Paramedic Transition into an Academic Role in Universities

Issues Related to Paramedic Clinicians Transitioning into Academic Roles in Universities in Australia and New Zealand

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ABSTRACT

To address the shortfall of academic paramedics in tertiary institutions in Australia and New Zealand, increasing numbers of paramedics are being recruited directly from their profession. For many of these academics, who have been employed because of their extensive professional knowledge, experience, and expertise, the culture of academia is confronting. Refashioning their professional identity to become a valued member of the academy presents itself as a challenge in a competitive environment that values research capacity and output, and teaching quality. Bourdieu's thinking tools of habitus, capital, and field, and Lave and Wenger's notion of a Community of Practice (CoP) are presented as theoretical frameworks through which the professional identity formation of the paramedic academic can be viewed and explained. How effectively the paramedic is occupationally socialized determines the ease of transition to the role of academic. Learning the culture, rules, expectations, and nuances of the new CoP requires newcomers to draw on the cultural capital of their field of paramedicine.

A major focus of this study identified the issues that paramedic professionals face when attempting to transition their habitus and capital from the CoP of paramedicine to the CoP of academia. The methodologies used for this research were a mixed-methods approach utilizing a quantitative survey and the thematic analysis of interviews with participants.

The research resulted in four publications: a scoping review of the literature related to the topic; a publication of the quantitative demographic survey of the study population; a presentation of the thematic analysis of the interviews; and a publication that focused on the issue of conflicting professional identities. The current situation indicates that the immediate focus should be on establishing more formal preparation and socialization of clinical practitioners into the academic environment by the CoP that they practise in, the paramedic employers, and the university sector.

STATEMENT OF AUTHORSHIP

Except where reference is made in the text of this thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis accepted for the award of any other degree or diploma. No other person's work has been used without due acknowledgement in the main text of the thesis. This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution. This work was supported by an Australian Research Training Program Scholarship.

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Chapter 1
INTRODUCTION

1.1 BACKGROUND TO THE RESEARCH

Paramedicine in Australia and New Zealand has undergone a transition in recent years from a vocational apprenticeship style of training to a tertiary model of education. In Australia, out-of-hospital (OOH) care is provided by paramedics. The peak professional body for OOH care in Australasia in 2015 (Paramedics Australasia) defined a paramedic as a health professional who provides rapid response, emergency medical assessment, treatment, and care in the OOH environment (Paramedics Australasia, 2012). Owing to the implementation of paramedic registration in December of 2018 (Australian Health Practitioner Regulation Agency—Paramedicine Board, 2018), it is mandatory in most jurisdictions for entrants into the paramedic profession to have a degree in paramedic science. As of 2019 it is estimated that there are 17 tertiary institutions in Australia and New Zealand offering undergraduate and postgraduate degrees in paramedicine (The Council of Ambulance Authorities & Ambulance New Zealand, 2019). To provide these graduates with the training, education, and mentorship required to complete their degrees successfully, universities have recruited, and continue to recruit, paramedics to assume academic roles within those programs. Little is known about the experiences of paramedics as they make the transition from the role of a uniformed OOH clinician to that of an academic in a university. This thesis explores the experiences of paramedic clinicians who have made this transition and examines whether this process could be improved for both the new academics and the institutions they are entering.

1.2 HISTORY OF PARAMEDIC EDUCATION IN AUSTRALIA AND NEW ZEALAND

The emergent profession of paramedicine, as it is structured today, is relatively new compared with medicine, allied health, and nursing. Conversely to the nineteenth-century model of prehospital care, when the sole role of civilian ambulance personnel was to transport the sick and injured to hospitals, the modern-day role of the paramedic evolved from the experiences of military medical personnel in the wars of the twentieth century and involves a system where treatment is provided prior to the transport of the sick and injured, if necessary. The techniques and innovations that evolved from the treatment and transport of soldiers during those wars greatly reduced the morbidity and mortality of battlefield injuries (Donnelly & Munro, 2011).

Following the Vietnam War in 1975, those in civilian medicine learnt from the experiences of their military counterparts and proposed applying some of those ideas to the management and treatment of civilian trauma and medical patients. The previous approach of civilian ambulance services of accessing patients quickly and transporting them to hospitals for treatment came under scrutiny based on the philosophy that the sooner a patient could gain access to medical care, the

better the potential outcome. With the development of new techniques—like cardiopulmonary resuscitation (CPR) in the 1960s by Dr Peter Safar (Lenzer, 2003)—and the development of relatively portable cardiac monitors and defibrillators in Ireland around the same time, the concept of taking the care to the patient instead of taking the patient to treatment in hospitals was born. In the United Kingdom (UK) the Millar Report (Millar, 1966) and the Wright Report (Wright, 1984) had significant influences on advocating for advancements in OOH care. This started the modern era of paramedicine (Donnelly & Munro, 2011).

As the development of OOH care progressed in the 1970s, a new level of training and education was required for ambulance personnel. No longer were a first-aid certificate, a driver's licence, and a strong back adequate qualifications for working as an ambulance officer (Donnelly & Munro, 2011). With the advent of improved and more complex treatments for heart-attack and trauma patients, the movement of care into the OOH environment required ambulance personnel to engage in a higher-level of study and preparation.

As individual communities in North America, the UK, Australia, and New Zealand embraced this new paradigm shift, the education and training of paramedics became situated in in-house, vocational-training programs within ambulance services and the curricula were designed and taught predominately by physicians and nurses. These programs were mainly skills-based and did not go beyond the most basic levels of understanding of anatomy, physiology, pathophysiology, and pharmacology. In the early 1990s the movement to transition paramedic education within the university sector in Australia and New Zealand began to take form (Lord, 2003).

There was a movement within the profession to gain more respect for and acceptance of paramedics and their role within the healthcare community and to start the long and arduous process of registration in Australia and New Zealand. In 1995 the first undergraduate degree program in paramedicine in Australia and New Zealand was started at Charles Sturt University in New South Wales. It was quickly followed by Monash University and Victoria University in Victoria and by others over the following years (Lord, 2003), and has rapidly expanded to 17 universities offering undergraduate and postgraduate degrees in paramedicine. According to figures provided by the Council of Ambulance Authorities (CAA), in 2015 there were approximately 6700 students registered in all years of study in paramedicine programs in Australia and New Zealand (Authorities, 2015). Graduates from these programs are employed predominately by ambulance services in Australia and New Zealand but have gained employment internationally with services in the UK and North America. A major challenge for the universities offering these programs has been the recruitment of academically qualified paramedics to assume academic roles within these institutions.

1.3 REFLEXIVITY AND THE RESEARCHER'S ROLE IN PARAMEDIC EDUCATION AND TRAINING

Within qualitative research there is a certain amount of subjectivity, as the interpretation of the data and the participants' behaviour are influenced by the experiences, values, and beliefs of the researcher. The process of *reflexivity*, which encompasses the ongoing analysis of the researcher's involvement in the study, attempts to make sure the process is open and transparent (Jootun, McGhee, & Marland, 2009). Reflexivity has also been defined as 'thoughtful, conscious self-awareness' (Finlay, 2002, p. 532). Another form of reflexivity is known as the *emic* approach to qualitative research. The emic approach is described as knowledge and interpretations that exist within a culture or community of practice (CoP) and are 'determined by local custom, meaning, and belief and are best described by a native of the culture' (Ager & Loughry, 2004, para 13).

My personal motivation for conducting this study was based on my own experience of transitioning from the CoP of paramedicine to the CoP of academia. After a career in Emergency Medical Services (EMS) that began in 1975 in Ontario, Canada, where I was a clinical practitioner, educator, and manager, I obtained a Bachelor of Health Sciences (Prehospital Care) degree and a Master of Health Services Management degree, both by distance education from Charles Sturt University (CSU) in Australia. I was offered a secondment in 2007 to CSU in Bathurst, NSW, to provide an international perspective to students and staff in the paramedic program.

On arrival in Bathurst I immersed myself in the culture of both the university and the local community. I had some doubt about what the university culture would be like, as my total experience with a university had been what I call 'from my dining-room table', having completed both my degrees by distance education. I had not had the experience of sitting in a lecture or tutorial with fellow students, interacting directly with teaching staff, or of social activities on a campus. At the end of my five months at CSU the Head of School asked me whether I would be interested in a full-time lecturer position in the program, and after some deliberation I applied for and successfully obtained a Lecturer B position in the paramedic program in Bathurst. After returning to Toronto I prepared to make the physical move to Australia and, more importantly, prepared to assume my new role as an academic at the university.

On arrival in Bathurst in July 2008 the many goals and objectives forming part of my terms of employment confronted me. These consisted of teaching, researching, and academic writing for publication. The expectations for teaching were easily met as I had extensive experience in this area, but the expectations for research, publication, and Ph.D. studies were daunting. There was an expectation, as part of the requirements for probation, to engage in and complete a Ph.D. within a set period of time. I was eager to begin the journey, but I was unsure about what was involved or what the demands on my time and well-being would be. I found that there was little formal support or mentoring for research and academic writing, and I was left to my own resources to seek out help and guidance in these areas.

As part of my development as a researcher, I became involved in a qualitative research project with three established researchers in our school who were looking at the experiences of academics who had entered the academy through two substantially different paths (Logan, Adams, Rorrison, & Munro, 2014). These paths were what we called the traditional path (those who acquired their degrees and moved immediately into academia and research positions in universities) and the professional path (those who practised in their profession for several years and then transitioned into academic positions in universities). My involvement with this study piqued my interest in knowing whether my experiences in making the transition from paramedic practice to academia were shared by my peers and colleagues. I was further interested in knowing how they coped with this transition and what strategies they employed and what their degree of success was in making the transition. As an ultimate outcome of my research I wanted to identify the key areas of concern and propose possible ways in which universities, the paramedic profession, and prospective paramedic academics could assist in preparing paramedics for assuming tertiary academic roles.

1.4 THE RESEARCH PROBLEM

Universities in Australia and New Zealand that run paramedicine degree programs are facing a shortage of qualified paramedics to assume academic roles (O'Meara & Maguire, 2018; O'Meara, 2006). The experiences encountered by these paramedics when they transition to these roles have not been reported in the literature. Thus this timely study sought to explore the demographic characteristics, the qualifications, and the experiences of paramedics making the transition from paramedic clinical practice to academia. Furthermore, the study examined the factors (if any) that may precipitate a more positive and productive process for new university paramedic academics.

1.5 AIMS OF THE STUDY

The aims of the study were fourfold:

1. To identify the demographic characteristics of the professional paramedic academic.
2. To determine the factors that influence paramedic academic identity.
3. To identify the issues related to the transition of paramedic professionals into the academy.
4. To develop a framework to assist in the transition of paramedics from clinical practice into academic roles in universities.

1.6 RESEARCH QUESTIONS

To achieve the research aims, the questions to be answered in this study were the following:

- What are the demographic characteristics, paramedic qualifications, and academic qualifications of the paramedic academics teaching in paramedic programs in Australia and New Zealand? (Aim 1)
- What are the factors that influence their professional identity? (Aim 2)
- What are the issues related to the transition from the CoP of paramedicine to the CoP of academia? (Aim 3)
- What processes could be implemented to assist both the universities and the new paramedic academics to make the transition more efficient and effective? (Aim 4)

1.7 SIGNIFICANCE OF THE STUDY

The significance of this study is paramount, as little is currently known about the qualifications and experiences of paramedic academics transitioning from paramedic clinical practice to academia. This study comes at a time when there is an increase in demand for suitably qualified paramedics to assume academic roles in university paramedic programs in Australia and New Zealand. Furthermore, the retention of academics already in academic positions is of importance, because as higher degrees in research are becoming mandatory for academic positions in most institutions, current lecturing staff may run the risk of being professionally 'left behind' unless they complete further studies or research qualifications.

It was envisaged that the results of this study would provide insights into the transition of paramedics to academia and provide a deeper understanding of the issues associated with a move from clinical practice to the tertiary sector. Furthermore, it provided an outline or guide for potential academic candidates by exploring the experience of paramedics who had already made the transition from clinical paramedicine to academia.

1.8 THE RESEARCH PROCESS

A major foundation of mixed-methods research is that it is practical and pragmatic, and allows the researcher to focus on the outcomes and benefits of the research rather than the means by which it is achieved (Johnson & Onwuegbuzie, 2004). This thesis examines the demographic make-up of the paramedic academics, their professional and academic qualifications, and who they are and where they came from, along with the experiences of these academics in making the transition from the CoP of paramedicine to the CoP of academia. This study included two phases: the first was the collection of quantitative data obtained from an online normative survey of all paramedic academics teaching in a paramedic degree program in Australia and New Zealand; the second involved the collection of qualitative data from semi-structured interviews (n = 16) of paramedic academics in academic roles in paramedic degree programs in Australia and New

Zealand. The results of the interviews were coded using directed-content analysis (Hsieh & Shannon, 2005; Humble, 2009) and an interpretive descriptive approach was utilized (Thorne, 2008) to interpret the findings.

1.9 OUTLINE OF THE THESIS

This thesis is a Ph.D. by publication. As a result, there will be some repetition of content and references between the publications and the chapters.

This thesis comprises seven chapters. Chapter 1 outlines the background, aims, and objectives of the study. Chapter 2 reviews the extant literature and discusses the theories regarding the construction of professional identity. Chapter 3 explores Lave and Wenger's concept of CoP, the French philosopher Pierre Bourdieu's concepts of capital, habitus, and field, and the results of a scoping review related to any published literature regarding the experiences of paramedics transitioning into academic roles in universities. Chapter 4 explores the concept of reflexivity and discusses the research project that initially inspired the candidate to pursue this research topic and gave the author much-needed experience in conducting mixed-methods research, which in turn resulted in one journal publication and a textbook chapter. Chapter 5 provides a description of the methods and methodology of the thesis. The mixed-methods paradigm was selected for this research so that the advantages of both of the other traditional research paradigms (quantitative and qualitative) could be explored in the gathering and analysis of the data collected. This thesis is representative of a fully mixed, sequential, dominant-status-design mixed-methods study (Attride-Sterling, 2001). Chapter 6 depicts the findings of this research in four peer-reviewed, published journal articles. Chapter 7 relates these findings to the theoretical frameworks of Lave & Wenger and Bourdieu. A framework for the preparation and recruitment of paramedic academics is proposed and conclusions and future recommendations for research are made as outlined in Figure 1.

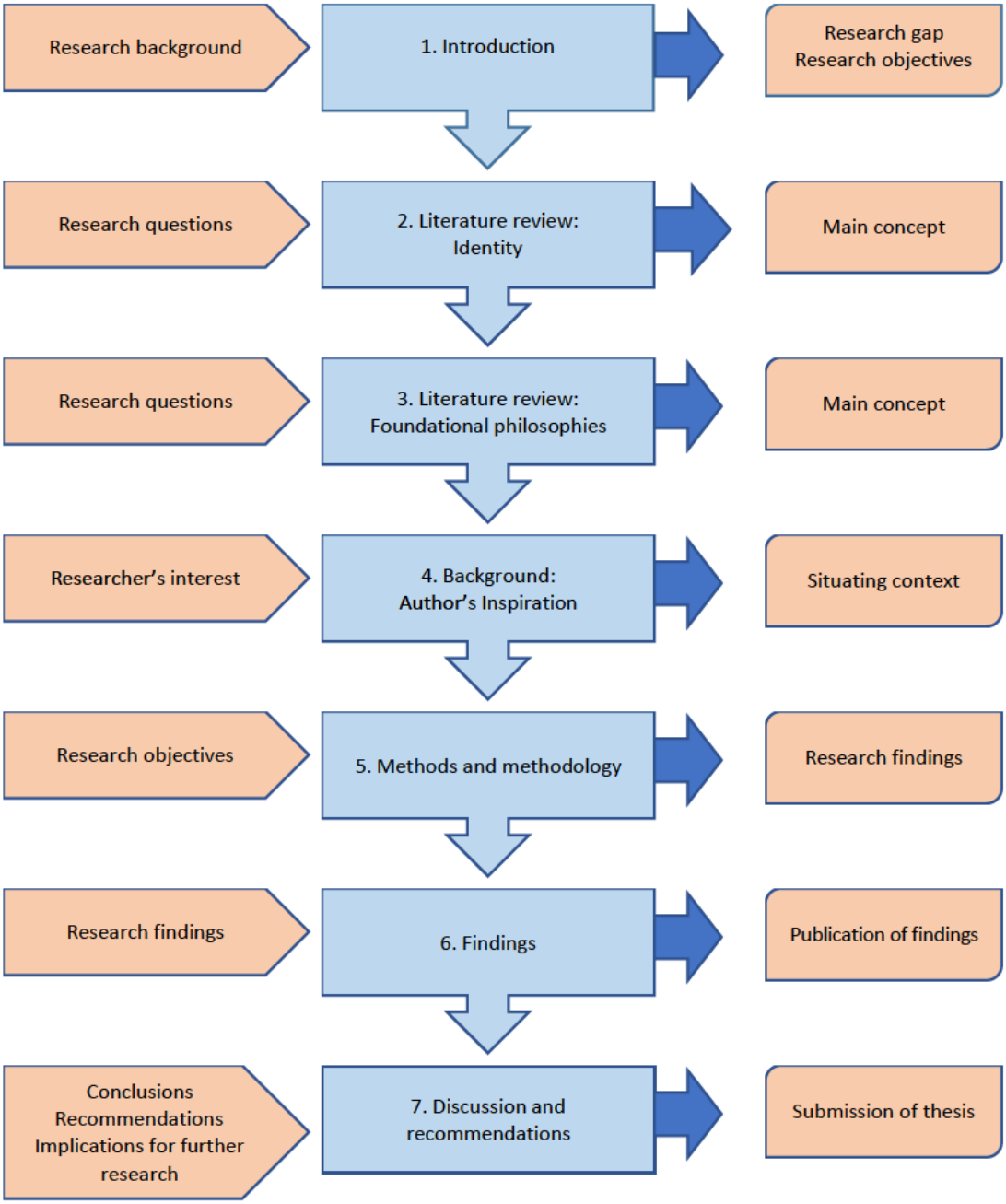

Figure 1.1: Thesis Structure

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Chapter 2
LITERATURE REVIEW ON IDENTITY

2.1 INTRODUCTION

In this chapter the extant literature about how personal, professional, and academic identity is formed and acquired is examined and discussed. An initial search of Google Scholar, using the search terms 'formation of professional identity' and 'formation of academic identity', returned multiple responses. A subsequent search of CINAHL was conducted using the same search terms. A review of abstracts was conducted and suitable articles were reviewed for content and relevance to the topic. A point of saturation was achieved when no new information was perceived to be relevant.

All articles were selected based on the following inclusion criteria:

- published in English
- published in a peer-reviewed journal or book
- no predetermined restriction on the date of publication
- relevance to the professions of nursing, teaching, and academics and academia.

(Refer to the Scoping Review article in Chapter 6 for a more detailed description of process.)

The abstract for each article was reviewed for relevance to the topics of the formation of professional identity and formation of academic identity. Articles that profiled nursing and teaching were selected because of their tangential connection to paramedicine, as there were only two articles found that were directly related to paramedicine (Munro, O'Meara & Kenny, 2016b). A table was constructed, and each article was entered listing the author(s) and date of publication, the name of the article, a synopsis and analysis of the key information provided in the article, and a list of themes relevant to the thesis. This enabled the synthesis and analysis of each of the themes and provided easy access to pertinent quotations and other data.

One of the great challenges in the study of identity is that a universally accepted definition of the concept is elusive. The term 'identity' is used by most people in personal conversation and professional discourse with a tacit acknowledgement of its meaning. Yet, when asked to define 'identity', they have difficulty in expressing a clear definition of the term (Gleason, 1983). Despite the absence of an accepted scholarly definition, the literature outlines various attempts to define identity. Chryssochoou (2003) defines identity as 'a particular form of social representation that represents the relationship between the individual and others (real or symbolic, individuals or groups)' (p. 227). Charles Taylor states, 'My identity is defined by the commitments and identifications which provide the frame or horizon within which I can try to determine from case to case what is good, or valuable, or what ought to be done, or what I endorse or oppose' (Taylor 1989, p. 27). A postmodern definition of identity advocates for not having a fixed identity, as this can lead to conflicts caused by contradictory identities (Henkel, 2005). Chryssochoou and

Taylor's definitions reflect a postmodern approach to attempting to define identity, which is characterized by a philosophy of fragmentation, fluidity, and the transitory.

Individual identities are developed based on the personal, social, and professional construct of the community within which individuals engage (Coles, 2000). For the purposes of this chapter, the concept of identity is addressed as the constructs of personal identity, professional identity, and the identity of academic communities.

2.2 REVIEW OF THE LITERATURE

2.2.1 Personal identity

Personal identities are constructed within the context of a community. It is the constructs and stability of these communities that reinforce the personal identity of individuals by preparing them to function within the community's rules and traditions. These constructs were observed by Erik Erikson, an early twentieth-century pioneer in the study of identity formation, in his study of the Sioux Indians of North Dakota (Coles, 2000). Erikson's studies of this community, which existed in conflict with the surrounding and dominant American society, highlighted the strong influences of the Sioux culture and language (discourse) on their theories and concepts of child-rearing. The notion of the individual's being the bearer of the traditions of a community, by inheriting and sometimes being forced to carry forward these traditions, has been supported in the literature (MacIntyre, 1981).

To further the concept of personal identity, Taylor (1989) emphasizes the importance of a defining community in the construction of the individual's identity. He stresses the importance of a distinctive language that enables individuals to express themselves and to interpret what they experience within their community. Furthermore, the importance of values being central to identity formation is stated in his research. Values are scaffolded over the dimensions of:

- obligation to others
- fulfilment or meaningfulness
- the influences of dignity, respect, and self-efficacy.

Research has built on the work of Taylor, and identifies two of Taylor's necessary conditions for identity, which she labels as the significance and identification conditions (Mok, 2007). These two conditions emphasize the importance of intrinsically high values being sought as a dramatic influence on identity. According to Taylor the significance condition relates to the component parts of our identity that only exist because we conceive them to be intrinsically worthy. They would not be part of our identity if we did not think that the pursuit of them would not lead to a positive benefit (Taylor, 1985). The identification condition relates to the value placed on the aspect of identity as to whether it has an overarching social significance or whether it is more just a matter of personal choice that has no impact one way or the other.

Identity is often a reflection of the generational attitudes, values, and standards of the time. Research examined the attitudes and motivations of three cohorts of teachers that entered teaching

in different eras spanning the 1950–60s, 1970–80s, and 1990s to the present (Goodson, 2007). The older or earlier cohorts demonstrated mostly an intrinsic motivation for their work; their identities were tied to a set of values that had been in existence during the formation of their individual and community identities and were transferred to the formation of their professional identities. The later cohorts demonstrated an extrinsic motivation for work which was a product of a very different set of values that existed during the formation of their identities. As individuals, this later impacted on the formation of their professional identities, which were in sharp contrast to those of their older colleagues.

2.2.2 Professional identity

As with personal identities, professional identities are constructed within the context of a community, in this case, a CoP (Lave & Wenger, 1991). Upon entering a profession, the practitioner is inducted or professionally socialized into the rules, values, and rituals of that profession. Many of these rules, values, and rituals are explicit in documents such as codes of conduct, ethical standards, and policy and procedure manuals. But many of these rules, values, and rituals are not formally documented; they constitute, however, major forces that govern the actions and principles of a given profession—the members of the profession just instinctively know how to behave based on experience within the group (Grenfell, 2008). Often, the informal socialization processes can be more powerful and influential than the traditional induction programs seen in many organizations (Browne-Ferrigno & Muth, 2004).

Pierre Bourdieu, the French philosopher, introduced the term ‘habitus’, which could be seen as synonymous with the term ‘identity’. Bourdieu stated when developing his concept of habitus, ‘all of my thinking started from this point: how can behaviour be regulated without being the product of obedience to rules?’ (Bourdieu 1994, p. 65). There is a potential for conflict between the rules, values, and rituals that paramedics hold and bring with them into academia, such as working in teams, working with other academics, and working independently.

The development of the understanding of the rules, values, and rituals of a profession begins within what Shulman (2005b) refers to as the nurseries of a profession; the educational institutions in which the student professional is exposed not only to technical knowledge, but to the culture of the profession. The Carnegie Foundation, of which Shulman was a member, conducted studies that sought to understand the critical role of signature pedagogies in shaping the character of future practice and in symbolizing the values and hopes of the professions (Shulman, 2005a, 2005b, 2005c). A signature pedagogy is a process or form that is used during education to prepare a student for a profession (Shulman, 2005b). These signature pedagogies have individual characteristics unique to a profession and instil fundamental dimensions of the profession, such as thinking, performing, and acting with integrity (Shulman, 2005a). In essence, signature pedagogies prepare the student to think and act like a doctor, a lawyer, or a nurse. Medicine, law, and nursing and allied health (Shulman, 2005c) have constructed signature pedagogies that define their professions and introduce the graduate into the culture of their practice. It is here that the

individual begins to develop their professional identity in conjunction with the personal identity that was previously formed.

One of the strongest and most effective methods of achieving the integration of professional socialization into practice is through the process of mentoring (Browne-Ferrigno & Muth, 2004; Dobrow & Higgins, 2005; Singh, Vinnicombe, & James, 2006). Most professions have, to some degree, a formal process of professional socialization. It is through this process that the novice professional is introduced to the realities of the workplace and how their professional practice is conducted (Devenish, Clark, & Fleming, 2016). For example, nurses are taught the ideal, best practice during their training, leading to expectations of the workplace and the profession that are not always realized upon commencement in the practice—in essence, expectations do not meet reality (Boychuk Duchscher, 2004, 2008; Kelly, 1998). Research reports that novice nurses or nursing students being mentored by experienced nurses indicated that the mentors had attitudes and practices that were in conflict with the theory they had been taught (Kelly, 1998). They often felt uncomfortable with the decisions being made by the nurses in an attempt to 'make it through the day'. These contradictions created conflict and stress in the novices as it challenged their moral values and ethical roles that were both components of their personal and professional identities. Their experience of the process was described by Kelly as the integration of a new professional self-concept or identity. A professional identity is not a static or fixed entity. The postmodern perception of identity is one that is fluid and ever changing. It is not homogeneous but is constructed of several contradictory selves (Sarup & Raja, 1996) and comprises two important features, perpetual mobility and incompletion, which reflect identity as a heterogeneous process. These two features illustrate that the construction and maintenance of an identity is an ongoing process that is constantly moving and that there is never a point at which identity is whole and complete.

2.2.3 Academic identity

The acquisition of an academic identity is a fluid and dynamic ongoing process. Original theories that viewed academic identity as being static and stable have changed to ones of identities' being flexible and open to change (Winberg, 2008). 'Identity is understood not as a fixed property, but as part of the lived complexity of a person's project and their ways of being in those sites which are constituted as being part of the academic' (Clegg 2008, p. 329). The basic components of the academic position that contribute heavily to an academic's identity are teaching and research (Robertson & Bond, 2001). In contrast, Henkel (2005) states that the two elements which were identified as most important for academic identities are the discipline and academic freedom. Cameron, Nairn, and Higgins (2009) further add that the foundation of an academic career is the ability to write effectively. Churchman (2006) illustrates this variance of perception of the components of the academic position by stating, 'The nature of the academic profession enables multiple, disparate definitions of academic self' (p. 8).

A major influence on an individual's acquisition of his or her academic identity is the pathway followed in developing and acquiring qualifications to enter the academy (Logan, Adams, Rorrison, & Munro, 2014). The two main avenues to entering the academy are through what are referred to as the traditional path and the professional path. The traditional path is what is often seen in the sciences, where a student obtains an undergraduate degree, then an honours graduate degree and a doctor of philosophy degree, and then completes postdoctoral work before attaining the role of a tenured, university academic (Anderson, Johnson, & Saha, 2002). The professional path is somewhat different, in that the new academic is usually employed for several years within a profession, having gained an undergraduate and graduate degree either before entering practice or by distance education while in practice. Then, based on qualifications and competence as a practitioner, he or she enters the academy for the purpose of preparing new members of the profession for entry into practice (Logan et al., 2014).

In one study (Gourlay, 2011) about new academics' entering the academy from the professions, academic CoPs are said to be a myth, further highlighting the multiple challenges that these professionals face during the transition from their current practice to academia. These challenges are: (i) no exchange of information on how things are done; (ii) expectations relating to 'figuring things out for oneself'; and (iii) no sense of team or teamwork, all of which lead to a sense of isolation. Challenges involved not only practices, but underpinned the values and ideologies of the academy. Additionally, there was a reported lack of focused, formal mentoring or direction from more experienced academics and the induction process was described as 'confusing, inauthentic and isolating' (Gourlay 2011, p. 69). Of particular importance is the notion of a strong clash between new academics' previous professional identities (particularly if in healthcare) and their new perceived 'academic' professional identity. The clash may result from the nature of the healthcare professional's work: having experienced strong, collaborative, team relations in previous practice, which was often very patient-focused. The conflict may result in a loss of the professional ideals upon entering the academy, perhaps leading to confusion, anxiety, and depression (Gourlay, 2011).

2.2.4 The shifting nature of academia

Since the 1970s there has been a struggle by academics to realign their academic identities with the paradigm shift of universities (Archer, 2008b). Institutions have shifted from being sites where academics experienced relative autonomy, and the pursuit of knowledge was for its own sake, to—as the Dean of Oxford once called large US universities—weapons of mass attraction (Patten, 1999) that are driven by a neoliberal philosophy of the audit culture and managerialism (Churchman, 2006). A move to neoliberalism and a higher focus on science and higher education being instruments of national economic policy caused a shift in identity for academics, thus reducing their boundaries of autonomy and self-direction (Henkel, 2005). The focus of government has changed to a neoliberal consumer base that is defined in terms of economics rather than politics, in which economies must be strong to compete internationally. Government

has become more centralized with many services being devolved to the private sector. Government policies are more evidence-based and require the participation of the higher education sector for research. This governmental need is driving the research agendas of universities rather than the older paradigm of research being the pursuit of pure knowledge for its own sake. The shift in the perceived role and purpose of universities has created a blurring of roles and academics are struggling with the loss of autonomy, control, and stature (Fanghanel & Trowler, 2008; Harris, 2005).

The drive to create outcomes that are beneficial to the government and the economy has placed research at the forefront of academic practice, ensuring that teaching is the subservient other less-valued practice. The prominence of research relegates teaching to managing student learning rather than the notions of a liberal education. Self-regulation and professional accountability has been replaced with a regimen of governance based on targets, audits, and outcomes. Market pressures force academics to construct their identities in line with the corporate identity. The relationship between research and teaching is seen as a problem at the corporate university, with teaching taking a backseat to research, which is perceived to be fundamental in the construction of both an academic and institutional identity (Harris, 2005).

A significant source of stress for academics and for universities is the conflict between those who adhere to or adopt their academic identity based on the construct of the academic environment that existed prior to the neoliberal revolution in higher education. The 'old days' (Goodson, 2007), where academics were considered to be autonomous, self-directed, and intrinsically motivated have ended, and the new professionals, considered to be technically competent, adherent to rules and policies, and extrinsically motivated in their work have taken their place. This dichotomy of identities creates conflict and dissension, not only between the academics and the corporate universities, but also between academics themselves (Archer, 2008a; Clegg, 2008).

2.2.5 Paramedic academic identity

The position of academic in a tertiary, paramedic undergraduate program primarily exists in Australia, New Zealand, and the UK. There are presently 17 paramedic university programs in Australia; 2 in New Zealand (The Council of Ambulance Authorities & Ambulance New Zealand, 2019); 12 in the UK (Health and Care Professions Council, 2016); and 2 in Canada (University of Toronto-Scarborough, 2016 & University of Prince Edward Island, 2019). The lack of suitably qualified paramedics to teach in these programs, particularly in Australia, has necessitated the recruitment of paramedics from overseas and local paramedics working in roles for which they are not well qualified. The vast majority of the academics teaching and researching in these programs have entered the academy through the non-traditional or professional pathways (Munro, O'Meara, & Kenny, 2016a). The transition of professionals into academia is highlighted by several complex issues. One issue that confronts both academics and universities relates to the amount of learning and teaching experience that new paramedic academics bring with them to the

academy and how the academy is situated to deal with any deficiencies. In addition, one of the defining aspects of being an academic is the ability to write well (Cameron et al., 2009). Academic writing is rarely taught unless courses in linguistics are offered. Rather, it is usually in the form of 'on-the-job' training. This can cause many adverse technical and emotional problems, particularly for early-career academics. Additionally, how new academics are received by their older professional colleagues may be problematic, with some new academics not using their academic credentials while in the company of members of their previous CoP (Clegg, 2008) for fear of no longer being considered one of the 'group'.

In the absence of peer-reviewed, published literature, experts in the field were consulted. One colleague in particular (personal communication, Marc Colbeck) highlighted some pertinent issues, which included the following:

1. In the current drive towards professional registration for paramedics in Australia, should there be a separate category for academic paramedics?
2. In the recruitment of academics to teach in paramedic programs, what level of training, education, and experience should the new recruit have?
3. Is specific clinical experience in the field of paramedicine required?
4. What rules should be set up for 'who can teach what'? For example, can someone who has never intubated in the field teach intubation to students? What if the person were trained and qualified but had never practised? (M. Colbeck, personal communication, 11 February 2012).

Our scoping review (Munro, O'Meara, & Kenny, 2016b) revealed two published works on paramedic academics and the acquisition of their identity (O'Meara, 2006; Pointon, McCarthy, Lazarsfeld-Jensen; Willis, & O'Meara, 2009). Pointon, et al. published a report that in part, discussed the proposed formation of the Australasian Paramedic Academic Network (APAN) in 2006 (later known as the Network of Australasian Paramedic Academics (NAPA)), with one of its goals being 'to support the development of paramedic academics and to provide these academics with a professional identity (Pointon et al., 2009, p. 76). At the inaugural meeting of the organization in 2008, one of the major issues identified by the participants was the need to dedicate time and resources to developing these new academics in the areas of research and teaching. Seminal paramedic academics have identified challenges that both universities and paramedics face in recruiting and retaining paramedic practitioners in academia (Pointon et al., 2009). Intrinsic rewards identified by existing paramedic academics, such as the joy associated with teaching, research, and policy development, are profiled as being important to consider. However, barriers and challenges associated with a move into academia, such as the lack of formal qualifications (at baccalaureate and master's levels) that resulted from paramedics' vocational educational heritage (O'Meara, 2006), are illustrated. Although the literature outlines recommendations (O'Meara, 2006; Pointon et al., 2009) a major change in the culture of paramedicine would possibly be required for these recommendations to be implemented. Owing

to a dearth of research about the transition of paramedics into academia, conclusions and analogies need to be made from literature associated with other relevant professional disciplines.

University academics are a heterogeneous group with many, divergent identities. In a study of new teacher educators in Australia (Martinez, 2008), it was recognized that these new teacher educators were an extremely heterogeneous group and that caution should be exercised when making any generalizations about the group. There were strong similarities evident between the conclusions reached in this study and the paramedic academic field. For example, many new paramedic academics have some form of experience teaching in vocational education programs, either at community colleges or with ambulance-service education and training units. The pedagogies employed tend to follow the vocational model and the student cohorts tend to be older, adult learners who have professional and life experience, as opposed to the university student body that tends to be younger, secondary school graduates. This often necessitates a pedagogical shift on the part of the new academic (Martinez, 2008). Another transition required is the moving from a highly regulated workplace to one of individual responsibility and self-reliance, along with different management structures and cultures. What is described as the modelling imperative details the pressure associated with having currency with the discipline-specific knowledge being taught in the classroom, along with the pressures associated with student evaluations that are linked to performance reviews, and the production of research and publication output (Martinez, 2008).

The research culture presents a whole new paradigm for most paramedic professionals entering academia. A further challenge is the drive to meet quantitative measures of success in order to maintain their 'research active' status. New academics possibly enter the academy with a sense of inferiority and a lack of confidence, and there is an assumption by established academics and administrators that new academics from the professions have some higher-degree preparation when entering the academy (Brown, 1998). However, new professional academics need a great deal of time to catch up with the scholarship, research skills, and research experience of their colleagues (Brown, 1998). It is important that when new academics enter the academy, they establish a strong bond with the other members of their discipline. The perception of their academic identity may be more closely associated with their discipline rather than with their role of 'teacher' or 'researcher', or as a member of the wider academic community, which follows later (Bath & Smith, 2004). The adherence to their previous identity is potentially a continuing source of conflict for many academics, illustrated by Trowler & Bamber (2005) who state, '. . . the relationship between institutions and academics is one of multiple games with competing goals and different rules' '(p. 79). The conflict is not confined to paramedic academics, but is seen in other healthcare disciplines where practitioners transition into academia to educate new participants in their CoPs.

2.2.6 Implications for this research

The examined literature focused on the acquisition and development of personal, professional, and academic identities. The literature that has been reviewed identified several key elements that will guide and influence future research. These are, namely, the construction of a personal, professional, and academic identity, the role of CoPs in the development of a professional identity, and the elements of the philosophy of Pierre Bourdieu, which will be addressed in greater detail in the next chapter. There is a symbiotic relationship amongst all of these elements, each contributing to the formation and constant metamorphosis of the others.

The types of identities profiled share common aspects, with the most important being the influence of community on the formation and maintenance of an identity. Erikson and Taylor examined personal identity (Coles, 2000; Taylor, 1989); Lave and Wenger examined professional identity (Lave & Wenger, 1991); and Bath and Smith examined academic identity (Bath & Smith, 2004). This indicates that there is a stronger allegiance by academics to their individual disciplines than to the university community as a whole.

In the initial process of searching the literature, only two publications were identified that alluded to the formation and acquisition of a paramedic academic identity. Within the wider scope of the literature examined, there were significant studies relating to other professions, particularly those of nursing and education, but none were found that directly examined what a paramedic academic identity is and how it is formed. A major focus of further research will be identifying the professional and academic identity of the paramedic academic. As noted earlier, academics within a discipline are a heterogeneous group with many facets to their identity. What are the values and beliefs that make up their individual identities? What are the skills and attributes that they bring with them to the academy that influence their teaching and research?

Having examined the extant literature, the next chapter examines the theoretical frameworks of Lave & Wenger's concept of CoP and French philosopher Pierre Bourdieu's notions of habitus, field, and capital that are associated with the construct of identity.

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Chapter 3
THEORETICAL FRAMEWORKS

3.1 INTRODUCTION

The purpose of this chapter is to introduce the two theoretical constructs that were used to analyse the research data and which also contributed to the design of this research. The two constructs are:

1. Communities of practice (Lave & Wenger, 1991);
2. Pierre Boudieu's notions of habitus, field, and cultural capital (Bourdieu, 1994).

These constructs both draw on the notion of community and the influence of community on identity and practice.

The results of the scoping review (Munro, O'Meara, & Kenny, 2016) revealed that there were no known previous studies of the experiences of paramedics transitioning from paramedic practice to academic roles in universities. Based on a search of the literature, this is the first study, to the author's knowledge, to explore the issues and challenges related to paramedics making this transition process.

3.2 COMMUNITIES OF PRACTICE

According to seminal theorists Lave and Wenger (1991), CoP can be defined as 'a set of relations among persons, activity, and world, over time and in relation with other tangential and overlapping communities of practice' (p. 98). Wenger (2000) describes the earliest construction of CoPs that were centred on basic social cultural groups during the early stages of human development and that provided opportunities for collective learning which led to the survival and development of that group. He further states that CoPs are *social containers* of the values and instruments by which the community functions. One of these assets is the discourse or the language by which the members of a CoP communicate with each other. This discourse can include formal terms and phrases, such as are found in science and medicine, but, just as importantly, terms that would be considered as slang or unique to that CoP, such as the acronyms used by many emergency services round the world, or the terms used by members in informal conversation. 'Meaning is not pre-existing, but neither is it simply made up. Negotiated meaning is at once both historical and dynamic, contextual, and unique' (Wenger, 1998, p. 54). The establishment of meaning within a discourse or within the greater sphere of the CoP is one of negotiation that is ongoing and never completed.

3.2.1 Three essential dimensions of a community of practice

A CoP is characterized by three essential dimensions:

1. mutual engagement
2. joint enterprise
3. shared repertoire (Wenger, 1998, pp. 72–73).

These three defining characteristics contribute to identifying whether a community is indeed a CoP rather than merely an occupational cultural community (Clark, 1996).

Mutual engagement is seen as a process in which members of a community establish values, rules of behaviour and collaborative relationships that provide the bridges connecting individuals within this social entity. A member of a CoP must engage with the community in order to be considered a member (Wenger, 1998). Those who act as brokers between communities may or may not have a sufficient level of engagement to be considered a *legitimate peripheral participant* (LPP) or a centripetal member. Wenger also indicates that engagement is as much about diversity as it is about homogeneity. It is the diversity of ideas, thoughts, opinions, and beliefs that stimulates the process of forming an identity or re-forming an existing identity within a CoP. Most of these engagements are usually interjected with tensions and conflict often being at the centre of the community and resulting in the community's being dysfuntional. Communities of practice are no different in this respect from the wider social communities at large.

Joint enterprise is seen as the shared understanding of what connects members that results from their interactions. This process, sometimes referred to as the *domain* of the community, is in a state of constant re-formation by its members. New ideas, rituals, concepts, and assets are continually being introduced as old ones are phased out (Wenger, 1998). This process is a collective one that is negotiated by its members with the goal of acquiring a sense of belonging and achievement. There is rarely a sense of homogeneity within the CoP, with every member bringing a unique perspective to the group; members need not all agree on everything to make the enterprise functional and successful. Often the CoP develops in the face of influences and forces that are not within its sphere of control. Wenger (1998) refers to this as an *indigenous enterprise* in which the participants create the CoP governed by explicit and implicit rules leading to a practice that is their enterprise.

Another foundation of a joint enterprise is what is referred to as a *regime of accountability*, which entails all members of a CoP being accountable, not only to their managers and the organization, but, more importantly, to themselves as practitioners. This regime determines how individuals react and respond to events that are occurring around them, their level of involvement and concern, and their ability to seek and find new meaning in what has occurred (Wenger, 1998).

A *shared repertoire* is a collection of shared resources and assets that are used by the members of the community and can be physical as well as symbolic in nature. Not all of the components of a CoP are of an official nature. They can comprise rituals and practices that have evolved over time, existing outside the prescribed policies and procedures. These may include

stories or folklore, symbols, slang, and acronyms that have been developed by the practitioners themselves and not by the organizations that employ those practitioners. Wenger identifies two key characteristics of the repertoire of a CoP that help to negotiate meaning:

1. It reflects a history of mutual engagement.
2. It remains inherently ambiguous (Wenger, 1998, p. 83).

An example Wenger uses is that of the spontaneous creation of metaphors. He shows that when combined with historical perspective, ambiguity does not mean that there is an absence of meaning; conversely, it provides an opportunity for the negotiation of its meaning, thus keeping it relevant to its present day use and context. Shared beliefs are always open to interpretation by the holder and may or may not cause conflict among members of a CoP. Even when conflict is present, this provides an opportunity to redefine or provide new meaning to the entity. This process is often seen in the context of being 'on the fly', which enables the members to proceed with the evolution of the practice. This does not mean that all CoPs are harmonious and homogeneous groups, always in agreement and pulling in the same direction. As Wenger (1998, p. 85) states:

> The importance of our various communities of practice can thus be manifested in two ways: their ability to give rise to an experience of meaningfulness; and, conversely, to hold us hostages to that experience.

3.2.2 Legitimate peripheral participants

CoPs are primarily constructed or evolve for the purpose of providing a venue for collective learning. Those new to a CoP are referred to as *legitimate peripheral participants* (LPP) (Lave & Wenger, 1991). The process of legitimate peripheral participation helps learners move from a position of newcomer, one that is on the periphery of the profession, to that of being a master of the skills and knowledge of old-timers that are at the centre of a CoP. 'Legitimate peripheral participation is proposed as a descriptor of engagement in social practice that entails learning as an integral constituent' (Lave & Wenger, 1991, p. 35).

The development of the concept of LPP arose from a collegial debate with Lave and Wenger (Lave & Wenger, 1991) regarding the definition of *situated learning*. The use of the term *apprenticeship* was offered, but it did not fully carry a definitive and fully accepted meaning. The need to develop a theory of learning within a CoP led to the formation of the concept of LPP (Lave & Wenger, 1991). In various studies of apprenticeship models round the world, it was observed that learning within a CoP was not just the repetition of skills or techniques, but the informal acquisition of values, language, and rituals that were absorbed by the novices or LPPs without the use of formal means of learning and teaching.

Another area of involvement for LPPs is their interaction and means of learning from their peers. Lave and Wenger (1991) suggest that the transmission of knowledge between peers occurs rapidly and effectively, and not all learning within the context of the apprenticeship model is from

old-timer to newcomer. Particularly within the transition from professional practice into academia there are varying levels of formal induction into the academy depending on the institution and discipline involved. Of particular interest to this author is the study by Gourlay (2011), in which he states that the components of a CoP—mutual engagement, joint enterprise, and shared repertoire—were not part of the experience of new academics entering the academy. A limitation of this study was that it involved only five participants from one institution, thus challenging the generalizability and validity of the findings. Figure 3.1 illustrates the three characteristic dimensions of a CoP.

Figure 3.1: Characteristic dimensions of a community of practice (Henderson, 2006)

3.2.3 Boundary

In the formation and maintenance of a CoP, there are produced what Wenger (1998) calls discontinuities between those who have been active participants in the practice and those who have not. These discontinuities are evident when someone crosses from one CoP to another. As much as communities create boundaries, they also attempt to create connections with the rest of society. CoPs do not exist in isolation from the rest of the world; they articulate in many ways, sharing artefacts and even members (Wenger, 2000).

Paramedics interact with and share many things in common with nurses, doctors, and many other allied healthcare professions. These include their use of technology and treatments, and an increase in their participation in research (Curtis & Ramsden, 2011). Academics, because of their proclivity for identifying with their disciplines, interact with other academics from similar and different disciplines, as well as with those existing in managerial and support CoPs. This aspect forms one focus of the current investigation of the challenges faced by paramedics in moving from the field and clinical practice of paramedicine into the CoP of academia.

Boundaries within a CoP can be maintained by both the degree of participation and the amount of reification that exists. Reification is 'the process of giving form to our experience by producing objects that congeal this experience into 'thingness' (Lave & Wenger, 1991, p. 58). For example, in paramedicine, the use of distinctive uniforms with insignia, titles, and certifications; in academia, degrees, gowns, and titles are used to give substance to levels of achievement. These boundaries, such as the use of terms, language, documents, and others, can exclude outsiders or they can create continuities across boundaries, such as in the case of healthcare workers who share medical terminology that is not exclusive to their practice. These continuities or connections can be accomplished in two main ways: by the use of boundary objects and by brokering.

3.2.4 Boundary objects

Wenger has used the term *boundary objects* created by the sociologist Leigh Star, 'to describe objects that serve to coordinate the perspectives of various constituencies for some purpose (Wenger, 1998, p.106)'. These include artefacts, documents, terms, and concepts that provide a means by which CoPs can communicate and interact. Within academia, academics complete a multitude of forms that contain terms and concepts that allow them to interact with other CoPs within the university, such as human resource managers, heads of school, and administrative staff. Characteristics of boundary objects include:

1. *Modularity:* Each of the communities can relate in some way to a portion of the boundary object, such as a university newsletter.
2. *Abstraction:* Each of the communities are served by only including those things that each of the communities have in common, such as the use of a common language.
3. *Accommodation:* The object can meet multiple objectives such as an office building that houses multiple disciplines.
4. *Standardization:* The use of a common form, such as a university employment contract. (Adapted from Wenger, 1998, p. 107)

An issue that needs to be considered is that boundary objects are open to individual interpretation by members of different communities and may require a level of coordination between communities to ensure that shared meaning is not lost or distorted.

3.2.5 Brokering

Not all communication between CoPs is by boundary objects. Often, individuals have involvement or membership in more than a single CoP. Wenger (1998) uses the term *multi-membership* to describe the ability to transfer some aspect of a practice into another. The construct of the CoP of paramedicine has members from the CoP of emergency physicians, ambulance service managers, nurses and other allied health disciplines along with paramedics. The involvement or distribution of the influence of these various communities is dependent on the state, province, or country in which the profession practices. Each of the members of these various CoPs, possess a level of 'legitimacy' or 'capital', which allows them to influence the

development of the practice and to address any conflicts that may arise. A frontline manager in an ambulance service may experience what Wenger refers to as *uprootedness*. The manager becomes the broker between the unionized paramedics and the management group. The manager may have a strong allegiance to the paramedics and yet, is also strongly connected to the management group. Managers often have to mediate discussions and conflicts between paramedics and senior management, particularly when issues of policy interpretation, wrongdoing, and potential discipline are involved. Deciding which CoP they should align with can potentially create an internal conflict for ambulance service managers.

Another aspect of a CoP is the brokers who function between CoPs. There are many types of these brokers functioning between CoPs such as:

- *Boundary spanners:* Taking care of one specific boundary over time;
- *Roamers:* Going from place to place, creating connections, moving knowledge;
- *Outposts:* Bringing back news from the forefront, exploring new territories;
- *Pairs:* Often brokering is done through a personal relationship between two people from different communities and it is really the relationship that acts as a brokering device (Wenger, 2000, pp. 235–236).

New academics may assume one or multiple roles as brokers between the CoP that they have just left and the CoP into which they have entered.

3.2.6 Trajectories

The development of identity is a transformative and ongoing process that occurs at various points within a person's life. As these stages of development occur, identities form trajectories that are situated both within and across communities (Wenger, 1998; Wenger, 2000). Wenger uses the following statements to clarify the meaning of trajectory:

1. Identity is fundamentally temporal (associated with time).
2. The work of identity is ongoing.
3. Because it is constructed in social contexts, the temporality of identity is more complex than a linear notion of time.
4. Identities are defined with respect to the interaction of multiple convergent and divergent trajectories (Wenger, 1998, p. 154).

Wenger's use of the term trajectory is predicated on the idea that trajectories are not fixed, unidirectional paths that have a beginning and an end, but, are fluid, multidirectional and provide unity through a connection to the past, present and future (Lave & Wenger, 1991). Newcomers are inducted into the CoP and are exposed to many different identities and possible trajectories from which they begin to construct their own identity along with a trajectory within that community.

The various types of trajectories are:

- *Peripheral trajectories:* Some people never move beyond the periphery or fringes of a community but their identity is influenced by their proximity to the CoP.
- *Inbound trajectories:* Newcomers aspire to move inward from the periphery to become a centripetal member of the community.
- *Insider trajectories:* Once full membership of a community is achieved the development of identity does not stop. Continual renegotiation of identity occurs as a result of the evolution of practice.
- *Boundary trajectories:* Attempting to maintain identities that cross boundaries is challenging but can be rewarding for the individual.
- *Outbound trajectories:* Often participation in one CoP ends and induction into another CoP begins. Lessons learned from participation in the former CoP can assist in entering the new CoP by redefining identity, position and the establishment of new relationships (adapted from Wenger, (1998, pp. 154–155).

3.2.7 Limitations to communities of practice

The concept of situated learning within a CoP was articulated by Lave & Wenger in 1991 (Lave & Wenger, 1991). The major tenants of this construct have been illustrated above. There have been critics of the concept of CoP: Lindkvist (2005) asserts that the meaning of the term 'community of practice' is not well defined and that much of the literature is 'still evolving and hardly coherent' (p. 1191). Lindkvist goes on to challenge the concept of CoPs being homogeneous rather than complex and heterogeneous groups. As discussed earlier, Wenger talks about the importance of diversity within a CoP as well as the homogeneity. It is the exchange of ideas and opinions that shapes and reshapes identities within a CoP. These conflicts and tensions, though, could threaten the stability and existence of a CoP and need to be closely monitored. Roberts (2006) questions whether CoPs within organizations of differing size and complexity will have varying degrees of success and influence. This is an issue that may exist across the multitude of universities involved in this study and that would benefit from further research.

The concept of CoPs is still an evolving process. As more study is conducted into the use and interaction of CoPs in different organizations and institutions, a greater understanding of strengths and weaknesses of this concept will become apparent. The construct of CoPs seems to correlate well with the aims of this study, and thus its inclusion as a theoretical framework in this thesis is justified.

3.3 HABITUS, CAPITAL, AND FIELD

The terms *habitus*, *capital*, and *field* are attributed to the French philosopher Pierre Bourdieu (1930–2002). Bourdieu is considered to be one of the most influential social philosophers of the twentieth century (Grenfell, 2008).

3.3.1 Habitus

The term *habitus* can be loosely interpreted as an individual's identity, but more formally defined as 'a property of social agents (whether individuals, groups or institutions) that comprises a 'structured and structuring structure' (Bourdieu, 1994, p. 170). Maton (2008) goes on to state that, 'it is structured by one's past and present circumstances, such as family upbringing and educational experiences. It is structuring in that one's habitus helps to shape one's present and future practices' (p. 51). It is often referred to by Bourdieu as a *feel for the game* that is embodied and turned into a second nature (Lingard & Christie, 2003).

Members of a social group tend to behave in similar ways even when there are no formal or clearly defined rules of behaviour—they just instinctively know how to behave, based on experience within the group. In attempting to formulate his construction of the concept of habitus, Bourdieu stated 'All of my thinking started from this point: how can behaviour be regulated without being the product of obedience to rules?' (Bourdieu, 1994, p. 65). Part of his dilemma was finding out how the concepts of *outer social* and *inner self,* or social structure and individual agency, could be acquiescent to mutual development (Maton, 2008).

Habitus does not exist in isolation, but is part of an equation:

[(habitus)(capital)] + field = practice.

Habitus, in relation to a professional identity within a CoP, is shaped by all of the components of an individual's personal identity and any professional identity that has been constructed to a point in time. Maton (2008) states:

> . . . habitus focuses on our ways of acting, feeling, thinking and being. It captures how we carry within us our history, how we bring this history into our present circumstances, and how we then make choices to act in certain ways and not others (p. 52) . . . empirically, one does not 'see' a habitus but rather the effects of a habitus in the practices and beliefs to which it gives rise (p. 62).

Habitus does not exist in isolation. It is directly related to and exists within a field and is primarily about relations between the individual and the social. In this research, an attempt is made to identify the structure of the habitus of both the paramedic practitioner and the paramedic academic.

The questions for research are: what particular structure of the habitus is in play here compared with other possible habitus structures and how can we tell when that habitus has changed, varied, or remained the same? (Maton, p. 62).

3.3.2 Capital

There are two basic types of capital: economic and symbolic. Symbolic is divided into subtypes:

- cultural
- linguistic
- scientific
- literary (Moore, 2008, p. 101).

The most common reference to the term capital is in its meaning within economics. Capital comprises assets that can facilitate the transfer of wealth and provide power to exercise influence. Outside the realm of economics, the term *capital* can be used to describe the movement or exchange of capital or assets within a social group or field. This can be refined to mean cultural or social capital developed and maintained by the individual (Bourdieu, 1977; Moore, 2008). According to Bourdieu & Wacquant (1992):

> . . . social capital is the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing *a durable network of more or less institutionalized relationships* [author's italics] of mutual acquaintance and recognition (p. 119).

It is important to understand the distinction between the two. In economic capital, the artefacts (money) and the intention of the transaction are overt. The exchange of money for goods or services is not an altruistic endeavour, but one that has an objective of making a profit or acquiring an asset. Some forms of symbolic capital can function in similar ways but justify themselves as having intrinsic motives.

CoPs and the relationships that exist within them are predicated on the pursuit and use of power. Capital is relative to the status that the members of the CoP ascribe to it. Some types of symbolic capital are situated within *hierarchies of discrimination* (some things have greater value or are better than others). This is referred to by Bourdieu as *symbolic violence*. This symbolic violence is manifested in the fact that the rules of dominance or power are somewhat arbitrary and are mostly grounded in self-interest (Moore, 2008). Capital is the fuel that drives the reformation of a field along a time continuum. It is the manifestation of power in different forms.

Different types of capital can exist in different forms:

- *Objectified:* physical entities; products and buildings;
- *Embodied:* within the corporality of the person as principles of consciousness in predispositions and propensities and in physical features such as non-verbal communication; for example, body language and gesture, suprasegmental features of communication such as intonation and lifestyle choices;
- *Habitus:* does not have a material existence in itself in the world since it includes attitudes and dispositions (Moore, 2008, p. 105).

There is an important point to be made about how forms of symbolic capital should be understood. Moore (2008) states that certain aspects of capital within a community, such as values, tastes, and lifestyles, assign higher status and social advantage to those who possess them. These have qualitative value and are understood differently within different social orders. Also, admission to a CoP does not automatically grant equal status or symbolic capital in the same way for each member. Those with a well-formed habitus will be higher in social capital, though not all forms of habitus and cultural capital carry the same weight in society.

3.3.3 Field

Bourdieu, (2005) stated that to understand fully an event or social phenomenon, study of the social space in which the event occurred must be included. This concept is reinforced by Shulman (2005) in his suggestion that if a society or, in his case, a profession is being examined, then study of the schools in which its newcomers were introduced into that profession or CoP must be completed. This was an adaptation of Erik Erikson's statement that society or cultural examination needs to include the study of its nurseries (Coles, 2000). A *field* is the social context or CoP in which the individual develops and maintains his habitus and capital (Thomson, 2008). Each of these three entities combined constitutes practice. Bourdieu, (1998) defines a field as:

> a structured social space, a field of forces, a force field. It contains people who dominate and people who are dominated. Constant, permanent relationships of inequality operate inside this space, which at the same time becomes a space in which the various actors struggle for the transformation or preservation of the field. All the individuals in this universe bring to the competition all the (relative) power at their disposal. It is this power that defines their position in the field, as a result, their strategies (pp. 40–41)

Thomson (2008) details several analogies that have been presented to describe or define *field.* These include a physical space such as a football field that will dictate how the game will be played; a science-fiction force-field that provides boundaries which protect what goes on inside and on the outside; and a force-field, which Bourdieu saw as a field that could be considered to be made up of opposing forces.

Bourdieu identified three steps that could be useful in researching a given field. These steps were helpful in the investigation of the fields of paramedicine and paramedic academia.

1. Analysis of the positions of the field vis-à-vis the field of power.
2. Mapping out the objective structures of relations between the positions occupied by the social agents or institutions who compete for the legitimate forms of specific authority of which this field is a site.
3. Analysis of the habitus of social agents; the different systems of dispositions they have acquired by internalizing a determinate type of social and economic condition, and which

find in a definite trajectory within the field—a more or less favourable opportunity to become actualized (Bourdieu, 1992, pp. 104–105).

3.4 SUMMARY

The two frameworks—CoP and Bourdieu's concepts of habitus, capital, and field—both focus on the important influence that community has on the construction of personal, professional, academic, and, in particular, paramedic academic identities. These concepts were fundamental to the collection and analysis of the data in this study.

Personal identity is formed within a community and is influenced by values, attitudes, and traditions. These facets of the personal identity become strong influences on the formation of a professional identity. This professional identity is developed within a community where the individuals form their habituses which are influenced by the personal identities that they bring with them into the CoP. Here, the new professionals or LPPs continue to develop their professional identities, which are supported by the social capital they acquired from within the wider social community, in addition to developing capital that is meaningful within the context of the CoP. The CoP or field that they are in has a structure that provides boundaries which aid in the development of the professional, but is not so constrictive that movement between fields is prevented, allowing certain members of a CoP to take on the role of broker, which in turn establishes linkages between fields or CoPs.

A major focus of this study was identifying the issues that paramedic professionals face when transitioning their habitus and capital from the CoP of paramedicine to the CoP of academia. The methodologies proposed for this research triangulated the data gathered by using a mixed-methods approach utilizing a quantitative survey and the qualitative thematic analysis of interviews with participants. These concepts are explored in more depth in the next chapter.

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Chapter 4
FOUNDATIONAL WORK

4.1 INTRODUCTION

In this chapter the concept of reflexivity is addressed. This is 'where researchers engage in explicit, self-aware analysis of their own role' (Finlay, 2002, p. 531) in the qualitative research process. Contrary to the foundations of quantitative research, where much of the process is focused on the elimination of bias, reflexivity can be seen as an opportunity for the researcher to use his or her insight, and ontological and epistemological viewpoint, to enrich the analysis of data. This also takes into account the concept of multiple realities (Schurtz, 1962), where the participants may not have shared the same experience as I have; they may have different interpretations of their own realities. My story, therefore, does not claim to represent the experiences of paramedic academics as a whole.

In 2008 I took up my role as an academic at the Bathurst, NSW, campus of CSU. Upon making the transition from paramedic practice to an academic role in a university, I developed a strong interest in becoming involved in conducting research. Unable to find any mentoring programs provided by the university that were designed to assist new academics in developing their knowledge and skills in conducting research, I sought help elsewhere.

As part of the performance requirements of the university, academics were encouraged to become members of school committees. While seeking mentorship and guidance as a new researcher, I joined the school research committee as a representative of the paramedicine course. As the paramedicine program was situated within a School of Biomedical Science, the vast majority of members of the School, and particularly the members of the research committee, were well-established, biomedical scientists whose focus was exclusively on quantitative research. But as I had become aware that my research interests lay within the qualitative-research paradigm, the challenge before me was to find common ground and support from the committee members. There was only one other member of the committee who was from my paramedic CoP and who was predominately a qualitative researcher. It quickly became evident that scientist members were sceptical and uninformed about qualitative research, and I found myself becoming an advocate for recognition of my chosen area and method of research. The interaction between the established academics and myself and the other paramedic academic could be considered a stigmatization of the relationship. It represented a conscious or unconscious exercise of power. Parker & Aggleton (2003) discuss Pierre Bourdieu's examination of 'how social systems of hierarchy and domination persist and reproduce themselves over time, without generating strong resistance from those who are subject to domination and, indeed, often without conscious recognition by their members (p. 18)'. This is a good example of what Bourdieu called 'symbolic violence'(Bourdieu, 1977), which is the use, by a dominant group, of words, images, and practices, along with hierarchies of

ranking, to get the dominated members to accept the situation through processes of hegemony. Koutrolikou, (2015) further states:

> drawing on the writings of Bourdieu, Foucault and Gramsci, they discuss the 'strategic deployment of stigma' and argue that it 'is part of complex struggles for power that lie at the heart of social life' and that 'stigma is deployed by concrete and identifiable social actors seeking to legitimize their own dominant status within existing structures of social inequality' (p. 511).

This struggle to overcome the domination of the established members of the committee was an ongoing stressor, but it furthered my determination to become engaged in research. It was from my membership of this committee that I was offered my first opportunity to participate in a research project.

4.1.1 First research project and publication

My first introduction to being an active member of a research team came about when I was invited to participate in a mixed-methods research project along with three other well-established researchers (Logan, Adams, Rorrison, & Munro, 2014). The lead investigator on the project, Dr Patricia Logan, had been a nuclear-medicine technologist before assuming an academic role at CSU, and was also a member of the School's research committee. It became clear that we both had some shared experiences in making the transition from clinical practice to academic roles, and that she was interested in exploring the experiences of others in various disciplines and professions. She invited me to join the research team.

The aim of Logan's study was 'to explore experiences of those taking up their first full-time academic appointment and whether differences exist for those who enter with a doctoral qualification to those who enter without a doctoral qualification (Logan et al., 2014, p. 35). I saw this project as being relevant to my own experience and an opportunity to participate in and learn about qualitative-research methods.

I participated in meetings with the other researchers where strategies were discussed on how to implement the methodology of the research study. It was decided that a group of semi-structured interviews would be conducted with a representative sample of practising academics from four Australian universities. Academics were equally divided between those who entered academia with a doctoral qualification and those who did not. I was given a list of four questions that the participants were to be asked. However, I was encouraged to take advantage of areas of discussion that may arise outside the confines of the structured questions. As this was my first experience in conducting these types of interviews, I was given some guidance. There were a total of twenty-four interviews conducted by the four researchers. All interviews were audio-recorded and later transcribed into Microsoft Word files.

A process of triangulation of the research data was completed by using two methods of identifying the themes generated by the interviews. Two of the researchers utilized the computer

program Leximancer to establish the initial coding of themes; the other two conducted a manual analysis of the transcripts without knowledge of the findings of Leximancer. This was conducted in an attempt to minimize the potential for researcher bias as all the members of the research group were academics and brought their own experiences to the project.

Following the generation of the thematic analysis, project meetings were held in which the experienced researchers continued to mentor and guide me through the process of coding and reporting the data and the general mechanisms of conducting qualitative research. The results of the study and the knowledge that I derived from the process motivated me to conduct my own Ph.D. research based on the structure and methods used. The results of the research revealed poignant expressions of concern, feelings of abandonment, and psychological and emotional distress that somewhat echoed my own experiences in making the transition to academia. This generated a desire, on my part, to pursue similar research about the experiences of both established and novice paramedic academics, and to search for methods to improve the selection, induction, mentoring, and professional development of paramedic academics.

Following the completion of the study, I was resolved to pursue this line of research and began the process of applying for admission to the School's higher-degree research program. I was accepted for admission and began the long and at times arduous process of beginning my Ph.D. research. The study findings were published in 2014 in the *Journal of Perspectives in Applied Academic Practice* (Logan et al., 2014) after I had enrolled in higher-degree research-degree studies.

4.1.2 Second publication from the study

After the completion of this study but before the publication of the results, one of the researchers, Dr Edwina Adams, was approached to contribute a book chapter to a publication entitled *Educating Health Professionals: Becoming a University* Teacher (Loftus, Gerzina et al. 2013). The chapter, 'Looking After Yourself: Lessons to be learned on entering academia' (Adams, Logan, Rorrison, & Munro, 2013), utilized the findings and conclusions generated in the transitions research and provided practical advice and guidance for new academics from multiple disciplines and professions. The findings of the research project and the advice provided in the book chapter further motivated me to find out what the shared experiences were of the members of my own CoP of paramedicine, whether any of the recommendations made would be of benefit to them, and whether there were any issues that were unique to my CoP.

The drive to begin and complete this thesis had a genesis in my observation that many of my peers were having varying degrees of success in making the transition from paramedic practice to academia and that many were extremely dissatisfied with their experiences, with some leaving their positions after varying periods of time. As there were no known studies that focused specifically on the experience of paramedics, I saw this as a good opportunity to examine, analyse, and construct recommendations for improvements to the process of transition.

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Chapter 5
METHODS AND METHODOLOGY

5.1 METHODS

Chapter 5 outlines the methods and methodologies used in this thesis. To answer adequately the research aims of this thesis, a mixed-methods approach was taken. This chapter addresses the construct of the mixed-methods approach, the inclusion and exclusion criteria, recruitment of participants, ethics applications, and research approval, as well as the collection and analysis of data.

The aim of this research was to identify the multidimensional aspects of the experiences of paramedic practitioners as they transitioned into academic roles at universities, and to explore the issues that were present from the participants' perspectives, uncovering deeper meaning and insight into their experiences (Ponterotto, 2002). An additional aim was to examine the participants' perception of their professional identity, and how it may have been transformed by the process. As illustrated earlier, the construction of an identity is heavily influenced by the values, attitudes, and traditions within a community. These ideals, which are closely linked to the belief that reality and knowledge are socially and historically determined, along with the ontological and epistemological perspectives of the social constructivist methodology, guided and determined the methods used to identify the participant group and to analyse the data obtained.

5.1.1 Paradigmatic decisions

The type of research method or methods, and methodology used in any research project, is determined by the question being asked by the researcher. It is the nature of the question that drives the research and its methods. It is important for the researcher to be able to match research goals and strategies (Guba, 1981; Higgs, 2001). Guba (1981) argues that there are no right or wrong research paradigms—rationalistic vs naturalistic—'but rather which paradigm provides a better "fit" to the phenomenon we seek to understand' (Guba, 1981, p. 77). Guba goes on to describe the differences between these two major paradigms, reinforcing the understanding that one is not superior to the other.

Table 5.1 illustrates Guba's basic distinctions between the rationalistic and naturalistic paradigms. There is a clear distinction between the two paradigms, which also illustrates some of the challenges in conducting mixed-methods research.

Table 5.1: Major differences in research paradigms (Guba, 1981)

	Rationalistic	*Naturalistic*
The nature of reality	• A single entity to which the researcher can direct inquiry. • Reality can be dissected into separate, manipulable parts also called variables. • These variables can be separated from the whole and studied without affecting the others.	• There are multiple realities. • Inquiry will be expanded rather than narrowed as more information is gathered. • All 'parts' of reality are interconnected so that the study of one part can influence the other parts.
The nature of the inquirer/object relationship	• There is a disconnect or barrier between the researcher and the object being studied. • Much of this form of research is devoted to ensuring this objectivity.	• There is a connection between the researcher and the participant. • All biases are acknowledged and efforts are taken to maintain some form of distance.
The nature of 'truth statements'	• Research findings can be generalized and be context-free. • Focuses on similarities between objects of research leading to generalizations.	• Generalizations are not possible and the best that can be achieved are 'working hypotheses' that are related to a certain context. • Focuses on the difference between objects as well as similarities.

5.1.2 Mixed methods

The mixed-methods paradigm was selected for this research so that the advantages of both traditional research paradigms (rationalistic vs naturalistic or quantitative vs qualitative) could be explored in the gathering and analysis of the data collected. There is some controversy in the literature about what the mixed-methods paradigm is (Johnson, Onwuegbuzie, & Turner, 2007), as there is little consensus among many of the leading experts (Johnson et al., 2007). Definitions of 'mixed-methods paradigm' can be categorized into the following themes:

- What is mixed?
- The mixing stage.
- The breadth of mixing research.
- Why mixing is carried out.
- The orientation of the mixed-methods research (Johnson et al., 2007).

Owing to the disparity among experts about the mixed-methods paradigm, a useful framework, labelled *mixed methods social inquiry* (Greene, 2006), was developed to guide thinking about this paradigm. Greene divided this approach to mixed-methods methodology into four domains:

1. Philosophical assumptions and stances (i.e. what are the fundamental philosophical or epistemological assumptions of the methodology?).
2. Inquiry logics (i.e. what traditionally is called 'methodology' and refers to broad inquiry purposes and questions, logic, quality standards, and writing forms that guide the researcher's 'gaze').
3. Guidelines for practice (i.e. specific procedures and tools used to conduct research; the 'how to' part of research methodology).

4. Sociopolitical commitments (i.e. interests, commitments, and power relations surrounding the location in society in which an inquiry is situated) (Greene, 2006).

Based on their analysis of the contributed definitions, Johnson, Onwuegbuzie, & Turner (Johnson et al., 2007) were able to produce a general definition for mixed-methods research:

> Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration. (p. 123)

As a type of research, Johnson, Onwuegbuzie, & Turner stated that 'a mixed methods study would involve mixing within a single study; a mixed method program would involve mixing within a program of research and the mixing might occur across a closely related set of studies' (p. 123). The nature of this research project and the methods used fitted nicely into the mixed-methods research paradigm as illustrated by Greene's four domains.

In Figure 5.1, Johnson, Onwuegbuzie, & Turner (Johnson et al., 2007) continue to divide what they assert to be the three main research paradigms into subsections. These are dependent on the degree of influence exerted by the qualitative and quantitative paradigms, thus suggesting that certain types of mixed-methods research are more heavily influenced or dominated by these paradigms. They have labelled these positions on the continuum illustrated as qualitative or quantitative dominant mixed-methods research.

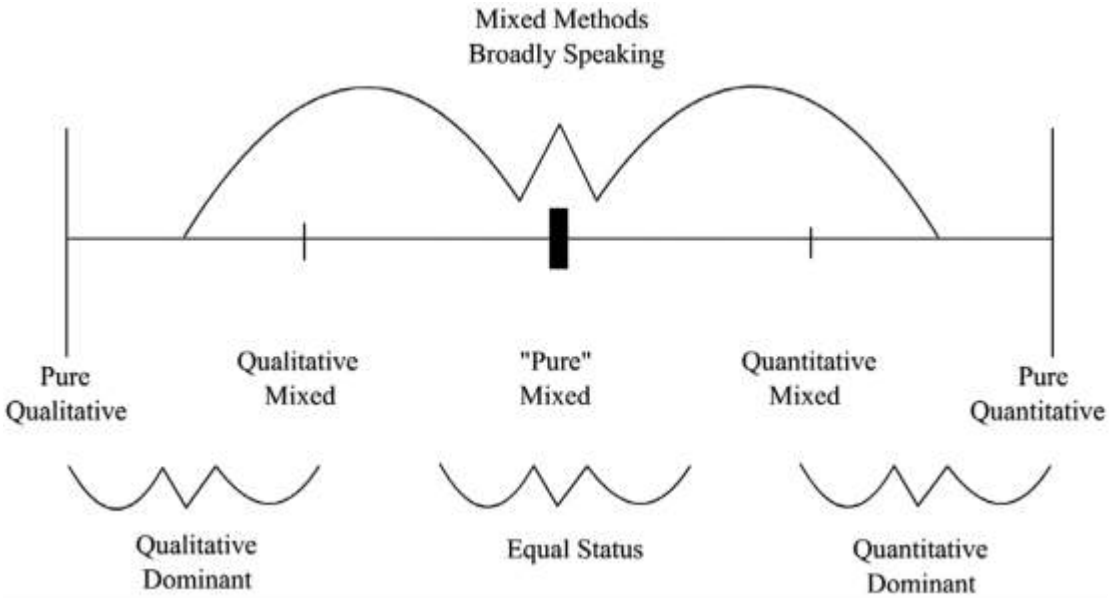

Figure 5.1: Graphic of the three major research paradigms, including subtypes of mixed-methods research (Johnson et al., 2007, p. 124)

Subsequently, Leech and Onwuegbuzie (2009) expanded on Johnson, Onwuegbuzie, & Turner's graphic depicted above, and provided a more detailed, three-dimensional typology of mixed-methods research. Their approach focuses on the design of a study based on three

dimensions of function: (i) level of mixing (partially mixed vs fully mixed); (ii) time orientation (concurrent vs sequential); and (iii) emphasis of approaches (equal status vs dominant status). This typology possibly provides a clearer understanding of the degree of influence that the two research paradigms of quantitative and qualitative methods have on the structure of the study and its subsequent analysis of data and formation of theories and potential interventions. Based on this model, the structure of this study would best fit under category (P4)—Partially Mixed Sequential Dominant Status Design, because this study was conducted by having the two major phases conducted sequentially in their entirety (the quantitative study conducted before the qualitative study) before the data were mixed at the final stages of analysis.

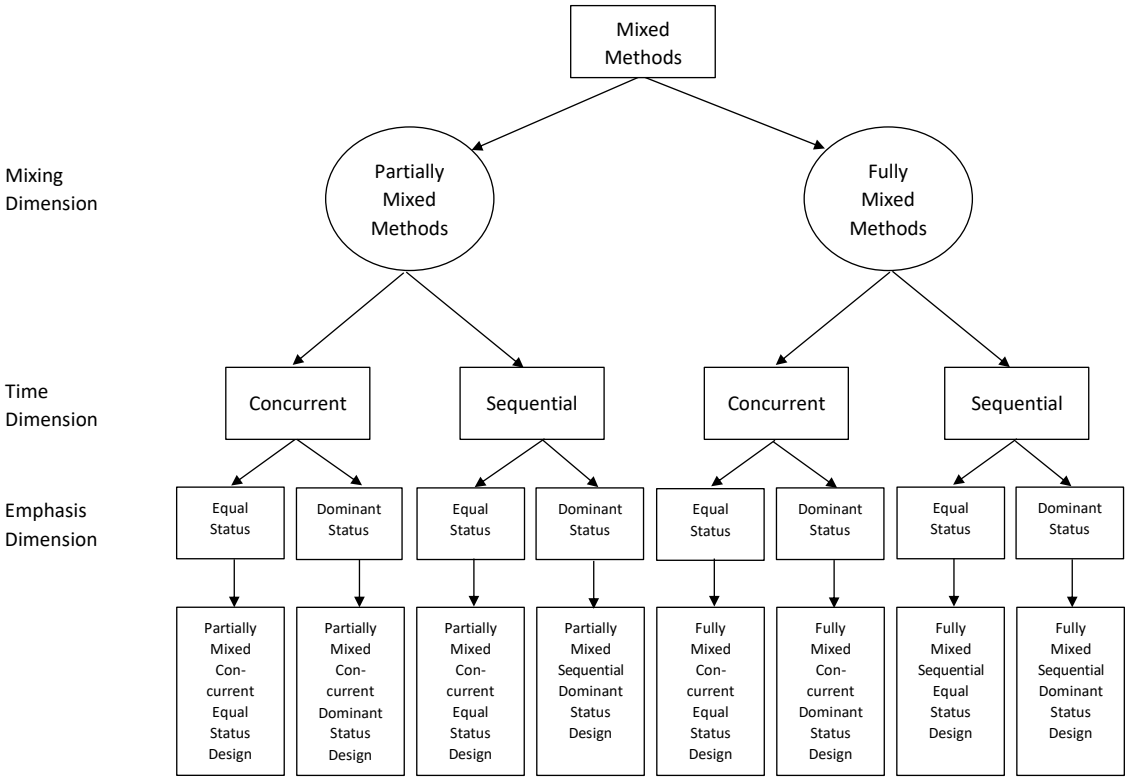

Figure 5.2: Typology of mixed methods (Leech & Onwuegbuzie, 2009)

In an additional model for structuring a mixed-methods approach (Creswell & Plano-Clark, 2011) (see Figure 5.3), the one design that most closely describes the process used in this study is the Explanatory Sequential Design. This design is predicated on the initial collection and analysis of quantitative data in an effort to answer one or more of the questions or aims of the study. This quantitative collection and analysis is then followed by the collection and analysis of qualitative data to assist with the interpretation of the quantitative data. In this study the quantitative data found in Paper 2 (Chapter 6) (Munro, O'Meara, & Kenny, 2016) assists with answering the question 'What are the demographic and qualification characteristics of the study population?' In this study the questions posed in the quantitative study were used to guide the direction of the inquiry in the qualitative study, and provided the areas of questioning, the questions posed, and the establishment of the ten higher themes.

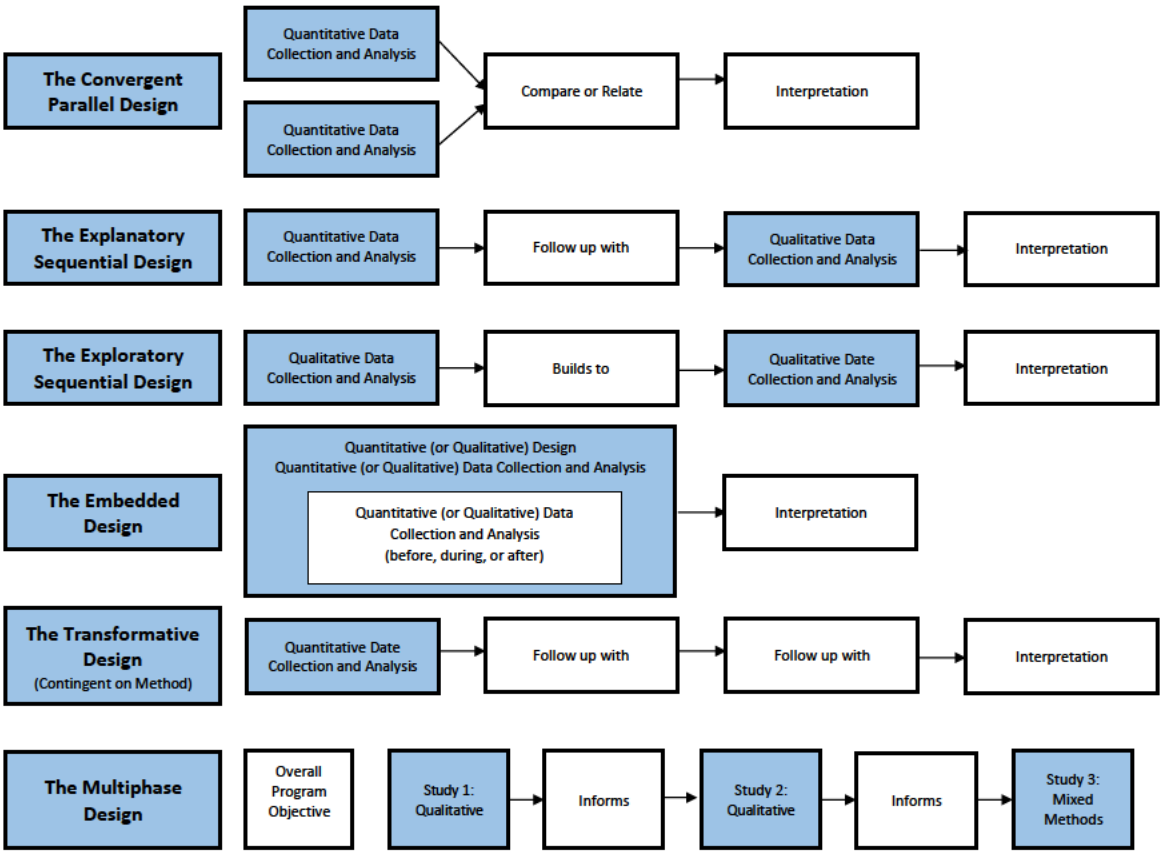

Figure 5.3: Prototypical versions of the six major mixed-methods research designs (Creswell & Plano-Clark, 2011)

Further to the above discussion on mixed-methods research designs, authors may argue that the mixed-methods paradigm is not a separate research paradigm; conversely, it is possibly a construct and element of pragmatism and postpositivism (Giddings & Grant, 2007). It has been argued in the literature (Giddings & Grant, 2007) that this positioning within pragmatism and postpositivism greatly increases the influence of the ontological and epistemological tenants of these paradigms, greatly weakening the influence of subjectivism or interpretativism in the gathering and analysis of data; in essence, on how the world is known and perceived.

For the purposes of this research, an initial quantitative survey was distributed to the wider study population of academic paramedics, as previously described, to establish the demographic and qualification characteristics of the overall sample population. Once the characteristics of the potential participant cohort were identified, the qualitative phase of the study commenced. A maximal variation sampling (Leedy & Ormrod, 2010) was conducted to ensure a breadth of personal and professional characteristics were represented in the participant group. This group was then interviewed using a semi-structured interview format to illicit a greater breadth and depth of understanding of the issues and themes associated with the transition of paramedic practitioners into the CoP of academic paramedics. A semi-structured interview allows for the interviewer to follow an interview guide, however it also allows for the exploration of additional themes that may be raised which would contribute to the richness of the data. A process called *directed content analysis* was later used to establish the predetermined codes and then to assign

data to each of the codes (Hsieh & Shannon, 2005). This will be described in more detail later in this chapter.

The results of the qualitative research of this study were published in two peer-reviewed journal articles that are located in Chapter 6—Findings.

5.1.3 Methodology—Narrative research

Qualitative Content Analysis (QCA)

The history of QCA began in the 1950s with a grounding in quantitative research, but later evolved into a method of interpreting the results of qualitative research, predominately in nursing and education (Graneheim & Lundman, 2004). Narrative-led research is seen as a term that encompasses inquiry; that seeks to situate the lived social experiences of individuals into a space of inquiry that is three dimensional: temporal, personal/existential, and place (Clandinin & Connelly, 2000; Connelly & Clandinin, 2000). This approach is most often seen by researchers as a flexible way of analysing verbal or textual data, such as interview transcripts (Cavanagh, 1997; Schreier, 2012). Others describe it as:

> the systematic gathering, analysis, and representation of people's own stories *as they tell them* [*author's italics*]. This approach allows analysing the experiences as well as the meanings, values, beliefs, and interpretations that the study participants attach to their lived experiences, and positioning them in relation to the theoretical framework guiding the investigation (Givati, Markham, & Street, 2017 p. 5).

One area with which this method has struggled has been the ability of researchers to substantiate the trustworthiness or validity of the findings. This has been, and still is, partly due to the various ontological perspectives of researchers concerning their various concepts of reality (Graneheim & Lundman, 2004; Shenton, 2004) and their research focus. Many quantitative researchers subscribe to a positivist perspective, which has concepts of validity and reliability that are not shared by qualitative or naturalistic researchers. Some researchers argue that it is difficult to provide a consensus or a set of quality criteria to qualitative research (Rolfe, 2006), mainly because there is 'no unified body of theory, methodology, or method that can be collectively described as qualitative research' (p. 305). Others state that there is no need to change the terms *validity* and *reliability* as the alternative terms often reflect the meanings of the traditional terms (Long & Johnson, 2000). The pursuit of rigour in qualitative research is seen by some as not equally applicable to all methods, with the pursuit of validity potentially undermining the method's philosophical underpinnings (Hammersley, 1992). The term *trustworthiness* was used by Lincoln and Guba (1985) as an alternative to the term(s) used in quantitative research, to illustrate that the findings of qualitative inquiry are 'worth paying attention to' (Lincoln & Guba, 1985). A common feature of many of the definitions of trustworthiness is 'that they aspire to support trustworthiness by reporting the process of content analysis accurately' (Elo et al., 2014).

To address this issue, Guba (1981) proposes terms and concepts that provide the same or similar reassurances of trustworthiness that positivists attempt to achieve in their research:

- credibility vs internal validity
- transferability vs external validity/generalizability
- dependability vs reliability
- confirmability vs objectivity.

Credibility

One of the key factors in establishing trustworthiness in qualitative research is ensuring credibility (Lincoln & Guba, 1985) or how the findings are aligned to reality. Also, one must ask whether the findings are related to the context of the research and whether the researchers found what they had intended to find (Merriam, 1998). In quantitative research, the term *internal validity* is used to describe whether the instrument or process used measured what it was intended to measure (Elo et al., 2014; Pitney, 2004). This definition is difficult to apply to qualitative research, so methods suitable to the type of research being conducted were developed. Patton (1999) lists three distinct but related inquiry elements that are essential for credibility in qualitative research:

- Rigorous techniques and methods for gathering high-quality data that are carefully analysed, with attention to issues of validity, reliability, and triangulation.
- The credibility of the researcher, which is dependent on training, experience, track record, status, and presentation of self.
- Philosophical belief in the value of qualitative inquiry; that is, a fundamental appreciation of naturalistic inquiry, qualitative methods, inductive analysis, purposeful sampling, and holistic thinking (p. 1190).

Pitney (2004) describes several methods that can be used to ensure credibility. These include triangulation, member checks, and peer review. Triangulation is the use of various methods of gathering data to ensure a level of accuracy in the findings (Brymen, 2006; Grbich, 2010). This can be achieved by drawing data from transcripts or pictures or from several participants, and from thematic analysis programs such as Leximancer or Nvivo, which then construct evidence for a code or theme (Creswell & Plano-Clark, 2011). Member-checking is a method where the researcher reviews the research findings with several of the participants to ensure accuracy of the findings or interpretations (Creswell & Plano-Clark, 2011; Pitney, 2004). Peer review can entail the use of an external researcher to examine not only the processes used to conduct the research but also the interpretation of the data (Pitney, 2004). Others argue (Houghton, Casey, Shaw, & Murphy, 2013) that analysis of qualitative research data is a personal, individual process and that no two researchers will come to the same conclusions. The purpose of peer review should be to clarify the process.

Transferability

Within the rationalistic paradigm, external validity is described as 'the extent to which the results of a study apply to situations beyond the study itself—in other words, the extent to which the conclusions drawn can be *generalized* to other contexts' (Leedy & Ormrod, 2010, p. 99). Within the naturalistic paradigm, many argue that it is not possible to generalize the findings of a qualitative study, as the study is usually specific to a small population and is situated within a specific context (Guba, 1981; Shenton, 2004). Others suggest that it is possible to extrapolate findings across broader groups (Denscombe, 1998; Stake, 1994), such as is seen with the research conducted within nursing and teaching illustrated in this study, which lends itself to comparisons with paramedicine. It is important for the researcher to provide the reader with sufficient contextual information so that the reader can make the connection between what is being presented and other similar contexts (Graneheim & Lundman, 2004; Shenton, 2004). This can be accomplished by the researcher's conducting the following processes:

- The use of purposive sampling is the selection by the researchers of participants, who are important and relevant and who represent a cross-section of the population being studied.
- Collect 'thick' descriptive data—this allows the reader to make comparisons based on context.
- Develop 'thick' description—the information provided by the researcher concerning his or her analysis should be sufficient for the readers to draw their own conclusions (Guba, 1981; Houghton et al., 2013; Leedy & Ormrod, 2010)

Dependability

Within the rationalistic paradigm, the term *reliability* is used to mean that the data or scores received from participants are stable and consistent over time (Creswell & Plano-Clark, 2011). This can be accomplished by the use of statistical formulae that ensure internal consistency. Shenton (2004) defines it this way: '[I]f the work were to be repeated, in the same context, with the same methods and with the same participants, similar results would be obtained' (p. 71). This concept is easily applied to quantitative research, but Plano-Clark (2011) advocates that this process is of limited value in qualitative research and is mostly related to 'the reliability of multiple coders on a team to reach agreement on codes for passages in text' (p. 211). In qualitative research the researchers should be providing the reader with information that will assist in understanding the methods and their effectiveness:

- The research design and its implementation—describing what was planned and executed on a strategic level.
- The operational detail of data gathering—addressing the minutiae of what was done in the field.
- Reflective appraisal of the project—evaluating the effectiveness of the process of inquiry undertaken (Shenton, 2004).

Confirmability

Confirmability is described as the process by which the researchers attempt to limit the influence of bias. This is done by ensuring the neutrality of the data as opposed to ensuring the neutrality of the researcher (Letts et al., 2007). Confirmability can be difficult to achieve as it is accepted that there will always be some admitted bias within the research process (Patton, 1999). This process of researcher-bias acknowledgement is part of a process of reflexivity, in which the researchers make statements about the degree to which personal beliefs, values, and biases may have influenced their inquiry (Creswell & Miller, 2000).

An important tool in establishing confirmability is the use of an audit trail. This process would allow someone to trace the course of the research from the descriptions of the procedures used and the decisions made by the researchers (Creswell & Miller, 2000; Patton, 1999; Shenton, 2004). Morse, Barrett, Mayan, Olson, & Spiers (2002) have challenged this belief:

> Contrary to current practices, rigor does not rely on special procedures external to the research process itself. For example, audit trails may be kept as proof of the decisions made throughout the project, but they do little to identify the quality of the decisions, the rationale behind those decisions, or the responsiveness and sensitivity of the investigator data (p. 16).

The research methodology *interpretive description* (ID), which is most appropriate for this research, is contained within the interpretive paradigm. The interpretive paradigm is based principally on the philosophy of idealism and describes a paradigm for inquiry, not a method (Guba, 1981). There are many different interpretations of this philosophy, including Berkeleyan, Hegelian, and Platonic idealism (Blackmore, 1979). In essence, idealism contends that reality is a construction of the mind, and that all physical entities are ideas (Matthews, 1969). This is in sharp opposition to the realist, objectivist, or empirico-analytical paradigm, which advocates that all knowledge is discovered and comes either from empirical processes or by observation and measurement (Ponterotto, 2002).

The interpretive paradigm can be focused further on the ontological and epistemological constructs that are most appropriate for this research. The ontological perspective most suited to this research is that of the social constructivist. This perspective embraces the belief that reality and knowledge are socially constructed, and, according to Berger and Luckmann (1985), reality exists because the individual gives meaning to it. Different cultures develop their perception of reality based on their social structures and these perceptions are seated within the context of historical and social practices (Higgs & Titchen, 1998). From an epistemological perspective, the social-constructivist approach sees knowledge as being determined by the social and historical perspectives of those producing and interpreting that knowledge, and that knowledge is constantly changing and is relative to members of that social group (McCarthy, 1996). Guba and Lincoln (1989) developed a specific set of authenticity criteria for the constructivist assumptions, and

these led to the ability to evaluate research that moved somewhat beyond the boundaries of traditional methodologies.

It is important to review the issues related to generic qualitative study methods, of which interpretive description is one of two sub-categories, the other being the descriptive qualitative approach (Caelli et al., 2003).

Generic qualitative research methods are best described as research that 'is not guided by an explicit or established set of philosophic assumptions in the form of one of the known [or more established] qualitative methodologies' (Caelli et al., 2003, p. 4). As suggested by (Lim, 2011; Litchman, 2010; Merriam, 2002) one could consider that generic studies purposefully do not adhere to any of the established methodologies; this allows the researchers to select a single methodology but then modify or deviate from its rigid structure in a way that may be beneficial to their study. Kahlke, (2014, p. 39) further illustrates this concept by stating, 'generic qualitative studies can draw on the strengths of established methodologies while maintaining the flexibility that makes generic approaches attractive to researchers whose studies do not fall neatly within a particular established methodology'. The constructs tying all generic research methods together are that these constructs all aim at understanding how the research subjects interpret, construct, or divine meaning from their experiences and the world around them (Merriam, 2002).

In the debate concerning the validity of generic qualitative research methods, there are some researchers who advocate for these methods and there are others who oppose the use of these generic methods. Some advantages of generic approaches are that they offer a fit for many studies, in that they provide the researcher with an opportunity to draw from the battery of available tools from the more established methods, which are then integrated into the research. In addition, there is a need to overcome the restrictions that the traditional methods impose, which, when accomplished, can result in new and innovative ways of conducting research (Kahlke, 2014). Chamberlain (2000) argues that an overreliance on rigid methodological rules and assumptions can be a hinderance to the critical evaluation of the researcher about assumptions at all levels. In addition, many have argued that research approaches, including those of methodology and methods, need to be informed by the research questions, and not the other way round (Annells, 2006; Caelli et al., 2003; Johnson et al., 2001; Thorne, 1991; Thorne et al., 2004).

Opponents of generic methods cite issues such as a lack of rigour or, as Atkinson and Delamont (2006) state, that generic qualitative research does 'little to acknowledge the intellectual traditions that frame such research, and obscure[s] rather than illuminate[s] the epistemological foundations of qualitative work' (p. 752). Also, it is argued that there is a lack of robust literature to support the rigour of these methods (Hunt, 2009; Thorne et al., 2004). While a third major detractor is the discussion around 'method slurring', which has been defined by Morse (1989) as 'such mixing, while certainly "do-able," violates the assumptions of data collection techniques and methods of analysis of all the methods used. The product is not good science; the product is a sloppy mishmash' (p. 4).

Although this is a very cursory illustration of the issues surrounding the debate concerning the validity of generic qualitative research methods, it can give one a sense of the reasons why interpretive description was chosen by the researchers of this study.

5.1.4 Interpretive description

The development of ID was championed from the work of a prominent nursing researcher, Dr Sally Thorne, at the University of British Columbia (Thorne, 2008). Thorne and other nursing researchers were challenged with establishing the legitimacy of the nursing discipline within the scientific and medical communities. They also sought to provide evidence not only of the benefits of the practical side of nursing, but also to seek out the evidence of nursing theories that were gathered from the experiences of practitioners and patients.

Before the development of ID, nursing and other allied health professionals were generally restricted to the traditional qualitative research methodologies that came predominately from the social sciences, namely ethnography, grounded theory, and phenomenology. Owing to the importance of context in nursing research, which it could be argued that paramedicine shares, Thorne and others began to advocate for a process that required less devotion to the rigid boundaries of these traditional methodologies. The process outlined by Thorne (2008) allowed for:

> an approach to knowledge generation that straddles the chasm between objective neutrality and abject theorizing . . . that would generate better understandings of complex experiential clinical phenomena within nursing and other professional disciplines concerned with applied health knowledge or questions ‘from the field’ (pp. 26–27).

Furthermore, the early development of ID was based on a premise that nursing research had reached a point where its intent was to ‘build methods that are grounded in our own epistemological foundations, adhere to the systematic reasoning of our own discipline, and yield legitimate knowledge for our practice’ (Thorne, Reimer Kirkham, & MacDonald-Emes, 1997, p. 172).

The use of ID allowed for the engagement and analysis of the data obtained from both phases of the study, particularly the qualitative data, without the restrictions of using the traditional methodologies. It also allowed for the utilization of a methodology that maintained the required validity and rigour necessary for this level of research. Though originally designed to meet the demands of nursing and other health-related fields, it has been successfully applied to tourism and leisure studies (Buissink-Smith & Mcintosh, 1999).

5.2 DATA COLLECTION

5.2.1 Ethics approval

Approval to conduct the two arms of the study (the quantitative survey and the participant interviews) was approved as a low-risk project on 12 June 2013 from the La Trobe University Faculty Human Ethics Committee (FEHC13/088). The demographic data were reported as de-identified profiles. Aliases were used for the quotations from participants. However, it is acknowledged that in this relatively small CoP, people may be easily identified. Therefore, every effort was made to de-identify the data as far as possible.

5.2.2 Quantitative study

A descriptive or normative survey was used to collect demographic and qualification data about the study population of Australasian paramedic academics. The descriptive or normative survey presented a list of questions to a group of volunteers and then summarized their responses in the form of percentages, frequency counts, or other forms of analysis (Leech & Onwuegbuzie, 2009). Additionally, the normative survey enabled the researcher to gather large amounts of data in a relatively short period of time, and the data were entered into an electronic database that facilitated quick and accurate presentation of the subsequent analysis (Schofield & Knauss, 2010).

A 17-item online normative internet Survey Monkey survey (see Appendix) was used to obtain demographic and qualification characteristics about the participants. The invitation to participate in this study was distributed by email to the membership of the Network of Australasian Paramedic Academics (NAPA). It was estimated at the time that there were 66 members of the Association (Maguire, B., personal communication). Non-members were also invited by word-of-mouth to participate. When potential candidates accessed the site, they were presented with a Participant Information Statement (see Appendix) that outlined the aims of the research, who was eligible to participate, a description of the process, the benefits and risks involved, the process of maintaining confidentiality, and how a candidate could withdraw from the study. A statement was also included stating that consent to participate was implied if they completed the survey.

The survey sought information in five areas: demographic data, professional qualifications, educational qualifications, learning and teaching experience, and level of academic skills. Data were collected over a two-month period in 2013 and then collated and reported utilizing the capabilities of the Survey Monkey instrument. The survey was conducted prior to the second qualitative phase of the study, thus following the Sequential Time Dimension category of the methods typology outlined in Figure 5.2 and the Explanatory Sequential Design highlighted in Figure 5.3.

A perceived limitation of the survey results was the question of what is an acceptable response rate for a survey. It was argued, based on a survey conducted by journal editors (Carley-Baxter et al., 2009), that there is no accepted standard for response rates in surveys, and that the

vast majority (96%) of journal editors surveyed either rarely or never rejected a paper because of a low response rate. So the effect of our 45% response rate to this survey is a matter of ongoing debate and discussion.

5.2.3 Qualitative study

Following the completion of the quantitative survey, 16 participants were recruited by utilizing a maximal variation sampling method (Leedy & Ormrod, 2010). Eight of the 16 face-to-face interviews with Australian and New Zealand participants were conducted in private rooms at the site of the Paramedics Australasia (PA) conference in Canberra, in October 2013. Initially, qualified candidates were approached for an interview, based on a desire to include a cross-section of participants based on age, gender, and years of experience as an academic, and on whether they were native to Australia or New Zealand, or had immigrated to take up academic positions. Any additional participants were offered an opportunity to participate through an announcement at the conference, regardless of whether they had completed the online survey or not. Subsequently, five interviews were conducted in early November at a major inland university, with selected volunteers followed by three additional interviews which were conducted at a major metropolitan university. Each participant was given a Participant Information Statement. Those who agreed to be interviewed read and signed a consent form.

5.3 DATA ANALYSIS

The anonymous, quantitative questionnaires were completed by the study population to determine the characteristics of the group. The data were collated and reported as part of the capabilities of the Survey Monkey tool. Where applicable, data were illustrated as both bar graphs and as tables showing number of responses and percentage for each response in that item. Other data were illustrated as individual responses to the specific survey item. Where measures of central tendency (means and medians) were required for reporting, these were calculated using Microsoft Excel. Because of the normative nature of the survey, no statistical-analysis programs were required.

For the qualitative data, a manual thematic analysis of the interviews was conducted, The interviews were transcribed by a paid, private transcriptionist. The transcriptionist completed and signed a Confidentiality and Intellectual Property Undertaking form (see Appendix).

A process known as *directed content analysis* is used in research projects where there is an existing theory or previous research. The researchers begin by identifying key concepts or themes as their starting codes (Potter & Levine-Donnerstien, 1999). In research projects where the data are collected primarily through interviews, as in this project, open-ended questions can be used, which are then followed with targeted questions based on the predetermined codes. In our case, the questions revolved around the ten higher codes listed in Box 5.1 below, which were developed based on a synthesis of existing theory and previous research. The process then highlights all of

the passages in the transcripts and assigns them to one of the codes. Any data that do not fit into one of the predetermined codes are placed in a 'miscellaneous' or 'other' code (Hsieh & Shannon, 2005; Humble, 2009)

A semi-structured interview process was used in which key questions were asked of all participants. The questions focused on obtaining information about the participants' experiences within the ten predetermined higher codes listed in Box 5.1. Opportunities for further exploration of ideas or content were explored through the use of open-ended, leading, and verifying questions. This provided richness to the responses and opened up new areas of discussion and analysis.

Box 5.1: Ten Higher Codes

Academia	Professional Identity
Challenges	Recruitment
Induction	Research
Mentoring	Teaching
Paramedic Experience	Transition from Paramedic Practice

The interviews lasted between 14 and 62 minutes with a mean time of 35 minutes. A thematic analysis was conducted manually, and in addition, the program Leximancer was used to provide a means of triangulation.

The areas of inquiry were formulated based on a review of the literature from other disciplines and from professional observations and experiences. This provided structure to the research process and insight into the experiences of those within the CoP of paramedicine.

Each of the participants' transcripts was read multiple times and quotes were obtained that fitted into each of the higher codes. Each of these codes, also known as *basic themes*, were then placed within one of five *organizing themes* (Attride-Sterling, 2001). These organizing themes were: CoP of Paramedicine, CoP of Academia, Entry to a New CoP, Expectations and Challenges, and Professional Identity.

The results of these research projects are demonstrated in the accompanying peer-reviewed journal articles listed in Chapter 6.

5.4 REFERENCES

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Chapter 6
FINDINGS

6.1 FINDINGS

The findings of this research are contained in four peer-reviewed, published journal articles, included in the following pages.

6.1.1 Paper 1

This article is a scoping review of the literature related to the topic of this research project.

Munro, G., O'Meara, P. & Kenny, A. (2016). Paramedic Transition into an Academic Role in Universities: A Scoping Review. *Journal of Paramedic Practice, 8*(9), 452–457. http://dx.doi.org/10.32378/ijp.v4i1.107

Paramedic transition into an academic role in universities: a scoping review

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Abstract

Objectives: In Australia and New Zealand, there is increasing demand for academically qualified paramedic practitioners to assume academic roles in university paramedic programs. However, little is known about the transition from paramedic practice to an academic role within a university. This scoping review was initiated to find any relevant literature that could answer the question, 'What is known about the transition of industry-based paramedic professionals to academic roles in universities?'

Design: This scoping review used a five-stage framework developed by Arksey and O'Malley, which identified the research question, relevant studies, study selection, charting the data and collating, and summarising and reporting results.

Data sources: Key search terms were selected to achieve the broadest acquisition of potential articles and other sources of information. The terms were used to search Medline, Cochrane, CINAHL, Wiley Online, Informit, and Google Scholar databases. The SPIDER tool was used to assist with the determination of the key search terms used in this review.

Review methods: An extensive search of titles was conducted, original articles were sourced and then inclusion and exclusion criteria were applied to select articles that were appropriate to the research question.

Results: In exploring the question: 'What is known about the transition of industry-based paramedic professionals to academic roles in universities?" no articles were deemed relevant'.

Conclusions: The dearth of literature on the transition of industry-based paramedics to academic roles within universities is a major gap but perhaps, not surprising, given that paramedicine is still moving toward professionalisation. However, as the paramedic profession matures, the demand for degree level education will increase, with an associated increase in demand for paramedic academics. Developing knowledge of transition experiences will be central to the successful recruitment of new paramedic academics.

Key words

● Academia ● Culture ● Qualifications ● Transition

Article accepted for publication 26 August 2016

In this article we present our findings from a scoping review that sought to identify what is known about the transition from industry-based paramedic professional to an academic role within universities. The position and scope of practice of paramedics is evolving (Stirling et al, 2007; Bigham et al, 2010). Traditionally, paramedicine was focused on medical and trauma emergencies within the public safety model of out-of-hospital care. This encompasses the response to medical and trauma emergencies by public safety agencies, such as ambulance services and fire brigades. However, over the last few years, there has been a trend toward paramedics having wider participation in the provision of primary health care, with community paramedic models now more prevalent (Lord, 2003; Stirling et al, 2007; Williams et al, 2009; O'Meara, 2009, 2014; Bigham et al, 2010; Evashkevich and Fitzgerald, 2014). To ensure that paramedics have the knowledge and skills to function in a rapidly changing and diversified health-care system, and different and emerging roles, there is a movement of paramedic education into tertiary education institutions. The move to universities is part of the professionalisation of paramedics, and is similar to the pathways taken by other health professional groups, notably nurses.

Wilensky (1964), states that a group or community of practice (CoP) must engage in a series of steps as they move toward professionalisation. One of the major steps is the establishment of training schools or colleges, with a connection to university education occurring within a few decades. In nursing, the move from vocational, hospital-based programmes into university degree programmes began as early as 1937 in South Africa at the University of the Witwatersrand (Horowitz, 2011). In the United States, following a shortage of trained nurses after World War II, associate degrees in nursing began

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at junior colleges (also known as community colleges), eventually spawning baccalaureate degrees in the 1960s (Mahaffey, 2002). In Australia, the transition of nurse education from hospital-based apprentice models to the higher education sector occurred in the 1980s, with full baccalaureate degrees granted in the 1990s (Madsen, 2008).

Internationally, there is wide variation in how paramedics are prepared for practice. In Australia, New Zealand, and the United Kingdom, paramedic education is situated in the university system, with graduates achieving undergraduate degrees (Black and Davies, 2005; Lord, 2003). The first paramedic undergraduate degree programme in Australia was established at Charles Sturt University in 1995 with subsequent programmes opening at Monash University the next year (Battersby, 1999; Lord, 2003). Paramedic education in Canada is primarily provided in the community college system (two-year programmes) (Pozner et al, 2004; Ontario Ministry of Health and Long-Term Care, 2014; National Association of Emergency Medical Technicians, 2014), while in the United States, it is provided across a range of institutions, with lengths of study depending on the jurisdiction and qualifications needed. United States' education models extend from basic first-responder training (80 hours) to advanced life support paramedic education in colleges, with 20 known university programmes offering paramedicine degrees. Given the relatively recent move of paramedicine to the tertiary sector, attracting qualified paramedic practitioners to pursue academic careers and fulfil their obligations to both the academy and their profession is challenging.

There is a documented body of knowledge on the experiences of nurses and teachers transitioning from practice into academic roles in universities (Hager, 1995; Korthagen et al, 2005; Trowler and Bamber, 2005; Balogun at al, 2006; Barlow and Antoniou, 2007; Martinez, 2008; Smith, 2010; Boyd and Harris, 2010; Logan et al, 2014); Findlow, 2012). Transferring knowledge and expertise from practice to academia, a focus on scholarship and the acquisition of research funding and publications, professional development within disciplines and academia, and the pressures to achieve performance measures to maintain academic positions have all been documented (Bourdieu, 1977; Anderson et al, 2002; Balogun et al, 2006; Barlow and Antoniou, 2007; Boyd, 2010; Adams et al, 2013; Logan et al, 2014). For the neophyte academic in nursing and education, being a broker between their discipline and the academy, the rise of managerialism within universities, and the challenges associated with adapting to a new professional culture and constructing new professional identities can be challenging (MacIntosh, 2003; Dison, 2004; Balogun et al, 2006; Goodson, 2007; Archer, 2008; Clegg, 2008; Cameron et al, 2009). Given the emergence of degree-level programmes for paramedicine, and the resultant increase in paramedic academics, it is unclear whether issues identified in the nursing and education literature are also faced by paramedic academics.

Background

There are shortages of qualified paramedic academics in Australia, New Zealand and the United Kingdom. The majority of paramedics recruited by universities to academic positions are not prepared with doctoral qualifications and most lack experience or track records in grants and publications (O'Meara, 2006; Jackson, 2009). To enhance recruitment, many universities in Australia and New Zealand are offering lecturer or senior lecturer positions to paramedics with the goal of meeting relatively high salaries that paramedic professionals have within practice. O'Meara (2006) and Jackson (2009) note that this has resulted in a lower level of qualifications amongst paramedic academics compared to other disciplines. Many paramedics recruited to Australia and New Zealand come from North America, the UK, and elsewhere (Munro, 2013). The impact of these individuals on the design of programme curricula, the content of subjects, and their influence on the formation of students' professional identities is currently unknown.

Refashioning the professional identity of a paramedic to become a valued member of the academy presents itself as a challenge in a competitive environment that values research capacity and output, and teaching quality. As early as 2006, leaders in tertiary, paramedic education were drawing attention to these issues (O'Meara, 2006; Williams et al, 2009).

The rationale for our study

Studies across other professional groups, such as nurses and teachers, has identified a multitude of challenges as industry-based professionals make the transition to academic roles within universities. As paramedicine develops further along the professionalisation trajectory, the proliferation of paramedic university programs will increase. Recruiting experienced paramedics from industry positions to academic roles is central but challenging, as individuals have well-developed industry careers with relatively high levels of remuneration. The increasing need for academics to teach and conduct research in paramedic programmes prompted our scoping review. Our aim was to identify research conducted about paramedics making the transition from paramedic

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Table 1. Inclusion and exclusion criteria

Criterion	Inclusion	Exclusion
Time period	January 1995 and November 2013	Any study outside these dates
Language	English	Non-English
Type of article	Original research article published in a peer-reviewed journal	Any article that was not original and/or unpublished
Study focus	Paramedic transition into academia	No reference to paramedic professionals move into academia
University	An undergraduate or graduate degree	Not an undergraduate or graduate degree
Geographical location of study	Australia, New Zealand, United States and/or United Kingdom	No reference to universities in Australia, New Zealand, United States and/or United Kingdom
Population and sample	Paramedic academics	Non-paramedic academics

practice into academic roles in universities. Through identifying what was known about this transition, our aim was to develop insights that could be used for developing strategies to strengthen academic recruitment and socialisation of paramedics into future academic leadership positions.

Methods

Study design

The method for our scoping review is based on the work of Arksey and O'Malley (2005) and Davis et al, (2009). Scoping reviews are effective in obtaining a preliminary assessment of the scope of available literature, thus providing conceptual clarity on a given topic (Kenny et al, 2013). Unlike systemic reviews, all types of study designs are utilised and the focus is not on the quality of the study, rather identifying what has been written (Arksey and O'Malley, 2005; Davis et al, 2009). Arksey and O'Malley propose a five-stage framework for scoping reviews to enable replication and strengthen methodological rigour. The five stages include; identifying the research question, identifying relevant studies, study selection, charting the data and collating, summarising and reporting the results.

Table 2. Key search terms using the SPIDER tool

SPIDER Tool	Search terms
S	("paramedic" OR "EMT" OR "ambulance") AND ("academic" OR "lecturer" OR "educator")
P of I	("transition" OR "entry" OR "induction") AND ("academia" OR "academy" OR "university")
D/E/R	("qualitative" OR "quantitative" OR "mixed-method" OR "case study" OR "cohort study")

Identifying the research question

To assist with the search process, broad parameters were ascribed to the definitions of key search terms in an attempt to 'generate breadth of coverage' (Arksey and O'Malley, 2005). The question; 'What is known about the transition of industry-based paramedic professionals to academic roles in universities?' was developed to encompass as wide a scope of potential literature as possible.

Identify the relevant studies

In an effort to streamline the search process and to utilise time and resources economically, inclusion and exclusion criteria were developed. A model utilised by Kenny et al, (2013) was used to develop the criteria for the search.

A challenge for researchers is identifying available methods used to develop a search strategy. One method developed by Kable et al (2012) uses a systemic approach for documenting a search strategy. It provides a clear, 12-step approach that focuses on a rigorous evaluation of the literature, rather than a more narrative approach that is not widely accepted by journals today. The traditional PICO method for developing a search strategy was originally constructed for predominately quantitative or epidemiological study searches (Cooke et al, 2012). The SPIDER tool (Cooke et al, 2012) was developed to enable qualitative researchers to more effectively search databases for documents that were relevant to their areas of interest. The SPIDER tool was used to assist with the determination of the key search terms used in this review.

The term paramedic refers to all levels of out-of-hospital (OOH) providers of emergency medical care delivered by a public safety agency (Paramedics Australasia, 2012). The term EMT or Emergency Medical Technician is widely used, particularly in the United States, to describe a provider of OOH emergency medical care at a basic level (Harris et al, 2006). The term ambulance refers to any public safety agency that provides Emergency Medical Services (EMS) utilising specially equipped transport vehicles National Association of Emergency Medical Technicians, 2016).

Key search terms were selected to achieve the

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broadest acquisition of potential articles and other sources of information. The terms were used to search Medline, Cochrane, CINAHL, Wiley Online, Informit, and Google Scholar databases.

Study selection

When using all key search terms, over 40,000 articles were returned. This number made a complete search of all articles difficult. When an extensive search of titles was conducted, original articles were sourced and then many were excluded because they pertained to nursing, education, or professions other than paramedicine. Those that did involve paramedics or paramedicine had a subject or focus on clinical or epidemiological outcomes, on the education of paramedics, and the movement toward professionalisation. These were excluded. There were only two articles, published in Australia that focused on paramedic academics that taught at a tertiary level. One was by O'Meara, an editorial in *Journal of Emergency Primary Health Care* in 2006, and the other a report by Willis et al (2009). Both of these documents explored the issues of developing and recruiting paramedic academics in the tertiary setting in Australia and the 2009 report made some observations based on personal interviews and discussion with an expert panel. The editorial by O'Meara was excluded because it did not meet the inclusion criteria of being an original research article published in a peer-reviewed journal, and the paper by Willis et al (2009) was excluded because the original focus of the report was not on the research topic and information presented was tangential. When the number of key search terms was reduced to using 'paramedic' and 'academic', no articles were returned by any of the databases.

Data charting and collation

The fourth stage of the Arksey and O'Malley framework is that of describing the charting process. This is done by summarising each article by documenting the information pertaining to author, year, location, study design, methods, and sample. As there were no articles accepted based on the inclusion/exclusion criteria this process did not occur.

Summarising and reporting finding

The final stage of the Arksey and O'Malley framework is to provide an overview of the identified articles that were relevant to the research question. Again, as there were no articles accepted this process did not occur.

Results and discussion

In exploring the question: 'What is known about the transition of industry-based paramedic professionals to academic roles in universities?' no articles were deemed relevant.

In adhering to the inclusion/exclusion criteria, the editorial by O'Meara was excluded because it was an editorial and did not report findings of research. The report by Willis et al (2009) was a peer-reviewed report that had been funded by the Australian Learning and Teaching Council (ALTC). It was a collaborative research project that involved the nine Australian universities that were running undergraduate paramedicine programmes at the time and the Australian College of Ambulance Professionals (ACAP). The aims of the study were to determine what could be learned from international pre-hospital service providers, paramedic professional bodies, universities, and the literature, in an attempt to construct meaningful improvements in the Australian paramedicine tertiary education programmes. In addition, a framework for the establishment of a network of paramedic academics was proposed to foster the recruitment and development of paramedic academics in Australia. Some general issues concerning the recruitment and development of paramedic academics were discussed, but not to any substantial depth. Given the absence of literature on paramedic transition to academic roles in universities, there is clearly a knowledge gap.

The dearth of literature on the transition of industry-based paramedics to academic roles within universities is a major gap but perhaps, not surprising, given that paramedicine is still moving toward professionalisation. However, as the paramedic profession matures, the demand for degree level education will increase, with an associated increase in demand for paramedic academics. Developing knowledge of transition experiences will be central to recruitment to ensure that paramedics have a good understanding of what the role will entail. Knowledge on transition will be important in ensuring that orientation, and socialisation processes are tailored to ensure those paramedics recruited are retained, and become future academic leaders. Developing strong academic leadership and a research base, developed through rigorous, high quality research is important for the development of the profession.

With a dearth of knowledge on paramedic transition, the development of recruitment and retention strategies is difficult. However, as the knowledge base is developed there may be some useful learning that can be drawn from the nursing and education professions as the path to professionalisation has been quite similar. New academic nurses bring with them a culture and standards of their clinical profession. They have

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Key points

- Transferring knowledge and expertise from practice to **academia**, a focus on scholarship and the acquisition of research funding and publications, professional development within disciplines and academia, and the pressures to achieve performance measures to maintain academic positions have all been documented.
- For many paramedic academics, who have been employed because of their extensive professional knowledge, experience, and expertise, the **culture** of academia is confronting.
- Knowledge on **transition** will be important in ensuring that orientation, and socialisation processes are tailored to ensure those paramedics recruited are retained, and become future academic leaders.
- The majority of paramedics recruited by universities to academic positions are not prepared with doctoral **qualifications** and most lack experience or track records in grants and publications.

developed high levels of professional capital within nursing that does not transition well into established cultures within academia. This is supported by Bourdieu's (Moore, 2008) concept of the restricted transportability of high cultural capital from one field to another. As university academics, nurses struggle with a conflict of expectations, in which their students expect them to be nurses, but their employers expect them to be researchers first and good educators second (Findlow, 2012).

For many school teachers leaving the classroom to take up academic roles in universities, there are many changes to their work environment. They are leaving a classroom of new learners (children) and confronting a heterogeneous student body of school leavers and adult learners. They are experiencing a new level of autonomy in the workplace that is one of individual responsibility and self-reliance. The pressure to conduct research and to produce publications is new, along with the link that this has to their performance evaluations, the maintenance of their positions, and to future promotion (Balogun et al, 2006; Martinez, 2008; Cameron et al, 2009). New nursing academics receive little to no education or preparation on how to be an academic. This is received with various degrees of success after entering the academy (MacIntosh, 2003). What is not known is if these same issues, along with others, confront paramedic practitioners when they transition into academic roles in universities.

Limitations

Limitations to this review were that articles were selected from English language-only databases, and did not explore the potential literature that may have been available elsewhere. In addition, because of the numerous articles that appeared based on the selection criteria, some may have been missed due to the volume, but it was determined that because the field is relatively new, there was little chance of finding directly related articles.

Conclusions

The lack of any pertinent literature concerning the issues that paramedic professionals are confronted with when transitioning into academic roles within universities in Australia and New Zealand, demonstrates the need for further study in this area. The number of paramedicine programmes is increasing and the pool of qualified, Australasian, paramedic academics is small and does not appear to be growing despite the fact that paramedics have been graduating from undergraduate paramedicine programmes for 20 years. The lack of suitable candidates has forced many of the programmes to recruit internationally. This movement of academically qualified paramedics from predominately North America and the United Kingdom, has presented additional challenges and issues for both the new academics and the institutions that are employing them. An understanding of the many issues confronting paramedics transitioning into academia will lead to the development of frameworks for the recruitment, induction, socialisation, and professional development of qualified paramedics embarking on careers in academia.

Conflict of Interest: None of the authors have any conflict of interest to declare.

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6.1.2 Paper 2

This article is a review of data collected from an online demographic survey of the study population.

Munro, G., O'Meara, P. & Kenny, A. (2016). Paramedic Transition into an Academic Role in Universities: A Demographic and Qualification Survey of Paramedic Academics in Australia and New Zealand. *Irish Journal of Paramedicine*, *1*(2). http://dx.doi.org/10.32378/ijp.v1i2.17

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RESEARCH

Paramedic Transition into an Academic Role in Universities: A Demographic and Qualification Survey of Paramedic Academics in Australia and New Zealand

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Abstract

Objectives

To identify the demographic and qualification characteristics of paramedic academics holding teaching and research positions at universities in Australia and New Zealand offering entry-level undergraduate or postgraduate degree programs in paramedicine.

Methods

A 17 item online normative internet survey was used to obtain demographic and qualification characteristics about the target group. The survey was divided into five categories: demographic data, professional qualifications, educational qualifications, learning and teaching experience, and level of academic skills. Data were collected over a two-month period in 2013 and then collated and reported utilising the capabilities of the Survey Monkey program.

Results

Of the estimated 66 eligible participants, 30 responded to the survey, 70% were male, the average age when entering academia was 43 years, and the average age when initially entering paramedicine was 23 years. Two-thirds completed their paramedic training in Australia and New Zealand, with the other third training in the UK, US, or Canada. There was a wide-range of levels of training and qualification reported with three having a PhD on entering academia, while most had little to no experience in research, academic writing, and publication.

Conclusions

Issues of the transference of cultural and professional capital from one community of practice (CoP) into another, the variance in the levels of academic qualifications amongst paramedics when entering academia, and the resources needed to mentor and educate a large majority of these new academics pose significant challenges to new academics and the universities employing them.

Keywords: *paramedicine, university, degree, transition, role*

Introduction

In this article we present the results of a survey of paramedic academics employed in Australian and New Zealand universities. The number of universities offering paramedicine degree programs is growing, and creates demand for qualified practitioners to assume academics roles. The results of this study indicate that most of those entering academic roles are underqualified to meet the traditional expectations of universities and there exist a number of challenges for paramedic academics and the institutions employing them. Little is known about the transition of paramedic practitioners into academic roles in universities. This study addresses this gap.

Paramedic Education

The discipline of paramedicine is relatively new compared to other more established healthcare disciplines, such as medicine and nursing. Universities provide undergraduate and postgraduate degree programs in Australia and New Zealand, where paramedic education has been situated in the university sector since 1995.(1) The Ambulance Service of New South Wales provides a vocational training pathway for entry as an alternative to graduate entry.(2) The employee then graduates with a Diploma in Paramedical Science after three years. The longevity of this pathway is unknown.

In its move toward official recognition as a registered health discipline in Australia and New Zealand, the quality of education and training in paramedicine at tertiary institutions must meet industry standards, that in Australia are jointly administered by the Council of Ambulance Authorities (CAA) and Paramedics Australasia (PA).(3) In the United Kingdom (UK), where professional registration has been in place since 2000 (4), paramedic education standards are set by the Health and Care Professional Council (5) and the College of Paramedics.(6) With the increase in the number and size of paramedicine programs in Australia and New Zealand, with six programs in existence in 2006 (7) to 19 in Australia and two in New Zealand as of 2016 (8), there is a high demand for academically qualified paramedics to assume teaching and research roles. A major challenge for both the universities and the paramedics is the demand by

many of the universities that candidates for fulltime, lecturer positions have a PhD or are actively working toward a PhD, as a condition of employment.

The Paramedic Association of Canada has recently released proposed changes to the way in which paramedics will be educationally prepared for entry-level practice. As part of the Canadian vision, the Association is advocating for all paramedic education to be at baccalaureate level by 2025.(9) In the Republic of Ireland, graduate diploma-level post-employment courses, as well as Master of Science degrees in Emergency Medical Services, are being offered at the University College Dublin (UCD).(10) They are planning to offer a baccalaureate degree in paramedicine at a future date to be determined. The University of Limerick has commenced a four-year undergraduate degree program in 2016 along with an online honours degree for experienced paramedic practitioners.(11) Our findings will assist in the development of tertiary education for paramedics internationally, providing universities and potential paramedic academics with insights into some of the issues that may confront them, particularly those related to recruitment and preparation of future academics involved in university paramedicine programs.

The Transition to Academic Roles

There are many challenges that confront professional practitioners who transition to academic roles within universities. These challenges are arguably the result of new academics being under-qualified and underprepared for their future roles. These characteristics impact on their level of academic appointment, induction and mentoring, performance management requirements, expectations of research and publication output, and professional development.(12) The existing literature largely deals with the experiences of those transitioning from nursing and teaching positions into academic roles in universities.(13-22) It is unclear whether paramedic practitioners experience similar issues.

The demographic and qualification characteristics of paramedic academics are unknown and a greater understanding of the makeup of this group would assist universities and the members of the paramedic academic community of practice (CoP) to facilitate the successful recruitment and transition of new academics. Our aim was to identify the demographic and qualification characteristics of paramedic academics holding teaching and research positions at universities in Australia and New Zealand offering entry-level undergraduate and postgraduate degree programs in paramedicine.

Methods

This study used a 17 item normative internet survey through Survey Monkey (Sydney, Australia®).

The target population consisted of all paramedic - qualified individuals holding academic positions in universities offering entry-level undergraduate or postgraduate degree programs in paramedicine in Australia and New Zealand. They were contacted by email to participate in the survey using the membership list of the Network of Australasian Paramedic Academics (NAPA). The membership of NAPA is currently restricted to fulltime lecturers in paramedicine degree programs in Australia and New Zealand and is a Special Interest Group (SIG) of Paramedics Australasia.(23) Non-members of NAPA were contacted through email and word-of-mouth by NAPA members. Reminders were sent out by email through the NAPA mailing list one-month following the original request for participation. It is estimated that there were 66 members in NAPA at the time of the survey, based on the email list for the group.

A search failed to identify any surveys that identified the demographic and qualification characteristics of paramedics in academic positions in Australian or New Zealand universities. As there was no previous validated survey instrument, the survey questions were initially developed by the researchers, then piloted with five individuals with similar backgrounds to the participant population outside of the target geographic region of Australia and New Zealand. Revisions were made to the survey before it was made available via the Survey Monkey website.

Data were collected over a two-month period in 2013. The survey consisted of an electronically-based questionnaire (Survey Monkey) with 17 items requesting responses. All items were designed as forced responses with no provision for "other" responses. The data were stratified into five groups; demographic data, professional qualifications, educational qualifications, learning and teaching experience and level of academic skills. All participants were presented with an information sheet that fully described the nature of the research and the conditions of participation, along with a consent form. By accessing and attempting to complete the questionnaire, they gave their consent on the date of access. A link to the survey was provided for the participant to access anonymously.

This study received ethics approval from the La Trobe University, University Human Ethics Committee Approval No: FHEC13/088.

The data were collated and reported as part of the capabilities of the Survey Monkey tool. Where applicable, data were illustrated as both bar graphs and by number of responses and percentages for each response in that item. Other data were illustrated as individual responses to the specific survey item. Any data that required means and medians for reporting were calculated by using Excel (Microsoft, Redmond, Washington). Because of the normative nature of the survey no statistical analysis software programs were required.

Results

Response Rate

The number of paramedic academics that are employed in universities offering undergraduate paramedicine degrees in Australia and New Zealand is unknown. An estimate was made that the potential study population was 66 paramedic academics, based on the number of members of The Network of Australasian Paramedic Academics (NAPA) on the email contact list. It is unknown how many potential participants were not on the NAPA list. At the end of the data collection period, 30 participants had completed the survey, providing a response rate of 45%.

Seventy percent (n=30) of the respondents were male, reflecting the current gender profile of the paramedic practitioner workforce in Australia and New Zealand which is 68% male and 32% female(24). The percentage of female paramedics in the 20 – 29 age group is 53% and growing, which is reflective of the changing demographic profile of the profession, which was predominately male until the mid-1980s.(24) The ages ranged from 28 to 56 with the median age being 43 years. The six age groupings and their data are illustrated in Table 1. The mean age when the participants entered the profession of paramedicine and the mean age of the participants at the time of the survey, equates to a mean time of 20 years of involvement in paramedicine before becoming an academic.

Table 1. Demographics

Variable	Value
Male n (%)	21, 70%
Age in years (mean, median)	43, 43
Age by category n (%)	
25-29 years	1 (3)
30-44 years	2 (7)
35-39 years	3 (10)
40-44 years	11 (37)
45-49 years	6 (20)
50-55 years	6 (20)
Age not reported	1 (3)
Median age (in years) at which respondent entered the profession	23

For the participant population, 67% (n=30) entered the paramedic profession in Australia and New Zealand. The remaining 23% began their careers in North America or the United Kingdom. The remaining 10% were non-respondents.

As there are no clear, internationally recognised definitions of paramedic qualifications or role descriptions, the levels of paramedic qualification used were obtained from the Paramedics Australasia document, Paramedicine Role Descriptions.(25) An Emergency First Responder is someone that has received accredited training in Advanced First Aid and usually responds prior to the arrival of more highly-trained emergency personnel. Primary Care Paramedic, Advanced Care Paramedic, or Paramedic is a healthcare professional who provides rapid response and a higher-level of assessment and treatment in the out-of-hospital environment. Presently, the entry to practice qualification in Australia and New Zealand is a Bachelor Degree in Paramedicine, with New South Wales still offering a vocational entry pathway in addition to the degree entry pathway. The Critical Care or Intensive Care Paramedic has a more advanced scope of practice which encompasses advanced resuscitation and treatment modalities. They may function in a land-based ambulance service or provide critical care retrieval services in a flight environment. The present qualification in many states is a Master Degree in Intensive Care Paramedicine. The category of Special Teams was included because of the potential number of participants that practiced in North America. Special Teams are comprised of paramedics that receive specialized training in Tactical Paramedicine (work with Police and/or Military tactical teams), and Chemical, Biological, Radiological, and Nuclear (CBRN) teams to name two. These specialized teams have yet to be formalized in Australia and New Zealand. Each of these definitions and qualifications vary according to the state or country. The length and type of their entry-level training, the location of their paramedic experience, and the level of scope of practice is illustrated in Table 2.

Table 2. Paramedic qualification and experience

Variable	Value n (%)
Location of paramedic system where initial training obtained	
Australia	20 (67)
United Kingdom	1 (3)
Canada	3 (10)
USA	3 (10)
No response	3 (10)
Length of entry-level training	
<6 months	7 (23)
6-12 months	5 (17)
1-2 years	4 (13)
3 years or greater	14 (47)
Type of entry-level training	
In-house vocational	16 (53)
College vocational	10 (33)
University diploma	3 (10)
University degree	1 (3)
Paramedic system where majority of experience gained as a paramedic	
Urban city	23 (77)
Urban/rural fringe	3 (10)
Rural	3 (10)
Remote	0
Military	0
Industrial	0
Air ambulance	1 (3)
Level of paramedic certification obtained	
Primary care paramedic	1 (3)
Advanced care paramedic	10 (33)
Critical care paramedic	14 (47)
Special teams	0
No response	5 (17)

The level of postsecondary education prior to entering academia is profiled in Table 3. This data contributes to the discussion of the influence of their experience in academia as a student to their perceptions and expectations of their role as a new academic in a university.

Table 3. Education

Variable	Value n (%)
Level of post-secondary education completed prior to entering academia	
None	1 (3)
College	1 (3)
Undergraduate degree	9 (30)
Graduate Diploma	5 (17)
Master's Degree	10 (33)
Doctorate/PhD	3 (10)
No response	1 (3)
Mode of tertiary education	
Full time/on-campus	6 (20)
Part-time/on-campus	11 (37)
Distance/online	11 (37)
No response	1 (3)

Table 4 depicts the level of instruction/teaching experience the participant had prior to entering an academic role in a university. This contributes to the discussion surrounding the type of learning and teaching experience the participant had in comparison to the methods and expectations of tertiary learning and teaching. In addition, Table 4 depicts the participant's average years of clinical practice before becoming involved in instruction/education.

Table 4. Learning and Teaching Experience

Variable	Value n (%)
Involvement in training/education prior to first position as part-time/full-time academic	
CPR/First Aid Instructor	10 (37)
Sessional instructor in vocational programme	13 (48)
Sessional instructor in tertiary programme	10 (37)
Full-time instructor/trainer	15 (56)
**Some participants responded more than once to some of the questions.*	
Years of paramedic experience before pursuing any educator role	
Mean	8
Median	10

Table 5 details participants' levels of qualification and experience in each of those academic skills categories that universities expect of novice academics. These data are particularly relevant to the discussion about levels of academic appointment, issues related to induction and mentoring, performance management requirements, and professional development.

Table 5. Academic Skills

Variable	Value n (%)
Level of experience in research before entering academia	
None	11 (37)
Participant	9 (30)
Member of investigation team	5 (17)
Chief investigator	3 (10)
Higher education qualification	8 (27)
Level of formal education in research before entering academia	
None	9 (30)
Self-taught	1 (3)
Undergraduate subject	4 (13)
Postgraduate subject	11 (36)
Research qualification	4 (13)
No response	1 (3)
Level of experience in academic writing before entering academia	
None	5 (18)
Self-taught	4 (13)
Undergraduate	7 (23)
Postgraduate	13 (43)
Doctoral/PhD	1 (3)
Experience in journal/book publication before entering academia	
None	20 (67)
Co-author	5 (17)
First author	6 (20)
Number of publications prior to entering academia	
None	21 (70)
1-3	8 (27)
3-5	1 (3)
> 5	0
**Some participants responded more than once to some of the questions.*	

Discussion

The path taken by paramedics when entering academic roles in universities is strewn with challenges and obstacles. While these transition experiences are not unique to paramedicine, there is little to no knowledge of their experiences.

The traditional role of the academic is to provide transference of knowledge and cultural tradition through formal and informal teaching and learning, as well as conducting research into their discipline and expanding the foundation of knowledge through publishing in peer-reviewed journals and other media. In addition, they are role models and mentors to the students who assist them with their entry into their respective community of practice (CoP).(26)

The demographic profile of paramedic academics in this study closely resembles that of the paramedic workforce in Australia and New Zealand.(24) One advantage is that this provides paramedicine students in university programs with a realistic representation of the workforce they will enter following graduation. This type of role modelling has been

shown to have a substantial influence on career choices, particularly for underrepresented groups such as women.(27)

For most students, their first exposure to the culture of paramedicine is obtained during their initial time spent in the classroom with academics and instructors prior to being exposed to practicing clinicians during field placements in paramedic services. This is the time when the effect of mentorship and role modelling can have its greatest impact. (28) The importance of this timeframe is demonstrated by Gibson (28), where he explores three major aspects of positive role models. First, students are able to perceive that they are similar in some aspects to the role model, which provides a level of satisfaction. Second, the role model can provide role-expectation information, standards of performance and expertise of skills that can contribute to Bandura's concept of self-efficacy.(29) Third, a role model can exemplify what the novice can possibly accomplish, after attaining prominence within the CoP. These aspects are all part of the early development of a student's emerging professional identity.

Australia and New Zealand have been graduating degree-qualified paramedics since the first undergraduate program was started at Charles Sturt University in 1995.(1, 30) Subsequent programs have evolved over the past 20 years, yet there remains a dearth of academically qualified paramedics willing to move from clinical practice into academic roles in universities. This has necessitated the recruitment of qualified paramedics from overseas to fill some of the growing demand in Australia and New Zealand (see Table 2).

With approximately 25% (n=30) of participants teaching into degree programs in Australia and New Zealand coming from outside of the region, important questions need to be asked about the positive and negative transference of paramedic culture, methods, practices and principles that overseas academics bring with them to paramedic programs in Australia and New Zealand. If students acquire their first exposure to the culture of paramedicine at university, what impact do these academics have on the formation of the students' professional identity? Wenger's concept of community of practice (CoP) would describe these students as legitimate peripheral participants (LPP); novices that remain on the outside of the community of practice with the aim of moving into the core of the CoP by attaining experience, knowledge, and acceptance (26), otherwise known as professional capital.(31) In relation to the international paramedic academic, the impact of differences in clinical practice, the philosophy of practice or ethos, and other principles that exist between their home cultures or CoPs and the cultures and CoP of paramedicine in Australia and New Zealand is unclear. More importantly, potential challenges to the international academic teaching in a paramedicine program needs investigation.

The reason that universities recruit internationally is possibly related to a desire to bring 'richness' and a difference in perspective and experience to the courses offered. In research conducted on the culture of universities in the UK, Kim (32) argues to the contrary:

...the contemporary condition and pattern of transnational academic mobility is shaped by neoliberal policy and market-framed research competitions. The international recruitment of academics in universities is mainly for research and research assessment exercises in the UK, and certainly not for 'interculturality' in higher education (32, p.396)

With the increasing focus by Australian universities on obtaining research funding, conducting research and the resulting publications that ensue, if the focus of Australian universities is similar to those in the UK, then the recruitment of paramedic academics without research and publication experience seems to be counterproductive to the forces that drive academic output. Additionally, it might be a threat to the continuing viability of paramedicine programs in 'elite' universities that often have strong policies to only recruit academic staff with doctoral-level qualifications. As the data reveal, 67% of participants had no prior experience of involvement in academic publications and 70% had no publications of their own.

This suggests that universities may have difficulty recruiting enough qualified paramedic academics to deliver their programs and to satisfy other scholarly objectives. A radical change in the structure and delivery of some paramedicine programs may be indicated, with a core group of academics assuming the traditional roles of research and publication while providing supervision, oversight and mentoring of a greater number of sessional teaching staff. Another option being utilised is that of joint appointments seen in medical and nursing programs in which academics continue to work in practice while holding part-time or sessional positions at the university. These models provide economic savings to the universities while providing students with exposure to experienced practitioners as positive role models.

It has been estimated that the average amount of time needed to bring a novice academic with little to no experience to independent performance in a university is seven years. (33) Universities need to be aware of this issue and if they wish to employ academics from the professions that are lacking a sufficient number of academically qualified practitioners, then considerable resources need to be dedicated to mentoring and developing these individuals to bring them to expected levels of performance.

Aside from teaching knowledge and skills, there is an expectation from universities that academics will have the necessary skills to begin the core duties of an academic on commencement of employment. The data in Table 5 demonstrates that a large majority of paramedic academics beginning academic roles in paramedicine programs in Australian and New Zealand universities did not have the

requisite skills required to permit them to start meeting performance expectations within the first year of their employment.(21) Due to these deficits, many new academics required a considerable amount of time and resources to enable them to acquire these necessary academic skills, such as research, academic writing, and publishing in peer-reviewed academic journals and textbooks. There may be a correlation between these challenges and the relatively high-rate of turnover of paramedic academics at Australian and New Zealand universities.

Universities have expectations that new academics bring a certain level of expertise with them concerning the pedagogical approaches utilised in universities. In this study we found that the majority of participants acquired their knowledge and experience in teaching and learning within the vocational education sector (Table 4). Thus, many bring with them the skills and concepts learned in their vocational educational experience as well as the methods utilised when they may have attended university. This is of concern when the belief is that most teachers teach the way they were taught, bringing with them good and bad methods and attitudes.(34) The extent to which their own learning experiences influence their ability as paramedic academics to adapt to and implement pedagogies associated with centres of higher learning need to be explored. This issue is partially addressed by universities, in that they require most new academics to undertake some form of course work into the principles of university learning and teaching, but the depth varies between institutions.

Academics teaching in paramedicine programs in Australia and New Zealand constructed their perceptions of academic culture and process in various ways. The data in this study indicate that most academics teaching into paramedicine programs in Australia and New Zealand obtained their degrees by attending university in the traditional way as young, fulltime, on campus students. However, it should be noted that a considerable percentage of them (39%) acquired their degrees, and ultimately, their construct and perceptions of academia "from their dining room tables" through online or distance education formats as mature-aged students, having spent various numbers of years within their profession. The issues confronting both groups of academics are documented in the literature for other health professions (21), but the impact on paramedic professionals transitioning into academic roles in Australian and New Zealand universities is unknown.

There has been discussion over the past ten years that some of the reasons that paramedics are not entering the academy is that salaries and benefits in the paramedic services are superior to those in universities.(35) Other arguments are that university appointments are unattractive when fixed-term contracts of one or two years are offered and when a post-graduate degree or PhD is an essential or desired qualification for relatively junior appointments. Some universities are mitigating these issues with offers of teaching focused positions, thus modifying the requirements for post-graduate qualifications and the need to demonstrate research and publication outputs.(36,37) These issues pose the question of why an academically gifted paramedic would leave a position of relative security to take on a role that is relatively insecure from a financial and professional perspective.

Even though Australia and New Zealand have a relatively high number of degree-qualified paramedics, there is limited evidence that universities or paramedic services are providing consistent and accessible avenues for professional development in an effort to assist those with a desire to upgrade their qualifications to post-graduate or doctoral levels before being recruited into academic roles. This raises the question of where the responsibility lies for the development of the paramedic academics of the future.

A dialogue between major stakeholders in the profession needs to take place to try and find a reasonable structure to facilitate professional development and career paths for those seeking to transition into academic roles. Possible avenues to explore would be to provide aspiring academic paramedics with academic professional development programs such as the program trialled at the University of Tasmania's Sydney campus in 2015/2016. Sessional tutors were mentored by academic staff and provided with learning materials and seminars on principles of adult learning, effective lecturing, debriefing of students engaged in simulated learning environments, and opportunities to conduct lectures with both written and verbal feedback provided by experienced academics. Anecdotal feedback from students, the sessional staff and academics was very positive indicating an increase in engagement from both sessional staff and students, an increase in satisfaction of the experience by the tutors due to more formal structure in the delivery of subject materials and a heightened sense of professionalism. Learning and teaching grants are available to provide support to the tutors who wish to pursue additional educational development opportunities. Further consideration is being given to exploring joint appointments and giving better qualified tutors opportunities to develop and deliver entire subjects under academic supervision. An additional benefit would be exposure to the culture of the university regarding research, publication and learning and teaching expectations.

Limitations

The survey instrument used in this study was constructed with forced-response questions that aimed to limit the responses available, thus forcing some participants to provide answers that may not have been an accurate description of their response.(38) In some of the questions, participants provided more than one answer thus skewing the results. Because the total number of paramedic academics working in paramedicine programs in Australian and New Zealand universities is unknown, it may be difficult to ascribe

accurate deductions from the data. There is presently academic debate concerning the relevance of response rates in quantitative surveys. In a survey by Carley-Baxter, et al. (39) of journal editors, they indicated that there was no agreed standard for acceptable response rates in the acceptance of papers for publication and that only 3% of respondents stated that they rejected primarily due to a low response rate; 69% indicated that this happened some of the time; and 29% stated that they never rejected a submission due to low response rates. So the effect of our response rate of 45% is a matter of debate.

Conclusion

The results of this survey indicate that a large percentage of paramedic practitioners transitioning into academic roles in paramedicine degree programs in Australian and New Zealand universities face challenges. These include the transference of cultural and professional capital from their previous community of practice (CoP) into the CoP of Australian and New Zealand universities; their ability to acclimate to the environment of academia; the degree to which they have developed the necessary academic skills to achieve an acceptable level of performance in undertaking research, obtaining research grants, academic writing and publishing, and teaching in the higher education environment; and the significantly increased burden of time and maintaining their psychological well-being as a result of the added workload needed to acquire or improve these necessary scholarly skills. Individual universities and the wider CoP need to recognise these challenges and decisions need to be made concerning the dedication of human and monetary resources to mentor and educate aspiring and new academics in the emerging paramedicine discipline.

Author contributions

GM was the principal author of the manuscript and performed the literature review. POM and AK validated the literature review and contributed to the final editing.

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6.1.3 Paper 3

This article reports on a thematic analysis of semi-structured interviews conducted with the study population.

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RESEARCH ARTICLE

PARAMEDIC TRANSITION INTO AN ACADEMIC ROLE IN UNIVERSITIES: A QUALITATIVE SURVEY OF PARAMEDIC ACADEMICS IN AUSTRALIA AND NEW ZEALAND.

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Abstract

Healthcare professionals who transition into academic roles in universities are confronted with many challenges. Universities offering paramedicine degree programs struggle to find qualified paramedics to assume academic roles, while at the same time little is known about the issues that confront paramedics transitioning into academic roles in universities. A maximal variation sampling method was used to interview 16 paramedic academics in Australia and New Zealand and a thematic analysis was conducted that generated a thematic network that encompassed five areas: the community of practice of paramedicine, the community of practice of academia, entry into a new community of practice, professional identity, and expectations and challenges. The resulting analysis revealed that new paramedic academics transitioning to academic roles in universities are often under-qualified and underprepared for academic positions. The induction and mentoring processes are often ad hoc and ineffective leaving the new academics feeling isolated and disillusioned. They struggle with establishing or maintaining a professional identity and meeting university expectations related to teaching, research, acquiring a PhD, and publication. Both these communities of practice need to engage in the development and preparation of these new academics so that paramedics will be attracted to these new roles and their transition to academia is a positive process.

Keywords: Community of practice; academic; induction; mentoring; transition; professional identity

Introduction

The experiences of professionals making the transition from their original community of practice (CoP) to the community of practice of academia are well-documented in fields such as nursing, teaching, and allied health.(1-12) However, little is known about the experiences of paramedics transitioning into academic roles in universities.(13) The literature related to the experience of nurses and teachers transitioning into academia has revealed several issues. MacIntosh asserts that new nursing academics receive little to no education or preparation on how to become an academic and is generally received after entering the academy.(9) Gourlay (14) challenges three of the concepts of Communities of Practice (CoP)(15), which are a shared repertoire, mutual endeavour, and expert-novice interaction. Gourlay suggests that for shared repertoire, there is no exchange of information on how things are done, you are basically on your own. For mutual endeavour, there is no sense of teamwork leading to a sense of isolation. This involved not only practices but underpinning values and ideologies. For expert-novice interaction, there was a lack of focused, formal mentoring or direction. The transition or induction process was described with experiences of confusion, inauthenticity, and isolation.

Martinez examined the experiences of teachers transitioning from teaching in schools to becoming educators in universities.(10) The major issues that were identified for teachers might be similar for paramedics and other healthcare professionals. Autonomy: the transition from a highly-regulated workplace to one of individual responsibility and self-reliance. Institutional Size and Structure: a transition to a larger organization with a different management structure and culture – establishing new social and professional networks as well as sorting out new workplace professional responsibilities. Work Environment, including technology: transition to having an office, own computer, access to internet, – productivity and time pressures. The Modelling Imperative: the pressure associated with "practicing what you preach" with regards to the delivery of education to students – pressure of student evaluations for promotion and the production of research and publication output. Research and Promotion Culture: this is a whole new paradigm for most paramedic professionals entering academia. Their previous experience with research is usually minimal or non-existent and the drive to meet quantitative measures of success to maintain their positions is a new challenge. Teachers are reported to have entered academia with a sense of inferiority and a lack of confidence and research and teaching experience.

A study by Girot and Albarran examined the risks to the academic workforce in 10 allied healthcare disciplines, including paramedicine, in the UK.(5) This study looked at how the age distribution of staff, the number of academic vacancies, and the qualifications of staff affected the quality of the work experience for the academics and profiled that, outside of nursing and midwifery, the number of working academics with doctoral qualifications was very small. The authors were interested in finding out if paramedic academics in Australia and New Zealand were experiencing challenges and conditions similar to those of teachers, nurses, and other allied health professions.

The impetus for this study was based upon the first author's experience of transitioning from the CoP of paramedicine in Canada after 30 years to the CoP of academia in Australia. The transition period and process was fraught with challenges and obstacles and it is important to examine the experience of others paramedics making the same transition to academia. This study explores this knowledge gap.

The authors explore and evaluate the themes and issues identified through a series of semi-structured interviews with paramedic academics in Australia and New Zealand. An analysis of those interviews and practical recommendations for improving the experience of paramedics transitioning into the community of practice of academia are provided.

Design and methods

The methodology employed in this study is that of qualitative content analysis (QCA), which is situated within the broader area of narrative research. Narrative-led research is seen as a term that encompasses inquiry; that seeks to situate the lived social experiences of individuals into a space of inquiry that is three dimensional: temporal, personal/ existential, and place(16, 17). This approach is most often seen by researchers as a flexible way of analysing verbal or text data, such as interview transcripts.(18, 19)

Within this domain is the methodology of interpretive description.(20) This methodology was used because it allowed for exploration and analysis of the data without the restrictions of the traditional qualitative methodologies, while maintaining requisite validity and rigour.

Sample

Maximal variation sampling (21) was used to recruit 16 paramedic academics teaching into paramedicine degree programs in Australia and New Zealand. This method was used to obtain the widest possible cross-section of paramedic academics in relation to gender, age, country of origin, qualifications, and years of experience.

Ethical Aspects

This study received ethics approval from the La Trobe University, University Human Ethics Committee Approval No: FHEC13/088. The demographic data were reported as de-identified profiles. Aliases were used for the quotes from participants. However, it is acknowledged that within this relatively small community of practice, people may be identifiable. Therefore, all efforts were made to provide as much de-identification of data as possible.

Data analysis

Directed Content Analysis

A process known as directed content analysis (DCA) was used to establish pre-determined codes that directed the content of the questions used in the interviews(22). This process is used when the data are collected primarily through interviews. The questioning starts with open-ended questions that are then followed by targeted questions based on the predetermined codes.

Sixteen interviews were conducted by the first author over a three-month period in 2013. Eight were conducted over a two-day period at a professional conference and eight were conducted over the next two months at three university campuses where the participants worked. All participants were given an information statement and then signed a consent form that ensured confidentiality of information and data. A semi-structured interview process was used in which several key questions were asked of all participants that focused on obtaining information about their experiences within ten higher codes listed in Box 1. Opportunities for further exploration of ideas or content were explored through the use of open-ended, leading, and verifying questions. This provided richness to the responses and opened up new areas of discussion and analysis.

- Academia
- Challenges
- Induction
- Mentoring
- Paramedic Experience
- Professional identity
- Recruitment
- Research
- Teaching
- Transition from Paramedic Practice

Box 1: Ten Higher Codes

The interviews were conducted and digitally recorded and professionally transcribed. The interviews lasted between 14 minutes and 62 minutes with a mean average of 35 minutes. A manual thematic analysis was conducted as well as the use of the Leximancer© software program to generate organising themes.

The areas of inquiry were formulated based on a review of the literature from other disciplines and from professional observations and experiences. This provided structure to the research process and insight into the experiences of those within the CoP of paramedicine.

Each of the participants' transcripts were read multiple times and quotes were obtained that fitted into each of the higher codes. Each of these codes, also known as Basic Themes, were then placed within one of five Organizing Themes.(23) These organizing themes were: CoP of Paramedicine, CoP of Academia, Entry to a New CoP,

Expectations and Challenges, and Professional Identity (see Figure 1).

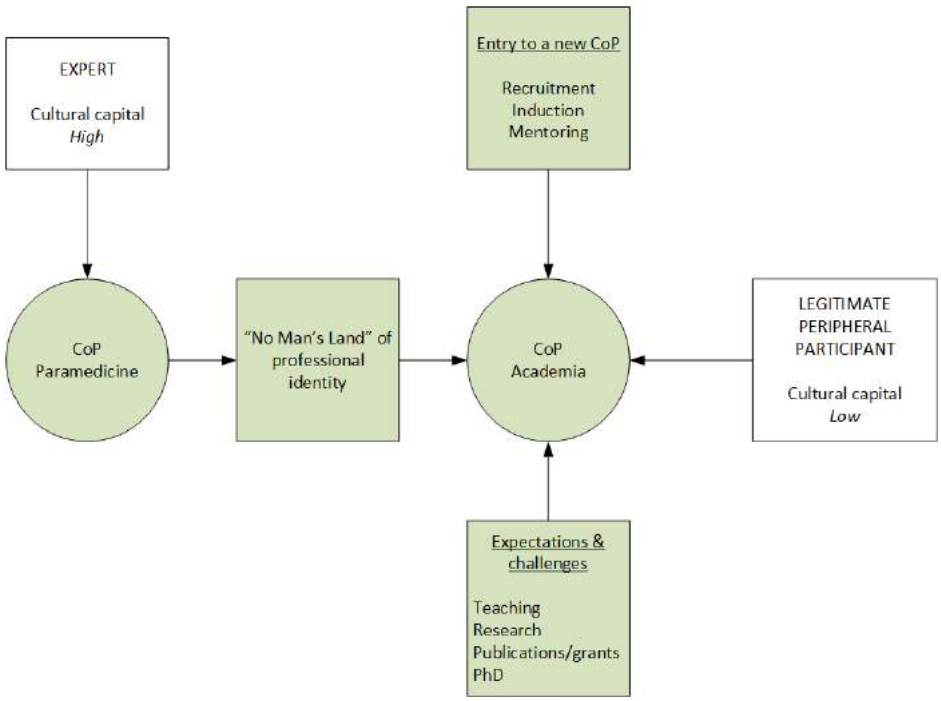

Figure 1: Structure of the thematic network

Discussion

An analysis of the participants' responses revealed many of the same issues and challenges that other health and education professionals have experienced in making the transition from professional practice to academia.

CoP of Paramedicine

An issue that is pervasive throughout the CoP of paramedicine is that paramedics have a difficult time defining just what their CoP is. A literature search of databases found no articles that addressed the CoP of paramedicine. In many discussions and interactions with paramedics in Australia, Canada, and the U.S.A., the prevailing theme seems to be one of having difficulty in separating the profession of paramedicine from ambulance services. The vast majority equate paramedicine with being a clinical practitioner in ambulance services and do not see their profession as existing outside of ambulance services. In the UK, paramedics are registered health professionals, have entry-level university education, and work in a wider range of settings. This is reflected in the College of Paramedics career structure that recognises paramedics practicing in four domains; clinical, management, education, and research. Paramedics practicing in these four domains can maintain their registration and continue to be recognised as valuable members of their CoP.(24) Starting on September 03, 2018, paramedics in Australia will become registered healthcare practitioners under the Australian Health Practitioner Regulation Agency (AHPRA).(25) A similar structure exists within other allied health professions, such as nursing.(26)

There exists a wide diversity in levels of qualification and training among paramedics in Australia and New Zealand and in the way that out-of-hospital care is delivered. Most states utilise a multi-level system of service provision that encompasses minimally-trained volunteers to highly-qualified critical care retrieval paramedics within the provision of emergency services.(27, 28) In addition, the emergence of community care and extended care paramedics within the non-emergency side of service delivery has created communities of practice within the broader CoP of Paramedicine.(29)

The participants responses revealed the vast majority of paramedics teaching into degree programs in Australia and New Zealand received their clinical training and qualifications within vocationally- based programs. This has been particularly prevalent

among the paramedics who were trained and gained their experience in North America, where tertiary education was not and is still not widely available for entry-level paramedic qualifications. The capital (social and professional assets), and the developed habitus (identity) that are acquired by the participants within the CoP of Paramedicine, does not appear to be easily transferred into the CoP of Academia and forces the new academics to begin acquiring their academic capital and habitus as legitimate peripheral participants (LPP) (novices), of the CoP of Academia.

CoP Academia

Many of the universities in Australia and New Zealand that offer paramedicine programs adhere to a traditional construct of the triad of the academic: teaching, research, and publication. Although all of the participants who were interviewed had some background in teaching (mostly vocational), they had very limited experience in research and publication and this hampered their ability to meet relatively rigid job qualifications. In the vast majority of position postings, a doctorate or near completion of a PhD is a standard requirement for a comparatively low-level lecturer position. In addition, the lack of a PhD is a considerable obstacle to advancement or promotion within the universities. (30-32) In addition, interviewees expressed feelings of inadequacy and the lack of a defined identity as an academic because they had not yet attained the academic status associated with having a PhD.

A common thread through the interviews and from subsequent conversations with paramedics interested in entering academia, is the perception that academic roles in paramedicine programs entail mostly teaching. When confronted with the prospect or expectation of engaging in research and publication, there is little enthusiasm and a reluctance to embrace these key components of a traditional academic role. Many who are already in these roles find the expectation of research and publishing daunting and struggle to fulfil these demands while often struggling to meet very high teaching loads. With the decrease in government funding for universities, there is increasing pressure being placed on academics to increase their publication rates and to bring in external funding in the form of research grants.(33, 34) As most paramedics are entering academic positions without a PhD and limited experience in research and publishing, they are not contributing to the revenue streams of the university. On average it takes seven years before a new academic is awarded their PhD or professional doctorate.(35) With the ever-expanding number of paramedic degree programs in Australia and New Zealand, there is an increasing demand for academically-qualified paramedics to fill academic positions. The traditional academic triad, plus the demand for doctoral qualifications, is limiting the number of paramedics who can meet the standards for employment and this results in unfilled vacancies. As a result, some universities are offering teaching only or teaching-dominant academic positions, to meet the demand (36, 37) along with the use of practicing paramedics to fill sessional or tutorial positions.

One of the issues that a large percentage of the participants identified was their perception or conception of academia and how they formulated it. In the study by Munro, O'Meara and Kenny (38) it was identified that 37% (n=11) of paramedic academics had completed their university education by distance learning and had formulated their idea of what academia was about without setting foot inside a university classroom. Their perceptions might have been constructed from this experience combined with films, television and other media.

> *So I think what I missed is, and still to this day, I miss being a university student on a traditional campus. But it is what it is … so my first experience as I said was traditionally ninety percent online and, in fact, all of my university life has been in that mode except for my PhD. (Robert)*

Entry to a New Community of Practice (CoP) (Recruitment, Induction, Mentoring)

Lave and Wenger (15) call new entrants into a CoP legitimate peripheral participants (LPP). These new participants are more than apprentices. They are inducted into their new CoP by formal means, while benefiting from the informal acquisition of values, language, and rituals that are absorbed by the LPPs without the use of formal means of learning and teaching. Both of these processes require some structure that directs the

formal induction of the new academic to the policies, procedures, and processes of the university and the more informal mentoring process that assists the new academic to navigate their way through the tacit values, language, and rituals of their new CoP. Often, the informal socialisation processes can be more powerful and influential than the traditional induction programs seen in many organisations.(39)

The participants in this study revealed a widely divergent experience with regard to the processes of recruitment, induction, and mentoring at the universities where they were employed in Australia and New Zealand. The consensus was that these three components of their entry into their new CoP of Academia were poorly implemented, with the induction and mentoring phases being considered to be informal, unorganised, and at times, counterproductive and demoralising. As mentioned earlier, studies over the past decade or more, regarding the quality and effectiveness of these processes within universities in Australia, New Zealand and elsewhere, have shown that little has changed and this study reinforces those claims. There is strong evidence that the quality of the mentor/mentee relationship is the key to a successful transition from one CoP to another. (40-43) The challenge to universities is to recognise the importance of these processes and to make concerted efforts to change the ways that they approach and implement recruitment, induction and mentoring programs.

> *The session was over the phone. You know here is a position are you interested, yes okay you start Monday, nothing more nothing less. The role was as advertised and I formally interviewed, was referee checked and the like. (Robert)*

> *(John) pretty much took me around and showed me where everything was. I was in a different office to begin with because this office wasn't ready and I was given a laptop initially and I was pretty much left to my own devices for a lot of it which was really, really rude for me because I had never done anything like this. So I really had no clue where to start with it and so it was like … Yeah kind of jumping in at the deep end. (Milley)*

> *They have some orientation courses that they offer so I have been to those. It's face to face, but they are fairly superficial and they are not directed necessarily at the academic staff. (Mike)*

Expectations and Challenges (Teaching, Research, Publication, PhD)

New academics and the universities are faced with their own sets of expectations and challenges that relate to teaching, research, publication, and the completion of a PhD. The universities have an expectation that the new academic is well-trained and experienced in teaching methods and philosophies of teaching and can basically 'hit the ground running' when they commence their new positions. For the majority of the participants interviewed, their teaching experience was restricted to the vocational sector and ranged from teaching in first aid and basic level paramedic programs to more advanced levels of paramedic practice. An issue for many of these vocationally-based teachers is that we tend to teach the way we were taught.(44) This poses a challenge to the new academic to rapidly change their pedagogical approaches to teaching and for the universities to provide professional development in methods of university learning and teaching. While this development of new academics in tertiary pedagogies is ongoing, the same cannot be said for their education and development in research.

The participants expressed concerns about the expectations of the universities regarding their ability and willingness to engage in research. There were no formal education programs in research reported, as there were in learning and teaching. They were expected to find research mentors to assist them with their learning and participation in research. Many of these mentors, if they existed, had various levels of knowledge and commitment to the task.

There is a concern that middle and senior managers within the universities are ill-informed about the profession of paramedicine and the lack of academically qualified paramedics to take on the traditional academic roles within the programs. As of August 2016, it was estimated that there are approximately 30 paramedics in Australia and New Zealand with doctoral qualifications and around 60 paramedics and paramedic academics

enrolled in higher-degree research programs (personal communication P. O'Meara).

Considering that this process of completing a doctorate can take the new academic an average of seven years (35), this poses an issue for the universities with regard to a substantial period of non-productivity from these academics in the areas of research and publication. Not all of these present and future doctoral-qualified paramedics are interested in engaging in fulltime academic appointments, many preferring to split their time between part-time academic duties and maintaining their qualifications in clinical positions in ambulance services. Their major reason for not wanting to take on a fulltime academic load was their reluctance to engage in research and a desire to remain connected to their profession. This connection to two communities of practice is described by Wenger(45) as brokering, specifically multi-membership, in which the individual has involvement or membership in more than one CoP.

> *They focused on teaching the instructing part. But they also made it pretty clear that they were expecting me to do research, to get a PhD, supervise research students and be a researcher. And a big part of the sell that they did was the support that I would get for that. (Tony)*
>
> *... and so I, I knew a little bit about it but to be honest then the workload just hit at the University and the idea of research was just out the window. (Kevin)*
>
> *You guys know until we start publishing, which is how the University makes its money, we are expendable and until we start publishing we are not a professional faculty. So this is a university and if we are not publishing we are going to perish. (Mike)*
>
> *I think again it might have been mentioned it was probably something that I would have had in my mind but wouldn't have even known really what a PhD was about let alone my topic. (Robert)*
>
> *So it was you know I was met by someone from the team who talked about research who was the research person and how it would be great to do a PhD that was foreign to me. I thought about leaving at that point to be honest with you. (Ralph)*

Professional Identity

Professional identities are constructed and developed within the structure of a community of practice.(15) When new members of a profession enter their new CoP, they are inducted or professionally socialised into the rules, values and rituals of the CoP. Over time, the individual acquires their professional identity based on their own engagement with the formal standards, values, and principles of that CoP along with the tacit and undocumented values and rituals that exist. For many individuals who are part of the profession of paramedicine, these professional identities are strongly held and can be integral to their sense of being and self-worth.

A major theme that evolved from these interviews was the aspect of a loss of professional identity for these new or already established academics. They revealed that, for most of them, they no longer considered themselves to be paramedics because they were no longer treating patients. When asked if they considered themselves to be academics, the majority stated that they did not because they did not have a PhD, which appeared to them to be a fundamental benchmark of being an academic. This has placed them in a position that the authors have labelled the *'No Man's Land'* of professional identity.(46) They are in a new CoP, existing on the periphery, without the qualifications or academic capital that would entitle them to advance on an inward trajectory toward acceptance as a centripetal member of the academic CoP. This lack of acceptance by their peers, their lack of a constructed and accepted academic identity, or both has created high-stress work environments and has caused many to question whether they should remain in academia, pursue modified positions within the university, or return to clinical paramedicine. Munro, O'Meara and Mathisen (46) explore and expand on this struggle to maintain a professional identity in more depth.

The responses from a majority of the participants indicated that they were confused and uncertain of their own professional identity.

> *...a typical academic to me that you know whenever you're talking to them always seems to be able to quote this one and that one. And they talk about writing papers and publishing and all of that sort of stuff. But I don't know really. I suppose I have never really given much thought to it. (Milley)*

Q: Do you still consider yourself to be a paramedic?

> *Yes by way of training, but now that I know that I am not practising and that is kind of hard. (Milley)*
> *Not at the moment no. No unless you are actually treating patients I don't know. No which is weird yeah. (Kevin)*

Q: Do you consider yourself to be an academic?

> *God no; absolutely not. (Milley)*
> *No, absolutely and still don't today consider myself an academic. (Ralph)*

Conclusion

The transition from the community of practice (CoP) of paramedicine to the CoP of academia is one that is challenging, and often disheartening. Their experiences are not unlike those that are reported in the nursing, allied health, and teaching literature. Some aspects, however, appear to be unique to paramedicine.

Paramedics struggle to define what constitutes their community of practice with little to no literature on this subject. The profession is in its relative infancy compared with other more established professions, such as medicine and nursing, which have more clearly defined roles, values, and rituals. Social capital developed in paramedicine is often not easily transferable into academia which, in many universities, still adhere to a traditional academic paradigm that many new paramedic academics struggle to meet. Expectations on both sides are often ill-informed and unrealistic, based on a lack of knowledge and understanding of each other's CoP.

After decades of study about the inadequacies of induction and mentoring programs in universities, there is still a lack of effective and focused programs to meet the needs of the new paramedic academics once they commence their roles. The prevailing attitude among the new academics is one of being left to their own devices; to quickly acclimatise themselves to the culture and processes of their university, one often expressed as being, 'thrown off the end of the dock and being expected to swim'.

One aspect of this study was that of the loss of professional identity by many of the new paramedic academics. It was expressed that the need to be actively working in clinical paramedicine, the need to be treating patients, was an integral part of their professional identity that was lost or greatly reduced once entering academia. In contrast, their lack of an academic professional identity was strongly rooted to the absence of a doctoral degree, and a record of research and publication, thus leaving them in a 'no man's land' of professional identity. This created feelings of inadequacy, high levels of stress, and desires to take on positions that were more teaching focused.

The employers of paramedics need to provide its members with more opportunities to engage in professional development activities that better prepare potential academics for roles in universities. These activities include, modified shift schedules that allow for academic study, opportunities for joint appointments in university programs, and more collaborative research projects between academics and paramedic professionals. The universities need to educate themselves about the demographics of the CoP of paramedicine and have more integrative induction and mentoring programs to assist the new academics with the transition into academia, which for many is a daunting and often confusing process.

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6.1.4 Paper 4

This article is an exploration of a major issue identified concerning a conflict of professional identity among the study population.

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Doctorate Studies

Paramedic academics in Australia and New Zealand: The 'no man's land' of professional identity

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ABSTRACT

Those transitioning from practice to academia can struggle with the perception that they might lose their hard-won and deeply-held professional identity, while grappling with the difficulty of creating an academic identity. This is a common experience for those entering universities with strong clinical identities. Paramedics, as members of an emerging health profession, share these challenges with nursing and allied health professionals. In this study of paramedic academics in Australia and New Zealand, a majority did not consider themselves to still be paramedics on the basis that they were no longer clinically active. Nor did they consider themselves to be academics as most lacked doctoral qualifications and associated scholarly achievements that made them feel worthy of a place in the 'academy'. This lack of a professional identity as either a paramedic or an academic places them in a 'no man's land' of professional identity. Many are unable to effectively fuse their paramedic and academic identities to become comfortable as 'paramedic academics'. For this to change, there needs to be a partnership between the paramedicine discipline and universities to ensure that paramedics entering academia have a recognised and valued career pathway and are better prepared to make the transition to academia.

1. Introduction

Many academics teaching into nursing and allied health programs in universities face challenges in identifying and forming their professional identities. In a previous component of our wider study of paramedic academics teaching in undergraduate paramedicine degree programs in Australia and New Zealand (Munro et al., 2017), participants expressed feelings of doubt and anxiety as to the nature and location of their professional identity. When asked if they still considered themselves to be paramedics, the majority stated that they did not. When pressed for a reason, they responded that it was because they were no longer active in clinical practice 'treating patients'. When asked if they considered themselves to be academics, the majority stated that they did not, because in most cases they did not have a PhD. This led us to label this phenomenon 'The No Man's Land of Professional Identity'.

The responses to these two questions revealed major factors that comprise the structure of their perceptions about what constitutes a paramedic academic identity. This issue is shared with those in other professions such as nursing and allied health. The concept identified as the 'no man's land' of professional identity is not exclusive to paramedic academics. In a study in the UK (Findlow, 2012), a group of nursing academics who did not have a doctoral qualification indicated that they did not consider themselves to be a 'proper academic'. Having come from a clinical background, they stated that they lacked what they referred to as 'academic authority'. This insecurity was accompanied by 'a fear of being found out' (p.128) by those academics who had higher levels of academic capital, such as those in medicine and law (Webb et al., 2002).

This paper will illustrate and discuss the issues surrounding the development of a paramedic's identity and then the development of an academic identity. This will be followed by the issues and conflicts experienced by healthcare practitioners in making the transition from clinical practice to academia. Also, how the changing face of academia is causing these new academics to experience conflict and experience a loss of their previous professional identity and the challenges associated with acquiring their new identity as an academic.

2. Acquiring a paramedic identity

There is some literature addressing the development and attributes

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of a paramedic professional identity (Campeau, 2008; Capsey, 2010; Carter and Thompson, 2015; Donnelly et al., 2015; Johnston and Acker, 2016; Murcot et al., 2013; O'Meara, 2009, 2011; Trede, 2009; Watson et al., 2012; Young, 2015). One study showed that paramedic identities are strongly linked to the paramedic's relationship with their patients and to the treatments that they employ (Watson et al., 2012). Another study (Donnelly et al., 2015) identified the areas of care giving, thrill seeking, strong duty and the specialized aspects of their profession to be major components of a paramedic identity. This supports the findings in our whole study of the attachment that paramedics in academic roles in universities have to their connection with treating patients and their paramedic professional identity. This may suggest a reason why so many of our study participants indicated that they no longer considered themselves to be paramedics while appointed to an academic role in a university.

3. Acquiring an academic identity

The difficulty in defining an academic identity was illustrated by two studies into the transition from clinical practice into academia. One was in the discipline of nursing (Murray et al., 2014) and the other profiled the transition of physiotherapists into academia (Hurst, 2010). In both studies, the authors referred to the role undertaken by these academics as that of a lecturer. There is little to no mention of the other roles and credentials of the traditional academic; namely, research and publication, community engagement, and the possession of a doctoral qualification. The inference is that they related an academic identity with teaching only. A model advocated by Murray et al. (2014), sug gested that new academics go through an "identity shift" (p.391) that is comprised of four phases spanning one to three years: feeling new and vulnerable; doing things differently; expecting the unexpected; and evolving into an academic. In both studies, they referred to these new academics as having feelings of inadequacy because of being under credentialed, yet there is research to show that it takes on average, seven years for a novice to reach academic status, due mostly to the time needed to complete a PhD (Coates et al., 2009). This illustrates the debate and controversy of what the definition is of an academic and what constitutes an academic identity.

The construction of an academic identity is somewhat more com plex. Clegg (2008) advocated that an academic identity is a matter of self definition. Billot (2010) stated, 'How an academic contextualizes their identity has an impact on the way in which they make sense of their workplace' (p.710). Furthermore, it is contingent on the pre paration the novice academic receives upon entry to their new com munity of practice (CoP) (Clark et al., 2010). Another study (Schriner, 2007) revealed that the lack of focused and structured preparation for the role of the academic nurse was a major contributor to nurses struggling to make the transition into academia. Part of that struggle might be attributed to maintaining a clear sense of professional iden tity.

In order to explore this phenomenon, we looked at Clegg's assertion that an academic identity is a matter of self definition and used Pierre Bourdieu's concepts of habitus, field, and capital (Bourdieu, 1977) to shape the discussion. Though difficult to provide a clear, concise defi nition of habitus (Maton, 2008), Bourdieu described it as 'a property of social agents … structured by one's past and present circumstances, such as family upbringing and educational experiences … one's habitus helps to shape one's present and future practices' (p.51). The concept of habitus is also seen as a disposition or 'a way of being' (Sweetman, 2009, p.493), as a sociological not a psychological concept and can be utilized at different times in different fields (Lingard and Christie, 2003). Bourdieu liked to use the analogy of a sporting field to describe the concept of field, wherein the field had structured boundaries, the players had set positions with distinctive roles, and novices had to learn the rules. The concept of capital is divided into two types; economic and symbolic capital. The most common understanding of the term capital, is best equated to its meaning within economics. Symbolic capital is divided into sub types: cultural, linguistic, scientific, and literary (Moore, 2008). Bourdieu went on to state that symbolic fields tend to establish 'hierarchies of discrimination' which he labelled as a type of symbolic violence, which is situated within rules of dominance and power that are predicated on self interest (Moore, 2008, p.104). The transition from clinical practice to academia is influenced by Bourdieu's concepts and those of the framework of communities of practice (CoP) (Lave and Wenger, 1991).

4. Professional capital and communities of practice

If we examine the fields of paramedicine, nursing and allied health, we see that they achieved status or standing in their respective fields by acquiring capital that had meaning and significance to that field. Another term that can be used to describe a field is a 'community of practice' (CoP) (Wenger, 2000). Wenger labelled a novice in a CoP as a legitimate peripheral participant (LPP) and during their time within that CoP, they develop social capital that moves them on an inward trajectory to the centre of the CoP, becoming what he described as a centripetal member (Lave and Wenger, 1991). When transitioning to academia from a CoP or field in which the paramedics, nurses and other allied health practitioners have achieved these relatively high levels of capital within their own disciplines, they assume the role of an LPP in this new CoP of academia. Much of their previously acquired capital or accomplishments lack '*transposability*' to this new field, thus leading to what Bourdieu called a 'less well constructed habitus' (Moore, 2008, p.112). In a prior component of our study (Munro et al., 2016), it was demonstrated that only 3 of 30 participants in the survey held a doc toral qualification in paramedicine and only 10 of 30 had a Master's degree when entering academia. This study further illustrated that the majority of the participants had limited training and experience in re search, academic writing and publication, and had very limited ex perience or education in learning and teaching beyond the vocational level. This suggests that whatever capital they had developed within their community of practice of paramedicine, was of limited value when transitioning to the CoP of academia.

According to Naidoo (2004) Bourdieu defined academic capital as, 'an institutional form of cultural capital based on properties such as prior educational achievement, a disposition to be academic and spe cially designated competencies' (p.458). The comments and insecurities expressed by the participants in the paramedicine and nursing aca demic studies appear to be directly related to Bourdieu's concept of academic capital. Their perceived insecurities related to a lack of aca demic authority are illustrated in their lack of a PhD (in some cases, a lack of a Master's degree), not being aware of what it means to be an academic and not having proficiency in other competencies such as research and publication. These insecurities related to professional identity are one contributing factor to a condition known as 'role stress" (Kahn and Quinn, 1970).

5. Role theory

A role within a CoP can be seen as being governed by a set of ex pectations placed on the participant by the present members of the organization and by those existing outside of the CoP (Brief et al., 1979). An individual who enacts roles that are in conflict with each other or are against their value systems, is said to be experiencing a form of "role stress" called role conflict. Another form of role stress occurs when an individual is in a role where the values, performance levels, and behaviours are not clearly understood (Brief et al., 1979). Role stress can also occur when the expectations of the individual do not reflect the work that they are actually doing or are expected to do by their employers (Wanous et al., 1992). This is further supported by Lazarsfeld Jensen (2014) in which the study revealed a situation, la belled "role dissonance" (p.735), in which graduate students from

paramedicine degree programs in Australia and New Zealand, partly blamed their university education for creating a substantial level of role confusion. They were confronted with older members of the profession being antagonistic to the new approaches to education, along with a rapidly shifting focus within the profession away from the paramedic being a rescuer to being an out of hospital deliverer of primary health care.

Conflict also exists when the new academic attempts to establish and maintain their academic identity, particularly when they come from clinically based professions. There is a misconception by many in academia, that there is a generic, homogenous academic identity that is held by all, regardless of their discipline. Often this misconception is reflected in job descriptions, promotion criteria and other areas that do not reflect the reality of the workplace (Churchman, 2006). In many circumstances, multiple academic identities exist within a department, as many academics identify more with their discipline than with their department or organization (Clegg, 2008). In addition, conflict is gen erated between the older, more established academics who have a more traditionally developed paradigm of what constitutes an academic identity, with newer academics who have been indoctrinated into the more recent neoliberal, managerial, audit based construct of today's universities (Archer, 2008; Clegg, 2008). There has been little research into the effect of age or generational perspectives when it comes to the construction of an academic identity. Younger academics tend to weave aspects of the past and present into the construct of their academic identity (Archer, 2008). Here, Bourdieu described a situation in which organizations and some individuals presumed that there is ‘a minimum level of agreement around basic principles, the field of higher education is in fact not a product of total consensus, but the product of permanent conflict’ (Naidoo, 2004, p.469). Our study participants substantiated this in their expressions of doubt, confusion and frustration.

Another source of conflict arises in the question of whether para medicine, nursing and other allied health disciplines should be con sidered academic disciplines. Nursing was confronted with this issue several years ago and, in many cases, is still struggling with this today (Andrew et al., 2009). In the case of paramedicine in Australia and New Zealand, where professional registration is still awaiting implementa tion in 2018, this may be a factor in the expressions of insecurity and feelings of not being accepted by the established academic community. New paramedic academics come from a discipline that is rich in clinical practice but somewhat deficient in research and teaching, and as a result are at a further disadvantage in the construction of their aca demic identity. This is further compounded by many who attempt to maintain a foot in both camps, or what Wenger refers to as multi membership in communities of practice, in which they engage in a process called ‘brokering’ (Andrew and Wilkie, 2007; Wenger, 1998). This may cause some confusion as to which CoP they owe their alle giance to; to which CoP they most identify with. They may be con fronted with inter role conflict if they continue to practice clinically while fulfilling their academic role (Clark et al., 2010).

At present, there are formidable challenges for paramedic aca demics in Australia and New Zealand who wish to maintain an accep table level of clinical currency. They endure heavy workloads of teaching, and the demands of completing PhDs or engaging in research, as well as the challenge of finding sufficient time or opportunity to meet standards for maintaining clinical certification with ambulance services (Munro et al., 2017). In contrast, registered paramedics in the UK and nurses in Australia are not restricted to fulfilling clinical hours to maintain registration. Nursing academics in Australia can maintain their registration by demonstrating recent practice, which can include teaching clinical content to pre and post registration nurses (Australian Health Practitioner Regulation Agency Nursing and Midwifery Board, 2016). Paramedics in the UK can maintain registration by being active in one or more of the four role definitions of clinical practice, man agement, researcher and education (College of Paramedics, 2015). For paramedic academics in Australia and New Zealand, professional registration may remove a major structural obstacle to maintaining their identity as a paramedic while still functioning in an academic role in a university.

The acquisition of an academic identity is a process of socialization into a CoP, often moving from one organization to another (Booth et al., 2007). Most new academics receive little to no education or preparation on how to be an academic. This is generally undertaken after entering the field (MacIntosh, 2003). For many new academic educators, this process of socialization or induction into the field of academia is often inadequate (Munro et al., 2017). For many, it is a case of ‘on the job training’ (OJT), relying on their previous exposure to academia, their intuition, and the seeking of information from colleagues (Clark et al., 2010). Better induction programs, mentoring, and preparation prior to entering academia, could assist these new academics to construct their individual academic identities and encourage them with their inward trajectory in their new CoP (Clark et al., 2010; Findlow, 2012).

6. The changing face of academia

Confounding this discussion of paramedic academic identity is the changing face of academia in Australia, New Zealand, and many other countries. The previous traditional construct of an academic career was one based on teaching, research and publication, and community en gagement. As stated earlier, many older or more established academics may still hold this vision of what an academic is, while younger or newer academics tend to combine aspects of the past with the present (Archer, 2008). Rosser (2017) suggests that at the professorial level in nursing in the UK, there are professors that are members of older, well established universities, that have the luxury of focusing on research, while those that are members of newer or less influential institutions, tend to focus on the development of research cultures and the men toring of those that will leave a research legacy in the future. In a study of primary school teachers (Goodson, 2007), researchers divided the participant group into three categories by the era in which they started teaching; 1950 60, 1970 80, and 1990 to the present. The first two cohorts related their teaching to “a central passion and commitment … their life's work” (intrinsic motivation) while the third cohort of newer teachers described their job as “just a pay cheque”, putting in the hours, following the rules, with a major focus on career advancement or life outside of work (extrinsic motivation) (p.133).

In addition, many universities have established teaching focused academic career pathways with minimal engagement with research (Australian Catholic University, 2017; The University of Queensland, 2016), further widening the schism between the more established, traditional academics and the newer, less credentialed academics. An area for further research may be on the changing values of what con stitutes work and professional identities. How do these new perceptions and attitudes contribute to the insecurities of newer academics and potentially, keep prospective future clinical professionals from making the transition from clinical practice to academia.

7. Conclusion

The transition from practice to an academic role in universities is a difficult process. It engenders a struggle between the threat of losing a deeply held clinical identity, and the difficulty in creating an academic identity that is acceptable in the established academic community. This ‘no man's land’ of professional identity is consistent with the concept of an identity being self determined, shaped by the individual and often in an environment of constant conflict. This ambiguous state of being is cultivated by a lack of preparation prior to entering the academy and to a lack of structured socialization upon entering the academy. Upon entry, the new academic is confronted with opposing views of what constitutes an academic identity from those who hold on to a vision of academia that was created in the past, and those who see a very dif ferent paradigm that encompasses a neoliberal, managerial approach to

higher education.

The move toward channeling these 'less qualified' academics into teaching focused academic pathways, while more credentialed aca demics focus on research and publication, may lead to or have led to the development of a tiered approached to academia, or more bluntly, two classes of academics within the university sector. The impact of this tiered academic structure on an emerging profession, such as para medicine, could be profound. It could relegate paramedicine, and po tentially nursing and some other allied health disciplines to a sub class of academia. The current situation indicates that the immediate focus should be on establishing more formal preparation and socialization of clinical practitioners into the academic environment by both the com munities of practice that they practice in (paramedicine, nursing, speech pathology and others), and the university sector. There needs to be a consolidated partnership between these two groups to ensure that those legitimate peripheral participants entering the academy can be better prepared to make the transition from clinical practice into the community of practice of higher education.

Conflicts of interest

Each of the authors of this manuscript declare that they have no financial or personal relationships with any other people or organiza tions that could inappropriately influence their work.

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Appendix A. Supplementary data

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Chapter 7
DISCUSSION AND RECOMMENDATIONS

7.1 INTRODUCTION

When I first set out to formulate my research question, my view of the scope of my research was insular. My interest was essentially in determining whether my paramedicine academic colleagues had the same or differing experiences from my own when making the transition from clinical practice to academic roles in universities.

The effects of the worldwide COVID-19 pandemic have strengthened the importance of my research owing to the impact of restricted international workforce mobility on the recruitment and retention of paramedic-qualified academics into the university systems in Australia and New Zealand. In early 2019, before the pandemic, it was common to recruit academic staff from outside Australia and New Zealand to meet the increasing demand (Paper 1). As this is no longer possible, universities are relying on the limited pool of paramedic-qualified academics to fill the growing number of positions and to replace experienced paramedic-qualified academics who have reached retirement age. This shortage of suitably qualified and experienced paramedic academics has resulted in many positions' remaining unfilled and programs' having to rely more on part-time and sessional staff to fill the gaps.

As my research progressed it became evident that the experiences, tribulations, successes, and setbacks experienced by the paramedic-qualified academics in my study population were shared with other health professionals and were common in the broader academic community. Though my original focus on the transition of paramedic-qualified professionals to academia was not diminished, it became apparent, through feedback from supervisors, other academics, and journal reviewers, that a broader perspective was needed to place the research in context.

7.2 DISCUSSION

The following discussion outlines the progression and evolution of this research project.

There is no literature specifically related to the transition of paramedics to academic roles in universities. The literature relevant to the search question was situated in the principles of nursing, allied health, and teaching.

As a result of these findings, I decided that further study was required to determine the experiences of paramedics' transitioning into academic roles in universities. The gap in the evidence base indicated that this was an area of research that had not and was not being conducted by other researchers; as such, it was an ideal project for my research and in some ways epitomized the very nature of a Ph.D. research project.

7.2.1 Challenges in recruiting qualified academics

Despite enrolments in and completions of undergraduate degrees in paramedicine in Australia and New Zealand for over 25 years (Battersby 1999, Lord 2012), there is a chronic shortage of qualified paramedics to assume academics roles in universities. This has necessitated the recruitment of academic candidates from overseas, mainly from North America and the UK. These overseas-trained candidates constitute 25% of the study's population (Paper 2). As stated in Paper 2:

> . . . important questions need to be asked about the positive and negative transference of paramedic culture, methods, practices, and principles that overseas academics bring with them to paramedic programs in Australia and New Zealand. If students acquire their first exposure to the culture of paramedicine at university, what impact do these academics have on the formation of the students' professional identity? (p. 5).

Once the ban on international travel due to COVID-19 restrictions is lifted, international recruitment of paramedic-qualified academics could resume, and the issues stated above could become relevant again. It is my contention that the values and experiences of the international academics greatly enhances the opportunities for the students from Australia and New Zealand to gain valuable insights into ways of thinking and doing that are different from those seen locally. They also provide the students and paramedic colleagues with a sounding-board for new and different ideas that, it is hoped, may overcome insular groupthink approaches to the profession.

7.2.2 Paramedicine community of practice

An important and pervasive issue within paramedicine is that paramedics struggle to define just what constitutes their CoP. There is considerable diversity of opinion within the community as to the nature and construct of the profession. Many see paramedicine existing solely within the provision of emergency ambulance services. Many have difficulty separating the profession from the ambulance service, even referring to the profession as 'ambulance' rather than paramedicine. In the past the in-house, vocational-training centres for many ambulance services were called Ambulance Training Centres. Until recently, the peak body for jurisdictional ambulance services in Australia and New Zealand, the Council of Ambulance Authorities, had 'Ambulance' within its title and within the name of its education committee (Council of Ambulance Authorities, 2010).

These titles reflected the view that the profession of paramedicine was situated predominately within the realm of ambulance services. This discussion is further expanded by considering how paramedics themselves see the role of out-of-hospital medical services. Some see ambulance services as having a sole focus on the delivery of emergency medical services to a select component of the population (around 10%) (Andrew, Nehme, et al. 2020) that responds to and manages acute, non-scheduled medical and trauma emergencies. Any patients who fall outside this narrow category are seen as unworthy of their time or expertise, with some

paramedics and ambulance-service operators being openly hostile to them. The contrary perspective, which is gaining prominence within paramedicine and the wider medical and governmental communities, is that paramedicine and the provision of out-of-hospital medical care is a part of the delivery of healthcare and should embrace all members of the community and their healthcare needs. The recent transition towards the provision of primary healthcare by community paramedics is an illustration of this move towards seeing paramedicine as the deliverer of mobile medical services to the community, rather than as a public safety, emergency-response service (International Roundtable on Community Paramedicine, 2017). This confusion about the role of paramedics within the healthcare community may be a contributing factor to the lack of clear professional identity that many of the study participants expressed. It manifested as a loss of their professional identity as paramedics among the participants, because they were not clinically active in treating patients, regardless of their worldview of paramedic practice (Paper 4).

The confusion at that time about role identity contrasts with the construct of the CoP of paramedicine in the UK, where paramedics have been registered health care professionals since 2000, have university degrees, and practise independently within a wide range of settings, including hospitals, doctors' offices, aged-care facilities, and private clinics. In addition, the College of Paramedics in the UK recognizes, through its career pathway framework, four domains that a registered paramedic can practise in: clinical, management, education, and research (College of Paramedics UK. 2017). This portrays a more holistic approach to their concept of the CoP of paramedicine in the UK. The model has been adopted in Australia within the construct of the national registration program, which started in the later part of 2018. It can be argued that the introduction of the registration of paramedics in Australia and New Zealand will contribute to a similar holistic perception and to a wider and more inclusive vision of the CoP of paramedicine.

The changing focus and vision of paramedicine has been further illustrated in an article from Canada that discusses how the conceptualization of paramedicine is changing (Tavares, Allana, et al. 2021). The key principles and enablers that were identified indicated an evolution of paramedicine in Canada, but possibly applicable to other jurisdictions. Previous discussion had indicated a transition to primary care, integrated care, and an emphasis on research, which continues to be a priority. The new research in this study revealed new opportunities and areas of interest:

- More accountability to and for itself
- A greater accountability to the public (there is fragmented and inconsistent professional registration in Canada unlike in Australia)
- A greater accountability related to better aligning services as solutions to health care challenges

Part of my recommendations for change within the CoP of paramedicine in Australia and New Zealand is a call for the present-day profession of paramedicine and the university sector to recognize the importance of formal collaboration between the operational and academic sectors.

This would involve the provision of the accommodation of paramedic professionals within services to access higher education at universities and for the universities to engage in more active preparation of potential candidates for academic positions.

Another issue that was illustrated in my findings was that most of the participants' experience with learning and teaching was within the vocational sector, and there was a lack of formalized education in tertiary education pedagogies. This suggested a reinforcement of the belief that most teachers teach the way they were taught in the absence of formal exposure to tertiary methods of learning and teaching (Johnson and Birkeland 2003). There is a danger that while they will model some of their teaching and curriculum development on good methods, modelling based on bad methods will also occur, as will some negative attitudes related to the vocational delivery of curriculum.

Based on my findings, I concluded that the capital and habitus achieved in the Paramedicine CoP was not readily transferable into the CoP of academia. The results from Paper 2 showed that most of the participants had considerable expertise or professional capital and a well-developed habitus within the CoP of paramedicine but lacked the attributes desired or required for acceptance into the CoP of academia. The capital and habitus achieved in the CoP of paramedicine is not readily transferable into that of academia. Most of the participants had received their clinical qualifications within vocationally based training programs, as well as in their teacher training and experience. This made it difficult for many to meet the expectations and requirements of the universities to deliver the curriculum within the pedagogical approaches inherent in higher education. Many of the participants, once started in their new positions, were immediately expected to assume the roles of subject coordinators and were also 'thrown' into the classroom with little to no preparation or education in the learning and teaching methods employed in tertiary education.

A similar phenomenon has been observed in the nursing higher-education sector in the United States, where novice nurse academics have been assigned the responsibility of managing entire subjects, sitting on committees, and participating in projects (Siler and Kleiner 2001). In part, this is related to the difficulty associated with nursing's struggle still to be accepted as a legitimate academic discipline (Andrew, Ferguson, et al. 2009). This continues to be a point of conflict between those that continue to advocate that a university-trained nurse cannot manage patients as well as a vocationally trained nurse (Watson and Thompson 2004).

Other healthcare professionals have been and are still being subjected to these and related transition challenges. Physiotherapists making the transition to academia have struggled with issues related to expectations and preparation, varying levels of peer-support, adapting to a new culture, having varying levels of perceived confidence, and feeling the stress of conflicting professional identities (Hurst, 2010).

Based on my findings it appears that it is little different in the paramedicine context. The conditions described have resulted in the creation of high levels of stress, anxiety, and feelings of

inadequacy among novice academic staff with a resulting high turnover of staff and many returning to clinical practice.

7.2.3 Entry to a new community of practice—Recruitment, induction, mentoring

Important issues that arose from these data have significance to both the paramedic academics and the students they teach. The academics serve as role models and mentors to the students. The students' first exposure to the CoP of paramedicine and its culture is on entry to the academy. This is the time when the effect of mentorship and role modelling can have its greatest impact (Gibson 2003). This is all part of the early development of a student's emerging professional identity.

The entry into a new CoP is a complex process of engaging in an outbound trajectory from the existing or previous CoP and engaging in an induction process into the new CoP. In many cases the new entrant leaves behind a position of considerable stature, one that involved the development of high levels of social capital and a well-developed habitus. Upon entering this new CoP of academia, the once centripetal member of the previous CoP, as a novice or LPP, proceeds on an inbound trajectory into this new CoP. For many of the participants this process was greatly hampered by their perceived lack of academic professional capital (Paper 4).

The relative isolation and great distances that exist in Australia and New Zealand provided challenges to the recruitment of academically qualified candidates for positions in universities offering paramedicine programs. This was particularly evident for the international paramedic academics, who made up 25% of the participant group in this study. The participants found many of their job interviews were haphazard and cursory, and were often hampered by breakdowns in technology (Paper 3). Many stated that during these interviews there was a lack of clarity about the roles and responsibilities associated with the positions that they were seeking. Often assurances were made to the candidate, such as support for mentoring in research and learning and teaching, that were not forthcoming upon commencement. Since this was first reported, the recruitment process might have improved in this respect, especially with the advent of online technologies such as Zoom and other platforms.

7.2.4 Community of practice of academia

The participants in this study went from being centripetal or high-ranking members in paramedicine to LPPs or novices within the CoP of academia. As reported in Paper 2, 37% of the participants had completed their degrees by online or distance education, or by what is sometimes referred to as 'from their dining-room tables'. Their perceptions of academia were constructed from their experiences as university students, from films, and other media. These perceptions about academia may have contributed to heightened levels of anxiety and unrealistic expectations about the culture and the work within this new CoP. A similar pattern can be seen in recently graduated nurses leaving their profession within the first five years of employment, partly because of unrealistic expectations of the profession and their workplaces (Parker, Giles, et al. 2014).

At the time of this study (2013) most universities offering paramedicine degree programs adhered to the traditional construct of the role of an academic as teaching, research and publication, and community engagement. Most universities required postgraduate qualifications for junior entry-level academic positions and doctoral qualifications were preferred for more senior positions. Most study participants had little to no experience and training in teaching in a tertiary institution, minimal experience in academic writing and producing peer-reviewed publications, and little concept of community engagement.

Many of the participants expressed doubts and uncertainty about the lack of a defined identity as an academic. They did not consider themselves to be academics, because they lacked the academic capital associated with holding a Ph.D. This ambiguous state of being is cultivated by a lack of preparation prior to entering and to a lack of structured socialization upon entering the academy (Paper 4). The new academic is confronted with opposing views of what constitutes an academic identity, on the one hand from those who hold on to a vision of academia that was created in the past, on the other from those who see a very different paradigm that encompasses a neoliberal, managerial approach to higher education (Goodson, 2007). This engenders a struggle between the threat of losing a deeply held clinical identity, and the difficulty associated with creating an academic identity that is acceptable in the established academic community.

The move towards channelling these 'less-qualified' academics into teaching-focused academic pathways—while more credentialed academics focus on research and publication—may lead to, or might have led to, the development of a tiered approached to academia, or more bluntly, two classes of academics within the university sector. The impact of this tiered academic structure on an emerging profession such as paramedicine could be profound, perhaps leading to limited career opportunities and a lack of personal and professional growth opportunities. It also impacts on the ability of the profession itself to mature and grow through the generation and dissemination of new and unique knowledge. This a core tenet or pillar of professionalization.

The current situation indicates that the immediate focus should be on establishing a stronger formal preparation and socialization of clinical practitioners into the academic environment by both the CoPs that they practise in (paramedicine, nursing, speech pathology, and others) and the university sector.

There needs to be a consolidated partnership between these two groups to ensure that those legitimate peripheral participants entering the academy can be better prepared to make the transition from clinical practice into the CoP of academia.

7.2.5 Strengths and limitations of the research

As with any research project there are strengths and limitations associated with the methods and methodologies that were used to conduct this research. The use of the mixed-methods paradigm allowed me to use the strengths of both methodologies to further strengthen the validity of findings.

In relation to the quantitative demographic survey in Paper 2, we had a relatively high response ratio of 45%. For smaller research groups of under 1000 participants a response ratio of greater that 30% is considered respectable (CSUM, n.d.). The justification for this is that increasing the size of the study population actually results in reduced accuracy. This relatively good response rate allowed us to select a subsample using purposive sampling that was representative of the study population for the following qualitative study (Hesse-Biber 2010), thus enhancing the strength of the research by providing a direct link to both studies (Torres, 2006). Because the study population was relatively small (n = 66), the use of 16 interviewees in the qualitative study mitigated the negative effects of using this method on a larger population.

The use of the mixed-methods approach enhances the triangulation of data to increase the validity of the findings. It provides a number of different perspectives for the answers to the questions. It also assists in preventing gaps in the information collected, reduces the aspect of researcher bias, and is advantageous in being able to provide more information than from one method alone (Bulsara n.d.).

The aspects associated with self-reporting surveys are a potential limitation to the study. As those involved in the online survey and the interviews were willing participants, the tendency towards social desirability bias (Bergen & Labonte, 2019) could not be eliminated. It is not unreasonable to assume that, because of the anonymity of the survey and the relatively simple responses needed for each of the 17 categories of data requested, that the participants would have been honest in their responses, though this could not be verified. The way that we selected our interview participants provided the widest level of credibility and representation of the study population to enhance the chances of obtaining a diverse cross-section of the experiences of the participants (Wisdom et al. 2011).

There could also be limitations to the generalization of the findings to other similar groups, though the literature search revealed that similar issues were contained within the nursing, allied health, and education professions. One interesting aspect of this is discussed in the implications for this research below.

7.2.6 Implications for this research

In 2015 the Paramedic Association of Canada (PAC) began to explore the issues surrounding the goal of moving paramedic education in Canada into the university system and making the entry-level qualification for employment an undergraduate degree in paramedicine, like the systems in Australia and the UK. In 2018 the PAC incorporated this proposal into its strategic plan by advocating the inclusion of the Canadian Paramedicine Education Guidance document into the concept of baccalaureate education (Poirier & Hood, 2018). In 2016 I presented an overview of Australian paramedicine university programs to a meeting of the PAC tertiary education symposium in Saskatoon, Canada, 5 June 2016. I presented some of the findings from my Ph.D. research to members of the paramedicine education community from Canada, Australia, USA, and the UK at the PAC tertiary education symposium. I outlined the history and structure of

the tertiary degree programs in Australia and New Zealand and then provided a synopsis of my research aims, methods, and preliminary findings. I gave the presentation the title 'Paramedic Transition into Academic Roles in Australia and New Zealand: A Cautionary Tale'. The main focus of my presentation was to bring to my Canadian colleagues' and friends' attention the multitude of issues that they would be confronted with in making the transition from vocational/community college education programs to tertiary degree programs.

I illustrated the importance of ensuring that there is an integrated approach across the universities, the profession, governments, and the employers in preparing their academic workforce well in advance to avoid many of the issues that were found in my research. They need to ensure that their academic workforce is adequately qualified in both university-based pedagogical/andragogical theories and in university-based paramedicine research methods. The optimal place to learn these basic skills is not on the job while trying to make the shift from the CoP of paramedicine to the CoP of academia, as illustrated in my research. A further obstacle in this movement in tertiary education in Canada from vocational training to the universities is the ongoing debate that challenges the validity of or need for this shift, with many questioning whether the need or desire is there. Some of the participants posed the question, 'Will a university-educated paramedic provide better service and have better outcomes than a vocationally-educated and trained paramedic?'. An answer to this question could be that vocational training is no longer meeting the needs of an expanding scope of practice within paramedicine, a scope that will require a much broader, more in-depth, and diverse educational background. The universal move to community paramedicine programs and a broader focus on paramedics as practitioners in primary healthcare (Eaton et al., 2021; Andrew, Nehme, et al. 2020) only reinforces the requirement for tertiary paramedic programs. This debate is not only occurring in Canada, but also dominates the discourse in the USA; mostly fuelled by the fire-department-based Emergency Medical Services (International Association of Fire Chiefs, 2018; O'Meara P. et al., 2018). If the PAC decides to pursue the goal of moving paramedic education into the tertiary sector by its target date of 2025, it is my hope that the findings of my research will make a substantial contribution to the decision-making process.

What are the implications of this research for Australia and New Zealand? From the time this research was conducted in 2013, the number of paramedic degree programs in Australia has increased to 17 in 2021 in Australia, with the number in New Zealand remaining at two (Brooks, Grantham, Spencer, & Archer, 2018). The issues raised from this research are still major factors that influence the recruitment and retention of paramedic academics in Australia and New Zealand. It is not clear how many paramedics in Australia and New Zealand have a doctoral qualification, but it is estimated that there are over 60, based on the self-registrations on the Paramedic Ph.D. website (Whitley, 2021), and it is known that not all paramedics have registered. Even though the number of paramedics who have been awarded a Ph.D. in Australia and New Zealand continues to rise, many are either retired or are soon to retire, thus depriving the discipline of valuable knowledge and mentorship. Those younger paramedics who have a Ph.D. or

doctoral degree and wish to enter an academic workplace are entering a workplace that is under considerable stress financially and structurally under the influences of managerialism and changing paradigms of tertiary education. This is further being exacerbated by the effects of the global COVID-19 pandemic, making many either modify their careers goals or even leave the academy to return to clinical work.

On a more positive note, after the publication of Paper 4 in 2019, I received an email from Dr David Long (personal communication, 2019), a paramedicine lecturer at the Queensland University of Technology (QUT) in Brisbane, Australia, stating how much he valued the insights in the article and that, along with a book chapter that I had co-authored in 2013 (Adams, Logan, Rorrison, & Munro, 2013) entitled 'Looking after yourself: "Lessons to be learned on entering academia"', he stated that he was going to give both articles to all recently employed and new paramedic academics at QUT as a means of making their move from clinical practice to academia a more informed and less ominous transition.

7.3 AREAS FOR FURTHER RESEARCH

Presented here are suggestions for further research that could contribute to our further understanding of the findings of my research and to identify areas not yet explored.

1. What is the impact of paramedic registration on academics' perception of their identity?
2. How is the demographic profile of paramedic academics changing in Australia and New Zealand? As the older, mostly vocationally trained paramedic academics are leaving the sector, how will the newer generation of university educated paramedics make the transition into the academy?
3. Have there been any improvements made to induction and mentoring programs at universities?
4. What steps are needed to improve the collaboration between the employers of paramedics, the professional colleges, and the universities to facilitate the development of the paramedic academics of the future?

7.4 CONCLUSION

The findings of this research indicate that the immediate focus should be on establishing more formal preparation and socialization of paramedic clinical practitioners into the academic environment by both the CoPs of paramedicine and the university sector. There needs to be a consolidated partnership between these two groups to ensure that those legitimate peripheral participants entering the academy can be better prepared to make the transition from clinical practice into the CoP of academia.

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FHEC No. **FHEC13/088**

PARTICIPANT INFORMATION STATEMENT

Project Title: ISSUES RELATED TO PARAMEDIC PROFESSIONALS TRANSITIONING INTO ACADEMIA

Researcher:
Graham Munro, La Trobe Rural Health School, graham.munro@latrobe.edu.au 03 5444 7697
Supervisors:
Professor Peter O'Meara, La Trobe Rural Health School, p.omeara@latrobe.edu.au 03 5444 7870
Dr. Amanda Kenny, La Trobe Rural Health School a.kenny@latrobe.edu.au 03 5444 7545

Dear interested study participant.

There are little to no published studies outlining the issues that paramedic professionals face when transitioning from the community of practice (CoP) of paramedicine to the CoP of academia. There are expectations that these new academics must engage in research, the acquisition of funding and writing for publication, yet few bring these skills with them from paramedic practice. This study is part of a doctoral research project, which aims to:

1. To identify the demographic characteristics of the professional paramedic academic.

2. To determine the factors that influence paramedic academic identity.

3. To identify the issues related to the transition of paramedic professionals into the academy.

4. Propose recommendations to improve the experience of paramedic professionals transitioning from practice into academia.

Who can participate?

In order to participate, you must be a paramedic academic affiliated with a tertiary, undergraduate, paramedic program in Australia, New Zealand or the United Kingdom.

What is involved?

Participants will be asked to complete a short, voluntary, anonymous, online survey to determine the demographic characteristics of the study population. This data will include gender, age, level of paramedic certification, years of experience as a paramedic practitioner, any previous teaching and research experience, level of education, year of experience as a paramedic academic and others.

Note: This study has been approved by La Trobe University's Ethics Committee. I understand that if I have any complaints or concerns about this research I can contact:

Secretary, Faculty Human Ethics Committee, Faculty of Health Sciences

La Trobe University, Victoria, 3086, Australia.

Telephone: +61 3 9479 3583, Email: fhechealth@latrobe.edu.auPlease quote reference number **FHEC13/088**

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From this group, a representative sample of respondents will be selected and asked to participate in a personal interview with the chief investigator that would last no more than 90 minutes. The interviews will be digitally recorded and then transcribed verbatim. The transcripts will be coded using pseudonyms to ensure the anonymity of the participant. The transcripts will then be analysed for dominant themes and the results will then be used in publications, conference presentations and a doctoral thesis.

What are the benefits of participation?

There is the possibility that there may be no individual benefit to the participant. The aim of this study is to identify the characteristics of the paramedic academic identity, the issues that confront paramedic practitioners that transition from practice to academia, and to make recommendations on how universities can better profile candidates for employment, and then, through selection processes and induction programs, make the transition into academia more effective and meaningful both parties.

Are there any risks to me being involved?

It is not expected that there will be any adverse consequences for any participant. However, in the unlikely event that any participant requires debriefing they will be referred to either their GP or free counselling services that are present in the primary health service.

What about my confidentiality?

The confidentiality of participants will be maintained at all times. All data will be identified by an identification number, pseudonym and date known only to the researcher. Consent forms and data will be stored separately and securely, as will all transcripts. Identifying material will not be included in subsequent manuscripts. This will be checked by the researcher.

All data will be de-identified and will be accessed only by the researcher. Data will be stored in a locked storage facility in the office of the researcher, in the Health Science Building, La Trobe Rural Health School Bendigo campus.

Some data will be stored electronically on the computer of the researcher, which will be protected by a password known only to the individual researcher and, any printed documents will be secured in a locked cabinet in the researcher's office. Any back-up files will also be password protected.

Following completion of the study, all data and consent forms will be stored in the research archives of La Trobe University, La Trobe Rural Health School, Health Sciences Building, Bendigo campus. All

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data will be held for a minimum retention period of five years from the date of collection, after which time it will be destroyed.

How will the findings from this study be disseminated?

You will be given an opportunity to review all transcripts and other information generated to ensure that it accurately reflects your ideas. Data collected in the course of this study may be included in a thesis, a report, published in journals or a book, presented at conferences, on a webpage or presented in appropriate public forums, such as the media and online. No individual participant will be identified in any dissemination mode without their written permission. Findings from the research will be available from the La Trobe Rural Health School web site located at http://www.latrobe.edu.au/health/about/schools/la-trobe-rural-health-school

Can I withdraw from the study after it commences?

Participation is entirely voluntary. You have the right to withdraw from the study at any time. If you wish data to be removed that has been generated from your participation (example your interview or in a focus group) you must request this within four weeks of your withdrawal.

If you would like to participate or have any questions:

If after reading this information sheet, you would like to participate in this research and/or would like further information, contact one of the following researchers:

Mr. Graham Munro La Trobe Rural Health School Faculty of Health Sciences PO Box 199 Bendigo Graham.munro@latrobe.edu.au 03 5444 7697	Professor Peter O'Meara La Trobe Rural Health School. Faculty of Health Sciences PO Box 199 Bendigo p.omeara@latrobe.edu.au 03 5444 7870
Associate Professor Amanda Kenny La Trobe Rural Health School. Faculty of Health Sciences PO Box 199 Bendigo a.kenny@latrobe.edu.au 03 54447545	

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Thank you for your interest in this project.

Sincerely yours,

[redacted]

Graham Munro

Peter O'Meara

Amanda Kenny

Note: This study has been approved by La Trobe University's Ethics Committee. I understand that if I have any complaints or concerns about this research I can contact:

Secretary, Faculty Human Ethics Committee, Faculty of Health Sciences

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30 July, 2013

Approval No: **FHEC13/088** (La Trobe University Human Research Ethics Committee)

CONSENT FORM: QUESTIONNAIRES

La Trobe University is a multi-campus university based in Victoria, Australia.

Title of project: Issues Related to Paramedic Professionals Transitioning into Academia

Investigators: Mr. Graham Munro
Professor Peter O'Meara
Dr. Amanda Kenny

Contact Details: Graham Munro
La Trobe Rural Health School, La Trobe University
Edwards Road, Flora Hill, 3552, Victoria, Australia
Telephone:+613 5444 7697 Email: graham.munro@latrobe.edu.au

I agree to take part in the above La Trobe University research project. The purpose of the research has been explained to me and I have read and understood the information statement given to me. I understand that by accessing and attempting to complete the questionnaire, I give my consent on the date of access. I understand that agreeing to take part means that I am willing to:

- Complete one questionnaire.

I understand that:

- I am free to withdraw my participation in the research at any time, and that if I do I will not be subjected to any penalty or discriminatory treatment.
- Any information or personal details gathered in the course of this research about me are confidential and that neither my name nor any other identifying information will be used or published without my written permission.

Sincerely,

[redacted]

Graham Munro

Note: This study has been approved by La Trobe University's Ethics Committee. I understand that if I have any complaints or concerns about this research I can contact:

Secretary, Faculty Human Ethics Committee, Faculty of Health Sciences

La Trobe University, Victoria, 3086, Australia.

Telephone: +61 3 9479 3583, Email: fhechealth@latrobe.edu.au.

APPENDIX 3

Demographic and Qualifications Questionnaire

1. Gender
    a. Male b. Female
2. Present age
    a.
3. Age when entering paramedic profession
    a.
4. Location of EMS system where initial training obtained
    a. UK b. Australasia c. Canada d. USA e. other
5. Length of entry-level training
    a. < 6 months b. 6 – 12 months c. 1 – 2 years d. > 3 years
6. Type of entry-level training
    a. In-house vocational b. College vocational c. University diploma d. University Degree
7. EMS system where majority of experience gained as a paramedic
    a. Urban city b. Urban/rural fringe c. Rural d. Remote e. Military f. Industrial g. air ambulance
8. Levels of paramedic certification obtained
    a. Emergency First Responder b. Primary Care Paramedic c. Advanced Care Paramedic d. Critical Care Paramedic e. Special Teams
9. Level of post-secondary education completed prior to entering academia
    a. None b. Graduate Diploma c. Undergraduate Degree d. Postgraduate Degree e. Doctorate/PhD
10. Mode of tertiary education
    a. Full time/on campus b. Part time/on campus c. distance/online education
11. Involvement in training/education prior to your first position as a part time/fulltime academic
    a. Instructor CPR/First Aid b. Sessional instructor in vocational program (non-university) c. Sessional instructor in tertiary program d. Fulltime instructor/trainer
12. Years of paramedic practice before pursuing any educator role. If you have never been in an education role, please enter 0
    a.
13. Level of experience in research before entering academia
    a. None b. Participant c. Member of investigation team d. Chief Investigator e. Higher Education qualification
14. Level of formal education in research before entering academia
    a. None b. Self-taught c. Undergrad Program subject d. Postgraduate subject e. Completed research qualification
15. Level of experience in academic writing before entering academia
    a. None b. Self-taught c. Undergrad d. Postgrad c. Doctoral/PhD
16. Experience in journal/book publication before entering academia
    a. None b. Co-author c. First author
17. Number of publications prior to entry into academia
    a. None b. 1-3 c. 3-5 d. > 5

(Please note: Questionnaire to be converted to Survey Monkey format.)

APPENDIX 4

Interview Questions

The questions used in the semi-structured interviews reflected the ten higher codes that had been identified as important for this research. Additional questions were used to clarify and expand on the existing codes and further questions were asked in an effort to explore other areas of interest that were not covered by the structured questions.

- Thanks for offering your time to help me out with this project. I was wondering if you can tell me a little bit about your background and how you got into paramedicine?
- Can you describe what the challenges were for you when you transitioned from paramedic practice into academia?
- Can you describe your teaching experiences prior to entering your teaching position at the university?
- What was the recruitment process by the university like for you?
- Can you describe the induction process when you started at the university?
- Were you assigned a formal mentor when starting at the university and what was that experience like?
- Can you describe what your vision of academia was prior to starting in tertiary education and what were your influences on this vision?
- Do you still consider yourself to be a paramedic? Do you consider yourself to be an academic?
    - When you are at a party and someone asks you what you do, how do you respond? OR
    - When you are on an international flight and you are filling in the border entry card and it asks you for your profession, what do you fill in?
- What was your experience with research prior to entering the academy, and what were the expectations of your employer regarding research?
- What do you consider to be the major challenges related to transitioning from clinical paramedicine to an academic role in a university?

[redacted]

From: Irish Journal of Paramedicine <editor@irishparamedicine.com>
Sent: Thursday, 2 September 2021 11:45 AM
To: 'Graham Munro'
Subject: RE: Permission to publish in PhD thesis

Hi Graham,
You retain the copyright for any article published in IJP and can reuse as you wish once you attribute the publication with a citation.
Thanks,
Alan

From: Graham Munro [redacted]
Sent: September-01-21 20:23
To: editor@irishparamedicine.com
Subject: Permission to publish in PhD thesis

To whom it may concern,

I would like to obtain your written permission to include the two published articles listed below in my PhD thesis publication as per the requirements of Latrobe University in Australia. Please provide me with any requirements that you may have regarding format.

https://www.lenus.ie/handle/10147/620962

http://irishparamedicine.com/index.php/ijp/article/view/107

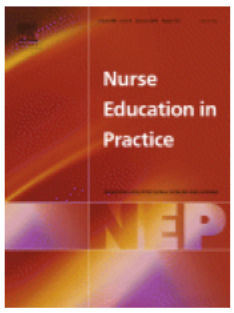
I thank you for your kind consideration of my request.

Sincerely,

Graham Munro

Sent from Mail for Windows

APPENDIX 7



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APPENDIX 8

You're Invited to a special meeting following the Paramedic Chiefs of Canada and IRCP Conferences!

WHAT: IRCP hosted college & university paramedic degree alignment planning

WHEN: Sunday, June 5, 2016

WHERE: Delta Hotel, Saskatoon, Saskatchewan, Canada

HOW MUCH: Free! Meeting facilities are being provided by the Paramedic Chiefs of Canada and the International Roundtable on Community Paramedicine

HOW: CLICK HERE to register for this session

Driven by changes in the healthcare environment communities globally are increasing their reliance on professional paramedic services. In response, several countries are responding with educational advances that include moving toward a degree requirement for entry to practice for paramedics. Even where not mandatory, some employers are seeking a degreed paramedic workforce and the paramedic workforce demands mobility.

Because of these changes the International Roundtable on Community Paramedicine is hosting a forum for colleges and universities that educate paramedics. The goal of this meeting is to further understand existing and proposed models of higher education in paramedicine to optimize and coordinate efforts and plan for increasing the global mobility of all paramedics (including but not limited to Community Paramedics). Through discussion the aim is to seek alignment among the paramedic academic community on essential content, (e.g., foundations, depth and breadth requirements) structure, academic department(s) etc., necessary to educate paramedics of all levels and advance the profession.

Why should my academic institution attend?

- By aligning required and desired coursework your institution will better support paramedic students and their employers.
- If you already have a degree program, we invite you to share your model as a potential standard to be considered.
- If you are considering a degree program in paramedicine, learn from others
- Debate the direction, appropriateness and utility of higher education in paramedicine broadly
- Contribute to the establishment of global educational goals in paramedicine degree programs (while ensuring local variation)
- Discuss educational advances and research impacting paramedicine education broadly