The Paramedic Preceptor Experience: Improving Preparation and Support

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Certificate of Authorship

I hereby declare that this submission is my own work and to the best of my knowledge and belief, understand that it contains no material previously published or written by another person, nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgement is made in the Thesis. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged.

I agree that this thesis be accessible for the purpose of study and research in accordance with normal conditions established by the Executive Director, Library Services, Charles Sturt University or nominee, for the care, loan and reproduction of thesis, subject to confidentiality provisions as approved by the University.

Hamish Carver

Name  Signature  Date
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Ethics Approvals

This research has been undertaken with approval from the following Human Research Ethics Committees:

Charles Sturt University
406/2012/11

South Eastern Sydney Local Health District
13/022 (LNR/13/POWH/90)
Abstract

The preceptorship model of clinical education is widely used across Australia to assist new graduate and trainee paramedics in their transition from the classroom to the practical real world of providing pre-hospital emergency care. Preceptorship has been explored in-depth in many of the health professions, but despite being recognised as an essential component of paramedic education, there is a dearth of research that has explored the experience of being a paramedic preceptor.

The aim of this study was two-fold. Firstly, to understand the experience of being a paramedic preceptor to novice paramedics who are in their first year of on-road clinical practice within an Australian ambulance service. Secondly, use this new understanding to inform the development of recommendations that will enhance the effectiveness of paramedic preceptorship programs. To achieve these aims, the study employed a hermeneutic methodology informed by the philosophical hermeneutics of Hans-Georg Gadamer (1900-2002). Audio recorded conversations were conducted with eleven qualified paramedics from a single Australian ambulance service who have experience as a paramedic preceptor in order to explore their lived experiences of being in the preceptor role.

Out of this research emerged a comprehensive understanding of the paramedic preceptor as a complex, multi-dimensional role in which a paramedic acts as a coach, role model, socialiser and protector while working one to one with a novice paramedic in their first year of on-road practice. Through in-depth conversations the psycho-emotional experience of being a paramedic preceptor was revealed as emotionally demanding, with participants describing a tangible sense of having a
greater level of responsibility, accountability and increase in work load, which led to feelings of stress, frustration, and mental and physical exhaustion. Despite this, paramedics gained intrinsic rewards and benefit from being in the preceptor role. Participants described feeling a sense of satisfaction from seeing the novice develop and grow professionally in their competence and confidence. It was also an opportunity for the preceptor’s own professional development, and many of the participants developed close friendships with their preceptees.

At the organisational level, this study disclosed a lack of preparation for paramedics to undertake the role of preceptor. Furthermore, the study participants described an environment of minimal support from on-road clinical educators during preceptorship. In contrast however, most participants felt well supported by their peers and colleagues. These findings highlight a substantial opportunity to improve paramedic preceptorship. To this end, important recommendations are made which include a proposed model for a preceptor preparation course that outlines three learning modules: understanding paramedic preceptorship, roles and responsibilities of the paramedic preceptor, and managing yourself during preceptorship. Further, several strategies are recommended that will improve the support provided to paramedic preceptors while undertaking this critically important role in the formative education of novice paramedics.

Significantly, this study offers a new framework for understanding paramedic practice and learning during paramedic preceptorship. Through a sociomaterial approach, the framework presented in this thesis emphasises the process of becoming a competent, autonomous paramedic as an effect of the everyday relational networks, of human and non-human elements, in which the novice and preceptor practice.
Chapter 1
Introduction

1.1 The Focus and Context of this Study

This study explores the lived experience of being a paramedic preceptor to novice paramedics in their first year of on-road clinical practice within an Australian context. Using hermeneutics, informed by the philosophy of 20\textsuperscript{th} century German philosopher Hans-Georg Gadamer (1900-2002), I engaged in conversation with eleven paramedic preceptors to co-create an understanding of what it means to be a paramedic preceptor.

In Australia, paramedics are responsible for providing emergency and non-emergency out-of-hospital clinical care to the community. The term paramedic in this thesis refers to all pre-hospital clinicians qualified or undertaking qualifications to provide emergency care under the auspices of a State Government ambulance service and is thus synonymous with ambulance officer or emergency medical technician.

Entry to the paramedic workforce in Australia generally begins with a period of formal education through tertiary degree or education by an ambulance service’s own training centre. An on-road internship is then undertaken prior to qualification as a paramedic. During this internship the novice paramedic is paired to work with an experienced paramedic who acts as their preceptor. A number of terms are used interchangeably to describe the role of the experienced paramedic including preceptor, clinical instructor, mentor, supervisor, paramedic instructor or clinical
educator (O’Meara, Williams, & Hickson, 2015). In this thesis I use the term preceptor.

The focus of this study was to connect with these experienced paramedics through conversation and rich discourse to develop an understanding of their everyday world while working closely with novice paramedics. Through one to one conversations and later with transcriptions of these conversations, I engaged with the narratives of the participants, seeking out the taken for granted and hidden meanings of the experience of being a preceptor. The understanding I articulate in this thesis gives a new and hitherto unexplored perspective of what it means to be a paramedic preceptor. In Chapter Eight, this study provides a new framework of understanding the development of paramedic expertise and learning through preceptorship. I use a sociomaterial approach to explain how expert practice emerges from within an intricate web of interconnecting social, cultural and material elements.

1.2 Paramedic Education in Australia: A Brief Overview

The emergence of tertiary level education in the discipline of paramedic education is a relatively recent phenomenon in Australia (Willis, Williams, Brightwell, O’Meara, & Pointon, 2010). It was not until 1994 that the first degree level qualification was realised for Australian paramedics (Lord, 2003). Lord (2003) asserts that this transition from a vocationally based, post-employment training model to a pre-employment tertiary model was to facilitate the move towards professionalisation of the paramedic discipline and to fill some perceived gaps in the vocational education traditionally received by paramedics. Apart from the clinical aspects of paramedic education, the professionalisation of paramedicine is also enhanced by the growth of paramedic academia with “its own body of knowledge, its own literature and
increasingly its own research base providing evidence for practice” (Joyce, Wainer, Piterman, Wyatt, & Archer, 2009, p. 535). This transition comes at a time when not only is the demand for ambulance services increasing, but there is also a significant change in the nature of paramedic work from a predominantly transport focused service, towards a more holistic primary health care service with increased responsibility for clinical decision-making and treatment (Joyce, et al., 2009; The Council of Ambulance Authorities, 2010). It should be noted however, that despite an overall trend towards higher education, both the post-employment vocational model and the pre-employment university model still exist as pathways to becoming a paramedic within Australia today (Edwards, 2011).

Paramedic academics and employing agencies continue to earnestly debate the readiness of new graduates to work as paramedics at the completion of their tertiary studies (Edwards, 2011; Willis, Pointon, O'Meara, McCarthy, & Lazarsfeld-Jensen, 2009; Willis, et al., 2010). Notwithstanding the debate surrounding specific attributes and competencies of new graduates, consensus does appear to have largely been reached that graduate paramedics are not ready to practice independently immediately following their university studies. It is only after a period of internship during which time the new graduate works with an experienced paramedic are they considered ready to work as an autonomous clinician (The Council of Ambulance Authorities, 2013). In South Australia, Flinders University regards the internship year as an essential component of the education of new paramedics before they are ‘industry ready’ (Pointon, 2004). Similarly, Edith Cowan University in Western Australia does not regard its graduates as ready to practise until completion of a one year internship (Willis, et al., 2009).
In New South Wales, university graduates complete a twelve month on-road internship under the guidance and support of a paramedic preceptor to develop the ‘practical aspects required of an operational paramedic’ (Ambulance Service of NSW, 2014). As of 2015, the Ambulance Service of NSW remains one of the few states that still offer a post-employment entry pathway to its ambulance service. At this time, student paramedics without a tertiary education in paramedical science still complete a twelve month supervised on-road practicum with a preceptor, but they must also undertake a further eighteen months on-road and an additional four week didactic course before becoming a qualified paramedic. Student paramedics who qualify through this pathway receive a Diploma of Paramedical Science (Ambulance) (Ambulance Service of NSW, 2014).

Ambulance Victoria only accepts graduate paramedics and no longer offers a vocational post-employment entry pathway. Upon employment graduate paramedics complete the Graduate Ambulance Paramedic (GAP) Program during their first twelve months, which sees new graduates work under the supervision of a paramedic preceptor, termed “Clinical Instructor”. Ambulance Victoria considers new graduates “academically qualified, but not yet ready to practice independently” (Ambulance Victoria, 2013, p. 7).

In Tasmania, new employees who have completed a recognised paramedical science degree undertake the Ambulance Tasmania’s Transition to Practice Program over a two year period, which serves to integrate them into clinical practice as a qualified paramedic (Ambulance Tasmania, 2015).
Similarly, becoming a paramedic in the South Australia Ambulance Service requires pre-employment completion of a Council of Ambulance Authorities accredited university degree to gain employment as a paramedic intern. New paramedics complete the SA Ambulance Service Paramedic Internship over a twelve month period, which is a “facilitated educational and operational program” (South Australia Ambulance Service, 2015).

Western Australia has a unique model for the recruitment and training of new entrant novice paramedics. Upon successful recruitment to St John Ambulance Western Australia (WA) as a Student Ambulance Officer, the novice enrolls into a Bachelor of Health Science (Major in Paramedicine) with Curtin University for a four year period. Their first year is undertaken as a non-paid, full time student. In the second year the Student Paramedic commences paid employment, with training co-located between Curtin University and the St John Ambulance WA College. Following an induction course, students commence an on-road internship with a paramedic preceptor. In years three and four, tertiary studies are continued simultaneously while working on-road. Upon successful completion of the degree and other training requirements, graduates become a qualified St John Ambulance WA Paramedic (St John Ambulance Western Australia (WA), 2015).

Queensland Ambulance Service has recently ceased their vocational entry pathway and transitioned to a pre-employment graduate entry only model to become a paramedic (Queensland Ambulance Service, 2015). New graduates complete the Graduate Paramedic Induction Program over a twelve month period. Graduate Paramedics initially complete a four week orientation and training course followed
by supervised on-road practice under the support and supervision of a paramedic preceptor. Upon successful completion of the required components, graduates qualify as an Advanced Care Paramedic Level 2 (Queensland Ambulance Service, 2015).

1.3 Significance of the Study

Preceptorship is a defining period in the formative education of the novice paramedic, with effective and dedicated paramedic preceptors being essential to the success of new graduate and trainee paramedics (Lazarsfeld-Jensen, Bridges, & Carver, 2014). However, a recent study by Devenish (2014) suggests paramedics are not adequately prepared for the added complexity of being a paramedic preceptor to new graduates. O’Meara et al. (2015) have similarly reported that paramedics may receive no preparation or training before being required to precept student paramedics on clinical field placements. Edwards (2011) and Willis et al. (2009) have demonstrated that ambulance services across Australia rely on paramedic preceptors as an essential partner in the formative education of novice paramedics. While a number of studies explore the experience of being a preceptor from nursing and other health professions (Charleston & Happell, 2005; Enrico & Chapman, 2011; Ohrling & Hallberg, 2001; Richards & Bowles, 2012), my comprehensive search of the literature revealed that little is currently known about the actualisation of undertaking this important role from the perspective of paramedic preceptors (see Chapter Two).

Research demonstrates that the first twelve months of clinical practice is a critical period of transition from student to clinician and the use of preceptorship during this formative period is cited as crucial to developing confident, safe, autonomous clinicians (Australian Senate, 2002; Casey, Fink, Krugman, & Probst, 2004; Whitehead, 2001). It is widely recognized that the preceptor model of clinical
education plays a critical role in the development of novice clinicians’ critical thinking (Florence Myrick & Yonge, 2004), facilitation of thinking beyond psychomotor skill development to a holistic perspective to patient care (Nehls, Rather, & Guyette, 1997), socialisation into the organisation (Devenish, 2014; Nesler, Hanner, Melburg, & McGowan, 2001), provides an encouraging environment that facilitates professional development (Dyess & Sherman, 2009) and builds professional confidence (Devenish, 2014; Joyce Mills & Mullins, 2008). Preceptorship is therefore an important topic of research.

There is a relative paucity of empirical research in paramedic practice compared with similar health professions such as nursing and other allied health professions and it is common place for evidence to be loaned from these neighbouring professions (Carter & Thompson, 2015). It has also been recognised that there are short falls linked with articulation of this evidence to paramedic practice (Carter & Thompson, 2015, p. 22). Therefore, given the very different working environment and contextualisation of the paramedic preceptor role to other health professions, it should not be assumed from research in other areas of health that the paramedic preceptor experience is well understood. Thus, there is clearly a need to explore paramedic preceptorship to better understand the meaning paramedics ascribe to the role of preceptor, the personal impacts of being a preceptor, and their perceptions of preparedness to undertake this vital role.

This study makes a significant and original contribution towards understanding the experience of being a paramedic preceptor. Moreover, recommendations are made to
improve the preparation and support of paramedic preceptors offering a valuable way forward to building more effective paramedic preceptorship programs.

1.4 Research Aims
Through a fusion of horizons (Gadamer, 1989/2004) between myself and participants, this research aimed to explicate a co-created understanding of what it means to be a paramedic preceptor to novice paramedics in their first year of clinical practice. Moreover, the new understanding revealed in this study will provide the empirical evidence to inform the development of recommendations to enhance the effectiveness of paramedic preceptorship programs.

1.5 Research Questions
The underpinning research question for this study is:

*What is the lived experience of being a paramedic preceptor to novice paramedics in their first year of on-road clinical practice?*

Sub-questions to support the research included:

i. What does it mean to be a paramedic preceptor?

ii. How do paramedic preceptors perceive their preparedness to undertake the role of preceptor?

iii. What are the challenges experienced by paramedics while performing this role?

iv. Are there benefits or rewards derived from being in the preceptor role?

v. What emotions are evoked by undertaking the preceptor role?

vi. Do paramedics feel adequately supported to effectively perform in the preceptor role?
1.6 Use of the First Person Narrative

As an equal partner in this co-construction of understanding the paramedic preceptor experience, use of the first person narrative was the most appropriate form to articulate this research. As will be discussed in Chapter Three, the result of a Gadamerian inquiry is not a reproduction of data, but instead represents a co-created understanding of the phenomena of interest that is reached between the participants and researcher as equal players in a fusion of their horizons. That is, the researcher becomes immersed in a dialectical and dialogical conversation with participants to construct and negotiate a shared understanding.

1.7 My Story

A key tenet of philosophical hermeneutics (Gadamer, 1989/2004) as the chosen methodology for this study is the shared understanding that develops between researcher and participants through the research process. As such, although I am the researcher, I am also a co-participant. The understanding of paramedic preceptorship elucidated in this thesis is a fusion of horizons, or perspectives, of all the participants in this study, including myself. A brief synopsis of my past relationship with the phenomenon is thus provided as a backdrop for the ensuing research.

I began my career as an Australian paramedic just over a decade ago. I entered the profession through the vocational pathway, not having a tertiary degree of any type. My training and education to become a qualified paramedic was through my employing ambulance service and took place over a period of three years. Once qualified, I undertook further studies to obtain a tertiary degree in paramedicine. After a brief career change into health management and obtaining a Master’s Degree in
Health Management, I returned to the role of operational paramedic and continue in this position today.

Throughout my career as an operational paramedic I have been in the role of paramedic preceptor to vocational trainees and tertiary graduate paramedics on at least a dozen occasions. Interestingly, it was both my first experience as a trainee being precepted and my first experience as a preceptor that have been most influential in my interest in pursuing this research topic.

As a trainee in my first roster on-road as a paramedic, I encountered a preceptor who was, by his own admission, burned out. He had been rostered with trainee after trainee and unfortunately my time was less than pleasant, emotionally challenging and led me to have feelings of inadequacy, frustration and thoughts of resigning before my career had even begun. This negative experience has stayed with me and serves as a reminder of how significant the preceptorship period is in the developing novice paramedic.

My first experience as a preceptor also shaped my interest in the preceptor-preceptee relationship. Immediately after my 12 months as a trainee and completing a further three week didactic training period, the next phase of my training was a further two years on road at an intermediate level. I was no longer a trainee nor was I qualified. Despite this, in my first roster back on-road I was paired with a trainee and expected to nurture and educate the novice as their preceptor.

It was from these early experiences of paramedic preceptorship and through more recent discussions with colleagues, where I encountered similar stories of the preceptorship process, that I recognised a need for change and a substantial
opportunity to improve paramedic preceptorship. These experiences were a defining foundation in developing a topic to pursue in my doctoral studies. I believe it is imperative that the experience of the paramedic preceptor be given greater focus and attention if opportunities to improve paramedic preceptorship are to be realised.

1.8 Limitations of the Study

In applying philosophical hermeneutics, I did not seek to develop an objective truth, but rather to articulate a convergence of horizons that is one interpretation of understanding paramedic preceptorship. I have presented this interpretation fully cognisant that understanding is evolutionary.

Due to the temporal nature of understanding, replicating this study in the future will not repeat the findings; thus no claim is made that this study offers a final and absolute interpretation of the phenomenon. Moreover, I readily accept that my readers, having their own prejudices will reach their own understanding from the information provided in this thesis.

This study also selected participants from one single ambulance service in Australia. As different jurisdictions in other Australian States and internationally have different models of preceptorship, the findings cannot be generalised to all paramedic preceptors. However, there are implications for paramedic preceptorship more broadly.
1.9 Chapter Summary

In this chapter, I have provided an outline of the study focus, which is to explicate an understanding of being a paramedic preceptor to novice paramedics in their first year of clinical practice. A brief overview of paramedic education in Australia was provided as contextual background for readers unfamiliar with the education of paramedics in Australia. Moreover, my own background in paramedic preceptorship was described to contextualise my prior understanding of the phenomenon in coming to this research. Further, the aim of the research was outlined and the guiding research questions identified. The next chapter explores the existing literature on preceptorship in order to define its meaning and purpose within healthcare education and to establish what is already known about preceptorship in paramedicine.
Chapter 2
Literature Review

2.1 Introduction

The purpose of this literature review was to determine what is already known about preceptorship within the healthcare environment and the extent, if any, to which paramedic preceptorship has been studied to establish a background for this research study.

I began the literature review on paramedic preceptorship using several databases available via NSW Health CIAP and the Charles Sturt University Library. The term \textit{paramedic} was combined with the terms \textit{ambulance} and \textit{emergency medical technician}. Similarly, \textit{preceptor} was combined with the terms \textit{mentor} and \textit{instructor} to ensure search results captured articles using the different terms.

Following my review of paramedic preceptorship, the literature search was broadened to include preceptorship within the health professions in general. It quickly became clear that the majority of research has been conducted within nursing; however other allied health professions such as dietetics have contributed to the research on preceptorship of both students and new graduate clinicians.

In addition to the scholarly search strategies, Google™ was used to search for grey literature. The majority of search results were typical of the web: blogs, forums, and marketing of preceptor courses by American community colleges. Some grey literature from various ambulance services in the US identified the roles of preceptors
in policy documents and descriptive expectations in student report templates. Some useful grey literature was found, including reference to an Australian Parliament Senate Report into nursing, and several United Kingdom National Health Service (NHS) policy documents and reports. One doctoral dissertation (Gurchiek, 2011) on being a paramedic preceptor to student paramedics in a North American university was also located.

In summary, an extensive search was undertaken of the extant literature using several electronic databases and a commonly used web search engine. Using various related terms relevant to the proposed study, it was determined that there is a significant array of research related to the concepts of preceptorship within the nursing domain, with only several studies specifically exploring the experience of being a preceptor. The search also revealed that at this time, there is a paucity of research into the humanistic aspects of paramedic practice. Specifically, there are no published studies into the lived experience of paramedic preceptors to novice paramedics and only one unpublished doctoral dissertation on paramedic precepting to student paramedics in a North American context (Gurchiek, 2011) was located.
Figure 2.1 below provides an outline of the structure of this chapter:

2.2 What is Preceptorship?

Clinical preceptorship is a widely used method of contemporary clinical education within many areas of healthcare, including paramedicine (Edwards, 2011; Lazarsfeld-Jensen, et al., 2014), nursing (Billay & Myrick, 2008), dietetics (Jay &
Hoffman, 2000), respiratory therapy (Jones-Boggs Rye & Boone, 2009), radiography (Harbottle, 2006) and pharmacy (Kairuz, Noble, & Shaw, 2010).

The concept of preceptorship can be traced back as far as the 15th century where it originally existed in the form of tutoring (Ryan-Nicholls, 2004). Modern preceptorship entered the nursing profession in the mid-1970s following the shift of nursing education out of the hospital based apprenticeship model and into a tertiary model and as means of allaying the reality shock felt by new graduates (Kaviani & Stillwell, 2000).

The Department of Health in the UK has formally defined preceptorship within nursing as:

A period of structured transition for the [new] practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning. (Department of Health, 2010, p. 11)

A defining characteristic of preceptorship is that it is a model of clinical education that occurs in the practice setting, which pairs a student or novice clinician with an experienced practitioner (Myrick & Yonge, 2005). The preceptorship model is used in several different contexts. It may relate to undergraduate students, who have not yet graduated and are completing clinical placements while still undertaking tertiary studies, new graduates who have completed a tertiary degree and are newly employed in clinical practice, or in relation to clinicians transitioning to work in a new specialty or subspecialty of clinical practice. A further characteristic of preceptorship is that it occurs over a set period of time (Hicks & Mee, 2011; Usher, Nolan, Reser, Owens, & Tollefson, 1999) unlike mentorship which can extend well beyond any particular
timeframe and may well occur over several years (Jane Mills, Francis, & Bonner, 2005).

Preceptorship attempts to ease the transition into professional practice, but also facilitates socialisation into the new role (Bain, 1996). In the transition to clinical practice novice paramedics face a number of challenges in coping with the realities of on-road practice in comparison to the classroom (Lazarsfeld-Jensen, Bridges, & Loftus, 2011). These challenges for the novice paramedic are more complex than psychomotor skills and substantially include the practical difficulties of scene management, the logistics of extricating patients from their homes and learning urgent duty driving. More than this, however, is the personal side of the paramedic role. Learning to communicate with patients and other health care professionals, building trust and rapport, and overcoming language barriers. Novice paramedics are also learning to fit-in to the organisation, learning the values, beliefs and culture of an emergency service (Devenish, 2014; Lazarsfeld-Jensen, et al., 2011), which is very different to the education environment. This interpersonal, intangible and unwritten knowledge cannot be taught from a text or simulation and must be learned and developed through experience. These are the challenges that can be overcome during a structured transition through preceptorship and with the support and guidance from a preceptor.

In North America, Pointer (2001) observes that many jurisdictions require new paramedics to be partnered with an experienced paramedic for a specified time period which varies from service to service; generally between two and six months. The goal of this preceptorship period is to “ensure acquisition of the experience necessary to
demonstrate competence” (Pointer, 2001, p. 380). To achieve this goal, several different methods are used. While some jurisdictions utilise a time period, others utilise a system that requires the new practitioner to undertake a predetermined number of cases before completing the preceptorship. As Pointer (2001) suggests, neither the time period nor volume of call-outs can guarantee a competent practitioner as the end result. A major reason for this is that the unpredictable nature of pre-hospital practice never guarantees what patients a paramedic will treat or encounter during any particular time interval. This is certainly the case within Australian ambulance services. Ambulances are generally tasked to a case based upon the closest available resource. The type of illness or injuries that a novice paramedic may be exposed to during their preceptorship is somewhat determined by random chance. While some may attend several serious traumatic events, others will only attend to medical emergencies and minor trauma. Where the preceptorship is a time-based program, many novice paramedics may not have had an opportunity to attend a full range of incident types.

Although the preceptor is often defined as being an experienced clinician in the nursing literature (Hicks & Mee, 2011; Usher, et al., 1999), and this may be an ideal trait of a preceptor, the reality is that as the paramedic workforce continues to grow in Australia and more ambulance services move to the post-employment model, those undertaking the role of paramedic preceptor may be recent graduates themselves (Edwards, 2011).

2.3 Mentor Vs Preceptor

The use of the terms preceptor and mentor are often used interchangeably in the literature, however there are fundamental differences between the two concepts
(Mantzorou, 2004). For example, the preceptorship relationship is time-limited and tends to be short term to assist novice clinicians during their transition to clinical practice (Kaviani & Stillwell, 2000), whereas the mentor relationship extends over a long period of time with no predetermined time limit on the relationship (Fawcett, 2002).

Further, the mentor-mentee relationship is more concerned with an interpersonal relationship; whereas the preceptor-preceptee relationship is between teacher and learner (Fawcett, 2002). The interpersonal nature of mentorship extends to its purpose of enabling personal growth and career development in the mentee, rather than being focused on support during role transition and focused on the specifics of a particular job role as in preceptorship (Ehrich, Tennent, & Hansford, 2002; Fawcett, 2002). Thus, a mentoring relationship is focused on nurturing the protégé rather than on teaching and learning, so the term preceptor is more accurate when referring to an experienced clinician engaged directly in a teaching and learning relationship with a neophyte practitioner (Billay & Yonge, 2004; Fawcett, 2002).

Beebe (2003) argues that the paramedic mentor and preceptor roles are different in that mentoring is a relationship, whereas preceptorship is an “instructional technique” (p. 43). The delivery of health care is a complex process that requires the clinician to apply their knowledge and contextualise past experiences to the current patient care situation. Each patient care scenario involves the processes of critical thinking and clinical decision making; it is in this application of theoretical learning to practical care that the mentor can assist the learner. Beebe (2003) calls this learning the art of paramedicine. According to Beebe (2003), preceptorship differs in that the focus is
on the teaching of technical skills and evaluation of the novice against competency standards and assessment of their theoretical understanding of disease processes and the human body. That is, focusing on the science of paramedicine (p. 43).

Jane Mills, Francis & Bonner (2005) conducted a literature review to clarify the difference between three models of clinical education: mentoring, precepting and clinical supervision. The distinction between mentoring and precepting is highlighted across five elements: context, timeframe, reporting relationships, level of commitment, and purpose (Jane Mills, Francis & Bonner, 2005, p. 6). These authors concluded that the context of mentoring is generally outside the work setting, while preceptorship is limited to the hours of the work roster. Further, mentoring goes beyond any structured time frame and the informal relationship that develops may extend across multiple employment roles of the mentee, whereas preceptorship is a formally assigned relationship over a short-term fixed period. The purpose of each relationship differs as well. While a mentor is focused on assisting the mentee’s personal and professional development, offering guidance and being a career advisor, the preceptor is focussed on clinical skill development and competency in the immediate role of the clinician.

Lastly, the difference between preceptors and mentors is that the preceptor is usually an assigned role, often forced upon both staff members with little respect for the personal harmony between the two; conversely, mentorship requires a mutually accepted relationship (Firtko, Stewart, & Knox, 2005). Moreover, the paring between preceptor and preceptee is often a random occurrence simply based on staff availability (Baltimore, 2004).
2.4 The Preceptor Experience

In this section I begin by reviewing the literature of the role, responsibilities and functions of the clinical preceptor. I then outline the lived experiences of clinicians as they undertake the role of preceptor (2.4.2), before exploring what benefits and rewards may come from working in this role (2.4.3). With a dearth of extant literature specifically exploring paramedic preceptorship, the scope of this literature review has been broadened to include other health care professions including nursing and dietetics.

2.4.1 Role of the preceptor

While the literature exploring the lived experience of paramedic preceptors is scant, Gurchiek (2011) conducted a phenomenological study examining the lived experience of being a field internship preceptor to student paramedics in North America. Gurchiek concluded that the overall meaning of being an ambulance preceptor is to be “understood as the gatekeepers of quality paramedic practice” (Gurchiek, 2011, p. 114). The ‘class to street’ theme in his study emerged in relation to the student paramedics difficulties in transitioning from the relatively structured environment of the classroom to the real world of pre-hospital care. Students were viewed by participants as struggling to manage the complexities and often chaotic environment of paramedic practice. Skills such as scene management, information gathering and prioritisation were initially lacking; and it was the preceptor who facilitated the students’ learning through role modelling, coaching, skill assignment and providing constructive feedback (Gurchiek, 2011, p. 121).
In the study by Gurchiek (2011) the need to provide a supportive environment for learning manifested as the theme ‘positive environment’. In this theme paramedic preceptors identified the importance of fostering a positive learning environment in which support, guidance and encouragement were the key strategies employed to enhance student motivation and learning. An interesting component of the findings within this theme was that preceptors draw on their own experiences as students: where the preceptor had a positive experience, they attempted to replicate their own experience; but where the preceptors own experience of being precepted was negative, they strived to provide a better experience for their preceptee (Gurchiek, 2011). Similarly, Boyer (2008) argues from the nurse preceptor perspective that a core role of the preceptor concerns the need for the preceptor to provide a safe learning environment “where the novice feels safe to learn, to asks questions, and even to make mistakes and learn from them” (E3)

A core function of the preceptor role is that as an educator. In structured preceptorship programs the preceptor has a formal responsibility for the validation of competency in the novice practitioner to ensure they are able to provide safe and effective care (Baltimore, 2004; Boyer, 2008; Elmers, 2010). Competency standards are usually provided by the organisation or university, but it is the role of the preceptor to facilitate the learning of the novice to become competent in pre-defined standards of practice. Students in a preceptorship are adult learners, each with their own unique backgrounds and prior experience. Therefore, the preceptor must work together with the preceptee to identify their learning needs and to establish through mutual agreement a set of learning goals (Baltimore, 2004; Kaviani & Stillwell, 2000). Once the learning needs and goals have been established, the preceptor has the
responsibility for planning learning experiences and assigning tasks to facilitate achievement of the learning goals (Baltimore, 2004).

In the study by Chen et al. (2011) the theme of ‘applying a variety of teaching strategies’ was adopted to describe the adaption of preceptor teaching methods to ensure patient safety is not compromised, and allowing supported and supervised hands-on practice by the new graduate to bridge the gap between the theory of university study and real-world nursing practice. This theme also included the idea of the preceptor connecting with their own peers to assist with the evaluation of the new nurse. The use of colleagues to support the preceptor in evaluating the student as confirmation of the learner’s progress and allow the preceptor to share the responsibility was similar to that found in the study by Ohrling & Hallberg (2001).

Ohrling & Hallberg (2001) studied the lived experience of being a nurse preceptor to student nurses in Sweden using an interpretive phenomenological approach. Assessing competence in the learner was an important aspect of the preceptor role in the study by Ohrling & Hallberg. Assessing competence encompassed a number of actions and decision-making processes by the preceptor in cooperation with the learner. The preceptor would set boundaries for assessment and negotiate timing of assessment to mitigate against the risk of the preceptee failing. Two main themes were elicited to create an understanding of preceptorship: ‘sheltering the students when learning’ and ‘facilitating the students’ learning’ (Ohrling & Hallberg, 2001, p. 530). Within the theme ‘sheltering the students learning’ the dimension of cooperation was highlighted as being mainly between the preceptor and the learner to identify learning needs and goals of the student. The preceptor took responsibility for
developing a learning plan and assumed responsibility for widening the students’ experiences.

Similarities of this dimension of cooperation were also found in a study by Charleston & Happell (2005) who explored mental health nurse preceptors perceptions of their role. This Australian study used a grounded theory approach to obtain insights of preceptorship from nine mental health nurse preceptors. In the theme of Actuality (the being preceptor) Charleston & Happell describe the preceptor’s responsibility over the students’ learning experiences as an orchestration of learning opportunities for the student and guiding the process through the preceptorship relationship (p. 57). Another overlap in the findings of these two studies is the need for the preceptor to adapt to the needs of individual students, recognising that each preceptee will have different past experiences, preconceived ideas and learning styles.

The need for flexibility as an attribute of the preceptor is continued by Ohrling & Hallberg (2001) where it was reported by participants that the clinical practice environment does not always allow a student to start with the easy tasks and build up to the complicated; sometimes the more complicated tasks came first. This is an important concept applicable to paramedic preceptorship. In the pre-hospital setting paramedic preceptors and their preceptees work as a double crew on an operational ambulance. Ambulance resources are then dispatched to cases on a basis of nearest resource. The consequence is that to a large degree the type of clinical cases and patient presentations that a novice paramedic is exposed to is akin to random chance. This means there is no luxury for the novice paramedic to progress from simple or straight-forward cases to the more complex patient situation. Paramedic preceptors therefore have an important function in balancing the level of independent versus
closely supervised and supported practice afforded to the novice paramedic. Gurchiek’s (2011, p. 121) phrase “stepping in or staying back” is a useful metaphor of this scenario. The preceptor must continually evaluate the capabilities, strengths and weaknesses of the individual preceptee and ensure they are provided opportunities to expand their independent practice, while simultaneously being protected from over reaching and left to struggle with their responsibilities.

Balancing independence with guided practice was raised in the nursing study by Ohrling & Hallberg (2001) who employed the theme ‘sheltering the student’ to describe the responsibility of the preceptor in managing the progression of learning in preceptees. Sheltering the student meant the role of the preceptor was to assess the individual’s capabilities and assign actions to avoid the student failing; but equally, when students wished to continue practicing tasks they were competent in and remain comfortable, the preceptor had to introduce new challenges and goals for the students and consequently encourage them to acquire a well-rounded and varied knowledge and skill base (Ohrling & Hallberg, 2001, p. 536).

The theme of preceptor as a role model pervaded the health care literature. This aspect of the preceptor’s role is less about technical proficiency and more about the preceptor’s behaviour and attitude exemplifying those of the professional and competent clinician (Baltimore, 2004; Kaviani & Stillwell, 2000). Chapleau (2007) asserts that as role model, the preceptor is able to facilitate the development of those difficult to teach aspects of being a clinician such as respect for patient’s rights, ethics and compassion. As Myrick and Yonge (2005) suggest, an effective role model must translate their values and professionalism into their “everyday actions in the practice
environment” (p. 34). By setting the example in everyday practice, the novice learns the standards expected (Chapleau, 2007).

Liu et al. (2010) identified that the preceptors in their study recognised the significance of being a role model. The closeness of the preceptor-preceptee relationship in the clinical environment means preceptees regularly see and hear how the experienced preceptor engages and interacts with patients, their families and other health professionals. It is in these moments that role modelling establishes expectations and demonstrates the how-to of the more personal and cultural elements of clinical practice such as building rapport, showing empathy and what being professional means.

Similarly, Gurchiek (2011) found that being a role model was an integral part of the paramedic preceptor’s role. As a role model the preceptor establishes the standards that are expected of the novice by setting the example in their everyday practice and interactions with others. Through role modelling the paramedic preceptor demonstrates what professionalism means through their care, character and appearance (Gurchiek, 2011).

Novice paramedics entering the workforce following their university education are involved in a period of professional and organisational socialisation (Devenish, 2014). Devenish contends that the socialisation of novice paramedics begins long before commencing employment as a paramedic and continues until after they complete their internship and into their practice as a qualified or registered paramedic. During the novice paramedic’s internship a “post-formal socialisation” (Devenish, 2014, p. 290) period occurs in which the novice paramedic transitions to on-road
practice where they encounter a contrasting environment to the university setting. Devenish concludes this period of socialisation is often difficult and challenging for the novice paramedic as they experience an initial culture shock of practicing within the command and control culture of an ambulance service, learn the routines of practice such as arriving for work early, and become socially integrated and accepted by learning the values, beliefs and attitudes expected of the profession.

The literature demonstrates that the preceptor has a central facilitating role in the professional socialisation of novice clinicians. The preceptor acts as social connector, assisting the preceptee to develop professional relationships and become familiar with organisational culture (Sedgwick & Yonge, 2008). It has been suggested that the most common reason why new employees leave a position within the first 12 months is because of a perception that they do not ‘fit in’ (Baltimore, 2004). To ‘fit in’, the new employee needs to understand how the workplace functions, where things are, and most importantly, to feel they belong. Feeling a part of the team requires the new graduate to assimilate into the workplace by adopting ‘socially acceptable’ behaviour (Goh & Watt, 2003). The preceptor has a crucial role in assisting the preceptee to understand their new environment. The preceptor can achieve this by introducing the new graduate to other staff members, explaining aspects of the organisations culture, providing a guided tour of the workplace, and explaining the administrative procedures such as payroll, rostering, chain of command and who to go to for what (Baltimore, 2004). Moreover the preceptor, as an embedded member of the team, can assist the new graduate to build professional working relationships with others in the workplace (Goh & Watt, 2003; Sedgwick & Yonge, 2008) When confronted with a new environment, not knowing these aspects can lead to frustration and confusion in
new graduates, which may result in them having a negative experience of their workplace (Delaney, 2003).

The preceptor-preceptee relationship is predominantly one of learning in the practice environment. In this context, Boyer (2008) argues that a fundamental component of the preceptors role is that of protector of patient safety. Learning to provide clinical care in the practice setting involves treating real patients with real consequences, unlike the simulated learning environment of tertiary education. As experienced clinicians preceptors are situated between the patient and novice and well placed to protect the patient from errors of judgement or practice by the novice-in-training. The central role of the paramedic preceptor in the protection of patient safety was also highlighted in the study by Gurchiek (2011) under his theme ‘guardian of care’. In this theme Gurchiek underscores the paramedic preceptor role as a safety net to safe patient care by their closeness to the novice in practice. Where potential mistakes are evident the preceptor is there to step-in and provide assistance, thereby averting clinical error. As overseer of patient safety while the student learned, the preceptor is required to balance the need to provide the student with opportunities to make their own decisions and practice independently, but must also be prepared to step in when the student could potentially harm the patient.

Chen et al. (2011) describe one strategy that preceptors use to ensure patient safety is to review procedures and critical knowledge with their preceptee before the novice’s performance on the patient. Hautala (2007) observed that it is incumbent on the preceptor to remain focused on this important aspect of their role. Vigilance in the preceptor as protector of physical and emotional safety was also noted by Charleston & Happell (2005) in their study of mental health nurse preceptors. In the psychiatric
setting, behaviours that were previously learned as acceptable when interacting with patients are not necessarily safe in the mental health setting. It was seen as essential that the preceptor constantly ensure the novice understands the challenges of mental health by “giving them an understanding of the differences in boundaries...and the need to be careful” (p. 57).

The preceptor role has thus been defined as multi-faceted and critical in the support of the novice as they transition to clinical practice. The preceptor’s role is much more than ticking a box on technical competencies; it encompasses a structural support around the physical, social and emotional well-being of the novice clinician as they learn to become an autonomous practitioner in their own right.

2.4.2 Being a preceptor

While several studies have explored paramedic preceptorship from the perspective of the preceptee or novice (Devenish, 2014; Huot, 2013; Lazarsfeld-Jensen, et al., 2014), there is currently a dearth of literature exploring the lived experience of being a paramedic preceptor. On the other hand, the role of preceptor has been widely explored in other health professions such as nursing. Only one study was located which explored being a paramedic preceptor (Gurchiek, 2011).

In his study Gurchiek (2011) found that being a paramedic preceptor was a polarity of positive and negative experiences. Participants in Gurchiek’s study viewed being a preceptor as more work. Additional demands were a result of having to demonstrate and explain to the novice paramedic the taken for granted practical aspects of being a paramedic such as how to complete the patient health care records, checking and restocking the ambulance. Further, whilst paramedics usually utilise their downtime
between cases to relax and recuperate, being a preceptor required this time between calls to be used for education and feedback sessions with the novice paramedic.

All participants in Gurchiek’s (2011) study mentioned the word stress at least once while discussing ambulance preceptorship (Gurchiek, 2011, p. 122). Experiences of stress were related to the additional time for a novice to perform many aspects of the paramedic role such as taking longer to write patient reports, take longer to assess the needs of their patient and perform skills such as cannulation and airway management. Feelings of stress were also related to the preceptor needing to look out for the welfare of the patient while the novice was learning. Where patient assessment was the responsibility of the novice the preceptors held concerns that not all the important information would be obtained in a timely manner, if at all, and the potential adverse impact on patient care this may have. Paramedic preceptors felt a sense of role conflict between advocating for the need of their novice to learn through experience and by taking control of patient assessment and care, but foremost needing to step in and be the advocate of patient care (Gurchiek, 2011, p. 111).

Nursing preceptors in the study by Ohrling & Hallberg (2001) also spoke of the difficulties they faced in balancing their roles of teacher and clinician during times of emergencies. In cases involving high acuity patients, the preceptors focus firmly shifted to that of treating their patient, which decreased the direct teaching interaction with their preceptee. As one participant described: “…when emergencies occur, it can easily happen that the students have to take a step back, because you quite simply do not have the time… you have enough trouble attending to [the emergency]” (Ohrling & Hallberg, 2001, p. 536).
In another study exploring the experience of being a preceptor to student nurses, McCarthy & Murphy (2010) conducted a survey questionnaire and found that 88.6% of preceptors enjoyed their role and 57.1% wanted to continue as preceptors. An interesting finding of this study is that 76.9% of respondents reported having never failed a student; and 47.2% stated they would find it very difficult to do so (p. 238).

The majority of the preceptors in the study by McCarthy & Murphy (2010) reported being a preceptor as stressful and demanding. One respondent spoke of the stress when a preceptor constantly has students assigned to them; leading to burnout and a lack of enthusiasm for teaching. Another preceptor went further, saying that the demands of precepting could lead to experienced staff leaving the profession (McCarthy & Murphy, 2010, p. 240).

Preceptors in the study by McCarthy & Murphy (2010) felt unsupported (38%) and not appreciated (42.7%) by their organisation. This contrasts to the findings in earlier studies which found nurse preceptors felt adequately supported by management and co-workers (Hautala, Saylor, & O'Leary-Kelley, 2007; Hyrkas & Shoemaker, 2007). Similarly, in a study of dietetic preceptors by Marincic & Francfort (2002), respondents felt supported in their role as preceptor from faculty administration and their immediate supervisors. In a survey of nurse preceptors to novice nurses, Fox, Henderson & Malko-Nyhan (2006) found 100% of respondents agreed or strongly agreed that they were supported by their colleagues in their role as preceptor at both the two to three month survey and the six to nine month survey. It should be noted, however, that the response rate for the second survey was only 29%. It may be that
following the first survey response, preceptor participants who felt unsupported chose not to participate in further research.

Hautala, Saylor & O’Leary-Kelley (2007) conducted a descriptive exploratory study using a questionnaire with a convenience sample of 65 nurse preceptors. The questionnaire focused on the perceptions of stress and support experienced by nurse preceptors to both new staff and students. A majority, 83%, reported some stress associated with the role; with only 11% reporting no stress (Hautala, et al., 2007, p. 66). Pearson’s correlation coefficient - which tests the strength of dependence between two variables - did not suggest that years of experience in nursing were correlated with the levels of stress experienced by preceptors.

Reported reasons for stress while in the preceptor role by participants in the study by Hautala, Saylor & O’Leary-Kelley (2007) included a perceived a lack of time due to tasks taking longer when being performed by a new staff member or student; inadequate preceptee skill in areas such as critical thinking; and increased stress due to a sense of responsibility for the actions and decisions of both themselves and their preceptee and ensuring patient safety. While most of the respondents felt they were adequately supported by their co-workers and that management was committed to the preceptor program, they also highlighted that when preceptors feel a lack of organisational support, such as inadequate support from nurse educators, there is an associated increase in the level of stress experienced in the preceptor role (Hautala, et al., 2007).

Another descriptive exploratory survey of stress in the preceptor role was conducted by Yonge, Krahn, Trojan, Reid & Haase (2002a) which had a sample of 295
respondents. Nearly three-quarters reported some level of stress associated with being a preceptor. Similar to the findings of the study by Hautala et al (2007) and the paramedic study by Gurchiek (2011), reasons for stress included: an increase in responsibility; the additional time required to complete tasks when precepting a new staff member or student; an increased workload; personality difficulties; and the issue of patient safety in regards to student performance and the responsibility for this felt by the preceptor.

Most studies into the preceptorship experience come from the western perspective. In a different perspective, a Taiwanese study by Chen et al. (2011) explored the experience of being a preceptor to new graduate nurses in a Taiwanese teaching hospital using a hermeneutic phenomenological approach to capture three main themes of being a preceptor: (a) applying a variety of teaching strategies, (b) feeling the burden of being a preceptor, and (c) developing a sense of achievement. Like the findings of western studies, preceptors in the Asian study by Chen et al. (2011) reported feeling “burdened” and “stressed” by their role due to perceptions of increased workloads, which lead to being time poor and consequently feeling like they were providing less than ideal teaching. Role conflict, between needing to teach as well as be a clinician simultaneously, led to negative self-evaluation as both preceptor and nurse, and a fear of failing as a preceptor led to perceptions of being negatively judgement by colleagues.

In the study by Liu, Lei, Mingxia & Haobin (2010) the theme of ‘being unable to do what one would like to do’ describes how preceptors felt there was limited time available for teaching due to the expectation that nurse preceptors had a normal
patient load as well as being a preceptor to a novice nurse. This finding parallels with several other authors where the feeling of being overwhelmed by the additional workload of precepting has often been cited as the principle cause of stress in the preceptor role (Chen, et al., 2011; Hathorn, Machtmes, & Tillman, 2009; Hautala, et al., 2007; Yonge, et al., 2002a). Another interesting aspect of this theme was illuminated in the response of a participant who stated:

I don't know how other clinical preceptors feel, to be honest; sometimes I have no confidence to teach students. ... Today's students are all baccalaureates, but I got only an associate degree many years ago; even though I have enough clinical experience, I found a lot of knowledge is outdated. (Liu, et al., p. 806)

This finding may well be replicated in the current study given the recent transition to tertiary education in Australian paramedic education. That is, many experienced paramedics undertaking the role of preceptor are likely to have entered through the vocational pathway and received a Diploma level qualification. These paramedic preceptors will now have preceptees with bachelor degrees.

2.4.3 Benefits and rewards of being a preceptor

Despite the more challenging aspects of being a preceptor, several nursing, allied health and paramedic studies have concluded that there are benefits and rewards of being a preceptor. In his study exploring paramedic preceptorship, Gurchiek (2011) found there were positive rewards of being a paramedic preceptor. His theme of ‘rebound learning’ highlighted the reciprocal nature of learning in the preceptor-preceptee relationship. Whilst it is the novice who is usually viewed as the learner and the preceptor as teacher, in reality it appears that both parties learn and grow, in a professional development sense, as a result of being part of the preceptorship
experience. Preceptors gain a sense of satisfaction in seeing students develop into competent practitioners in their own right, as well as being a facilitator of the profession’s next generation of paramedics, which manifested as pride in the sub theme of ‘legacy’.

Dibert & Goldenberg (1995) conducted a descriptive correlational study between nurse preceptors’ commitment to their role and the perceived benefits rewards and support. This Canadian study had a sample of 59 nursing preceptors who had experience preceptoring both newly hired nurses and student nurses. Data was collected using questionnaires utilising Likert-type scales and data was analysed for statistical significance (p=0.05). The findings of this study found that the more preceptors perceived there were benefits and rewards to being in the role, the more they were committed to the preceptor role (p=0.000). The authors also found that perceptions of support for the role positively correlated with commitment to being in the preceptor role. Conversely, no statistical significance was found between the number of years nursing experience and preceptors’ perceptions of benefits and rewards, supports, or commitment to the role. A number of benefits were highlighted by respondents and included: the opportunity to integrate new staff into their unit, teach newly hired staff, gain a sense of personal satisfaction from the role, share knowledge with new staff and improve their own teaching skills. Least important benefits were: improving the chance of promotion and influencing change on the unit. The study by Dibert & Goldenberg (1995) concludes that nurses appear to undertake the role of preceptor for altruistic reasons, which is consistent with the personality traits one might expect from health professionals.
Additional findings in the study by Dibert and Goldenberg (1995) were that preceptors felt they had functioned in the role too often and many felt that Nurse Educators were not available to assist them in developing their role as preceptor. Given the positive correlation between levels of support and commitment to the role, I suggest that if preceptors are not given adequate support for their own professional development as preceptors, then organisations risk losing the vital support from experienced staff to act as preceptors to newly hired staff.

In 1999, an Australian study by Usher et al. (1999) replicated the research by Dibert & Goldenberg (1995) using a sample of 134 nurses. Similar to the Dibert & Goldenberg (1995) study, they found a correlation between preceptors perceptions of benefits and rewards associated with the preceptor role and the level of commitment to the role of preceptor. In relation to perceptions of support in the role, Usher et al (1999) found a positive association exists between the preceptors' perceptions of support and their commitment to the role. In the third research question, which examined whether there is a correlation between years of experience and commitment to the role of preceptor, both Usher et al (1999) and Dibert & Goldenberg (1995) found no statistical significance. Results for the perceptions of rewards and benefits largely mirrored those of the Dibert & Goldenberg (1995) study including the sharing of knowledge, a sense of satisfaction and helping new staff to integrate into their new work place. Unlike the Canadian study however, preceptors did not feel they were required to act as preceptors too often.

Another study which closely replicated the Dibert & Goldenberg (1995) study was conducted in North America by Hyrkas and Shoemaker (2007). This study consisted of two sub groups with a total sample of 82 preceptors. The findings of this North
American study were largely consistent with those of the earlier research by Usher et al (1999) and Dibert & Goldenberg (1995). A statistically significant correlation was found between the perception of support and commitment to the role of preceptor. Further, non-material benefits and rewards, such as an opportunity to assist new staff and students to integrate into the workplace, developing one’s own professional knowledge base and a sense of personal satisfaction gained from the role, all ranked highly among respondents. Also similar to the earlier studies, Hyrkas & Shoemaker (2007) found that the rewards of improved chances for promotion and organisational involvement ranked low in importance for preceptors.

Research in other health professions on the rewards and benefits of preceptorship have found similar results to those within nursing. In a descriptive correlational study using a survey instrument adapted from Dibert & Goldenberg (1995), Marincic & Francfort (2002) conducted a study of preceptors to dietetic interns in North America. The sample size consisted of 116 respondents. Findings in this study were largely consistent with those from nursing and the authors found a positive correlation between preceptors feeling supported and their commitment to the role. The higher ranking benefits and rewards were again similar to those reported in the nursing studies. That is: sharing their knowledge, sense of personal satisfaction from the role, and keeping current within their area of clinical practice. Likewise, respondents disagreed that a benefit of precepting is about improving one’s own chances of promotion and advancement.

Jay & Hoffman (2000) conducted another study within the field of dietetics in a North American context to explore the perceptions of intangible benefits and rewards
gained from being in the role of preceptor to dietetic interns. Their study investigated the non-tangible benefits to being a preceptor to dietetic interns using a five point Likert-type questionnaire. Consistent with the studies from nursing, the highest ranking benefits were a sense of satisfaction from the role in seeing the new staff develop, preceptorship providing an opportunity for the preceptor to develop professionally in their area of practice, and the role providing a sense of achievement to the preceptor.

Preceptors in the study by Chen et al. (2011) also reported that precepting has its benefits and rewards, which mirror those of other studies, such as a sense of personal satisfaction and achievement in seeing new nurses develop into competent clinicians, positive affirmations from colleagues and managers increased preceptors’ feeling of achievement, and a sense of growth in their own professional development and capabilities that came from being in the role of preceptor.

In another Asian study, Liu, Lei, Mingxia & Haobin (2010) used a descriptive phenomenological method to explore the meaning and experience of being a preceptor in the context of nursing preceptorship in China. Interviews were conducted with twenty clinical preceptors and identified four themes describing being a preceptor: (i) ‘teaching is learning’, (ii) ‘being unable to do what one would like to do’, (iii) ‘experiencing bittersweet moments’, and (iv) ‘being a role model and acting as a mother’ (p. 806). In the theme ‘teaching is learning’, participants emphasised the personal and professional development that accompanied being a preceptor. These findings again correlate with other authors who have also reported “personal satisfaction and self-enrichment” as a reward and benefit of precepting (Dibert & Goldenberg, 1995; Hyrkas & Shoemaker, 2007; Jay & Hoffman, 2000; Marincic &
Francfort, 2002). The third theme ‘experiencing bittersweet moments’ was briefly described and provides a snapshot that while being a preceptor there is juxtaposition of experiences that at times are rewarding and satisfying, at other times there is disappointment, stress and concern (Liu, et al., 2010).

2.5 Transition to Practice

The period of transition into clinical practice is challenging for new paramedic graduates (Huot, 2013; Lazarsfeld-Jensen, et al., 2011). Transition to clinical practice has been characterised by stress, anxiety, feelings of inadequacy, and deficits in both skill and knowledge domains (Casey, et al., 2004; Devenish, 2014; Huot, 2013; Lazarsfeld-Jensen, et al., 2011).

In the study by Goh & Watt (2003) a major concern of the graduate nurse was the perception of being ill prepared for the realities of clinical practice. Graduates felt that their clinical experience as a student was inadequate in preparing them for the transition to the nurse role. The authors note that the expectations that new graduates had of themselves were often unrealistic (p. 20). The amount of clinical practice was also raised as an issue for new graduates in a study by Ellerton & Gregor (2001) who believed that their clinical practice opportunities as students had been deficient. In a study by Whitehead (2001), newly qualified nurses also expressed that their time as a student did not adequately prepare them for the new role. This is important for the current study, as unlike nursing, which has a number of sub specialty areas, the pre-hospital placements undertaken by paramedic students would be relatively consistent over the duration of their study. Similar reasons for feeling ill-prepared have been expressed by paramedic graduates. In a study by Lazarsfeld-Jensen et al. (2011),
paramedic graduates did not feel adequately prepared by tertiary studies for the reality of the emergency environment. Some graduates felt that the required clinical skills could not be learned in the brief placements of 3-weeks duration, but rather required a sustained period on-road working as a probationary paramedic (p. 17). Some of the participants in the study by Huot (2013) similarly expressed uncertainty about their competence in the early transition to practice as a paramedic. This uncertainty led to feelings of stress and anxiety. Novice paramedics in the study by Devenish (2014) also reported feelings of stress on their first emergency call with many participants feeling that they were expected to “step-up and be work ready from day one” (p. 215).

Delany (2003) found that stress was experienced by the new graduate where they felt “overwhelmed” by the new level of responsibility and the need for time management and organisational skills. Time management appeared largely due to the responsibility of having between four and six patients to look after; a situation not usually confronted by the paramedic graduate who will usually only be required to look after one patient at a time. Being overwhelmed also related to the need to perform practical skills, for example when starting intravenous lines and cannulation: both skills that the graduate paramedic is expected to perform from day one on-road.

Another finding of Delany’s (2003) nursing study where a comparison with new graduate paramedic’s experiences may be found is the difficulty that new graduate nurses had in coping with death and dying. It is an unfortunate fact that paramedics must deal with death on a routine basis in their role. The exposure to death for the paramedic is often much more complex than what nurses would experience. For the paramedic, not only are they often responsible for making the clinical decision as to whether to start or continue resuscitation, they must also deal with traumatic death
and the associated horrific scenes, but the most difficult situation it may be argued, is having to be the one that tells the family members of the deceased that nothing can be done. In Devenish’s (2014) study, paramedic interns described the emotional difficulties of coping with these more confronting aspects of paramedic practice. The intern year was an important time where novice paramedics build resilience techniques to cope with these difficult situations. Devenish reports a number of coping strategies are employed including the use of dark humour, depersonalisation, developing support networks, finding an emotional balance between the positive outcomes and not only focusing on the bad, finding an emotional release such as crying, and the unhealthy strategies of turning to alcohol and tobacco. Important to my study is the finding by Devenish that novice paramedics often developed these resilience techniques by observing their preceptor and learning how they and other more experienced paramedics managed the emotional toll of attending confronting cases.

Tertiary level education of paramedics is a relatively new concept in Australia (Willis, et al., 2010). This has presented some unique difficulties for new graduates transitioning into paramedic practice. In the study by Lazarsfeld-Jensen et al. (2011) six out of eight participants reported resistance to graduate education for paramedics. In some instances, new graduates experienced stigma to such a degree that they hid their tertiary qualifications from colleagues. Suggestions from the respondents as to the reasons for negative attitudes included: a macho culture within the ambulance service; feeling intimidated by new graduates who may have a greater knowledge as a result of their tertiary studies; viewing new graduates as a threat – although ‘to what’ was not explored or reported by the authors; and finally, it was suggested that
all graduates were being stereotyped as having a poor attitude and ‘arrogance’ because they were degree qualified, based on the experience of a limited few graduates from the past. The stigmatisation experienced by university graduates in Lazarsfeld-Jensen et al. was also found in the study by Devenish (2014). Devenish reports that the source of this stigma could be based on a history of new graduates being perceived as “cocky and lacking life experience” (p. 225). Devenish concludes that a possible rationale for the stigmatisation experienced by new graduate paramedics is the lack of training provided to paramedic preceptors, leaving them ill equipped to support new graduates entering the workforce. This supports the need for my study as a further exploration of the preparation of paramedic preceptors and demonstrates the adverse impact of not adequately preparing paramedics for their role as preceptor.

2.5.1 The role of preceptors in role transition

The role of the preceptor is well documented in the literature as a means of supporting new clinicians during their transition period. In Delany’s (2003) phenomenological examination of new graduate nurses’ experience during their transition to practice, having an experienced preceptor assisted transition by easing the anxiety of the novice and is evident in the statement by one graduate: “It was good; she eased me in so I was less nervous” (p. 439). The author concluded that preceptors had a significant effect on the transition and outcomes for graduates and those who displayed the qualities of “seasoned experience, critical judgement, clinical expertise” together with the interpersonal qualities of “a caring, supportive attitude” facilitated a positive transition of graduates into clinical practice (p. 442). Conversely,
where preceptors did not demonstrate these characteristics, the graduates’ transition was adversely affected and their progress was delayed.

A significant benefit of preceptors in assisting new graduate’s transition to clinical practice is their close proximity to the novice. As a beginner the novice requires support, guidance and feedback and the preceptor is highlighted as an important resource immediately available when the novice feels unsure of their own competence or has questions about practice (Goh & Watt, 2003; Zinsmeister & Schafer, 2009). Furthermore, new graduates are encouraged by positive feedback to know how they were progressing and develop self-confidence. Conversely, when constructive feedback is lacking it can negatively impact on the transition of the novice and delay their social integration (Devenish, 2014).

The support of the preceptor is valued during the new graduate’s socialisation into the organisation. New graduates in the study by Lazarsfeld-Jensen et al. (2011) encountered difficulties associated with stigma and a stereotyped view of tertiary trained entry-level paramedic. Importantly however, where the novice had the support and guidance of a preceptor, they were much better placed to navigate the cultural minefield of the organisation. This was illustrated by one graduate who responded:

I had really great training officers [preceptors], and people that understood where I’ve come from, and that understood that there is a bit of a stigma against CSU students, but helped me understand the culture of the ambulance service, and what was okay to do, and what wasn’t, and who would have an issue and who wouldn’t. So I was really lucky (Lesley). (Lazarsfeld-Jensen, et al., 2011, p. 16)
The study by Devenish (2014) also highlighted the role of the paramedic preceptor as novice paramedics transitioned to the real world and having to experience the more confronting aspects of paramedic practice such as major trauma, cardiac arrest and death. Devenish found that novice paramedics often emulated their preceptor as a way of developing resilience strategies that enable them to cope with these challenging and highly emotional aspects of a paramedic’s work.

What is evident from the literature is that the preceptor plays a crucial role in providing a scaffold around the novice as they transition to clinical practice. Moreover, preceptors provide the safety net so desired by the novice while they “balance the tension between independence and dependence” (Casey, et al., 2004, p. 309).

2.5.2 Development of critical thinking in preceptees

Critical thinking and clinical judgment have been described as a fundamental skill required by new paramedics (Gurchiek, 2011). However, no literature was located that directly explored the relationship between paramedic preceptorship and the development of critical thinking in novice paramedics. Several studies from nursing have demonstrated the positive benefits of preceptorship in developing student’s critical thinking (Forneris & Peden-McAlpine, 2009; Florence Myrick, 2002; Florence Myrick & Yonge, 2004; H. Sorensen & Yankech, 2008).

Using a grounded theory approach, Myrick (2002) investigated the process of how critical thinking was developed in nursing students during preceptorship. The sample consisted of six preceptors and six preceptees where the preceptees were fourth year bachelor of nursing students. Experience of the preceptors ranged from one to ten
years. The overall finding of this study was preceptors were enablers of their students’ opportunity to learn to think critically. To achieve this, the first identified requirement was the need for an appropriate environment, termed climate by Myrick (2002). Preceptors were found to be instrumental in creating the ideal learning climate through “their supportive attitudes, their valuing of the preceptees, and their ability to work with them” (Myrick, 2002, p. 159). Further in the provision of a supportive environment was the attitude of other staff in the unit. Where students felt accepted and part of the team, their critical thinking development was enhanced. This again highlights the importance of the preceptor as socialiser; that is, assisting preceptees to fit in and build professional relationships with their new colleagues.

The second component of the preceptor-preceptee relationship reported by Myrick (2002) was the process in which preceptors encouraged their preceptees to pose questions, examine problems, and consider alternate ways of thinking about patient situations. It was the preceptor’s role modelling that stimulated students to think critically. Preceptors were also found to enable the development of students’ critical thinking through their teaching methods such as providing guidance, together with giving the student time to put the pieces of the puzzle together. By allowing the student the time to come to their own conclusions, rather than the preceptor always providing the answer up front, the student was encouraged to think in a critical way. Moreover, preceptors contributed to the development of critical thinking through direct questioning of the preceptee, encouraging them to think about specific case situations and providing guidance on alternatives which must be considered for safe patient care. Significantly, it was found that the indirect method of stimulating critical thinking that predominated in the preceptor’s actions through role modelling,
facilitating and guidance was far more effective than through direct questioning (Myrick, 2002).

Notwithstanding the methods employed to promote critical thinking, Myrick (2002) also found that the learning environment can either afford or constrain the development of critical thinking and that it was the preceptor who was instrumental in determining the nature of this environment. In the practice setting, preceptors were pivotal in creating a learning environment conducive to critical thinking by fostering a positive and collaborative atmosphere in which the preceptee felt safe to ask questions, was supported and encouraged, and made to feel valued as a member of the nursing staff (Myrick, 2002).

While Myrick’s (2002) study focused on the development of critical thinking in undergraduate nursing students in the preceptor-preceptee relationship, a later study by Myrick & Yonge (2004) focused on the preceptorship experience and its role in enhancing critical thinking in graduate nursing students. A grounded theory approach was also utilised in this study, with a sample of eight preceptors and ten graduate students. Overall, 45 interviews were completed with participants.

The authors suggest that within the preceptorship experience, there is a “relational process” which is a “complex ongoing interpersonal dynamic occurring between the graduate student and the assigned preceptor” that enhances the critical thinking ability of the graduate nurse preceptee (Florence Myrick & Yonge, 2004, p. 374). Two key elements were considered pivotal to this relational process: (1) the one-to-one relationship between the student and preceptor and (2) a driving force, described by
the researchers as ‘moving forward/keeping back’ that was intricately interwoven throughout the preceptorship experience.

Myrick & Yonge (2004) concluded that a positive relationship between the preceptor and preceptee was pivotal to the enhancement of critical thinking in graduate students. Furthermore, Myrick & Yonge (2004) found that certain behaviours of preceptors such as respect, flexibility, openness, safety/trust and scepticism, facilitated critical thinking development; whilst behaviours such as role consciousness, constraint, lack of safety and an unquestioning attitude, negatively affected the preceptorship experience and inhibited the preceptees development. Safety and trust was a significant theme in the responses of the preceptees of this study. For critical thinking to occur and develop, the preceptee had to feel secure that they could put forth their ideas and point of view, knowing their preceptor would respect and accept their input. Without trust, preceptees feel unsafe and became more and more reluctant to verbalize their own perspective, instead focusing entirely on what it is that the preceptor would like to hear: “in essence, their ability to think critically literally dissipates” (Myrick & Yonge, 2004, p. 378).

In a small case study, Forneris & Peden-McAlpine (2009) examined the impact of a preceptor coaching intervention in developing the critical thinking skills of novice nurses they were precepting. The sample consisted of six novice nurse/preceptor dyads from an acute care facility in North America. Prior to undertaking the preceptorship period, preceptors were engaged in a coaching program with three learning objectives: “1) engaging a critical conversation about the attributes of critical thinking; 2) discussion on reflection and reflective practice; and 3) engaging directly
in reflective practice using a narrative story from practice” (Forneris & Peden-McAlpine, 2009, p. 1718). A fourth learning outcome “evaluating critically reflective thinking using preceptor experiences and evidence of novice nurses’ critical thinking” was undertaken following the preceptorship experience. Prior to the coaching program, preceptor’s description of critical thinking centred on time management and prioritisation of tasks, routines and procedures (Forneris & Peden-McAlpine, 2009, p. 1718). Following the coaching intervention preceptors changed their description of critical thinking to being a dialogue for shared thinking and understanding rationale. This new understanding of critical thinking in the preceptors flowed through to their clinical teaching with preceptees. Following the coaching intervention, discussion between preceptor and preceptee moved beyond content focused discussions to more critical conversations which used reflection and dialogue to explore contextual understanding of clinical situations (Forneris & Peden-McAlpine, 2009).

Sorensen & Yankech (2008) also examined the relationship between education of preceptors and the development of critical thinking in new graduate nurses. A quasi-experimental, mixed methods design was used. The quantitative component of the study measured critical thinking using the California Critical Thinking Skills Test (CCTST); a standardized, 34-item, multiple-choice test developed to assess post-secondary level students. Qualitative data was collected using semi-structured interviews in two focus group and two individual sessions. The sample size in the control group consisted of a convenience sample of 16 new graduate nurses; with the experimental group consisting of a convenience sample of 15 new graduate nurses. Using a two tailed t-test, no statistically significant results were found between the
experimental and control groups. Even after controlling for the co variables of age, length of preceptorship, and total years of health care role experience, a statistically different result was only found in the evaluation subscale of the CCST. Quantitatively, there was little benefit of preceptors undertaking a theory-driven education program to improve the critical thinking development in preceptees. The authors further explored the intervention through the qualitative component of the study. Here, preceptors were found to have a new awareness of learning-styles and demonstrated evidence of a shift towards a learner centred approach to preceptorship. Preceptors who participated in the education program also incorporated new learning-teaching strategies into the precepting experience (H. Sorensen & Yankech, 2008). The authors concluded that the critical thinking skills of the new graduates were improved through the preceptor education program.

2.5.3 Readiness to practice

The concept of readiness to practice is not new and references debating the readiness of new graduates in the nursing literature can be traced to the 1970s. Concerns about just how ready tertiary trained nurses are upon entering the workforce continue today (Wolff, Regan, Pesut, & Black, 2010). Despite the plethora of research in this area, job readiness remains conceptually ill-defined and poorly described (Wolff, et al., 2010). A similar tension exists within paramedic education where job readiness, often referred to a road readiness, is also debated, but where the establishment of an agreed definition remains wanting (Willis, et al., 2009). The fundamental question with the elusive answer appears to be: what are graduates supposed to be ready for? (Wolff, et al., 2010) In the complex pre-hospital environment, the debate has largely centred around whether graduate readiness is about clinical skill performance or the capacity
for novice practitioners to respond to the social and interpersonal issues frequently encountered by paramedics (Willis, et al., 2010).

In Australia, the peak body which accredits tertiary paramedic education courses, The Council of Ambulance Authorities (CAA) (The Council of Ambulance Authorities, 2010), provides an umbrella term for road readiness which states that universities have a responsibility to provide students with a base level of education that makes them suitable for employment as an entry level paramedic. Moreover, the CAA (2013) defines road readiness in the graduate paramedic as one who has “the core foundation elements to practice under supervision, and that, at the end of the graduate induction period of up to one year, the paramedic should be ready to practice independently” (p. 16). To further guide educational institutions and industry employers, the CAA has developed a set of paramedic professional competency standards (The Council of Ambulance Authorities, 2013) which details the breadth of competencies, behaviours and knowledge areas expected of a competent, professional paramedic.

In a study by Dawson (2008) of paramedic students perceptions of their job readiness following an undergraduate paramedic program in Australia, students reported feeling adequately prepared for their new role. In contrast, students’ paramedic supervisors interviewed in the same study believed that while students had a sound theoretical knowledge base, they were lacking in practical skills (Dawson, 2008). Paramedic supervisors also reported that students became competent within one year of being on-road (Dawson, 2008).
In a study of final year paramedic students in an Australian university by O’Brien, Moore, Hartley & Dawson (2013), students reported a mix of being ‘adequately prepared’ to only ‘somewhat prepared’ by their tertiary studies to enter the paramedic workforce. This small, mixed methods survey (n=23) suggested that while two-thirds of students felt prepared for the paramedic role at the completion of the degree, students did feel that limited clinical placement time meant they will require more experience in the clinical practice setting and exposure to real patients to consolidate their skills and learn to apply the knowledge they have gained through the university course.

These findings are similar to a study by Hickey (2009) who explored nurse preceptors’ perceptions of new graduate nurses readiness for practice in a large teaching hospital in North America. In Hickey’s (2009) study, 62 preceptors completed a quantitative survey instrument of 18 items using a Likert Scale to measure: (a) areas of developing clinical competence and (b) the importance preceptors placed on these areas. Consistent with the findings of Dawson (2008) in the paramedic context, Hickey (2009) found that 63% of preceptors believed the new graduate nurses required more assistance to perform practical skills than they expected. Further, 76% of preceptors believed new graduates could only perform advanced technical skills - such as IV fluid maintenance and medication administration – only “sometimes or less often” (p. 38). In addition, in the qualitative component of the study, respondents were asked to answer the question: “Are there any skills . . . that the new graduate was particularly weak in, or lacking upon hire?” (p. 38) Results of this qualitative question where more than 50% of respondents commented on a particular area of weakness in the new graduates were: (1)
psychomotor skills (2) assessment skills (3) critical thinking (4) time management (5) communication: written and verbal and (6) teamwork (p. 38).

While Hickey (2009) explored the concept of readiness to practice from the preceptor’s perspective, a key finding from Casey et al. (2004) was that new graduates themselves identified that it took up to a year for them to feel comfortable and confident practising in the acute care setting. The performance of technical procedures was highlighted with new graduates identifying 54 procedures they were uncomfortable performing at the beginning of their new role; with more than 50% of new graduates reporting they felt uncomfortable with cardiac arrest situations (p. 306).

In a study by Ellerton & Gregor (2001) most novice nurses interviewed expressed frustration in their communications with patients and families. The authors asserted that the novice nurse does not have the expertise or experience to have meaningful or helpful conversations with patients about their health care. Lazarsfeld-Jensen et al. (2011) found similar experiences with new graduate paramedics. All graduates in the study named communication as being a core skill required to be an effective paramedic (p. 20). As in the Ellerton & Gregor study (2001), novice paramedics consistently felt they struggled in the area of patient communication (Lazarsfeld-Jensen, et al., 2011).

The overall impression from the Lazarsfeld-Jensen et al. (2011) study of new graduate paramedics was that while the university can provide students with the theoretical knowledge to be a paramedic, novice paramedics are ill prepared for the complexity and intensity of emergency service work - managing scenes with multiple
patients, being part of a multi-agency response, the logistical challenges of extrication and transporting patients and coping with overwhelming stimulus of such a work environment.

2.6 Learning Theories

The following section reviews three alternative perspectives of how knowledge and knowing may be conceptualised. Preceptorship is largely a relationship in which a novice transitions from student to competent, autonomous clinician. It is therefore useful to analyse the nature of what it means to know and how learning leads to expertise.

2.6.1 The cognitive view of learning

The dominant view of workplace learning has previously centred on the individual, with learning and development reflected in metaphors such as acquisition, transfer and application (Boud & Hager, 2012). Cognitive theories of workplace learning privilege human consciousness and intention for understanding work performance as a process of thinking (Hager, 2013). In these cognitive approaches to learning, knowledge is conceptualised as a product or substance which can be sent, transferred, and is subsequently received and stored by the learner for use at a later time (Boud & Hager, 2012; Gherardi & Nicolini, 2000; E. Sorensen, 2009). Billet (2001, p.2) defines expertise in this view as a “product of the breadth and organisation of [an] individual’s domain-specific knowledge comprising orders of procedures and levels of conceptual knowledge”. Lakoff & Johnson (1980, as cited in Hager, 2013) use the metaphor of the mind as a container. Learning is thus conceived as the acquisition of knowledge, filling this container for transfer and application as required (Hager,
The focus of learning is therefore on an individual’s cognition in relation to a particular subject matter. This conceptualisation views knowledge as stable, preformed and pre-given to practitioners to later use in practice (Mulcahy, 2011). Expertise is regarded as having a greater cognitive organisation and indexing of domain-specific knowledge which the individual can then recall for problem solving and transfer into action (Billett, 2001). The journey from novice to expert is generally portrayed as a linear progression as the practitioner builds their internal library of systematized and catalogued domain knowledge. In this view, expertise develops as the practitioner’s library grows larger, as do the connections and associations between their internal knowledge resources and hence the capacity to perform non-routine tasks. Expert knowledge is separate from the context in which it is acquired and practice is seen as irrelevant for becoming knowledgeable.

**2.6.2 The social view of learning**

In more contemporary accounts of knowledge and expertise, knowing and learning have shifted away from a learning as product perspective (Hager, 2004). Assumptions that knowledge can be de-contextualised and that learning can be explained as an individual, psychological endeavour have been eschewed in favour of metaphors such as participation, construction and becoming (Boud & Hager, 2012). Learning is instead conceived as a social and cultural phenomenon (Gherardi & Nicolini, 2000). In this social paradigm, practice knowledge and expertise is not a possession of individual practitioners which resides as a mental substance in their heads; it is social, discursive and distributed among groups, tools and learning environments (Kemmis, 2005; Leander, Phillips, & Taylor, 2010). Expertise is understood as located in the performance of social (such as work) activities and professional knowledge and
“knowing is held to be an active and reciprocal process [of] engaging with the world beyond the physical self and drawing together both knowledge how, and knowledge that” (Billett, 2001, p. 4).

Within the workplace learning literature, Lave & Wenger (1991) and Wenger (1998) have been influential over the past two decades in their contribution to understanding learning as a social activity. In their book, *Situated Learning: Legitimate Peripheral Participation*, Lave & Wenger (1991) argued for a situated learning theory in which learning and knowing is a social phenomenon that occurs through the participation in shared activities of a community of practice. That is, they contend that learning is always situated in practice and knowledge is socially constructed through participation in the social world. Situated learning theory contends that the learning process is inextricably tied to the activities and practices that are performed by members of a community of practice. The notion of community of practice was originally defined by Lave & Wenger (1991) 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). Rather than being a defined profession or single institution such as a university or single workplace, a community of practice is less defined by a name and is better conceptualised as a social relation among people with shared concerns. This is reflected by Wenger and his colleagues (Wenger, McDermott, & Snyder, 2002) who revised the definition of a community of practice to “groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis” (p. 4).
In understanding how newcomers learn to become expert practitioners, Lave & Wenger (1991) provide the metaphor of ‘legitimate peripheral participation’. Newcomers to a workplace are seen as beginning on the periphery. That is, participation by novices is at first peripheral because their practice begins with simple, routine aspects of practice, but it is legitimate because they are still contributing to the shared activities of the workplace (S. Fox, 2000). According to Wenger (1998) learning is not a separate activity, but rather, takes place in the shared activities of our everyday lives. In the concept of legitimate peripheral participation, novices engage in the shared activities of work together with more experienced colleagues. Experienced colleagues help to mediate the progression of the novice’s participation from periphery to full participation. The notion of moving from the periphery as a newcomer to full participation as an ‘old-timer’ is used to explain how learning and expertise is intertwined with the formation of identity within the community of practice. To fully participate means to not only to have the knowledge and skills to perform all of the activities and practices of the community, but to be identified as a full member of the community by other members.

Workplace learning in this way is extra-individual. Learning is no longer an individual acquisition and an internalisation of knowledge, but a relational process of social participation in shared practice, where expertise is understood as a distributed knowing, a joint construction of meaning in relation to the historical and cultural context where practice takes place (Lave & Wenger, 1991). Fundamentally, knowing and expert practice are thus explained by what is shared and mutually understood between those within the community of practice.
Materiality and the role of material objects is largely ignored by Lave & Wenger (1991), but is taken up later by Wenger (1998) who discusses the role of materials in practice through reification. Reification being “the process of giving form to experience by producing objects that congeal this experience into ‘thingness’” (Wenger, 1998, p. 58). Representations of practice and shared meanings are distributed in reified material forms such as tools, equipment, protocols and texts. These material elements play a central role in the shared repertoire of paramedic practice. The interaction of material elements in paramedic practice is not, however, limited to reified objects, but also encompasses an array of natural and human-made elements such as other bodies, geography, built environments and physical objects. Moreover, reification does not adequately address the power of materiality to influence and shape practice as it is enacted and performed. Therefore, in the next section I explore learning as a sociomaterial assemblage.

2.6.3 Learning as sociomaterial assemblage

In the sociocultural theories of learning the use of artefacts and other materials are subordinated as background and often given little focus in discussions of the teaching and learning process. In a radical move, sociomateriality moves beyond the social and embraces the power of materiality as an influencing cofactor in workplace learning. A sociomaterial approach is not a single theory, but a standpoint that reclaims materiality as co-constituting human practices rather than being a secondary consideration. Sociomaterial approaches move outward to examine practice and learning from a whole of system perspective rather than at the individual practitioner level. There is a focus on the interaction of elements, human and non-human, as they become entangled in a dynamic web of interconnections (Fenwick, Nerland, &
Jensen, 2012). New possibilities for action/practice emerge among these interconnections. Knowledge and learning are viewed as embodied in practice and treat materiality “as integral to the enactment of human existence and social life rather than as simply background context or tools” (Fenwick & Edwards 2013, p.49). Materiality is used in the broadest sense to encompass the environment, tools, artefacts, but also texts and discourses such as policy, protocols and curriculum. In healthcare and paramedicine this would include diagnostic equipment, the vehicles, roads and houses, medications, organisational policies, checklists and medical records, uniforms and dress codes, patient handovers to medical staff, and other bodies – everyday things both organic and inorganic that form part of living in the world.

Social theories of learning, and in particular those of situated learning and communities of practice (Lave & Wenger, 1991; Wenger, 1998), were an important step in moving beyond the individual and toward an understanding of how context and sociocultural dimensions are implicit in workplace learning. It has, however, been criticised for being too focused on social participation at the expense of the power that materiality has to enable or resist learning and practice (Fenwick, et al., 2012; S. Fox, 2000). A sociomaterial analysis alternatively seeks to reclaim the materiality of social life. Orlikowski (2007, p.1436) contends that “every organisational practice is always bound with materiality”.

A sociomaterial approach decentres the human subject and interrupts the epistemological view of knowledge as ‘out there’ in reified objects such as texts or manuals or in the minds of individuals (Orlikowski, 2002). Instead learning and practice emerge as effects of relational webs of connections between human and non-
human entities (Fenwick & Edwards, 2013). In this view material things are not inert but act on and with humans to “exclude, invite, and order particular forms of participation in enactments” (Fenwick & Edwards, 2013, p.53) that are termed education, practice and learning to produce a distributed expertise. Expertise is no longer viewed as sitting inside the individual, but at a certain time and in the space of shared meanings between practitioners, practice environments and material collectives. The concept of knowledge is replaced with the verb of knowing and knowledgeability in action (Orlikowski, 2002). Learning and knowing become time and space dependent, emerging only through activity and practice.

Each of these heterogeneous elements (i.e. all things including people, social discourses, materials and so on) are assembled to form a network and are considered actors who exhibit force and are capable of forming together in a network or expand existing networks (Bleakley, 2012). Networks in this sense are not to be conceived as static structures that simply map one actor to another, like a freeway or electrical circuit, but instead refers to a concept that enables us to trace the relationships and interactions between actors (Latour, 2005). These social assemblages are continually taking form, breaking down and reforming in a multiplicity of ways. Networks are dynamic and organic flows of entities. This is where the heart of a sociomaterial analysis lies. Practice and learning are to be understood as relational effects of the connections between the heterogeneous materials (human and non-human) (Fenwick & Edwards, 2013). As disparate elements come together, learning and knowing must be negotiated (Fenwick, Edwards, & Sawchuk, 2011, p. 10). In the sociomaterial analysis these effects can be traced back to the relationships and connections within the heterogeneous assemblages of human and non-elements (Latour, 2005).
If practice and learning are understood as effects or consequences of the interrelations and associations of multifarious entities, the question is then how these assemblages are formed, hold together or breakdown. In the sociomaterial this is explained through the power relations between entities to exert force on other actors in the network (Fenwick & Edwards, 2011). The term *actor* is used here to denote any entity in the network; it may be human or non-human. All actors in a network are considered to have agency because in a sociomaterial account, materials are equally able to affect, influence and force change in the associations between other actors. Bleakley (2012) makes an important point though that to invoke agency in non-human elements, such as technologies, is not the same as subscribing to animism. Agency of non-human elements does not argue that equipment or natural and man-made objects have soul or a life force with an ability to choose or negotiate in the same sense that a human practitioner can, but instead reflects the idea that material elements have the power to influence meaning and what is known, as well as how practice is enacted. The purpose of analysis is thus to understand what they do, “and what they do is always in connection with other humans” (Fenwick & Edwards, 2011, p.3).

### 2.7 Chapter Summary

In this review of the literature it has been shown that preceptorship is a structured period of learning in the clinical practice setting where a novice or student clinician (preceptee) works closely with a more experienced colleague (preceptor) for a defined period of time to ease their transition into clinical practice. Preceptorship is widely used across the health professions, including paramedicine, where the preceptor is present as a critical partner who provides a scaffold of support around the novice during their transition from student to independent, safe and competent
clinician. Several studies highlighted the correlation between a positive transition to practice and the support of a preceptor.

Being a preceptor was often reported as a stressful experience with preceptors needing to balance the demands of their usual clinical role with the supplementary work of being a preceptor. Being responsible for the preceptee’s actions was also a commonly reported source of stress for preceptors.

Despite accounts of being a preceptor as demanding and stressful, a number of studies described the experience as rewarding. The rewards consistently reported in the literature included the satisfaction gained from sharing knowledge, the sense of achievement in seeing a novice grow in skill and confidence, and identified preceptorship as an opportunity for the preceptor’s own professional development.

In this review I have also explored and compared the cognitive, sociocultural, and sociomaterial perspectives of learning. Principally, the cognitive view depicts knowledge as representational, something which is ‘out there’ waiting for the learner to acquire, store and apply later as needed. In contrast, a sociocultural understanding of learning views knowledge as socially distributed, shared between people engaged in a common purpose, and inextricable from participation in practice. In this view workplace learning is not something that can be separated from practising and the social and cultural context in which it occurs. In a further leap, a sociomaterial approach to learning has been presented which shifts way from the anthropocentric sociocultural view to foreground the role of materials in workplace education and learning. The sociomaterial perspective not only recognises that materials, texts, technologies and artefacts are involved with learning and practice, but that they are
entangled and inseparable from them. Just as social and cultural elements have the power to influence, afford or hinder learning and practice, materials too will afford or constrain how learning and practice become realised.

Preceptorship has been recognised as the signature pedagogy for paramedicine (Lazarsfeld-Jensen, et al., 2014). However, this literature review has revealed there is currently a paucity of research in the area of paramedic preceptorship. No peer reviewed studies were found that directly explored the meaning of being a preceptor from the perspective of paramedics. An unpublished doctoral dissertation by Gurchiek (2011) was found that explored the experience of paramedic preceptorship exploring preceptorship to paramedic students from a North American university. In another unpublished doctoral thesis, Devenish (2014) explored professional socialisation of Australian and UK paramedics. His findings suggest that ambulance services are not adequately preparing qualified paramedics for the added responsibility and complexity of the paramedic preceptor role (Devenish, 2014, p.296). This literature review has highlighted the importance of my study as there is a significant need for further research to better understand paramedic preceptorship.

In the next chapter, the philosophical and methodological framework of the study is explicated by outlining the key constructs of hermeneutics as informed by the philosophical hermeneutics of Hans-Georg Gadamer.
Chapter 3
Approach to the Inquiry

3.1 Introduction

This chapter describes the methodological framework of Hans-Georg Gadamer’s (1989/2004) philosophical hermeneutics which underpins the qualitative approach to this study. The chapter begins by situating this study of the paramedic preceptor experience in Gadamer’s interpretive paradigm and describes the epistemological and ontological position of the research. This is followed by a discussion of the key constructs of Gadamer’s hermeneutics to describe the philosophical lens through which I approached the participant conversations to derive a new understanding of the paramedic preceptor experience.

3.2 A Qualitative Approach

Qualitative inquiry is concerned with the meanings people attach to their experiences and how they make sense of the world they are in. It is an interpretation of social phenomena through an exploration of “people’s subjective understandings of their everyday lives” (Pope & Mays, 2006, p. 6). It favours language and words rather than numbers to elicit a description of a social experience in rich detail and develop an understanding of meaning from the perspective of the participants (Houser, 2013). Research studies utilising questions which explore feelings, emotions and other subjective experiences are well suited to qualitative inquiry (Houser, 2013).

The purpose of this study was to develop an understanding of the experience of being a paramedic preceptor to novice paramedics in their first year of on-road clinical
practice. Therefore, with the aim of developing an understanding of the social phenomenon of being a paramedic preceptor through an exploration of the subjective experiences of the participants, a qualitative approach is most applicable.

3.3 Locating the Study within the Interpretative Paradigm

While a consensus definition of the term paradigm is difficult to determine, Guba (1990) defines a paradigm as “a basic set of beliefs that guides action” (p. 17). These beliefs which guide the researcher refer generally to how we view epistemology, the theory of knowledge and what constitutes what can be known, ontology, what is the nature of reality, and methodology, how do we go about determining knowledge (Guba, 1990, p. 18). That is, a paradigm provides a framework of assumptions on which a study is based. For example, if one accepts the ontological position that there is only one reality out there to be discovered, that the researcher is an independent observer of objective facts, then our methodological approach is designed to control for extraneous influences, remove biases and ensure the study is free from any value judgements. Such methodological considerations include randomised sampling, use of control groups and structured protocols. This contrasts with the alternative ontological position that there are multiple realities, and that as humans we construct and interpret our worlds differently to others. The researcher with the latter ontological position will take an entirely different methodological approach, one that accepts that the results are contextual, that alternative findings are possible at a different time and place, and yet still accept that this understanding does not detract from the credibility of the original research. Thus, locating the study within a paradigm has important implications for the type of research questions asked, the data collected and the conclusions drawn from the findings of the study.
There are two opposing paradigms, the positivist and interpretivist. In order to locate this research within one of these paradigms it is useful to compare their characteristics through the lenses of epistemology, ontology, and methodology as expounded by Guba (1990).

Within the positivist paradigm, the researcher’s ontological position is that there is one reality *out there*. This realist ontology presumes that the world is made of structures and objects which can be investigated by way of disassociated neutral observation. Epistemologically, positivist research aims to identify and describe objective value-free knowledge that can be verified through the scientific method. In the study of phenomena, findings are reducible to patterns of behaviour and essential structures which can be described.

An alternative epistemological position to the positivist paradigm is the interpretivist paradigm. For the interpretivist there are multiple realities, meaning that experiences are relative to the individual and open to a multiplicity of variation (Finlay, 2006). Epistemologically, what can be known is not an objective truth, but rather understanding is always a human construction, determined and influenced by our social, historical, cultural and linguistic situatedness (Finlay 2006, p. 19). In the interpretative study there is an inescapable interaction between the inquirer and the inquired, there is no distinct line between epistemology and ontology as there is a fusion between what can be known and the knower in a “coherent whole” (Guba, 1990, p. 26). The interpretive researcher embraces the inescapable implication of the researcher in the research process, a process that is a journey of discovery to find a shared meaning between the inquirer and the inquired to co-create understanding of
the topic (Monti & Tingen, 2006). It is the interpretivist paradigm that I have chosen to situate this study.

In this study I develop a comprehensive and shared understanding of the lived experience of being a paramedic preceptor. I use rich thick descriptions to describe this social phenomenon in a way that offers readers a vicarious experience of how paramedics perceive their role as a preceptor, what they believe to be their responsibilities, the challenges they face and the emotions that are evoked. The interpretive paradigm allows me to illuminate a reality that is constructed by individuals and firmly contextualised in the experiences of being in the familiar role of paramedic preceptor.

The philosophical hermeneutics of 20th century philosopher Hans-Georg Gadamer (1900-2002) has been chosen as a suitable methodological approach for two reasons. Firstly, this approach was compatible with the epistemology and ontology of the interpretative paradigm and well suited to the aims of this study. Secondly, while exploring the literature for an appropriate approach to undertake my research, I was immediately struck by Gadamer’s ideas while reading his seminal text *Truth and Method* (1989/2004), particularly his view that understanding occurs through a fusion of perspectives of the inquirer and the subject-matter, giving equal space for both in the event.

The philosophical hermeneutics of Gadamer is not actually a methodology as such, but rather an approach to inquiry through a philosophical lens that views the notion of understanding as an ontological event from being in the world and “a theory of the real experience that thinking is” (Gadamer, 1989/2004, p. xxxiii). Gadamer argues
that by clarifying the conditions in which understanding takes place, beyond methodology and self-consciousness, we develop a philosophical stance that recognises that understanding is not based on a set of principles or techniques, but rather is an event that precedes consciousness.

To give further clarity to this philosophical position, in the next section I will briefly describe the key concepts of philosophical hermeneutics. In doing so, I will elucidate how one comes to understand a subject matter before us and emphasise the epistemological position that understanding is an inter-subjectively shared truth between the inquirer and the inquired.

### 3.4 Key Concepts of Gadamer’s Philosophical Hermeneutics

In this section I briefly describe some of the key concepts of Gadamer’s philosophical hermeneutics employed in the approach to this study, including the notions of:

- understanding as an ontological event
- prejudice as positive and necessary to understanding
- Bildung, the centrality of dialogue and language
- the hermeneutic circle
- understanding as a fusion of horizons

#### 3.4.1 Understanding is ontological

In philosophical hermeneutics, understanding is viewed as an ontological way of being-in-the-world. Gadamer describes understanding as “not just one of the various possible behaviours of the subject but the mode of being of Dasein itself” (Gadamer, 1989/2004, p. xxvii). That is, it is not a conscious intentional act of cognition; it is “not what we do or what we ought to do, but what happens to us over and above our wanting and doing” (Gadamer, 1989/2004, p. xxvi).
Gadamer’s view of understanding as an ontological concern comes from his teacher Martin Heidegger (1889-1976). The word *Dasein* in Heidegger’s usage refers to an entity and it’s Being-in-the-world. Van Manen (1990) simplifies the definition of *Dasein* as “that entity or aspect of our humanness which is capable of wondering about its own existence and inquiring into its own being” (p. 176). Understanding is thus not restricted to the conscious task of interpreting a historical text, as in philology or scripture, but in fact understanding is an event that pervades all human relation to the world (Gadamer, 1989/2004). That is, understanding in a Gadamerian sense is not a detached knowing about an object, rather it is the constant and unending process or event of understanding our orientation and our place in the world. It is Gadamer’s thesis – and one that I have firmly adopted – that when we seek to understand the experience of something, for instance art, or philosophy itself, or undertaking a professional role such as that of paramedic preceptor, the truth of this experience “is communicated [in ways] that cannot be verified by the methodological means proper to science” (Gadamer, 1989/2004, p. xxi).

### 3.4.2 Prejudices as a positive

The second tenet of philosophical hermeneutics is Gadamer’s rehabilitation of *prejudice*. In scientific enquiry the term prejudice has long been equated with a negative connotation. For results to be accepted as empirically valid the researcher goes to great lengths to describe how they have eliminated their prejudices and biases from the research process to achieve objectively valid data. Gadamer (1989/2004) asserts that this negative connotation of prejudice only finds its origin during the Enlightenment. Before the Enlightenment, prejudice meant “a judgment that is rendered before all the elements that determine a situation have been finally
examined” or a provisional legal verdict (Gadamer, 1989/2004, p. 273). Gadamer says:

Prejudices are not necessarily unjustified and erroneous, so that they inevitably distort the truth. In fact, the historicity of our existence entails that prejudices, in the literal sense of the word, constitute the initial directedness of our whole ability to experience. (Gadamer, 1966, p.123)

What Gadamer is stating here is that our prejudices are what give us orientation to everything around us and our ability to experience something. That is, we can never proceed towards understanding from a presuppositionless position, we are always and already thrown into the inescapable history of our culture, language and past experience and thus understanding proceeds from what is historically pre-given to us (B. Phillips, 2007). I suggest it may be summed up as: **I am who I am, because of who I have been.** Understanding as an ontological concern can thus never be free from prejudice, and in fact there can be “no understanding that is free of all prejudices” (Gadamer, 1989/2004, p. 484).

The idea that prejudices and biases are always with us does not, in hermeneutic philosophy, mean that our prejudices are immutable. Nor is it as simple as cognitive self-reflection. It is through the event of understanding-as-being that prejudices are brought to the fore. In descriptive phenomenology, researchers are said to maintain objectivity of the phenomena through the notion of *bracketing* – or putting aside one’s pre-conceived ideas (Koch, 1995, p. 122). Gadamer however, following Heidegger, disputes that this is even possible:

> To try to escape from one’s own concepts in interpretation is not only impossible but manifestly absurd. To interpret means precisely to
bring one's own preconceptions into play so that the text's meaning can really be made to speak for us. (Gadamer, 1989/2004, p. 398)

The hermeneutic inquirer therefore does not make a vain and unattainable attempt to put aside or bracket away their preconceptions, but rather acknowledges their prejudices and places them at risk. Our prejudices become questionable and this opens us to the possibility that something new may be discovered and our prejudices may be challenged and (re)formed (Gadamer, 1989/2004). Gadamer calls this *historically-effected consciousness* (Malpas, 2009).

As an experienced paramedic and paramedic preceptor myself, I readily acknowledge that I enter this study with a historically-effected consciousness formed through my own experiences of being a preceptor and being precepted. I do not and cannot assert that as researcher I have put aside my preconceptions of what it means to experience being a paramedic preceptor. Rather, what is important is that I acknowledge the inescapability of my own history, but equally that I acknowledge my understanding may be incomplete and that other paramedics may have had different experiences of this phenomenon. I therefore undertake this research from a certain horizon and set of beliefs about preceptorship, but with a readiness to accept my current understanding is contestable. This disposition to have my beliefs challenged is the character of Bildung.

### 3.4.3 Bildung

If we come to every event of understanding with historically given prejudices, how then does one reach beyond these preconceptions to discover the truth? Gadamer (1989/2004) asserts that one must have the character of Bildung. I have described the notion of Bildung as a character because it is neither a learned skill nor an observable
behaviour. Rather, it is a way of being, an attitude of being receptive to an otherness, a “keeping of oneself open to what is other – other more universal points of view” (Gadamer, 1989/2004, p. 15), in order for one to be continually transformed through a receptivity to that which is beyond our own particularity.

Bildung is not an end-state nor is it a goal that one strives to achieve, Bildung is in a constant state of development within us, it is a “maturity which exhibits itself in both a receptive and reflective disposition to the lifelong challenges of experience” (Fairfield, 2011, p. 46). It prepares us for the constant task of challenging our preconceptions of our own horizon (Fairfield, 2011). Having the character of Bildung is what allows us to enter the hermeneutic circle and distance ourselves from ourselves to rise beyond one’s private purposes and see things “in the way others see them” (Gadamer, 1989/2004, p.15).

3.4.4 Understanding through dialogue and language

Gadamer uses conversation and dialogue as the model to explicate the mediation of understanding another. Dialogue in this sense is not limited to spoken conversation between two people, it may also pertain to the process of dialogue between a person and a text (Fleming, Gaidys, & Robb, 2003). To interpret text on a page, we must treat the text not as an inert object of fixed meaning, “but as a partner, a partner in dialogue” (Lawn, 2006, p. 82). Thus the notion of dialogue is central to how we come to understand the other. It is through dialogue and “… the process of question and answer, giving and taking, talking at cross purposes and seeing each other’s point” that the communication of meaning occurs (Gadamer, 1989/2004, p. 361).
Whether one is engaged in conversation with another person or a text, the process is similar in that the interpreter is trying to reach an agreement, to come to understand what the other is saying about a common subject matter, be it text or interlocutor. This understanding of the subject matter takes place through the form of language because “language is the medium in which substantive understanding and agreement takes place between two people” (Gadamer, 1989/2004, p. 386).

Gadamer emphasises the role of language in mediating interpretation because language presupposes thought and meaning. Even thoughts are internal dialogue with one’s self – that is, we can only think in a language (Gadamer, 1966). Thus, “all experience is revealed as something that can only be expressed via language” (Lawn, 2006, p. 81).

The notion that language precedes consciousness is further explicated by Gadamer in his use of play as a metaphor to describe participants engaged in conversation. Let me first reiterate that a genuine conversation in which “understanding...like an event ... happens to us” (Gadamer, 1989/2004, p. 385), it is not one that we consciously act out, but rather,

the more genuine a conversation is, the less its conduct lies within the will of either partner ... [it is one that] we fall into ... or even that we become involved in ... with the conversation taking its own twists and reaching its own conclusion. (Gadamer, 1989/2004, p. 385)

Gadamer here is emphasising the ontological structure of language as understanding through the notion that genuine conversation transcends the subjective consciousness of the individual participants. The metaphor of play is used to describe how the to-and-fro movement of words between interlocutors in genuine conversation is very
much similar to a ball game. Within this game, the players become enmeshed in the constant movement beyond pre-intended moves. As the ball moves in and of itself the players must play the flow of the ball. It is in this way that conversation transcends the consciousness of the players:

The common agreement that takes place in speaking with others is itself a game... In speaking with each other we constantly pass over into the thought world of the other person; we engage him, and he engages us. So we adapt ourselves to each other in a preliminary way until the game of giving and taking - the real dialogue - begins... And surely the elevation of the dialogue will not be experienced as a loss of self-possession, but rather as an enrichment of our self. (Gadamer 1966 p. 56-57)

As described earlier, the true hermeneutic experience requires the character of Bildung to transcend the particularity of oneself. In the genuine conversation this requires that we do not merely put our own point of view forward and view understanding as successfully asserting our preconception of the subject matter as truth, but being transformed into a “communion in which we do not remain what we were” (Gadamer, 1989/2004, p.371).

3.4.5. The hermeneutic circle

The hermeneutic circle is used metaphorically to describe how understanding takes place. It has its origins in ancient rhetoric and involves the circular nature of understanding where the anticipated meaning of the whole is only fully realised when the parts make sense in terms of the whole, but the whole only makes sense in terms of its parts (Gadamer, 1989/2004). Understanding is said to occur when there is a harmony between the details with the whole. When this harmony does not occur, understanding continues to elude the interpreter.
The hermeneutic circle is not to be conceived as a geometric circle though, “but describes understanding as the interplay of the movement of tradition and the movement of the interpreter” (Gadamer, 1989/2004, p. 293). It is in this “polarity of strangeness and familiarity” (Gadamer, 1989/2004, p. 295) that the process of coming to understand takes place.

When we seek to understand an Other, we project an expectation of meaning for the whole, guided by our prejudices and conditioned by our traditions. We begin from the standpoint that we will understand the meaning of the object of our attention because of our prior involvement in the subject matter (Gadamer, 1989/2004). When the object of our attention fails to be understood, we enter into the hermeneutic circle, an iterative back and forth movement between our fore-projection of meaning grounded in our own effective histories and what the other reveals to us in its own historical strangeness, where our anticipatory fore-projection of meaning is constantly revised “in light of a better and more cogent understanding of the whole” (Grondin, 2002, p. 47). It is in this space, somewhere between familiarity and strangeness, that the locus of hermeneutics is situated.

To further explain, I shall borrow an example from Schmidt (2006). When we begin to read a play by William Shakespeare we project an anticipatory meaning of the text/script as a whole. This preliminary meaning emerges from expectations because of our historical traditions. Familiar as most of it may be, there is frequently a strangeness in the prose which does not fit and we do not understand. In Hamlet for example, take the phrase “stop and unfold thee!” If I am to understand what this means, I must not only know the meaning of the words, but also the totality of the context they are uttered. In Hamlet these words are said by a guard to another person.
Now let us consider how a person can unfold? It is not that this other person is folded like a piece of paper, but in Shakespearian time unfold was used to mean disclose or reveal. Therefore, by understanding the single phrase in light of the larger tradition in which the text was written, we can understand that a guard is asking a person to stop and identify themselves. We cannot view the world as Shakespeare viewed it, our task is rather to derive an understanding of his texts from the linguistic usage of the time and the tradition in which it is situated (Gadamer, 1989/2004).

In Gadamerian research the hermeneutic circle remains an ontological concern rather than a methodological prescription. It is, however, central to the approach of data analysis. Gadamer’s (1989/2004) reclamation of the concepts of prejudice and the hermeneutic circle work together, not so much to prescribe a series of steps to be taken, but as a philosophical comportment of the researcher towards an interpretation that is intersubjective and worked out of the to-and-fro movement between the whole of the researcher’s traditions and the meanings of the subject matter as ascribed by the participants.

As the researcher I am also an experienced paramedic preceptor. As such, I began this research with an inescapable fore-projection and expectation of the meaning of paramedic preceptorship. The task of revealing a new understanding of paramedic preceptorship is the process of working out this fore-projection, which is constantly revised in terms of what emerges from my participants narratives, this is “understanding what is there” (Gadamer, 1989/2004, p. 269). Understanding is thus not subjective nor objective, but realised as a unified meaning that “is always co-
determined by the historical situation of the interpreter (Gadamer, 1989/2004, p. 296) and those of the research participants.

3.4.6 Understanding as a fusion of horizons

Gadamer uses the metaphor of a horizon to describe our perspective of the world in which we experience life. Our horizon includes the range of historical, cultural and linguistic preconceptions we have developed over time (B. Phillips, 2007). It is from within this horizon that we come to the event of understanding. However, our horizon is never static or absolute, it constantly moves with us, expanding in every moment of our historical being as we experience the everydayness of the world in which we live (Gadamer, 1989/2004).

This horizon, being our perspective or vantage point, is given to both the interpreter and the Other (whether this is another person or a text) that one is seeking to understand. Therefore, what exists in the event of understanding between the self and the other are two horizons. When we wish to understand the other, we enter into a dialogical process of question and answer that tests one’s prejudices against the horizon of the other, remaining open to something that may be new to us. It is in this process that the productive nature of understanding comes to the fore, where the two limited horizons of the interpreter and the other “are fused into a common view of the subject matter – the meaning - with which both are concerned” (Linge, 1976, p. xix).

This fusion of horizons is not an appropriation of one for the other, but rather, it is an understanding which expands beyond either of the two original horizons. In other words, the meaning of a text or subject matter for the interpreter “does not depend on
the contingencies of the author or his original audience [and] is certainly not identical with them ... for it is always co-determined also by the historical situation of the interpreter” (Gadamer, 1989/2004, p.296). Hence, “not occasionally but always, the meaning of a text goes beyond its author. That is why understanding is not merely a reproductive but always productive activity as well” (p. 296).

This concept is central to understanding that the findings of this study are a co-created meaning of paramedic preceptorship. As an experienced paramedic who has precepted novice paramedics, I bring to this research a personal history rich in the experiences of paramedic preceptorship. Rather than make a futile attempt to set aside my views and prejudices, which Gadamer (1989/2004) argues is “not only impossible but manifestly absurd” (p. 398), my horizon is legitimately and meaningfully incorporated into this research of understanding paramedic preceptorship as a valuable contribution.

3.5 Sociomateriality and Philosophical Hermeneutics

There is a congruence between the sociomaterial exposition of paramedic practice and preceptorship developed later in Chapter Eight and the philosophical hermeneutics of Gadamer (1989/2004). To begin with, both adopt a relational ontology in which “understanding proves to be a kind of effect” (Gadamer, 1989/2004, p. 336) which is not a priori, but emerges from our Being-in-the-world. According to Law & Urry (2004, p. 395) “reality is a relational effect” between the knower and what is known. In sociomaterialism this concept is written as our embeddedness in networks and complex systems, whereas Gadamer speaks of a historically effected consciousness. For Gadamer (1989/2004) understanding is
intersubjective, not relativist but perspectival. As Law & Urry (2004, p.397) explain, “the world is multiply produced in diverse and contested social and material relations. The implication is that there is no single ‘world’”. Gadamer (1989/2004) similarly surmises: “Not just occasionally but always, the meaning of a text goes beyond its author. That is why understanding is not merely a reproductive but always a productive activity as well” (p.296). The salient point is this: knowledge of the social, such as paramedic practice, is not out there waiting to be acquired, rather it is emergent, context-dependent and contestable. Practice that first appears recursive, especially that which is reified as protocols, texts and policy, must still be translated into embodied action at the time it is enacted by the practitioner. The reified version is thus an incomplete representation, practise must be performed into existence and our horizon for understanding is always in motion (Gadamer, 1989/2004).

3.6 Chapter Summary
In this chapter, I have summarised the interpretivist epistemological and relational, inter-subjective ontological stance taken to explicate an understanding of being a paramedic preceptor to novice paramedics in their first year of clinical practice. Further, I have outlined the qualitative approach I applied, which is informed by the philosophical hermeneutics of 20th century philosopher Hans-Georg Gadamer (1900-2002). In the discussion of philosophical hermeneutics, I have explicated several important concepts that pervaded the research approach, namely: that understanding is an ontological structure of being in the world, the rehabilitation of prejudice as a positive and an essential structure for understanding to occur, Bildung as the characteristic of being open to other meaning, the dialogical nature of inquiry and the centrality of language, the hermeneutic circle, and understanding as a fusion of
horizons between myself and the participants. I then outlined the congruence between philosophical hermeneutics and sociomateriality as the theoretical framework that I later use in Chapter Eight to explicate a relational ontology of understanding paramedic practice and preceptorship.

The implication of this view of understanding is that in this Gadamerian study, my own experiences as a paramedic preceptor are valued and explicit in the construction of the understanding which unfolds. My involvement in this research is as much a participant as it is researcher. In the next chapter, I will outline the methods I employed to undertake this study.
Chapter 4
Methods

4.1 Introduction
In this chapter, the methods employed in the study are presented. Ethical considerations, sampling, data collection techniques and a brief description of the study setting are described. Data analysis guided by the philosophy of Gadamer (1989/2004) is also described. Finally, I discuss the framework that was used to establish trustworthiness and rigour in the study’s findings.

4.2 Ethical Considerations
This qualitative study was undertaken with the involvement of human participants. As such, a number of steps were taken to ensure that the research was undertaken to the highest ethical standards.

4.2.1 Ethics approval
Ethics approval was sought and received from Charles Sturt University under approval number 406/2012/11. Further, at the request of the ambulance service which employed my participants, I received ethics approval from the South Eastern Sydney Local Health District under approval number 13/022 (LNR/13/POWH/90).

4.2.2 Informed consent
Informed consent was obtained from all participants prior to the commencement of their participation in the study. Four elements were considered necessary to ensure the validity of the consent by participants:
1. Competence – participants must be responsible, mature individuals who are able to understand the nature of what they are consenting to and the consequences; their capacity to consent must not be impaired by medical conditions, drug and alcohol consumption, intellectual impairment or immaturity;

2. Voluntariness – participant consent is given freely and without coercion, knowing the potential risks;

3. Disclosure of information – includes adequate disclosure of enough information regarding the risks and benefits, purpose of the research, the procedures to be followed, and explicit information that consent may be withdrawn at any time; and

4. Comprehension (or understanding & acceptance of the information) – it is not enough for information to be provided, the researcher must ensure the participant appreciates and understands the information provided to them (L. Cohen, Manion, & Morrison, 2007, p. 52; Kerridge, Lowe, & McPhee, 2005, p. 216).

These four elements of informed consent were achieved through the following strategies:

1. All participants were working adults deemed competent by the researcher;

2. Participation was on a voluntary basis. Participants were free to withdraw at any time without giving reason or consequence (however, no participant chose to withdraw);
3. Prior to agreeing to be involved, potential participants were provided with an information sheet that clearly articulated the purpose of the research, the involvement required by the participant, potential risks to participating, how the interviews would take place, and the strategies being employed to maintain confidentiality (see appendix 1).

4. Confirmation of comprehension was sought through the signing of a consent form that clearly articulates what the participant is consenting to. Secondly, both the participant information sheet and consent form have been written in “language which is simple and free of jargon” (Kerridge, Lowe & McPhee, 2005, p. 220) to aid the comprehension process.

4.2.3 Risk of harm

Implicit in the informed consent process is the anticipation of any potentially undesirable consequences for participants (Oliver, 2010). It was recognised that the process of interviewing may remind participants of difficult situations or otherwise cause the participant to feel uncomfortable or possibly distressed. To mitigate any risk of harm, at the beginning of each interview, participants were reminded that their participation was entirely voluntary and that they may decline to answer a question or discuss a particular topic (Oliver, 2010). Moreover, they could request the interview to cease immediately at any time and without reason. The participant had the option to cease the interview temporarily for a break, have the digital recording stopped or terminate the interview effective immediately. All participants completed the interview in a single session without voicing any concerns.

Further, as the participants were recruited from a specific ambulance service, they were reminded of the employee support services that are available in their workplace.
Each participant was provided brochures for these services which included access to peer support officers, chaplaincy services and an Employee Assistance Program which makes available a free 24/7 counselling service.

### 4.2.4 Participant confidentiality

Maintaining participants’ confidentiality was an important consideration in this study. All participants were recruited from a single ambulance service in which they continue to be employed. The advantage of maintaining confidentiality of participants is that if they were to be identified, they may be guarded in what or how much they reveal about their experiences; knowing that their identity was kept private may have offered them the confidence to truly express their feelings of the phenomenon (Oliver, 2010).

Confidentiality of the participants has been maintained through the use of unisex pseudonyms in this thesis and will also be used in any associated publications using data from this research project. The use of unisex pseudonyms was chosen for two reasons. Firstly, while some researchers have presented participant excerpts denoted by a simple letter (Ohrling & Hallberg, 2001) or more generically as “one subject” (Whitehead, 2001), with dialogue and conversation being a key tenet of Gadamerian research, the use of names, even as pseudonyms, is most appropriate in presenting the voices of my participants in the process of negotiating a shared meaning of preceptorship. As Gadamer (1966, p. 65) argues, “to speak means to speak to someone”. Secondly, the use of a unisex pseudonym further protects the identity of participants by adding an additional layer of de-identification from gender.
A further strategy employed to maintain participant confidentiality was the de-identification of specific contextual details that could reveal the identity of the participant. Names of work locations, emergency incidents and preceptee names were omitted or changed as appropriate.

Confidentiality has been further maintained by limiting access to the transcripts with identifying data. No information will be released to the employing organisation or other parties without the express consent of the participant.

**4.3 Study Setting**

Participants in this study were operational paramedics within a single Australian ambulance service. The study organisation employs over 4,000 people, with 90 per cent being operational staff employed to deliver front line services. The organisation provides ambulance services to a population of approximately 7.6 million people in metropolitan, regional and rural areas, across an area of 800,600 square kilometres. In 2013/14 the organisation responded to over 1.2 million emergency and non-emergency calls for assistance.

**4.4 Inclusion Criteria**

The inclusion criteria for this study were participants who were qualified paramedics and had undertaken the role of paramedic preceptor to novice paramedics in their first year of clinical practice on at least two occasions. There were no specific exclusion criteria as such.

**4.5 Participant Recruitment**

Participants in this study were operational paramedics within a single Australian ambulance service. Purposeful sampling was used to recruit participants who were
able to engage in information-rich conversations that allowed me to learn a great deal about the phenomena of paramedic precepting (Patton, 1990, p. 169). Invitations which included the participant information sheet were sent to 44 prospective participants via email. Prospective participants were identified by the researcher as meeting the inclusion criteria and whom worked within several differing geographical locations of the study organisation. Within the invitation it was made clear that participation was voluntary. A number of invitees declined to participate and several provided no response. The non-responses were assumed to be a declination of participation.

The researcher did not hold any position of authority or power over the invitees that would pressure them to take part in this study. Further, participants were not provided any incentive such as monetary or gifts in exchange for participating.

A total of 11 qualified paramedics were recruited to investigate the experience of being a paramedic preceptor to novice paramedics. Although a probability sample was not the aim for this study, participants that took part in this study had a variety of backgrounds and entered paramedicine through each of the pathways including vocational, tertiary and with recognition of prior learning, such as their nursing experience. Further, participant experience as a paramedic and preceptor ranged from relatively new to very experienced. Table 1 outlines the demographics of the participants.
<table>
<thead>
<tr>
<th>Participant</th>
<th>Age group</th>
<th>Years as a qualified paramedic</th>
<th>Number of Preceptor experiences</th>
<th>Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim</td>
<td>41 +</td>
<td>9 +</td>
<td>11 +</td>
<td>Vocational Diploma</td>
</tr>
<tr>
<td>Robin</td>
<td>41+</td>
<td>4 - 8</td>
<td>11 +</td>
<td>Vocational Diploma</td>
</tr>
<tr>
<td>Leigh</td>
<td>31-40</td>
<td>1 - 3</td>
<td>6 - 10</td>
<td>Bachelor’s Degree (nursing)</td>
</tr>
<tr>
<td>Sam</td>
<td>22-30</td>
<td>4 - 8</td>
<td>6 - 10</td>
<td>Vocational Diploma</td>
</tr>
<tr>
<td>Chris</td>
<td>31-40</td>
<td>4 – 8</td>
<td>11 +</td>
<td>Vocational Diploma</td>
</tr>
<tr>
<td>Charlie</td>
<td>31-40</td>
<td>4 - 8</td>
<td>6-10</td>
<td>Bachelor’s Degree (nursing)</td>
</tr>
<tr>
<td>Andy</td>
<td>22-30</td>
<td>1-3</td>
<td>11 +</td>
<td>Vocational Diploma</td>
</tr>
<tr>
<td>Jordan</td>
<td>22-30</td>
<td>4-8</td>
<td>11 +</td>
<td>Vocational Diploma</td>
</tr>
<tr>
<td>Alex</td>
<td>31-40</td>
<td>9 +</td>
<td>11 +</td>
<td>Paramedic Degree</td>
</tr>
<tr>
<td>Taylor</td>
<td>31-40</td>
<td>9 +</td>
<td>11 +</td>
<td>Vocational Diploma</td>
</tr>
<tr>
<td>Drew</td>
<td>31-40</td>
<td>9 +</td>
<td>11 +</td>
<td>Vocational Diploma</td>
</tr>
</tbody>
</table>

Table 1: Participant demographics

4.6 Data Collection: Understanding through dialogue

Understanding is achieved through dialogue and conversation (Gadamer, 1989/2004). It is through the process of question and answer that we put our prejudices at risk and allow them to be challenged and to hear what the Other has to say to us. In conversation “we get to know other people, get to learn about their experiences, feelings and hopes and the world they live” (Kvale, 2007, p. 1). In this two-way dialogue the research interview becomes a medium where knowledge is constructed through the interaction of researcher and participant (Kvale, 2007).

To understand the experience of being a paramedic preceptor, I met face-to-face with my participants to engage in one-to-one in-depth conversations about their experiences in the role of preceptor. The conversations were semi-structured in that although I prepared several questions to guide our discussions, the flow of conversation was allowed to move back and forth of its own accord. As Gadamer (1989/2004, p. 385) argues, it is in this genuine conversation that the interlocutors are
less its leaders than being led as the conversation takes on “a spirit of its own, and that the language in which it is conducted bears its own truth within it—i.e., that it allows something to emerge which henceforth exists.”

Throughout the conversations I encouraged the participants to reveal their personal experiences and insights of paramedic preceptorship in depth and clarity, guiding them along the journey of inquiry “but remained flexible enough to allow the participants to uncover their deeply held beliefs” (Sorrell Dinkins, 2005, p. 111). Sorrell Dinkins (2005, p. 128) suggests that the hermeneutic interview as a conversation is an appropriate method for developing understanding in hermeneutic inquiry if one remains faithful to its origins as an “inter-view”; which then allows both the researcher and participant to reveal something of themselves and be equals in the co-creation of understanding.

Each conversation was conducted at a time and place convenient to the participant. Five participants chose to be interviewed at their place of work, two in their own home and four in a public library study room. Conversations were recorded using a digital audio recorder which was clearly visible and the recording only began after participants had read and signed the consent form. All participants agreed to have our conversations recorded in full. Interview lengths ranged from 36 minutes to one hour and 26 minutes.

Field notes were recorded during and immediately after each interview. In these I recorded my initial thoughts and ideas, contemplating our discussions and asking myself how the participant’s horizons were different from my own; purposively
seeking to challenge my prejudices and asking how their experiences were different from my own.

Following the interviews, all but one recording was transcribed by a professional transcription service. I personally transcribed one interview. These transcriptions then formed the text for further interpretation. The importance of transcribing the interviews was that it allowed me to engage with the dialogue with my participants and revise my fore-projections of meaning in an iterative process. Understanding is never reached on a whim. As Gadamer (1989/2004) asserts, “all correct interpretation must be on guard against arbitrary fancies and the limitations imposed by imperceptible habits of thought, and it must direct its gaze on the things themselves” (p. 269). This occurs through the constant task of working out my fore-projections and constantly revising them “in terms of what emerges as [I] penetrated into the meaning [and] understanding what is there” (Gadamer, 1989/2004, p. 269).

4.7 Data Analysis: The process of gaining understanding

The process of data analysis in this study, which could more correctly be termed developing understanding was underpinned by the Gadamerian principles of Bildung, openness to an otherness of meaning, prejudice, in a positive sense, embracing the idea that I approach this research through a lens carved by own history of culture and tradition, engagement in the hermeneutic circle, the process of coming to understand the phenomenon in a cyclical to-and-fro between the parts and the whole of the text, and finally, reaching a fusion of horizons, the shared understanding of the phenomenon that is reached when my own horizon intersects with those of the participants (Gadamer, 1989/2004).
Data analysis did not begin with the transcribed texts, it had already begun as I engaged in conversation with the participants, listening and thinking about the meaning of what was being said to me (M. Cohen, 2000). Following the transcription of each interview, I immersed myself in the data by reading and re-reading each transcription. I also listened to the interview again and again to hear the voice of the participants, to gain a deeper understanding of their words by listening to the tone and inflections, the laughs and pauses which also say so much. As Cohen (2000) states, the aim of this immersion is to establish an initial interpretation of the subject matter, which can then be further developed in the iterative back and forth movement of hermeneutic analysis.

Subsequent stages of the data analysis involved using the assistance of the NVivo 10™ and MS Word™ software programs to undertake further data transformation. As the analysis continued, I made decisions about what was important and relevant and what was not, reorganized sections of each interview into coherent themes and selected exemplars to articulate the meaning of paramedic preceptorship (Cohen, 2000).

Contextualisation of my own horizon pervaded the data analysis by foregrounding my prejudices throughout the process. This essential element differentiates philosophical hermeneutics from simple thematic data analysis. This is not to say the interpretation was ad-hoc or subjective, but rather it is an epistemological position that acknowledges the inter-subjective and shared construction of meaning.

The task however was not to reaffirm my prejudices, but to question them and be prepared for the participants to tell me something different (Gadamer, 1989/2004).
We always come to a conversation with prejudices, formed from the history of our traditions and cultures in which we live. Our prejudices cannot be bracketed away or set to one side however, as Gadamer (1989/2004) asserts “[to] try to escape from one's own concepts in interpretation is not only impossible but manifestly absurd (p. 398). To interpret means precisely to bring one's own preconceptions into play so that the text's meaning can really be made to speak for us”. This is where the character of Bildung is so essential for the hermeneutist. One must have an openness to other more universal points of view and be prepared for the object of attention to tell me something and remain open to the meaning of the other person (Gadamer, 1989/2004).

With my prejudices brought to the fore through the provocation of conducting this study and an openness for what the participants may reveal to me about being a paramedic preceptor, my engagement in the hermeneutic circle continued through a dialectical to-and-fro between the individual parts (answers to individual questions) and the whole (my anticipatory fore-projections of the meaning of the phenomena). This back and forth movement continued as my projections were replaced over and over until a cohesive, shared understanding of being a paramedic preceptor emerged between the participants and myself. Gadamer’s concept of this union in the event of understanding is a fusion of horizons between me and the other participants (Fleming, et al., 2003).


4.8 Establishing Rigour

Within the extant literature, robust debate exists regarding the criteria and establishment of rigour within qualitative research, with little consensus on a criteria for the evaluation of quality in qualitative research. Rolfe (2006) even argues that consensus is not possible because “there is no unified body of theory, methodology or method that can collectively be described as qualitative research” (p. 305).

Despite the enduring discourse, de Witt & Ploeg (2006) offered a useful framework for evaluating the rigour of this interpretative research. Importantly, there was an epistemological and ontological congruency between this framework and my Gadamerian Inquiry. Therefore, I have chosen their framework as a guide to ensure the study findings are a credible contribution to the body of knowledge of paramedic practice.

The de Witt & Ploeg (2006, p. 224) framework has five expressions of consideration:

1. Balanced integration;
2. Openness;
3. Concreteness;
4. Resonance;
5. Actualization.

Each of the five expressions are introduced in the next section.

4.8.1 Balanced integration

The first expression of balanced integration required that throughout the study there was an intimate connection and intertwining of the philosophical concepts. Clear
articulations of the philosopher’s central concepts may be readily found in the methods used and the interpretations made. Furthermore, there is a balanced representation of the participant’s voices in the interpretation with exemplars used throughout the findings chapters, while also including my own thoughts in the interpretive process.

4.8.2 Openness

Interpretations made within an interpretive study are never final or absolute, there is no right or wrong interpretation of the experience (Debesay, Naden, & Slettebo, 2008). As researchers we have a responsibility to ensure our research findings are sound. The expression of openness is closely related to the concepts of transparency and auditability. While the study findings represent my own interpretation of the experience of being a paramedic preceptor, I have included a clear link to the participants themselves through the inclusion of exemplars for every finding, often including several exemplars from different participants to demonstrate their horizons.

4.8.3 Concreteness

The third expression of concreteness - although an awkward expression from the authors – refers to the interpretations having a familiarity for the reader, a sense of contextualisation where the reader can see their own life in the interpretations.

Achieving concreteness required writing up of the final report in language which maintains a sensitivity for the need to bridge the explication of understanding the experience of paramedic precepting with contextualisation to the everyday life-world of my readership (de Witt & Ploeg, 2006). I have written this thesis with the hope
you as reader can vicariously experience the world of the paramedic preceptor that my participants and I have co-constructed.

### 4.8.4 Resonance

Resonance is closely connected with concreteness. Whereas concreteness is contextualisation of the interpretations, resonance is the personal experience, a sympathetic understanding felt by the reader. Again, like concreteness, in the writing of the final thesis I was aware of the need to avoid the use of esoteric and abstruse language. I have replaced or explained jargon throughout in favour of everyday expressions. Moreover, use of first-person narrative in the presentation of the thesis has also been used to enhance the prospect of the research resonating with the readership.

### 4.8.5 Actualisation

The final expression of the framework is actualisation. This expression is the least described by de Witt & Ploeg (2006). The authors allude to the potentiality of the research and future relevance of the interpretations. It is my interpretation of this expression that we undertake a research project for its significance and contribution it can make in the area of study. As researchers, we do not conduct a study to be written and shelved for the sake of it, but rather, in the hope that it will broaden the understanding of the subject-matter in the broader academic and professional circles; it will enrich the body of knowledge and be used to improve our field of practice. It is this potential actualisation on which we may judge an interpretative inquiry. This fifth and final expression of rigour is in the hands of the reader, but through a commitment to sound research based on the first four expressions and a clear
articulation of the importance and significance of the study, I hope to offer my readership a reasonable argument for actualisation of this study.

4.9 Chapter Summary

In this chapter, I have outlined the methods that were used to conduct this inquiry into paramedic preceptorship. Several important ethical considerations were addressed and the strategies I employed to undertake an ethical research project were made clear. Data collection was clarified as more an engagement in dialogue with the participants through one to one conversations to further develop an understanding of being a paramedic preceptor. This dialogue extended from the audio-recorded conversations to a dialogue between researcher and text (transcripts). The data analysis process was illuminated through a review of the key tenets of philosophical hermeneutics which pervaded the analysis.

Finally, the framework of de Witt & Ploeg (2006) was presented as the chosen approach to ensure this interpretative study may be judged as rigorous and sound by an appropriate set of criterion for a Gadamerian inquiry.
Chapter 5: Multidimensional Role of the Paramedic Preceptor

5.1 Introduction

In this, the first of three findings chapters, I shall demonstrate that previously used descriptions of the paramedic preceptor as training officer, clinical mentor or instructor are insufficient and incomplete in defining the complex, multidimensional role and responsibilities of the paramedic preceptor. In the following exposition I will demonstrate that the role of the preceptor consists of four key responsibilities: coach, role model, socialiser and protector.

Section 5.2 explores the theme of preceptor as coach. Several sub themes are presented to illustrate recurring strategies used by paramedics in coaching their novices. Section 5.3 looks at the paramedic preceptor as a role model and illustrates how the preceptor’s actions and behaviours are an influential component of learning in the preceptor-preceptee relationship. Section 5.4 describes the importance of the preceptor’s role in facilitating the professional socialisation of the novice paramedic. Section 5.5 focuses on the role of the paramedic preceptor as a protector. All of the participants in this study highlighted their responsibility for ensuring patient safety while their novices learned to become competent, professional paramedics. Moreover, it also became clear that the preceptor’s role included protecting the novice and this too is explored in this section. Lastly, Section 5.6 presents a discussion of the findings in this chapter.
Figure 5.1 below provides an outline of the structure of this chapter:

Figure 5.1 Structure of findings in Chapter Five

5.2 Preceptor as Coach

In describing the paramedic preceptor’s role in the education and teaching of a novice paramedic, the most appropriate term is Coach, rather than teacher or trainer. The participants in this study consistently described their role in the teaching and educating of a novice paramedic as being focussed on the novice as a whole
practitioner, using strategies of support, guidance and advice rather than the delivery of informational content or instructional training in technical skills.

In further developing this understanding of the paramedic preceptor as coach, this section explores several strategies for coaching that pervaded the participant interviews.

**5.2.1 Understanding your learner**

The participants in this study expressed the importance of establishing an understanding of their preceptees as individual learners who have come to paramedicine with different backgrounds, skills and experience. Novice paramedics can enter the profession through several different pathways. They may be new graduates from university, or they may be mature individuals who have become paramedics as a career change later in life. As such, although being a novice as a paramedic, they are likely to come with a breadth of experience and prior knowledge in other areas, including diverse clinical backgrounds such as nursing or one of the allied health professions. Effective adult learning embraces these individual differences and uses the knowledge of a novice’s prior experiences to tailor the learning experience, which in turn makes the adult learning environment more effective (Knowles, Holton, & Swanson, 2011). It is important that preceptors exchange information with their preceptees about their previous personal and professional experiences, communication and learning preferences, and their responses to stressful situations which may affect their learning (Baltimore, 2004).

Many of the preceptors interviewed for this study entered paramedicine through the vocational education pathway without a paramedic degree. This influenced the
approach of the preceptors because they believed that their novice may have a greater theoretical knowledge than themselves as preceptor:

Well because they’re fresh out of uni they would probably have a greater understanding of pathophysiology than I would, um in some regards. (Robin)

I’ve found I’ve come up against students who’ve come through [university] and know more clinically than I do… (Sam)

The participants believed the focus of the preceptorship for tertiary graduates is therefore more focused on putting into practice what was learnt at university rather than teaching theoretical knowledge. Jordan commented that tertiary graduates should already have a good understanding of theory, but the preceptor needs to coach them in how to perform their skills in the real world:

The main role I guess would be just to support them and make sure they’re keeping on track with their education and their skill development. ... how they’re working with their skills. I mean they should already have the sort of knowledge in the back of their head from school, but really we’re not here to be their primary knowledge giver in a way, they should have already had background information from college or from university and they should know all the sort of history, you know. ... So I shouldn’t be the one actually telling them what’s the purpose of taking our blood pressure, they should already know that. I should just be sort of mentoring and watching their skills on how they’re actually doing it in a way. (Jordan)

Generally speaking, VET\(^1\) entrants begin their transition year with very limited clinical knowledge. The novice paramedic who enters the profession through this pathway may come from a variety of different roles including trades, finance,

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\(^1\) VET: Vocational Education & Training. This is the non-tertiary entry pathway in which new paramedics receive post-employment training through the organisation to qualify as a paramedic.
teaching and so on. New employees through the VET pathway may also have clinical backgrounds such as nursing or another health profession.

Kim commented that preceptors should not presume to know the preceptees’ knowledge level or understanding of patient care based solely on their entry pathway:

[You need to] listen to them, in the first short period, like the first day or two, hear where they’re coming from, try and find out what their background is. They may not have just been a shop assistant all their life. I’ve had a few that are actually from a nursing background that had decided not to fast track, to come through the system the old way, through the VET system; and clinically they’re switched on. (Kim)

Like Kim, Andy also expressed the importance of talking with the novice early on to explore their background prior to becoming a paramedic:

I always ask them what they’ve done previously to this job. Because there’s plenty of times where you get someone who’s a probationer and they say oh, I did medical science for three years at university, or you know, I was a doctor in another country but now I’ve moved here and I can’t practise. Or ... one probationer I had, he was a nurse for a couple of years before he did this job. So not just looking at someone seeing blue on their epaulettes2 and thinking they don’t know anything. (Andy)

Andy elaborated further that there is opportunity in understanding your learner beyond the novices’ training needs. With some novices having considerable clinical backgrounds, they can become a source of knowledge that the preceptor can draw on and be a valuable resource in the partnership:

2 In the study setting, paramedics wear different epaulettes to signify their clinical level. Trainee and graduates in their first year have blue writing.
I think a good thing is to ask them what they did previously, because they will have experiences that you don’t have, no matter what, and they will be able to contribute. (Andy)

Andy shows us that understanding the novice creates an opportunity for learning to occur both ways; it also establishes respect for the leaner as an adult who also adds value to the preceptor-preceptee relationship.

In addition to understanding the novice’s life background, the preceptors also established an understanding of their learner through observation. Sam articulates that each novice, irrespective of their background, will have particular strengths and weaknesses. Sometimes the best way to determine these is to see the novice in action.

The preceptor can use this information as a reference to guide the learning process:

After your first job you pick out that maybe they’re not a good communicator or they’re not very good at knowing where to set up the stretcher. You can debrief that. I might not see that until I see them interacting with a patient and on a job. I would find it easier when I see them at work when they have dealt with a patient to know where we could guide training. (Sam)

To set the stage for an effective learning partnership, the preceptors understood that novice paramedics are adult learners who have come to their new role with a wide diversity of backgrounds and knowledge. This understanding is then a platform on which to base the learning needs of the novice and establish the focus of the learning which needs to occur.

5.2.2 Beyond the classroom

I guess that’s what this (preceptorship) is designed to do, follow-on from [the organisation’s training school] in terms of education. And use that, I guess, clinical knowledge in a practical sense on the road and teach as you go. (Chris)
A number of authors have suggested that novice clinicians enter the clinical practice setting with a theory-practice gap in their knowledge despite receiving formal education (Corlett, 2000; Kaviani & Stillwell, 2000; Mantzorou, 2004). The preceptor is well placed to mediate a bridging of this gap as the nexus between theoretical learning and the clinical environment (Corlett, Palfreyman, Staines, & Marr, 2003; Gurchiek, 2011; A. O’Brien, Giles, & McGregor, 2013).

The paramedic preceptors in the study setting felt that their role as educators was helping novices to translate their theoretical knowledge learned in the classroom to an applied use in the real world clinical environment:

I think the treating of patients is more than protocol and procedure and that is, yeah, presented with a patient with complaining of the symptoms and they’re not, they’re not a diagnosis, they’re a person and you need to, as you discussed, and we discussed, build rapport with them and you’ve got to figure out what is going on. Because not everything is always your typical straight up and down chest pain. You’ve got to be able to differentiate chest pains or abdominal pains and really talk to the patient, rather than just seeing everything as a black and white response, which is, I suppose what they could come out with thinking if they’ve spent the whole six, seven weeks learning verbatim just through the book. It’s this, this and this and it’s not always like that. (Drew)

Sam succinctly stated this was about teaching the novice “how to become an ambo”.

Similarly, Taylor commented that theoretical clinical knowledge should be learnt in the classroom environment and that the role of the preceptor was to facilitate the actualising of this knowledge in the clinical practice setting:

The clinical stuff is what they should be teaching you in school, and putting into practice and doing your job as a whole is what the training officer does. (Taylor)
Kim conceptualised this as the back and forth movement between and across clinical protocols that occurs with real patients, rather than following any singular protocol in isolation:

It’s application of the protocols. When out on the road we, we don’t alter the protocol, but we don’t necessarily apply total protocol to a situation. We might jump protocol to protocol. (Kim)

Stringently following protocols is not always the best course of action for either paramedic or the patient (Jones, 2004). For the novice this may be a difficult concept, so the preceptor’s role is to assist them to take a big picture view of the patient’s situation and the complexities of clinical practice:

You are getting them day one and starting them off and showing them how to do this job. And basically there’s a hundred and one little things to know. And it’s basically just being able to put them all together for that person and just guide them through it. I mean the university, going back to that, I think is good. But you can, this is such a hands-on job, 80% of it is easily experience. Seeing what does and what doesn’t work. Whilst obviously taking your protocols and Pharmacologies in to account, and going down that line. But there’s just so many shades of grey. Not everything is black and white unfortunately. People don’t always present the way they’re supposed to in the text book. (Andy)

According to Wyatt (2003) this type of tacit understanding and contextual knowing is characteristic of the expert paramedic. Alex articulates this as teaching to have street sense:

[Y]ou’re just teaching them like the street sense I suppose, what to do when you’re walking into somewhere. When to judge, like your instincts, or when to go by the book and do things the way your protocols say. (Alex)

Simulation is increasingly being used in the undergraduate training of paramedic students within Australia to present students with an opportunity to consolidate their
knowledge though experience in situations designed to replicate the ‘real world’ (Boyle, Williams, & Burgess, 2007). In contrast, Alex felt that despite these best efforts, the simulation environment cannot replace the authentic clinical setting where the novice learns to appreciate the nuances of context and build genuine rapport with their patient:

I actually for the last two shifts got a chance to work with a graduate that was doing their ride-along. So had a chance to work with them, which I haven’t for a while, and I more or less let her go about how she would talk to patients or build a rapport and that sort of thing. She was good, she’d been out for a little while, but we were reflecting about how that’s not really taught to them at university. They have this million dollar SIM room where they walk in and there’s a mannequin lying on the ground and it coughs and vomits and talks to them, but they don’t really have that chance to build a rapport, to communicate with the patients, understand body language or verbal cues, non-verbal cues. (Alex)

At the end of this narrative, Alex comments on the importance of the novice learning to understand body language and verbal and non-verbal cues. Most of the participants commented in one way or another about the importance of the novice developing an aesthetic and situational awareness of the patient’s environment and its influence on clinical care:

It’s just from seeing it and hearing it and smelling it and being there, that yes, we know what to do. (Andy)

Sam too commented on the differences of the clinical environment to classroom or simulation learning and how preceptorship is a period where situational awareness can be developed:

We have to do scenarios on dummies, they don’t look like people. You can walk into a room and work out so much about a patient without even talking to them but if you walk into a room with a
manikin, it doesn’t give you anything. You might look at someone’s living situation, the clothes they’re wearing to see how they care for themselves, if they have family to take care of them…their perfusion, a manikin doesn’t have colour, it doesn’t sweat, it doesn’t make noise, it doesn’t live anywhere and you can get so much from that when you’re in actual person’s house ... so yes you can learn how to do a skill but when the patient you’re treating is a human being I think that’s very different. (Sam)

And Charlie also felt that preceptorship provides an opportunity for learning that can only occur through experience and not in a classroom:

Because most of our job is just talking to people and just perceiving what’s going on and that’s something that I don’t think you can just kind of teach. (Charlie)

A specific skill essential to paramedic practice which cannot be taught in a classroom is urgent duty driving. Urgent duty driving under lights and siren is a very different skill to normal daily driving. Learning this skill requires experience and practice with real-time coaching to learn how to safely navigate traffic under high pressure and through potentially dangerous conditions unless performed skilfully. It requires the paramedic to engage in constant decision making and risk assessment; anticipating potential outcomes from manoeuvres and actions of other drivers. The preceptor is in an ideal position to coach the novice in this skill. For Robin it represents a large part of the preceptor’s role, but feels it is sometimes given lower priority than it should be:

But as far as service life, I think, driving is another, something I’d forgotten then, driving is 50% of the job and I don’t think there’s enough emphasis on driving skills. (Robin)

Chris also felt that the preceptor has responsibility for teaching this skill and commented that in the study setting, the organisation does not provide any driving
course to novice paramedics. It therefore rests solely on the preceptor to support the novices’ development in urgent duty driving:

I think definitely initially in the driving aspect because I think that’s a whole new world for everyone coming into the job, lights and siren et cetera, and the build-up, where there is – I think there’s very little training, let’s be honest, in how to do that. And we don’t go through any defensive driving courses or anything. So that is largely probably up to the training officer when they feel that person’s ready. (Chris)

The salient point of each of these findings is that despite well intentioned attempts to bring fidelity to formal education, the role of a paramedic is broader than the treatment of a clinically ill or injured patient. Paramedicine happens in the greyness of the real world, and as such is involves a complex, relational interaction between paramedic, their patient and all that it is to be a human, and a host of environmental and material elements including, but limited to, vehicles, pharmaceuticals, housing and technologies.

5.2.3 Guiding reflective practice

Reflective practice uses first-hand experience as the starting point for learning by purposively reflecting on our experiences in a thoughtful way and critically analysing them to consider alternative courses of action and their potential consequences (Jasper, 2003). Being a reflective practitioner and engaging in reflective practice is increasingly being recognised as an essential attribute of the contemporary professional paramedic (Jones, 2004; Sibson, 2009).

Guiding novice paramedics in the process of reflective practice was a key method reported by the preceptors in this study to facilitate learning. While none of them used terms such as ‘reflective practice’ or the ‘reflexive practitioner’, their responses
clearly demonstrated that they frequently use higher-order questioning to guide the novice in critical thinking about the cases that they have attended:

So I think it’s alright to say to a trainee “Do something”. But if you don’t then visit it and say “The reason we did it is”, or “The reason we didn’t do it”, and that’s probably a bigger issue, when you don’t do something, why we didn’t do something, if you don’t tell them why, they’re not going to learn. They know the book says to do it, we didn’t do it. “So we don’t do it ever?”, “No, we didn’t do it in this case because of”, whatever the reason. So I think debriefing jobs, it’s one of the tricks I use. (Kim)

Taylor encourages the reflective thinking process about all aspects of the job, recognising that being a paramedic is much more than clinical skills. Learning to be safe on the job as a paramedic requires the novice to have an understanding of whole situation, appreciating the importance of how they answer a door or where they park their ambulance:

Talk them through every single step of the way, and you can’t do that on every job, but if you pick out something on each job and then reflect back and go, “Well, this morning where did you park the car? Does that apply this time? How did you answer the door? How did you stand, or where did you stand when they answered the door? When you walk into a room what did you notice? Was there anything out of the ordinary? So you didn’t notice the knife on the table? You’re supposed to.” (Taylor)

Robin too engages in reflection with preceptees and highlighted that it can be used by the novice not just for reflecting on their own action, but also those of the preceptor:

And if I’m treating then I’m doing the talking and I’ll say to them afterwards; anything else I could have asked them? And then hopefully by the next day if we get a similar job they’ve learnt something. (Robin)
Andy also commented on the role of the preceptor in guiding the novice to reflect on their actions and use it as learning opportunity:

I’d talk to my probationer afterwards and I’d recap that and I’d say look, we haven’t done this before, what could we have done better? What would you do next time with the knowledge you now have? What did you do wrong? All those kind of things. We’d go through each job, I’d try and get out as much as I could, just to help build them up and show them where they could do things better, where they did things well. (Andy)

While commenting on the use of reflection with preceptees, Alex also stated that the experienced paramedic can benefit from reflection on their own performance and the improvement that may come of this:

Yeah, definitely do reflective questioning and reflect at the end of a job but you know, I might say “how do you think that went”, “why didn’t you do this”, or “why did you do that”. And just play the devil’s advocate. That’s just the way that I also think about jobs I’ve done and how could I have done it differently, what if I had done this, and that sort of thing. So reflection is important, yeah, and so is debriefing, equally, which is also reflecting on circumstances and what went on. (Alex)

The importance of using reflective practice as a means of facilitating learning was clearly demonstrated in the frequency with which the paramedic preceptors reported using this in their daily practice:

I honestly, I debrief every job with a brand new probie. Every job we do on the way back to station I debrief with them. “What went wrong, what went right, what do you think we could have improved, anything happen that you didn’t understand, why did we do this? Don’t know, ask”. And I do that on every job at least for two to three weeks into the job with a probationer. (Kim)

After every job, you say to someone how do you think that job went? What would you like to do differently? What did you learn from it? What did you expect me to do for you? Um... definitely talk.
No job we do is black and white; even every arrest we do is different every time … and you learn from reflection of a job. When you’re training someone it’s important that you talk about it afterwards. It’s a big thing. (Sam)

Yeah, every job I’ll talk about with them, unless it’s just a basic transfer, which may even bring up, you know, patslide techniques or whatever. But definitely I’ll ask them how they felt the job went, or talk about the clinical side of it in terms of why we did certain things. Sometimes I’ll give them a couple of devil’s advocate questions: “What would you have done in this situation?” (Chris)

Guiding reflective practice was a prominent strategy for the paramedic preceptors in this study. Interestingly, although none of the participants reported receiving any formal training on how to go about this process with their preceptees, they appeared to intuitively recognise how this process can increase knowledge, change and improve practice and ultimately improve patient care.

**5.2.4 Creating learning Opportunities**

The preceptors in this study took an active role in creating learning opportunities for their novices. Although many saw the value of creating learning opportunities, such as practicing skills on station, time was very limited, restricting the opportunity for quarantined practice sessions:

I mean if you’re at a busy station you don’t get time to do scenario practices. (Charlie)

In the absence of allocated training time during shifts, the preceptors constructively use their time while travelling to cases as an opportunity to engage with the novice in discussion for learning purposes. Paramedics are provided with information on the type of call they are attending such as the clinical nature of the case and occasionally with information such as the patient being trapped or located some way off a road.
The participants commented that they use this information and discuss with their novices the relevant clinical protocols and potential actions that may need to be taken once they arrive at the job:

On those first few days I’ll just try and chat about the job on the way … what sort of questions are you going to ask, what are we going to assess, are we going to move the patient are we going to check something before we move it, things like that. (Robin)

Um, I come up with a plan or something, especially if it’s going to be deep down in the bush or whatever, sort of unusual circumstances, try and get them thinking about it before they get there. Which I think is helpful, rather than turning up and then going, oh, well, now what am I supposed to give or do or whatever, and stuff. (Leigh)

To a certain degree the cases a paramedic crew responds to are open to random chance. Emergency cases are generally dispatched to the closet available ambulance. Within the study setting, no change to this process occurs simply because a crew is a preceptor/preceptee dyad.

Occasionally the paramedic preceptors will hear a case being given to another crew which could be a good learning experience for their novice. Kim commented that one way for the preceptor to facilitate exposure is to make a direct request to the Control Centre Dispatcher to be given this case for the benefit of their novice. The jargon is ‘to jump a job’:

[I]f I hear a [cardiac arrest] go down … we’ll clear for that straight away. Because they need that experience. So you are jumping jobs that you would normally not jump. Because let’s face it, there’s some jobs that you just would prefer not to go to … [but] all of a sudden you think “Well, they have never done something like that, I’ll jump the job”. (Kim)
Drew will also take the initiative to try and get the novice experience by proactively asking to attend cases that sound like they will be a good learning experience:

If there’s something like a code 9\(^3\) or a cardiac arrest or a stabbing or shooting, by all means I’ll say we’re clear and can assist with that. You try and get them into it that way. (Drew)

Charlie too will request to attend certain jobs that may offer a learning opportunity to the novice:

I try to … I’ve said on the radio before, if I’ve got a trainee officer who’d like to attend that job, especially if you’ve just got a 2A or like a low acuity job and then it’s in the hands of the dispatcher. (Charlie)

This method of jumping jobs was not found across all the preceptors. For Sam, jumping jobs was not used as it was seen as interfering with the control operator’s planning:

No I don’t, I see co-ord as having the bigger picture, and if they put a car on it, that’s their decision I don’t want to meddle with what they’ve planned. (Sam)

While Sam would not usually ‘jump jobs’ like Kim or Charlie, opportunities for the novice to learn were found through other means. Sam discussed how she encourages the novice to learn through observation of the clinical care provided within the hospital environment:

I do get probationers to follow a crew into [the resuscitation bay] and watch things yeah … I’ll introduce them and say you go in with John and have a look and watch. (Sam)

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\(^3\) Code 9 is used to denote a person trapped requiring paramedics and a rescue unit to attend
Similar to Sam, Charlie also encourages novices to learn through observation of patient care inside the emergency department and to gain a more holistic view of the patient’s treatment:

[I]f there’s an interesting job or an interesting patient and given that we’re not pushed for doing another casualty or whatever obviously, um I’ll try to say, “hey let’s go and watch this and let’s go and do this.” And there’s been times when I’ve gone into [the hospital ED] for example and I’m quite well networked there, and I’ve gone up to the doctors and said, “hey guys is there anything really interesting in the department?” We’re watching people from SVT\(^4\) being reverted with adenosine and yeah it’s not a drug that we carry but the whole process, you get to watch what’s happening. Um, going out to the Cath lab\(^5\) for example, watching people get stented\(^6\) if time permits. Um I’d definitely really encourage that because that’s how I learn. (Charlie)

Drew also encourages this observation as a means for the novice to learn how their role fits in the patient’s journey:

Most [serious] patients that we sort of take in with trauma, cardiac arrest, they stay in and watch any additional procedure they can, especially if we transport a STEMI patient or at the Cath Lab. Always stay back with the trainee and get them involved in observing them do the stenting and angiograms and that sort of stuff and so they can have a look at the, everything in practice and working.(Drew)

And Leigh encourages the novice paramedic to engage in learning through observation of other senior paramedics where possible:

[I’m] encouraging them to go and listen to the hand-over from the IC\(^7\), or whatever, or talking to the IC if they can, like after, or whatever, in the ambulance bay or whatever, or going through, yeah,

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\(^4\) SVT: Supraventricular Tachycardia – a potentially life threatening abnormal heart rhythm  
\(^5\) Cath lab: Cardiac Catheterisation Laboratory  
\(^6\) Stent: a wire mesh device inserted inside an artery within the heart to keep it open to blood flow  
\(^7\) IC: Intensive Care Paramedic
Leigh continued to express that observation such as this can be a valuable tool to expose the novice to clinical presentations which they may not have seen, or may be unlikely to see on a regular basis:

[E]specially if it’s a big trauma or something unusual, and they are doing chest thrusts or whatever for extreme asthma or something, then – because the stuff you wouldn’t see often, or how they might treat pulmonary oedema or what it sounds like, and stuff that’s really important to get a grasp on, but you mightn’t have come across it in a year or two, or whatever. So yeah, try and make them available to get into it, sort of thing, yeah. (Leigh)

During preceptorship the novice paramedic is learning through practise, rather than as a separate, distinct activity. On a day-to-day basis paramedic preceptors are using their resourcefulness to create learning opportunities for their novice. Opportunities for learning are diverse, and for the paramedic preceptor it is implicit in their role as coach to seize these moments by volunteering assignment to a case, encourage the novice to observe patient assessment and treatment by medical staff, and through collaboration and reflection with senior colleagues. The objective for the paramedic preceptor is the same: to broaden the experience of the novice in ways beyond which random chance that case assignments would allow.

**5.2.5 Communication Skills**

A lot of the time it’s just as simple as communicating with a patient, different culture, different people within the health service and other emergency service personnel. (Drew)

Communication is an important component of clinical care to establish rapport and facilitate patient assessment and treatment (Lazarsfeld-Jensen, et al., 2011)
Moreover, patient-centred communication leads to a positive patient experience by making patients feel safe, reassured and cared for as individuals (McCabe, 2004). It has been reported that novice paramedics frequently struggle with their interpersonal communication skills, especially early in their transition to practice (Lazarsfeld-Jensen, et al., 2011).

Taylor commented on the importance of communication and conversation as a means of making patients feel more relaxed while in the care of paramedics. Moreover, Taylor mentions that while education providers may teach students about clinical questioning for assessment purposes, small talk and general conversation can be just as important to comforting someone and making them feel more at ease during a difficult situation:

I have discussed on a number of times making small talk, so you come out of class knowing that you have to ask people questions and knowing that you have to figure out what’s going on with them, but I don’t think they really discussed at school the fact that if there’s nothing else going on, the patient’s stable and you’re just riding to hospital, make small talk; it makes them a lot more comfortable, it makes the patient more comfortable, and it, in a way it makes you more comfortable because you’re not sitting there going, “What should I be doing for them? Shouldn’t I be doing something?” If you make small talk you are doing something because you’re putting them at ease, you’re getting their mind off whatever the problem is, so they are actually more relaxed after a bit of a chit-chat on the way to hospital than what they would have if they had uncomfortable silence. (Taylor)

Kim recalled an experience with a novice who was too focused on the clinical interaction and needed prompting from his preceptor to remember the importance of introductions and establishing rapport before assessment begins:
I had a [graduate intern] not that long ago that came out and it was, we’ve got to do three sets of obs on every patient. The first thing he would do when he walked in was kneel down and take the blood pressure. I was like ‘Aren’t you going to introduce yourself? Who are you?” [The intern’s response was] “Oh, well, we’ve got to get a base set of obs... we were always taught that you have to”. “No, well, you do need a base set of obs, but talk to the patient first”. (Kim)

In the communication process sometimes the preceptor’s role is that of mediator. Jordan recounted a story of working with a relatively young intern where they were confronted with a patient who had attempted suicide. Whilst the novice was probably well meaning, his approach appears to have put the patient offside and created a tension which needed to be calmed by the preceptor:

You can get [graduate interns] from the university that have gone to uni at 18 and they finish their degree at 21 or 22 and they get a job at 22 and they can’t communicate with someone … I’ll give you an example, I had a person who’s been a young probationer and they couldn’t at all empathise, not that we all want to sympathise, but empathise with a 40 year old male, 40 or 50 year old male that has just tried to hang himself because he caught his wife having an affair and then she ended up getting the children as well, gaining custody of the children … And the patient said to him (the intern), he goes, what would you know, you don’t know anything, you’re all but 22, what advice have you got to give me? And it was true, he pretty much dumbfounded him and he nothing else he could say. But that’s where I kind of jumped in and said look, I can’t understand what you’re going through, but I know that you wanting to hurt yourself and harm yourself is not the right way of doing this because you’ve still got your children you know. And he (the intern) didn’t have the life skills or like the advanced life experience in a way to understand that and use that as an approach. (Jordan)

A further example of the preceptor as mediator could be found in the following narrative. Kim recalled a novice who struggled to assess his patient because he was too focused on using medical terminology. As the preceptor, Kim was well placed to guide the novice in how to more effectively communicate with their patients:
And a classic on that, I had a trainee who went to, we went to a patient that was from a non-English speaking background, laying on the floor with abdominal pain, and he said to her “Do you feel nauseous?” And she looked at him, and I could tell by looking at her face she had no idea what he meant. So when she said “What?” he repeated the same question word for word. He did that three times before I stepped in and said “Do you feel like you want to be sick?”, “Yes”. And when I questioned him about it, he said “Well, that’s not my fault, everyone should know what nauseous means”. This guy was 11 months into the job. I was like “Your job’s to talk to him in English. You can talk to the hospital staff or me in medical terms, and even I don’t do that, I talk 90% of the time in plain English”. (Kim)

Hartley (2012) has found paramedics of all levels of experience often have difficulty communicating with patients from culturally and linguistically diverse backgrounds. Moreover, his study highlighted how essential communicating with patients is for cultural and religious sensitive paramedic practice.

Sam assists the novice to learn culturally sensitive communication by setting an example so that the novice can model their own behaviour with that of an experienced paramedic:

I’m hoping they’re learning from watching me so just how to talk to someone, how to gauge, to take into account their religious views or how to talk to an older person as opposed to a younger person (Sam)

Language barriers can make assessment difficult for any paramedic. Add to the scenario a novice who is still learning what questions to ask in the first place and the preceptors role becomes more complex. While over the phone interpreter services are available for the paramedics in the study setting, the conversation becomes a three way message chain. When the novice needs prompting by their preceptor, there are now four people trying to engage in a conversation which can get very difficult. Taylor commented on this type of situation and how the best approach to learning is
for the novice to observe and listen carefully to the preceptor until they become more confident with their assessment skills:

I find that you kind of take over the job a little bit more and more direction is needed, like using an interpreter service over the phone I’ve done before with a probationer, and it gets way too hard to be telling the probationer what to ask the interpreter to ask the patient to find out the answer to, “Now what do I do with that information? Your next question is…? Cut out at least one of the middle men and do it yourself, just for the time being until they get the confidence of knowing at least part of it. (Taylor)

The paramedic preceptors also commented on their role in helping the novice to develop their inter-personal communication with other health professionals. Paramedics routinely interact with other health professionals during the handover of patient care on arrival at hospitals. The preceptor can assist the novice in these situations too by giving advice and feedback on how the novice can improve. Interestingly, universities may be spending limited time on helping students in this area. Alex recalled a conversation with a graduate intern who felt she did not spend very much time on interpersonal communications while at university:

And then also the other thing I thought was interacting with other medical staff. So interacting with triage nurses, bedside nurses and doctors when you have to give a handover. And just being confident in yourself and talking in a good, loud, strong voice, trying not to stop, um, ah, and those sorts of things. And she (graduate intern) agreed, that it’s not really anything that they teach them or they don’t usually teach them a lot of those things at the university. It’s a lot of clinical stuff, it’s a lot of anat/phys, skills based, not really interpersonal communications. And it’s something that takes a long time to develop. I don’t think you can really teach it in a classroom. (Alex)
5.3 Preceptor as Role Model

As a role model, the paramedic preceptor can be the most important person in moulding the new novices’ attitudes and behaviour (Chapleau, 2007). By demonstrating professionalism, compassion and confidence, the preceptor can give the new employee a model on which to build their own practice.

Role modelling was an important method used by the paramedic preceptors in this study to set expectations and standards for the novice to follow. Role modelling was used in all aspects of the position of paramedic; whether it be inter-personal interactions with patients, colleagues or managers, driving, and adherence to organisational policies and procedures:

... from me they would get the right way to do things. I try to be as professional as I can with patients, with hospital staff, colleagues, as what I can be. ... they’ve got to learn that there is a time and place to joke around and a time and place to be serious and game face sort of thing, so to speak. (Drew)

And the trainee will feel how the training officer performs, too, whether it be driving or whether it be talking to patients, or whether it be talking to management, I think that’s really like a sponge, I’m sure, in the first few months. So I think setting that example is important and staying within the guidelines. (Chris)

At the start it’s totally beyond them, but towards the end of their training they should really be taking in what you’re doing as well as what they’re supposed to be doing. So it is a role model when you’re doing your job and you’re doing it properly, then they should notice that as well. (Taylor)

Being a role model was recognised as needing to be more than just words. As Myrick and Yonge (2005) suggest, an effective role model must translate their values and professionalism into their “everyday actions in the practice environment” (p. 34).
Chris commented that preceptors must ‘walk the walk’, emphasizing that the novice is more likely to emulate how the preceptor behaves rather than what they say should happen:

If I say, “Oh, you need to build a rapport with that patient,” then I go to the next patient and go, “Come with me,” be abrupt and stern and not be patient, it’s not going to – it’s going to fall on deaf ears. So I guess it’s like any leader. People learn from the leader’s actions rather than their words. (Chris)

Taylor also commented that role modelling was not about telling the novice how to act or behave, it is “what you actually do” that matters:

Yeah, that’s attitude, it’s everything. It’s what you actually do, what you say, it’s your attitude, it’s how you interact with your colleagues, how you interact with hospital staff, police, everything. (Taylor)

Building the rapport that Chris mentioned is such an important aspect of health care. A trusting and positive relationship with the patient is paramount for quality patient outcomes (Hartley, 2012). As paramedics, we often deal with people at their most vulnerable. We enter their private world as strangers and see them as they do not want to be seen. You cannot teach someone the rules or technique for empathy, for sensitivity and giving dignity to others. These examples of tacit knowledge can however be demonstrated and modelled. The importance of role modelling these traits is highlighted by Andy in the following response. Andy’s conclusion “I feel like I’ve done my job” shows how central this is to being a preceptor:

I guess the best way I do this, for me, is try and lead by example. I let the probationers see how I build a rapport with the patient, how I talk to them. And hopefully try and get my probationer to emulate that. Because being able to build a rapport with someone who you’re a complete stranger with, when you’re walking in to their bedroom and they’re you know, can be stark naked lying in their bedroom at
their most vulnerable. You’ve got to be able to build a rapport quickly with that person. Let them know that you’re in charge, you’re controlling the scene and you’re going to look after them. And that you’re someone who they can feel supported by and not threatened and hopefully if I can demonstrate that my probationer takes that on and I feel like I’ve done my job. (Andy)

Alex also expressed how role modelling is useful to frame the expectations of how the novice should interact with patients:

I like to show them how I approach a patient, how I talk to them, treat them, what I do as an ambulance officer and therefore what I expect of them. (Alex)

While the preceptors commented that they set the example as a role model for the novice paramedic, they also recognised the need to respect that each practitioner will find their own style and encouraged their novice to find their own professional identity:

[I will] say to them, “look there are 10 different ways to do it so this is how I do it, this is the reasons why I do it, this is why I think it works for me but if you see someone else do it for a different way then that’s great. Learn from that as well then work out what you want to do.” (Charlie)

I would make sure that I let them see how I’m treating, what I’m, the way I do things, what I’m like, to give them an idea of how they want to treat. Because how they want to treat is going to be different to me and everyone else around them, it’s so individual. But at least then we give them an idea, if they see the things they like the way I do it and they might take that on board themselves and the next person they work with they’ll find things they like and incorporate to that style and eventually have their own way of doing things. (Andy)

There’s a lot of different things where you have the same procedures done five different ways, and it all ends up with the same result, but, there’s no right or wrong. And I think it’s up to you to make your decision which way it works. (Leigh)
Preceptors felt that role modelling may also have implications for preceptee motivation and job satisfaction. If the preceptor displays a commitment to their role, is positive about coming to work and is motivated, this can rub off on the novice and create a work climate which is encourages positivity:

If they see someone who’s genuinely interested, who’s trying to do the job the right way and do the best they can, and they’re brought up with that positive environment, I think that definitely rubs off on them and they’re more likely to adapt that style, you know, see that this is a good job and you can do a lot of good things with it. (Andy)

The practice of paramedicine constitutes much more than the performance of clinical skills. It predominantly involves interpersonal interaction with patients, their families and other health professionals. It involves building trust and rapport and operating in an empathetic and sensitive manner. This aspect of paramedicine cannot be easily explained in a textbook or taught in classroom. However, through role modelling the preceptor is able to demonstrate the expectations of professional practice, sets an example for their novice to emulate and embodies the empathetic practitioner.

5.4 Preceptor as Socialiser

Supporting the novice and helping them to fit-in was a strong theme to emerge during conversation with all participants. Within the literature, a key role of the preceptor is to socialise the new employee into the organisation by introducing them to colleagues, orientating them to workplace practices and introducing them to cultural norms of the workplace (Baltimore, 2004). Within the study setting, the paramedic preceptors reported they take responsibility for the socialisation of novice paramedics:
Because I mean they’re the new kid on the block. You’ve been around for a while. They’re not going to know anyone, they’re going to be out of their comfort zone. I think, for me personally I take the point myself of introducing them to everyone and let them know how things are and what’s happening, just so they feel included. (Andy)

Understanding the organisational culture was seen as an important part of helping the novice to fit-in and learn the routines and norms of workplace practice:

I think part of what’s expected, I suppose, like in terms of maybe part of their culture of – equipment and who does – the driver does the – has the portable and is responsible for which roles of – and saying who does what, and what you’d need IC backup for, and what you’d need Inspectors for and – because I think a lot of that stuff, well, I don’t think when I was getting trained, I don’t think a lot of that stuff was very clear at [the education centre]. (Leigh)

Socialisation is a learning experience in itself. For the novice paramedic it is a process of learning the rules of the game when these rules are not written anywhere. Preceptors have a clear role in passing along this abstract and tacit knowledge which has broad implications for the novice’s continuing acceptance into the organisation:

So I guess it would be to impart my experience, knowledge onto that junior officer in the sense of, I guess clinical abilities but not only that, all the culture of the organisation that we work with, all the unspoken kind of rules that people don’t actually tell you unless you’re mentor to the [trainee]. (Charlie)

There is definitely a culture and there’s a lot of unwritten rules that it’s just expected that you know and follow, and you definitely have to teach your trainees those rules. You don’t want them to make a mistake because they’re not aware of a particular rule (Alex)

Socialisation also covers many of the material aspects of orientation. Feeling included is about having a place to put personal items, being part of a tea fund, knowing how to complete paperwork and other workplace processes:
Think it probably depends on where they are up to in that first year as well. I guess if they’re, if it’s their first shift and first roster out, you know, start from scratch, like all the basics of where they are stationed, station duties and all that sort of stuff, and work from the ground up. (Leigh)

It up to me to introduce them to people to show them the station ... Once we’ve gone through the car I will introduce them to [the Station Manager], allocate them a locker and show them around. (Sam)

But it means that they know where the store is, they know where the fridge is, the tea fund, they know where their locker is, all that sort of thing. (Kim)

Anything to do with service life, so timesheets, emails or PHCRs, stores, where things are in the station, equipment issues, how to trouble shoot with equipment issues and you might be able to get yourself out of a jam if you know what to do there.(Robin)

This responsibility to introduce the novice into the everyday aspects of the working environment and support their assimilation into ambulance life were seen as important, not just to facilitate a positive introduction to the organisation, but also to assist the new employee to feel part of the team:

And you’ve got to work in with everyone on the station, teamwork is fairly important, and if you don’t work within the station’s system, you aren’t ever going to be part of the team, no matter how clinically capable you are. So yeah, it is equally important. (Kim)

Alex gave a good anecdote of how understanding organisational culture is very important for fitting in and getting along with colleagues of different clinical status:

So either pulling them up if they’re doing the wrong thing or talking to them after the fact and saying “what you said is probably right but that’s not really the way it rolls on the road” and just and then explain what the situation is, why what they’re saying was correct but why it’s also not really correct and then outline those reasons. A senior paramedic may be treating someone or intensive care
paramedic doing something differently than the student’s been taught, the student pulls them up then and there, or says something, that’s not really okay. It is okay to ask a question but you don’t do it in front of a patient or you just don’t go around it a particular way that they may or may not have. (Alex)

From the participants’ narratives, professional socialisation of the novice paramedic is the process of gaining acceptance and learning to fit-in to the cultural norms of being a paramedic. Socialisation crosses social, cultural and material elements of paramedic work life and the preceptor clearly plays an important role as the keeper of the rules.

5.5 Preceptor as Protector

A significant and important dimension of the paramedic preceptor role to emerge from this study was that of protector. In this section the protector role is illuminated as it pertains to protector of both the patient and of the novice paramedic.

5.5.1 Preceptor as guardian of patient safety

Because patient safety is the most important thing we do. (Drew)

As health care professionals, paramedics are entrusted with care and safety of their patients. Paramedics are aware that every action, medication administered or not administered, comes with risk and benefits that must be carefully weighed and assessed to ensure that everything that is done to and for patients is beneficial. When working as a preceptor with a novice paramedic, the participants in this study expressed that this responsibility now extends beyond oneself to also include everything that the novice does to and for the patient.
Although it is often the novice who will lead the treatment and care of the patient, the preceptors were cognisant that it was they who had final responsibility for the safety of the patient:

Robin: Well I’m the senior officer, so if it’s something we can quickly rectify and they might miss it, it could have been detrimental, it could be harmful to the patient.

Hamish: And whose fault is that?
Robin: That’s going to be me. My fault. Absolutely.

It always comes back to the [Training] officer (Sam).

You have the responsibility of the vehicle, you’re the senior clinician. If someone was to go pear shaped it would more than likely be on your head as to why it happened or why it went that way. (Alex)

Essentially the buck stops with us, being the only qualified operator in the car. And if something happens that compromises their safety it’s pretty much our fault. We should be there to watch them like a hawk, so to speak. And make sure they’re doing everything correctly. Because if something travels south it’s usually not going to end very well for us. (Drew)

Being a guardian of patient safety was conveyed as requiring an attention to both clinical and non-clinical actions of the novice. Alex gave an example of how even the simple task of having the novice unload stretcher needs to be supervised. Through experience, the preceptor’s intuitive awareness of the ground around the vehicle is a warning that the stretcher could fall and injure a patient. The novice may not see or understand the risks as easily as their experienced partner:

Experience tells you that if the camber or the unloading of the stretcher is a little bit of a bad position that you should always have two people. So although a trainee’s more than happy just to rip a
stretcher out of the back of an ambulance with a patient on it, sometimes you need to think of your patient but also your trainee and say, “hey look, this is going to be awkward, just wait for me to get out and get around and help”. That’s looking after your patient’s wellbeing and you know, an indirect cause, your trainee may not be aware of those sort of areas. (Alex)

In a major challenge for the preceptors, their working environment emerged as a significant challenge to protecting their patient’s safety. In the preceptor-preceptee relationship of most health professions the preceptor is usually close at hand to guide the preceptee in the learning process. In contrast, the environment in which paramedics work frequently places a physical separation between the preceptor and their novice.

This occurs when the novice paramedic is treating a patient in the rear of the ambulance during transport to hospital. As a two person crew, the preceptor is by necessity driving and not able to be with their novice. Although this separation by distance is not far, the preceptor is concentrating on driving and at times it is difficult to hear the conversation that is occurring between the treating novice paramedic and patient.

The paramedic preceptors were very aware of the risk that physical separation can have on patient safety and employed a variety of strategies to mitigate the risk to their patients. Constant communication was the vital link between preceptor and preceptee. Having the novice provide frequent updates on the patient’s condition and the findings of their observations was seen as very important so that the preceptor can maintain a mental picture of what is occurring with the patient and ensure that their novice is following a correct line of treatment and the patient remains safe:
I wouldn’t take a back seat and just drive and not be aware of what’s going on in the back of the ambulance. I’m listening to what’s being said in the back. (Sam)

Robin also encourages constant communication between preceptor and preceptee:

Well…depending on what sort of patient we have but I would often say, well what are the [oxygen levels] now, or what is the heart rate now? If we’re giving fluids for a hypotensive patient, what’s the blood pressure now? … I’m not just letting them write it down and me not know because it’s up to me. So I always ask or get them to call it out, heart rate 80, blood pressure whatever it might be. (Robin)

A further strategy used by the preceptors was to use the time available on the scene of a job when the preceptor and preceptee are together to prepare for the journey to hospital. Sam ensures the fundamentals are done and develops a clear picture of what needs to happen before loading the patient into the ambulance:

We have half an hour allocated on scene to treat the patient before being questioned where we are, and with someone new I would use that time to make sure we’ve covered everything and done all of our observations. (Sam)

Sometimes however, the patient’s condition is such that the preceptors make the decision that the novice is not ready to look after a patient who is acutely unwell and will swap with the novice and treat the patient:

[When you’ve got a sick patient in the back and they are treating for the shift, often I’ve swapped and got them to drive and I’ll treat, because I’m not yet comfortable with them being competent enough to deal with that situation… But I think it’s about the patient, it’s not about – like, it’s not always about training the probationer. Sometimes it’s actually more about the patient, because their welfare needs to be considered, because that’s why you’re there. (Chris)

Physical separation also occurs when attending to a patient in their home or workplace. The usual procedure is for the two paramedics to enter the premises to
assess and begin treatment as necessary. Logistical planning must then come in to play and a plan to extricate the patient is made. This will frequently require the use of additional equipment from the ambulance such as a carry-sheet or chair, and will usually require the movement of the ambulance stretcher to within a close proximity to the patient’s location. To undertake this retrieval of equipment however, it is necessary that one paramedic leave the patient and his/her partner to return to the ambulance. A situation is now created where the preceptor must consider the immediate role of the novice giving due consideration to a number of factors including the acuity of the patient’s condition, the capability of the individual novice, the time it will take to retrieve such equipment, and the overall complexity of the extrication.

The preceptor must make these decisions on a daily basis. Frequently it is a matter of trust in the capability of the novice to look after a particular patient:

> Until in my mind that trainee officer is at the level of competency that I feel they can do that. The question is, do you leave them with the patient, or do you get them to get the gear? It’s definitely a consideration. And my preference has always been that I’ll stay with the patient, because I’m the qualified officer, in case something happens. That’s not always possible. Sometimes for whatever reason you need to go and get something that they don’t know where it is, or say something on the radio and your portable’s not working, or whatever. And yeah, definitely, because it takes time for trust to be built up. (Chris)
In Robin’s experience, the novice should be given a list of tasks to keep them focused on what is required:

I would normally give some sort of instruction. I’ll say well while you take a BSL\(^8\), I’ll go out and get the carry chair, things like that. (Robin)

Drew similarly uses the method of leaving the novice with instructions or tasks to perform while they are alone with the patient so that they have some direction while the preceptor is briefly absent:

I’ll make sure that the trainee is comfortable with what they’re doing with the patient and I’ll make sure I’ve given them a set of tasks to do while I’m gone, just to keep their mind active and not thinking too much what can I do now? So they’ve always got something to do. (Drew)

When the patient’s condition is more serious, Robin weighs the risks of the situation and will usually take the cautious approach of remaining with the patient and have the novice retrieve the equipment:

But again if the patient is critical or unstable, I would remain with the patient. (Robin)

Drew too takes this approach of assessing when a novice is not quite ready and will swap roles to ensure that the patient remains safe:

If the patient’s ever that critical where I think that I shouldn’t be leaving the probationer with the patient to do something, I’ll say how about you go to the car, you get this and I’ll continue on with the patient. (Drew)

\(^8\) BSL: Blood sugar level
Even when the preceptor decides that the novice can be left alone with the patient, they remain concerned for the patient and their preceptee:

I guess you’re always wondering what they’re doing in there. (Robin)

You’ve got to trust them to an extent that they’re doing the blood pressures, they’re doing it correctly. You don’t know what the patient’s doing. (Kim)

Managing the risk of being separated from the novice in the ambulance environment became strikingly clear in the stories relayed by two of the participants. When things go wrong, it weighs heavily on the preceptor. Kim recalled a case where a novice did not relay to their preceptor that the patient was deteriorating. Kim felt that with the right information, intervention could have prevented the patient’s condition worsening:

I can use an example where we had a person in the back of the car. When I asked what was going on, they just said “Just keep going, everything’s fine”. In the end I pulled over because it just didn’t feel right, and the patient was in respiratory arrest. But they just wanted to get going and get to the hospital. Where had they said there was something, the respiration was going down or the pulse was showing low numbers early, I might have been able to do something before they went into arrest. (Kim)

Charlie had a markedly similar experience to Kim. Recalling a case of a patient in respiratory distress, Charlie conveyed the difficulties faced by the preceptor in trying to manage the physical separation from the novice and the consequences when the novice does not speak up and ask for help:

For example … [the] patient was in respiratory distress, reasonably stable when we left the house. [The patient] was a CO₂ retainer which we didn’t know about. No one knew about. So high flow
Paramedics have a clear responsibility for the safety of their patients. For the paramedic preceptor there is an additional level of complexity in that this responsibility now extends to the actions and decisions of the novice paramedic.

5.5.2 Preceptor as guardian of the preceptee

As well as being a guardian of patient safety, the role of the preceptor extended to protecting the wellbeing of the novice paramedic. The pre-hospital clinical setting can be unpredictable and potentially dangerous. It is unfortunate, but a reality that some patients and their families present a danger to paramedics. The experienced paramedic preceptor protects the novice by managing scenes and ensuring the novice is aware of the potential dangers and provides guidance on strategies to protect themselves:

I would do it mainly before arriving on scene [such as] a violent scene or to a car accident or something. You can discuss how you park and position the vehicle for a speedy getaway or just to look out for X,Y,Z when you go inside the house. If you’re suspecting they’re going to be a violent patient you want to make sure you’ve always got an escape plan sort of mapped, marked out, that sort of thing. (Drew)
Alex made similar comments about needing to discuss potential dangers and management strategies with trainees as a means of protecting them from physical dangers paramedics may come across:

Yeah there’s also like the element of like your own safety and rather them almost being naïve about things and not really looking at the bigger picture in terms of maybe it’s an unsafe house or an unsafe area and just doing some little things that you’ve been around for a while. It’s not taught to you, it’s just something that you learn and they haven’t had that experience to learn. You know, walk into a house, make sure the front door is unlocked and you can open it again, rather than letting patients lock doors behind you. (Alex)

Taylor also used the term “naïve” to describe how a new paramedic may be at risk of harm when on the job and the need for the preceptor to ensure potential risks are highlighted to the novice:

Depending on where they come from, they may never have come into any situation where their wellbeing might be threatened. So really naïve as to what could happen; the fact that we’re in uniform, we can be targeted and if they’ve not worn a uniform before they probably don’t know that either. So you have to educate them as to what could happen, how to prevent it, and if it does happen, what to do after that as well; so all aspects of safety is really what you need to teach them, depending on what their background is. (Taylor)

Drew’s comments continue the theme that the novices’ lack of experience and exposure to the emergency environment places them at risk of being put in harm’s way and the importance of the preceptor in highlighting potential risks and how the novice can manage them:

You do [look out for the trainee’s safety], but I’d say no more so than protecting the safety of a partner you’d normally be working with, just it’s harder with a trainee because they don’t have the same on road experience or sometimes life experience or common sense to appreciate what’s going on around them, so that can be a little bit challenging. (Drew)
Robin recalled an actual experience when working with a trainee who was being abused by a patient. As the patient became more and more aggressive, Robin took control and stepped in:

He was getting blasted by this patient and he didn’t know what to do.
So I had to step in and calm the situation. (Robin)

Andy too recounted a story of working with a novice who could have potentially placed himself at serious risk had it not been for the advice and protection of the preceptor stepping in and managing the situation:

We went to someone who had an ice overdose and they were, oh they were acting irrationally at the time but they weren’t aggressive. But I knew from experience and just looking at this person, I could tell that at any moment they were like a powder keg about to explode. The partner I was working with wanted to put this patient in the back of the car and I said no, I said he’s going to basically tear it in half. I said we’re just going to keep him where he is. I said go and get the police here, R1. So I stayed with the patient and just tried to stop him from hurting himself, because he was stumbling around the place. So I did the best I could. The police got there quite quickly and we actually ended up having to help them wrestle this person to the ground and handcuff them and then the riot police turned up and he was trying to kill everyone, this guy. But the big thing there, I would not let my partner get in the back and put this person, who was drug affected and going to be extremely aggressive, who I could see it coming. I didn’t want to expose them to that and put them in the back of the car in a confined space. Because this person was going to get injured if I did that. (Andy)

Apart from their physical safety, the preceptor also looks after the novice paramedic’s emotional wellbeing. The approach of the preceptor was important in how they guided the novice should their assessment or treatment not be proceeding how the preceptor would like. While the preceptor may need to step in and take control, this needs to be done in a sensitive way that ensures the novice’s self-esteem and
Self-esteem and confidence can be diminished in the novice if they feel they are not progressing in their development as well as they would like. The preceptor can offer encouragement and support in these circumstances:

Just to say, that expectation, I know you’re hard on yourself today because of this but it’s a long road of learning, I’m still learning after eight years but you don’t stop learning... just hang in there. (Sam)

Building confidence is also about providing a safe learning environment where the novice feels comfortable to learn and make mistakes, but knowing they will be supported in the process and not criticised:

And just basically the way I do it is just try and guide them along and yeah, make them feel comfortable, give them a chance to make mistakes within reason, so long as they’re not big ones. But let them learn things for themselves too. But act mostly as a guide and someone who’s going to be there to support them. (Andy)

Drew also commented on the preceptor’s role in creating a safe learning environment by ensuring the novice feels safe to ask questions without the fear of ridicule:

Part of it I suppose is to make them feel as relaxed and comfortable as possible and just continually reassure them that they are the trainee, they are the learner. No matter what they want to ask, what they want to know, regardless of how simple or stupid they think it might be, it’s a question that needs answering and now’s the time to
learn, rather than when you’re in my shoes and you’ve got a trainee and they ask you the question and you don’t know it. (Drew)

Sometimes support came in the form of giving the novice prior preparation for a patient encounter. In Sam’s case, giving them a list of questions so that if they get struck, they can refer to the preceptors ‘cheat sheet’ and give the appearance in front of the patient they are competent:

I remember writing down questions, so if you’re stuck, ask this and this, give them ten questions they could refer to if they run out of things to say. (Sam)

Providing a safe learning environment also occurred by protecting the novice from unrealistic expectations of other paramedics. Kim provided an example of how the preceptor should speak up as an advocate for the novice:

[All of a sudden they’re working with John they’ve never met before, who’s an IC Officer, who’s barking out rules, “Draw me up morphine”, handing him the morphine vial, read it out, draw it up, and they’ve never drawn up a vial. It’s all of a sudden “Oh, I’d better draw it up”. And I know I’ve been at cases where that’s been done to a probationer, and I’ve just said “They’ve never done it before”. “Oh, can you run through it”. (Kim)

Clinical practice in paramedicine can be emotionally demanding. Paramedics must deal with death, trauma and distressed patients and families as an everyday part of the job. Most people don’t see in a lifetime what a paramedic can see in a month. While it is common for people to talk with their family about any difficulties they may have experienced at work, the nature of a paramedic’s work means that their own family may not be comfortable talking about what the paramedic witnessed or had to do. This is where the preceptor is in an ideal position to support the novice in
building resilience for this type of work environment. The preceptor was there and understands in a way others may not:

I think, a concern for welfare, but also duty of care. You are their main mentor, and who else is going to check up on them? Management is certainly not, and educators aren’t, certainly. So I think that’s again an added responsibility, that their welfare personally comes into it too, their emotional stability and their ability to take various scenes on board, whether it be emotional, whether it be traumatic, or whether it be challenging for them. Everyone’s got a different background, so there will be different triggers for different people. So until you know what their triggers are, I think it’s important to follow up on their welfare, because it’s not just a desk job. (Chris)

The triggers that Chris spoke of are different for everyone. Difficulties in coping with an event or situation often come down to association. That is, it is not necessarily the severity or outcome of the case which makes people need assistance, but when the individual relates the patient’s situation to their own previous experiences or one of a family member. Taylor mentioned the importance of the preceptor being vigilant of the novice’s wellbeing; even if they don’t divulge things overtly, the preceptor should be looking out for more subtle signs that the novice is concerned and in need of help:

You’d still help them out with everything, so most definitely an emotional assistance is there as well because if they’ve got kids of the same age that you go to a job, if they’ve got a parent that’s gone through a similar thing, if they’ve got a history of being in a car accident, and they don’t divulge that sort of stuff but at the end of a job you notice that there’s something wrong, if you can help them get over that then you’re going to help them deal with the job in general. (Taylor)

Drew highlights that the close proximity of the preceptor-preceptee working relationship places the preceptor in an ideal situation to identify when a novice requires support and then be there for them. Equally important though was the need
for the preceptor to recognize when professional psychological support is required and refer the novice on to the most appropriate service for assistance:

It’s probably a large, probably one of the more important roles in emotional support of a trainee, because we’re the ones face to face with them every day and we should be able to recognise when something’s wrong or what not and be able to firstly try and assist them small as possible or recognise when you have to refer them on to management or the assistance programs to be supported, chaplaincy, depending on what’s going on. (Drew)

Charlie also commented on the preceptor making themselves available as a confidante to the novice so they have someone to talk about the difficult things they may have witnessed:

And letting them talk through how they feel about that, um because sometimes they may not have a partner or friends in their own life that understand all those sort of issues. And they feel that they can’t, what’s the word I’m trying to think of? Like debrief with them because they don’t really understand what they see at work. (Charlie)

Andy recalled an experience of attending a traumatic case with a novice. As an experienced preceptor Andy proactively opened the communication lines with the novice to ensure they knew Andy was available to talk to about the experience, but also making sure the novice was fully aware of the counselling and other support services which were available to them:

Yeah, still a novice, where I’d been a P1 for years. I remember this is probably the most horrific injuries I’ve ever seen out of any job ... This person was very junior, and also very young. And what they witnessed was, at the time they were able to handle it, and because they were busy doing and I was telling them what to do and we were working together, the job went as smoothly as it could. But afterwards the person realised the gravity of the situation and what they’d witnessed. And it was, oh I could see straight away that it was going to affect them ... I remember one of the first things I did
was talk to them, I remember talking to this person and I said look, you know, if you ever want to talk to me about this, or you’re not sure, or you’re upset, I said give me a call, I’m more than happy to chat about it with you ... But this person I made sure they had that support as well. And that they knew other services and areas they could go to talk to as well if need be. (Andy)

The paramedic preceptor as guardian of the novice emerged through the participants’ narratives in a multitude of ways. This dimension of the paramedic preceptor role is palpably important to both the physical and emotional wellbeing of the novice paramedic who will likely be confronted by a number of difficult and emotionally challenging situations from the very beginning of their career.

5.6 Discussion of the Multidimensional Role of the Paramedic Preceptor

My study provides a new and in-depth understanding of the paramedic preceptor as a composite role constituted by four key dimensions: coach, role model, socialiser and protector. This chapter illuminated a complexity to the paramedic preceptor role well beyond psychomotor skill development or clinical tuition. While clinical development is a fundamental component of the novice paramedic’s learning during preceptorship, the character of teaching and educating by the paramedic preceptor was that of a coach. Someone who not only provides information, but more importantly one who facilitates a translation of knowledge into embodied practice. Role modelling emerged as a coaching strategy, but also as a complementary means to exemplify behaviours and attitudes and the professionalism expected of paramedics. Furthermore, it became clear that paramedic preceptors have a central role in the early professional socialisation of the new paramedic. Lastly, but perhaps
most importantly, was the role of the paramedic preceptor in protecting patient safety as well as the novice’s physical and psychological wellbeing.

In this section these four constituent roles of the paramedic preceptor are discussed more fully.

![Diagram of Multidimensional role of the paramedic preceptor]

**Figure 5.2: Multidimensional role of the paramedic preceptor**

**Coaching**

The term *coach* is the most appropriate way to describe the methodology of how paramedic preceptors support professional development in the novice paramedic. It is more suitable to view the preceptor as coach rather than instructor because instructor has connotations of technical and procedural skill development. As this chapter has demonstrated, becoming an expert paramedic goes well beyond having technical skills and knowledge of logistics management. The expertise of paramedic practice is not simply competency of skills or an expansive internal knowledge library, but involves a continuously negotiated and embodied performance of practice
in a complex, unpredictable and often unsafe environment. Paramedic practice in this sense is regarded to be the enactment and skilful comportment of bringing together the various elements of knowledge and skill in the conduct of ‘professional artistry’ (Schön, 1987). The professional artistry is in the paramedic translating their expert knowledge while being attentive to the particulars of the scene in front of them in its entire situated context (Chan, 2005).

The situated context of Chan (2005) describes the complex work environment of the modern paramedic. Emergency scenes are often characterised by an aesthetic and sensory barrage. Making sense of this chaos and comprehending the entirety of the scene requires an aesthetic perception and situational awareness of what is all around the practitioner (Ingham, 2009). Assisting the novice paramedic to develop this aesthetic and situational awareness was described by one of the participants as developing a ‘street sense’. Novice paramedics find this difficult as they transition from the relative structure of the classroom to the chaotic emergency setting (Gurchiek, 2011; Lazarsfeld-Jensen et al, 2011). Cohen (2013) suggests situational awareness is a tacit knowledge of the expert practitioner; an understanding of the big picture and an ability to prioritise care that comes from assessing not just the patient, but also their environment, using each of the senses to see, hear, touch and smell what is happening.

Gurchiek’s (2011) findings support the concept that paramedic preceptors facilitate the translation of knowledge from the educational setting to its enactment in the clinical setting. Gurchiek (2011) termed this ‘class to street’, where preceptors help the novice to appreciate and consider the big picture and to become street smart or
having the ability to prioritize, delegate, and manage an array of patient care issues in an unstable environment (p.113).

For the participants in my study the role of preceptor is not to present information or simply provide technical advice on psychomotor skills. Rather their purpose is to guide, support and encourage the novice through their practice as they develop their expertise as a translation of knowing-that to a knowing-how within the complexity of the clinical practice environment. The salient feature of coaching in the clinical practice environment, as opposed to in university simulation or classroom practicum, was to assist the novice paramedic’s understanding of how practice in the real-world is dynamic from case to case and even moment to moment (see 5.2.2). Unlike in the formal learning environment, paramedic practice plays out in a dynamic, complex relationship between the paramedic and a multiplicity of sociomaterial variables that may promote, afford and simplify practice, but may equally impede, constrain or hinder treatment and transport of the injured or ill person.

Learning to become a competent paramedic through preceptorship was represented as a time where practice and learning were enmeshed and inseparable (Lave & Wenger, 1991). Under the watchful eye and careful guiding hand of the paramedic preceptor, the novice learns to translate knowledge into knowing, as an understanding of being part of a network of social, cultural and material elements. Becoming competent and developing expertise thus occurs through engaged participation in the performativity of paramedic practice (Fenwick & Edwards, 2013).
Guiding Reflective Practice

A central finding of this study was how frequently paramedic preceptors used informal reflective practice as a coaching tool to facilitate professional development and critical thinking in the novice paramedic. Being a reflective practitioner is recognised as a fundamental characteristic of professional paramedic practice (Sibson, 2009; Jones, 2004). Nearly all of the participants reported taking time to engage in a narrative account of their cases after every job (see 5.2.4). Participants viewed the post-case analysis as an important opportunity to engage with their learner in a critical reflection of how the case was managed, what the novice learned from the experience and to explore ways in which practice could be improved.

Interestingly, none of the participants had received any formal education in reflective practice as a tool for coaching. Despite this, there appeared to be an intuitive understanding of the benefits of critical reflection as a vehicle for improvement and change in practice (Levett-Jones, 2007). As a coaching strategy reflective practice enables the novice practitioner to understand themselves better and offers a means to not only explore their own volitions, motives, and assumptions, but through facilitated exploration, to challenge these assumptions and consider alternatives to their practice (Duffy, 2009; Price, 2004). Because the preceptor was present during the actual experience, they are ideally positioned to guide and facilitate this critical reflection.

Reflective practice does not cease after preceptorship. It remains an important tool for ongoing professional development throughout a paramedic’s career. Hence, the
role of preceptor as a coach and advocate of critical reflection is also important as it embeds a lifelong learning attitude in the novice from very early on.

**Role Modelling**

An important characteristic of being a paramedic preceptor to emerge from this study was that of preceptor as role model (see 5.3). Preceptors in other health professions, such as nursing, also frequently cite being a role model as an important part of what they do (Hathorn, et al., 2009; Lillibridge, 2007; Liu, et al., 2010). Professionalism, ethics and empathy are very difficult to teach, but by demonstrating these qualities the preceptor can provide the new employee a model on which to build their own practice (Chapleau, 2007). As a role model, the paramedic preceptor can be the most important person in moulding the novice’s attitudes and behaviours.

In this study, Chris made the comment that “people learn from the leader’s actions rather than their words”. Myrick and Yonge (2005) also suggest an effective role model must translate their values and professionalism into their “everyday actions in the practice environment” (p. 34). Role modelling for the participants in this study served as way of leading by example. Particularly in the very early stages of the preceptorship, preceptors described how they initially take control of the scene and patient management with the novice acting primarily as an observer. Through role modelling, the preceptor is able to demonstrate the expected standards of professional care in the clinical setting. Role modelling however, is more than demonstrating psychomotor skills. For the participants in this study it was equally about exemplifying professionalism, empathy and how to build rapport in the interactions with patients, their family and other health professionals (see 5.2.5).
Professional Socialisation

A further dimension of the paramedic preceptor role to clearly emerge from my study was the paramedic preceptor as socialiser. That is, the paramedic preceptor plays a central role in the early professional socialisation of the novice paramedic into their new workplace, and the paramedic profession more generally. Baltimore (2004) argues that the preceptor should assume primary responsibility for socialising the new employee into the social culture of the organisation, introducing them to other team members, norms and operational duties expected of them. Moreover, Sedgwick & Yonge (2008) suggest that a sense of belonging is central to the success of the precepted clinical experience. The participants in my study all identified that part of their role was to ensure the novice was integrated into their new organisation. A number of strategies were employed to achieve social integration and belongingness. Novices were introduced to managers and peers, social and cultural norms and etiquettes were explained and shared with the novice and role modelled by the preceptor. Not to be overlooked though was also the importance of material elements of socialisation. Having a place within the team meant being able to identify as a member through tangible objects. Examples included providing the novice with a locker for their personal effects, a pigeon hole to receive mail, being part of the email distribution group and being included on communications. These aspects have nothing to do with clinical knowledge yet play a critically important part of the preceptor’s role in facilitating the professional socialisation of a novice paramedic.

The importance of highlighting the role of paramedic preceptor as socialiser is evidenced by the findings in Devenish (2014), who found intern paramedics find
early professional socialisation during their internship year difficult and challenging. Devenish’s study of new paramedics entering the profession emphasised that many paramedic students experience a culture shock when transitioning from university to the workplace. According to Devenish the first year on-road is a period where new paramedics experience a number of challenges as they not only develop their competence and abilities as a clinician, but also struggle to become socially integrated as a member of the paramedic community. Devenish highlights many social integration challenges including mastery of routines and cultural practices, assimilation into the paramilitary command and control structure of an ambulance service and developing resilience strategies to cope with the stresses and confronting nature of paramedic work.

My study has identified the paramedic preceptor as being ideally placed to facilitate this integration as they work closely with the novice in their first twelve months of practice. In addition to the material and more tangible aspects of socialisation described above, preceptors also help the novice to understand the intangible and informal aspects of becoming and being a paramedic. They help their novice in understanding the processes and procedures that are often informal, intangible and indefinable rules of interpersonal communications and day to day operations. This includes how to appropriately interact with paramedics of a higher clinical level, how particular phrases are used in routine communications, and the nuances of understanding the day to day flow of operations within an ambulance station, and the paramedics position and role within the health system more broadly.
Preceptor as Protector

The final key dimension of the paramedic preceptor role to emerge from this study was that of preceptor as a protector or guardian, both of patient safety and to the novice paramedic. All of the participants in this study clearly expressed that patient safety was the highest priority for paramedic preceptors (see 5.5).

Paramedic practice is unique in comparison to other health professions due to the frequency in which paramedics work in isolation, often at best working in teams of only two (Edwards, 2011). Contextually, this increases the challenge of ensuring patient safety when preceptor and novice are separated in the work environment.

Separation between novice and preceptor was a key issue identified for paramedic preceptors in this study in two contexts (see 5.5.1). Firstly, on a job scene it is routine for one officer to return to the vehicle for more equipment. Secondly, during transport to hospital the preceptor and novice are separated in the ambulance. Participants commented that keeping patients safe meant operating with a constant tension, deciding between leaving a novice alone with the patient or temporarily relieving them of the treating role to have the preceptor remain with the patient. This finding appears unique to the paramedic preceptor role due to the unusual demands of their working environment.

Vigilance and constant communication between novice and preceptor were key tools utilized by the participants in my study to manage risk and maintain control over the patient care episode. Constant awareness and risk assessment enabled the preceptors to step in and correct the novice’s actions when necessary. In Gurchiek’s (2011)
study of paramedic preceptors the concept of ‘guardian of care’ similarly explored protecting patient safety through vigilance and correction to the novice if the novice’s performance could risk patient safety. Similar findings around this aspect of the protector role have been reported in the field of nursing by a number of authors (Chen, et al., 2011; Hautala, et al., 2007; Öhrling & Hallberg, 2000; Richards & Bowles, 2012; Yonge, et al., 2002a).

In my study the paramedic preceptors’ trust and understanding of their novices’ capabilities also emerged as an important explanation of how paramedic preceptors manage risk in the clinical learning setting. In section 5.2.1 the need to understand the novice as an individual was identified. This understanding helped paramedic preceptors develop trust in their novices’ capacity and capabilities and enabled the preceptor to make more informed decisions about the level of responsibility and autonomy that could be provided to the novice. This finding also links with the earlier discussion on the challenge presented by preceptor-preceptee separation. Deciding whether or not to leave a novice alone with the patient was always a uniquely individual decision about matching each particular patient’s presentation and acuity to the novice’s capabilities at the time.

Paramedic preceptors need to be confident that their novice will speak up if they are uncertain about their performance or understanding of the patient’s condition. Only then can the preceptor increase the level of responsibility given to the novice. Several participants in my study reflected on cases where the novice failed to speak up about the clinical deterioration of their patient and the negative impact this had on patient care. This finding is echoed in the nursing setting in a study by Öhrling & Hallberg
(2001) who similarly reported the significance of building trust between preceptor and preceptee as a means of ensuring patient safety.

The tension for paramedic preceptors in balancing patient safety and learning was highlighted in the participants’ anecdotes of managing cases involving critically ill patients. In many of these cases the paramedic preceptors often limited their novice’s responsibilities to more basic tasks in order to manage the complexities of the emergency situation even though they recognised this would place learning second (see 5.5.1). Ohrling and Hallberg (2001) similarly identified how nurse preceptors believed that sometimes the most appropriate action for the preceptor is to deprioritise learning for the safety of the patient: “… when emergencies occur, it can easily happen that the students have to take a step back, because you simply do not have the time” (p.536). As a paramedic crew of only two, when presented with a critically ill patient the tasks to be performed are numerous, many of which are beyond the novice’s scope of practice. Faced with competing priorities, the need to bring order to chaos, to administer medications and perform several clinical interventions, learning and explanation often necessarily become a lower priority. Importantly what this highlights is that to be an expert paramedic, and indeed paramedic preceptor, is that clinical knowledge is not enough. Expert practice becomes visible in the manoeuvring and performance of the paramedic as s/he navigates within this dynamic network of diverse, interconnecting elements of people, medications, protocols, technologies and the environment. As a paramedic the situation can be difficult, being a preceptor adds another layer of the complexity to the situation.
Participants in the current study reported that an important component of their role as a preceptor is to be aware of the wellbeing of their novice. The paramedic preceptor’s role in patient safety has been clearly identified, but they must also act as a protector of the novice too (Boyer, 2008). In my study the role of the paramedic preceptor in taking care of the novice paramedic was illustrated in Chapter Five through three distinct ways: as a critical friend, through protection from danger, and by providing a safe and supportive learning environment.

Paramedics work in a complex and difficult environment and the risk of experiencing psychological distress as a paramedic is well documented in the literature (Alexander & Klein, 2001; Halpern, Gurevich, Schwartz, & Brazeau, 2009; Jonsson, Segesten, & Mattsson, 2003). Through shared experience of critical incidents and similar situations, paramedic preceptors are well placed to be a critical friend to the novice to discuss any emotional difficulties that may be experienced. The experience of human suffering and horrific injuries is not unusual for a paramedic. The sight of blood is a normal part of the role. As is becoming involved in a family’s distress such as telling a husband or wife their partner of 40 years is deceased or that the baby they brought home only months ago has died during the night and nothing can be done to save them. For many people, going home at the end of the day and sharing stories of your day with loved ones is cathartic and therapeutic. For the paramedic though, it is uncommon for those not in the industry to understand or even be able to listen to such stories. The paramedic preceptor, however, can listen and reflect on these situations and experiences. There is a common bond, a shared knowing of what it is like and the emotional toll these situations can take. An understanding of how at the time of an incident all seemed well, but then at 2am or three weeks later, a particular patient, a
particular decision has a way of creeping up on you in an all too malicious way. Preceptors are not trained psychologists however, and it was also recognised by the participants in my study that the preceptor must identify when being a colleague is not enough. As such, it was also important that preceptors identify when to refer the novice to professional psychological services.

Within this study, protecting the novice from the physical dangers of the out of hospital emergency environment was also identified. This involved teaching the novice paramedic the importance of approaching a scene with caution, being aware of the risks that wearing a uniform can bring and noticing potential weapons, such as knives, when engaging with difficult or aggressive patients. Simulation and problem based learning in the university setting does not replicate the multitude of potential dangers for the paramedic. Material elements in all manner of forms can present a danger to the unsuspecting novice paramedic. Taylor’s example of a novice not noticing a knife was typical (see 5.2.3). Every case for a paramedic means entry to unfamiliar territory. Whether being on the roadside with moving traffic, a person’s home or workplace, physical dangers are plentiful. Most of the time these can be managed and the risk significantly mitigated. The preceptor’s role in teaching the novice to be aware is critical in ensuring their long term safety. This is not unique to the paramedic preceptor, it is a common component of all preceptors in healthcare settings. Charleston & Happell (2005) have similarly reported the preceptor’s role in protecting the novice from physical harm in relation to boundaries in the psychiatric healthcare setting.
A further aspect of protecting the novice that emerged from my study was the need for preceptors to create a safe learning environment. Paramedic preceptors have an important role in creating an environment where the novice feels secure and safe to put their own ideas and thoughts forward, to ask questions and give answers that may be wrong and perhaps make mistakes from which they can learn. Similarly, Boyer (2008) and Myrick & Yonge (2004) also report on the importance of creating a safe and supportive learning environment in their findings from studies into nursing preceptorship. In my study participants commented that while coaching a novice it is important to make them feel comfortable and allow them to take the lead whenever practicable. Hathorn et al. (2009) also reported that a critical part of the role of preceptor is ensure the novice is protected from emotional harm during the learning process, whereby the preceptor comforts and supports them in situations which could jeopardize their confidence. Where guidance or correction was required for patient safety my participants identified this must be done in a constructive and sensitive manner which supports the preceptee’s confidence and does not discredit them in front of the patient (see 5.5.2).

**In Summary**

Describing the paramedic preceptor as a *clinical mentor* or *field instructor* are insufficient to explain the complex and holistic role that the paramedic preceptor has in supporting the transition of a novice paramedic through their first year on-road.

In this study the paramedic preceptor role has emerged as being multidimensional, constituting the four key dimensions of coach, role model, socialiser and protector. As coach the paramedic preceptor provides the novice with the necessary guidance,
advice, support and correction as they learn through practicing and participation in the complex, unpredictable and real world of paramedic practice. Role modelling was highlighted as a key strategy for the preceptors in my study, but it also emerged as a principal means for representing and conveying the informal, intangible and difficult to explain aspects of the paramedic role such as cultural relations, developing rapport and showing empathy. As socialiser the paramedic preceptor plays a key role in facilitating the novice’s developing professional identity and their social integration as part of a professional community. As protector the paramedic preceptor is responsible for the safety and wellbeing of the patient as the novice paramedic learns to become a safe, competent and autonomous clinician. Moreover, the preceptor acts as protector of the novice paramedic’s emotional and physical wellbeing throughout the preceptorship.

This new, in-depth understanding of the paramedic preceptor role as being multidimensional, inclusive of functions which go well beyond the development of clinical knowledge, is significant because it is only through a proper understanding of the paramedic preceptor role can we adequately prepare and support paramedics to undertake the important role of preceptor and improve the way in which paramedic preceptorship is managed.
Chapter 6: The Affective Experience

6.1 Introduction

In this chapter I will illustrate the emotional and intrapersonal experiences of being a paramedic preceptor. What follows is an interpretation of how being a preceptor affects the individual paramedic personally, and the psychological impact of the role.

What emerged was a tale of two stories, one negative and the other positive. As participants recounted stories of their time as a paramedic preceptor they described feelings of being weighed by the additional responsibilities and the emotional toll being a preceptor can take. On the other hand, each of the participant’s narratives of preceptorship included positive experiences. It afforded them opportunities for learning, friendship and a sense of achievement and satisfaction. In this chapter I have endeavoured to present a balanced account of this double edged sword as illustrated in figure 6.1.
6.2 Feeling the Weight of Responsibility

This section elucidates the more challenging intrapersonal experiences of being a paramedic preceptor through the sub themes of: thinking for two, the emotional toll, needing a break, and feeling underappreciated.

6.2.1 Thinking for two

Being able to do the jobs of two people, so being able to keep an eye on your partner, being able to do all the paperwork and how to fix the car up and make sure everything’s in order and then look after the patient as well. That’s a lot to manage whilst listening to the [ambulance] radio. It’s a lot to juggle. (Andy)

The typical paramedic crew consists of two qualified paramedics working closely together, each with pre-defined roles and a general understanding of the delineation
of responsibilities. For example, as the driver for the shift you understand that it is your responsibility to drive the ambulance, use the radio to provide scene reports and operate the stretcher. The treating paramedic assesses and provides medical treatment to the patient as required. When each paramedic is equally qualified, the partnership works as alternating sub roles that allow the two person team to efficiently operate without the need to constantly refer to the other about who does what.

A significant benefit of this arrangement is that as the treating paramedic you can focus on communicating with your patient, building a clinical picture and implementing a treatment regime without the additional problem solving of how to get to the scene, retrieving equipment from the ambulance, how to extricate a patient from their location, and other more logistical issues that frequently arise.

In the preceptor–preceptee dyad, the dynamics of this partnership become quite different. The theme of thinking for two emerged as participants described that when working with a novice paramedic, there is no delineation between these two roles. It became apparent that the preceptors felt they were thinking about all aspects of the job: from driving, treating, supervising the learner’s practice, maintaining communications, and managing scenes. That is, doing the job of two people at once:

The days you’re driving, sometimes you’re treating and driving. So if there’s IV\(^9\) access to be gained twelve lead [ECG]s\(^10\), drugs to be given, um terminology the trainee’s not familiar with, the medical condition the patient’s not familiarly with. So contraindications the trainee’s not familiar with. So yeah you are sometimes definitely driving and treating. (Robin)

\(^9\) IV: intravenous

\(^10\) ECG: Electrocardiogram (records the electrical activity of the heart).
While they’re assessing the patient, you’re also assessing the patient. So you’re doing a dual role all of a sudden. Not only are you ascertaining egress access, but you’re now also doing a treating role on top of that. (Kim)

Robin and Kim have commented that working with a preceptee was like doing two roles at once. Charlie also commented that even when the novice has an extensive clinical background, many of the non-clinical functions will still need to be learned and until this occurs, regardless of their novice paramedic’s background, the preceptor will still be required to perform both roles:

I mean they’re someone that’s just walked off the street or even like I said, I was an RPL\textsuperscript{11} so clinically I felt that my capabilities were on par but using equipment for example and just all the use of radio communication and giving SITREPS\textsuperscript{12} and things like that. Um, you can’t rely on them. They don’t know how to do it, I don’t expect them to know how to do it and sometimes it takes a couple of rosters until, you may not get a decent MVA or a decent job that needs a good SITREP you know, for a year into your job. And if you haven’t done something before then definitely you need to be aware of that as a training officer that they haven’t done something, and you can’t trust them even though you want to you just can’t trust them because they haven’t done it before. (Charlie)

The sub theme of thinking for two pervaded the conversations with all my participants in one way or another. Chris, Jordan, Leigh and Drew again reinforced this feeling that the preceptor must consider all aspects of the work regardless of which officer has primary responsibility for driving or treating:

On a really bad day it would be like taking a high school work experience student to a stabbing or a trauma or something where pretty much you’d just be like you’re there by yourself and no matter how good you are or how hard you work, it’s going to be as hard as

\textsuperscript{11} RPL: Recognition of Prior Learning
\textsuperscript{12} SITREPS: Situation reports; reports provided over the radio to supervisors and the control centre as a line of communication.
hell until someone else comes to help you out, because this person, as good as what they are standing next to you to try and help, they just don’t have the thought processes in place. They don’t have the training behind them, the on road practical experience of the, they just don’t have the daily practice to be able to cope and process what they’re being confronted with. You could be like starting there with the deer in the headlights sort of thing. And it’s not poor reflection on them, they’ve just never been in that scenario or situation, they can be very overwhelmed over quickly with what’s in front of them. It can be very hard to get them to function after that point. (Drew)

There is a lot of responsibility, and often you do feel like you’re the only one on the job, early on in that trainee’s career, and making all of the decisions. (Chris)

Whereas sometimes with probationers, or with all probationers I guess, you really, when you’re driving you’re also treating at the same time, so you’re listening and going right, they’re doing the right thing, have they checked this, have they checked that, are they making sure that everything’s done. So in a way, you’re working two jobs for that whole roster unfortunately, which isn’t very good. (Jordan)

It’s quite different from when you’ve got two qualified paramedics, to having a trainee. You’ve got to try and figure out what they are capable of, and what they are comfortable with, whether they can be in the back with the patient, or whether are quite good driver, whether you switch, and whether they’re comfortable driving, passing the Code 3, getting IC, trying to rendezvous, trying to do whatever while you’re in the back [of the ambulance]. (Leigh)

Thinking for two meant being aware that minor, often taken for granted assumptions and details, are important when working with a preceptee. That is, communication between two experienced paramedics can take for granted that a request for a piece of equipment necessarily means a request for several associated items. The novice, however, needs detailed instructions to correctly carry out the task assigned to them:

Like “can you get the spine board?” I wouldn’t even have to say to you “get the spine board Hamish”, you’d just go and get it. You know, but you’d get the straps and sand bags as well. If I just said “can you get the spine board?” to a probie, a brand new one, they
wouldn’t think of straps and sand bags. And so you have to think of all the add-on on bits that you kind of just wouldn’t normally think of. (Charlie)

Charlie highlights the uniqueness and complexity of paramedic practice in that unlike many other clinical roles, the paramedic not only performs clinical treatment, but also concurrently needs to consider patient extrication and transport. A notable difference between the experienced officer and novice is their ability to see the big picture. The novice is often task orientated and focused on individual details. Experience affords the seasoned paramedic the benefit of seeing the broader implications of a particular line of patient management. Charlie’s example of a spine board is a useful demonstration of how the seasoned paramedic is able to connect the whole of scenario with individual actions. That is, a spine board also means stabilizing the head, securing the patient and transporting on a stretcher. The ambulance therefore needs to be moved to allow the stretcher to be removed and loaded; loading a stretcher downhill is easier than uphill and the vehicle should therefore be moved before returning to the patient. This complex array of planning and actions must be managed, and connections made, in a very short period of time. This thinking process becomes taken for granted and assumed when working with experienced colleagues. The driving paramedic will usually take responsibility for these planning manoeuvres without question or discussion. When working with a novice the preceptor must have both hats on to ensure the entire case runs smoothly.

For the preceptor, this challenge of thinking for both officers was heightened when responding to multiple victim situations. The preceptor must decide the capability of
their novice and delegate appropriate tasks, rather than equally delegate responsibilities:

Well, I guess, a perfect example is a shooting I went to, two patients, one multiple gunshot wounds, one single gunshot wound, and I was the first on the scene with a probationer ... once you get in there, delegating to that probationer – what I ended up doing was going to the multiple shot victim, and said to my probationer, “I want you to check out the single shot victim,” ... I wanted him to go and come back and let me know what was going on. Because obviously the attention was more towards this one person. And until backup arrives, you’re basically by yourself making those decisions. Because they are more of a robot rather than a clinical decision maker. (Chris)

To describe the novice as ‘a robot’ may be hyperbole, but what Chris is intimating is similar to Charlie’s example of the request for a spine board. Novice paramedics have a tendency to think narrowly, to become single task focused. While they learn to consider the broader scene and multitude of dimensions of a multi-patient scene, the preceptor must remain vigilant that treatment of all patients is appropriate, ensuring that the novice is not left to manage a situation beyond their abilities and that overall management of the scene remains with them as preceptor.

6.2.2 The emotional toll

Few would argue that being a paramedic is easy. Paramedics work in complex, unpredictable environments and they enter people’s lives at difficult moments. It requires a certain level of personal investment and resilience to deal with people during what can be their most vulnerable periods of life. Not all cases are life or death, in fact relatively few cases attended by the contemporary paramedic are life threatening, but all cases are personal; they require an empathic professional to support the patient, a professional who is willing to give something of themselves.
When the responsibility of being a preceptor was added, the emotional toll on the individual paramedic was acutely evident. The additional responsibilities weighed heavily on the participants and being a preceptor was reported as stressful by several of the participants:

I find that it’s very stressful sometimes. (Charlie)

I’d say it’s probably stressful. (Leigh)

Oh well it’s a lot of stress (Andy)

Physical manifestations of fatigue and exhaustion were very prevalent in the participants’ narratives when describing the feelings associated with being a preceptor:

I know when I was training a lot of probationers, over time you get burned out – I guess it’s the right word – in terms of giving all day. You’re giving to patients, yes, but you’re also giving to someone you’re training, and giving your time and your energy and your knowledge, and your – I guess your focus. And that can be exhausting. (Chris)

So I never have an issue with having them, but having them continually it does drag, it just drags you way down, it just exhausts you. (Kim)

[I]t is exhausting having a trainee because you have got to think of absolutely everything and you have got to spell it out in plain English. (Charlie)

I guess that (feeling like one is doing both roles) makes you more fatigued (Robin)
The constant demand of being a preceptor has a cumulative effect, adding to the negative emotional experiences of the participants:

Like they train people back to back, sort of thing, and they are usually put with the trainees. Which is great for the trainees, but it’s hard for the trainers, because they just, like I said before, you’re always on a heightened sense of looking after someone, basically, and responsibility is on you. And so quite often you – it’s just nice to have a roster or time when you’re not with a trainee for a bit, just for a bit of time out where you’re not having to always look after them. (Leigh)

Probationers are hard work, and personally when I work with one probationer after another after another that’s, one set of nine weeks with one person, another set of nine weeks with another person, and then another set of nine weeks with another person, my attitude to training at the end of that is different to what it was at the start of the first one. (Taylor)

I wouldn’t say I feel overwhelmed, but sometimes you just think when’s it going to stop? When am I going to get a break, or when’s the, yeah, when’s it going to stop? That’s the best word phrase I can come up with. Because it feels like it’s very relentless and there is not an end in your day at all and you’re having bad days there, really, really bad days. (Drew)

While none of the participants in this study disliked being a preceptor, morale and job satisfaction were negatively affected over time:

I think, I think over time. Like I think, you sort of expect – like I enjoy training and expect that’s part of the job. I think it’s sort of, it would be nice, I suppose if it was sort of evened out with alternate roster or something, wherever that was possible. (Leigh)

Probably on the motivation more than the satisfaction, where you just “Do I have to go in again? Here we go again”. The job can be frustrating enough without trainees. (Kim)

Very draining, yeah. Fair bit of very tired at the end of the days and that. It does make you not want to come into work, especially when you’ve got someone you don’t like working with and you’re in that
confined space. It’s not very nice. Yeah, if they’re not showing you the respect that you deserve as the training officer and senior officer, you know, doing things differently when you ask them to do something. (Jordan)

Adding to the mental fatigue was the knowledge that the paramedic takes on the role of preceptor without any financial reward:

It’s more responsibility, it’s more anxiety, and it’s more stress, that you otherwise wouldn’t have. And you’re still getting paid the same. (Chris)

Like there’s no financial incentive to do it. Um, there’s no, it’s just expected of the job I guess. (Charlie)

The emotional challenge was articulated not just as exhaustion, but also frustration. Although the participants recognised that trainees will necessarily be dependent on their senior colleague in the early stage of their career, there is an added pressure when working with a novice as opposed to another qualified officer:

As two people working you can get a lot of different things done but when one person’s doing both jobs and it takes longer you just want your partner to back you up, just know the next step, that person (another qualified officer) just knows what to do; but when they’re just starting out they don’t and you want them to and it’s frustrating. (Sam)

You’ll feel totally out of your depth because you’re trying to do two jobs instead of one, you’re going to feel frustrated because they’re not understanding exactly what you want when you want it because the patient’s really sick and it just needs to be done. And you get frustrated because there’s no one else around to help you; it’s just up to you. (Taylor)

Another source of frustration for preceptors is when teaching a novice who is slower to become proficient in a skill than the preceptor expects:
...it can be frustrating. Especially when you’ve told them or taught them something two or three times and they’re still not doing it correctly. (Robin)

Frustration also stems from the cycle of having trainees. The preceptor works with a novice and sees them progress and become proficient over the course of the preceptorship period. Then comes the defeating let-down of the beginning of a new roster when the preceptor receives another trainee, and the cycle starts again:

I just remember having a new person, and then maybe it was three rosters... but I remember just feeling I’m banging my head against a wall, you’ve just done how to do your job again for eight weeks then you start again, with someone brand new, and you’re saying the same thing over and over again. I think it would be alright if you had a brand new person then someone who is later on in their first year and then come back around; but having a new person all the time it can be a bit stressful at work. (Sam)

Not so much aggression but frustration I think is the biggest thing. You know, you’re not upset with, you’re upset if this person doesn’t have the knowledge – not angry at them but it is tough when you know all these things that need to be done and the person you’re with, you can only give them so much information in such a short time with, you know, when things are quite critical and you are put in very stressful situations. It can be very tough. (Andy)

The preceding narratives have exposed the emotional toll of being a paramedic preceptor, in terms of negative feelings of stress, frustration and exhaustion.

### 6.2.3 Needing a break

And sometimes you kind of feel, oh God I’d just like to have a break. (Charlie)

As it became clear that being a paramedic preceptor is an emotionally demanding role, it was concerning to find the frequency with which paramedics were required to act as preceptors. Nearly all commented that they had continuously been in the role
for at least 12 months. Of more concern was the apparent lack of organisational monitoring that occurs to rotate paramedics through the preceptor role. Again, nearly all of the participants commented that it was themselves who had ask for a break from the role when it became too much. Kim and Chris both commented that it was they who had to ask for the break:

I suppose going back a couple of years, I got Level 1s continually for over 12 months … By the end of the 12 months, I was asking “Can I please work with a qualified officer”, just so I can switch off when I’m driving, even if it’s only for a nine week [roster]. (Kim)

I mean, I think I did 15 in a row from Level 2 to P1 and beyond, and by the end of it I actually said to this [Station Officer], I said, “I need a break,” (Chris)

And yet again, Leigh spoke of the continuous demand of being required to precept novice paramedics:

Hamish: So you’ve had that experience of being with back-to-back trainees?
Leigh: Yeah, well mostly. I mean, I hardly ever work with, since being qualified, hardly ever worked with another qualified, I think maybe one roster or something.
Hamish: How long has that been?
Leigh: Two, maybe two years. Yeah.

The impact of this demand on the preceptors was highlighted where the participants themselves reported the very real consequence of paramedics becoming burnt out as a result of the continuous pressure to precept:

Because so many people didn’t want to do it because they just had one probationer after the other after the other. Which burned a lot of people out. (Andy)
I know when I was training a lot of probationers, over time you get burned out – I guess it’s the right word – in terms of giving all day. (Chris)

Jordan too commented on burn out and had also experienced reaching the point of asking for a break:

[Y]ou can see why a lot of people get burnt out when they have probationer after probationer after probationer. There was a time, like even when I was in level 2 and just out of [being qualified], I was just smashed with probationers. I think I had like a whole year worth of probationers … At one stage I just remember going up to the [Duty Manager] and saying I can’t have another probationer, I just want a [qualified paramedic], I just want to be able to relax and have a day where you're driving and have the confidence in that treating officer to say you can stand back and not say anything and not have to jump in. (Jordan)

Burnout and the negative impact of this demand was all too real for Taylor. After a period of working back-to-back with novice paramedics, Taylor described how management did not seem to understand or want to recognise the emotional toll:

I got to a point when I was working in a station that I was pretty much in tears at the start or end of each shift for a couple of weeks in a row, and I was trying to move stations because all I did was work the probationers, and I just, I couldn’t do it anymore. I was over it, I didn’t want to be at work, I kept turning up for work because I needed the money, you can’t not go to work, but I was stressed, I was emotional, I wasn’t training anywhere near what I wanted to train my probationer, and it felt like management just wasn’t listening or just wasn’t helpful to say, “Oh, I can see the stress you’re under. Let’s assist that.” (Taylor)

I have personally experienced the impact of this issue from both sides. As a preceptor I remember times when I have asked to work with another qualified officer and not be partnered with a novice. And when I was a trainee myself, I experienced the burned out preceptor and the negative impact this had on my learning and job satisfaction. I recall questioning whether I should even remain in the role I had worked so hard for.
At the conclusion of the interview with Kim, I made the following notes where I recalled this experience:

[Kim] spoke of the difficulty in being rostered to work with trainees consistently for a long period of time. This reminded me of my own experience as a trainee, something which I had completely forgotten about. My first roster on-road as a new trainee paramedic was less than pleasant. I recall the tensions that existed between my preceptor and me. I remember him being short tempered and quick to become frustrated with me. I thought it was just me for many weeks. But, at some point I recall confiding in a senior paramedic on station and asking for advice. It was during this conversation that I was told “don’t worry it’s not you, Rob13 is just over training, he’s had trainees for over twelve months”.

With this new knowledge, I developed the confidence to speak with Rob and let him know how I was feeling. I remember Rob was quick to apologise and admitted to me that it wasn’t personal; it was just that he was in need of a break from training. He said that he had asked management for a break but they were not supportive. What is interesting about my own experience over ten years ago is that it appears that this same difficulty is still faced by preceptors today. (Hamish)

The demands being placed on paramedic preceptors are clearly a concern for the participants of this study.

6.2.4 Feeling underappreciated

Collectively, the participants expressed disappointment at the lack of recognition and acknowledgment from the organisation for their efforts as preceptors. Some of the participants felt that because the organisation expects all qualified paramedics to act

13 pseudonym
as preceptors as a core component of their role, it is taken for granted that paramedics will be preceptors and no special attention is therefore needed:

It’s expected of everyone, so there’s really no feeling of appreciation or anything from the organisation. (Alex)

No. I think it’s just an expectation that they just – I think they just try to get by. Like I think it’s just, well, they need you to train, and that’s kind of just, once you’re qualified, it’s kind of like a thing that you do, you can – there’s your trainee. So I think they – I think it’s, yeah, a bit of a let-down in terms of how they approach it. There’s kind of just the hope that you do it well and you do it right, and it’s kind of, there’s an assumption that you’ll do it. (Leigh)

And then at the end of the day there’s no reward, there’s no real gratification from the service as to, “oh you did really well there with that trainee” or anything like that. It’s just, oh yeah, next job, off you go. (Alex)

Kim too commented on the lack of financial or other compensation for paramedics as a contributor to feeling underappreciated:

The other thing is I think that there’s no recognition for the trainer in the car … I honestly think that if you’re going to act as a trainer, you need to be acknowledged, and if that’s a financial recognition, so be it, but it may not necessarily be financial, it doesn’t have to be, but there should be some other recognition other than “Here’s your one point”14. (Kim)

There was also a perception that ambulance managers were too focused on their own careers and priorities, which meant that frontline preceptors are not a priority and do not recognise the work of the paramedic preceptor:

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14 Paramedics in the study setting must accumulate a set number of points each cycle to be certified to practice. They receive one point per week of being a preceptor towards this.
[Do you feel appreciated or recognised by management?] God no. I find most of them are too busy with the bottom line, they’re too busy trying to climb the ladder. (Andy)

No, no one has ever said, like management-wise in the service, “Thanks for being a training officer. Really appreciate it.” No. (Taylor)

And I guess the overwhelming feeling over time in the role is that it’s not recognised as much as it should be, and that can be frustrating, because there’s an expectation there without adequate training or adequate compensation for that. And so I think people get a bit cynical. (Chris)

This finding is important because it is clear that when preceptors feel underappreciated, there is a negative flow on effect on their motivation and this contributes to the stress and emotional toll of the role.

### 6.3 Rewarding Aspects of the Preceptor Role

Despite being weighed with the responsibilities of the preceptor role, the participants in this study also expressed a number of positive rewards inherent in taking on the role of paramedic preceptor. In this theme I explore these non-tangible benefits that emerged from the preceptor experience.

#### 6.3.1 Pride and satisfaction

A significant part of the preceptor’s role is to support the professional development of their novice through a personal investment in the new paramedics’ learning. This personal investment on the part of the preceptor was rewarded as the preceptor witnessed the novice becoming more skilled and autonomous:

It can be rewarding, too, because you see them develop. (Chris)
I get a bit chuffed when I take someone that doesn’t know how to do something, and two weeks later they go in the same situation and they actually can do it. I think “Yeah, it worked, that’s good”.

(Kim)

Yeah, because afterwards, after they stop working with you it’s another person that you know quite well that will come up to you and go, “Hey, do you remember that job that we went to? Well I went to another one really similar and you know how we talked about this? Well that’s what they did.” And for them to be able to relate something that perhaps you taught them and actually came back and told you about it, it’s like, “Yeah, sweet. They’ve paid attention and actually did it next time.” (Talyor)

When you can see them learning it’s very rewarding. You can see them do things the way you do and it’s certainly flattering to think they think that much of you that they like the way you do things so they’re going to mould the way they treat patients around the way you do that. That’s very good. (Drew)

Satisfaction also emerged as pride in the novice when the preceptor could witness their novice take control of a situation and manage clinical situations with confidence:

[M]y last [vocational] trainee ... the patient was sort of semi critical ... [and] the patient was with two midwives at a homebirth. They’d put an IV line in, couldn’t get it to run, so my Level 1 took control of the situation, flushed it, got it to run ... And I was very, very proud of him. (Robin)

Development in the novice is not limited to clinical ability. Of course clinical aptitude is a major component, however the preceptor also gains satisfaction in seeing the novice grow emotionally; watching their self-confidence build and with this the novice beginning to enjoy their work as their nerves subside:

Seeing someone on their first day being nervous not being able to talk to people and at the end of the nine weeks they’re able to get through almost half or more of the first chat with the patient, being able to sort out …the assessment of the patient and start thinking clinically about what their treatments going to be and see them have
more confidence. See them enjoy work. At the end of the nine weeks and you feel maybe you were part of that and helping them. (Sam)

Charlie also conveyed the inner sense of satisfaction received from being part of the professional development of a novice and seeing the new paramedic grow and become successful in their career:

I enjoy building relationships with those people and I enjoy watching them throughout their career do well knowing that oh, I was that person’s, you know, they were my probie when they first started and look at them now they’re ICP\textsuperscript{15} or whatever they are. To me that’s quite satisfying ... I think I get a lot of satisfaction out of that because I know that I’m responsible for that in some part. So you know, I just enjoy, I think it’s very rewarding it that sense. (Charlie)

Watching the novice grow in confidence and competence was also a benefit for Leigh:

I mean it’s, hopefully you’d see your trainee grow and learn and whatever, and improve. And I think that’s reward, I suppose, in itself, trying to – because you kind of feel responsible for them and try to look after them, and sort of get them through the tough jobs or whatever, and things, and try to get them I suppose, to sort of make them feel like they can – the next roster they’re more comfortable and confident. (Leigh)

Andy too has experienced the reward of being part of the development of a novice and seeing the positive impact of the preceptor’s advice and teachings:

I’ve trained quite a lot of people now. Because I started training when I was a brand new level two. And it is great to see those people come up through the ranks and you see them doing the things you’ve actually taught them and it’s nice when they actually listen. And incorporate them. You can see them doing well, you can see that they’re confident and they look to you and they’re still quite

\textsuperscript{15} IC: Intensive Care Paramedic
friendly and they respect you for the help you’ve given them. That’s a big thing I’ve found. (Andy)

For Jordan the satisfaction in being a preceptor not only meant being part of the professional growth of a novice to qualified paramedic, but also in being an important part of their career advancement later on:

It’s good to see like… like one of my [trainees] who I trained, she’s an ICP and she’s a [manager] and you know, it’s good to see. So yeah, that’s great, she's done really well for herself and you kind of like to think that there’s a little piece of me in there, in a way I guess. I don’t know really, it’s good to see, when you can see someone is confident and going through the job and just excelling in the job and you’d like think that possibly you helped them out in that sense. (Jordan)

For all of the participants, being a paramedic preceptor was a rewarding experience. There was a palpable sense of satisfaction and personal achievement in seeing a newly minted paramedic grow professionally into a competent and confident practitioner.

6.3.2 The preceptor as learner

Being a paramedic preceptor was also viewed by the paramedics in this study as an opportunity for their own professional development. Working with a novice would invariably lead to questions being asked to which the preceptor did not have the answer. Rather than being embarrassed about not ‘having all the answers’, most of the participants viewed these moments as an opportunity to increase their own professional knowledge:

I find probably one of the benefits is I get to learn, because as I said earlier, they ask you a question and I don’t know the answer, I’ll go and find the answer. And I’ll tell them straight, “I don’t know, but I’ll get back to you next week with the answer”. And I’ll go out and
research it, come back with the answer. If it can’t find it, I’ll ask a [ICP], I’ll ring a [educator] up, ask the question, get the answer, and that increases my knowledge. So that is a benefit. (Kim)

Self-improvement opportunities for the preceptor also occurred through the process of precepting. This happens in a number of different ways; from just working with different people to reflecting on how well the preceptor conducted themselves in the milieu of the case:

I think you learn probably as much as the trainee, just in terms of how you communicate on jobs, and when there are issues and miscommunications, where – or just problem solving, and how you do things when you sort of realise how different people operate, and, yeah, the judgment calls you make in terms of what you could do better or worse then, I think, yeah. I don’t think you ever really stop learning. (Leigh)

Another way in which reciprocal learning takes place is through revision. Not dissimilar to two students studying together, both the preceptor and preceptee can benefit from revising important information, such as protocols and pharmacology:

Because when I was going for my ICP interview, I was working with a level 2 who was going into P1 and that was really good because we were like right, well let’s just run through our drugs altogether and let’s just work through all the drugs to go through the Pharmacologies. So we were studying together in between jobs and stuff. So yeah, no, definitely in a way it still helps my professional development. (Jordan)

In continuing the study partner metaphor, Andy could see the benefit of discussion and peer feedback as a way of learning together:

I think it can be a positive thing where you do learn those things together. Because the things you remember you can talk about. You can bounce those ideas back and forth. Yeah, and I think you can grow together by doing that. (Andy)
Other participants also felt that as a preceptor you learn in partnership, which can
build a sense of collegiality:

Say someone has an illness I’ve never heard of and your partner hasn’t either, so after the job you find out what it is and learn things that way, there’s always stuff I don’t know, you get to learn, they’re learning, you’re learning you’re finding it out together. (Sam)

I’ve always said to them, “I can only teach you what I know. Anything else we can look up.” So I guess it’s a learning process for both people. You can both learn off each other, depending on their background, too. (Chris)

On-going learning was also a source of motivation. The novices’ need for information keeps the preceptor ‘on their toes’ and focused on the job:

I like having trainees. It keeps you motivated, it keeps you learning. I think if you worked just with a [qualified paramedic] all the time you’d probably get a bit lazy. (Robin)

I think them challenging you or asking questions and you teaching keeps you up to date with current skills, procedures. It keeps you kind of focused on what you’re there for. (Charlie)

I think they can challenge you as well to be like, or think about how you do what you do. And I find like I’m quite open to trying to improve and do things better. (Leigh)

The opportunity for professional development is not limited to finding information about particular clinical topics though. The complex nature of paramedic practice involves not only clinical practice, it also requires logistical problem solving regarding how to get a patient out of their home, from the base of a cliff, or from the inside a wrecked vehicle. We all develop habitual practices, although these may not be the most efficient or practical means. Sometimes it takes an outsider with a fresh perspective, unencumbered by habit to offer a more suitable alternative:
It’s been on occasion where they’ve given a different angle on, whether it be an extrication of a patient, whether it be a science based thing if they’ve come from a science background, in terms of treatment or in terms of medications the patient is taking, what that interaction is with possibly what we’re going to give them, et cetera, et cetera. But also their view on how a job could have improved from an outsider’s perspective, who probably hasn’t done six or seven years on the job. So, yeah, that fresh angle on it sometimes can be refreshing I guess, just, rather than how you’ve always done, you can look at new ways to do things, yeah. (Chris)

Charlie also commented on the benefit of having a trainee give a fresh perspective:

It keeps you on top of your game. I like having fresh perspectives you know. Like I said there’s more than one way to do so many things. And if I do something this way, you do something this way, I like to learn your way. (Charlie)

As discussed previously, novice paramedics often come to the role from other clinical roles. A novice paramedic may then be a very knowledgeable clinician and this experience can be source of learning for the preceptor:

You’ve, as a senior officer obviously got a lot to teach them, but they’ve just been at school, they could learn something new, they might have experience in another role in another job and go, “Well, why can’t you apply this here?” “Well actually, yes you can. Good idea.” So yeah, definitely I’ve learnt things off my probationers. I’ve learnt medical stuff off my probationers, like the one that I do remember is what’s a PET Scan, I didn’t know at the time. And she’s like, “Oh well, it does this and that,” and, “Oh, thanks.” So she knew something I didn’t. (Taylor)

Having a novice can also shake up the preceptors habits by questioning why something is done:

They often have good questions, they make you think about why you’re doing something a particular way, treatment options. You know, they just make you realise why you actually do the things automatically. So that again just helps you to sort of reflect and say “okay, well I might have done a million of these before but this is
why I do it, or maybe I should have done something a bit differently because they’re actually questioning you as to why you’ve done something a particular way. (Alex)

By its nature, a habit is an automatic response, but when forced to reflect and think about why you do something, there is an opportunity to reconsider whether your actions or decisions are best practice and what alternative approaches are possible

### 6.3.3 An Opportunity for friendship

Friendships are forged through the experience of paramedic preceptorship. Working closely together in the confines of a vehicle over long shifts of 12 hours or more, paramedic preceptors and their preceptees experience all the highs and the lows together, seeing wonderful events like child birth, but also the tragic deaths of others, often within the same twelve hour shift. Out of these closely personal experiences enduring friendships are forged:

Some of the probationers that I have trained that are no longer in this sector or even in the division, I would talk to weekly. They’d ring me up, talk to me, if I’m on the bariatric truck and we’re in their town, we’ll have dinner. 90% of the probationers I’ve had I’ve kept close with, because you build that bond. So that’s nice. (Kim)

Being involved in such a tight little spot such as an ambulance for 12 hours minimum a day, as you know, um you get to talk about a lot of things, you do jobs that will, are quite emotive at times and that sometimes leads you to talk about things personally that it just seems the right time and place to discuss. And that’s all bonding you know. (Charlie)

[Y]ou spend so much time together as well. But you get quite close over the roster as well. We spend however many hours a week together doing lots of things, and you kind of bond over those stressful situations as well. So yeah, definitely I make good friends with, well, most of the people I work with, I suppose. (Leigh)
Across the interviews, the benefit of friendship was a consistent feature in the responses from the participants:

I’ve become very good friends with many of the people I’ve trained. Still see them around, go surfing with them. Yeah. (Andy)

Yeah, definitely, yeah. Like Blake I’m working with now, we’re great mates, we hang out outside of the job as well. Who else? Dan, me and him and good mates, Kieran as well, yeah, for sure. I mean you’re a mentor but you obviously want to, they’re also your workmate as well, so you’re obviously going to develop good friendships with workmates. (Jordan)

I think it’s personal as well. I think it’s like any other colleague in a job, you form a bond when you’re doing jobs together… I’ve stayed friends with a number of my trainees that I’ve had. Actually the majority of the trainees I’ve had, I’ve formed friendships with after. And they come to me for advice still now. (Chris)

I have a lot of friends that are still in the job that I’ve trained. So yeah, you do develop friendships. (Alex)

There’s heaps, [laughs] I have kept in touch with people that are not in the job anymore, I’ve kept in touch with people who are in different sectors, I’ve kept in touch with people that are now at my station and they’re qualified and they still come back and ask questions. So yeah, it’s nice. (Taylor)

It is clear that despite the previously described challenges and difficulties of being a paramedic preceptor, it is also an intrinsically rewarding experience. Through personally shared experience, a close and enduring bond is often formed.
6.4 Discussion of the Affective Experience

The findings of this study clearly demonstrate the lived experience of being a paramedic preceptor to be a double edged sword. Being a preceptor for many of the participants was emotionally demanding and exhausting work. Notwithstanding these challenges, all of the participants in this study were able to convey a feeling that the preceptor role is associated with intrinsic rewards and benefits which make the effort of the role worthwhile.

Figure 6.2 below represents this balance between the intrinsically rewarding and psychologically demanding findings in this chapter.

![Figure 6.2: Affective dimensions of being a paramedic preceptor](image)

Being a preceptor is frequently reported in the literature as presenting additional workload for the clinical preceptor (Chen, et al., 2011; Hathorn, et al., 2009; Hautala, et al., 2007; Liu, et al., 2010). In this study, additional demands of the role emerged
in the form of ‘thinking for two’ (see 6.2.3). Paramedics usually work in dyad partnerships with tasks and responsibilities shared between the two officers. Much of the time there is a knowing, an assumption that certain roles and responsibilities will be handled by the other paramedic. That is, there is a delineation of responsibilities shared between the treating paramedic and driving paramedic. In contrast, in the preceptor-preceptee partnership this dynamic significantly changes. The taken for granted and assumed can no longer be relied upon and the preceptor is charged with doing the thinking for both officers.

Working in this dyadic partnership increases the mental workload of the paramedic preceptor as they must maintain a constant vigilance of the preceptees treatment, the information that is coming to light and watching for signs of patient deterioration that may be missed by a novice. It is, however, much more than a focus on clinical treatment. The paramedic preceptor is thinking for two in every aspect of the case. It begins even before patient contact is made. There is a need for increased awareness and an active focus of coaching by the paramedic preceptor during urgent duty driving towards the scene (see 5.2.2). Once on scene, management of logistics – such as providing the Control Centre with a radio report, assessing and organising patient extrication, retrieving additional equipment from the ambulance, and sourcing of background information from bystanders, is usually the domain of the driving paramedic. However, the novice paramedic will usually require assistance to instigate, plan and perform these tasks. The paramedic preceptor must therefore be attentive to both treatment of the patient and overall management of the patient care episode. The sharing of responsibilities in the paramedic-preceptee partnership thus becomes indistinct, with responsibility for both roles falling to the preceptor.
Gurchiek (2011) included the theme of “more work” in relation to paramedic preceptors having to demonstrate to novices how to perform routine tasks such as vehicle and equipment checks, completing documentation and teaching specific skills. While this is also true of the preceptor’s role in the current study, my findings highlight the additional psychological demands of being a preceptor which are not limited to specific tasks. The demand of thinking through every aspect of the job is an emotionally and physically exhausting commitment for the preceptor.

As a learner, the novice paramedic does not necessarily have the skills and knowledge to be an independently safe clinician. Paramedic preceptors therefore have final responsibility for the safety of the patient and being responsible for the preceptees’ actions. This responsibility was not lost on the participants of this study (see 5.5.1). Each expressed how this demand weighed heavily upon them each day on the job. Similarly, in Gurchiek’s (2011) study of paramedic preceptors, participants reported this greater level of responsibility. One participant in his study commented “[as the preceptor] you’re responsible for everything that student does, good, bad, or otherwise” (p.92). The constant task of being accountable for another person was variously described by the participants in my study as being “emotionally stressful”, “draining” and “exhausting” (see 6.2.2). Nurse preceptors too have reported the demands of being responsible for their learner’s actions with narratives of feeling stressed and burdened by the additional accountability of precepting (Hathorn, et al., 2009; Hautala, et al., 2007; Öhrling & Hallberg, 2000). Preceptors in these nursing studies also similarly describe the emotional experience of being a preceptor as tiring (Yonge, et al., 2002a), draining (Henderson, Fox, & Malko-Nyhan, 2006), and exhausting (Liu, et al., 2010).
Stories emerged from many of the participants in my study that they were required to act as preceptors for many months or years without the opportunity for a break, despite requests to management (see 6.2.3). This finding is consistent with evidence submitted to the General Purpose Standing Committee No. 2 (2008) into the management of an Australian Ambulance Service on the supervision of trainee officers. The Committee noted concerns, which reflect that of the participants in this current study, about the role of preceptor being thrust upon paramedics without consultation and the frequency in which paramedics are expected to act in the preceptor role: “The training officer is chosen for the job without his/her consent. Many officers have complained bitterly about having been given trainees or multiple trainees (one after another). This situation does not provide a good training atmosphere” (p.56).

The tension and strain of being a paramedic preceptor appears to be heightened by a culture within the study organization that inadequately recognises the efforts and demands being placed on paramedics in the preceptor role. Participants felt management did not understand the significance and impact precepting a novice can have on a paramedic. Few participants felt their managers recognised their efforts and hard work. Overwhelmingly, they felt underappreciated for their role as a preceptor. This finding correlates with those of other authors who have also reported a concern for the lack of recognition and acknowledgement for the importance of the preceptor role in other health professions such as nursing and dietetics (Hjälmhult, Litland, & Haaland, 2013; Nasser, Morley, Cook, Coleman, & Berenbaum, 2011; Yonge, Hagler, Cox, & Drefs, 2008b)
The consequences and personal impact of this environment were evident. Participants at times spoke of being ‘absolutely exhausted’ and burned out which led to decreasing job satisfaction. This finding is important because of its potentially negative impact on the quality of education and learning provided to novice paramedics. Under constant pressure to perform the role of preceptor and without adequate recognition of the demands or efforts of the preceptor, paramedics become dissatisfied and disengaged from the role of preceptor and the effort it demands, and focus on the novice decreases. The result is a lose-lose situation for both paramedic and preceptee.

Being a paramedic preceptor is a rewarding experience. Through my conversations with the participants in this study, it was clear that paramedic preceptors invest a lot of themselves in the professional development of the novice paramedic. The participants invest their time, effort and energy to ensure that they support the novice in a safe transition into the workforce and are afforded the opportunity to become competent, safe, professional clinicians. So the question I had was: “Do paramedic preceptors receive anything in return?” Despite the challenges and emotional cost of being a paramedic preceptor, all of the participants expressed that it can be a rewarding experience too. While in the study setting there were no reported financial rewards for being a preceptor, such as additional pay or bonuses, all participants reported several intrinsic rewards associated with being in the preceptor role (see 6.3).

It emerged in this study that in the often stressful and demanding working environment of paramedicine, a close bond can develop between preceptor and preceptee. This bond and friendship often extends beyond the collegial working relationship and time of the preceptorship. In their working environment, paramedic preceptors and their preceptees spend a great deal of time in close quarters with each
other while working from a vehicle during shifts lasting 12 hours or more. Moreover, the type of work encountered as a paramedic can be psychologically demanding. Many of the participants used the word bond to describe the connection they developed with their novice. Friendships flourished between preceptor and preceptee and continue to last long after the formal preceptorship period had been completed. Not all participants had this experience as some liked to keep their work and personal lives separate, however for the majority, it was a potential benefit that comes with being a paramedic preceptor. I personally have friends with whom I first met as my probationary novice over a decade ago. In fact, the Best Man at my wedding and my closest friend was one of my own preceptors! And I too was Best Man at his wedding! This finding was interesting and not one that I have found in the broader literature.

The participants in this study identified being a preceptor as an opportunity for their own professional development (see 6.3.2). In a preceptorship, it is the novice who is usually considered to be the learner. Nevertheless, opportunities for the preceptor to develop their own knowledge occurred through preceptorship. For example, the novice will occasionally ask the preceptor questions for which that they do not have an answer. This prompted many of the participants to seek out the information in order to provide the learner with answers and thus also increase their own knowledge and understanding. Alternatively the preceptor and preceptee would explore the question together through shared study. Paramedics in the study by Gurchiek (2011) similarly reported being a preceptor as an opportunity for learning and he labelled this reciprocal learning. Again in the study by Lilibridge (2007) preceptors also reported similar circumstances where enquiries from the novice lead to a shared learning experience.
In the current study, learning directly from the novice was also reported as a means of learning for paramedic preceptors. For example, most people develop habits and preferred approaches to their job. Being in partnership with a novice was reported in the current study as an opportunity to bring a fresh perspective to situations where the novice offers suggestions for doing things differently. Paramedic preceptors in the study by Gurchiek (2011) made similar comments that working with a novice presents a new way of looking at situations: “It’s kinda (sic) nice to see a different aspect, learn things from them sometimes, of how to do things” (p. 86).

The paramedic preceptors in my study highlighted the importance of tailoring the learning experience to the individual needs of their novices. As adult learners, the novice brings to the relationship their own personal and professional experiences, which can be a wealth of knowledge for the preceptor to learn from. As discussed by most of the participants in this study, some novice paramedics come to the profession of paramedicine with experiences in nursing, allied health, exercise science or other clinical backgrounds. Being a preceptor to these individuals can offer the chance to learn from them and their particular experiences. I remember working with a particular novice who had a decade of clinical experience as a physiotherapist before he decided to become a paramedic. So whilst I was the preceptor, when attending to patients with sporting injuries my novice was the expert. I learnt a great deal about musculoskeletal assessment and management from this particular novice. Learning from the novice is a common theme that recurs in other studies of being a preceptor. For example, in a study by Lilibridge (2007) one participant succinctly commented “they teach me” (p. 46). Further, nurses in a study by Charleston & Happell (2005) also reported that preceptorship is a relationship in which mutual learning takes place.
Again, in a study of preceptors to new graduate nurses by Henderson, et al. (2006), participants reported a benefit of being a preceptor was the opportunity to learn from the graduates.

In my study, working with novice paramedics was also a way of keeping up to date with policy and protocol changes. Participants reported that having a novice partner motivated them to review organisational policies to ensure they were providing the preceptee with the most up-to-date information. Furthermore, with the novice being fresh from university or an education unit, they were likely to have been briefed on the most recent procedural changes and rationale for practice which may be slow to disseminate across the wider organisation. Working with a novice is an opportunity for the paramedic preceptor to discuss these changes and updates with their preceptee.

A further intrinsic reward to emerge in this study was the pride and satisfaction paramedic preceptors felt when seeing progress and career achievements in their novices (see 6.3.1). Transition to practice from student to novice clinician is characterized by stress, anxiety, feelings of inadequacy, and deficits in both skill and knowledge (Casey, et al., 2004; Delaney, 2003; Lazarsfeld-Jensen, et al., 2011). As the novice develops their knowledge and skills and becomes more confident in their role, the preceptors felt a personal sense of pride and satisfaction that they played an important part in this development as a result of their guidance, support and teaching. Many of the participants in this study commented that being a preceptor can be intrinsically rewarding when seeing their novice professionally advance years after the preceptorship. Examples from participants included when colleagues who were preceptees became an intensive care paramedic or station manager.
This sense of satisfaction from being an integral part of a new clinician’s growth and development has also been reported in several other studies within the healthcare literature (Chen, et al., 2011; Dibert & Goldenberg, 1995; R. Fox, et al., 2006; Liu, et al., 2010; Stevenson, Doorley, Moddeman, & Benson-Landau, 1995). In a study by Richards & Bowles (2012) participant preceptors to new graduate nurses reported that it was very rewarding to seeing their preceptees grow into competent, critically thinking nurses through the support of the preceptor. Similarly in the study by Gurchiek (2011) paramedic preceptors also reported their experience to be rewarding when seeing their novice grow in competence and confidence.

In light of the findings elucidated in this chapter, the affective experience of being a paramedic preceptor can be viewed as a tension between the intrinsically rewarding and psychologically demanding experiences. While the role is psychologically demanding, the intrinsic rewards associated with the experience help maintain an equilibrium.
Chapter 7
Preceptor Preparation & Support

7.1 Introduction

In this chapter, I focus on the experience of being a paramedic preceptor in relation to the organisational structures which have the potential to influence the experience as being positive or negative. In the first theme of preparedness to precept I look at what the preceptor role means to the participants and their understanding of the role. Further, I explore what education and training they received in preparation for being a paramedic preceptor.

In the second theme Support for paramedic preceptors, I explore aspects of support that the participants receive while in the role of paramedic preceptor.

Figure 7.1: Structure of findings in Chapter Seven
7.2 Preparedness to Precept

A central focus of this study was to explore the preparedness of paramedics to undertake the role of preceptor. In this section I will demonstrate that in the study setting there are significant short falls in the preparation being provided, and in lieu of this paramedics are attempting to fill this gap in formal preparation with heuristic methods and reflection on their own experiences of preceptorship.

7.2.1 Lack of preparedness

There is a presumption in the study setting that being a qualified paramedic makes you suitable to be a preceptor. However, being a competent clinician does not necessarily equate to being a good preceptor (McCarty & Higgins, 2003; Troxel, 2009). A key finding across all the participants was the limited formal training the paramedics had received to undertake this critical role. Formal training was limited to a brief session being included in their final didactic course prior to becoming qualified paramedics:

[A]s far as what we’re talking about tonight, no it wasn’t a good preparation. (Robin)

[T]he only preparation they gave us was one lecture or two lectures … But in terms of what I’ve done since joining the ambulance service to prepare me for the role, very little, let’s say, very little. (Chris)

What’s the organisation given me? Not too much to be honest … So bar that short train the trainer course where they do a little one day course I think it was. No, there’s not really too much. (Jordan)

I don’t think the organisation really prepares you at all, really, like in terms of – well nothing formally. (Leigh)
A key element of the training the participants did receive was teaching the class to perform a skill in five minutes. I recall my own experience of this session being treated by the class with little sincerity. Furthermore, the topic areas of choice were not aligned to clinical or ambulance practice in any way. My experience was reflected by the participants and many of them recalled random topics:

[I]t was “Here is an object, stand up and tell everyone about it, you’ve got five minutes, and teach them how to use it”. And it could be simply a remote control that’s been handed to you, you take your five minutes, you go “Yeah, okay, you just push this button, and that turns the TV on”, that’s it, you’ve passed the course. Well, I think training and mentoring is a little bit more than just teaching a monkey to push a button. (Kim)

They do train the train the trainer at [the education centre] as P1. I think it was a 3hr lecture and you have to pick a topic that you’re familiar with that you want to show the class…it can be absolutely anything from someone who knows how to juggle teaching people how to juggle, I think it’s just us as an officer standing in front of people and explaining a task and then you get everyone in the group to copy it. That what I remember of train the trainer. (Sam)

I think I taught them how to juggle or something. (Chris)

I remember doing [the qualified paramedic didactic education] and having to prepare a 10 minute seminar instructional type talk to the rest of my class to teach them something, and I could do it on whatever I wanted, and I don’t know, everyone in my class passed so I’m not sure exactly what they were marking everybody on but some did better than others and that’s about it. (Taylor)

The participants expressed feelings of dissatisfaction and disappointment at being asked to take on the responsibility of training a novice paramedic without adequate training or preparation:

Absolutely nothing. But I was a brand new level two, off you go, I had a brand new probationary day one and I did pretty much
everything with that probation under the sun. I was running a
[cardiac arrest] on my own. No, you know, no formal training for
that. Service didn’t say oh this is what you need to do as a training
officer. They just threw you in the deep end, couldn’t care less. It
was just bums on seats. (Andy)

It was pathetic ... You know what I mean? Like, it was, yeah, it was
ridiculous. (Chris)

Within the study setting, paramedic preceptors were being asked to take on an
important role without any substantial formal preparation. The question is then: How
do they learn to become a preceptor and what influences their approach to the role?

**7.2.2 Being compelled: Being a preceptor is just expected**

[Y]ou don’t get a choice to be a training officer, if you’re a [qualified
paramedic], it’s just expected of you that when you get a junior staff
member you train them up. (Sam)

In the study setting, becoming a preceptor was not a voluntary role. All qualified
paramedics are expected to act in the preceptor role at the discretion of the
organisation. Moreover, paramedics were not usually given any formal notification
that they will be precepting a novice paramedic. Rosters are posted on a notice board
in the ambulance station seven days before commencement and it is only at this stage
that the paramedic finds out they will be acting as a paramedic preceptor for the
following 9 week roster. There is no email or phone call provided by local
management or educators asking whether a paramedic would like to become a
preceptor or more importantly if they have reasons to decline the role. It is just
expected that you suddenly perform this important role:

So I will find the roster and see that I have a probationer for that
time. No one’s called me, I haven’t got an email saying this is
someone new coming out, I’m just looking at the roster and when
they rock up fresh faced, there’s your answer, they are a new person
and they don’t even know who they working with so I introduce myself. (Sam)

As far as they’re (The Organisation) concerned it our jobs, part of the job and therefore we should just kind of get on with it. (Charlie)

Although all qualified paramedics are expected to act as preceptors, the participants highlighted their concerns that some paramedics should not be given the role. Their reasons were altruistic as they were concerned that the novice practitioner will suffer the consequences of a poor preceptorship:

You should be able to volunteer to be a training officer, not just be lumped with it. Because some people, let’s be honest, aren’t suited to it, and some people don’t want to do it. And there’s many a story of people saying to trainees, “I’m not going to train you, you’re going to deal with it, just – I’m not going to go out of my way for you.” And unless that trainee pops up and says something, which then creates possibly a reputation, it’s – nothing’s going to change for that trainee, it’s going to be a really difficult roster... there are certainly people out there that will have a negative impact on someone’s career. And it’s the luck of the draw. (Chris)

Anyone and everyone can be a training officer and is often expected to be a training officer and expected to train trainees. And there’s people out there that should not go within like 200 metres of probationary officers at any time. (Alex)

That’s right. Yes, just because you’re a qualified officer doesn’t mean you should be a training officer. I think that, like looking on this station, there’s probably four of us that could train, and be capable of training people quite nicely. There’s four that you wouldn’t, it’s silly to give them, but yep, they get them, because they’re qualified officers. (Kim)
For the benefit of the novice paramedics, Andy would like the preceptor to be a separately defined role:

I think it would be good to actually have set clinical mentors. Because I don’t necessarily agree that everyone should be doing it. I think it’s a good thing for people to do but unfortunately people are individuals, you are going to get people with attitude and they shouldn’t be near probationers. (Andy)

Similarly, Sam and Robin too would like the role to be voluntary rather than imposed on paramedics, meaning those that do take on the responsibility as preceptors are motivated and enthusiastic:

I think it would be nice if you could to put your hand up to say you want to be a trainer. There are some people that shouldn’t be and are. (Sam)

Well I think mentoring Level 1s should be a privilege in the service not a right. Because there’s people that shouldn’t be having trainees and there’s people now unofficially that aren’t given trainees for that very reason. (Robin)

In the study setting the role of paramedic preceptor is an adjunct to the role of qualified paramedic. The organisation does not have separate preceptors nor is being a preceptor a voluntary role. Reassuringly, the participants appear to make a case for changing this out of interest in seeing the novice paramedic receive a high quality preceptorship.

7.2.3 Sense of Agency: Making it ones’ own

With limited formal preparation provided by the participant’s organisation, the paramedics in this study frequently relied on their own experiences as a novice to guide their performance as a preceptor:
I remember, in training what it like was, I kind of reflect on how I was trained, I suppose, to sort of how I would train other people, and what I found helpful and not helpful. (Leigh)

I remember as a Level 2 talking, going through my Level 2 training talking about what you as a probationer liked in your training officers, and if you ended up training officer, do those bits as opposed to the bits you didn’t like, but as for any other preparation I’m not entirely sure that there was much provided. (Taylor)

I was pretty lucky in the sense that I only had three training officers and one, so probably, they were all polar opposites of each other. You can imagine, my first one was very uptight, anxious, flustered the whole time. My second training officer was very laid back, probably almost to the point of being maybe a bit too laid back and relaxed. And the third one was probably a combination of being relaxed and quiet, but is, not saying that he was bright or smarter than my two previous training officers, but he was a little bit more, had an idea of how to communicate information and instruct and teach trainees... I learnt not to be flustered, not to be too laid back, but just to be relaxed enough that you’re not putting too much pressure on your trainee and then instead of, along the lines of how to train them day by day. (Drew)

For Andy it was essential not to continue the negative attitudes and behaviours experienced as a preceptee, but instead use the negative experience as a lesson in the importance of being a positive role model and supportive preceptor:

I mean, when I came out I was only trained by a level two as a probationer, so plenty of them only had so much experience and there was a lot of belittling. They, you know, they didn’t really build you up, they put you down a lot and made you feel like an idiot for being new and not knowing anything. And a big thing for me was I made an effort not to be anything like that with any of the people I trained. (Andy)
A learn as you go approach was another method employed by paramedics in developing the skills of preceptor. Each time the paramedic acted as preceptor they learnt what worked and what did not:

Each time I’ve had a new probationer I’ve done things differently ‘cause I’ve learnt from the time before. Thinking maybe that didn’t go so well, let’s try something different … you just make it up as you go. (Sam)

I guess you sort of fumble your way through your first couple of probationers and figure out what worked and what didn’t, and you develop your own style and that’s about it. (Taylor)

Drawing on previous experiences outside of their paramedic role was also useful for participants. Jordan commented on having training from sport and starting a vocational course on training and assessment as a source of knowledge for approaching the preceptor role:

Well I’m kind of lucky in a way that I’ve done sort of a level O in coaching for my [sport], so I can understand different coaching techniques in that sense. I did a little bit of Cert IV in Training and Assessment but I didn’t finish it. (Jordan)

For some of the participants, experience gained in previous careers gave them the skills and knowledge they could use in their new role as a paramedic preceptor:

I draw on a lot of my previous career knowledge for it. And I wonder, I mean, I can’t put myself in those shoes, but I wonder how I would feel about it if I didn’t have that background. (Chris)

Taylor also had experience from a previous career and used this knowledge and experience to guide how one acts as a paramedic preceptor:

I guess I was a training officer in a similar role in a previous job, being senior at what I was doing and then having junior people come
through, and it was a very practical job as well. So you show and you talk, and that’s pretty much what we do here, show and talk. (Taylor)

The participants seemed cognisant that their own preceptee would soon be required to perform the role of preceptor. Moreover, they knew that the organisation would not provide the requisite preparation and thus would provide advice to their novice to reflect on their current experience:

I would say at the end of my time with them, remember the good things I’ve taught you or the things that you’ve liked and the things you haven’t like that I’ve done and when it comes to you being a training officer you can act on that. So, all the things that you’ve like how I’ve taught you or the things that you didn’t like about me. So that’ll give you a focus when you’re teaching someone don’t do as I do teach how you like to be taught. (Robin)

Overwhelmingly, learning to be a paramedic preceptor has emerged as a heuristic process, mostly of trial and error through personal experience. In the absence of formal preparation, the participants draw on their own experience as novice and preceptor, as well as prior roles before coming to paramedicine.

7.3 Support for Paramedic Preceptors

Fundamental to preceptorship and the role of the paramedic preceptor is the support they provide to novice paramedics. With the notion of support so intrinsic to preceptorship, this section explores the level of perceived support being provided to the paramedic preceptor as they undertake their role in the clinical practice setting.
7.3.1 Support from peers

The support preceptors received from their peers varied between the participants. This support came in the form of recognition that being a paramedic preceptor is more taxing than being partnered with another more experienced paramedic:

Yes, in the way that I guess they understand that if you’re on a certain job, or you’ve had a busy day, they will help you out a little bit more than they normally would, because they know you’ve probably been worked off your ass. (Chris)

If you see someone who is in a rush, they’re asking someone to clear or someone who’s a new probationer and showing them how to write a case sheet and you’re with a partner who’s quite fully qualified, then you’re more likely to jump the job and say yep, we’re ready. To give your other team mates a chance to go through and show their probationer new things and give them time to finish that job. (Andy)

Leigh also felt well supported by colleagues and appreciated the opportunity to debrief about precepting experiences. Just as Chris felt that peer support comes from a mutual understanding of the pressures of the role, Leigh too commented on the benefit of talking with others who can relate to similar experiences:

Yes, I think that’s probably a big help. And part of it is probably just venting sometimes like a bit of frustration, when a trainee frustrates you or something, or whatever, and having a laugh maybe. But I think, because they are often in a similar situation … and they are often doing the same thing, training back to back Level 1’s and 2’s or whatever. So they appreciate where you’re coming from, and it’s nice to sort of have that reassurance that it’s across the board, more or less, with the other [qualified paramedics], that you’re always working with someone junior that you sort of have to train up, or whatever. Peers are always keen to give ideas and say what sort of works better. (Leigh)

Drew’s experience of support from peers was also positive:

They do, they’re fantastic. Pretty lucky here on this station. I probably, now probably, all the senior officers within their own right,
would be fantastic CTOs and they’ve had lots of years experience and that’s just essentially what you’re looking for when you need help with a probationer. And they’ve all been around for a long time, very friendly, easy-going people. And they’re more than happy to help out where there’s an issue. (Drew)

Charlie also felt that peers could be accessed for support. Although cautioned not everyone should be approached. While peers can be supportive, knowing who to go to was important for paramedics:

I think it depends, like there are people that you know that will help you that really love instilling their knowledge and experience onto you and onto anyone that might ask. There are people that aren’t interested in that … So I think it’s a matter of knowing who to approach and having that time to do that, the right time frame to do that. (Charlie)

Interpersonal trust between co-workers is associated with employees’ organisational commitment and performance (Tan & Lim, 2009). When peer trust is present, individuals are more likely to make themselves vulnerable to others in the expectation that their peer will not exploit this vulnerability (Cox, 2012). While exploring the notion of support that the participants received from their colleagues while in the role of preceptor, I was surprised to find a level of mistrust that resulted in the participants being reticent to seek peer support for guidance and advice on their performance as preceptors.

A culture of mistrust emerged in the discussions with participants as we explored their willingness to approach peers for advice on preceptorship. Chris explained that support from colleagues was sought at times of experiencing interpersonal conflict with the preceptee. Going to peers was a method of seeking ideas and different approaches to manage the conflict. Similar to Charlie, Chris was clear that trust was
a significant factor in who is approached. Like many of the participants, Chris maintains an inner circle of trusted friends who can be relied on to provide confidential advice:

I guess I’d go to my friends on the job … Someone I trust, I guess. Where it’s not going to be spread around as gossip; it’s more, I guess, you’re in a circle of friends who you know you can rely on for information, but confidentiality, too. (Chris)

An interesting cross-over here is the link between trust and role modelling. As Chris continued, it also became clear that the trusted inner circle that Chris has created is made up of those respected colleagues who Chris aspires to be like:

Because I guess it’s the people who you go to are the ones which you aspire to be like, too. Especially the [intensive care paramedics] which I know, which I aspire to be, they are the ones I would probably go to for advice. (Chris)

The theme of a trusted an inner circle permeated across the participants. Like Chris, Kim also spoke of accessing peers for advice and support but narrowed these people to an inner circle of trusted colleagues:

Trusted [colleagues], yeah, definitely. There’s a [qualified paramedic] on this station that I fully trust, and he’s prepared not only to answer the question but then explain his answer. (Kim)

[I do] talk to the other officers on the station. But to do that you, I mean here I would probably talk to two other officers only that I would feel comfortable or confident with running things through and getting feedback off them. (Kim)

Discussions with participants revealed an interesting paradox that members of the most trusted profession (Readers Digest, 2014) are cautious in trusting their peers when it comes to seeking support and advice. Chris indicated that this guarded
approach comes down to a perception that opening up to some of their colleagues place at risk their reputation as a competent preceptor. There is a perception that others may “spread around as gossip” (Chris).

Robin infers that the apprehension may also relate to protecting oneself from the vulnerability of being embarrassed amongst colleagues:

Uhh, maybe they’re too embarrassed to say I need help in teaching this person. (Robin)

Similarly, while Andy was prepared to approach peers for advice on precepting, Andy “wouldn’t go to everyone” believing there was a risk that some colleagues may belittle you for reaching out:

I might ask people later on, what they’ve done with their probationers as training officers, things like that. So definitely I’d ask the people around me... [but] I probably wouldn’t go to everyone. It would be probably more people I know and I feel comfortable with who aren’t going to, you know, belittle you for asking. (Andy)

Trust has emerged as an important element in the process of preceptor support from the perspective of preceptors reaching out to both educators and to colleagues. The level of support preceptors receive appears to be enmeshed within the culture of the paramedics work environment, as much as it is a function of the formal structures put in place by the organisation.

7.3.2 Feeling under supported by the organisation

For many of the participants, the role of preceptor was undertaken with limited support from their organisation. Many of the paramedic preceptors felt that once rostered to work with a novice paramedic, they take on this responsibility with a sense
of isolation and without formal mechanisms of support from their managers and educators:

As a training officer there’s no one looking out for you, it’s just, it’s not a role, it’s expected of you ... I feel you’re on your own, yeah. (Sam)

Support to training officers is pretty crap. (Taylor)

Feelings of isolation from the support of the organisation and educators were conveyed throughout the interviews by most of the participants:

At times it feels like it’s kind of you and the trainee and it kind of stops there, it’s kind of not the – you don’t feel like there’s – like in terms of just feeling, you’ve got your peers around, but there’s kind of not that, the next step up that’s kind of a – like someone to go to. You’re sort of going to your trainee a lot and between yourselves, but there’s not kind of the – who do you go to and back and forth – apart from your peers and briefly maybe you’d mention things are difficult or whatever, there’s not another line of communication that’s available to you that sort of helps support you. (Leigh)

Day to day I’d say poorly. You get given a probationer and they’re your responsibility for nine weeks pretty much, so there’s, almost as if they expect you to do the burden of having this one person regardless of how fantastic they are or how much extra assistance they need. (Drew)

In the study setting, education falls into two distinct categories. Firstly, there are the educators who only provide the didactic classroom teaching at the education centre. These educators teach to a curriculum during defined courses at different stages of a paramedic’s career. Secondly, there are on-road educators, Clinical Training Officers (CTO) who are assigned to a geographical sector to provide support to paramedics in the field. It is the CTO who has prime responsibility for providing education support to preceptors.
Participants in this study reported they “rarely” or “never” interacted with a CTO on a proactive basis:

Hamish: Do you get much support as a training officer from…?
Chris: From?
Hamish: educators?
Chris: None,
Hamish: How often would you hear from an educator?
Chris: Never.

To assist me with trainees, not very often. I’ve only ever had them involved on one occasion. (Drew)

Hamish: How often do you see a [Clinical Training Officer]?
Robin: Um, just in passing. Or they come to find me because I’ve ticked something they’re not happy with in the reports.
Hamish: But there’s no regular contact with an educator as such?
Robin: No. No.

Hamish: Do you get regular phone calls?
Sam: No, no, never (laughs)…I’ve never had a phone call from anyone (still laughing).

I can count on the fingers of one hand how many times I’ve seen these clinical educators driving around. They just don’t seem to be there or they’re not interested. I don’t know. (Andy)

This theme was continued with nearly every participant. Charlie has worked at several different ambulance stations, but each time with limited interaction with educators:

I don’t think I’ve ever had a conversation with a CTO in regards to me being a mentor or a trainer … Yeah but never at [Station A] or [Station B] have I ever had them on station educating or talking about “hey, oh you know how are you going with so and so?” or whatever, whatever, “any problems?” I don’t think anyone else has that I can think of either. It’s not really the culture to kind of do that. (Charlie)
Alex too felt under supported by the educators and only heard from them when the preceptor had not completed the progress reports for their novice:

I don’t really feel you get much support from our educators. Your probie will come along with a report for you to fill out, or anything. And you don’t usually get like a handover or a background story about your probationary officer. Like unless you actively chase down their last training officer and say “hey, what sort of areas where you working on, what things do you need to work on”, you don’t really get that lead-in, you just get lumped with a person that you’ve got to meet and understand, work out where their weaknesses and strengths are and try and do that. Education doesn’t really talk to you, they just want to know why you haven’t put a report in or that the report was good. (Alex)

Taylor commented that while educators did make themselves available for general skill upgrades and updates, there is little focus on specifically supporting preceptors:

If there’s new skills and new procedures come in then I do feel that the CTOs are getting around a lot more than they used to actually talk to people and run them through things, whether it’s on station or at hospital, I think they are a bit more visible now. But in terms of getting around talking to training officers, no, it’s not something I’ve ever seen them do. (Taylor)

In contrast however, Jordan actually felt well supported by CTOs:

If there are any issues that the [manager] can’t sort out, then it does get moved onto a clinical training officer or a paramedic educator. So in saying that, there is good support for a senior officer or training officer, but if you feel that your techniques aren’t working that well, I could ring up [the CTO] and just say look, I want you to come for a ride along for the next four shifts and just see how I’m doing and see if it’s just me. (Jordan)

With the majority view that preceptors receive very limited support from educators and only one dissenting view from Jordan, why is it that preceptors don’t see the CTOs?
Leigh’s perception is perhaps it’s a culture within the educators, an underlying assumption made by them that preceptors will make the proactive call for help should they require assistance:

It’s more like, if we don’t hear from you, then we’d just assume it’s all good, sort of, that’s my sort of understanding. (Leigh)

An alternative perspective of some of the preceptors was that the CTOs are simply struggling to cover the large geographical areas they are responsible for:

It’s not happening. I mean, in this area we’ve got two CTOs running around, I think. But we’re a big area. And we’re not the only big area ... geographically I’m talking about, yeah. I don’t think that we probably need more CTOs, but I think a lot of them are getting tied up in the administration of the role rather than doing what they’re meant to do. (Kim)

Charlie too believed it was the organisational rather than individual factors that restrict the CTOs being available to support the preceptors:

And I think they’re understaffed and underfunded, like there’s what, two CTOs for the whole […] sector or something. And then trying to get people when they’re part timers or they only work weekends or you know. With us and our rotating shifts it’s just really hard to keep track of, I feel. So they’re under resourced but yeah we don’t see them that often. (Charlie)

Jordan offered a different view however, alluding that perhaps the paramedic preceptors themselves are unwilling to take responsibility for approaching the educators when needed:

“Whether it gets used to its best advantage, I don’t think so”. (Jordan)

Jordan’s alternative view was interesting because most of the participants were very clear about receiving limited support. From Jordan’s perspective, rather than it being
the CTOs who need to be more proactive to increase support, the preceptors themselves need to take more responsibility for seeking out support and asking for help, and not waiting to be asked.

7.4 Discussion of Preceptor Preparation and Support

In the study setting paramedics are underprepared for the role of paramedic preceptor. All participants expressed feelings of being ill prepared by their organisation to undertake the role of preceptor (see 7.2.1). Preparation for being a paramedic preceptor did not include any substantial background of the widely accepted essential areas of knowledge to be an effective preceptor such as: understanding the role and responsibilities of the preceptor, adult learning principles, clinical education strategies, accommodating different learning styles, using reflective practice, guiding critical thinking, or dealing with conflict (Boyer, 2008; Elmers, 2010; Hyrkas & Shoemaker, 2007; Marincic & Francfort, 2002).

This finding is concerning as it is widely accepted that adequate preceptor preparation is essential to the success of the preceptorship experience (Luhanga, Dickieson, & Mossey, 2010; McClure & Black, 2013). Despite this, the lack of formal preparation communicated by the participants in my study is reflected in other studies within the nursing literature (Alspach, 2008; Luhanga, et al., 2010; McClure & Black, 2013). Formal and specific preparation is necessary to ensure that clinicians have the necessary skills, knowledge and attributes to fulfil the preceptor role as being an experienced clinician does not necessarily equate to being a good preceptor (Luhanga et al., 2010; Nasser et. al., 2011). When preceptors lack the knowledge and understanding to facilitate learning or how to effectively communicate their
knowledge, it is the student or novice that misses out on an effective learning experience (McClure & Black, 2013).

While the participants in the current study did receive some training during their final didactic in-service education course to become qualified paramedics, this appeared limited to a short lecture and skills demonstration to their class. Moreover, this skill appeared to hold no correlation with those of precepting. Examples provided by participants included making paper planes, juggling and dancing. Furthermore, this focus on skills in the preparation of the preceptors appears to have influenced some of the participants understanding of the preceptor’s role. For example, Sam perceives the preceptor role to be that of a “skills mentor” and Robin’s approach is to encourage “practice, practice and more practice”. This focus on technical skills is perhaps an historical legacy of the vocational education era which has dominated paramedicine until only very recently. With the transition to higher education and the shift in ambulance service delivery requiring greater levels of clinical decision making and referral (Joyce, et al., 2009), ambulance services need to adequately prepare preceptors with the skills and knowledge to facilitate development in the novice paramedic beyond technical tasks, and guide learners to become competent and critically reflective professionals.

My study has clearly shown the influence and responsibilities of the paramedic preceptor reach far beyond technical competence. Without an adequate understanding of the complexity and breadth of their responsibilities as illustrated in Chapter Five, it is unlikely paramedics will consistently be able to effectively perform in the preceptor role.
Many of the participants in this study commented that because of the lack of formal preparation for the role, their knowledge and approach to being a preceptor has developed on the job through an accumulation of their own experiences as novices and how they were precepted, as well as employing a heuristic method of learning to precept through their experiences as preceptors to novice paramedics. From the nursing literature, it appears common that when formal preparation programs are not provided, many preceptors learn in this way in a process of trial and error to develop the attributes they interpret as being necessary to be a preceptor (Alspach, 2008; Luhanga, et al., 2010; Yonge, Hagler, Cox, & Drefs, 2008a). This finding highlights a significant risk that novice paramedics are unlikely to be receiving consistently high quality preceptorship. With a heavy reliance on heuristics, each rotation, such as a roster period, is likely to be quite different for the novice paramedic, almost a lucky dip as to much they will benefit. Potential risks of receiving low quality preceptorship may include: clinicians completing their internship with inferior clinical acumen, risks to patient safety, delayed or inadequate socialisation into the workforce, higher stress and anxiety levels in the novice and in the paramedic preceptor, and decreased staff retention should the novice become overwhelmed and feel unsupported during their preceptorship.

A further key finding of this study was the limited support and appreciation felt by the participants in their role as a paramedic preceptor (see 7.3.1). Within the study setting the organisation provides on-road educators dedicated to the education of operational paramedics. While all of the participants were aware of these educators, the majority had no substantial contact with them on a regular basis for the purpose of educational support as preceptors. In fact, words used to describe the interaction
with these educators included rarely and never. This lead to feelings of isolation and many of the participants felt they were “on their own” when it came to precepting due to not receiving adequate educational support for their role.

This feeling was compounded by a general lack of appreciation from managers as expressed in Chapter Six. Despite the additional demands and the importance of being a paramedic preceptor, participants felt that their organisation views the preceptor role as a core function of being a qualified paramedic and therefore no additional recognition or acknowledgment is required. One participant in the study by Hautala et al (2007, p. 67) echoed this sentient well when commenting: ‘‘very often I feel I’m operating in a vacuum and on my own.’’ The expressed lack of support provided to preceptors by the organisation in this study correlates closely with similar findings in studies into preceptorship in other healthcare professions (Alspach, 2008; Henderson, et al., 2006; McClure & Black, 2013).

Despite the limited support from educators, many participants were reluctant to blame the individual educators for the problem. Instead they felt the educators were restricted in the support they could provide due to their limited numbers and the large geographic areas they were expected to cover. In general, within the study organisation there may only be two educators who have responsibility for the education of staff across nine or ten ambulance stations.

Another reason to come to light in this study that may explain the disconnect between preceptor and educator is a culture of paramedic preceptors not reaching out to the educators in the first place. Some participants felt there is a culture amongst paramedics that associates contacting and working with educators with remedial
action. That is, only those novices or paramedics whose competency is lacking will spend time with an educator. Therefore, paramedics are reluctant to reach out to the educators for fear of ridicule or embarrassment and as a potential risk to their reputation amongst colleagues. Such as focus on maintaining one’s reputation amongst colleagues is a strong cultural value within paramedicine as a profession (Devenish, 2014; Huot, 2013).

In contrast to the finding of limited support from educators, participants largely reported feeling supported by their peers and colleagues (see 7.3.2). This support was expressed as a sympathetic understanding by peers who themselves had experienced the challenges of the additional responsibility and emotional fatigue of being a paramedic preceptor. Support from colleagues was not unqualified and in terms of asking for advice, most of the participants expressed that not all colleagues will be supportive. Many of the participants spoke of only reaching out to trusted friends or otherwise risk embarrassment or ridicule. Again the cultural value of reputation is highly influential on the willingness of paramedics to seek support. This finding is important because mistrust among co-workers hinders professional development. Moreover, together with the finding of limited preparation, if preceptors are also not comfortable in seeking advice or guidance from colleagues, the isolation of being a preceptor is heightened, but this environment of mistrust also limits opportunities for paramedics to receive feedback on their approach to preceptorship and improve their practice. According to Reina & Reina (2006, p. 5) high levels of trust amongst colleagues creates ‘a safe climate in which communication channels open, ideas are shared, colleagues collaborate more freely and employees have greater commitment to their organisation’.
The findings from this chapter reveal a situation which demonstrates paramedic preceptors are not being adequately prepared for their role. Limited specific education is currently being provided and paramedics are reliant on their own experiences in a trial and error approach. This highlights significant concerns about the potential quality of preceptorship that novice paramedics are receiving. In Chapter Five the role of the paramedic preceptor was revealed to be multidimensional, encompassing important facets of not only psychomotor skills but professional socialisation, clinical and non-clinical practices, and responsibility for patient safety. If paramedics are unaware of the complexity of their role, and its broad nature, there is a risk that many of these functions will not be adequately attended to.

There also appears to be significant limitations in support mechanisms available to paramedic preceptors and this may be contributing to the reported feelings of exhaustion and burn out elucidated earlier in Chapter Six.

In the next chapter I use the findings elucidated in Chapters Five, Six and Seven as the foundation for explaining paramedic practice and learning through preceptorship using a sociomaterial framework.
Chapter 8
A Sociomaterial Horizon of Paramedic Practice and Learning

8.1 Introduction

Due to the inadequacy of extant theories to describe the complexity of paramedic practice and paramedic preceptorship, in this chapter I apply a sociomaterial analysis to generate a new model that demonstrates paramedic practice and learning as emergent effects within a dynamic web of interconnecting social, cultural and material elements.

Over the past two decades social theories of practice and workplace learning have pervaded the healthcare literature. While these theories emphasise the sociological constituents of practice and learning, materials are generally subordinated as tools to be used and context as the background to practice (Fenwick & Edwards, 2013). More recently, however, there has been an increasing shift away from the preoccupation with professional practice and learning as only a social phenomenon that occurs between people, towards a relational effect which emerges out of the connections and associations between human and non-human material elements (Fenwick, 2014a; Fenwick, et al., 2012; Orlikowski, 2007). For example, consider the everyday practice of a paramedic treating a patient experiencing a heart attack. This practice not only occurs between paramedic and patient, but at all times is interconnected and co-constituted as part of a wider connection of non-human elements including protocols, medications, technologies such a defibrillator or ECG, and tools such as a stethoscope and blood pressure cuff. Human practice, and paramedic practice, can therefore be
metaphorically understood as a tapestry of interrelating elements in which the social, cultural and material forces each influence and are influenced by the other. The sociality of practice cannot be disentangled from the material elements. In addition, the model presented below includes the element of environment to emphasis to the reader that this new perspective of knowing in paramedic practice is at all times an assemblage that includes the space in which practice is performed. The knowing that is embodied in that practice does not simply occur within a setting, but emerges in relation to, and shaped by, the environment within which the individual is immersed. Furthermore, experience is included in this sociomaterial context to highlight the relationship of the practitioner’s past and present to their embodied practice. Experience, however, is not proficiency through rehearsal, but the collective lived experience of the practitioner and their connectedness to their sociomaterial context, in all forms, over time. Proponents of this sociomaterial approach have recently explored professional learning in medical education (Bleakley, 2012; Fenwick, 2014b) and relevant to this study, the practice and learning of emergency service personnel such as police officers (Slade, 2013) and paramedics (Fenwick, 2014a).

Figure 8.1 below illustrates the thesis of this chapter in defining expertise and learning in paramedic practice as emergent from the inseparable interplay of social, cultural and material elements.
8.2 Understanding Practice and Learning through a Sociomaterial Framework

In this section I will demonstrate how paramedic practice and the development of paramedic expertise can be understood as relational effects by tracing the linkages in heterogeneous assemblages. Assemblages in this sense is used to denote how disparate social, culture and material elements come to be assembled together to produce effects that we know as education, learning and practice. I will show that paramedic professional practice knowledge is provisional and emergent, situated in the enactment of practice. By zooming in on the nexus where disparate social, cultural and material elements connect, and analysing the effects of this confluence, the practice of paramedicine becomes illuminated.

Learning to become a paramedic, like most professions, begins with a period of learning in which students attend tertiary institutions or classroom lessons.
Conceptual and theoretical knowledge is learned from texts, psychomotor skills are developed in laboratory-based procedures and the beginnings of practice and performance occur through simulation and role play sessions.

While this mode of education is an important and a necessary stage in the development of new paramedics, the period of preceptorship has been identified as the critical link to becoming an expert paramedic, it is the signature pedagogy of the profession of paramedicine (Lazarsfeld-Jensen, 2014). It is contended here that only during preceptorship can novice paramedics become fully immersed, and thus connected, with the intricate heterogeneous networks of paramedic practice. In this sociomaterial account, learning cannot be separated from the situatedness of practice. This is because expertise in a professional practice cannot be gleaned from the pages of texts and stored within the individual practitioner, no matter how many lectures or labs are attended. Paramedic professional practice knowledge and expertise is emergent within the performativity of practice, inextricably entwined with the materiality of the moment and always provisional through time and space. This conceptualization of paramedic practice foregrounds the criticality of preceptorship as an essential vehicle for learning to become a paramedic by highlighting the inseparability of practice from materiality, context and situatedness. Regardless of how well case studies and simulation scenarios are prepared, they cannot replicate the unpredictable, unstable and complex environment of paramedic practice. For example, simulation has advanced with technologies and manikins that now talk and have a pulse, but this does not replace the bodies of real patients, the colour of skin, the emotional responses of a patient or their distracting and confusing stories of their illness or their distraught families.
Schatksi (2002) has argued that all practices are “intrinsically connected to and interwoven with objects” (p.106). The objects and materials linked to the practice at the time of enactment equally define its actualisation, as have the social and cultural forces behind its occurrence. Paramedic practice is thus performative and co-constituted with materials and not just mediated by them. For example, to perform a patient assessment necessarily requires a patient, together with a blood pressure cuff, stethoscope, the physical touch and manipulation of the patient’s body. Cannulation requires cannulas, dressings, veins, the tactile touch and bounce of a vein and the feel of the cannula advancing. Patient extrication requires stretchers, boards, other bodies, and is always contingent upon the circumstances of each situation; be it extrication down six flights of stairs, from a cave underground, or atop a 10 storey building. Practice also occurs within or outside policies and organisational procedures. Directives, protocols and local procedures encourage, support or limit various practices. Thus paramedic practice is not only constitutively enmeshed with the material, but contingent upon it (Schatksi, 2002). Pickering (2001) also contends that any account of practice cannot be explained by the human variables alone; we must also consider the constitution of the community of practitioners in relation to their struggle with the material world. In this way, Pickering (2001, p.164) argues for a move beyond the humanist to a post humanist social theory “that recognises from the start that the contours of material and human agency reciprocally constitute one another”. From this horizon (Gadamer, 1989/2004) learning through paramedic preceptorship is occurring in the space between the agency of the novice, preceptor, and the materiality of the world around them.
The following sociomaterial analysis of cannulation is used to illustrate the usefulness of this approach in understanding the multiplicity of interconnections that are present in this everyday practice of a paramedic. This analysis highlights that procedural knowledge is insufficient to enact this skill as a professional practice.

Cannulation is a routine technical skill performed by paramedics for obtaining access to the vasculature of the patient to administer medications or drawing blood for analysis. It cannot, however, be reduced to a step-by-step technical process memorised from a procedures manual. Novice paramedics entering preceptorship will have had experience in the classroom setting, practicing this skill on manikins and plastic arms designed to enable the student to learn how to cannulate. Nevertheless, to be an expert in cannulation, the novice must learn to perform this skill as it is enacted with real patients in real clinical environments, with all its complexities and unpredictability. The expertise that develops is an effect of the heterogeneous elements of the practitioners consciousness, volitions, and their aesthetic judgment to identify and choose an appropriate vein to use; the technological elements including the cannula, adhesive dressings and tourniquets; it requires the body of a patient, their veins and the blood coursing through them. In the lab the plastic arm does not flinch, the arm is not sweaty and slippery. In practice patients may initially protest the treatment and need reassurance. At each and every occasion the knowing-how of cannulation is performed into existence in a form that is unique to that moment of practice, in a way that is constituted from the sociomaterial assemblage of the present. Knowledge and recall of procedural steps, or even the dexterity and motor skills such as insertion of the cannula into a vein, in and of themselves are always insufficient to explain practice expertise. Enmeshed
into this assemblage are also the organisational discourses of protocols and guidelines informing practitioners when and upon which patients they are authorised to perform this skill. It also incorporates the social and ethical discourse of patients giving consent to be cannulated and accepting that this invasive skill being performed is something paramedics do for medical reasons. This example of cannulation demonstrates the complexities of the sociomaterial assemblages that must be negotiated by the novice paramedic as they develop their expertise.

Understanding expert practice requires the novice paramedic to construct meaning of what is proper or good practice within a particular situation. It involves cultural competence where meaning and values are negotiated at the junction of sociomaterial networks to determine how knowledge, resources, technologies and artefacts are used by practitioners (Gherardi & Nicolini, 2000). This is not limited to the oft cited religious needs of patients. Although paramedic practice should be sensitive and respectful of all religious and cultural discourses (Hartley, 2012), social discourses and cultural competence also refers to the wider performance of paramedic practice within the space of an aged care facility versus a private home, operating within a corrective services facility and the obligations and rules of treating a patient who is also a prisoner. It is practicing as a member of the wider inter-professional health arena and the position of paramedics during multi-agency responses with other emergency services. Participants in this study were of the view that while their organisation had a culture, each ambulance station also had its own culture to which novices entering service must become enculturated. During preceptorship novice paramedics learn to navigate these cultural discourses and how to modify and fit their practice knowledge seamlessly into the situation at hand.
Uniform, rank and clinical level were pervasive forces of power and identity to emerge in this study. Many ambulance services still operate as paramilitary organisations (Lazarsfeld-Jensen, 2014), and the study setting was no different. Within the narratives of the study participants, learning to fit-in and knowing when and how to interact within the social constructs of the organisation meant developing a sensibility of how rank and clinical level were often determinates for practice and social interaction. For example, when working in teams of paramedics the higher clinical level practitioners such as Intensive Care Paramedics are not only afforded the privilege of establishing and leading treatment and care of the patient, an inherent respect is expected for one’s senior clinical colleagues regardless of years of experience or personal views. Similarly, as a paramilitary organisation respect for authority and adherence to chain of command through a pre-given rank structure is foundational to practice as a paramedic. Information and communication flows up the organisation through the ranks, and to circumvent this configuration results in conflict and reprimand. Scene command and control works in a similar way. The significance of rank is not limited to the novice’s own organisation though. Paramedic practice is frequently performed through interagency collaborations with other organisations such as police and fire. Each of these organisations also places a significant importance on rank to delineate role responsibilities and inform the command structure.

Clearly it is not practical for paramedics to learn the rank or clinical level of every other individual in their organisation, nor could they ever expect to know the position and rank of individuals from other agencies. This is also unnecessary because translation occurs through not only the social and cultural dimensions, but through
material artefacts, symbols and discourses which invite and regulate how participation in work happens (Fenwick, 2014). Materiality is present in many forms. Policy provides written discourse on structure, responsibility and chain of command. Uniforms provide visual representation of identity, both intra and interagency, and epaulettes represent clinical level and rank through different symbols. A good example here of the relevance of materials as representations of rank and its influence on practice is the process of learning to determine who is in-charge at an incident. On arrival at even the most complex or major incident, materials identify which vehicles belong to which agency, uniforms identify members’ organisations and epaulettes allow the rank of each member to be known without the need for verbal discussion. For the novice paramedic learning to identify others in the milieu is essential to effective practice. In the study setting, Paramedic Inspectors are usually the scene commander and readily identified by their uniform and epaulettes of a crown or three stars. Intensive Care paramedics have “Intensive Care Paramedic” on their shoulder. Qualified paramedics have white wording and novice paramedics blue wording. In a multiagency setting, for example arrival at a fireground, paramedics are required to approach the Fire Officer in charge. Understanding that one needs to approach the firefighter wearing the red helmet enables the paramedic to immediately identify the officer in charge and communicate with them to determine the initial needs of the scene, patient locations and number of causalities. Similarly, at a crime scene the paramedic must approach the Police Inspector, Sergeant or Leading Senior Constable. Each of these roles is readily identified by three stars, three chevrons, or two chevrons and two bars respectively. These materials matter. They facilitate work
practices and help bring order out of chaos. They provide structure to complexity and are integral, not background to, paramedic practice.

Documentation, policies and manuals are another significant material influence on the practice and learning of paramedicine. In the study setting there were two types of novice paramedics: (1) the vocational trainee and (2) tertiary graduates. Organisational policy is a material force in the learning process for novice paramedics. Within the study setting the procedures that could be performed by a novice were limited by policy and vary considerably between the vocational and tertiary novice. Protocols dictate that vocational trainee paramedics have authority to administer very limited medications. Interventional procedures such as cannulation and advanced airway devices were prohibited, even under the direction of the paramedic preceptor. By comparison, the novice tertiary graduates were able to administer all medications and perform all skills of the qualified paramedic as long as they were supervised. The materials of policy were therefore influential in how paramedic preceptors performed their role. As a preceptor the paramedic is bound to follow these organisational policies and in turn practice can once again be seen as a relational effect of sociomaterial forces. Policies which inhibit or limit the actions of novices directly impact the preceptors’ role. Those who had vocational trainees felt increased pressures as their novice was not able to perform routine skills such as cannulation or administer pain medications. This work was then put back on the preceptor to perform every time. Moreover, it limited the learning opportunity of the novice to observation rather than performance. In this sociomaterial account of learning, by removing the novice from practice, it may also be argued that current policy discourse also inhibits learning.
The data analysis of Chapters Five to Seven gave a clear account of the impact of material elements in the challenges of being a paramedic preceptor. In the web of sociomaterial connections, physical properties of the workplace present barriers to effective supervision of the novice and control the practice of preceptorship. An often cited example in the current study was the separation that occurred between preceptor and preceptee inside the ambulance. Physical distance challenged communication, influenced how and when interventions were carried out, and inhibited the learning that occurred.

Many of the psycho-emotional challenges were also the effect of an assemblage. Within the study organisation, preceptorship was managed from the top down. Education policies limited the preparation and support available to preceptors. Rostering practices meant preceptors had little say in when or how often they were expected to act as preceptor. Participants reported being assigned multiple preceptees over long periods of time. This study suggests the cultural and discursive practices of managing preceptorship is leading to paramedics becoming disaffected and devaluing their role in the formative development of novice paramedics.

In Lave & Wenger’s (1991) notion of legitimate peripheral participation, the novice moves in a linear way towards expertise through ever increasing participation in the role. The expertise developed by paramedics as preceptors did not present itself in this way in this study. Rather, being a preceptor was an effect of the diverse networks which they had been part of over time. There was little evidence to suggest any linearity in progression to becoming a good preceptor. As previously stated, formal preparation provided to paramedics to become a preceptor in the study setting was limited. Instead, the expertise of preceptorship was dependent on and developed in
the space of individuals’ networks. Expertise was constructed through their own experiences of being preceptored as a novice, and the heuristic nature of seeing what worked and learning through each experience as a preceptor. Participants’ previous roles outside that of being a paramedic also had crucial influences on their practices now as paramedic preceptors.

In this study it was clear that legitimate peripheral participation and the corresponding notion of linear progression was also insufficient to explain preceptees’ development as expert paramedics. Nearly all the participants voiced the importance of recognising the backgrounds of their novices. Becoming a paramedic is often a second or third career path for many individuals and as such they bring a variety of experiences and depth of knowledge to the team. A novice paramedic may in fact be an experienced physiotherapist, an intensive care nurse or overseas trained doctor. These experiences mean that at times the preceptor learns from the novice and paradoxically the novice becomes the expert. For example, if the paramedic preceptor and novice attend to a patient with a mental health condition, the novice with a mental health nursing background will likely manage the patient with distinct expertise not available from the preceptor. Similarly, some of the vocationally trained preceptors were quite happy to accept that their tertiary trained novice may have a much more in-depth understanding of the pathophysiology of disease processes. And again, a cited benefit of working with novices as expressed by the participants in this study was the opportunity it afforded for fresh perspectives on practice. Fuller et al. (2005) have also argued that a novice comes to their new community (i.e. paramedicine) already constituted as a whole person and that the experienced members of the community (i.e. preceptors) must consider what the novice brings from the outside to the learning
process: “Equally important is what the worker brings to that community, from outside ... prior learning, including education, has helped construct the whole person who arrives (p. 66).

8.3 Chapter Summary

Through a sociomaterial account of paramedic practice and learning, this chapter has illuminated a new understanding of learning through paramedic preceptorship as the effect of a heterogeneous network of actors, human and non-human. By foregrounding the materiality of practice I have been able to explore how expertise emerges in practice and not separate to it. Moreover, by giving materials the same focus as the sociocultural elements I have demonstrated the power relations between elements and their influence on practice and how learning takes place.

This sociomaterial approach moves beyond the theory-practice gap debate to a sensibility that appreciates the constant symmetry of sociomaterial influences and the constant negotiation and translation of meaning in the everyday lived world of the paramedic. For paramedics acting in the preceptor role and managers determining policies of preceptorship, a greater appreciation for the influence and power of materiality in learning may help to highlight that an over emphasis on clinical knowledge will only be detrimental to the development of a truly expert paramedic.
Chapter 9
Recommendations and Models for Improved Preceptor Preparation and Support

9.1 Introduction

This study has been a participative engagement between eleven paramedic preceptors and myself as researcher in which an expanded horizon (Gadamer, 1989/2004) of paramedic preceptorship emerged. This new understanding revealed practice, learning and the development of paramedic expertise to occur within a sociomaterial context where knowing emerges from the dynamic interplay of the social, cultural and material constituents of practise. In this chapter, I use the new understanding of paramedic preceptorship revealed in this study to make recommendations for improving the preparation and support of paramedic preceptors. Recommendations for future research are also presented.

Within the study setting it is evident that paramedics received very limited preparation for the role of preceptor to novice paramedics in their first year of clinical practice. This is significant as it is recognised that being a competent clinician does not automatically mean being a competent preceptor (McCarty & Higgins, 2003; Troxel, 2009). Moreover, several studies have shown that formal preceptor preparation programs are beneficial for clinicians in learning to be effective preceptors and have resulted in increased awareness of learning styles, increased feelings of support, improved satisfaction in the role of preceptor, greater self-confidence, and critical awareness of the role of the preceptor (Hyrkas & Shoemaker,
My research has demonstrated that the fundamental role of paramedic preceptor encompasses much more than clinical knowledge development. Through this study the role of the paramedic preceptor has been clearly illuminated as multidimensional, constituting not only a clinical component, but equally having responsibilities as a role model, in facilitating the professional socialisation of the novice paramedic, as a protector of patient safety, and guardian to the novice paramedic’s physical and emotional wellbeing. It is therefore essential that specific and appropriate training and preparation be provided to the clinician if they are to understand the breadth and complexity of the preceptor role and be successful as a paramedic preceptor.

A major contribution of this research is the elucidation of paramedic practice and learning through a sociomaterial framework. Understanding from this horizon enables practice development and preceptorship to be analysed by tracing the connections between sociomaterial elements. In understanding preceptorship and paramedic practice as an effect of these interconnections, the findings of this study and subsequent analyses have been used to construct recommendations for improving the preparation and support of paramedic preceptors.

Throughout this study a number of salient elements came to light as having power and influence in the conduct of preceptorship. In particular was the current insufficiency in understanding the role responsibilities of paramedic preceptors and the related concepts of coaching, role modelling, socialising and protecting. Moreover, the inadequate support provided to preceptors is an effect of the elements of limited educator involvement, and quite notably, existing policy and management
of preceptorship which generally led to preceptor burnout, a lack of recognition and feelings of inadequate support. In addition to the major themes that resulted from the findings were more subtle, yet important insights into preceptorship practices that serve as useful highlights in preparing paramedics for preceptorship in the future.

9.2 Recommendations for Improving Paramedic Preceptorship

Recommendation 1

That an improved preparation course be made mandatory for paramedic preceptors

Over the course of this study it became clear that there are fundamental gaps in the current preparation of paramedic preceptors. The purpose of this recommendation is to outline those aspects of preceptorship that are considered essential to adequately preparing paramedics for this important role.

The findings of this study clearly demonstrate that paramedic preceptors receive limited information on the complexity and breadth of the preceptor role. A more complete understanding of their role is required to ensure they are adequately prepared to fulfil all the responsibilities encompassing the preceptor role, that of coach, role model, socialiser and protector. In addition to understanding each of these four dimensions, preparation must also provide them with strategies and tools that may be used in the enactment of being preceptors.

In Chapter Eight, I presented a sociomaterial framework for understanding practice and learning. Conceiving practice and learning in this way enables the process of knowledge translation and expert practice to be viewed as the coming together of not
only people, but also of materials into patterned networks. By embedding this concept across the preparatory course, preceptors will gain an appreciation and sensibility for the important meaning and significance of the intricate and multiple heterogeneous elements and their connection with their daily activities.

In figure 9.1 below, I recommend the content for a paramedic preceptor course which fills the gaps and meets the needs identified by this study. The course is presented in three modules:

✔ **Module 1: Understanding Paramedic Preceptorship**
  
  o Sets the stage by introducing the concepts of networks, highlights the significance of interconnecting sociomaterial elements, and positions the paramedic preceptor in the broader organisational network of preceptorship.

✔ **Module 2: Roles and Responsibilities of the Paramedic Preceptor**
  
  o Emphasises the key finding of this study that the paramedic preceptor is not only responsible for the clinical development of the novice paramedic, but is also performing a multidimensional role as a coach, role model, socialiser and protector of patient safety and novice wellbeing. Moreover, it provides paramedics with strategies and tools to effectively perform in these roles.

✔ **Module 3: Managing Yourself During Paramedic Preceptorship**
  
  o This study revealed that being a preceptor is emotionally demanding and poorly supported. Module three focuses on the wellbeing of the paramedic preceptor and engenders a culture of support and joint participation of organisation, educator and preceptor.
Figure 9.1: Proposed model for a paramedic preceptor preparation course
**Recommendation 2**

**Delivery of the preceptor preparation course using a blended learning methodology**

While recommending that ambulance services develop and deliver preceptor specific education to paramedics who will be expected to perform in the paramedic preceptor role, I am cognisant of the competing demands that clinical content will place on the available time, from an organisational point of view, afforded to this additional content. For this reason I recommend that preceptor training is developed as a blended learning program offering online modules in addition to face-to-face workshops. In this way, the time required for a workshop is minimised and used to greater effect by using interactive learning, role plays and discussion sessions. A further benefit of a blended approach is that it makes the theoretical content and tools available to paramedics for review and revision after they have completed any initial training, should they want to revisit certain modules.

Within the proposed model, the online modules are a prerequisite, completed prior to attending a face-to-face workshop, and they cover the majority of the theoretical knowledge. To encourage paramedics to access the modules while on shift, the modules should be designed to be completed in brief sessions lasting no more than approximately 15 minutes. The issue that paramedics are likely to face while completing these modules during shift is that they may be called out at any time. Due to the nature of their work they are generally not able to have any quarantined time, including meal breaks which can be interrupted. By keeping the modules short,
paramedics are more likely to complete an entire module in a single sitting rather than attempting to complete a lengthy module over the course of several sessions.

Delivery of preceptor education through an online course is an appropriate means of providing timely, up-to-date information which accommodates the busy schedules of clinicians while minimising the impact on patient care from staff being removed from service to undertake workshops (J. Phillips, 2006). Further advantages to online education include the convenience of access which allows modules to be completed either at work or at home; learning is self-paced and flexible; delivery of training is consistent; and the cost of education are borne by the organisation (J. Phillips, 2006).

In an inter-disciplinary healthcare study evaluating the effectiveness of an online preceptor preparation course, Kassam et al. (2012) found that the online course was “very applicable” to participants and resulted in greater self-confidence and increased knowledge and skills required for precepting such as teaching, providing feedback and conflict resolution. The use of eLearning to deliver preceptor preparation courses has been somewhat validated in a small study by Zahner, Rather, & Schendzielos (2009) which found that participant knowledge increased from pre-test to follow up.

Following completion of the online modules, the preceptor can then be enrolled in a face-to-face workshop to be afforded the opportunity to engage in active learning with a trained facilitator. Active learning strategies engage the learner in all aspects of the process and promote higher order thinking and analysis (J. Phillips, 2005).

While there does not appear to be consensus on the ideal length for a preceptor preparation workshop, authors have suggested workshops ranging from four hours to
two days (Boyer, 2008; Elmers, 2010; Pickens & Fargotstein, 2006; Schaubhut & Gentry, 2010; Smedley, 2008). My recommendation here is for a one-day workshop supported by the prerequisite online learning component as a balance between the need to provide adequate time to sincerely engage with the course content and provide time for active learning strategies, while being cognisant of the time pressures and constraints of educators and operational needs.

It is recommended here that the instructional design of the workshop be focused on maximising student engagement and active participation. For adult learning to be effective, it must offer opportunities for students to be fully involved in the learning process (Rogers & Horrocks, 2010). That is, teaching and learning strategies should include methods which facilitate discussion, dialogue & questioning, and interactivity between student and teacher as well as between students (Muijs & Reynolds, 2011).

The workshop is therefore an opportunity for paramedics to engage with other paramedics who are or will be preceptors and to put into action the theory that has been learned in the online modules. Teaching strategies which facilitate interactivity and participation as suggested by Ota, DiCarlo, Burts, Laird, & Gioe (2006) include group discussion, problem-solving, case based problems, simulation exercises, games, and role-play. The proposed model for delivering preceptor preparation is presented in figure 9.2.
Recommendation 3

Ensuring there is increased recognition and reward for paramedic preceptors

At the completion of the training program it is recommended that paramedics receive appropriate recognition for their efforts and the increased knowledge and skills they have acquired. A certificate of recognition should be provided. Furthermore, if the organisation has a continuing professional development (CPD) program that requires paramedics to gain CPD points, completion of this program should provide for a number of points to be obtained.

Participants in this study, as well as participants from other studies, such as nursing and allied health, frequently identify that being a preceptor as additional workload, responsibility and level of accountability. To recognise this, the additional demands
of the preceptor role and provision of extra remuneration as an allowance to paramedics whilst they are directly acting in the role of preceptor are recommended.

**Recommendation 4**

**Strategies are implemented to increase support for paramedic preceptors**

The majority of participants in this study reported carrying out their role as a paramedic preceptor with limited or no support from educators or managers. It is therefore recommended that improvements are made to the way paramedic preceptors are supported in their role. It is well established in the nursing literature that preceptor’s commitment to their role is closely correlated with their perceptions of support (Dibert & Goldenberg, 1995; Usher et al, 1999; Hyrkas & Shoemaker, 2007). The following strategies for improving support were derived from the conversations with the participants in this study and from a review of the literature of preceptorship in other health professions.

**4.1 Support through improved preparation**

The first strategy recommended for improving support is establishing a more robust framework of education and training that paramedics receive to prepare them for the preceptor role. Hyrkas & Shoemaker (2007) argue that preceptor preparation is a form of support by providing preceptors with the knowledge and tools to perform their role. These authors also make the point that while preparatory workshops are an essential component, a workshop does not replace ongoing support mechanisms (Hyrkas & Shoemaker, 2007).
4.2 Increased support from educators

Marincic & Francfort (2002) have suggested that support for preceptors involves establishing channels of communication between educators and the preceptors through phone calls, offering advice, and pre-arranged meetings. Yonge et al. (2002b) also suggest the best support for preceptors is the continued and visible presence of educators who make themselves available to provide advice and feedback. Participants in the current study also suggested they would like an increased level of communication and interaction with educators. Although the preceptor will operate independently for the majority of the time, they must be provided with the means and opportunity to discuss their novices’ progression, seek advice if needed, and receive support in precepting a novice who is not progressing as required or is difficult to manage. While the perception of being unsupported by on-road educators pervaded the conversations with most of the participants, it also appears that the preceptors themselves are not reaching out for support. The support process must be a two-way partnership where both parties are encouraged to make contact. That is, just as the preceptor has a role in establishing a safe learning environment for the novice, the educators must ensure that preceptors feel safe and encouraged to reach out for assistance and ask for help should they be having difficulty with a novice. Module 3 of the preparation course in Recommendation One is partly focussed on building this culture of collaboration between educator and preceptor.

4.3 Establishing reasonable time periods as a preceptor

Many of the participants in this study reported being paired with a novice and working as a preceptor for extended periods of time, with most reporting periods
lasting 12 months or more. The participants also reported the emotional exhaustion and strain that accompanies this responsibility. Moreover, they reported that it was themselves who had to request a break from precepting. Hyrkas & Shoemaker (2007) have suggested that organisations can support preceptors by allowing them to decline the position at intervals to prevent stress and burnout.

In light of this, it is recommended that where the preceptor role is not a separate position volunteered for by paramedics, ambulance services have a policy where paramedics are relieved of the responsibility from precepting for a roster period at least once every third roster rotation. This allows the paramedic time to reenergize and rebuild their resilience while working with another qualified or more senior paramedic.

4.4 Initial third-up crew rostering

A further strategy to improve support provided to paramedic preceptors is the concept of novice paramedics working with a double paramedic crew in their first few weeks on road. This strategy was suggested by several of the participants in this study. The first few weeks of a new novice being on-road presents a particular challenge for preceptors. In this time, the new novice is developing their ability to communicate with patients, learning to ask the right questions for a thorough assessment and, from stories relayed by the participants in this study, could potentially miss signs of a deteriorating patient. To facilitate a smooth transition from the classroom to the clinical setting, exploring the possibility of having the novice paramedic third on an ambulance with two other officers is recommended. In this model, the novice is not a ride-a-long observer, but assumes the role of a paramedic and is responsible for
patient care much the same as if they were paired with their preceptor alone. While one paramedic has responsibility for driving in the first few weeks, the preceptor and novice can work closely together with a focus on patient care. By removing the responsibility for driving and the challenge of separation so often revealed in this study, the preceptor is able to remain close to the novice throughout the patient care episode and observe the performance of the novice.

There are three benefits from this arrangement: (1) the preceptor is able to closely observe the novice and assist with directing treatment as required to support the confidence of the novice as they are introduced to the clinical setting; (2) the close proximity of the preceptor allows the preceptor to step in and prevent an adverse event occurring from a novice’s mismanagement, and thus potentially improve patient safety; and (3) during these initial weeks, the learning needs of the novice can be determined and a learning plan developed.

![Figure 9.3: Recommendations to improve paramedic preceptor support](image)

**Figure 9.3: Recommendations to improve paramedic preceptor support**
The importance of the paramedic preceptor role is indisputable, and it appears that this can be a difficult and exhausting role. To ensure that paramedics remain committed to their role as preceptors and provide a positive learning environment for the novice paramedic, organisations must take responsibly for supporting preceptors while they support the novice. Figure 9.3 illustrates the interrelated elements of mandatory preparation, improved educator collaboration, establishment of reasonable precepting timeframes, and initially rostering preceptors third-up, each designed to improve preceptor support.

9.3 Recommendations for Future Research

Paramedic practice and learning through preceptorship are relational effects of the negotiations and translations that occur at the interconnections of disparate social and material elements within heterogeneous networks. As an emerging theory for understanding paramedicine, sociomateriality provides future researchers with a theoretical framework to research practice beyond human intentionality, enabling us to zoom in on the power structures and influences of the multifarious human and non-human elements at play within the various networks. Significant opportunities exist for further research in paramedic scope of practice, team dynamics, risk mitigation, and equipment procurement. This research can occur within any of the paramedical subspecialties such as rescue, critical care, aeromedical, and low-acuity/community paramedicine.

In the area of paramedic preceptorship specifically, there is a dearth of extant literature. While the findings of this study make a significant contribution to filling the current void, additional studies which explore the experience of being a paramedic
preceptor from different institutions will continue to expand our horizon of understanding this phenomenon.

Additionally, the findings and recommendations of this study will be useful for developing preceptor programs that offer improved preparation and support to paramedics who are expected to be preceptors. An action-based research study could be used to assess the impact of implementing these preparation and support strategies within an ambulance service.

Finally, this study specifically explored paramedic preceptorship from the perspective of the preceptor. Future studies which focus on preceptorship from the perspective of the preceptee would further expand the body of knowledge in paramedic preceptorship.
Preceptorship is recognised as the signature pedagogy of paramedicine (Lazarsfeld-Jensen, et al., 2014), and is a well-established model of clinical education across the healthcare professions (Billay & Myrick, 2008; Harbottle, 2006; Jay & Hoffman, 2000; Jones-Boggs Rye & Boone, 2009; Kairuz, et al., 2010). While the readiness of new graduates to practice following completion of their formal education continues to be debated by academics and industry organisations, consensus has largely been reached that while graduate paramedics are theoretically qualified, they are not ready to practice independently until completion of an internship under the supervision and support of a paramedic preceptor (The Council of Ambulance Authorities, 2013). The first twelve months of on-road clinical practice therefore remains a critical period of learning for novice paramedics as they transition from a theoretical education to the real world of clinical care.

Although the literature from other health professions is rich with empirical research that explores preceptorship, studies into the experiences of the paramedic preceptor are limited. While several studies have explored the experience of the novice paramedic or preceptee (Devenish, 2014; Huot, 2013; Lazarsfeld-Jensen, et al., 2011), my review of the literature located only a single doctoral dissertation from North America exploring the experience of being a paramedic preceptor (Gurchiek, 2011). To the best of my knowledge, this study is the first time paramedic preceptorship has been empirically explored in an Australian context. Therefore, this
study makes a significant and original contribution to our hitherto limited understanding of the lived experience of being a paramedic preceptor who takes on the critical responsibility for supporting the transition of novice paramedics from student to competent, safe and autonomous clinician.

The underpinning research question for this study was: What is the lived experience of being a paramedic preceptor to novice paramedics in their first year of on-road clinical practice? Several sub-questions to support the research included:

i. What does it mean to be a paramedic preceptor?

ii. How do paramedic preceptors perceive their preparedness to undertake the role of preceptor?

iii. What are the challenges experienced by paramedics while performing this role?

iv. Are there benefits or rewards derived from being in the preceptor role?

v. What emotions are evoked by undertaking the preceptor role?

vi. Do paramedics feel adequately supported to effectively perform in the preceptor role?

Sociomaterial framework

In Chapter Eight I presented a sociomaterial framework as a new way of understanding paramedic practice and learning through preceptorship. Through this lens, expert practice is performed into existence at a particular moment in time and place. Expert paramedic practice is provisional, dynamic and emergent in the performativity of situated practice within a network of interconnecting social, cultural and material forces.
Learning through paramedic preceptorship was a social interaction between preceptor and preceptee, but situated in practice, it also occurred between preceptee and patient, patients’ families, colleagues and members of other emergency and health service agencies. Cultural elements entwined within preceptorship were not limited to religious sensitivity, they also included learning how to fit-in with the command and control structure of an ambulance organisation. Communication and social interaction with patients, their families and other health professionals all involved learning the appropriate behaviours, language and values of a professional paramedic.

The power of materiality to facilitate or constrain practice and learning emerged repeatedly throughout this study. Organisational discourse led to preceptor dissatisfaction and exhaustion as a result of limited choice on whether to be a preceptor or being repeatedly required to act in the role. Challenges to patient safety resulted from separation in the work environment. Cultural competence in terms of positioning oneself in the organisational structure and identifying interagency lead roles involved learning the value of materials in distinguishing rank and clinical skill levels of senior officers, managers and senior clinicians through uniform symbols and colour.

Situated within these dynamic sociomaterial networks, the paramedic preceptor opens up the horizon of the novice paramedic, helping them to draw together the disparate elements of practice and allow the big picture to appear by being attentive to all things, human and non-human, in the enactment of practice. Clinical knowledge, protocols, patient signs and symptoms, medications, technologies, and environmental factors viewed in isolation are chaotic and have little meaning. In bringing sense and structure to this chaos, each and all of the disparate elements come
together to form a story of what the paramedic needs to do and how and why they do it. For the bewildered novice, the paramedic preceptor is close at hand, guiding, modelling, and protecting them every step of the way.

Reflecting on Gadamer and sociomateriality

The findings and analysis of this research were underpinned by a methodology grounded in Gadamer’s (1989/2004) philosophical hermeneutics and a sociomaterial theoretical framework. This study proceeded from the philosophical/methodological principles of Gadamer’s notion of understanding as a practical event that takes place between researcher and the phenomena of interest. With my own history steeped in the experience of paramedic preceptorship, philosophical hermeneutics gave me an authentic way of engaging with the research topic and my participants without the guise of reducing the findings to a completely bias-free description. Moreover, as a co-participant my experiences of paramedic practice and preceptorship offered not only an additional perspective, but also a credible means of teasing out a deeper analysis of preceptorship that may have been lost without a pre-given, yet recognisably incomplete, understanding of the phenomenon. This approach was advantageous at the data collection and analysis phases of the research as I engaged in conversation with the participants and was able to draw out a richer and fuller description of their lived experiences.

Co-participation, however, was also a disadvantage. Imputations of bias were forthright in my mind and this required an enormous effort throughout the research process to ensure rigorous adherence to the principles of philosophical hermeneutics. In particular, it is necessary that one recognises the prejudices that one brings to the
research as a historically-effected consciousness (Gadamer, 1989/2004) and be prepared to place these at risk so as to overcome the prima facie limitations of this through a “keeping of oneself open to what is other – other more universal points of view” (Gadamer, 1989/2004, p. 15).

From the outset, Gadamerian hermeneutics offered much to the methodology of explicating paramedic preceptorship. However, as much as Gadamer (1989/2004) lays out what he calls “the conditions in which understanding takes place” (p.295), elucidating the phenomena of paramedic preceptorship such that one can illustrate the what and why of everyday practice required something more in the research process. To this end, a theoretical framework that was congruent with philosophical hermeneutics was sought.

The starting point for this was of course Gadamer’s concepts of understanding. In particular is the concept that all interpretation is never final, but contingent upon the historical horizon of the knower and that which is to be understood. Moreover, understanding is more than a subjective, relativist perception, but a shared meaning that has been negotiated in the space between knower and what is known. Gadamer’s use of the metaphor of play illustrates that the event of understanding is like a game (whatever that may be) in which the game itself transcends the subjectivity of the players, but recognises “that they play their role in relation and regard to the whole of the play” (Gadamer, 1989/2004, p.109). Gadamer (1989/2004) later goes on to explain that “understanding is to be thought of less as a subjective act than as participating in an event of tradition, a process of transmission in which past and present are constantly mediated” (Gadamer, 1989/2004, p.291). Understanding paramedic practice and preceptorship is thus a relational event, an interconnectedness
of the individual paramedics with the tradition in which practice is performed. It is from this conceptualisation of understanding that I came to sociomateriality; a broad theoretical framework, but one which held congruency with philosophical hermeneutics.

I have explicated the details of sociomateriality elsewhere (see 2.6.3 and Chapter 8), but importantly, a sociomaterial view emphasises human practice and knowing as a temporal, ontological effect of the social and material elements of our lives fusing in such a way that the two distinct entities overlap and become imbricated and the boundary of the two disappears. Throughout this research discussions of paramedic practice and preceptorship highlighted the inextricability of material elements in practice. Paramedic practice was negotiated and translated to have meaning for the moment it was performed into existence. Representations of practice reified in protocols and procedures, or endured through cultural discourse only held up as incomplete and insufficient for knowing. It was only through performativity that knowing came into being. As with philosophical hermeneutics, sociomateriality draws on the contestability of knowing as temporal and emphasising the knower as part of history. As a theoretical framework, sociomateriality enabled me to illustrate the participants lived experiences of paramedic preceptorship, including the organisational constructs of preparation and support by framing them as heterogeneous entanglements of sociomaterial elements (Fenwick & Edwards, 2013). This analysis traced not only how individuals, but material and discursive elements have the power to shape, promote or regulate these constructs. The findings and analysis presented in this thesis are therefore a confluence between Gadamerian hermeneutics and sociomateriality.
A significant finding of this study is that the traditional descriptors of the paramedic preceptor as clinical mentor or field instructor are insufficient to describe this complex role. In this study I have demonstrated that the complex and multidimensional role of paramedic preceptor is constituted by the four key dimensions of coach, role model, socialiser and protector. Paramedic preceptors have an important role in the clinical development of the novice paramedic and in this study the term coach emerged as the most appropriate term to illustrate how preceptors facilitate learning in practice. Being a role model who embodies the behaviours, attitudes and values of a professional paramedic was an important part of the learning process. Furthermore, this study has clearly demonstrated that the preceptor has a crucial role in assisting the novice paramedics’ professional socialisation. As socialiser, the paramedic preceptor supports the novice’s integration into the organisation’s culture, relationship building with colleagues and managers, and facilitates the novices’ emerging professional identity and sense of belongingness. The final key dimension of the paramedic preceptor role to emerge was that of protector. In this capacity the paramedic preceptor has a critically important role as protector of patient safety and guardian of the physical and emotional wellbeing of the novice paramedic. As a guardian of patient safety the preceptor ensures that patients receive the highest quality care while the novice paramedic is still learning to be a competent, safe practitioner. Moreover, the preceptor is there to protect the novice’s psychological and physical wellbeing. This is achieved by creating a safe and supportive learning environment, being alert to potential physical dangers the novice may not have adequately noticed or prepared
for, and being present as a critical partner at times of emotional distress that may result from the difficult and often stressful environment of paramedicine.

The affective experience of being a paramedic preceptor

The experience of being a paramedic preceptor emerged as an emotionally and physically exhausting role in which paramedics heavily invest themselves in the process of coaching and nurturing a novice paramedic toward becoming a competent and autonomous professional. This psychological burden originated from several factors of the preceptor experience. Paramedics felt a weight of additional accountability that came from working with a novice paramedic. Patient safety was always the highest priority for the paramedics and they all felt the responsibility of not just providing high quality, safe patient care themselves, but also for the actions and decisions of their novice. Role conflict was evident as the paramedics constantly weighed their responsibility to provide learning experiences for the novice and allow them to take control of clinical care, but at all times assessing the risk to the patient and the need to step in and have the novice step back. The demands of being a preceptor were also evident in the reports that while being a preceptor there is little opportunity to switch off. As a preceptor the paramedics felt they were in a constant state of vigilance, needing to be aware of the novice’ actions at all times, but also needing to think for two; that is, doing both roles of the driver and treating paramedic which are usually divided between the paired paramedic crew. The psychological drain was also exacerbated when the requirement to be a preceptor is sustained for extended periods of time and nearly all participants expressed the need for a regular break.
Despite these difficulties, it also emerged that being a paramedic preceptor can be intrinsically rewarding. Being a preceptor presents opportunities for the preceptor to develop professionally and learn from the novice in a reciprocal learning relationship. Further, many of the participants had developed close bonds and enduring friendships with those whom they once precepted. Working with a novice paramedic also gave the preceptors a sense of achievement and satisfaction as they witnessed the growth in their novices’ competence and confidence.

*Inadequate preparation for paramedic preceptors*

A further key finding of this study was the limited and inadequate preparation participants received for the role of paramedic preceptor. In the study setting preparation was limited to a brief lecture and skills demonstration that had little benefit demonstrating how to undertake the role of preceptor. In lieu of formal preparation paramedics relied on their own experiences of being precepted and a heuristic methodology of trial and error as they precepted novice paramedics. With this new understanding I made several recommendations for improving the preparatory education for paramedic preceptors. Through improved preparation, paramedic preceptors will have the requisite knowledge and understanding of how to facilitate learning in the practice setting and communicate their expertise to nurture and cultivate novice paramedics in their formative, yet critical period of transition to clinical practice.

*Inadequate support to paramedic preceptors*

This study revealed an environment of inadequate support and recognition for paramedics undertaking the preceptor role. Limited or no interaction with on-road
educators was common and participants felt isolated and on their own in the preceptorship process. Further, paramedics were reluctant to reach out for support to others for fear of embarrassment or ridicule. Therefore, further recommendations have been made to improve the ongoing support that is provided to assist paramedic preceptors to perform their role. In particular it is recommended that greater support be provided to paramedics from educators so that preceptors do not feel isolated and have access to an experienced resource person that can assist them with advice, feedback and support. Additionally, it is important that ambulance services recognise that being a preceptor is demanding. To prevent burnout and ensure that preceptorship remains an effective and positive learning experience, paramedics must be given regular opportunities to work with other qualified paramedics and relieved of the responsibility of being a preceptor.

*Attending to rigour*

Rigour and trustworthiness have been ensured by embedding De Witt & Ploeg’s (2006) five expressions of openness, balanced integration, concreteness, resonance and actualisation throughout this thesis. Openness and balanced integration have been achieved by describing the themes that emerged in this study through Chapters Five, Six and Seven by giving a voice to the participants in using excerpts from the transcripts of our conversations. While concreteness and resonance are mostly in the eye of the reader, I have attended to these dimensions by providing exemplars of practice and a focus on the activities of the working paramedic so that the findings of this research are clearly located in the everyday experiences of the paramedic preceptor. Only the future will tell if actualisation is to be achieved. However, the
recommendations provided earlier in Chapter Nine are focussed on realising opportunities for real change in the preparation and support that is provided to paramedic preceptors, rather than stopping at theoretical statements of the need for change.

In summary

This study offers a new empirical understanding of the complexity of the paramedic preceptor role and the lived experience of being a paramedic preceptor. It is my hope that this study will provide managers and educators responsible for ambulance preceptorship the evidence required to improve the preparation and support offered to our paramedics who carry out their valuable role in the formative development of the next generation of paramedics every single day.
References


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Appendix One – Participant Information Sheet

Title of Research: The Paramedic Preceptor Experience: Improving Preparation and Support

My Name is Hamish Carver; I am a PhD paramedic with ASNSW and a Doctor of Philosophy student at Charles Sturt University undertaking a research study under the supervision of Dr Ann Lazarsfeld-Jensen that aims to gain a better understanding of being a Paramedic Preceptor to novice paramedics in their first year of clinical practice. You may also know this role as “Training Officer” or “Clinical Mentor”. The focus is on understanding your experience as preceptor to probationary paramedics – both SCT graduates and/or vocational Level Ones.

I am seeking volunteers to be participants who will be interviewed in this qualitative study which will use hermeneutics as the methodology. Primarily, this is a research process which uses conversation between you as a participant and me as the investigator to improve our understanding of the preceptor role.

What is involved and how much time will be required?
Participants will be confidentially interviewed one-on-one by me and recorded using a digital audio device. I expect the interview to take approximately one hour; during which time we will have a reasonably unstructured conversation that will explore areas of being a paramedic preceptor such as: your emotional experiences; expectations of the role; likes and dislikes of performing the role; perceived preparedness to undertake the role; and any other aspects you feel will illuminate what it is like to be a paramedic preceptor. I may also need to speak with you briefly and/or email you following the interview to clarify any particular areas of our discussion.

What are the benefits of this research?
There is currently very little research about paramedic preceptorship from the perspective of the preceptor. This research aims to increase the understanding of this role with a view to the findings of the study being used to inform improvements in the education and support of paramedics undertaking the preceptor role.

What will happen to the information I provide?
The information collected will be used to develop a doctoral thesis on paramedic preceptorship. The study will also be used to publish in peer-reviewed journals and may also be submitted to non-peer reviewed publications. Your privacy and anonymity is very important to me. Only the principal investigator will know of your participation. Your real identity and work location will remain confidential.

What happens after the interview?
Following the interview, the audio-recordings will be transcribed. These will then be used by me to analyse and develop an understanding of the experience of being a Paramedic Preceptor. You may be contacted by me via phone and/or email should any clarification be needed or further information about a part of the conversation.

What about privacy and Confidentiality?
Your participation in this study will be strictly confidential. Some verbatim responses will be included in the final report and associated publications, however unique pseudonyms will be assigned and any names and places changed to ensure your anonymity. Your participation in this study, your real identity or work location will not be disclosed to anyone.
Are there any risks to me?

It is not expected that your participation in the study will cause any discomfort. However, should you feel uncomfortable during the interview, you may request that the interview is ceased temporarily or completely or you may request that the interview continue without audio-recording. You are free to withdraw from the study at any time without providing reason.

In the case that you require psychological support, I will make available to you the contact details of the EAP support program (24-hr free counselling service), peer support officer contacts and/or chaplaincy contact details.

If I agree to participate, what happens next?

Should you agree to participate, I thank you in advance for your time and opinions. Please contact me on 0414 (blank) or hcarver@ (blank), so that I may send you a consent form that must be read and signed prior to any involvement in the study. Once I receive the signed consent form, I will contact you to make arrangements to conduct the interview at a time and place that is convenient to you. If you agree to participate, you are free to withdraw your consent and participation at any time, and if you do so, you will not be subjected to any penalty or discriminatory treatment.

NOTE: This project has received ethics approval from two separate Ethics Committees. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Ethics Committees through the Executive Officers. Each of their details are provided below.

Charles Sturt University, School of Biomedical Sciences’ Ethics Committee:

Study Approval No. 406/2012/11

Ingrid Stuart
Locked Bag 49
DUBBO NSW 2830
AUSTRALIA
Tel: 02 6883 7327
Email: i.stuart@csu.edu.au

South Eastern Sydney LHD HREC Executive Committee (Northern Sector):

Study Approval No. 13/012 (LNR/13/POWA/90)

Deborah Adrian
Room G71, East Wing, Edmund Blackett Building
Prince of Wales Hospital
RANDWICK NSW 2031
AUSTRALIA
Tel: 02 9382 3587
Email: ethics@sesahs.health.nsw.gov.au

Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

Contact details

Researcher/Principal Investigator

Name: Hamish Carver
Mobile: (blank)
Email: (blank)

Principal Supervisor

Name: Dr Ann Lazzarfeld-Jensen
Phone: (blank)
Email: (blank)
Appendix Two – Participant Consent Form

Participant Consent Form

I, [full name], declare that I give my free and voluntary consent to be a participant in the doctoral research project “The Paramedic Preceptor Experience: Improving Preparation and Support” being undertaken by Hamish Carver under the supervision of Dr Ann Lazarfeld-Janssen towards the degree of Doctor of Philosophy through Charles Sturt University and any subsequent publications based on this research.

I give my consent on the understanding that:

a) I have been given the opportunity to ask questions about the research and received satisfactory answers;

b) I have been provided with, read and understood the information sheet;

c) 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;

d) The purpose of the research has been explained to me, including the potential risks/discomforts associated with the research and been given the opportunity to ask questions and received satisfactory answers;

e) Interviews will be audio-recorded and transcribed by a professional transcription service with the intention that transcripts will be analysed as part of the research project;

f) My participation will be kept private and confidential, including the use of unsex-pseudonyms in the final report and any subsequent publications;

g) No further use of the audio recordings is granted unless I expressly give further written consent;

h) I have been provided with adequate information regarding the procedures that will involve my participation;

i) I am not entitled to any financial reimbursement, nor can I receive time off in lieu, overtime payment or any other entitlement from the Ambulance Service of NSW for participating in this study;

j) I consent to being contacted by the principal investigator post interview (for a period limited to 12 months from the date of the interview):

1. By email (please initial and provide email address if you agree) init: ___ Email: ____________________________
   and/or

2. By phone (please initial and provide email address if you agree) init: ___ Phone: ____________________________

NOTE: This project has received ethics approval from two separate Ethics Committees. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Ethics Committees through the Executive Officers. Each of their details are provided below.

Charles Sturt University, School of Biomedical Sciences’ Ethics Committee:

Study Approval No. 406/2013/1.1

Ingrid Stuart
Located Bag 69
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Tel: 02 6885 7327
Email: istrut@csu.edu.au

South Eastern Sydney LHD HREC Executive Committee (Northern Sector):

Study Approval No. 13/033 (N.R/10/POWH/QQ)

Deborah Adrian
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Prince of Wales Hospital
RANDWICK NSW 2031
AUSTRALIA
Tel: 02 5382 3587
Email: ethicsmm@sesahs.health.nsw.gov.au

Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

Signatures

Participant: ______________________________ Print Name: ______________________________ Date: ______________________________

Witness: ______________________________ Print Name: ______________________________ Date: ______________________________

Investigator: ______________________________ Print Name: ______________________________ Date: ______________________________
Appendix Three - Ethics Approvals

Mr Hamish Carver

21 November 2012

Dear Hamish,

The School of Biomedical Sciences Ethics in Human Research Committee has reviewed your proposal "The Paramedic Preceptor Experience: Improving Preparation and Support" and has approved your proposal for a twelve month period from 21 November 2012. This committee commented that this application was: well written, easy to read and understand, and well researched.

The protocol number issued with respect to this project is 406/2012/11. Please be sure to quote this number when responding to any request made by the Committee. You must notify the Committee immediately should your research differ in any way from that proposed.

Please note that the Committee requires that all consent forms and information sheets are to be printed on School of Biomedical Science letterhead.

You are also required to complete a Report form, and return by email to the address above (not as listed on the form) on completion of your research project or in twelve months if your research has not been completed by that date. The appropriate form is dependent on the progress of the research. Forms are available at http://www.csu.edu.au/research/ethics_safety/human/ehr_manegeing

The Committee wishes you well in your research and please do not hesitate to contact Ingrid Stuart on telephone 6385 7327 or email symethics@csu.edu.au if you have any enquiries.

Further information can be sourced from the Human Research Ethics Committee website.

Yours sincerely,

Dr. Patricia Logan

Chair RMS Ethics Committee
Lecturer - Health Sciences
Course Co-ordinator: B General Studies (Science)

www.csu.edu.au
CRICOS Provider Number: 00309J; ABN: 99 735 170 982; ABN: 63 478 708 581

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15 March 2013

Mr Hamish Carver
NSW 2114

Dear Mr Carver,

HREC ref no: 13/L22 (LNR/13/POWH/80)


Thank you for submitting the above Low/Negligible Risk Application for review by the Human Research Ethics Committee (HREC). Based on the information you have provided and in accordance with the NHMRC guidelines [National Statement 2007 – Section 8 Institutional Responsibilities and “What does qualify assurance in health care require independent ethical review?” (2003)], this project has been assessed as low risk and is therefore exempt from full HREC review.

The project was considered by the HREC Executive Committee on 16 February 2013. The Committee asked for clarification of certain matters/ modifications and delegated authority to grant final approval to the Executive Officer.

I am pleased to advise that with your correspondence dated 13 March 2013 the requested information and revised documents were received incorporating the recommendations of the Executive. Ethical approval has been granted for the above project to be conducted at:

- Ambulance

The following documentation has been approved:

- Cover Letter, not dated
- Low/negligible risk application, submission code AU/8/63E111, dated 24 January 2013
- Participant Information Sheet, not dated
- Participant Consent Form, not dated
- Interview Guide, not dated
- Response to HREC Executive Committee queries, dated 13 March 2013

Conditions of Approval

1. This approval is valid for 5 years from the date of this letter.
2. Annual reports must be provided on the anniversary of approval.

Princess of Wales Hospital
Community Health Services
Bourke Street
Randwick NSW 2031

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3. A final report must be provided at the completion of the project.

4. Proposed changes to the research protocol, conduct of the research or length of approval will be provided to the Committee.

5. The Principal investigator will immediately report matters which may warrant review of ethical approval, including unforeseen events which might affect the ethical acceptability of the project and any comments made by study participants.

Optional: It is the responsibility of the sponsor or the principal investigator of the project to register the study on a publicly available online registry (e.g. Australian New Zealand Clinical Trials Registry www.anzctr.org.au).

For NSW Public Health sites only. You are reminded that this letter constitutes ethical approval only. You must not commence the research project until you have submitted your Site Specific Assessment (SSA) to the Research Governance Officer of the appropriate institution and have received a letter of authorisation from them.

Should you have any queries, please contact the Research Support Office on (02) 8322 3587. The HREC Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the Research Support Office website:

Please quote HREC ref: 13/022 in all correspondence. We wish you every success in your research.

Yours sincerely,

[Signature]

Deborah Adrian
Executive Officer, Human Research Ethics Committee
Appendix Four - Semi-structured Interview Protocol

Thank you for participating in this study into paramedic preceptorship. Just a reminder that I am recording our conversation and will later have it transcribed to use quotes as part of the thesis. I will however protect your identity by using unisex pseudonyms to attribute quotes. Do you have any questions about your participation?

To avoid confusion, I will use the term ‘preceptor’ during our interview, but you may know the role as ‘clinical mentor’ or ‘training officer’ – you can use whatever term you are comfortable with.

To begin with, please tell me what you believe are your main responsibilities as a preceptor (training officer)?

*Interviewee prompts*
- Clinical learning?
- Non-clinical? Logistics, communication, socialisation...
- What goals or outcomes do you work towards during the preceptorship period?

What methods or strategies do you use to train and support your trainees?
- Role modelling
- Reflection and debriefing
- Do you seek out learning opportunities?
- Do you encourage critical thinking in your trainees?

Do you, as preceptor, play a role in regards to patient safety? Why or why not?

What is your role with regards to the trainee’s safety?
- Emotional/Physical

How would you describe the personal experience of the preceptor role?
- Do you feel a personal responsibility for the trainee?
- Can you give me some stories of your experiences as a preceptor?

How is your role as a preceptor impacted when on the “big jobs”?
- E.g. Code 2 (cardiac arrest), multi-vehicle MVA etc.

What are the rewards and benefits of being a preceptor?
- Stories/examples of when you felt rewarded.

What challenges and difficulties have you faced as a preceptor?

Is it challenging when you are separated from a trainee e.g. back of the car, in a house when going to get equipment?
- How do manage this?

Have you ever been rostered with trainees on multiple rosters back-to-back?
- If yes, how do you feel about that?

How well did your organisation prepare you for the preceptor role? Could you please outline the training you received?

Do you feel paramedics are adequately prepared for the role of preceptor?

What could be done to better prepare paramedics for the preceptor role?

How well do you feel recognised and appreciated for being a preceptor?

Could you tell me about the support you receive as a preceptor? From CTO-Managers/peers...

How could you be better supported in the preceptor role?

Are there differences between graduate interns and vocational trainees? How does the preceptorship experience differ when you have a graduate compared with a vocational trainee, or is it much the same?

That’s all the questions I have for you. Thank you for your time today in being part of my research. Is there anything you would like to add or need clarified?