | ‘Individual agency and the conscious role of the individual’ |
| Schon (1991) | Reflection on action | ‘Individual agency and the conscious role of the individual’ |

**Figure 1**: Critical review structure with sub-ordinate areas:

Text

Description automatically generated

Whilst I have found that refining the literature in this manner has been useful for identifying areas of focus, for the purposes of the analysis I believe that they may not completely encompass the personal and subjective nature of the research question, or the conceptions of ‘self’ and individual ‘meaning’ underpinning the ethos of hermeneutic phenomenology (Paley, 2017). This is something that I began to consider whilst undertaking the critical review and during the early stages of the interview transcription. I thus began to consider that whilst social theories represent a useful tool for exploring how individuals navigate the social world around them from an observer’s perspective, in accordance with Paley (2017), there needed to be an additional overarching theory which could be used as a lens to consider how individuals attribute value and meaning to their experiences. The following extract from my analysis journal (dated 10th October 2019) suggests my dilemma in this respect:

*- How am I supposed to analyse this lot! We are looking for an exploration of meaning for the individual - remember the premise of phenomenology!*

In considering an alternative approach, and in alignment with Paley’s (2017, p.177) suggestion to use ‘useful theory from a relevant discipline’, the analysis is therefore grounded within the philosophy of seminal phenomenologist Martin Heidegger and the concept of ‘Dasein’ as defined within ‘Being and Time’ (Heidegger, 1927). This approach has merit in that Heidegger is considered to be the founder of interpretative phenomenology; concerned with the existential meaning of ‘Being’, how individuals exist as entities within their ‘average’ everyday world, and how they relate to one another (Wisnewski, 2013, p.33; Heidegger, 1927). This approach accords with the structure used to review the literature, as it encapsulates the work of prominent social theorists such as Bourdieu and Foucault, who are both acknowledged to owe a debt of philosophical influence to Heidegger (Dreyfus and Hall, 1992) – for example, Bourdieu’s (1986) concept of habitus is broadly encompassed by Heidegger’s conception of ‘Thrownness’ and ‘Disposition’; whilst Foucault’s (1977) conception of how individuals are ‘normalised’ within society through surveillance and discipline may also be incorporated within ‘Fallenness’ and the ‘inauthentic’ sway of ‘The They’ (or ‘Das man’). This section will therefore provide a review of the literature in accordance with my suggested social theory structure and outline some of the key areas of Heidegger’s philosophy which I will subsequently use to analyse the interview findings.

To avoid confusion when exploring the various research studies and other forms of evidence included within the review and the discussion chapter, I will refer to the findings and focus of this thesis as ‘the current study’.

### An exploration of social theory: The Structural Field of Practice

Within the context of this review, ‘The Structural Field of Practice’ represents the practice placement environment within which the student’s identity development and enculturation may be considered to occur (albeit in a peripheral capacity due to their status as a university student). This has been in-part derived from Bourdieu’s conception of ‘field’, which alludes to a pervading and encompassing social and cultural arena within which notions of identity are negotiated by individuals. It signifies a microcosm of accepted practices, determinations, and acknowledged authority, and represents ‘….a battlefield wherein the bases of identity and hierarchy are endlessly disputed….’ (Wacquant, 1998, p.222; Bourdieu, 1993). For Goffman (1983) the ‘field’ is representative of a theatrical ‘stage’ upon which individuals perform a ‘presentation of self’ to an audience consisting of other members of the ‘field’ (representative in this context of ambulance staff within the pre-hospital workplace). In this respect, although undertaking a ‘performance’ of themselves, individuals are cognisant of how the pervading social context ‘requires’ them to tailor their actions, and of how they may be perceived by the audience - who need to support the performance if it is to be successful and if the individual is to feel accepted by the group (Goffman, 1964; Williams, 1998). Swann’s (1987) theory of ‘self-verification’ highlights the tension which may arise if an individual’s ‘performance’ is not accepted by the audience, and they are not seen as they wish to be seen. Swann (1987) also suggests that the process of ‘behavioural confirmation’ represents ways in which observers may try and channel an individual’s ‘performance’ in such a way as to elicit a pattern of response which confirms their group expectations.

In accordance with the theories of Foucault, I have also envisaged ‘The Structural Field of Practice’ as an arena for emphasising applied social control and power. In this respect Foucault’s (1977) *Discourse of Discipline* conceptualises the ‘field’ as a stage for the observation, measurement, regulation, and ‘normalising’ of behaviour in accordance with what is considered acceptable - as dictated by the pervading conceptions of ‘normality’ (in this case, the cultural conventions which may exist within the pre-hospital workplace). Foucault (1977) considered the ‘normalisation’ of an individual’s behaviour to be a great instrument in the exercising of power, something routinely achieved through the perception that individuals are in a state of constant surveillance (Allan, 2013, p.25). Foucault (1977) usefully uses Jeremy Bentham’s *panopticon* as a metaphor for the ‘normalisation’ of social behaviour through the perception of surveillance. The *panopticon* was thus a design of prison surveillance system which placed an observation tower in the centre of a courtyard surrounded by a ring of glass-fronted prison cells. The tower afforded the guards complete ‘all-seeing’ twenty-four-hour observation of the surrounding cells and was designed in such a way that the prisoners could never tell exactly when (or if) they were being observed by the guards. To avoid risk of punishment through not conforming to the prison regulations, the prisoners had to assume that they were under permanent surveillance and behave in accordance with the rules at all times. For Foucault (1977), the *panopticon* represents a powerful metaphor for pervading social control and the sometimes-subliminal self-policing of individual behaviours. It seeks to emphasise the ‘normalising’ process encountered by every individual within a particular social ‘field’ in relation to what is considered ‘appropriate’ behaviour (Hope, 2013, p.37; Barth, 1998). The enaction of discipline through perceptions of observation and social normalisation through enforced and self-policed adherence to the ‘rules’ are factors which are considered to effectively ‘make’ individuals as instruments who accept the inherent *discourse of discipline* within the ‘field’ and assist with its replication via the identification, labelling, and/or reporting, of behaviours deemed as ‘deviant’ (Hope, 2013, p.44; Foucault, 1977).

Foucault’s (1977) *Discourse of Discipline* is considered to be effective predominantly within the confines of a clearly defined ‘field’ with its own knowledgebase/area of expertise, forms of authority, and with only a limited number of people (Deleuze, 1988). These elements resonate with the pre-hospital workplace paramedic students are exposed to as part of their university programme. Students may thus experience a sense of surveillance in relation to the professional requirements of the registering body for paramedics that they will be required to meet (HCPC, 2016), and the course-specific academic regulations relating to module completion and professional suitability (CoP, 2019). Not adhering to these requirements and standards could be considered as a potential ‘deviation’ which may require reformative measures or indeed result in expulsion from the ‘field’. Whilst students are not yet directly monitored by the registering body, they are aware that they are still required to meet the prescribed professional standards, and they are also aware that for their paramedic mentors and pre-hospital paramedic workplace colleagues the consequences of ‘deviance’ from professional regulations and standards within the ‘field’ could be the requirement to formally justify their actions as part of a HCPC fitness-to-practice enquiry (HCPC, 2015).

A potential drawback with the application of many social theories involving normalisation, performance and discipline is that they are not tailored towards enculturation and learning within a professional context (such as the pre-hospital workplace), or for the learning of a new professional role. Lave and Wenger (1998) attempt to address this through moving the emphasis away from institutionalised learning processes (such as universities), and more towards the peripheral nature of student participation within the pervading workplace (White, 2010). Consideration of a CoPr may be of particular value for exploring the paramedic workplace context as the concept is generally used to represent learning within a professional environment. Within this context a CoPr is also thought to be representative of a ‘social field’, providing a forum for more experienced colleagues to represent the ethos, history, and continuance of the community and to perform a significant role in the process of the socialisation for new ‘initiates’ (Wenger, 1998). These concepts will be explored further within the ‘workplace socialisation’ section of this review.

Whilst this review will go on to explore social theory in relation to potential influences upon individual perception and action, at this stage it is germane to consider the paramedic profession-specific themes which I have identified as falling within this area.

### Workplace and cultural environment

Due to its unscheduled nature and demand for intense physical and mental application (often under unfavourable conditions), the pre-hospital workplace has traditionally been considered as highly stressful (James, 1988; Sterud, 2011). A recent systematic review exploring alcohol/substance misuse amongst paramedics additionally found suggestions that paramedics and student paramedics may be suffering from higher rates of occupational and post-traumatic stress than the general population (Hichisson and Corkery, 2020).

Describing the current working daily experience of paramedics as ‘very unforgiving’, McCann and Granter (2019, p.6) highlight how the volume of emergency calls has risen by approximately 21% between 2013 and 2017. For the year 2020 to 2021, the Association of Ambulance Chief Executives (AACE) cite 12.4 million contacts were made to the Emergency [ambulance] Operations Centre, an increase on 11.7 million from the previous year (AACE 2020). In order to meet an ever-increasing demand, McCann and Granter (2019, p.5), describe how NHS ambulance trusts are driven to ‘sweating the employee asset’ (extracting the most possible work from the hardest-working employees) in order to meet performance targets. A potential effect of this may be reflected within a HCPC commissioned study involving semi-structured interviews with 11 paramedics. This study sought to explore why a disproportionate number of complaints are received against paramedics within the UK and found increased demand to be a potential contributing factor. Additional elements were suggested to include the imposition of closely audited performance targets, increased levels of autonomy, and changes to care provision necessitated by more complex service user needs (van der Gaag *et al.,* 2017).

Concurring that paramedics are currently expected to manage an increasing number of service users with a greater diversity and complexity of health and social care need, Newton (2019, p.140) suggests that only approximately 5% of emergency ambulance calls are for what could be considered ‘acute emergencies’ from a ‘purely clinical perspective’. This evolution involves a rise in lower acuity cases involving holistic complex social and mental health problems which require an empathetic caring approach and inter-professional collaboration within the community. For some ambulance staff, this may represent a shift away from a professional identity once synonymous with high-acuity emergencies and reflects a ‘femininisation’ of the role which may be at odds with the working repertoire and backgrounds of many established employees (Proctor, 2019; Johnston and Acker, 2016; Clompus, 2016). For Newton (2019), this is embodied by incompatibility between ambulance service culture and the needs of service users (and staff) and compounded by the failure of senior ambulance managers to modernise a model of provision which is historically orientated towards acute care and transportation of patients to hospital.

In a study involving semi-structured interviews with 25 student paramedics and 9 paramedics, Devenish (2014, p.183) describes an ‘underlying division’ and bitterness within the pre-hospital workplace between operational staff, managers, and control personnel. Utilising participants from Australia, the findings of this study may not be directly transferrable, although they do resonate with other UK research. Such studies include a Care Quality Commission (CQC) report on the London Ambulance Service. This report features interviews, focus groups and drop-in sessions, and found that whilst staff were complementary and supportive of their immediate managers, they were much less favourable towards more senior managers who they saw as distant and out of touch with the reality of operational working conditions (CQC, 2015). In an ethnography involving 8 paramedic student participants within one UK ambulance Trust, Donaghy (2020, p.139) similarly alludes to a sense of ‘distrust and resentment’ between ambulance staff and managers.

These tensions may be characteristic of the historic ‘Emergency Service’ militaristic structure and origins of the ambulance service, and a perceived ‘boys club’ through which benefits, and preferential advancement are assumed to occur (Devenish, 2014, p.41). Vestiges of this ‘chain-of-command’ and disciplinary driven culture are reported as still continuing (van der Gaag *et al.,* 2017, p.73; Wankhade, 2016), despite being considered at odds with the intellectual freedoms and values endorsed at university. According to van der Gaag *et al* (2017, p.73) and Donaghy (2020), an emphasis is still placed upon discipline, with reporting to the HCPC cited as the ultimate ‘big stick’ within a blame-orientated culture of conflict and fear. This ethos was also found to be present to some degree within the research undertaken by Kirk *et al.* (2018), Granter *et al*. (2018), McCann *et al.* (2013), and the CQC (2015) – who also document concerns regarding a culture of fear and bullying towards operational staff and an unwillingness to use their initiative with patients or raise concerns due to a fear of repercussions.

It is within this environment and culture - described by Newton (2019, p.145) as ‘toxic’ and ‘target driven’ – that newly graduated paramedics may find themselves when commencing employment with a UK ambulance Trust. Utilising secondary data from the CoP Recruitment and Retention Survey (977 responses), Harris (2019) discusses how this new all-graduate workforce is more mobile than a previous generation of employees, with less allegiance to their employer. For Harris (2019), this change in workforce demographic represents a challenge for the more traditional ambulance management structure, which may be seen as out of touch due to the ‘through the ranks’ mode of promotion and associated lack of formal managerial training. Echoing Harris, Newton (2019, p.145) suggests that ambulance culture is ‘less than conducive’ for the aspirations of graduate paramedics ‘who have more opportunities to migrate to primary, hospital or other care sectors.’ Indeed, the *Post Registration - Paramedic Career Framework*, published by the CoP (2018) emphasises the baseline requirement of a degree level education for each of the four recommended pillars of paramedic career progression: Clinical Practice, Leadership and Management, Research and Development, Education. It therefore seems that a key difference for graduate paramedics entering the pre-hospital workplace is the knowledge that they may have greater career aspirations than their vocationally trained predecessors, and that McCann and Granter’s (2019, p.6) ‘very unforgiving’ workplace may not be their only employment option.

### ‘Blue-collar professionalism’

Coined by Donald Metz (1981) during his ethnography of US ambulance workers in the late 1970s, the term ‘blue-collar professionalism’ represents the moral positioning and practical engagement of a semi-autonomous uniformed workforce (most commonly emergency service workers) involved with unpredictable, potentially dangerous, and often stressful ‘street-level’ public work. It symbolizes a stoic devotion to duty through the application of tacit knowledge and experience in the face of feeling undervalued, underappreciated, underpaid, and having limited opportunities for progression. It is additionally considered to encapsulate (and be perpetuated by) forms of resistance to the perceived imposition of a ‘command and control’ militaristic managerial structure and a potentially exhausting target-driven audit culture (McCann and Granter, 2019, p.8). Such resistance includes traditional ‘blue-collar’ workplace coping strategies such as, high sickness rates, go-slows, working-to-rule, and the taking of informal breaks (Givati *et al.,* 2018; McCann *et al.*, 2013)

However, according to McCann and Granter (2019, p.7), uniformed emergency services in the UK may be superseding conceptions of ‘blue-collar professionalism’ through being compelled to professionalise in a manner more akin to established ‘white-collar’ professions (such as medicine and law). This need is driven by greater accountability and public scrutiny, and an increase in lower acuity (but often more complex) cases involving mental health and social care. These changes are considered to necessitate the devolvement of the potentially inflexible traditional ‘command and control’ structures, the enhancement of individual skill sets, greater autonomy, and better interagency communication (McCann and Granter, 2019; Reed, 2018).

Whilst this process of professionalisation in the UK is arguably less apparent within the Fire and Rescue Services - who have recently experienced an overall decrease in core demand and maintain no specific educational requirements for new recruits - both the police and ambulance service have adapted and enhanced their educational and functional provision in a similar manner (Charman, 2015; Department for Communities and Local Government, 2013; UCAS, 2021). In a study involving semi-structured interviews with 23 police officers and 22 ambulance staff, Charman (2015, p.170) additionally cites many shared cultural and organisational features between these two emergency services and suggests that this may be due to having a common workplace context and a similar nature of involvement with the public (also termed a ‘camaraderie of exposure’). As part of their professionalisation process, paramedics have thus experienced enhanced levels of clinical expertise grounded upon evidence-based practice (including the ability to prescribe), professional regulation with the HCPC, the creation of a supporting professional body in the form of the CoP, and from September 2021, a graduate-only route of entry (van der Gaag, 2012; HCPC, 2018). Comparably, over recent years police officers have experienced the introduction of an evidence-based policing approach, the creation of the College of Policing, and a (mostly) graduate-only route of entry from 2020 (Brown *et al*., 2021; Martin, 2021; Cox and Kirby, 2017).

Whilst it could be said that these changes are compelling both the police and ambulance service in the UK to move away from cultures once synonymous with notions of ‘blue-collar professionalism’ (McCann and Granter, 2019), it is apparent that there are persisting occupational pressures which may perpetuate ‘blue-collar’ working practices. For the ambulance service, such continuing pressures include what Newton (2019, p.145) describes as a ‘restrictive, target-driven culture’, and frustrating levels of managerial monitoring, control, and performance measurement which is ‘not necessarily conducive to autonomy’ (Donaghy, 2020, p.171; Granter *et al*., 2018). It is under these tensions that many paramedics have been observed to adopt ‘coping strategies’ such as the taking of unsanctioned breaks, working at a slower pace, and a self-imposed restriction of professional autonomy through simply conveying all patients to hospital; thereby reducing the perceived risk of making a clinical error and subsequently facing disciplinary action (Kirk *et al.*, 2018; Clompus, 2016; McCann *et al.*, 2013, p.768).

For van der Gaag *et al.* (2017), this instinct for self-preservation may lead to hidden and entrenched working practices and the underreporting of potential issues. They also suggest that for paramedic students undertaking workplace placements the ethical and professional teaching of open reporting at HEIs may become overridden by exposure to this element of workplace culture, and students may ‘become contaminated’ and ‘hidden in their activities’ (Van der Gaag, 2017, p.73). Within his ethnographic study, Donaghy (2020) similarly found that participants were sometimes complicit with the anti-management sentiments and work-avoidance strategies employed by ambulance crews. He argues that students learning to navigate the sub-culture of the ambulance service have little option but to mimic and align with such witnessed behaviours, as though they were themselves already qualified and employed members of staff. Donaghy (2020) also suggests that challenging such behaviour risks hostility and potential ostracism from the workplace CoPr, something students are keen to avoid. Similarly, within their survey of 84 university police students, Cox and Kirby (2017, p.557) found a rapid comparable identification with workplace culture, and also report negative experiences associated with students ‘not fitting in’.

For McCann (2013, p754), ‘blue-collar professionalism’ represents the ‘hallmark of ambulance workers’ occupational identity’. Alignment (or not) with this model of behaviour is therefore likely to be important for understanding how paramedic university students become enculturated and develop their own sense of professional identity within the pre-hospital workplace.

### Attitudes towards university students

Within a participant observation study involving 21 paramedics and including 11 semi-structured interviews, Rolf *et al.,* (2020, p.3) cite how some ‘older generation’ paramedics experience a sense of nostalgia and loss in relation to how their role has changed from the halcyon ‘good old days’ of high-acuity emergency work. This sentiment is mirrored by accounts from experienced ‘older generation’ police officers, who similarly feel that their role is diminished by a departure from the crime fighting emphasis of their profession, and that policing is no longer a ‘job for life’ (Sausdal, 2018, Martin, 2021, p9).

For many such police officers and paramedics this perceived undermining of professional identity is synonymous with academisation, which has been regarded by some with mistrust, cynicism, and a reluctance to acknowledge its potential benefits. This is exacerbated by the perception that there is now less value associated with years of practical experience, and internal routes for non-graduate progression are declining (Donaghy, 2020; Givati *et al*., 2018; Cox and Kirby, 2017; Henderson, 2012). According to McCann and Granter (2019, p.6), even for those ‘older generation’ police officers and paramedics who wish to embrace new educational opportunities, obtaining a ‘mid-career’ degree is often considered impractical and too expensive.

Within this climate, it is perhaps unsurprising that there are reports of ‘friction’ between experienced ‘older generation’ staff and the university student cadre who are perceived to embody such changes within the workplace (Rolfe, 2020, p.3). Mistrust and dislike towards university paramedic students was found by Gallagher *et al.* (2016) during interviews with 16 participants with differing experience levels and backgrounds within the ambulance service. The following citation is from one former student:

*A lot of people were distrustful of ‘uni bods’ as they called us, and I remember turning up second to this job, the patient was already in the ambulance….the paramedic who answered the door at the back of the ambulance made it quite clear that he did not want me there and simply told me to go away* (Gallagher, 2016, p.4)

Further accounts of mistrust and cynicism are reported by Givati *et al*. (2018) in a study involving in-depth interviews with 20 paramedics (from a mixture of clinical and educational settings) and a focus group discussion with 8 final year paramedic students. This study highlights the perception that graduate paramedics need to earn the respect of established ambulance staff and that they may experience resentment from those who find themselves unable to progress because they lack a university education. This sentiment is supported further by an ethnographic case study which involved more than 70 semi-structured interviews and 100 hours of observation (Wankhade, 2016). This study describes a sense of wariness towards university students, and the feeling that this ‘new cadre’ are advancing too quickly without appreciating ‘the realities of the road’ (Wankhade, 2016, p.133). Similar attitudes have been more recently reported by Donaghy (2020), who found the continuance of underlying tensions between experienced staff and graduates (although Donaghy’s data was several years old at the time of publication). With regards to this element of workplace culture, there is likely to be credibility in the combined evidence of Gallagher *et al.* (2016), Givati *et al*. (2018), Wankhade (2016), and Donaghy (2020) despite some low participant numbers and the age of some data.

With reported parallels including a sense of nostalgia and loss concerning their occupational role, an underlying bitterness towards managers, and mistrust of those who represent academia (Rolf et al., 2020, Givati et al., 2018; Cox and Kirby, 2017; Devenish, 2014), the perceptions of established police officers and paramedics can also be seen to mirror Argyris’s (1991) theory of defensive reasoning. This theory posits that even educated professionals have a propensity to act defensively and project blame onto external factors in relation to their own perceived failures and frustrations. According to Argyris (1991), this is due to a fear of embarrassment and an inability to admit culpability in the breakdown of workplace communication and team performance. This inability is subconscious and represents a significant barrier to learning as individuals are unable to recognise the recurring negative effects of their own behaviour, nor are they able to engage with the more in-depth objective ‘double-loop’ learning required to recognise their own failings and affect change. Defensive reasoning may therefore help to explain why some established police officers and paramedics have broadly similar perspectives concerning their managers, the evolution of their profession, and consequently their attitudes towards university students.

Whilst this evidence suggests that participants within the current study are likely to encounter a degree of friction with ambulance staff during their practice placements, it should be remembered that there have been increasing numbers of graduate paramedics entering the workplace over the last 20 years, and that the only educational route for paramedics is now via one of 68 HCPC accredited HEI paramedic courses (HCPC, 2018; HCPC, 2021). As McCann and Granter (2019) suggest, it is reasonable therefore to assume that as a higher proportion of graduates enter the workplace, there will be a corresponding shift towards greater acceptance of university students. This adds further value to the current study in that there are likely to have been changes in relation to the enculturation experiences of student paramedics which have not yet been reflected within the literature.

A further area which is not broadly represented within the literature is the potential impact of the supernumerary status usually assumed by full-time university paramedic students within the pre-hospital workplace. Whilst the current study exclusively focusses upon these full-time students, there is however a separate and comparable group of paramedic students who are employed by the local ambulance Trust. These employed students are following a different apprenticeship-style pathway towards becoming a qualified paramedic, and as such work as a rostered member of ambulance staff whilst studying part-time at university (NHS, 2022). Although both groups are in the same workplace and learning in parallel, unlike full-time university students the employed students are not supernumerary when in practice, and wear almost the same uniform as qualified staff. Whilst the experiences of both groups makes for an interesting comparison, the literature is sparse in relation to differences in treatment by existing ambulance staff. There are however close parallels within the nursing literature when that profession was at a similar stage of academisation.

In a study utilising semi-structured interviews with 16 qualified nurses which sought to explore perceptions towards supernumerary nursing students and rostered nursing Diploma students (learning whilst working as a member of ward staff similar to employed paramedic students), Hyde and Brady (2002) found that the qualified nurses were less likely to consider supernumerary nurses as part of the workplace ‘team’. It was also found that the rostered nursing students were more likely to have greater involvement with the social “life” of the workplace because they were considered to be “one of them” and deemed less likely to cause “disruption” to the existing “social structure” of the workplace (Hyde and Brady, 2002, p.624). In an action research study involving thirty-one participants, Joyce (1999) found that supernumerary nursing students experienced a sense of alienation and were unfavourably compared with those following a working apprenticeship-style pathway. This was also found by McGowan (2005) who, following semi-structured group interviews with sixty students, found that some supernumerary nursing students reported feeling disillusioned and disappointed with practice.

Whilst these findings may not be directly comparable to the experiences of university paramedic students due to their professional dissonance and age, they do suggest that the participants within the current study may have experienced conspicuous differences in attitude attributable to their supernumerary status. As cited above, the nursing literature in this area makes specific mention of differences in socialisation between the two student groups. The workplace socialisation of university paramedic students is an area I intend to explore within the next section.

### Workplace socialisation and ‘community’ affiliation

According to Lave and Wenger (1991), learning is socially situated and fundamental for the process of identity formation within a CoPr. It is acknowledged however, that students lack the required skills and experience to undertake a ‘central role’ in this process, and their inclusion within the community is uniquely dependent upon their more established workplace colleagues (White, 2010, p.796). Termed as ‘Legitimate Peripheral Participation’ (Lave and Wenger, 1991, p.53), this form of inclusion incorporates how students are reliant upon sponsorship from more established members of the CoPr to ‘legitimately’ absorb and demonstrate the cultural knowledge required to conduct themselves (and to self-identify) as community members. The creation of an identity within the CoPr may thus also be influenced by the facilitation of learning through sponsorship, a process which is thought to be iterative owing to the changing nature of the workplace and increasing levels of student participation (Lave and Wenger, 1991; Wenger, 1998).

In alignment with these theories, Filstad and McManus (2011, p.771) document that newcomers to the pre-hospital workplace need to learn how and when to apply their ‘educational knowledge’ in accordance with context and through participation with colleagues. For this to happen they must become conversant with the implicit ‘values, traditions and ways of thinking’ and learn through participation how the applicable professional language and behaviours permeate within the organisational culture. According to the authors, newcomers need to engage with the daily use of language which forms part of the embodied culture and that social participation and practicing with colleagues is vital to their acceptance within the workplace – something perceived to be even more important than ‘educational knowledge’ learned outside of the practice context. They suggest that for this to happen a ‘pathway to participation’ and socialisation needs to be established which allows them to interact and have the support of a more established colleague (Filstad and McManus, 2011, p.773). Although this ethnographic study only had 12 paramedic participants and focussed upon recruits in Oslo, it did include an exploration of local power relations and politics relating to learning through peripheral participation. Areas of interest include how access to knowledgeable colleagues must be earned, and that newcomers need to become attuned to the ‘social energy’ of the workplace. It is suggested that proactive newcomers may more easily access experienced colleagues, but where there is a personality clash, or if the newcomer is shy, then access to this sponsorship could be denied (Lawrence *et al.* 2005; Filstad and McManus, 2011). The potential effects of such social exclusion are highlighted by Levett-Jones *et al.* (2007) in a critique of the concept of belongingness for student nurses. This critique posits that many students experience feelings of alienation whilst on placement, with adverse reactions including stress, anxiety, maladjustment, a decrease in general health, cognitive deficits, and a decrease in self-esteem.

The importance of sponsorship from an established colleague as a route to social participation for student paramedics is supported by Devenish (2014) in relation to having a mentor who is familiar with the university system, and by van der Gaag *et al*. (2017) who found an emphasis upon the role of mentors in providing a supportive link between education and practice. In a study exploring professionalism, the HCPC (2011) also found that contextual influences included the importance of day-to-day role-modelling by experienced colleagues. Whilst this study included 112 paramedic students, it does not disclose any details other than that they had work experience at a more junior clinical grade and worked for an Ambulance Trust (HCPC, 2011). As these participants were employed and had some prior workplace exposure, they are likely to have different placement experiences to the participants included within the current study.

Lave and Wenger’s (1991) theories and the concept of sponsorship within a CoPr may resonate with the situation student paramedics encounter within the workplace. However, criticism has been levelled with regards to their lack of consideration of the role played by the individual (Morley, 2016). The importance of this, and the personal impact of socialisation within a new professional context is highlighted within the seminal work undertaken by Kramer (1974) and the ‘reality shock model’. This theory is inspired by the professional socialisation experiences of newly qualified nurses in America and indicates that there is an initial brief ‘honey-moon’ period during which individuals concentrate upon mastering the required skills and workplace procedures. Underpinning this, is the desire to ‘fit in’ and gain acceptance with colleagues - both inside and outside of the workplace. Following this, individuals are considered to experience ‘moral outrage’ and disillusion as their prior conceptions of the role are realigned to the daily workplace reality. Confronted by the reality of their role, individuals may; leave at this stage or pursue a non-clinical role (behavioural capitulation), continue with the role but abandon their pre-conceived workplace values (value capitulation), reduce interactions with colleagues to the minimum possible (withdraw), reject the values of the workplace culture and their preconceived ideals (a plague on both your houses), or merge their values with the overarching workplace culture (biculturalism) (Kramer, 1974). Whilst not newly qualified, it is logical to assume that paramedic students entering the workplace with knowledge and skills learned at university and pre-conceived ideas of the workplace may experience a degree of Kramer’s ‘reality shock model’.

Evidence of some potential ‘value capitulation’ amongst UK paramedic students is evident within the ethnography conducted by Donaghy (2020), and a thematic analysis conducted by Baronowski (2020) involving group semi-structured interviews with thirty Canadian paramedic students. Both of these studies found that participants adopted the personality traits and cultural attitudes which are expressed by their mentors and other established members of staff as a means of gaining acceptance within the pre-hospital workplace. In an earlier study, Devenish (2014) suggests that in order to be accepted, student paramedics may mimic the negative behaviours of more experienced staff, including a pervading pessimism and dissonance towards ambulance managers and alignment with the culturally negative attitudes towards calls which are not seen as true emergencies.

*I think to fit in….you’ve got to be pessimistic….find opportunities to say things that people expect you to say….Take the opportunity to criticise management, criticise getting a late job….It is just what you need to do to fit in* (Devenish, 2014, p.222)

Within the nursing literature, it has been similarly found that for many students the desire to belong to the social group through the adoption of pervading attitudes may be more important than resisting negative work-place cultures, providing an appropriate quality of care, and in achieving their course requirements. (Levett-Jones et al., 2007; Tradewell, 1996; Bradby, 1990). According to Henderson (2012, p.587), having to rely upon staff who may not be ideal ‘socialisation agents’ may thus be problematic for paramedic students in terms of adjustment to the role and in meeting their educational needs.

In sociological terms, the desire to engender a favourable impression is broadly encompassed by Erving Goffman’s (1959) ‘impression management’ theory, which has also been explored in relation to the experiences of midwifery and nursing students within the practice environment. Due to their extremely junior status, students within this context are thus described as being subject to an ‘inequity in power’, and particularly vulnerable due to their reliance upon a small number of more senior staff within a fairly insular professional group (Capper, 2020, p.6). In parallel with university paramedic students and their mentors, this reliance is manifested through such staff members effectively acting as ‘gatekeepers’ to the students in realising the necessary clinical exposure, and in the conferment of ‘competency’; with keeping such staff ‘on-side’ perceived as essential for achieving the necessary grades and in ultimately gaining employment (Capper, 2020, p.8; Gillen et al., 2008). Midwifery and nursing students in these contexts have thus reported that in challenging situations they often seek to ‘keep a low profile’ and just ‘get on with it’ so as to maintain good relations with their mentors (Ion et al., 2015, p.904; Hunter, 2005).

In addition to the potential adoption of pervading attitudes and the desire to maintain favourable relationships, learning to use relevant professional language is also suggested to be an important part of affiliation and socialisation (Filstad and McManus, 2011). The use of occupation-specific language is thus considered to be representative of belonging to a distinct organisational and specialist culture and is symbolic of its exclusivity. To use it in an appropriate context suggests identification with a particular community, and learning its meaning and application is thought to represent an important part of the enculturation process for newcomers (Rebrina and Generalova, 2019; Clouder, 2012).

According to Monrouxe (2009, p.42), our sense of identity is ‘embedded in language and interaction’, and the use of positioning pronouns such as ‘we’ and ‘they’ is also representative of the commitment (or sense of difference) individuals feel towards a particular community group. In a longitudinal narrative enquiry exploring the professional identity development of seventeen medical students, Monrouxe (2009) found that the use of such pronouns provided an insight into the participants’ developing sense of identification as a doctor, and their accordant relationships with medical colleagues and service users. Although the only applicable study which could be found exploring the use of pronouns, Monrouxe’s (2009) findings suggest that the verbal positioning used by students may indicate their developing sense of identification with their prospective professional community.

### Support from peers

Although it is acknowledged that unfavourable comparisons amongst peers may be detrimental to an individual’s self-confidence (Dennis, 2003), it is broadly suggested that peer support is a key interpersonal resource which allows individuals to offset threats to self-esteem and confidence through discussing their worries and sharing experiences with like-minded people (Clompus and Albarran, 2016; Wills and Shinar, 2000). Within her review of peer support within healthcare, Dennis (2003) additionally suggests that it may have a ‘buffering effect’ in relation to some of the harmful effects of stress upon health. Indeed, it has been reported that according to most paramedics, being able to emotionally decompress with crewmates after a traumatic incident is by far the most commonly utilised means of coping with stress, and that this is preferred over any other informal or formal method. It is also suggested that those with limited peer support networks, or who are unable to chat with colleagues after a traumatic call can display significantly worse stress symptoms (Mildenhall, 2012; Alexander and Klein, 2001; Jonsson and Segesten, 2004). Whilst within a quasi-experiment involving 78 Australian paramedic students Pinks *et al.* (2021) conversely found that the introduction of a formal peer support system did not influence participants’ actual experience of work-related stress, it was however found that their emotional expression and emotion-focussed coping abilities were enhanced.

In this respect, the potential importance of peer support is further suggested by Clompus and Albaran (2016) within a qualitative study exploring emotional resilience within a sample of six UK paramedics. This study found that participants not only relied upon informal peer networks at work, but that such support was even more important for emotional resilience as they deliberately kept some particularly emotive or traumatic experiences away from their loved ones. In a questionnaire-based comparative study involving 39 paramedics and 32 non-emergency service shift-workers in Australia, Shakespeare-Finch et al. (2002) similarly found that ambulance staff had the ability to compartmentalise their traumatic experiences and generally avoided discussing them within the family environment. The authors hypothesise that this ability to keep work and homelife separate may be due to formal training and participants having their own repertoire of prior experiences to act as a buffer (Shakespeare-Finch et al., 2002). In alignment with this hypothesis however, it could be argued that with their inexperience, students may be less likely to compartmentalise in this manner.

Within a study exploring the introduction of a peer support system for a cohort of 26 student learning disability nurses, Green (2018, p.58) found that participants experienced an enhanced sense of ‘community/belonging’. Participants additionally stated that the support given by their ‘peer leaders’ had given them a greater sense of professional identity. Cant and Higgs (1999) cite that such peer support represents an informal but important element in the achievement of professional socialisation, and this is potentially corroborated by the HCPC (2011) commissioned focus-group study, ‘Professionalism in Healthcare Professionals’. This study included 112 health students from three professions (including paramedics) and found evidence of peer-assisted learning between participants in terms of establishing their own norms for the modelling of professional behaviour.

All of these findings broadly align with the seminal works of Bandura (1986), which suggests that the assimilation of new learning and the acceptance of support occurs more readily when proffered by ‘similar others’ with common experience and a mutual sense of identification. However, Pinks *et al.* (2021) and Jennings (2017, p.292) cite that paramedic students may feel an ‘unspoken need’ to cover up their emotions and suppress their expression in the presence of their mentors. When this is combined with their potentially peripheral social status within the workplace, it could perhaps be argued that students may not be fully able to enjoy the peer support networks which are available to ambulance staff. This may make being able to communicate with their fellow student peers all the more important.

According to Lazarsfeld-Jensen (2019, p.512), ‘younger paramedics’ have a dependence upon social media which influences their ‘emotional sensitivities’ and the way they communicate. The potential value of social media in building a sense of community amongst university students has been explored by Hou and Macnamara (2017). Following interviews with 26 participants, they suggest that the adoption of social media for this purpose may contribute to a sense of social capital and identity development and represents a mode of communication which is readily familiar to the majority of students. Within a study involving semi-structured interviews with a group of 22 newly qualified teachers, Mercieca and Kelly (2018) additionally found that private social network group sites (such as those afforded by Facebook) represent a predominant means for creating a social community of like-minded peers who are able to support one another.

Whilst studies exploring the adoption of private social media platforms for the creation of student peer support groups are limited, and may have some professional and educational dissonance, it is perhaps reasonable to infer that they are likely to represent a readily available and familiar means for paramedic students to access support from their peers. However, this may not be something which is either regulated or properly accounted for by educators. Indeed, according to Van Den Beemt *et al.* (2020, p.42) the use of social media platforms in this context may be unfamiliar to many teachers, and they are likely to require training and appropriate ‘scaffolding’ in order to appreciate how it could be used for educational and professional development purposes.

### Use of humour and ‘Banter’

Humour and banterous teasing are considered to be informal characteristics of everyday working emergency services culture (Scott, 2007). For ambulance staff, their use is deemed to represent a ubiquitous and socially acceptable coping strategy which enables the emotional detachment and resilience which is sometimes considered necessary (Charman, 2013; Scott, 2007). Humour and banter are also suggested to represent a means for reducing stress, anxiety, and tension, and help to create a supportive sense of camaraderie between those who are involved (Lancaster and Phillips, 2021; Rolfe et al. 2020; Mildenhall, 2012).

Perhaps due to the ‘camaraderie of exposure’ engendered by frequently sharing the same public working domain, there are many similarities in the use of humour and banter for both police officers and ambulance staff (Cox and Kirby, 2017; Charman, 2013). For both professional groups their expression is thought to represent a similar cathartic coping function, the informal importance of which is summed up by Charman (2015, p.161) who describes this element of police culture as the canteen ‘repair-shop’. Humour which is shared between such occupational colleagues is also considered to be reflective of a bond based upon shared experiences and values, and an acquired appreciation for what may be considered ‘funny’ within the group context. It has been described as a form of ‘social glue’ which contributes to group solidarity and identity, the sharing of which may define who is (and who may not be) an accepted member of the group (Charman, 2013, p.157; Clompus and Albarran, 2016; Scott, 2007).

Within her focus group study which explored the expression of humour amongst emergency personnel, Scott (2007, p.357) suggests that a ‘social contract’ needs to exist between colleagues who share a joke, and that in the case of ‘dark’ or ‘black’ humour this must be restricted to a trusted group of initiates to avoid the risk of causing offence or being reported for saying something racist, sexist, or otherwise risqué. For Rowe and Regehr (2010) such humour represents a means of reducing negative feelings through expressing something which could be considered socially unacceptable by those who are not part of the culture. In alignment with this, the expression of ‘dark’ humour amongst ambulance staff normally occurs as a ‘back-stage’ private performance away from public scrutiny (Rolfe, 2020, p.2). Indeed, even family, and non-workplace friends are usually excluded on the basis that they wouldn’t understand or appreciate the underpinning context (Clompus and Albaran, 2016).

The ‘camaraderie of exposure’ experienced by both police officers and ambulance staff is also cited as creating similar areas of humour and a resulting bond between the two professions. One shared source for anecdotal ‘back-stage’ humour is reported to be some of the situations which members of the public have called them for, whilst another generic source of joint humour is reported to be the remaining emergency service – the fire and rescue service. This latter source of joint humour seems to be in-part based upon perceived differences and allowances in working practices, such as being able to sleep at night whilst on duty, and a propensity to be overzealous with their procedures at the scene of an incident (Cox and Kirby, 2017; Charman, 2015). This form of humour was most commonly found to be described as light-hearted ‘banter’ by the police officers and ambulance staff involved within Charman’s (2015, p.165) study. It should be remembered however that as no fire and rescue service personnel were involved, their perceptions may well be different.

### The influence of the university

Within the non-medical literature concerning education and identity development there is a consensus which suggests that universities should promote the ownership of professional and personal values and engender an ethos of active participation where students are encouraged to, ‘stop, think and reflect’ after encountering a challenging or transformative situation. (Bramming, 2007, p.48: Hunter *et al.* 2007; Cornelissen and van Wyk, 2007). This is mirrored within the professional medical literature which - whilst acknowledging that HEIs already encourage critical thinking processes and structured reflection - suggest that this process may be enhanced through ‘a skilful mix of support and challenge’ from educators (Wald, 2015, p.702). This is advocated as a means of facilitating professional identity development by encouraging students to have a heightened sense of self-awareness and by enabling them to identify their own professional development needs (First *et al.* 2012; Wald, 2015; Trede *et al.* 2007). According to Trede *et al.* (2012) and Wald (2015), it is incumbent for universities to create such learning opportunities, provide corresponding guidance from academics, and have an assessment structure which enables students to develop the social, critical, cultural, professional, and personal aspects of their intended role.

In this respect Trede *et al.* (2007, p.380) suggest that universities should develop a much more explicit approach to the development of professional identity, with more appropriately orientated programme objectives, the building of a professional ‘community’, and the celebration and promotion of difference and boundaries relating to other professional groups and the public. This is intended to help students recognise that they are part of a particular professional group, and that those who are not part of the same ‘community’ have rights that a professional healthcare worker needs to recognise and respect. According to Filstad and McManus (2011) this approach requires that students reflect upon their relations and reactions to others, be encouraged to develop their understanding of workplace culture and context and learn how to identify and navigate embedded power-relations. Van der Gaag *et al.* (2017, p.191) also advocate that it is the responsibility of educators to ‘lay the foundations of professionalism’, with the inclusion of inter-professional learning being a specific recommendation. Trede *et al.* (2012, p.381) additionally suggest that educators should explore ‘strategies and innovations’ which enable students to more easily identify with their professional community. This may include learning alongside other professions to recognise role boundaries and areas of expertise, and ultimately to better understand their own professional identity.

There has however been a dissonance identified within the literature between the reality of the practice environment and the programme content taught at university. Although their study only involved 8 interviews and may have limited generalisability to the UK due to being conducted in Australia, Lazarsfeld-Jenson *et al.* (2011) report that their participants (newly qualified paramedics) felt that university left them generally ill-equipped for the professional workplace. Whilst these participants acknowledge that they had some opportunity to utilise their more advanced theoretical learning, their experiences resonate with Devenish (2014) and Donaghy (2020), who similarly describe experiences of student unpreparedness due to perceived differences between what is taught at university and the reality of the pre-hospital workplace. A similar misalignment between the curriculum and the practice environment was explored by West and Chur-Hansen (2004) in their study exploring the ethical and moral development of 6 undergraduate medics through open interviews. Although of limited application to the current study due to the relatively small sample and professional dissonance, the authors suggest that universities should acknowledge the potential existence of a ‘hidden curriculum’ and adjust their provision more towards action and behaviour (rather than theory and concepts). This accords with the findings from other studies which additionally suggest that in relation to healthcare courses, the ‘hidden curriculum’ may be even more influential than that which is formally taught (Raso *et al.*, 2019; Devenish, 2014; Hafferty, 1998).

According to Hafferty (2015, p.133), the ‘hidden curriculum’ represents the conveyance of values from a pervading organisational culture which are ‘taken for granted’ and therefore invisible to educators who may be (or may have been) a part of that culture. Within higher education, it has also been defined by Cotton et al. (2012, p.192) as ‘the societal, institutional, or lecturers’ values that are transmitted unconsciously to students.’ In relation to paramedic student education, Devenish (2014) highlights the implicit and disproportionate emphasis which may be given to the critical intervention and acute life-saving aspects of paramedic work during the formal periods of education – when the daily reality of pre-hospital care is acknowledged to involve a much greater proportion of ‘complex health and social care’ cases (Newton, 2019, p.140; Proctor, 2019). According to Devenish (2014), this dissonance may reflect the older in-house vocational models of paramedic education, and an occupational identity which was once defined by trauma and invasive clinical skills. It may also account for why paramedic lecturers could be less inclined to emphasise certain aspects of the curriculum or relay personal experiences which are aligned more with mental health and social care. Alluding to similar perceived misconceptions within a six-year study involving 29 medical residents, Pratt et al. (2006) suggest that educators need to have greater cognisance of what they may be unintentionally conveying to students.

## Individual passive influences

The themes explored within the ‘Structural Field of Practice’ are likely to be important for a phenomenological exploration of paramedic student professional identity development in relation to the pervading environment and culture. Bourdieu’s conception of ‘field’ represents a helpful depiction of such influences, which accordingly may both enable and constrain individual thinking and behaviour (Wacquant, 1998). For Bourdieu, this ‘struggle’ is loosely defined as ‘practice’ and represents the means through which individuals identify and interpret social meanings according to time and circumstance. However, the degree to which individuals may ‘produce’ (contribute to) and/or ‘consume’ (or benefit from) ‘practice’ is reliant upon what is defined as ‘habitus’ (Rawolle and Lingard, 2013, p.123).

For Bourdieu, habitus is representative of our subconscious disposition to participate with and contribute to practice in accordance with historical ‘social conditions and conditionings’ (Wacquant, 1998, p220). This is manifested through affiliation towards seemingly familiar situations which may incorporate social, cultural, and political elements, and with individuals whom we perceive to have analogous life experiences and backgrounds (Rawolle and Lingard, 2013). Bourdieu (1998, p.80) referred to this potentially advantageous disposition as having a ‘feel for the game’.

The experiential and social inheritance which underpins habitus is described by Bourdieu (1986) as capital. Acknowledging the more commonly understood concept of economic or financial capital, Bourdieu additionally suggests that individuals have social capital (denoting access to social networks and ‘connections’) and cultural capital (denoting educational credentials and informational resources), which depending upon the circumstances may bring cultural and social advantage or disadvantage. For Bourdieu, cultural capital is insentiently passed on via an individual’s upbringing and family through ‘social reproduction’, which is itself determined by socio-economic status (Kleanthous, 2013, p.156; Bourdieu, 1998).

As they must now possess the economic and cultural capital to successfully complete a paramedical bachelor’s degree at university, concepts such as habitus and capital are thus likely to be important for exploring how paramedic students negotiate their sense of identity within the professional workplace (HCPC, 2018). Indeed, cultural, and social assets which may be advantageous in gaining access to a university education may not be conducive for a professional workplace whose members may still affiliate with ‘blue-collar’ working practices. (McCann *et al.*, 2013).

Although there is some debate as to whether the enaction of habitus is a completely unconscious act (Basford, 2016), I have included it within this section on the basis of it being a potentially passive – rather than a deliberate process. Additional areas included within this section on the same basis include, preconceptions and personality, age and life experience, gender, and ethnicity.

### Socio-economic background and habitus in the pre-hospital workplace

The inception of paramedic science at university within the UK fell within the context of the response to the Dearing Report (1997), which recommended that higher education should contribute to the ‘learning society’ with regards to scholarship, research and ‘lifelong learning’. It also advocated that employers should engage with higher education in order to promote economic competitiveness and social justice through fostering wider applications from ‘non-traditional’ and under-represented groups who may not have considered a more traditional academic course (Hayton and Tang, 2016, p.75; QAA, 2010; DfEE,1998).

However, despite a continuing political promise to widen participation at university (Connell-Smith and Hubble, 2018), the establishment and maintenance of tuition fees has potentially contributed to a lack of representation from socially deprived groups, and concerns from potential applicants about being burdened with a significant debt should they go to university (Hayton and Tang, 2016; Chitty, 2014; DfEE,1998). Indeed, according to Greenbank (2009) and Whitty (2016), applicants from lower socio-economic backgrounds have been effectively excluded from higher education through having an aversion to accruing such debt. This is something which may have been exacerbated recently for paramedic science by the requirement to have a bachelor’s degree at the point of registration (HCPC, 2018); a change which will generally increase the course length (and therefore the tuition fees) in comparison to the prior foundation degree and diploma programmes (UCAS, 2022).

Unfortunately, there is a dearth of literature which explicitly explores the socio-economic origins of university students who are enrolled upon professionally orientated courses. What has been published however, suggests that in accordance with Bourdieu’s (1998) concept of habitus, an individual’s background and demographic may influence their capacity to socially network and integrate within the workplace (Devenish, 2017). For the purposes of the current study, the potential exclusion of applicants from poorer socio-economic backgrounds may thus create a predominant group who may not have a ‘feel for the game’ within a ‘blue-collar’ professional workplace. Indeed, within the context of similar educational/professional changes, Charman (2015, p.168) found suggestions that graduates within both the police and the ambulance service represent a ‘new breed’ who may have more in common with each other than with their respective ‘long-service’ non-graduate professional colleagues.

According to Cox and Kirby (2017), the view that all police officers should be graduates has divided opinion, with some arguing that policing organisations within the UK should be representative of the populations they serve – most of whom do not have a degree. Some policing students within this study also reported experiencing some pejorative dissonance with members of the public and had already established an ‘us and them’ mentality (Cox and Kirby, 2017, p.556). Although different in terms of their professional engagement, paramedic students within Devenish’s (2014) study similarly reported feeling judgemental towards those who live in lower socio-economic areas. Acknowledging their own limited life experience and naiveté, one student additionally describes encountering the health conditions and living situations of patients from lower socio-economic groups as ‘shocking’ and ‘scary’.

In a review exploring the admission criteria of medical schools in the US, Bowman (2007) also questions the work-readiness of medical students from ‘elite’ and ‘professional’ backgrounds; suggesting that students from middle or lower-income families may make the best candidates due to their potential diversity of age and life experience and their capacity to relate to patients from lower socio-economic backgrounds. It has been documented however that students from such backgrounds and more diverse ethnic groups frequently under-perform at such ‘professional schools’ (Costello, 2005, p.117). Perhaps echoing Bourdieu’s (1986) conception of habitus, the reason for this difficulty is cited to be ‘identity dissonance’, which represents the experience of trying to reconcile a new professional identity with an established personal identity – which may well have been forged under different socio-economic circumstances to their student and professional peers. Once established, personal identities are considered to be less malleable and more ingrained than professional identities, requiring students to adopt, ‘different values and emotional orientations.’ The integration of a new professional identity is thus considered to be a relatively easy process for those whose personal identities and backgrounds are consistent with it, but ‘traumatic’ for those who experience a conflict (Monrouxe, 2010, p.42; Costello, 2005).

Although the literature is sparse in relation to the socio-economic status of university paramedic students within the UK, that which does exist suggests that by virtue of their university student status, they are unlikely to have a lower socio-economic background. In accordance with Bourdieu’s (1986) concept of habitus, this may affect their ability to relate to non-graduate professional peers, and indeed the health and living conditions of some service users.

### Pre-conceptions and personality

The aspiration to undertake a university course which is affiliated to a particular profession, and eventually become a member of that professional group, is broadly thought to originate from an individual’s schooling and socio-economic/cultural background. It is considered to be influenced by parental role-modelling, and the belief that the professional position (once qualified) will align with their intellectual abilities and personal ideals (Cant and Higgs, 1999; Barbara-i-Molinero, 2016).

In relation to paramedic university student pre-conceptions, Devenish (2014) accordingly found that the influence of family and friends had the greatest impact, with potential professional contacts enabling them to find out more about the role. Devenish *et al.* (2017) also suggest that due to stereotypical and misleading preconceptions which may be commonly created by television and popular media, it is advantageous to have an associated health professional as a family or friend for providing a more realistic insight.

However, within a survey of 102 Australian paramedic university students, Johnston (2020) found that the majority (74.5%) of participants had very limited prior engagement with the paramedic profession or occupational role-modelling from parents or close family. Whilst both Devenish (2014) and Johnston (2020) cite that there is a dearth of literature which explores the professional socialisation of paramedics, their findings do support the value of role-modelling from family and friends, although they do also suggest that there may be a lack of such support for paramedic university students. This lack of role-modelling was also more generally found by Adams *et al.* (2006) within a survey of 1254 Health and Social Care UK university students. This study found that the actual influence of family members is negligible, although prior relatable healthcare experience does seem to facilitate the development of a stronger sense of professional identity and affiliation.

In terms of personality, Granter *et al.* (2018) suggests that paramedic work is representative of ‘edgework’, a professional field which attracts individuals who thrive in a pressurised high-stakes environment. Whilst this study had 12 paramedic participants and included 150 hours of observation and 80 semi-structured interviews, it may be of limited value in relation to the current study as it does not explore educational background and no students are included. However, within a focus group study exploring the concept of professionalism which did include paramedic students, the HCPC (2011, p.35) found a consensus that ‘the right sort of person’ will be attracted to a particular profession, and that an individual’s personality may be linked to their aptitude within that profession. This was found by Hallam *et al.* (2016) in a survey comprising 160 nursing students and 50 paramedic students in their first week at university. This study suggests that both health professions tend to attract those with analogous personality traits, which for the paramedic students included higher scores relating to emotional stability and extraversion – although this may have been confounded by the younger average age of the nursing students.

For paramedics, the importance of a personality which has some congruence with the working and learning environment is suggested by Filstad and McManus (2011). They suggest that whilst proactive newcomers might find it easier to gain acceptance from professional colleagues, where personalities clash or someone is shy, access to support may be denied. In a study which sought to explore learning within a working practice environment, Cheetham and Chivers (2001) undertook surveys and interviews with 452 professional representatives (from such professions as dentistry, accountancy, and the Civil Service). Whilst this study broadly found that the personality of the learner may play an important part in benefitting from a particular formative workplace experience, it did not include paramedics, and therefore may have some dissonance.

Whilst the literature may suggest that the emergency pre-hospital workplace attracts individuals with particular personality traits, and that congruence with the CoPr is likely to be important for accessing and benefitting from formative learning, the concept of ‘cognitive flexibility’ may also represent an important factor. ‘Cognitive flexibility’ thus encompasses social awareness and an individual’s ability to restructure knowledge in a novel situation. It includes their ability to observe, adapt, assert, and be responsive to the ‘relational needs of others’, and is hypothesized to influence how readily individuals embrace a new professional identity (Adams *et al.*, 2006; Martin and Anderson, 1998; Spiro and Jehng, 1990). This concept is mirrored by Filstad and McManus (2011) who assert that knowledge and learning are dynamically embedded within the context and culture of the pre-hospital workplace. They recommend that newcomers would benefit from development work which enables them to identify and navigate embedded power relations and which enhances their ability to socialise and participate within the pre-hospital workplace.

### Age and life experience

Since moving its educational provision to university, paramedic science has attracted a potential workforce which is often younger and is deemed to have less applicable life experience than those recruited under the previous vocational system (Lazarsfeld-Jensen, 2019; Willis *et al.*, 2010; Joyce *et al*., 2009). In a focus group study involving 96 paramedics (which included academic staff, students, and qualified paramedics), Willis *et al.* (2010, p.4) accordingly found that there was a perceived lack of empathy, maturity and interpersonal skills amongst ‘novice graduates’. However, this study was based in Australia and is now twelve years old; a factor which may reduce its applicability since there will have been many more graduates entering the profession since then, and university/practice educators have had more time to tailor their provision.

Those entering healthcare are however ideally considered to need sufficient life and care experience to engender appropriate empathy and communication with patients; the lack of which is a potential area of concern (Williams *et al.*, 2015a; Bowman, 2007). This is supported by Lazarsfeld-Jenson (2019, p.513), who suggests that young students may lack ‘socio-emotional competence’ due to societal changes over recent decades (such as a generalised breakdown in family cohesion) and undertake ‘their most significant relationships’ within disembodied online communities (Lazarsfeld-jensen, 2010, p.371). However, according to Waxman and Williams (2006), maturity is often erroneously conflated with life experience within the literature, and that it is quite possible for an 18-year student old to have significant and applicable life experience. Indeed, within a study involving semi-structured interviews with 8 student participants Henderson (2012) found that some graduate-entry students had incredibly valuable life-experiences (such as exposure to alcohol and substance misuse) which established staff sometimes found disconcerting.

When commenting on their workplace exposure, participants within Henderson’s (2012) study generally reported that their age had impacted upon their experience. Mature students found this to be generally positive and some were able to relate aspects of the pre-hospital workplace to their prior life experiences, which quickly engendered commonality and credibility with established staff. A similar ability to relate and ‘negotiate learning opportunities’ with established staff was found by Kevern and Webb (2003, p.301) in a focus group study involving 32 mature (mean age of 41) nursing students entering the workplace. This study also cites that the students’ age and life experience enhanced their ability to relate to patients. For younger paramedic students however, some older studies suggest that their experiences seems to be generally more negative, with a perceived lack of credence given by both ambulance staff and service users (Henderson, 2012; Waxman and Williams, 2006). Devenish (2014) found a similar theme, and documents that more mature students had less fear of appearing ignorant and were consequently more likely to seek clarification if they didn’t know something. Mature students were also seemingly better able to avoid conflict, with younger students clashing more frequently with established staff.

Perhaps of particular relevance to the current study are the results of two questionnaires conducted by Williams *et al.* (2015b) and Williams and Teese (2016) with undergraduate students in Australia (involving 479 and 1,264 participants respectively). These studies suggest that older/mature students are less likely to self-identify as university students, and that such students may already have an established sense of self-identity before attending university. Williams and Teese (2016) also hypothesise that a professional identity takes years to build, and that mature students more readily understand that such a development necessitates having an appreciation of the specific roles and responsibilities of their chosen field.

### Gender

The pre-hospital workplace has been described as traditionally dominated by high acuity emergency calls and characterised by a masculine militaristic culture. It is apparent however, that in congruence with developments in professionalisation and academisation, there has been an increase in the more ‘feminine’ empathic nature of the role, with associated changes to the workforce gender demographic (Williams, 2011, p.370; Johnston and Acker, 2016). This change is reflected within the literature from the UK and Australia (which has witnessed similar organisational and operational changes to the UK), and both countries have seen a rise in the number of females joining the paramedic profession via a graduate route of entry (Johnston and Acker, 2016; Joyce 2009). Indeed, according to the UK Commission for Employment and Skills, the paramedic workforce within the UK in 2020 was 45.4% female, indicating an erosion of the numerical domination by males in the pre-hospital workplace (GOV.UK, 2020).

Despite such demographic changes, there are suggestions that a masculine cultural legacy still exists within pre-hospital care and that females may feel pressurised to become ‘geezer birds’ through adopting a more robust, loud and banterous demeanour in order to fit in (Clompus, 2016, p.3). As a further potential consequence of this legacy, some female ambulance staff and students report that they have received negative and sexist comments from male staff pertaining to their physical strength and suitability to undertake the role (Baronowski, 2020; Boyle, 2008; Michau, 2009).

Further evidence that discrimination may still persist however, was found within a recent survey of 2815 participants working as part of the equivalent Emergency Medical Services (EMS) within the United States. It was found that females were still 58% more likely to experience incivility and sexually orientated comments in the workplace from male members of staff (Cash et al., 2018). This is supported by a mixed methods survey from the UK which explored bullying and harassment within one large NHS Ambulance Foundation Trust. This report describes an embedded culture of overt and covert sexualised behaviour towards females, with descriptions of inappropriateness being considered “the norm”, and predatorial male managers offering advancement in exchange for sexual favours and effectively grooming female students for “sexualised ends” (Lewis, 2017, p.36).

Noting a dearth of research exploring gender preferences between students and mentors, Lewis et al. (2019) undertook a quantitative study in the United States which analysed the clinical interventions of 16,466 emergency calls and the gender mix of paramedic trainees and their instructors. Admitting to a prior assumption that there would be incompatibility between male instructors and female students, the authors found no evidence to suggest any difference in performance related to having either a male or female instructor; although it was found that female students were statistically less likely to perform certain clinical skills whatever the gender of their instructor. However, in a quantitative survey exploring the performance and motivation of 20,000 students in science- related subjects at the University of California, Solanki and Xu (2018) found that gender congruence between students and teachers positively influences the learning process. Whilst with female instructors there was some desired narrowing of the educational attainment gap in these subjects between males and females, they also found that male students tended to respond more negatively. The author’s link these findings to identity-based motivation theory, which suggests that a sense of identity compatibility is important for motivation, and that students may more readily identify with a subject area represented by someone of the same gender (Oyserman, 2007).

### Ethnicity

Within the literature there are accounts of Black and Minority Ethnic (BME) staff and students being subjected to endemic and persistent inequality and racism within the pre-hospital workplace. In a qualitative study exploring barriers to paramedic education for BME groups, Farquharson et al. (2017, p.24) report participants encountering ambulance staff with stereotypically racial preconceptions and an insensitive lack of cultural understanding. They describe ‘inappropriate communication’ from non-BME staff and incidents which have overtly or seemingly unconsciously caused ‘racial offence’. In a personal reflection as a newly qualified paramedic from an East African-Asian Muslim background, Bandali (2020, p.401) recalls receiving offensive remarks about wearing her hijab, being asked why the Taliban are ‘over here?’, and being told to ‘just eat some bacon’ whilst fasting. In addition to experiencing such behaviour from workplace staff, Bandali (2020) also describes receiving racist comments on several occasions from members of the public. This is mirrored by a phenomenological investigation of physiotherapy student experiences from a BME background, which revealed examples of ‘blatant racial/ethnic discrimination’ from members of the public in the practice setting (Hammond *et al*., 2019, p.8).

When asked about how their experiences make them feel, staff and students from BME backgrounds working in healthcare commonly report feeling marginalised and alienated from their peers. A sense of ‘profound loneliness and isolation’ was reported by Gardner (2005, p.156) in a phenomenological study involving 15 nursing students from BME backgrounds. With evident emotion, several participants relayed how they had felt excluded by non-BME students, and that there was no one they could confide with who could understand. Hammond *et al.* (2019, p.8) similarly found that physiotherapy students from BME backgrounds felt like outsiders on the course and had a sense of ‘not fully belonging’ in their chosen area of study. This sense of exclusion is also reflected in the pre-hospital workplace by Farquharson *et al.* (2016) and Bandali (2020, p.401), who similarly describe feeling out of place, and having “no sense of belonging”. These descriptions are of potential significance for the current study, as Hammond *et al.* (2019, p.5) posits that feeling ‘positioned as an outsider’ will have an impact on the professional identity development of BME students and their own sense of authenticity for undertaking the professional role.

It is perhaps logical to assume that such a pattern of experience is likely to discourage applications from BME groups and reduce their retention within the workforce. Whilst there are no specific suggestions of improper or isolating behaviour, the Workforce Race Equality Standard (WRES) 2020 data also indicates that BME clinical staff numbers (bands 5-7) are disproportionately low amongst pre-hospital ambulance employees. Table 2 contains a selection of BME clinical staff percentages from the 11 UK ambulance services; the mean average for UK healthcare organisations is 21.5% (WRES, 2021). These comparatively low percentages suggest that many ambulance services are potentially missing out on what Asamoah-Danso (2020, p.290) suggests could be a more diverse ‘multi-layered, stronger model of care’.

**Table 2**:

WRES 2020 data for BME clinical staff within a selection of ambulance services.

|  |  |
| --- | --- |
| UK ambulance service | Percentage of clinical staff from BME groups  (bands 5/7) |
| North West Ambulance Service NHS Trust | 2.1 |
| South East Coast Ambulance Service NHS Foundation Trust | 3.3 |
| North East Ambulance Service NHS Foundation Trust | 1.2 |
| South Central Ambulance Service NHS Foundation Trust | 3.6 |
| South Western Ambulance Service NHS Foundation Trust | 1.9 |
| East of England Ambulance Service NHS Trust | 2.2 |

In terms of offsetting the potentially exclusionary feelings of seclusion and dissonance, the concept of reverse mentoring has been employed within some professional organisations over recent years. This initiative represents a reversal of the traditional model of mentorship and partners an experienced mentee (who usually occupies a more senior position within the organisation) with a junior and professionally inexperienced mentor – who nonetheless has a specific area of personal experience. The junior mentor is thus able to share their experiences and raise awareness of potential disadvantage and discrimination (Curtis *et al*., 2021; Murphy, 2012). For junior employees from a BME background, reverse mentoring has gained momentum within healthcare, with initiatives such as the Reverse Mentoring for Equality, Diversity and Inclusion (ReMEDI) project and the commencement of a BME focussed reverse mentoring programme announced by Health Education England for the London area (FFF, 2020; HEE, 2019). Whilst the overall aim is for increased cultural understanding and a decrease in negative stereotypes, a considered benefit for mentors from a BME background is an increase in ‘social capital’, which may include having greater social ties with more established staff within the workplace (Murphy, 2012, p.562; Stephenson, 2016).

## Individual agency

### Experiential learning

Considering the process of enculturation to be an amalgam of social, cultural, and unconscious factors, arguably ignores the potential influence of an individual’s active participation and deliberate action (Emmerich, 2015, p.1056; Bramming, 2007). Described as ‘an important mediator between experience and identity’, experiential learning and the concept of ‘reflection-on-action’ thus represent the realignment of an individual’s perception after an experience has been deliberately analysed (DeWerdt *et al.*, 2006, p.318; Schon, 1991). According to Shimahara (1975, p.148) and Peel (2005) professional identity development and enculturation represent a conscious ‘personal odyssey’ which requires an active and ‘creative process of enquiry’ to achieve a unique change and realignment of concepts according to the interpretation of an experience. Universities are considered to be vital in the facilitation of such ‘moments of vision’, and essential for the acquisition of the analytical skills which enable the application of abstract theory to a transformative learning experience (Trede *et al.*, 2012, p.378). In this respect, experiential learning is considered essential for professional identity development and academic guidance is thought to be instrumental in learning to engage with a process which is not necessarily instinctive (Wald 2015). The importance of critical reflection for paramedics is also stressed by Boyle *et al.* (2008) who suggest that it plays a vital part in metacognitive learning processes, and in learning how to learn.

In a study of medical students however, West and Chur-Hansen (2004) found that many of the theoretical concepts learned within the classroom were abandoned upon entering the workplace and that the influence of the university upon the assimilation of a professional identity was actually quite weak. They suggest that the focus of education needs to be orientated towards ‘action and practice’. This does not however concur with the need for what Kolb (1984) describes as ‘abstract conceptualisation’ - the interpretation of events and interrelationships according to theory. Without this, according to Kolb (1984), learners fail to comprehensively complete a structured cycle of reflection and may fail to achieve the desired levels of reflexivity. In accordance with this, the ability to become more self-aware through self-reflection and experiential learning is likely to be important for an exploration of enculturation and professional identity. For O’Donovan (2006) being appropriately taught how to undertake reflective practice is vital, but students also need to be given adequate time to do it within the workplace. This was found to be an area of difficulty for the nursing students in O’Donovan’s (2006) study.

The potential impact of experiential learning and abstract conceptualisation (as part of Kolb’s (1984) cycle of reflection) may also mirror Heidegger’s philosophy concerning developing self-perceptions and the potential ability to have ‘moments of vision’ as individuals socialise and interact with other people (Wisnewski, 2013, p.126). Within Chapter 4 I will explore the key elements of Heidegger’s philosophy which I have used to expand upon the personal and subjective nature of the research questions and to further explore the conceptions of ‘self’ and individual ‘meaning’ which underpin hermeneutic phenomenology (Paley, 2017).

### Choosing who and what to emulate

Learning through observing others is suggested by Bandura (1986) to comprise of four key elements: attention, retention, production, and motivation. The first element necessitates that the observed behaviour is attractive in some way to the learner, which may be influenced by how much they like or identify with who or what they are witnessing. The last element suggests that there needs to be some kind of reinforcement or implied benefit to learning what is being observed. According to Cheetham and Chivers (2001) these two elements highlight that not everything which is observed will be learned, and that this may be dependent upon an individual’s level of application and desire to learn at that time.

In their research involving professional trainees, Bucher and Stelling (1977) additionally reject the notion that learners simply model themselves upon just one person and instead suggest that a variety of role models are drawn upon as the learner tailors their own schemata of professional identity. In this respect, Bucher and Stelling (1977) identify five kinds of modelling behaviour, summarised below:

* The partial model – the demonstration of a particular skill or characteristic deemed worthy of learning
* The charismatic model – inspiration and idealisation
* The stage model – the demonstration of the level which should be aspired to
* The option model – the provision of alternative professional viewpoints
* The negative model – a demonstration of how not to act

In terms of professional healthcare, this is contextualised by Kirsten *et al.* (2017) in a narrative study involving 14 student nurses. Within this study it was found that specific features found to be inspiring included good clinical knowledge and experience, and that whilst students were assigned to specific mentors, they may identify any member of staff as a positive role model. Within a similar study involving 8 ‘exemplary’ nurses, Perry (2008, p.39) also found that attending to the ‘little things’ in terms of kindness towards service users and demonstrating understanding for student inexperience were considered important behaviours for role models.

Within a study involving semi-structured interviews with 5 newly graduated nurses, Hunter and Cook (2018) found that participants similarly valued observing professional attributes such as calmness, respect and empathy, and that there is a distinct element of choice in terms of what learners chose to emulate. It was also found that in accordance with Bucher and Stelling (1977), participants were able to utilise the modelling of negative attributes in helping to discern behaviours that they would avoid adopting. Of key interest for the current study is perhaps the projection of this selectivity towards their own role modelling behaviour. Participants were thus able to critically analyse both positive and negative learning experiences for when they would be potential role models for future nursing students.

Whilst there are some limitations in terms of the transferability of these findings due to some low participant numbers and professional dissonance between nurses and paramedics, it is still likely that there will be some areas of similarity for students learning within the pre-hospital workplace. Indeed, within a study involving semi-structured interviews with 8 student paramedics, Lane (2014) found that participants acknowledged the importance of role modelling, with specific positive reference given to good clinical knowledge and enthusiasm. However, Lane (2014) also suggests that other healthcare professions do not mirror the idiosyncrasies of pre-hospital care, especially in relation to the unique one-on-one model of supervision. This is a feature which may logically limit the range of observable professional role models available to student paramedics.

## Chapter summary

This chapter has outlined the overarching research question and the objective of the current study. It has described the personal, professional, and educational context, and has included a critical review of the literature structured around pertinent social theory. The next chapter will present the methodology and design of the current study. It includes a section devoted to a reflexive exploration of my own professional and academic experiences and my approach towards analysing the data. It additionally includes a description of the elements of Heidegger’s phenomenological philosophy I have used to structure the findings and guide the discussion.

# CHAPTER 3

Research methodology and design

## Research methodology and design

### Overview

Following on from the review of the literature, this chapter outlines the research methodology, its design, and my approach to analysing the findings. It also includes a reflexive section within which I have attempted to convey my own ‘Thrownness’ in relation to the subject and my potential for bias (see *The concept of Thrownness* section on p. 92)

### The Paradigm of enquiry

The paradigm of enquiry represents the principles and assumptions which are shared by researchers within a discipline and provides direction on which methods of inquiry are likely to yield the most appropriate information (Bunniss and Kelly, 2010). As a conceptual framework, it may provide structure, coherence, and consistency through underpinning all aspects of a research project and contextualising theoretical and philosophical assumptions (Durham, 2015). For Collins, (2010, p.3) it represents the ‘lens through which we view the world’.

In accordance with Punch (2011), the paradigm of enquiry for the current study will express my own assumptions in relation to the nature of knowledge and the modes and methods of enquiry which are most likely to elicit the desired data. These assumptions are based largely upon my prior experience of the phenomenon, an exploration of the literature, what kinds of data are considered most likely to answer the overarching research question, and relatable elements of hermeneutic phenomenology - such as the intention to combine both the literature and my own pre-conceptions in order to explore the ‘socially situated meanings, habits and practices’ of the participants (Matua and Van Der Wal, 2015, p.25). There are three key areas which will help to explore these assumptions and illustrate connections between the underlying philosophy and the chosen methods. These areas include ontology, epistemology, and methodology (Punch, 2011).

### Ontology

Ontology represents an assumption about the nature of knowledge and reality. It represents a commitment to how the researcher believes individuals interact with the world, and the approach which should be employed in answering a research question (Basit, 2010; Collings, 2010).

In accordance with the interpretive nature of the research question and considering its potential place within the reviewed literature, I have chosen a subjective ontological stance which encompasses evolving social constructions, interactions, individual perceptions, and patterns of behaviour (Collins, 2010). This stance is supported by Durham *et al.* (2015) who suggests that this approach seeks to explore the meaning attributed by individuals to experiences of socially constructed reality and through their interactions with others. This contrasts with a less appropriate (in this context) objective ontology, which posits that the environments and circumstances in which individuals exist and interact are part of a distinct external and separate reality which may be isolated and empirically studied (Basit, 2010; Durham *et al.,* 2015).

For Basit (2010, p.6) ontological assumptions are concerned with the nature of the social phenomenon being explored, and ‘the very nature of being’. Exploring this concept is fundamental for the philosophy of Martin Heidegger, who considered that ‘Western thought’ has forgotten to question what it means to ‘be’, and simply assumes that notions of our existence are commonly understood and beyond question (Heidegger, 1927, p.19). An exploration of ‘Being’ is however complicated in that the very act of questioning presupposes the existence of something – if only the individual asking the question, or the assumption that there will ‘be’ a predicate answer of some sort. To overcome this, Heidegger began his investigations into the nature of ‘Being’ through focussing upon the inquirer as a means of orientation, whereby; there ‘is’ an inquirer, there ‘is’ an object of analysis, there ‘is’ a question, and there ‘is’ the assumption that there will be an answer. This led Heidegger to consider that our understanding of ‘Being’ is contextual and related to the world in which we exist (Wisnewski, 2013). Heidegger goes on to claim that our knowledge of the world is created partly through the projection of our own meaning and understanding upon it, and that this creation is shared with the other people who share the same milieu. For Heidegger, our own understanding of ‘self’ is thus based upon the understandings we share with others, and that we are ontologically ‘in’ (and help to create) a world of shared social context and significance (Wisnewski, 2013). The incorporation of such a phenomenological philosophy (which encompasses the creation and sharing of social context) I believe further supports the adoption of an overarching subjective ontology for this study.

### Epistemology

The next structural layer within a paradigm of enquiry is the consideration of epistemology. Epistemology relates to the researcher’s assumptions regarding the nature and forms of knowledge, and how it may be acquired and conveyed to others (Cohen *et al.*, 2010). The exploration of professional identity development in the pre-hospital workplace according to a subjective ontology is thus likely to generate data which is relativistic, contextual, and subject to interpretation (Cohen *et al.* 2010; Basit, 2010). In accordance with Durham *et al*. (2015) and Basit (2010) I therefore decided that the best method of exploring and analysing the subject area would be through an interpretive or constructivist approach, which aims to explore individual perceptions, experiences, and behaviour.

Although constructivism and interpretivism are terms which are used interchangeably by Morgan (2007), a distinction is drawn by Punch (2011, p.18), who suggests that the former depends upon individual or group constructions of ‘reality’ in accordance with social and experiential factors, whilst the latter relates to meanings which are created by individuals and applied to situations as a means of understanding the world (O’Donoghue, 2007). In alignment with an interpretive approach, I have therefore applied the concept of hermeneutic phenomenology underpinned by the philosophy of Heidegger (1927) in relation to ‘Dasein’, ‘inauthenticity’ and the temporal structure of ‘Care’.

A hermeneutic phenomenological approach is intended to incorporate the exploration of individual experiential interpretations (or ‘lived experience’) and the attribution of meaning to those experiences. It differs from descriptive phenomenology which focusses more upon objectively describing the general characteristics of a phenomenon rather than considering an individual’s experience of it (Matua and Van Der Wal, 2015). Descriptive phenomenology - based upon the work of phenomenologist Edmund Husserl (1859 – 1938) - seeks to effectively disregard context and interpretation, and to instead explore the essence of the phenomenon in its purest pre-reflective form. To achieve this the researcher must acknowledge and seek to ‘bracket’ their potential pre-conceptions, interpretations, and bias so that unprejudiced data may be collected and analysed (Husserl, 1900; Matua and Van Der Wal, 2015; Tuohy *et al.*, 2012).

However, in alignment with interpretive phenomenology (and my own personal perspective), Finlay (2008) suggests that an individual’s personal bias and preconceptions should be acknowledged and used to help understand the meaning that people attribute to their experiences. It is this attribution of meaning which according to Paley (2017) is unique to phenomenological research and which may also help facilitate the subjective and contextual interpretations of ‘self’ and ‘Being’ associated with the work of Heidegger and with the potential development of professional identity (Wisnewski, 2013). Many authors also consider it nearly impossible for a researcher to transcend their preconceptions, or to side-line the background of understandings which led them to undertake the research in the first place (Matua and Van Der Wal, 2015; Koch, 1995; Finlay, 2008; Humble and Cross, 2010). An interpretative phenomenological approach thus makes allowance for my own pre-conceptions and bias, integrating them into the data analysis, and facilitating the achievement of a deeper understanding of the phenomenon (Humble and Cross, 2010; Flood, 2010).

### Methodology

In considering the ontology and epistemology for the current study, the adoption of a predominantly qualitative methodology would seem to fit with interpretive phenomenology, and the view that subjective social reality is context-bound, dependent on interaction, and both perceived and ‘created by human experience’ (Basit, 2010, p.16). In selecting a methodological approach however, I am cognisant that it will be worthwhile exploring what Holloway and Wheeler (2013, p.23) describe as the ‘paradigm debate’. This ‘debate’ can be traced to criticism of the traditional nineteenth and early twentieth century scientific modes of quantitative research which were concerned with numerical evidence, objectivity, and replication of results. It was however believed that this positivist approach could not fully account for the complexities of human behaviour, which led to a rise of interest in more subjective qualitative approaches (Holloway and Wheeler, 2013; Bunniss and Kelly, 2010; Collins, 2010). Accordingly, the growth of qualitative approaches represented a challenge to traditional positivism, and caused a divide within the research communities, with researchers becoming polarised in their views towards each methodological approach (Punch, 2011).

Over recent years, such polarisation has been considered too restrictive and it is recommended that research designs should therefore lie along a continuum between complete objectivity and subjectivity, with a mixed-methods approach being ideal (Holloway and Wheeler, 2013). For Basit (2010) such combinations are becoming increasingly favoured, allowing for the subjective exploration of personal experience along with the inclusion of greater numbers, thereby potentially generating greater transferability.

Whilst I did consider the inclusion of a quantitative questionnaire for this study – to include the opinions and feelings of a larger sample and potentially increase transferability – I felt that it would not lend itself to an interpretative phenomenological epistemology, nor allow me the time to fully explore the meaning which is attributed by individuals to their ‘lived experience’ (Smith *et al.*, 2012, p.32). For Basit (2010, p.17), a mixed-methods approach does ‘not suit every researcher or research problem’, and it is important to ensure that methodological and ‘epistemological congruency’ is realised between the research question, the aims, methods, data collection and analysis – something which I felt would be more readily achieved via focussing upon a qualitative approach involving interviews (Punch, 2011, p.4; Taylor and Francis, 2013). According to Punch (2010, p.64), ‘it is better to do a smaller project thoroughly than a larger project superficially’ and ‘trimming a project’ to an appropriate size is a matter of judgement.

### Reflexivity

Through adopting a subjective ontology, interpretive phenomenological epistemology and a qualitative methodology involving interviews, I am conscious that my own potential bias and assumptions may have affected the collection and interpretation of the data (Lincoln and Guba, 1985; Haynes, 2010). In accordance with Cohen *et al.* (2010, p.171), I may have thus brought my own ‘biography’ which may have influenced the behaviour of the participants and their own interpretations. Bunniss and Kelly (2010, p.363) also suggest that it should be a ‘basic assumption’ that the perspective of the researcher will be ‘inextricably bound’ to the findings of the study, and that eliminating bias should not be a goal for interpretive research.

Having over twenty-five years of experience within the pre-hospital working environment may undermine my objectivity, but it may also facilitate greater understanding of the phenomenon and engagement with the participants, thereby attributing greater meaning through ‘researcher-participant interaction’ (Punch, 2011, p.45; Weaver and Olson, 2006; Taylor and Francis, 2013). For Bunniss and Kelly (2010, p.363), the creation of knowledge within an interpretivist paradigm is a participative ‘social act’. They additionally suggest that one of the aims should be an exploration of how the researcher’s ‘thoughts, feelings, opinions, and experiences’ influence what is observed and recorded. This is considered by Gerrish and Lacey (2006) to be integral to the process of undertaking qualitative research, requiring constant self-reflection and self-examination with regards to how the ‘position’ of the researcher affects the responses of the participants, the approach to data collection, the analysis, the write-up, and its dissemination. In this respect, through embracing and engaging with the possibility of bias, reflexivity effectively supports validity and reliability through revealing it and placing it in context (Noble and Smith, 2015; Cohen *et al*., 2010; Lambert *et al*., 2010). For Ahern (1999) such revelations and contextualisation are of more relevance than attempting to limit bias through taking an objective stance. For example, due to some poor initial experiences of the pre-hospital workplace and my own bias towards ensuring the welfare of the participants, it is possible that during the interviews I subconsciously expressed a hint of my own ire at some of the behaviours that they encountered. Not only could the participants have picked up on this and adjusted their responses in accordance with something which clearly sparked some emotion in me, but it is also probable that my subsequent questions were orientated with some assumed negativity towards the pre-hospital working environment. Although I was conscious of this at the time of the interview, I applied additional caution in interpreting the subsequent transcriptions. I additionally made reflective comments in my coding journal as I was transcribing each interview, and before I subsequently conducted any more. I found this to be beneficial both at the time, and subsequently when reviewing all of the transcriptions for chapters 3 and 4.

Had I adopted a more objective stance which did not try to account for unconscious bias, it is possible that the data could have been interpreted without appropriate reflexivity or consideration of this context. In accordance with Basit (2010, p.210) and Cohen *et al.* (2010), I have therefore recounted my own experiences and perceptions where appropriate, with the intention of informing the reader of how my ‘Thrownness’ or ‘Disposition’ (including my own perceptions of the pre-hospital workplace and education) may potentially influence the interpretation of the findings and the subsequent analysis.

A note of caution relating to reflexivity is however expressed by some authors who suggest that it has the potential to become self-indulgent on the behalf of the researcher (Weick, 2002; Tomkins and Eatough, 2010), and that it may privilege their opinions and beliefs above those of the participants (Fournier and Grey, 2000). For Haynes (2010) there is also a danger that the reflexive process may take dominance over the subject of the research itself. For the purposes of this study, in accordance with McGhee *et al.* (2007) I have attempted to foster self-awareness through maintaining reflective research journals for documenting thoughts and feelings as they have occurred. The below example is an excerpt from my analysis journal and includes my thoughts immediately after one interview. It involves my suspicion that the answers were tailored in accordance with propriety, and suggests my own potential for bias relating to answers which did not accord with what I expected to hear – and therefore must be ‘too good to be true’:

*A little guarded with her answers. I'm getting a vibe that this is all too good to be true. I am not sure she is telling me the whole story. Her sentences feel 'scrubbed' - denied that the crews she's been on with time wasted. Is this likely to be true? If she is covering (and I think she is), what does this suggest in terms of loyalty? She already says that she feels like a member of staff. Bearing in mind that every crew time-wastes - check out the other interviews. Too good to be true?*’ (From my reflective analysis diary dated 13th March 2020 (Garratt, 2020))

Subsequent reading of this journal entry highlighted my potential bias in this area, prompting greater caution during the interpretation and analysis.

To help explore my own reflexivity in this context, I have adopted a reflexive framework created by Houston (2015) based upon Layder’s (2006) ‘theory of social domains’. Contending that notions of power circulate through each area acting as an enabling and constraining force, Houston outlines five distinct domains – as outlined within Table 2 below:

**Table 3**: Houston’s (2015, p.252) ‘social domains’

|  |  |
| --- | --- |
| Domain | Reflexive component |
| Psychobiology | An individual’s unique life experiences and the critical events therein |
| Situated activity | The impact of everyday social interactions and relationships |
| Social settings | The role and impact of formal organisations, institutions and their associated bureaucracies |
| Culture | The meaning that is associated with social life including, ‘attitudes, beliefs, tastes, styles, fashion and use of language’ |
| Politico-economy | to the driving influence of neoliberalism and the potential for inequality and commodification |

### Reflexivity: Psychobiology

Finishing formal education in 1989 I joined the local ambulance service as a control-room dispatcher/call-taker. I continued through the ambulance dispute and strikes of 1989 and 1990, which was made harder by not receiving the necessary training to take 999 calls and through not having a mentor. My interest was however spiked by the paramedic role and the desire to work on the ‘front-line’ of an emergency service. At this time, progression to ‘front-line’ was strictly limited to those who had spent several formative years as part of the non-emergency Patient Transport Service and there was no provision to transfer from the control-room. Determined to follow this career pathway however, I repeatedly petitioned my line-manager until eventually an opportunity to undertake the entry assessments arose.

Undertaking basic ambulance training in 1994, I studied hard and passed all assessments. Following the completion of training I was transferred to a busy ambulance station which at that time had a good working reputation. Unfortunately having just finished training I perceived (and was told by ambulance staff colleagues) that I was a burden and fit only to drive the ambulance rather than attend to patients. This was made more apparent through having a control-room background and a lack of experience of communicating directly with patients.

The overall experience was poor, with what I perceived to be overt bullying and favouritism on the behalf of staff and managers, being blamed for the clinical mistakes of others, hazing, and receiving humiliating comments in front of members of the public. Determined to overcome this, I agonised for a period of a few weeks about how to engender some respect and civility. Having to overcome my inclination to avoid conflict, I eventually elected to confront one of the more challenging staff members (who was also a line-manager) about his behaviour. This proved to be something of a turning point, with the bullying and humiliating behaviour ceasing, and some trust being afforded in relation to working responsibilities.

After this negative period of enculturation, I started to enjoy the autonomy which came with gaining clinical experience and I willingly embraced many of the attitudes and behaviour of others on station. This included creating self-designated breaks, an ‘us-and-them’ attitude towards managers, attempts to manage workload, and rivalry with other emergency services (particularly the Fire Service). One area which I did pride myself in however was in establishing and maintaining high clinical standards. Indeed, I had a reputation as being a ‘bookworm’ and for constantly studying treatment guidelines and protocols.

The paramedic course of this era was an additional 4-weeks of in-house training with several weeks of clinical exposure at hospital. Applying for this course after the required 2 years, I completed the training and became a qualified paramedic in 1997. After 3 further years of practice, I left ambulance work to join the police, but when this detrimentally affected my family-life, I resigned and became a paramedic again in 2002 with a different ambulance service. This particular ambulance service was pioneering some innovative areas of practice including the Emergency Care Practitioner (ECP) programme, which offered joint advanced university-based education or both paramedics and nurses.

Although studying some distance-learning university modules previously, the ECP programme introduced me to campus-based university education. This was undertaken alongside practice elements and whilst working full-time until being awarded the BSc (Hons) Autonomous Emergency Practice. During this time, I worked as an ECP in primary care and within the pre-hospital environment, where many of the ambulance service attitudes and behaviours were again observed. From some quarters there was also additional resentment towards ECPs, who were seen as being privileged and given an easier working day due to not being used as a standard resource to respond to emergencies.

In 2007 I began work at a local university as a paramedic clinical-skills instructor involved in teaching students on all paramedic science courses, becoming a Senior Lecturer in 2009 and a Principal Lecturer (PL) in 2018. As the PL overseeing the paramedic provision, I now have responsibility for all courses, students, and professional staff involved in the educational delivery of paramedic science at a university within the Midlands.

### Reflexivity: Situated activity

As the PL for Paramedic Science, I interact with the paramedic academic staff as their line-manager and as a professional colleague. I maintain involvement with teaching and with student issues, as well as being present at student representative forums. I am also responsible for the overall student experience as formally recorded within the National Student Survey (NSS) and for creating action plans for improvement where necessary.

I have 2 children, one of whom is studying Medicine at a university in the south-west of England, whilst the other is studying Paramedic Science at another university in the East Midlands area. As a parent of university students (pursuing professionally affiliated courses), I am conscious of how much emotional toil goes into their applications, in moving out of home, and in keeping up with coursework. I believe that I am therefore quite highly attuned to the student experience, with the propensity to be biased towards their needs when issues arise.

### Reflexivity: Social settings

In my position I liaise with the professional leaders of other HEIs within the region, as well as senior managers within the local ambulance service at regular Consortium and Contract Review meetings. It is at these meetings that the operationalisation of pre-hospital placements and student mentorship is discussed, and student issues are raised. I am also responsible for ensuring that the practice placement elements hosted by the local ambulance service - with mentorship provided by their staff - continue to meet the validation requirements of the HCPC.

I am a Fitness to Practice (FTP) Paramedic Panel Member for the HCPC. It is here that I have direct involvement with the disciplinary processes of the registering body that supports the regulatory processes. This is achieved through being part of the decision-making panel on FTP hearings, which entails reaching decisions relating to misconduct and lack of competence on the behalf of operational paramedics. It is within this context that I am also exposed to some of the worst behaviour of paramedics; something which I am aware may influence my judgement with regards to the current study. This is something that I am conscious of and have reflected upon within my research journals.

### Reflexivity: Culture

Through liaising with students and still being involved with the local ambulance service, I am cognisant of the significant cultural changes which have occurred over the last 25 years. Paramedics now require professional registration to be able to practice and the underpinning education has moved almost completely to HEIs – with regional training centres now providing only a supporting role. Where discrimination and bullying were once a more accepted part of the culture, the move towards university education and greater awareness of such practices has seen a greater institutional intolerance of this sort of behaviour (CQC, 2015).

### Reflexivity: Politico-economy

A key difference between my own initial experiences of the pre-hospital workplace and that of current university students is that they are effectively a paying customer, and that the university is an advocate for their welfare. The student thus has a powerful voice in relation to course reviews and with the NSS (a voice which I did not have when I started). As the PL for paramedic science at my employing institution I have a vested interest in ensuring that their experiences on placement are positive and that their needs are met.

Our recruitment for paramedic science is dependent upon the placement provision and commissions provided by the local ambulance service. Whilst the Consortium and Contract Review meetings are always convivial and constructive, this economic and political factor is still an underlying consideration when I am liaising with the placement provider. In other words, I do feel politically pressurised to make sure that good relations are maintained to avoid any potential difficulties in terms of the continuation of the students’ essential practice placements or for our recruitment commissions in the future.

### Method of enquiry

Continuing with the established epistemological and methodological congruency of the current study, and in providing an answer to the overarching research question, the participant data is qualitative in nature. This allows for a phenomenological interpretation of meaning which is attributed by each participant to their ‘lived experiences’ and the application of Heidegger’s philosophy concerning the nature of ‘Being’. It enables participants to appropriately express their ‘experiential accounts’, and for the researcher to question further when an interesting line of enquiry emerges (Taylor and Francis, 2013, p.206). I decided that these requirements are most likely to be comprehensively met by one of the more popular methods of investigation within the interpretivist perspective - the research interview (Green and Thorogood, 2014; Basit, 2010).

As a means of collecting data, the research interview is considered to exist within a spectrum of structure and standardisation. At one end, the structured interview consists of mainly standardised and ‘closed’ questions which are asked in a pre-specified order with the aim of creating answers which are comparable between each participant. As with a quantitative study, objectivity is preferred on the behalf of the researcher, and the responses are generally intended for conversion to a numerical format for analysis and comparison (Green and Thorogood, 2014; Taylor and Francis, 2013,). At the other end, the unstructured interview comprises ‘open’ questions which enable participants to freely express their experiences and perceptions. Although with this approach interviewers are supposed to still have some guidance for the participant in mind, ‘constructs introduced by the interviewee’ can be assimilated into follow-on questions and potentially help guide the interview process itself (Basit, 2010, p.103; Punch, 2010).

In considering alignment with the paradigm of enquiry, the unstructured approach did initially seem to be the most appropriate. However, whilst having advantages in terms of flexibility of participant expression and being a ‘powerful’ inductive tool for educational research, the unstructured interview is also considered to require skill and experience on the behalf of the researcher to spot and probe ‘meanings, interpretations and symbolic significance’ (Punch, 2010, p.148). As an inexperienced researcher, I therefore chose a method which falls at some point along the spectrum of research interview techniques – the semi-structured interview.

Incorporating pre-defined questions, the semi-structured interview aligns with the paradigm of enquiry for the current study by allowing participants freedom of expression (with a degree of standardisation) and also retaining the flexibility for the interviewer to probe their answers further (Taylor and Francis, 2013; Kelly, 2011; Robson, 2010). Having some pre-determined questions, is considered to be of benefit to neophyte researchers conducting multiple interviews as it may aid analysis through ease of finding comparable responses from participants (Quinn-Patton, 2015).

Although standardisation within interviews is considered to be a means of ensuring reliability (Silverman, 1993), it is suggested by others that trustworthiness, authenticity, detail and depth of response and relevance to the participants is more important, and that reliability is better demonstrated through answering the research questions and being ‘scrupulous, honest and precise’ (Basit, 2010, p.70; Oppenheim, 1992). There is thus a tension concerning validity and reliability with regards to how research interview questions should be structured and delivered (May, 2001; Kitwood, 1977). Replication (and therefore reliability) may be promoted through a more structured approach, but the desired rapport and ‘trustworthiness’ is less likely to be achieved, with participants less likely to feel at ease and provide truthful (and therefore valid) answers. Opting for the semi-structured interview therefore represents a ‘judicious compromise’ which may ameliorate the potential tension between structure and freedom of expression (Kitwood, 1977, p.172).

An additional risk to validity within the interview process may also lie within perceptions of hierarchy between the participants (who are students) and myself as the PL for their university course. For Kvale (1996, p.126) such an ‘asymmetry of power’ may damage truthfulness and validity through interviewees being less willing to provide answers which they perceive will not be appreciated by someone in a position of influence on their course. From my own perspective, the ‘halo effect’ may also pose a risk to validity, whereby subconscious bias and selectivity may influence the interview and subsequent analysis through the existence of pre-formulated opinions and prior knowledge of the interviewees (Basit, 2010, p.65)

### The creation of research instruments

According to Savin-Baden (2013, p.99) it is essential for researchers to articulate overarching questions which capture the ‘topic and purpose’ of a proposed study, and which protects against the tumult of concepts and ideas which may occur at initial and later stages of development. However, whilst Punch (2011) suggests that research questions written at the outset help ensure that the project has coherence and that it may be a mistake to vary them once the empirical stages have commenced, Robson (2010) advocates that qualitative research should not necessarily be restricted to predefined questions which are rigidly adhered to. Basit (2010) also suggests that it is a mistake to prematurely finalise research questions, and that it may be more appropriate to reconsider and refocus them as the research progresses. Miles and Huberman (1994, p.23) similarly suggest that research questions may either be formulated ‘at the outset or later on and may be refined during the course of the field work’.

As a neophyte researcher, I have followed the recommendations of Punch (2010) with the initial creation of well-developed questions which may be deductively refined into data collection instruments. For Basit (2010, p.49), ‘research questions form the foundation for developing research instruments’, and they should have a clear link with the overarching research question. In accordance with both Punch (2010) and Savin-Baden (2013) this process began with the identification of a research subject area which reflects my background and areas of expertise.

The research subject area is:

* *The enculturation of university paramedic students to professional clinical practice*

The next level of conceptual deduction incorporates a more specific topic area. This represents a level of definition which more closely aligns with the perceived deficiency within the literature and an area of personal interest for myself. The more specific topic of interest is:

* *The enculturation of university paramedic students to professional clinical practice and an exploration of the role played by notions of ‘self-identity’*

The next level is the determination of a general research question, which for Punch (2010) is essential for organising and directing the study, but which in itself is not directly answerable.

The general research question for the current study is:

* *How are paramedic student notions of ‘self-identity’ formed/negotiated as part of the enculturation process within professional clinical practice?*

In moving from general questions to more answerable questions (a process described as ‘unpacking’), Punch (2010, p.61) advocates the creation of specific research questions which are more detailed and concrete. In accordance with an exploration of social theory and identity development within a professional workplace and the review of the literature, I believe that these questions should encompass the following:

* The concept of habitus and the ease with which students become acclimatised to the workplace social community
* The influence of professional and local structures
* The preparation and engagement of students prior to experiencing the pre-hospital clinical practice environment

Please see Appendix 1 for a breakdown of the specific questions which are intended to further explore these areas. Please see Appendix 2 for the list of the finalised questions (developed from the specific questions) which were used within the current study. In alignment with the ethos of semi-structured interviews, I was conscious that these questions should not be a ‘straight-jacket’, and that a flexible approach should be adopted which allows for exploration and potential deviation should an area of interest arise (Thomas, 2013, p.199).

### Piloting the method of enquiry and the research instruments

Conducting a pilot study is ‘imperative’ for enhancing the validity and reliability of a study through trialling procedures relating to sampling, face-to-face interview technique/schedule, ethics and for the testing and revising of the instruments themselves (Basit, 2010). As a neophyte researcher I also found that conducting a pilot was important for refining my interview technique, and the finalised questions prior to embarking upon the main study.

The pilot comprised of one male and one female paramedic student. One student was near the end of the programme, whilst the other was approximately half-way through; although both had life-experience relating to employment which may have affected their pre-hospital enculturation (Lazarsfeld-Jenson and Loftus, 2011). I had hoped to recruit one student who had enrolled upon the course straight from school, but unfortunately none volunteered to take part. This was potentially due to the timing of the pilot, which occurred during a university holiday period and the recruitment process itself, which consisted of an email request to all paramedic students outlining the nature of the study and a copy of the participant information sheet. The response to this email led me to consider that for the main study, greater consideration should be given to advertising and timing, with the inclusion of an explanatory poster, a clearer description of the research study, and the avoidance of holiday periods.

Although effective in eliciting data from the participants, in alignment with Basit (2010), piloting the questions did inductively highlight some areas for addition and adjustment. This included the supportive effects of student peer groups and the modification of a question relating to local employer procedures to encompass the impact upon teaching and potential ‘coping mechanisms’ employed by the operational ambulance crews. It also highlighted that a useful time for each interview was approximately an hour, and that guidance from the interviewer is sometimes needed to keep to time.

Despite concerns which were raised during a review of the instruments by doctoral peers, the use of colloquial terms (such as ‘leg-pulled’) within the interviews seemed appropriate, and I believe that this contributed to placing the participants ‘at ease’ – an element which is considered to promote ‘openness and confidence’ (Burton *et al.* 2014, p.140). However, I also became mindful that both interviews became almost too congenial in places and more closely resembled a student pastoral tutorial – with an increased interview time and the inclusion of nonrelevant data. When revisiting and transcribing the pilot interview recordings, I also became aware of my propensity to ask long, rambling, and potentially leading questions, thereby undermining participant freedom of expression. These factors are considered by Punch (2010) to pose a risk for data analysis. To mitigate for this, I ensured that I reflected appropriately within my overarching journal and ensured that for the main study I had a clear listing of the questions in front of me along with a means of observing the time.

### Ethical considerations

Defined as ‘the moral principles that guide activity from inception to completion’, ethical considerations should be interwoven within the design of a research project, from the initial selection of an area of focus, through to the formulation of post-analysis recommendations (Dahlberg and McCaig, 2010, p.41; Wood and Smith, 2010). Owing to my experience and relationship to the students, particular areas of ethical concern for this study are likely to be reflexivity (including negative bias towards the practice placement environment), and power asymmetry between the interviewer and interviewee. According to Cohen *et al.* (2010, p.151) notions of ‘power’ within the research interview introduce social and political dimensions, which may undermine validity through the interviewee feeling obliged to provide answers that they feel will be preferred by the interviewer, or which at least will not lessen their professional standing. Through knowing and empathising with the participants, the ‘halo effect’ may also introduce subconscious bias on my part in terms of data interpretation and analysis (Basit, 2010, p.65).

Ethical approval for this study was obtained from the Staffordshire University School Ethics Committee (Appendix 3), and as the participant-sample comprised of paramedic students at my employing institution, approval was sought and obtained from the Health and Life Sciences Faculty Ethics and Governance Committee at Coventry University (Appendix 4). ‘Gatekeeper’ permission was also gained to access the students at Coventry University via a letter signed by the Head of the School for Nursing, Midwifery and Health (Appendix 5)

As part of meeting the requirements of both ethical committees and in accordance with the British Educational Research Association (BERA) ‘Ethical Guidelines for Educational Research’ (BERA, 2018), voluntary informed consent was sought and documented from each participant. Although I met with the student cohort and explained the purpose of the research and the participant requirements as part of the recruitment strategy, interested parties were given a more detailed participant information sheet (Appendix 6) which more thoroughly explained; the intentions of the study; what taking part involves; participant time commitments; that participation is voluntary (and that they can withdraw at any time without a need to explain their decision); a description of potential benefits and risks; and how any collected data will be stored, handled, and eventually destroyed.

Having read the participant information sheet and following an opportunity to ask their own questions, participants were asked to read and complete a participant consent form (Appendix 7). This aligns with BERA (2018) guidance in documenting that participants are not under duress and that they have received appropriate information about what will happen during the study and with their data. The consent form also informs participants that confidentiality will be maintained and that they will not be directly identified within the final thesis. For Dahlberg and McCaig (2010) anonymity represents a cornerstone of research ethics, something which is reflected within the BERA guidelines. However, BERA (2016) also acknowledge that despite best efforts, complete anonymity may not be possible within a ‘close-knit community’.

Whilst making efforts to maintain participant anonymity is thus an ethical priority, it is suggested that researchers exercise honesty with the participants and inform them that it may be impossible to guarantee (Wood and Smith, 2011). I have used pseudonyms to replace participant names for the purposes of data storage and analysis, but each participant was also made aware before their interview that they could still be potentially identified within the final thesis owing to the unique nature of pre-hospital practice and the involvement of others within clinical situations and interactions that may be described. Participants were also made aware in accordance with BERA (2018) that there may be a need to disclose information given in confidence should any illegal activity or situations resulting in patient harm be disclosed.

Both the participant information sheet and consent forms relay how the data was to be stored. For this study, the data and its analysis were securely stored on a password protected and encrypted computer within a secure premises and destroyed in alignment with university and data protection guidelines (GDPR, 2018).

### Sampling

In order to answer the overarching research question, the desired data needs to be obtained from an appropriately selected sample (Punch, 2011). At my employing university this potentially relates to two different groups of paramedic students, with distinct educational pathways and differing placement experiences. One group are ‘traditional’ full-time university students who are studying for a two-year foundation degree (and more recently a three-year Bachelor of Science degree), whilst the other group are part-time students on a truncated programme who are employed by the local ambulance service. Prior to embarking upon their university educational component, these students have undertaken significant pre-hospital exposure and have worked as part of an ambulance crew at a more junior clinical grade. In this study, I have chosen to recruit only from the full-time group of students as the part-time employed group will have prior exposure to the workplace as uniformed employees and will be known in this capacity by the ambulance staff they will be encountering. Focussing upon the full-time group may also produce results which are more relevant as this educational pathway is universal across the United Kingdom (HCPC, 2018).

The selection of participants followed a face-to-face invitation and explanation to each student year cohort. In each case, this consisted of a 10-minute presentation (conducted by me) which outlined the nature of the study and what would be involved for anyone interested in taking part. Mindful of the potential for bias and subjectivity within ‘teacher-researcher-own-classroom’ research (Punch, 2011, p.44), I understood that having their course PL deliver a presentation to them within a university classroom about research he was heavily invested in might have some undesired effects. These potentially included:

* Feeling pressurised to take part by a senior academic on their course
* Volunteering because they believe that there might be some advantage in it for them
* Volunteering because they believe that there might be some disadvantage for them if they didn’t

The risk of potential bias here could be that entering into the research with the desire to avoid disadvantage or to impress could result in answers which are either perfunctory or tailored for acceptance (Basit, 2010). With these potential factors in mind, I was careful to base the presentation upon the Participant Information Sheet (Appendix 6), which had received prior ethical approval. This included emphasising the voluntary nature of participation, that there would be no personal or material benefits for anyone who took part, and that there would be no detriment for those who chose not to. I was additionally conscious that if participation were to be considered as an additional learning opportunity, then I would most likely have volunteers who were motivated by additional theoretical learning, and that the sample could therefore be unrepresentative. With this in mind, I stressed that whilst those who took part may gain direct experience of a qualitative research method, the potential learning benefits would not outweigh what they had been (or would be) taught within their curriculum – so there would be no disadvantage in terms of learning if they did not wish to take part. So as to capture any potential students who did not attend the presentations, the same details were sent via email to all students.

Addressing the students in this manner provided me with a potential sample frame from which to select participants of approximately two hundred paramedic students. The appeal to both the first and second year cohorts was intended to allow for the inclusion of students with varying levels of placement exposure and differing clinical ability. Expressions of interest were requested via either email or face-to-face. A total of twenty students expressed an interest.

Participants were selected from the volunteers via purposive sampling. In the context of the current study, purposive sampling is advantageous due to selection based upon characteristics which have been identified as significant within the surrounding literature and after the pilot study (Basit, 2010). In accordance with these principles, the sampling criteria was influenced by the acceptability of a small sample size balanced with the selection of suitable participants to meet the specific needs of the study; including those who may only form a low proportion of the actual student population (Robson, 2002; Ritchie and Lewis, 2003).

According to Cohen (2010, p.115) a non-probability technique such as purposive sampling derives from the targeting of a specific group and is thus ‘unashamedly selective and biased’, with no intention of representing the wider population. For Ritchie and Lewis (2003, p.80) however, purposive sampling ‘requires clear objectivity’ and may overcome suggestions of bias if researchers consider how their choice of participants could be independently justified. Whilst ‘clear objectivity’ may be problematic in a phenomenological study of this nature, having a sampling strategy and rationale which fits with the internal coherence of the study is considered essential (Punch, 2010, p.163). Cognisant of the assertion by Miles and Huberman (1994, p.27) that ‘you cannot study everyone everywhere doing everything’ and the need to have an approach which is feasible in terms of time and access, the purposive sampling plan outlined within table 3 below was utilised:

**Table 4**: Sampling plan

|  |  |
| --- | --- |
| **Inclusion criteria:** | **Rationale:** |
| At least one student who is over 30 | Age and life-experience are considered to play a role in social integration |
| A mix of students who have achieved the course entry criteria via different educational routes | This *may* be a useful indicator of socio-economic group. Students from poorer households are less likely to have the pre-requisite A levels straight from school (Wyness, 2017) |
| A mix of male and female students | The ambulance service is a traditionally male-dominated working environment |
| At least one student from a black or minority ethnic (BME) group | This area is not fully explored within the literature |
| A mix of students from different cohort years | It may be useful to compare the perceptions of students who are at different stages within the course. This may help with the interpretation of experiences over time, both in individual cases and in a comparison between participants |

Having a small sample for this form of research is considered appropriate as there is no intention to explore elements such as statistical significance, ‘incidence or prevalence’ for which increased numbers are desirable (Robson, 2002, p.264; Ritchie and Lewis, 2003). As a qualitative phenomenological enquiry seeking ‘in-depth information from those who are in a position to give it’, the current study instead requires that time and attention to detail are given to the transcription of the interviews and the subsequent analysis of experiences from the selected participants (Cohen, 2010, p.115).

In terms of the appropriateness of the sample size, I was mindful of Mason’s (2010) assertion that it should reflect the purpose and aims of the study, and that actual numbers may have less relevance than the quality of the data obtained and its analysis. I was also cognisant that the commonly acknowledged “more is better” purposive sampling approach does not account for the labour and time required for transcription and analysis (Rijnsoever, 2017), and that a sample which is larger than needed potentially wastes participants’ time and could therefore be considered unethical (Francis *et al.*, 2010).

With these factors in mind, I initially considered that a sample of eight participants would be appropriate. As a neophyte researcher this seemed to be sensible for a manageable sample and reflected the sample sizes adopted by comparable studies (Basit, 2010; Lazarsfeld-Jenson and Loftus, 2011; Kelly and McAllister, 2013). However, after the decision to exclude a quantitative survey element, I decided to increase the sample to ten participants in order to increase heterogeneity. I then determined that it would be logical to transcribe and analyse each interview in turn, and then (as the data was being coded) judge whether additional interviews could elicit more valuable data.

Once data collection and analysis had commenced however, it became apparent that all participants had several months or at least a year of experience and had some experiential ‘distance’ from what it was like to be ‘brand-new’ in the pre-hospital workplace. I therefore sought participants from a new cohort of students who had recently embarked upon their initial period of placement and were in effect ‘brand-new’. Of further interest is that this cohort is the first at my employing university undertaking a three-year BSc (hons) in Paramedic Science, which has slightly higher educational entry requirements. With these factors in mind, two further volunteers from this cohort were invited for interview.

Whilst there were enough volunteers to meet most of the selection criteria, there were unfortunately no volunteers over the age of 30. This criterion had been selected as prior life-experience has been identified within the literature as a factor which potentially aids pre-hospital workplace enculturation (Lazarsfeld-Jenson and Loftus, 2011). There were however several volunteers who were in their late-twenties, and three of these students were included on the basis of having potentially significant prior life-experience. The growth of the sample is reflected within table 4 below:

**Table 5**. Final sample:

|  |  |  |
| --- | --- | --- |
| Original sample | Extended sample | Final sample |
| 8 participants | 10 participants | 12 participants  (Including two who were very new to the workplace) |

The attributes of the twelve participants which are relevant to the aims of this study are outlined within table 6 below:

**Table 6**. Participant attributes:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Attributes | Female | Male | Age>21 | Age<21 | White | BME | Year 1 | Year 2 | Direct A level route of entry | Non-A level route of entry |
| Number of participants within each category | 7 | 5 | 6 | 6 | 10 | 2 | 5 | 7 | 4 | 8 |

The decision to invite two students from the new BSc course to be interviewed was based upon the sense that there could be some relevant additional data to be collected from this source. The expansion of the study in this manner broadly aligns with the intention to achieve data saturation. The concept of data saturation in qualitative research is considered to represent the point at which data has been continuously collected until nothing new of any significance is being revealed and/or replication of data is occurring (Given, 2016; Morse, 1995). According to Guest *et al.* (2006, p. 60) this process is ‘the gold standard by which purposive sample sizes are determined’.

For some authors however, the concept of achieving data saturation is unclear and often poorly understood. According to Mason (2010) and Francis *et al.* (2010), the collection of any data will generally add something new, and that the point of saturation is therefore difficult to decide. Saunders *et al.* (2018, p.1903), additionally draw attention to the logical futility of ‘determining that further data collection or analysis is unnecessary on the basis of what has been concluded from the data gathered hitherto’.

Strauss and Corbin (1998, p.136) alternatively suggest that data collection should continue until the point where it becomes ‘counter-productive’ to continue; whilst Mason (2010, p.16) suggests that there will be a point of ‘diminishing returns’ as data collection continues, and that the decision to stop will be ‘inevitably arbitrary’. In relation to deductive studies with some a priori areas of investigation (similar to the current study), Saunders *et al.* (2018) add some potential clarity by suggesting that appropriate saturation could be considered at the point where there is enough representative data for each theme.

For the current study the decision to cease data collection after twelve interviews (and that appropriate saturation had been reached) was thus based upon several factors. These included the practicalities of appropriately analysing the large volume of data which had been collected in relation to a priori and emergent themes; the diminishing number of new codes which were emerging; and my own sense that there was more than enough original data to meet the objectives of the current study and provide for an interesting discussion within the parameters of this thesis.

## Gathering the data

All interviews took place on the premises of the university at which the participants were undertaking their programme of study. This location had the advantage of convenience and salience to the subject matter for all parties; it also allowed me to pre-book a specific room for each interview, thereby limiting potentially harmful interruptions (Ritchie and Lewis, 2003; Cohen *et al.*, 2010). With prior access to each room, I was also able to arrange tables and seating in such a way as to reduce potential intimidation and discomfort on the part of the interviewee, a consideration which is deemed important by Cohen *et al.* (2010) as part of creating an appropriate atmosphere.

At the beginning of each interview, I ensured that the participants had read the participant information sheet (Appendix 6) and offered them a warm drink to aid rapport. In each case I reiterated the nature, scope, and purpose of the interview, and how the format is intended to work; with them being free to answer questions however they wish, with potential follow-up questions from me. In accordance with Cohen *et al* (2010), Robson (2002) and Basit (2010) they were also told; how long their interview would last (approximately an hour); that they were welcome to ask questions about the interview or the research; that they could decline to answer a question; could ask me to repeat a question; that there were no right or wrong answers; what use would be made of their data; how their data would be stored; that their data would be treated in the strictest confidence; and that every effort would be made to ensure their anonymity. With regards to anonymity, I also followed BERA (2018) guidelines by explaining that within a close community such as the paramedic student population, it may still be possible for other people to infer their involvement from the final thesis purely from some of the unique circumstances which may be described.

I reminded each participant that their voluntary informed consent was needed, and that they had the right to withdraw that consent at any time (BERA, 2018). At this point, they were presented with the participant consent form (Appendix 7) and invited read it, tick each box, and provide a signature if they were satisfied and that they understood the process. Although permission to audio record the interview is mentioned on the consent form, I sought additional verbal approval for this as the presence of a recording device may be considered obtrusive and undermine efforts to create a congenial atmosphere (Cohen, 2010).

According to Basit (2010, p.114), ‘all interviews should be audio-recorded and transcribed verbatim’ and that interviewers may wish to actively listen and concentrate on the interviewee rather than take notes. For the current study, only a few notes were made (in an interview log) for each interview, most notably in relation to non-verbal communication cues. These were added in brackets during the full transcription for each interview as outlined below:

*“So I thought, ‘ok, just get cracking, get stuck in, get gloves on and do it.’ Erm, I was excited at first and you know, happy to get that going. She, when, she was in a non-shockable rhythm”* [fingers heard drumming on table] (Louise, 20th November 2019)

Gaining experience, learning from mistakes, and honing interview skills is something which is considered normal for researchers during the interview phase of their research (Basit, 2010). For me, significant learning occurred following the first interview. In this case, I continued beyond the hour which had been initially stated – despite a similar observation being made during the pilot study. Upon analysis, another feature of this interview is that I occasionally asked long and/or double-barrelled questions, something which according to Robson (2002) undermines a coherent answer and should be avoided. From this point on, I was mindful to keep to time and ask short straightforward questions for subsequent interviews.

In accordance with BERA (2018) the interview recordings, and the full transcriptions which followed were stored on a password protected and encrypted computer on secure premises. Interviews were deleted from the recording device as soon as they were transferred to the encrypted computer.

## Data analysis

According to Punch (2010, p.171) there is no ‘single methodological framework’ when it comes to the analysis of qualitative data. As a logical initial step however, I listened to each audio recording several times and then created a verbatim transcription. In accordance with Hycner (1985), I then read each transcription several times to gain a sense of the context, from which I could then derive ‘units of meaning’ such as codes and themes. However, whilst it is suggested that the researcher should return to the interviewees with the completed transcript as a form of ‘validity check’ (Hycner, 1985, p.291), I decided not to do this in accordance with Basit’s (2010) assertion that upon seeing their words in isolation, interviewees may feel embarrassed and wish to change something which makes them seem opinionated or contradictory, and that valuable analytical data may be lost in this way.

Following the recommendations of Robson (2002) and Burton *et al.* (2014), I utilised a bespoke software package (NVivo 12) and uploaded the transcriptions as they were completed (see Appendix 8 for an example). This software was very useful in terms of having just one organised single location for data storage and the ease by which data can be managed. A further benefit was that segments of data could be consistently coded, tagged, retrieved, and displayed for the subsequent creation of themes and analyses (Basit, 2010; Weitzman and Miles, 1995; Cohen *et al.* 2010). Utilising NVivo 12 also allowed for the storage of my ‘memos’, and for links to be made between them and segments of transcript.

The process of creating and the recording of ‘memos’ began during the transcription phase and whilst the interviews were ongoing. These ‘memos’ were grouped and placed under the headings of ‘Journals’ according to their topic area. These included, ‘Analysis Journal’, ‘Overarching Journal’, and ‘Coding Journal’ (see Appendix 9 for an example). ‘Memoing’ is considered to be a key feature of qualitative data analysis and represents the recording of theories, opinions, insights, intuitions, reflections, and ideas for subsequent analysis as and when they occur to the researcher (Robson, 2003; Cohen *et al.* 2010). For Punch (2010, p.180), memos represent the potential for ‘new patterns’ of thought or the uncovering of ‘deeper-level concepts’, and help to link coded data to a more creative, speculative and abstract level necessary for the development of propositions and theories. The following is just one example of a ‘memo’ from my ‘Overarching Journal’ which led to an additional line of questioning within subsequent interviews relating to the use of ambulance-related language and jargon:

*18/5/19*

*Just transcribing 3rd interview. It would be worth exploring the use and application of language and wordage in terms of meaning attribution (for phenomenology). The adoption of language as a part of enculturation. Would this be a useful line of questioning? e.g., when did you feel comfortable using the terminology?*

Alongside the creation of ‘memos’, the process of coding is considered to be a basic analytic technique for the operationalisation of qualitative data (Punch, 2011; Miles and Huberman 1994). Initial coding is described as a process whereby segments of data (such as transcribed paragraphs, sentences, phrases, or single words) are organised, labelled, and tagged into superordinate and subordinate categories. These categories may be deductively derived from the research question or the literature review, or they may inductively emerge as areas of similarity, regularity, or interest from the data itself (Miles and Huberman, 1994; Robson, 2002; Burton *et al.*, 2014; Basit, 2010). Initial codes are suggested to be simple descriptive labels for organisation, requiring minimal inference beyond the data segment itself. They are the foundation for more advanced secondary or pattern coding, which represents a more inferential ‘meta-code’ under which initial descriptive codes are grouped in relation to the researcher’s developing interpretation of the data (Punch, 2011, p.176).

Whilst adopting the process of initial coding for the current study proved a useful starting point, I did find it difficult to compartmentalise the coding process to an initial set of non-inferential descriptive labels. Instead, I found that during initial coding, pattern coding was intuitively occurring whereby greater interpretation and abstraction was leading to links with the literature and potential themes at an early stage. Whilst pattern coding is suggested to be a secondary product of the analytical process (Punch, 2011), for Miles and Huberman (1994) it is seen as an ‘integral’ part of the initial coding process. Concurring with the assertion that qualitative data interpretation is a ‘non-linear’ and ‘iterative process’ (Burton *et al.*, 2014, p.202), I continued to undertake pattern (inferential) coding alongside descriptive coding during initial and subsequent readings of each transcript (see Appendix 10 for an example of the coding structure within NVivio 12). For the current study one such pattern code which was developed during the initial coding process was, *‘being equipped for the context of work’*. This particular code arose inductively from the data and the development of my thoughts at this stage; it encompasses descriptive codes which relate to the participants’ life-experience and more inferential patterns of thought relating to conscious and sub-conscious preparation for the emergency pre-hospital environment (see Appendix 11 for an example of this pattern code).

Adopting an interpretive phenomenological approach for this study makes allowance for my own ‘positioning’ (Matua and Van Der Wal, 2015, p.25) and acknowledges the assertion of Cohen *et al.* (2011, p.469) that, ‘the analysis and findings may say more about the researcher than about the data’. In this respect, I am conscious of the potential for reflexive bias and in accordance with Matua and Van Der Wal (2015) I ensured that the interpretation of meaning was derived from a blend of the coded data and my own experiences and pre-conceptions.

In order to explore the participant’s developing sense of ‘self’ and professional identity more effectively in the pre-hospital environment, and in accordance with Paley (2017), the analysis was then tailored to incorporate an overarching phenomenological theory. In this case I have adopted some of the concepts advocated by prominent interpretive phenomenologist Martin Heidegger (1927) as expressed within *Being and Time*.

During the analysis, a-priori codes based upon prominent social theory and the findings from the literature were applied, and codes have also arisen inductively from the data itself. I have however additionally adopted Heidegger’s (1927) concept of ‘Dasein’ and the supporting structure of ‘Care’ as key principles with which to frame and present the findings. This approach aligns with the exploration of social theory undertaken for the review of the literature as ‘Dasein’s’ everyday understanding of the world (and of itself) is considered to relate closely to the social world in which it exists (Wisnewski, 2013). It is worth noting that even in the context of describing our own personal experiences, ‘Dasein’ is generally used in the 3rd person.

## Heidegger’s philosophy: an overarching phenomenological theory

On exploring Heidegger’s philosophy, I believe that ‘Dasein’ may represent a useful overarching concept with which to explore and contextualise the research question and incorporate the elements of social theory which underpin the critical review so far - but which I feel fall short in terms of an individual interpretive analysis of self-identity formation and enculturation. In other words, I do not believe that an analysis based upon an exploration of social theory with an associated review of the literature is sufficiently tailored towards capturing the essence of how we ‘become’ something, or how we come to ‘identify’ as something or someone.

Heidegger’s (1927) philosophy concerning how individuals exist (and are affected) as entities within the world, their ability to self-analyse, and how they relate to other people is encapsulated within the concept of ‘Dasein’. Of additional significance for this study is that ‘Dasein’s’ everyday understanding of the world and of itself relates closely to the social world in which it exists (Wisnewski, 2013). Heidegger describes ‘Dasein’ as being underpinned by the unifying arrangement of ‘Care’. This is a temporal structure consisting of Thrownness (past), Fallenness (present) and Projection (future) (Collins and Selina, 2012; Wisnewski, 2013).

### The concept of Thrownness

The concept of ‘Thrownness’ represents ways in which individuals have a subconscious understanding of the world which is historically aligned and ingrained by the social community in which they are born and in which they are raised. It represents the ways in which individuals are equipped or potentially limited in relation to dealing with the social situation they find themselves within, through an approach based upon what they have received from the past, and the imbibed worldly understandings of those who have influenced them prior to that time. This inheritance is unchosen and beyond individual conscious control, but nevertheless influences how the world is perceived, and may potentially restrict opportunities in life, through for example, limitations relating to specific life-skills, abilities, and social experiences (Collins and Selina, 1999). Whilst an individual may seek to reject what has been imparted in this manner, they are thought to only do this with the understandings that they have been ‘trained’ to have (Wisnewski, 2012, p.77). In other words, change can only be enacted with the cognitive processes and terms of reference which have been ingrained and learned from the world to which they have so far been exposed. This limits individual agency and scope to enact change in accordance with what has been encountered before. ‘Thrownness’ incorporates how individual ‘Dasein’ have preceding understandings, perspectives and skill sets which are considered to affect their ‘disposition’ - or ‘mood’ - through which they encounter the world. This ‘disposition’ which may be considered akin to Bourdieu’s conception of habitus (please see page 39 for a description), may thus restrict (or enable) an individual’s possibilities in life and affect their engagement with the social world in the present time, and also their available choices for the future (Wisnewski, 2012; Collins and Selina, 1999; Heidegger, 1927). In this respect the ‘Projected’ future may thus be dictated by possibilities which are only made available by the ‘Thrown’ past.

### The concept of ‘Fallenness’

The concept of ‘Fallenness’ encompasses the way that ‘Dasein’ is pre-occupied and absorbed with the world at the present time and is bound to other people (other ‘Dasein’) who exist within the same sphere of significance (in this case, the professional practice environment). ‘Fallenness’ encapsulates how individual ‘Dasein’ exist in a fundamental state of ‘inauthenticity’, which represents our everyday interactions with other people and our absorption within the psyche of those who surround us (alternately described as ‘The They/Them’ or ‘Das Man’). It also represents how individual ‘Dasein’ are immersed in the social world of ‘The Them’ (regarded by Heidegger as an amorphous and faceless entity rather than as identifiable individuals), such that ‘Dasein’ is compelled to experience pleasure and enjoyment as ‘They’ do; and experience sadness and surprise in the same things that ‘They’ do (Wisnewski 2012, p.75). It is in this way that ‘Dasein’ develops an understanding of the world and is compelled to dissipate itself within the understandings of other people so that an individual ‘Dasein’ becomes part of ‘The They’, and ‘The ‘They’ become part of ‘Dasein’ (Wisnewski, 2013, p.75). Indeed, according to Heidegger (1927, p.127):

*In this inconspicuousness and unascertainability, the real dictatorship of the ‘They’ is unfolded. We take pleasure and enjoy ourselves as ‘They’ take pleasure; we read, see, and judge about literature and art as ‘They’ see and judge….we find shocking what ‘They’ find shocking. The ‘They’, which is nothing definite, and which all are, though not as the sum, prescribes the kind of Being of everydayness*

For Heidegger, most people, most of the time are governed by ‘inauthenticity’, which is a mode of being and interpretation considered to be ‘constantly compelling’. Whilst it is possible to have ‘authentic’ moments of ‘vision’ in which individuals consider themselves agents apart from the ‘inauthentic’ sway of the people around them, this agency can only be expressed with the emotional and experiential tools which are available to them. This is confined by the schemata of an individual’s own ‘Thrown’ capabilities, and the selection of behaviours which are acceptable within the particular ‘Inauthentic’ environment they find themselves within (Wisnewski, 2012, p.126; Heidegger, 1927). Even under these circumstances however, individuals are still considered likely to suffer from anxiety and a sense of the *unheimlich* (uncanniness and unease) when experiencing ‘authentic’ self-awareness and separation from the ideals of ‘The They’ (Heidegger, 1927, p.232).

### The concept of ‘Projection’

The concept of ‘Projection’ represents how ‘Dasein’ is characterised as being “ahead of itself” in that its existence within the present time is always affected by the consideration of what it may do or become in the future (Collins and Selina, 2012, p.79). These future possibilities are not created, designed or chosen *per se* by ‘Dasein’ but are bound and limited by ‘Thrownness’, or by what ‘Dasein’ receives from the past – which in the context of the current study could be an individual’s skill-set or work experience. In terms of ‘Being’, ‘Dasein’ also understands itself in terms of what opportunities are possible for it to live out in the future and what things it can or cannot do. This renders an individual’s existence as being reliant upon ‘Thrownness’ and almost wholly influenced by what has shaped them in the past. It is in this way that ‘Dasein’ is always considered to be projecting ahead of itself into the future, with a capacity for self-understanding and decision-making which is governed by its own ‘Thrownness’ and the ‘potentialities-for-being’ that these possibilities might allow (Wisnewski, 2013, p.68).

Existing in the ‘Fallen’ present and ‘Projecting’ into the future in terms of the realisation of possibility (which is also dictated by ‘Thrownness’) is characterised by Heidegger as ‘everydayness’, or the way in which individuals exist in their day-to-day world (Heidegger, 1927, p.370). I believe that Heidegger’s concept of ‘Dasein’ and the underpinning temporal ‘Care’ structure provides a useful analytical tool with which to explore individual conceptions of ‘self’ and provide a useful insight into how their sense of professional identity (considered in this context as a form of ‘Being’) is formed within a potentially intimidating and alien (to them) environment. Figure 2 is a representation of the key elements of Heidegger’s ‘Care’ structure, how each part relates to the other, and its relationship with temporality:

**Figure 2:** Adapted from Heidegger’s (1927) underpinning ‘Care’ structure:

Diagram, text

Description automatically generated

## Chapter summary

This chapter has outlined the research methodology, its design, and my approach to analysing the findings. It has included a reflexive section within which I have attempted to convey my own ‘Thrownness’ in relation to the subject and my potential for bias. It has included ethical considerations, and an outline of the coding process. It has additionally explored Heidegger’s conceptions of ‘Dasein’ and ‘Care’, illustrating why these concepts represent a useful analytical tool for exploring the development of professional identity from a student perspective. The next chapter will present the findings of this study in accordance with the superordinate and subordinate themes which have arisen from the analytical coding process. Heidegger’s temporal structure of ‘Care’ is used as an overarching framework.

# CHAPTER 4

Findings

## Findings

### Introduction

This chapter presents the findings of the current study and is structured in accordance with the overarching analytical framework – Heidegger’s (1927) structure of ‘Care’. The superordinate themes include an analysis based upon conceptions of ‘Thrownness’, ‘Fallenness’, and ‘Projection’; within which I have created subordinate sections which have arisen from the analysis of the data. These have been derived deductively during the process of analysing and coding each transcript in accordance with my review of social theory and the profession specific literature, as well as inductively from the data as potential areas of interest and originality arose.

Within this chapter, each superordinate section contains a presentation and exploration of the relevant underpinning theory in order to place it in context, whilst each subordinate section contains an explanation of how each one has been derived. Table 7 below contains the three superordinate themes and a description of the corresponding subordinate sections which I created during the coding process and placed in accordance with how I believe the data aligns with the temporal nature of Heidegger’s (1927) structure of ‘Care’.

**Table 7**: superordinate themes and subordinate sections:

|  |  |
| --- | --- |
| **Superordinate themes**  Based upon Heidegger’s structure of ‘Care’ | **Subordinate sections**  Based upon selected elements of social theory, profession-specific literature and themes arising from the data itself |
| **Thrownness** | Being equipped for the context of the working environment. Including:   1. *The establishment of ‘capital’ relevant to the working environment* 2. *Understanding the cultural ‘rules of the game’* 3. *Being surprised or frustrated by the nature of the role* 4. *Being surprised by the living conditions of service users and patients* |
| Perspective: ‘Thrown’ prior experience |
| Impact of gender and ethnicity. Including:   1. *Gender* 2. *Ethnicity* |
| A confident or extroverted disposition |
| **Fallenness** | Commonly witnessed behaviour of ‘Das Man’. Including:   1. *Witnessing control over the allocation and pace of work* 2. *‘Dark’ humour and banter* 3. *Taking liberties during the working day* |
| Remembered instances of admiration or respect |
| Factors or circumstances which may promote a sense of integration |
| Factors or circumstances which may create dissociation or discomfort |
| Feeling 'at one' with ‘Das Man’ |
| **Projection** | Evidence of shorter-term projection |
| Evidence of longer-term projection |

### Participants

Twelve participants took part in the current study. In order to protect their identity, I gave each one a pseudonym. Please see table 7 for details of participant pseudonyms, additional pertinent details (including gender, age, ethnicity, cohort year, and educational route of entry), and the order of interview. I believe that demonstrating the order of interview is important as I allude to some development of the questions based upon participant responses as the interviews progressed:

**Table 8:** Participant pseudonyms and other details:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Interview order | Participant pseudonym | Gender | Age | Ethnicity (white British or BME) | Cohort year | Direct A-level route of entry |
| 1 | John | M | 26 | WB | 2 (FdSc) | N |
| 2 | Michael | M | 20 | WB | 2 (FdSc) | Y |
| 3 | Beth | F | 22 | WB | 1 (FdSc) | N |
| 4 | Emma | F | 25 | WB | 2 (FdSc) | N |
| 5 | Adeeb | M | 22 | BME | 2 (FdSc) | N |
| 6 | Ellie | F | 20 | WB | 2 (FdSc) | Y |
| 7 | Steph | F | 21 | WB | 1 (FdSc) | N |
| 8 | Todd | M | 21 | WB | 1 (FdSc) | N |
| 9 | Louise | F | 27 | WB | 2 (FdSc) | N |
| 10 | Aaron | M | 27 | WB | 2 (FdSc) | N |
| 11 | Amara | F | 19 | BME | 1 (BSc) | Y |
| 12 | Penny | F | 20 | WB | 1 (BSc) | Y |

The following section contextualises the superordinate theme of ‘Thrownness’ with the subordinate sections identified from the data.

## Thrownness

The concept of ‘Thrownness’ (see *The concept of ‘Thrownness’* section on p. 92 for more details) is a key element within Heidegger’s (1927) structure of ‘Care’ which in turn underpins the concept of ‘Dasein’. In accordance with Heidegger’s philosophy regarding ‘Dasein’, I believe that contextualising the findings in accordance with the concept of ‘Thrownness’ is important for understanding how individuals attribute meaning to their own existence and how they perceive the actions of other people within a social context. This accords with Paley’s recommendation that phenomenological research should be framed by ‘useful theory from a relevant discipline’ (Paley, 2017, p.177). ‘Thrownness’ also incorporates some key elements of social theory which have driven the review of the literature (such as notions of habitus and ‘the discourse of discipline’), and encapsulates themes which have inductively arisen from the coding process; such as finding that many participants seemed to be largely unprepared for the true nature of paramedic work.

In order to conduct an analysis of the findings, I have identified some key areas of interest which have arisen from the coding process and from applying the concept of ‘Thrownness’ as a lens with which to structure the data. The following subordinate sections were identified:

* Being equipped for the context of the working environment
* Perspective: ‘thrown’ prior experience
* Issues surrounding perceptions of age
* Impact of gender and ethnicity
* A confident or extroverted disposition

### Being equipped for the context of the working environment

This theme has an a-priori grounding in Bourdieu’s concept of habitus which is representative of an individual’s social disposition and ability to participate and benefit from a particular environment. (Bourdieu and Wacquant, 1992). This resonates closely with the concept of ‘Thrownness’ which represents how individuals are equipped or potentially limited through what they have received from the past and the imbibed understandings of those who have influenced them prior to that time. Indeed, Bourdieu’s conception of ‘field’ (which includes the concepts of capital and habitus) is considered to be attributable to Heidegger’s philosophy concerning ‘Thrownness’ and ‘inauthenticity’ (Dreyfus, 1992, p.1).

This theme has been further subdivided into areas of similarity between participants identified during the coding process. Each area relates to a different facet regarding the participants’ levels of preparedness. The subdivided areas within this section are:

1. The establishment of ‘capital’ relevant to the working environment
2. Understanding the cultural ‘rules of the game’
3. Being surprised or frustrated by the nature of the role
4. Being surprised by the living conditions of service users and patients

### The establishment of ‘capital’ relevant to the working environment

None of the participants had parents or close family involved with pre-hospital emergency ambulance work who may have influenced their career aspirations. Whilst Beth, Emma and Adeeb all related that they had close family involved in healthcare and nursing, only Amara stated that she had been influenced to pursue a career in healthcare:

* *“Oh, ok, so my mom’s in healthcare, she works in* [names hospital] *and then my sister’s a nurse, she works in* [names hospital and department] *and they all like say, ‘do something in healthcare’. ‘Cos erm, I think with healthcare you know there’s a job always guaranteed at the end of it. So that was like a big influence”* (Amara)

John related that he had accrued some interest in emergency-response work from his mother who was in the police, and that he had friends in the ambulance service who he would chat to. John also had significant prior experience within St Johns Ambulance Service (SJA) and had treated patients alongside qualified paramedics. He stated that this led to a removal of “naivete” in relation to paramedics, although he had learned respect for their levels of responsibility:

* *“….it instils inside you that erm, fear of becoming a paramedic ‘cos you sort of think I have worked within my little boundaries, now I’m the person whose going on. So it’s probably a good thing to have that inside you because it made you not go out with naivete, thinking, ‘I can do it all’…..”* (John)

Another participant (Michael) also had experience of SJA and had a partner who was a student paramedic a year ahead of him on a different course. He related that this gave him an advantage in relation to socialising with ambulance staff on placement:

* *“I think in terms of finding things to talk about, and what sort of things are good to talk about on station especially in terms of clinical stuff as well a bit of a head start ‘cause my partner’s a, she’s one year ahead of me, she’s now an NQP1 down in* [names area of work]*”* (Michael)

Other participants described their prior working experience and how they felt that it may have helped them. In Beth’s case, she described how working as a security officer aided her with talking to people and dealing with confrontation:

* *“….so I like dealt with like a couple of things there, I learned how to deal with confrontation….and it’s very customer service, I know security doesn’t sound it, but at a shopping centre, well the one I used to work at is very much customer service focussed – that’s the first role - and then security kinda secondary role, but I also used to do customer service beforehand so, I can talk to people….erm”* (Beth)

Emma related how her experiences as cabin crew for an international airline and having been a fast-food restaurant branch manager were of benefit for socialising in the clinical practice environment:

* *“….Like erm, my mentor mentions stuff about being cabin crew, “Oh she’ll bring the tea and biscuits in”, and stuff like that, but not like in an offensive way. He wouldn’t have said that right at the start of meeting me, he just says it as a joke”* (Emma)

Both Louise and Todd also cited their previous experience in retail and I.T. as being of benefit in relation to communicating on placement:

* *“Erm, I’ve had a variety of retail jobs and then moving into more of an office-based erm, which involved a lot of talking to customers, clients, other workers…..so I’d never get out of communicating with people. So, I think that definitely influenced my communication, erm, which probably prepared me a bit more for the course”* (Todd)

Conversely, Amara – who had started the course straight from school - considered a lack of working experience and her young age (nineteen) to be advantageous:

* *“Ok, so with age, it’s because I’m young and I haven’t had like a proper, proper job, I think I can just easily get into it now because I’m just exposed to it now, rather than like comparing it to other stuff….”* (Amara)

At the time of the interview Amara was a first-year student with only 5 weeks of placement experience. This exposure was significantly less than most other participants.

### Understanding the cultural ‘rules of the game’

Of all the participants, John, Michael and Emma conveyed the greatest understanding of how to engage with the ambulance culture whilst on placement. This was expressed in terms of being conscious of the impression they were making, and how their words and actions could be perceived by others. Both John and Michael had SJA experience, and they relayed that they knew it might not be wise to divulge this owing to the poor opinions of SJA often held by full-time pre-hospital ambulance staff:

* *“...’cause no one wants sort of a jumped up ‘bertie’* [a slang term for SJA volunteers] *thinking they know everything do they* [laughs]?” (Michael)

Both John and Michael perceived that an appearance of being keen to fit in, to learn, and participate also had to be tempered to match the more relaxed approach (on station) generally taken by those around them:

* *“So I think, going into the workplace for the first time, and the one thing I was always conscious of was….be chatty, but don’t be too chatty, like don’t harass the crews and then be keen, but don’t be too keen”* (John)

Whilst John was older than many university students (twenty-six) and had prior working and college experience, a similar degree of sensitivity was also demonstrated by Michael who had joined the course straight from school:

* *“Sometimes it’s about knowing when not to talk as well as when to talk”* (Michael)

Although Emma did not have equivalent SJA experience, at the age of twenty-five she did have considerable and varied working experiences which she stated made it easier to chat with people on placement. In a similar manner to John and Michael, Emma was seemingly able to navigate a pathway of socialisation and interaction through perceiving the motivations of others and asserting herself to some degree to make communication easier. In commenting on the relationship with her mentor and the difficulties that she has observed other students have, Emma also stated that she would be willing to speak directly to a mentor with whom she was experiencing difficulties and hinted at her own role in the communication process. In the following comment, Emma suggests that a successful student/mentor relationship may perhaps be dictated by her and not the mentor:

* *“But I always think that if I didn’t get along ‘em, I just would for them couple of months just because, why would you not want to?”* (Emma)

At the time of interview, John, Michael, and Emma were nearing the end of their two-year course. Other participants in the same position however did not express the same levels of social perception. Ellie for example conveyed that she was not usually included in general conversations and ‘banter’ and instead found that conversations generally only revolved around work-related issues:

* *“….a lot of things they talk about is like getting paid and overtime and stuff and obviously we don’t have to worry about any of that. And they’ve got, they’ll be looking at like the shift patterns and shift swaps, and we don’t have to worry about any of that and they’ll have to get like keys and radios and stuff, and obviously we don’t have to worry about that either, so it’s just….yeah just that”* (Ellie)

In relation to the “keys and radios” (essential items for an ambulance crew to have at the beginning of their shift), John stated (in contrast to Ellie) that he would obtain these items for the ambulance he had been allocated before the crew came on duty. He stated that he did this as a means of gaining “brownie points” by preparing the ambulance for them, and so that they would have no option but to find him before their first call – thereby ensuring that they would be introduced to each other at the start of their shift.

In a similar manner to Ellie, Adeeb did not seem to initially engage with general workplace socialisation. By his own admission he “didn’t grasp the nature of the job” and would therefore shy away before the conversation became “personal” and veered towards non-work-related questions. Adeeb described an extremely busy and traumatic first shift on placement which left him somewhat shocked and believing that every day would be extremely intense. He described how this was noticed by the ambulance staff, who repeatedly asked if he was OK. Adeeb helped with the cleaning of the ambulance equipment and relayed how he subsequently pitched in as much as he could with tasks on station and with calls to try to become “part of the team”. This willingness seemed to be well received by ambulance staff who Adeeb described as being helpful and supportive. He was given the nickname, “shit-magnet”, following the intense nature of his first day. Adeeb confirmed that this nickname was meant in a joking way and as a means of inclusion:

* *“….and I take that as welcoming into the workplace. Like that’s ‘you’, that’s your thing now….gotta run with it or, do you know what I mean?”* (Adeeb)

### Being surprised or frustrated by the nature of the role

Some participants stated that their prior conceptions had been shaped to varying degrees by the popular television shows which focus on the work of paramedics in the UK. This was the case for Adeeb who stated that prior to starting the course he “literally just absorbed” himself in watching the shows, and with no other point of reference had some initial difficulties in understanding what being a paramedic entailed. Having also watched the shows, Amara expressed some surprise at the difference she perceived in communication between ambulance crews and the control room staff, as well as the attitudes of ambulance staff towards responding to emergency calls:

* *“….‘cos when you watch shows, like they’re all so excited and eager to go to like these emergencies. But they’re bloody not. They’re not….”* (Amara)

When asked about her preconceptions of the role, Stef stated that she had experience of working alongside paramedics as part of the SJA for several years, had attended university open days, and had done her own research into the role; with some humour she confirmed, “….I kind of knew what I was getting myself in to”. Whilst Stef seemed embarrassed to admit that she had also watched the television programmes, she acknowledged that there was some similarity between the shows and what she had experienced on placement. She did however highlight some differences that she perceived towards certain groups - such as intoxicated patients:

* *“I’d say it’s similar, but erm, I think different paramedics would’ve reacted to different scenarios, knowing them a little bit better, than I’ve seen on the tele….they would’ve….kind of not, not been horrible to them, but probably gave him a few home truths and that they’re wasting the ambulances time, kind of thing”* (Stef)

Although stating that the levels of professionalism of paramedics did not surprise her on placement, Stef did express some frustration about the non-emergency nature of some of the calls, and for cases where she felt an ambulance was simply not required. This was similarly expressed by Beth who admitted having a very different expectation of the role, conveying surprise and disappointment at the volume of socially-related calls and her perception of a frequent lack of actual requirement for an emergency response:

* *“So, I guess in some sense it’s a bit, a little bit disappointing.…I feel so many people coming into it expect emergency care, “I’m gonna save that person’s life….”. I’ve literally just only been to one workable cardiac arrest, and you’re expecting to be doing that basically every shift….”* (Beth)

Beth expressed frustration with “regular callers” who have seemingly “nothing” wrong with them, but “know what to say” to warrant an emergency response. She also conveyed frustration with emergency calls she had attended for things she would not have called an ambulance for and relayed her own thought processes pertaining to an occasion that she could have requested an ambulance for a friend who was having an allergic reaction. In this context she expressed exasperation with members of the public who seemingly abuse the system:

* *“So yeah, I could’ve just sat back and called an ambulance, but no, my car was outside, so why wouldn’t I just drive? So that’s, that’s my issue, is when….and definitely when they know better, when they should know they shouldn’t really call an ambulance, yet they still do because, “why not, it’s free to me….””* (Beth)

Ellie, similarly, expressed surprise and frustration at the number of non-emergency calls. She conveyed that she was not expecting the high volume of non-traumatic medical calls and was surprised at the volume of knowledge which is required in this area. Although stating that she was initially annoyed by some of these calls, Ellie conveyed that her views had since changed upon realising that many people in this position had called the 111 urgent care line only for advice or for a doctor and not for an emergency ambulance. Her frustration has since become focussed upon the 111 service whom she described as “really pushy” in relation to initiating an emergency response for callers:

* *“Erm, and I wasn’t expecting that as much. So, I think ‘cos first I was really annoyed about it, like we’re going out to all this stupid stuff, but I’m a lot less annoyed now ‘cos I know that like 70% of them don’t want us there and they’ve been pushed into this corner of having us sent out”* (Ellie)

In terms of attending calls, both Penny and Adeeb expressed that they had experienced some initial difficulty with the impersonal nature of entering the houses of complete strangers, asking personal questions, and having short but otherwise fairly intimate contact during the assessment process.

* *“….And I struggled a little bit, feeling like an intrusion initially and stuff like that, but I think, kinda worked through that and talked to the paramedics….and they were just like, “if you make yourself comfortable, you’ll often make them feel more comfortable”, ‘cos you’re not just stood there – hovering awkwardly”* (Penny)

Adeeb additionally described that he felt as though he was “barging into people’s houses” and stated that he wasn’t initially prepared for undertaking this kind of transition in personal contact several times a day.

### Being surprised by the living conditions of service users and patients

Most participants expressed that they were initially surprised by the poor living conditions of many service users that they encountered on placement. This included what was described as “uncleanliness” and “poor hygiene” and was even expressed by participants with some significant prior life experience. For Aaron, this surprise was despite experience of low-budget world-travel, backpacking, and living in fruit-picking accommodation:

* *“….I’ve lived in some major dives, but like going to some of these places, you’re like, “erm, people still live here?”. Like, when I was in Australia, we used to wash in river water….So like, I can appreciate having to live in smelliness, but….like the…..uncleanliness is a bit, is quite a shock that personal hygiene….is not everyone’s priority”* (Aaron)

At the age of twenty-seven, Louise conveyed that she had significant prior working and life experience but stated that she was still surprised by some of the conditions that she encountered. Both Louise and Emma - who conveyed that she had witnessed some extreme poverty during her travel experiences - relayed surprise at the conditions that they found regular drug users to be living in:

* *“…we walked in and she was a heroin user and erm….you are shocked, surprised by the conditions that some people live in”* (Louise)
* *“ I remember once I went to like what you class as a drugs den, and I was like, “oh my goodness, people are living here….””* (Emma)

For John and Amara, surprise at poor living conditions and deprivation was additionally contextualised in terms of the higher standards they expected in relation to more affluent areas and entering houses which, “look nice on the outside”, but are “horrendous on the inside” (Amara):

* *“I’ve been shocked at the situation….you sort of maybe went in with the mentality that, “oh these places are gonna be quite nice places””* (John)

With prior experience of attending service users in the community as a domiciliary nurse, Stef felt as though she had some idea of what to expect. She stated that she had previously been in what were described as “hoarders” houses which smelled badly, but still admitted some surprise at the conditions she found on placement. Similarly mentioning “smells” and “hoarders”, Todd stated that he knew beforehand that he would encounter deprivation and poor conditions, but that he couldn’t properly imagine it until he’d actually encountered it:

* *“….you can’t imagine smells until you’ve been there….but the house that he lived in was, he was a hoarder, and there was just stuff everywhere. Erm, it just makes you think, like, how can people live like this?”* (Todd)

Only Beth expressed that the living conditions she found were mostly what she expected. Whilst stating that she felt lucky to have experienced good standards in her own homelife, she relayed that she has relatives who have had to raise large families in relatively poor living conditions and that she is, “used to seeing not the nicest houses….”. Beth expressed that she was not surprised by uncleanliness per se, but that she was most affected by those living in poor conditions because they are not receiving the care and support they need in the community.

Surprise at a perceived lack of organised community support was similarly conveyed by other participants. Adeeb expressed surprise at the number of elderly service users who were unable to care for themselves but choose to still live independently “at massive risk”; whilst Penny expressed shock at how she had seen some elderly service users who did not have care in place and who had been allocated unsuitable living accommodation:

* *“They were placed there by the council….they were up some stairs that they practically could not get down and that really got to me more than anything else*….” (Penny)

For John, Beth, Emma, Adeeb, Ellie, Steph and Amara, poor living standards were often related to a surprising prevalence of mental health issues and social decline. These issues were also felt by most to be unsupported within the community:

* *“Like they live there on their own, and they’ve got dementia and they’ve got like no support at all, which is a bit shocking”* (Ellie)

Although a lack of official support for such service users was frequently mentioned, some participants also expressed surprise at the number who had family members whom they felt should provide help but do not. Louise thus conveyed surprise at the family of one elderly service user who “weren’t interested” in either staying with him at hospital or in helping him to return home. Frustration with a lack of family support was also relayed with some passion by Michael:

* *“I’m quite surprised by the amount of older people who have got children who have nothing to do with them, and they don’t help with the care or anything….And the amount of people you go to who’ve been say on the floor for 2 or 3 days and they’ve not had carers or family come in to check they’re OK. Like if you were ringing your Nan and they weren’t replying probably you would go round, there wouldn’t you?”* (Michael)

### Perspective: ‘thrown’ prior experience

This subordinate theme has arisen inductively from the data and encompasses how some participants expressed that they had a particular perspective on elements of their pre-hospital placement exposure. In accordance with Heidegger (1927), these findings may convey how some individuals seem to have made sense of what they have witnessed (and the actions of others) based upon specific ‘Thrown’ prior experience.

With often limited prior working experience, many participants expressed sympathy with ambulance staff in terms of the volume of calls attended in an average day. Emma however did not convey such sympathy, comparing what she had witnessed on placement with her own prior working experiences in a fast-food restaurant and as airline cabin crew. This view was however tempered with an understanding that the workload had increased somewhat within the working lifetime of many established ambulance staff:

* *“I think it’s because the older generation, they used to have what like 3, 4 jobs a day max and now they’re getting 7 jobs a day they feel like, they’re hard done by, but for me, running around on my feet all day at* [names fast food restaurant] *or on the airplane, I think, the way it is now, what I’ve seen, I’m like this is so much more relaxed in a way than what I’m used to, and a lot less hard work than what I’m used to”* (Emma)

John similarly compared what he had witnessed as a student with prior experience as an ambulance subcontractor and with a friend who works for a different ambulance service. This was expressed in terms of a perspective on the complaints of ambulance staff on placement who may not have been allocated a meal break or who may have finished late. John stated that in comparison, he considers the working conditions of the ambulance Trust he was doing his placement with to be superior to others, and that he has even expressed this to some of the staff on placement:

* *“….I suppose at times that it’s….sort of stand up for the service almost because I’ve heard people saying like they get a late meal break, or we’ve finished half an hour late or something like this, and I’ve had conversations before where I said like, “you don’t realise how well off you are” sort of thing”* (John)

This contrasts with the views expressed by other students which may more closely reflect an unfiltered adoption of the pervading opinions of ambulance staff:

* *“You come into that mentality that, great, this is my job, I have to do this. Crap, I don’t want to go here, they’re sending me this far away from station, I’m gonna finish late….”* (Adeeb)

Throughout their interviews Emma and John seemed to avoid the adoption of such views. They also seemed to avoid attitudes which other students may have felt would meet the approval of their mentors. Hearing negative attitudes towards service users, from other students, John expressed disapproval, and the belief that they were simply mimicking what they had heard from their mentors:

* *“I’ve heard other students as well who’ve been fairly sort of…. they’ve obviously just copied their mentor, or copied some other paramedic”* (John)

Some participants did express some frustration with the number of mental health cases that they responded to and judged that many did not warrant an emergency response or may have been wasting their time. Based upon her own prior experiences in this area, Louise however expressed a more empathetic perspective:

* *“I quite like mental health cases, I don’t, I don’t mind them. I don’t think err, I don’t really wanna judge them, but I’ve, I’ve been in situations myself where I’ve been at a place where it’s not great, so I don’t, I just feel empathy towards them. Yeah”* (Louise)

### Impact of gender and ethnicity

In a similar manner to other subordinate themes, this one has also inductively arisen from the data and involves the expressions of participants with specific reference to either their gender or ethnicity. These factors represent further ‘Thrown’ properties over which participants have no control and which may play a part in the creation of prior dispositions towards the placement environment and the attitudes of others (Heidegger, 1927; Wisnewski, 2012).

### Gender

Several female participants commented on what they perceived to be judgemental behaviour on the behalf of members of the public towards them based upon their gender. Beth expressed that whilst ambulance staff are aware that all staff and students receive training on moving and handling and are expected to be able to carry service users, the public are sometimes more judgemental about her ability (and the ability of other female crewmembers she may be with) to be able to physically carry them:

* *“No….‘cause I think at station, they know that we have to be able to lift a person. Err, whereas I think general people, they’re like, “oh, you’ll have to bring some men round….””* (Beth)

Ellie related that because she was “young and a girl”, she felt that male members of the public would often not take her seriously, would ignore her during clinical questioning and directly address their answers to her older male mentor. “Not being taken seriously” was something also related by Penny, who gave an example of a male service user who seemed to refuse to listen to the clinical questions which were being asked by her and a female paramedic. She stated that it was only after the other male crew member had told the service user that he needed to answer the questions that they obtained the information they needed.

Some female participants also believed that members of the public were more respectful to them because of their gender. This was conveyed by both Ellie and Amara, who described how the public sometimes seemed to find female ambulance staff more approachable and were less inclined to be rude to them. The examples which were given universally involved male service users:

* *“Erm, patients are more respectful to females. That’s one thing I’ve noticed. It’s like we went to a patient who had apparently had a heart attack, and erm, so, he was being quite rude to the guy, but then like to my Associate* [mentor] *he was being quite nice shall I say, he’s been quite polite to her”* (Amara)

In terms of interacting within the placement environment, some participants relayed that paramedic mentors sometimes preferred students from a particular gender. In Todd’s case, his female mentor had expressed a preference for teaching male students, whom he suggested tended to cause “less drama” than female students. He also stated that he had found females on placement to be generally more accommodating towards students, although when there was disharmony between a mentor and a student, he felt that it tended to involve a female mentor:

* *“I do feel as though females are more accepting towards students….Erm, there are exceptions. Erm, the previous cases where I’ve felt like the mentors didn’t get on with the students, most of the time it’s certain females….”* (Todd)

From a student perspective, Emma expressed her own preference towards having male mentors. With a prior working history including airline cabin crew and as a branch manager for a fast-food restaurant, she conveyed how she felt more intimidated by females in the working environment, describing how she found them to be “quite….tense” at times. Stating that “males seem to be quite a bit more laid back”, and that she could “have more of a laugh and a joke with them”. She also described females as being “really bitchy sometimes” with a propensity to “turn their nose up to other girls”. She did however state that she had more latterly “worked” with a female paramedic and found that she did “love working with her”:

* *“I think I’ve always thought, ‘Oh, I don’t really want to work with a female’, but when I have it’s been alright”* (Emma)

Emma conveyed that she is more regularly placed with males (which she said she does not mind) and that there is a greater proportion of males in the pre-hospital workplace. Without further elaboration and demonstrating a desire to change the subject within the interview, Emma expressed that she would prefer to be female in that environment, and that a large male workforce probably makes it “easier” for females. Emma was however the only participant to report that she had been the subject of a sexually orientated comment – made by a male member of staff. Although stating that she wasn’t upset, she relayed that it had made her feel uncomfortable and that it was something she wouldn’t forget. When asked about her welfare in relation to this comment, Emma relayed that she took this to be a misjudged comment, and that she had reported it to her mentor at the time.

### Ethnicity

A few participants from a white-British background expressed that they felt their ethnicity made it potentially easier for them on placement compared to other ethnic groups. Some also relayed that they had occasionally witnessed behaviour from ambulance staff towards patients and students in minority ethnic groups which made them feel uncomfortable. Whilst on placement Beth observed a Muslim student being quizzed about Ramadan by ambulance staff. In this case he had divulged that he would have to break his fast and start his fast within the same shift, which elicited some questions, and the expression of some dissenting opinion, to which Beth felt obliged to interject:

* *“….I just thought, “is that needed?”, like is he saying “no other place does this fasting for so long and no other religion does it…” so I kinda said that “Christians do fasting as well”, erm, I was just thinking, there’s no need to talk about his religion now, that’s his own belief”* (Beth)

Louise also expressed that people from non-white-British backgrounds are treated differently on placement, and that she witnessed jokes being made out of their earshot which would not be made in their presence. She stated that she felt this had the potential to make members of minority groups feel quite isolated:

* *“….Erm, there would be, there’s jokes that hap, occur….erm, not necessarily racist, but they could be seen as, and they wouldn’t necessarily be said in front of people of that – you know, err ethnicity. So, err, yeah, it could be erm, quite isolating if you were, maybe….which is unfortunate. But erm….”* (Louise)

Conversely, Adeeb relayed that he had found his South Asian ethnicity and the ability to speak Punjabi empowering as a student in the placement environment. He stated that he had enjoyed a sense of inclusion and relative power from an early stage when he was responded with ambulance crews of white-British ethnicity to service users of a South Asian ethnicity who spoke little English. He was thus able to occupy an important position through being able to ask relevant clinical questions and relay the answers to the paramedics who were there with him. Adeeb also stated that being based in an area with a high proportion of service users from a South Asian background was advantageous for him as he understood their traditions and values and was in a position to be able to educate ambulance crews accordingly:

* *“….I suppose being an Asian man makes it a bit easier, especially the area we work….I already know the boundaries, you know, that sort of thing, erm, plus I know the language. Erm, I’m able to explain certain things about my culture to staff who don’t quite get it”* (Adeeb)

In relation to preconceived ideas he had sometimes witnessed on placement about ethic minority callers, Adeeb stated that it made him “happy” that some assumptions were being made. He considered that this was preferable to suppressing or ignoring possible inclinations of what the call could be about. Adeeb also remarked that he drew comfort that such comments were expressed in front of him, and took it that the comments were not meant in a detrimental way:

* *“They weren’t being negative, it’s just the way it was. I liked it when paras or techs would openly say, “oh, it’s this place again”; they’re saying that in my presence, which means that they’ve kind of not meant it in a harmful way. If you meant it in a harmful way, you wouldn’t say it when I’m there, sort of thing”* (Adeeb)

In commenting overall about the impact of variables such as his age, gender and ethnicity upon his placement experience, Adeeb was very positive, stating:

* *“….to date being the age and like male and Asian hasn’t been a negative thing….it’s been brilliant!”* (Adeeb)

### A confident or extroverted disposition

This subordinate theme has arisen from the descriptions given by participants relating to how they interact with ambulance staff and service users. It includes potential differences between being relatively quiet, shy, and appearing unsure, and being able to confidently join conversations and/or put an opinion forward. This theme is intended to embody a “Thrown” property which represents apparent self-assurance/confidence in an unfamiliar social environment. Whilst such a disposition may logically follow the accumulation of life-experience, this theme is intended to also capture the exhibition of such behaviour by students who may have limited comparable life-experience.

Although one of the older participants with prior working and studying experience, John described how he felt he had benefitted from good conversational skills and gave a few examples where he had been able to chat with ambulance staff from an early stage. In illustrating this ability, he related how during a conversation with his mentor’s work-partner he had found little in common in terms of their sporting interests. Rather than a barrier, this was considered with some humour by John, who conveyed that they were still able to find things to talk about:

* *“….I remember one of the first days working with my mentor and the guy he usually works with….asked things like what team do you support, and I was like, “I follow rugby….”. “Oh I don’t like rugby….”. I remember after a couple of minutes he said, “don’t think we’re going to have very much to talk about here are we?”’’* (John)

As one of the youngest participants (aged twenty), and having joined the course straight from school, Michael conveyed an insight into the social dynamics of communication which was not demonstrated by some of the older and more experienced participants. He talked about the need for an individual to sometimes push themselves outside of their communication comfort zone to be accepted by the surrounding social group:

* *“I think it’s a bit of give and take isn’t it? If you put yourself out there and push yourself a little bit, people will be more receptive. If you sit in the corner and sort of, with eyes glued to your phone, people are not going to try are they?”* (Michael)

When asked about how he had established what the “rules of the game” were in terms of social dynamics and communication on placement, Michael relayed that he had initially observed the environment to find some commonality upon which to base his conversation. He also relayed how as a gregarious person he found this fairly easy to do, and that he was able to develop this skill over time. A similar ability was demonstrated by Emma. Although twenty-five years old and possessing some significant working experience, Emma described how she was the sort of person who would initiate conversations and be able to create amiable communication in most situations:

* “*Yeah, but I think that’s just me as a person more than maybe the situation I was in. I will talk to anybody* [laughs]*, I don’t mind”* (Emma)

Suggesting a more leading role in socialisation than most other students demonstrate, Emma described how even with apparently taciturn members of ambulance staff she would deliberately “force” conversations in order to make her “life easier” on placement. She described how she would use the reciprocal exchange of information about personal lives to generate conversation, and in some cases manipulate conversations by using what she gauged people like to talk about:

* *“I think you kind of get to know what they like and sometimes you want to talk about things that you know they like because it’s gonna make them feel a bit better, and easier to talk about, and stuff like that”* (Emma)

Although admitting that he was quite shy for his first few weeks on placement (despite prior working experience), Todd similarly related that he very quickly began to engage in general chat with service users and ambulance staff, developing the ability to “waffle on to anyone about anything”. This was also expressed in relation to having the confidence to join in uninvited with bigger group conversations amongst ambulance staff during lunchbreaks on station. For Todd, this was something he had witnessed other members of staff do, and found that being able to do this led to a feeling of acceptance by the larger group:

* *“I think it helps to not be afraid to kind of jump into conversation. Erm….from what I’ve witnessed people just walk in and join in the conversation, and I started doing that myself, and no one bats an eyelid, so, ‘oh, I’m kind of in’”* (Todd)

Having the self-assurance to initiate or join interactions with ambulance staff was not conveyed by all participants. At the age of twenty-two, Beth expressed that prior working experience in a customer service and security capacity gave her confidence in talking to people and being able to get along with “most people of any age”. Whilst this may have translated well in relation to service users, Beth also expressed that she was reluctant to participate with workplace conversations and banter with ambulance staff for fear of creating a socially awkward situation. She conveyed that she would instead sit quietly in the ambulance crew room and wait for an appropriate time to join in:

* *“I’m very much a person that has to gauge erm whether it’s OK to talk, what kind of jokes I can say or how to speak to that person. I like to know what I’m doing so I don’t embarrass myself or make them feel uncomfortable, so I just stay quiet….”* (Beth)

It may be the case that the attitude towards students at Beth’s placement location was harsher than in other areas, and she did express that she felt it was a case of, “stay quiet unless you’re spoken to”. However, from a more personal perspective, during a period when she believed her mentors were not conversing with her in their usual friendly manner, she related that she had internalised this to a degree which manifested with feelings of nervousness, anxiety and actual physical symptoms (Beth’s pastoral welfare in relation to this was discussed aside from her interview). In terms of ambulance staff attitudes towards other students at the same location, Beth also made comparisons between herself and a more apparently gregarious student peer who she describes as being popular, “able to just fit in anywhere” and whom “everyone seems to get along with”.

## Fallenness

‘Fallenness’ (see *The concept of ‘Fallenness’* section on p. 93 for more details) is a key element within Heidegger’s (1927) structure of ‘Care’ - which in turn underpins the notion of ‘Dasein’. I believe that contextualising the findings in accordance with ‘Fallenness’ is pertinent for understanding how individuals attribute meaning to their own existence in the present time, and how they perceive their own sense of ‘Being’ in accordance with the ‘inauthentic’ world of ‘Das Man’ (Heidegger, 1927). In other words (and in this context) it represents a lens through which to explore factors which may influence paramedic students’ sense of ‘self’ in accordance with the everyday pre-hospital workplace and community of practice.

This superordinate theme incorporates areas of social theory which have driven the review of the literature (such as Goffman’s (1964) ‘Presentation of Self’), associated concepts found within the literature (such as ‘blue-collar professionalism’), and topic areas which have inductively arisen during the coding process (see Appendix 12 for an excerpt from my NVivo analysis journal). This process has generated the following subordinate sections:

* Commonly witnessed behaviour of ‘Das Man’
* Remembered instances of admiration or respect
* Factors or circumstances which may promote a sense of integration
* Factors or circumstances which may create dissociation or discomfort
* Feeling 'at one' with ‘Das Man’

### Commonly witnessed behaviour of ‘Das Man’

This subordinate theme includes what participants have relayed about the behaviours of ambulance staff on placement and their feelings about these where they are expressed. It represents elements of Heidegger’s (1927) ‘average everydayness’ which may be unique to the pre-hospital emergency care environment. This theme has inductively arisen during the coding process as an area of interest between participants and has been further divided into the following areas of correlation and commonality:

1. *Witnessing control over the allocation and pace of work*
2. *‘Dark’ humour and banter*
3. *Taking liberties during the working day*

### Witnessing control over the allocation and pace of work

All participants relayed that they had witnessed ambulance staff exercising an unofficial degree of control over the allocation of calls allocated to them and the pace at which those calls were managed. This was frequently expressed in terms of ambulance staff being strategic in notifying Control when they had completed a call (that they were ‘clear’) and were ready to be allocated more work. This was perceived by some participants as a means of self-preservation in lieu of a potentially relentless workload, and considered with empathy in several cases:

* *“….I know why it is….It’s….to spread your jobs out a bit more to make the job a bit easier for you. Because otherwise you do get slammed, and I have been, I have worked with people that will literally just assess the patient in 10-20 minutes, and then roll onto the next one. And you’ll do, what I dunno, 15-20 jobs – that knackers you out. Then you remember, ‘oh I need to get home, then I need to be back in tomorrow’. So I can understand why they do that”* (Adeeb)

Whilst relaying how some ambulance staff manage their time and sometimes delay giving their ‘clear’ notifications to ‘Control’, Michael also described what he felt to be an almost perverse sense of game-playing involved. Acknowledging that this would probably be considered abhorrent by people unfamiliar with the culture, Michael relayed that in the context of the pre-hospital working environment – and the perceived dissonance between ambulance staff and Control - it became an abstruse means of entertainment that helped to ease the passage of a busy day:

* *“I think it’s just an extra bit of comedy. An extra bit of just….I think it’s ‘cause they want it so much, it’s quite fun to withhold it* [laughs]*. That sounds really bad doesn’t it?”* [laughs] (Michael)

Of all participants, only Penny stated that she had never been supervised by a crew who had deliberately shoehorned-in their own breaks and managed their time, although she acknowledged that she had seen others do it. She did however relay that the pace of work did vary sometimes in relation to what time it was and when they were due to finish. In relation to managing their finishing time, Aaron relayed how he perceived that some crews would invite him to do more of the patient assessments and interventions if the length of time on a call “needed” to be stretched. He stated that he felt that this was done because as a student he would be generally slower and more methodical than the experienced ambulance staff. Todd also relayed that he had witnessed crews varying their pace of work to suit themselves. When asked further about this, he stated that to some people being a paramedic is just a job and that not everyone wants to be “a superhero”. He did however feel that everyone’s “heart was in the right place” and that most crews would act quickly when the need arose. Conveying a similar sentiment, Louise also stated that she had witnessed variations in pace of work, with some cases being “a bit rushed”, but that in her view it would never affect the actual care given to the patient.

### ‘Dark’ humour and banter

It was broadly acknowledged by participants that away from public scrutiny, ambulance staff often exhibit a ‘dark’ sense of humour in terms of joking about things which could be perceived as distasteful by those who are not part of the workplace culture. The degree of this humour was a surprise to Michael, who stated that even with SJA experience, he had not been exposed to it before. Describing ‘dark’ humour as being quite niche to the ambulance service, Michael relayed how during his first few weeks on placement he had found such an apparent lack of empathy “a bit harsh”. He stated that he has however since become accustomed to it and understands that staff engage with it as a means of coping:

* *“….as you go on you sort of think well if you didn’t make jokes like that about patients, you’d go home every night worrying about every sepsis alert….you know and you’d never get through a week”* (Michael)

Todd however conveyed that the expression of ‘dark’ humour was something he expected to see and that it would be somewhat naïve to expect ambulance staff to act otherwise. Stef similarly said that she expected this kind of humour and relayed an example of a paramedic making jokes about a traumatic cardiac arrest that he had attended. According to Stef, humour in this context was being used as a coping mechanism, but she also felt that whilst “it’s ok on station”, it certainly wouldn’t be appreciated by members of her own family. Expressing that she had found that the level of this humour seemed to vary across individuals, Louise confided that she has quite a ‘dark’ sense of humour herself and said with a laugh that it was “refreshing” to find so many like-minded people. Alongside a sense of ‘dark’ humour, many participants also described the generic heckling and banter which was exhibited by ambulance staff towards each other and sometimes towards students.

Having been part of a workplace before, John said that he did not find such banter surprising and that it represents a helpful means of reducing stress; although he did acknowledge that it could potentially be judged as “workplace bullying” by external parties. Similarly, with working experience, Beth said that she was unsurprised by the way that ambulance staff joked with and heckled each other. She did however outline that following a possible complaint at her placement location, attempts had been made by the managers there to ban it. With evident disapproval of this measure, Beth relayed how she felt banter should be taken in a light-hearted way and represented a means of relieving stress. She also conveyed the belief that for this reason ambulance staff were unlikely to stop doing it.

### Taking liberties during the working day

In addition to attempts by ambulance staff at managing their workload and time, some participants also relayed how individuals would try to build in time for their own needs and errands during the working shift. According to Emma, this was reflected by a member of ambulance staff who would inform Control that he needed to go to a supermarket to get food for his break. Once given permission however, he would additionally undertake some household shopping. On returning to station with the shopping, he would load it into his car before telling Control that he was ready to go on break.

For Emma, this kind of behaviour runs parallel with a sense of resentment by more established ambulance staff towards the changing nature of the role and nostalgia for how they perceived things used to be. This nostalgia was described as encapsulating how much more work there is now considered to be, how there used to be more “proper jobs” (or more “genuine” patients), and how they could no longer have fun in the form of water-fights or barbeques during a shift on station. Whilst expressing some sympathy with how they feel that the job has deteriorated, Emma described how ambulance staff seem to feel a disproportionate sense of injustice (especially in comparison with her own busy work experience), and feel the need to take small liberties – such as doing some household shopping - in order to compensate:

* *“Little things like that. I think it’s because like we said about feeling hard done by now, and they’ve gotta do so much more work and….Put em’ into* [names fast-food chain] *for a day and then they’ll realise what it’s like”* (Emma)

Relaying how she had witnessed ambulance staff managing their time during nightshifts, Stef described how they frequently ringfenced their break period for sleeping rather than eating. To be able to do this, Stef explained how crews would take their food and drink out with them in the ambulance when attending calls. By eating and drinking in between calls, they were then able to devote the time allocated for their official break for sleeping.

### Remembered instances of admiration or respect.

This subordinate theme includes what participants have expressed about behaviour from ambulance staff (or other healthcare professionals) which they have admired or respected and which they may choose to adopt. For Ellie this included how her mentor had been attuned to her lack of confidence and encompassed how she had even defended her against other ambulance staff who thought Ellie should have been more forthright in her communication. Ellie relayed respect for how her mentor hadn’t “shoved” her into dealing with situations which were beyond her and had developed her confidence as the placement progressed:

* *“….my confidence isn’t very good, erm, but I think she really helped with that and let me, like still develop without like pushing me so far that I was just going to breakdown and cry…”.* (Ellie)

Adeeb conversely admired a mentor who publicly questioned and pressurised him during each call, and essentially drove him to improve his knowledge and decision-making skills for fear of not knowing the answers. Experiencing something similar, both John and Michael described how they felt this kind of pressure was inappropriate during patient interventions, but for Adeeb this approach – coupled with some “straight-up” feedback afterwards – worked well for him and was worthy of admiration:

* *“Yeah, he wasn’t mean about it, he was just like, simple questions like, “is this patient ready to move?” I’d be like, “I don’t know, I think so”, he’s like, “why don’t you know? Have you done your job, have you strapped them in?” Really like, getting me to question everything I do, not just taking it for routine. That made me think, and I admired him for that”* (Adeeb)

Aaron expressed admiration for a paramedic mentor who was seemingly very structured in his approach to both mentorship and patient care. He explained how this mentor would get him to observe a detailed and thorough patient assessment before encouraging him to do more on each call until he became quite proficient. Describing himself as being very conscientious with his learning, Aaron would carry a notebook on placement, and this mentor would offer specific tips about patient care for him to write down. He also described how this mentor would later allow him to undertake as much of the patient assessment as he could, and if he became stuck the mentor would take over without fuss. Although seemingly less confrontational than Adeeb’s mentor, this mentor would also teach Aaron during actual patient assessments (seeking permission from the patient first), explaining his thought processes and actions as he went along. In expressing how much he learned from this individual, Aaron said:

* *“….he would like say to them, “I’ve got a student here, do you mind if I explain things?” and, they’re like, “….oh, no, no. Go….”. So he would go through things and then he would tell me information that nobody else has….but what he did like, I’ve got a book and I could write a book about what he said, ‘cos there’s so much stuff….”* (Aaron)

Expressing a similar admiration for one paramedic’s extensive clinical knowledge, Louise relayed how this was demonstrated through asking a patient about specific signs and symptoms concerning a rare condition which was unfamiliar to her. She was also impressed with how he used his knowledge and experience in the practical treatment of patients and gave an example of the therapeutic management of a drug-user who refused to travel to hospital after an overdose. This practical application extended to a seemingly uncanny ability to be able to make rapid and accurate diagnoses:

* *“….Yeah. So, you’d go to someone and he would immediately diagnose them, and you’d be like, ‘you haven’t even asked him any questions’, and then, it would turn out that’s exactly - like an hour later after the findings - you’d find out that’s exactly what it was”* (Louise)

Admiration for high levels of clinical knowledge and experience was expressed by other participants such as John, Adeeb and Penny. In Penny’s case, this included her mentor’s willingness “to go the extra mile” by undertaking research outside of work. She relayed how he also sets her research-orientated homework to try and instil a similar work ethic and level of clinical knowledge.

In addition to clinical knowledge and experience, several participants expressed admiration for kindness and attention which was paid to service users. In Beth’s case, this included a hospital doctor who she had witnessed chatting with a patient admitted with a mental health condition. In this instance, the patient had become agitated following the removal of her music headphones. Beth explained that although this seems a relatively small thing, it demonstrated a personal touch from a very busy clinician:

* *“So it’s something small like that that made her feel so much more at ease, because most doctors don’t really speak to patients unless they need to, and that’s fine….they’re very busy, but it’s nice that she just took that extra step to come over and try to like calm her a little bit; and so she’s aware of who she is, and she’s not just coming in randomly later. I thought that was such a small thing – but it probably meant so much to that girl….”* (Beth)

In the context of both regular patients and highly-pressurised incidents where it may be natural for ambulance staff to become protocol focussed, John similarly expressed admiration for clinicians who he had seen add a “personal touch”. This involved seeking to calm patients by speaking to them directly and treating them as a person rather than a problem to be fixed.

The ability to remain (or appear to remain) calm in stressful situations was also a feature which was admired by participants. Relaying details of his first traumatic cardiac arrest - at night and by the roadside - Todd explained how his mind went blank and he forgot some of the more basic clinical skills. Due to the number of casualties, a paramedic from a different ambulance took charge, and whilst undertaking his own interventions, calmly gave Todd clear instructions on what to do:

* *“‘Cos I’d completely forgotten how to use the suction at this point I was looking at it like, ‘please help’* [laughs]. *Erm, but I think them being calm, not shouting, understanding that it’s not a normal situation to be in….and just allowing you to have the time to just calm down - even though with how time-critical stuff is they, he did it right. Erm, and it definitely put me at ease”* (Todd)

For Todd, this paramedic seemed to understand his shock and how disorientating the situation was for a student. The fact that this paramedic didn’t shout and had a calming effect on a very stressful situation was something which Todd felt was worthy of admiration.

### Factors or circumstances which may promote a sense of integration

This subordinate theme contains factors or circumstances within the placement environment which may have promoted participants’ feelings of integration and belonging. Whilst exposure to some of these factors is universal, the degree of perceived inclusion has some variance, and this has been identified within the data.

Banter and joking thus represent areas of pre-hospital workplace culture to which all participants had been exposed. For Todd, this element of workplace culture was something that he said he enjoyed and that, “you want to be part of”. He described how crews would “take the mickey” out of his accent and how he was once forced to wear a tiara and a “Birthday Girl” sash for an entire shift when they found out that it was his birthday. He also described how the crew he was with once told him that they were responding to a call where a roof had collapsed and that he needed to wear full protective equipment, including high visibility jacket and helmet. When he entered the address and there was no sign of a roof collapse and the patient had a medical condition, he realised that a prank had been played. Todd described how the crews enjoyed playing pranks and stated that, “whilst they wouldn’t do it with everyone, I think they knew I was quite happy to be part of it”. When asked, he relayed that the banter and joking made him feel a part of the culture, and that he would also play pranks and joke back with the crews. In terms of feeling included in this context, he said that when he first went out on placement he felt like a “bit of a burden”, but that by the mid-point of his first placement he “just felt like part of the crew”.

With some humour, Beth similarly relayed that ambulance staff would mock her northern accent and that even during her first few days on placement they would call her “bollock-head” owing to how she wore her hair in a bun on top of her head. She said this was all without apparent malice and that this level of familiarity actually made her feel more at ease:

* *“I feel that if they are able to take the mick out of you then, it’s gonna be like, it’s fun isn’t it? They’re not saying it to be nasty and it’s obvious with a name like, ‘bollock head’, erm, but yeah I’m fine with that. I’ve….unless you’re saying something personal, I’ve no issue….”* (Beth)

With only a few weeks of experience in the placement context, Penny also relayed that she would frequently have jokes made about her non-British accent. She stated that this became a useful means of being included within conversations on placement because the jokes would generally lead to ambulance staff wanting to know more about where she was from. In this respect the jokes became a useful conversation-starter, which Penny would actively encourage and engage with:

* *“….it does make you feel like more the group, you’re not kinda sat back watching other people talking, and it’s kind of the British way isn’t it. You kind of egg each other on – take the mick and stuff like that”* (Penny)

For Louise the banter included being teased bout her height:

* *“No. No. Someone did mention that yesterday – oh, he was trying to reverse back and he couldn’t see me* [in the mirror]*. So I had to wave….he said, ‘4 foot 6’?, and I said, “I’m not quite a midget, I’m a bit taller than that”* [laughs]*”* (Louise)

Whilst for Aaron it was being heckled about where he used to live:

* *“So* [laughs], *they’re like, “oh just watch out this one’s a scouser”* [laughs], *like “hide your purse….””* (Aaron)

Most participants related analogous experiences involving banter and jokes, and a similar sense of inclusion as a result. Only Ellie denied ever having her “leg pulled” or the “mickey taken” out of her, although she did allude to joking with ambulance staff to relieve tension after a “bad job”.

A specific time Ellie stated she did feel included however, involved her attendance at a fatal road traffic collision where a trauma-trained doctor was managing the scene. According to Ellie, the doctor made her feel part of the team by giving her a briefing and didn’t leave her “just stuck on the side” in her student capacity. After the incident, the doctor found out that it was Ellie’s first such trauma case and deliberately took time to explain what she had done and her decision-making processes. This impressed Ellie because despite how busy the doctor must have been and however many similar calls she must have attended, she still took the time to single her out and talk to her.

With a little emotion, Stef similarly relayed an example of when she was with a paramedic who made her feel, “equal to them *kind of thing*”. In this case, the paramedic invited Stef to swap with her in terms of sitting in the front of the ambulance between calls and in using the radio. Stef was allowed to attend calls like a qualified member of staff, and the crew members would fetch and carry whatever equipment she needed as though she were the lead clinician, and they were there to support her. This was something that Stef stated had given her a strong sense of inclusion:

* *“Yeah….they made you feel like you were their crew, not just the student….”* (Stef)

Recounting how her own mentors would similarly try and find time for her, Emma also expressed feeling lucky in terms of her mentorship, and how she had been included by them as much as possible. As an exception to the norm, she related how on one occasion there was not enough physical space in the rear of the ambulance, necessitating that she sit in the front passenger seat en-route to hospital. Her mentor even apologised for this unavoidable exclusion:

* *“He wouldn’t just chuck me in the front or something ‘cos there was doctors in the back or whatever and then I remember one time I did need to sit in the front and he kept apologising….”* (Emma)

Whilst degrees of inclusion with the clinical role did vary between participants, it does however reflect an unavoidable reason for their presence within the pre-hospital placement environment. Something which is not a requirement of either ambulance staff or students is their inclusion with non-work-related conversations. According to Todd, after just three to four weeks of placement exposure he was “pretty chummy” with his mentor, and they were talking about facets of their personal lives. With only a few weeks more exposure, Penny felt similarly able to chat with ambulance staff about her flat-mates and have what she described as “inane conversations”:

* *“Like we had a very long conversation about biscuits one time. It’s just….I don’t know, it just felt really nice and casual”* (Penny)

Other participants such as Adeeb, Stef and Aaron also recalled general conversations with ambulance staff during their placements about such things as their tastes in music, their hobbies and what they were doing at university. Ellie was the only participant who stated that she did not have such conversations, and that when she was with her mentor they tended to “just talk about work”.

A further non-essential area of potential inclusion was whether participants had been invited to social events and meetings outside of the workplace. For John, this didn’t occur until approximately twelve months on placement, although he stated that he had become pretty friendly with some of the paramedics and had been invited out for meals, drinks and even a stag-weekend. John relayed that he had been included in the coffee mornings that had been organised following the death of a paramedic in that area and had also even been invited to the funeral and the wake. For John, being invited to such “intimate” station events had made him really feel part of the “family”.

With less than a year on placement, Todd relayed that he had already been out for drinks with ambulance staff and that there were “a lot of out-of-work relationships”, although he admitted that he knew some students who would never consider going for a drink with their mentor. Both Aaron and Adeeb had also been invited to non-work functions (a hill-climb and a football match), but both stated that they chose not to go, whilst Emma had been invited to a staff member’s house as a quiet place to do some studying. Such was Emma’s sense of social inclusion on station that she confided, “I know if they were going out, they’d invite me”. Recounting a very different experience however, Stef stated that whilst social events did take place at her placement location, she had never been invited to them – nor to her knowledge had any other university students.

In addition to a sense of inclusion seemingly governed by invitation from ambulance staff, many participants also recounted how they felt support from their student peers played an important part in their ability to integrate with the pre-hospital workplace. This generally included a sense of kinship and understanding with others who were in the same situation, which was readily accessible through either seeing them on station or via social media group chats.

As someone who admitted being generally quiet around ambulance staff, Beth stated that she found communication with some of her student peers to be a valuable support mechanism. She relayed that they would enquire after each other’s well-being following a difficult call and sometimes “chill out” together outside of placement. She also stated that after she had been severely reprimanded for a mistake by her mentors, it was only the support of her peers that had enabled her to go back into placement. Other participants such as Ellie, Louise and Adeeb similarly stated that talking to their peers represented a useful coping mechanism, and an outlet to discuss elements of their own mentorship with people who were in a position to understand and offer an opinion.

* *“Erm….it’s cool to say if you get like a job and you don’t agree with the other mentor on it as much. It’s good to like relay back to people at uni like your friends at uni and see what they think….”* (Ellie)

Additionally, for Stef, Todd and Adeeb the uniqueness of the pre-hospital emergency environment and the nuances of the pervading culture made them feel unable to discuss many of their experiences with family members, or other people. For these participants, student peers represented a body of people who they could talk to without risk of causing distress and who are able to understand what they are talking about:

* *“….’Cos you can’t really talk about the jobs we go to to normal people….it’s not, you just can’t. So, and if they are in the same cohort, you, they’re your friends, they understand where you’re coming from….”* (Adeeb)

The sense of inclusion and the immediacy of support from student peers was further outlined by Todd, who after a particularly harrowing call, messaged ahead about his return to station. When he arrived back on station, he relayed that there were a few students “ready and waiting” to receive him and check on his welfare.

### Factors or circumstances which may create feelings of dissociation or discomfort.

This subordinate theme contains circumstances within the placement environment and/or the actions of ‘Das Man’ which may have prompted feelings of dissociation or discomfort amongst participants. The degree of perceived dissociation or discomfort varies between individuals, but there are some distinct areas of similarity.

One area of such similarity was a sense of being spoken “down to” or being spoken to in an unpleasant manner by ambulance staff. For Michael and Louise this included what they perceived to be an unwarranted exertion of power on the behalf of a mentor or other paramedic. In Michael’s case, this involved being intensively “grilled” by a paramedic about the functioning of specific drugs that he had administered to a patient and the analysis of their electrocardiogram recording. According to Michael the paramedic criticised his lack of knowledge, and whilst conceding that he should have known more of the answers, he felt as though this was more of a demonstration of superiority and relative power.

For Louise, feelings of discomfort would be caused by being frequently undermined and corrected in front of patients by her mentor. Away from patients she also felt that some of the feedback she received was not very respectful and consisted more of a “punishment type conversation” involving heavy criticism and being informed that what she was doing was “not good enough”. In laying ground rules at their very first meeting, Louise relayed that this mentor had stated “I’d like to be treated with respect….”, which made it difficult for her to disagree or challenge him and represented a level of formality not conveyed by other participants. When asked about this statement, Louise seemed to stumble over her choice words, but conceded that he was probably aiming to establish his authority from the outset:

* *“He just needs to be erm, he just needs to be, he’s the, he’s trying to assert an authority….”* (Louise)

Beth relayed that it was the way in which she was sometimes admonished for mistakes by her mentors which upset her and “made me feel crap”, and that on occasion this veered more towards a “telling off” rather than correction. Beth also recounted how after an error (which she was extremely embarrassed about) her mentors had been quite harsh in reprimanding her. Whilst Beth stated that she understood the need for sternness under the circumstances, she relayed that the mentors had become quite distant towards her for several days, making her feel as though she was no longer able to talk to them. Beth relayed that this became very uncomfortable and represented an unpleasant and unnecessary continuation of something she felt she had already been reprimanded for.

Although conveying that she was confident enough to not be unduly affected, Emma described a member of ambulance staff who would make some students feel uncomfortable by being specifically sarcastic and rude to them on station. She described how this individual would continue to jibe until the recipient stood up for themselves and said something back, whereupon he would show some measure of respect:

* *“I think you’ve gotta give him as much as you get, and if you do that then he kind of respects you more”* (Emma)

Emma also recounted how on the back of an ambulance and in front of her mentor this member of staff had once rudely told her to give up her seat to allow him to sit down. Emma had refused to move for him, forcing him to sit elsewhere. It was her belief that he was seeking to find how far he could “push it” with her, but that once she had stood up to him “he didn’t try again”. According to Emma, this refusal also earned her the respect of other ambulance staff who witnessed what had happened.

Relaying details of how the behaviour of ambulance staff had caused him some embarrassment and discomfort, John recounted witnessing a very public argument between an ambulance crew and an operational manager involving his own supervision. In this case, the crew that John was supposed to be supervised by were unavailable, and an operational ambulance manager had driven him to a local accident and emergency department with the intention of having him join a different crew there. The paramedic crewmember was however extremely unhappy about having to supervise a student and argued passionately against doing it. The argument took place outside of the hospital and in front of other people and became quite heated. Although the paramedic crew member reassured John that the argument was not personal, and was more about resisting an imposition which he felt to be unfair, John nevertheless said that he felt quite uncomfortable and decided to take himself out of the situation:

* *“….the argument outside got to the point where I….the awkwardness of standing between the two fighting over me, I just went back in to the hospital and made them all a cup of tea* [laughs]*….cause I was like, I can’t stand out there”* (John)

Remaining with the crew for the rest of the shift, John relayed that after the argument they had “got on really well” and there were no further issues. This difficulty had only arisen however due to the supernumerary status that full-time university students have during their pre-hospital placements; something which can sometimes leave them feeling like a burden to the supervising crew. This was described by Todd as feeling at times like a non-essential “extra” and being “in the way”. He went on to describe that they were also frequently left isolated in the rear of the ambulance and forced to put their head through the small bulkhead window into the cab in order to be included in conversations or to find out details of the next call. This feeling also extended to encountering patients as part of the working day, and having to explain to them why three people (instead of the usual two) were in attendance:

* *“We feel like we’re intruding on their normal day to day work, ‘cos everyone, even when you go to a patient’s house, they’re like, ‘oh, there’s three of you. Why is there three of you?’. And then you have to introduce yourself as a university student, I think that kind of puts the barrier up between you and your mentor and the other staff”* (Todd)

Several participants (including Todd) stated that some ambulance staff would also refer to them as “student” rather than by their name and would do this at the beginning of their shift when informing Control who was working on the ambulance. Whilst John said that he would not allow this to annoy him, he did infer that “not bothering to learn my name to sign on” was one of those “little things” which highlighted a difference between him and the crew.

According to most participants this perceived difference was made more apparent through comparing themselves (as full-time university students) with another group of students in the workplace who are on a truncated paramedic university course but are actually employed by the local ambulance service. Although comparable in terms of education, clinical skills and knowledge, these employed students are different to full-time university students in that they are not supernumerary, they are able to drive the ambulances, and they wear the same uniform as ambulance staff.

In drawing a comparison between the two types of student, Emma stated that she felt university students were generally “more undervalued” and given “a lot less respect”. In relaying an example, Emma outlined how whilst on station one particular member of ambulance staff would always insist that university students “make the tea” but refrained from making the same demand from the employed students. A similar perceived lack of respect was suggested by Stef, who believed that despite being at the same academic level as university students, employed students are treated more like qualified members of staff. According to Stef, this sense of inclusion even extended to being invited to external social events; something not offered to university students at her placement location.

For Michael, the “divide” between employed and university students also manifested itself with a difference in the attribution of blame when mistakes were made in practice. He considered this to be partly due to employed students wearing the same uniform as qualified ambulance staff, and that their actions would tend to “blend into everyone else”. According to Michael, wearing a different uniform thus makes university students more easily identifiable for their inexperience and consequently more likely to be remembered (or blamed) for a mistake: “….anything you do wrong is akin to being a uni student sort of thing” (Michael).

### Feeling 'at one' with ‘Das Man’

This subordinate theme contains potential indications of how participants have become immersed within the world of pre-hospital care in accordance with how Heidegger suggests that Dasein is compelled to be a part of the inauthentic world of ‘The They’ or ‘Das Man’ (Wisnewski, 2012). It includes instances which may suggest an alignment with the pervading pre-hospital emergency ambulance culture, and some of the generic views and values commonly expressed by ambulance staff.

The first area I would like to explore is the direct expression of support from participants towards some of the self-regulating behaviour of ambulance crews. In relation to how he found that crews would manage their time during a call or in calling ‘clear’, Adeeb expressed both understanding and sympathy. For Adeeb, it was essential for ambulance staff to “make the job easier” for themselves in this way so as to avoid being “slammed” with a relentless stream of calls. He also expressed support for crews declining to respond to a late call that might be classed as a lower category of emergency:

* *“So just saying, we can’t do a job because we’re in our last 20 minutes…..that sort of thing, and I agree with that personally. If they’re trying to give you a lower category call in your last 20 minutes, then for one, it’s not fair, and that will use up a resource. Because then you finish late and the next crew starts late – stuff like that”* (Adeeb)

Recounting shifts he had undertaken on response cars - which often involve a faster discharge of patients, and therefore the potential for a higher volume of calls - Michael also expressed support for ambulance staff who managed their pace of work. He considered this to be a valid coping mechanism in the face of unfair expectations and a means of avoiding an untenable workload:

* *“….and you’re leaving so many more people at home when you’re on a car, and you could easily bash out 20 jobs in a shift if you worked perfectly to how the Trust wanted you to work, but if you did that, you’d burn yourself out in a week”* (Michael)

The same sentiment was expressed by Beth in relation to how ambulance staff create time to “chat to the receptionist” and “have tea” at hospital. Relaying how every paramedic seemed to build in such “downtime”, Beth expressed that she felt it was a necessary measure to avoid the exhausting stream of work which would otherwise be allotted to them. Whilst discussing this phenomenon, Todd also expressed understanding, and acknowledged that he would probably adopt the same behaviour when qualified:

* *“….how do you feel about, and will you adopt do you think when you are qualified, that, that kind of bit of judgement, bit of self-care maybe?”* (Interviewer)
* *“Erm….I like to think I wouldn’t. But I think I’d be lying if I said I didn’t”* (Todd)

Although not necessarily expressed as behaviour they had directly adopted from ambulance staff, many participants expressed some degree of assumption or scepticism towards certain service user groups. This was articulated by Adeeb who admitted that he had adopted the views of some ambulance staff towards callers who live in certain locations. For Adeeb this was acceptable because it wasn’t meant “in a bad way”, but rather as a means of preparing himself for what the call was possibly going to be like. Both Michael and Stef also relayed that they had learned to be sceptical concerning the reported nature of the call owing to the much less serious situation they had frequently found on arrival. For Todd this scepticism included assumptions based upon reported age and the actual likelihood of the service user having a serious life-threatening condition:

* *“Say if it comes through as a chest pain for a 37-year-old male, you think, ‘oh, it’s not going to be a heart attack’ instantly”* (Todd)

With apparent alignment with views of some ambulance staff, Todd described that such opinions were based upon collective experience, and that it was common for a pre-determined diagnosis to be made in this way before arriving on scene. Although largely corroborating Todd’s experience, Adeeb did however reflect that such assumptions were sometimes proven wrong:

* *“Yeah, you make some judgements about, if it’s this apartment complex, it’s gonna be messy, it’s gonna be unhygienic, they’re probably this sort of person….I think a couple of times I’ve actually been surprised. Like just a normal family living there, just living their life, and they needed help and it was a genuine thing”* (Adeeb)

In addition to assumed views, many participants also expressed frustration recalling the non-emergency nature of some calls and the expectations of service users once they had arrived on scene. Both Aaron and Stef recounted calls that they considered to be of a less serious nature and/or where service users could perhaps have transported themselves for treatment. In this context Aaron expressed frustration in attending an address that was very near to the hospital, and exasperation in being diverted from a potentially serious call to attend someone with tonsillitis who was unwilling to make their own way to the local walk-in centre:

* *“‘Cos she was literally as close to* [the hospital]*, she could literally throw a stone from her house and hit it. You’re just there like, ‘are you serious?’. And when you feel like you were going to a more important call, and then you go to someone who actually knew they had tonsillitis, we walked in, she’s like, “I think I’ve got tonsillitis”, and I’m like, “and you’ve called 999?””* (Aaron)

Stef similarly recounted how she had attended calls to patients who “weren’t really that ill” and had family members with cars parked outside who could easily have transported them for care:

* *“….so, they could have driven them to hospital but, ‘oh you’ve got an ambulance they can have pain relief, and you take them’. That was a bit frustrating. They, that’s how the ambulance service are known instead of being an emergency ambulance dealing with emergency situations…. just a taxi”* (Stef)

Adeeb described how his overall opinion of service users has lowered considerably since undertaking pre-hospital placements. He went on to relay that he didn’t feel this way before commencing placements because he believed that he used to be a part of the “general public”, and that his views have since become more polarised since encountering service users who have naïve or unrealistic expectations of what can be done for them:

* *“So it changes your viewpoint. I was like how stupid some people can be….like the lack of common sense is just astounding”* (Adeeb)

Expressing similar frustration, Todd relayed how as soon as “maybe the second week” of placement he felt very unsympathetic towards some service users. In alignment with Aaron and Stef, he expressed frustration with the seemingly trivial nature of some calls which potentially diverted resources away from something more serious. Todd conveyed his exasperation through recounting a case where his ambulance was redirected from a patient in need of end-of-life care to someone complaining of trapped wind. His frustration was worsened because they apparently had family members who could have driven them to hospital.

The adoption of views which may have formed whilst on placement thus represents a potential overt alignment and assimilation with Heidegger’s inauthentic culture of ‘Das Man’. A less-overt potential indicator which became apparent was participants’ use of language. Several participants thus frequently referred to themselves as though they were a part of the ambulance crew (seemingly regardless of placement exposure) when recounting experiences, and framed their responses as though they were a working member of ambulance staff rather than a student. This included terms such as “we” and “us”, as well as vernacular arguably more suited to someone with greater workplace experience:

* *“….we can only do so much, we can only do it as fast as we can, and we’ll clear when we clear”* (Beth)
* *“…..Because of the area I work it’s….you kind of get a sense….”* (Adeeb)
* *“….they might be lonely because that’s why they’ve phoned us”* (Stef)
* *“‘Cos some of the techs I’ve worked with are useless….”* (Amara)

Without exception, all participants demonstrated some adoption of parlance specific to the emergency pre-hospital workplace. This included ubiquitous reference to each call as a “job” and referring to an ambulance as a “truck”. For Aaron, this practice became so entrenched that he even included it once when completing official clinical documentation:

* *“….In your head, it’s so ingrained that it is a ‘truck’, and then my mentor was sat in the front reading my paperwork and just laughed and she’s like, “you wrote truck”* [laughs]*, but that’s like because you don’t identify it as an ‘ambulance’”* (Aaron)

According to Todd, this terminology was adopted as soon as the words were learned, and he couldn’t even recollect a time when he didn’t refer to an ambulance as a “truck”. He recounted that nobody challenged his use of such vernacular, and that he felt it’s use is even “kind of expected”. Only Amara with 5 weeks of placement experience stated that she did not call an ambulance a “truck”. When asked why she had adopted some words, but not this specific example, she stated it was simply because, “I’m not used to it yet”. Other forms of universally adopted terminology included medical abbreviations such as STEMI (for S-T Segment Elevation Myocardial Infarction), ROLE (for Recognition of Life Extinct), COPD (for Chronic Obstructive Pulmonary Disease), ACPO Acute Pulmonary Oedema) and “big-sick” (for seriously ill patients).

In addition to the adoption of language, some participants expressed a reliance upon support networks available to them from ambulance staff or students. This was seemingly in preference to those available from the university, and in one case even their own family. For Michael, it was thus easier to seek support from ambulance staff for placement issues, owing to their immediacy and their likelihood of understanding. This sentiment was reflected by Beth who recounted how speaking to other ambulance staff and being involved on station would allow her to “re-align” her thoughts, “chill out” and de-stress after a demanding or otherwise traumatic call. Following a traumatic call (which required him to go home afterwards for a clean uniform), Todd expressed what seemed like an emotional need to return to the ambulance station and just be around his mentor and other ambulance staff. When asked about seeking psychological support for this harrowing incident, he mentioned that he did speak to his mother, but did not feel she would understand and therefore didn’t want to unduly burden her:

* *“….I spoke to my mom, but I didn’t mention everything. I knew that she, she’d be sympathetic and she’d care, but she wouldn’t understand”* (Todd)

When asked specifically about whether participants felt more like a student or a member of staff on placement, the response was varied. Whilst it was perhaps to be expected that with just 5 weeks of exposure Amara would state that she felt like a student, it was interesting to find that with only a few weeks more exposure, Penny had a different perspective:

* *“I feel a bit like a member of staff. I feel like a ‘new’ member of staff, but I feel like a member of staff….”* (Penny)

For those participants who felt more like a member of staff, this tended to be justified in terms of being able to use what they had learned and being able to function as a useful part of the ambulance crew. This sentiment was framed by Louise, who recounted that she felt like a member of staff after having independently (although whilst being monitored) attended to patients and conversed accordingly with hospital staff for a period of two complete shifts. Aaron and Ellie similarly conveyed that when they were able to confidently assess and manage patients they felt like members of staff, although for Ellie this feeling did not seem to continue after the call and once back on station. This sense of fluctuation between feeling like a student and a member of staff was explained further by John, who after nearly two years of placement experience conveyed that he was able to “fit in a bit more” and therefore did feel more like a member of staff. He did however also relate that this feeling very much depended upon who he was “working” with, and how included they made him feel. Being made to feel like a student rather than a member of staff could thus occur through “little” insensitivities, such as failing to use their name when telling Control who was on the ambulance that day:

* *“….it’s just sometimes you hear those little things and you sort of well….If they’re not bothering to learn my name to sign on sort of thing, you’re just called, “student….””* (John)

## Projection

Whilst Thrownness and Fallenness embody the influence of the past and the ‘inauthentic’ present upon how ‘Dasein’ understands and interprets the world, ‘Projection’ represents the influence of future possibility (see *The concept of ‘Projection’* section on p. 94 for more details). As individuals we are thus engaged and driven by our future possibilities in the world, and yet at the same time restrained by ‘Thrownness’ which may implicitly or overtly limit what we can achieve. Through exploring ‘Projection’ in accordance with my understanding of Heidegger’s (1927) ‘Care’ structure, I have identified two key areas which I feel are substantial enough to be included as subordinate themes. These include:

* Evidence of shorter-term projection
* Evidence of longer-term projection

### Evidence of shorter-term projection

This subordinate theme incorporates what participants may hope to achieve within the immediate future context of being student paramedics within the pre-hospital placement environment. This is likely to be influenced by the understanding that successful completion of each placement element is dependent upon the conferment of ‘competence’ from their ambulance mentors, and evidence that they are suitably ‘applying’ themselves as students. In order to be successful and continue with their course, they are therefore necessarily orientated towards demonstrating that their mentors have appropriate confidence in their abilities and that they have undertaken the required hours of exposure – verified via confirmatory signatures from their mentors. During interview, participants demonstrated an understandable orientation towards learning what they feel they need to learn, engendering a good impression with ambulance staff, and avoiding anything which may risk their progression. Evidence of this understanding in the short-term context of being a student was articulated by Emma who jokingly alluded to being willing to beg her mentor for the required competency signatures. She then more seriously described how this distribution of power was perceived:

* *“….In a way they know that they’ll sign us off – so what they say kind of goes”* (Emma)

Self-awareness in terms of engendering a good impression with ambulance staff was demonstrated by several participants. For John, this was apparent through carefully relaying that he had a great deal of experience as a member of the SJA. Demonstrating some prior ‘Thrown’ understanding of how SJA membership may be perceived, John recounted that he was conscious of being negatively thought of as a “know-it-all”, but yet was keen to engender some advantage through ambulance staff knowing that he could do a “bit more” than other students.

Recounting that whilst he was initially lacking confidence on placement and wouldn’t readily engage in conversations with ambulance staff, Adeeb stated that by his second year he made a great effort to get out of his “bubble” and “make the most of it”. With a similar aim to John in terms of improving his clinical exposure, Adeeb relayed how he became determined to get to know those around him better, and to not be thought of as a “third wheel” – a reference to how university students are a supernumerary addition to each ambulance - and potentially risk being side-lined during a working shift:

* *“So I was deliberately trying to get to know my crew mates, trying to get them to like me. Get to know each other, erm….so I can work more comfortably, and they can maybe rely on me a bit more. Rather than seeing I’m just a student”* (Adeeb)

For Louise, an expressed desire to avoid antagonising her mentor may also represent short-term projection in terms of behaviour which is orientated towards a successful outcome on placement. In one particular case, she recounted how her mentor had been officious with her and had berated her for something that she felt really wasn’t her fault. As an older student with prior life experiences, she described how she considered this to represent poor behaviour on his part and had considered giving him a response which accordingly reflected her thoughts. She didn’t do this however, so as to avoid potentially provoking her mentor and giving him any cause to be vindictive towards her or withhold the required competency signatures. Her decision to avoid this confrontation seemed to be difficult for her to express:

* *“I didn’t say it because I didn’t want to challenge him back because he was a, quite a….he would get, I’ didn’t want to not, didn’t want to, he was my mentor, so I wanted it to be a easy relationship, I didn’t want to cause any friction”* (Louise – her pastoral welfare was checked in relation to this interaction aside from her interview)

A focus upon short-term aims was also expressed by Louise in response to being asked about whether she socialised with ambulance staff on station. Her reticence to do this as a student was contextualised via the more pressing goal of passing the course and becoming a paramedic:

* *“I feel like I could get into that when I start the job. Yeah, ‘cos I’m trying to focus on, you know this, passing”* [laughs] (Louise)

### Evidence of longer-term projection

This subordinate theme is intended to capture what participants may hope to achieve beyond the short-term goal of passing the course and becoming a paramedic. This involves consideration of what kind of clinician they aspire to be when employed as a paramedic in the future and how this may influence their behaviour and thought processes as students. This includes the potential establishment of a particular way of working, traits displayed by ambulance staff that they might wish to emulate or avoid, and how they might go about eventually teaching their own students.

For John, this included the adopted practice of telling service users and their families the whole truth about their conditions, and details of what was found during their medical assessment. He relayed that several paramedics had challenged him about the merits of doing this, and the risk of causing undue distress by for example actually telling a patient that they were having a “heart attack”. John stated that he felt it was better to be completely honest, and that in his opinion telling the truth helped establish trust and gave patients a higher level of confidence in his abilities. John relayed that this represented a “way of working” that he would take forward when qualified, and as such represents something he has defended when challenged about it as a student.

With projection towards one day being qualified and registered as a paramedic, Michael made a comment about how underestimating the clinical needs of certain service users could potentially lead to losing his registration. When asked if this scared him, he related how it didn’t scare him per se, but the potential loss of his registration would be a factor in his future decision-making as a paramedic:

* *“I wouldn’t say I’m scared of losing my registration – well, I haven’t got it yet. But I think it’s something that will be in the back of my mind leaving someone at home…. Sort of can I justify it”* (Michael)

In this context, Michael relayed how as a student he sometimes had concerns about patients who were left at home by ambulance staff. Using his future registered status as a lens, he stated that he had sometimes read the clinical documentation for these patients and thought, “‘if anything goes wrong, this just does not sound right at all does it…?”. When asked about whether he thought future concerns about losing his registration could even override a potential lack of clinical need for a patient to be conveyed to hospital, he stated that he believed it would always make him err on the side of caution.

Several participants described some of the actions of ambulance staff and other healthcare professionals in terms of attributes which they intended to emulate when qualified. For Beth, this was a display of kindness by a doctor towards a patient suffering from a mental health crisis in an A&E department. For Todd, Louise and Emma this was the display of apparent calmness on the behalf of certain paramedics when under intense pressure:

* *“And the way he handled it was really well, and the way that he directed me was really well. So you can, he was very calm. Erm, his tone would stay really calm, erm, even talking to the family. Err, his briefing that he would do with me after was very relaxed tone, yeah. Yeah”* (Louise)
* *“Would you take that forward do you think?”* (Interviewer)
* *“Yeah, I’d like to yeah, yeah”* (Louise)

John Similarly recounted how he had been impressed by a paramedic who took the time to reassure a panicking patient whilst treating a traumatic injury. He described this as treating the person in a more holistic way, rather than being focussed just upon their injury:

* *“….Trying to treat the person at the end of the day rather than just the patient essentially and the people that’s around them, so yeah I suppose that taught me to try and treat more than just the injury”* (John)

Stef conversely described examples of what she considered to be poor practice as inspiration to do things differently when qualified. Unimpressed with the somewhat blunt and unsympathetic approach taken by ambulance staff towards a regular caller, Stef stated that would endeavour to be more compassionate when qualified:

* *“Erm, I would think, ‘this person’s just still a person, they might be lonely because that’s why they’ve phoned us. They might actually be in pain….’”* (Stef)

Stef also recounted being unimpressed by ambulance staff who for the sake of convenience would convey every patient to hospital regardless of clinical need. When qualified, she stated she would try and find alternative and more appropriate referral pathways for patients.

Informed by their experiences of student status and different styles of mentorship, several participants reflected upon how they themselves will tutor students in the future when they are qualified. In the context of some of the shortfalls she felt to be apparent in her own mentorship, Beth relayed that she *“would love to do mentoring in the future”* and described how she would try to be more structured, encouraging, and personable towards her students. Having also experienced mentoring which she described as being difficult at times, Louise spoke about the proactive and more jovial style of mentoring she had experienced from a different paramedic, and described how she would, “make sure that I was a mentor that was a bit more like that”. Describing a very positive mentorship experience during which a paramedic went out of their way to make her feel included as part of the team and to ensure she had relevant clinical exposure, Stef similarly recounted:

* *“….the way she made me feel, I would want to be the same if I ever had students with me”* (Stef)

As the two participants with the least placement exposure, Amara and Penny also seemed to have the most limited expression in terms of long-term projection. Whilst they both described admirable traits in their mentors (sense of humour and confidence for Amara, and a desire to keep learning for Penny), neither really articulated the observed behaviours of ambulance staff in a way which demonstrated potential projection for their own future behaviour. As an example, Penny was the only participant to deny that she had ever witnessed ambulance staff overtly managing their workload – and was therefore unable to express an opinion about it. This may be a genuinely observed anomaly that runs counter to the descriptions of other participants. It could also represent an unwillingness or inability to acknowledge such potentially negative behaviour on the behalf of ambulance staff and a limitation (at this stage of her practice) on the influence of projection in this area.

## Chapter summary

This chapter has presented the findings of the current study utilising Heidegger’s (1927) temporal structure of ‘Care’ as an overarching thematic framework. Subordinate areas arising from the review of the literature and from the coding process have additionally been used to analyse the findings. The next chapter will explore and expand upon key areas of interest and originality suggested by the findings in alignment with the overarching research question and objectives. It will seek to contextualise these areas in accordance with the literature review presented within chapter 1, a more specific review of the literature focussing upon each area, and my own reflexive observations where appropriate.

# CHAPTER 5

Discussion

## Discussion

Within this chapter I will consolidate and explore a selection of the key findings and contextualise them in relation to the review of the literature included within chapter 2. For each topic, I have additionally included my own reflexive perceptions for additional hermeneutic context. In accordance with Burton *et al.* (2011), in structuring this chapter I have returned to the overarching research question and objectives in order to maintain coherence and to ensure that relevant areas are included. The requirements for both objectives thus helped to broadly determine the topic areas for discussion:

Objective 1:

To explore the development and/or negotiation of paramedic professional identity from the perspective of the university student

Objective 2:

To explore the role played by the university in the professional enculturation of paramedic students

Whilst several topics for prospective discussion arose from the findings in accordance with these objectives, the ultimate determination of what to include was based upon perceived originality and potential differences with what is more commonly found within the literature. Table 8 below outlines the five key topic areas which are focussed upon within this chapter along with additional details of what will be discussed:

**Table 9:** Chapter topics areas:

|  |  |
| --- | --- |
| Key topic area derived from findings: | Discussion areas: |
| Experiences of the pre-hospital workplace | 1. Student perceptions of the pervading pre-hospital workplace and culture 2. Suggestions of change: attitudes relating to gender within the workplace 3. Suggestions of change: attitudes towards BME groups in the workplace |
| Suggestions of cultural immersion and evidence of ‘authenticity’ | 1. Alignment (or not) with the pervading attitudes of ambulance staff 2. Inclusion with ‘dark’ humour and ‘banter’ 3. Use of profession-specific language |
| Overarching motivations for students on placement | 1. Passing placement (and the avoidance of ‘risk’ in this area) 2. Deciding upon what sort of clinician students aspire to become |
| A perceived lack of preparation | 1. The potential influence of a ‘hidden curriculum’ 2. A confident disposition and the potential of ‘cognitive flexibility’ |
| Integrating and supporting factors | 1. Informal peer support and smartphone tech’ 2. Utilising the coping strategies of ambulance staff |

## Experiences of the pre-hospital workplace

Relating predominantly to objective 1, this section explores some of the participants’ recollections of the pre-hospital workplace and culture which were revealed within the findings. I believe that this is key for understanding how professional identity is formed/negotiated, as whilst theorising that an individual’s perception of the world may be contingent upon prior understandings which are afforded by the ‘Care’ structure, Heidegger (1927) also considers our self-understanding to be in-part determined by others who exist within the same ‘totality of significance’ (Wisnewski, 2013, p.39). According to Heidegger our understanding of the world and of ourselves is thus one which is shared with other people who inhabit the same collective context (otherwise known as ‘The They’ or ‘Das Man’) such that; ‘The They’ prescribes one’s state of mind and determines what and how one “sees”’ (Heidegger, 1927, p.213). Similarly, for Wisnewski (2013, p.60), all of our understandings of the world are related to the understandings held by other ‘Dasein’ – even our understanding of ourselves ‘ultimately depends on the other ‘Dasein’ with whom [we] exist’. For the following sections I have therefore focussed upon participants’ descriptions of the attitudes and behaviours of ambulance staff, and how these factors relate to the literature.

### i. Student perceptions of the pervading pre-hospital workplace and culture

In terms of witnessed behaviour, all but one of the participants perceived that every ambulance crew they observed exercised a degree of informal control over their availability to receive further calls and the pace at which those calls were undertaken. This was largely achieved through a tactical approach to when they informed Control they were ‘clear’ and adopting a pace of working in accordance with the urgency of the call and/or the proximity of their finishing time. Correlating with the findings of McCann and Grantner (2019) and Clompus (2016), this behaviour was relayed by Michael, Beth and Adeeb as being in response to the potentially exhausting volume of work which would otherwise be allocated to them, and to avoid working significantly beyond the allotted shift finishing time. Reflecting upon such behaviour, Michael additionally observed that some ambulance staff seemed to harbour resentment towards their managers and control-room staff; one perceived cause of which was a performance-driven reduction in the permissible time they had to complete their documentation after each call. This finding mirrors the workplace tensions reported by Donaghy (2020), Grantner *et al.* (2018), Clompus (2016), and Devenish (2014).

Mirroring the findings of Rolfe (2020), Emma described how established ambulance staff sometimes voiced their feelings of nostalgia about perceived lost halcyon days of better working conditions. She described how they seemed to resent the lack of what they felt were “proper jobs” and perceived that they harboured a sense of injustice with how much busier they are nowadays and that there is no longer any time for “fun” on station. For Emma, this sense of unfairness was synonymous with their desire to take small liberties during the working shift - such as doing household shopping in-between calls. Whilst she expressed some sympathy with the changes to the working experiences of established staff, she also reflected that she did not share their views because she had never experienced the “good old days”, and because in comparison to her own prior work experiences, she considered their workload to be quite reasonable.

This perceived sense of injustice, nostalgia, and antipathy towards change is not a unique or new phenomenon for ambulance staff. It is encapsulated by the findings of Johnson and Acker (2016) and Clompus (2016), who describe similar resentment towards the general increase in lower-acuity cases and the associated ‘feminisation’ of the role over recent years. It also potentially aligns with Argyris’s (1991) theory of defensive reasoning and the unconscious propensity that educated professionals have towards projecting blame onto external factors. In alignment with this, from my own experience I can recall that over two decades ago, an amalgamation of pessimism, resentment, and nostalgia for what has been ‘lost’ represented a pervading (and immersive) dogma which was synonymous with pre-hospital cultural rhetoric. Whilst in my experience not a new phenomenon, I also believe that this facet of pre-hospital culture can be compelling for newcomers, and why (in accordance with Heidegger (1927)) they may be drawn to adopt views which are commensurate with those held by more established staff. As a university paramedic educator however, I am also concerned to hear reports of negative attitudes which are displayed towards students and the potential effects that such behaviour may have upon them.

For Michael and Louise this included being spoken to disrespectfully, being overly criticised, and being undermined in front of others; something considered by both participants to be an excessive demonstration of relative power and authority by those involved. Beth relayed how she had been ‘told off’ by her mentors and recalled how upset she became when she perceived that she was ignored by both for several days after being admonished for an error. Although generally praising the attitude of her assigned mentors, Emma also described how she had witnessed one member of ambulance staff be specifically discourteous and sarcastic towards university students. This may reflect some of the tensions reflected within the literature between university student paramedics and ambulance staff who were trained via the prior vocational route (Donaghy, 2020; Givati *et al*., 2018; Gallagher, 2016; Wankhade, 2016; Henderson, 2012). As some of the studies cited within this thesis date back several years, it would be reasonable to assume that the influx of graduate paramedics during this time would have an ameliorating effect. However, as the findings from the current study suggest, university student paramedics may still encounter disrespectful behaviour from some members of established ambulance staff.

How this perceived manifestation of disrespect may be orientated towards university students is highlighted within the current study through comparisons with a different cadre of students who are employed and partially educated in-house by the local Ambulance Trust. Such employed students are comparable to full-time university students in terms of education, skills and knowledge but differ in the workplace context in that they are not supernumerary and wear the same uniform as ambulance staff. In describing how she perceived that university students are sometimes treated, Emma recounted that at her placement location university students are often instructed to “make the tea” by ambulance staff but employed students are not expected to. According to Michael, university students are more readily blamed for mistakes than employed students. Whilst according to Stef, at her placement location employed students are treated more like qualified staff and (unlike university students) are invited out to external social events. Stef’s experience in this respect does however run contrary to the experiences of participants such as Todd and John, who were both invited out by ambulance staff to social events.

Being supernumerary to the ambulance crew during operational shifts is also reported by participants within the current study as a source of potential alienation. According to Todd being a non-essential “extra” to the normal complement of staff made him feel like something of a burden, and that having to repeatedly explain to service users why there were three people on the ambulance only reinforced his sense of dissociation. Highlighting this sense of isolation and distance, several participants relayed that at the start of the shift when informing Control what the names of the rostered crew were, some ambulance staff would simply state that they had “a student” with them – rather than finding out their names and passing that information on along with their own details. Whilst this sense of dissonance associated with supernumerary status has not been broadly explored within the literature in relation to the pre-hospital workplace, there are cited parallels of dissatisfaction within the nursing literature (Hyde and Brady, 2002; Joyce 1999).

However, in contrast to what had been reported in relation to supernumerary nursing students (McGowan, 2005), the participants within the current study did not generally report that they were disillusioned or disappointed by their exposure to the pre-hospital working environment. In fact, despite the negative attitudes that have been relayed within this section, participants such as Adeeb, Emma, Ellie, Aaron, Louise, Amara, and Penny overtly praised their mentors and other ambulance staff for the way in which they had been welcomed and treated as students. I am thus conscious that focussing upon the negative elements of pre-hospital workplace culture in this manner (and perhaps more broadly) may be a symptom of my own bias arising from unpleasant early experiences within this world of work. However, the similarity of participant recollections in this area does suggest that university paramedic students still face some unique challenges in relation to how they negotiate their sense of ‘self’ within this environment. I will explore the apparent adoption (or not) of attitudes which are synonymous with the pre-hospital culture further within the ‘suggestions of cultural immersion’ section. The following sections will discuss the findings with specific reference to gender and ethnicity – both of which highlight some potentially interesting areas of originality.

### ii. Suggestions of change: attitudes relating to gender within the workplace

Whilst the pre-hospital workplace has been described as traditionally dominated by high acuity emergency calls and characterised by a masculine militaristic culture, it is apparent that there has been an increase in the more ‘feminine’ empathic nature of the role, and an increase in the number of females within the workforce over recent decades (GOV.UK, 2020; Johnston and Acker, 2016; Williams, 2011; Joyce, 2009). However, with suggestions that a discriminatory and misogynistic culture may still exist (Baronowski, 2020; Clompus, 2016), it was reassuring to find that none of the seven female participants in the current study reported receiving negative comments from male members of staff relating to their ability to undertake the paramedic role, or that they had been treated differently in this context due to their gender. It was also reassuring that none of the female participants described having to adapt their behaviour in accordance with a perceived masculine culture; as described by Clompus (2016, p.3) in relation to females feeling pressurised to become robust, loud, and banterous ‘geezer birds’ in order to fit in.

Several female participants did however recount that they had encountered judgemental behaviour from service users concerning their physical abilities, and that their clinical questions were sometimes ignored in preference to those asked by male members of staff. It was also recounted that in some cases male service users would be more respectful and potentially less aggressive towards female ambulance staff and students. With no evidence of gender-based discrimination from male ambulance staff, the findings from the current study thus seem to run contrary to what is generally reported within the literature and may suggest a more recent positive change in the pre-hospital workplace (and certainly since my own early experiences of practice). They do however indicate that paramedic students may still experience gender-based inequalities during interactions with service users.

In terms of encountering sexualised behaviour within the current study, there was unfortunately one reported instance of an inappropriate comment made to a female participant (Emma) by a male paramedic. Whilst this is clearly unacceptable behaviour in any quantity, the single reported lewd comment does not seem to reflect the “norm” of the embedded and inappropriate sexualised conduct and incivility reported within the literature (Cash *et al.*, 2018; Lewis, 2017). The tone of the interview at this point even suggests that it may have been specifically remembered because of its uniqueness.

Despite being the recipient of the inappropriate comment, it is noteworthy that Emma still expressed a preference for having a male mentor and even suggested that having a large male paramedic workforce was probably advantageous for females. She elaborated by relaying some difficult experiences of interacting with other females in the workplace, and how she found males to be generally much more “laid back” and easier to work with. Todd similarly described that whilst female mentors seemed to be generally more accommodating towards students, he had found that where there was discord it was more likely to be a female mentor involved. He described how he had found that some paramedic mentors expressed a preference for teaching students of a particular gender, and that his own female mentor had said that she preferred to teach male students.

Whilst there is thus some evidence within the current study of a gender-determined preference between students and mentors, it is interesting to note that these expressions seem to run contrary to the affiliation for gender congruence and identity formation which is suggested by Solanki and Xu (2018), and Oyserman (2007). It must be acknowledged however that there is a dearth of research in this area, and that gender preferences between mentor and student may not necessarily translate to an actual variance in student experience. Both cited quantitative studies are also from the United States and only one involves paramedic students, so transferability may be limited.

### iii. Suggestions of change: attitudes towards BME groups in the workplace

Within the literature there are numerous accounts of BME staff and students being subjected to endemic and persistent inequality and racism within healthcare. These experiences are associated with feelings of marginalisation, alienation, loneliness, and having ‘no sense of belonging’ (Bandali, 2020, p.401; Hammond *et al.*, 2019; Farquharson *et al*., 2017; Gardner, 2005). Such a pattern of experience is logically likely to discourage applications to health care professions and may be a contributing factor in the proportionately low number of BME clinical employees within pre-hospital care. Indeed, with a BME clinical workforce (bands 5-7) of just 1.2%, the North East Ambulance Service NHS Ambulance Trust is just one example of an organisation that could be missing out on a more diverse ‘multi-layered, stronger model of care’ (WRES, 2021; Asamoah-Danso, 2020, p.290).

Although never the victim, my own earlier experiences as an operational paramedic unfortunately support the literature. Indeed, I remember witnessing ambulance staff making negative comments in the station crew-room about service users from BME backgrounds. Such comments were common, and generally involved prejudicial and trivialising remarks about the likely nature of calls to these groups. I had assumed that with the passage of time, academisation and professionalisation, this behaviour would have disappeared - although some of the more recent literature suggests that it still persists. However, in undertaking the current study I was fortunate in being able to interview two participants from BME backgrounds – Amara and Adeeb, and It was encouraging to find that their descriptions seem to differ significantly from what is reported within the literature and my own recollections.

During her interview Amara was very animated in the praise she gave for her mentors, stating on numerous occasions that they were “brilliant”. She described being excited and “really happy” in the prehospital placement environment and that she had become good friends with one of her mentors. In recounting how she had been generally made to feel by ambulance staff, she stated that everyone was very friendly and that she felt quite relaxed. When asked specifically about whether she believed her ethnicity may have made any difference to her placement experience, she stated that it had not, and when asked whether she had felt excluded in any way she replied, “no, I feel quite part of the team”. Whilst Amara’s interview responses regarding her placement experiences were overwhelmingly positive - it should however be remembered that at the time of the interview she had only completed five weeks of placement. Her experiences may therefore represent a potential “honeymoon period” of initial exposure – as suggested within Kramer’s (1974) seminal ‘Reality Shock’ model involving the perceptions of newly qualified nurses.

With nearly two years of pre-hospital placement experience, Adeeb described how supportive he had found ambulance staff to be and how from an early stage they seemed to want to make him feel like a part of the team. Following an extremely traumatic first shift, they nicknamed him “shit magnet”, which he interpreted as an informal welcome to the banterous culture. Moving to a smaller station, Adeeb described how ambulance staff at that location became “like a family”. When asked specifically about whether he felt his ethnicity had made a difference to his placement experience, he replied that being Asian and being able to speak Punjabi enabled him to play an important role in overcoming language barriers between Asian service users and ambulance staff. This allowed him to occupy a position of responsibility when responding to such emergency calls as he would be relied upon to accurately translate questions and explain clinical procedures. Such close involvement with the assessment process enabled him to attain valuable clinical experience and meant that he was often relied upon by ambulance staff from an early stage of his pre-hospital exposure.

Adeeb additionally recounted that his ethnicity placed him in a position to be able to educate ambulance staff about traditions, values, and boundaries within some South Asian communities. This resonates closely with the concept of reverse mentoring, whereby a junior employee mentors a more senior colleague with a view to sharing their personal experiences and expertise (Murphy, 2012). Whilst the overall aim is for increased cultural understanding and a decrease in negative stereotypes, a considered benefit for mentors from a BME background is an increase in ‘social capital’ with established staff within the workplace (Stephenson, 2016; Murphy, 2012). Whilst there was no formal reverse mentoring arrangement in place for Adeeb, being able to educate his mentors in this manner may have contributed to his positive workplace experiences. It also potentially explains why his perceptions may run contrary to what is reported within the literature and the experiences of BME students who may not have had mentors who were receptive to being educated about ethnicity and culture.

## Suggestions of cultural immersion and evidence of ‘authenticity’

Relating predominantly to objective 1, this section explores how many of the participants seemed to display indications of perceptual alignment with the rhetoric (and implied perspectives) synonymous with pre-hospital culture. This accords with Wisnewski’s (2013, p.75) assertion that, ‘Dasein’s primary mode of existence is one of immersion in ‘The They’’. This section will also introduce Heidegger’s (1927) concept of ‘authenticity’ as a means of exploring why individuals do not always conform with the predominant perspectives and actions espoused by ‘The They’.

‘Authenticity’ is considered to represent a form of ‘Being’ derived from an individual’s tailored appropriation of their ‘Thrownness’ and their experience of the ‘inauthentic’ world. ‘Authenticity’ represents “moments of vision” in which individuals envisage alternative attitudes or behaviours to those extolled and/or demonstrated by those around them (Wisnewski, 2013, p141; Heidegger, 1927). It is through such demonstrations of ‘authenticity’ that I intend to explore how notions of self-identity in the professional clinical practice environment may be both formed and/or negotiated.

### i. Alignment (or not) with the pervading attitudes of ambulance staff

Although there were exceptions, most participants within the current study at some point expressed alignment with the attitudes and behaviours synonymous with pre-hospital workplace culture. Adeeb for example, conveyed irritation about the need to sometimes respond to calls beyond the allotted shift finishing time and admitted that since becoming a student paramedic, he had become generally much more cynical towards some service users, sometimes struggling to understand their “lack of common sense”. Ellie, Beth Aaron, and Stef all voiced frustration towards the non-emergency nature of some calls; whilst Todd recounted that although he was initially “very sympathetic”, he very quickly lost a great deal of empathy towards those who did not seem to have a “genuine” reason for calling. This alignment does not seem to relate solely to length of exposure, as Todd described how his loss of empathy (which he stated has since returned) occurred after just a few weeks of placement, whilst others (such as John) had completed nearly two years and were seemingly more consistently empathetic. Indeed, participants with varying levels of experience (including Adeeb, Beth, Michael and Todd) expressed alignment with ambulance staff in terms of the intensity of their workload and considered this to be justification for some aspects of behaviour and self-regulation.

Aligning with Heidegger’s (1927) philosophy concerning the compelling draw of ‘The They’, Baronowski (2020) similarly found that paramedic students often adopted the attitudes of ambulance staff as a means of gaining acceptance. This has also been found within the nursing literature, with the desire to be accepted through mimicking the attitudes of established staff even overriding the quality of care given (Levett-Jones et al., 2007; Tradewell, 1996; Bradby, 1990)

However, expressing potentially ‘authentic’ views which do not align with the more general perspectives of ‘The They’, Emma and John did not subscribe to the consensus of negative attitudes displayed by some ambulance staff. Citing prior experiences of very hectic working environments and knowledge of how working conditions within other Ambulance Trusts are much harsher, they conveyed limited sympathy in relation to complaints about workload. John even voiced disapproval of fellow students he had witnessed adopting some of the negative attitudes towards the role which are more usually exhibited by ambulance staff. Alluding to a facet of her own prior life experience, Louise also expressed a more empathetic view of service users who may have called with a complex “non-emergency” mental health or social care issue.

Having such ‘thrown’ prior experience accords with Henderson’s (2012) assertion that university students may have some extremely valuable and applicable life experiences – which existing ambulance staff may even find unsettling. In Heideggerian terms this ‘unsettling’ may relate to how participants such as Emma, John and Louise are seemingly able to reject elements of the pervading ‘inauthentic’ cultural rhetoric at times and develop an alternative ‘authentic’ perspective based upon their own life-experience and a more cautious appropriation of the pervading rhetoric of ‘The They’. Whilst from my own experiences I believe that these perspectives are unlikely to be fully expressed by students in the workplace (due to the likelihood of creating discord), they represent an ‘authenticity’ expressed within the context of their interviews which runs contrary to the ‘inauthentic’ sentiments of ‘The They’ (Heidegger, 1927; Wisnewski, 2013).

The degree to which student paramedics develop an alignment with the perspectives and beliefs synonymous with the prehospital workplace culture may represent an important part of their own sense of professional identity and its development. Additionally, exploring how individuals potentially synthesise and integrate their ‘Thrown’ experience and (in some cases) are able to reject aspects of the pervading ‘inauthentic’ workplace rhetoric may also be important for ascertaining how the appropriation of professional identity may be ‘negotiated’ in conjunction with prior life experience.

This ‘negotiated’ appropriation (and ‘authenticity’) may be additionally important for changing future patterns of embedded behaviour within the pre-hospital workplace. According to Argyris (1991), in order to overcome the aforementioned inclination for defensive reasoning, individuals need to understand how they may be the unconscious authors of their own difficulties and failures, and that the perceived coping mechanisms that they employ may in fact be compounding the problems. For Argyris (1991), change has to come from the top, and it is for senior managers to communicate with their staff in such a way as dismantle the barricades of defensive reasoning and embed an ethos which supports productive relationships and critical reflection. The ability to transcend the negative rhetoric of ‘The They’ which was displayed by some of the participants within the current study suggests that graduate paramedics with a more diverse perspective may be able to affect positive attitudinal changes should they become senior managers in the future.

### ii. Inclusion with ‘dark humour’ and ‘banter’

All participants within the current study recounted that away from public scrutiny they had witnessed ambulance staff demonstrating ‘dark’ humour and banterous joking with each other. Whilst Michael stated that he initially found the degree and ‘harshness’ of the humour to be surprising, other participants (including Todd, Stef, John and Beth) stated that it was something they expected and understood it to be a means of managing stress.

Within the literature, ‘dark’ humour and banter are broadly considered to be ‘back-stage’ features of pre-hospital ambulance culture. In alignment with recollections from the current study, they are deemed to be socially acceptable methods of coping with what can be an extremely intensive working environment (Lancaster and Phillips, 2021; Rolfe et al. 2020; Givati et al. 2017; Charman, 2013; Rowe and Regehr, 2010). Humour has also been described as a form of ‘social glue’ which may define who is an accepted member of the culture (Charman, 2013); whilst Scott (2007, p.357) suggests that a ‘social contract’ needs to exist between colleagues who share a potentially inappropriate ‘back-stage’ joke. Indeed, even family and non-ambulance-friends are usually excluded on the basis that they wouldn’t understand or appreciate the underpinning workplace context (Clompus and Albarran, 2016; Mildenhall, 2012).

The esoteric nature of ambulance humour and banter was outlined within the current study by Stef, who stated that whilst it was acceptable “on station” it would be improper to share it with her family. Resonating the importance of ‘trust’ and for a ‘social contract’ to exist to share such humour, John also relayed his belief that banter between ambulance colleagues could even be categorised as “workplace bullying” by external parties who might be unfamiliar with the culture. In discussing their own engagement with the banter of ambulance staff – and having the ‘mickey’ taken out of them – Beth, Louise, and Aaron recalled that it had offered them a sense of inclusion, whilst for Penny it had provided an invite to engage in conversation. Recalling his own engagement (and reciprocation) with the banter, jokes and pranks played by ambulance staff, Todd similarly expressed how from an early stage it had made him feel like an accepted part of the crew.

However, whilst being included with ‘dark’ humour and banter was seemingly almost universal amongst participants, there was also a suggestion that the same pathway for inclusion might not be extended to everyone. Indeed, even with two years of experience, Ellie stated that she had never had the “mickey taken” by ambulance staff and relayed that she had also not really experienced a sense of inclusion with workplace conversations and banter. During her interview Ellie referred to herself as generally lacking in confidence on placement, being considered “young”, and not having “common ground” with either ambulance staff or her peers. In this respect, Ellie may therefore have been what Charman (2013, p.157) describes as being ‘outside of the cultural wall’.

Due to strong associations with the professional workplace and the social group affiliations of ambulance staff, the inclusion of students with the expression of ‘dark’ humour and banter may therefore represent an important indicator of their developing sense of enculturation and professional identity. This is not something which seems to have been explored to a significant degree within the UK literature pertaining to professional identity development.

### iii. Use of profession-specific language

Whilst participants within the current study demonstrated some overt conscious alignment with the pre-hospital workplace culture, there was also evidence of more subliminal affiliation and adoptive behaviour. Most notably this included the use of pronouns such as “we” and “us” when referring to circumstances involving themselves, ambulance staff, and the workplace, and the use of pre-hospital jargon such as “job” (instead of call), “big-sick” (instead of seriously ill), and “truck” (instead of ambulance). Without exception, all participants used contextual pronouns and occupational jargon to some degree, and some (including Beth, Adeeb, and Stef and Amara) used language more akin to that of an employed member of ambulance staff. This often included describing their time on placement as “work”.

According to Monrouxe (2009, p.42), our sense of identity is ‘embedded in language and interaction’, and the use of positioning pronouns is representative of the commitment (or sense of difference) individuals feel towards a particular community. The use of occupational jargon is also considered to suggest affiliation with a particular group, and learning its meaning and application is thought to represent an important part of the enculturation process for newcomers (Rebrina and Generalova, 2019; Clouder, 2012).

Although limited, the literature thus suggests that the verbal positioning used by participants within the current study is indicative of a developing identification with the pre-hospital professional community. The almost universal use of occupational jargon may also reflect their sense of professional affiliation with the pre-hospital workplace. Whilst only one participant within the current study (Amara) indicated that she didn’t feel comfortable using some of the jargon (although she did use verbal positioning pronouns) it is perhaps noteworthy that she had the least amount of exposure in the pre-hospital workplace. Neither the use of verbal positioning or professional jargon are factors which have been broadly explored within the healthcare literature pertaining to the development of professional identity.

## Overarching motivations on placement

According to Heidegger (1927), ‘Dasein’ is characterised by ‘Projection’. This represents how each of us is orientated towards the future within our daily interactions; whilst our potential to make decisions and enact change is simultaneously dictated by our ‘Thrownness’ - see The Concept of ‘Projection’ section on p. 94 for more details. Our (projected/future) orientation towards achieving our goals or projects is thus considered to influence our interpretation of the world and our place within it at the present time (Wisnewski, 2013). This hermeneutic cycle is represented within this discussion via an exploration of how the participants’ day to day interactions may have been affected by their aspirations within the pre-hospital workplace. Relating to both objectives, I have divided this into a discussion of the universal short-term aim of achieving their placement competencies (in order to pass the course) and their longer-term aim of deciding what kind of paramedic they wish to become.

### i. Passing placement (and the avoidance of ‘risk’ in this area)

Evidence of short-term projection within the current study was apparent with regards to how participants orientated their behaviour in accordance with what they perceived would be beneficial for passing the practice placement elements of their course. This included the desire to attain the appropriate approval and confidence from their mentors in order to obtain the competency signatures required for successful completion. It also included the considered avoidance of ‘risk’ with regards to these relationships and the desire to engender a favourable impression.

Correlating with Erving Goffman’s (1959) ‘impression management’ theory, the application of such behaviour was described by John and Michael in terms of their reluctance to disclose details of their significant prior experience with SJA; although rather than simply avoiding the subject, John chose to carefully navigate how he revealed this as he wanted his mentor to know that he could do a little bit more than other students. Adeeb was similarly determined to engender a better relationship with ambulance staff so as to increase his clinical exposure, whilst Louise chose to avoid potentially arguing with her mentor so as to avoid antagonising him and risk a potential refusal to sign her “off” as being competent. In commenting on some similar mentor-student interactions that she had observed, Emma also relayed that even when placed in challenging situations, students generally feel compelled to remain on favourable terms with their mentors.

This is mirrored within the nursing literature, whereby students in the workplace are subject to an ‘inequity in power’ due to their reliance upon established staff who act as ‘gatekeepers’ to the necessary clinical exposure, and in the conferment of ‘competency’ (Capper, 2020, p.6; Gillen *et a*l., 2008). As with the observations of Louise and Emma, midwifery and nursing students in these contexts have similarly reported that in challenging situations they often seek to ‘keep a low profile’ and just ‘get on with it’ so as to maintain good relations with their mentors (Ion *et al*., 2015, p.904; Hunter, 2005).

The recollections of the students and the literature accords with some of my own experiences as a junior clinician within the pre-hospital workplace. That students are prepared to make behavioural compromises so as not to jeopardise their progress or how they are thought of on placement is thus understandable, but not something that seems to be readily considered by paramedic education providers. In accordance with the findings of Curtis et al. (2006) and Ion *et al*. (2015) relating to midwifery and nursing students (and noting parallels with the current study) it may well be that paramedic students are similarly inadequately prepared at university for the workplace. The pre-hospital literature is however limited in this area.

### ii. Deciding upon what sort of clinician students aspire to become

Evidence of ‘Projection’ which is more long-term is represented here by participants’ aspirations beyond the completion of their course. This includes expressions of what kind of healthcare professional they would like to be, how they intend to practice when qualified, and even how they plan to treat their own students in the future. In Heideggerian (1927) terms of ‘Projection’ (as the concept relates to an individual’s sense of ‘self’), this represents the influence of future post-qualifying aspirations upon participants’ day-to-day engagement as a student paramedic within the pre-hospital workplace. In this context it encompasses a participant’s expressed motivation to potentially adopt (or not) particular ways of working and mentoring.

For John this became manifest with his adoption of complete honesty in his communications with service users, and his defence of this position when overtly challenged by ambulance staff. For Michael, it involved using his aspired status of being a registered paramedic as a lens through which to question the standards of clinical decision-making he had witnessed in practice. For Todd, Aaron, and Emma, it included the desire to one day emulate (or avoid) the levels of clinical competency and/or empathy they had seen displayed by particular paramedics in practice. For Beth, Louise and Stef, it also involved making a judgement about the standard of mentorship they had received and being determined to adopt a potentially more proactive teaching style if they were ever to mentor students themselves.

Participants additionally expressed admiration or respect for a variety of qualities they had witnessed from ambulance and other healthcare staff during their practice placements. Whilst this was frequently their assigned mentor, it was sometimes a clinician they had not met before, but whose behaviour made such a positive impression that they remembered it and aspire to emulate it when qualified. For Ellie, this included how her mentor seemed to be attuned to her lack of confidence and acted as her advocate with other ambulance staff. Whilst for Todd, it was an unknown paramedic who calmed him, guided him, and seemed to understand how overwhelmed he was as an inexperienced student at the scene of a serious traffic accident. These findings reflect Bandura’s (1986) model for learning through observation, and Bucher and Stelling’s (1977) assertion that students may adopt observed traits from a variety of individuals.

The findings from the current study correlate with Kirsten *et al*. (2017) in that participants such as Aaron, Louise, and Penny overtly praised ambulance staff who were not their assigned mentors but nonetheless demonstrated impressive levels of clinical knowledge and the experience to apply it in practice. Mirroring the findings of Perry (2008, p.39) Beth and Ellie also described how they admired and intended to emulate non-ambulance healthcare staff who they had observed attending to the ‘little things’ and who exhibited kindness towards service users and inexperienced students.

These findings are pertinent in that they represent memorable experiences from a variety of sources which participants stated they intend to imitate when qualified. They also reflect my own recollections as a junior clinician, and my determination to adopt the observed behaviours of some individuals, and to actively avoid exhibiting the behaviour of certain others. For university and workplace placement coordinators this highlights the potential impact of ‘informal learning’ through unstructured and unplanned observation, and that students may benefit from observing a variety of clinicians in practice – as opposed to just one assigned mentor. Of additional potential interest in this area, Cheetham and Chivers (2001) suggest that the personality of the learner may also play an important part in benefitting from a particular formative experience. This became apparent within the current study as some participants relayed very different interpretations of similar behaviour exhibited by ambulance staff. Indeed, whilst Adeeb commended one particular mentor for his aggressive and demanding style of teaching, a similar approach experienced by Michael and Ellie was heavily criticised.

## A perceived lack of preparation

In terms of their backgrounds, the findings of the current study concur with the literature in that university paramedic students tend to have limited prior engagement with the paramedic profession or occupational role-modelling from parents or close family (Johnston, 2020; Du Toit, 1995). However, prior relatable healthcare and teamworking experience is suggested to lend itself to the development of a stronger sense of professional understanding and affiliation (Johnston, 2020; Adams *et al*., 2006). Seemingly possessing such experience, participants such as John and Emma demonstrated a good understanding of the unwritten cultural ‘rules’ of how to engage in the pre-hospital placement environment; including being conscious of how to create a favourable impression though cognisance of how their words, actions and behaviour could be perceived by those around them. This accords with Goffman’s (1959) ‘Presentation of Self’ and how individuals may undertake a ‘performance’ which is tailored for the pervading social context, and Bourdieu’s (1998, p.80) conception of ‘habitus’ in understanding the ‘rules of the game’.

Adeeb’s perceived initial difficulties may also have been compounded by having a prior frame of reference which he admitted was predominantly formed through watching popular mainstream UK ambulance television programmes. With reference to the same programmes, Amara and Stef relayed some key differences they had found between the media’s portrayal of ambulance staff and the realities of practice. These potential misconceptions are described by Devenish (2017) as forming the ‘anticipatory socialisation’ stage, which is subject to change when students undertake university studies and practice placements. In this respect, Adams *et al*. (2006) suggest that professional identity development amongst new health workers involves a perceptual realignment in relation to prior idealisation and their developing understanding about the actual nature of the work. In relation to such idealisation however, the findings of the current study suggest that a perceived lack of preparation for the reality of practice may additionally be a product of a ‘hidden curriculum’. I believe that such a ‘hidden curriculum’ may be encountered by paramedic students during their application stage, and during their initial period at university; prior to their first practice placement. In accordance with objective 2, this section will therefore explore the role which may be played by the university in this area.

### i. The potential influence of a ‘hidden curriculum’

In terms of experiencing pre-hospital care, several participants (including Beth, Stef and Ellie) expressed frustration with the non-emergency nature of many calls and stated that they had quite different expectations of the role whilst at university and before entering the workplace. Both Penny and Adeeb expressed that they were unprepared for the way in which they were expected to enter the houses of strangers and have intimate, yet impersonal physical contact with people as part of the medical assessment process. Even though some participants relayed evidence of significant prior working and travelling life experience, nearly all participants expressed some initial surprise at what they considered to be poor and unhygienic living conditions of many service users. Many participants (including Ellie, Emma, and Beth) also conveyed some dismay at the prevalence of associated mental health conditions, and frustration with the lack of social support within the community and/or from family members. The latter being voiced with some exasperation by Michael.

As cited within chapter 2, some of this dissonance may be due to the participants (as university students) being unlikely to have experience of living within a socially deprived environment (Whitty, 2016; Greenbank, 2009). However, whatever their background and life-experience, all participants had a period of education within the university setting prior to embarking upon their first pre-hospital placement; a period of exposure which could be considered ideal for preparing them for the reality of the workplace. Kennedy (2015) however suggests that in this respect, there is often a distinct difference between what is conveyed at university and the reality of practice.

Within the context of university paramedic education, the ‘hidden curriculum’ may be revealed through there being a disproportionate emphasis placed by educators upon the acute life-saving aspects of the role, at the expense of the more prevalent complex social care and mental health conditions (Devenish, 2014; Newton, 2019). Reasons for this are speculated to include embedded allusions to an occupational identity once synonymous with acute care, and the desire to define the professional role in relation to other undergraduate health courses (Devenish, 2014). This accords with the findings from other studies and the suggestion that in relation to healthcare courses, the conveyance of implicit and tacit attitudes by educators as part of a ‘hidden curriculum’ may be even more influential than that which is formally taught (Raso *et al*., 2019; Hafferty, 2015; Cotton *et al.*, 2012; Pratt *et al*., 2006; Cant and Higgs, 1999).

Reflecting upon my own experiences as a paramedic educator, the presence of a ‘hidden curriculum’ corresponds with the early emphasis that I have seen placed upon the delivery of life-saving skills and more invasive interventions, arguably at the expense of what may be more commonly encountered in practice. In terms of teaching, this integrates a logical desire to ensure that students know what to expect should they encounter such an acute call within their first few weeks of placement. However, such critical interventions are also usually simpler to teach in terms of conceptual understanding; their purpose and use being much easier to convey and formally assess than multifaceted and complex social care interventions (Devenish, 2014). In alignment with what is taught, there is also a potentially misleading emphasis placed upon life-saving skills and more invasive interventions in terms of what is summatively assessed.

During university Open Days there may also be tacit pressure to impress and encourage potential applicants with the more ‘exciting’ and paramedic-specific elements which are taught, and to demonstrate the use of the expensive clinical skills labs; something which may be continued (in accordance with these established expectations) during the students’ first few months at university. This pressure is also inferred by the literature pertaining to neo-liberal educational policy, with those responsible for course recruitment being compelled by the organisation to recruit to capacity so as to secure the maximum amount of income from student fees (Hayton and Tang, 2016; Chitty, 2014). In terms of preparing students for the reality of the workplace, the findings from this study lend further weight to the assertion of Pratt *et al.* (2006) in that educators need to be more aware of what they may be unintentionally conveying to students, and that the presence of a potentially misleading ‘hidden curriculum’ needs to be further explored within the undergraduate paramedic curriculum.

### ii. A confident disposition and the potential of ‘cognitive flexibility’

Within the current study there were some notable differences between participants in terms of what could be perceived as self-assertion, with those who were apparently more confident in their actions and communication seeming to enjoy a more productive and enjoyable placement experience. Whilst John and Emma were older and had more life-experience than most other participants, they were not the only ones to reap the benefits of greater social awareness and confidence in communication. Indeed, despite coming straight from school, Michael was seemingly able to become quickly attuned to the social dynamics of prehospital workplace culture; whilst Todd relayed that through observing the behaviour of ambulance staff, he was able to confidently join workplace conversations and gain acceptance at an early stage. Conversely, despite being older and having several years of prior teamwork experience in customer services, Beth expressed that she was reluctant to join in with workplace conversations for fear of embarrassment and social awkwardness.

The findings from the current study mirror the literature in terms of apparent benefits for students who become quickly attuned to the social dynamics of the pre-hospital workplace culture. This is described by Filstad and McManus (2011) as leaning the social ‘code’ which enables cultural participation and sponsorship from more experienced staff, and a sense that they are part of the workplace ‘family’ – a term similarly used within the current study by Adeeb when describing his own positive sense of inclusion. Filstad and Mcmanus (2011) also suggest that whilst proactive newcomers might find it easier to gain this acceptance, where there is a personality conflict or if someone is prone to be shy, then acceptance may be denied – as perhaps suggested by Beth’s recounted reticence to engage with staff on station and some of the social isolation she encountered.

In terms of character and personality, several studies suggest that emergency medical provision attracts a certain kind of person, and that individuals with a more extroverted and outgoing disposition are more likely to be drawn by it (Granter *et al.,* 2018; Hallam et al. 2016; Klee, 2012; HCPC 2011; Pajonk *et al*., 2010). Whilst this *may* be true, an individual’s cognitive flexibility is also hypothesised to influence how readily they are able to observe, adapt, assert and be responsive to the emotional needs of others as they become enculturated within a new environment (Martin and Anderson, 1998; Spiro and Jehng, 1990). The ability to adapt and adopt behaviour in this manner - through observing the interactions of established staff and gauging what would (or would not) be considered socially appropriate - aligns with the approach recounted within the current study (with apparent success) by John, Emma, Michael, and Todd.

This concept is mirrored by Filstad and McManus (2011), who recommend that newly employed paramedics would benefit from development work which enables them to identify and navigate embedded power relations and which enhances their ability to socialise and participate within the workplace. Education in this area is not something which is overtly included within the university paramedic science curriculum studied by the participants within the current study. However, as something which may enhance students’ sense of acceptance and learning, ‘cognitive flexibility’ represents a potentially important area for further research and inclusion within the initial phase of paramedic education at university.

## Integrating and supporting factors

This section relates predominantly to objective 1 and will focus upon two key areas which I have identified within the findings as being potentially important for participant perceptions of integration within the pre-hospital workplace: ‘Informal peer support and smartphone tech’’ and ‘Utilising the coping strategies of ambulance staff’. Whilst I have chosen to focus upon these areas due to their apparent originality, there is one significant area of similarity between the findings and social theory/literature which I would like to briefly outline here.

In accordance with Lave and Wenger (1991), the findings from the current study suggest that paramedic students who have appropriate sponsorship and support from established staff are seemingly better able to access a CoPr, and accordingly feel a greater sense of inclusion and/or professional identity. In mirroring this process, the findings also support the concept of ‘legitimate peripheral participation’ in terms of how learning may be embedded within a social context, and that the support of established staff (acting as ‘socialisation agents’) is essential for students to be able to effectively apply their educational knowledge in practice (Lave and Wenger, 1991; White, 2010). Whilst it is interesting to note that some of the findings from the current study accord with the seminal theories of Lave and Wenger, I have chosen not to focus in detail on this area due to it being an area of significant congruence with what already exists within the literature. The following sections however, pertain to perceived areas of originality for how student paramedics may become enculturated.

### i. Informal peer support and smartphone tech’

A potentially important area of support which was relayed by participants within the current study was their ability to access informal peer groups comprising of their fellow paramedic students. As specifically recounted by Todd (who was able to message his student peers ahead of his return to station after a traumatic incident), ‘smart-phone’ technology and messaging platforms such as ‘WhatsApp’ also mean that access to peer support is virtually immediate and always available in a way that previous generations of learners in similar environments (such as myself) could not experience.

Whilst Dennis (2003) acknowledges that unfavourable comparisons amongst peers can be detrimental to an individual’s self-confidence (supported by Ellie’s recounted insecurity when she compared her levels of knowledge to other students), the findings from the current study indicate that informal peer support networks are distinct and important for student paramedics. Indeed, whilst Beth recounted that she did not feel particularly included on placement by ambulance staff at her placement location, she praised the informal support given by her fellow students and stated that it was only their encouragement which enabled her to continue after a particularly bad experience. Other participants (such as Ellie, Louise, Stef and Todd) relayed how communicating with their peers represented an important coping mechanism and an outlet to discuss concerns which they perhaps couldn’t share with their mentor, and that their family and ‘outside’ friends wouldn’t understand. This was explicitly relayed by Adeeb, who stated that whilst he was unable to talk to “normal” people about placement, his fellow students could usually offer him some understanding. Whilst there are some studies which do explore the potential of peer support networks (Clompus and Albaran, 2016; Dennis, 2003; Wills and Shinar, 2000), they do not involve paramedic students or explore the potential immediacy and capacity for inclusion offered by contemporary ‘smart phone’ technology and messaging services.

In relation to the development of a supportive community, Hou and Macnamara (2017) suggest that the adoption of social media messaging for this purpose may contribute to students’ social capital and sense of identity. Lazarsfeld-Jensen (2019) additionally suggest that ‘younger paramedics’ now depend upon this mode of communication; although Van Den Beemt *et al.* (2020) indicate that this may not be the case for many teachers, who are likely to need some assistance in order to appreciate its potential application for educational support purposes. Indeed, as a ‘digital immigrant’ to the contemporary era of social media platforms and group connectivity, I acknowledge that I have previously overlooked the use of ‘smart-phone’ technology as a means for student support, and I freely admit that I am not as adept as most students with regards to community engagement in this manner. This is an area of potential inclusion, learning and support which may be overlooked by educators (certainly by me), but which is ripe for further exploration.

### ii. Utilising the coping strategies of ambulance staff

A further area of integration conveyed by participants within the current study relates to utilising the support of ambulance staff as a primary means of coping with the stresses of the pre-hospital workplace. For Beth this was described as simply being able to chat after a stressful call with a group of like-minded people who understood what she was feeling. For Todd however, this seems to have involved an almost visceral need to be with his mentor and other ambulance staff after an extremely traumatic call. Even after being sent home for clean uniform, Todd returned (to the surprise of his mentor) to help with the process of cleaning-up and have a chat and joke with ambulance staff and his student peers. Whilst discussing the use of coping mechanisms after the traumatic call he mentioned calling his mother but stated that he decided not to speak about the call as he felt she wouldn’t understand and because he didn’t want to be a “burden” to her.

A similar desire to avoid burdening loved ones with the details of traumatic incidents was found amongst qualified ambulance staff by Clompus and Albaran (2015) and Shakespeare-Finch *et al.* (2002). Shakespeare-Finch *et al.* (2002) also hypothesise that an ability to compartmentalise stressful experiences in this manner may be due to formal training and experience. Whilst there is little research focussing upon student paramedics in this area, the findings from the current study suggest that despite their limited experience, students may compartmentalise their work-related stress in the same manner as experienced ambulance staff. It should be remembered however, that at the time of interview most participants did not have a catalogue of prior experiences to draw upon to help them cope. In relation to student paramedics, the findings from the current study do not therefore support the hypothesis that such compartmentalisation may be due to a prior repertoire of experience.

Where the findings of the current study do in-part align with the literature relating to coping-strategies, however, is with the informal support participants sought from ambulance staff (Alexander and Klein, 2001; Jonsson and Segesten, 2004). In accordance with the findings of Mildenhall (2012) where possible, participants within the current study engaged with the camaraderie associated with pre-hospital working culture as a readily available means of decompressing and coping with stress. For this to occur, students would logically need to feel included and able to express their emotions with ambulance staff – something which Pinks *et al.* (2021) and Jennings (2017) suggest may be problematic for them. Whilst coping strategies were not expressly explored within the current study, the recollections of some participants, however, certainly suggest that in relation to stress management they were able to engage with this source of emotional support.

## Chapter summary

This chapter has focussed upon some key broad areas of potential originality from the findings and contextualised them in relation to the literature review presented within chapter 2. These broad areas include:

- Experiences of the pre-hospital workplace

- Suggestions of cultural immersion and evidence of ‘authenticity’

- Overarching motivations for students on placement

- A perceived lack of preparation

- Integrating and supporting factors

It has additionally included a more focussed review of the literature for each area and some of my own reflexive experiences. The next chapter will seek to review and summarise what has been explored so far. It will seek to identify potential limitations and offer recommendations for future practice with an emphasis upon employer policies and guidelines.

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# CHAPTER 6

Conclusion and recommendations

## Conclusion and Recommendations

This chapter briefly revisits the aim of the current study, the research question and objectives, and the application of Heidegger’s (1927) concept of ‘Dasein’ and the temporal structure of ‘Care’ as an analytical framework. The analysis and discussion of the findings will be summarised with a focus upon where the findings suggest originality or potential variance to what is more commonly suggested within the literature. This chapter also includes my recommendations for future practice based upon the analysis and discussion, with an emphasis upon what may be achieved by university educators in alignment with employer policies and guidelines. It will conclude with an exploration of further research which could be undertaken, and an outline of the work that I plan to carry out next in accordance with the findings and recommendations.

## Aim and conceptual underpinnings

This study aims to explore how paramedic students at one UK university develop their sense of professional self-identity as they become enculturated within the pre-hospital working environment. It is predicated upon the development of professional identity being a process whereby an individual’s self-perception becomes commensurate with the knowledge, skills, behaviour patterns and values which define a particular professional role, and which also represent society’s expectations of that role. Rather than the simple learning of procedure however, developing such a sense of self-conceptualisation is considered to be a process of socialisation within that particular professional group, with the acquisition and application of learning restricted by the social boundaries which may regulate behaviour within the relevant field of practice. For individuals it enables ‘feelings of personal adequacy and satisfaction’ and provides a ‘lens’ through which they may evaluate, learn, and make sense of the world (Ewan, 1988, p.85; Schein, 1978; Higgs, 1993; Pettifer and Clouder, 2008). Due to the socio-cultural context, the development of professional identity is considered to be an individual negotiation of ‘meaning-making’ which takes place within a professional community of practice, and also within the mind of the learner as they seek to align a new way of viewing the world with their existing schemata of perceptions and experiential understandings (Monrouxe, 2009, p.42; Hunter *et al.* 2007).

Acknowledging an emphasis upon the social, communal, and interpretive underpinnings of professional identity development, I have chosen to adopt a hermeneutic investigative approach inspired by social theory. This approach has merit as according to McCann *et al.* (2013, p.752), professions are ‘vitally important social actors’ and according to Grantner *et al.* (2018, p.2), ‘ambulance work has received scant attention from sociology’. However, whilst social conceptions such as Bourdieu’s ‘field’ of practice and habitus are relevant to this study (Bourdieu, 1993; Wacquant, 1998), I believe that aspects of the hermeneutic philosophy of phenomenologist Martin Heidegger offer a more encompassing and novel framework with which to explore individual ‘self’ perceptions of professional identity development. As prominent social theorists such as Bourdieu and Foucault are considered to owe a philosophical debt to Heidegger (Dreyfus and Hall, 1992) it has also been possible to include pertinent aspects of their social theories within the umbrella of the chosen analytical framework.

In undertaking a phenomenological study, Paley (2017, p.177) stresses the importance of adopting a ‘theory from a relevant discipline’. For this study, I have therefore chosen Heidegger’s concept of ‘Dasein’ and the temporal structure of ‘Care’. According to Heidegger (1927, p.7), ‘Dasein’ (or ‘being there’ when translated from the original German) relates to an individual’s conscious and unconscious perception of the world, of themselves and others. It is underpinned by the temporal arrangement of ‘Care’ which pertains to how – in our day to day lives - we are embodied by our past (‘Thrownness’), present (‘Fallenness’) and future (‘Projected’) selves. ‘Thrownness’ is representative of how our perceptions are aligned and ingrained by the social communities we have had prior contact with; ‘Fallenness’ encapsulates how we are absorbed by the world at the present time and how we are drawn to others; ‘Projection’ represents how we are at all times thinking about the future and living out the possibilities which our ‘Thrownness’ makes available to us (Wisnewski, 2012). In addition, Heidegger (1927) suggests that we are compelled by the ‘inauthenticity’ of those around us, which is the embodiment of the knowledge, understanding, values and culture of the social community we are engaged with (otherwise known as ‘The They’ or ‘Das Man’). For Heidegger, such ‘inauthenticity’ is inescapable, such that we inevitably find ourselves experiencing the world (even in terms of emotions such as pleasure, enjoyment, sadness, and surprise) in the same way that ‘They’ do (Wisnewski, 2012).

In relation to the broader literature pertaining to professional identity development, I believe that the application of Heidegger’s concept of ‘Dasein’ and the temporal structure of ‘Care’ represents a unique and original approach. It is an approach which allows us to effectively explore how individuals identify themselves as something or somebody (such as a paramedic student), and why this is in each case an individual negotiation involving their past, their interactions within the present, and their future aspirations.

## Research question and objectives

The research question which has underpinned this study asks:

*How are paramedic student notions of ‘self-identity’ formed/negotiated as part of the enculturation process within professional clinical practice?*

In support of this question, there are two objectives:

Objective 1:

* To explore the development and/or negotiation of paramedic professional identity from the perspective of the university student

Objective 2:

* To explore the role played by the university in the professional enculturation of paramedic students

Within Chapter 4, Heidegger’s temporal structure of ‘Care’ is utilised as an a-priori superordinate template with which to structure the subordinate categories of data which arose from the findings. Chapter 5 focusses upon findings which suggest areas of potential originality and difference in accordance with the literature review, a more focussed review of the literature, and my own reflexive experiences. Heidegger’s temporal structure of ‘Care’ and the concept of ‘Dasein’ are also utilised to provide structure and a framework for the discussion.

The following section highlights key areas of interest and originality which have arisen from the current study. I have emphasised areas which may pertain to the development of professional identity (in accordance with the overarching research question and objectives), and where the findings may offer an alternative narrative to what is commonly suggested within the literature.

## Review of findings, analysis, and discussion

For this section I have condensed the findings, analysis, and discussion down to three areas. These areas have been derived deductively from the discussion and are intended to represent a broad concluding summary. They are also intended to provide a clear and logical basis for subsequent recommendations. The three areas are highlighted within table 10 below:

**Table 10:** Concluding review and summarised content

|  |  |
| --- | --- |
| **Area of review** | **Summarised content** |
| Occupying a unique position within a unique professional culture | Exposure to the pre-hospital workplace culture  The draw of ‘The They’, and evidence of immersion  Being a supernumerary university student within the pre-hospital workplace  Student dependency upon paramedic mentors and selective role-modelling |
| Suggestions of change | Attitudes towards females and BME groups  Smartphone technology: greater potential for informal peer group support |
| The need for better student preparation | The lack of prior role-modelling or realistic expectation  The influence of a ‘hidden curriculum’  Navigating a ‘pathway’ towards acceptance |

## Occupying a unique position within a unique professional culture

All participants within this study witnessed ambulance staff exercising their own informal strategies to control their allocation and pace of work. Some recollections however seemed to reflect deeper frustrations, resentment, and a sense of injustice towards changes which have occurred within the workplace and with regards to the nature of the paramedic role. Whilst some participants demonstrated alignment with the expressed cynicism and antipathy of some ambulance staff, others conveyed an ‘authentic’ disapprobation of these perspectives and of students who they observed apparently mimicking such attitudes. The findings of this study suggest that the approbation (or not) of these perspectives may represent an adopted ‘lens’ through which some participants view the pre-hospital workplace. This may be analogous to the ‘lens’ associated with professional identity development suggested by Trede *et al.* (2012) through which individuals evaluate, learn and make sense of the world. It may also represent the potential that some graduate paramedics have for resisting the defensive reasoning which may be exhibited by established ambulance staff within the workplace (Argyris, 1991).

Several participants described how they had at some stage encountered disrespectful, discourteous, and undermining behaviour from a minority of ambulance staff whilst on placement. This mirrors some of the tensions reported in the literature between university students and established staff which may be in-part fuelled by the broader vocational changes and career limitations which some perceive Higher Education to represent (Givati *et al*., 2018; Henderson, 2012). For the participants within the current study, these feelings also seem to be intensified by comparisons which are made with students who are employed by the local ambulance service. Although similar in terms of education, these students are not supernumerary to the crew allocation on an ambulance, and many participants relayed that these students are treated more like qualified members of staff and held in higher regard. Whilst the pre-hospital literature is limited in this respect, there are some similarities within the nursing literature, with unfavourable comparisons occurring within the workplace between supernumerary nursing students and employed nursing students (who were part of the workplace staffing levels); with the latter group experiencing greater acceptance and inclusion within the workplace (Hyde and Brady, 2002; McGowan, 2005; Joyce, 1999).

In terms of observed culture, the findings from the current study concur with the literature in terms of how niche ‘dark’ humour and banterous joking are ubiquitous elements of the pre-hospital workplace. It is suggested that this expression of behaviour is an acceptable means of coping with stress, and that because a ‘social contract’ needs to exist between sharing members, it also enables a sense of group solidarity and belonging (Charman, 2013, p.157; Scott, 2007). This was reflected within the findings, with most participants relaying that they had been involved with the pre-hospital workplace humour and banter and that it gave them a feeling of acceptance and inclusion. The degree to which students feel included with this facet of ambulance culture could represent a useful indicator for their sense of enculturation and developing professional identity. This is not something which seems to be broadly researched within the healthcare literature, and therefore represents a unique area of observation from the current study.

In addition to the overt conscious cultural alignment expressed by some, all participants demonstrated more subliminal evidence of affiliation through their use of positioning pronouns (such as “we” and “us”) and pre-hospital jargon (such as “truck”) during their interviews. In this respect, it is suggested that language embodies our sense of identity and commitment towards a particular community, and the use of professional jargon is an exclusive symbol of a specialist organisational culture which newcomers learn as part of their developing professional identity (Monrouxe, 2009; Rebrina and Generalova, 2019; Clouder, 2012). The findings in this area suggest that all participants (including one with only five weeks of exposure) felt some degree of professional affiliation and identification with the professional workplace culture. This is not something which seems to have been broadly researched within the healthcare literature, and therefore represents a unique area of observation from the current study.

In terms of group affiliation and cultural immersion, the findings suggest that when experiencing stress, participants would often seek solace with either their student peers or ambulance staff rather than family or friends. This is reflective of the compartmentalisation which has been found to occur amongst qualified ambulance staff who do not wish to ‘burden’ their families with their experiences at work (Clompus and Albarran, 2015, p.5). However, whilst the authors suggest that this ability may be due to formal training and experience, this is less plausible for students who have had limited pre-hospital exposure. The findings of the current study include several instances where participants (some of whom were still in their first year) have felt more able to ‘decompress’ along with ambulance staff after a difficult call. There is also a suggestion that some participants perceive those who are not part of the pre-hospital culture as being different to them; for example, assertions that they are unable to talk to “normal people” about their pre-hospital experiences. Whilst there is some literature relating to how qualified ambulance staff rely upon their professional colleagues to manage stress, there is comparatively little concerning students. This represents a unique area of observation from the current study and a potentially important area for future research. When experiencing stress university student paramedics may thus feel drawn towards the ambulance culture (perhaps at the expense of other support networks), yet because of their student status, they perforce occupy a uniquely peripheral position within the pre-hospital workplace.

The uniqueness of the students’ position (and potential vulnerability) within the pre-hospital workplace is further highlighted by their reliance upon established staff (specifically their assigned mentors) to obtain the required clinical exposure, and to be confirmed as being ‘competent’ in practice. With the ‘Projected’ desire to pass the practice-based elements of their course, the findings suggest that student paramedics may thus consciously or unconsciously adjust their behaviour so as to avoid ‘risk’ in this area and to engender a more favourable impression with those who are perceived as the ‘gatekeepers’ for their success (Capper, 2020). In parallel with the findings, Kramer’s (1974) seminal ‘reality shock model’ explores ‘value capitulation’ amongst neophyte nurses, and Ion *et al.* (2015, p.904) describe how midwifery students in the workplace are sometimes reported to ‘keep a low profile’ so as to maintain good relations with their mentors. There is however limited research which pertains to how healthcare students may adjust their behaviour in accordance with their aim of passing the practice placement elements of their course.

Whilst reliant upon established ambulance staff for their progression during their practice placements, the findings additionally suggest that participants can be selective in deciding which role models and behaviours they intend to emulate when qualified. This accords with Bandura’s (1986) seminal theory concerning how students identify with specific ‘role models’ and may seek to imitate them. However, the findings from the current study additionally support Bucher and Stelling’s (1977) assertion that rather than just one key individual, students tend to admire and adopt traits from a variety of role models. The disparate collection of admired behaviours described within the current study supports Cheetham and Chivers’ (2001) suggestion that students perceive and potentially benefit from learning experiences and approaches to mentorship in different ways. It also supports their assertion that a student’s personality is likely to play an important part in how much they benefit from a particular formative experience. Owing to the distinct ways in which students may perceive and respond to learning experiences, Cheetham and Chivers’ (2001, p.285) highlight the potential impact of unplanned, informal, and unstructured learning events and suggest that educators should avoid being too prescriptive in relation to ‘best practice’ for professional workplace education. This is not something which seems to have been broadly researched within the healthcare literature, and therefore represents a unique area of observation from the current study.

## Suggestions of change

Despite considerable demographic and educational developments over the last two decades, recent studies still report generalised discrimination, sexualised incivility, and harassment directed towards females in the pre-hospital workplace (Baronowski, 2020; Cash *et al*., 2018; Lewis, 2017). The findings of the current study however do not accord with what is more commonly reported. None of the seven female participants within the current study recalled receiving discriminatory or negative comments from ambulance staff based upon their gender. Whilst one participant relayed that she had received a sexually inappropriate comment, this seemed to be recalled because of its uniqueness (although still clearly unacceptable). There were however reports of judgemental attitudes and gender-orientated differences in behaviour from service users. Despite this, the findings from the current study run contrary to the common narrative concerning negativity towards females within the pre-hospital workplace and suggests positive changes may have occurred in this area. This is a potentially unique finding which is important for the professional identity development of female student paramedics in accordance with the acquisition of communal views and behaviours which are thought to be a part of this process (Ewan, 1988, p. 85; Schein, 1978; Higgs, 1993).

A further finding from the current study which does not accord with the broader literature relates to the perceived gender preferences of tutors and students. In this respect, the concept of ‘gender congruence’ and ‘identity-based motivation theory’ suggest that students generally prefer and more readily identify with tutors of the same gender (Oyserman, 2007; Solanki and Xu, 2018). There is some evidence from the current study however which suggests that students may prefer to be taught by a mentor from the opposite gender – and that this preference may also be true from the perspective of the mentors. Whilst such a preference may not necessarily translate to a variance of experience, the ability to identify and be motivated by a tutor is logically an area which has the potential to influence the formation of professional identity and is therefore worthy of further research.

In another interesting departure from what is more commonly reported within the literature, both BME participants within the current study were overwhelmingly positive about their experiences on placement and about how they had been made to feel welcome and included by ambulance staff. One participant additionally conveyed that he was able to occupy a position of responsibility and reliance with ambulance staff from an early stage when they were responded to South Asian service users who did not speak English. He also recounted how he was able to usefully educate ambulance staff about some of the traditions, values, and boundaries within South Asian communities. This particular finding accords with the positive experiences which have been described when BME students are appointed as cultural tutors for established staff as part of a formal reverse mentoring programme (Murphy, 2012; Stephenson, 2016).

Representing a further area of more recent potential change, the findings indicate that ‘smartphone’ technology was widely used by participants to communicate with their student peers. Signifying a fairly recent innovation (certainly in relation to previous generations of learners), the participants’ use of ‘smartphone’ technology and group messaging platforms thus enabled informal group peer support to be almost instantaneous. The immediacy of such a support mechanism, with its potential to include all students, may represent a new dynamic which may not be generally acknowledged or considered by paramedic educators in the current age of personal connectivity. In addition, whilst the benefits of having informal peer support networks in the pre-hospital workplace accords with the literature relating to qualified staff (Clompus and Albaran, 2016), little has been published relating to how students use such networks. The potential benefits (and/or drawbacks) for paramedic students of readily accessible informal peer support from a large group of individuals is an area which is worthy of further research.

## The need for better student preparation

In accordance with the literature (Johnston, 2020; Du Toit, 1995), participants generally had limited prior engagement with the paramedic profession and/or occupational role-modelling from close family. The apparent benefits for those who had some prior relatable healthcare and teamworking experience was also found to accord with the literature (Johnston, 2020; Adams *et al*., 2006), with such participants seemingly able to ingratiate themselves more easily within the pre-hospital workplace. However, with many participants expressing frustration with certain aspects of the paramedic role and with almost all expressing surprise at the living conditions of service users, it seems that as a group, they were generally ill-prepared for the reality of pre-hospital practice.

As all participants had a period of education at university prior to their first practice placement, this misalignment implies a potential dissonance between what is conveyed at university about the reality of practice and may suggest the presence of a ‘hidden curriculum’ (Hafferty, 2015, p.133; Kennedy, 2015). For paramedic science, this ‘hidden curriculum’ is considered to focus upon critical interventions at the expense of the more commonly encountered cases involving mental health and social care (Devenish, 2014). Whilst this may reflect the persistence of older vocational models of education, additional influences are likely to exist for university paramedic educators who are competing for student applications. With cognisance of how a ‘hidden curriculum’ may be more influential than what is overtly taught (Hafferty, 1998; Cant and Higgs, 1999), the findings from the current study support the assertion of Pratt *et al*. (2006) that university educators need to be more aware of what they may be unintentionally conveying to students and potential applicants. As this phenomenon is not isolated to the current study, the findings suggest that there is a need for university paramedic educators to explore the potential existence of a ‘hidden curriculum’ and consider ways in which their students may be better prepared for the reality of practice.

The findings and analysis arising from the current study also accord with the literature in that students who are attuned to the social dynamics of the workplace culture and who are quickly able to learn the ‘social code’ for participation seem to have a more productive and enjoyable experience (Filstad and McManus, 2011). Whilst there is evidence to suggest that more extroverted personalities may be drawn to emergency care (Klee, 2012), the findings from this study suggest that prior working and life experiences may also be less influential. Indeed, with no prior full-time working experience, two of the younger participants still seemed able to successfully navigate the social dynamics of the pre-hospital workplace culture – whereas a slightly older participant, with a couple of years of experience working in the public sector seemed to struggle.

The concept of ‘cognitive flexibility’ may be important in this respect. ‘Cognitive flexibility’ is considered to represent an individual’s social awareness; including their ability to observe, adapt and respond to the ‘relational needs of others’ (Martin and Anderson, 1998, p.4; Spiro and Jehng, 1990). It is also hypothesised to influence how readily a new professional identity is embraced (Martin and Anderson, 1998, p.4; Spiro and Jehng, 1990). Making a similar observation, Filstad and McManus (2011, p.777) suggest that neophyte paramedics would benefit from developmental work which incorporates the navigation of the cultural ‘power relations’ associated with workplace socialisation. ‘Cognitive flexibility’ in terms of workplace socialisation is not something which is routinely included within the general UK university paramedic science curriculum. These findings however suggest that it is something which university educators could consider exploring and including in terms of developmental work and in creating greater social awareness.

Table 11 summarises the original contributions made by the current study to what is known about professional identity development amongst student paramedics:

**Table 11:** Areas of originality and details of contribution

|  |  |
| --- | --- |
| Areas of originality | Details of contribution |
| The use of Heidegger’s philosophy to explore professional identity development | The concepts of ‘Dasein’ and the temporal ‘Care’ structure offer an encompassing and unique phenomenological framework with which to explore how individuals develop their professional identity  It enables an exploration of how individuals ‘become’ something (both consciously and unconsciously), and in this respect goes further than the narrower application of social theory which more commonly exists within the literature |
| An up-to-date exploration of the prehospital workplace from the perspective of student paramedics | The current study represents an up-to-date exploration of the ‘field’ of pre-hospital practice. Prior studies do not seem to fully reflect the professional changes which have occurred over recent years, nor the impact of more graduate paramedics joining the workforce |
| Evidence of positive change towards female staff and students | The findings in this area run contrary to the more common narrative relating to discrimination, bullying and ‘normalised’ sexualised behaviour towards females within the pre-hospital workplace  Contrary to the literature, female students did not report having to adopt more masculine behaviour in order to fit in. These findings could suggest more recent positive change in this area |
| Evidence that paramedic students did not prefer gender congruence with a mentor | The findings in this area run contrary to the more common narrative within the literature. Several participants suggested that they would prefer a mentor from the opposite gender. This highlights an area for further research |
| Evidence of positive change towards students from a BME background | The findings in this area run contrary to the more common narrative within the literature. Participants reported feeling included and part of the workplace ‘family'. This is a finding which could suggest more recent positive change in this area  One participant described how he was able to educate ambulance staff about traditions and boundaries within the South Asian community – and felt more valued because of it. This may have been akin to the concept of reverse mentoring, which could be trialled within UK ambulance services |
| The potential impact of supernumerary status within the workplace | Whilst there is some older literature relating to the experiences of nurses, there is very little which explores the impact of being supernumerary within the pre-hospital workplace. Several participants described how this particular aspect made a difference to their experience. This is a potential area for further research |
| Inclusion with humour and banter | The inclusion of student paramedics with this particular facet of pre-hospital culture may be an indication of their enculturation and sense of acceptance. This is a different application of the existing literature, and a potentially original finding from the current study |
| Use of ambulance staff coping strategies | Participants described how they utilised the informal peer support network of ambulance staff to ‘decompress’ after a stressful call  This is potentially very significant as the findings from this study suggest that student paramedics may avoid sharing their work-related stresses with family members or friends. Due to their student and supernumerary status, they may also not be fully included within these informal support networks by employed staff. This could leave students isolated in terms of their stress management. This is an important area for further research |
| Use of positioning pronouns and jargon | The use of positioning pronouns such as ‘we’ and ‘us’, as well as jargon such as ‘truck’ may suggest a developing perception of professional identification. This has not been fully explored within the professional healthcare literature |
| Use of ‘smart’ phone messaging platforms for peer support | Being able to message student peers within an online ‘group chat’ was described as an important means of support by several participants. This represents an original finding as its potential importance has not been explored within the contemporary professional/healthcare literature |
| Participants were generally unprepared for the pre-hospital workplace | This is suggested by a potential dissonance between university students and service users from lower socio-economic backgrounds. There may also be social differences between university students and the established ‘blue-collar’ workforce  There may also be a ‘hidden curriculum’ during the initial phases of university education which fails to prepare students for the reality of practice. This is an important finding in relation to the education of paramedic students at university |
| Understanding the pre-hospital workplace 'rules of the game’ | Some participants were better able to ‘navigate’ aspects of the pre-hospital workplace culture and enhance their learning experiences. Students may also benefit from developmental work concerning power relations within the workplace and in developing cognitive flexibility  Why some individuals seem better able to integrate themselves within pre-hospital culture has not been explored before within the literature. The application of Heidegger’s (1927) ‘Care’ structure has helped to explore this |
| The value of variety in observing workplace educators | Many participants described important learning experiences which were unscheduled and unplanned. It may benefit students for placement organisers to introduce greater variety in terms of learning experiences and mentorship (as opposed to the more usual allocation of one student to one mentor). This does not seem to have been explored in relation to the pre-hospital environment |

## Limitations

I have identified a number of limitations within the current study.

The purposive sampling technique enabled the selection of a range of participants in accordance with a relatively small sample size (Robson, 2002), and also allowed me to recruit two additional participants when it became apparent that the study was lacking students who were very new to the pre-hospital workplace. However, this technique has been described as ‘highly prone to researcher bias’ (Sharma, 2017, p.751), something which in itself could be considered a limitation. Indeed, whilst I have tried to retain a reflexive and self-critical approach throughout, it is quite possible that I was swayed towards selecting participants who I thought would interview well (potentially making the sample unrepresentative). I was also fortunate in being able to include two participants from a BME background and had a good mix of male and female students from different cohort years. However, I was unable to recruit a participant who was over the age of thirty, nor could I make an effective selection based upon students who have achieved the course entry criteria via different educational routes. Bernard (2002) notes the importance of having participants who are available and willing to participate with purposive sampling, and the potential lack of more mature students from a variety of educational backgrounds could be considered a limitation and a missed opportunity to gather data which might be unique to these groups.

With an intended aim of exploring the development of professional identity, the cross-sectional nature of this study (single interviews with different participants) could also be considered a limitation. A longitudinal approach would have usefully allowed me to explore individual experiences of enculturation over time; however, due to constraints of time and continuing participant accessibility, I did not deem this approach to be feasible.

Whilst each interview included the same series of pre-piloted questions, and it was fully explained to each participant that their responses would be anonymous, I believe it is quite possible that some answers were tailored in accordance with the relationship between themselves as students and myself as one of their educators. Cited by Basit (2010) and Punch (2011), this potential risk to validity includes the possibility that participants may have wished to impress me or give answers that they deem to be more socially acceptable.

A further limitation may also exist in the form of my own potential for bias based upon some extremely poor initial experiences of the pre-hospital workplace, and the advocacy that I feel as an educator towards the students who are becoming enculturated within that environment. Adopting a qualitative approach may also compound the risk of magnifying such bias, as according to Cohen *et al.* (2010, p.495) ‘issues of projection and counter-transference’ mean that any interpretation of qualitative data is likely to be based upon the stance taken by the researcher as much as it reflects reality. Whilst an approach which attempted to objectively ‘bracket’ such bias was considered (based upon the work of phenomenologist Edmund Husserl), I concur with authors who suggest that it is probably impossible to completely transcend researcher bias, and that individual preconceptions should be used as part of the analytical approach and declared to the reader (Matua and Van Der Wal, 2015; Koch, 1995; Finlay, 2008; Humble and Cross, 2010). In accordance with this I have tried to acknowledge my own areas of potential bias throughout the current study and included excerpts from the reflective research journals which were maintained over its duration.

Whilst there are some interesting areas identified within this study which seem to run counter to the more common narratives within the literature, caution must also be exercised with regards to drawing conclusions – especially in relation to the relatively small sample size in each case. Of key significance here are the inclusive recollections of both participants from a BME background, and the lack of discriminatory experiences recounted by all of the female participants. However, whilst it is acknowledged that qualitative data analysis generally reflects an in-depth detailed exploration of the phenomenon and the drawing of logical inference rather than statistical transferability (Basit, 2010), credence may perhaps be given to the findings on the basis that many areas of the current study correlated closely with what is more generally reported within the literature.

The next section focusses upon the recommendations I have made based upon the findings which were analysed within the discussion section.

## Recommendations

### Greater cognisance of a potential ‘hidden curriculum’ by university paramedic educators

With evidence of dissonance between what is conveyed at university and the reality of workplace practice within paramedic science, education providers and employers need to explore the potential presence and impact of a ‘hidden curriculum’. This should be considered in relation to how paramedic science and similar programmes are marketed, taught, and assessed so as to avoid misleading potential applicants and students about the nature of the professional role.

This phenomenon may however encompass a much broader area than can be resolved by the immediate teaching team at university. Indeed, as indicated within the discussion, those responsible for recruitment are likely to experience pressure to secure the maximum amount of income from student fees (Hayton and Tang, 2016; Chitty, 2014) by ensuring that courses are filled to capacity. It also potentially benefits educational staff to have a broader selection of applicants so as to recruit those who may perform better on paper. Of even more salience, is the potential disappointment and cynicism experienced by the students, and the impact this might have upon the profession.

What is within the remit of paramedic educators however, is ensuring that their programmes adhere to the CoP Curriculum Guidance, which offers detailed up-to-date guidance on course content (CoP, 2019). Whilst this is key, perhaps of even greater importance could be the inclusion of both existing and former students, and operational ambulance staff at the design stage of any new course so as to ensure that the realities of contemporary practice are appropriately embedded. The inclusion of students and operational staff within Recruitment/Open Days at university may also help to prevent potential applicants from receiving a false impression about the role.

With regards to placing emphasis upon appropriate taught elements, it will almost certainly be of additional value to make provision for university paramedic educators to experience regular operational shifts within the pre-hospital workplace. Whilst this may sound like an essential and logical element in maintaining clinical currency, there is currently no provision to do this within the local ambulance service (relative to the current study) without a contract which necessitates a weekly commitment of work – a policy which I know from experience excludes most full-time academics.

### The implementation of a reverse mentoring programme within ambulance service organisations

As can be seen within chapter 2 table 2 (p. 51), ambulance services across the UK are currently employing a disproportionately low number of clinical healthcare staff from a BME background. Whilst both BME participants within the current study reported that they had felt welcomed and included by ambulance staff, on a national level, ambulance services are clearly experiencing difficulties in recruitment and/or retention of personnel from BME backgrounds.

A potential reason why Adeeb conveyed such a positive experience within the current study could be that he was in a position to be able to educate ambulance staff about the traditions and boundaries of South Asian service users. His experience resonates with reverse mentoring, which has been introduced within other areas of healthcare, and is believed to increase the social capital of BME staff within the workplace (HEE, 2019; Stephenson, 2016; Murphy, 2012). Whilst this may not automatically lead to an increase in clinical staff, it is perhaps logical to assume that a better experience for existing staff may contribute to increased applications and improved retention. A key recommendation is therefore that ambulance service senior managers should consider introducing their own reverse mentoring programmes in alignment with the ReMEDI project (FFF, 2020).

### Greater cognisance of the importance of informal peer networks and ensuring that no students are excluded

The findings from the current study suggest that informal peer networks are an important means of support for paramedic students on placement. Paramedic educators who have limited experience of ‘smart’ phone social messaging platforms ideally need to become more aware of how they may be used and how vital they can be for students. Whilst it would probably be inappropriate and too time-consuming for a member of academic staff to provide moderation, guidance could perhaps be given to students on how best to implement and use these platforms for informal peer support. In accordance with Dennis (2003), it is important that students try to avoid making unfavourable comparisons between themselves and others within such peer groups, and it is also important that all students have the same opportunity to be included – something which may not occur if they are entirely student led. Indeed, whilst it may not be feasible for them to be directly involved, it should be quite possible for paramedic educators to set out ‘ground rules’ for these groups prior to the students entering placement and to invite appropriately trained student representatives to monitor them.

### Acknowledging the pre-hospital cultural context within the curriculum

Paramedic educators should be cognisant of the learning context characterised by the pervading pre-hospital workplace culture. Whilst there have been some positive changes in this respect since I became a newly qualified paramedic, the findings of the current study suggest that there are still some recognisable and persisting elements of negativity and resistance which mirror Argyris’s (1991) conception of defensive reasoning. Although some participants seemed able to demonstrate a selective ‘authentic’ approbation of this aspect of workplace culture, educators should be aware of how inescapable these ‘inauthentic’ perceptions may be to many students in accordance with Heidegger’s (1927) philosophy.

Some authors suggest that neophyte paramedics could benefit from developmental work which supports their understanding of power relations within the workplace (Filstad and McManus, 2011), and others infer that ‘cognitive flexibility’ may also be of benefit (Martin and Anderson, 1998, p.4; Spiro and Jehng, 1990). In alignment with these suggestions, prior to their first practice placement, some form of educational input surrounding socialisation within the pre-hospital workplace is likely to be of benefit for paramedic students. With appropriate support from educators, this could perhaps be led by existing students.

### The value of observing alternative learning environments and role-models

Educators and placement coordinators need to be aware that owing to their very ‘Thrownness’, students will benefit (or not) in disparate ways from their exposure to different practice learning environments and different potential role-models. This selectivity was found within the current study, and it was interesting to note that beyond their assigned mentor, participants observed and learned from a variety of ambulance staff and other healthcare professionals. Remembered behaviours ranged from a paramedic demonstrating calmness at the scene of a chaotic and traumatic road traffic collision, to a doctor showing kindness to a service user amidst a busy emergency department.

These findings suggest that in accordance with Bucher and Stelling (1977), educators should be cognisant that students will create their own schemata of professional identity through adopting facets of behaviour from different individuals under different circumstances. Beyond the essential programme requirements, educators should therefore avoid being overly prescriptive in relation to how and where they think students will have what they consider to be beneficial clinical exposure. The findings also suggest that the traditional model of mentorship for paramedic students (having one assigned mentor for a set number of months) should be revisited.

## Recommendations for further research

### Further research into the findings relating to positive change for student paramedics and staff from BME backgrounds

The experiences of the two participants from a BME background within the current study run counter to the more common narrative of discrimination and isolation within the literature. I have suggested that this could represent a more recent positive change in this area. In this respect however, whilst some of the cited sources are fairly old (Gardner, 2005), others are much more recent (Bandali, 2020, Hammond *et al.,* 2019), and certainly the WRES (2021) data suggests that even in 2020 UK ambulance services were struggling to recruit and/or retain staff from a BME background.

It could be that the findings from the current study may represent an anomaly or could be inaccurate for a variety of reasons. It could be that one participant was still enjoying Kramer’s (1974) ‘honeymoon period’, whilst another was unknowingly benefitting from a reverse mentoring experience. Further research in this area would be extremely valuable in order to explore whether there have in fact been recent positive changes within the pre-hospital workplace.

### Further research into the findings relating to positive change for Female students/paramedics

The experiences of all seven female participants within this study run counter to the more common narrative concerning gender discrimination, incivility, and sexualised behaviour within the pre-hospital workplace. I have again suggested that this could represent a more recent positive change in this area. However, some of the sources citing such behaviour are themselves fairly recent (Baronowski, 2020; Lewis *et al.*, 2019); although more recent change certainly seems to be apparent in that the proportion of female employees within UK ambulance services is more representative at 45.4% (GOV.UK, 2020).

It could again be that the findings from the current study represent an anomaly or are simply inaccurate. Indeed, one participant did disclose how she had received an inappropriate sexual comment from a male member of staff, and it is possible that this was only a glimpse of more prevalent behaviour. Despite my efforts to reduce potential bias through placing them at ease and allowing each participant freedom to speak, it is quite feasible that the female participants were unwilling to disclose their experiences to a male researcher. Further research in this area would therefore be valuable in order to explore whether these findings are an anomaly, or whether there have been more positive changes which are not yet broadly reflected within the literature.

### Mentors as ‘socialisation agents’ and gender congruence

Further research into the potential pairing of students with mentors would be beneficial. The importance of sponsorship from a ‘socialisation agent’ is reflected within the literature and supported by social theory (van der Gaag *et al*., 2017; Devenish, 2014; Lave and Wenger, 1991). Whilst all participants within this study had an assigned mentor who was ideally placed to play this role, their experiences of social inclusion had considerable variation. In this respect, personality pairings may be an important area for further research as some participants were critical of a particular mentoring style, whilst others approved of the same approach. Indeed, Cheetham and Chivers (2001) suggest that benefitting from a particular formative experience may be influenced by the personality of the learner.

Additionally, the theoretical benefits of gender congruence between tutors and learners cited by Solanki and Xu (2018) and Oyserman (2007) were not supported within this study. The findings from the current study suggest that students may actually prefer to be taught by a mentor from the opposite gender, and that this preference may also be true for some mentors. Whilst this could again be an anomaly or a symptom of an unexplored deeper issue, this area is worthy of further research. Identifying and being motivated by a tutor is something which has the potential to influence both learning and the formation of professional identity.

### Acknowledging the unique position occupied by university paramedic students within the prehospital workplace in relation to their management of stress

Reflecting the experiences of a previous generation of nursing students, the findings of the current study suggest that the supernumerary (and non-employed) status of university paramedic students in the pre-hospital working environment places them in a unique position in terms of enculturation and the development of their professional identity (Hyde and Brady, 2002; McGowan, 2005; Joyce, 1999). In alignment with this, university paramedic educators need to ensure that they appropriately prepare students in relation to how their supernumerary status may impede some aspects of their inclusion within the workplace, and that comparisons with employed students will almost always be unfair and likely to cause disenchantment.

The findings of the current study suggest that this potential isolation may be even more important in relation to the management of pre-hospital workplace stress. In this respect it seems as though paramedic students may compartmentalise events that they have found stressful in a similar manner to ambulance staff; through avoiding discussing unpleasant experiences with family and ‘outside’ friends (Clompus and Albarran, 2016; Mildenhall, 2012). Several participants instead relayed how they had used the company of ambulance staff to enjoy some inclusive banter, have a joke, and destress after witnessing something traumatic or upsetting. Whilst this mirrors the coping strategies of ambulance staff, problems may arise in that due to their supernumerary status, university students perforce occupy a peripheral position within the pre-hospital workplace and may not always have access to the same informal support networks.

University educators must ensure that the workplace stress which may be experienced by supernumerary student paramedics is being appropriately managed and must not assume that they will have the access to the informal networks which may be afforded to ambulance staff. Further research into how student paramedics manage their workplace stress levels is needed, and alternatives explored should they be unable to access the informal coping strategies of ambulance staff.

## Transferability

The findings and recommendations from the current study may have relevance for other professional groups which have educational and working similarities. In terms of healthcare, phenomenology is frequently used as an interpretive framework by nursing educators (Felsted and Springett, 2015; Kelly and McAllister, 2013; Humble and Cross, 2010; Gardner, 2005), and as such, this unique application of Heidegger’s (1927) philosophy may be a useful tool for future research. In addition, the nursing profession shares many similarities with paramedicine in terms of their interactions with service users and university requirements. For example, in parallel with participants within the current study, university nursing students are expected to be supernumerary when learning within the workplace (NMC, 2019). This potentially raises the same issues which have been highlighted pertaining to social inclusion and stress management.

With an acknowledged ‘camaraderie of exposure’, the UK police also has many professional and educational similarities with paramedicine (Charman, 2015). Both professional groups have thus experienced occupational changes in terms of a reduction in acute emergency work, the devolvement of their traditional ‘command and control’ structures, a rise in overall demand, and the need to develop new skill sets for a workload involving a greater emphasis upon aspects of social care. Within both professions, there seems to be a similar perception of nostalgia and loss, with many established ‘older’ generation employees feeling side-lined by the requirement to now have a university degree (Martin, 2021; McCann and Granter, 2019; Reed, 2018; Sausdal, 2018; Charman, 2015). With such areas of workplace similarity, it is likely that university policing students will experience comparable challenges to university paramedic students. For example, with the same organisational pressures upon them, it is quite possible that university police educators may inadvertently foster a hidden curriculum which potentially fails to properly prepare students for the reality of the workplace. Ensuring appropriate preparation may be similarly important for policing students as there is likely to be the same potential for social dissonance between themselves and their service users (Cox and Kirby, 2017).

## Concluding commentary

Within the current study I have sought to explore the enculturation and professional identity development of twelve university paramedic students within the pre-hospital practice environment. I have used the philosophy of seminal phenomenologist Martin Heidegger (1927) to explore how notions of ‘self-identity’ may be influenced by an individual’s past, their ‘inauthentic’ relationship with the present, and their projected future aspirations. In accordance with the research question, the use of this analytical framework has allowed me to explore how notions of ‘self’ and identity within the pre-hospital workplace may be unconsciously formed under certain circumstances and more subject to conscious negotiation at others. In order to inform the reader of my own potential (conscious and unconscious) bias, I have also sought to include some of my own experiences and perspectives of pre-hospital professional practice and of paramedic education.

The findings of this study have supported much of what has been previously suggested within the literature concerning the professional identity development of healthcare students, although there are some significant and interesting areas of deviation which are of potential importance for paramedic educators and employers. These areas underpin my recommendations which may help to inform local educator and employer policy - such as the probable presence of a ‘hidden curriculum’ and the potential benefits of a BME reverse mentoring programme within paramedic practice. The findings have also allowed me to suggest some potentially important areas of further research – such as the need for an up-to-date exploration of the experiences of BME and female students in the pre-hospital workplace.

From here, I will seek to disseminate the key findings at conferences (such as those regularly organised by the College of Paramedics) and aim to have them published within profession-specific and educationally orientated journals. I also intend to undertake further research in some of the key areas I have suggested. Indeed, at the time of writing, I am involved in designing a study seeking to explore the experiences of newly qualified BME paramedics which will be jointly undertaken between my HEI employer and the local Ambulance Trust.

From my own perspective, the findings of this study suggest that the experiences of newcomers to the pre-hospital workplace seem to have broadly improved since my own initiation to that environment over twenty-five years ago. Whilst there are areas of improvement, certain cultural characteristics also seem to have persisted. These include the ubiquitous use of banter and ‘dark’ humour, as well as a sense of antipathy towards the role sometimes demonstrated by more experienced staff. However, as a senior paramedic educator, I am in an ideal position to contribute to conversations regarding local educational provision and its orientation towards further improving the student experience during their pre-hospital placements

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## Appendix 1

Specific ‘unpacking’ questions which explore the general areas of interest include:

* *How does an experienced professional/mentor affect the ‘ease of transition’ and the development of professional identity?*
* *Do students wish they could be ‘more like’ any particular individual(s) in the professional workplace? Why?*
* *How do local employer policies and national guidelines/regulations affect students’ developing views and experiences whilst on placement?*
* *In terms of educational processes, how well does the university and the practice placement environment facilitate the enculturation of students?*
* *Is there a relationship between family income, schooling and/or prior work experience and how easy students find it to ‘fit in’ to an ‘emerging’ ‘blue collar’ professional environment?*

I believe that these questions accord with Punch (2010) in terms of providing a foundation for the finalised questions, which were themselves further refined after a pilot study and following a review forum comprising of doctoral student peers and a research supervisor.

## Appendix 2

Finalised questions which were asked of participants:

|  |  |
| --- | --- |
| Question no | Question details |
| 1 | What influenced you to become a paramedic? |
| 2 | Please describe how you were introduced you to the workplace. Were you made to feel like part of the ‘team’? |
| 3 | Were you surprised by the workplace culture during your initial practice placement? |
| 4 | During your early introduction to the workplace, do you recall any particular conversations or situations involving experienced members of staff? |
| 5 | Do you think you have adopted any of the views of the paramedics on placement? |
| 6 | Have you been invited out on any social events? |
| 7 | Can you tell me about a paramedic or other person you have met on placement that you particularly admire or respect? |
| 8 | What is it about them that you admire or respect and do you want to be like them when you are qualified? |
| 9 | Did you find that you could chat easily with the paramedics you met on placement and that you had ‘common ground’? |
| 10 | Do you think your age, gender, or your ethnicity may have made a difference to your placement experience? |
| 11 | Did you at any time have your ‘leg pulled’ in relation to your background, your accent or your prior life experience? Did you find this off-putting or upsetting? |
| 12 | Please describe what placement preparation you had. Do you feel it was adequate? |
| 13 | Please tell me about how well supported you felt by the university whilst on placement. Could more be done? |
| 14 | Have found the support of other students helpful whilst on placement? |
| 15 | Do you find sufficient time to reflect whilst on station? |
| 16 | Do you believe that the pressures of work affect the attitude of experienced staff and your learning experiences? |
| 17 | Have you witnessed any coping strategies on placement – such as ‘work to rule’, go-slows’ etc? |
| 18 | Do you see yourself more as a member of staff whilst out on station, or as more of a student? |
| 19 | Are you generally surprised by the conditions that some service-users/patient’s live in? |
| 20 | Have you changed your views of service-users/patients in general since commencing practice placements? |

## Appendix 3

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## Appendix 4

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## Appendix 5

Text, letter

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## Appendix 6

**Participant Information Sheet**

**Title of Research Project:**

* **How are paramedic student notions of ‘self-identity’ formed/negotiated as part of the enculturation process within professional clinical practice?**

You are invited to take part in the above research study. Before you decide whether or not you are happy to take part, it is important that you understand what the project is about, why you have been invited to take part, and exactly what is involved. Please take the time to read the following information carefully.

**What is the project about?**

The aim of this research study is to explore how university-based paramedic students develop and negotiate their budding sense of professional identity.

There are some specific areas that I would like to explore. These include the influence of the clinical practice environment (including regulatory structures, social structures, and experienced members of the workforce); how your own social and family background might play a part in how easy or difficult this process may be; and the role played by the university in facilitating the process of professional enculturation.

This project is ultimately intended to make recommendations for the ways in which university-based paramedic students are prepared and supported for the clinical practice area (and for their eventual careers as paramedics).

**Why have I been invited to take part?**

You have been invited to take part because you are enrolled upon a university-based paramedic science course and have experience of the relevant clinical practice placement area.

**What does it involve?**

Taking part would involve being invited to engage in a face-to-face interview with the researcher. The interview will last for approximately 60 minutes and will take place on the Coventry University Campus site at a time and location that is convenient for you.

**Are there any risks or benefits?**

Whilst it is possible that participation may cause stress or anxiety in some individuals, there are no intended or foreseen personal risks or disadvantages involved in taking part in this research project. Although you will be talking about your experiences as a paramedic student, this research has nothing to do with your progress on the course. If you decide to go ahead, you will be asked to sign a consent form to make sure that you fully understand what you are agreeing to. The research has been approved by the University Ethics Committee at both Staffordshire University and Coventry University.

There are no personal benefits for the people who take part, but any knowledge that is gained as a result of the research will eventually be made available to the relevant teaching teams within the School of Health and Social Care. This will be so that we can consider how things might be done differently in the future in order to improve the experience of students in future academic years.

Your participation is completely voluntary. If you change your mind at any point, you can withdraw at any time up to the point at which the data becomes aggregated for analysis purposes and you don’t have to give a reason for doing so. If there are any questions in the interview that you would prefer not to answer, you do not have to answer them.

If you experience any adverse effects either during or after your participation in the project, the lead researcher will be more than happy to take time to support you; or if you would prefer, you will be welcome to contact the CU Counselling and Coaching Service.

Lead researcher contact details:

Mark Garratt

024 7765 5369

[aa3136@coventry.ac.uk](mailto:aa3136@coventry.ac.uk)

CU Counselling and Coaching Service contact details:

024 7765 8029

[counsell.ss@coventry.ac.uk](mailto:counsell.ss@coventry.ac.uk)

**Will I be identified in the report?**

No. None of the information that you provide will identify you, or be attributed directly to you in the final report. The anonymity of everyone who takes part will be protected in the final document.

Any personal information that you provide will be confidential and accessed only by the researcher. Transcripts of the interviews will be stored securely whilst the research is being undertaken, and will be destroyed in accordance with University and Faculty procedures that are in force when the project is completed.

**‘General Data Protection Regulation 2016 (GDPR)’**

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR). The data controller for this project will be Staffordshire University. The University will process your personal data for the purpose of the research outlined in this information sheet. The legal basis for processing your personal data for research purposes under GDPR is a ‘task in the public interest’. You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you. You have the right to access information held about you. Your right of access can be exercised in accordance with the GDPR. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer. If you wish to lodge a complaint with the Information Commissioner’s Office, please visit www.ico.org.uk.

**FOR FURTHER INFORMATION**

This research is being undertaken for the purpose of completing a dissertation for a professional Doctorate in Education at Staffordshire University – although the research itself will take place solely on the Coventry University campus site. If you have any queries or questions related to this research, please contact me on 02477655369 or by email at [aa3136@coventry.ac.uk](mailto:aa3136@coventry.ac.uk). If you have any concerns about this research, please feel free to contact my supervisor, Dr. Gill Forrester. Her email address is [Gillian.Forrester@staffs.ac.uk](mailto:Gillian.Forrester%40staffs.ac.uk). If you would like to receive a copy of the preliminary interview questions, please leave an email address on the space provided on the Consent Form.

Thank you for taking the time to read this information sheet.

## Appendix 7

Participant consent form:



**Participant Consent Form**

**Project Title**:

*How are paramedic student notions of ‘self-identity’ formed/negotiated as part of the enculturation process within professional clinical practice?*

Please read each statement, and tick the box next to it to indicate that you are in agreement with the statements

|  |  |
| --- | --- |
| I have read the participant information sheet and the nature and purpose of this research has been explained to me. | □ |
| I have read the information sheet regarding the General Data Protection Regulation 2016 (GDPR) and I give my consent for my data to be processed in accordance with the GDPR. | □ |
| I understand that my participation in this project is voluntary, and that if I change my mind, I can withdraw up until the data has been aggregated for analysis purposes. I can do this without prejudice and without giving a reason. | □ |
| I understand that I do not have to answer every question if I do not wish to and I don’t have to give any explanation. | □ |
| I understand that confidentiality will be maintained throughout this project, and that I will not be identified in the final report. | □ |
| I confirm that quotations may be used in the report, provided that the quotations are anonymised and do not reveal my identity. | □ |
| I understand that the information I provide may be potentially used (anonymously) in teaching, research publications, conferences and other formal research outputs. | □ |
| I confirm I have been given the opportunity to ask questions about the project and my participation in it. | □ |
| I understand that my data will be securely stored in accordance with Staffordshire University protocols and current data protection guidelines. | □ |
| I confirm that I agree to take part in this research project. | □ |
| I agree that any interview that I take part in may be audio recorded | □ |

|  |  |
| --- | --- |
| Should I wish to receive a copy of a summary of the study findings I will provide my contact email in the address box below | |
| **Participant Name** (please print) |  |
| **Signature** |  |
| **Date** |  |
| **Researcher Name** | Mark Garratt |

## Appendix 8

Graphical user interface, text, application

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## Appendix 9

Graphical user interface

Description automatically generated with medium confidenceAn example of an NVivo 12 memo for the current study:

## Appendix 10

Graphical user interface, table

Description automatically generatedAn example of the NVivo 12 coding structure used for the current study:

## Appendix 11

Graphical user interface, text, application, email

Description automatically generatedAn example from the ‘Being equipped for the context of work’ pattern code:

## Appendix 12

An excerpt from my NVivo 12 analysis journal containing an example of how codes were derived from the data:

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