Innovation Among Elite Paramedics the Dynamics of Interprofessional Identities and Practice

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***Abstract*—This article presents an ethnographic account of professional identity formation among a new breed of Elite paramedics in the UK. Drawing on interviews, observations and documentary evidence, we establish an emergent theory of 'intersectional professional identity' that highlights the interaction between personal and public selves in the construction of professional identity. Our analysis evaluates intra- and inter-professional relationships between Elite healthcare professionals engaged in pre-hospital care and draw on intersectional theory to understand how intersecting personal identities are situated in organizational systems of privilege or oppression. Our findings demonstrate that professional identity formation is driven by a combination of 'knowledge constitutive' interests that operate at technical, practical or emancipatory levels.**

***Index Terms*—Professional identity, intersectionality, knowledge constitutive interests, identity politics, medical socialization, paramedics**

I. Introduction

Jazz is often considered as the ultimate representation of freedom and authenticity. But Jean-Paul Sartre [1] contends, in a circular self-validating manner, that authenticity can have an illusory quality:

"If you seek authenticity for authenticity's sake, you are no longer authentic*."*

But where is this authentic, core or true self in the everyday lives of professionals? Management theorists tend to focus more on public rather than authentic selves where favoured perspectives suggest that professional identity is developed through socialization processes or the construction of self-narratives. Existing theories tend to overlook the nature of the personal and how it interacts with the public self to form professional identities and inform action. The assumption of personal selves can be one of a unitary, immutable and privileged subject unhindered by the messiness of subjectivity. Emancipatory interests are neglected where conflicts and struggles in organisations prevent the development of authentic selves [2].

It was these unanswered questions around identity formation which prompted our guiding research question: How do professional personal and public identities interact to inform practice? The objective of this paper is to contribute to a better understanding of the mutually constitutive relationships between public and personal selves in the construction of professional identity.

Manuscript received June 30, 2017; revised October 30, 2017.

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II. Conceptual Foundations

A. Potential Selves and the Construction of Professional Identities

The way professionals create their identities is central to how they create practical knowledge (praxis) to inform their actions in any given situation. Ibarra [3] argued that it was a stable constellation of attributes, beliefs, values, motives and experiences that shape each professional role. Other scholars have claimed that professional judgement, reasoning, critical self-evaluation and self-directed learning are essential components for an individual's 'sense of being a professional'. While the promotion of ethical standards may be another commonality, such attributes are unlikely to be universal or taken with the same vigour by each individual. Minimum technical and interpersonal competence threshold levels are likely to exist in each professional role even if wide disparities exist among professionals. The literature goes beyond "I do, therefore I am" notions of professional identity and suggests it's more precarious and under threat from internal self-questioning and doubt as well as external predicaments of organisational life.

Socialization theory as an explanation for professional identity is problematic as the psychological is neglected with a greater emphasis on the social. Professional identity is not purely a function of relationships and role changes but an inner process of agency of the mind. Professionals do have considerable control over their self-conceptions and self-beliefs. But there is little in the literature on how these notions of 'professional self' develop at the conscious and unconscious levels [4]. In addition, the role of memory in the development of professional identity appears to be side-lined. Memories of self, memories of previous career transitions and memories of past experiences that shape private and public identities are neglected in such conceptions. There is little room for emancipatory possibilities of professional identity where resistance, conflicts and struggles in relations of meaning occur in the workplace [2] and prevent the development of the authentic and free self.

B. Identity Clarity: Augmenting Professional Identity with Intersectionality and Knowledge Constitutive Interests

We argue that clarity of identity can only occur when conceptions of professional identity are augmented by intersectional theory, a feminist theory arising from gender, queer and postcolonial studies, which examines identity at the most fundamental level of gender, race, class, ability, sexual orientation, age, nationality, religion and so on and how these axes of identity interact on multiple and simultaneous levels [5]. Intersectionality serves to subvert binaries of identity such as race/gender divides by theorising

them in a more complex fashion as occurring at intersections of social processes associated with race and gender [6]. To understand subordination of black women is to examine the intersection of gender and race that are mutually constitutive rather than to consider social processes related to race and gender separately almost in an additive manner. Clearer understandings of identity arise when more than one category of identity are analysed and where multiple axes of differentiation such as economic, political, cultural, subjective and experiential intersect in historically specific contexts [7]. Our starting point is that professional identities have multiple intersecting identities including those associated with vocational aptitudes and occur at a set of intersecting social relations. Professional identity is complex as it is inextricably linked with vectors of power and where the nature of subjectivity is messy. The reason why categories of race, gender, social class and sexuality are central in defining professional identity is that they do not purely describe similarities or differences in groups but the intersection of these categories encapsulate historic and 'continuing relations of political, material and social inequalities and stigma'. This expression of professional identity is about giving voice to the personal self as well as the oppressed, unheard voices and multiply marginalised professionals [8]. The paradox is that a person may experience marginalisation and empowerment at the same time as they are advantaged in their status by belonging to a certain professional group but disadvantaged by their belonging to a certain social category such as black women doctors [9].

III. Research Design

Our primary motive was to understand professional identity among a new breed of Elite paramedics and explore how personal and public identities interact to inform practice. We chose ethnography to seek to understand the social world of all the members associated with this innovation [10]. Our findings are based on an 18 month ethnographic study. This was the first introduction of any form of advanced paramedics among ambulance services in the UK. One of our researchers entered the field as a daily participant to observe the actions, meanings, artefacts and outcomes of the innovation process. An ethnographic record was created to deepen our understanding and to create accounts of the cultural lives of all those involved. This involved combining daily observations with conversations, interviews, documentary evidence and survey data held by the Trust. We were committed to methodological holism and were careful not to discard any material, no matter how trivial, in case it shed light on the cultural whole and aid future theory building.

IV. Research Findings

A. The Case Study Setting: The Siren Ambulance Trust

The Siren Ambulance Trust responds to emergency calls from the public and healthcare professionals and provides non-emergency patient transport services. Patients can range from critically ill and injured to those with minor healthcare needs that can be treated at home or in the community. The Trust receives almost 500,000 calls each year in the UK and employs around 3000 staff. Calls can be life threatening such as heart attacks and serious blood loss where the speed of response can be critical to saving lives or improving clinical outcomes. Less serious conditions are also managed which may require alternative care pathways rather than taking patients to hospital.

The Trust decided to develop a new role of Elite paramedics in response to a number of national reports critical about pre-hospital care for seriously ill and injured patients. One common thread in all these reports was the need to reduce 450-770 preventable deaths annually in England and to improve patient survival rates (20% higher) comparable to those in the United States and Australia.

B. Intersectional Professional Identity and Praxis

The data structure of the study is shown in Fig. 1 and our emergent model of intersectional professional identity and praxis is shown in Fig. 2 below:

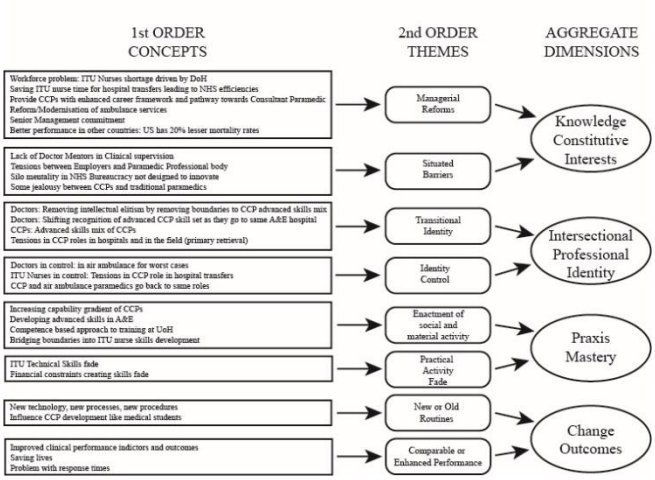

Figure 1 Data structure of study

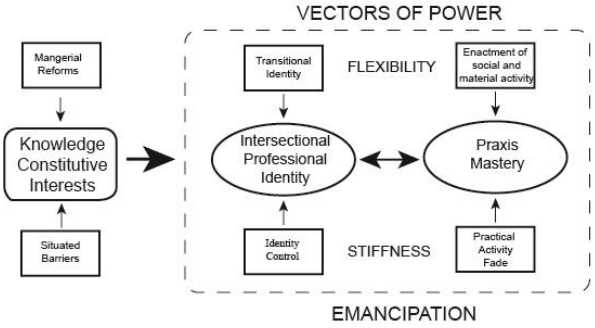

Fig. 2. Emergent model of study.

C. Intersectional Professional Identities

For the purposes of this paper, we will focus on the intersectional aspects of our findings. The notion of stable and enduring identities against unstable and temporal identities emerged from our analysis. We gave stable identities the quality of stiffness and unstable identities the quality of flexibility. We found that these labels better described our impressions in the field and modelled the notion of ambiguity as a linear entity between these two qualities.

Here we found 'transitional identities' that provided ambiguous flexibility in the change process as well as 'identity control' that provided ambiguous stiffness. For Elite paramedics, transitional identities arose from their new

clinical leadership roles and identities that were in a state of flux. The context was plastic. Such a role did not exist anywhere else in the UK and hence Elite paramedics needed to develop new identities with their advanced skills set and prestige for attending the most serious cases of trauma. In this sense they have taken on a clinical leadership in the field:

'Personally I see it as providing clinical leadership where historically there hasn't been one within the structure of the Ambulance Service. Usually that's something that has been provided by external bodies such as HEMS (air ambulance).' (Elite paramedic)

But the transitional identity created a blurring between the skill set of Elite paramedics and doctors; one with years of medical training in hospitals and the other with years of training in a pre-hospital care. The differences between a diagnostic approach by doctors and a protocol driven approach of Elite paramedics was reflected by one A&E consultant:

'So yes I think Doctors are different from nurses, paramedics and other people. It doesn't mean they're better, but I always really felt that not to be case. It doesn't mean they're cleverer. Its means they can assimilate a different skills set quickly and differently and that allows you to make different diagnoses and think about other rare things and try and channel down to different areas, which medical school training of course encourages you to do.'

A certain stiffness in professional identity arose from different forms of 'identity control' where each healthcare professional wanted to maintain their everyday identity with little change. In air ambulances (HEMS), doctors maintained their identities by remaining in control even though Elite paramedics could undertake many of the clinical procedures under their supervision. Their Australian counterparts are primarily involved in debrief roles allowing Elite paramedics to conduct the clinical leadership roles in all forms of pre-hospital care:

'I've just come from the debrief today. The debrief was only done this afternoon on that whole deployment to Samoa and all of the doctors unanimously were absolutely rapt with that command structure. They felt that they could do the stuff that they're good at …we did all of that so that the two paramedic team leaders did all that stuff and the doctors were then able to provide their know-how' (AU Elite paramedic)

Similarly, ITU nurses were reluctant for Elite paramedics to undertake their roles in hospital transfers as it undermined their professional identity. They reasoned that Elite paramedics could not be relied upon to care for unstable critically ill patients as they were not enmeshed in intensive care on a daily basis, did not maintain their critical care skills and their ITU placement were too short and inadequate. They argued that Elite paramedics lacked the experience of ITU nurses who looked after major trauma patients for many weeks, knew their families, their doctor and their specialist equipment. What they failed to argue was why the same level of training for AU Elite paramedics resulted in 40% of their work involved in inter-hospital transfers compared to 5% for Elite paramedics in the UK.

This level of subordination meant that Elite paramedics soon lapsed back to their roles in patient retrieval due the lack of transfer opportunities and regular contact with ITU nurses. They had developed the skills in this hybrid role but they were not being deployed to conduct work in hospital transfers unaided:

'…transfer wise it's still got a little bit of way to go, because the idea was that we didn't take an ITU Nurse with us. Transfer wise at the moment, if we take an ITU Nurse with us, it's still filling a role but it's not quite all the way there.' (Elite paramedic)

V. Discussion

A. Construction of Public Selves

Processes of medical socialisation [11] suggest that the three Elite actors (doctors, nurses and paramedics) in this study would maintain their relative status and identity despite major changes in the role of the Elite paramedics that overlapped some of the skills of Elite doctors and nurses. Each had similar skills sets; one in pre-hospital care and the others in the hospital context. Here the formal socialisation process was moving away from the traditional paramedic mindset and more towards a fresh cultural outlook based on new knowledge, values and attitudes [12]. This was particularly the case in undertaking new clinical leadership roles and navigating new transitional identities in realms outside their everyday actions. During the course of their studies, considerable conflict and confusion was observed among Elite paramedics as they made sense of differences between their University learning, clinical work placements and realities of their everyday work.

But socialization is problematic here as the paramedic profession does not socially control the assimilation of certain norms and values associated with this new role [13]. The role of Elite paramedic has not existed previously in the UK and there is no template on how the individual becomes part of a new professional group. Traditionally new recruits have developed their new sense of selves through the process of observation of current professionals, imitation and internalisation of their behaviours [14]. Recourse to these behaviours is unavailable to this new professional breed. Instead, socialization becomes a negotiated process between the project sponsors, traditional paramedics elevated to higher knowledge-based roles as well as Elite doctors and nurses engaged with saving patient lives.

B. Construction of Private Selves

Professional identities do not exist in isolation. Instead, we argue that these public selves are augmented with personal selves; what it is to be human. At the most basic level, Elite paramedics in this case study came from a disadvantaged group of white working class men; one of the most under-represented groups in British higher education. One cannot erase this identity from their public persona but recognise that multiple forms of subordination and domination arise when these axes of identity interact on multiple and simultaneous levels.

Let us deconstruct two forms of domination found in this case study. The first is the fact that only 5% of Elite paramedic workload was involved with inter-hospital transfers compared to 40% with their Australian counterparts. Elite (ITU) nurses were traditionally engaged in accompanying severely ill and injured patients in ambulances to specialist hospital centres. They continued in

this role even though Elite paramedics had developed the necessary skills to do so. Encroachment of professional boundaries would have been minimal and only associated with transporting patients. Given that Elite nurses were over-stretched in hospitals and there was a major shortage of their skills throughout the UK, there didn't appear a rational argument not to use Elite paramedics in this role. As a group, most Elite nurses were white middle class women in this study. Adopting intersectional analysis, one can see professional inequalities and exclusions rooted in gender, class and organisational hierarchy. Social location becomes a mediating factor as intersectionality becomes an interplay of power relations between the professional and their location [15]. Professional identity of Elite paramedics in Australia is undeterred by social inequalities similar to those found in the UK.

Another example of domination is in the continued use of doctors on air ambulances when Elite paramedics have similar skill sets and abilities in pre-hospital care to treat and deliver severely ill or injured patients safely and speedily to specialist hospitals. Whereas Australian Elite paramedics undertake clinical leadership roles in air ambulances, this is not currently the case in Britain. The identities of Elite (A&E) doctors in this case study was one of privilege not only from their hierarchical standing but also as predominantly white middle class men. From an intersectional perspective, personal selves of subordination were constituted through the subjectivities of prevailing groups where social differences became embedded in historically constituted structures of domination; in this case those of working class men [7].

In our conception of professional identity, we argue that identity is formed through socialization by mutually reinforcing vectors of race, class, gender, sexuality and hierarchical status; where the public and personal selves intertwine. Intersectional professional identity occurs through social relations of political, material and social inequality and stigma. While we have argued that personal selves are underlined by intersectional subjects and oppression, this is clearly less of a case in professional doctors from their privileged axes of identity.

VI. Conclusions

Our research was motivated by a search to understand the formation of professional identity more fully. We recognised that current favoured perspectives around socialisation and self-narratives downplayed the personal over the public in the construction of professional selves. The assumption in the current literature was that individuals would behave in the same automated manner despite differences in their personal identities. A black woman professional from a deprived neighbourhood would act identically to a white male professional from a privileged one. No recourse was made to how axes of personal identities interact to create social injustices or inequalities in the lives of certain groups of professionals.

This article provides three contributions to the literature through an ethnographic study of Elite paramedics in the UK. First, we develop an emergent theory of professional identity that closely fits our research findings. Our alternative theory is coined 'intersectional professional identity' to highlight the interaction between personal and public selves in the development of professionals. Each of these selves is driven by professional needs and interests, 'constitutive interests', which inform professional practice and action. Second, we draw on intersectional theory to understand the construction of personal selves through various axes of identity interacting on simultaneous levels. Our study highlights systems of organisational oppression and privilege arising from these intersecting social identities; in particular the plight of white working class male Elite paramedics in their interactions with Elite nurses and doctors with similar skill sets in pre-hospital care. We go beyond black women as protypical subjects of intersectional studies and demonstrate how personal identities can create professional inequalities that ultimately inform practice. Third, we explain the drivers in the construction of professional identities as triggered by knowledge constitutive interests. These needs or interests are produced by socio-historically situated subjects and allow a greater understanding in the variability of professional identity constructions; whether driven by technical, practical or emancipatory interests or a combination of them.

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