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PROFESSIONALISM

The Politics of Professionalisation: Some Implications for the Occupation of Ambulance Paramedics in Australia

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Abstract

A range of health care occupational communities have travelled down various pathways in a quest for professional status. Some have been more successful than others and the evidence indicates that the most successful occupational communities pursued political strategies and tactics. This paper draws on their experiences to suggest ways that Australian ambulance paramedics could proceed in their quest for increased professional status and autonomy.

The health care workers who have been more successful than others in their journey towards professional status did more than follow such well-espoused pathways as long years of university education, delineate a set of professional ethics and engage in scholarly research. The history of professionalisation shows that they also engaged in political behaviours, and tactics. Ambulance paramedics could learn much from their strategies. This paper uses a sociological analysis - historical, structural (politics and economics) cultural and critical - to reveal the political strategies and tactics required by ambulance paramedics in their quest for full professional status.

The word 'politics' often carries negative connotations. However, it simply means exercising power or control or the contestation between individuals or groups for power and control. Politics is an everyday event in all organizations as coalitions vie over resources and/or the power to implement their ideas. Power need not necessarily be coercive, disempowering another body.**[1]** An internationally recognised management consultant contends that 'power is the energy to get things done'. Autonomous practice is the hallmark of a professional **[2]** and as this paper demonstrates, achieving autonomy after political contestation is an important part of the professionalisation process.

Paramedics have a good justification for their bid for professional status. They not only have the authority to use a limited number of prescription drugs without reference to a medical doctor but of necessity they have to make quick diagnoses in physically difficult and uncomfortable circumstances - literally in the gutter - without the aid of detailed medical histories, sophisticated tests or reference to other specialists. An experienced paramedic does more to save lives than any other health worker.

This paper outlines five political strategies that have been used successfully by health care occupations to enhance their autonomy and further their professional status. Gardner and McCoppin **[3]** note that male dominance has been an asset in the professionalisation stakes because men are more prepared to engage in politics than women. Hence, this paper also seeks to explain why ambulance paramedics in Australia are the exception to this observation.

Strategy 1: Develop a role and expertise different from and independent of general medical practitioners

The history of two of the more successful health occupations in terms of professionalisation - nursing and physiotherapy - shows that their success was dependent on them finding a niche for their services that was different from, and therefore independent of medical doctors. This was not always the case. Both occupations were female dominated and both occupations provided the hand maidens for a male dominated medical fraternity. They were mostly employed in hospitals under the direction of doctors.

Although not elite professionals as yet, nursing has come a long way. Nursing has broken away from the health science faculties at some Australian universities to head up their own faculties of nursing. Clinical nurse specialists and nursing managers can enjoy a relatively high degree of autonomy and remuneration. Doctors no longer sit on their registration boards. Nurses have achieved this autonomy by emphasising that their skills and experience are vital to the recovery of patients and that their care plans are based on knowledge and experience that medical practitioners do not possess. They emphasise *care* not treatment.

That is, they are not competing with medicine but have carved out their own niche in the health care system that is free of interference/control by medical doctors.

On the other hand, it could be argued, that physiotherapists have achieved full elite professional status in Australia as a measurement of their degree of autonomy, status in the universities and their potential to earn high incomes. At the University of Sydney, when medicine was an undergraduate degree, potential physiotherapy students needed a tertiary entrance ranking (TER) score which was just below medicine to enter the course. A physiotherapist in private practice can earn as much or more than a general medical practitioner.

Today, physiotherapists are no longer dependent on doctors' referrals to build their clientele as they can set up private practice, order x-rays, issue sickness certificates. Their qualification is also recognized and covered for rebate within private health funds.

Physiotherapists enjoy high clinical legitimation (patients believe that their treatments are efficacious and return) and are the recognised experts on the treatment of musculo-skeletal conditions by physical means; not by drugs. This is an area that general practitioners had little time for and therefore did not develop expertise. Therefore by emphasising physical therapy physiotherapists have been able to be independent of medical practitioners. Medical doctors are no longer on their registration boards.

What can ambulance paramedics as a profession learn from the history of nursing and physiotherapy? Paramedics have already carved out their own niche and have already established themselves as the recognised experts on resuscitation and emergency obstetrics. Their skills and experience are superior to the average general medical practitioner by virtue of sheer experience. Initially I qualified this statement by writing, 'although not superior to medical specialists in emergency medicine'; however I revised this statement because Australian paramedics are more experienced in the field. Until such time as medical officers accompany the ambulances at all hours of the day and night and are prepared to work in any physical environment, paramedics will continue to be the experts in pre-hospital emergency diagnosis and treatment in Australia.

Strategy 2: Recognize and capitalize on your experience and skills

Paramedics need to capitalise on their expertise and experience. Although there is a lot of mystique surrounding medical knowledge **[4]** (Willis 1989) there is nothing mystical about knowledge. It is either explicitly conveyed via a book or a teacher or it is tacitly learnt from experience. Tacit knowledge is often based on years of experience on the job and it is sometimes difficult to transform tacit knowledge into explicit knowledge. From my research with ambulance paramedics I found that paramedics are high on tacit knowledge but status anxious about their explicit knowledge. **[5]** They are in awe of medical doctors, making comments during tutorials such as, "but they've done six years at university".

Physiotherapists no longer defer to medical doctors and neither do nurses. Originally nurses were also status anxious however they were quite strategic when they entered the universities. At the University of Sydney the Nurses Registration Board was quite astute in insisting that their nursing students did the same subjects and at the same degree of difficulty as the other health science students. In 1992 with the introduction of the Batchelor of Nursing degree, nursing students, similar to the other health science students were service taught by bio-scientists, psychologists, sociologists and experts in research methodology such as epidemiologists. The School of Nursing like the other schools taught their own clinical and

occupational specific skills[i]. When paramedics are able to study at the same level as the other health science students there will be no need to be 'status anxious'.

Strategy 3: Protect and maintain your occupational boundaries from encroachment

Gardner and McCoppin **[3]** emphasise the importance of protecting your occupational territory in the struggle for professional status and survival as an occupational community. They highlight both vertical encroachment from above or below and horizontal encroachment from other occupational groups at the same level of expertise and status.

Whilst physiotherapists and nurses have been successful at protecting their occupational territories from encroachment, occupational therapists have not been so successful.**[3]** The occupational therapists have allowed their aids – once known as diversional therapists – to break away from their control and form their own occupational community who engage in activities/roles which were once the domain of their 'bosses'. Diversional therapists previously completed a diploma and mostly worked in nursing homes, whereas today they complete a degree labelled 'Leisure and Health'. Their changed status is evident at the University of Sydney, in that the demountable building which houses their craft and potting shed is now labelled the Creative Arts Laboratory. The semblance of science both imbues and denotes their improved status.

Nurses, physiotherapists and social workers have successfully prevented their aids from engaging in vertical encroachment. How have they accomplished this? Nurses have not given any of their responsibilities to either the state enrolled nurses (who complete a Tertiary and Further Education (TAFE) course or nursing aids. No aspect of patient care is considered menial, trivial or demeaning. Whilst they may have delegated tasks to their subordinates they take full responsibility for such indicators of a lack of care as pressure sores, constipation, malnutrition and so forth. It is the responsibility of the registered nurses to write the care plans.

Social workers protect themselves from horizontal and vertical encroachment by including their aids – welfare workers – in a section of their professional association and by ensuring that all advertisements, which go out for a position of social worker or welfare worker state that all applicants must be a member of the association. That is, all applicants must hold specific qualifications in social work or social welfare. This effectively excludes applicants who may have done a counselling course through an unrecognised institution.

Another method of curtailing aids from breaking away to form their own occupational group is to make the pathway into the professional group as clear and unambiguous as possible. In other words, communicate to your aids that they can also be a part of the professional community if they are prepared to put in the effort. However the entrance criteria needs to be clear and also the required study. This is where I found the ambulance services to be weak in Australia. **[5]** Unless they give their patient transport officers (PTOs), who presently do the non-emergency transport, a clear pathway to obtain entry into the elite paramedic courses their frustration will mount until they devise a method to break away and form their own occupational community. There is evidence that the services and hospitals are pushing PTOs to take on more high dependency patients without a fully equipped ambulance or nurse escort. **[5]** This is highly responsible work and PTOs could well make a case for their own occupational niche thereby encroaching on the role and responsibilities of what are known as general duties ambulance officers in Australia.

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[i] I gained this information first hand, as I was employed in the Faculty of Health Sciences, University of Sydney at the time.

Strategy 4: Own and control the technology of your profession

Another strategy to prevent both vertical and horizontal encroachment is to have exclusive control over the technologies of your profession. Medical technologies – and these include machinery as well as pharmaceuticals – save lives and prevent premature death. The people who use and control these technologies are similarly imbued with the power to save lives. Medical doctors are imbued with more of this sort of power than other health workers because they have achieved state patronage. That is, the government has put laws in place that give doctors the exclusive right to use and control certain technologies. Only qualified medical doctors with a government issued provider number can prescribe life saving drugs such as antibiotics and only radiologists can read and diagnose from x-rays. Whilst other health workers may also know when antibiotics are indicated and have the ability to read and diagnose from x-rays, the law dictates that only doctors provide these services. The justification for such technical control by medical doctors is the protection of patients from unqualified 'quacks' or those who do not know what they are doing. The exclusive control over vital technologies ensures a closed market for doctors' services while at the same time effectively protecting their occupational boundary from encroachment. There would not be a shortage of doctors in rural areas if other health care professionals could use these technologies and thus provide services.

Nurses and physiotherapists acknowledge the power of control over technology and are very careful not to give away any control they have already achieved. Although only doctors can prescribe pharmaceuticals in hospitals (even medications which can be bought over the counter) registered nurses maintain their occupational boundary by insisting that only a registered nurse administer medications. This is supported by law, necessitating the employment of registered nurses at every in-patient facility including nursing homes, and hostels. Similarly, physiotherapists closely monitor the tools of their profession. For example, they oversee the use of such technology as the interferential, a muscle stimulating machine.

History indicates that ambulance officers as an occupational group need to gain state patronage in terms of the exclusive use and control over the technologies of their craft if they too are to maintain their occupational territory. There has been a constant threat of horizontal encroachment by other emergency service workers. The police and fire fighters want to be able to use such life saving drugs as adrenalin and if this was to come about it would blur the edge between occupational boundaries. This has happened overseas. In some states of the USA a 'paramedic' is a combined emergency health care worker as well as a fire fighter and a specialist in rescue.

Having established that ambulance paramedics are the recognized experts in 'out-of-hospital' resuscitation by virtue of their sheer practice and experience, it makes political sense for Australian law to make provision for the exclusive right of paramedics to oversee the use of defibrillators in the pre-hospital environment. Ambulance paramedics need to employ the same ideology that has been so successful for doctors, in that there is a need to stress the dangers to patients, the use of this technology in the wrong hands.

Whilst the argument about 'time being of the essence' in an emergency, is a powerful argument and that the first person at the scene of an emergency should be allowed to use life saving drugs and technology, it is not an argument that has seriously curtailed doctors' control over technology. There are only a few concessions in Australia. Remote area nurses can administer some drugs without reference to a doctor and paramedics can administer set

quantities of a limited number of prescription drugs (five in the State of New South Wales) without a doctor's approval. Doctors have not given much control away, such that 'protecting the community from quacks' continues to be a stronger argument than 'time is of the essence'.

Strategy 5: The professional association take control of education, qualification and registration

The professional associations of the other successful occupations in terms of professionalisation decide who is a qualified practitioner - *not* the employing organizations nor the universities or training schools. The Nurses Registration Board vets every proposed university course and they make the decisions about curriculum, level of knowledge and the length of practicums. This is not to say that nursing managers from the various employing organizations are not on these decision making committees; they can wear two hats. The point is that nurses as a professional occupational community would not tolerate either the universities nor the employing organizations deciding upon qualification as presently happens to ambulance paramedics in Australia.

Registration is not an option it is a necessity in the political struggle for recognition as a professional because registration is about more than lofty ideals of ensuring ethical practices and standards. Registration in itself is also a political tactic of control. Registration can control qualification, pay and conditions of work. Presently, there is not a lot preventing private ambulance services from employing whoever they like and calling them whatever they like – and in these days of enterprise bargaining of paying them whatever they like. If and when registration comes about, only registered paramedics will be able to call themselves paramedics and all those registered will have to be paid as paramedics whoever employs them. The professional association will decide both the knowledge base necessary and the experience necessary before an officer can become a registered paramedic. For the protection of the occupational community registration is indicated sooner than later.

The great gender conundrum

It has been claimed that male dominated occupational communities have been more successful in achieving professional status than female dominated occupations.**[2,6]** This immediately raises a conundrum for the male dominated ambulance occupation. How has it come about that ambulance officers are laggards in the professionalisation stakes?

There is still an underlying perception in society that men have more authority than women and that men are the breadwinners and hence have a right to higher status, salaries and management positions. This is evidenced by statistics on female dominated professions where the few men in the occupational community hold most of the executive positions. For example, although men make up only 10% of registered nurses in Victoria they hold 50% of nursing management positions (Victorian Nurses Association 1993). Men are also more prepared to engage in political behaviours. For example Gardner and McCoppin maintain that occupational therapists have not been as successful as physiotherapists in terms of professional autonomy because occupational therapy remains dominated by middle class women who are not prepared to engage in politics. **[3]** Occupational therapy has lost many of its work roles, responsibilities and technologies to physiotherapy.

What is more puzzling, in reference to ambulance officers is that in terms of pay and working conditions the all male ambulance services in the 1970s were ahead of nursing. During 1985-86, when nurses mounted a case for equal pay for work of 'comparable worth', the Australian Council of Trade Unions (ACTU) asked the Arbitration Commission to compare nurses to

ambulance officers. The nurses argued that ambulance officers had better remuneration and working conditions than nurses, whereas nursing work was more responsible and knowledgeable. **[2]**

What is the explanation for this conundrum? How did an occupational group which continues to be male dominated fall behind? I will present some putative suggestions. Firstly it would appear that the nurses union has been more active than the ambulance officers' union. Secondly the more successful occupational groups foresaw the advantages of a university education. Tertiary level education not only imbues the status of science, it is also the great legitimation exercise. No party can accuse your occupation of being inferior to them if you have undergone the same level of education. Thirdly the other occupational groups achieved registration which, as already explained is a political strategy in itself. However, the inertia and lack of foresight on the part of ambulance officers needs to be explained. From my historical study of one of the Australian ambulance services, I found the service to be very insular, inwardly focused and complacent - for reasons explained below - and it is this attitude that I consider has held the occupation back - even though it is male dominated.

Until recently the ambulance services were monopoly employers and this can explain their insular perspective. Once trained by a service to be an ambulance officer there was little choice of employer other than to go interstate. Hence, the executive of the services had considerable control over all aspects of an officer's working life.

Secondly, as statutory authorities, the services had the ability to raise some of their own revenue through fees and therefore had a degree of autonomy denied the big government bureaucracies. Wilenski **[7,8]** who was commissioned to review the Public Service, found the statutory authorities to be a law unto themselves. He singled out the ambulance and fire services for special mention maintaining that they managed to evade government control and were "secretive about their accounting systems, assets, and did not keep statistics". Wilenski's report in 1982 was also particularly critical of the undemocratic recruitment and promotional systems in the emergency services. **[8]**

Hence, while the ambulance services were doing 'their own thing', working to their own rules without scrutiny, other state departments were pressured to explore more contemporary ways to manage. They realised the importance of becoming open systems, that is, of scanning the environment for change and responding accordingly.

The third reason I propose for the services becoming complacent is that in comparison to health services, essential services – fire, police and ambulance – have always been better resourced than health care services. It has only been in recent times that the ambulance services have been under pressure from the State to rationalise expenditure, whereas health services have been rationalised since the beginning of the withdrawal of the *Welfare State* in the early 1980s. It has been in the services' best interest to see themselves as "essential services" before "health services".

In contrast to the community of ambulance officers, other health care workers could not afford to be complacent. They were continually lobbying for better pay and resources, under pressure to improve their accountability and management practices and protecting their occupational territory from encroachment.

To summate: although public perceptions of male power and authority and a belief in 'men as the breadwinners' may originally have given ambulance officers the edge in terms of pay and

working conditions, they have lost this advantage by way of the ambulance services' inwardly focussed attitudes and complacency, all of which do not foster foresight.

Conclusion

Although 'politics' simply means exercising or seeking power, or the contestation between parties for power and control, the word often has negative associations. However, as discussed above, politics is an everyday part of life as people/parties vie over ideal and material interests. The health care occupational communities who have been successful in attaining autonomy and professional status were/are prepared to engage in politics. They have extricated themselves from medical dominance by developing a role and expertise different and therefore independent of medical practitioners; they have found their own occupational niche and protected their roles, responsibilities and duties from encroachment by others and as a community they have decided upon qualification. One important political tactic is to lobby the government to make legislation that prevents others from using the technologies of your craft or impinging on your work role. State registration is another such law that not only protects the public from unqualified practitioners but will also protect ambulance paramedics' material interests.

Ambulance paramedics, as an occupational community need to cease being complacent and insular or risk being subordinated or usurped by other more politically active health care professions.

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