‘One of Us’ – The Values and Beliefs that Underpin a Paramedic Internship

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GLOSSARY OF TERMS AND ABBREVIATIONS USED THROUGHOUT THIS THESIS

Value	A value is "a broad tendency to prefer certain states of affairs over others" (Hofstede 2001 pg 5).
Belief	A belief is an individuals' enduring interpretations and application of a value they hold to be true (Hofstede 2001).
Culture	Culture is "the collective programming of the mind which distinguishes the members of one organisation from another" (Hofstede cited in Waisfisz, Minkov et al. (2015 pg 6)
Attitude	A settled way of thinking or feeling about someone or something, typically one that is reflected in a person's behaviour
Behaviour	The way in which one acts or conducts oneself, especially toward others
Mental Program	"A person's behaviour, to some extent, can be predicted and is specific to a particular situation and person" (Hofstede (2001 pg 1)
Crew	Operational ambulance officers/paramedic/ICPs that staff an ambulance (generally in pairs)
Ambulance Officer	Operational staff that hold at minimum a Cert IV level of training (Note: there may be minor differences between state definition, this is the term and definition used in the context of this study)
Paramedic	Operational staff that hold at minimum an undergraduate degree level of education. (Note: there may be minor differences between state definition, this is the term and definition used in the context of this study)
ICP	Intensive Care Paramedic (see Chapter 3 – Clinical Levels for more information which are state specific)
ECP	Extended Care Paramedic (see Chapter 3 – Clinical Levels for more information which are state specific)
Station	Facility that ambulances are based when not being tasked to jobs
Non-Operational	Staff of the Ambulance Service that do not work at a service delivery clinical level. They include administration, payroll, human resources, etc.

Operational	Staff of the Ambulance Service that work at a service delivery clinical level. They include paramedics, ambulance officers, ICPs.
Tasked/Dispatched	When an ambulance has been assigned a job
Road Ready	Normally assigned to paramedic interns, meaning they are competent, fit into the organisation and have the tacit operational ability unique to the ambulance profession.
Job	An emergency event that requires the attendance of the ambulance service
Load and Go	Phrase to describe the provision of minimal clinical treatment to the patient. Place the patient in the ambulance and rush to hospital.
Stay and Play	Phrase to describe the provision of maximal clinical treatment of the patient. Take time to stabilize the patient and then transport the patient to hospital.
Region	A geographical region that includes multiple suburbs/towns and ambulance stations.
AOTS	Ambulance Officer Training School
MICA	Mobile Intensive Care Ambulance (state specific terminology generally reserved for Ambulance Victoria's ICPs)
PICER	Paramedic Intern Clinical Evaluation Reports
ISTO	In Service Training Officer
VET	Vocation Educational and Training
VASA	Victorian Ambulance Services Association
AOTAC	Ambulance Officers Training Advisory Committee
TAFE	Technical and Further Education
AV	Ambulance Victoria
TPPP	Transition to Professional Practice Program
CAA	Council of Ambulance Authorities
CPG	Clinical Practice Guidelines
PIDT	Paramedic Intern Development Team
OSCE	Objective Structured Clinical Examinations

SUMMARY

In Australia, each state-based ambulance service has its own internship programme, therefore if a paramedic moves interstate they are required to redo an internship. Given there is no difference in the role undertaken, there is neither an educational rationale nor a difference in the prevalence or sorts of illness/injury to explain this. As paramedics continue to enhance their professional status, cross state or cross jurisdiction recognition is important. One step would be to simply abolish this duplication of internship training, but such steps are risky without a good prior understanding of the reasons behind the system. The objective of this study is therefore to explore the values and beliefs that underpin the expectation of state-based internship from the perspective of organisational and national culture.

Semi-structured interviews were conducted with six major stakeholders of an internship within one state, including managers (operational/general) and ambulance education staff. The interviews were audio-recorded and transcribed. The transcripts were analysed using an interpretative framework by Hofstede and Waisfisz to understand the organisational and national culture.

Eight core themes were identified, layered according to the people that hold the greatest influence over the theme and discussed using the study's interpretative framework (cultural dimensions). These core themes describe the concerns respondents held over elements around the paramedic internship, which include the structure, content, quality, attitudes, behaviours and the profession. It is clear that the paramedic internship is deemed necessary to ensure a paramedic can successfully navigate between competing demands of each dimension. It is to ensure a paramedic can fit into the paramedic culture and is accepted into the organisation. For the organisation to be able to be confident that such enculturation has been achieved, a prolonged observation period of each individual is achieved via the paramedic internship.

Understanding dominant cultural insights of the ambulance organisation allows the interpretation of the results into a meaningful picture. Cultural insights include the balance between risk aversion (policy/procedure) versus risk taking (the unknown work environment); structure (militaristic) versus independence (autonomy); hierarchical power relationship and competency power relationship, and finally indulgence (socialisation for organisational acceptance) versus restraint (becoming a professional).

Internships primarily consolidate knowledge and enable the development of clinical competence, however they also serve a role as an induction into the local organisation and culture. Whilst it is recognised that paramedics who have completed an internship will be competent to practice safely, there remains values and beliefs around the need for local enculturation, for managers and peers to have confidence in their work abilities. A pragmatic solution, for example mandated national

registration, is likely to be ineffective because it does not address the importance of the acceptance of each other's organisational culture. Addressing the issues of confidence and the need for local induction are key issues for the profession to address to enable national recognition of internship training, leading to national registration.

DECLARATION

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed...

Date...

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1. INTRODUCTION

Paramedics in Australian cannot move employment from one state to another state without undertaking further training and assessment in their new state. Each state's paramedic internship program holds no national accreditation standard and is not recognised by other states. This is illogical because paramedic undergraduate training, the job role, base guidelines and practices are the same between states. Other health professionals like nursing, medicine and midwifery are recognised by a national registration system which allows them to move freely from state to state. National paramedic registration is scheduled for September 2018 through the Australian Health Practitioner Regulation Agency (AHPRA) (Paramedics Australia 2016). Currently, a lack of national recognition has generated issues for the paramedic workforce across Australia, including transportability of the paramedic workforce between states (The Council of Ambulance Authorities Inc 2011). Between 2006 and 2011 there was a 31% growth of paramedic employment which was driven by a 37% growth in demand for ambulance services (Paramedics Australia 2012). However, on average across Australia, only 6% of paramedics had moved across states and territory boundaries in the five years prior to the 2011 census (Paramedics Australia 2012). This suggests that although there is a large growth of paramedic numbers across Australia, most of the recruitment is from intra-state via the paramedic internship. This low percentage of interstate recruitment of qualified paramedics compared to that of growth in paramedic numbers requires further questioning. It is plausible that interstate recruitment is hindered as paramedic training is not nationally recognised, and they would be required to undertake further training and assessment in their new state.

In Australia there has been little attention paid to reform of the pre-hospital care environment. Currently, there is no government driven strategic national approach in place for the development of ambulance services and the paramedic workforce (Joyce, Wainer et al. 2009)..As a result there is a disequilibrium of graduates from university paramedic degree programs and the number of intern places within the ambulance service. Therefore, this limits interstate recruitment as interstate qualified paramedics are in competition with the oversupply of university graduates for the limited intern places. In the event of significant national paramedic workforce shortages, interstate recruitment of qualified paramedics would be highly desirable as it takes, on average, 12 months to complete an internship. However as the paramedic internship is not recognised across state borders, the reliance is placed back onto the ambulance organisation to increase intern numbers. . The simple solution to address acute shortages of the paramedic workforce would be the national recognition of the internship, which would result in interstate recruitment being void of the need to redo an internship.

South Australian Ambulance Service (SAAS) is the state government administered state-wide ambulance service providing emergency services, aeromedical services and out-of-hospital patient

care to the population of South Australia. Only 7% of the total Australian population resides in South Australia, (Australian Bureau of Statistics 2016), inhabiting 12.7% of the land mass of Australia (Geoscience Australia 2016). In 2011, SAAS held 8% of the national paramedic workforce which had grown 35% over the preceding 5 years (Paramedics Australia 2012). Currently, in 2016, there is only one tertiary education provider based in South Australian that delivers a Council of Ambulance Authorities accredited paramedic degree program (Council of Ambulance Authorities 2016).

In contrast, Ambulance Victoria is the state government administered state-wide ambulance service to Victoria. In Victoria, 25% of the total Australia population resides in the state (Australian Bureau of Statistics 2016), inhabiting 3% of the land mass (Geoscience Australia 2016). In 2011 Ambulance Victoria held 27% of the national paramedic workforce which had grown 36% over the proceeding 5 years (Paramedics Australia 2012). Currently, in 2016, there are five tertiary education providers based in Victoria that deliver a Council of Ambulance Authorities accredited paramedic degree program (Council of Ambulance Authorities 2016).

The above illustrates the large growth of the paramedic workforce within SAAS (a 35% increase in 5 years) whilst employing 8% of the total national paramedic workforce and having only one state-based tertiary education provider. This means SAAS would be in a vulnerable position if there were a rapid surge in ambulance service demand (growth), requiring more paramedics (% of national workforce) while there is only one tertiary provider. As a result, SAAS would be an organisation highly likely to recruit interstate. Therefore, understanding the barriers to cross state paramedic portability is highly valuable to SAAS. The obvious solution would be to simply abolish the state-based internship system in attempt to remove barriers of interstate recruitment, but such steps are risky without a good prior understanding of the reasons behind the system. One way of looking at this is from the perspective of organisational and national culture to gain a better understanding of the values and beliefs that underpin a state-based internship.

Historically Australia's ambulance services have been largely independent of one another. Australia has six states and two territories, each with its own state-based ambulance service. Currently in 2016, each ambulance service is administered by either state or territory government or a private organisation, the St John Ambulance Service. As each state is independent from the others, the organisational cultures and delivery models differ. The organisational cultures in these various ambulance services have developed over 100 years within each single state-based organisation. National collaboration and leadership through the Council of Ambulance Authorities, and a strong representation of the ambulance workforce through the professional body, Paramedics Australasia, has seen the professional landscape change drastically over the past 20 years. This is crucial for the argument presented in this thesis, as a current agenda item for Paramedics Australia is the national regulation and registration of the paramedic workforce.

Exploration of the values and beliefs that underpin a paramedic internship will enable us to better understand the importance of a local internship. This understanding will be valuable to paramedics and ambulance organisations, and in particular, to the one being focused on in this study (SAAS) and for informing the current argument towards national registration. But first, understanding the background of paramedics in Australia will provide insight into the differences between these states to help inform our research question. The aim of this study is to explore the values and beliefs that underpin the expectation of state-based internship from the perspective of organisational and national culture using semi-structured interviews with various highly-informed stakeholders.

It is important that researchers consider their role in a study as a component of reflexivity. I am a paramedic, having undertaken a Bachelor of Health Science (Paramedic) from 2007 until 2009. Upon the completion of the paramedic internship I gained an interest in clinical education and commenced study of the Graduate Diploma in Clinical Education at Flinders University. During this time, I held an active role in SA Ambulance Service Clinical Education Unit facilitating workshops for paramedic interns, delivering ambulance officer vocation qualification, being a part of the paramedic internship review committee and assisting the development of the Graduate Diploma in Intensive Care Paramedicine (Flinders University). At that time, there was very little research into paramedicine in Australia and I experienced a poor level of understanding behind the methodology of paramedic education, at the ambulance organisation level. The prompted the commencement of this study. The study commenced in 2013 during my employment with SA Ambulance Service as a Paramedic.

During the time of this study, I continued my employment as a paramedic and held no role in the design, development and delivery of the paramedic internship. The participants were selected for the interviews by a manager with overarching insight into education in SAAS. I held no hierarchical control or influence over their job role, and only held a professional relationship with them. This was to assist in having honest and open conversations surrounding aspects of the paramedic internship during data collection and analysis. Data was transcribed from these interviews and I, as the primary researcher, used different methods to code and analyse this data. I do acknowledge that my position and experience within SAAS could colour the lens of my interpretation of this data. However, it is important to understand the setting and context of this study, so that the results are interpreted in a meaningful way. My position in SAAS and my experience allows this to occur. Furthermore I have used multiple layers of rigour in an attempt to offset any amount of bias that could have been potentially introduced into the study. What follows below is my interpretation of the interviews of the key stakeholders on aspects of the paramedic internship through the lens of my interpretative framework.

Chapter one will explore the history of paramedicine in Australia with specific reference to ambulance officer education. Here, the transition from internal education to university education for paramedics is detailed. Following this, linking university knowledge to professional practice is examined specific to the paramedic context with the known literature from workplace based education, competency and comparing other transition to professional practice programs, like nursing and medicine. Chapter two will outline the organisation used as the setting for this study, South Australian Ambulance Service (SAAS). This chapter not only includes background information on SAASs' organisation and clinical level, but also includes the details of the paramedic internship. Chapter three is entitled 'cultural lens' and frames the interpretative framework used for this study which is derived from Hofstede's (Hofstede 2001) work into national culture and Waisfisz, Minkov et al.'s (Waisfisz, Minkov et al. 2015) work into organisational culture. Chapter four outlines the studies methods to answer the research question through the lens of the studies' interpretative framework.. Chapter five explores the study's findings by highlighting the themes that were derived from the data collection. Lastly, the discussion takes place in chapter six to create a meaningful picture of the findings which leads to the final conclusions to summarise what has been learnt from this study.

2. BACKGROUND

Introduction

The paramedic internship is unique but not well understood. To understand it better, this chapter will describe the historical origins of ambulance services within Australia, in particular comparing the professional journey of ambulance officers to nursing. Further to this, it will describe the embedment of educational ideology and organisational culture within a paramedic internship. This chapter will also highlight key concepts which have hindered the growth of the paramedic profession to uncover how paramedicine has evolved to what it is today.

The History of Paramedic Education in Australia

Only a limited literature exists on the history of paramedic education within Australia, therefore a well-documented account of Ambulance Victoria's educational pathways by Sally Wilde (1999) – 'From Driver to Paramedic: The history of the training of ambulance officers in Victoria' is heavily drawn upon for within this chapter.

Origins of Ambulance Services

The concept of an ambulance service can be dated back to the siege of Malaga in 1487, where Queen Isabella of Spain introduced mobile military hospitals to assist the injured away from the front line to receive medical care (Wilde 1999). The term ambulance is derived from ambulare (Latin: to walk). The injured were transported back to a military hospital by stretcher barers on foot and later in horse-drawn carts staffed by surgeons. Rapid transport of injured soldiers to military hospitals was shown to have increased rates of survival (Wilde 1999). A civilian model of an ambulance service was developed from this military model, of which the foundations were heavily embedded with a strong militaristic ideological culture. The militaristic ideological culture includes authoritarianism, structure and control via regiment and rank, rapid transport of the sick, and a masculine and male exclusive workplace.

It is important to briefly discuss the origins of our state-based ambulance services in Australia, as this will establish the deeply-embedded origins of each service across the nation. Australia is a relatively new nation (early- to mid-1800s) with vast distances between capital cities (Wilde 1999). These distances hampered the spread and growth of new ideas and concepts about ambulance service delivery. Ambulance service delivery was based on community needs and was demand-driven by the increasing access to healthcare facilities provided by extended road and rail networks. The delivery model used for ambulance services in Australia in the late 1800s was heavily influenced by the Order of St John from England. The St John Ambulance Brigade was formed in England in 1882 and, up until the present day, leads the provision of ambulance services

in many countries (Howie-Willis 1985). By the early 20th century, most countries had their own ambulance service providers which included fire brigades, police departments, funeral directors, volunteers, and even private companies (Wilde 1999).

Ambulance services in Australia developed in each state with their own service delivery model. This was basically an inward-looking focus on the local context for only local needs. Additionally, with limited contact and communication with other services around Australia, and the world, this approach was seen as 'best practice' for this period. The following is a brief summary of the beginnings of each state's ambulance services, and the ambulance models which they used.

- In Victoria, the St John Ambulance Association was formed in 1883 (Wilde 1999). Local divisions were based in local hospitals and consisted of a mix of paid and volunteer staff. Then in 1916, the Victorian Civil Ambulance Service (VCAS) was formed. The service delivery model in Victoria was known at that time as the classical model, as it was seen as the first ambulance service model in Australia, and the state lead the nation in the delivery of ambulance services(Wilde 1999). Within this model, St John first-aid training programs led to the staffing of local ambulance units which set the Victorian ambulance service model apart from the other states.
- The City Ambulance Transport Brigade in Queensland was founded in 1892 and operated under the auspices of the Queensland state government (Wilde 1999). The St John Ambulance Association was set up in 1908 and operated as an independent division of the organisation. The overarching control of the Queensland Ambulance Transport Brigade and the St John Ambulance Association by the Queensland state government was known as the federal model of ambulance service (O'Meara and Grbich 2009).
- The Civil Ambulance and Transport Brigade of NSW began in Sydney in 1895 and operated side-by-side with the St John Ambulance Brigade (Wilde 1999). This ambulance service was delivered in different ways by a range of different groups (St John, the hospitals, and Community Ambulance Brigades), and was known as the decentralised model (O'Meara and Grbich 2009). In 1919, the state government passed the Ambulance Transport Service Bill which governed the overall direction and provision of ambulance services in NSW (Wilde 1999).
- In Western Australia, early services were provided by local fire brigades before St John Ambulance assumed control in 1922 (Wilde 1999). The service delivery model in Western Australia was known as the St John Ambulance Model I, because the ambulance service was solely administered by St John Ambulance which was independent of government and had a balance of full-time paid staff and volunteers (O'Meara and Grbich 2009).
- In South Australia, there were eight separate ambulance services across Adelaide until St John Ambulance gained control in 1952 (Wilde 1999). The service delivery model in South Australia was known as the St John Ambulance Model II, and was similar to that in Western

Australia, because it was solely administered by St John Ambulance and had a mix of volunteers and paid staff. St John provided ambulance services until 1989, when the metropolitan workforce was converted to a fully-paid career-based service, and in 1992, the South Australian Ambulance Service (SAAS) assumed full control of state ambulance service provision (South Australian Ambulance Service 2015b).

- Tasmanian ambulance services were established with funding from local councils and were generally attached to hospitals (Wilde 1999). There was no coordination of services until 1959, when the state government established the Ambulance Commission of Tasmania. St John Ambulance delivered Hobart's ambulance service from 1959 until the government gained control in 1965 (Wilde 1999). The service delivery model in Tasmania is known as the St John Model III, which was similar to those used in South Australia and Western Australia, as it was solely administered by St John and consisted of paid officers in major towns and volunteers in the country regions (O'Meara and Grbich 2009).
- In the Northern Territory, multiple volunteer services were established, and by 1957, St John Ambulance assumed responsibility for these services (Wilde 1999). The service delivery model in the Northern Territory was known as the St John Model IV and again was administered by St John with a mix of volunteer and paid staff (O'Meara and Grbich 2009).
- Finally, in the Australian Capital Territory, the fire brigade provided an ambulance service from 1925 until 1955 (Wilde 1999). After 1955, the Canberra Hospital Board assumed control of the services. The service delivery model in the ACT was known as the government model, as it was the only model in Australia administered by a government department at that time (O'Meara and Grbich 2009).

In summary, it is evident that most of the nation's ambulance services were administered by St John during one point in their history. This management at a national level is historically important because it shows that nationalisation had occurred during one point of time across Australia. St John managed these state-based services because, at that time, they held the most knowledge and practice to administer a civil ambulance service that drew upon their humanitarian practices caring for the sick and wounded especially during times of war (The Order of St John 2016). Over time, most states across Australia had assumed control over their state-based services, but the St John organisational culture and origins are still deeply embedded into these services today. This is because most ambulance services across Australia were either administered by, or worked in conjunction with, St John ambulance in one point of their history. These organisational culture influences of St John is seeded in the history of each ambulance service across Australia and influenced the developed of the ambulance services we see today.

Ambulance Service Training History

Since the establishment of ambulance services across Australia by the early 1900s, their ongoing growth and development has also seen advances in ambulance education. Ambulance officer training, in the same way as nursing training, had many different motivators that drove education from an internal form of training towards tertiary education, and this process will be discussed in greater detail in the following chapter. The pathway towards professional identity, which was underpinned by focusing education on the job role, was uncharted territory for the ambulance community. However, in the decades prior to the establishment of ambulance services in Australia, the nursing profession also faced a similar pathway with the expanded scope of their role and identity. Given the lack of paramedic literature on this issue, it is valuable to parallel the journey of the nursing profession (education, motivators for change, experiences, etc.) in Australia with the journey of the ambulance profession in order to uncover similarities between them. The reason why nursing and ambulance roles are comparable is because both are primary healthcare roles introduced in Australia in the late 1800s. The Victorian Ambulance Services were the leaders in ambulance education in Australia in the mid-1900s and this continued through to the present, with a well-documented pathway from internal training, to education within the Vocational Education and Training (VET) sector, and finally, towards tertiary education. This pathway through the three forms of paramedic education is outlined below.

Internal Training

Internal training of new healthcare workers (nurses, doctors, etc.) was the standard of education in the early 1800s in Australia. The internal training model met the direct needs of the institution (hospital) or service provider (out of hospital) which was normally led by a medical doctor who, at that time, was seen to hold dominance over other health roles. It was a particularly powerful form of hierarchal control which undervalued those roles that were below that of a doctor (Wilde 1999). In the late 1800s, there were no defined standards, or any regulatory body, to oversee healthcare worker education in Australia. The education of ambulance officers was conducted internally by doctors who generally had military backgrounds, maintaining the concept of ambulance services originating from the military context before the 1800s (Wilde 1999). The transition of ambulance services from the military to the civilian context was in its infancy at this time, with the educational pedagogy instilled with the values of the medical doctor holding dominance as the expert, who holds all the knowledge and who must not be questioned (Wilde 1999). Ambulance officers were taught basic first-aid by these doctors and usually learnt other skills and knowledge on the job with no further organised training. While ambulance officer education was in the transition phase from the military to the civilian context, nursing already had an established system borrowed from the United Kingdom known as the Nightingale system. So, although like ambulance officers, nurses were trained internally on the job, the fundamental difference was that they were taught that the

needs of the hospital, whether this was the patients', the doctors', or staffing needs, took priority (Walker and Holmes 2008).

In Victoria, St John Ambulance developed a syllabus written by doctors to guide the basic education of ambulance officers. The first text seen as the standard of ambulance officer education was "First Aid to the Injured" (Shepherd 1878). Lectures were designed to be both simple and practical. Similarly, in early nursing texts, such as "Practical Points in Nursing" (Stoney 1907), the language and content used reinforced the anti-intellectual nature of the profession at that time (Walker and Holmes 2008). Nurses were told what to do by doctors and were told not to question this authority. Ambulance officers were taught through a similar approach. Transporting the patient to the hospital was the ambulance officer's only role, and they were taught only what they needed to know to do this, while additional skills were learnt through repetition on the job. Both the intellectual and hierarchal control by doctors over other allied health staff ensured the restriction of these roles to ensure that the power continued to be held and controlled by the medical fraternity (Wilde 1999).

In the early 1900s, ambulances were staffed by volunteers who were passionate about delivering a valuable service to their community. Wilde (1999) explains first-aid training of ambulance officers focused on illnesses and accidents that would fit particular criteria and their treatment; however, not every patient would fit neatly into such criteria. Ambulance officers were therefore expected to practice common sense, to be quick thinkers, and to improvise. Ambulance officers worked within the community away from doctors, and therefore, could not be directed and supervised during their diagnosis and treatment of patients (Wilde 1999). This caused concern for doctors as the environment of ambulance work facilitated unsupervised practice, potentially leading to errors or cause harm to patients. It was also possible that ambulance officers could practice outside of their protocols with a fairly high degree of autonomy. As a result of this autonomy, the ambulance environment re-emphasised the need for the medical fraternity to heavily supervise and direct the ambulance workforce. Doctors at this time resisted any improvements in education as it was their view that ambulance officers simply transported patients to the hospital (Wilde 1999). Similarly, nurses had little, or no, opportunity to develop their professional expertise or clinical judgement as they were strictly directed in what to do. The nursing environment in the hospitals was also directly supervised by doctors, and therefore, nurses were directly accountable for any deviation from the doctors' expectations and requests (Walker and Holmes 2008).

The environment that ambulance officers worked in was unique and lead towards a significant gender bias. Ambulance officers generally worked with a driver (in a crew of two), without supervision by a medical doctor, and had little or no support on the scene with a patient. Ambulance officers were generally men because of the heavy lifting involved, the perceived need for emotional detachment, and their rapid decision-making ability, as well as the need for

mechanical knowledge of the ambulance vehicles. In the early ambulance officer curricula, men and women could not undertake training together (Wilde 1999). Men were taught how to move the injured, whereas women were taught how to set up the first-aid room and prepare for the arrival of the patient (Wilde 1999). The early curriculum included topics such as nursing, driving, administrative tasks, and motor vehicle mechanics. Nursing formed a part of the ambulance officer education, but was primarily viewed as a female profession (Walker and Holmes 2008). This gender bias was deeply embedded in both nursing and ambulance officer culture in the early 1900s.

In the mid-1950s, the Victorian Ambulance Services Association (VASA) identified the need to establish an ambulance officer training school in Victoria (Wilde 1999). In 1957, VASA proposed to the hospitals and charities commission of Victoria that standardised education was required for ambulance officers on a national basis (Wilde 1999). The St John Medal was the standard of ambulance officer education at the time, but it was delivered by local ambulance divisions which led to inconsistencies in the training. As explained above, doctors continued to resist improvements to ambulance officer education, despite the establishment of the ambulance officer school (Wilde 1999). Similarly, doctors also resisted the advancement of nursing education as it was perceived that nursing experience (on-the-job practical learning) was more important to patient outcomes than a formalised type of education (Cowan and Hengstberger-Sims 2006). Nursing education was delivered within the hospital system with students contributing significantly to the workforce, and thus was central to the hospital's needs. Centralization and standardization of nursing education was not an issue because it was based in, and aligned to, a particular hospital, therefore national alignment was not deemed to be necessary (Walker and Holmes 2008). As multiple St John divisions offered training for the St John Medal across Australia, this resulted in decentralised ambulance officer education and inconsistences with training (Wilde 1999). The result of this was the need for a centralised ambulance officer training school.

In the early 1960s, the Ambulance Officer Training School (AOTS) was established in Victoria to meet the need for standardizing and enhancing the education of ambulance officers (Wilde 1999). However, there was a lack of ambulance educators to teach the advanced curriculum and this established the need for specialist ambulance officer educators (Wilde 1999). Therefore, the program relied on tutor sisters (nursing educators), and specialist doctors in emergency medicine with no ambulance background, to deliver the content. Both medicine and nursing were blended and contextualised into the ambulance environment so that the content was more applicable to ambulance staff (Wilde 1999). The Manual of Ambulance Nursing (Ambulance Victoria 1960) was developed and became the standard text for the curriculum. Training officers were employed by Ambulance Victoria from 1962 to deliver the ambulance officer course. Comparisons were made between the training of nurses and ambulance officers so that the ambulance officer curriculum could be modelled on the nursing curriculum (Wilde 1999). This curriculum included classroom

blocks at the ambulance officer training school with placement in the hospitals. The training officers considered this to be the best approach to ambulance education. Victorian ambulance officer training had a profound effect on service delivery as it raised the skill levels of ambulance officers and was considered quite advanced at the time (Wilde 1999).

Ambulance Victoria trialled a number of alternative methods of delivering ambulance officer education in the 1960s (Wilde 1999). In 1965, demand for the ambulance officer course grew so rapidly that the facilities simply could not cope. To ease this demand, regional recruits were rostered on for duty with an experienced officer who educated, mentored, and debriefed the recruit. This apprenticeship style delivery method identified the value of a mentor to support ambulance officer education. In 1965, a cadet scheme was trialled in which school leavers aged between 17 and 18 years participated in a three-year course whereby a job as an ambulance officer was guaranteed upon completion (Wilde 1999). The cadet scheme consisted of several residential courses (two to six weeks each year) at the AOTS, and placements in hospitals and other specialist areas within the ambulance service, including communications centre, administration and workshop. The rest of the time, the cadets worked normal ambulance duties with a supervisor (P O'Meara, 2017, Personal Communication, 10th January). The cadet scheme was discontinued in 1978 as it was perceived by ambulance officers to be a source of cheap labour which exploited the cadets (Wilde 1999).

Move to the VET Sector

Ambulance officers pursued the need to advance their education as their environment became more complex with new technologies and treatments being introduced and an increasing public perception to 'do more' (Wilde 1999). The medical fraternity previously opposed, but now supported, an increased level of training for ambulance officers in the 1960s and 1970s (Wilde 1999). At this stage, the frequency of serious vehicle accidents was on the rise, and ambulance personnel were on the front-line of the management and treatment of these patients. The ambulance officer's role had expanded to include cardiac care which also required additional training. The Ambulance Officers Training Advisory Committee (AOTAC) was formed in the 1960s with the purpose of influencing ambulance education in Victoria (Wilde 1999). The medical profession realised that it needed to recognise the value and the role of ambulance officers in order to enable the additional training and skills required for their updated role. Similarly, the field of nursing experienced the influence of rapidly advancing technologies, and an upgraded job role as a result. During the 1970s and 1980s, concerns from the nursing peak professional bodies arose about the limitations of the theoretical aspects of nursing and the narrow understandings of clinical nursing practise (Wilde 1999). Teaching staff for both ambulance and nursing education were selected to undertake additional training to increase their skills. The different knowledge-base and skill-sets of both nurses and ambulance officers led to the recognition of a broader range of clinical levels within their respective fields.

Whilst the Ambulance Officer Training School (AOTS) conducted its first internal course in the mid-1960s, concerns grew in the following years as it became evident that there was a lack of basic educational standards in English language proficiency and mathematical skills (Wilde 1999). In the early 1970s, the Ambulance Officer Training Advisory Committee made a recommendation to overhaul the assessment system as ten years had passed with little change to the curriculum. Issues were identified with the current ambulance officer training program which included a need to update assessments, a lack of feedback, and delays in receiving assessment results (Wilde 1999). It was clear to the AOTAC that internal education could not support the growing level of ambulance officer education and this started the discussion to move ambulance officer education towards the VET sector (Wilde 1999). However, recognition of increased education was needed and this resulted in the development of differing clinical levels within the ambulance service.

In 1971, the Mobile Intensive Care Ambulance (MICA) system was developed to cater for the needs of higher levels of medical treatment and the requisite training of these ambulance officers (Wilde 1999). At times, doctors would staff these ambulances alongside the MICA ambulance officers to attend case-specific jobs. The MICA ambulance officers were trained to give drugs, intravenous therapy, and to defibrillate. MICA training held no formal accreditation and was administered under an agreement with the Royal Melbourne Hospital (Wilde 1999). To qualify for the MICA course, students had to have completed the certificate course and 12 months of on-the-road experience. Tensions grew between the MICA and ambulance officer groups as they saw the MICA group as elitist and arrogant (Wilde 1999). Parallel to this development in the ambulance context, nurses became unhappy with their wages and conditions, and lobbied through the peak nursing body to establish different levels of education. The 1960s saw the introduction of two levels of nursing: the enrolled nurse (EN) and the registered nurse (RN) (Fetherstonhaugh, Nay et al. 2008). Both ambulance and nursing education had changed to meet the needs of increasing skill levels, knowledge, and practice by creating different clinical levels. The foundation for these different clinical levels was based on the level of education of the healthcare worker.

Job portability was another area of concern for ambulance officers. With no formalized qualification prior to 1978, it made it impossible for ambulance officers to move from state to state without undertaking further training (Wilde 1999). Similarly, nurses found it difficult to move between hospitals because their education, at the time, was hospital-based and not formally recognised (Fetherstonhaugh, Nay et al. 2008). Accessibility and diversity of both the ambulance and the nursing workforce was limited due to the lack of nationally-recognized qualifications. To achieve this aim, national collaboration of key stakeholders with the VET sector would serve to formalise the learning outcomes of the student, and set a minimum entry requirement for prospective employees. In 1973, the ambulance service leaders across Australia convened and agreed on a national course for ambulance officers to standardize ambulance education (Wilde 1999). National

recognition of formal qualifications would allow employees, to move between states, and indeed, between hospitals.

Ambulance officer training moved to the VET sector in the late 1970s (Wilde 1999). The Certificate of Applied Science (Ambulance Officer) was developed by the Technical and Further Education (TAFE) sector in 1974 (Wilde 1999). The development of this course included input from a vast array of highly-skilled ambulance officers, doctors, and allied health workers. Including these people ensured both diversity and transparency in what was being taught within the curriculum. The Certificate of Applied Science (Ambulance Officer) gained accreditation in 1977 and was formally accepted by the national ambulance peak body (the Institute of Ambulance Officers) in 1980 as the standard level of education required by ambulance officers in Victoria and soon spread nationally.

Concerns from the nursing sector also grew in the early 1970s due to a lack of knowledge and ownership of educational material (Russell 2005). In 1973, key stakeholders within the nursing profession convened to discuss nursing education and agreed on its importance and the need to move forward to improve standards (Wilde 1999). The state government was another important driving factor that supported increased education for nurses. The state government advocated for the standardization of nursing by introducing minimum pre-entry requirements (school completion) and theoretical and clinical competencies. To achieve the increased level of theoretical and clinical competencies required by nurses, the 1978 Sax Report outlined the need for nursing education to move to the tertiary sector (Russell 2005). Nurses argued that the internal training of the apprenticeship system lacked the opportunity for students to analyse their own practice and to gain professional autonomy, which is the key to achieving professional recognition (Kelly and Ahern 2009). In 1984, the watershed decision was made to move nursing education from the hospitals to the tertiary sector (Russell 2005), and in 1985, the government ensured that this took place. At this time, the Diploma of Applied Science in Nursing was established to become the accepted standard of education (Russell 2005). Therefore, nursing achieved earlier, greater and faster profession recognition compared to that of paramedicine.

The role of the ambulance sector and its place within the healthcare system was still relatively unknown in the 1980s (Wilde 1999). Ambulance officers held no specific body of knowledge, nor a delineated occupational territory, which made it difficult to establish the emerging profession within the healthcare workforce. Doctors held their role at the top of the health system, and nurses held theirs within the hospital system under the doctors (Wilde 1999). Ambulance officers worked outside of the hospital environment with basic equipment and knowledge, and were expected to simply transport patients to the hospital. Nevertheless, ambulance officers were expected to 'do more' by the public because of advancing medical technology, treatments, and research, coupled with the complex and declining health status of patients. To move forward, ambulance officers had

to challenge the medical domination of the healthcare system, and fight to establish their own place within it (Wilde 1999).

In the late 1980s, ambulance officers and doctors worked together to rewrite the curriculum, blending medical and ambulance practice. Students spent most of their time in ambulances within their own divisions, and only returned to the AOTS (the course providers) part of the course for 12 weeks a year, usually in three-week blocks. The course covered topics including obstetrics, paediatrics, psychology, and body systems, together with non-clinical topics such as communication and report writing. The More Report (Ambulance Victoria 1982) was commissioned to review ambulance officer education in Victoria and revealed that the Certificate of Applied Science (Ambulance Officer) course was not ambulance-orientated enough with an over-emphasis on non-clinical topics. The report also suggested that there was a lack of ongoing education programs (in-service training) for ambulance officers (Wilde 1999). Students were satisfied with the content, but were lacking opportunities for the specific application of the content to the ambulance environment within the course. In 1984, Ambulance Victoria introduced an ongoing educational program to further develop the skills and knowledge of current ambulance officers. However, the skills and knowledge within these in-service training programs were not covered by the Certificate of Applied Science (Ambulance Officer) curriculum, and therefore, the certificate became obsolete (Wilde 1999).

The Certificate of Applied Science (Ambulance Officer) was rewritten in response to these concerns in 1987, becoming the Associate Diploma of Health Sciences (Ambulance Officer) but, according to ambulance staff, still lacked the depth and breadth of knowledge required (Wilde 1999). Advancing training beyond the VET sector to allow for an increased body of knowledge, and its application to incorporate the use of new technologies and equipment, broadened the scope of practice of the ambulance officer. As a result, the job title shifted from ambulance officer to paramedic (Wilde 1999).

The transition to the University Sector

Shifting the workforce from ambulance officer to paramedic had a massive impact on the education required, and questions were raised about whether the vocational education sector could facilitate this. The Victorian government, at that time, imposed heavy cost-cutting measures that affected the healthcare system, especially Ambulance Victoria (AV). The budget of the AOTS was cut in 1992, and recruitment had basically ceased (Wilde 1999). In 1994, it was recommended that the AOTS be closed and the Certificate of Applied Science (Ambulance Officer) be moved to the TAFE sector. The cost to deliver the course at TAFE were far less than at the AOTS; however, it was seen by the industry that the level of training would go backwards and be less ambulance-orientated. Disbanding the AOTS created great concern within the industry, as it was believed that the institutional body of knowledge would be lost (deWit 1997). Ambulance officers lobbied for

ambulance training to be moved under the umbrella of the university sector instead of TAFE. Ambulance officers believed that professionalisation of the ambulance workforce could only be achieved by moving ambulance education to the university sector.

In 1994, in response to the state government's budget constraints, a viability review conducted by the AOTS concluded that they should not be closed down, and that instead, they needed to find a mainstream partner to affiliate with to deliver ambulance officer education. The AOTS was approached by a range of educational providers to partner in the delivery of ambulance officer education (Wilde 1999). The state government believed that the basic qualification should be delivered by the TAFE sector, but that the AOTS should partner with the university sector. In 1995, an expression of interest was announced for the procurement of an educational partner for the AOTS. Monash University was awarded the tender and a MOU was signed in 1995 (Wilde 1999). The Ambulance Officer Degree Program Steering Committee had representatives from the ambulance community, and from the tertiary sector, primarily including nursing staff and nurse educators. The paramedic unit was located within the nursing faculty, but was not administered by the Department of Nursing (deWit 1997). At this stage, the Paramedic Department had no higher education clinical educators and relied on the experience and staff from the Faculty of Nursing to guide the paramedic program (Wilde 1999). The nursing profession had well-established nurse educators, program designers, and curricula to aid the transition of ambulance officer education from the VET sector to paramedic education within the tertiary sector. In 1997, the AOTS moved to Monash University and established the Monash University Centre for Ambulance and Paramedic Studies. Monash University became responsible for the educational standard of the AOTS and for the delivery of educational programs to Ambulance Victoria staff (Wilde 1999). This transition from internal based education to university based education was not unique for Victoria as other state based ambulance services were in consultation with the university sector to develop, or had developed, an undergraduate paramedic degree (Balon-Rotheram 2003, Lord 2003).

Similarly, in the early 1990s, education for the nursing profession also moved from the VET to the university sector, and in 1992, the Bachelor of Nursing was introduced as the standard for nursing education (Russell 2005). Tertiary education provided students with a platform for their use of theory and knowledge in a variety of nursing disciplines.

The transition of education from the VET to the university sector was an eventful process and had its critics from both the nursing and paramedic professions (deWit 1997, Wilde 1999). A number of key stakeholders in the nursing profession were critical about the move towards tertiary education as they felt they would lose the need to meet both the hospitals' needs and basic patient care (Fetherstonhaugh, Nay et al. 2008). Such arguments stated that current tertiary education systems no longer fostered a traditional passing-down of knowledge and clinical expertise (Newton and McKenna 2007). This created a divide amongst the old hospital-based, internal training system and

the new bachelor degree within both fields. A major concern for the hospitals was the nursing graduates that the university produced were not ‘work ready’, being ill-prepared for the nursing workforce (Harwood 2011). Within paramedics, the transfer of paramedic education to the university sector was disjointed and had a number of setbacks (deWit 1997). Many new graduates perceived they were bullied by their diploma counterparts because it was believed they were not ‘road ready’, meaning they were not considered able to independently, confidently, and effectively apply knowledge to practice (Willis, Pointon et al. 2009). In fact, Lord (2002 pg 32) stated that “when the maturity of the paramedic is discussed, it is often confused with experience”. Current paramedics also invested little time into training and mentoring new paramedics, as they were seen as having no life experience, which was historically an essential element of being a paramedic. “Life experience is meaningless without the context of how attitudes, abilities, and behaviours are developed and integrated” (Waxman and Williams 2006 pg 6). As a result, new graduate paramedics entering the workforce found it very stressful, in addition to the stress from the nature of the work itself (Lowry and Stokes 2005, Gayton and Lovell 2012, Maguire, O'Meara et al. 2014).

Similarly, graduate nurses were reported to have been bullied and in conflict with their peers. Nursing staff were unwelcoming to students and were critical of their inability to apply theory to practice (Levett-Jones and Fitzgerald 2005). Graduates were under-prepared for the clinical environment because they were fearful of making mistakes, and of failing and taking responsibility. The clinical preparedness of nurses was sorely lacking, so a national consultation for a Transition to Professional Practice Program (TPPP) was undertaken (Levett-Jones and Fitzgerald 2005). The TPPP is a structured educational program after completing the nursing degree that is workplace-based to smooth the transition from university to the workplace environment. Active collaboration was required between the university and the healthcare sector to design the program. The university would deliver nursing knowledge incorporating a variety of clinical placements in different clinical settings over a short period of time (Harwood 2011). The TPPP would consolidate these skills in the hospital environment with dedicated education units to facilitate graduates’ knowledge of theory into practice (Fetherstonhaugh, Nay et al. 2008). Paramedic graduates were also not ‘road ready’, and so required a transition program as well; this became known as the paramedic internship (Willis, Pointon et al. 2009, Edwards 2011). The paramedic internship has become a vital element in the consolidation of skills, cultural indoctrination, and assimilation into the paramedic community, which will be further discussed later in this chapter.

Multiple factors have influenced the development of education in nursing and paramedicine. Initially, the Council of Ambulance Authorities (CAA) were against national paramedic registration as it appeared to be synonymous with control and standardization (O'Meara and Grbich 2009). In 2004, a review of paramedic education programs and the quality of their graduates was undertaken. Paramedic education was formulated into three layers; undergraduate, postgraduate,

and ongoing professional development (O'Meara 1997). Similarly, the rapid development of postgraduate courses for specialist areas of nursing grew to include the Graduate Certificate and the Graduate Diploma, as well as Masters and PhD programs (Russell 2005). Both professions are now well-established within the tertiary sector with many similarities between them. However, the nursing profession has progressed further and faster than paramedics, and a national nursing registration system has existed since the early 1990s, while a paramedic registration system still does not exist. Similarly, historical pathways exist between the nursing and paramedic professions, and yet the latter is far behind its nursing counterparts. Next, we will look at the history of TPPP within the healthcare sector and how this process relates to the paramedic profession.

Transition to Professional Practice

Before discussing the TPPP the essential elements of the value of workplace learning and its educational pedagogy are presented.

Workplace-Based Education

Education programs within the healthcare workforce have evolved from an apprenticeship model of on-the-job training, towards formal classroom education, whether this is via the VET or the university sector, in addition to workplace-based placements. This substantial move forward has a number of motivating factors, including increased public expectations, advancing technologies, increasing autonomy and accountability, and national regulation (McAllister, Paterson et al. 2010). It has been well established that workplace-based education is the core of any undergraduate health professional program, as knowledge alone does not produce a work-ready practitioner (McAllister, Paterson et al. 2010). Similarly, workplace experiences are not sufficient for recognition as a professional and are only legitimized through their integration with, or as a follow-on from, courses in education institutions (Billett 2001).

The connection between knowledge and practice is essential in traditional education and is best facilitated by involvement in a genuine situation or experience within the professional environment (Billett 2001). When a student experiences a genuine situation, information is gathered from the experience which is then interpreted through a range of varying solutions. This ability to test solutions makes experiential learning an ideal tool for the student to discover the validity of the solutions for themselves (Brockbank and McGill 2007). When the broad knowledge learnt at the undergraduate level is applied through experiential learning to the clinical context, it is highly valued by both educators and students (McAllister, Paterson et al. 2010). The process of workplace-based education helps the student to establish a professional identity through an understanding of the competencies expected by the profession, while at the same time, advancing problem-solving skills and professional decision-making abilities (McAllister, Paterson et al. 2010). These skills are contextualised within a safe and controlled environment inside the classroom to an

unpredictable and complex real world environment outside. However, the environment should be specific to that of the profession; a skill learnt in one professional domain might not work in, or be adaptable to, another profession. For example, cannulation techniques may be taught differently by nurses and paramedics, but performed in very different contexts in practice whilst both achieve the same goal.

Profession-specific education has a role in socialising and inducting the new graduate into the workplace environment. Learning is a social process which influences the degree of exposure experienced by the learner, and therefore, the degree of control they have over the learning event (Brockbank and McGill 2007). This is important as it allows the student to assimilate to the organisational culture of a particular professional workplace. Students learn and model the accepted attitudes, practises, language, behaviours, values, and beliefs of an organisation, which aid the student in assimilating to the workplace (Brockbank and McGill 2007). However, as demonstrated below, a steep learning curve is often stressful and unkind. Embedded in this social context, there is a shift from the student as the learner towards emphasising the role of managers and co-workers to help facilitate the student within the learning environment (Billett 2001). Workplace mentors play a significant role in workplace learning as the processes of learning and working are interdependent. Mentors introduce students to the activities undertaken within the profession, facilitate and support the student, and guide the ways in which the student interacts, interprets, and constructs knowledge from these situations (Billett 2001). Mentors also aid the learning of the hidden curriculum of a profession; those aspects of the profession which are not taught by the university, but are accepted, and expected, knowledge and practice within the clinical environment. The events and situations experienced by the student will shape their future practice and influence their future employment options within that environment.

Historically, students are educated in ‘silos’ in the university environment (McAllister, Paterson et al. 2010). For example, paramedic students are taught about the cardiovascular, respiratory, and neurological systems as individual topics (Flinders University 2015). However, in the clinical environment, these three systems work together, so students need to be able to integrate their knowledge of these systems and how they are interpreted in the clinical context, which is achieved through workplace-based education. Finally, workplace-based education specific to a particular professional environment also positions the student to gain a better understanding of health care systems, local health demographics and populations, and key industry partners. Students position themselves within a healthcare team and have constant engagement with other healthcare staff. For the student, this establishes a knowledge of the place of the profession within the healthcare system, and how other aspects of the health system influence and impact upon their profession. Authentic learning is achieved from this process and students hold it in high regard (McAllister, Paterson et al. 2010).

The above outlines the importance of workplace-based education for the transition to professional practice. Therefore, the next logical question is 'what are the graduate attributes (which are somewhat predictable) that workplace-based education can be derived from'? Four current expectations for the graduate entering the workforce are described by McAllister, Paterson et al. (2010). They include graduates that hold a high level of competence, justifies their practice within an evidence based environment, inter professional practice and teamwork and status and competence to be internally mobile (McAllister, Paterson et al. 2010). A workplace curriculum is desirable to frame this transition to support the new graduate to be able to adapt and move from being a student to a graduate employed in the workplace, Five key premises underpin the case for a workplace curriculum, as described by Billett (2001).

Firstly, the workplace learning environment should facilitate everyday thinking and acting within the particular profession. This is important for establishing ongoing routine work practices. Secondly, the work environment can only expose the graduate to the circumstances afforded by the workplace environment in which they are situated. The student cannot be expected to understand the knowledge and practices that fall outside of this workplace environment or their professional domain. Thirdly, simply learning by 'doing the job' will not suffice. Deep underpinning knowledge and practice at multiple clinical context levels are the hallmarks of the professionally-skilled worker. Fourthly, workplaces have multiple groups within them. They can be delineated between managers and workers, or by teams, age, affiliation, area, or even on the basis of employment status. Relationships between these groups are important in understanding one's role and positioning within the wider organisation (Worley 2002). Lastly, there is a recognition that the experiences within the university-based and the workplace-based components are complementary to each other (Billett 2001). The workplace cannot discount the role of the university sector and vice versa. Reciprocal benefit or symbiosis between the two is an important relationship to foster (Worley 2002).

The above discussion describes the essential elements of the value of workplace learning and its educational pedagogy. Next, the measurement of the integration of workplace learning to enable the transition to profession practise, or clinical competency, will now be discussed.

Competence

Competence is a difficult concept to define. Epstein and Hundert (2002 pg 226) define professional competence as "the habitual and judicious use of communication, knowledge, technique, skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served". Competence is built from educational theory that underpins the modern-day medical curriculum. Blooms Taxonomy describes three domains of learning, the cognitive (knowing), the conative (doing), and the affective (feeling) (Bloom 1964). Similarly, Miller's pyramid also describes the process of learning as multilayered with the levels of "knowing",

“knowing how”, “showing how” and “doing” (Millar 1990). Both frameworks describe a process that is based on the interaction between knowledge and application, but application (or performance) alone is not the hallmark of competence. Performance is directly measureable, whereas competence has to be an inferred quality that is contextual to the environment (Epstein and Hundert 2002). Professional competence is more than a demonstration of an isolated competence; instead, it is a wider holistic characteristic. Competence is also heavily dependent on habits of the mind. As Polanyi (1974) argues, competence is defined by tacit knowledge, including the use of heuristics (rules of thumb), intuition, and pattern recognition, rather than explicit knowledge. However, patients may not fit into a normal pattern, and it is in these high-risk situations where experts draw upon several strategies to think, plan, and act. Schön (1983) cited in Epstein and Hundert (2002 pg 227) argues that professional competence is defined by “the ability to manage ambiguous problems, tolerate uncertainty and make decisions with limited information”.

There is a necessity to identify the human component of competence within the curriculum and in assessment. Emotional intelligence and self-awareness in the clinical practice setting are central to all judgement and decision-making (Epstein and Hundert 2002). These characteristics, as described above, need to be assessed to determine competence. The content of the curriculum should be drawn from both discipline and education experts, and it is these outcomes that are assessed that need to be contextualised within a particular workplace environment (Schuwirth 2004). If the experts do not agree on the assessment, it is difficult to define a clear answer schema, which can compromise the institution (Schuwirth 2004). The assessment of competence itself is a statement of institutional values (Epstein and Hundert 2002). The institution promotes these values through the time invested in the student and in the standards that have been set. When assessing competence, students model these institutional values as part of a global judgment of competence. This, in turn, forms a well-rounded practitioner.

Workplace education driven by a local internship forms a workplace curriculum. This pedagogy should aim to guide practice and to assist in conceptualising instruction to support learning in the workplace (Billett 2001). This can only be successful if workplace experiences are well utilised, contribute to successful performance and the ability to transfer that performance to new tasks (Billett 2001). The nature of paramedic work is changing with increased responsibility for clinical decision-making, the changing public expectations of the ambulance services, and a heightened emphasis on ‘treat not transport’ patients with referrals to alternative care pathways (Joyce, Wainer et al. 2009). This new scope of practice creates unique challenges within paramedic education. Patient assessment and decision-making skills are frequently time-limited, with only minimal time being spent engaging with the patient, but this can have a significant emotional and physiological influence on the patient.

Within nursing, Benner (1984) describes the nurse's journey from novice to expert, a journey which has many similarities to the paramedic profession. Her worked built on the work of Dreyfus and Dreyfus (1980), who postulated that the development of expertise follows a reasonably predictable pattern (Brennan, Corrigan et al. 2012). Expertise involves an intuitive holistic approach which relies upon both analytical and experiential knowledge specific to the situation at hand as a mark of a competent practitioner (Bowles 2009), as can be seen in the relationship between experience and positive patient clinical outcomes (Edwards 2011). Reflection-in-action (Schön 1987) is also important for the situation at hand, especially for the paramedic profession. Initially, knowledge-in-action guides the establishment of the path of assessment and treatment (the check function); however, when there is a change in the expected circumstances, reflection-in-action gives rise to a modification in the way action is to be taken as it has immediate significance for action (Schön 1987, Eraut 1994, Brockbank and McGill 2007).

The above discusses the meaning of competence, its place in workplace education via an internship and what it means to the paramedic and nursing professions. Next, the transitional workplace-based education pathways within the nursing and medical professions will be explored.

Transition to Professional Practice Programs

Previously, this chapter has discussed the value of undertaking workplace-based placements within health to bridge the gap from undergraduate student to practising as a competent health care professional. This next section will look specifically at the nursing transition to professional practice programs and medical internships in order to understand the common experiences, patterns, and attitudes between these two health care domains.

Nursing Transition to Professional Practice Program (TPPP)

Nursing TPPP were established following the move to the tertiary sector. Nursing TPPP had three goals: to develop a competent and confident registered nurse; to facilitate professional adjustment; and to develop a commitment to a career in nursing (Levett-Jones and Fitzgerald 2005). Nursing TPPP are designed to be a time-limited, experiential learning process within the nursing environment with an expert mentor (Haleem, Manetti et al. 2011, Thomas, Bertram et al. 2012). The clinical learning culture within an organisation is the key to nurturing and supporting the graduate nurse and for facilitating teaching, imparting knowledge, and fostering critical thinking and reasoning (Levett-Jones and Fitzgerald 2005, Haleem, Manetti et al. 2011, Thomas, Bertram et al. 2012). Graduate nurses need to feel that they belong, and to be given autonomy in a positive environment in order to facilitate a successful and smooth transition (Zinsmeister and Schafer 2009, Paul, Olson et al. 2011). Also, early assimilation into the nursing role within the first 3 to 6 months is essential for the graduate nurse to be accepted into the workplace (Greenwood 2000).

Thomas, Bertram et al. (2012) stated that the greatest challenge for a graduate nurse is applying knowledge to practice and role ambiguity during this transition period. Factors that have an influence on the learning environment include staff knowledge about the student role and the unit culture, staff relationships with each other and the clinical instructor, the ability to integrate theory into practice, communication, the quality of relationships (acceptance) and involvement, the provision of feedback and support by staff, and how the students fit into the social culture of the unit (Paul, Olson et al. 2011).

Socialisation of the nurse into the nursing culture is a significant issue. New graduates learn about the professional role and the associated skills, knowledge, and behaviours during the transition period of the internship (Kelly and Ahern 2009). Additionally, values, attitudes, and professional identity of the nursing role are learnt during the internship. Socialisation is important in shaping new graduates attitudes' towards nursing, affecting their work quality and self-perception (Kelly and Ahern 2009). Assimilating to the culture can be a difficult transition for nursing graduates with documented cases of bullying and verbal abuse within nursing units (Kelly and Ahern 2009).

Common experiences during the nursing TPPP include:

- High levels of stress (Blanzola, Lindeman et al. 2004, Kelly and Ahern 2009, Thomas, Bertram et al. 2012)
- Poor relationships with doctors (Blanzola, Lindeman et al. 2004)
- Communication issues (Blanzola, Lindeman et al. 2004)
- Making mistakes/worrying about failing (Thomas, Bertram et al. 2012)
- Lack of confidence in taking on patient care responsibilities (Kelly and Ahern 2009, Thomas, Bertram et al. 2012)
- Bullying (Kelly and Ahern 2009, Thomas, Bertram et al. 2012)
- Power games, hierarchy, bitchiness (Kelly and Ahern 2009)
- Being 'thrown into the deep end' (Kelly and Ahern 2009)

In Australia, graduates can register as a registered nurse (RN) once completing an approved program of study or its equivalent (Nursing and Midwifery Board of Australia 2015). Registration is nationally recognized across Australia, and there is no requirement for graduate nurses to undertake a nursing TPPP for employment as a registered nurse. However, both the public and private sectors perceive a knowledge-practice gap for graduates and provide nursing TPPPs, as their preferred pathway for entry employment within that sector. These programs normally run for six to 12 months, in which the student is exposed to a diverse range of clinical environments with support from the employer's education unit (SA Health 2015). Despite their preference for TPPP graduates, employers, such as SA Health, do not require employees to have completed a nursing TPPP (SA Health 2016b).

Medical Internships

Medical internship programs were introduced in the 1940s to bridge the gap between knowledge and practice for newly-graduated doctors. These internships consisted of a one-year supervised program spread across a variety of disciplines (MS Al-Moamary, Mamede et al. 2010). The evidence suggests that few medical students were prepared for the challenges that awaited them after completion of their formal undergraduate training (Bowman 2007). Textbooks only provide one means of securing knowledge; however, the workplace offers learning outcomes that move beyond tacit knowledge through meaningful interactions with patients (Brennan, Corrigan et al. 2012). Acknowledgement of this basic premise is evident in the long-established model of medical internship in which clinical competencies are gained in the context of supervised practice (Sheehan, Wilkinson et al. 2005). The learning environment is optimised by an experienced clinician who guides reflection and learning from real cases and the problems they present. However, for this to be an effective learning process, there needs to be a balance between supervision and the autonomy of the student (Bearman, Lawson et al. 2011). The facilitation of autonomy within the medical internship program means that the students need to combine competence with performance in an increasing unsupervised learning environment.

Historically, the focus of medical schools has been based on knowledge and the competency of safely performing skills and tasks. Lacking in this equation was performance; the ability to put all these tasks together in a timely manner (Wilkinson and Harris 2002). Performance can only be consolidated in the clinical environment, and it was seen that this link between knowledge and practice could be best achieved via a medical internship (Wilkinson and Harris 2002). The introduction of the medical internship also shows the importance for the students of gaining an understanding of the larger picture of health care, including administrative roles, management systems and processes, and organisational structures within hospitals and health care organisations (Leeder 2007). The interns themselves placed a high valued on good orientation into the workplace, mentorship, and a nurturing environment, in order to soften the transition from being a student to becoming a doctor (Leeder 2007).

Although the medical internship provides students with an experiential learning process within a socially-engaging environment, the desirable personality qualities required of doctors cannot be taught. Poor attitudes, including poor interpersonal skills, rigidity, and adverse personal attributes are predictors of long-term failure as a doctor (Wilkinson and Harris 2002, Doherty and Nugent 2011).

Common experiences during the medical internship include the following:

- High levels of stress (Bearman, Lawson et al. 2011, Doherty and Nugent 2011, Brennan, Corrigan et al. 2012)
- Lack of shared responsibility (Bearman, Lawson et al. 2011, Brennan, Corrigan et al. 2012)

- Difficulty with socialisation to the work environment (Bearman, Lawson et al. 2011)
- Identity construction (Bearman, Lawson et al. 2011)
- Concerns about dealing with uncertainty (Wilkinson and Harris 2002, Brennan, Corrigan et al. 2012)
- The hierarchical structure of medicine (Leeder 2007)
- Working undesirable shifts and poor working conditions (Leeder 2007, Kendler 2010)
- Perfectionism (Leeder 2007)

The completion of a medical internship is now a requisite to registration as a medical officer, but is only required to be completed once (Medical Board of Australia 2015). The Medical Board of Australia defines the supervised intern training requirements that must be completed in order for graduates of a recognised program to be eligible for general registration (Medical Board of Australia 2015). The intern period of mandatory general clinical experience allows students to consolidate and apply clinical knowledge and skills with increasing responsibility within a supervised environment. This period is completed once a recognised and approved program of study has been completed. Interns must complete:

- At least 8 weeks in emergency medical care (i.e. emergency department)
- At least 10 weeks in medicine (i.e. medical ward/diagnosis and treatment of illnesses)
- At least 10 weeks in surgery (i.e. surgical ward/surgery)
- A range of other approved terms to make up a total of 12 months (a minimum of 47 weeks of full-time equivalent service)

Paramedic Internship

Similar to medicine and nursing with education being in the university sector, the paramedic internship evolved to support the transition of the new graduate into the workforce. The paramedic internship was developed to be undertaken following an undergraduate paramedic degree to consolidate clinical practice (deWit 1997). Universities consider an intern period, post university degree, as an essential component of becoming work-ready paramedic in Australia (Willis, Pointon et al. 2009). The paramedic internship is consistent with other disciplines, whereby graduates complete around 12 months of clinical on the job practice to ensure that the skills of the profession are consolidated (Willis, Pointon et al. 2009). Although there is limited research into the understanding behind the paramedic internships, why they exist and what they attempt to achieve; there are key workforce statistics and internship structures that is known and practiced across Australia. These key findings are used in this study to inform key pillars underpinning a paramedic internship.

Let us first look at the workforce statistics of those new graduates entering the paramedic internship. The transition from diploma to degree has changed the demographics of the workforce, with a greater number of younger graduates who have a lack of maturity and have less life

experience coming into the profession with a change from predominantly male students to more female students (Waxman and Williams 2006, Joyce, Wainer et al. 2009). Current paramedic graduates are likely to be part of a trend towards a portfolio of careers which focus on flexibility (moving between organisations), advancing clinical knowledge and skills (further training/education and higher clinical rank), and moving across traditional occupational boundaries (i.e. paramedic practitioner) (Joyce, Wainer et al. 2009).

A summary of paramedic internship programs across Australia as of the time of data collection is provided in Table 1. Although care is taken to ensure information is accurate and correct at the time of production, it was difficult to access some paramedic internship information and the reader needs to take note that programs change over time.

Table 1 Paramedic internship programs across Australia

Region	Name of Ambulance Service	Entry Requirements	Length of Internship	Assessments	End
Northern Territory (St John Ambulance (NT) St John Ambulance Australia (NT) 2015)	St John Ambulance (NT)	Bachelor Degree	12 Months	Logbooks Viva Voce Exam 1500 Hours	No Job Guarantee (Contracted Position)
Queensland (from an email M Lindeman – Queensland Ambulance Service 2016, personal communication 18th January)	Queensland Ambulance Service (QAS)	Bachelor Degree	12 Month	*No Public Information*	No Job Guarantee
New South Wales (NSW Ambulance New South Wales Ambulance 2015)	New South Wales Ambulance Service (NSW Ambulance)	Bachelor Degree OR Trainee Paramedic (Diploma once completed)	12 months OR 3 Years	Practical Assessment Theory Assessment	Ongoing Permanency
Australian Capital Territory (from an email H Wren – ACT Ambulance Service 2015, personal communication 12th January)	ACT Ambulance Service	Bachelor Degree OR RN Grad Dip Conversion Pathway	15 Months	Practical Assessment Theory Assessment VIVA Assessment	No Job Guarantee (However 18 Months Contracted ongoing Position)
Victoria (Ambulance Victoria 2015)	Ambulance Victoria (AV)	Bachelor Degree	12 Month	Practical Assessment Skills Stations Verbal Scenario	Ongoing Permanency (Under review)
Tasmania (Tasmania Ambulance Service 2015)	Tasmanian Ambulance Service	Bachelor Degree	2 Years	Practical Assessment Theory Assessment	No Job Guarantee
South Australia (SA Ambulance Service South Australian Ambulance Service 2015c)	South Australian Ambulance Service (SAAS)	Bachelor Degree	13 Months	On Road Evaluation (PICER) Skills Log Practical and Viva Assessment	No Job Guarantee (Contracted Position)
Western Australia (St Johns Ambulance WA St John Ambulance Western Australia 2015)	St John Ambulance (WA)	Bachelor Degree OR Student Ambulance Officer (degree once completed)	3 Years OR 4 Years	Practical/Theory Completing University Degree Practical/Theory	Ongoing Permanency

The paramedic professional is not recognised as a healthcare professional by Australian Health Practitioner Regulation Agency (2016). The inconsistencies of the paramedic internship between states as identified above. Furthermore, a synopsis conducted in 2004 concluded that Australian ambulance services are not moving towards a consistent and standardised approach (nationalisation) to the planning, development, and delivery of the paramedic internships (Willis, Pointon et al. 2009). This creates multiple issues at both the local and national levels, including workforce planning, cultural clashes within organisations, and the portability of qualifications when competency has been reached.

The paramedic internship is not just about competency, but also the assimilation into the workforce and the enculturation of becoming a paramedic. The nursing TPPP teaches beyond competency with graduate nurses learning their own professional identity and professional values and beliefs (Kelly and Ahern 2009). Similarly, the medical internship facilitates identity construction (Bearman, Lawson et al. 2011) and understanding of the organisational structure, practices, policies and procedures (Leeder 2007). It is logical that the paramedic internship must also induct paramedic interns into the profession and the organisation via enculturation. Therefore, this study will employ a cultural lens on the internship.

Cultural Induction

Before moving onto a discussion of cultural induction for new interns entering the ambulance service, it is important to develop an understanding of values, beliefs, and culture so that the discussion can be contextualised.

A value is “a broad tendency to prefer certain states of affairs over others” (Hofstede 2001 pg 5). Values are long-standing beliefs about what is important to a person that do not require proof. Beliefs are individuals’ enduring interpretations and application of a value an individual holds to be true. Values have intensity (relevance) and direction (good or bad), and are invisible, until they become evident in behaviour. As well, values should not be equated to deeds, as behaviours depend on the person (and their mental programming) and their situation. Hofstede (2001 pg 1) described mental programming; a person’s behaviour, to some extent, that can be predicted and is specific to a particular situation and person. Such mindsets are developed by the individual during early childhood and are then reinforced by schools and other organizations the person has contact with. Each person’s mindset, or mental program, is constructed through three levels: the universal (shared with others), the collective (shared with a group), and the individual (self) (Hofstede 2001). ‘Social systems can exist only because human behaviour is not random, but to some extent predictable. But for each prediction of behaviour, we try to take both the person and the situation into account ’(Hofstede 2001 pg 1-2) . It is assumed that mental programming is stable over time, showing more or less the same behaviours in similar situations. These patterns of predictive behaviours at the collective level are known as norms. Behavioural norms within a group can be

separated into 'the desired' and 'the desirable'. Desired norms relate more to pragmatic issues, while desirable norms relate to ideology. The following example will place these values and norms into context. As a paramedic, I value a safe working environment (a value at the universal level). To be a safe working environment, I believe we should have breaks spread out evenly during the shift (a belief at the collective level). I may plan to buy my food on the way back to the station because I am due for my break (behaviour at the individual level). I am hoping that I get my break on time (a desirable norm), but it is unlikely because I may have another job assigned to me, but I will get my break eventually (a desired norm).

Culture is defined by Hofstede cited in Waisfisz, Minkov et al. (2015 pg 6) as "the collective programming of the mind which distinguishes the members of one organisation from another" Organisational culture is deeply rooted in assumptions that are difficult to identify for a new employee (Carlstrom and Ekman 2012). Being accepted within the workplace may be determined by the employee's replication of behaviours, actions, and norms of the workplace in front of their peers (Carlstrom and Ekman 2012).

Conclusion

This chapter has provided insights into the origins of the ambulances services in Australia, the transition of ambulance service education from internal to university based education and lastly discussed the literature from workplace based education, competency and comparing other transition to professional practice programs, like nursing and medicine. The profession comparison of the paramedic internship with the medical internship and nursing TPPP provides insights to the importance of programs, including the cultural indoctrination into the profession and organisation. Next, this study will discuss the setting of this study, the South Australian Ambulance Service.

3. THE PARAMEDIC INTERNSHIP IN THE SOUTH AUSTRALIAN AMBULANCE SERVICE

Introduction

It is important to understand the organisation in which this study is positioned. South Australia Ambulance Service currently administers the state-wide ambulance service to the public of South Australia, Australia. This chapter will present with SAASs structure and framework, explaining the differing clinical levels practiced and the current (when writing this thesis) structure of the paramedic internship.

South Australian Ambulance Service (SAAS)

The SAAS is an integral part of South Australia's health system as the principle provider of emergency medical assistance, treatment, and transport to the people of South Australia. The SAAS delivery model includes out-of-hospital emergency care, non-emergency patient transfer, major event management, an advanced rescue service, and an emergency medical retrieval service. The SAAS services 983,482 square kilometres of the state of South Australia with over 2,600 paid and volunteer staff, 110 ambulance stations and 417 vehicles (South Australian Ambulance Service 2015f). In addition, the service responds to over 400 triple zero (000) phone calls each day (South Australian Ambulance Service 2015f). The organisational structure of the SAAS consists of a number of operational service delivery departments, including metropolitan patient services, country patient services, specialist services (patient transfer services, special operations) and non-operational support departments, including human resources, educational services, customer service, clinical governance and patient safety, supply and procurement, and fleet (see Appendix A) (South Australian Ambulance Service 2015a). Both sets of operational and non-operational departments support one another to ensure that the SAAS delivers a high-quality service to the community.

The SAAS operates under the auspices of SA Health which is a portfolio of the South Australian government (see Appendix B) (Government of South Australia 2015a). Due to being a government department, the SAAS must adhere to SA Health policies and procedures, with a major one relevant to this study being the Public Sector Values and Behaviours Framework (see http://publicsector.sa.gov.au/wp-content/uploads/20150710-Public-Sector-Values-and-Behaviours-Framework.pdf) (Government of South Australia 2015b). This framework was developed to enhance collaboration between government staff by forming a shared culture and vision. Eight principles have been identified in the framework: service, professionalism, trust, respect, collaboration and engagement, honesty and integrity, courage and tenacity, and sustainability (Government of South Australia 2015b). The SAAS has developed and published their own values and mission statement which is underpinned by the Public Sector Values and Behaviours Framework, which is as follows:

> “Vision: The community of South Australia is secure in the quality of service provided by their ambulance service.
>
> Mission: To save lives, reduce suffering and enhance quality of life, through the provision of accessible and responsive quality patient care and transport.
>
> Values: We value our reputation and professional profile and these values influence the way our business is conducted and how our organisation is managed.
>
> We do this with accountability, integrity and innovation. We value the passion, effectiveness and potential of our people, and their need to feel valued and respected” (South Australian Ambulance Service 2015e).

It is important to understand that not only does the government have its own vision, values, and beliefs, but that the SAAS also has its own distinctive guiding principles. Both organisations are different and need to work and interact with one another to ensure the smooth functioning of the healthcare system in South Australia. It may be confusing and difficult for an individual within the SAAS to adapt to, and model, the Public Sector Values and Beliefs Framework, but what is important for staff is to understand that these principles exist. It is important to understand the values and beliefs framework because it is desirable for the organisation that staff employed within the organisational follow them. As well, it is very important that they understand which attitudes need to be adopted to ensure a smooth symbiotic relationship between the two organisations so that both sets of values can be incorporated and modelled.

Clinical Levels

The SAAS has a range of operational staff who work at different clinical levels. The various members of staff that are needed to deliver these services include ambulance officers, paramedics, intensive care paramedics (ICP) and extended care paramedics (ECP). The increasing complexity of these clinical roles highlights the hierarchical nature of the operational staff within SAAS.

Ambulance officers generally hold a Certificate IV in Health Care (VET Sector Training) and practice life support under clinical practice protocols. In small country towns, volunteer ambulance officers provide rural and remote responses. Ambulance officers also work within the non-emergency patient transport service, which provides services such as intra-hospital transfers, and transfer to and from appointments and residential care facilities.

Paramedics have completed a three-year undergraduate program, as well as successfully completing a paramedic internship program. Completion of the internship program does not automatically entitle the paramedic to employment; instead, they need to apply for an ongoing

position within the SAAS. Paramedics apply clinical practice guidelines in advanced life support rather than simply applying protocols when treating patients, which allows for additional autonomy in their practice. Paramedics generally staff ambulances (crew of 2) in the metropolitan hub and in the larger country towns.

ICPs are paramedics with a minimum of two years' experience who have completed a Graduate Diploma in Intensive Care Paramedicine and successfully completed the Intensive Care Paramedic Internship program. ICPs practice advanced life support in complex situations through broader clinical practice guidelines. ICPs also staff ambulances in metropolitan and country areas, and act as managers (generally), single responders (generally), and work in the staff rescue services arm of the ambulance service.

ECPs are ICPs with a minimum of two years' experience who have completed an internal training program to practice non-urgent ongoing community-based care. ECPs work individually on the road and manage a range of health conditions in the home or in residential care facilities. Care is administered in conjunction with other health services that can include GPs, Palliative Care Teams, Hospital-at-Home Teams, Nursing Homes, and so on. ECPs may also operate as clinical consultants to ambulance officers/paramedic crews when an additional scope of practice is required or advice is needed.

The Paramedic Internship Program

The SAAS paramedic internship program is a 12-month service induction and skills consolidation program that undergraduate students undertake before commencing ongoing employment as a paramedic within the SAAS. As the largest employer of paramedics in South Australia, the SAAS has developed an industry-specific induction program that bases itself on the tertiary education already held by paramedic interns. This enables the acquisition of further knowledge and skills taught in the clinical setting, and supports graduate learning through consolidating knowledge, developing critical thinking skills, and gaining confidence with clinical practice (South Australian Ambulance Service 2015c pg 5). Paramedic interns are placed in the Adelaide metropolitan area in one of the four regions (north, south, east, or west), and within these regions, are attached to one of four teams (i.e. North A, B, C, or D). The objectives of the paramedic internship program for the SAAS are:

Professional Objectives:

- *Demonstrates professional autonomy, practicing within an approved scope of practice;*
- *Works safely and effectively with regard to self and others;*
- *Develops professional relationships with colleagues, patients and other allied health care staff; and*
- *Practices self-evaluation and reflection.*

Clinical Objectives:

- *Demonstrates the assessment, formulation and implementation of a treatment plan for patients within SAAS clinical practices guidelines and procedures*

(South Australian Ambulance Service 2015c pg 7).

The SAAS paramedic internship has sustained minor changes since the Paramedic Internship Program Review, which was conducted in 2011 as confirmed by email (M Borrowdale 2016, personal communication, 10th January), with data collection for the review occurring in 2013. The following is an overview of the current SAAS Paramedic Internship Program as published in January 2015 (South Australian Ambulance Service 2015c).

Recruitment/Selection

Paramedic internship applications for the SAAS are only considered if the candidate has completed an undergraduate university degree which is recognised by the Council of Ambulance Authorities. Fully qualified paramedics from interstate are able to apply when positions are advertised, but would be required to redo a paramedic internship in the new state. Job advertisements are circulated online via the SA Health Careers website and the print media. Professional groups such as Paramedics Australia may circulate the advertisement nationally, but recruitment is generally targeted within the local state-based setting. For example, print advertisements are not undertaken in other states and employment information sessions conducted by the SAAS are held only at Flinders University, the sole paramedic undergraduate degree provider in South Australia.

Potential applicants who meet the minimum selection criteria submit a curriculum vitae and complete an online application form. A selection panel shortlists the applicants who are then required to undertake a medical/physical/functional test, psychometric testing, criminal history screening, immunization requirements, and any other testing strategies used at the discretion of the SAAS interview panel. The interview panel is selected by the panel chair and may include both operational and non-operational staff, psychologists, union representatives, and so on. The panel chair is either a manager whose portfolio includes the management of the paramedic internship or a proxy selected by them. The applicants are further shortlisted, after which interview requests are made and final referee checks are conducted. Currently, in 2015, only two groups of 16 applicants per year are successful in their application for employment as a paramedic intern.

Induction/Clinical Practice Guidelines (CPG) Workshop

Paramedic interns must complete two stages prior to commencing their on-road practice (staffing an ambulance with another paramedic), including the induction stage and a clinical practice guidelines workshop. Preceding this block of training, the interns (will replace paramedic intern) are

expected to complete a suite of pre-workshop self-directed online learning modules to orient themselves to the guidelines, and the policies and procedures of the SAAS. The induction phase consists of five weeks; three of which are classroom-based orientation facilitated by an experienced clinical educator, and two weeks of driver training. The areas covered by the induction phase include an Introduction to the SAAS and SA Health, the Manual Handling Program, Workplace Health and Safety, Infection Control, Communications, SAAS Equipment, and Child Safe Environments. The issues covered by the following two weeks in the driver training phase include urgent and non-urgent tasking (both theory and practical), and vehicle operations. Following the successful completion of the induction and driver training phases, the interns are placed within their allocated metropolitan regions for two weeks as a third 'paramedic' (working with two fully-trained paramedics) to orient themselves to the ambulance environment, the local area, and the people who work in the team.

The Clinical Practice Guidelines (CPG) workshop commences after the induction phase and has a strong focus on the practical application of guidelines, real-time simulations, and case-based learning (CBL) (South Australian Ambulance Service 2015c). Clinical educators facilitate the practical application of existing knowledge from the university degree with hypothetical cases (made up of the type of jobs that a paramedic may actually attend) as a learning strategy. CBL encourages discussions within the group to develop ideas, aid in problem-solving, and to explore how the SAAS CPGs and policies can be applied. The interns then apply the outcomes of the CBL exercises in real-time simulations using realistic locations, patients, and social environments. The intern practices the application of the SAAS CPGs, demonstrating a range of technical skills, including interpersonal and multidisciplinary communication, teamwork, and leadership skills (South Australian Ambulance Service 2015c pg. 19). These simulated events are reflected upon by the intern and the clinical educator which allows the intern (and their peers) to deconstruct the events, provide a rationale for their reasoning, and identify learning points. In completing the CPG block, the interns will have covered the majority of the SAAS CPGs in a simulated work environment and be considered safe to crew an ambulance under the direct supervision of a clinical instructor.

Paramedic Intern Development Team (PIDT)

The Paramedic Intern Development Team (PIDT) supports the supervised practice of interns as they exit the CPG workshop. Each PIDT is managed by a Team Leader and employs four clinical instructors who are experienced paramedics specifically selected to mentor interns. Interns work a normal roster for 26 weeks (2 days, 2 nights, 4 days off) and are tasked to a range of standard jobs while they complete Objective Structured Clinical Examinations (OSCEs) and Paramedic Intern Clinical Evaluation Reports (PICERs). OSCEs are isolated clinical skills that are facilitated and supervised by the clinical instructor to ensure the meticulous detail and efficacy of that skill (i.e.

cannulation, drawing up medication). PICERs are completed by the clinical instructor, summarising the intern's progress and journey, including reflection on cases, attitudes, competence, scene management, and so on (South Australian Ambulance Service 2015c pg. 22).

Assessment

During the PIDT phase (at the 16th week), the interns complete a clinical assessment to evaluate whether they are practising at a safe and effective level. Interns complete a simulated case (practical) followed by a reflective case review (knowledge underpinning practice) in front of a panel of assessors. If the assessment is completed successfully, interns are deemed safe to continue until the completion of the internship program and are not subject to further clinical assessments. Failure to successfully achieve competence (including a review, learning plan, and resit) may result in the termination of the interns' contract.

Lateral Placement

In this phase, the interns are allocated to a lateral emergency team (i.e. North A, B, C, or D) for supported practice working with a paramedic for the remainder of the internship program (26 weeks). Lateral teams are standard emergency ambulance teams comprising experienced paramedics or intensive care paramedics. PICERs are still completed by the interns' supervising partner, but when engaged in practice, interns are expected to act with less supervision.

Final Review and Interview

A final review and interviews with the interns are conducted towards the end of the 26-week lateral placement. The interview panel considers each paramedic intern's clinical educator reports, clinical assessment grades, PICERs, performance review, and development pathways (South Australian Ambulance Service 2015c pg. 27). Ongoing employment beyond the contract end date is not guaranteed, which is made transparent at the beginning of employment. Ongoing employment opportunities are based on organisational needs and performance at the final review. Interns who are offered paramedic positions can be offered full-time or contract positions to either metropolitan or country locations.

Conclusion

This chapter has described the setting used for this study. It described, in detail, the organisation that is SAAS, the clinical levels that are practiced and the step by step process of the paramedic internship. Next we will explore the cultural lens that will be used as in interpretative framework for this study to understand the layers of culture and its values and beliefs that underpin them.

4. CULTURAL LENS

Introduction

Two important multi-dimensional cultural lenses applicable to this study are national culture, derived from the work of Hofstede (2001), and organisational culture, derived from Waisfisz, Minkov et al. (2015). However, as mentioned previously, various dimensions of these cultural lenses have many different meanings and interpretations, each of which is specific to the context to which they are applied. Therefore, an open interpretation may cause ambiguity for the reader and may lead to misinterpretations of the discussions and conclusions of this study. Therefore, refining and mapping these dimensions to the specific context of this study will now be done to provide optimal clarity.

The paramedic intern program is a state-specific local induction program for new paramedic employees to the ambulance service. Like any new employee, paramedic interns are likely to have the desire to fit into the organisation as smoothly as possible, by successfully embracing and modelling the cultural norms, behaviours, and rituals of the organisation given the experience in nursing and medicine. Cultural norms are not directly taught within the intern program, and therefore, they form part of the so-called hidden curriculum. This reliance on informal learning to understand the cultural norms often causes anxiety for new interns. There are several ways in which cultural norms, behaviours, and rituals are embedded in the paramedic intern program. The most obvious is through the actions and behaviours of all people who are part of the program, such as the clinical instructors, mentors, and educators. More importantly, the people who are selected to design paramedic education, or who are tasked with the organisation of the internship, have the power to heavily influence the declared, as well as the hidden messages, about the organisational culture in their design of the intern program. The internship program, therefore, combines both the organisational values (which form the culture) as enacted in the design of the internship program, as well as the personal values from the key stakeholders in the education of interns. As this program is delivered to all paramedic interns, these cultural values and belief systems are constantly passed onto the new, incoming workforce. To study and understand the values and belief systems in an organisation, both at the individual and organisational levels, theoretical frameworks are needed to ensure that data collection and interpretation occur in a meaningful way.

For this thesis the starting point is that the values, norms, and beliefs of an organisation are influenced by the societal/national culture in which the organisation exists, as well as its own specific organisational culture. Hofstede's (2001) framework on national cultural dimensions and Waisfisz, Minkov et al's (2015) framework on the organisational dimensions can therefore assist in understanding the educational decisions made in ambulance organisations. Hofstede's(2001) model for national culture was selected for this study because it was one of the earliest theories to

national culture and is widely used and cited amongst many researches (Jones 2007). Hofstede's study commenced in 1980 and solely studied the culture of the IBM Corporation, a multinational computer company. Hofstede's Values Model Survey has been completed over 166,000 times, with 60,000 respondents (same people filling out the questionnaires over a period of time) conducted in over 50 countries. It is for this reason, Jones (2007) asserts that a strength of Hofstede's theory is it's rigour; embedded in the systematic design and data collection with coherent theory. Furthermore, Jones (2007) showed Hofstede's research has been reproduced 61 times with the majority confirmed Hofstede predictions. Hofstede's model has had a marked effect on academics and practitioners alike, including its application in training designs, workgroup dynamics, performance innovations and management control systems (Jones 2007). It is for these reasons it was considered a suitable theory to inform this study.

Waisfisz, Minkov et al's (2015) model for organisational culture was also selected for this study because it built upon the work of Hofstede's (2001) model of national culture. This is important because Hofstede identified very early in his work (Hofstede, Neuijen et al. 1990) that he believed that national culture dimensions could not be used for organisational culture, because the definition of organisational culture is more specific than that of national culture (i.e. sub groups that distinguish itself from other groups within a nation) (Waisfisz, Minkov et al. 2015 pg 8). Waisfisz, Minkov et al. (2015) revealed six dimensions of organisational culture that were fundamentally different from Hofstede's dimensions of national culture and developed the practical application of these dimension into the organisational environment. A combination of national and organisational culture was considered important and valuable to frame this study.

Understanding culture is very complex. Culture itself is to humans collectively what personality is to the individual. Culture can be defined as "the interactive aggregate of common characteristics that influences human groups responses to its environment" (Hofstede 2001 pg. 10). Asking questions in semi-structured interviews and analysing the participants' responses is useful for assessing constructs such as beliefs, attitudes, and personality, to infer these cultural values. Hofstede (2001) describes national culture as a predictable mental program shared by individuals across one nation. Waisfisz, Minkov et al. (2015 pg6) argue that cultures exist only through comparison, and that a culture is, by definition, about groups rather than individuals. They also argue that organisational culture is learned from the passing down of practices such as rituals, behaviours, symbols, and norms, from the existing to the new employees (Waisfisz, Minkov et al. 2015 pg. 6). Thus, organisational culture is behaviour that is unique to a particular organisation because it is comprised of the practices modelled and learned from those already within the organisation (See Figure 1 Three Levels of Mental Programming). However, elements of national culture still exist in organisations, because they consist of individuals who hold their own values and beliefs influenced by the national culture.

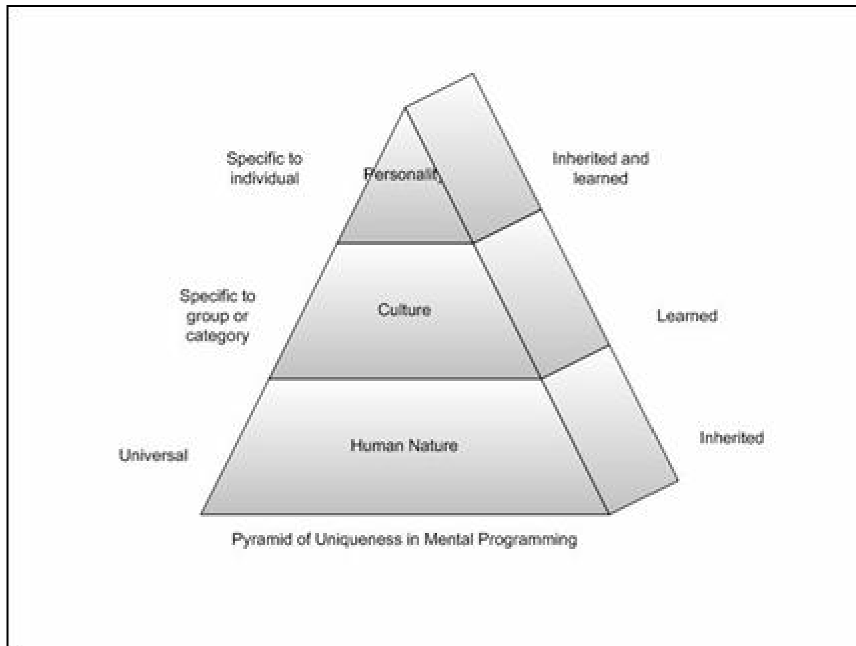


Figure 1 Three Levels of Mental Programming (Waisfisz, Minkov et al. 2015 pg 6)

Another distinction is that where national culture concerns itself with the values an individual holds, organisational culture concerns itself with practices that are displayed by members, including rituals, heroic symbols, and behaviours specific to a particular organisation (Figure 2 Different Levels of Culture

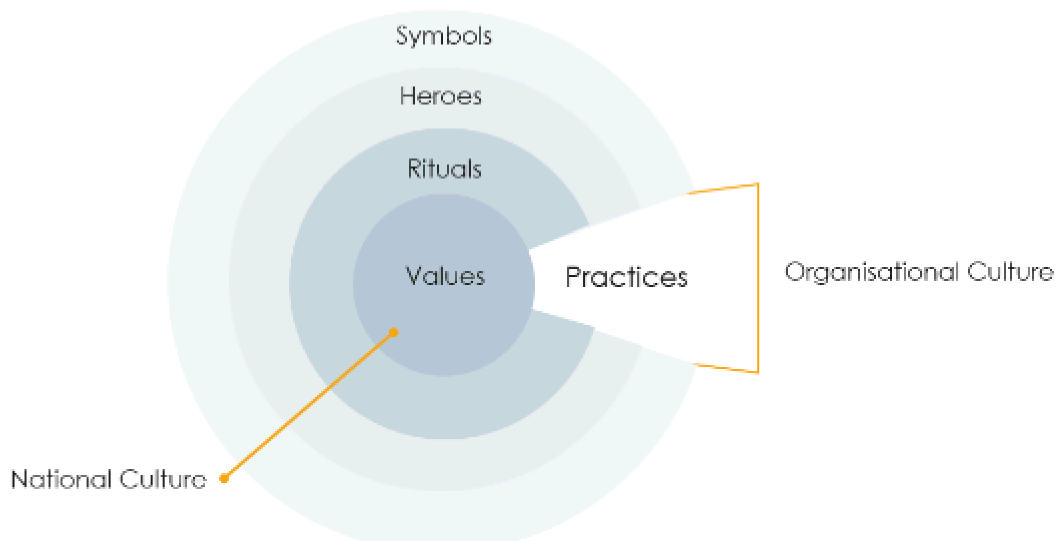


Figure 2 Different Levels of Culture (ITIM International 2016)

Shared values are the core of an organisation's culture (Peters and Waterman 1982). However, work practices are designed according to the values of the founders, and later, by significant managers at the head of the organisation. This does not mean that all members of the organisation share these values. Members have to follow the practices if they wish to remain members, but they do not have to confess to, or even like, the values. According to Hofstede (1998), leaders' values become the followers' practices. This means that the organisational culture represents the characteristics of the organisation rather than of the individual, but this is manifested in, and measured from, the verbal and non-verbal behaviours of individuals (Hofstede 1998).

Therefore, combining national cultural dimensions (for everyone), with organisational cultural dimensions (for some), allows us to optimally interpret culture at both levels. National culture is inherited into the individuals' mental program by their social environment, primarily during the first 10 years of life (Hofstede 2001 pg 4). Although the inheritance of these values and beliefs may not be overt, they are universally accepted norms and behaviours within a nation. These individuals with specific national values are the same individuals that make up an organisation, when that organisation is isolated to one country. Therefore organisational culture is underpinned by national culture, as organisations are constructed by individuals that reside in a nation, and therefore have inherited a national culture. 'Hofstede has always argued that the core of national culture consists of values (which are important to people), whereas the core of an organisational culture consists of practices (what people do)' (Waisfisz, Minkov et al. 2015 pg III). Hofstede also argues that values are practically impossible to change, and if they do, only evolve very slowly as a function of ones long life experiences. Therefore, it is difficult for managers to instil new values or reverse existing values of the workforce. However, managers can modify workers behaviours through positive and

negative reinforcements (Waisfisz, Minkov et al. 2015).The preceding paragraphs explain why the use of the cultural models derived from Hofstede and Waisfisz were chosen as the best to use for this study. There is however, many critiques of Hofstede's model (McSweeney 2002, Jones 2007, Ailon 2008, Brewer and Venaik 2012, McSweeney 2013, Venaik and Brewer 2013). According to Jones (2007), issues of cross-cultural research include (and not just specific to Hofstede):

- Definition problems - the work culture itself open to interpretation
- Methodological simplicity - is based on an ethnocentric pattern, and they represent a sign timeframe only, these errors can provide bias in research
- Functional equivalency: that a functional role in one country is the same in another (ie push bikes in Australia vs Vietnam rec vs mode of transport
- Conceptual equivalence: the cultural utility of behavioural or attitudinal constructs. For example company loyalty in Asia may be seen as devotion to ones workplace by following then rules while in Australia it maybe following instructions and not breaking the rules.
- Instrument equivalence and measurement equivalence: the cross cultural consistency of the research instruments, weather it is equally represented across the entire sample. Fo4r example some cultures will tend not to provide an extreme levels on a scaled questionnaire, while other culture tend to.

Furthermore, Jones (2007) summarises arguments against the use of Hofstede's work for the following reasons:

- Relevancy – A survey is not an appropriate instrument for accurately determining and measuring cultural disparity
- Cultural Homogeneity – Hofstede study assumes that domestic population is a homogenous whole, but most nations are groups of ethnic units.
- National division – Nations are not the proper units of analysis as cultures are not necessarily bounded by borders.
- Political Influences – Outcomes in particular to 2 dimensions, may have been sensitive to the timing of the survey.
- One company approach – A study fixed on one company cannot possibly provide information on the entire culture system of a country.
- Out Dated – Too old for any modern value, particularly with today's rapidly changing global environments.
- Too few dimension – four or five dimensions do not give sufficient information about cultural differences.
- Statistical integrity – found that on occasion, used the same questionnaire item on more than one scale, and several have significant cross loadings.

Although Jones (2007) provides detailed concerns about cross-cultural research and arguments against Hofstede, he too provide arguments to support Hofstede's research (as previously explained when selecting Hofstede for this study). Although there are critiques about Hofstede's

work, Hofstede along with most cultural researches find culture to be a dynamic, constantly changing field (Jones 2007). Therefore, it still remains a valuable piece on work but needs to be developed further and adapted to capture the shifting cultural landscape.

For this reason, I have chosen to use the work of Hofstede (2001), combined with the work of Waisfisz, Minkov et al. (2015), to interpret the values and belief systems within the ambulance organisation. To minimise ambiguity, this chapter will provide a concrete description of these dimensions both at the national level and the organisational level. Each dimension will firstly be introduced, and then subsequently applied to the ambulance organisation in a concrete way. In addition, each dimension will be illustrated through specific examples of where they appear to determine the chosen actions or activities of people within the ambulance service.

Hofstede (2001) describes six national cultural dimensions: power distance, uncertainty avoidance, individualism vs collectivism, masculinity vs femininity, long-term vs short-term orientation, and indulgence vs restraint. Hofstede compared national culture within the same organisation (IBM Corporation) over 64 countries. Hofstede assigned a value of where that particular country laid in comparison with the other 64 countries. As the host country for the setting of the study is in Australia, the follow values reflect Australia's national culture dimensions

National Culture Dimension	Australia's Score (out of 100)
Power Distance Index	36
Uncertainty Avoidance Index	51
Individualism vs Collectivism	90
Masculinity vs Femininity	61
Long Term vs Short Term Orientation	21
Indulgence vs Restraint	71

For this study, each dimension is best interpreted (and visually explained in this study) on a scale. The diagrams under each dimension, for both national and organisation culture, demonstrate characteristics that have the tendency towards one side of the dimension. The bold heading is the dimension, for example below is Power Distance Index (PDI). The code PDI in the brackets represents the short hand version of the dimension. Under the bold heading is the direction of each dimension. On the left-hand side, the reader can see Small Power Distance, a zero, and within the red box, what the characteristics of the direction of the dimension mean. Similarly, on the right-hand side, the reader can see the opposite pole of that dimension, in this example large power distance, with the number 100, and the red descriptor box underneath. In addition, after the diagrammatic representation of the dimension, each dimension is explained according to Hofstede or Waisfisz, then applied to the context of this study with a description of how it applies to the ambulance service from my experience.

Power Distance Index (PDI)

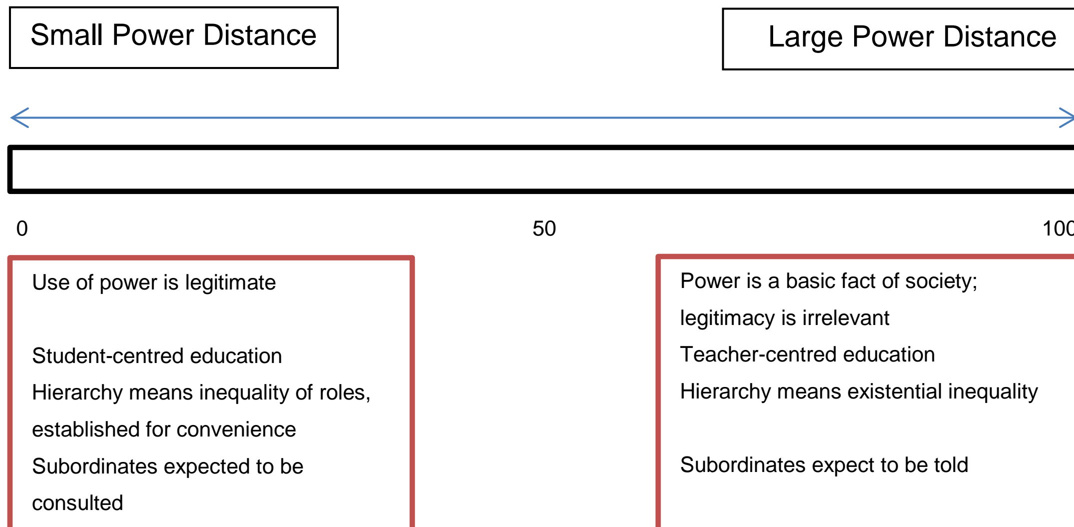


Figure 3 Power Distance Index

The concept of power distance was initially postulated by the Dutch social psychologist Mauk Mulder in 1977, and further developed by Hofstede in the late 1980s (Hofstede 2001). Hofstede described a power distance index that quantifies social inequality within a culture, by evaluating particular social factors, including physical and mental characteristics, social status, wealth, power, and law (Hofstede 2001). In other words, power distance expresses the "degree of which the less powerful members in society accept and expect that power is distributed unequally" (Hofstede 2001 p79). Mulder identified the following six key concepts that structure power distance within a cultural setting, and this was further developed by Hofstede (2001 pg 83):

1. 'The mere exercise of power will give satisfaction to the one who holds it.
2. The more powerful individual will strive to maintain, or to increase, the power distance to the less powerful person.
3. The greater the distance is from the less powerful person, the stronger the striving to increase it.
4. Individuals will strive to reduce the power distance between themselves and more powerful persons.
5. The smaller the distance from the more powerful person, the stronger the tendency to reduce it.
6. The 'downward' tendencies of the powerful to maintain the power distance and the 'upward' power distance reduction of the less powerful reinforce each other' (Mulder1977 cited in Hofstede 2001 pg 83).

Simply put, a person may become addicted to power because of the satisfaction it gives them. The effort one takes to maintain this distance, or to reduce it, are comparable to one another.

Several mechanisms exist that maintain the current power distance within the ambulance setting. Firstly, there is hierarchical power in organisational culture. Managers hold power over the workers (ambulance officers/paramedics), and their supervisors hold power over them, and so on. The exertion of power from managers is rationalized by their duty to ensure that the service delivery model is adhered to. However, managers are also typically in a position to discipline those who do not follow their directions. Such actions not only work in a direct manager-to-worker relationship, but also in a peer-to-peer context in which colleagues are able to observe the consequences of non-adherence to directions. There are other ways in which peer-to-peer processes act to maintain power distance in the organisation, such as according to level of expertise, knowledge, skills, or experience. Although paramedics within peer groups hold no formal, organisationally-vested power over others, when related to clinical level and scope of practice – basically, the skills/techniques/ medications a paramedic can undertake – there is a maintenance of power distance by social status. Social status can include factors such as how long the paramedic has been employed (inherent experience), how well liked they are amongst their peers, how much knowledge they hold (formal/informal), and their authority based on clinical practice (ambulance officer, paramedic, intensive care paramedic) and so on.

Power distance is highly contextual; who holds the power depends on the other people in that environment. Paramedics work in varying environments, including private homes, on the road, in nursing homes, in hospitals, and so on, and interact with a large array of people, including the general public and healthcare workers. This means that an organisational culture and hierarchy already exists in all of these environments and is unique to that particular environment. Therefore, when paramedics interact within these environments, they need to orient themselves to find where they fit into the organisational hierarchy. For example, a doctor in a hospital will hold more power than a paramedic, but a paramedic will hold more power that a first aid officer in the workplace. A patient may hold the most amount of power over healthcare professionals because they can refuse (some) medical treatment.

The next factor in power distance relates to that between the paramedic professional and the general public. The general public view the paramedic profession with positive regard because of the professional power it holds in situations where paramedics are called upon to help the sick or injured in a time of need (Fitzgerald 2015). The patient experiences fear, anxiety, and uncertainty (plus any physical symptoms), and paramedics hold the expertise to relieve this and to provide care. In addition, given that many ambulance professionals now hold a university degree this adds to their professional credibility, maintaining the power distance between the profession and the general public.

Finally, power is granted within law. This allows paramedics to legally do things that members of the general public are not allowed to. Typical examples include adhering to the road rules when driving (use of lights and sirens), and intervening with human bodies (for instance, injecting).

Uncertainty Avoidance Index (UAI)

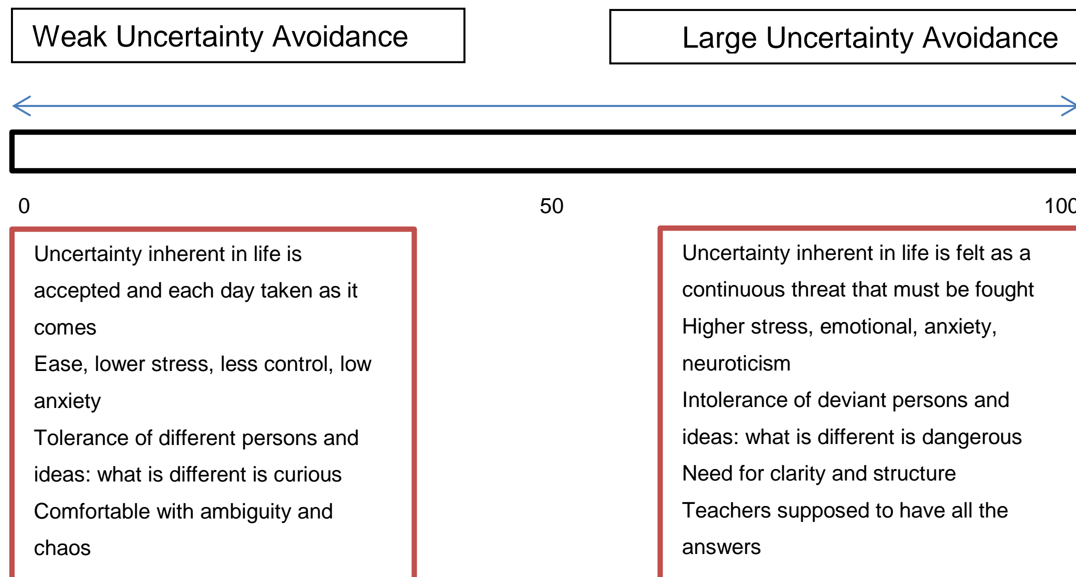


Figure 4 Uncertainty Avoidance Index

Hofstede described uncertainty avoidance as the "degree to which the members of a society feel uncomfortable with uncertainty and ambiguity" (Hofstede 2001 pg 145). Uncertainty avoidance includes tendencies towards prejudice, rigidity and dogmatism, intolerance of different opinions, traditionalism, superstition, racism, and ethnocentrism (ethnic superiority). All of these relate to a norm centred around the intolerance of ambiguity (Hofstede 2001). Organisations create rules which reduce internal uncertainty caused by the unpredictable behaviour of people. However, these rules need to take into account both predictable and unpredictable outcomes. Rules can be formal such as policies and procedures, or informal such as rituals and cultural behaviour. Therefore, the rules that are made should tolerate the accepted level of uncertainty avoidance of the organisation that is best-aligned with the work undertaken in that environment.

Dealing with uncertainty is stressful. Stress is a subjective phenomenon in human life which is provoked by four types of influences as described by Pettigrew 1972 (cited in Hofstede 2001):

1. The individual's personality, including personal history and traits.
2. The individual's non-work, private life environment.
3. The individual's work and organisational environment.
4. The larger socio-cultural environment in which the individual's personality, non-work life, and the organisation in which he or she works are all embedded (Hofstede 2001 pg 149).

It is important to identify that stress will alter a person's actions in specific situations; making uncertainty avoidance unpredictable, especially in the ambulance environment. However, this is not only limited to paramedics, but also applies to patients, family, friends, and hospital staff in the highly emotional, risky, and stressful context of healthcare.

There are several ways in which uncertainty avoidance is prevalent within the ambulance setting. Firstly, the nature of the paramedic work environment is unpredictable. Paramedics will be dispatched to all types of jobs, including deaths, aggressive patients, suicidal patients, car accidents, and minor injuries and ailments. Emergencies may be described over the phone when an emergency phone call has been made, but on arrival at the scene, paramedics may be presented with a completely different job and so may be ill-prepared. Also, the paramedic's workplace can be almost any environment, including factories, houses, the road-side, outdoors, and so on, that a paramedic may not have previously experienced or been exposed to before. This means that when entering an unfamiliar scene, paramedics not only have to manage the patient, but they also need to manage bystanders, families, and other emergency services personnel, all of which may or may not have a vested interest in the scene. For this reason, ambiguity and chaos is the norm for paramedics in this highly-stressful environment because of the multiple unknowns of the situation that paramedics are presented with.

Another factor is the limited diagnostic capabilities inherent within the pre-hospital environment. In the absence of a definitive diagnosis, rigorous patient examination and assessment ensure that the most likely provisional diagnosis is achieved, and the treatment is then tailored to that diagnosis. At times, paramedics may not know what is causing an illness/injury, and therefore, the management of this uncertainty may simply entail transporting the patient to hospital for definitive care. As a result of uncertainty in the patient's medical condition, rules are used to manage risk to ensure patient safety.

Rules for practice remove autonomous judgement. This creates an element of tension as rules, on one hand, serve to minimize uncertainty, but on the other, attempt to regulate something which is unpredictable. This is because the pre-hospital environment is unique, with each patient presenting with a condition that is surrounded by other factors that influence health, such as co-morbidities, the environment, family history, and so on. As a result, rules attempt, but often fail, to take into account the uniqueness of the patient's condition and the environment they have presented in. This means that rules are generated to take into account worst-case outcomes, and therefore, risk management involves the process of risk minimisation. As a result, rules become broad and generic, which means that paramedics may in fact break these rules if they feel that the benefits outweigh the consequences, including clinical risk and organisational disciplinary actions. On the other hand, rules are put in place due to the limited pre-hospital diagnostic capabilities of paramedics, and the heavy reliance on intuition and other patient examining techniques.

To illustrate the above point, assume that a paramedic needs to transfer a paediatric patient to the hospital. The child is screaming and agitated which, in turn, makes the medical condition worse and places increased stress on the parents. The rules may state that the patient has to be transported to the hospital in the ambulance as the insurance does not extend to private cars, as a community member is driving and there is no medical equipment on hand in the car. However, if it is perceived that the clinical risk is low, and the benefits and comfort of the paediatric patient being in a familiar environment (their car seat in their parents' car), the paramedic may choose to break this rule and travel in the car with the patient.

Finally, there is a degree of certainty about people's behaviours who are involved within and around ambulance organisations. A degree of certainty exists between people within an organisation (both inside and outside of the ambulance setting) because of the rules of the organisation. However, during times of acute medical emergencies, emotions are high which tend to cloud rational, predictable actions. For example, paramedics spend a large amount of time together dealing with emergencies, so their behaviours are more predictable. At the level of the patient/public/family/friends who do not frequently experience medical emergencies, and the person suffering such an emergency may be their family or friend, there exists a high level of uncertainty. The patient is uncertain about what is happening, is anxious for help and answers, and for their condition to be fixed. People around the patient are highly emotional because it is someone close to them who is suffering a medical emergency; they do not know what is happening, they may not be able to help them, and they want the patient to be treated. Consequently, this is the primary work environment of the paramedic; therefore, uncertainty is a part of the normal work environment for paramedics and is managed by the organisation through rules and somewhat learnt certainty of the behaviours and actions of other paramedics.

Individualism versus Collectivism Dimension (IVD)

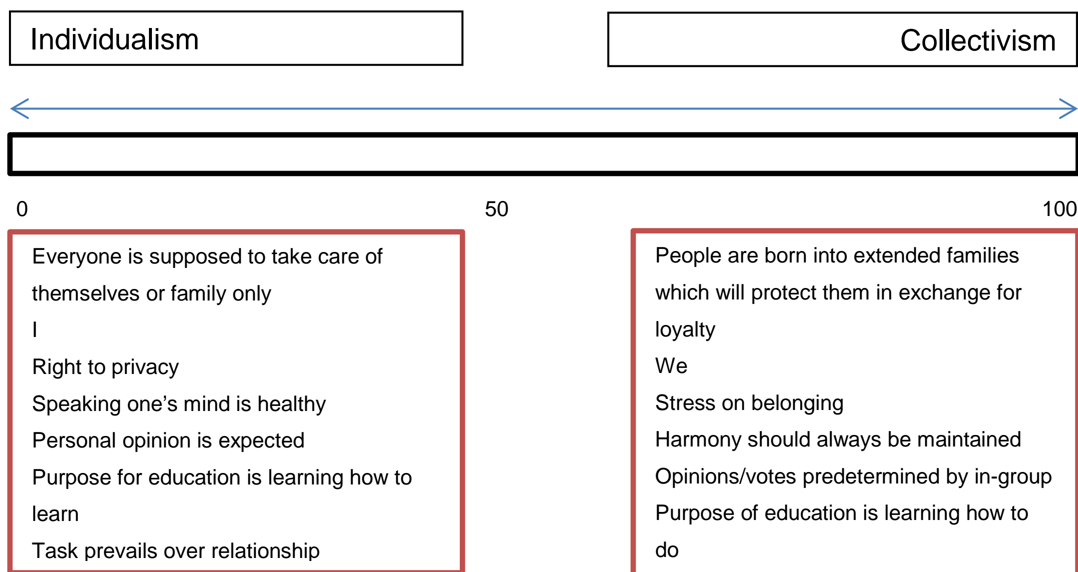


Figure 5 Individualism versus Collectivism Dimension

Individualism vs collectivism described by Hofstede (2001) is the relationship between the individual and the collective in societies, and reflects the way people live together. The relationship between the individual and the collective in society stems not only from family upbringing and the ways in which people live together (outside of the family context), but is also linked to societal norms (Hofstede 2001 pg 210). Societal norms are a reflection of a shared system of values that carry strong moral overtones (Hofstede 2001 pg 210). In this way, individualism vs collectivism is deeply embedded into a person's behaviour and attitudes towards their relationship with themselves and others. Therefore, individualism and collectivism affect the structure and functioning of many institutions as these reflect the relationship between the person and their organisation (Hofstede 2001 pg 212). This relationship extends to and affects the type of person admitted into positions of influence within the organisation because their leadership reinforces organisational values and beliefs (Hofstede 2001 pg 213). Other factors that determine the degree of individualism/collectivism within an organisation, in addition to societal norms, include employees' educational levels, and the organisation's history and culture.

There are several factors that affect individualism vs collectivism within the ambulance environment. Firstly, an overtone of collectivism exists within the profession because paramedics work in a team environment normally as a crew of two, that forms part of a larger team (area/ region). Also, collectivism is demonstrated in ways such as the uniform that is worn by paramedics (blue or green in Australia), the education a paramedic receives (currently an undergraduate university degree), and the job role they undertake (pre-hospital healthcare). Finally, paramedics form the majority of the staff of an ambulance service, and therefore, a collective identity is

facilitated because they form the largest group within the service. This identity may be portrayed according to the region/area they work in, who their partner is, or even having no identification to a group but only to the ambulance service as a whole.

On the other hand, aspects of individualism exist in the ambulance service as the organisation is formed by individuals who have the ability to think and act independently. As a result, paramedics hold the final decision as to what treatment path to take, or whether to enter a house if it appears unsafe. Also, patients hold their own unique expectations of paramedics and the service they are expected to provide. Clearly, this varies from patient to patient because of factors such as level of education, past experience with the ambulance service, hearsay through word of mouth, the media portrayal of the ambulance service, and so on. Therefore, every patient is treated as a unique individual, both in the clinical and communicable sense, which is achieved through a degree of individualism that draws from experience, expertise, and intuition, and from this, opinion as expressed by the paramedic.

However, individualism is contextual; this means that the extent of individualism exercised is specific to the environment, organisational tolerance, and the cause. For example, in a scenario with one patient and two paramedics, each paramedic has a different set of beliefs about the management of the patient; one perhaps according to organisational norms and guidelines, the other perhaps from personal experience and what is in the best interests of the patient. As a consequence, decisions made as a collective may be formed through many individual opinions. This is a concrete example of the balance between individualism and collectivism.

Finally, individualism vs collectivism is not only restricted to the patient/paramedic axis, but also extends to the management of an ambulance service. Service delivery is based on the expectations and values held by the wider community, balanced with government/healthcare expectations, and are administered by managers for the frontline workers (the operational staff). Importantly, managers form a smaller part of the ambulance service because there are more paramedics than managers, which allows the managers to be more easily identified and held more accountable for their actions. As a consequence, managers are under intense scrutiny for their actions when balancing the needs of the ambulance workforce against the expectations of their superiors and the government/healthcare sector.

Masculinity vs Femininity (MAS)

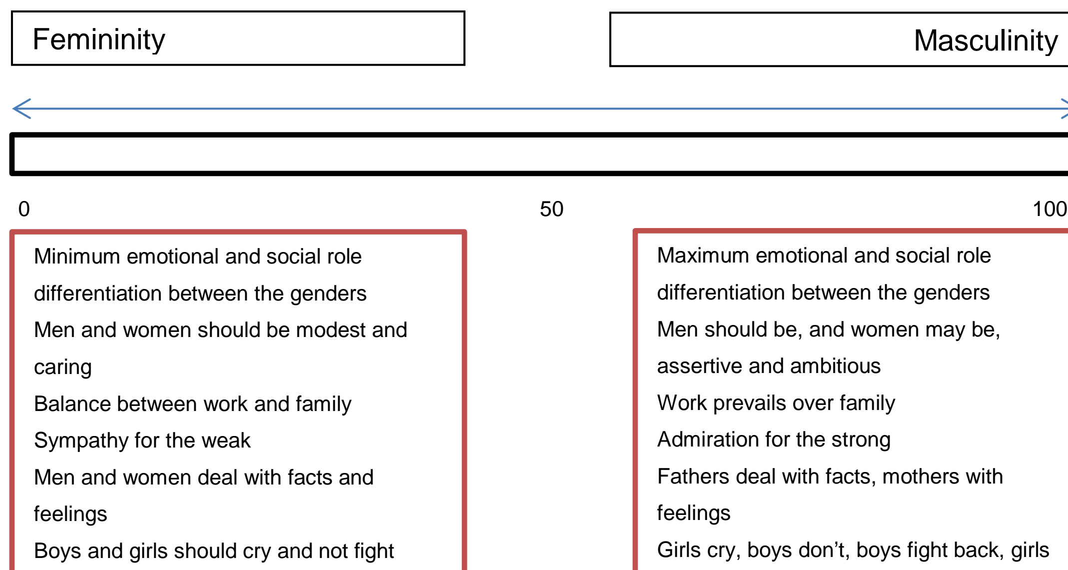


Figure 6 Masculinity versus Femininity

Masculinity is embedded in a "society in which men are supposed to be assertive, tough, and focused on material success; women are supposed to be more modest, tender, and concerned with the quality of life. The opposite pole, femininity stands for a society in which both men and women are supposed to be modest, tender and concerned with the quality of life" (Hofstede 2001 pg. 261-262). Hofstede argued that, on one hand, biological differences may exist between men and women; which are largely present irrespective of the specific social norms, as women bare children and men beget them. "Men, on average, are taller and stronger (but many women are taller and/or stronger than many men), women have, on average, greater finer dexterity and faster metabolism" (Hofstede 2001 pg. 280). Yet, on the other hand, every society recognizes many other behaviours as being more respectively suitable to females or males. These more or less represent choices that are mediated by cultural norms and traditions. So, it is important to delineate between the terms sex and gender. Sex represents the biological functions, whereas gender represents the social functions. This distribution of gender roles mediated by society concludes that men must be concerned with economic stability and family protection while women must be concerned with taking care of people and, in particular, children (Hofstede, Arrindell et al. 1998). In the context of this study, we use gender as the social function in relation to masculinity and femininity as discussed by Hofstede (2001).

Hofstede sees gender role socialisation as something that commences in childhood and is influenced by family, extended family, peer groups, and school. Socialisation he argues, continues throughout childhood into adult life via the media, life experiences, and heroes/role models (Hofstede 2001 pg 279). This means that the masculinity/femininity dimension is not about the

visible roles in society, such as men going to work and women staying at home to care. It is about the emotional roles in the home and the values they possess (Hofstede, Arrindell et al. 1998 pg. 11). As an example of the differing roles and values each possesses, Tannen (1992) researched gender differences in values, and found that more men ‘report talk’, transferring information by telling what to do and more women ‘rapport talk’, using conversation to exchange feelings, tell a story, and establish relationship.

Masculine and feminine roles have had a major impact on the ambulance service both currently and historically. Firstly, historically the ambulance officer role was considered a male profession until the mid-1970s (Wilde 1999). Wilde (1999) argued that this was because the job role required physical strength, emotional dissociation, and task orientation. The ambulance service perceived that this would be best suited for men, which became accepted as the cultural norm (Wilde 1999). However, ambulance officer education advanced from a diploma with ‘on-the-job’ training to an undergraduate university degree which attracted more females towards the profession, as they tend to be more academic than males (Waxman and Williams 2006, Joyce, Wainer et al. 2009). As a result, since the 1990s, more females have entered the workforce as ambulance officers, resulting in the male-only stereotype of ambulance officers waning (Waxman and Williams 2006). Furthermore, the paramedic job role has expanded from ‘load and go’ to ‘stay and play’, which has led to more time and emotional investment with the patients (Fitzgerald 2015). Although the male to female (sex) ratio had evolved over time, reflecting the changes in education and job roles, this can be commonly mistaken for an evolution of gender roles within the ambulance service. Defining the cultural gender norm stems from the differing views of gender diversity within the ambulance service and how this is widely accepted among peers.

Long-term versus short-term orientation (LTO)

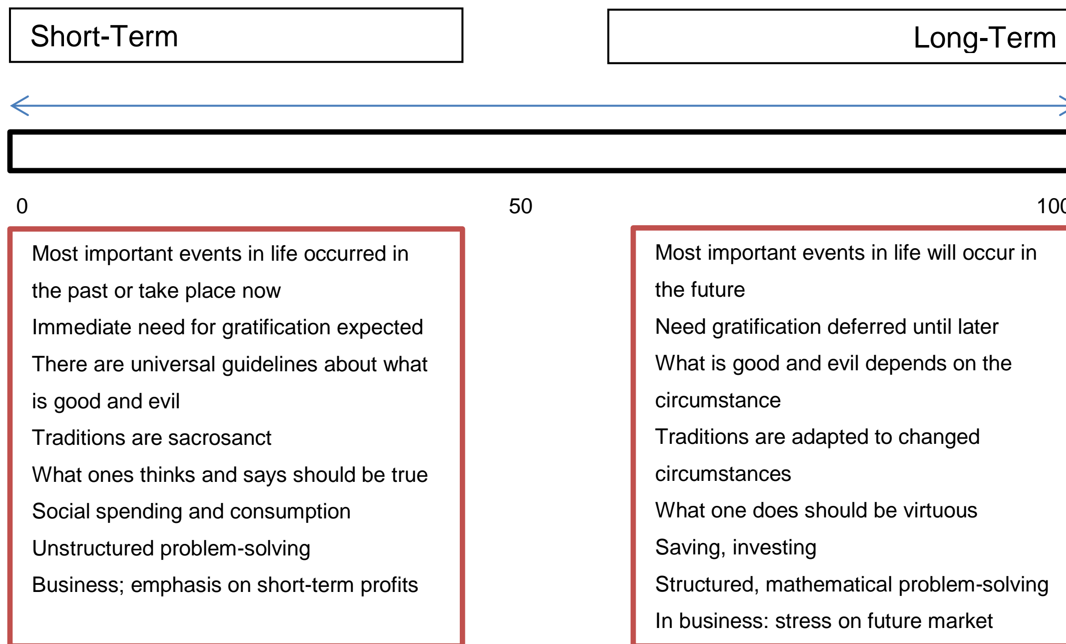


Figure 7 Long-term versus short-term orientation

This dimension describes decisions about, and attitudes towards, short- and long-term orientations. "Long-term stands for the fostering of virtues oriented toward the future, in particular thrift and perseverance. Short-term stands for fostering the virtues related to the past and present, in particular traditions, preservation of 'face', and fulfilling social obligations" (Hofstede, Hofstede et al. 2010 pg. 239). Every society must maintain some links with its own past, while dealing with the challenges of the present and the future. Consequently, past experiences influence the way in which attitudes towards decisions are made today, and this reflects people's attitudes about both the short-term (today) and the long-term (tomorrow) (Hofstede, Hofstede et al. 2010). Different groups of people tend to prioritize short- and long-term orientations in different ways. Short- and long-term thinking can be split into two areas, one dealing with work, family, and social life, the other dealing with ways of thinking (the goal to live well for example) (Hofstede 2001 pg. 351). In a business context, this dimension is referred to as normative (the short-term), which includes policy/procedures/rituals, versus the pragmatic (the long-term), which includes logical solutions to problems. In this study, both the business and the personal context of short-term vs long-term orientations will be explored as they are interconnected within the ambulance environment.

At a national culture level, people carry their own short- and long-term orientations; however, businesses also carry their own normative and pragmatic orientations. As businesses are made up of individuals, there is an element of national short- and long-term orientations influencing businesses' normative and pragmatic orientations. Staff can choose to display behaviours in line with their own personal orientations towards long term orientation, but if they do not align with business orientations towards the pragmatic, conflicting interests can occur. To harmonise these

conflicting interests, as it is reasonable to assume that all employee orientations will not directly align with business orientations, a degree of tolerance exists between the individual and the organisation.

The following scenario describes the balance between the long term orientation (individual) and the pragmatic (business). Assume that a crew needs to take a patient to hospital, and it is near the end of the crew's shift. The patient has recently been discharged from a hospital (30 minutes away) and the current condition is related to a recent illness. However, the nearest hospital (10 minutes away) can manage the condition as well. The personal short-term outcome would be that the crew could take the patient to the nearest hospital and finish on time. The personal long-term outcome would be that the crew could take the patient to the most appropriate hospital, but may finish late. In comparison to the business context, the normative may reflect simply conveying the patient to the nearest hospital, because they can manage the patient's generic condition; the pragmatic may mean that they would convey the patient back to where they were discharged from, because they are known to the hospital which can better manage the patient on a long-term basis.

Indulgence versus Restraint Dimension (IND)

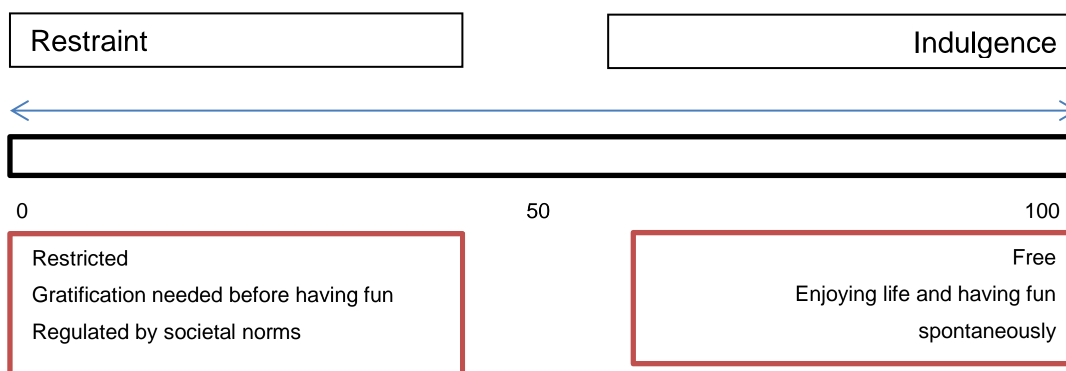


Figure 8 Indulgence versus Restraint Dimension

Indulgence and restraint are opposing values of an individual's desire, and a person's position between these can affect the work culture. "Indulgence stands for a tendency to allow a relatively free gratification of basic and natural human desires related to enjoying life and having fun. Its opposite pole, restraint reflects a conviction that such gratification needs to be curbed and regulated by strict social norms" (Hofstede, Hofstede et al. 2010 pg. 281). Varying degrees of indulgence and restraint are hallmark characteristics of human behaviour that vary between different cultural environments, particularly the differences between work and outside of work. The level of one's feeling of indulgence vs restraint in the workplace affects one's personal happiness.

For example, leisure is a closely-held personal activity that correlates to personal happiness and is a good predictor of feelings of control over one's own life (Hofstede, Hofstede et al. 2010 pg. 218).

Personal happiness is important within the ambulance environment because it correlates to positive attitudes towards work and productivity. More importantly, happiness at work affects happiness outside of work which leads to better feelings of control over one's own life. This means that happiness is interconnected between inside and outside of work, which makes it difficult to separate these two domains; for example, a negative day at work will bring negativity to life outside of work (home, sport, leisure) and vice-versa. Therefore, fostering a positive organisational culture at work that is meaningful and well-supported will ensure happiness both inside and outside of work for the employee.

Organisational Culture

Waisfisz, Minkov et al. (2015) described eight dimensions of organisational culture: means vs goal orientation, internally vs externally driven, easy-going versus strict work discipline, local vs professional, an open vs a closed system, employee vs work orientation, and degree of acceptance of leadership style, and of identification with the organisation. ITIM International (2015), founded by Hofstede and Waisfisz, is an international company that delivers organisational culture and intercultural management from the realm of academia into the business application and is heavily referenced in the following organisational culture dimension. Each of these will now be presented in the same manner as was done for the national culture dimensions.

Means-oriented versus Goal-oriented (MGO)

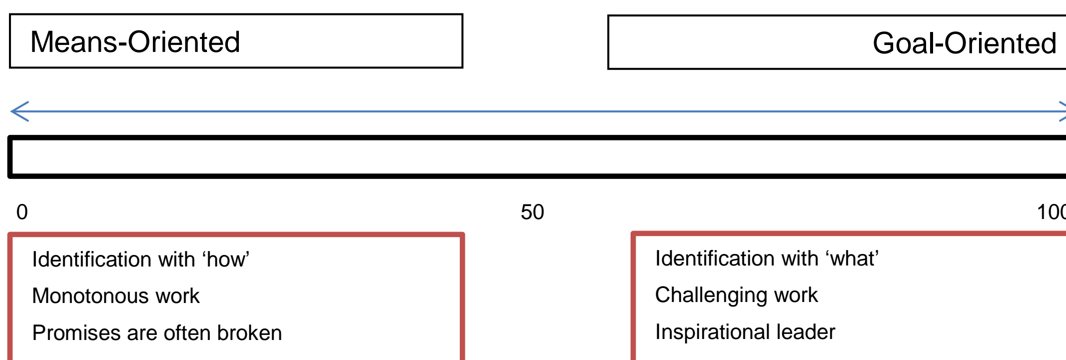


Figure 9 Means-oriented versus Goal-oriented

The key difference between means- vs goal-oriented organisations is in how the work is carried out (ITIM International 2015). A means-oriented workplace is concerned with the process (steps/how)

through which a task is achieved. A goal-oriented workplace is concerned with the result (performance/what) (Waisfisz, Minkov et al. 2015) .

There are many factors which affect means- versus goal-orientation in the ambulance service setting. Firstly, defining the endpoint of the patient's treatment journey is the key in the ambulance environment because the personal or the organisational view drives how the endpoint is achieved. Historically, in the mid- to late-1900s, the endpoint of a person calling an ambulance was to take them to hospital (Wilde 1999). In the 21st century, increasing education, the expanding scope of practice, and increased public perception of the role of the ambulance service in the community has driven the endpoint from the 'hospital' to one of 'patient healthcare' (Wilde 1999). However, the hospital is a physical, reliable, and certain endpoint, while patient healthcare is an ambiguous, complex, and unique endpoint. Therefore, definitive healthcare can be achieved in many ways, whether a patient attends a hospital, their local GP, or another healthcare provider. This means that for the pre-hospital setting, hospitalisation as the endpoint may achieve the desired results for the patient, but other pathways, such as seeing a GP, can achieve the same results.

As well, the treatment of illness/injury is a challenging process of diagnosis, treatment, and review to ensure the efficacy of the treatment plan. Depending on the organisational view, a means-oriented treatment plan will identify the steps required to achieve the goal, whereas a goal-oriented treatment plan will look at what the treatment plan is aiming to achieve. Consequently, both can be present within a single ambulance service, and the plan entirely depends on how the individual applies it.

A goal-driven paramedic for example, or even a goal-driven ambulance service, may take a patient who has an amputated hand to the nearest hospital under lights and sirens with minimal treatment. This achieves the goal of getting the patient to the hospital. A means-driven paramedic/ambulance service may take the same patient directly to the right hospital, one that has plastics/vascular/orthopaedics and commence treatment on the journey with intravenous fluids, and may take time managing the stump and hand correctly to ensure that it remains viable for surgical intervention. These additional processes may take more time to achieve, but may result in better long-term outcomes for the patient.

Internally-driven versus Externally-driven (IED)

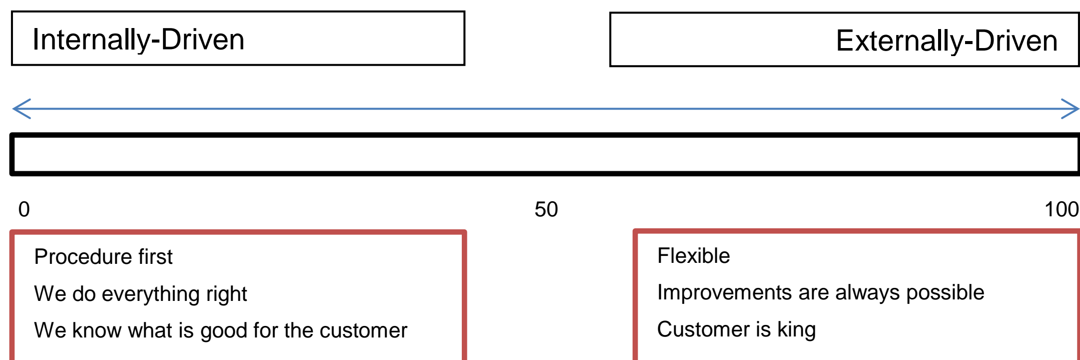


Figure 10 Internally-driven versus Externally-driven

The key difference between internally- and externally-driven organisations is where the motivation to do business originates from (ITIM International 2015). For internally-driven businesses, ethics and honesty matter most to the customer, and the organisation knows what is in the best interests of the customer, whereas externally-driven businesses place great emphasis on meeting customer requirements, and the results are most beneficial when they are achieved in a pragmatic way (Waisfisz, Minkov et al. 2015).

Ambulance organisations have both internal and external driving factors which assist in achieving good patient care. In this regard, an important question to answer is who believes they know what is best for patient (customer) healthcare; whether it is the patient themselves or the healthcare professional? The healthcare professional can frame what a normal state of health consists of for the patient and has the tools to best assess, manage, and treat the patient's health to the desired level. However, the patient knows how they are feeling and thinking, may have undertaken some research into their own state of health, can question healthcare professionals' decisions/advice, and can ultimately refuse treatment. Therefore, people entrust healthcare professionals to recommend treatment plans because of the level of training, experience, and knowledge inherent within the healthcare professions, but the professional needs to rationalise this with the patient's own beliefs, experiences, and views to achieve a symbiotic relationship.

Paramedics comprise only a small part of the healthcare team and are not normally the endpoint of patient care. To understand the role of the paramedic, break down what the term means; 'para' means 'ancillary to' and 'medic' means 'medicine'. This means that the profession is 'assisting medicine'. Medicine, and more broadly health, has many layers of expertise, including medicine, nursing, occupational therapy, social work, mental health, health promotion, and so on. Therefore, there are difficulties within paramedicine in delineating occupational boundaries, because paramedicine overlaps with many of the above-mentioned healthcare roles. For this reason,

policies and procedures are in place to ensure that paramedics stay within their operational boundaries and that the patient receives, and/or is directed to, appropriate healthcare.

Finally, the external factors that influence the ambulance organisation are the patients (what they are calling for, the volume of calls), the healthcare system, and government policy/expectations. The healthcare system and government policy need to reflect and respond to the current state of health of the Australian population. In Australia, there is a growing but ageing population which is becoming increasingly unhealthy (Australian Insitute of Health and Welfare 2014). Therefore, demand has increased for ambulance services, which increases staffing and costs. Despite this, budget constraints may limit increases in staffing numbers, which means that ambulance organisations may need to change their service delivery model, which could have negative consequences on public expectations and on patient care. Due to this, ambulance services need to remain responsive to external factors, changes in population to meet the current needs of the community, and government expectations.

Easy-going work discipline versus Strict work discipline (ESD)

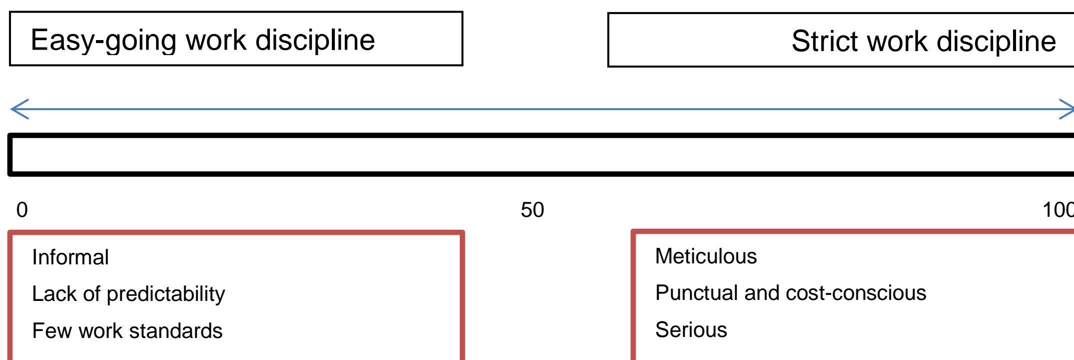


Figure 11 Easy-going work discipline versus Strict work discipline

Easy-going vs strict work discipline relates to the internal structure, control, and discipline of the work environment (ITIM International 2015). Easy-going work discipline has a loose internal structure, a lack of predictability, and little control over discipline. In contrast, a strict work discipline is very controlling, punctual, and serious (Waisfisz, Minkov et al. 2015).

There are many factors that affect work discipline within the ambulance setting. Easy-going discipline exists within the ambulance service because paramedics work from various stations and commonly in teams of two. Therefore, supervision of operational staff by managers becomes difficult, because these teams of two work on the road in an ambulance dispersed across the region. Micro-management of operational areas across the state/territory is used to assist with the

holistic management of the ambulance services across that state/territory. The absence of constant direct supervision by managers fosters an easy-going work discipline.

On the other hand, a strict work discipline also applies to ambulance services because managers have poor direct supervision over their staff and manage this by workplace policies and procedures (management by administration). Policy and procedure balances the easy vs strict work discipline because it provides a framework for operational staff to work within. If staff operate outside of these policies and procedures, and the rules are broken, disciplinary action may take place, which could include verbal or written warnings. This is because the rules are in place to provide a predictable, safe, and effective work environment, and operating outside of these rules could cause harm to the person and the organisation. Expectations, accountability, and roles are also outlined in workplace policy and procedure to provide transparency and clarity to those who operate within them (staff) and others that utilize them (patients, healthcare workers). The level of work discipline in the organisation is balanced by if/how these consequences are enforced and how much policy and procedure is embedded within the organisation.

Local versus Professional Orientation (LPO)

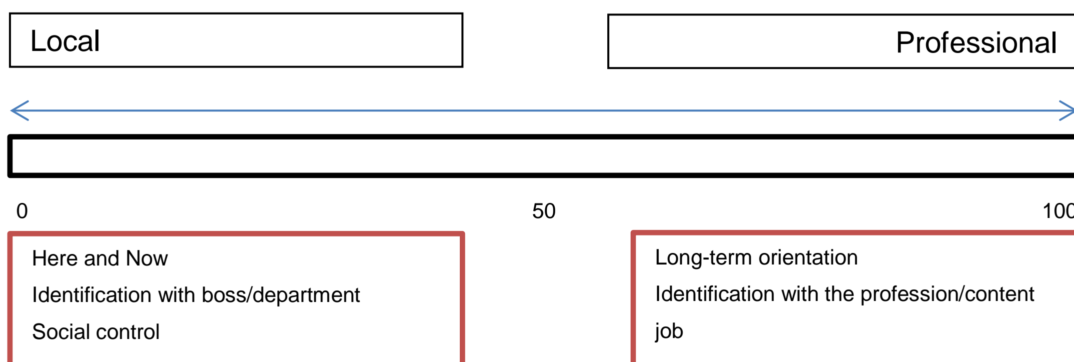


Figure 12 Local versus Professional Orientation

Local vs professional orientation (see figure 12) is how the employees identify themselves. An employee with a local orientation will identify themselves with their line manager or the area in which they work. One with a professional orientation will identify themselves with the job role and the content of their job (Waisfisz, Minkov et al. 2015). In a local culture, employees are short-term and internally focused with a strong social orientation to be like their colleagues. In a professional culture, employees are long-term and externally focused with a loose social orientation to be like everyone else (ITIM International 2015).

Local vs professional orientation varies between ambulance services and is highly dependent on the public's view of the organisation and the profession. Firstly, paramedics may identify

themselves as a part of a crew, team, region, state, or the profession. This study simplifies the identity of the profession as 'paramedic' because it is the broadest term used to describe the majority of people who undertake these tasks. An individual does not create culture; a culture is created by people, and an organisational culture by a group of like-minded people (Waisfisz, Minkov et al. 2015 pg 6). Therefore, how people identify themselves strongly correlates to the relationship that exists between them and the people in that organisation, as well as how society perceives the profession (Waisfisz, Minkov et al. 2015 pg 6).

In addition, professional identity does not exist when people do not identify themselves as part of the profession. When people do not identify themselves as a part of the profession, the profession is diminished in its growth and place in society, which results in un-delineated and fragmented professional boundaries, and reduced lobbying power. The role of the ambulance service in the broader healthcare sector is ambiguous because there are no delineated professional boundaries. For example, a paramedic may be allowed to refer a patient to see their GP in one state, but not in another. Consequently, local vs professional identification is an important indicator of successful embedding of the profession within society because it reflects the organisational culture that these organisations hold and the professional identity the individual holds.

Open System versus Closed System (OCS)

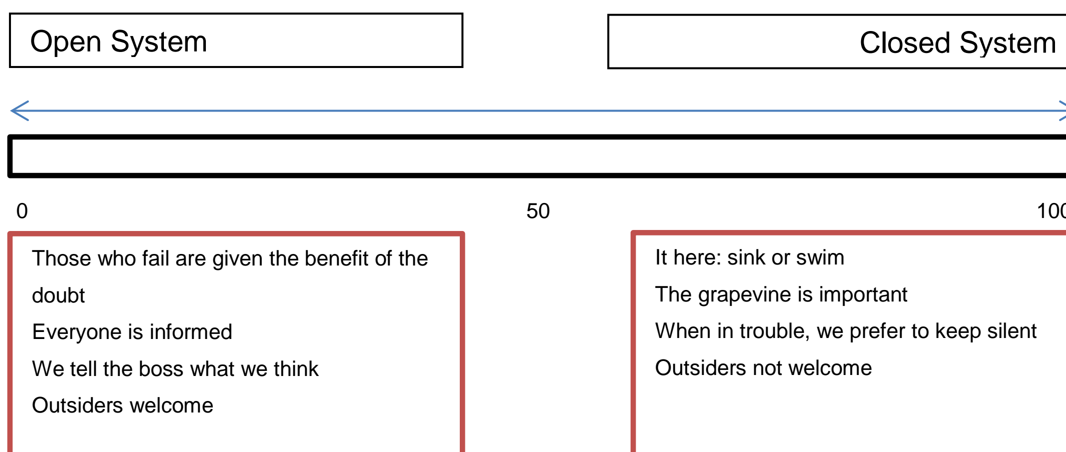


Figure 13 Open System versus Closed System

An open vs closed system is how the organisation welcomes outsiders into the organisation (accessibility) (see figure 13) (ITIM International 2015). In an open system culture, outsiders are welcome and are seen as being able to easily fit into the organisation, whereas in a closed system culture, outsiders are unwelcome, may be bullied, and do not fit into the organisation (ITIM International 2015, Waisfisz, Minkov et al. 2015).

Open vs closed systems within the ambulance environment can be represented by the degree of openness that the ambulance service has with outside organisations, including professionals, students, interns, teams, and state level operations. Firstly, first aid services provided by other professional organisations, for example, industry, companies, event organisers, or transfer services, are a similar service to those provided by the state-based service, but instead attend to the needs of specific groups. The differences between these groups can include the level of training, the scope of practice, service delivery, equipment, behaviours, norms, and so on, and consequently, the state-based ambulance service openness to these organisations may be impaired. In addition, first aid services may be in competition with the state-based ambulance service for tenders and contracts, which will influence the openness that these organisations have with one another.

Secondly, the relationship that exists between the university and the organisation has a significant influence on the level of openness that exists between them. The student level includes those participating in undergraduate university placements (joining an ambulance crew for workplace exposure). Communication between the university and the organisation in relation to placement outcomes, expectations, and requirements is important, because it facilitates a better learning experience for the student. In addition, the relationship between the student and the crew/team is also important because of the symbiotic educational relationship that exists between the facilitator (crew), the student, and the patient, which has significance for enhancing educational outcomes (Worley 2002). Furthermore, the amount of time invested in educating the student by the crew can vary as students are not employees of the ambulance service. This means that questions are raised concerning the value of educating (and investing time into) students when they may not end up being employed within the ambulance service (Lord, McCall et al. 2012).

Thirdly, ambulance service staff may not be very welcoming to new interns because of their limited life experience in a highly moral and ethical job (Waxman and Williams 2006). Unlike students, interns are employed by the organisation and therefore the stigma concerning the value of spending time to educate them is diminished. A cultural gap exists due to the nature of recruitment and employment of new paramedics into the ambulance service. Previous to undergraduate education, paramedics were recruited from the general public and did not require any previous education (training would be conducted within one's employment via a diploma). This recruitment pathway was desirable to those who were looking for a change in their career and drew in a large pool of diverse people with varying degrees of life experience. Currently, paramedic interns require an undergraduate university degree before an application for employment as a paramedic is considered. Therefore, this recruitment pathway is more desirable to the school leaver entering university because the full-time commitment to study is achievable, generally in the absence of financial burdens (i.e. house, children, etc). The diploma vs degree situation has created a cultural

(and educational) ideological gap between the two groups within the ambulance service and was based on what people perceived to be the best way to train paramedics.

Next, at the team level, it describes the team's openness with another team or other members (individuals) from another team (within the same ambulance organisation). Between teams within the same organisation, there is a shared scope of practice (clinical guidelines), organisational rituals, and policies and procedures. When a paramedic moves from one team to another, what is not known to that paramedic is the new team's specific culture, rituals, and values, and the relationship those team members have to one another and to the team. Furthermore, a level of regard and reputation, whether direct or perceived from others, has been established about the paramedic moving into the team, which will dictate the level of openness the new team will have towards them. Similar attitudes and beliefs exist between teams (not just the individuals) and this too will dictate the level of openness the teams will have towards each other.

Finally, an organisation's openness at the state level relates to when paramedics move between states and the attitudes and culture of the organisation accepting them. What is known about the paramedic moving from another state's ambulance service to the local state is they have been a practising paramedic in their home state. What is not known, is how they have been trained, how competent they are, and how they will fit into the local ambulance culture. A paramedic who has been inducted into a different ambulance organisation will bring across that organisation's values and belief system into the new ambulance organisation. Therefore, a local induction program for new employees will not only contain organisational policies, procedures, practises, and rituals, but will also seek to embed the organisational values and belief systems into the new paramedics.

Employee-oriented versus Work-oriented (EWO)

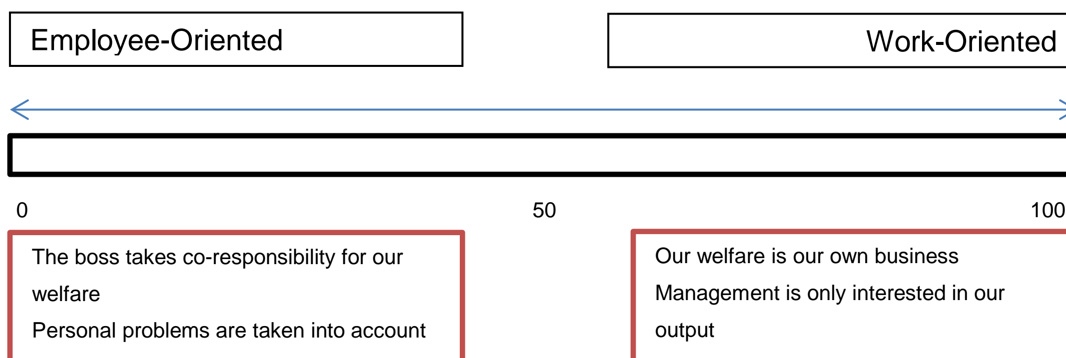


Figure 14 Employee-orientated versus Work-orientated

Employee- vs work-oriented is how the organisation treats the employee (see figure 14) (ITIM International 2015). In a very employee-oriented workplace, the staff feel that their personal

problems are considered and that the organisation has a responsibility for their welfare; whereas in a very work-oriented workplace, employees are under pressure to complete tasks and the welfare of the employee is not considered (Waisfisz, Minkov et al. 2015).

There are several ways in which the employee vs work orientation is present within the ambulance service setting. Ambulance crews work long hours, generally in pairs, and with the same people within a team. Long hours spent with a partner at work builds a rapport with them and with it, professional empathy, which makes the partnership more relaxed, understanding, and personal. Constantly being exposed to the sick or injured can take an emotional toll on the well-being of the paramedic. Consequently, the relationship built between the crew can be a successful strategy to deal with this stress and emotional burden (Sofianopoulos, Williams et al. 2012). In fact, ambulance organisations are required to provide a safe working environment under the law and this includes supporting the emotional well-being of workers (Safe Work Australia 2007, Sofianopoulos, Williams et al. 2012). Resources to support the emotional well-being of paramedics may include peer support programs, councillors, and psychologists (South Australian Ambulance Service 2015d).

In comparison, work-orientation within an ambulance service is a necessity because it is an emergency service with both public and government expectations of performance. The ambulance service is an emergency service with finite resources (on-road ambulances) and variable demand (how many calls for an ambulance are received). Ambulances are called during emergencies with an expectation (public)/requirement (health policy) to arrive promptly, according to national benchmarks, in order to deliver quality clinical care (Productivity Commission 2015). Therefore, ambulance crews are affected by the workload as they can be dispatched to any job at any time, which could mean that the crew may not get breaks on time, or at all, or may finish late. Consequently, crews are expected to accept each task even if it means finishing late, because it is an expectation that every emergency call receives an ambulance. Frequent over-time and late, or no, breaks are considered normal, although undesirable, within the ambulance environment. A fine balance exists between the employee well-being orientation to finish on-time so that time can be spent with the family, versus the work-task orientation to serve the wider community and accepting a job even if it means finishing late.

Degree of acceptance of leadership style (ALS)

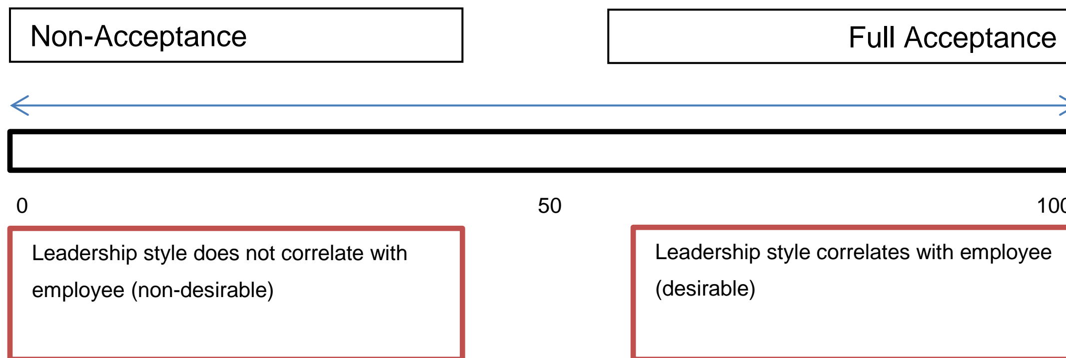


Figure 15 Degree of acceptance of leadership style

The degree of acceptance of leadership style is how employees align their preferred leadership style to that of the one being displayed by their line manager (ITIM International 2015). The degree of acceptance of leadership style (see figure 15) is important within the ambulance service and can be viewed on a spectrum ranging from non-acceptance to acceptance.

The degree of acceptance of leadership style includes the alignment between employee expectations and managers' delivery of leadership style. Leaders are placed into management positions because they reflect good decision-making abilities, have a high level of regard/reputation, and they model organisational values and beliefs. Power is inherently embedded in the manager's role, but this may not mean that the subordinates (the staff below them) agree with their leadership style. Leadership is often coupled with managers, but is not restricted to them; it can exist between a crew or a group of peers. In addition, clinical leadership exists when staff who have greater clinical authority to practise guide the further treatment of a patient. An example of this in the ambulance context is when an area manager arrives at a complex job. Staff under them may prefer the manager to take control of the job and tell everyone what to do. On the other hand, the staff may prefer the leader not to take control, but to stand back and help to facilitate the job with the collaboration of all the staff at the scene.

The coherence of organisational culture is enhanced by people who possess similar leadership styles to those they lead because acceptance is more widespread and consistent across the organisation. These shared sets of values of good leadership are shown at different levels including the crew, the team, and management; and consistency across an organisation is considered a norm and this becomes what is expected of a leader. Therefore, leadership experiences, both good and bad, shape the values an individual holds towards good leadership.

Degree of identification with the organisation (IWO)

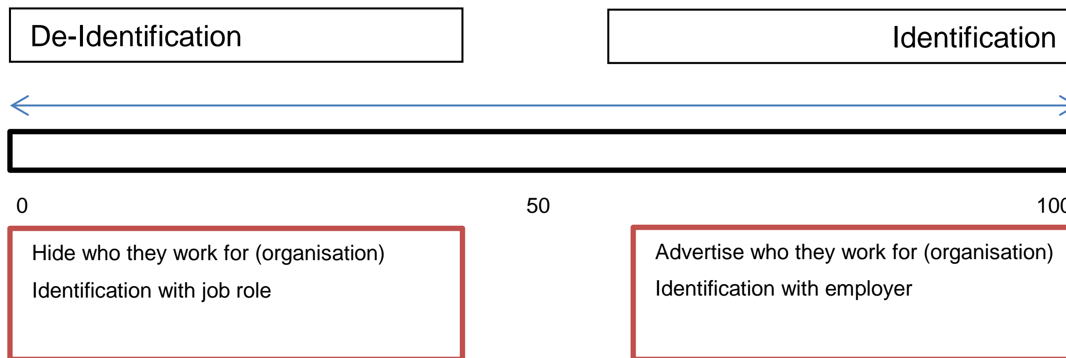


Figure 16 Degree of identification with the organisation

Degree of identification with the organisation is how employees identify themselves with the company in its totality (see figure 16) (ITIM International 2015). The factors that influence identification with the organisation within the ambulance context can include public perception of the profession/organisation, company morale, happiness and treatment of the employee. Identification with the organisation is similar to local vs professional orientation (LPO) but differs in viewing the organisation on a personal level. In the ambulance context, these dimensions all contribute to the degree of identification a worker has to the employer. How individuals and organisations view each dimension will determine the overall level of identification, and can vary between organisations and cultures. Therefore, similarities between the individual and the organisation should lead to greater identification with the organisation, whereas differences will lead to less identification.

Interpretive Framework

The aim of this study is to gain a deeper understanding of the educational need for, and value of, the paramedic internship. Given the complex nature of ambulance services in Australia and the turbulent educational history, a cultural lens has been chosen as the interpretive framework. Hofstede (2001) and Waisfisz, Minkov et al. (2015) dimensions of national and organisational culture have been selected as the most appropriate for this. National cultures differ from each other primarily in their values, while organisational cultures differ mainly in their practices, and is hence why both are important for the interpretative framework for this study (Hofstede 2001). Therefore, the research question is: what are the values and beliefs that underpin a paramedic internship using an interpretive framework derived from Hofstede and Waisfisz et al's cultural dimensions? Table 2 provides a summary of the dimensions used for this study.

Table 2 Dimension of National and Organisational Culture

National Culture – Geert Hofstede	Organisation Culture – Bob Waisfisz
• Power Distance • Uncertainty Avoidance • Individualism vs collectivism • Masculinity vs femininity • Long-term vs short-term • Indulgence vs restraint	• Means-oriented vs goal-oriented • Internally-driven vs externally-driven • Easy-going work discipline vs strict work discipline • Local vs professional • Open system vs closed system • Employee-oriented vs work-oriented • Degree of acceptance of leadership style • Degree of identification with the organization

Conclusion

This chapter has defined the concept of culture and outlined Hofstede's (2001) dimensions of national culture and Waisfisz et al.'s (2015) dimensions of organisational culture. The connection of each dimension with ambulances services has also been demonstrated. Using these definitions and descriptions, the following chapter will describe the methods used to answer the research question.

5. METHODS

Introduction

This chapter will outline the methods undertaken to gather and analyse data about the values and beliefs that underpin a paramedic internship. A qualitative research design was chosen as it was considered ideal to achieve to the research aims and answer the research question. To understand the values and beliefs that underpin a paramedic internship, an interpretive framework, derived from Hofstede's (2001) 'national culture model' and Waisfisz, Minkov, et al's (2015) 'organisational culture model', as described in the previous chapter, has been chosen.

Research Design

The research design needed to ensure an understanding of the phenomena being studied by interpreting the participants' behaviours, attitudes, beliefs, and meanings. A qualitative design is frequently used in health research because of its strength in understanding values, attitudes, and beliefs by observing, interpreting, and inferring behaviours (Schneider and Whitehead 2013). To answer the research question for this thesis, the question itself needs to be broken down and explained to ensure clarity about who and what the study aims to research, and the methods through which this will be achieved.

<u>The Values and Beliefs that Underpin a Paramedic Internship</u>

Values and Beliefs

In order to understand the concept of values and beliefs it is important to explore Hofstede's (2001) concept of mental programming. Hofstede (2001 pg 1) described mental programming as a person's behaviour that, to some extent, can be predicted and which is specific to a particular situation and person. Values and beliefs are explored by presenting the individual a particular situation and then analysing their responses, which are unique and specific to the individual (Hofstede 2001). Values are a "broad tendency to prefer certain states of affairs over others" (Hofstede 2001 pg 5). Beliefs are individuals' enduring interpretations and application of a value to which they hold to be true (Hofstede 2001). The exploration of values and beliefs can best be achieved by purposively selecting participants to undertake semi-structured interviews.

The Paramedic Internship

The paramedic internship is the educational program that paramedic interns complete at the beginning of their careers to be inducted and placed into the job role and the organisation. The people who are a part of the design, delivery, and development of the program, the key stakeholders, embed their own and the organisation's values and beliefs into the program. This is

done to ensure that the next generation of paramedics are able to understand and assimilate into the culture of the ambulance service.

An interpretive framework was needed for this study to ensure that the research question would be adequately addressed to generate meaningful results. The following will explain why the interpretive framework, adapted from the work of Hofstede (2001) and Waisfisz et al. (2015), was used to interpret the data within the context of the paramedic internship.

The interpretive framework selected needed to be able to facilitate the answering of the research question which focused on understand values and beliefs. Values and belief systems are embedded in cultures, and culture is defined as:

> *a patterned way of thinking, feeling and reacting, acquired and transmitted mainly by symbols, constituting the distinctive achievement of human ground, included embodiments in artefacts; the essential core of culture consists of traditional ideas and especially their attracted values (Kluckhohn 1951 pg 865).*

Hofstede is one of the most notable researchers of national culture (values held at a national level that are considered societal norms) of his time (1980s), and his cultural model remains widely used across the world (for examples see Detert, Schroeder et al. 2000, Scott, Mannion et al. 2003, Jippes and Majoor 2008, Jippes, Driessen et al. 2015). Hofstede's first publication presented the results from the Values Model Survey (VMS) into national culture which conducting a survey across the same organisation that held offices in many different nations. Although Hofstede's model has its critics (for example see Jones 2007, Brewer and Venaik 2012 , McSweeney 2013), it was popular because there was minimal research into culture at that time, and his research met the growing demand for a cultural framework (Jones 2007). Culture is a constantly changing field (Hofstede 2001, Jones 2007), and some have argued that using Hofstede's model for analysing an individual in a group is inappropriate, because national culture does not apply at the individual level (Brewer and Venaik 2012, McSweeney 2013). However, De Mooij (2013) argued that there is an overlap of individual values with those at the national level; therefore, national values are an indicator of individual values. Institutions reflect the values of the individual members of the society in which they belong, and if they do not, that society will not be able to function (De Mooij 2013).

Dimensions of Hofstede's model have been used in previous studies as an interpretive framework for cultural measurement within organisations (Detert, Schroeder et al. 2000), and in the healthcare sector (Hofstede, Neuijen et al. 1990, Scott, Mannion et al. 2003, Jippes and Majoor 2008, de Kort, Wagenmans et al. 2010, Borg, Camilleri et al. 2012, Jippes, Driessen et al. 2015). Hofstede's six dimensions are:

- Power Distance Index (PDI)
- Uncertainty Avoidance Index (UAI)
- Individualism vs Collectivism (IVD)
- Masculinity vs Femininity (MAS)
- Long-Term vs Short-Term Orientation (LTO)
- Indulgence vs Restraint (IND)

However, Hofstede and others, have identified that his model is specifically intended for developing an understanding of national culture and was not intended to be used to analyse organisational culture (Hofstede 2001, de Kort, Wagenmans et al. 2010, Brewer and Venaik 2012, The Hofstede Centre 2014). As Hofstede (1980) believed, elements of national culture and organisational culture overlap, and with the help of his colleagues, he started to study how national culture could help to explain organisational culture. Hofstede, Neuijen et al. (1990) asked employees of 20 Dutch and Danish organisations to describe the culture of their organisation. The analysis revealed eight dimensions of organisational culture that were fundamentally different from Hofstede's six dimensions of national culture. As mentioned previously, elements of national and organisational culture do overlap (De Mooij 2013),but the differences are that the core of national culture consists of values (what is important to people), whereas the core of organisational culture consists of practise (what people do) (Minkov, M cited in Waisfisz, Minkov et al. 2015 pg 3). These eight dimensions of organisational culture have been validated and published by Waisfisz, Minkov et al. (2015) in "Constructing the Best Culture to Perform". These eight dimensions are:

- Means vs Goal orientation (MGO)
- Internally vs Externally driven (IED)
- Easy going vs Strict work discipline (ESD)
- Local vs Professional orientation (LPO)
- Open vs Closed system (OCS)
- Employee vs Work orientation (EWO)
- Degree of Acceptance of Leadership Style (ALS)
- Degree of Identification with the Organisation (IWO)

Waisfisz, Minkov et al.'s (2015) model for organisational culture has not been used to date in any study design, possibly because the model has only recently been published. However for this study, we will use both Hofstede's (2001) six dimensions of national culture and Waisfisz et al's (2015) eight dimensions of organisational culture as the interpretive framework for this study.

Setting

One paramedic internship formed the setting of this study. The ambulance service that was the setting of this study, SAAS, is the largest recruitment organisation in the state and is where new graduates are first employed as paramedics in South Australia. The SAAS is the only paramedic internship provider in South Australia. Further details of the SAAS have been presented in chapter three.

Ethics

Ethics approval was sought from South Australian Department of Health (SA Health), the South Australian Ambulance Service (SAAS), and Flinders University. A National Ethics Application Form (National Health and Medical Research Council 2013) was required to gain the approval of SA Health and the SAAS in order to conduct this research.

Upon initial submission, the SA Health Human Research Ethics Committee (HREC) determined that the research protocol required a peer reviewer. Dr Louise Reynolds was approached, who at that time (2013) was the topic coordinator for Qualitative Methods for Social Health Research at Flinders University, and was a qualified paramedic formally employed by the SAAS. Dr Reynolds is an expert in qualitative research who understands the culture of the paramedic context, and hence was a suitable choice to review the study protocol. Dr Reynolds identified a few minor issues with the protocol which were rectified.

The SA Health HREC was concerned about participant confidentiality and requested further clarification of the process to de-identify the participants. The SAAS is a relatively small organisation and staff members are known for their views on certain issues which could make them easily identifiable. Furthermore, the participants sought for this study were in management positions and were senior to the primary researcher (also a SAAS employee); therefore, the potential power imbalance was in favour of the senior management rather than the researcher. Participants were encouraged to respond freely and honestly to the questions being asked, and were reassured that they would remain anonymous and their answers confidential. In order to maintain confidentiality and anonymity of the participants given the small number of such positions within the SAAS, generic terms (ie, manager 1, 2, 3) replaced specific job role terms (ie General Manager XX) in the transcribed data. Furthermore, to enhance the protection of individuals the views and opinions collected were de-identified throughout the research.

The ethical issues identified by the SA Health HREC were addressed and the application approved on 3/5/2013 (HREC/13/SAH/24 See Appendix C). This approval was then forwarded onto the Flinders University SBREC for file reference. The Site Specific Assessment (SSA) was presented to the SA Ambulance Service Research Committee who approved the document (SSA/14/SAH/80). This concluded the ethics approval process.

Participants

The participants sought for this study held direct influence over the paramedic internship and, in particular, over its content and delivery. In 2011, the SAAS undertook a review of their paramedic internship to update the curriculum and to move the program forward to meet contemporary standards (Borrowdale 2015). This review used selected people, workgroups, and course designers to re-model the existing curriculum. These key stakeholders had direct influence in what they, and the organisation, perceived was the best way to design, develop, and deliver the paramedic intern program. The stakeholders were selected with diversity in mind, in order to capture staff with a vast array of personal experiences and roles who held varying views on the expectations of the desired/desirable outcomes to be invested into the new intern program. This project sought a sample of these stakeholders, and therefore, some local knowledge was required to identify appropriate individuals. The general manager of clinical education was approached by email and asked to identify a sample of key stakeholders in the paramedic internship review process. The general manager was chosen, as their role was to oversee clinical education within the SAAS. The manager's response identified five key individuals who would be appropriate for participation in this study.

The five key individuals were approached via an email, sent by the general manager of clinical education on behalf of the researcher, and included an information sheet which contained details about the primary investigator and the supervisors, a description of the study, the purpose and benefits of the study, what they would be asked to do, and how they could register their interest (See Appendix D). All five people responded within two weeks either directly by email or indirectly via their personal assistants. One participant had to withdraw prior to the data being collected, due to unforeseen circumstances. The participant withdrawal was discussed with the general manager and the person who acted as their reliever (filled in their job role) was recommended as a proxy. A sixth participant was further identified by one of the participants in the study as an important key stakeholder and as being particularly useful for the context of this study. The additional participant was discussed with the general manager who confirmed that they would be an appropriate participant, and they were subsequently included in the study.

Written consent was gained from the participants prior to data collection via a standard consent form (See Appendix E). The participants were informed that they would be de-identified, were free to refuse to answer questions, and were able to withdraw from the study at any stage, without recourse. A copy of the consent form and the information sheet were provided to the participants and all originals were kept on file.

Data Collection

Interviews were selected as the best way to gather data about the individuals' values and beliefs regarding the paramedic internship. Direct data would be gained from the participants via a semi-structured individual interview. Semi-structured interviews allow participants to be more flexible with their responses and also allow the interviewer the additional freedom to explore and discuss responses generated from the set questions (Schneider and Whitehead 2013). The use of semi-structured interviews also facilitated clarification of themes that developed during the data collection and analysis phases because the researcher could ask more questions to attain better understanding of emerging ideas and themes. Interviews were viewed as the best way to attain data. Interviews can be conducted one on one, in a private space, where concepts can be discussed in details and, in this study, audio recorded. Focus groups were not appropriate as the influence of others may restrict the open and honest conversations. Surveys were not appropriate as they could not capture the depth of the questions being asked and could not be discussed further with the participant to seek clarity. Ethnographic approach would be inappropriate as the primary researcher works for the organisation being studied.

Interview questions need to have an underpinning meaning and a purpose beyond the overt to ensure good data can be generated to answer our research question (Schneider and Whitehead 2013). Questions need to be directed at elements that construct the paramedic internship, as the overt meaning, but underpinning the respondents answers are the individual's values and beliefs. This is achieved by asking questions that place the participant into a specific situation, then further probing their response and their rationale for responding in that particular way. The questions also needed to relate to the respondent's thoughts and feelings about how they believed the paramedic internship should be structured and conducted. In addition to this, the respondents needto establish how they saw themselves within the ambulance service (regard) and how they think others see them (reputation) . These questions will provide cultural insights into the organisation, the participants, and how much value and power they (both the participant and the organisation) place on themselves and others in making decisions within the organisation. How they react, or say how they would react, would reflect their mental programming, which can be used to generally predict their behaviours (Hofstede 2001). The questions (see Appendix F) were broken down into the following key areas:

<u>Experience</u>

These questions allowed us to gain background information from the participants about their years of service and the location of that service as a paramedic. This helped to establish workplace diversity and past experiences as a context for to the participant's responses to the questions.

Influence

The aim of these questions was to establish how much power and influence the participant has, or perceives they have, over the paramedic internship. The questions in this section were answered through a Likert-type scale, with number 1 being poor and 10 being great. The participants were then be asked to provide their rationale for the ranking provided. This provided magnitude to the values and beliefs they wish to place into the internship program.

Internship Structure

These questions explored how the participants believe the internship should be structured (outcomes, goals, etc). This identified their ideal model for a paramedic internship and validated which elements of the current internship they value and which they do not.

Competency

The term 'competency' has a very broad definition and is interpreted differently by different people. The aim of these questions was to identify how the participants view competency within the internship.

Learning

The educational ideology of the participants was explored. This established the different level of educational expertise the participants have, and the educational ideology that the participants hold, within the ambulance service.

Quality

Questions regarding the quality of the paramedic internship were asked because the internship is very diverse from state to state and can be a very topical issue. This set of questions was asked to identify how the participants measure the perceived quality of the intern program by comparing the different types of educational pathways used by the ambulance services.

Status

The aim of these questions was to identify the role of the participants in the internship review and how their views were received. This explored the hierarchy and the collaborations within the group that conducted the review.

Behaviours

Questions asked here relate to how the participants perceive the behaviours of paramedic interns. The idea behind these questions was to explore the internship through the eyes of the paramedic intern. This identified the level of understanding the participants have of interns' needs, views, desires, and wants. The questions in this section were in the form of statements pertaining to what the internship is designed to achieve.

Profession

Concerns about the portability of paramedics to move from state to state initiated this study, and therefore, it was felt to be important to explore this situation and to identify the barriers. This aided in the discussion of how to overcome these barriers, and will hopefully lead the profession towards a system of national registration.

The interview script was piloted with Dr Reynolds (Flinders University) in the presence of the researcher's supervisors, to ensure that the desired depth of the questions being asked was achieved and that the interview timeframes were tested. Some minor rephrasing was undertaken as a result of this pilot.

Interview Location, Length, and Recording

Interviews were conducted during business hours at a SAAS location chosen by the participant. Interviews were conducted between August and September 2013, and the primary researcher was the sole interviewer during this process. The interviews were digitally recorded and later transcribed by a professional transcription company. The length of the interviews ranged from 45 to 90 minutes. Notes were taken during the interview process to ensure that answers could be further developed and that any issues that may have been missed were covered at some point during the interview. This process ensured that the interviews ran smoothly, efficiently, and on time. The data collection process is shown in Figure 17.

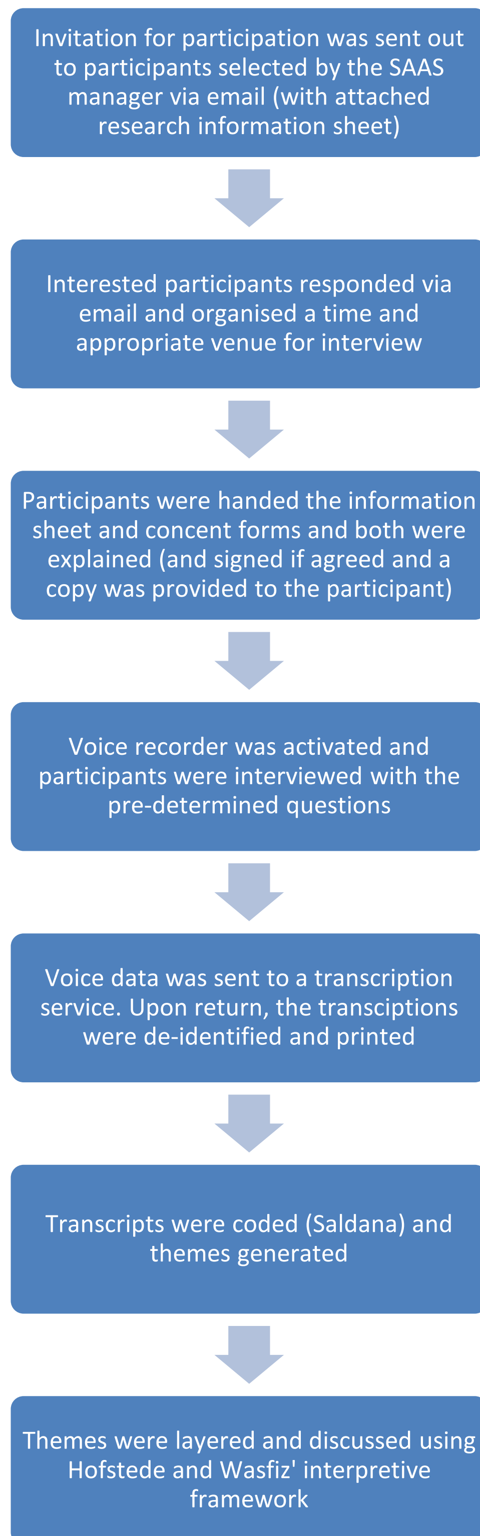


Figure 17 Data collection and analysis procedure

Data Management

The data were stored in electronic and paper-based formats in line with the National Health and Medical Research Council (NHMRC) policy (National Health and Medical Research Council 2015). Email communication was conducted through the researcher's SAAS account or the Flinders University student account, both of which are password-protected. Emails were deleted if they did not contain information that needed to be stored; for example, interview requests. All paper-based data, such as consent forms and interview notes, were kept in a folder and secured in the researcher's office. Voice-recorded data were uploaded in an encrypted online format to a transcribing service, Pacific Transcription, which abides by the Privacy Act 1988 (Pacific Solutions Pty Ltd 2015). The transcribed interviews were then de-identified by substituting names with generic role terms, i.e. Manager 1. The original electronic transcripts (raw and de-identified) were saved onto the researcher's password-protected computer. The de-identified transcripts where then printed and held within a folder for data analysis. Upon completion of the study, all the data including the paper-based data will be digitised, where it will be stored securely at Flinders University for seven years, while all the remaining paper-based data will be shredded.

Data Analysis

Coding

The data were coded, themed, layered, and interpreted using the theories of Hofstede (2001) and Waisfisz, Minkov et al. (2015) as a multi-layered approach to data analysis. Paraphrasing the participant responses on the printed de-identified transcripts assisted in enhancing the clarity of the conveyed messages and the understanding of the participants' actions. These paraphrases were then analysed using multiple first-cycle coding methods to yield individual codes (Saldana 2013). The three coding methods used were: descriptive coding, to provide a summary of the points discussed; process coding, to understand human action; and values coding, to reflect the participants' values, attitudes, and beliefs (Saldana 2013).

Descriptive Coding:

Descriptive coding summarises statements that are important to ensure that the correct statement and meaning is conveyed (Saldana 2013). Participants can sometimes tend to not answer questions directly and can give convoluted or intertwined responses. Paraphrasing the participants' responses aided in the interpretation of what each participant was saying in the context of the ambulance profession. Research bias could be perceived here, as my interpretation of the participants' responses could be placed in the context of what I feel is important. However, my employment with the SAAS could be beneficial to the responses, as I can understand and apply meaning to the current context.

Process Coding:

Process coding provides conclusions with a clear and authentic decision-making pathway (Saldana 2013). The decision-making process is generally made up of clear and logical sequential steps. Within these steps, the individual person's values and belief systems will influence the direction of the process. Values and belief systems can therefore be determined by the steps, whether actual or perceived, that the participant took in response to the questions.

Value Coding:

Value coding is the analysis of data that reflects the participant's values, attitudes, and beliefs. The language that is used when responding to the questions will direct whether the response is a value, an attitude, or a belief. However, the language used can be deceptive because of the environment, situation, and context, or even the level of privacy assured, which can yield inauthentic responses if privacy is not secure (Saldana 2013). As a result, value coding can be unrealisable in isolation, so it is best to be interpreted in conjunction with other coding methods, which has been the approach in this study.

First-pass coding using the above techniques generated 132 different codes from the six interviews. In order to narrow the 132 codes down to generate themes, firstly categorisation was undertaken to link similar codes to one another, and then eight major themes were identified.

Layering and Interpretation

Firstly, the eight themes were layered to identify the similarities between the groups that hold ownership of the themes. These were then broken down into Profession (Job), Organisation (Management), Workplace (Team), and Employee (Me) (discussed in more detail in the findings chapter). Following this, each theme was discussed to reveal its meaning and importance, with the provision of supporting statements from the interviews. Next, the literature to support the themes was discussed. Finally, the themes were interpreted using the key dimensions of Waisfisz et al.'s (2015) organisational culture and Hofstede's (2001) national culture. These key dimensions are the core values and beliefs that underpin the paramedic internship.

Rigour

A combination of techniques was used to ensure the rigour of this study, particularly the trustworthiness of the qualitative research design, by clearly outlining the steps used to accurately report the findings. Guba and Lincoln's (1989) criteria for rigour, cited in Schneider and Whitehead (2013 pg 154) was used to demonstrate the trustworthiness of this study.

Trustworthiness is judged on the following four elements:

- Credibility (internal validity) – the truth of the findings as judged by others within the

discipline;

- Auditability (dependability with reliability) – the adequacy of the information through the various steps of analysis taken to interpret the findings;
- Fittingness (transferability with external validity) – the everyday reality for the institution being researched; and
- Confirmability (with objectivity) – findings that reflect the implementation of credibility, auditability, and fittingness standards (Schneider and Whitehead 2013 pg 154).

Ensuring that these four elements are considered in each process of the research design will increase the trustworthiness of the findings for the reader. Trusting the analysis of this study will not only link the values, beliefs, and organisational culture together, but will also aid in answering the research question for this study. With a robust and rigorous outcome, we may influence the ambulance community by helping to disentangle the cultural divide between state-based ambulance services and the perceived necessity of a state-based internship.

Credibility

A qualitative design was selected because values and beliefs are based on the mental programming of the individual and their behaviours and verbal responses when a situation is presented to them. The study is designed to develop ideas but not to measure them. The primary researcher is employed by SAAS (for past seven years) and it can be assumed that the culture of the organisation is well-known to the researcher. The researcher has a Bachelor in Health Sciences (Paramedic), and a Graduate Diploma in Clinical Education.

A SAAS manager selected participants whose role had influence on the design and development of the paramedic internship. These participants were purposively selected as the research question aimed to explore the values and belief system embedded in the program. Therefore, the participants needed to have played a direct part in this program, and to be able to express their individual values and beliefs, and how these were embedded into the paramedic internship program. The data were collected via interviews with these participants whose roles within the organisation varied from non-operational managers, through to operational managers and ambulance education staff. The participants were continually reminded that they were able to withdraw at any stage, and to not answer questions during the interview if they wanted.

Semi-structured interviews were used to collect the data to ensure that interactive questioning could take place, and so that each question could be fully explored. Further questions were asked from the thoughts and feelings of the participants in relation to how they believed that the paramedic internship should be structured and delivered. The interviews also probed for information on how the participants saw themselves and how others saw them within the ambulance service.

The research protocol was reviewed by an expert in qualitative research, specifically in relation to culture and the paramedic context. The research design was reviewed by two research supervisors. The interview questions were piloted with a peer who provided feedback on the interview questions. During the data collection phase, a reflection on the methods was fed back to the supervisors to ensure that the methods process could be further refined to ensure the gathering of optimal data and thorough analysis. All of these processes enhance credibility.

Auditability

A peer review process was undertaken to ensure the appropriateness of the research design and methods. This was achieved by presenting the research design to the supervisors and to a qualitative research design expert. The research proposal and design was reviewed by the SA Health HREC and by the SAAS Research Committee before being approved. All data and analysis was discussed with the supervisors and thick description with quotes used to evidence the findings.

Fittingness

Six participants who helped to create the paramedic internship were selected for interviews. The participants were identified by the general manager of clinical education as the key stakeholders, to ensure a wide spread of people who had input into creating the intern program. Six interview sessions were conducted lasting approximately one hour each. Finally, the data were collected over a period of one and a half months.

Confirmability

The primary researcher works for the SAAS and is predisposed to his own assumptions about the values and belief systems which could impact on the interpretation of the data. The researcher avoided this by not undertaking any involvement with the SAAS clinical education process during the study period. As well, the collected data resulted in a range of common themes from a diversity of respondents.

The SAAS is a small organisation with few managers. Identification of the participants could be narrowed down by their role, so every effort was made to de-identify them and to use generic job-role terms; i.e. manager. However, as managers can conceivably be narrowed down to those who have had involvement in the development of the paramedic internship, this could lead to participants being identified. Some participants may have felt concern over being able to speak freely when responding to the questions; therefore, semi-structured interviews were favoured as this allowed for deeper exploration of the questions being asked, but it was stressed that participation was voluntary.

The data were analysed through a range of methods described by Saldana (2013). First-pass coding allowed for an interpretation of passages within the respondent's text. Figure 18 outlines the process taken from the raw data through to the development of the themes.

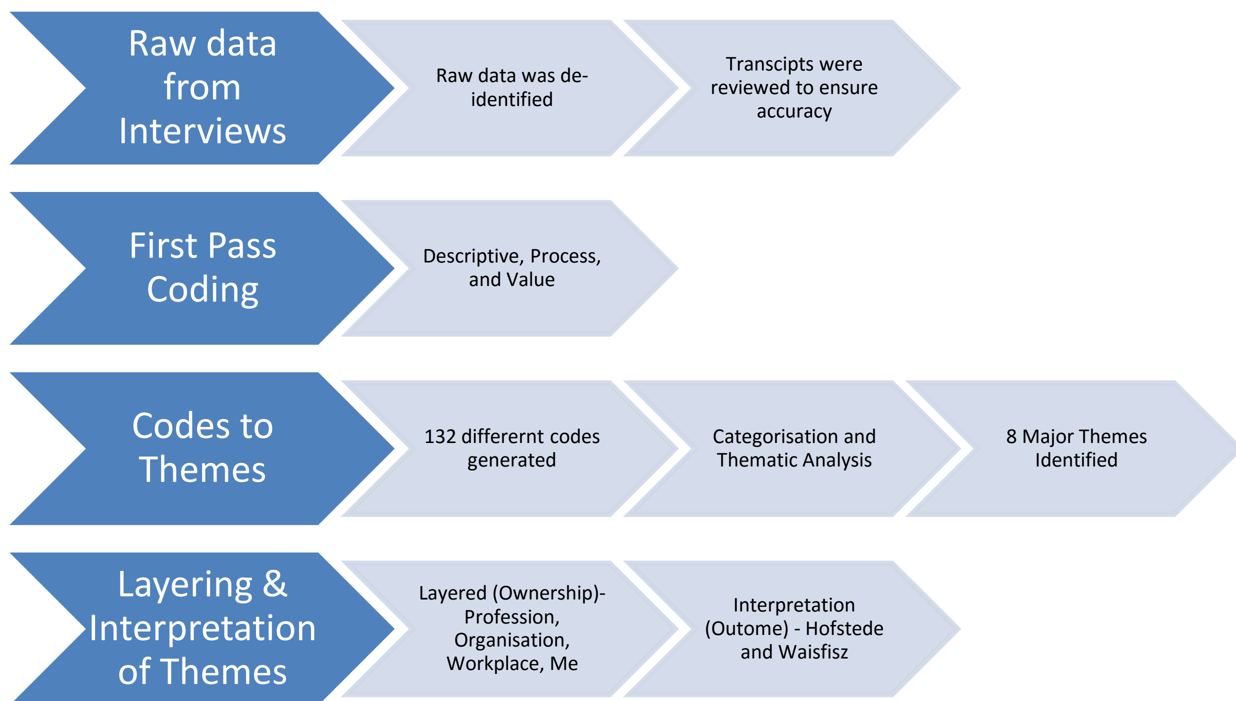


Figure 18 Data analysis process

Conclusion

This chapter has described the methods used for this study. The methodical approach has been detailed with enough clarity and detail for the reader to understand the underpinning theory, research design, data acquisition and analysis, and the steps taken to ensure the rigour of the study. It describes, in detail, how the interpretative framework attempts to answer the research question, how the participants were selected and used for this study and value and application of semi-structured interviews to gather the data. Following this, the methods describe how this data is coded to be used in conjunction with a thematic analysis to identify themes. The steps outlined in the 'rigour' section ensured that the reader can fully understand the validity, reliability, efficiency, and sensitivity of the results. The next chapter will discuss the data that emerged from the interviews, including defining the eight core themes and the layer they belong too (ownership), and will also interpret the data using Hofstede (2001) and Waisfisz, Minkov et al. (2015) interpretive framework.

6. FINDINGS

From the six interviews conducted for this study, 132 codes were generated using three first pass coding methods (descriptive, process, and value), as described in Saldana (2013). These codes were condensed into categories and then themes in the form of a thematic analysis. From this analysis, eight themes were generated. These themes are:

- Attitudes
- Education
- Communication
- Organisation
- The Internship
- Recruitment and Selection
- The Profession
- Culture

Within these eight themes, a range of sub-themes were identified that underpins each theme. Following the overview of the themes and sub-themes, this chapter will explore what is currently known in the literature about each sub-theme. Finally, the findings are interpreted using the interpretive framework derived from Hofstede's national cultural dimensions and Waisfisz et al.'s organisational cultural dimensions.

Layering

The eight themes have been organised and are presented in a specific order. This is to help us understand where the core functions of each theme lies in respect to the entire paramedic profession, assigning responsibility for the theme to a person or a group of people. This allowed us to direct any measures for change towards the group that has responsibility for the theme. This is not to say that other groups do not play a part in a particular theme; instead, it conveys the idea that the identified group has the greatest influence over the theme. The group that holds the greatest influence can drive change for that theme, which will be discussed further in the discussion chapter of this thesis.

Hofstede (2001) hypothesised three levels of enculturation, which are partly unique to each individual, and partly shared with others (See Figure 1). Similarly, the layers used for this study models that applied at the organisational level; that is, the enculturation that is unique to the individual (the employee), shared (the workplace and organisation), and universal (the profession). Behaviours, being the outcomes at the top of the pyramid, reflect all those influences of enculturation that are present at the underlying levels, and the relationship they hold to one another, which are reflections of personal values and the belief systems of an organisation.

Employee

The employee is at the top of the pyramid, as it is here that the enculturation is most unique. The themes that can be controlled by the employee are attitudes and education. Attitudes towards people, organisations, etc. can only be controlled by the individual, but can also be influenced by others around them. Similarly, education is controlled by the self, as the drive for education and any required education needed for practice can only be learnt by that individual, if desired.

Workplace

The workplace is the next level of relationship which extends to a small group of people, which can include a team, a station, a region, or any other sub-group within an organisation. The enculturation at this level is collective in nature, because of the common connections within the small work-group. Practice that arises from organisational policies and communication are two themes that are owned at this level. Practices that are interpreted from policies are the core of what happens within small work groups in the ambulance service because of the type of work paramedics are exposed to, and the family-like attitude within the team. Communication is also critical at this level because the people that frequently work in such small teams often work together, especially in highly stressful and critical situations.

Organisation

Next, the organisational level relationships extend further outwards to encapsulate the entire organisation. The enculturation at this level is still collective in nature as people within the organisation share like-minded values and belief systems to ensure that the organisation works effectively. The internship, and recruitment and selection, are the two themes that are owned at this level. The internship is owned by, and is a product of, the organisation; therefore, the only group that can alter or change it is the organisation itself. Similarly, recruitment and employment is controlled by the organisation, and therefore, will only employ people who meet the job criteria.

Profession

Finally, the professional level is a universal level of enculturation of people that hold the same job role (paramedicine). At this level, cultural and the profession themes are heavy influences. Culture is important to paramedicine as it represents the relationships, behaviours, values, rituals, and symbols that people have, and exchange, with one another in paramedicine. Also, healthcare professionals are particularly important for the establishment of paramedicine as a profession in Australia because a collective effort will strengthen the lobbying power of the profession and will thereby positively influence public/professional opinion.

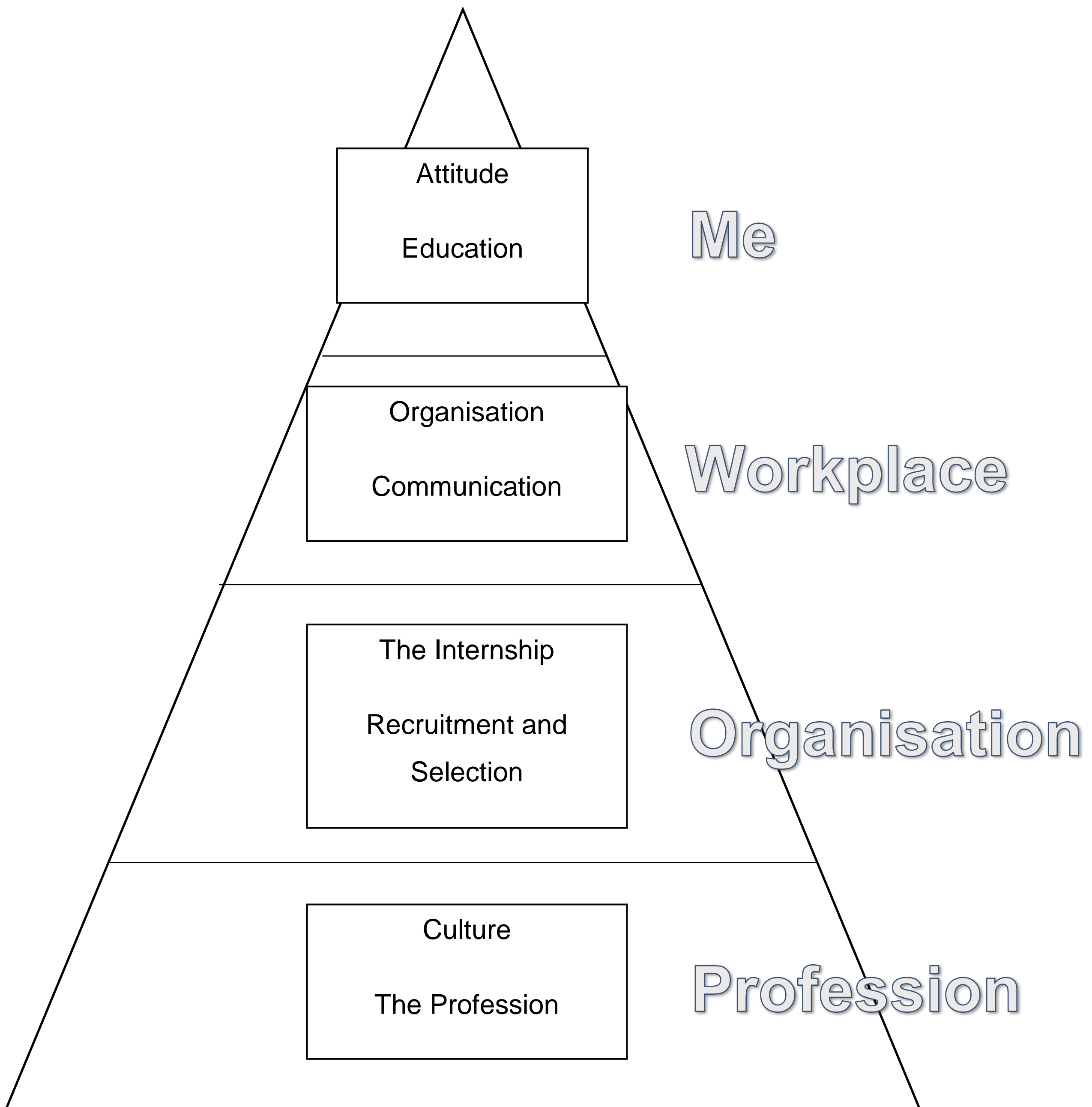


Figure 19 Layering of Themes

Themes

Each of the eight themes and the sub-themes will now be presented.

Theme 1: Attitudes

The first theme was about individuals' perceptions of the interns' attitudes about their internship. It was evident from the respondents that they had concerns about the attitudes of paramedic interns toward the paramedic internship. There were three concepts that emerged from the analysis of the data which informed this theme are: 'standards', 'socialisation', and 'performance culture'.

The sub-theme of 'standards' describes how the respondents perceived the attitudes of paramedic interns and the need to manage these perceptions. The respondents saw the paramedic interns as highly motivated individuals, but with limited life experience. Given the relatively young age of the graduates, the respondents concluded that the paramedic interns also had inadequate professional workplace or life experience to fulfil their professional role. Therefore, professional workplace attitudes were generally seen as not being fully developed yet, which was often interpreted as interns having a poor understanding of appropriate workplace attitudes. Often, these limitations then resulted in a perception by the participants of interns not valuing the importance of the internship program. More explicitly, the participants described the need for the organisation to set professional workplace standards for the interns.

Respondent 2 shared their view of the type of people that paramedic interns tend to be.

> *… it should recognise the fact that we're bringing in very motivated, intelligent individuals, who - and this is probably more related to SAAS rather than a generic internship as such - but tend to have limited life experience, due to the nature of the degree. But that doesn't apply to all of them, and every group will throw a couple of people in there, who come with a broad life experience. But as a general rule, in the majority, it brings in very intelligent, passionate people, but with limited life experience (Int2Pg21).*

In addition, Respondent 6 related this to the setting of standards within the paramedic internship.

> *I suppose it comes down to, for me, what's the standard? ... - but a nice person doesn't always cut it, so some of those interpersonal things make it very hard of what's the standard that we want and we expect (Int6Pg5).*

These findings demonstrate that there is an *implicit* expectation about having a good attitude towards the internship, and the way these should be demonstrated on a day-to-day basis. As a result, the organisation then sees the need to explicitly set *standards* of appropriate workplace attitudes so that paramedic interns can avoid uncertainty.

The sub-theme of 'socialisation' describes how the interns interact and build relationships with people within the organisation. The respondents saw that 'doing time' was important for interns for becoming accepted as part of the organisation. Given that the paramedic interns are new to the organisation, they generally have a desire to be accepted. Furthermore, the participants stated that the sooner a paramedic intern feels that they have been accepted into the organisation, their chance of ongoing employment appears to increase. In addition, the participants suggested that interns hold this perception as well. This is seen to create a sense of urgency to be accepted, causing undue stress for the interns. As a result, interns are perceived to invest too much of themselves into the organisation and its people by *over-socialising*. This over-socialisation into the organisation, and the stress of being accepted, often leads to a poor work/life balance.

Respondent 4 spoke of the importance of work/life balance as an intern:

> *Don't give up your life out of SAAS. Don't stop socialising with people who aren't ambos. Don't stop playing your team sport. I think it's very important a work/life balance to their experience. Because it's so easy to become all about the job and only social[ise] with ambos because you've switched to shift work; it's easier just to see those people when you're off during the week. So, I think work/life balance is really important. … And I have seen them have a significant personal issue and have nobody to turn to because all their friends are who they work with now and they've cut off everyone else outside their life. They can't talk to their family and all they've got is work. And I think that has a very negative impact (Int4Pg26).*

These findings reflect an attitude towards balancing socialisation and reducing the stress of being accepted as part of the organisation. As a result, there is a voiced expectation that the organisation needs to address the appropriateness of work/life balance issues and socialisation.

The final sub-theme of 'performance attitude' shows that the respondents believed that there is a performance-based attitude held by the paramedic interns. The respondents described how some paramedic interns undertook additional training and study sessions to gain a competitive edge over others within their intern group. They did so on the assumption that these actions would increase their knowledge and practice, and thus, their chances of ongoing employment. During the interviews, the respondents suggested that these performance-based attitudes are difficult to change. This is understandable as performance-based attitudes have been normalised for interns over recent years. For example, there is a requirement for *performance* in high school, as a high ATAR (Australian Tertiary Admissions Rank) score determines whether one is accepted or not into the paramedic course at university. This competitiveness continues through tertiary education, as there are more university graduates than the number of intern placements thus generating competition, as well as through their vocational performance ranking by the SAAS to determine whether they are offered ongoing positions.

The negative consequences of the performance culture were illustrated by Respondent 1:

> *… as a result, it's a highly competitive. As a result, we see behaviours in interns that are not high[ly] desirable in people in their first year entering a profession (Int1Pg26).*
>
> *… if there's one thing I'd like to change, it would be that degree of performance orientation that leads - sometimes clouds - learning a little bit, I'd love to be able to take the pressure off these guys so they could just focus on learning and not where they sit in a ranking or how their mates are doing in comparison to them (Int1Pg27).*

These findings demonstrate the deeply embedded performance-based attitude held by paramedic interns and that this is considered to be a cultural norm in the organisation. As a result, there are organisational concerns over how these attitudes influence other elements of the organisational culture, such as education, clinical practice, and the culture itself.

Having identified and discussed the sub-themes that underpin the themes of 'attitudes', the literature helps to further explain how attitudes are important for the values and beliefs that underpin the paramedic internship.

Firstly, the 'standards' sub-theme is supported by the literature which also describes the new interns as a young and highly motivated workforce with a view to a career as a paramedic. The career perspective of the interns includes increasing their scope of clinical skills and moving across traditional occupational boundaries, such as is done by paramedic practitioners (Waxman and Williams 2006, Joyce, Wainer et al. 2009). Lord (2002 pg 32) emphasised that "life experience is meaningless without the context of how attitudes, ability, behaviours are developed and integrated". Thus, it can be said that even life experience itself is not sufficient if it is not well directed. Therefore, it is logical that respondents see limited life experience as an indicator of limited professional experience. What is less logical, though, is that the respondents seemed to automatically infer that this implies poor attitudes towards professional working standards. This is not logical, firstly, because limited experience, in itself, is not a sufficient reason for poor attitudes. Secondly, and more importantly, limited life experience is a group characteristic of interns, while attitudes towards professional standards is an individual characteristic of each intern. Therefore, this inference runs the risk of producing stereotypes.

Next, the 'socialisation' sub-theme shows the value of time spent employed in the ambulance service for being accepted into the ambulance culture. deWit (1997) demonstrated that in the early stages of the profession, when the employment pathway evolved from the diploma to the degree, many degree-trained co-workers were bullied by the diploma-trained workers because it was assumed that they were not 'road ready', as they had not spent sufficient time learning 'on the road'. Unfortunately, such behaviour does not serve the organisation nor the public, because

learning is a social process which occurs through interaction, talking, listening, and engaging (Brockbank and McGill 2007). Good relationships between students, mentors, and patients are essential for effective clinical education (Worley 2002). Therefore, how the interns socialise to build these relationships will influence the facilitation of their learning. It is clear that an exclusionary and bullying context is unhelpful for learning, and in a knowledge-dependent organisation, bullying practices run counter to the organisation's strategic aims. The stress of socialisation and acceptance is not a new concept, as it is also reflected in other healthcare sectors. Socialisation and acceptance have been shown to be important to graduate nurses in shaping their attitudes towards nursing (Kelly and Ahern 2009). Similarly, research has shown that trainee doctors experience difficulties with socialisation and feeling accepted into the medical fraternity and, as a result of the desire to socialise and be accepted by their peers, they too distance themselves from family and friends (Bearman, Lawson et al. 2011).

Finally, the existence of a performance-based attitude is evident within the literature. For example, the ATAR required for entry into the Flinders University Paramedic Degree program in 2016 was 94.8 (out of 100) (Flinders University 2016c), showing it to be a highly competitive entry process. Further to this, in 2015, 103 students graduated from the Bachelor of Paramedic Sciences degree from Flinders University confirmed in an email (A Cayetano 2016, personal communication, 19th July) with only two groups of 16 paramedic interns being accepted into the paramedic internship in the SAAS, also confirmed in an email (P Adams 2016, personal communication 16th June). Finally, assessing the global performance of paramedic interns determines the rank for offering ongoing employment, with paramedics being ranked according to global performance to determine who will gain ongoing employment (P Adams 2016, personal communication 16th June). This performance attitude is not unique to the paramedic profession, as other health profession degrees have high ATAR entry requirements as well, including nutrition and dietetics (96.8), medicine (95+), and midwifery (90.2), with competition continuing amongst graduates to gain employment (Flinders University 2016b, Flinders University 2016a, SA Health 2016a, SA Health 2016b, South Australian Medical Education and Training 2016b).

Research into the cultural dimension at the organisational and national levels is helpful for better understanding the relationship between these themes and the initial research question. The dimension of 'internally- versus externally-driven organisation' helps with understanding the theme of 'attitudes'.

For the organisation, it is essential that ambulance staff are able to strike a balance between internal and external drivers of behaviours. The organisation has a high social profile; it is seen as an important link in the acute healthcare system. Events around ambulance services quickly attract media attention and public opinion. Therefore, it is paramount for the organisation to ensure that staff have, and exhibit, good professional attitudes. Yet, this control cannot be exerted at all times,

simply because of the nature of the work of a paramedic, which requires independent, rapid, professional decision-making in often complex situations. This, of course, creates tension. Reliance on external drivers and regulations - which may lead to a workforce dependence on explicit standards for every decision to be made - is undesirable for an ambulance organisation because it creates an unworkable context. Logically, internalisation of individuals' attitudes as a workable alternative is important for the organisation to ensure confidence in the autonomy of their paramedic workforce. The most obvious way to ensure the internalisation of the rather complex set of expected attitudes and related boundaries is to require an internship in which on-boarding and socialising can happen.

When it is stated that the ambulance service operates in a high-profile setting, this needs to be understood in the context of the national cultural dimension. One of Hofstede's suggested dimensions seems to be most illuminating here, namely 'uncertainty avoidance'. Australia scores in the mid-range (51/100) on Hofstede's 'uncertainty avoidance' dimension; which means that, culturally, Australians balance autonomy and regulation. In any country, acute healthcare issues are seen as important because they are the epitome of uncertain unfortunate life events, but in a country in which uncertainty avoidance plays a considerable role, the paramedic profession is a high-stakes, highly visible, and high profile profession that is constantly under the social microscope across the globe. Negative events which may be only remotely connected to attitudinal or professional issues for ambulance staff can quickly attract attention and may lead to public sentiments that more regulation is required. To avoid an unworkable situation of too many explicit internal or, even worse, external standards, internal processes such as the internship need to be carefully guarded. Yet, there is no getting around the organisation becoming more risk averse, as evidenced by increased standard setting with an increased volume of policies and procedures in addition to the requisite internship.

Next, the Power-Distance Index dimension is important for understanding interns' attitudes when exercising power. Paramedicine is a high-profile profession, and power, whether it is enacted in law, or through professional status, or even at a clinical level, needs to be exercised with care. Australian national culture scores low on Hofstede's Power Distance Index dimension (36/100), which suggests that culturally, the use of power is fair and legitimate. Yet, as an organisation, the ambulance service is hierarchical and seeks to have a clear power relationship between the layers. In an Australian low power-distance culture, it is very hard to 'climb' the hierarchical ladder quickly through formal processes, as used in higher power-distance societies. Developing valued expertise in an organisation is the most obvious approach to climbing the organisational ladder, but building good collegiate relationships helps as well. This is a delicate process and there is a fine line between being a good colleague, becoming too friendly, or overstepping other boundaries, as voiced by the respondents. Therefore, the internship period is an important period for the organisation to gauge which interns navigate this delicate process of collegiate relationship

building well (becoming one of the team) without overstepping boundaries, and for the interns to be able to demonstrate this ability.

A useful lens on the issue of private versus professional life is the dimension of ‘indulgence versus restraint’. Australia scores high on this dimension (71/100), which means that, culturally, Australians are somewhat lacking in self-regulation. So, activities by interns that appear to be overly-focused on work at the cost of private life can easily be seen as ‘overdoing it’, and therefore, disingenuous behaviour. Of course, for the organisation, the balance between indulgence and restraint is not an easy one. An ambulance organisation that allows too much indulgence in its workforce will give its people too much freedom in the way they approach their work. On the other hand, when there is too much restraint, team building, collegiality, and such ‘lubricants’ of the organisation are stifled, which is likely to reflect negatively on day-to-day operational activities. Again, the internship is a period in which new potential employees have the opportunity to develop a sense of this fine line, and for the employer to evaluate the interns in this delicate domain.

Theme 2: Education

It was evident that the respondents expressed concerns about the quality of the education programs embedded in the paramedic internship program, and the organisational attitudes held towards these. Consequently, education became the second theme for this study and, upon analysis of the data, three sub-themes were generated, including ‘university education’, ‘SAAS educational culture’, and the ‘SAAS educational model’.

The sub-theme of ‘university education’ describes the respondents’ understandings of the undergraduate university program and its perceived effects on the paramedic internship. The respondents suggested that the internship was more than simply a cultural indoctrination to the organisation, but was instead a requisite platform for linking theory to practice. The linking of theoretical knowledge to practice is discussed by Respondent 1:

> *So, I know how to communicate, I've been taught, I did communication 101, I have an ambulance to sit in and someone to talk to, there's your scope of practice skill stuff. But with experience, you learn to adapt your communication between an elderly person, a very young person, a very small child, someone who's quite obnoxious (Int1Pg25).*

There was a belief that since the transition from the diploma to the degree program, the organisation has lost control of the content being taught, which has become the domain of the university. As a result, the university has changed the content of the degree and these changes only address the universities’ agendas rather than the needs of the profession. Respondent 4 shared their view of university control of the paramedic degree:

I mean, that's really up to the universities though, isn't it? Well, how much control do we have over the degree and how much does the university have? … I certainly know that, for the university, it also comes down to a bit of financial and political stuff with them as well (Int4Pg31).

Finally, Respondent 3 shared their views about the university attending to their own agenda:

… well, the degree, we have limited control over the content. The degree - the objective of the degree is not an objective that we've written. I'm not saying it's not the right objective, but Flinders have their objectives for the degree and who they select for it and who they'll put through (Int3Pg28).

Furthermore, to keep up with the changes to the university degree, the participants believed that the SAAS should constantly update their paramedic intern program. This would be to ensure that there are no gaps between the education delivered by the university and that provided by the ambulance organisation, and to avoid re-teaching the same content. However, the respondents suggested that the SAAS do not keep up with these changes, and educational gaps have developed. Consequently, the interns recognise these gaps in the internship, and learn beyond the internship to ensure they understand the content sufficiently. Learning outside of the scope of the internship is not always received positively by peers. Re-teaching the degree during the internship program was discussed by Respondent 1:

A long time ago, we recognised we were re-teaching the degree. Now, if you ask someone who's come through an undergraduate program, do you know this stuff, they look at you vaguely and go oh no, not really, and so you re-teach it, and the fact is the majority of them are actually quite smart and would know it with a two-minute refresher (Int1Pg17).

In addition, Respondent 5 highlighted the interns' desire to learn beyond what they needed to know for the paramedic internship:

We need to have the right people going in that are educated the right way that go, no this is what you need to be taught. Don't come and ask me about what MedSTAR (SA Ambulance Services Medical Retrieval Service) do, because this is not part of your education. You can learn that later on. So, we need people who can clearly define what they're there for, what their role is, and make sure that they stick to it (Int5 Pg53).

These findings demonstrate a poor level of communication between the university and the organisation. Communication is required by both the university and the organisation to ensure that the curricula complement one another. Strengthening communication between the two organisations to build a better relationship will ensure that the complementing curricula will facilitate the seamless transition of education from the undergraduate level to professional practice.

Currently, because of poor communication, both the organisation and the university keep attending to their own agendas when developing their programs. For the university, the focus is on education, while for the organisation, the focus is on operations.

The sub-theme of ‘SAAS educational culture’ describes the organisational attitudes held towards the variations within the education programs. The respondents perceived that the transition of ambulance education from the diploma to the degree program generated a cultural divide within the organisation, because staff held differing educational ideologies based on their entry qualifications. The differing opinions that divided the operational staff within the SAAS were based on which pathway, the diploma or the degree, would produce a better paramedic. Both educational pathways were perceived as having both desirable and undesirable elements. The diploma pathway resulted in a paramedic holding more ‘hands-on’ procedural knowledge, whereas the degree pathway resulted in a paramedic holding more conceptual knowledge. This led the respondents to question whether the organisation’s orientation towards the value of education favoured procedural or conceptual forms of knowledge. The cultural divide as a result of the degree program was discussed by Respondent 3:

> *One of my questions was about what is the degree doing to the culture of ambulance? Because we have taken the gene pool of selection from the whole of society to this, with a few outliers … in that group, you had a whole range of skills and expertise and very broad, from nursing through to trades, through to young school leavers … now we have a degree, where the demographic of selection and that - we are picking from a group that someone else has picked. So we have no control, no say, over that … so you get two different people out of those processes. Two very different people … (Int3Pg28).*

Respondent 1 expressed their views on the undergraduate degree training of paramedics:

> *But they don't necessarily want to learn by doing, they want to know, and I think it's a function of our industry migrating from a highly vocational approach to education, to an undergraduate tertiary approach, somewhat remote from the industry. Because we see in interns this desire to know and know and know and know and know, but not necessarily be able to do (Int1Pg28).*

The transfer of paramedic education to the university sector, has resulted in the ambulance sector loosing some of their expertise in paramedic education. As a consequence, the respondents perceived that the SAAS now has a poor understanding of modern educational ideologies that complement undergraduate education. Respondents 4 and 5 highlighted the poor understandings of education:

The level of learning that you get within the degree is far more than the diploma. I mean these people that we're employing now, their level of knowledge far outweighs what mine was and what it did. I'm not even going to try and keep up with them. I'll just keep going, oh well that's fine, but I've seen it all and done it all. Because that's all I've got left (Int4Pg29).

Now there is a lot more emphasis put back on adult education and professional accountability, so when a student comes in now, if they don't understand the pathophysiology of anaphylaxis or the pharmacology of adrenaline, it is their problem, not SAASs or this unit's problem anymore (Int5Pg10).

These findings demonstrate a sub-standard educational culture within the SAAS. As a result, there is a lack of motivation for investment to be made by the organisation to improve the standard of their educational model.

The final sub-theme, the 'SAAS educational model', describes the practical consequences of the previous sub-theme of the 'SAAS educational culture'. The SAAS educational model presents some of the key elements highlighted by the respondents in relation to the paramedic internship framework. A core issue perceived by the respondents is the poor synergy between university and ambulance organisation expectations. As a result, there is confusion about the content that needs to be taught to paramedic interns and, consequently, gaps have emerged within the internship program. Respondent 1 described the imperative for the university to produce a certain product:

The industry changes and we've got to make sure that the university keeps producing the generic product for the industry. Is there a risk? Absolutely. There's a huge risk because we are crossing our fingers and hoping that the university does actually produce someone with the knowledge and skills we need them to have, what we are inducting them into, but it's not a trust model. We actually spend a lot of time talking with the university. If we identify problems in the people we get, we go straight back to the uni and say can you fix that? (Int1Pg18).

Moreover, Respondent 6 discussed the 'silos of learning' within the university system and the inability of graduates to integrate these areas of knowledge together. This highlights the need for experience to be integrated with knowledge in order to make practical sense of the university learning. Respondent 6 spoke of the integration of the 'silos of knowledge' for practical application:

You then see some trends where they come out and see (sic) a cardiac patient, well 95 per cent of the cardiac patients have other co-morbidities, but we've taught them cardiac and they have cardiac in a cardiac silo, so it's then getting them to work out why that a cardiac patient doesn't fit that cardiac picture because their diabetes is [impacting]on it. So, I don't

think that the university puts that transverse across, … of linking all of those things together (Int6Pg23).

Furthermore, there remains confusion about the educational endpoint for the paramedic internship during this experiential learning process. Respondent 1 discussed the educational endpoint of the paramedic internship and how this can be achieved:

What is variable, it's your own rate of progression, but the end point's not variable. So, you've either got to go slow at the start and then go really quick, or you can pace yourself all the way through, or you can excel very quickly and then kind of coast (Int1Pg33).

These findings demonstrate the impact that the transition to the university degree has had on the educational culture of the organisation, which has resulted in problems with the educational model currently being employed. It appears that the organisation does not know how to address these problems because of the poor understanding of contemporary, graduate-specific, educational ideologies. Therefore, there was a sense that the organisation needs to re-focus on education, and to develop a greater understanding of educational ideologies to better inform their graduate education. Through achieving this, the organisation can develop a responsive education model through a positive educational culture that supports the transition of undergraduate students to becoming paramedics.

Having identified and discussed the sub-themes that underpin the theme 'education', an appraisal of the literature helps to further explain why education is important for the values and beliefs that underpin the paramedic internship. Firstly, the literature supports the organisations' concerns about losing control of the content of ambulance education under the sub-theme of 'university knowledge'. This is as a direct result of the transition of paramedic education from a diploma to a degree structure. Internal training was abolished due to funding issues, which led to the AOTS (Ambulance Office Training School) being disbanded and moving ambulance education to the TAFE system (Wilde 1999). This decision was viewed by the organisation as a backwards step, as it was believed that the institution's body of knowledge would be lost and, as a result, the course would be less ambulance-oriented (deWit 1997). Following this transition, as ambulance practice surpassed the knowledge being taught at TAFE, the primary education of paramedics was passed onto the university sector (Wilde 1999). Within 30 years, the institution that administered primary paramedic education had changed three times and, as a result, the teaching of procedural knowledge was lost in these transitions.

In addition, the literature provides evidence of the need for an internship to support the transition from university knowledge to clinical practice. Currently, tertiary education does not foster the traditional passing down of knowledge and clinical expertise (Newton and McKenna 2007), and it is recognised that undergraduate degrees do not produce work-ready practitioners (McAllister,

Paterson et al. 2010). Similarly, workplace experiences are not sufficient for recognition as a professional and are only legitimised through their integration into courses provided by education institutions (Billett 2001). Therefore, both university knowledge and workplace induction programs (the Internship, Transition to Professional Practice, and the Professional Development Year) are equally valued, and therefore, lead to good relationships being built between the two organisations to facilitate an optimal learning environment.

Next, the SAAS educational culture shows a cultural divide between staff as a result of the move from the diploma to the degree. There are many factors that have caused the educational cultural divide in the ambulance service. The key factor which initiated the start of the cultural divide was the transition of education from the organisation to the university sector, and the consequent loss of the profession's body of knowledge (Wilde 1999). As a consequence of this early transition, the ambulance service did not have appropriate staff to teach the university program which meant that the university had to rely on nursing lectures to fill the gap (Wilde 1999). The final factor for the cultural divide was that new graduates were being bullied by their diploma-educated counterparts because they were not considered to be 'road ready' (deWit 1997). The staff in the organisation had to accept, despite the strong opposing views, that the diploma could not provide the depth and breadth of knowledge required for contemporary paramedicine; however, the degree itself could not deliver a road ready paramedic as it lacked the critical procedural knowledge. As a result, becoming road ready incorporated the need for an undergraduate degree together with a paramedic internship (Joyce, Wainer et al. 2009). This satisfied the concerns of the organisation as they still held the crucial element of paramedic education to ensure that their graduates would be road ready.

Furthermore, the literature reveals that ambulance services across Australia devalue the education they provide. In 2004, a synopsis concluded that ambulance services were not moving towards a consistent and standardised approach towards education (O'Meara, Pointon et al. 2009). It was suggested that one of the reasons for the reluctance to create an Australia-wide approach towards paramedic education at the service level was the lack of funding and the poor quality of in-service training programs (Willis, Pointon et al. 2009). It was considered that ambulance organisations do not understand educational ideology which devalues education; this could be a result of the relinquishing of base-level education in favour of the university sector. This resulted in the scaling back of ambulance organisations' education departments (deWit 1997)

Finally, the SAAS educational model is a derivative of the SAAS educational culture, with the literature suggesting that ambulance organisations have a poor understanding of educational ideologies. As previously discussed, losing control of the entry education program resulted in less emphasis from the organisation to invest in education. Further to this, the poor understanding of educational ideologies and the under-researched education models specific to the profession leads

to the poor quality of internal training programs (deWit 1997, Willis, Pointon et al. 2009). Therefore, ambulance service education models have been based on fieldwork education models adopted from nursing or medicine. Fieldwork education ideology is well established as the core of any undergraduate health professional program, as knowledge alone does not produce a work-ready practitioner (McAllister, Paterson et al. 2010). The connection between knowledge and practice is essential in traditional education and is optimal as a follow-on from the courses in higher education institutions (Billett 2001).

In addition, the literature highlights that both medicine and nursing have adopted internship programs based on profession-specific research, because each discipline has invested in the professional development of education at the organisational level. In the 1970s, nursing moved away from the apprenticeship model towards university-based education in addition to a Transition to Professional Practice (TPP) program (Kelly and Ahern 2009). The clinical learning culture was highly valued within nursing to nurture and support new graduate nurses and for facilitating teaching, imparting knowledge, and fostering critical thinking and reasoning (Levett-Jones and Fitzgerald 2005, Haleem, Manetti et al. 2011, Thomas, Bertram et al. 2012). Furthermore, employers such as SA Health place a high value on education at the organisational level and have departments specific to nursing education (SA Health 2015). The valuing of profession-specific education leads to further research into educational theories specific to the profession; for example in the United States of America, Benner's 'Novice to Expert Model' (Benner 1984). Similarly, medical internships were introduced in the 1940s to bridge the gap between knowledge and practice for new doctors (MS Al-Moamary, Mamede et al. 2010). In South Australia, doctors are supported by South Australia Medical Education and Training, a unit within SA Health, which supports the education, training, and workforce function for the South Australian health system (South Australian Medical Education and Training 2016a). In addition, frameworks for medical education have also been developed; for example, to name one of many, Worley (2002) Symbiosis in Medical Education framework.

Research into cultural dimensions at the organisational and national levels is helpful for better understanding the relationships between the theme of education and the research question. The cultural dimension of 'Internally vs Externally Driven' is important for understanding who drives the educational culture in the ambulance organisation. It is clear from the respondents' comments and the literature that education is externally driven. The bulk of paramedic education is delivered, and therefore driven, externally at the university level, which has led to the devaluing, and consequent scaling back, of in-service education. This has generated a reliance on the university to teach the requisite core knowledge for the paramedic role. What is clear is that the organisation sees itself as playing a pivotal role in the transition to professional practice which goes beyond simply showing the graduates what to do. It makes sense that the organisation requires paramedics to undertake a new internship when moving from another state to ensure that the organisation's intern program

validates the underpinning academic knowledge that has been taught. Therefore, the internship program requires a greater level of ownership by the organisation. This action would increase the internal value of the education provided.

The next dimension, 'Open vs Closed System', highlights organisational compliance towards balancing out the internal vs external drivers that underpin education. The respondents and the literature suggest that the organisation is unable to adapt their educational model and culture to modern educational practices. The current paramedic intern program is based on previous programs, because they are familiar to the organisation. Issues or problems inherent within the previous programs have been reviewed internally and addressed to update the program. However, a failure to look outside of the organisation highlights a closed system of education. Already identified previously is that the key relationship of the university, student, and organisation is important for clinical education (Worley 2002). Poor relationships will produce a poor workplace curriculum. A closed attitude from the organisation is not compatible with learning and applying contemporary educational ideologies, and may negatively affect the interns. An intern program is the product of the organisation's educational ideologies, and therefore, an intern needs to be able to learn within the context of these ideologies. However, the SAAS still needs to adopt an open system towards education to recognise the importance of the university education, improve the relationship between them, and adopt contemporary educational ideologies to improve the curriculum.

When considering national culture, two dimensions, the 'Uncertainty Avoidance Index' and 'Long Term vs Short Term Orientation' help us to understand the culture in relation to the 'education' theme. The dimension of 'Uncertainty Avoidance' is important to understand organisational attitudes towards educational culture. From the interviews it is apparent that the ambulance service displays a high level of uncertainty avoidance. As a result, the model of education defaults to that which is well-rehearsed, and known to work by the organisation. Consequently, the organisation invests poorly in the cultivation of a robust educational culture and ideology to improve the paramedic internship curriculum.

Again, Australia scores in the mid-range (51/100) on the Uncertainty Avoidance Index dimension, which means that culturally, Australia balances autonomy and regulation. The findings from the 'education' theme reveal an organisation with a high level of uncertainty avoidance towards education. In addition to this, the high level of uncertainty avoidance is also consistent with the 'attitude' theme. It is evident that the organisation is exercising a high degree of uncertainty avoidance towards education. This cultural norm is not sustainable as the existing educational model embedded in the paramedic internship does not support the advancing of undergraduate education to enable a fluid transition from undergraduate student to road ready professional. Therefore, to minimise uncertainty for the organisation, due to the misalignment of the internship

with the evolving undergraduate education, paramedics from other states are required to re-do the paramedic internship to ensure that their qualifications fit with the organisational educational model.

Finally, the dimension of 'Long Term vs Short Term Orientation' follows on from the previous discussion of the educational model evolving to meet the needs of the undergraduate student. The current educational model has not conformed quickly enough to the changes to undergraduate education, to ensure a smooth transition from undergraduate to road ready professional. In addition to this, the above arguments also reflect an organisation that focuses on the 'here and now', rather than the future, because of its inadequate investment in education. As a result, the organisation has a very short-term orientation towards education. Consequently, it is convenient for the organisation to simply put new paramedics from others states through the paramedic internship because it inducts the paramedic into what they need to know 'here and now'. Australia's national long term vs short term orientation is relatively low (21 out of 100), which indicates short-term (normative) style of thinking with a focus on achieving quick results with great respect for traditions and the past. The national expectation appropriately matches the cultural norms reflected by the organisation.

Theme 3: Communication

The respondents to this study identified the importance of communication at the organisational and operational levels. There were three sub-themes that were evident from the analysis of the data that formed this theme of 'communication'; the 'importance of communication', 'transparency', and 'feedback'.

The sub-theme of the 'importance of communication' highlights communication as a core function of the paramedic role. The respondents suggested that communication is vital for the core job role, as talking to patients and other healthcare professional staff is a large part of day-to-day activities. Equally as important is the internal communication between the team and management. Respondent 4 mentioned the role of communication in the paramedic setting:

> *Because I would say 80% of the job is practical. Eighty per cent of the job is hands-on doing physical skills, it's talking to people, it [is] communicating with people. While I think the students do a communication course - which every uni degree has a communications unit - that really doesn't teach them how to talk to people; how to relate to people (Int4Pg12).*

However, particular to the paramedic internship, the respondents suggested that poor communication from management has a direct impact on the paramedic internship because there

is a lack of clarity in the outcomes of the internship. Poor communication from management was mentioned by Respondent 6:

> *That's cool, but if you don't have two ops managers who control that and - that - it comes down to communication, that the internship management structure needs to communicate (Int6Pg54).*

These findings reflect good communication between paramedics and patients, but poor communication between management and paramedics within the SAAS. It would seem logical that these communication skills would be transferable between these roles. However, the two different contexts, one being a customer service role, the other an organisational role, demonstrate that communication styles vary considerably within the SAAS.

The sub-theme of 'transparency' describes the consequences of poor communication by management (from above) particularly in the paramedic internship. The respondents described a lack of transparency in the expectations and outcomes of the paramedic internship. Given this uncertainty, the respondents also described interns filling these gaps through their own interpretations, which can include expectations towards study, practice, socialisation and attitudes. However, they also described interns doing what they are supposed to be doing, but that this is open to interpretation by the interns due to the lack of transparency from management around the outcomes of the internship. This lack of transparency as a result of poor communication is mentioned by Respondent 4:

> *So, I think it's because it's a lack of understanding of what's going on and a lack of communication. They might say management does a terrible job because they don't get the communication to know what's really going on, which is our problem (Int4Pg8).*

The misalignment of the expectations of interns by managers, as opposed to what the interns should be doing, is highlighted by Respondent 2:

> *So yeah, they need to focus on the long-term, but I think they focus on the long-term at the expense of the now. So, rather than focusing on what they can do themselves to get the most out of their internship, they tend to focus on what they can do - what do they think we want them to do in order to look good at the end of it (Int2Pg34).*

Similarly, Respondent 6 reaffirmed the concern about what interns should be doing because of the perceived negative impact of 'missing out':

> *I suppose sometimes what they think they need to achieve is not actually what they need to achieve, and so they take the view of oh, if everybody else in my group is going to training sessions, if I don't go, then I'm going to miss out on something (Int6Pg13).*

These findings demonstrate the need for the SAAS to have clear expectations of, and outcomes for, the paramedic internship. As a result, the interns' perceptions of what they need to do to impress management, as opposed to what they should be doing, focus the internship away from education, and towards manipulation. Manipulation means that the interns act and think strategically in relation to what they perceive will impress their mentors/managers, with the assumption it will lead towards better job opportunities.

The final sub-theme of 'feedback' highlights the importance of providing feedback to paramedic interns. The respondents believe that open, honest, and precise feedback from mentors is important for the development of the paramedic intern. This is an imperative as it enables the intern to reflect and alter their practice to improve their performance and fittingness for the job role. However, without clearly defined expectations of, and outcomes for the internship, feedback can be individualised (providing the view of the mentor rather than the organisation), vague, and non-specific. As a result, the intern may devalue such feedback, which can consequently feed into the poor attitudes held towards the internship. The value of feedback is discussed by Respondent 1:

> *So it's that - I think there is an element of life experience, and what we try and do in internship is condense that and compress that by having very, very good supportive coaching, very strong performance tools, so that people get rapid feedback and accurate feedback very quickly rather than getting to the end of a year and finding stuff out (Int1Pg21).*

> *Vague feedback doesn't help. You'll be a great paramedic in time. How much time? What do I need to be doing in that time? Which bits of me need time? Are there some parts of me that don't need time? It means nothing (Int1Pg23).*

Respondent 6 also discussed the value of feedback:

> *So, you've got some people went I'll take it on board. You had some people who sat there and went oh, oh oh. Then you got the feedback, oh they weren't happy with the feedback you gave them. Well the feedback was honest. The feedback was honest and was constructive. If you take it personally, that's your problem. What you choose to go and do with it - and I already know that some of them that didn't take it are now struggling out on the lateral teams, because of their ability to change (Int6Pg33).*

These findings reflect the fact that feedback delivered to interns is based on the mentors' perception of what makes a 'good paramedic'. In the absence of a consistent organisational approach to clearly defining what a 'good paramedic' actually is, the organisation relies on the people who are selected to mentor the interns to individually interpret what a 'good paramedic' is. As a result, feedback can vary from mentor to mentor and this raises further questions about the

validity of such feedback, particularly if it is from the view of the individual rather than of the organisation.

Having identified and discussed the sub-themes that underpin ‘communication’, the literature helps to further explain why communication is important for the values and beliefs that underpin the paramedic internship. Firstly, the literature supports the importance of communication as it is highlighted within the paramedic education curriculum. Historically, the ambulance service curriculum at Ambulance Officer Training School (AOTS), when it was being delivered internally, embedded communication as part of their induction period (Wilde 1999). Currently, communication in the healthcare setting is still taught as part of the induction block for the SAAS (South Australian Ambulance Service 2015c). A critical element highlighted in this study is that in order to facilitate effective professional communication skills to students, the mentors themselves need to have strong communication skills (Johnston, MacQuarrie et al. 2014). As a result, the organisation needs to ensure that interns initially have effective communication skills and that the mentors model appropriate communication specific to the paramedic environment. In addition, communication is a core component of competence, which is supported by Epstein and Hundert (2002 pg 226) who defined professional competence as “the habitual and judicious use of communication, knowledge, technique, skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served”.

Although communication skills are practiced within this healthcare environment, there is a strong need for these skills to be taught during the undergraduate phase of education (Morison, Boohan et al. 2004). In contrast to the literature, the Flinders University Bachelor of Paramedic Sciences degree, as the main recruitment pool for the SAAS, does not include a stand-alone communication topic as part of its curriculum (Flinders University 2015). This may affect the communicative ability of undergraduate students when they come to be employed as paramedic interns.

Next, the literature highlights the importance of the sub-theme of ‘transparency’ in curriculum design to clearly define outcomes for paramedic interns. Transparency is important for curriculum design and, as described by Prideaux (2003), transparent outcomes should focus on those that are significant and enduring. A curriculum is “underpinned by a set of values and beliefs about what students should know and how they come to know it” (Prideaux 2003 pg268). Therefore, a popular method of curriculum design is ‘outcomes-based education’, in which a set of clearly defined outcomes is worked backwards from to produce a curriculum (Prideaux 2003). This method of generating a curriculum is very popular with medical educators, but it relies heavily on clear outcomes. According to Harden (2001), in order to ensure that clear outcomes are generated and communicated to the students, it is necessary to align three different types of curriculum, the declared curriculum (assuming what students are learning), the taught curriculum (the presented curriculum), and the learned curriculum (what is actually learnt) (Harden 2001). This will ensure

that one clear curriculum is taught so that content is not missed or repeated. Furthermore, students and teachers can map areas of discussion to the depth to which they need to be explored. Currently in the SAAS, interns are provided with hard copy information that describes the outcomes of the internship program the key dates, and the assessment items (South Australian Ambulance Service 2015c).

Finally, the sub-theme of feedback is not a new concept, as it is also present in other healthcare sectors. There is only limited paramedic-specific literature about giving feedback in the paramedic profession; but, as shown throughout this study, the profession has adopted the literature from nursing and medicine. Giving and receiving feedback is a core aspect of clinical education (Thomas and Arnold 2011). The key elements of feedback in the clinical education setting, as described by Wilson (2013 pg 20-22), include:

- A good working relationship and mutual respect between the mentor and student
- Describes the observed performance rather than offering judgements
- Should be informative, and aim to guide and improve future practice, rather than summarise the past
- Pays attention to the environment in which the feedback is delivered
- Identify and manage the effects on the student of the given feedback
- Facilitate student self-reflection
- Provide concise observations through good feedback language
- Facilitate the creation of an action plain

Research into cultural dimensions at the organisational and national levels is helpful to better understand the relationship between the above themes and the research question. However, for communication, organisational cultural dimensions lack the depth and breadth to explain these as organisational concerns. Therefore, when considering national culture, the themes of ‘Individualism vs Collectivism Index’ and the ‘Uncertainty Avoidance Index’ were the best dimensions to help us understand organisational culture in relation to the ‘communication’ theme.

Firstly, the ‘Individualism vs Collectivism Index’ is important for understanding communication in the workplace. The nature of the paramedic profession is very open, honest, and trusting because paramedics are expected by patients to give their professional opinions when advising on their health. Similarly, paramedics carry the same attitudes towards giving feedback to paramedic interns. The expectation of personal opinion expresses an individualist organisation. In contrast to this, paramedic interns experience the stress of belonging to the organisation during their internship, which primarily consists of learning how to do the job. This shows that paramedic interns show some degree of collectivism. Therefore, the paramedic internship also describes, from a communication perspective, the transition of the paramedic intern from the values of collectivism towards those of individualism. In Australia, national culture scores 90 out of 100 on this dimension, which supports the idea that Australia is a highly individualistic country. Therefore,

the quality of the communication in the feedback process is unique to the individual which is supported by an organisational culture consistent with national cultural expectations. How feedback is received by paramedic interns is tested during the paramedic internship to ensure that they have the ability to reflect upon, and alter if necessary, their practice. This provides the organisation with the comfort to ensure that its professional paramedic staff can learn and continually improve their practice as the paramedic profession's knowledge-base and practice grows.

Finally, the theme of the 'Uncertainty Avoidance Index' (UAI) is relevant for understanding workplace communication. Clear direct communication is important for delivering and receiving the right message in an often time-critical, high-stakes environment. Paramedics cannot afford to make mistakes when a person's life might be in danger. However, low levels of transparency and poor communication by management are evident from the views of the respondents.

Therefore, in the absence of clear outcomes for the paramedic internship communicated by management, paramedic interns approach the internship with high levels of uncertainty avoidance. It is understandable now why the respondents perceived that interns try to predict what they want their managers to see from them and then display these attitudes/practices/traits. As a result of the organisation's low levels of transparency of paramedic internship outcomes and poor communication by management, the organisational culture has adopted high levels of uncertainty avoidance. Remembering that Australia scores in the mid-range (51/100) on this measure, which is consistent with the other themes, the ambulance service exhibiting a high UAI might be surprising given that the national culture sits in the mid-range. Although the paramedic internship enables the organisation to minimise uncertainty by closely supervising the interns during the trial period, poor transparency and communication about internship outcomes decreases the effectiveness of such measures. Therefore, interns need to have the ability to speak up during times of uncertainty. This is important to an organisation that operates in a high-risk, highly public environment in which life and death decisions are made on a regular basis.

Theme 4: Organisation

It was evident from the respondents' views that they held concerns about negative organisational effects on the paramedic internship. There were three concepts that emerged from the analysis of the data which formed the theme of 'organisation' being 'stress', 'ICP (Intensive Care Paramedic) being highly valued', and 'management: clinical vs educational'.

The sub-theme of 'stress' describes the highly stressful environment encountered by paramedic interns. The respondents believe that paramedic interns are under a great amount of stress that has its origins in a range of different sources, including the high levels of performance demanded, poor long-term job prospects, the uncertainty of being accepted into the organisation, and the

general stress of paramedic work. Respondents 1 and 6 expressed their concerns about the levels of stress that affect paramedic interns:

> *I think the competitiveness of the internship - very much a strong influence - drives a very strong performance culture in people at times, which I don't think is always a good thing (Int1 Pg32).*

> *They worry about that. They get that real 'am I hitting the standard?', knowing that they're going to be rated against each other in a competitive employment process at the end and I think it is a very pervasive piece of thinking that hits them right the way through (Int1Pg38).*

> *It can be very easy, and the problem with the SAAS is to come into the SAAS and try to impress everybody and become SAAS-ified (Int6Pg33).*

In addition to this, Respondent 5 highlighted the stress of shift work and the paramedic work role:

> *So, we're taking somebody in their very first job and it's not - as you know, it's not traditional Monday to Friday 9:00 to 5:00 job, so we put them in an environment quite stressful and then their first job is a shift work environment, so that's quite interesting (Int5Pg27).*

There are multiple stressors experienced by the paramedic intern. As a result, the organisation needs to set clear strategies to reduce these stressors and to support the paramedic interns because they may not have the inherent strategies to manage their own stress. This is critical during their initial employment period which affects their long-term job prospects and their emotional sustainability.

Next, the sub-theme of 'ICP being highly valued' describes how the organisation and its staff place a higher value on those who are ICP than staff at other clinical levels, by favouring them for higher management positions. In this context, the additional value is not added to the individual person, but rather to the clinical qualification they hold. The respondents suggested that ICPs are highly regarded by staff, especially paramedic interns, but they are unsure why this is the cultural norm. Respondent 2 spoke about the value of the ICP role:

> *… it's clear that they have a very high regard for the title of ICP and, in fact, they're almost pushed down that path by people that educate them. Which seems to be the fact that a lot of the educators are ICP, for where they come in. So, they have a very high regard for the ICP level. I find it interesting that in probably 60 per cent of the groups that I talked to, inevitably at some point in time while I'm discussing my career on SAAS, the inevitable question gets asked, am I an ICP? (Int2Pg10).*

Furthermore, Respondent 6 discussed two opposing points regarding ICPs and the organisation's inherited assumptions about the skills they hold:

> *I sat there and went I've already picked out who I think will be our future ICPs, who will be our future managers and who will be our future clinical leaders (Int6Pg28).*

> *But you need to have some ability to pick the people for the right reasons, not just because they're an ICP. Just because they've got a higher clinical level, doesn't mean they can educate (Int6Pg47).*

These findings reflect the organisational valuing of the ICP role and its entrenchment as a cultural norm. However, it is important to address the fact that although ICPs hold a greater level of clinical experience and skills, this does not necessarily mean that they make good managers. It appears that the organisation has accepted that ICPs hold the relevant managerial skills to be good managers without questioning this assumption.

The sub-theme of 'management: clinical vs educational' describes the organisation's attitudes toward the optimal background required by managers (clinical or educational) when appointed to different departments of the ambulance service. The respondents acknowledged that management do hold a very powerful position within the organisation, and that decisions made by these individuals can tarnish the management group as a whole. This points to the fact that, from the perspective of the staff, good and bad decisions are not made by a particular manager, but by 'the management'. The impact of decision-making was discussed by Respondent 1:

> *I think it's the level of impact you have. When I deliver a training session, I don't have an extraordinary impact on that person or their work life … Whereas when you go to some of the other environments that I work in, even some of the national committees and things, you understand that your decisions and actions have impact and people feel that impact very closely (Int1Pg9).*

In addition, Respondent 4 spoke of the collective nature of the management group:

> *You're talking to a manager of SAAS. And they go, oh yeah, but I don't mean you. So, there tends to be this clumping of what management is, and management becomes this thing rather than individual people - rather than Paramedic 1 doesn't do a very good job; it's all the people don't do a very good job (Int4pg7).*

Understanding the importance of management decisions is critical for addressing the concerns that the respondents have when decisions are made that directly impact on the education of paramedic interns. This concern is important for the paramedic interns' learning as the respondents believe

that managers will preference operational needs over educational needs. Respondent 5 highlighted the organisational struggle between operations and education:

> *Me personally, particularly with operations, it can be an exceptionally hard slog sometimes. They obviously have completely different needs from an educational thought. They are looking at issues such as rostering, recruitment selection, ongoing employment and it doesn't always fit in well with an educationalist's thought. So, I think there's a lot more open dialogue now between operations, HR, and clinical ed … we were never asked an opinion, we were just a function and a service provider (Int5Pg31).*

Further too this, the respondents then questioned the appropriateness of an operational manager being in a position with an educational role. Respondent 1 discussed the dynamics between education and operations and the people in charge of these roles:

> *As a clinical manager, you have a quality assurance role over the education products, or we did back then. So, a lot of the content would be developed by non-clinical people, or clinical people on secondment, and it was our job to quality assure it (Int1Pg4).*

> *You've got to balance that off against two things. People learn at different rates but our rosters don't (Int1Pg25).*

These findings reflect the concerns held about the type of manager that leads education in the SAAS and the relationship this has to addressing the best interests of the education of paramedic interns. What is concerning is the attitude held that operational needs will always supersede educational needs. This attitude has a direct consequence on the learning opportunities of the interns. Therefore, the organisation needs to address the best educational interests of the intern if the organisation wishes to improve the educational culture.

Having identified and discussed the sub-themes that underpin 'organisation', the literature helps to further explain why the organisation is important for the values and beliefs that underpin the paramedic internship. Firstly, the literature supports the stressful nature of paramedic work, including its inherent unpredictability and the existence of many high-pressure situations (Lowry and Stokes 2005, Gayton and Lovell 2012, Maguire, O'Meara et al. 2014). In addition, learning is a social process which means that interns are under pressure to be accepted in the workplace (Billett 2001). Furthermore, the performance of paramedic interns is under scrutiny with the heightened emphasis on correctly (and safely) advising 'treat not transport' patients, which leads to additional stress to ensure that correct decisions are made (Joyce, Wainer et al. 2009). Stress during an internship is also evident in other healthcare professional areas, including nursing (Blanzola, Lindeman et al. 2004, Kelly and Ahern 2009, Thomas, Bertram et al. 2012) and medicine (Bearman, Lawson et al. 2011, Doherty and Nugent 2011, Brennan, Corrigan et al. 2012). Finally,

within paramedic internships in Australia, only two states have guaranteed employment opportunities after the paramedic internship (NSW and WA), while in one state (VIC) this issue is currently under review, and in all other states, there is no guarantee of employment whatsoever.

Next, the ‘ICP being highly valued’ sub-theme, historically, uncovers the early formation and training requirements of differing clinical levels of a range of healthcare roles. In 1971, the Mobile Intensive Care Ambulance (MICA in Victoria) system was developed for deployment to incidents that required a higher level of clinical need. They were normally staffed by a doctor and a MICA ambulance officer, who were trained to give additional treatment. Despite holding no additional formal education, MICA ambulance officers had to hold a Certificate of Applied Science (Ambulance Officer), in addition to having completed 12 months of on-road experience. Tensions grew between the MICA and the ambulance officer groups, as they saw the MICA group as elitist and arrogant (Wilde 1999). Similarly, in nursing different clinical levels were developed. The 1960s saw the introduction of two nursing levels, the Enrolled Nurse (EN) and the Registered Nurse (RN) (Fetherstonhaugh, Nay et al. 2008). In addition to this, RNs are able to undertake additional training to specialise in particular areas (i.e. palliative care, diabetes education, intensive care) (Flinders University 2016d) and can also undertake further accredited courses that can lead to the nurse practitioner role (Nursing and Midwifery Board of Australia 2016). Likewise, in medicine, there are different clinical levels that require increasing levels of education (and years of experience), ranging from intern and resident medical officer (RMO) through to registrar and consultant (Australian Medicial Accociation 2016).

Finally, the literature provides evidence to support the respondents’ concerns about the best people to manage education that underpin the sub-theme of ‘management: clinical vs educational’. In interpreting the literature that supports this sub-theme, I have used an educationalist perspective because the research question focuses on the paramedic internship to which education is central. The outcome for the organisation of the paramedic internship is professional and clinical competence. For competence to be achieved, the university-workplace relationship (Worley 2002), in addition to the curriculum (Billett 2001), must complement one another to optimise effective learning in the workplace environment. However, our study has already demonstrated the existence of a poor educational ideology and model, and therefore, a sub-standard workplace curriculum (see Theme 2: Education). So from an educationalist perspective, understanding the literature that underpins competence and curriculum generation can best inform the balance between operational and educational expertise in management positions.

The literature suggests that simply learning by ‘doing the job’ will not suffice in the workplace environment (Billett 2001). The content of the curriculum should be drawn from both discipline and educational expertise (Schuwirth 2004). If the experts do not agree on the curriculum and its assessment, it is difficult to produce clear outcomes for the paramedic internship (Theme 2:

Education), which has been identified in the literature and which can also compromise the organisation (Schuwirth 2004). Therefore, in the ambulance service context, it is important to draw from both operational and educational expertise to inform curriculum design. However, the current organisational attitudes do not facilitate such an approach, as the respondents have suggested that operational needs supersede educational needs, highlighting a mismatch of priorities.

Research into the cultural dimensions of the organisational and national levels is helpful for better understanding the relationship between these themes and the research question. The 'acceptance of leadership style' dimension is important for understanding how the organisational culture accepts its leaders. It is clear from the above that the clinical level in the ambulance service dictates where the organisational leaders come from. On one hand, holding a higher clinical level enables the intensive care paramedic (ICP) to apply more skills, and therefore, to do more for a patient. On the other hand, just because ICPs hold more clinical skills does not mean that they automatically have leadership skills. It is a cultural norm that management positons in the ambulance service are reserved for ICPs. This cultural norm has also come to be expected by paramedic interns as well, showing that internships can help the organisation to validate the acceptance of a particular leadership style. Of course, there is little choice of leadership style as this is dictated by clinical rank. However, as has been highlighted within this theme, the organisational culture accepts this, despite its unknown origin and the attention being drawn to this. This could suggest that the lowering of the tolerance of this assumption because it is being questioned.

Next, the organisational attitude towards the sub-theme of 'stress' will be explored through the 'employee versus work orientation' dimension. The reason why this dimension was chosen for this part of the analysis is because stress has a profound impact within this dimension. As an organisation, the SAAS has a number of staff welfare programs, examples of which include peer support programs and the presence of mental health professionals to aid employees during times of hardship. Valuing staff by investing in these programs ensures the emotional well-being of the employees. In addition, the organisation thoroughly screens to ensure that the right type of person is suited for this line of work. This points to an organisation that is employee-oriented. Yet, there are some elements that produce stress for the interns that the organisation can control. These include the competitive ranking of interns and orientations by management where choices are based on operational rather than educational needs. Therefore, stress in the paramedic job role is protected by an employee-orientation, but specifically in relation to the stresses unique to the paramedic intern, the organisational attitudes tend to be towards a work-orientation. Consequently, the organisation appears to vary this orientation depending on the role played by the individual in the service, thereby segregating and devaluing the paramedic interns from the rest of the paramedic cohort. This is often the experience during the paramedic internship; however, paramedics that move from other states have already experienced managing the stressors

associated with this type of work. What they may not be able to cope with is the stress to perform and of not gaining ongoing employment. It is assumed that when they leave their home state, they understand the consequences of moving to another state. This may mean that the paramedic might have experienced an employee-orientation in their state of origin but may not be comfortable being treated as an intern through a work-orientation. The organisation needs to ensure that the intern can do the work under these conditions of a work-orientation, as the internship is performance-based with no guarantee of ongoing employment.

The application of Hofstede (2001) dimension of 'masculinity versus femininity' is also relevant here as, following on from the 'employee vs work orientation' dimension, there is an inequality in organisational treatment depending on whether the person is an intern or a paramedic.

Hofstede's model implies that the gender divide is fundamentally concerned with the socially constructed roles of individuals. Applying this model to the paramedic profession, qualified paramedics would be constructed as being emotionally resilient and work-oriented, which would be considered within the profession to be masculine traits. Paramedic interns, being new to the profession, would be assumed to lack the resilience to deal with the emotional load of trauma, death, injury, grief, and even workload issues, which might be socially constructed as feminine traits.

The organisation, through the paramedic role, has historically been male-dominated. As a consequence, masculine traits have been socially constructed around the paramedic role as the accepted norm within the profession. However, as a result of the transition from the diploma to the degree, paramedics have seen a large influx of females entering the profession, and yet, the socially-accepted masculine traits of the profession have been preserved. Again, applying Hofstede's model, it can be stated that females enter the profession on the basis of displaying masculine traits.

Australia is considered to be a masculine society from a national cultural perspective, with a score of 61 (out of 100). This is consistent with the organisational culture of the ambulance service being masculine; however, in applying Hofstede's model, one could suggest that the nature of the masculinist organisational culture may actually be more dependent on the core values that are held by the institution.

Finally, the dimension of power-distance is important for understanding why the organisation places a higher value on ICPs. The SAAS clinical rank establishes that ICPs hold a power-distance over paramedics. This is because ICPs are assumed to have greater knowledge than paramedics which enables them to operate at a higher clinical level with an increased scope of practice. In addition to this, ICPs are also highly valued in management positions. The organisation ensures that the accepted power-distance held by ICPs is established and respected, especially when

paramedic interns are two clinical levels lower than ICPs when they are in the paramedic internship. In Australia, at the national cultural level, power-distance is low (36/100). The organisation displays the opposing trend against the nationally accepted norm, as the organisation values ICPs more than other staff, and only they can hold management roles. It is evident that holding greater power over others affords the opportunity to climb higher in the organisation.

Theme 5: The Internship

The paramedic internship is the central focus of this study, and it was evident from the participants' responses that they held concerns about the purpose, content, and outcomes of the internship program. There are many factors associated with the paramedic internship that are relevant to this study, as evident from the other themes presented. This 'internship' theme focuses on the purpose, content, and outcomes of the paramedic internship, and is informed by the SAAS educational model which was presented in the Theme 2: Education. Three concepts that emerged from the analysis of the data, which form the 'internship' theme are 'induction versus teaching', 'structured program', and 'competency'.

The sub-theme of 'induction versus teaching' describes the core functions of, and the organisation's concerns about the purpose of, the paramedic internship. The respondents questioned the organisation's understanding of the purpose of the paramedic internship. The concerns held were around whether the organisation viewed it as simply an induction process or whether it was also an educational process. It was understood by the organisation that the university would teach all the underpinning knowledge, including anatomy and physiology, body systems, and paramedic practice, leaving the internship to induct the intern into the organisation and its policies, procedures, guidelines, and practices. The respondents conceded that the paramedic internship is an induction process for the organisation, but is also an experiential learning process to consolidate knowledge and practice. Respondent 6 illustrated the education and induction process:

> *I believe that the educational process doesn't supply knowledge, but it shouldn't, because educationally you have a university degree, you have a knowledge base and it should be making you a SAAS person and SAAS policy and procedure and SAAS equipment (Int6Pg10).*

Often, this experiential learning process can take quite a long time, and concerns were raised by the respondents about the length of the internship, which is currently fixed in the SAAS at 13 months. Furthermore, the respondents raised concerns about the large sums of money being spent on interns because it was the view that the organisation was spending time during their induction program to teach interns what the university should have taught them.

Respondent 3 illustrated the internship at a range of levels, including the cost to the organisation because of reteaching the degree during the internship, and the competencies gained during the experiential learning process:

> *The amount of time that we've got them in the classroom with us teaching them stuff, that's - there's a bit of frustration in how I look at that. I think we still spend too much time - and I'm not saying necessarily that the university should be doing it either (Int3Pg7).*
>
> *But probably, more importantly, the internship needs to produce at the end someone who is experienced and competent as a practitioner on their own, basically … … Pragmatically for me, it's learning in that 12 months what the classroom can't teach you. Or giving you the experience to put what you've learnt into practice. But also learning that your patients haven't read the textbook, so they don't know what they're supposed to present like … but it's basically taking the academically trained product and giving it the experience to give context, that they then actually understand the full picture (Int3Pg13).*

Respondent 6 illustrated the organisational understanding of the length of the paramedic internship:

> *Why 12 months? I think it's purely based on history of other health professions. Nursing graduate programs 12 months, medical internships 12 months, I just think it's the magical number. I don't think there's actually any theory or science behind why that number (Int6Pg8).*

Finally, Respondents 4 and 5 emphasised the cost and time spent on interns:

> *I guess we've put so much time and effort, and they've put so much time and effort into this, I would hate to let go of someone who could be a really valuable SAAS staff member and who could really make our organisation better (Int4Pg39).*
>
> *We have other ambulance services who cannot believe how much time, money and emphasis we put into graduate training. In particular, Victoria cannot believe that we allocate so much classroom off-road time, both our function time while you're on PIDT [when a Paramedic Intern crewed ambulance from the Paramedic Intern Development Team is allocated time to stay on station to undertake training] (Int5Pg30).*

The respondents also stated that successful completion of the paramedic internship is achieved through good mentoring and on-road supervision by SAAS staff. The importance of finding the right person to mentor paramedic interns was explored by Respondent 1:

I think you can accelerate its gain by having good mentoring or coaching in the operational environment. I think by having someone who can help you to critically reflect on your behaviour, you accelerate that process greatly (Int1Pg21).

Similarly, Respondent 3 shared their views on how mentors allow interns to navigate uncertainty in their environment by supervising safe practice in a real-life environment to accelerate their learning:

So, you need a good ISTO [In Service Training Officer]/mentor that will take you through that, but allow you enough freedom to do it, and learn it. Not just show you all the time, but let you do it and then talk about it afterwards … … So, you need a - so it comes down to having the right ISTO/mentor, during their period, so that they can put into practice what they've learnt in the classroom. Learn the contradictions to what they've learnt in the classroom as they appear on the road. Learn, like I say, that the patient hasn't read the textbook, so they don't all present with the classic symptoms (Int3Pg23).

Respondent 3 also discussed the importance of good mentoring from the right people during the internship to produce a product (paramedic) for the ambulance service:

But that's the aim, is to put them with the right people in the internship, to develop, coach, mentor and work on them, to bring the product out at the end (Int3Pg16).

Interestingly, the respondents referred to the interns on completion of the internship, as products of the system, describing it more like a manufacturing process than a professional training program. Describing the intern as a product of the system gives insight to the attitudes that the organisations hold towards their interns. It describes an organisation that views the internship as a set of steps to produce a generic worker.

Respondent 6 used the term ‘product’ frequently when referring to the paramedic professional at the end of the internship, when discussing mentorship and education:

My view is very much Flinders is a university that provides - and this is my management view … Flinders very much provides a service to supply an end product and an outcome. What we need to determine is does that end product meet what us, as an employer, needs? So, some of the things that we looked at in the review is which things the university don't do; such as, do we put all the paramedic interns through a driver training test? (Int6Pg25).

So, it's - for me, it's that whole process of mentoring of, I'll give you options, you've got to go - and you can't do it all in one session. You go away and you think about it and come back. That - that's hard because I don't think we've got a workforce that is ready to do that.

We've got people out there that don't want to have the hard conversations. Probably some of that has come because in the previous processes they've written bad PICERS [Paramedic Intern Clinical Evaluation Reports] or they've not recommended people for jobs and we've just gone and employed them anyway. We're at the point that we don't need to do that, [and] that people are starting to see the benefit (Int6Pg39).

These findings demonstrate that the paramedic internship is both an induction and a teaching process. As a result, the organisation spends large amounts of money on the paramedic internship program. This has caused concern for some of the respondents who have suggested that the organisation is spending too much. One way to reduce costs is to reconsider the length of the internship, but there are risks of producing poor-quality paramedics. In an organisation that considers their interns as 'products of the system', finding 'production line' efficiencies to produce the same product quicker and cheaper aligns with the national attitude of cost-saving measures, especially within the wider healthcare arena. Although the organisation attempts to predict graduate student attributes, and has designed paramedic intern programs around these, all graduates entering the paramedic internship have a range of experiences, and therefore, are all unique. In addition, the paramedic internship, although being a structured program, needs to take into account that each intern's journey is different, which requires different levels of engagement and involvement by the mentors, or different self-directed learning methods. Therefore, the paramedic internship does not produce a standard product; instead, it is producing a competent, safe, and work-ready professional.

The sub-theme of the 'structured program' describes the paramedic internship as a fixed-structure program designed for the undergraduate university degree student. The respondents explained that the paramedic internship is a fixed-structure program designed for the generic new graduate of an undergraduate program. As a result, when the respondents were asked if the program is flexible or rigid, most confirmed it as being rigid. This means that the internship is not able to cater for a person who needs more time to complete, as the rosters are fixed in advance with specific intern vacancies, or who needs more theoretical education, as this would cost the organisation additional money for a trainer and time off-road for the intern. This is because the internship is an experiential learning process, and experiences can vary greatly between interns. Overall, these tendencies display a strongly work-oriented organisation. It is assumed that university graduates are adult learners and that people who struggle during the internship due to educational gaps, will have the know-how to learn for themselves. Respondent 1 spoke about the flexibility of the paramedic internship:

So, you can be quite flexible in how fast you learn or how fast you achieve that, but it is fixed and defined and then it's competitive after that. So, our model does what it does, but organisationally – (Int1Pg27).

Some of the things we've said before, it is over set timeframes, not tailored to your individual learning style. It has set components, it's not tailored to your individual learning style … … What is variable is your own rate of progression, but the end point's not variable. So, you've either got to go slow at the start and then go really quick, or you can pace yourself all the way through, or you can excel very quickly and then kind of coast. So, I don't, yeah, I would say it's pretty rigid, yeah (Int1Pg33).

Although this is an assumption of the traits of the recruitment pool that the SAAS select from, correct recruitment of paramedic interns is important to ensure that they have the ability to fit into this fixed-structure program and are able to be self-directed learners. It seems further unlikely at the moment that the organisation would have the time or money to significantly alter the internship program, specifically for a student who does not bring with them the ability for self-directed learning (which is assumed by the completion of the degree), and the right attitudes and personality to undertake this type of job. In this way, the organisation relies on the university to produce a graduate with the underpinning theoretical knowledge for paramedicine that will form the recruitment pool. The organisation will select interns from this pool who they feel have the right attitude and personality to fit into the organisation. Respondent 2 emphasised that the paramedic internship is a structured program designed for a specific type of person:

So, I think the internship is still slightly geared towards a certain type of person, a certain personality. If you fit within an ambo sort of personality type, you tend to do quite well. If you're someone who is a little bit left of centre, unfortunately the program doesn't seem to do as well. It tends to rely quite heavily on your ability to engage with people and get on with people. So, if you're someone who is a bit of an introvert and that - I tend to find that those people tend to struggle a bit more in a program. Versus the extrovert, who can come into a station and blend very quickly in that, if you like, culture, which then seems to allow them to get a head start a bit quicker than the others (Int2Pg29).

Respondent 5 spoke about ensuring that interns have the capacity for self-directed learning:

Now, there is a lot more emphasis put back on adult education and professional accountability, so when a student comes in now, if they don't understand the pathophysiology of anaphylaxes or the pharmacology of Adrenaline, it is their problem, not SAASs or this unit problem anymore. We'll give them the tools and the ability to reflect on both the university studies and the information here, but there's no more didactic. If you miss that at university, and weren't paying attention, it really is your professional responsibility (Int5Pg10).

The undergraduate student model, in which the students undertake clinical placements as part of their degree, is an important prerequisite to the paramedic internship program. The respondents

described a poor student placement model. This means that the process of undergraduates taking placements looks good on the outside, but is ineffective on the inside because it is perceived by the respondents that the students' attitudes are directed towards meeting the accreditation requirements of placements, rather than meeting the aims of preparing them for the internship. These aims include familiarisation with the ambulance environment and practising skills in the operational environment. In this way, the organisation views these placements as a 'tick and flick' process for the students, and the negative consequences could transition to the internship.

It appears that the students under-estimate the value of these placements, as illustrated by Respondent 2:

> *I'm not sure why they - the approach tends to bring, if you like - I see a bit of the textbook university student view to the placement, that I don't think many people really understand what the placement is about. So, I think people, unfortunately, approach the placement as a bit of a 'oh, I've got to tick 14 of these off. Oh, the lights and sirens bit is cool, and seeing this bit is cool. Other than that, I'm just going to kick back and relax' (Int2Pg17).*

Furthermore, Respondent 3 pointed to students not achieving the aims of student placements:

> *Because when they come out of the degree, I don't know how much of the picture they've got, but they've only got a certain picture. The clinical placements aren't reliable, because it depends who they're with as to what value the clinical placements provide in giving the context of that. But I think the clinical placements are more about giving them context for what they're currently learning, not about developing them into a finished product (Int3Pg13).*

Respondent 5 spoke about the attitudes that had been developed in the student placements being brought over to the paramedic internship:

> *It was interesting, once we had told them from day one we don't want to hear the word exam during that workshop, they actually did change their mindset that this was an education process, it was a safe environment, it was a learning environment, it wasn't either an HR process or this tick and flick in a box process. We are breaking down those barriers slowly (Int5Pg13).*

These findings demonstrate that the paramedic internship program is structured for a certain type of undergraduate student to fit into. This type of undergraduate student is a product of a poor student placement model. Therefore, individual student attitudes towards student placements have an effect on the attitudes they hold during the internship. It is then reasonable to use the attitudes displayed by students in university placements to guide the recruitment of paramedic interns (this is discussed further in Theme 6: Recruitment and Selection).

The sub-theme of 'competency' describes, from the viewpoint of the organisation, what are seen as critical elements of the paramedic internship that define the organisation's understanding of competence. A common question highlighted by the respondents was "what is competency?" and "how do we measure it?" in the context of the paramedic environment? Respondents 3 and 5 put forward their views on competency:

> *I've asked academics to quantify that for me a number of times, when they go, oh you know, if you don't practise the skill, you get skill degradation and, … well, will you quantify that for me? Is it a month; is it two months; is it a year? (Int3Pg16).*

> *So, (1) what are we assessing, (2) is it a fair and consistent assessment, is it acknowledging that we're assessing a graduate paramedic who's at the beginning of their career, and I think the most important, is this a relevant assessment - are we assessing just for the sake of assessing or are we assessing to make sure they're safe, competent, however, but is it relevant to both their needs and the organisation's needs as well? (Int5Pg21).*

When there is a clear lens on the organisation's understanding of competency, then the organisation can attempt to answer the respondents' question about whether the organisation is getting the paramedic internship right. Achieving the aims of the internship is discussed by Respondent 1:

> *I think the best thing we do is the on-road supervision with the paramedic intern development teams because I've looked at a lot of graduate models and nothing is as intensely supportive as what we do (Int1 Pg15).*

> *Whether I've got it right [laughs] because I sometimes wonder. Because I don't think there are any right answers. So, it's whether the model is, I'd use the term empowering someone, to practice as a paramedic at the end. Are we providing the right things? You know, education, training, experience, supervision, coaching, all those things (Int1 Pg39).*

To address the question of competency, the organisation firstly needs to establish what they view to be a good paramedic. The SAAS must already hold a pre-conceived notion of what makes up a good paramedic because they have developed a tool to measure the performance of paramedic interns, known as PICERS, or Paramedic Intern Clinical Evaluation Reports. These reports historically map and track paramedic performance to ensure that the interns are on the right path towards competency.

Understanding competence is a dilemma faced by the organisation. Respondent 3 illustrates why this is the case:

How many stabbings do you need to go to, to have good stabbing competence? You might never do a stabbing in the first two or three years of your career. Does that mean that you're not competent at it? I haven't put a tube in for - probably be three, four years now, but I'd be pretty confident that 90 per cent of the time, I'd be able to get one in. If not, recognise that I'm not going to, and therefore stop stuffing around and do what needs to be done. But then again, it's - as they say, you can teach a monkey to put a tube in. It's teaching them when, is the trick (Int3Pg16).

The traits of a good paramedic were discussed by Respondent 3:

But you - ambulance practice - see, I've got some views about what makes a good ambo. So, it really comes back to that, to some degree. I do think it's important to learn what not to do, but how you teach them that without being a bad role model is hard (Int3Pg24).

Respondents 1 and 6 spoke about the value of the PICERS towards understanding competence:

Well, take the Paramedic Intern Clinical Evaluation Report. We've mapped out what we think a paramedic should be able to do, and then what we do is we get the person working with an intern to try and measure where they stand on that scale and we've basically said a good paramedic sits here and there are some sub-scales, or some sub-points below that (Int1Pg23).

So, a PICER is a feedback, it's for development. It's for open and honest communication that helps the intern develop. It shouldn't be used as a management tool. You then look - and this was my view of reviewing the whole process - you look at a PICER and go, we told someone they weren't meeting the grade, but at no point did we very clearly identify timeframes for them to go and meet something (Int6Pg9).

The respondents suggested that during the internship, it is acceptable to push boundaries, make mistakes, and learn from both the positive and negative experiences. Competency is developed in the paramedic internship by pushing the interns outside of their comfort zone in uncertain situations. Only a paramedic internship can ensure this because competency is not solely about consolidating knowledge through practice, but also incorporates the development of intuition which cannot be taught in the university setting and is essential to becoming a successful paramedic.

Respondent 6 reflected upon interns understanding for themselves what they view as a good and bad paramedic:

You've been on the road now for six, nine months. Who do you see are the good ICPs and the good paramedics? Why? Who are the bad ICPs and the bad paramedics? Why? You don't need to tell me who they are, but I know that you've got names - or you've got pictures

in your heads of different people. What is it about those people? You start to break that down. Well you know what, they've all got the same level - set of clinical skills. They've all got the same education. What makes them different? It doesn't come down to a knowledge or a set of guidelines. It comes down to their interpersonal skills and their professionalism and their ethics and values. So it's really starting to push that across (Int 6 PG 30).

Respondent 3 discussed the pushing of boundaries during the internship:

So, all of that stuff is very hard to codify, quantify or whatever, and you need good role models to take you through some of those experiences, so that you can learn how to do that. But - in that, like I say, an ambo needs to be naughty. Because they need to have fun in the job, push the boundaries. They told us we couldn't do that, but they didn't tell us we couldn't that. Therefore, we must be able to do that. Push the boundaries and do those things, to learn what is fair and what's no. … … Ambos need to be naughty. We operate in an environment that has very poor legislative protection. We operate in the real world that might be governed by legislation, but doesn't actually apply when you're in the house of some of the patients we go to, and things like that. Legislation doesn't help you when you've got someone that's trapped behind a toilet door and wedged in there. How do you get them out? Legislation doesn't necessarily help you when you're debating with the firies [firemen] about how you should get that patient out. They want to do this and you want to do that. … … You need an ambo that knows how to get - how to be a very good consequential thinker. If I do this, what's the risk? If I do - if I don't do that, what's the risk? Which risk am I willing to put up with the most? Very good, quick, algorithmic thinkers with the patient. If I do this, do that. Very good at taking a set of things - signs, symptoms and history, and situation - and putting it together to make good, logical conclusions. Then test those conclusions, to see if what they've thought is right or not, to do the right thing for the patient (Int3Pg25).

Although the organisation has employed methods to measure competence, without fully understanding what competence is for the paramedic profession, it is unable to have a clear picture of the assessment to be used to measure competency. It is logical, and this is supported by the respondents, that the current internship program uses poor assessment tools to measure competency. Respondent 4 explained a feeling of being left behind by the university degree, but highlighted the value of on-road time to maintain competency:

The level of learning that you get within the degree is far more than the diploma. I mean, these people that we're employing now, their level of knowledge far outweighs what mine will and what it did. I'm not even going to try and keep up with them. I'll just keep going, oh well that's fine, but I've seen it all and done it all. Because that's all I've got left (Int4 Pg29).

Furthermore, Respondents 2 and 5 indicated that paramedic interns are being taught and assessed at the ICP level and this is not appropriate for the organisation, because it is not the aim of the paramedic internship to produce ICPs:

> *I'm not sure. If I could answer that, I'd know then that I could start to work on how to fix it. But it's evident, and having recently gone through a process with looking at the internship after a series of the assessments didn't go well. Having to talk to 50 per cent of a group that didn't pass, and try to go through what went wrong in that … in doing that, and reviewing their educational time, it's clear that they have a very high regard for the title of ICP and in fact, they're almost pushed down that path by people that educate them. Which seems to be the fact that a lot of the educators are ICPs (Int2Pg10).*

> *We still haven't got it right and we acknowledge that. Graduates are still being assessed at really an ICP instead of looking at - and that high end level instead of looking at are we assessing you as - and this is why we keep using this term - are you a safe junior, beginner, whatever you want to call it, practitioner who is going to - are we happy for you to go out and continue learning, but it's not just in your graduate program (Int5Pg15).*

Respondent 5 shared their views on the assessment methods used by the SAAS:

> *Well, … I guess (1) what are we assessing because really there's been no consistency. We were still using the same assessment forms used in the vocational training program up until recently. So (1) what are we assessing?, (2) is it a fair and consistent assessment? Is it acknowledging that we're assessing a graduate paramedic who's at the beginning of their career and I think the most important is, is this a relevant assessment? - are we assessing just for the sake of assessing or are we assessing to make sure they're safe, competent, however?, but is it relevant to both their needs and the organisation's needs as well? (Int5Pg22).*

These findings demonstrate the resulting effects on the organisation due to not clearly defining what a good paramedic is. As a consequence, the SAAS has developed a curriculum based on a descriptive curriculum model, which describes what a good paramedic is, rather than a perspective model, which knows what a good paramedic is (Prideaux 2003).

Having identified and discussed the sub-themes that underpin the 'paramedic internship' theme, the literature helps to further explain why the internship is important for the values and beliefs that underpin the paramedic internship. Firstly, the 'induction vs teaching' theme shows that the paramedic internship serves the purpose of consolidating the clinical skills of the intern through an experiential learning process and of inducting new employees into the organisation.

The value of the connection between knowledge and practice through real-life experience is not a new concept (Billett 2001). When the broad knowledge learnt at the undergraduate level is applied through experiential learning to the clinical context, it is highly valued by both educators and students (McAllister, Paterson et al. 2010). This ability to test solutions, even if bad choices are made, makes experiential learning an ideal tool for the student to discover the efficacy of the solutions for themselves (Brockbank and McGill 2007). Both nursing and medicine value the experiential learning process as an essential element of education which cannot be taught in the university setting (Wilkinson and Harris 2002, Doherty and Nugent 2011, Haleem, Manetti et al. 2011, Thomas, Bertram et al. 2012).

Organisational culture is deeply rooted in workplace behaviours that are difficult to identify for a new employee. Being accepted within the workplace may be determined by the employee's behaviours in front of their peers (Carlstrom and Ekman 2012). Therefore, it is important for the organisation to understand that both induction and education are equally essential elements of the paramedic internship and that the organisation has sole responsibility for both aspects. This contravenes the respondents' suggestion that the university, rather than the organisation, is primarily responsible for paramedic education.

Next, the 'structured program' sub-theme explores the recruitment pathways to becoming a paramedic intern in Australia, and the need for the university and organisational curricula to complement one another. The evolution of paramedic education from internal training to the undergraduate university degree has been widely discussed in the literature (Wilde 1999). In Australia, the majority of ambulance services have adopted the completion of an undergraduate paramedic degree to be eligible for employment as a paramedic. Only two states, NSW and WA, have programs that enable people who do not hold, or do not have the capacity to complete, a university paramedic degree, to become a paramedic, as defined by their state. The NSW Ambulance Service still maintains an internal diploma program that enables the recruitment of people from a wider sector of the community who may have not previously had the opportunity to become a paramedic. The St John Ambulance (WA) service has a program in which aspiring paramedics work as student ambulance officers while they complete an undergraduate paramedic degree. Nevertheless, this pathway still requires the academic prerequisites for university entry. In the SAAS, the only recruitment pathway is to complete a paramedic university degree from an institution approved by the Council of Ambulance Authorities (South Australian Ambulance Service 2015c).

In addition, the importance of the complementarity of the university and the workplace curriculum to produce a work-ready professional has also been discussed in depth (see Theme 2: Education) (Billett 2001, Newton and McKenna 2007, McAllister, Paterson et al. 2010). It is clear that the majority of organisations have adapted to the combined university degree and paramedic

internship model for educating and producing a work-ready paramedic professional. However, as NSW still considers their current diploma-trained staff as paramedics (New South Wales Ambulance 2016a), a national approach towards defining what a paramedic is, may be difficult to achieve. These inconsistences between the ambulance organisations in NSW and the rest of Australia cause confusion when discussing paramedicine at the national level. Hence, there is a need for a local paramedic internship to ensure that incoming paramedics can be identified as paramedics in their new state.

Finally, the literature explores what competency is and how it is applied to the paramedic context. Competence has been well researched, yet is a difficult concept to define, especially in the under-researched paramedic profession. Epstein and Hundert (2002 pg 226) have defined professional competence as “the habitual and judicious use of communication, knowledge, technique, skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served”. However, competence can be delineated into two areas, isolated competence or professional competence (Epstein and Hundert 2002). Isolated competence demonstrates the ability to undertake a single skill habitually. Professional competence is the combining of a number of skills seamlessly and simultaneously to be able to operate and make rational decisions, which is vital when dealing with complex and urgent medical needs.

Polanyi (Polanyi 1974) argued that competence is defined by tacit knowledge, including the use of heuristics (rules of thumb), intuition, and pattern recognition, rather than through explicit knowledge. Commonly, patients may not fit into a normal pattern, and therefore, professional competence is defined by Schön (1983), in Epstein and Hundert (2002 pg 227), as “the ability to manage ambiguous problems, tolerate uncertainty and make decisions with limited information”. It is important in the paramedic profession is to ensure that paramedic interns can tolerate and adapt to uncertainty. Schön (1987) described professional adaptability in his reflection-in-action theory. Initially, knowledge-in-action guides the path of patient assessment and treatment; however, when there is a change in expected circumstances, reflection-in-action gives rise to a modification in the way action is to be taken (Schön 1987, Eraut 1994, Brockbank and McGill 2007).

It is believed that professional competence is achieved within the paramedic profession upon successful completion of the paramedic internship. The paramedic transition to professional practice is consistent with other disciplines in which university graduates need to complete a minimum of 12 months of practice to ensure that the skills of the profession are consolidated (Willis, Pointon et al. 2009).

Finally, the assessments for, and length of, paramedic internships across Australia will be discussed. The current assessment tools to determine the competence of paramedic interns used by ambulance services across Australia include:

- Log Books - Tracks the performance, cases, training, and case study of the paramedic intern
- VIVA - Oral examination of knowledge and practice
- On-Road Hours - How many hours are completed actively working in an ambulance
- Practical Assessment - Using simulations to assess performance
- Theory Assessment - Written examination
- On-Road Evaluation - Assessments conducted while actively working in an ambulance treating real patients
- Skills Logs - Practicing isolated skills and logging performance

The length of paramedic internships across Australia ranges from 12 months to two years for paramedic interns who hold an undergraduate degree, and up to four years (in WA) while undertaking the degree. In the NSW Ambulance Service, candidates who are employed to undertake the diploma to become a paramedic in NSW take three years to complete.

Research into the cultural dimension at the organisation level is helpful for better understanding the relationship between these themes and the initial research question. The 'local versus professional' dimension helps us to better understand the 'internship' theme. It is important to understand the role of the organisation and of the profession when generating an intern program. The local orientation focuses on the organisation and it is seen as a local induction to the organisational policies/procedures/guidelines. Yet the organisation also has a role in inducting new interns into the paramedic profession. However, the lens of what a paramedic means to that organisation could change from state to state as there is no national consistency of what a paramedic is. As a result, it is reasonable to assume that an internship will not only induct new staff into the organisation, but will model the organisation's understanding of what a paramedic is. It is evident that the organisation needs to take care when balancing the essential need for local organisational induction versus the profession's views of what a paramedic should be.

How the organisational work discipline operates is important in order to understand the rules of the organisation that are applied in the operational context, and therefore, embedded as a set of cultural norms. The internship simply cannot be informal as it is an educational process restricted in time with key assessment points throughout. In addition, it is important for standards to be set during the internship, as discussed in Theme 1: 'Attitudes', as the interns bring with them an under-developed set of standards. Managing uncertainty in the context of paramedic work relies on intuition and this, in part, defines competency within the profession. Strict adherence to rules, policies, and procedures, especially within the highly uncertain environment of paramedicine is not plausible. There is a distinct difference between adherence to the rules, set by policy and procedure, and staying within operational boundaries, which describe the limits of these policies and procedures which still allow the necessity of some degree of interpretation. The paramedic internship allows the tacit ability to test these boundaries, as has been highlighted in the sub-

themes, and it is considered that pushing boundaries is good for an intern as it aids in the learning of intuition and leads towards competency. This demonstrates an organisation that provides a balance between strict and easy-going work discipline.

Finally, using means- and goals-orientations can help to uncover how attitudes towards competency are generated from the organisational culture. A means- versus a goals-orientation, quite simply, can be understood by the organisation as the paramedic intern's journey or endpoint. It appears that both are equally important for the organisation to aid the understanding of competence. A means-oriented approach indicates that the process is well-defined, and therefore, there is an expectation that it will lead to a good outcome. It is therefore quite rigid because if one deviates from the process, there is no guarantee that the outcome will be good. A goal-oriented perspective has a clear view about the outcome and can therefore be more flexible with the process. The problem here is that both the process and the outcome appear to be unclear, but there is apparently a tacit idea about what the outcome should be, and because it is so tacit, one organisation clearly does not trust the process of other organisations. It is for this reason that paramedics from other states are required to undertake a new internship in their new state.

Theme 6: Recruitment and Selection

It was evident from the participants' responses that they had concerns about the recruitment and selection process for the paramedic internship. There were two concepts that emerged from the analysis of the data which formed the theme of 'recruitment and selection'; these are 'recruitment' and 'employment'.

The sub-theme of 'recruitment' describes the areas of concern about the current limitations and consequences of the recruitment pathway by the organisation of paramedic interns. The respondents suggested that as a result of the conversion from the diploma to degree structure, the organisation has only a limited recruitment pool from which to choose paramedic interns. This recruitment pool is completely controlled by the university and limits the type of people the organisation can choose from. The limited recruitment pool is highlighted by Respondents 3 and 4:

> *So, that's one of the problems that we wrestled with early in the degree, because we were interviewing from a pool that someone else had chosen. So, we had to wrestle with our selection process year after year, to try and get it to the point. Because to be quite frank, if I had been on those interview panels, I probably wouldn't have employed any of them. Because they were all Gen Ys, with that attitude of you'll be privileged if I come and work for you. Me with that baby-boomer attitude, well [expletive] you! But well (expletive) you, I'm the boss. So you'll be grateful that I'm giving you a job. (Int3Pg29).*

We have to take the product that the university offers. Because the university doesn't do the degree online, I think it's very difficult to do it part-time. What you tend to get are those students straight out of high school - they go into the degree at 18-years-old they finish when they're 21 - you don't get a huge amount of cultural diversity in them. What you don't get - which you used to get in the diploma school - was the 40-year-old plumber who decided he needed a career change. Because he now can't afford to give up his job and go to uni and study full-time, whereas in the diploma, they got paid to study (Int4Pg14).

As a result, the respondents have seen a change in the workforce. What once was a male-dominated profession is now in the transition of becoming a female-dominated profession. The respondents suggested that this is because female school leavers are more academic than their male counterparts. Respondents 1 and 2 discussed the gender bias as a result of the transformation from the diploma to the degree:

The first one is why [there are] more females than males in the paramedic internship. It's probably because the university graduates more females than males from their undergraduate program, which is probably a function of the number of people who go into the undergraduate program. … … These findings demonstrate the removal of the gender bias to the paramedic role and this is a direct result of the transition to paramedic education to university degree. Therefore, the recruitment pool the organisation selects from has highly predictable traits. One trait that is important to the paramedic profession is life experience, as previously discussed. Selecting from a group of university graduates limits the range of life experience the organisation selects from. The consequences of this are yet to be seen (Int1Pg40).

What does the degree bring us? Again, the degree brings with it its own challenges. It tends to have a far more restricted diversity structure within it. So, whilst it might have a whole range of diversity from an ethnicity sort of perspective, it doesn't necessarily bring with it an age diversity. So, it tends to be focused on school leavers, with a low number of mature age entrants that come into it. Again, interestingly, compared to the diploma, if you look at our recruitment, it now tends to have a stronger female bias than previously, whereas the diploma had a male bias (Int2Pg30).

The sub-theme of 'employment' demonstrates how the organisation manages the ongoing employment of paramedic interns. Upon successful completion of the internship, the organisation has the power to select its future staff. The respondents suggested that this is a difficult process, partly because of the highly competitive process and the limited job opportunities. Respondent 1 spoke about the selection of staff:

... sometimes, I don't like being an educator in an organisation that employs, because sometimes the employer in me, as a senior manager, goes yep, let's pick the cream because they're the people we want and we've tested them for 12 months. That's who I want on ambulances going to the clients that call us. I'm quite happy to be ruthless about that. Does it make for a great educational environment? Possibly not (Int1Pg27).

The highly competitive recruitment process is explored by Respondent 6:

So, we need to have a relationship, but we need to be defined, and I think it needs to be - it definitely has to be a break, because the university is putting out so many numbers that you go - we're now going down to - looking at going down to 32 intake - internships. We are an employer. The other thing is, we're now in the position where can afford to be more picky. If you look at the intern group that's about to start, and the group that started before them, we had over 200 applicants for 32 positions that got shortlisted. … We interviewed I think it was something like 80 people for 32 positions (Int6Pg27).

The other dominant element that causes concern is ensuring that the organisation selects the right person for the right job. This is to ensure that the selected paramedic not only practices safely and competently, but can also reflect the organisation in a positive light in a highly-public environment. Selecting the right person for the right job is discussed by Respondent 4:

Like really, we used to employ every student from the internship and I think it's good we've moved away from that and we are saying no. I think we should continue and there should be that little bit of the, well it's not like I'm in and that's it job for life. I do have to do well, and I do have to be good at what I do to get a job at the end of the internship (Int4Pg35).

As a result of the organisation becoming more selective, the respondents mentioned that the interns are constantly worried about future employment. Respondents 3 and 6 confirmed the concerns held by interns about future employment:

So - like I said at the beginning, it's that bit of pressure that we've got to get rid of. It is the noose, if you like, hanging around your neck the entire internship, about the opportunity for employment at the end. So I think, unfortunately, and sometimes people can become so focused on it that it's detrimental to their internship (Int3Pg33).

Groups are always competitive, and I suppose the problem that you have is when you look at the recruitment and selection process, the university has large numbers that they're putting through the intakes. We don't have the positions available for them, so it is competitive to get into the internship and so that competition continues on because they know that they're all - at the end of it, they want a job, and they know that they're not

guaranteed a job. Not - and that uncertainty then makes it competitive, which in my view can sometimes also be negative to the process or the development (Int6Pg13).

These findings demonstrate that even knowing that the organisation has no ability to control the recruitment pool, it still has the choice to pick paramedics that fit into the organisation. It therefore makes sense for ambulance organisations to not guarantee employment at the end of the internship, as the internship is also viewed as a trial period without the need for ongoing commitment.

Having identified and discussed the sub-themes that underpin ‘recruitment and selection’, the literature helps to further explain why the correct type of people employed by the ambulance service is important for reflecting the values and beliefs that underpin the paramedic internship. Firstly, the literature supports the ‘employment’ sub-theme by providing evidence that supports the university employment pool traits. The demographics of the workforce have been established in the literature, with a greater number of younger female graduates who are less mature and have less life experience coming into the profession (Waxman and Williams 2006, Joyce, Wainer et al. 2009). Current paramedic graduates are likely to be part of a trend towards a portfolio of careers which focuses on flexibility (moving between organisations), advancing clinical knowledge and skills (further training/education and higher clinical rank), and moving across traditional occupational boundaries (i.e., paramedic practitioner) (Joyce, Wainer et al. 2009).

In addition, the literature reveals a gender bias in the early formation of the ambulance services in Australia. The concept of an ambulance service initially developed through the need to rapidly move injured patients from the battlefield in World War One. A civilian context was developed out of the military model and, at that time, it was only considered to be a male profession because of the male dominant militaristic origins (Wilde 1999). Ambulance officers were generally men because of the heavy lifting involved, the perceived need for emotional detachment, and the socially accepted view of the time of men’s rapid decision-making ability under pressure, and their mechanical knowledge. In the early ambulance officer curriculum, men and women could not undertake training together. Men were taught how to move the injured, whereas women were taught how to set up the first aid room and prepare for the arrival of the patient (Wilde 1999).

Finally, evidence from the Australian Bureau of Statistics supports the transition of the paramedic workforce towards equal gender participation. In the 2006 census, only 26% of those who considered themselves paramedics were female, increasing to 32% in the 2011 census (Paramedics Australia 2012).

The literature that supports the sub-theme of ‘employment ’is limited to the employment opportunities that exist within each organisation. The existence of increases in cost-saving measures in the Australian healthcare system has been well-established (Australian Insitute of

Health and Welfare 2014). As a result, there is only limited funding for additional staff, which generates uncertainty for paramedic interns in terms of ongoing employment. It is understandable why only two states in Australia offer ongoing permanency after the successful completion of the paramedic internship (see Literature Review: Paramedic Internships in Australia). The remaining ambulance organisations do not guarantee ongoing employment, with some only offering ongoing but temporary contracts. In addition to this, New South Wales Ambulance (2016b) has a high workforce retention rate, reporting in 2013/14 a 4.3% resignation rate for paramedics as opposed to a national average of 16% in 2015 (Australian Human Resoruces Insitute Limited 2015). As a direct result of cost-saving pressures and low employee turnover rates, ongoing job opportunities cannot be wedded to the internship.

Research into the cultural dimension at the organisational and national levels is helpful for better understanding the relationship between these themes and the initial research question. The dimension of 'the internally- versus the externally-driven organisation' helps us to further understand the theme of 'recruitment and selection'. The paramedic intern recruitment pool is controlled by the university which means that recruitment is externally driven. However, the organisation cannot simply allow another organisation to deliver a graduate that is a product of a university system that deems a student to have the required knowledge to become a paramedic. As a result, the organisation's selection from the recruitment pool is internally driven. The organisation has the ability to pick and choose who they feel will fit the organisation and have the necessary skills and knowledge to enable successful completion of the paramedic internship. Therefore, the organisation needs to firstly understand which skills/knowledge/personalities they desire in their paramedic interns. Following this, they need to successfully screen the applicants, within a highly competitive recruitment process, to ensure that they choose the right people for the job. To validate this process, only a paramedic internship can provide feedback to the organisation on the required information needed to evaluate the success of their recruitment methods.

It is easy to jump to conclusions about the gender gap that is present within the ambulance service. The section below will explore the gender gap in the 'recruitment' theme within a national cultural context using Hofstede's 'masculinity vs femininity' dimension. Australia leans slightly towards masculinity (61/100) according to Hofstede's 'masculinity versus femininity' dimension. Historically, the concept of an ambulance service had its origins in the military setting, a male dominated profession. In the lens of this study, masculinity versus femininity is not about gender; instead, it is about the emotional roles attached to them. Masculinity describes a maximal differentiation of emotional and social roles which, in the context of paramedic work, is essential to have the ability to separate emotions from work. Femininity describes a minimal differentiation of emotional and social roles, which allows emotion and work to complement one another. Despite the paramedic role still being masculine (applying Hofstede's model), more females are entering the profession. This demonstrates that it is culturally acceptable for females to display masculine

traits within the paramedic work role. However, at times, it is important to balance out masculine traits with some feminine traits, as masculinity in isolation will be viewed by the public as lacking in empathy in what is considered to be a caring profession. This can be achieved by limiting emotions in specific situations. Therefore, it is difficult to display the balance between these traits without testing how paramedics contextually apply them, without putting them through an internship. Those who show too much femininity in terms of emotional investment will find it difficult to manage the inherent stressors of the job.

Finally, the Uncertainty Avoidance Index (UAI) is important for understanding the impact on employment for ambulance services across Australia. As previously mentioned, the internship is a highly competitive process, and with limited funding and a high retention rate, it makes sense for most ambulance services to refuse to guarantee ongoing employment. This represents a high UAI. Australia scores in the mid-range (51/100) on Hofstede's Uncertainty Avoidance Index, which means that culturally, Australia balances autonomy and regulation. The organisation wants to maintain this high UAI to ensure that they have the ability to select the most appropriate paramedic interns (the highest ranked in SA) when there is sufficient funding to do so. It is understandable that interns wish to reduce this uncertainty, but the organisation needs to be fair, realistic, and transparent with post-internship employment opportunities to avoid unrealistic expectations. The paramedic internship simply allows the organisation to test and select those who fit into the organisation, and not to commit long-term employment to those who fail to achieve this.

Theme 7: The Profession

It was evident from the respondents' views that they had concerns about the professionalisation of paramedics across Australia and the impact this has on the paramedic internship. There were two concepts that emerged from the analysis of the data which formed the theme of 'the profession', these are 'paramedic professional' and 'professional comparisons'.

The sub-theme of 'paramedic professional' describes the respondents' concerns about whether paramedicine is considered to be a profession in Australia. It is clear that the respondents consider paramedicine as an emerging profession. The view is that the profession needs an internship to ensure that paramedic interns are culturally indoctrinated into the profession. Respondent 1 spoke about the paramedic professional and the necessity of the paramedic internship:

> *I think we do have - I'm a thousand per cent convinced we've got a healthcare profession with an acceptable level of variation given the variety of employers that are out there, which again harks back to the nursing analogy where, based on what an employer needs of a healthcare professional, defines the scope of practice which is defined by the service delivery. It all depends what your particular employer is trying to achieve, and that's why*

internships are important because you've got to teach people what this particular employer wants to achieve (Int1Pg36).

The respondents clearly perceive that there are very talented people already in the profession working hard to model what a good professional is. Talented people are employed in the ambulance service and this is identified by Respondent 1:

I think we get some amazing people. They are driven in ways I can't even imagine. I'm too slack in my old age, but I look at these young guys that are really keen to improve and learn and to an extent challenge, to make sure they know the right things at the right time, and it's incredibly impressive, very motivational to work in a role like mine (Int1Pg32).

One of the biggest hurdles identified by the respondents in overcoming the struggle for professional recognition was the absence of national regulation and registration. National regulation and registration, if and when it is introduced, will have many positive consequences for the profession, including greater advocacy with a united voice, allowing for greater national portability with qualifications, transparent training standards, consistency in job titles, and developing a body of knowledge owned by the profession at the national level. Respondent 4 spoke about the power of having a single collective voice of the profession as a result of national registration:

I think once we're registered that might be different. I think if all the ambulance services registered and we all got together as one voice, then I think we'd have far more ability to own our own education (Int4Pg32).

The issues that national registration would resolve were also discussed by Respondent 2:

I think one of the problems - and I've said this in several forums - is that in the absence of registration, the portability of the qualification is not quite there. So, a strong believer that an internship model is a good model, as opposed to a pre-employment. However, it really has its value in a point in time where the qualification is portable. Where you're able to actually obviously take that qualification and go work in Victoria, go work in New South Wales, go work in Queensland or whatever (Int2Pg33).

The - and it's not that registration is the answer to everything, because registration is going to bring with it a pile of problems. I'm not 100 per cent convinced (a) that I know what they are, and (b) that the workforce understand what some of the impacts of it will be. But in the absence of it at the moment, we have several ambulance services across the country that all deliver training in their own way. All have their own expectations, with no clear definition on what it is to become a paramedic. No clear definition on what it is to be an ICP. No clear definition on what it is to be an ECP, an AO and all the various things within it. At the

moment, that capacity to take your paramedic qualification to Victoria, Victoria don't have any formal way of recognising it. It doesn't align necessarily with what Victoria deliver, so therefore they tend to struggle with how to translate it. From our perspective, when we do interstate recruitment - albeit we don't do it very often, because of the numbers. But when we do do it and we have discussions, again, you are bringing people in with a - who have come through a different educational process. Who - and trying to match that to our structure is always difficult (Int2Pg38).

These findings demonstrate the poor identification of the paramedic profession within the Australian healthcare sector because of the absence of national regulation and registration. Ambulance organisations play a critical role in post-university training via the internship, and other internal training programs to maintain high levels of clinical knowledge. As a result of the lack of national regulation, and therefore a lack of national standards, paramedic training has no formal consistency between the states, making portability of the paramedic internship impossible. Further complicating these issues, with the lack of national registration, the states have no clear definition of what a paramedic is, and therefore, tend to use different terminology to describe the various clinical levels.

The sub-theme of ‘professional comparison’ compares the successful professional journey of both nursing and medicine in Australia to the struggling professional journey of paramedicine. The respondents confirmed the hybrid nature of people who are employed in nursing, medicine, and paramedicine in the healthcare environment. Paramedicine relies on research from nursing and medicine to guide professional principles and practices, as there is only minimal Australian research into the paramedic profession. Respondent 2 discussed the links that exist between people who move between the professions of nursing, medicine, and paramedicine:

If you look at what people that come in, we tend to get - not a large number, but a reasonable number of people transition across from a variety of health science, but nursing is one of them. Likewise, we also have a reasonable portion of staff that once they're in here, subsequently go on to do the 12 months transit to gain their nursing registration. We've got some obviously transitioning across to medicine where that sits. So, there just seems to be a link (Int2Pg36).

Modelling paramedicine through nursing is not a new concept and aspects of this are discussed by Respondent 5:

We’ve got a SAAS version of that. We’ve adopted the nursing model and we’ve told them by the time they leave here, we would like to see them at the competent level but you may not be (In5pg8).

Nursing shares the advantage that we don't have, and that is a set standard curriculum - not curriculum but standards. So, the Australian Nursing and Midwifery Council determines what a registered nurse's knowledge they must have as a bare minimum to be registered as a nurse. We don't have that in the ambulance practice and until registration occurs then maybe that also occurs (Int5Pg12).

It is for this reason, in addition to the lack of national registration and regulation, that the profession has struggled to be clearly grounded in the Australian healthcare sector. However, as the profession becomes more grounded within the healthcare sector with specific occupational boundaries, the ability for knowledge to be developed specifically for the paramedic profession grows. Respondent 1 highlighted the extrapolation of the nursing and medicine literature to paramedicine:

The health industry started to develop a body of knowledge around paramedic work, as opposed to the extrapolation of nursing predominantly, and then medicine, as some of the practice levels advanced (Int1Pg34).

It is clear, that in comparison to nursing and medicine, there has been a lack of research and ownership of knowledge by the paramedic profession. Again, this is another hurdle for the profession to overcome on the journey towards professionalism. Concerns about the profession's body of knowledge are explored by Respondent 1:

Now we wanted to start to do research but we had people who didn't understand research methodology. The healthcare system was becoming a complex place and we had people taking a very simplistic view (Int1Pg35).

These findings demonstrate that by comparing the professional journey with nursing and medicine, it can be identified that the problem is more than just national regulation and regulation. There are broader issues affecting the establishment of the paramedic profession, one of which is owning the body of knowledge that is specific to the profession by investing in research. However, this can only be achieved by changing the culture of education within the profession (as discussed in the Theme: Education and the Theme: Culture), and thereby investing in a long-term perspective for the profession.

Having identified and discussed the sub-themes that underpin the 'professional' theme, the literature helps to further explain why attitudes are important for the values and beliefs that underpin the paramedic internship. Firstly, the literature supports the sub-theme of 'paramedic professional' through identifying what a professional is, how professionalisation occurs, and what some of the key hurdles are for paramedicine in order for the discipline to be considered as a profession in Australia. Currently in Australia, paramedicine is not recognised as a profession

according to the Australian Health Practitioner Regulation Agency (Australian Health Practitioner Regulation Agency 2016). A profession has been defined as:

> ... 'a disciplined group of individuals who adhere to ethical standards and who hold themselves out as, and are accepted by the public as possessing special knowledge and skills in a widely recognised body of learning derived from research, education and training at a high level, and who are prepared to apply this knowledge and exercise these skills in the interest of others' (Allied Health Professions Australia 2008 pg 8).

Furthermore, the attributes of a professional, according to Williams, Onsman et al. (2010), include:

- Altruism
- Authority
- Autonomy
- Code of Ethics
- Commitment
- Prestige
- Professional Association
- Service
- Theoretical Base
- Trustworthiness

It is important to understand the difference between a profession and professionalisation. Without clearly defining what a paramedic profession is, the path to professionalisation is meaningless. According to Williams, Onsman et al. (2010 pg4), professionalisation is "the process of an occupation attempting to obtain the status and recognition of a profession". There are a number of steps in this process, according to Wilensky (1964), which have been summarised by Williams, Onsman et al. (2010 pg4):

1. "Development of full time occupation and formation of occupational territory
2. Establishment of training schools or colleges; linkage to university education should occur within several decades
3. Occupational promotion to national and international parties
4. Professional licensing and accreditation
5. Codes of ethics is implemented"

Williams, Onsman et al. (2010) also summarise the key barriers for the professionalisation of Australian paramedics through a political alliance with medicine, as well as registration/regulation issues, and the higher education development of the body of knowledge. A political alliance with medicine was central to the pathway for professionalisation for both nursing and physiotherapy. Accepting that nursing and physiotherapy are guided by the medical profession was an important decision in allowing the occupational territory to be established. Next, clearly delineating the lines of their sub-speciality under medicine was undertaken to ensure clarity for their profession.

Regulation and registration are also important to understand, as a review by Paramedics Australia, the peak professional body for the profession, uncovered the complexities associated with achieving a national standard in a situation in which all states and territories are undertaking activities differently (Paramedics Australia 2016). Finally, understanding the importance of higher education is essential for the development of the profession's body of knowledge. It is in these institutions where the occupational boundaries are established and protected from the encroachment of other healthcare professions. This sets a precedence for the profession in which to operate, and thus, is essential for the transition to professionalisation because it sets the occupational boundaries.

Finally, the literature illustrates the journey of professionalisation within other healthcare professions. Both nursing and medicine are regulated professions within Australia (Australian Health Practitioner Regulation Agency 2016). Within nursing, new graduates learn about the professional role and the associated skills, knowledge, and behaviours during the transition period of the 'internship' (Kelly and Ahern 2009). Furthermore, the medical internship makes the link between the professional role and practice (Wilkinson and Harris 2002). It is clear that medicine and nursing use their internships to orient their new graduates to their professional role. The paramedic profession has many similarities to the education (undergraduate university degree) and workplace training (internship) processes associated with nursing and medicine. Yet, there remain many complex issues to address before the professionalisation of paramedicine can be satisfactorily achieved (Paramedics Australia 2016). It is essential, due to the highly public, high risk, and high stakes nature of the profession, that there is national standardisation and accountability via national regulation to reassure public confidence in placing trust in the healthcare professions, such as has happened with medicine and nursing.

Regulation has many benefits for the healthcare sector. Clementi (2004) states that the key functions of regulation include:

- Setting minimum entry standards and training
- Formulating professional roles to which individuals are expected to adhere to
- Monitoring the individuals providing services
- Enforcing professional roles where necessary
- Implementing a complaints procedure
- Implementing a disciplinary procedure for individuals who neglect or breach the professional codes of practice

Furthermore, according to the Council of Ambulance Authorities (2011 pg 6), ambulance practice is more heavily regulated that many other registered professions through a combination of:

- 'Ambulance employers determining clinical competencies at every level of practice (from volunteers to students undergoing training to paramedics to IC paramedics).

- Ambulance employers monitoring and reviewing clinical practice determining clinical protocols often with formal statutory body involved in determining clinical protocols and use of scheduled substances.
- States Poisons legislation governing authority to administer scheduled substances only to those personnel identified by ambulance authorities.
- Ambulance employers determining which employees will cease clinical practice in their state or "drop" to a lower level of practice, or undergo training and skills assessment before continuing to practice a specific skill or set of skills or procedures.
- Procedures in place with every CAA member to review standards of education and clinical practice in credentialing qualified personnel recruited from other CAA members or from overseas, with mutual recognition processes in place to varying degree based on determinations made of equivalency (or differences) of qualifications between some jurisdictions.
- Codes of conduct applying to personnel employed by CAA members which mirror ethical conduct standards used by registration bodies in other health occupations'

It is clear from the literature that there has already been significant investment in establishing the paramedic profession. There are still many hurdles to overcome, but there is overwhelming evidence of support from paramedics and their representing professional body (Paramedics Australia) for national registration and regulation.

Research into the cultural dimensions at the organisational and national levels is helpful for better understanding the relationship between these themes and the initial research question. Firstly, Waisfisz's organisational cultural dimension of 'local vs professional' is important for understanding how the organisation views paramedic professionalization. An organisation that is local is concerned about the 'here and now' with the central focal point being the organisation. Attitudes towards the paramedic profession are generated at the local level; this represents what a professional looks like in the view of the organisation. A professional attitude by the organisation is concerned with the long-term future of paramedicine, with the central focus being on the paramedic. Attitudes toward professional orientation include what a professional looks like from the view of the professionals themselves at the national level.

The SAAS is attempting to transition from local to a national professional orientation for the identification the paramedic profession. But the organisation still has a short-term orientation towards the paramedic profession and their attitudes are deeply held about what it means to them. The organisational focus may, in part, be due to state-based parochialism, as identified in the Theme: Culture. Therefore, to turn the local attitude of the organisation into a long-term solution for the paramedic profession, we need to explore the national cultural elements, through the Power-Distance Index and the Uncertainty Avoidance Index, to explain how professionalisation can evolve from the attitudes held in the local context. Currently, paramedics need to take a local internship because professional orientations are still focused at the local level, and hence is why paramedics

need to be trained in 'our way' (that is, the organisation's way) to be considered as a professional in their home state.

Before discussing the profession at the national cultural level, another organisational dimension that complements, and is frequently mentioned in the 'local vs professional' dimension, is the 'long term versus the short term orientation'. As previously discussed, the local context is a short-term orientation, whereas a professional context is a long-term orientation. This is why it is important to discuss both the local and the professional, and the short-term versus the long-term orientation, as both dimensions complement one another. Traditionally, ambulance organisations have been oriented towards the short-term, which makes sense with their core function being simply to transfer patients to hospital. This attitude is deeply embedded within the history of the ambulance service culture. Currently, due to external healthcare pressures, the organisation is moving towards a long-term orientation for patient care; for example, 'treat not transport' options and referral onto GPs. Therefore, a long-term orientation is not completely foreign to the ambulance organisation, but is still a new concept for them. The SAAS is very protective towards traditions and practices because they are known, and therefore safe, to the organisation. Stepping outside of these traditions generates uncertainty for the organisation and may even disrupt the balance of power held by the profession over other healthcare professions. This is relevant for the paramedic internship as it is a familiar process for the organisation for producing a work-ready professional, or what the organisation deems as a professional, who is safe and can practice as a paramedic.

Next, the 'Power-Distance Index' dimension is important for the organisation for understanding how power affects professional status. It is clear from the literature that recognising the medical hierarchy was the key to the professional establishment of nursing and physiotherapy before they could delineate their own professional boundaries from medicine. This demonstrated a *recognition,* but not an *acceptance,* of a high power-distance between these fields and medicine before the delineation of their practices occurred. Paramedicine is still working on the delineation of their occupational boundaries in Australia. However, this will be impossible in the current circumstances because occupational boundaries need to be identified as part of the same discussion as the establishment of national regulation/registration and the clear defining of what a paramedic is. Yet, even discussion at the national level for the national regulation of the profession will be difficult because there is evidence (as will be seen in Theme 8: Culture) of state-based parochialism. This demonstrates a high level of power-distance exercised between the state-based ambulance services.

The above demonstrates the benefits of identifying where other healthcare professionals are situated within the broader context of medicine and that this was initially important to move their professional status forward. Paramedic organisations at the national level still exercise a high level of power-distance between the states. This high level of power-distance may impair the ability of

paramedicine to accept (through reducing power-distance) that the profession falls under medicine. A high level of power-distance specific to paramedicine, which goes against the national cultural trend (36/100), is consistent with the findings from the power-distance dimension in other themes, and the necessity to undertake new internships in each state.

It will be interesting to observe whether the organisation will be able to foresee the consequences for professionalisation of consistently demonstrating a high level of power-distance. Combined with the aforementioned evidence, it will undoubtedly affect the push towards professionalisation. It appears logical that the profession could simply accept that their profession falls under the scope of medicine, as doing so will improve the likelihood of being nationally-recognised as a professional group. This could mean that paramedicine, at the national level, does not know how to reduce (or tolerate) a reduction in its level of power- distance. Therefore, it would appear that the profession is attempting to become recognised as a standalone profession that does not fall under the umbrella of medicine. This could be one of the reasons why the national push towards professionalisation has been struggling. However, this interesting discussion will be explored further in the discussion chapter.

Finally, core to the professionalisation of paramedicine is the Uncertainty Avoidance Index. The move towards professionalisation is an unfamiliar and unknown journey for paramedicine. It is reasonable that the organisation displays a high level of uncertainty when attempting to travel down this path. Many organisations are involved with the professionalisation of paramedicine, but the most vocal is Paramedics Australasia. This organisation has attempted to provide some reassurance to key stakeholders (ambulance organisations/government bodies/ education institutions/special interest groups) by undertaking research, writing proposals and gaining expert opinion on how the journey to professionalisation is to be undertaken. Although the work of paramedics is generally accepting of low levels of uncertainty avoidance, because of the unpredictability of the work due to the high-risk, high-stakes, short-time environment with limited diagnostic tools, the organisation attempts to makes practices safe through the enforcement of policies. This attitude is rational and displays a high level of uncertainty avoidance by the organisation.

High uncertainty avoidance is engrained into the organisation and it therefore the journey towards professionalisation has been difficult. Therefore, reducing uncertainty avoidance at the organisational level would be accepted at the national cultural level (scoring mid-range 51/100), and is important for moving the professionalisation of the paramedic workforce forward. As a result, organisations would not need to test paramedics when they move from one state to another because paramedic internships across Australia would be embedded with nationally-accepted guiding principles towards professionalisation.

Theme 8: Culture

It was evident from the respondents' views that they had concerns about the culture that surrounds the paramedic internship. There were three concepts that emerged from the analysis of the data which formed the theme of 'culture', these are being in 'the club', 'state-based parochialism', and 'cultural indoctrination'.

The sub-theme of 'the club' describes the respondents' views of management selecting others to become part of the management team. The respondents cited ambulance culture as being very unique. Culture can be defined as "the interactive aggregate of common characteristics that influence a human group's responses to its environment" (Hofstede 2001 pg. 10). Ambulance culture, as it is today, has been built from unique origins. The St John Ambulance organisation is very significant to the culture at both the state and the national level. Respondent 6 drew upon the history of St John and how the profession has developed:

> *Asking them to step up and take an academic approach when they've never like - do you know what I mean? They've always gone, like they started off with a First Aid certificate when they were in St John and as an organisation we've moved them up. Well, we've now got to take the next step as an organisation and move them up into research, and move them up into driving a paramedic profession. So, that's scary for them because they've never done it (Int6Pg23).*

Therefore, some of the cultural elements from St John are still present in the organisation today. The respondents suggested that people are highly selective of who enters the management group, which in this study, is referred to as 'the club'. Respondent 6 also highlighted that the future managers of the organisation have already been decided upon:

> *I sat there and went, I've already picked out who I think will be our future ICPs, who will be our future managers, and who will be our future clinical leaders (Int6Pg28).*

In addition, Respondent 2 outlined the power held by managers in selecting people for the club:

> *I'm fortunate that I'm in a position of reasonable influence and am able to see a lot of the proposals and stuff I put through, get through, which I believe also speaks for the regard. I don't often ever get anything knocked back as it progresses through (Int2Pg4).*

These findings demonstrate the ongoing existence of the St John culture in various elements of today's organisational culture. As a result, management tends to be highly selective of those entering the management group and will seek to limit the diversity of opinions/ backgrounds/ ideologies of those that are not consistent with those of the management group. This will limit the

ability of the organisation to grow as it attempts to maintain the power divide between management and the workers, while continuing to take an internalised view of practices and culture.

The sub-theme of 'state-based parochialism' describes the perceived competition between the state-based ambulance services. The respondents are concerned with the level of state-based parochialism and the consequences it has for organisational and national culture. This concern is based on organisational attitudes that one state produces better paramedics than the others. State-based parochialism is explored further by Respondent 3:

> *Interstate parochialism is one of the first lines. That has gotten a bit less over time, but at the end of the day, a Melbourne paramedic is always better than a South Australian one. Sydney's paramedics from the biggest and largest ambulance Service in the world, so they must be better. Queensland, well they are from Queensland, so they're not going to be really much chop. WA, that's run by South Australia - by St John's, so they can't be any good. How are you ever going to get them all to agree? … … So, there's parochialism about who is better and who is not. There - and then they will then hide behind the clinical differences. … … One of the really weird phenomena that I've found - and I've worked in three states as an ambo, in a sense. I've actually gone out on an ambulance in about - I don't know. Three, four, five different countries. The really weird thing is that the patients all bleed the same. Their breathing difficulties are all the same, and all of that. But apparently, depending on where you're an ambo, as to how good you are or not and all that. … … So that's where I get frustrated around the interstate portability. It's as much around the state-based parochialism, as it is of anything. So, there should be no barriers - it's an interesting question, because why do I think - or what barriers do I think are there? Well, I don't think there should be any, and so therefore, it's just the interstate parochialism. Because if that wasn't there, you could bring those barriers down. Because the barriers are surmountable (Int3Pg38).*

These findings demonstrate poor organisational attitudes towards other states' paramedics which devalues their title and training. As a result, this is counterproductive for the profession as these attitudes are embedded in the organisational culture and tend to generate power-distance and conflict between the states.

The sub-theme of 'cultural indoctrination' describes the importance for the organisation of paramedic interns being inducted into the norms of the organisation. The respondents also believe that the internship program is an important part of paramedic cultural indoctrination. This is achieved through the socialisation of the interns within the organisation and its workforce. Respondent 1 discussed socialisation and cultural indoctrination within the paramedic internship:

I think our internship is about some elements of socialisation. You're wearing our uniform, you're talking our language, you're participating in our workflows. That's about becoming part of a group. Now, that's a bit of cultural indoctrination. … … I've pushed the internship towards induction because I really do see that a lot of what we are doing is taking someone with a fairly generalist body of knowledge and saying that's great, but here in SAAS our policies and procedures, our rules of engagement, our clinical pharmacology, what we have available to you, tools and stuff is this. That's all you've got and you need to use it this way (Int1Pg13).

Therefore, the interns can assimilate, learn, and reflect the organisation's values and beliefs which is very important according to the respondents. The importance of teaching organisational values and beliefs were highlighted by Respondent 6:

I suppose the internship, when you come to the crux of it, what we should be teaching is values and beliefs. They're the values of the organisation, and the values of good patient care. The clinical stuff will come (Int6Pg45).

I don't think that - they do need to be aware of SA Health, but I suppose we don't really - other than health policy and procedure, we don't go into anything with Health. We don't expect them to deal with - so I wouldn't expect them at the end of the internship to have a lot to do with that, other than knowing they have got to follow the code of conduct and that they are a public servant. That comes with a whole lot of expectations and responsibilities, but they are also the values and beliefs of SAAS, so (Int6Pg61).

These findings demonstrate that the learning of organisational values and beliefs are essential to being accepted into the organisational culture. As a result, paramedics (at the end of their internship) are considered to be 'one of us' or accepted as part of the organisation.

Having identified and discussed the sub-themes that underpin 'culture', the literature helps to further explain why culture is important for the values and beliefs that underpin a paramedic internship. Firstly, the literature related to the themes of 'the club' and 'state-based parochialism' reveals the cultural consequences that stem from the historical origins of ambulance services in Australia. The foundations of the civilian service were heavily embedded with a strong militaristic ideological culture (Wilde 1999). During the late 1800s, the Order of St John from England was the only organisation at the time that provided any form of ambulance service. The St John Ambulance Brigade was formed in England in 1882 and, until the present day, leads the provision of ambulance services in many countries (Howie-Willis 1985). Table 3 below shows the influence of St John Ambulance in the administration of ambulance services across Australia (Wilde 1999).

Table 3 National comparison of when St John Ambulance administered state based ambulance service.

State	St John Ambulance (part or full administration)	Ceasing St John administration
Victoria	1883	1916 (Victorian Civil Ambulance Service)
Queensland	1892 (service only)	1991 (Queensland Ambulance Service)
New South Wales	1895	1919 (New South Wales Ambulance Service)
Western Australia	1922	Still to Date
South Australia	1952	1989 (SA Ambulance Service)
Tasmania	1959	1965 (Tasmanian Ambulance Service)
Northern Territory	1957	Still to Date
Australian Capital Territory	No recorded St John services	

It is evident that St John Ambulance has been deeply embedded into the majority of ambulance services across Australia. In particular, the SAAS was formed in 1989 and this, in contrast to other states, is considered to be very recent. Therefore, St John and its militaristic culture, is still embedded in parts of the SAAS organisational culture today.

Furthermore, as the transition from St John to the state-based administration of the ambulance services across Australia occurred over a 100-year span, organisation cultures have developed at different rates in each state. During the early stages of ambulance services in Australia, St John provided some consistency across the nation. As the states started to assume control of their own ambulance services, they were left to develop their own culture. The amount of cultural impact of St John in a state, for example in NSW where control was relinquished in 1919, would be minute compared to the substantial influence in South Australia where control was relinquished in 1989.

How the St John culture relates to the 'the club' is interesting. Two key points will assist in explaining the link. The first is the militaristic past of St John and the hierarchical dominance embedded into their culture. The second is the recent transition from St John to the SAAS and the hostilities within the industry that surrounded this transition (Ambulance Empolyee Association SA 2016). It can, therefore, be perceived that people who currently hold management positions that have been in the ambulance service for a lengthy period of time (during the St John era) are attempting to keep people who hold the same ideology as them within management. This is achieved by being highly selective of those who enter 'the club' and using power to benefit their

position. In this way, their political ideologies would be similar, which means that there would be greater coherence for decision making.

Finally, the importance of ‘cultural indoctrination’ within the ambulance service is evident within the literature. Shared values are the core of an organisation’s culture (Peters and Waterman 1982). Learning is a social process which is important for allowing the student to assimilate to the organisational culture of a particular professional workplace (Brockbank and McGill 2007). Students learn and model the accepted attitudes, practices, language, behaviours, values, and beliefs of an organisation, which aid the student in assimilating to the workplace.

As previously mentioned, the paramedic internship has a role in inducting the new employee into the organisational culture. In Waisfisz, Minkov et al. (2015 pg 8), Hofstede (2001) defines organisational culture as “the way in which those working in an organisation relate to each other, to their work and to the outside work, compared to other organisation”. Hofstede continues; “the word ‘relate’ is used to show that culture comprises of more than just behaviour. It included many more elements, such as symbols, attitudes and beliefs or convictions” (Hofstede 2010 cited in Waisfisz, Minkov et al. 2015 pg 8). Organisational culture is deeply rooted in assumptions that are difficult to identify for a new employee (Carlstrom and Ekman 2012). It is for this reason that it is vital for the organisation to understand the importance of cultural indoctrination through the mixing of its employees with the new paramedic interns. In this way, the intern can rapidly assimilate to the culture and feel part of, and identify themselves with, the organisation as ‘one of us’.

Research into cultural dimensions at the organisational and national levels is helpful for better understanding the relationship between these themes and the initial research question. The dimension of an ‘internally- versus externally-driven organisation’ helps us to understand the theme of ‘culture’. The organisation is highly selective of its management group only allowing those in who they feel will fit into this club. This displays an organisation that is internally-driven because the organisation assumes that they know what is right. However, what is right for the management group as opposed to what is right for the organisation may be two different things which only an external view will have the capacity to encapsulate. As a result, the organisational culture cannot change if the same type of people are selected for these roles. Rigidity and ‘fitting in’ also apply to the paramedic internship. The internship will therefore only allow a particular type of person to fit in, as the organisation will not tolerate those whose views are different.

Professional identity is important for understanding Waisfisz et al.’s dimension of ‘local versus professional’ in relation to culture. A local identity means that paramedics identify themselves with the organisation. A professional identity means that paramedics identify themselves with the profession. The impact of organisational culture will determine how a paramedic identifies themselves. The path followed through the development of ‘state-based parochialism’ demonstrates an organisation that values their own identity and which holds certain beliefs about

the identity of other states. This demonstrates that there is a high regard for a local orientation and this is supported by the need for paramedics from other states to re-do a local internship to be inducted into ‘our’ (the local organisation’s) values and beliefs towards ‘our’ way of thinking and acting.

Similarly, as an organisation that holds a high regard for having a local orientation, this has direct cultural consequences for the ‘identification with work orientation’ dimension. A local orientation ensures that the organisational values and beliefs are taught to the paramedic interns. The SAAS is highly protective of its local induction program (the paramedic internship) as it is a highly competitive process to induct new staff into the organisational culture. Gaining an internship position creates a feeling of exclusivity just to be afforded the opportunity to work for the SAAS. As a consequence, the organisation wants the interns to show a strong identification with their work when they successfully complete the internship. The internship gives the intern an opportunity to embrace the organisational culture, accept it, and consequently, to fit into the SAAS. Those who do not identify with the SAAS will not fit into the organisation, and therefore, will not be given ongoing employment.

Finally, the national cultural dimension of the ‘Power-Distance Index’ helps to understand the rationale behind being selected for ‘the club’ and ‘state-based parochialism’. The staff member who has been selected to be part of the management club increase the power-distance between them and others below them. However, as previously mentioned, the people who select these staff members need to be cautious because there is also a decrease in power-distance between the selector and the selectee. If the ideologies of the two align, this will have only minimal foreseeable consequences, as previously discussed. If however they do not align, due to the small power-distance, it could compromise the position and the power held by the person who initially selected them. This demonstrates a high level of power-distance that is culturally tolerated by the management team at the organisational level.

Next, it is evident that there is a range of attitudes (which are primarily negative) held towards other ambulance services across Australia. These concerns are centred around one state’s paramedics being ‘better’ than those from another state. This ideology reinforces the high level of power-distance that is tolerated culturally at the national level. Australia scores, at the national cultural level, 36/100 with a relatively low level of power-distance which is far lower than the power-distance exercised by the SAAS. At the national level, it seems peculiar to require a paramedic to redo a paramedic internship when moving states because, essentially, all paramedics undertake the same job role. However, at an organisational level, because of the high Power-Distance Index, it is culturally accepted to redo the internship to ensure that a high level of power-distance is exercised over other states. What the organisation accepts culturally is that the internship

conducted in one state is not good enough for the other states. Therefore, the paramedic needs to undertake the internship again.

Conclusion

It is clear from the multiple themes explored above, and their underpinning sub-themes, that the paramedic internship is a highly complex program that the ambulance organisation administers to induct new paramedics into the SAAS. These themes include attitudes and education which are unique to the individual; organisational communication which is unique to the workplace; the internship and recruitment and selection which are unique to the ambulance organisation; and professional and culture which are unique to the profession. There are key dimensions that are specific to each theme that explain the findings from the data through the lens of national and organisational cultures. Although the above exposition has identified and discussed each theme, the next chapter will discuss what the findings mean in the context of this study.

7. DISCUSSION

After presenting the eight themes from the data analysis in the previous chapter, it is now possible to identify and further explore the main overarching issues in relation to the initial issue that underpins the overarching research question. This will provide further cultural insights into the paramedic internship, and subsequently, the ambulance organisation. What these insights mean, in conjunction with the findings, for the future of paramedicine in Australia will then be discussed.

Currently, the future of paramedicine in Australia has many pressing issues, such as national registration, that are being discussed at the national level. The findings from this study may help to shed light on these issues to help work through the problems. There are exciting but challenging times ahead for paramedicine in Australia as the profession attempts to embed itself within the healthcare sector through professionalisation. This is a substantial leap forward for the profession, which will pave the way for more research, innovation, and better practice to assist pre-hospital healthcare for the Australian community.

Before discussing what the findings mean, it is important to reiterate and summarise the problem that generated the initial research question. Paramedics need to undertake a paramedic internship in part to consolidate knowledge to practice, and to be culturally inducted into the ambulance organisation. However, a paramedic would have to re-do a local internship if they wanted to move their employment from one state to another. This does not make sense as they are considered to be a paramedic in their home state, and yet they are not considered as a paramedic in the new state until they have completed a local internship. From a pragmatic point of view, this appears to be odd and a waste of time, money, and expertise. So this begs the question as to why there is no reciprocal recognition of experience of paramedics between states.

There are many similarities in paramedic practice between the states. Morbidity and mortality figures and causes are largely the same across Australia. The training of paramedics is quite similar across Australia with the requirement for an undergraduate paramedic degree plus an internship (except in NSW). Ambulance service organisational structures and service delivery models are also not dissimilar. Fundamental clinical practices and treatments are guided at the national level through the Australian and New Zealand Resuscitation Council (Australian and New Zealand Resuscitation Council 2016). Furthermore, the type of people employed as paramedics are quite similar and all are required to have the skills to manage stress, uncertainty, emotional resilience. Finally, there is a shared history of ambulance services across Australia with similar patterns of ambulance service organisational development towards education, clinical practice, and management.

As previously discussed, with all these similarities, a pragmatic lens would conclude that ambulance organisations should simply accept incoming paramedics and abolish the need for local internships. However, in reality, this does not occur and therefore a normative lens is considered to be better to explain why paramedics are required to re-do an internship; but why would an organisation choose to adopt a more normative culture when there are these significant similarities between paramedics from all states?

To understand a preference towards a normative organisational culture, we must first take a step back to place the national cultural dimension under the microscope. Hofstede (2001) 'Short-Term versus Long-Term (LTO)' orientation can explain, at the national cultural level, why there is a normative tendency within the organisational culture. "Long-term stands for the fostering of virtues oriented toward the future, in particular thrift and perseverance. Short-term stands for fostering the virtues related to the past and present, in particular traditions, preservation of 'face', and fulfilling social obligations" (Hofstede, Hofstede et al. 2010 pg. 239). This dimension describes decisions about, and attitudes towards, short- and long-term orientations. Every society needs to maintain some links with its own past, while dealing with the challenges of the present and the future. Consequently, past experiences influence the way in which attitudes towards decisions are made today and this reflects people's attitudes about the short-term (today) and the long-term (tomorrow) (Hofstede, Hofstede et al. 2010). In a business context, this dimension is referred to as normative (the short-term), which includes policies/procedures/rituals, versus the pragmatic (the long-term), which includes logical solutions to problems. What this means is that the short-term vs. long-term orientation at the national level is comparable to the normative vs pragmatic at the organisational level.

Australia is rated on the short-term vs long-term orientation with a score of 21 out of 100, which demonstrates that the national Australian culture has a tendency towards a short-term orientation. Consequently, this explains why Australian organisational culture has a tendency towards the normative, is embedded with policies and procedures, and closely holds onto virtues from the past. Therefore, from a normative perspective, it is most useful to look at some of the cultural dimensions within the organisation and the interplay they have with the cultural values of society.

Cultural Interpretations of Themes

In this study, we have looked at the various elements and considerations that may play a role in the organisation's decisions. These are outlined below in relation to the above discussion.

Attitudes of interns

It was evident from the respondents that they had concerns about the attitudes that paramedics held toward the internship. The issues identified included the need to set transparent professional workplace standards, the fine balance between over- and under-socialization, and the

performance-based culture which all contributed to the respondents' perceptions of poor attitudes towards the internship. The limited life experience of the interns, the internship (paramedicine/nursing/medicine) stressors, and a strong performance culture (to be accepted) supports the sub-themes. Overstepping the social vs work boundary was a key product of this theme, which can be explained by the balance found in the indulgence vs restraint dimension. This also influences the large power-distance exercised by the organisation, including by the paramedic interns, and the concerns around its legitimacy to gain an additional advantage in employment within the service which is supported by the performance culture.

Education versus production

The respondents raised concerns about the levels of education and the organisational attitudes held towards education within the paramedic internship. The identified issues here included the role of the university sector in solely focusing on the teaching of underpinning knowledge, the educational cultural divide between the differing qualifications (diploma vs degree), and the poorly understood educational ideology and the unclear education model adopted by the SAAS. It was clear that the SAAS classified the paramedic interns as products of the system, such as on a production line through a one-size-fits-all process. It is evident from the literature that the internship and the university degree complement each other in the attempt to produce a competent and safe practitioner. In addition, the literature acknowledges the dissociation between the ambulance service and the investment/ownership of educational practices and principles, which has resulted in the poor quality of in-service training programs. Uncertainty towards the educational philosophy in the ambulance organisation ensures a normative response with attitudes reflecting what is known to currently work and what has worked in the past. As a result, the organisation displays a 'closed system and internally driven' approach towards education, when it is actually rather clear that there are both internal, SAAS' educational responsibility, and external, universities educational responsibility, drives.

Organisational influence

It was clear that the respondents were concerned about how the organisational climate influenced and affected the paramedic interns. Issues here included the amount of stress experienced in the job role and the internship, and the accepted norm of the high regard and exclusivity in management for ICP job roles. Finally, 'the club' of operational managers hold orientations towards paramedic interns' education that favour the operational need of the ambulance service over the educational need of interns. It is well known, and acknowledged by the literature, that there is a large amount of stress in the paramedic role and in internships (paramedicine/medicine/nursing). Furthermore, the high regard for the ICP role, the clear delineation of operational roles, and the tension that is apparent between the clinical levels has been well documented by Wilde (1999). The masculinity versus femininity dimension, interestingly, transitions over the course of the internship. The social construction of the paramedic role still holds masculine tendencies when

applying Hofstede (2001) model, even in an increasingly female workplace, which also demonstrates that it is culturally accepted for females to display masculine traits. Additionally, the exercise of a large power-distance is obvious, with the ICPs being allowed to use more skills, and undertake more practices, which leads to greater autonomy. Clinical autonomy is highly desired by paramedics and interns.

Communication in the organisations

The importance of communication in the paramedic environment was evident for the respondents. Concerns were raised about the communication exhibited by the SAAS, in particularly management, in relation to the paramedic internship. As a result, this was seen as leading to issues in transparency of internship outcomes, and interns becoming dissociated from the SAAS' expectations of them. In addition, the core role of communicating feedback was highlighted as a vital element for the learning of the interns, which is directly impacted by a poor communication culture. The importance of communication is supported by the literature, which describes it as an essential topic to be taught in undergraduate studies. The importance of feedback in clinical education among healthcare professionals has been well researched (Thomas and Arnold 2011). Uncertainty avoidance is the dominant cultural dimension for this theme as a lack of transparency and poor communication results in large amounts of uncertainty. As a consequence, this leads to behaviour by interns to attempt to reduce uncertainty. These behaviours are the predication of what managers/supervisors expect to see the intern to do and reflect such behaviours. This can be a problem because the best way to reduce uncertainty in a complex situation is to gain experience and appropriate tacit knowledge.

Recruitment and future employment

The respondents were also concerned with the limited recruitment pool resulting from the transition to undergraduate education and the effect it has on the SAAS selecting the right people to fit into the ambulance organisation. The recruitment pool includes a predictable cohort, being generally young, intelligent, highly motivated, and increasingly female. The respondents identified the large amount of money and time invested in paramedic interns and in ensuring they are observed and tested during the internship. As a result, the organisation is able to select the best-suited paramedics at the end of the internship; this means that, from an intern's point of view, there is very little security of ongoing employment. The graduate traits literature also supports the paramedic intern recruitment pool traits as described in this theme. In addition, there is a significant gender bias that has transitioned from the male-dominated, militaristic, and protocol-driven workplace to an increasingly female, highly academic, and guideline-driven environment. The key cultural dimension arising from this theme is the newly-culturally accepted norm that females can display masculine traits in a paramedic role that is essentially masculine. In addition, the high level of uncertainty of ongoing employment within the service has resulted in interns becoming highly

competitive as performance, in the view of the interns, equates to a greater chance of ongoing employment.

The internship as a workplace induction process

It was clear from the respondents that the paramedic internship is not simply a process of consolidating knowledge in order to practice, but is also an induction into the organisation and the profession. The issues surrounding the paramedic internship include the experiential learning process that is better facilitated through good mentorship. This is to ensure that the ‘products’ of the system are competent, according to the SAAS. The literature describes the symbiotic and complementary nature of university knowledge and workplace induction (Worley 2002). Furthermore, the structured internship programming that complements the degree has been adopted by all state-based ambulance services across Australia. Finally, although competency (and the assessment of competency) has been well researched in multiple clinical domains, there is still a lack of research into the assessment of paramedic competency. Paramedic competency appears to be defined by the application (or the non-application) of tacit knowledge learnt during the paramedic internship. Three main cultural dimensions help to explain the internship theme. Firstly, the internship has a role for induction into the profession through both an organisational and a national interpretation, which needs to be balanced out by the local vs. professional orientation of the organisation. Secondly, there needs to be a balance between a strict and an easy-going work discipline which allows the intern to navigate within the boundaries set by the organisation for achieving tacit competency. Finally, there needs to be an understanding of the educational process of the internship as either a means vs a goals orientation (the journey or the endpoint), because both are poorly understood by the organisation.

Comparative culture

The respondents suggested that during the cultural induction process into the ambulance organisation, there are a number of dominant influences that are embedded within the paramedic internship. These are historical influences from the St John organisation on current ambulance culture and the resultant ‘management club’, the high level of state-based parochialism, and the desire of the interns to assimilate and reflect the organisation’s values and belief systems. The deep embedding of the militaristic style of control that originated from St John in ambulance services across Australia, and their gradual detachment away from managing these state-based ambulance services, is well documented (Wilde 1999). Furthermore, learning is a social process which is important for the assimilation of accepted organisational practices, values, and beliefs which is supported by the literature. A local versus professional orientation is important here as it guides the focus, whether it be towards the ‘paramedic’ or the SA Ambulance Service (which is also an identification with work orientation), of the cultural induction process by the organisation. State-based parochialism can be explained through the power-distance lens, as each state desires to maintain a degree of power over the others as the profession moves towards nationalisation.

The perception of the 'healthcare professional'

Finally, the respondents identified the lack of clarity in defining and describing what the paramedic professional is and looks like. The respondents' next logical step would have been to compare paramedicine with other healthcare professions such as medicine and nursing. The main concern is related to the lack of a professional identity and of clearly delineated occupational boundaries. Furthermore, it is unclear to the ambulance organisation what their definition of a good paramedic is. When comparing the journey towards the nationalisation of nursing and medicine with paramedicine, there are key milestones that paramedicine has yet to achieve. One of the perceived hurdles concerns whether paramedicine fits under the umbrella of medicine or whether it is a separate entity. This has a direct consequence on the power-distance between medicine and paramedicine. The paramedic profession is venturing into uncharted territory as they head towards professionalism. Coupled with the high levels of risk avoidance of the ambulance organisation, it is understandable why this transition has been very slow and uneventful. The SA Ambulance Service aims to maintain and protect its unique organisational culture which results in the high presence of a local versus professional orientation.

Ambulance Culture and the Local Setting

In the previous section, I have discussed each theme's key finding and what it means to this study. These themes draw rather strong conclusions about SAAS, the ambulance organisation central to this study. This may paint a negative impression of SAAS, but it is important to understand how these issues have come about and are sustained when we see them from the perspective of the competing demands SAAS has to juggle. From these themes, there are three dominant over-arching findings resulting from the discussion of these themes, and these are discussed below.

The ambulance service is an organisation that needs to constantly juggle competing demands. On the one hand, paramedics need to be able to provide the best and most evidence-based and reliable service, and strictly adhere to an almost military organisational style; on the other hand, they need to be able to make individual decisions in ad-hoc situations based on their expertise and tacit situational knowledge. This, for example, requires a fine balance between being able to 'obey the rules of engagement', and being able to make executive decisions within implicit boundaries.

Paramedics also have to be able to be utterly professional, focused on the patient, and almost 'robotically' act as individuals, while being 'one of the team' at the same time. This, for example, requires a delicate balance between a professional role, collegiate communication, and a safe private life. There are many more examples of such competing demands within the organisation which are further magnified by the position of the organisation in society.

Navigating such competing demands in everyday work is not easy and requires a fine situational awareness. Therefore, the paramedic internship not only serves the purpose of transitioning

knowledge to practice but, more importantly, it serves as a local induction. So, if a paramedic moves from interstate, there may be an assumption that they are competent in their home state and therefore there is no need to transition their knowledge to practice in their new environment. Nevertheless, the organisational concerns still remain as to whether this paramedic is able to fit into the local organisational culture. This is because the delicate balance described above cannot simply be captured through rules and regulations, but requires a fine situational awareness from the paramedics to act appropriately in every situation and avoid transgressing occupational boundaries.

Another question however is whether the ambulance organisation can simply accept the competency of the incoming paramedics verbatim. This study has also raised many concerns about the unexplored meaning of competency within the paramedic environment. As previously mentioned, there are no clear delineated occupational boundaries held by the paramedic profession. Furthermore, paramedicine consists of a unique set of practices with only limited diagnostic tools and so it relies on tacit knowledge to be able to act in the correct way every single time. This requires an exacting curriculum with good mentorship and a clear understanding of what a good paramedic actually is. This is necessary to ensure that clear verbal and non-verbal communication of attitudes, practices, and values become embedded into the life-world of the interns, thus requiring explicit feedback to be delivered. Competency is a broadly defined term and its assessment is based on the unwritten, hidden curriculum of tacit knowledge and intuition. It therefore makes it very difficult to assess because it has a different meaning for different people when discussing paramedic competency at the national level.

It is logical, therefore, that an organisation is not able to determine the fine situational awareness that is required in any one-off assessment situation, nor can they rely on the assessments/ evaluations being conducted in another paramedic organisation because they are organisation-specific. This means that the organisation understands the value in undertaking a prolonged observation of the intern's behaviour in the workplace as a means to gauging whether the intern is able to successfully navigate between the competing demands and demonstrating the right situational awareness. From this point of view, it is entirely understandable that any university graduate, and even a paramedic from interstate, is required to do (or re-do) the internship.

This is an important finding because it shows that a rational argument about morbidity and mortality figures being similar in different states would be beside the point; it is not solely about the general paramedic competence nor about the knowledge, it is about the fit with the local culture and the ability to demonstrate the necessary situational awareness.

This conclusion has implications for proposing a way forward which would lie in processes that would establish mutual trust in each other's organisation and which would promote situational awareness in one context actually being a sufficient guarantee of situational awareness in another.

Overarching Cultural Insights

There are important overarching cultural insights within these findings which help to explain why the organisation requires incoming paramedics to re-do their paramedic internship. These insights explain the organisational concerns of the incoming paramedics underpinned by a cultural dimension. The following four insights cover three national cultural elements, the uncertainty avoidance Index, power-distance, and indulgence versus restraint. .Although these insights are dominate when answering the question as to why incoming paramedics are required to re do an internship, these cultural insights transcend the organisation across all actions, behaviours and attitudes exhibited by the organisation and the individuals that make up the organisation. Therefore, these are the values and beliefs that underpin the organisation, and not simply the paramedic internship. It is for this reason why these insights are so important for the organisation to understand if, in future, cultural change is needed.

Risk aversion versus risk taking

Ambulance organisations need to manage a fine balance between risk aversion and risk-taking which is best discussed through the lens of the Uncertainty Avoidance Index used in this study. It has already been established that the organisation displays a high Uncertainty Avoidance Index with their many policies and procedures. However, the job role requires that paramedics do not avoid uncertainty because 'the unknown', and in fact 'the unknowable', is often a factor when responding to a job. Compared to the national cultural context, Australia scores 51/100, which shows that Australians will equally accept and avoid uncertainty. This means that organisations need to tolerate and accept a large range of uncertainty within their organisational culture.

The preceding two concepts are not unique to paramedicine, but can also be applied to the nursing and medical contexts. This begs the question, how have other healthcare providers, such as nursing and medicine, been able to manage a wide range of uncertainty, and does paramedicine fit into the same boundaries as medicine and nursing?

Historically, medicine is the oldest healthcare profession and is considered to have the highest level of control over other healthcare professionals. As Williams, Onsman et al. (2010 pg 6) put it, "Nursing and physiotherapy aligned themselves strategically within the medical profession; embracing distinctly subordinate roles to physicians, but nonetheless drawing lines in the sands defining their own scope of practice and body of knowledge". Supervision of nursing could be facilitated within a hospital setting; therefore, supervision and the control of nursing practice could be closely monitored. Years of nursing practice further developed trust which paved the way towards greater autonomy. Yet, paramedicine could not be directly supervised as the control by doctors was within the hospital setting (in its infancy) while practice was situated in the community in the pre-hospital setting. This indirect supervision has its risks and is unique to the pre-hospital

environment. The next logical question, therefore, is how can practice be safely managed and supervised by medicine and the ambulance organisation management?

Organisational structure and history (military) versus independence (on the road)

The organisation's answer to this question was through control by administration by using and enforcing many layers of policies and procedures. This is understandable given the militaristic origins of the ambulance service, resulting in a 'do as I say to get it right' attitude. This was put in place to ensure that, although practice could not be directly supervised, it was nevertheless controlled.

As much as policies and procedures can guide a working environment by predicting workplace situations, the unpredictability of the paramedic environment meant that it was impossible to rely solely on policies and procedures. The paramedic job requires a vast amount of tacit situational awareness and knowledge; which is most likely why there has been a transition from explicit protocols to explicit guidelines with implicit boundaries. These help the intern to learn the tacit approach to navigating practices within those boundaries. However, as the organisation moves away from protocols to guidelines, it increases the risk accepted by the organisation of paramedics' actions. This is why paramedic competency is becoming increasingly important for managing organisational risk. It is clear that tacit knowledge operating within boundaries is part of the larger competency picture of a paramedic.

Operating within boundaries allows the paramedic a great deal of autonomy in their practice; however, there is the potential for this autonomy to be abused. It is logical that our next question concerns how power is maintained in a workforce that is becoming increasingly autonomous. Here, power-distance is the ideal cultural lens to explain this concept.

This begs the question of how power-distance in the ambulance service compares to the national cultural context and the working environment. It is clear from the findings that there is a high level of power-distance exhibited within the workforce that was consistent across many themes. Complementing this is the high level of power-distance in the working environment, whether it is perceived such as having medical knowledge or enacted such as breaking road rules when responding to urgent jobs. Power-distance at the national cultural level in Australia scored low on Hofstede's scale with 36 out of 100. The organisational cultural power-distance norm opposes the national cultural power-distance tolerance. The next logical question is why is there a high level of power-distance within the organisation, and what are the perceived consequences, mainly to the ambulance organisation but does include the paramedic interns in this context, of this when it opposes the national norm?

Hierarchical power relationships and competency power relationships

The paramedic profession is a developing profession in Australia. This is, in part, a result of an increasing standard of practice, education, and autonomy, and the public demand to 'do more'. This increases the power-distance gap between the profession and the community. However, in doing so, the profession has reduced the gap between themselves and management, as a result of having greater knowledge, and attempting to use that knowledge to lobby for greater power. In addition, this has also reduced the gap between the profession and medicine, again through knowing and doing more.

So, what would be the consequences of varying these power-distance gaps? Increasing the gap with the community would, logically, be largely unopposed to a point. This is because paramedics are a high profile, high-stakes profession called upon in times of urgent medical need. So, it is logical that paramedics doing more for people that one is close to would, of course, be desirable. However, the decreasing gap between management and/or medicine would have major political consequences for the profession.

We know that one of the patterns of power-distance, as subordinates attempt to reduce it, is that their superiors put in equal effort to maintain the level of power-distance. In addition, if you increase the clinical scope of practice for one clinical level, power-distance would predict that there would also be an equal increase in those above and below that level in order to maintain the power-distance. Therefore, the use of power-distance is maintained to hold overall control of a profession, when their professional body is attempting to increase the autonomy that the paramedic practice owns. The way in which an organisation does this is by increasing the amount of policies and procedures to keep ahead of the autonomisation wave. This attempts to reduce risk for the organisation.

Maintaining power-distance between staff and management is the same as maintaining a risk 'buffer' to compliment the high level of uncertainty avoidance that is demonstrated by the ambulance organisation. As a result of the unclear and poorly understood meaning of paramedic competency within the SA Ambulance Service, it is understandable that there is no tolerance to decrease this risk 'buffer' in a highly policy- and procedure-driven workplace.

Indulgence (becoming accepted into the organisation) and restraint (becoming a professional)

How this large amount of power-distance held by paramedics (and interns) is exercised is explained by how much 'indulgence versus restraint' is exercised. Again, management attempts to police the high level of power through the boundaries of practice. Paramedic interns are in the process of learning to navigate these boundaries with a mentor during their internship. As they are learning to use a large amount of power, this requires a fine tacit balance between indulgence and restraint.

Power can be given by the patients to the paramedic intern via medical treatment/guidance, although paramedic interns are yet to hold the authority to practice within SAAS which results in the final decision being made by the mentor. This is a situation in which there is a false sense of power felt by the intern. Another platform in which power could be used is between interns and paramedics/ management (superiors) although, as paramedic interns are new employees with no guarantee of ongoing work and yet to have any authority to practice, they may be fearful of applying any power at all. This is because they may fear the repercussions of such actions on their ongoing employment opportunities.

The final group of people that paramedic interns have the ability to apply power over are their peers within their own paramedic intern group. In this context, power is real rather than perceived, and the benefits are vast but hold measureable risks. The primary example from this study is that the respondents held concerns about using over-socialisation for a power advantage. It is perceived that socialisation with other paramedics, mentors, and people within their team, has the ability to increase power between them and other interns because they believe they would be accepted as part of the organisation. This rapid acceptance is perceived to lead to a better chance of being employed.

Learning to successfully navigate these organisational specific cultural insights via the Paramedic Internship

It is well-understood that the internship is designed to ensure that the paramedic intern, or a paramedic from another state, is accepted into the organisation. It therefore interns would attempt to use any power they hold to gain an additional advantage of employment, and thus, the overt confirmation of being accepted. Having said this, learning is a social process, but the question is 'how much is too much?" It was clear from the findings that many interns are over-socialising which results in their work-life balance being out of order. Additionally, the organisation is highly visible in the public eye and so it makes sense that it does not want its employees to make mistakes, and consequently, to portray a negative image of the organisation. Mistakes could include clinical ones that affect not only the patient, but also social expectations, the organisational or professional boundaries, and/or how they fit into the organisation. This dilemma demonstrates the learning about, and application of, the fine line between indulgence and restraint during the internship at multiple levels.

The internship enables the organisation to test these competing dimensions which are underpinned by the individual's threshold of indulgence and restraint, especially in those dimensions that are opposed to the national cultural accepted levels (UAI and PDI). These themes require careful navigation by the employee. There is no one-size-fits-all approach as rules and regulations have only limited value, boundaries are fuzzy, and employees have to be able to navigate between competing purposes which may be different from organisation to organisation

and from state to state. So, the concern is not whether someone from interstate is a competent paramedic, but whether they are a competent paramedic in 'OUR' context.

This however cannot be judged from a test or a job application interview, but instead, requires close observation of the employee in various situations to see whether they have the fine 'touch' or situational awareness to navigate between competing demands and to stay well clear of overstepping any boundaries.

Where to from here?

After the above discussion, the question becomes: where to from here and what does this study mean for the future of paramedic professionals in Australia? How would we overcome this issue so that paramedics would not be required to re-do a paramedic internship?

Merely political solutions, such as government-mandated national registration, will not solve this problem. Such an approach would not be able to encompass each individual ambulance service's local organisational culture. This has become clear from this study, as national culture and organisational culture are unique and have different meanings in different contexts. As a result, a top-down approach would lead to at least some level of disobedience. Organisations would bend the rules or find other pathways to ensure that their own needs would remain central rather than those initiated by a national body.

A pragmatic approach to solving this problem in the form of national competency testing and assessment may also be ineffective. This is because, although it may address the concerns around competency, it would fail to recognise the value and the perceived importance of local culture. Furthermore, all states would need to be in agreement with this national standard and it is perceived by the author that this would generate a great deal of opposition.

Finally, a bottom-up approach might lead to some creative, more acceptable and therefore more effective solutions to this issue. For example, paramedic representatives from each state might complete parts of a paramedic internship in another state to ensure that paramedic internship meets the same level of education, organisational induction, and tacit skill development from their homes state. This would be a sort of mutual accreditation of each other's program. This is just an illustration of strategies that are based on exchanges of experiences between non-competitive organisations. Such exchanges would attempt to foster a community of practice which would be more likely to be successful, but would take some time to achieve. Often organisational changes can be a continuous uphill battle and less effective where working with the people can achieve better outcomes.

Limitations

All research has potential and real limitations. One of the main limitations of this study is that the data were collected from only a single state. As a result, it may not have captured all the themes associated with the values and beliefs that underpin a paramedic internship.

As well, this study interviewed only those senior managers in the ambulance service who were considered key stakeholders in the service. This highly selective process was directed by one manager who oversaw education within SAAS which could have potentially skewed the results. Furthermore, the author currently works as a paramedic for the organisation. During the length of this study, the author had no role or vested interest in the design, development, or delivery of the paramedic internship program. This 'boundary' was put in place to ensure that there would be no influence on the outcomes of the internship, and that there would be no influence on the author's perceptions from the intern program.

Future directions

The future directions of this study are broader than just simply replicating the study in other states. There is no question that this study has shed more light on the logic behind the perceived importance of the local internship. The question is how elements from this study can inform future research into the paramedic profession. It has already been established that paramedic research in Australia is limited. The author has identified two examples of future potential research projects to complement and expand on the present study, which will be explained below.

With the increasing likelihood for interstate recruitment of qualified paramedics, the SAAS is yet to develop an intern program specific for qualified paramedics entering the local workforce. As a result, it is highly likely qualified paramedics would be placed in the same intern program as new paramedic interns. Future research could explore their experiences during the internship. This would uncover deeper understandings of the cultural gaps between the state they are leaving and their destination state, and would confirm any differences in knowledge, guidelines, rituals, practices, and so on.

Also, undertaking a learning-needs analysis in a nation-wide context would assist with comparing the gaps in the knowledge of paramedics across each state. This might confirm the need for a local internship, but the question would arise of how this learning-needs analysis can be applied so that the internship could be tailored for the incoming paramedics? How then does the organisation accept this change in the paramedic internship and how would it affect the learning experiences of the paramedics? Answering these questions will enable us to understand the organisational compliance to change and if an induction program can be explicit enough to teach implicit organisational values and beliefs.

8. CONCLUSION

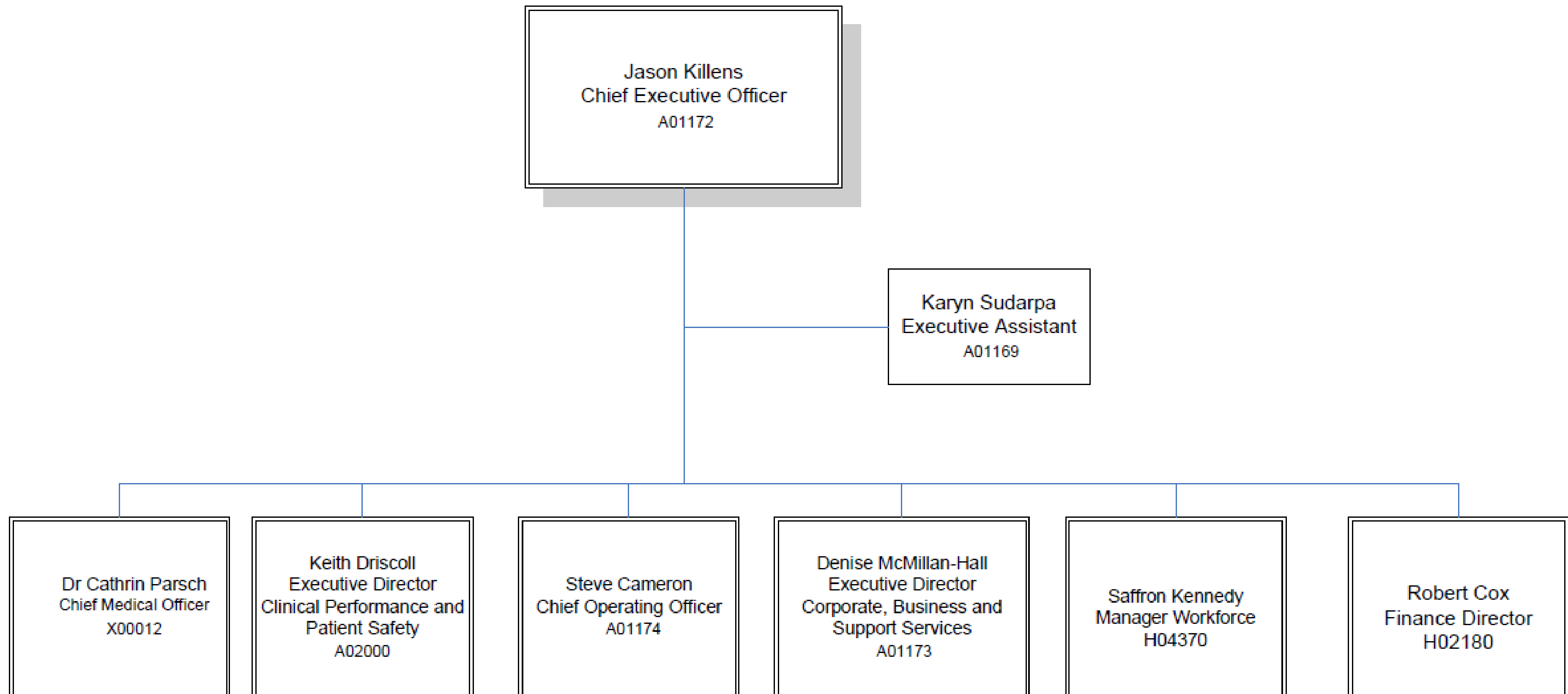
In summary, the study shows that the paramedic internship serves not only to consolidate knowledge and practice but, equally as important, to enculturate new employees. The enculturation into the organisational values and beliefs systems is essential from an organisational perspective, but also requires new paramedics from other states to re do the paramedic internship.

There is a problem with having to redo the internship and the role of the internship itself. A pragmatic and logical reason does not really exist. There are issues at the organisational level but given the tensions the organisation has to work within, it is logical that prolonged observation to see whether an intern fits the own organisation is essential. Therefore, it is clear that any form of paramedic, whether it is an intern, or qualified paramedic from interstate, is required, at minimum to undertake an enculturation program.

A pragmatic solutions or mandated top-down solution, like nationalisation, are likely to be ineffective as acceptance of each other's organisational culture is needed. This study has shown the complexities of this question with competing cultural dimensions which the organisational highly values, and that can only be answered and observed during a period of observation. Enculturation is essential for the ambulance organisation to ensure the right people fit into this organisation, to belong to our organisation, to be accepted as one of us.

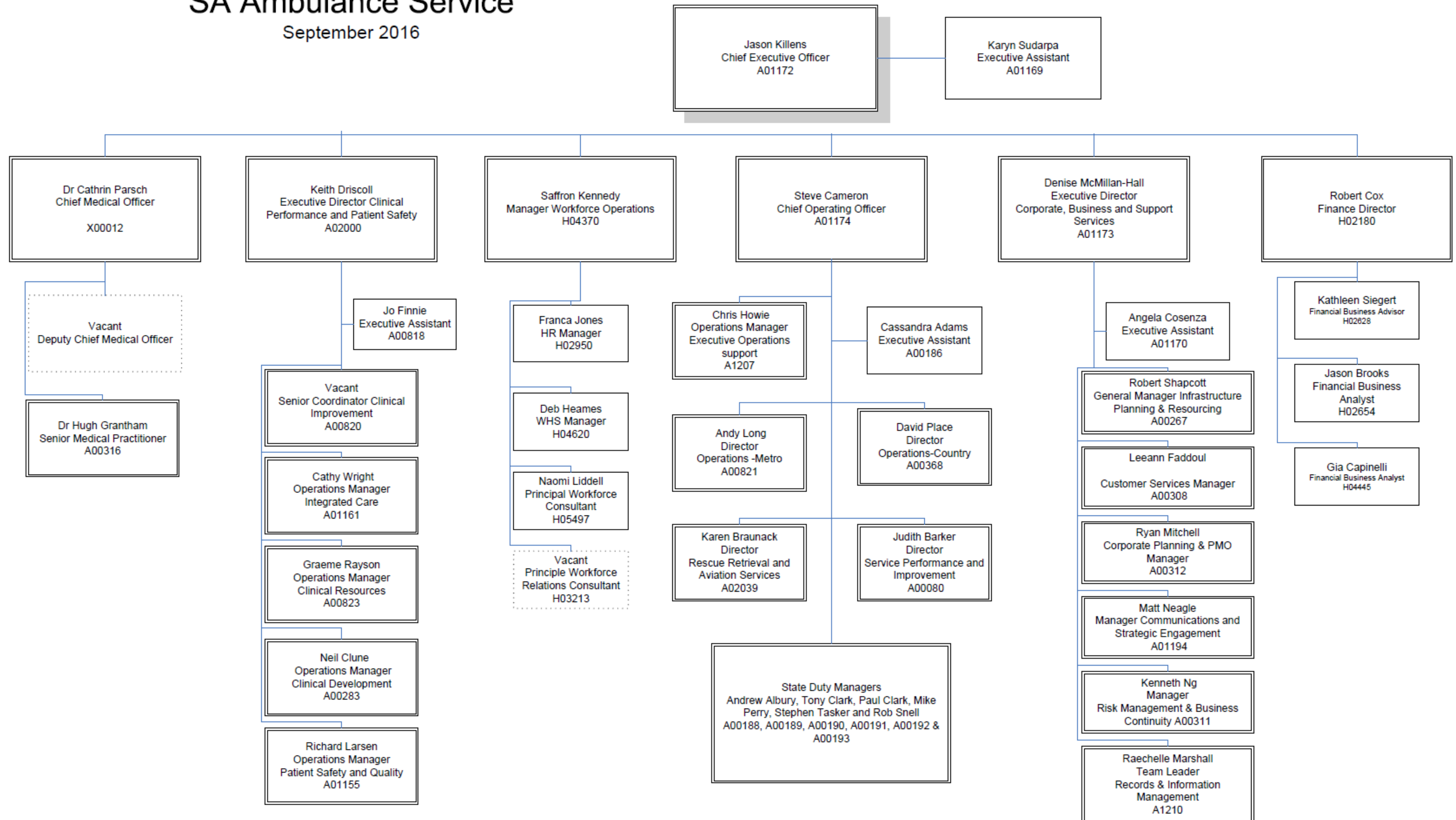
APPENDICES

Appendix A: SA Ambulance Service Organisational Charts

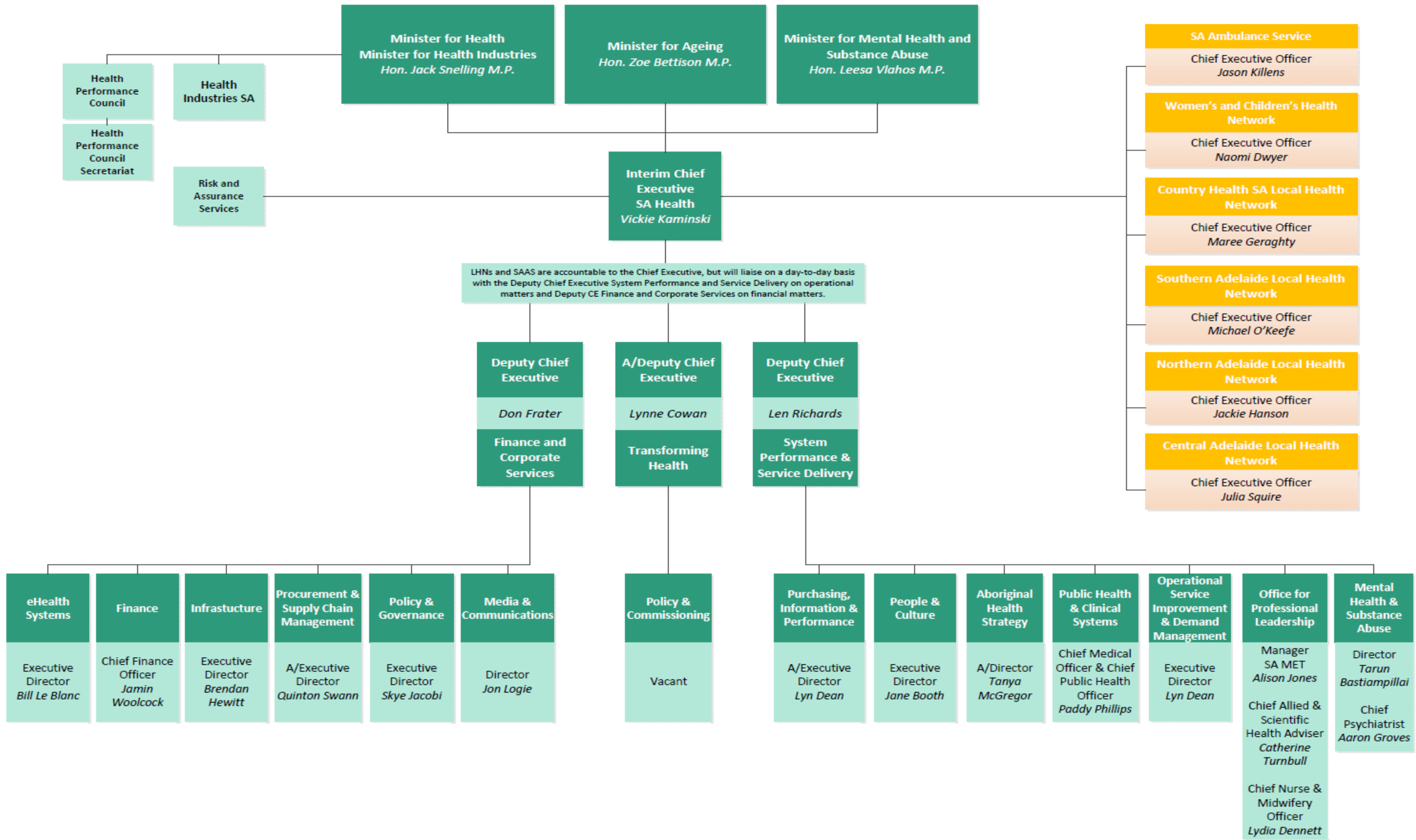


SA Ambulance Service

September 2016



Appendix B: SA Health Organisational Chart



Appendix C: SA Health Human Research Ethics Committee Approval Letter HREC/13/SAH/24

Government of South Australia
SA Health

SA Health Human Research Ethics Committee
Level 10, Citi-Centre Building
11 Hindmarsh Square
ADELAIDE SA 5000
Telephone: (08) 8226 6367
Facsimile: (08) 8226 7088

Mr Aaron Caudle
SA Ambulance Service
PO Box 2358
SALISBURY DOWNS SA 5108

Dear Mr Caudle

HREC reference number: HREC/13/SAH/24

Project title: Values and beliefs that underpin a paramedic internship.

RE: HREC Application – Approval

Thank you for responding to the issues raised by the SA Health HREC in relation to the above project. Your response was considered by the SA Health HREC at its meeting held on 1st May 2013.

I am pleased to advise that your application has been granted full ethics approval and appears to meet the requirements of the *National Statement on Ethical Conduct in Human Research*.

Please note the following conditions of approval:

- The research must be conducted in accordance with the 'National Statement on Ethical Conduct in Human Research.'
- A progress report, at least annually, must be provided to the HREC.
- When the project is completed, a final report must be provided to the HREC.
- The HREC must be notified of any complaints by participants or of adverse events involving participants.
- The HREC must be notified immediately of any unforeseen events that might affect ethical acceptability of the project.
- Any proposed changes to the original proposal must be submitted to and approved by the HREC before they are implemented.
- If the project is discontinued before its completion, the HREC must be advised immediately and provided with reasons for discontinuing the project.

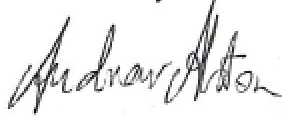
HREC approval is valid for 3 years from the date of this letter.

Should you have any queries about the HREC's consideration of your project please contact Lauren Perry, Executive Officer of the HREC, on (08) 8226 6431 or hrec@health.sa.gov.au

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a SA Health site until separate authorisation from the Chief Executive or delegate of that site has been obtained via the completion of a Site Specific Assessment form. Please contact David van der Hoek via email at ResearchGovernance@health.sa.gov.au to discuss this process further.

The HREC wishes you every success in your research.

Yours sincerely



Andrew Alston
DEPUTY CHAIRPERSON
HUMAN RESEARCH ETHICS COMMITTEE

3/5/13

Appendix D: Information Sheet

Associate Professor Linda Sweet

School of Nursing and Midwifery
Faculty of Health Sciences

GPO Box 2100
Adelaide SA 5001

Tel: 0404 837665
Linda.sweet@flinders.edu.au

CRICOS Provider No. 00114A

INFORMATION SHEET – Stage 1

Title: Values and Beliefs that Underpin a Paramedic Internship

Researcher
Mr Aaron Caudle
Flinders Innovations in Clinical Education
Flinders University
Ph: 0402 724 980

Supervisors

A/Prof Linda Sweet
School of Nursing and Midwifery
Flinders University
Ph: 0404 837665

Prof Lambert Schuwirth
Flinders Innovations in Clinical Education
Flinders University
Ph: 8204 7174

Description of the study:
This study is entitled '*Values and Beliefs that Underpin a Paramedic Internship*'. This project will investigate SA Ambulances Services' organisational culture, values, beliefs and its influence of the development of, and application of, the Paramedic Internship as perceived by the paramedic interns at different stages of their internship. This project is supported by Flinders University Innovations of Clinical Education Unit.

Purpose of the study:
This study aims to find out what are the values and beliefs that underpin the development and application of a paramedic internship. This will:

- Increase our understanding of the values and beliefs associated with the paramedic internship in order to inform curriculum development and enhance educational consistency within Australian paramedic internships.
- Identify the values and beliefs held by interns across different stages of training of the current internship program.
- Determine similarities and difference in values and beliefs across stakeholders of the internship
- Increase our understanding of these values and beliefs, to inform curriculum development, to enhance educational consistency within internships across Australia

What will I be asked to do?
Stage 1 will invite specifically selected people due to their influence on the development of and implementation of the paramedic internship for a 1:1 interview. It is anticipated that the interview will take no longer than 60 min.

What benefit will I gain from being involved in this study?

inspiring achievement

The sharing of your perceptions on the underpinning values and beliefs of the paramedic internship will allow ambulance services to better develop paramedic internships to improve the quality of future education for paramedics.

Will I be identifiable by being involved in this study?
We do not need your name and you will be anonymous. Once the interview has been typed-up and saved as a file, the voice file will then be destroyed. Any identifying information will be removed and the typed-up file stored on a password protected computer that only the coordinator (Mr Aaron Caudle) and supervisors (A/Prof Linda Sweet & Prof Lambert Schuwirth) will have access to. The same applies to the survey as you will not be required to input your name, unless you wish to partake in an interview, of which the above still applies. Your comments will not be linked directly to you, although can be difficult for specific roles within the ambulance service (ie Chief Exec Officer) in which case an umbrella term will be used (ie manager).

Are there any risks or discomforts if I am involved?
Other group members may be able to identify your contributions even though they will not be directly attributed to you.
The investigator anticipates few risks from your involvement in this study. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the investigator.

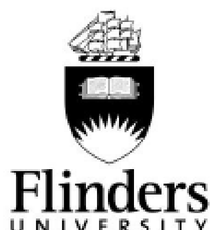
How do I agree to participate?
Participation is voluntary. You may answer 'no comment' or refuse to answer any questions and you are free to withdraw from the interview at any time without effect or consequences. A consent form accompanies this information sheet. If you agree to participate please contact me by telephone or email to arrange a time for the interview. A signed consent form will be required for all interview participants.

How will I receive feedback?
Outcomes from the project will be summarised and given to you by the investigator if you would like to see them upon the conclusion of the research.

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

Ethics approval for this study has been granted by SA Health Human Research Ethics Committee reference number **HREC/13/SAH/24**. Further information contact hrec@health.sa.gov.au. Additional approval has also been attained from Flinders University Social and Behavioural Research Ethics Committee (SBREC) and SA Ambulance Service Research Review Committee (SAASRRC).

Appendix E: Consent Form



CONSENT FORM FOR PARTICIPATION IN RESEARCH By Interview

Values and Beliefs that Underpin a Paramedic Internship

I ....

being over the age of 18 years hereby consent to participate as requested in the Letter of Introduction and Information Sheet for the research project on Values and Beliefs that Underpin A Paramedic Internship.

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to audio recording of my information and participation.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:
   - I may not directly benefit from taking part in this research.
   - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
   - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
   - Whether I participate or not, or withdraw after participating, will have no effect on my role in this service.
   - Whether I participate or not, or withdraw after participating, will have no effect on my progress in my course of study, or results gained.
   - I may ask that the recording be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
6. I agree/do not agree* to the tape/transcript* being made available to other researchers who are not members of this research team, but who are judged by the research team to be doing related research, on condition that my identity is not revealed. ** delete as appropriate*
7. I have had the opportunity to discuss taking part in this research with a family member or friend.

Participant's signature...Date.......................

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name...

Researcher's signature...**Date**.........................

NB: Two signed copies should be obtained.

Ethics approval for this study has been granted by SA Health Human Research Ethics Committee reference number **HREC/13/SAH/24**. For information contact hrec@health.sa.gov.au. Additional approval has also been attained from Flinders University Social and Behavioural Research Ethics Committee (SBREC) and SA Ambulance Service Research Review Committee (SAASRRC).

Appendix F: Interview Questions

Experience

- Can you please describe briefly to me your years of service and responsibilities with Ambulance Services.
- What roles did you play in the development and delivering education programs in the ambulance service?
- What did you have to do, or you had, to get into your current position where you have an influence on educational practices in SAAS?
- Do you have any other educational training or educational experiences outside the ambulance service setting?

Influential Power Matrix (Front of Paper)

- How would you rate your level of regard that people have for you for your work with your current role? Can you explain why you gave that rating? (Professional Trait)
- How would you rate your level of reputation that people have for you? Can you explain why you gave that rating? (Personal Trait)
- How would you rate our relationship between your job role and its influence on paramedic internship? Can you explain why you gave this rating?
- How would you rate your educational experience and its relevance on influencing the paramedic internship? Can you explain why you gave this score?
- How would you rate your clinical paramedic experience its relevance on influencing the paramedic internship? Can you explain why you gave this score?

The Internship Structure

- What do you believe should be the outcomes of the Paramedic Internship? (Broad)
- What do you think SAAS does well in the Internship program? Why?
- What do you think SAAS does not do well in the internship program? Why? What are the priorities for improvement?

Domains of Competency

- What are the broad domains of competency that you believe need to be conveyed and why?
- What did you feel is the most important domain to convey within the intern program and why?

Learning Locus

- What do you think is the best way that paramedic interns learn? Why? What methods would be the best to achieve this? Facilitate Large

- Who do you think controls interns learning? Why?
- There are many factors that influence paramedic's interns learning during the internship. These could include relationships, religion, personality traits, upbringing, mentors, etc.
- What factors outside of SAAS influence the interns learning? What do you believe is key here?
- What factors within SAAS influence the interns learning? What do you believe is key here?
- Would you describe the internship as flexible or ridged? Why? What impact do you think this has on the teaching and learning within the program?

Quality Control

- What are the advantages and disadvantages of the old diploma training? What are the advantages and disadvantages of the degree training? What pathway would you choose is best and why?
- Do you think the quality of our paramedics post internship is the same quality to those from other states?

Feelings Behaviours Traits

- Given the recent curriculum review there were a lot of ideas and beliefs proposed by others about the re-development and application of the Paramedic Internship.
- Were you receptive of the ideas and beliefs of others? Do you feel that others were receptive of your ideas and beliefs? Discuss.
- What do interns worry about during the internship?
- What do you worry about with respect to the internship?
- Why do you think there are now more females to males in the paramedic internship? Has this changed the culture of the profession? Facilitate More Why?
- Do you think the internship is designed to: (Back of Paper)
    - Encourage collaborative teamwork or autonomous individualism. Why do you have that opinion?
    - Encourage to get the job done in a timely manner, or getting the job done right. Why do you have that opinion?
    - To occasionally deviate protocols or to strictly adhere to them? Why do you have that opinion?
    - Be service focused on the patients, SAAS or SA Health? Why do you have that opinion?

Ambulance Profession

- What do you think are the barriers for a paramedic to move from one ambulance service to another? How could this be overcome?

Appendix G: Rating Scales

Values and Beliefs that Underpin a Paramedic Internship

Regard - How would you rate your level of regard that people have for you for your work with your current role? Can you explain why you gave that rating?

1 2 3 4 5 6 7 8 9 10

No Regard Some Regard for your work High regard for your work

Reputation - How would you rate your level of reputation that people have for you? Can you explain why you gave that rating?

1 2 3 4 5 6 7 8 9 10

Negative Reputation Neither Negative or Positive Positive Reputation

Enrolment No. Time: Date:

Job Role - How would you rate our relationship between your job role and its influence on paramedic internship? Can you explain why you gave this rating?

1 2 3 4 5 6 7 8 9 10

No Related at all Some relation Direct Relation

Paramedic Clinical Knowledge - How would you rate your clinical paramedic experience its relevance on influencing the paramedic internship? Can you explain why you gave this score?

1 2 3 4 5 6 7 8 9 10

Ambulance Officer Level Paramedic ICP/ECP

Enrolment No. Time: Date:

Educational Experience - How would you rate your educational experience and its relevance on influencing the paramedic internship? Can you explain why you gave this score?

(Formal Qualifications)

1 2 3 4 5 6 7 8 9 10

No formal Qualifications/Training — Some Quals and Training — Extensive Quals and Training

(Experience)

1 2 3 4 5 6 7 8 9 10

No Experience — Some Experience — Extensive Experience

Enrolment No. Time: Date:

Encourage collaborative teamwork autonomous individualism.

Encourage to get the job done in a timely manner getting the job done right.

To occasionally deviate protocols to strictly adhere to them

Be service focused on the patients SAAS SA Health?

Enrolment No. Time: Date:

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