FRACTURED:

A STUDY OF PARAMEDIC PROFESSIONALIZATION

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A STUDY OF INTRAPROFESSIONAL PARAMEDIC DYNAMICS ON PROFESSIONALIZATION IN ONTARIO, CANADA

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Lay Abstract

Professions are a special type of occupation that has high social status. Social scientists have long studied how occupations try to gain status and recognition, a process called professionalization. In recent years, researchers have highlighted that it may be more challenging for occupations to professionalize as they face pressures from governments and their employers. This thesis aims to contribute to this research by presenting three papers examining paramedic professionalization in Ontario, Canada through the eyes of paramedic leaders and documents. Paper 1 found that paramedic leaders are divided on the need for changes to paramedic regulation to professionalize. Papers 2 and 3 found that paramedics are pursuing new roles for paramedics in healthcare and academics as a professionalization strategy. Paramedics face an internal conflict that has limited their ability to pursue a collective professionalization strategy. If differences across the profession cannot be resolved, it may continue to fracture the profession.

Abstract

Despite documented threats and challenges to professional workers, occupations and professions of all kinds remain motivated to pursue professionalization projects aimed at improving their social location. However, to drive professionalization from within an occupation means resisting or adapting to a variety of pressures from other professions, managerial organizations, and neoliberal government agendas. Emerging research has highlighted that some professions can adapt to or resist these pressures, while others falter. How intraprofessional dynamics impact professionalization in these conditions is less understood. This thesis aims to address this gap through a qualitative case study of paramedic professionalization in Ontario, Canada. Data from interviews with paramedic leaders and a document analysis were used to examine how intraprofessional dynamics have impacted paramedic professionalization. Drawing on various theoretical and conceptual threads from neo-Weberianism and neo-institutional theory, each empirical chapter examines a topic related to professionalization: regulation, higher education, and expansions in work. The findings of each chapter reveal widespread intraprofessional stratification, and at times, conflict. Some paramedic leaders are driven to improve paramedic status, recognition, and autonomy, however, must do so in increasingly flexible, collaborative, and subtle ways. While intentional stratification is at times pursued as an innovative strategy in response to organizational and government pressures and mandates, it comes at a cost to professional unity. Others are resistant or skeptical of professionalization that may change the physical, boots-on-the-ground ethos of frontline paramedics. The finding of this thesis sheds light on the intraprofessional dynamics of an understudied occupation and how they relate to contemporary

scholarly debates about the processes and outcomes of contemporary professionalization.

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Thank you to everyone who participated in this research and who continue to advocate for the future of paramedicine, in whatever form that may mean. By sharing with me your experiences, I hope that this research helps shed light on a topic that I know is important to you, and many others in paramedicine.

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This thesis is dedicated to my Mom, Brenda, who was a paramedic for 31 years.

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Declaration of Academic Achievement

This thesis is a report of original research I conducted under the supervision of Drs. Jim Dunn, Walter Tavares, Gina Agarwal, and James Gillet commencing in September 2015. Committee members contributed to the: development of the research proposal; research ethics submission; data analysis; and feedback on paper drafts. I was the only interviewer and analyzer of raw data for all papers. I transcribed all audio recordings of interviews.

CHAPTER 1. INTRODUCTION

Historically, the professions have benefited from a prestigious social position that allowed for considerable status, authority and control over their work, knowledge and jurisdiction (Abbott, 1988, Larson, 1977; Witz, 1990; Freidson, 2000; Muzio et al., 2013, 2020). The ideology of professionalism has been consequential to the social organization of work and knowledge production, helping to shape the professional values of trust, expertise, and legitimacy. The longstanding appeal to professionalism has driven many occupations to pursue professionalization, the process by which occupations seek to improve their status (Larson, 1977; Evetts, 2013).

The number of new occupations seeking professional status has continued to rise despite significant changes and challenges to professional work and the ideology of professionalism (Evetts, 2011; Colley & Guery, 2015; Muzio, Aulakh & Kirkpatrick, 2020). Once elite professions such as medicine have been documented as losing autonomy and power to the state, organizations, and the market and at risk of deprofessionalization (Freidson, 2000; Evetts, 2003, 2011; Colley & Guery, 2015). Large-scale organizations are now a common source of employment for professionals, imposing the doctrine of managerialism onto professions and resulting in increased accountability, rationality, and bureaucracy (Evetts, 2003; 2013). In Western countries, professions are often increasingly accountable to the state, which has argued in some contexts that they are unable to protect the public interest (Adams, 2017, 2020). Professionalism driven from within the occupation has been replaced by professionalism imposed on occupations to enforce state or organizational control (Evetts, 2013). Professions, broadly defined, remain critical social actors, although they may be increasingly required to uphold their legitimacy to the state, organizations, and other professions as a means to survive.

Occupations may be motivated to pursue professionalization (Muzio et al., 2020; Nancarrow & Borthwick, 2021), although the ability to professionalize from within an occupational group has been long questioned (Evetts, 2011, 2013). A question then becomes: what are the processes and understandings of professionalization in a time when professions are under pressure? This thesis aims to unpack this question through the case of paramedic professionalization in Ontario, Canada.

Broadly defined, paramedics are emergency service workers as part of emergency medical services (EMS) in many North American and European countries (Corman, 2018). The primary role of paramedics is to provide community-based emergency care (often in land and air ambulance services), although that role is expanding and broadening, including into non-emergency settings (Rowland & Brydges, 2021). Paramedics are an interesting case to study professionalization as they occupy two sectors of work: public safety (working alongside other emergency services such as police and fire) and healthcare. McCann & Granter (2019) describe an expansion in the roles of emergency responders simultaneous to ambiguous role expansions and increasing demands for emergency services. In the United Kingdom, emergency services have become more managerial and connected to other government services such as healthcare, social work, housing and mental health care. As the authors state, this has pushed emergency service workers "in short… to become 'professional.'" New healthcare roles for paramedics are viewed as an essential source of occupational change for paramedics (Tavares et al., 2021; Allana & Pinto, 2021). Research from Australia and the United Kingdom has also documented expansions in paramedic healthcare roles as an important driver of professionalization (Reed et al., 2019).

The healthcare professions are no stranger to studies in the sociology of professions. Medicine has been long touted as the quintessential profession, securing high social and economic status and maintaining its place at the top of the hierarchy of professions (Freidson,

1988; Starr, 1982, Abbott, 1988; Witz, 1990, 1992). In his seminal work, Freidson argued that medicine is an example of profession dominance, with the power and ability to control its profession and, uniquely, that of others such as nursing and other healthcare professions. Medical authority has been arguably on the decline in the face of mounting state pressures, although its location at the top of the hierarchy of the healthcare professions remains (Nancarrow & Borthwick, 2021, p. 211).

While medicine is touted as the exemplar profession, the literature on the professionalization of allied health professions is more relevant to the study of paramedics. Over the last twenty years, healthcare policy in many Western countries such as Canada, the U.K., and Australia, has sought to broaden and increase the flexibility of the healthcare workforce outside of medicine, leading to the professionalization of many other healthcare occupations, notably allied health professions (O'Reilly, 2000; Borthwick et al., 2010; Leslie et al., 2021; Nancarrow & Borthwick, 2021). The allied health professions, broadly defined as diverse professions outside of medicine and nursing (and that otherwise do not share a set of professional skills, boundaries or purposes), represent a small but significant body of literature in the sociology of professions (Nancarrow & Borthwick, 2021, p. 6). Drawing on cases from Australia and the UK, Nancarrow & Borthwick argue that allied health professions were initially subordinate to medicine and, with professionalization driven by the state, became viewed as a set of independent practitioners capable of patient care without medical instruction.

Nancarrow & Borthwick (2021) describe that for all of the differences between the allied health professions, they share an important similarity: "none enjoy a legally sanctioned authority or scope of practice equivalent to the medical profession. They are or have been constrained by legislation or regulation to a more limited scope of practice" (p. 17). Nancarrow & Borthwick argue that the allied health professions have improved their status

and legitimacy and broken with medical dominance but have yet to professionalize with the same success as medicine (p. 19). Instead, the state granted the professionalization of allied health workers to meet workforce shortages and address gaps in the healthcare system. What has been interesting about the allied health professions is that professionalization of allied health "must serve the system rather than themselves, their worth measured by how much they alter their role to for the needs defined from above" (p. 212).

While there has been a recent increase in scholarship on paramedic professionalization, the topic remains understudied (Reed et al., 2019; McCann & Granter, 2019), particularly in the Canadian context. Paramedic professionalization has been studied primarily in the United Kingdom (notably McCann et al., 2013; Givati et al., 2019; McCann & Granter, 2019) and Australia (Williams, 2010; Brooks et al., 2018; Reed et al., 2019). This literature describes paramedics aiming to professionalize through regulatory changes, advancing education, and increasing roles and capabilities. Except for a small body of scholarship (see McCann et al., 2013; Givati et al., 2019; McCann & Granter, 2019), most of the literature on paramedic professionalization has been from functionalist or trait theories (Reed et al., 2019) and would benefit from further engagement with contemporary theoretical or conceptual approaches and debates.

This thesis aims to address the gap in the literature on paramedic professionalization, particularly in the Canadian context, and contribute to contemporary debates in the sociology of professions, specifically relating to the processes of professionalization in changing and turbulent times. This thesis examines paramedic professionalization through the eyes of paramedic leaders. Each chapter examines an important aspect of professionalism once tight coupled with professionalization: regulation, higher education, and expansions in a jurisdiction. Paramedics must navigate an increasingly precarious government and organizational landscape, growing demands for service, and an intraprofessional identity

crisis. Consequentially, paramedic professionalization is marked by stratification and division, with implications for professional unity.

BACKGROUND

Defining Professions, Professionalism, and Professionalization

Functionalist and trait approaches were once common in the sociology of professions until the 1960's, which defined professions based on a series of unique traits and characteristics and linked these to power and prestige (Leicht & Fennel, 2008; Evetts, 2013; Saks, 2016; Burns, 2019, p. 17). Functionalist accounts did little to unpack the power of some occupational groups or explain the growing appeal of professionalism (Evetts, 2013). Functionalism assumed that professionalization was inherently *good,* meaning it had social and economic value (Burns, 2019, p. 20). Further to this, Burns (2019) argues functionalist accounts did little to relate professional change to "large-scale socioeconomic and cultural processes" (p. 17).

In response to functionalist accounts, the 'power' or critical approaches of the 1970s illuminated the antagonistic side of professionalization: unfair hierarchies, interprofessional competition, and self-interest (Burns, 2019, p. 20). Critical approaches highlighted the historical situatedness of professions as reflections of political and social arrangements at the time. As the scholarship in the field grew, so did the diversity of professional forms, resulting in what Adams (2010) notes as an ongoing definitional problem. Some scholars have categorized professions based on their knowledge or expertise, while others have conceptualized professions as an occupational category focused on managing client risk or uncertainty. Professions are "dynamic, historically changing entities" (Adams, 2010, p. 67; Evetts, 2013) or, as Freidson argued, a "folk concept" that is determined through empirical research (1988b; p. 127). Burns argues that a rejection of functionalism leaves professions

defined as simply "one possible occupational arrangement in the modern division of labour" (p. 24). Evetts (2013) notes that many researchers no longer differentiate rigidly between professions and occupations but view both as a form of social organization. Ultimately, Adams (2010) call to focus studies of professions on "the ways in which their status is acquired, and the way in which their relationships with the state, the public, and other workers are structured" (p. 67).

Consequently, defining professionalism has also been a challenging task. Evetts (2003; 2013) defines professionalism as an ideology (a set of values, norms, discourses and practices) used to change occupations. Evetts outlines how it was once a powerful ideology that led to a particular occupational arrangement, rooted in the social contract that lay people can trust professions to perform complex work. Professions were rewarded with high social status due to not violating this social contract and abusing their position of power. Occupational groups are influenced by professionalism in their drive for autonomy in decision-making and work, ownership over an area of expertise and knowledge, and collegiality. Freidson (2001) also wrote extensively on the concept of professionalism, describing it as a particular logic that positioned professions as having the trust and ability to have autonomous control over their work and workers. Freidson argued for preserving professionalism in the face of mounting managerialism and market pressures. The discourse of professionalism has also been used to describe how a wide range of workplaces and occupations have used the rhetoric of professionalism to meet a desired end (e.g. occupational group, recruiting customers, disciplinary control) (Fournier, 1999). More recent scholarship has debated that professionalism is increasingly connected to a broader ecology of organizations, knowledge, and work (Noordegraaf, 2020; Adams et al., 2020b).

Drawing on the work of McClelland (1990), Evetts (2013) highlights how discourses of professionalism have different consequences when imposed from above or within the

profession. Professionalism from within is when the occupation itself is the driver of professionalism, and this process helps clarify its occupational identity and negotiate with the state for self-regulation. Employers or managers impose professionalism from above to control workers by using the ideology of professionalism to appeal to occupational groups. Evetts argues that this is how many caring occupations in North America and Europe were professionalized and, through processes of rationalization, enhanced the government's control over workers. Evetts delineated between the ideology of occupational professionalism, driven from within a profession and upholding the values of trust, collegiality and autonomy, and organizational professionalism, based on the principles of managerialism, standardization and accountability as a means for external control.

This research aimed not to determine whether paramedics are or are not a profession but to examine the paramedic professionalization project. I adopted the concept of a professionalization project to define the processes by which an occupational group seeks to use cultural and technical capital to improve its social and economic position (Larson 1977, 1979). Professionalization projects are ideological strategies used to legitimate a specific social arrangement. In professionalization projects, this is often to improve the social and economic status of the occupation, although not all professionalization projects are successful. Further, while some have criticized occupations as only acting in their interest, occupations may also professionalize for the public's interest (Saks, 1995). Professionalization is an ongoing process as professions and occupations constantly negotiate their position with other actors, including the government, different professions, and workplaces. Studying professionalization processes, even when unsuccessful or disjointed, in an era where professions are rapidly changing, helps us understand the contemporary dynamics impacting this particular form of social organization (Muzio, Aulakh & Kirkpatrick, 2020).

Theoretical Framework

To explore the paramedic professionalization project, I adopted a theoretically eclectic approach advocated for by Saks (2016), drawing on neo-institutional theory, and neo-Weberian approaches to professionalization. Neo-Weberianism has been influential in studies of professionalization as it approaches to study the "structural and historical aspects of the professionalization process", particularly securing an exclusionary legal position (p. 175). Neo-Weberians "are interested in the process by which certain occupations have been able to regulate the market conditions in their favour, despite competition" (p. 175, 176). Elite professions such as medicine have successfully obtained these benefits and thus formed the basis of many empirical examples in neo-Weberian approaches. Since neo-Weberianism positions professions as status groups, it has fewer theoretical tools to examine how occupational groups without status aim to improve their position. I used concepts from neo-institutional theory and the broader literature on boundary work to address these gaps.

A neo-institutional perspective on professionalization provides a theoretical framework to examine broader socio-cultural and political influences on occupational groups and how individuals understand and respond to these influences. Neo-institutional theory posits that dominant sets of norms, belief systems, and values become taken for granted-institutionalized-and regulate social behaviour. Institutions are the regulatory structures, laws, courts, and governmental agencies that create a rule-like system that structures behaviour and thought (DiMaggio & Powell, 1983). Institutionalization is when these rules become embedded in organizations to the point where they become taken for granted. This leads to many organizations adopting similar traits, even when it is not efficient, which is called isomorphism. This dissertation draws on the concept of institutional work, which refers to the process in which individuals gain some degree of conscious awareness (which the authors

refer to as reflexivity) over their role in the institutional environment and can introduce variation into institutionalization patterns of behaviour (Suddaby & Viale, 2011). Institutional work aims to explain the relationships between social actors and their institutional arrangements rather than major changes.

Neo-institutional theory has gained prominence as a theoretical approach in the study of professionalization as professionals are increasingly embedded in organizations and are subjected to managerial pressures (Leicht & Fennel, 2008). Professionals working in large-scale organizations must negotiate both occupational professionalism and organizational professionalism. As Saks (2016) states, "neo-institutionalists espouse an ecological approach where professions are conceptualized as competing for jurisdiction and social position symbiotically with both other professional groups and institutional forms" (p. 181). Neo-institutional theory has been used to showcase how professionalization has had stability as a social process (Muzio, Azulah & Kirkpatrick, 2020) and how professions can be agents of institutional change (Muzio et al., 2013). Thus, it is an ideal complementary perspective to neo-Weberianism as there is a conceptual framework to consider changes to the processes and motivations of professionalization.

Defining Paramedics

In this research, 'paramedic' refers to individuals employed by a municipal land or air ambulance service, per the legislation governing paramedics in Ontario, the *Ambulance Act* (1990). While the term paramedic is not universal, it is used in Ontario to describe individuals regulated and certified by the government to provide land and air ambulance services. 'Paramedicine' refers to the occupational/professional community/category that represents not only frontline paramedics but also the managers, municipal staff, regulators, educators, union leaders and others (discussed later) that comprise the field of paramedics.

Sociological Perspectives on Paramedic Professionalization

From a sociological perspective, paramedics professionalization has received little attention. This most likely reflects paramedics' relatively recent professionalization documented, with the first literature emerging in the 1980s in the United States (Mannon, 1981; Metz, 1982). At the time, paramedics in many jurisdictions, including Ontario, were not called paramedics but instead referred to as "ambulance attendants" or "drivers" (Mannon, 1981, Metz, 1982). This meant that ambulance workers, trained in first aid and some advanced resuscitation skills, would arrive at the scene of an accident, grab the patient and take them as quickly as possible to the hospital. Training standards were absent or minimal, working conditions were substandard, and attendants had few medical skills (Metz, 1982).

There is a small body of literature examining "ambulance attendant" professionalization, which in many countries burgeoned into "paramedics." From 1981 to the present, a common theme underlies this small body of literature: a lack of control at the level of the profession, compounded by a "blue-collar" approach to work (low education, poor working conditions). In part, these tensions are reflective of the immaturity of the occupation, as argued by Metz (1982) and Mannon (1981), who demonstrate the tension paramedics face as a young occupation. Metz (1982) wrote an ethnography based on his experiences training and working as an Emergency Medical Technician (EMT) in an urban American city. Metz argues that 'blue-collar professionalism' is the primary identity of paramedics/EMTs. This term described paramedics as "dedicated individuals with an ideal of public service, who enjoy some autonomy in decision-making and share a desire to further an occupational mission despite stressful and exhausting working conditions, poor pay, and limited prospects for upward mobility" (p. 57).

Mannon (1981) conducted an ethnography of paramedics working in a large metropolitan city. Mannon argued that paramedicine, while an occupation in its early stages, can be conceptualized as an emerging profession, stating: "emergency ambulance workers are eager to promote their occupational interests. In particular, they want more recognition and prestige and greater control over the content and conditions of their work" (p. 142). However, Mannon also warned that despite this desire to be seen as a profession, high worker turnover, limited education, and direct physician control over paramedicine's scope of practice (instead of self-licensure) are factors which may limit the future professionalization of paramedics. Palmer & Gonsoulin (1990) also argued that paramedics were under "medical control," as they were certified to practice via a physician's license and had to adhere to a set of rules for patient care that are prescribed and enforced by physicians. Despite this regulation, paramedics must evade the formal norms prescribed by medical control to cope with the harsh realities of paramedic work, such as uncooperative patients or family members and dangerous or unpredictable environments.

There is a gap in the literature examining paramedicine professionalization following the work of Mannon (1981), Metz (1982) and Palmer (1983, 1990) until research began emerging from the U.K. and Australia in the 2000s. McCann et al. (2013) investigated the U.K. paramedicine professionalization project and found that "blue-collar professionalism" has endured over time and remains the primary identity of paramedics. While the professional project of paramedics resulted in a College of Paramedics, McCann et al. argue that for paramedics, institutional work is muted due to a lack of autonomy over their daily work activities and work-related pressures described as the "relentless, relentless grind" (p. 767). While paramedics tolerate and, at times, celebrate these forms of work as part of their professional duty, the nature of the work means that other professions do not want to perform it (McCann et al., 2013). McCann et al. have argued that in the U.K. context, the nature of

paramedic work and broader organizational pressures to uphold efficiency resulted in unsuccessful professionalization projects at the street-level worker. Paramedic professionalization could not change the organizational demands placed on paramedic operators to lower costs and maintain efficiency or change the nature of paramedic work. These factors limit paramedics' professionalization and the desire for paramedics to see themselves as "professionals."

Since this research has been conducted, more studies have emerged, painting a complex picture of paramedic professionalization. For example, research has examined the role of higher education, the impact of regulatory reforms, and broadening scopes of practice and areas of care (Williams et al., 2010; Brooks et al., 2018; Givati et al, 2019; Reed et al., 2019; McCann & Granter, 2019). While in Australia, higher education is often discussed as an enabling factor in professionalization, its importance has had mixed effects in the U.K. context. Givati et al. (2019) examined paramedic professionalization post-educational reform to university-level education in the U.K. This expansion was part of the U.K. government's policy mandate to expand the usage of non-medical healthcare professions. They found that paramedics have a paradoxical relationship with higher education. Paramedics saw increases in their clinical responsibility and autonomy; however, this eroded the collegiality between paramedics who had advanced education and those who did not. These tensions are reflexive of professionalism driven from above by ambulance service management rather than professionalism driven by paramedics.

The recent work of McCann & Granter (2019) has highlighted government neoliberalism's impact on paramedic professionalization. The authors consider paramedics as *controlled* professionals, as they are employed by organizations engrained with managerial and market ideologies that prioritize performance measures and efficiencies above all else. While paramedics in the U.K. have state licensure, strong ideals of public service, and are in

high demand by the public and governments, the professionalization of paramedics is under pressure. While this thread of research has been largely unexplored in the Ontario context, the government has also adopted a neoliberal approach to health and social services since the 1990s (Braedley, 2015).

There is substantially less literature on paramedic professionalization in Canada, which has left us with uncertainties in understanding emergency service workers' professionalization. Some literature tangentially examines professionalization issues, such as healthcare integration, roles for paramedics in new areas of care and conducting research, and regulatory matters (e.g. Batt et al., 2019; Carter et al., 2021; Agarwal et al., 2022). A recent study examining the future aspirations of Canadian paramedics revealed many areas traditionally related to professionalization: the desire to be seen as autonomous professionals, recognition as a healthcare profession, and research and evidence-based medicine (Tavares et al., 2021).

However, the Canadian literature on paramedics has yet to substantially engage with a theoretical approach that professionalization is a sociological process occurring within the broader context of acute changes to professionalism and professional work. There is an implicit functionalist tone to the current paramedic professionalization literature in Canada, which assumes that paramedic professionalization is something worthy of upholding, that the profession drives it, and that it will progress towards a series of specific attributes and traits. There has been little problematization of this process or consideration of the broader literature and theoretical debates on professionalization or professionalism. In this area of inquiry, this thesis aims to address this gap.

RESEARCH AIMS AND APPROACH

When I set out to conduct this research, my goal was to understand how and why

paramedics were professionalizing in Ontario, Canada, as seen through the lens of paramedic leaders. At the time, I surmised that those in leadership roles in the education, regulatory, clinical, union, and operational sectors of paramedicine would be in the position to direct paramedic professionalization and discuss how and why paramedics were professionalizing. There was an assumption inherent in this aim that there would be a paramedic professionalization project and it was being acted on in some way. Instead, I found that the paramedic leaders I spoke with held vastly different perspectives on paramedic professionalization. On some topics, there were similarities between "groups" (e.g. educators) or across most of the sample, while at other times, participants had unique and distinct views. In short, how and why paramedics were professionalization was chaotic, unclear, and disjointed. There was no clear or unified project occurring.

The messiness of paramedic professionalization pushed me to consider a broader range of theoretical approaches and areas of scholarship to make sense of why there were such disparate views at times of paramedic professionalization. This thesis focuses on the professionalization of paramedics in the post-professional era, where the social, economic and cultural conditions for the professions, broadly defined, are rapidly changing, rendering functionalist explanations of professionalization unavailing (Burns, 2019). Each empirical chapter of this thesis examines how the paramedic leaders understand and perceive the legitimacy of pursuing various aspects of the paramedic professionalization project. In summary, the chapters reveal cracks in what were once core aspects of professionalism and expose intraprofessional tensions and division in the process of professionalization. The findings of each paper also show how innovation and hybrid strategies have emerged in the face of government and managerial pressures. It also exposes how paramedics, as a technical, public safety occupation, are attempting to make sense of their changing identity and role in the context of rapid changes to professional work.

Methodologically, this research takes the form of a qualitative constructivist case study (Merriam, 1988). I adopt a constructivist view of knowledge production, where social facts are co-constructed by the researcher, and the researched through "interactions, discourse and shared meanings" (p. 534). Within the broad frame of constructivism, there is an ontological assumption that meanings, and thus knowledge, are *negotiated* by social actors in a specific context (Berger & Luckman, 1966). These social facts are "real," however, only in that they "exist independently of the observer, persist in time, and depend on the continually sustained reflexive subscription to that very reality" (Lynch, 2000).

I employed a constructivist case study design grounded in a reflexive epistemology. As a paramedic in Ontario for the past ten years, epistemic and methodological reflexivity was a central component of my methodology. The primary data source in the case study was semi-structured interviews with 25 paramedic leaders from various organizations across paramedics in Ontario, Canada. I supplemented the interviews with documents that contextualized my understanding of paramedic professionalization identified by participants and publicly available documents.

OVERVIEW OF THE DISSERTATION

The remainder of this dissertation contains three empirical chapters from my case study of paramedic professionalization in Ontario, Canada and a concluding chapter which discusses the implications of the thesis for our empirical and theoretical understanding of professionalization. Each chapter takes the format of a preamble, followed by the main body of text structured in an academic paper format. There is some overlapping content in the methods section of each chapter as each paper was from the same case study methodology.

In chapter 2, I examine how paramedic leaders perceived the role of self-regulation in paramedic professionalization. Self-regulation once allowed some professions to gain social

closure, a sociological term for the process where professions try to turn social and cultural capital into economic rewards. Most healthcare professions in Ontario are self-regulating, although there have been increased public roles and government powers in regulation. In Ontario, paramedics are regulated by a government body and physician-led organization. This puts them in a unique position compared to other healthcare professions and paramedics in other provinces and countries. Professional associations representing paramedics and paramedic services operators have advocated for self-regulation; however, the topic has received polarizing responses from other paramedic groups, such as unions. In this chapter, I use the concept of institutional work from neo-institutional theory to examine paramedic leaders' opinions on the current regulatory model of paramedics in Ontario. In the findings section, I outline diverse types of institutional work participants engaged in where they disrupted once taken-for-granted assumptions about paramedic responsibility and paramedics' relationship to the government, the public, and other professions. This research found no agreement amongst paramedics about the need for regulatory reform or its ties to professionalization. Without a means to communicate across these differences of opinion, fragmentation and, in some cases, conflict and distrust have developed. This paper concludes with a discussion around our understanding of intraprofessional conflict and division on professionalization projects. If professions cannot speak with one voice, they risk their ability to further their professionalization project.

In chapter 3, the role of higher education in paramedic professionalization is examined. In this paper, I position education as an institution central to the professions; however, higher education faces considerable threats to its social and cultural legitimacy. If the social value of education has changed, what is the impact on professionalization? There is a need for contemporary empirics to understand the legitimacy of claims to education as a professionalization strategy. Paramedics are educated at the entry-to-practice level in public

or career colleges. There has been discussion in the paramedic industry to add more entry to practice education at the university level. This paper found tension in claims to using higher education to professionalize paramedics. Some view higher education as empowering paramedics, particularly a small number of paramedics who seek advanced credentials, a role I term academic paramedics. Other participants view higher education as dividing the workforce and irrelevant training for the 'street knowledge and skills needed to perform paramedic work. There is also an unclear role for education in furthering jurisdictional expansions and maintaining existing boundaries of paramedicine as credentialing is viewed as economically risky. Pursuing additional education as a professionalization strategy is contested rather than a taken-for-granted feature of advancement. University education is a leveraged strategy for a small number of entrepreneurial individuals rather than representing an occupation-wide strategy. An implication of this has been increased re-stratification within paramedics, creating a new hybrid role, the academic paramedic, to resist managerial pressures and drive professionalization from within.

In chapter 4, I use the concept of boundary work to explore the process of jurisdictional change in paramedics into a new area of work called community paramedicine. A consistent theme in the sociology of professions literature was how professions used jurisdiction expansion, often through competition with other professions, as a feature of professionalization. However, a broader look at the literature on boundary work reveals more nuanced and varied ways social groups aim to conduct boundary work, broadly defined as a process of differentiation from other groups. I use Langley et al.'s (2019) typology of boundary work as a lens to examine the emergence of community paramedicine. Drawing on interviews with paramedic leaders and documents related to community paramedicine in Ontario, I describe three types of boundary work: competitive, collaborative, and configuration. This paper is significant as it aims to explain how paramedics have used

community paramedicine as a bridge between paramedics from a first responder role to the broader healthcare sector. Community paramedicine has provided space for paramedics to redefine their role, although this role remains ambiguous and unclear. Boundary work is known to be unstable and chaotic. This lens highlights the significance of how jurisdictional change can impact intra and interprofessional relationships and is corroborated by government policy.

In the final chapter, I discuss the theoretical, empirical and methodological implications of this thesis. I also reflect on the COVID-19 pandemic, discuss the limitations of this research, and suggest areas for future research.

REFERENCES

Abbott, A. (1988). *The System of Professions. An Essay on the Division of Expert Labour.* Chicago: University of Chicago Press.

Adams, T. L. (2010). Profession: A useful concept for sociological analysis?. *Canadian Review of Sociology/Revue canadienne de sociologie*, *47*(1), 49-70.

Adams, T. L. (2015). Sociology of professions: International divergences and research directions. *Work, Employment and Society*, *29*(1), 154-165.

Adams, T. (2016). Professional Self-regulation and the public interest in Canada. *Professions & Professionalism*, *6*(3).

Adams, T. L. (2017). Self-regulating professions: past, present, future. *Journal of Professions and Organization*, *4*(1), 70-87.

Adams, T. L., Kirkpatrick, I., Tolbert, P. S., & Waring, J. (2020). From protective to connective professionalism: Quo Vadis professional exclusivity?. *Journal of Professions and Organization*, *7*(2), 234-245.

Adams, T. L. (2020). Health professional regulation in historical context: Canada, the USA and the UK (19th century to present). *Human Resources for Health*, *18*(1), 1-7.

Agarwal, G., Keenan, A., Pirrie, M., & Marzanek-Lefebvre, F. (2022). Integrating community paramedicine with primary health care: a qualitative study of community paramedic views. *Canadian Medical Association Open Access Journal*, *10*(2), E331-E337.

Allana, A., & Pinto, A. D. (2021). Paramedics Have Untapped Potential to Address Social Determinants of Health in Canada. *Healthcare Policy*, *16*(3), 67.

Allied Health Professions Australia. (2022). What is Allied Health? https://ahpa.com.au

Ambulance Act. 1990. Government of Ontario.

Batt, A., Steary, D., Mason, P., Hines Duncliffe, T., Johnston, W., & McArthur, B. (2019). The students are our future: growing the next generation of paramedic researchers in Canada. *Fanshaw College Faculty and Staff Publications.*

Berger, P. L.& Luckmann, T. (1967). *The Social Construction of Reality*. Anchor books.

Borthwick, A. M., Short, A. J., Nancarrow, S. A., & Boyce, R. (2010). Non-medical prescribing in Australasia and the UK: the case of podiatry. *Journal of Foot and Ankle research*, *3*(1), 1-10.

Brooks, I. A., Grantham, H., Spencer, C., & Archer, F. (2018). A review of the literature: the transition of entry-level paramedic education in Australia from vocational to higher education (1961–2017). *Australasian Journal of Paramedicine*, *15*(2).

Burns, E. A. (2019). Theorising professions: A sociological introduction. Palgrave Macmillan

Carter, A. J., Arab, M., Cameron, C., Harrison, M., Pooler, C., McEwan, I., ... & Crick, S. (2021). A national collaborative to spread and scale paramedics providing palliative care in Canada: Breaking down silos is essential to success. *Progress in Palliative Care*, *29*(2), 59-65.

Corman, M. K. (2018b). Titrating the rig: How paramedics work in and on their ambulance. *Qualitative Health Research*, *28*(1), 47-59.

Colley, H., & Guéry, F. (2015). Understanding new hybrid professions: Bourdieu, illusio and the case of public service interpreters. *Cambridge Journal of Education*, *45*(1), 113 131.

DiMaggio, P and W. Powell, (1991). *The New Institutionalism in Organizational Analysis*. Chicago: University of Chicago Press.

Evetts, J. (2003). The sociological analysis of professionalism: Occupational change in the modern world. *International Sociology*, *18*(2), 395-415.

Evetts, J. (2011). A new professionalism? Challenges and opportunities. *Current Sociology, 59*(4), 406-422.

Evetts, J. (2013). Professionalism: Value and ideology. *Current Sociology, 61*(5-6), 778-796.

Fournier, V. (1999). The appeal to 'professionalism' as a disciplinary mechanism. *The Sociological Review, 47*(2), 280-307.

Freidson, E. (1988a). *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. Chicago: University of Chicago Press.

Freidson, E. (1988b). *Professional Powers: A study of the institutionalization of formal knowledge*. Chicago: University of Chicago Press.

Freidson, E. (2001). *Professionalism, the Third Logic: on the practice of knowledge*. Chicago: University of Chicago press.

Givati, A., Markham, C., & Street, K. (2018). The bargaining of professionalism in emergency care practice: NHS paramedics and higher education. *Advances in Health Sciences Education, 23*(2), 353-369.

Health and Care Professions Council. (2022). *Who we regulate*. https://www.hcpc uk.org/about-us/who-we-regulate/the-professions/

Langley, A., Lindberg, K., Mørk, B. E., Nicolini, D., Raviola, E., & Walter, L. (2019). Boundary work among groups, occupations, and organizations: From cartography to process. *Academy of Management Annals, 13*(2), 704-736.

Larson, M. (1977). *The Rise of Professionalism: A Sociological Analysis*. Berkeley: University of California Press.

Leicht, K., & Fennell, M. (2008). *The Sage Handbook of Organizational Institutionalism: Institutionalism and the Professions*. Sage Publications.

Leslie, K., Moore, J., Robertson, C., Bilton, D., Hirschkorn, K., Langelier, M. H., & Bourgeault, I. L. (2021). Regulating health professional scopes of practice: comparing

institutional arrangements and approaches in the US, Canada, Australia and the UK. *Human Resources for Health*, *19*(1), 1-12.

Lynch, M. (2000). Against Reflexivity as an Academic Virtue and Source of Privileged Knowledge. *Theory, Culture & Society*, *17*(3), 26-54.

McCann, L., Granter, E., Hyde, P. and Hassard, J. (2013). Still blue-collar after all these Years? An ethnography of the professionalization of emergency ambulance work. *Journal of Management Studies, 50*(5), 750-776

McCann, L., & Granter, E. (2019). Beyond 'blue-collar professionalism': continuity and change in the professionalization of uniformed emergency services work. *Journal of Professions and Organization*, *6*(2), 213-232.

Mannon, J. M. (1981). *Emergency encounters: A study of an urban ambulance service*. Kennikat Press.

Metz, D. L. (1982). *Running hot: Structure and stress in ambulance work.* Abt books.

Merriam, S. B. (1988). *Case study research in education: A qualitative approach*. Josse Bass.

Muzio, D., Brock, D. M., & Suddaby, R. (2013). Professions and institutional change: Towards an institutionalist sociology of the professions. *Journal of Management Studies, 50*(5), 699-721

Muzio, D., Aulakh, S., and Kirkpatrick, I. (2020). *Professional Occupations and Organizations*. Cambridge: Cambridge University Press.

Nancarrow, S., & Borthwick, A. (2021). *The Allied Health Professions: a Sociological Perspective*. Policy Press.

O'Reilly P. (2000). *Health care practitioners: an Ontario case study in policymaking*. Toronto: University of Toronto Press.

Palmer, C. E. (1983). “Trauma junkies” and street work: Occupational behavior of paramedics and emergency medical technicians. *Urban Life, 12*(2), 162-183.

Palmer, C. E., & Gonsoulin, S. M. (1990). Paramedics, protocols, and procedures: “Playing doc” as deviant role performance. *Deviant Behavior, 11*(3), 207-219.

Reed, B., Cowin, L. S., O'Meara, P., & Wilson, I. G. (2019). Professionalism and professionalisation in the discipline of paramedicine. *Australasian Journal of Paramedicine, 16*, 1-10.

Rowland, E & Brydges, M. (2021). Chapter 16, 'Paramedics', in *Introduction to the Health Workforce in Canada*. Ivy Bourgeault (ed). Ottawa: Canadian Health Workforce Network.

Saks, M. (1995). *Professions and the Public Interest: Medical Power, Altruism and Alternative Medicine.* London; Routledge.

Saks, M. (2015). Health Policy and Complementary and Alternative Medicine, in Kuhlmann, E., Blank, R.,Bourgeault, I. and Wendt, C. (eds) *The Palgrave International Handbook of Healthcare Policy and Governance*, p. 494–509. Basingstoke: PalgraveMacmillan.

Saks, M. (2016). Review of theories of professions, organizations and society: Neo Weberianism, neo-institutionalism and eclecticism. *Journal of Professions and Organization 3*(2), 170-187

Starr, P. (1982). *The Social Transformation of American Medicine*. New York, NY: Basic Books.

Suddaby, R., & Viale, T. (2011). Professionals and field-level change: Institutional work and the professional project. *Current Sociology*, *59*(4), 423-442.

Tavares, W., Allana, A., Beaune, L., Weiss, D., & Blanchard, I. (2021). Principles to guide the future of paramedicine in Canada. *Prehospital Emergency Care*, 1-11.

Williams, B., Onsman, A., & Brown, T. (2010). Is the Australian paramedic discipline a full profession? *Australasian Journal of Paramedicine*, *8*(1).

Witz, A. (1990). Patriarchy and professions: The gendered politics of occupational closure. *Sociology*, *24*(4), 675-690.

Witz, A. (1992). *Professions and Patriarchy*. London: Routledge.

CHAPTER 2: AGREEING TO DISAGREE: INTRAPROFESSIONAL CONFLICT AND STRATIFICATION IN THE ONTARIO PARAMEDIC PROFESSIONALIZATION PROJECT

PREFACE

This chapter examines how paramedic leaders perceived the role of self-regulation in paramedic professionalization. The main contribution of this chapter is to examine the dynamics of intraprofessional conflict and division on paramedic professionalization. This chapter is currently under peer-review for publication as an original research paper at the Journal of Professions and Organization.

The Ontario Paramedic Association's (OPA) application for self-regulation was one of the first documents I read that sparked my interest in paramedic professionalization. In 2013, the Ontario Paramedic Association (the professional association representing paramedics in Ontario) submitted an application to the Health Professions Regulatory Advisory Council (HPRAC) for paramedics to become a self-regulating healthcare profession under the Regulated Health Professions Act. At the time, HPRAC was responsible for advising the Ontario government's Minister of Health on regulatory matters. The application had to make the case to HPRAC that paramedics met the risk of public harm, meaning the current regulatory model did not safely regulate paramedics and it was in the public's best interest for paramedic's to be self-regulating. At the time, knowing little about professionalization, I was surprised at the breadth of topics and issues the application covered, such as the lack of regulation for community paramedicine roles and patient care transport services. Following the OPA's application, HPRAC conducted a large consultation and concluded that paramedics did not need the regulatory change as they were significantly

(although complicatedly) regulated (HPRAC, 2013). The Minister of Health for the Ontario government never made a public ruling on the matter.

When I was in the early stages of this research, I was surprised at the polarizing views on self-regulation that I often came across on social media or when I talked with my paramedic peers. I became curious about the link between self-regulation and professionalization. The sociology of professions literature showed me this relationship is not surprising at all. Self-regulation once allowed some professions to gain social closure, a sociological term for the process whereby professions try to turn social and cultural capital into economic rewards. In the Ontario context, when allied health professions were included in the legislation, this helped them further their professional projects as it let them gain control over their own members and in the case of subordinated (to medicine) professions, it allowed them to distance themselves from medical control and legitimate their area of practice (O'Reilly, 2000).

This chapter explores participants views on the topic of self-regulation in paramedic professionalization. I draw on neo-Weberianism and the concept of institutional work from neo-institutional theory to examine paramedic leaders' opinions on the relevance of regulatory reform in professionalization. In the findings section I outline diverse types of institutional work that participants engaged where they disrupted once taken-for-granted assumptions about paramedic responsibility and paramedics' relationship to the government, the public, and other professions.

ABSTRACT

Self-regulation historically provided some professions power and market control. Currently, self-regulation has been increasingly scrutinized, and government priorities have shifted towards other mandates. This study examines the case of paramedics in Ontario, Canada, where self-regulation is still the dominant regulatory model for the healthcare professions but not for paramedics. Paramedics in Ontario are co-regulated by a government and a physician-directed model, rendering paramedics subordinate to both. This paper drew on interviews with paramedic industry leaders analyzed through the lens of institutional work to examine perspectives regarding the relevance of pursuing self-regulation to further the paramedic professionalization project. Participants had varying views on the importance of self-regulation in obtaining professional status, with some rejecting its role in professionalization and others embracing regulatory reform. Paramedics disagree on what being a profession means, which has stalled paramedics collective professionalization project. This research has implications for understanding the impact of intraprofessional relationships and conflict on professionalization projects.

INTRODUCTION

The sociology of professions literature has broadened its study of diverse occupations, such as in the fields of allied health and emergency services. This research has revealed a persistent desire to pursue professionalization, even if occupations never succeed in obtaining occupational closure (McCann and Granter, 2019; Muzio, Aulakh & Kirkpatrick, 2020; Nancarrow & Borthwick, 2021). The question of why some professions are more successful in professionalizing than others remains relevant under intensifying conditions for the professions. Some scholars have argued that professions can no longer drive professionalization from within due to managerial and neoliberal pressures (Evetts, 2011;

McCann & Granter, 2019; Adams, 2020; Nancarrow & Borthwick, 2021). Professionalism is based on the values of collegiality and autonomy, which can be oppositional to managerial ideologies focused on marketization, consumer choice, and rationalization (Noordegraaf, 2015, p. 191). Alternatively, others have argued that professions have created hybrid identities that are adaptable to the pressures of managerialism (Noordegraaf, 2007; Noordegraaf, 2015). The uncertain impact of managerialism and neoliberal governance on the professions provides a scholarly context to examine current professionalization projects.

This study aims to build on this literature by examining the professionalization project of paramedics in Ontario, Canada. This study found that paramedic industry leaders, assumed to be in a position to drive paramedic professionalization, were divided on whether to pursue regulatory reform, leading to intraprofessional conflict. While it would seem that professional solidarity may be a more practical approach to professionalizing, in reality, stratification within the professions is common (Abbott 1988; Nancarrow & Borthwick, 2005). What is less understood is the impact of intraprofessional division and conflict on professionalization (Nancarrow & Borthwick, 2005; Boateng & Adams 2016; Adams, 2020a).

The cause and impact of intraprofessional relationships are not fully understood, particularly as it relates to professionalization. Stratification can result from dividing labour within a profession, common in many health professions that created subgroups or aids for specific tasks (Nancarrow & Borthwick, 2021). Intraprofessional dynamics have been studied in nursing, with several studies finding that the profession is increasingly internally diverse as a result of specializations and role changes, and this has led to intraprofessional conflict and division (Martin, Currie & Finn, 2009; Comeau-Vallee & Langley, 2020; Boateng & Adams 2016; Felder et al., 2022). For instance, Boateng and Adams (2016) note that professional unity can come at the cost of undermining professional work and restricting the voices of new and minority nurses. Alternatively, another study found that professional collegiality and

harmony between different levels of nurses helped them manage workload and expand their roles (Miller & Kontos, 2016). Comeau-Vallee and Langley (2020) highlight in their study of a multidisciplinary healthcare team that professionals, even those of similar status in the same profession, are competitive and strive to maintain their hierarchical position amongst themselves.

The cause and impact of intraprofessional relationships are not fully understood, particularly as it relates to professionalization. The lack of a collective voice could hinder a profession's ability to advocate for themselves to the government and public, in turn destabilizing a profession's authority and power over to control their affairs (Adams, 2020a). Thus, examining the topic of self-regulation as it relates to professionalization projects and intraprofessional division is an area rich for exploration. Self-regulation once afforded some influential professions (like medicine) status, and legitimacy by monopolizing an area of practice and expertise (Adams, 2017; 2018). Even less powerful professions, such as midwives, nursing, and complementary and alternative medicine professions, have been described as professionalizing through self-regulation (Bourgeault & Fynes, 1997; O'Reilly, 2000; Adams, 2004). In the United Kingdom and Australia, government reforms have targeted the allied health professions to address workforce shortages, leading to advancements in scopes of practice, state regulation, and autonomy from medicine (Nancarrow & Borthwick, 2021, p. 211).

Some scholars view self-regulation, alongside expansions in scope and higher education, as consequential to paramedic professionalization (Givati et al., 2019; Reed et al., 2019; O'Meara et al., 2018; Tavares et al., 2021). In the Australian context, inclusion as a healthcare professional under the state legislation and higher education is positioned as a cornerstone of paramedic professionalization, leading to autonomy and control, the solidification of paramedic identity, and new healthcare roles (Joyce et al., 2009; Williams &

Eglington, 2019). Scholarly perspectives on paramedic professionalization from the United Kingdom have revealed a murkier picture (McCann et al., 2013; Givati et al., 2019; McCann & Granter, 2019). While paramedics have obtained many of the traits of other professions, the government often imposes professionalization rather than driven from within the profession (McCann et al., 2013; Givati et al., 2019). This finding aligns with Evett's (2011) work that argued professionalization can occur from above the profession to serve the government's needs.

In the UK, paramedics are *controlled* professionals. They work in publicly funded organizations facing mounting operational strains and demands for service and rooted in managerialism and marketization (McCann & Granter, 2019). Paramedics in Canada are also described as facing pressures on their day-to-day work due to neoliberal reforms prioritizing efficiency and cost-cutting (Braedley, 2015; Corman, 2018). McCann and Granter (2019) state, "there is a danger that professionalism under conditions of managerialism and austerity is recast simply as compliance. All occupations exist in a social realm increasingly dominated by market logics, in which managers and managerialism become the organizational profession par excellence" (p. 227). These conditions suggest that efforts to drive professionalization from within are increasingly complex.

In the Canadian context, paramedics primarily provide emergency care to people in the community, although their role is expanding to address gaps in the healthcare system (Corman, 2018; Tavares et al., 2021). There are over 11 000 paramedics in Ontario that respond to 1.75 million emergency calls every year (OPA, 2022). Paramedics in Ontario are government regulated and not self-regulated like most allied health professions or paramedics in other provinces. In Ontario, the topic of self-regulation has sparked polarizing responses from paramedic organizations. In 2013, the Ontario Paramedic Association (OPA), the paramedic professional association, applied to the government to change the paramedic

regulatory model to self-regulation (OPA, 2013). A union representing thousands of paramedics in Ontario publicly rejected the OPA's application, calling discussion on the matter as having the potential to "undermine the profession" and questioning the OPA's role in paramedic representation (Bueckert, 2016). The professional associations representing paramedics (OPA, 2013; 2022) and Paramedic Service providers (OAPC, 2016, 2019; AMO, 2021) continue to publicly endorse the self-regulation of paramedics.

The findings of this paper are from interviews with paramedic leaders across different sectors of the paramedic field (employers, unions, educators, regulators, and advocacy groups) which examined perspectives on paramedic professionalization. This paper examines intraprofessional dynamics through the concept of institutional work. This paper aims to illuminate and explain the cause and consequence of intraprofessional conflict and division in paramedic professionalization by analyzing these perspectives.

THEORETICAL FRAMEWORK

If professions are increasingly internally diverse, our conceptual framing of professionalization needs to extend to reflect this. This research adopts the complementary frameworks of Neo-Weberianism and neo-institutional theory (Saks, 2016) to examine the paramedic professionalization project. This study starts with Larson's definition of a professional project, referring to the efforts made by an occupational group to gain social and economic rewards and improve their status (Larson, 1977, 1979). Professionalization projects are "projects of collective occupational and social ascension" (Larson, 1979, p. 608). While not all professionalization projects are successful, they aim to standardize and homogenize a professional group. Larson contends that professionalization projects are ideological: "they serve a legitimating function and contribute to the perpetuation of existing social arrangements" (p. 613).

Self-regulation has been linked to professionalization as it allowed professions to obtain market control over an area of practice (Adams & Saks, 2018). From the neo-Weberian tradition, social closure refers to a process whereby groups seek to monopolize an area of practice and expertise, leading to social, cultural, and economic gains (Larson, 1977; Saks & Adams, 2019). Social closure draws attention to the profession's legal boundaries and their creation and maintenance. Self-regulation *can* tip the balance of power towards the profession as they hold the dominant position as the expert and judges of their work and their colleagues, but not in all circumstances.

Institutional work is relevant to professionalization as professions enact institutional work to change, maintain, or transform institutions (Lawrence & Suddaby, 2006). Institutions are the regulatory structures, laws, courts, governmental agencies, and professions that create a rule-like system that structures behaviour and thought (DiMaggio & Powell, 1991). Institutionalization is the process where these rules become embedded to the point where they become taken for granted. Institutions exert pressure on organizational fields that results in actors in the field sharing similar attributes to gain legitimacy rather than solely organizational effectiveness. Professions are vital agents of institutionalization, as professionalization "is one of several ways to give order, structure and meaning to a distinctive area of social and economic life" (Muzio et al., 2013, p. 705). For example, professions can change broader fields (e.g. healthcare) by creating new professional boundaries, roles, or knowledge (Suddaby & Viale, 2011).

Institutional work is a theory of action whereby action is both cognitive and structural, shaped by the "social construction of rules, scripts, schemas, and cultural accounts" (Lawrence & Suddaby 2006, p. 218). These social scripts can constrain what actions actors think are possible, but actors can become reflexive about their environment and manipulate these constraints to enact change. Conceptualizing institutional work requires

examining the processes that lead to action rather than solely outcomes (Lawrence, Suddaby & Leca, 2011). Institutional work illuminates "how actors not only respond to changes in their work and the larger welfare state but also actively shape institutional change both within and outside their own organization" (van Bochove & Oldenhof 2020, p. 112).

This paper examines how paramedic leaders perceived regulatory reform as a means to professionalize using three forms of institutional work: disrupting, construction, and maintenance work (Lawrence & Suddaby, 2006, p. 235). Disruption work is aimed at 'undermining' the belief systems that comprise institutions. Constructing work creates new identities that alter the relationship between the actor and field. Maintenance work refers to work aimed at supporting and complying with existing institutional norms. This conceptual framing provides an apparatus to examine why there were differences in views and, consequently, intraprofessional division. This overcomes an assumption in the concept of a professionalization project that occupations pursue a collective and shared effort towards upward mobility (Larson, 1977). This perspective also moves beyond the binary between professionalization and deprofessionalization.

BACKGROUND

Healthcare Regulation in Ontario

In Canada, the provinces are responsible for regulating healthcare professionals (Lemmens & Ghimire, 2019). This study takes place in Canada's largest province, Ontario, where self-regulation is the dominant regulatory model for the healthcare professions, although it has faced many changes (O'Reilly, 2000; Adams, 2020b). Few healthcare professions were autonomously self-regulating little government involvement until the 1970s and 1980s (O'Reilly, 2000; Adams, 2018). As the number of healthcare professions with little

or no regulation grew, the government started a consultation process to overhaul the regulation of healthcare professions. This coincided with government policy increasingly concerned with enhancing the healthcare system's efficiency and accountability (O'Reilly, 2000; Adams, 2017).

The result was the creation of the Regulated Health Professions Act (RHPA), which increased state oversight and enhanced public protections (O'Reilly, 2000; Adams, 2018). The Ontario model has been described as the "middle ground" between fully autonomous professional regulation and government regulation (Lemmens & Ghimire, 2019). The RHPA upholds a key principle of self-regulation: professionals have the expertise and trust to oversee their members. Professions have legal power to determine entry-to-practice criteria, ongoing practice competencies and quality assurance, and oversight over the practice of its members, however, professional colleges are comprised of professional *and* public members. The Ministry of Health is responsible for administering the RHPA alongside other government-funded healthcare services (Lemmens & Ghimire, 2019). The Minister of Health can instruct a regulatory college to perform actions to uphold the RHPA. There is an independent Review Board comprised of individuals (who are not health professionals or government employees) responsible for reviewing College investigations and other bodies and legislation to ensure fair access to regulation for internationally trained healthcare professionals. The government also determines which professions can be self-regulating under the RHPA. For professions to become self-regulating under the RHPA, they must have met a "risk of harm" threshold caused by a lack of adequate regulation (p. 130).

When the RHPA was created, it allowed some excluded and subordinated healthcare professions to be legally recognized. While physicians still maintained their extensive scope of practice and expertise, healthcare professions were granted regulatory autonomy from medicine by having their professional college (O'Reilly, 2000). For instance, midwives were

granted a college in the legislation after being legally excluded from practicing midwifery for several decades (Bourgeault & Fynes, 1997; Coburn, 1993). There have been enhanced autonomous and interprofessional roles for professions such as nurses and pharmacists (Bourgeault & Grignon, 2013). In general, healthcare professions have been pushed to become collaborative and avoid 'turf wars' (Adams & Saks, 2018, p. 70).

While the creation of the RHPA was considered a win for some healthcare professions, the political environment in Ontario has altered the legitimacy of self-regulation as a feature and right of the professions. Regulation of the healthcare professions has many aims, from healthcare efficiency to healthcare system sustainability, and the power of the professions may be waning (Adams, 2020b). Adams argues that as healthcare has continued to advance in complexity and intensity, governments increasingly view self-regulation as a hindrance compared to other priorities favouring competition and cost efficiency (Adams, 2016, 2020b). There are ongoing concerns that self-regulating professions fail to ensure their members' competence and manage misconduct (Adams, 2017; Lemmens & Ghimire, 2019). Further, while interprofessional conflict has been discouraged, medicine remains in a dominant position over other healthcare professions and has higher incomes and social status (Adams & Saks, 2018).

The Ontario Paramedic System and Regulation

Paramedics are regulated differently than professions under the RHPA. Paramedics are regulated by a government-led health authority, the Ontario Ministry of Health, Emergency Health Services Branch, which sets performance agreements with paramedic operators and Base Hospital organizations, entry-to-practice requirements and ongoing training and care standards, and conducts investigations (MOH, 2022). The Ministry of

Health contracts Base Hospital organizations, which have physicians as their medical directors and oversee paramedics' advanced skills (MOH, 2022; OBHG, 2022).

A rigid definition legislatively binds Ontario paramedics, defined as "persons employed by or a volunteer in an ambulance service who meets the qualifications for an emergency medical attendant as set out in the regulations, and who is authorized to perform one or more controlled medical acts under the authority of a base hospital medical director, but does not include a physician, nurse or another healthcare provider who attends on a call or an ambulance" (Ambulance Act, 1991). This means paramedics are *only* paramedics under the specific condition that they are employed by an ambulance/paramedic service, meet the Ministry of Health entry-to-practice requirements, and are certified to practice via a Base Hospital program. Practitioners working for patient transfer companies or event medical service are not paramedics under the Ambulance Act (1991).

Designated delivery agents employ paramedics. In Ontario, there are 52 designated delivery agents of land ambulance services (OAPC, 2022). Most delivery agents are the municipalities that co-fund land ambulance services with the provincial government (AMO, 2021). The province funds one air ambulance service. Within municipal organizations, land ambulance services are often called Paramedic Services or Emergency Medical Services. Paramedic Services are responsible for ensuring that provincial regulations and legislation are upheld (MOH, 2022). Paramedic Services are accountable to the Ministry of Health, which monitors key performance standards such as the maximum amount of time an ambulance can take to get to an emergency call, patient outcome performance measures, and conducts investigations to determine violations of the Ambulance Act. The paramedic field in Ontario is summarized below in Table 1.

METHODOLOGY

Overview

This research adopted Merriam's (1988) constructivist case study approach. Merriam's epistemological stance on case study design emphasizes understanding and describing a particular social phenomenon from the perspective of those doing and making meaning in their social world. From Merriam's view, a case is a bounded system that is studied through "an intensive, holistic description and analysis of a single phenomenon" (p. 21). The purpose of the case is to arrive at a comprehensive understanding of the case and its processes. This study obtained ethics approval from the researchers' university ethics board.

Reflexivity

During this research, the primary researcher was a paramedic in Ontario and a graduate student studying paramedic professionalization. She conceptualized reflexivity as methodological (how her positionality impacted the research process) and epistemic (how her meta-theoretical/ontological assumptions impacted the research). To operationalize methodological reflexivity the researcher engaged in memoing during and after the interviews, reflecting on her rapport with participants and how her positionality may have impacted the interview. Memos were used to contextualize data analysis. Participants were aware the researcher was a paramedic and graduate student in the study invitation letter and at the beginning of the interview.

Enosh, Ben-Ari and Buchinder's (2008) and Enosh and Ben Ari's (2016) approaches to epistemic reflexivity were also employed, focusing on differences in worldviews and moral stances as a means to examine the production of knowledge critically. These authors suggest iterative phases of enacting epistemic reflexivity. In the discovery stage, the

researcher turns inwards to discover the differences, incongruences, or contradictions that arise in producing knowledge that highlights something new to be understood and explored. This could occur by remarking on lightbulb moments in the research, surprising findings, or things that contradicted earlier working ideas and hypotheses. In the construction phase, the researcher examines these ideas and uses them as new knowledge that advances the research or theoretical perspective.

Data and Methods

This research drew on interview data conducted with paramedics who had previously or were actively practicing as paramedics, now in leadership positions across the paramedic profession in Ontario. A document analysis of publicly available documents was also conducted. Participants of the interviews were from service delivery organizations (termed Emergency Medical or Paramedic Services), clinical practice and regulatory organizations, education institutions, unions, and professional associations. The rationale for focusing on individuals in leadership positions in these organizations is they were thought to be in a position to influence or be knowledgeable of paramedic professionalization (Muzio et al., 2013). We sought participants from these organizations who had experience and perspectives as paramedics (current or former) and were active in their role at the organization at the time of the research. The public documents and the research team's experience in the paramedic community were used to identify relevant organizations. Data collection occurred iteratively to allow the interview data and documents to inform one another.

From April 2018 to December 2019, 49 potential participants were mailed or emailed a study invitation. Mailing addresses and emails came from publicly available websites. One participant participated in the research as a result of snowballing. A total of 25 people participated in an interview conducted by the principal researcher. An interview guide was

used that focused on the topics of self-regulation, the history of paramedics in Ontario, paramedics' interprofessional relationships, education, and paramedic work. The interviews ranged from 45 minutes to 95 minutes. Two participants participated in follow-up interviews to gather more information. Four interviews occurred in person and the remainder over the phone. Participants could review their transcripts to highlight comments they did not want quoted, clarify statements for quality, or retract information.

Publicly available documents were a secondary source of data to create a richer understanding of the phenomenon (Bowen, 2009; Varpio et al., 2016). Documents helped uncover meaning, provided historical background information, and contextualized the interview findings. A document search using Google was conducted in January/February 2018 and January 2020. Documents spanned the areas of policy, research reports, environmental scans, regulation (proposals, responses, regulatory websites), visionary documents, and standards and legislation. Some participants of the interviews also identified documents. Documents included in the analysis appeared to be consequential to paramedic professionalization (e.g. legislation, policy documents), monumental or created by a paramedic organization to describe or position paramedics in the future. Fourteen documents related to self-regulation were analyzed for this paper.

Interview Sample Description

The participants of this research were a varied group of individuals. Most participants had experience in multiple paramedicine sectors (e.g. education and practice/clinical). Based on their primary role at the time of the research, participants were from the following sectors of paramedicine: education (five), labour/union (four), advocacy (three), clinical practice (three), operational (nine), and anonymous (one). Five participants were women. Participants had experience working as paramedics ranging from eight to 34 years. Eight participants

were active as a frontline paramedic at the time of the research. Most participants described that they worked as a paramedic for 10 to 15 years before moving to another role. Most could not maintain their certification as a paramedic once they took on another role. Based on total years of working in the paramedic sector: seven participants had over 30 years of experience, 13 participants had between 20-30 years of experience, four participants had 10-20 years, and one had under ten years of experience. Seven participants had graduate education level credentials (master's or professional designation). The paramedic community in Ontario is small, so to maintain the confidentiality of participants they are all referred to as "paramedic leaders" and not identified by sector.

Organization	**Roles**
Ministry of Health-Emergency Health Services Branch	Role: Regulator -Set performance agreements with paramedic operators and Base Hospital organizations -Set entry-to-practice requirements and ongoing training and care standards -Conducts clinical and professional investigations and quality assurance -Fund a portion of paramedic service delivery
Base Hospitals	Role: medical oversight for the regulator -contracted by the Ministry of Health - physician medical director -provide training and continuing education, quality assurance -uphold a clinical quality assurance program -8 Base Hospital Organizations
Paramedic Services	Role: organization that delivers paramedic services -designated by the Ministry of Health (MOH) -meet requirements of MOH and Base Hospital; have additional clinical and professional quality assurance program -employ paramedics as defined in the Ambulance Act, 1990 -upper-tier municipalities share responsibility for funding and delivery -52 land ambulance services and one air ambulance service
Unions	Role: labour representatives of paramedics employed by paramedic operators -union organizations are specific to each paramedic operator -thousands of paramedics are represented by the Canadian Union of Public Employees or the Ontario Public Service Employees Union
Education institutions	Role: Educators -Ministry of Health recognized public and private career colleges to train paramedics at the entry-to-practice level (28 programs)

	-some education institutions provide advanced training for paramedics (12 programs)
Professional Associations	Role: Advocacy -Federal: Paramedic Association of Canada, Paramedic Chiefs of Canada -Provincial: Ontario Paramedic Association, Ontario Association of Paramedic Chiefs

TABLE. 1. The paramedic field in Ontario

Analysis

This research employed abductive analysis described by Tavory and Timmermans (2012; 2014). Abductive analysis describes the goal "of producing new hypotheses and theories based on surprising research evidence" (Tavory & Timmermans, 2012, p. 170). As a starting point, abductive analysis requires the researcher to have knowledge and awareness of many theoretical perspectives and "socially and historically situate" this knowledge (p. 171). Knowing various theories serves to sensitize the researcher to the scope of the research and seek out surprising findings. In abductive analysis, existing theories can explain the phenomenon being studied; however, researchers need to "push against existing theories to identify changed circumstances, additional dimensions, or misguided preconceptions" (Timmermans & Tavory 2012, p. 179).

In abductive analysis, novel explanations are compared against new data to determine theoretical rigour (Timmermans & Tavory, 2012). Data is revisited in light of theories and ideas, a process of doubling back to examine the relationship and variation between existing theorizations and new or unexpected findings. An essential aspect of abductive analysis is alternative casing, where the research aims to understand the data from many different perspectives. This process requires the researcher to be highly reflexive and reconsider their earlier ideas and claims regarding new data and established ideas. Abductive analysis is complementary to our approach to epistemic reflexivity. For instance, the reflexive cue to consider the "differences that make a difference" was one way to differentiate between what

was familiar and taken-for-granted in the data and what was strange or surprising in light of the professionalization literature. This research initially considered a wide breadth of scholarship in the sociology of professions. What was surprising in this research was that participants had diverse views on whether and why self-regulation was important to professionalization and knew that this topic was a source of intraprofessional division. A pluralistic theoretical approach provided a means to unpack intraprofessional dynamics.

Data analysis started as soon as data collection began. Following each round of interviews, a descriptive coding analysis was undertaken, and emerging codes, memos and notes were considered in relation to the existing literature. The first round of descriptive codes and memos included why participants thought something should/should not be pursued in paramedic professionalization, how change was occurring, sources of power, critical historical changes for paramedics, and novel topics or ideas to probe in subsequent interviews. After completing the interviews, we identified that the phenomenon of interest was the disagreement between participants' views. Using the concept of institutional work, the analysis focused on describing differences, similarities and tensions between participants and within individual accounts. Documents were used to contextualize the emerging findings.

FINDINGS

The first three findings examine diverse perspectives on paramedic regulation through different types of institutional work: disrupting work, constructing work, and maintenance work. In the fourth finding, the impact of participants' diverse views on professionalization–a fragmented and divided occupation–is examined.

Disruption work: Questioning the paramedic-physician relationship

Participants described how the Base Hospital organizations and physician medical directors were central to paramedic professionalization and significantly contributed to

paramedics' evolution from 'ambulance attendants' in the late 1980s. Physicians helped enable paramedics increased scope of practice. The 'ambulance attendant' changed to 'paramedic 'across Ontario partly after a successful research study deemed paramedics as safely providing advanced life-saving clinical interventions (Stiell et al., 1990; 1999). Participants from different sectors of paramedicine reported that they believed the Base Hospital system and physician medical directors were champions of an evidence-based approach to paramedicine, which helped legitimize paramedics growing scope of practice.

Where participants' views varied was on the state of paramedic-physician relations. Some participants expressed frustration with the lack of autonomy and paramedic voice in the current regulatory model. One participant described the Base Hospitals as having a "sense of superiority" and, at times, a "paternalistic" relationship with paramedics. Another descriptor of the paramedic-physician relationship was that of a parent-child: "we have no say. We are kind of like the children who have not been allowed to grow up".

Some participants believed that self-regulation would level the playing field with physicians and allow paramedics to self-direct their future. As one participant described:

> "We are at a level where I think a College should play a key role. It allows paramedics to drive their future. The problem is, we never had a chance to drive our future; it was always someone else who drove it, some physician or whoever. But now, we are at a level where we say we are a profession. We need to look after our own. We need to hold our own accountable" (participant 22).

Other participants discussed how paramedics should have their own college as they were the experts of work and should have representation by a peer over practice disputes. Participants described paramedic work as "chaotic," unique, and complex, and many argued

that paramedics were best positioned to understand and regulate their peers (interviews; OPA, 2013, p. 37). This expertise meant they should have a central role in paramedic regulation. Participant 12 stated, "there is no recourse or representation with the Base Hospitals if they decide to deactivate them. They haven't done that haphazardly, but paramedics do not have representation. But with a college of paramedics, they self-represent".

It is important to note that most participants who supported regulatory reform wanted to keep physicians included in paramedic regulation. Many participants conceptualized a role for physicians in a self-regulating college. One participant stated, "I hope it would not change the Base Hospital relationship. We need medical oversight. I would not support a college that will eliminate collaborative or interprofessional collaboration. I have no reason to believe we would ever eliminate emergency physician input into our practice, medical directives, and licensing" (participant 3). Participants discussed how this was a typical relationship for other healthcare professionals to have with physicians: "all professions have to work off of the standard of practice from the medical world, for healthcare. Nursing or any other regulatory college has their own principles and ethics, but are still based on the bigger medical regulatory college" (participant 20).

This disruption work showcases that paramedics are attempting to alter the once taken-for-granted belief that physicians are central to paramedic professionalization. While most participants remained cautious in how they approached this change, equalizing their role rather than replacing physicians, this shift is a notable change given paramedics' historical trajectory with physicians.

Disruption work: Questioning the Structure of Existing Paramedic Regulation

For some, calls for regulatory reform were around the structure of the current regulatory model of paramedics. As one participant stated bluntly, "we have the most archaic,

dysfunctional system that is unique to the world from a medical process" (participant 10). As the Ontario Paramedic Association described in their application for self-regulation, "self-regulation must be understood as the transformation of the existing system" (2013, p. 2). Several participants described the current regulatory system as confusing, overly complex, and over-regulates paramedics. Many participants did not think patients could navigate the complex regulatory system: "If I am a true patient advocate, we need to move to a single regulatory body. Not two, not eight, not nine. There is a public face to it, and people can go to the website and have the means to complain. We are all held to the same level of accountability" (participant 15). Another participant stated:

> "Look at how we are regulated. We go through rigorous testing and certification. We answer to a Base Hospital. We answer to the Ministry of Health. We answer to our service. We answer to the public. We are regulated. Now, from a public policy perspective, there is redundancy and over-regulation. Why do we have these multiple bodies and spend money on them to regulate paramedics when it could be done by one body?" (participant 2).

Several participants were concerned that different areas of paramedic care are regulated by various entities. New areas of practice were not regulated clearly in the current framework. For example, some participants discussed how new roles for paramedics working in community health or primary care, called community paramedics, were not clearly regulated under the current framework, a claim confirmed by an analysis of documents (OPA, 2013; OAPC, 2016). The community paramedic role raised questions for some participants regarding the appropriateness of the current regulatory system to oversee these new areas of care and was used in documents from the provincial associations as a rationale

for paramedic self-regulation (OPA, 2013; OAPC, 2016, 2019). Participants were also concerned that the current regulatory model poses a barrier to the future of new models of care. For instance, some participants described how other healthcare partners do not understand the paramedic's regulatory system and navigating the current regulatory model can hinder partnerships with healthcare organizations. One participant explained that it was challenging to find medical oversight of some community paramedicine programs since there was no familiar regulatory model or roadmap for agencies to use.

In this form of disrupting work, some participants identified challenges and limitations in the current regulatory model, which they used to make a case for paramedic self-regulation. Participants were able to identify systemic issues, such as a lack of regulation over new areas of work and the lack of a patient-centred approach. This form of reflexive awareness showcases how participants engaged in disruption work aimed at understanding gaps in the current legislative and organizational structure.

Constructing work: the creation of Paramedics as a Healthcare Profession

Paramedics originated in the public safety/emergency services sector, which situates paramedics as uniformed first responders alongside police and fire services, a unique starting position when compared to other healthcare professions. Paramedics perform work that involves rushing lights and sirens in an ambulance to various chaotic scenes and responding to individuals in life-threatening distress. While participants remarked that many 911 calls were for non-emergency situations, emergency work remains essential to the paramedic's understanding of their professional identity. It can be seen in aspects of paramedic culture, such as paramedic's tactical uniforms and a frontline culture that privileges emergency work ("good calls") over non-acute calls.

Rapid changes to paramedic roles and public and government expectations have broadened and shifted the boundaries of what a paramedic is. As paramedics' medical scope of practice increased, participants and documents described the need to leave the "ambulance driver" identity behind and for paramedics to be recognized as healthcare professionals (EMSCC, 2006; PAC, 2016; OAPC, 2016, 2019). Participants described how evidence-based medicine has also been an important hallmark of paramedic professionalization as a healthcare provider.

Service delivery models of paramedics have also reflected the shift towards healthcare. For instance, service providers were once called Emergency Medical Services (EMS), and many recently changed their name to Paramedic Services, reflecting their broadening mandate. Paramedics have taken on community-based non-emergency roles, termed community paramedics. Documents examining community paramedics have received government attention and financial support to help provide a diverse array of healthcare programs in the home, primary care, and long-term care sectors (Sinha, 2013; Bringing Care Home, 2015; MOHLTC, 2017).

For some participants, self-regulation would help consolidate paramedics' identity as a healthcare profession. The OPA's application for self-regulation and more recent documents from the Ontario Association of Paramedic Chiefs (2016, 2019) signify this desire. Several participants remarked that self-regulation would mean paramedics were recognized as a "true profession." Participant 23 stated:

> "It is an acknowledgement through legislation that the profession is a legitimate part of healthcare. We have always been the Cinderella of emergency services. We have never gotten to go to the ball. We need to be recognized as legitimate healthcare

> providers because our work is hard. It is unlike any other work that is currently done by any other healthcare provider".

To be excluded from the primary healthcare professions' legislation and yet be trusted with a large and complex *medical* scope of practice seemed contradictory and frustrating for some participants. Participants felt that paramedics were not consistently recognized by other healthcare professions or organizations, despite taking on more prominent roles in healthcare delivery. Participant 12 described, "when we are invited to have a seat at the table, we get the little chair." The constructing work of paramedics aims to clarify paramedics' identity as a healthcare profession and, in doing so, improve paramedic legitimacy and recognition to other healthcare professions and organizations.

Maintenance Work: Supporting the Current System

Some paramedic leaders did not view regulatory reform as necessary for paramedic professionalization. Some of these participants had concerns similar to participants who supported self-regulation, such as the complexity of the current regulatory model. However, for these leaders, self-regulation was irrelevant to professionalization because they viewed paramedics as professionals. As one participant stated: "we behave professionally. We put the good of society before our good. We will go running into the problem rather than run away from it. There is a level of trust. There's that professionalism" (participant 5). Other participants indicated that paramedics had a collective identity and were viewed as a profession by the public. Paramedics were dedicated, trusted public servants who brought value and were accountable to local communities. As participant 19 stated, paramedics were professionalizing despite self-regulation: "the claim that we're not a health profession until we're a regulated health profession, it's just dubious."

Many participants discussed how the current regulatory system provides title protection for working paramedics, is evidence-based and has led to rapid advancements in paramedic practice with wide safety margins. One participant stated: "I read college decisions and see members being prosecuted for relatively minor things. I don't know how that system ensures patient safety any more than ours" (participant 19). For some participants, the current system was functioning appropriately, and they were cautious about the idea of major regulatory reform. For example, one participant cautioned that paramedics in other countries moved forward too quickly, adding new skills, and had those skills revoked when errors were made. Participant 11 stated, "It doesn't matter what system is in place. There will always be concerns about patient safety and having evidence-based protocols right? With the shift in our protocols becoming more evidence-based, we're going as fast as possible".

Paramedic leaders who wanted to preserve the current system felt that paramedics were involved in decision-making and had representation at the clinical level (e.g. Base Hospitals) to voice their ideas and concerns. One participant stated:

> "I am very happy with the status quo. When you asked me how you have seen the profession change over the years, the Base Hospitals have done a fantastic job advocating for the patients. They do a great job analyzing what is needed for the profession. They are very safe, and they involve paramedics in paramedic practice discussions. And they seem very focused on paramedics and patients. So I do not know that rebuilding the wheel is necessary at this point. So as far as the benefit, I do not know that benefits outweigh the status quo at this point" (Participant 9).

Several participants questioned if self-regulation could even enable advancement. When discussing paramedic advancement, participant 9 remarked, "how much further ahead

could we be already?" and that paramedics did not need to change at the pace seen in earlier decades. Some participants were resolute in their position that the current system was worthy of preservation. From this lens, self-regulation was not linked to professionalization, decoupling its linkage to improving paramedic's status and legitimacy.

Stratification, Distrust, and Conflict in the Paramedic Profession

Consistently participants discussed that the paramedic community's biggest challenge was the degree of stratification across the profession. Differences across the paramedic sector are maintained structurally, such as the separation of regulation across different organizations and the sheer volume of service providers, unions, educational institutions, and several professional associations. The complexity of the paramedic system has led to an unequal pace of change across paramedics. Some participants described collaboration and improved coordination occurring at a local level; however, several participants felt that the paramedic advancement was unequal and fragmented. Some participants described access to financial and operational resources and expertise in research and education have led to paramedic progress in some areas but not others.

According to some participants, stratification is also created because of the different ideologies informing paramedic professionalization. Participant 16 stated, "I think part of the problem is we have too many groups, too many associations, too many leaders with different visions." The multiple organizations of paramedicine have prioritized different values and ideas about what is needed for paramedics. There was considerable tension across participants regarding who constituted the paramedic profession and could be the legitimate voice of paramedics. Like the advancements made by the Base Hospitals, some participants credited paramedic unions with advocating for improving working conditions, pay, and benefits for paramedics. Some participants discussed that the unions were not always

included in decisions around paramedic advancement; others felt they were in conflict with professional associations at times.

Whether self-regulation was viewed as consequential or irrelevant to professionalization related to whether participants thought paramedics were a "profession ." On this question, there was no agreement. Some participants felt that since paramedics were regulated and trusted by the public, they deserved to be recognized as a profession. Others viewed professions as self-regulating occupations with a university degree for entry-to-practice, meaning paramedics were not a profession. As one participant stated:

> "I will balance the profession and what we call our workers. Some people still consider themselves blue-collar workers because we have not transitioned and moved forward in many areas. But I do not think you are ever going to change that. Most people would say we are a profession, but we are not a profession. That is where I am at on it. Because we still get confused as individuals between professional medical oversight and union responsibility. So, if we become a profession, you have to look after your own professional activities. So we still wrestle with that as a profession" (participant 21).

When one participant was asked if paramedics were a profession, they answered, "does it matter? Will it change our trajectory?". While this question has philosophical merit, it is clear that without agreement from paramedics on what being a profession means to them, there is no means to decide what matters most to paramedics or others. Without communication, skepticism, hesitancy, and distrust between paramedic organizations have developed. One participant reflected on this dynamic and remarked that the profession has

"set ourselves up to fail" (participant 16). Some participants admitted they did not fully understand some claims made by other paramedic organizations.

When asked if paramedics could move forward as a collective and how this could happen, many participants suggested the need for new insights and external support. Some participants believed a regulatory college could help create a common voice for paramedics and, in participant 10's terms, "help simplify a complex and dysfunctional system." Others were worried that a regulatory college would offer false hope and "not solve the problems it was thought to solve" (participant 5). Several participants suggested that evidence and research, driven from within the profession, could help determine a path forward. For instance, participants pointed to this research as an opportunity to help "fix" the problems of the profession. Other participants stressed the role of the government in determining the direction of paramedicine: "there are too many voices, it is very divisive. Government has to take the lead and take the advice of those in the industry and say, this is the direction it is going" (participant 24). The lack of immediate action options maintains the fragmentation across paramedics.

DISCUSSION

This paper complements a growing body of scholarship on professionalization, providing further insight into intraprofessional relationships, particularly as it relates to division and conflict. Previous research on the healthcare professions has limitedly focused on intraprofessional relations and their impact on professionalization. However, doing so can reveal important insights into the variable pathways of professionalization and its threats (Brosnan, 2017; van Bochove & Oldenhof, 2020). The concept of institutional work illuminated why there were distinct views on paramedic professionalization. Rather than adopting taken-for-granted opinions of what it meant to be a profession in the healthcare

field, participants had a reflexive awareness of the current state of paramedics and paramedic regulation. However, the lack of professional unity in paramedicine can undermine professionalization and set the stage for further intraprofessional conflict.

This research improves our understanding of the influence of intraprofessional relationships on professionalization and, through the concept of institutional work, why professional heterogeneity can occur. Many paramedic leaders wanted to improve paramedics' status and autonomy and gain legitimate recognition as a healthcare profession. To some, self-regulation serves as a symbolic measure of professional status. However, as seen in the findings of this research, support for self-regulation must be responsive to the government's needs and interests rather than professional interests. Adams (2017) notes that self-regulation and professional advocacy have historically been separated in Canada, which has protected the model from the critique that the model faces interference from professional interests. Further, advocating for regulatory change has become increasingly challenging as governments prioritize healthcare goals that are misaligned with self-regulation (Adams, 2020b). This research shows that some paramedic leaders may want paramedic professionalization to occur neo-Weberian terms, however, they must frame the issue as meeting government needs. This explains why recent documents endorsing self-regulation connect the topic with community paramedic roles and other healthcare system crises (OAPC, 2016, 2019; AMO, 2021).

The divisive views found amongst participants are also partially explained by their social position. Participants of this research were hybrid professionals (Noordegraaf, 2015), such as paramedic managers or paramedic-educators. Research on hybrid professionals, such as those who occupy manager-professional roles, has found a variety of impacts on professionalization (Adams, 2020a). For instance, Hogdson et al. (2015) describe the professionalization project of management professions where they pursued a hybrid strategy

that included collegial and corporate professionalism to balance these two competing logics. Alternatively, in a recent study of engineer-managers, Adams (2020a) found that the dual influence of managerialism and professionalism was causing conflict and tension within the engineering profession as some roles were privileged over others. This research aligns with Adam's concern that "although internal divisions within professions have long existed by specialty and role, increased diversity, specialization, and organizational differentiation within professions bring new challenges with implications for professional collegiality, identity and unification" (p. 102). The paramedic sector consists of dozens of organizations with unique mandates and priorities. The social hierarchy between the various organizations was chaotic, with participants across sectors expressing forms of exclusion.

What is a surprising finding in this research is that there are influences other than managerialism or neoliberal healthcare policy that can cause intraprofessional division. Paramedics face an internal contradiction between the desire to pursue classic professionalization strategies versus the street medic uniformed identity of paramedics. Paramedics have a similar 'masculine, boots-on-the-ground occupational history and culture to other uniformed emergency services such as police and firefighters (McCann & Granter, 2019, p. 223). It is worthwhile to reconsider the blue-collar professionalism thesis first coined by Metz in their 1982 study of ambulance attendants, the precursor to paramedics. Metz argued that 'blue-collar professionalism' was the primary identity of ambulance attendants, describing them as "dedicated individuals with an ideal of public service, who enjoy some autonomy in decision-making and share a desire to further an occupational mission despite stressful and exhausting working conditions, poor pay, and limited prospects for upward mobility" (Metz, 1982, p. 57). In McCann et al.'s (2013) study of UK paramedics, they found paramedics face the lingering effects of 'blue-collar professionalism' as professionalization failed to change the organizational demands placed on paramedic operators to lower costs

and maintain efficiency or alter the intense working conditions for paramedics. This study aligns with research documenting an internal tension within the paramedic profession about their status as a blue-collar, street-medic group against increasing pressures to gain status and recognition through the traditional professionalization pathways of higher-level education and self-regulation.

In the UK context, McCann and Granter (2019) argue that paramedics have the potential to overcome these challenges. In the UK, paramedic culture is changing due to state regulations and educational reforms, and paramedic services are in high demand. Others have been less optimistic about the success of occupational closure strategies in professionalization. However, speaking on conflict within nursing, a profession with a long-standing history of standardization and licensure, Boateng and Adams (2016) argue that standardization and licensure can be less effective in contributing to occupational closure due to intraprofessional stratification and conflict. The authors state, "professions have long tried to display a standard image to the world, but in doing so, they may hide and obscure internal inequalities and conflicts" (Boateng & Adams, 2016, p. 41). While it is clear the paramedic sector is undergoing an internal conflict, it also raises the question of what voices are being kept invisible in paramedic professionalization, such as people of colour and women, which are underrepresented in leadership roles (Cameron et al., 2020).

In contemporary times, Adams' argues that profession-state relations have become increasingly tense as the expertise of professionals has been eroded against the neo-liberal government policies and overall skepticism towards expert knowledge (2020b, p. 6). For instance, while Ontario professions uphold many features of self-regulation, government involvement continues to increase, and some regulatory bodies have amalgamated. Since this research was conducted, the government has proposed regulatory changes aligning with this trend. Following a change in the Ontario government in 2019, HRPAC was quietly dissolved

(Ontario, 2021). A new bill was introduced that, if passed, would regulate physician's assistants under the College of Physicians and Surgeons of Ontario (versus establishing a college) and found a regulatory 'authority' for an undefined group of personal and health support workers. Paramedics are also facing changes to how they are regulated. A report examining the Ministry of Health's investigative process for paramedics was released in 2021, finding that the approach to investigate potential paramedic misconduct needed a considerable overhaul (Patient Ombudsman, 2021). Similar to the concerns of participants of this research, the report found an overly complicated and difficult to navigate oversight system. The Ministry accepted all 53 recommendations in the report, many of which enhance and strengthen the Ministry's ability to conduct thorough and transparent investigations. The report does not discuss the topic of self-regulation. Future research examining the impact of these changes on professionalization will be of interest.

CONCLUSION

In a time where traditional pathways to professionalize are under pressure, conceptual tools to describe this process in current conditions are needed. The concept of institutional work applied to the case of paramedics adds to a growing body of research highlighting the importance of considering intraprofessional division in professionalization. This research found that paramedic leaders lack a common voice (and vision), impacting paramedic professionalization. As a professionalization strategy, the lack of professional unity can result in ambiguity, conflict and tension. Intraprofessional contention may not fail the paramedic professionalization project; instead it reflects the current possibilities for professionalization as neither clear nor smooth. However, as Adams (2020b) cautions, if professions cannot agree about what they value most, they limit their ability to speak with a collective voice to the government and other professions.

REFERENCES

Abbott, A. (1988). *The System of Professions. An Essay on the Division of Expert Labour.* Chicago: University of Chicago Press.

Adams, T. L. (2004). Inter-professional conflict and professionalization: dentistry and dental hygiene in Ontario. *Social Science and Medicine, 58*(11), 2243-2252.

Adams, T. (2016). Professional Self-regulation and the public interest in Canada. *Professions and Professionalism, 6*(3).

Adams, T. L. (2017). Self-regulating professions: past, present, future. *Journal of Professions and Organization*, *4*(1), 70-87.

Adams, T. (2018). *Regulating Professions: The Emergence of Professional Self-Regulation in Four Canadian Provinces*. Toronto: University of Toronto Press.

Adams, T. (2020a). Professional employees and professional managers: conflicting logics, hybridity, and re-stratification. *Journal of Professions and Organization*, *7*(1), 101 115.

Adams, T. L. (2020b). Health professional regulation in historical context: Canada, the USA and the UK (19th century to present). *Human Resources for Health*, *18*(1), 1-7.

Adams, T., and Saks, M. (2018). Neo-Weberianism and changing state-profession relations: The case of Canadian health care. *Sociologia, Problemas e Préticas, 88*, 61-77.

Ambulance Act. 1990. Government of Ontario.

Association of Municipalities of Ontario. (2022, January 13). *The Municipal Role in Paramedic Services During COVID-19 and Beyond.* AMO. https://www.amo.on.ca/advocacy/emergency-services/municipal-role-paramedic services-during-covid-19-and-beyond

Association of Municipalities Ontario and Ontario Association of Paramedic Chiefs. (2022, June 28). *Community Paramedicine Policy Framework Paper.*

https://www.amo.on.ca/sites/default/files/assets/DOCUMENTS/Reports/2021/MOHLTCLTRAMOOAPCCommunityParamedicinePolicy%20Frameworkwjoint%20papr2021-06-28.pdf

Boateng, G. O., and Adams, T. L. (2016). "Drop dead… I need your job": An exploratory study of intra-professional conflict amongst nurses in two Ontario cities. *Social Science and Medicine, 155,* 35-42.

Bourgeault, I. L., and Fynes, M. (1997). Integrating lay and nurse-midwifery into the US and Canadian health care systems. *Social Science and Medicine, 44,* 1051–1063.

Bourgeault, I. L., and Grignon, M. (2013). A comparison of the regulation of health professional boundaries across OECD countries. *Eur. J. Comp. Econ*, *10*, 199-223.

Braedley, S. (2015). Pulling men into the care economy: The case of Canadian firefighters. *Competition and Change*, *19*(3), 264-278.

Brosnan, C. (2017). Alternative futures: fields, boundaries, and divergent professionalization strategies within the chiropractic profession. *Social Science and Medicine*, *190*, 83-91.

Bueckert, K. March 3, 2016. 'Paramedics don't need a regulatory college, CUPE says'. CBC. https://www.cbc.ca/news/canada/kitchener-waterloo/ontario-paramedics-don-t-need a-regulatory-college-cupe-says-1.3474010

Cameron, C, Abela, A, Donelon, B, Doiron, M, and Hutchinson, B. (2020). Representation of Women in Paramedicine-A Perspective from Alberta. In *Introduction to the Health Workforce in Canad*a. Ivy Bourgeault (ed). Ottawa: Canadian Health Workforce Network.

Canadian Institutes of Health Research and Health Canada, Government of Canada. (2017*). Best Brain Exchange Report. Innovative Approaches and Pathways Used to Integrate Community Care with Primary Health Care for Elderly Persons in Rural Canada.*

Coburn, D. (1993). State authority, medical dominance, and trends in the regulation of the health professions: the Ontario case. *Social Science and Medicine*, *37*(2), 129-138.

Comeau-Vallée, M., and Langley, A. (2020). The interplay of inter-and intraprofessional boundary work in multidisciplinary teams. *Organization Studies*, *41*(12), 1649-1672.

Corman, M. K. (2018). *Paramedics On and Off the Streets*. Toronto: University of Toronto Press.

County of Renfrew Paramedic Service. (2013). A *Survey of Community Paramedic Programs in Ontario.*

CPSO. (2022). Delegation of Controlled Acts. College of Physicians and Surgeons Ontario. Retrieved from https://www.cpso.on.ca/Physicians/Policies Guidance/Policies/Delegation-of-Controlled-Acts

DiMaggio, P and W. Powell, (1991).*The New Institutionalism in Organizational Analysis.* Chicago: University of Chicago Press.

Emergency Medical Services Chiefs of Canada. (2006). *Future of EMS in Canada.* https://pscs.ca/images/stories/committee/EMSCC-Primary_Health_Care.pdf

Emergency Medical Services Chiefs of Canada. (2012). *Community Paramedicine in Canada*. https://nasemso.org/wpcontent/uploads/CommunityParamedicineCanada.pdf

Enosh, G., Ben-Ari, A., and Buchbinder, E. (2008). Sense of differentness in the construction of knowledge. *Qualitative Inquiry*, *14*(3), 450-465.

Enosh, G., and Ben-Ari, A. (2016). Reflexivity: The creation of liminal spaces—Researchers, participants, and research encounters. *Qualitative health research*, *26*(4), 578-584.

Evetts, J. (2011). A new professionalism? Challenges and opportunities. *Current Sociology*, *59*(4), 406-422.

Expert Group on Home & Community Care, & Donner, G. J. (2015). *Bringing care home: report of the expert group on home & community care*. Expert Group on Home & Community Care.

Felder, M., Kuijper, S., Lalleman, P., Bal, R., & Wallenburg, I. (2022). The rise of the partisan nurse and the challenge of moving beyond an impasse in the (re) organization of Dutch nursing work. *Journal of Professions and Organization*, *9*(1), 20-37.

Frangou, C. (2022*). PTSD, burnout, and a pandemic. How COVID pushed the country's overworked first responders into emergency territory*. Maclean's. https://www.macleans.ca/longforms/canadian-paramedics-are-in-crisis/

Givati, A., Markham, C., and Street, K. (2018). The bargaining of professionalism in emergency care practice: NHS paramedics and higher education. *Advances in Health Sciences Education, 23*(2), 353-369.

Government of Ontario. (2021, April 15). *Dissolution of the Health Professions Regulatory Advisory Council under the Regulated Health Professions Act, 1991*. Ontario's Regulatory Registry. https://www.ontariocanada.com/registry/view.do?postingId=37050andlanguage=en

Government of Ontario. (April 27, 2021). *Proposed Legislation to Strengthen the Health and Supportive Care Workforce During COVID-19 and Beyond.* https://news.ontario.ca/en/backgrounder/1000016/proposed-legislation-to-strengthen the-health-and-supportive-care-workforce-during-covid-19-and-beyond

Health and Care Professions Council. (2022). *Which professions do HCPC regulate?* https://www.hcpc-uk.org/public/which-professions-do-hcpc-regulate/

Health Professions Regulatory Advisory Council. (2013). *Paramedicine in Ontario: Consideration of the Application for the Regulation of Paramedics under the RHPA, 1991. Volume 1 and 2.*

Hodgson, D., Paton, S., and Muzio, D. (2015). Something old, something new?: competing logics and the hybrid nature of new corporate professions. *British Journal of Management*, *26*(4), 745-759.

Joyce, C. M., Wainer, J., Archer, F., Wyatt, A., and Pitermann, L. (2009). Trends in the paramedic workforce: a profession in transition. *Australian Health Review*, *33*(4), 533 540.

Larson, M. (1977). *The Rise of Professionalism: A Sociological Analysis*. Berkeley: University of California Press.

Larson, M. S. (1979). Professionalism: Rise and fall. *International Journal of Health Services*, *9*(4), 607-627.

Lawrence, T and Suddaby, R. (2006). Institutions and institutional work. In: Clegg, S.R., Hardy, C., Lawrence, T., and Nord, W. R. (eds) *The Sage Handbook of Organization Studies*, p. 215-254. London: Sage.

Lawrence, T., Suddaby, R., and Leca, B. (2011). Institutional work: Refocusing institutional studies of organization. *Journal of Management Inquiry*, *20*(1), 52-58.

Lemmens, T., and Mahadevia Ghimire, K. (2019). Regulation of health professions in Ontario: self-regulation with statutory-based public accountability. *Journal of Health Law*, *19*(3), 124-204.

MacDonald, K. M. (1995). *The Sociology of the Professions*. London: Sage.

Martin, G. P., Currie, G., and Finn, R. (2009). Leadership, service reform, and public-service networks: the case of cancer-genetics pilots in the English NHS. *Journal of Public Administration Research and Theory*, *19*(4), 769-794.

McCann, L., Granter, E., Hyde, P. and Hassard, J. (2013). Still blue-collar after all these years? An ethnography of the professionalization of emergency ambulance work. *Journal of Management Studies*, *50*(5), 750-776.

McCann, L., & Granter, E. (2019). Beyond 'blue-collar professionalism': continuity and change in the professionalization of uniformed emergency services work. *Journal of Professions and Organization*, *6*(2), 213-232.

Merriam, S. B. (1988). *Case study research in education: A qualitative approach*. Jossey Bass.

Metz, D. L. (1982). *Running hot: Structure and stress in ambulance work.* Abt books.

Miller, K. L., and Kontos, P. C. (2013). The intraprofessional and interprofessional relations of neurorehabilitation nurses: a negotiated order perspective. *Journal of Advanced Nursing*, *69*(8), 1797-1807.

Ministry of Health and Long-term Care (2022, January 30). *Emergency Health Services.* https://www.health.gov.on.ca/en/pro/programs/emergency_health/default.aspx

Muzio, D., Aulakh, S., and Kirkpatrick, I. (2020). *Professional Occupations and Organizations.*Cambridge: Cambridge University Press.

Muzio, D., Brock, D. M., and Suddaby, R. (2013). Professions and institutional change: Towards an institutionalist sociology of the professions. *Journal of Management Studies*, *50*(5), 699-721.

Murphy, R. (1988). *Social closure: The theory of monopolization and exclusion*. Oxford: Clarendon Press.

Nancarrow, S., and Borthwick, A. (2021). *The Allied Health Orofessions: a Sociological Perspective*. Policy Press.

Noordegraaf, M. (2007). From "pure" to "hybrid" professionalism: Present-day professionalism in ambiguous public domains. *Administration and Society*, *39*(6), 761 785.

Noordegraaf, M. (2015). Hybrid professionalism and beyond:(New) Forms of public professionalism in changing organizational and societal contexts. *Journal of Professions and Organization*, *2*(2), 187-206.

O'Meara, P., Wingrove, G., and McKeage, M. (2018). Self-regulation and medical direction. Conflicted approaches to monitoring and improving the quality of clinical care in paramedic services. *International Journal of Health Governance*.

Ontario Association of Paramedic Chiefs. (n.d.) *About Us*. https://www.oapc.ca/about/

Ontario Base Hospital Group. (2022). *About us.* Retrieved January 20 2022 https://ontariobasehospitalgroup.ca/index.php/elementor-91/

Ontario Ministry of Health and Long Term Care. 'Regulated Health Professions Act, 1991. Last modified 2018. https://www.health.gov.on.ca/en/pro/programs/hhrsd/about/rhpa.aspx

Ontario Ministry of Health and Long-Term Care. (2017). *Community Paramedicine Framework for Planning, Implementation and Evaluation, Home and Community Care Branch.*

Ontario Ombudsman. (2021). *Oversight 911: Investigation into how the Ministry of Health oversees patient complaints and incident reports about ambulance services*. https://www.ombudsman.on.ca/Media/ombudsman/ombudsman/resources/Reports on-Investigations/Ombudsman-Report-Oversight-911-May-2021-EN-accessible.pdf

Ontario Association of Paramedic Chiefs (2016). *Response to Patient's First: A proposal to Strengthen patient-centred Health Care in Ontario Discussion Paper*.

Ontario Association of Paramedic Chiefs (2019). *Letter to Dr. Rueben Devlin, Chair, Premier's Council on Improving Health Care and Ending Hallway Medicine.*

Ontario Paramedic Association. (2022). https://www.ontarioparamedic.ca

Ontario Paramedic Association. (n.d.) *Self-Regulation Frequently Asked Questions*. https://www.ontarioparamedic.ca/self-regulation/faq/

Ontario Paramedic Association. (2013). *Health Professions Regulatory Advisory Council Application. Regulation of Paramedics under the Regulated Health Professions Act, 1991*. https://www.hprac.org/en/projects/resources/OPAapplicationforparamedicself regulation13March2013.pdf

O'Reilly, P. (2000). *Health care practitioners: an Ontario case study in policymaking.* Toronto: University of Toronto Press.

Paramedic Association of Canada. (2016). *Paramedic Association of Canada Strategic Plan 2016-2018.* https://pac.in1touch.org/document/2346/2016%20Strategic%20Plan.pdf

Paramedic Association of Canada Strategic Plan. (2018-2020). https://pac.in1touch.org/document/4862/PAC2018 2020StrategicPlan2018November17boardapproved.pdf

Reed, B., Cowin, L. S., O'Meara, P., and Wilson, I. G. (2019). Professionalism and professionalisation in the discipline of paramedicine. *Australasian Journal of Paramedicine, 16*, 1-10.

Reed, B., Cowin, L., O'Meara, P., and Wilson, I. (2021). Perceptions and Knowledge of Self Regulation of Paramedics in Australia. *Australasian Journal of Paramedicine, 18.*

Saks, M. (2016). Review of theories of professions, organizations and society: Neo Weberianism, neo-institutionalism and eclecticism. *Journal of Professions and Organization 3*(2), 170-187.

Saks, M., and Adams (2019). Neo-Weberianism, professional formation and the state: Inside the black box. *Professions and Professionalism.*

Sinha, S. K. (2013). *Living longer, living well: Highlights and key recommendations from the report submitted to the Minister of Health and Long-Term Care and the Minister*

Responsible for Seniors on recommendations to inform a senior's strategy for Ontario. Ontario Ministry of Health and Long-Term Care.

Stiell, I. G., Wells, G. A., Field III, B. J., Spaite, D. W., De Maio, V. J., Ward, R., ... & OPALS Study Group. (1999). Improved out-of-hospital cardiac arrest survival through the inexpensive optimization of an existing defibrillation program: OPALS Study Phase II. *Jama*, *281*(13), 1175-1181.

Stiell, I. G., Wells, G. A., DeMaio, V. J., Spaite, D. W., Field III, B. J., Munkley, D. P., ... & OPALS Study Group. (1999). Modifiable factors associated with improved cardiac arrest survival in a multicenter basic life support/defibrillation system: OPALS study phase I results. *Annals of Emergency Medicine*, *33*(1), 44-50.

Suddaby, R., and Viale, T. (2011). Professionals and field-level change: Institutional work and the professional project. *Current Sociology*, *59*(4), 423-442.

Tavares, W., Allana, A., Beaune, L., Weiss, D., and Blanchard, I. (2021). Principles to guide the future of paramedicine in Canada. *Prehospital Emergency Care*, 1-11.

Tavory, I., and Timmermans, S. (2014). *Abductive analysis: Theorizing qualitative research*. Chicago: University of Chicago Press.

Timmermans, S., and Tavory, I. (2012). Theory construction in qualitative research: From grounded theory to abductive analysis. *Sociological Theory*, *30*(3), 167-186.

van Bochove, M., and Oldenhof, L. (2020). Institutional work in changing public service organizations: the interplay between professionalization strategies of non-elite actors. *Administration and Society*, *52*(1), 111-137.

Williams, B., and Edlington, T. (2019). Attitudes towards continuing professional development: a qualitative study of Australian paramedics. *Australasian Journal of Paramedicine*, *16*.

Witz, A. (1992). *Professions and Patriarchy*. London: Routledge.

CHAPTER 3: INTENTIONAL STRATIFICATION IN PARAMEDIC EDUCATION AS A PROFESSIONALIZATION STRATEGY: THE CASE OF ONTARIO PARAMEDICS

PREFACE

This chapter examines the role of higher education in paramedic professionalization. In this chapter, I position education as historically central to creating occupational professionalism, however facing considerable external threats to its social and cultural legitimacy. In the contexts of threats to higher education, what is its role in professionalization? Paramedics are an interesting case to examine this topic as they are educated at the entry-to-practice level in public or career colleges and there has been discussion in the paramedic industry to add more entry to practice education to the university level. The findings of this chapter are also what prompted me to re-examine what reflexivity meant in the research methodology as the research project, and myself as a researcher became a source of data that I struggled to understand and examine. Following a deeper reading of the literature on reflexivity, I adopted the concept of epistemic reflexivity to help me arrive at a deeper understanding of the research findings.

I am graduate of Ontario's first joint college and university paramedic degree program. I completed my undergraduate degree and paramedic college education at the same time, allowing me to enter the paramedic workforce while still completing my undergraduate degree, and later graduate school. My university program had an undergraduate paramedic research course, and it was this early experience conducting qualitative research on paramedics that motivated me to complete a master's degree and later enroll in a PhD program. While I was working on my master's thesis in 2014, I was part of a small paramedic research lab group comprised of fellow paramedics conducting master's or PhDs. At the time

the sentiment amongst many of us in the group, including myself, was that paramedics who wanted to conduct research in Ontario did not have an academic home like some other health professions (notably medicine and nursing). This lab group tried to fill this gap, and later went on to form the McNally Project, a formal community of researchers aiming to build research capacity in paramedicine (see http://mcnallyproject.ca/about).

This history is relevant given the topic of this chapter. Drawing on interview data from paramedic leaders, this chapter describes how pursuing additional education as a professionalization strategy is contested, rather than a taken-for-granted feature of paramedic advancement. Some viewed higher education as empowering paramedics, particularly a small number of paramedics who seek advanced credentials, a role I term academic paramedics. Other participants view advancing higher education as further dividing the paramedic workforce and poorly suited to education paramedics in the 'street knowledge and skills needed to perform paramedic work. Participants' were also concerned that educational advancements were economically risky. University education is a leveraged strategy for a small number of entrepreneurial individuals, rather than representing an occupation wide strategy. An implication of this has been increased re-stratification within paramedics, creating a new hybrid role, the academic-paramedic, as a means to resist managerial pressures and drive professionalization from within. The main contribution of this chapter is that higher education is leveraged as a selective and marginal strategy, intentionally stratifying the workforce through the leveraging of academic-paramedics.

ABSTRACT

This paper investigates how paramedic leaders in Ontario, Canada, perceive the role of higher education as a strategy to improve paramedics' occupational status. This research found that participants selectively viewed higher education as a professionalization strategy. There are barriers to using higher education to professionalize due to the unresolved paramedic identity issues and the perceived negative economic repercussions of advancing frontline paramedic education. Due to their ability to generate and claim ownership over paramedic specific knowledge, the establishment of paramedic-academics was a preferred professional strategy of professionalization. This research has implications for our understanding of paramedic professionalization in a post-professional world as occupational groups strive to establish security, status and legitimacy in an increasingly crowded landscape.

INTRODUCTION

Higher education credentials and professionalization have a long and complex relationship with each other (Saks, 2012). Historically, the professions have typically been defined as expert occupations (Freidson, 2001; Saks, 2012). For some elite professions, the standardization and monopolization of expertise were a powerful means to gain authority and autonomy (Freidson, 2001; Saks, 2012). Claims over areas of expertise were a key way that professions defended and broadened their authority (Abbott, 1988; Witz, 1990). Adopting a credentialist ideology allowed elite professions to use claims of expertise to gain and uphold occupational control (Saks, 2012). In his original work on the systems of professions, Abbott (1988) highlighted the significant relationship between universities and professionalization, arguing that "professions rest on knowledge and universities are the seat of knowledge in modern societies" (p. 195). The global expansion of universities in post-modern knowledge

societies also supports an enduring relationship between higher education and the professions (Frank & Meyer, 2015, p.19).

Since the classic work of Freidson and Abbott, the sociocultural and economic conditions for professionalization are intensifying and occurring in increasingly complex institutional contexts. Elite professions no longer have exclusive control over an area of expertise as the pooling of expertise is needed to address complex societal issues (Muzio, Azulah & Kirkpatrick, 2020). Some have argued there has been deskilling and deprofessionalization of the workforce due to rapid changes in technology and managerialism (Susskind & Susskind, 2015). The university sector has been criticized as unresponsive to rapid changes in work (Collins, 2011; Muzio, Aulakh & Kirkpatrick, 2020, p. 26). Credentialing has also been argued as a form of professionalization from above, used by employers to control workers at a distance (Evetts, 2013). Simultaneous to these pressures, the demand for expert knowledge has expanded and the number of new professionals has grown (Muzio, Aulakh & Kirkpatrick, 2020, p. 1). Adams et al. (2020) also argue how professions can mobilize their expertise and rise to the challenge to resist challenges to their authority.

This paper aims to examine how one professionalizing occupation, paramedics, understood the role of higher education and credentialling in professionalization in the context of these complicated conditions. Viewed through the lens of neo-institutional theory and neo-Weberianism, the aim of the research was not to determine if paramedics are a profession (versus an occupation) but rather how paramedics as an occupational group are making claims to professional status. This research uses the concept of a professionalization project, referring to the process by which an occupation attempts to organize and improve their professional status to gain cultural, political, and economic rewards (Witz, 1992; Larson, 1977, 1979). Larson (1979) outlines that professionalization projects are ideological

strategies that perpetuate and legitimate a particular social arrangement (p. 613). Professionalization projects are not always successful; rather, occupations must make their case to the state, public, and other professions under specific sociopolitical conditions (Adams, 2004, p. 2245). Studying professionalization projects in process, even those that falter, improve our understanding of contemporary professionalization in an era where the dynamics of professionalization are rapidly changing (Muzio, Aulakh & Kirkpatrick, 2020). The occupation of paramedics is an ideal site to explore these kinds of evolving dynamics.

Paramedics are often conceptualized as a uniformed, public safety occupation (McCann & Graner, 2019). Until the 1970s, paramedics were primarily called ambulance 'drivers' or 'attendants.' Since the 1970s and 80s, research has found that paramedics in the United Kingdom (UK) and Australia have been professionalizing through enhanced clinical capabilities, integration with the healthcare system, regulation, and the transition to university credentials for entry-to-practice (Williams, 2010; Givati et al., 2019; McCann & Granter, 2019; Reed et al., 2019). This occupational change is significant because paramedics' initial education was rooted in short, technical training programs. Paramedics, alongside other uniformed emergency service occupations, are most often labelled as para-professionals in the academic literature (McCann & Granter, 2019). McCann et al. (2013) found that frontline paramedics were bound by blue-collar professionalism, describing paramedics as having a strong sense of professional duty but limited autonomy and control over their day-to-day work.

While the literature on paramedic professionalization remains limited (Reed et al., 2020; McCann & Granter, 2019), several themes have emerged. Paramedics in several countries appear to be professionalizing by adopting the traits of other healthcare professions, including self-regulation and higher education. A limited number of studies have examined the role of higher education in professionalizing paramedics. Research from Australia and the

United Kingdom comprises the majority of this literature as paramedics from these countries have recently adopted university-level education (Williams, 2010; Brook et al., 2018; Givati et al., 2019; Reed et al., 2019). In Canada, professional autonomy over evidence generation and evidence-based-decision were recently identified as an important feature of paramedic advancement (Tavares et al., 2021), although the role of higher education credentials in meeting these goals has yet to be extensively examined in the literature.

Studies on paramedic professionalization in the UK found there to be tension between the ideology of professionalization granted by the state and the occupational professionalism of frontline paramedics (McCann et al., 2013; Givati et al., 2019). Givati et al. (2019) examined the impact of education reforms on paramedic professionalization in the UK. The authors described how government reforms in the 1990s to 2000s resulted in changes to paramedic education at the university level to 'better utilize practitioners' skills to meet cost and efficiency targets' (p. 355). Post-reform, Givati et al. argue this has resulted in a 'paradoxical' role of higher education for paramedics, eroding some of the collegiality of pre-reform paramedics in replace of enhanced clinical responsibility and accountability. Further, there is tension between organizational and occupational professionalism, a trend noted by Evetts (2011). In paramedics, this manifests as a tension between professionalism driven by ambulance service management focused on increased efficiency and the occupational professionalism driven by frontline paramedics (Givati et al., 2019).

This paper aims to build on this small body of scholarship by examining paramedic industry leaders' perspectives on the role of higher education in paramedic professionalization in Ontario, Canada. The remainder of this paper is as follows: part one describes the theoretical framework used in this research; part two explains the context of this research; part three describes the methodology informing this paper; part four presents findings from the research; and lastly, part five discusses the implications for our

understanding of how higher education relates to professionalization and provides recommendations for future research.

THEORETICAL FRAMEWORK

Neo-Weberian and neo-institutional approaches to higher education and professionalization

This research adopts a theoretically eclectic approach of neo-Weberianism and neo-institutionalism to examine the role of higher education in the professional project of paramedics. Saks (2016) argues for the use of these two theoretical frameworks to be used together as they are complementary to the study of professionalization. Neo-Weberianism provides a macro-structural and historical lens to examine the process by which higher education is used to make claims to professional status. It gives space to consider non-linear pathways to professionalization (as proposed in functionalist accounts) (Saks, 2012). Neo-institutionalism helps explore why there can be a disconnect between theoretical expectations and empirical realities.

Neo-Weberianism approaches professionalization as a competitive process where occupations make claims to the state to control and regulate market conditions in their favour (Saks, 2016; Saks & Adams, 2019). The goal of professionalization projects was to secure a "monopoly of opportunities" through market control and high social status (Larson, 1979, p. 609). Larson (1977, 1979) and Freidson (2001) viewed education and credentials as consequential to professionalization because they created a uniform system of training and certification needed to secure market control. Credentialism allowed professions to control access to the occupation's knowledge and subsequent work practices. Larson (1977) further specified that a profession's research function allowed professions to have additional legitimacy, which could be used to persuade the state to protect them through ideological

claims. Further to this, credentialing and higher education resulted in the standardization of the workforce, and were a powerful source of professional unity.

Freidson (2001) argued that claims to higher education were a powerful source of social prestige that were necessary for claims to professionalism. This positioning forms the basis of the professional logic, which positions professions as having the trust and capability to control themselves. This allowed professions to have autonomy and control over their knowledge base and day-to-day work. Freidson highlighted a particular difference between technician education and "ideal type professionalism" (p 92, 121). Ideal type professionalism qualified professionals to be in positions to establish policy, work autonomously, and control the work of others. Universities became linked to "ideal-type professionalism" because they allowed a profession to claim formal authority over an area of knowledge and make intellectual claims to a particular jurisdiction.

Professions are granted legitimacy and status from the knowledge system they carry; hence higher education and universities have been prominent in theories of professionalization (Meyer et al., 2007, p. 8, p. 30). A neo-institutionalist perspective sees higher education as an institutionalized logic for the professions, explaining why many occupations seek credentialing in university-level institutions (Muzio, Brock & Suddaby, 2013). An institutional logic refers to a set of norms, values, and rules that together create a rule-like system that structures behaviour and thought (DiMaggio & Powell, 1983). Logics can be stable based on their cultural legitimacy, which pushes social actors to converge around similar structures and practices (DiMaggio & Powell, 1983).

Institutions are not as stable as once thought and can be changed as individuals become reflexive about their institutional environments and enact change (Suddaby & Viale, 2012). Selective coupling explains how actors, in the context of institutional complexity, adopt some aspects of the dominant logic to gain legitimacy, however, they do so only

marginally and adopt different institutional logics in other aspects (Pache & Santon, 2013; Ehlen et al., 2020). For instance, hybrid organizations can use selective coupling to mitigate the tension between logics and avoid decoupling (Pache & Santon, 2013). Pache & Santon also showcased how organizations in weaker positions can strategically use institutional logics to their advantage to gain legitimacy. Ehlen et al. (2020) extended Pache & Santon's work to argue that established organizations also use selective coupling to solve issues or pursue goals rather than always being motivated to gain legitimacy.

The dual-lens applied in this research is important as Saks (2012) highlights that some occupations with significant knowledge and expertise have failed professionalization projects or vice versa. Previous research on the professionalization projects of complementary and alternative medicine practitioners (Saks, 2012) and nurses (Sena, 2017) has found that not all occupations with considerable amounts of education have successful professionalization projects. Saks argues that "explanations of professionalization are sought less in concrete knowledge and expertise and more in a profession's tactic of competition and the prevailing socio-economic conditions" (p. 5). Professionalizing occupations must negotiate an increasingly complex environment where they may be driven to pursue ideal type professionalism, but are limited by managerialism. A neo-institutional lens provides a conceptual framework to examine how actors respond to these paradoxical ideologies.

BACKGROUND

Background to Paramedics in Ontario, Canada

Ontario is Canada's most populous province. In Ontario, the government has adopted a neoliberal ideology to manage public services (Adams, 2016), which impacts publicly funded healthcare services and emergency services like paramedics. In Ontario, paramedics are the primary provider of land and air ambulance services. Paramedics are government

regulated by a complex regulatory framework (Brydges et al., 2022). Paramedics are employed by designated Paramedic Services or Emergency Medical Services. There are 52 publicly funded land ambulance services and one air ambulance service. Most paramedics are unionized members and many are in large unions such as the Ontario Public Service Employees Union and the Canadian Union of Public Employees, the largest public sector employee union in Canada.

Paramedic Training

In Ontario, the higher education sector is comprised of universities, colleges, and private career colleges. Colleges grant certificates, diplomas, apprenticeships and a limited number of degrees, and universities grant under-graduate and graduate degrees and deliver professional programs (Ontario, 2022). The Ontario government's Ministry of Health influences or informs the program standards that are then used by the Ministry of Colleges and Universities to determine the training requirement for paramedics and regulates and approves training programs (MOHLTC, 2022).

Training programs for paramedics are offered at the primary, advanced, or critical care level. Training programs for primary care paramedics (the most common entry-to-practice level) are provided by public colleges, which offer the program as a two-year diploma program, or private career colleges, which often provide the program in a shorter period. Twenty-eight public and private colleges approved to provide the primary-care paramedic program (MOHLTC, 2022). There is one paramedicine university degree program that allows students to undertake a university and college credential simultaneously. Entry-to-the practice as a paramedic occurs upon completion of the college portion of the program. University credentials are not required to practice as a paramedic in Ontario.

METHODOLOGY

This paper presents a subset of findings from a constructivist case study of paramedic professionalization in Ontario, Canada. This research used Merriam's (1998) qualitative case study approach, which emphasizes understanding the social processes of people, places, and organizations within the phenomenon of interest. Data was collected from interviews conducted with individuals in leadership positions in the paramedic industry. The field of paramedicine was conceptualized as various organizations and bodies, including professional associations, unions, educational institutions, service providers, and regulatory bodies.

Reflexivity

At the time of data collection, the lead author (MB) was a frontline paramedic in Ontario, Canada. This gave her a dual insider-outsider position since, although she was a paramedic, she was not in a leadership role and was also an academic researcher. Reflexivity was an important aspect of the research. Methodological reflexivity was enacted to reflect on how her positionality as a non-racialized paramedic woman with advanced education impacted the research. Memoing before and after interviews was used to document rapport with participants, identify surprising or uncomfortable moments during the interviews, and identify areas for future research.

MB used the concept of epistemic reflexivity to examine how her positionality impacted the knowledge creation process. Epistemic reflexivity refers to the process of exposing the interests of the researcher and their relationship to the object of study as a knowledge-generating tool. Ben-Ari & Buchinder (2008) and Enosh & Ben Ari (2016) suggest using differences and contradictions in how the researcher views the research (compared to participants) to produce analytical insights into the research. An example when this approach was utilized was when some participants remarked on the importance of this

research being conducted to help the community professionalize. This led to feelings of discomfort for MB, who did not position this research or herself as an activist for the paramedic professionalization project. MB used this discomfort as an opportunity to question the significance of academic paramedics and consider the axiological implications of this research.

Semi-structured interview methods

Eligible participants were those who occupied a leadership position (e.g. manager, leadership role in a union or association) in a paramedic sector organization at the time of the research and previously or currently worked as a paramedic. Individuals in these positions were sought out because they were theorized to have a stake in future changes to paramedics, may have been in a position to determine or comment on the future direction of paramedicine, and had historical knowledge about paramedic development.

Ethics approval was obtained from the McMaster University research ethics board. Participants were recruited directly by email, or a mail letter invitation and one participant was identified via a referral from another participant. Mailing addresses or emails were obtained from publicly available websites. The majority of interviews were conducted over the phone. The interviews ranged from 45 minutes to 95 minutes. Interviews were transcribed verbatim before analysis. In total, 25 semi-structured interviews were conducted with paramedic leaders in Ontario, Canada, conducted from 2018 to 2019.

Analysis

The interview transcripts were analyzed using abductive analysis (Tavory & Timmermans, 2012; 2014). Abductive analysis analyzes empirical findings in relation to existing theories to produce new insights (p. 174). This research used the analytical method of alternative casing, which involves examining the data from different theoretical

perspectives to examine differences in the interpretations, and by examining surprising findings. At the outset of the research, a wide breadth of scholarship on professionalization was considered. While analyzing the data, it was surprising how divergent the views on the value of higher education were and there was no easily identifiable cohesive professionalization strategy. To unpack this complexity, two complementary theoretical perspectives were needed. During each of the following stages of analysis, emerging findings were examined against these theoretical approaches.

For each participant, MB made a summary of how professionalization had occurred, barriers/opportunities to professionalize, and identified key actors, organizations, and documents. For this paper, MB extracted interview segments where the topic of higher education was discussed. This net of data was intentionally kept initially very large to consider intersections with other findings. MB analyzed then interview transcripts, notes and memos were then considered against the existing literature.

Participant Characteristics

Participants identified as being from the following sectors of the paramedic field at the time of the research: education institutions (5), labour/union (4), professional associations (3), clinical practice (3), service operators (9), and anonymous (1). There were five women participants. Eight participants were working as frontline paramedics. The remaining participants had previously worked as a paramedic ranging from eight to 34 years before moving on to other roles. Seven participants had completed master's level education. Several participants did not consent to be identified based on their sector, and as such, all participants in the manuscript are referred to as "paramedic leaders."

FINDINGS

Paramedic practice advancement precedes educational advancement

Based on participants' accounts, advancement in paramedic roles has preceded educational advancement. Paramedics across the province saw a large jump in their emergency scope of practice starting in the late 1990s, a trend which has continued through to the present. Scope of practice expansions, legitimized by clinical research studies (i.e. Stiell et al., 1999), later led to the educational change from a one-year college certificate to a two-year college diploma program (for public sector colleges).

The trend of work changes preceding educational change has continued. Participants described how paramedics respond to a wide range of acute and chronic health and social issues for patients. This has further led to practice expansions for paramedics as they identify gaps in care due to the broad range of patients seen in the field. As participant 16 stated, "we started to see the scope grow out of necessity. The rigid protocols didn't fit with the patients we were seeing. And I think that is still the case today. We are starting to see more and more presentations, and paramedics are trying to create their own system to try and offset what they know exists". Paramedic Services, are the location of many scope of practice changes for paramedics. Some participants discussed that paramedic service providers were often responsible for driving forward new roles, as they could determine needs and gaps and create an agenda to meet those goals. Paramedic Service providers also often pay employed paramedics to undertake advanced paramedic training and, in some areas, act as gatekeepers for this educational pathway.

Participants described how role expansions continue to drive paramedicine forward. For instance, many participants were passionate about community paramedic roles. Although they were ambiguously defined, community paramedics often work in non-acute settings

(e.g. health promotion clinics). Paramedic service operators were identified as a driver of community paramedic roles. As participant 13 stated, "the paramedic profession usually starts out being driven by the employer because they have a demonstrated need, so they can train a dozen of their medics on community paramedicine in-house." Community paramedic roles have expanded across the province, although participants described that diverse training had been offered and there is no provincially mandated credential or training program.

Barriers to Using Higher Education in Paramedic Professionalization: Higher education credentials will (further) divide the workforce

When asked whether paramedics should require a university degree for entry to practice, many participants expressed concerns that this type of educational change would be resisted by the workforce and may cause division and conflict. As participant 7 stated, "paramedics don't like change on that level." Some participants were concerned that this change could divide the workforce between those who obtained university education credentials and those who didn't. At the heart of this issue was the perceived tension between the "street smarts" of paramedics obtained once working "on the road" compared to academic "book knowledge."

Participants described the tension between academic and street knowledge as a historical issue in the paramedic industry. Participant 14 described how twenty years ago, paramedics who had previously obtained a university degree faced barriers when seeking employment: "the service would see it as, well, you aren't going to stick around." Several participants highlighted this issue as resolving, as many students enter paramedic training programs with a previous university degree in another field. However, other participants were concerned this was a lingering issue. Some participants were concerned that a degree at the entry-to-practice level would mean that it would potentially attract students that were less

invested in a career as a paramedic and use it instead as a "stepping stone" to another career path. Another participant stated:

> "I think there is a clash with even now. I am a road medic. You are a book medic. There is an existing culture in which you have to earn your stripes. I think there is a negative connotation placed on the highly educated. There is some fear of advanced education taking the place of someone's experience" (participant 16).

Another participant stated how a degree would "change the individual who was attracted to paramedicine and….I don't know enough about whether we're going to have the appropriate, I'm going to use skill mix as the term. The soft skills are part of what makes the paramedic a paramedic. You want the individual who is a problem solver" (participant 5). Some viewed academic knowledge as oppositional to the technical skills needed to become a paramedic. As participant 2 stated:

> "We are a blue-collar, white-collar hybrid. We use expert knowledge, but we're on the front line and are using physical attributes. You have to lift the patient onto our stretcher, and we have to get them physically to the hospital. Paramedicine itself can be a dirty, grueling job and to have academically minded people in there only, I don't know if they would serve the profession well. I think you need both" (participant 2).

Ensuring paramedic graduates were "ready" for employment and connection to the "real world" was very important to many participants. Even for participants who supported a university degree for paramedics, connecting the program to the realities of paramedic work

was essential. As participant 19 stated, "I am not a proponent for creating degrees to hang on a wall. They have to be practical and applicable to what we're doing as paramedics".

In summary, this theme describes how participants have concerns about the acceptance of higher education amongst frontline paramedics and its implication for professional unity.

Barriers to Using Higher Education in Paramedic Professionalization: Economic risk

It was evident in some participants' perspectives that educational change toward a university degree at the entry-to-practice level could have negative economic implications for paramedics. There was a view that a degree at the entry-to-practice level was not realistic due to the economic ideology held by the government. Healthcare was viewed as an industry that was on a "fixed budget" (participant 5) with a history of shifting healthcare tasks to aids or attendants to save costs. Many participants referenced the nursing profession as an example of the negative consequences of higher education in stratifying the nursing workforce.

Some participants remarked that the healthcare providers that transitioned to a degree before the 1990s "killed it" for allied health professions such as paramedics because the government realized how expensive these were. Another participant stated the government was concerned about "credential creep," referring to skepticism over the *need* for university education at the entry-to-practice level (participant 10). For instance, participant 15 stated, "if the lower level of education is adequate, and the government can only afford that, then that undermines the whole concept of a degree."

Participants were concerned that a degree would "price paramedics out of the market" when compared to other healthcare or public safety workers (participant 8). Other participants expressed concerns that it would be difficult to prove a degree is needed. As participant 13 stated, "there would be a lot of additional costs and, you know, is it necessary?

You are trying to prove the point that you need an undergraduate degree to work as a paramedic, but everyone's been working for years and years and years without it". Even participants who supported university education for paramedics were candid about the economic pressures facing paramedics and the challenging prospect of *proving* that additional education is needed. This perception is compounded by a concern that higher education may impact the market for paramedic work in Ontario.

Leveraging Higher Education as Professionalization Strategy: The Creation of Academic-Paramedics

While participants were divided or wary of the need for university credentials for the entire workforce, select paramedics who complete graduate-level education were viewed as a powerful source of advancement for paramedics. Paramedic academics are individuals who obtain graduate credentials in fields such as education, research, policy or management. There are currently no Canadian graduate-level clinical education pathways for paramedics, which participants acknowledged as a gap.

Many participants viewed academic paramedics as facilitating paramedics taking ownership over their knowledge base and legitimizing academic principles amongst paramedics. As participant 3 stated:

> "professionalization comes with having knowledge and judgement, right? To be able to differentiate further in all the shades of gray, to be able to take ownership and reflect on the pros and cons of very small bits and pieces. And I think you require a foundational education as a profession to do that. What we have now are some innovators who are paving that path, proving what impact education can have on paramedicine in Ontario".

Many participants identified academic paramedics who specialized in research as particularly valuable. Research has been an important part of paramedic advancement, as clinical trials led by physician-researchers have led to paramedic practice expansions and introduced evidence-based medicine to paramedicine. Paramedic-academics were seen as allowing paramedics to take ownership over their knowledge base, which has historically been driven by physicians. Participant 2 stated:

> "The profession is finally at a stage where you have enough people that are driven enough and smart enough to do the things that you're doing. Whereas before, it was always relying on physicians typically to do that and trying to translate in-hospital medicine practices to the road. I think we've understood that it needs to be done in the prehospital setting and ideally by pre-hospital-based individuals. And not to say they can't become doctors or Ph.D. students or whatever the case is, but they still have a route to the profession because it gives a better understanding of what things are work and don't work. The nuances you can't gain from the outside. It's about a profession leading itself."

Participants suggested that physicians would continue to play a role in paramedic education and research; however, as paramedics advance, it could become paramedic driven:

> "as paramedics advance, as the education advances, you could have paramedic-led medicine. I still think there's a role for physicians unless the paramedic education became so in-depth that the physician wasn't required. There's a huge transition timeframe there for that to happen. Just right now,

> it's largely physician-controlled, and they consult with paramedics. I don't think they act in isolation by any means, but it's not necessarily paramedic driven".

Participants viewed academic paramedics as consequential to paramedics assuming some degree of autonomy over paramedic expertise. This is a soft professionalization strategy, given that it is not mandated for all paramedics to enter the workforce. However, it is a powerful one based on paramedic-academics alignment with the ideology of evidence-based medicine and the university sector in general.

Leveraging Higher Education as Professionalization Strategy: Higher Education will allow for recognition as a healthcare profession

Participants described that paramedics were originally conceptualized as emergency first responders, and education has historically focused on the skills needed to undertake this role. Paramedics must have technical skills, such as lifting and extricating patients as well as emergency driving. Participants argued that paramedics experienced a role shift over the last decade from being viewed as "technicians" to "clinicians." Participant's described that this shift is reflected in paramedic training standards and the paramedic industry derived National Occupational Competency Profile, which aimed to standardize paramedic competencies across most of Canada. Participant's described that paramedics are increasingly viewed as flexible healthcare providers and are seeing a broadening in their roles in various healthcare settings– changes that align them increasingly with the healthcare sector.

For many participants, advancing paramedic education addressed the misalignment between paramedic practice and the current education model rooted in paramedics' first-responder role. For instance, some participants felt that paramedic training had yet to fully

recognize paramedics' role as a healthcare provider or prepare paramedics for future changes to their role. Participants felt that many patient populations and needs were not reflected in paramedic education, such as "understanding health care systems, social determinates of the health, gerontology, palliative care, mental health, and specialized care" (participant 10). Others highlighted the increased responsibility and accountability paramedics have in caring for patients. Recommendations to improve paramedic education increasingly align paramedics with other healthcare professions, although there was no agreement on the specific educational model to achieve this goal. Some participants felt that educational change could occur within the current system, while others felt that a university environment (in full or in part), would be better suited.

Other participants believed that a university education is needed for paramedics to gain recognition as healthcare providers. Some participants described paramedic organizations as being left out of important healthcare decision-making processes because they were not recognized as healthcare providers. Participant 20 stated,

> "The second reason why a baccalaureate is important would relate to the fact that I don't believe that paramedics are sufficiently recognized as a health care partner. Paramedics are not at the table because we don't have a college, and we don't have a baccalaureate of education. On a global sense, the World Health Organization doesn't recognize paramedics as a profession. They recognize them as a first responder".

The healthcare industry was viewed as academic and research-focused, and paramedics may need degrees to be seen as legitimate in this space. Participant 24 stated:

> "Whether it makes a real difference about making someone a better paramedic is debatable, but in the world of healthcare having a degree makes a difference, if purely for optics. So for better or worse, healthcare respects someone who has a degree instead of someone who has a college program."

The above two findings showcase why some participants view advancements in higher education as a key aspect of the paramedic professionalization project. Academic paramedics are viewed as having the legitimacy to take ownership over paramedic knowledge and expertise. Advancing education and including additional medical content is viewed as facilitating a shift to paramedics being recognized as healthcare clinicians versus their origin as technicians and first responders.

DISCUSSION

Neo-Weberianism and neo-institutional theories expect higher education and credentialing to be tightly coupled to professionalization as it results in shared professional norms, unity, and monopolization. An unexpected finding of this study was that higher education had a contested role in the paramedic professionalization project and paramedics have been left with little option other than to pursue intentional stratification through leveraging paramedic-academics. Paramedics must negotiate a complex organizational and political context and navigate intraprofessional issues that have pushed them to this strategy. Many participants viewed credentialing the entire workforce negatively, with concerns that it would exacerbate intraprofessional division and risk the economic viability of paramedics and publicly funded providers.

On the one hand, the limitations to using higher education as a professionalization strategy reflect Evetts' (2013) argument that not all professionalizing occupations have the

power to successfully make claims to professional status. This can be due to professionalization imposed by or restricted by external forces, such as the state or organizations (Evetts, 2011; 2013). It also reflects the incorrect assumption in theorizations of professionalization that occupational groups are uniform and internally coherent (Larson, 2020). This research and that on paramedic professionalization in the UK (McCann et al., 2013; Givati et al., 2019) has found that paramedics have had mixed success in securing professionalization in terms of occupational closure. McCann & Granter (2019) are more optimistic on this front and argue that paramedic's professional status has the potential to rise due to the alignment between a growing demand for emergency and crisis services and paramedic's "active and embodied" nature that puts them in the public eye (p. 4). However, they argue that neoliberalism and managerialism will continue to pose a threat to paramedic professionalization, also a factor in the Ontario context. The COVID-19 pandemic has further exacerbated frontline paramedic services, with reports of high rates of burnout and paramedic service shortages (Frangou, 2022). These contemporary conditions will continue to impact paramedic professionalization in new and unexpected ways.

This study found that a new strategy emerged for paramedics to professionalize: intentional stratification. Academic paramedics were leveraged as an important pathway for paramedics to build autonomy over profession specific knowledge, while the remainder of the profession is kept economically viable. The leveraging of academic elites is not surprising, as Abbott (1988) and Larson (1979) highlighted the importance of professions using academic, abstract knowledge and research to legitimate work jurisdictions (p. 55). The significance of paramedic-academics relies on their legitimate relationship with the university sector (Abbott, 2005). Paramedic academics are in the position to be– in Abbott's words–"a hinge" linking the paramedic sector to the university sector (p. 255). Abbott argues that hinges create alliances between different sectors by using strategies in each sector that create

rewards in both. However, Abbott notes that how different sectors are connected remains an empirical question (1988, p. 210; 2005). The university sector and professional sector can symbiotically advance each other, or they can be decoupled if the innovations in the university sector do not align with the practice requirements of working professionals. Whether paramedic-academics will be connective or disruptive is still to be determined.

The intention stratification of paramedic-academics represents a strategy to maintain professionalization driven from within the profession and a resistance to economic, managerial pressures. This strategy is a form of selective coupling, whereby the logic of credentialing is upheld in some contexts, and then shielded in others. Paramedic-academics allow paramedics to adopt the ideology of occupational professionalism (Evetts, 2013) and strive for autonomy over paramedic knowledge, problem-solving and decision making. However, the intention stratification of paramedics may have implications for professional unity (Adams, 2020). This research and a recent study by Givati et al. (2019) found that paramedics struggled with the division created between paramedics with and without a university education. Adams' (2020) recent work on professional-manager hybrids in engineering found that there were differences in responses to professionalism and managerialism that led to intraprofessional conflict. In other words, hybrid roles results in different experiences and perspectives that can "undermine professional unity" (p. 112).

As argued at the outset of this paper, there is debate underway about the significance of higher education in processes of professionalization given rapid changes to professional work, intensifying societal problems, and emerging and poorly understood issues related to technology. If professionals can't keep up with knowledge changes in their sector, they risk losing their jurisdiction to another profession. While university education is a highly entrenched norm for the professions, Abbott (1988) also noted it is not well-positioned to provide lifelong retraining and continued education for professionals (p. 210). This research

found that paramedics are pursuing a hybrid professionalization strategy as a means of navigating an increasingly complex sociopolitical and economic context. Taken-for-granted aspects of professionalism, such as higher education, are selectively coupled with professionalization as a means to navigate organizational and managerial pressures. The selective use of credentialing is a way for paramedics to exert some degree of occupational control in the process of professionalization. Future research should continue to explore and advance this line of thinking by engaging with Abbott's (1988) ecological approach and adopting theoretical and conceptual approaches that engage with these broader sociopolitical and economic trends will be critical to understanding professionalization in paramedicine and beyond.

Limitations

While we did consider participant positionality in our analysis, we are unable to report on additional biographical details in this manuscript. The paramedic community in Ontario is small enough that sharing these additional biographical details may render our participants identifiable. As such, while we did consider the interplay of gender, seniority, and credentialing in our analysis, but we cannot report on all of those analytical threads. The literature on paramedic professionalization has yet to critically examine the gendered nature of paramedic professionalization. As Adams (2010) notes, the growing number of women in male-dominated fields and the professionalization of women-dominated professions such as midwifery and nursing has consequences for understanding how gender intertwines with professionalization projects. Similar to the gender representation of the research participants, women paramedics are underrepresented in leadership roles despite making up 30 to 40% of the occupation (Mason, 2017; Cameron et al., 2020). Future research on paramedic professionalization would benefit from a gendered lens, such as by drawing on the work of

Witz (1990, 1992), to examine how gender has impacted inter and intraprofessional paramedic relations.

While all participants of this research had at one time worked as a paramedic (and some still were at the time of their interview), not all participants may have identified themselves as paramedic leaders. Participants' views are likely to be different from those of frontline paramedics, which future research would benefit from examining. Lastly, professionalization is an ongoing process, and as such, participants' views on this topic may have shifted since the time of this research, particularly in light of the COVID-19 pandemic.

CONCLUSION

In conclusion, the assumed interdependency of higher education and professionalization has been dominant in the sociology of professions literature. Intensifying threats to once taken-for-granted aspects of professionalism, such as higher education, have altered the process of professionalization. The case of paramedics showcases how professionalization has adapted to these changes, intentionally privileging intraprofessional stratification as a means to resist managerial and economic pressures. Paramedic professionalization is best understood as a hybrid process, of which theories of professionalization are only beginning to conceptualize and understand.

REFERENCES

Abbott, A. (1988). *The System of Professions: An Essay on the Expert Division of Labour.* Chicago: Chicago University Press.

Abbott, A. (2005). Linked Ecologies: States and Universities as Environments for Professions. *Sociological Theory, 23*(3), 245-274.

Adams, T. L. (2004). Inter-professional conflict and professionalization: dentistry and dental hygiene in Ontario. *Social Science & Medicine, 58*(11), 2243-2252.

Adams, T. L. (2010a). Profession: A useful concept for sociological analysis? *Canadian Review of Sociology, 47*(1), 49-70.

Adams, T. L. (2010b). Gender and Feminization in Health Care Professions. *Sociology Compass, 4*(7), 454-465.

Adams, T. L. (2017). Professions, hybrid professionalism and internal stratification: Evidence on Canadian engineers. *Canadian Sociological Association*.

Adams, T. L., & Saks, M. (2018). Neo-Weberianism and changing state-profession relations: The case of Canadian health care. *Sociologia, Problemas e Práticas*, (88), 61-77.

Adams, T. L. (2020). Professional employees and professional managers: conflicting logics, hybridity, and restratification. *Journal of Professions and Organization*, *7*(1), 101 115.

Andersson, T., & Liff, R. (2018). Co-optation as a response to competing institutional logics: Professionals and managers in healthcare. *Journal of Professions and Organization*, *5*(2), 71-87.

Bell, A., Hammer, S., & Seymour-Walsh, A. (2021). The role of educational theory in the future development of paramedicine as a profession: An integrative review. *Australasian Journal of Paramedicine, 18*.

Bévort, F., & Suddaby, R. (2016). Scripting professional identities: How individuals make sense of contradictory institutional logics. *Journal of Professions and Organization*, *3*(1), 17-38.

Brès, L., Mosonyi, S., Gond, J. P., Muzio, D., Mitra, R., Werr, A., & Wickert, C. (2019). Rethinking professionalization: A generative dialogue on CSR practitioners. *Journal of Professions and Organization*, *6*(2), 246-264.

Brooks, I. A., Grantham, H., Spencer, C., & Archer, F. (2018). A review of the literature: the transition of entry-level paramedic education in Australia from vocational to higher education (1961–2017). *Australasian Journal of Paramedicine*, *15*(2).

Bromley, P., & Powell, W. W. (2012). From smoke and mirrors to walking the talk: Decoupling in the contemporary world. *The Academy of Management Annals*, *6*(1), 483-530.

Brosnan, C. (2017). Alternative futures: fields, boundaries, and divergent professionalization strategies within the chiropractic profession. *Social Science & Medicine*, *190*, 83-91.

Brydges, M., Dunn, J., Agarwal, G., & Tavares, W. (2022). Agreeing to Disagree: Intraprofessional conflict and stratification in the Ontario paramedic professionalization project. *Under review at the Journal of Professions and Organization.*

Burns, E. (2019). *Theorizing Professions: A Sociological Introduction*. Palgrave Macmillan.

Cameron, C, Abela, A, Donelon, B, Doiron, M, & Hutchinson, B. (2020). Representation of Women in Paramedicine-A Perspective from Alberta.In *Introduction to the Health Workforce in Canada*. Ivy Bourgeault (ed). Ottawa: Canadian Health Workforce Network.

Collins, R. (2011). Credential inflation and the future of universities. *Italian Journal of Sociology of Education*, *3*, 228–251.

DiMaggio, P. J., & Powell, W. W. (1983). The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields. *American Sociological Review*, *48*(2), 147-160.

Ehlen, R., Ruiner, C., Wilkesmann, M., Schulz, L., & Apitzsch, B. (2022). When multiple logics initiate a butterfly effect: the case of locum tenens physicians in Germany. *Journal of Professions and Organization*, *9*(1), 38-61.

Eklund, S. (2021). To Co-Opt or To Be Co-Opted? The Role of Professional Elites in Strengthening Professional Control Vis-à-Vis Clients. *Professions and Professionalism*, *11*(3).

Enosh, G., & Ben-Ari, A. (2016). Reflexivity: The creation of liminal spaces—Researchers, participants, and research encounters. *Qualitative health research*, *26*(4), 578-584.

Enosh, G., Ben-Ari, A., & Buchbinder, E. (2008). Sense of differentness in the construction of knowledge. *Qualitative Inquiry*, *14*(3), 450-465.

Evetts, J. (2011). A new professionalism? Challenges and opportunities. *Current Sociology, 59*(4), 406-422.

Evetts, J. (2013). Professionalism: Value and ideology. *Current Sociology, 61*(5–6), 778–796.

Frangou, C. (2022). PTSD, burnout, and a pandemic. How COVID pushed the country's overworked first responders into emergency territory. *Maclean's.* https://www.macleans.ca/longforms/canadian-paramedics-are-in-crisis/

Frank, D. J., & Meyer, J. W. (2015). Worldwide expansion and change in the university. In *Towards a Multiversity?* (pp. 19-44). transcript-Verlag.

Freidson, E. (2001). *Professionalism, the third logic: on the practice of knowledge.* Chicago: University of Chicago press.

Givati, A., Markham, C., & Street, K. (2018). The bargaining of professionalism in emergency care practice: NHS paramedics and higher education. *Advances in Health Sciences Education*, *23*(2), 353-369.

Hindhede, A. L., & Larsen, K. (2020). Prestige hierarchies and relations of dominance among health professionals. *Professions and Professionalism*, *10*(2), 1-20.

Hodgson, D., Paton, S., & Muzio, D. (2015). Something old, something new?: Competing logics and the hybrid nature of new corporate professions. *British Journal of Management*, *26*(4), 745-759.

Larson, M. (1977). *The rise of professionalism: A sociological analysis*. Berkeley: University of California Press.

Larson, M. S. (1979). Professionalism: Rise and fall. *International Journal of Health Services*, *9*(4), 607-627.

Larson, M. S. (2020). The rise of professionalism. In *The Rise of Professionalism*. California: University of California Press.

Leicht, K., & Fennell, M. (2008). *The Sage Handbook of Organizational Institutionalism: Institutionalism and the Professions*. Sage Publications.

Mason, P. (2017). Identifying the barriers to female leadership in paramedicine. *Irish Journal of Paramedicine*, *2*(1).

McCann, L., Granter, E., Hyde, P., & Hassard, J. (2013). Still blue-collar after all these years? An ethnography of the professionalization of emergency ambulance work. *Journal of Management Studies*, *50*(5), 750-776

McCann, L., & Granter, E. (2019). Beyond 'blue-collar professionalism': continuity and change in the professionalization of uniformed emergency services work. *Journal of Professions and Organization*, *6*(2), 213-232.

McDonald, R., Waring, J., Harrison, S., Walshe, K., & Boaden, R. (2005). Rules and guidelines in clinical practice: A qualitative study in operating theatres of doctors' and nurses' views. *BMJ Quality & Safety*, *14*(4), 290–294.

McPherson, C. M., & Sauder, M. (2013). Logics in action: Managing institutional complexity in a drug court. *Administrative Science Quarterly*, *58*(2), 165-196.

Merriam, S. B. (1988). *Case study research in education: A qualitative approach*. Jossey Bass.

Metz, D. L. (1982). *Running hot: Structure and stress in ambulance work.* Abt books.

Meyer, J. W., & Rowan, B. (1977). Institutionalized organizations: Formal structure as myth and ceremony. *American Journal of Sociology*, *83*(2), 340-363.

Meyer, J. W., Ramirez, F. O., Frank, D. J., & Schofer, E. (2007). Higher education as an institution. *Sociology of Higher Education: Contributions and Their Contexts*, *187*.

Munro, G. G., O'Meara, P., & Mathisen, B. (2018). Paramedic academics in Australia and New Zealand: the 'no man's land'of professional identity. *Nurse Education in Practice*, *33*, 33-36.

Muzio, D., Brock, D. M., & Suddaby, R. (2013). Professions and institutional change: towards an institutionalist sociology of the professions. *Journal of Management Studies*, *50*(5),699-721.

Muzio, D., Aulakh, S., and Kirkpatrick, I. (2020). *Professional Occupations and Organizations*. Cambridge: Cambridge University Press.

Noordegraaf, M. (2015). Hybrid Professionalism and Beyond: (New) Forms of Public Professionalism in Changing Organizational and Societal Contexts. *Journal of Professions and Organization*, *2*(2), 187–206.

Olakivi, A., & Niska, M. (2017). Rethinking managerialism in professional work: from competing logics to overlapping discourses. *Journal of Professions and Organization*, *4*(1), 20-35.

Ontario Ministry of Health and Long-term Care. (n.d.). *Paramedic Training Programs in Ontario. Emergency Health Services Branch*. Retrieved from https://www.health.gov.on.ca/en/pro/programs/emergency_health/edu/schools.aspx

Ontario government (n.d.). *Going to College or University in Ontari*o. Retrieved from https://www.ontario.ca/page/go-college-or-university-ontario

Ontario Ombudsman. (2021). *Oversight 911: Investigation into how the Ministry of Health oversees patient complaints and incident reports about ambulance services, May 2021*. https://www.ombudsman.on.ca/Media/ombudsman/ombudsman/resources/Reportson-Investigations/Ombudsman-Report-Oversight-911-May-2021-EN accessible.pdf

Pache, A. C., & Santos, F. (2013). Inside the hybrid organization: Selective coupling as a response to competing institutional logics. *Academy of Management Journal*, *56*(4), 972-1001.

Reed, B., Cowin, L. S., O'Meara, P., & Wilson, I. G. (2019). Professionalism and professionalisation in the discipline of paramedicine. *Australasian Journal of Paramedicine, 16*, 1-10.

Saks, M. (2012). Defining a profession: The role of knowledge and expertise. *Professionsand Professionalism, 2*(1).

Saks, M. (2016). A review of theories of professions, organizations and society: The case for neo-Weberianism, neo-institutionalism and eclecticism. *Journal of Professions and Organization*, *3*(2), 170-187.

Sena, B. (2017). Professionalization without autonomy: the Italian case of building the nursing profession. *Professions and Professionalism*, *7*(3), e1900-e1900.

Stiell, I. G., Wells, G. A., Spaite, D. W., Lyver, M. B., Munkley, D. P., Field III, B. J., ... & OPALS Study Group. (1998). The Ontario Prehospital Advanced Life Support (OPALS) Study: rationale and methodology for cardiac arrest patients. *Annals of Emergency Medicine*, *32*(2), 180-190.

Starr, P. (1982). *The Social Transformation of American Medicine*. New York: Basic Books.

Tavares, W., Allana, A., Beaune, L., Weiss, D., & Blanchard, I. (2021). Principles to guide the future of paramedicine in Canada. *Prehospital Emergency Care*, 1-11.

Tavory, I., & Timmermans, S. (2014). *Abductive analysis: Theorizing qualitative research*. Chicago: University of Chicago Press.

Timmermans, S., & Tavory, I. (2012). Theory construction in qualitative research: From grounded theory to abductive analysis. *Sociological Theory*, *30*(3), 167-186.

Williams, B., Onsman, A., & Brown, T. (2010). Is the Australian paramedic discipline a full profession? *Australasian Journal of Paramedicine*, *8*(1).

Witz, A. (1990). Patriarchy and professions: The gendered politics of occupational closure. *Sociology*, *24*(4), 675-690.

Witz, A. (1992). *Professions and Patriarchy*. London: Routledge.

CHAPTER 4: EXPLORING CHANGING PARAMEDIC ROLES THROUGH THE CONCEPT OF BOUNDARY WORK

PREFACE

In chapter 4, I use the concept of boundary work to explore the process of jurisdictional change in paramedics into a new area of work, called community paramedicine. The topic of community paramedicine also initially drew me in to the topic of professionalization. When I finished my Master of Arts thesis, which examined patient perspectives of a community paramedicine program, I was left wondering why there was little discussion (to my knowledge) about the impact of paramedics working in these new roles on other healthcare professions, such as nursing. Throughout the research process, I was always intrigued by how often community paramedicine was linked to nearly all aspects of paramedic advancement, but always in subtle ways. The significance of community paramedicine in paramedic professionalization is a theme throughout this dissertation. In chapter 2, community paramedicine was used as a means to highlight the need for regulatory reform and in chapter 3, community paramedicine was used to advocate for more education.

In this final chapter, I aim to show why sociological perspectives on professionalization are relevant to the healthcare human resources and policy field. A consistent theme in the sociology of professions literature is how professions used jurisdiction expansion, often through competition with other professions, as a feature of professionalization. This is an influence of Abbott's (1988) influential work on the topic where he theorized about how professions interact in a system where they engage in competitive boundary work over jurisdictions. When analyzing the interview and document data, it became clear that paramedics were not overtly trying to compete with other healthcare professions. Many participants explicitly discussed how paramedics were avoiding stepping on other profession's toes, and were using language that reflected the desire to be seen as

collaborative partners. A broader look at the literature on boundary work reveals more nuanced and varied ways in which social groups aim to conduct boundary work, broadly defined as a process of demarcation from other groups. I used Langley et al's (2019) typology of boundary work as a lens to examine the emergence of community paramedicine. This conceptualization of boundary work includes non-competitive forms of boundary work that has more explanatory power to examine subtler forms of boundary work.

Drawing on interviews with paramedic leaders and documents related to community paramedicine in Ontario, I describe the creation of a new jurisdiction for paramedicine, community paramedicine, through three types of boundary work: competitive, collaborative, and configuration. This paper is significant as it aims to describe how paramedics have used community paramedicine as a bridge between paramedics from a first responder role to the broader healthcare sector. Community paramedicine has provided space for paramedics to redefine their role, although this role remains ambiguous and unclear. The concept of boundary work illuminates how the reconfiguration of occupational boundaries is a social and political process. Paramedics have been constrained and enabled by healthcare policy enabling broader scopes of practice for allied healthcare professions.

ABSTRACT

Community paramedicine is a new area of practice for paramedics across Canada and internationally. Limited peer-reviewed studies have explored this expansion in Canada through a sociological lens. This topic is important as professional role expansions have implications for professional identity, inter-professional relationships, and healthcare human resources policy. This paper presents results from a case study of paramedic professionalization in Ontario, Canada. Data collected from semi-structured interviews and documents were analyzed using the sociological concept of boundary work. Three types of boundary work were conducted by paramedic leaders: competitive, collaborative, and configurational boundary work. This boundary work is significant in advancing our understanding of community paramedicine as a social process.

INTRODUCTION

The professionalization literature in sociology provides a conceptual lens to examine how the occupation itself is a driver of change. One way to occupations change is to expand or protect areas of jurisdiction, called boundary work (Abbott, 1988). Boundary work was first described as how groups, organizations, or individuals aim to define themselves differently from each other (Gieryn, 1983, 1999; Liu, 2018). The concept of boundary work draws attention to how groups, occupations and organizations interact with each other through this process of demarcation and how power mediates these dynamics (Langley et al., 2019).

This paper uses the concept of boundary work to examine the emergence of community paramedics in Ontario, Canada. In Canada, recent scholarship argues that the emergence of community paramedics is a significant driver of change within paramedicine (Cameron & Carter, 2019; Leyenaar et al., 2019; Tavares et al., 2021; Allana & Pinto, 2021).

Higher education, self-regulation and professional autonomy have been discussed as a central means for expansion in areas such as community paramedicine (O'Meara et al., 2014; Allana & Pinto, 2021; Tavares et al., 2021; Limogene et al., 2021). The study of community paramedicine has yet to be viewed through the lens of professionalization.

In Ontario, paramedics primarily deliver emergency healthcare (Ontario, 2022). In 2014, following the emergence of a small number of programs using paramedics in non-emergency roles, the Ontario government's Ministry of Health and Long-term Care funded 30 pilot programs under the umbrella term of community paramedicine (Leyenaar et al., 2019). In 2017, following the evaluation of the pilot programs, the Ministry released a framework for planning, implementing and evaluating community paramedicine programs. By 2019, there were over 143 unique community paramedics programs, with 92% (48/52) of all provincial paramedic service providers providing at least one program.

What started as a small number of pilot programs has now been described as a "growing field of paramedicine that emphasizes a more proactive and preventative approach to care that utilizes paramedics in expanded roles" (Leyenaar et al., 2019, p. 8). There are now diverse typologies of community paramedic programs in Ontario, including assessment and referral programs, community paramedic-led clinics, home visit programs (MOH, 2017), remote patient monitoring programs, community paramedic-specialist response programs, hospital discharge programs, and influenza surge programs (Leyenaar et al., 2019). Paramedic Services have reported that their community paramedic programs have resulted in partnerships with healthcare system organizations in home and community care, primary care, long-term care, palliative care, mental health care, and public health units.

In the sociology of professions, boundary work is a long-standing concept looking at the relationships between actors in a work or occupation field or setting (Gieryn, 1999). This paper begins with a definition of boundary work "as a set of social processes over sites of

difference with other professions or laypersons" (Liu, 2018, p. 47). This concept is expanded to include three typologies of boundary work identified by Langley et al. (2019): competitive, collaborative, and configurational. According to this configuration, boundary work is socially constructed and fluid and enacted at the individual, group, or field level (Buchere et al., 2016). This paper uses Langley's (2019) typology as a conceptual framework to explore the boundary work of community paramedicine at the group (occupational) level.

Applied to the professionalization of paramedics, this conceptual framing of boundary work is important as it recognizes how boundary work can be fragile and de-stabilizing (Bos-de Vos, Lieftink & Lauche, 2019). Boundary work is open-ended and chaotic as actors work through shifting their symbolic, physical, and social arrangements (Langley el, 2019). Further to this, recent research has highlighted how new or weaker actors (compared to others in the field) may engage in multiple forms of boundary work and may do so in subtler and more collaborative ways (Bucher et al., 2016; Langley et al., 2019).

METHODOLOGY

This study draws upon data from a constructivist case study (Merriam, 1998) of paramedic professionalization in Ontario, Canada. A constructivist case study is a holistic research approach that aims to understand a phenomenon by examining the socio-cultural processes of people, places and organizations. The data for this study consists of qualitative semi-structured interviews with paramedic leaders in Ontario and publicly available documents. This study drew on the concept of boundary work to examine how the paramedic industry has engaged in processes of jurisdictional change as it relates to community paramedicine.

Following ethics approval, from 2018 to 2019, the principal researcher (MB) conducted 25 semi-structured interviews with paramedic leaders in Ontario, Canada.

Paramedic leaders were from different organizations such as professional associations, unions, service providers, education institutions, and regulatory bodies. Most participants were in managerial, education, or other professional roles after having worked as a paramedic for many years, and eight participants were working as a frontline paramedic at the time of the study. Participants were invited by mail or email. Interviews were conducted primarily by telephone due to the geographical distance between the participants and the interviewer. The interview length was from 45 to 95 minutes. The interviews were recorded and transcribed verbatim prior to data analysis. In the findings section, all participants are referred to as paramedic leaders to protect their identity. The findings of this paper come from portions of the interviews where participants discussed the role of community paramedicine in shaping paramedic professionalization.

Documents were used as a supplementary source of data to create a more comprehensive understanding of the phenomenon (Bowen, 2009; Varpio et al., 2016). Documents provided background information and added historical context to the analysis. The documents were also analyzed to examine the rhetoric used to describe community paramedicine. The document search was restricted to publicly available documents focusing on paramedicine in Ontario. An initial search was conducted using Google in January and February 2018 and January 2021 (to update the search with more recent documents). Documents were also searched for if they were identified by participants during the interviews. The eleven documents included in this analysis were related to the topic of community paramedicine (see Table 1).

Data (interviews and documents) were analyzed using abductive analysis (Tavory & Timmermans, 2012; 2014). Abductive analysis uses both deductive and inductive analytical strategies to consider empirical findings in the context of existing theoretical perspectives. Through the process of alternative casing, the data is viewed through the lens of different

theoretical perspectives while also allowing for new or unexpected findings to shape the analysis process. The stages of abductive analysis first involved descriptively coding the data. Codes, memos and notes were then analyzed in relation to the existing literature. Abbott's conceptualization of boundary work was initially examined to explain jurisdictional change, however did not explain the collegial and collaborative work expressed by paramedic leaders. A broader examination of the literature revealed Langley's typology of boundary work which provided additional nuance to examine the different types of boundary work in this study.

Document Archive
1. County of Renfrew Paramedic Service. (2013). *A Survey of Community Paramedic Programs in Ontario*. DrL. 2. Emergency Medical Services Chiefs of Canada. (2006). *Future of EMS in Canada*. 3. Emergency Medical Services Chiefs of Canada. (2012). *Community Paramedicine in Canada.* 4. Expert Group on Home & Community Care, & Donner, G. J. (2015). *Bringing care home: report of the expert group on home & community care.* Expert Group on Home & Community Care. 5. Leyenaar, M. Strum, R., Haque, M. Nolan, M, & Sinha, S on behalf of the Ontario Community Paramedicine Committee. (2019). *Report on the Status of Community Paramedicine in Ontario.* The Ontario Community Paramedicine Secretariat. 6. Ministry of Health and Long-term Care. (2017). *Community Paramedicine Framework for Planning, Implementation and Evaluation.* Home and Community Care Branch. 7. Ontario Paramedic Association. (2013). *Health Professions Regulatory Advisory Council Application. Regulation of Paramedics under the Regulated Health Professions Act, 1991* 8. Ontario Association of Paramedic Chiefs. (2016). *Response to Patient's First: A proposal to Strengthen patient-centred Health Care in Ontario Discussion Paper*. 9. Ontario Association of Paramedic Chiefs. (2019). *Letter to Dr. Rueben Devlin, Chair, Premier's Council on Improving Health Care and Ending Hallway Medicine.* 10. Paramedic Association of Canada Strategic Plan. (2016-2018). 11. Paramedic Association of Canada Strategic Plan (2018-2020). 12. Sinha, S. K. (2013). *Living longer, living well: Highlights and key recommendations from the report submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to inform a senior's strategy for Ontario*. Ontario Ministry of Health and Long-Term Care.

Table 1. Document Archive

FINDINGS

In the following sections, three types of boundary work are described as they relate to community paramedicine. In competitive boundary work, paramedics *bridged* the boundaries of paramedicine to community health using community paramedicine and also intraprofessionally *blurred* the boundaries between paramedicine and community paramedicine as a means to expand paramedic jurisdiction. In collaborative boundary work, community paramedicine was a means for paramedics to work together with healthcare organizations to solve complex healthcare problems. In configurational boundary work, paramedics *defined* a problem and presented community paramedicine as a *solution* to create the *inter-discipline* of community paramedicine. In the final section, barriers to using community paramedicine to alter paramedic jurisdiction are discussed.

Competitive Boundary Work

Competitive boundary work can be creative as groups seek to gain legitimacy in a wider domain (Langley et al., 2019). Langley et al. draw attention to the recent empirical literature, which found that newer or weaker actors used boundary-blurring or bridging techniques to be positioned *similar and closer* to privileged others. The sentiment across those in the study is that while paramedics were once viewed as solely emergency first responders, community paramedic roles were slowly changing this view and positioning paramedics closer to the healthcare sector. For instance, participant 16 stated community paramedicine is a recognition that "we are bigger than just transporting people to the hospital." Participant 6 stated, "community paramedicine is changing the philosophy of what paramedics are."

One way that paramedic service organizations have sought legitimacy in the healthcare domain has been to blur and bridge the boundaries between traditional paramedic

work and new areas of care. The EMS Chiefs of Canada (2006) wrote that, “EMS is the glue that links components of the health and public safety systems together” (p. 20). They go on to say, “partnering more closely with the medical community will help identify opportunities to enhance EMS’ role in the provision of health services” (p. 21). Participants also did bridging work by highlighting how paramedics have special skills and qualities that transfer effectively into community health roles. Participants described how paramedics are mobile and flexible, which allows them to access hard-to-reach populations and make them "great value" to the healthcare system. Community paramedics were described as being able to reach isolated or "off the grid" populations. Participant 6 stated that because paramedics have first responder skills, "it gives us a leg up on other health care providers. Our training allows us to deal with emergency situations". Paramedic attributes were also used as a blurring technique. Participant 23 argued that paramedics "have the public's trust. They can go into people's homes".

Paramedics have attempted to bridge to the healthcare sector by advocating for self-regulation. In Ontario, the majority of healthcare providers are governed by profession-specific self-regulating colleges. Paramedics are not regulated under this legislation, rather are uniquely government-regulated. A visionary document produced by Emergency Medical Chiefs of Canada in 2006 described a “vision to have paramedicine recognized in health care legislation and particularly in primary health care” (p. 3). Documents from the Ontario Paramedic Association (OPA, 2013), the Paramedic Association of Canada (PAC, 2016, p. 34), and the Ontario Association of Paramedic Chiefs (2016) show support for paramedics to be included under provincial legislation governing other healthcare professions. A document from the Ontario Association of Paramedic Chiefs wrote:

> "Quality oversight of community paramedicine in Ontario is currently characterized by a loose patchwork of legislation, regulation and implementation. Under the current system, provincial base hospitals have well-established protocols their affiliated paramedics may perform when providing emergency patient care. This level of oversight is not as well established for community paramedics as medical oversight is provided by primary care physicians, community care access centres, or Family Health Teams. This inconsistency represents a threshold for risk to the public. The OAPC recommends that the best approach to strengthening community paramedicine is the development and implementation of the College of Paramedicine that supports a collaborative approach to inter-professional community-based teams. Self-regulation would create one regulatory body with a clear vision of patient care and reinforce the 'patients first' philosophy" (OAPC, 2016, p. 4-5).

Several participants intertwined their narratives about self-regulation with community paramedicine. Participants discussed how community paramedicine justifies the need for self-regulation as paramedics have grown professionally and are taking on larger and broader healthcare system roles. Others stressed how community paramedicine could be further clarified or defined as a result of self-regulation. Another participant discussed that it would help other organizations better integrate community paramedic roles as the current regulatory system is complicated and confusing, which can be a barrier to collaboration. These narratives highlight that community paramedicine is a way for paramedics to bridge with the healthcare system by being included in the regulations governing other healthcare professions. Blurring the boundaries between paramedics and community paramedics allows new roles to grow, with an expansion into community health justifying an expansion back to the core role of paramedics in emergency care.

Collaborative Boundary Work

Collaborative boundary work is when social actors align boundaries to work together to meet shared goals, or they align in productive ways (Liu, 2018; Langley et al., 2019). Langley et al. (2019) describe collaborative boundary work as work that helps "get things done." Many participants expressed how community paramedics were helping solve systemic healthcare system issues, in addition to managing the growing demand for 911 services. These were described as practical, although complex, problems, for which community paramedics were one of many solutions. Many participants clearly defined community paramedicine as a collaboration with other healthcare partners and services. Participant 22 described community paramedics as a "spoke in the wheel of service delivery. It is not its own wheel".

In recent years partnering with healthcare organizations has become crucial to community paramedicines' success. Some participants claimed that partnering with community health organizations allowed for new funding streams and relationships that were previously unavailable. Participants described how paramedic services were traditionally siloed from other sectors of healthcare, and community paramedic programs allowed paramedic service providers to integrate with the healthcare system. As participant 18 stated:

> “We were not seen always as an equal partner in providing care when we were speaking with physicians, nurses, and other healthcare providers. I really think that the profession has grown to have that level of respect by those other professions. And I think those other professions are now really looking to us as bringing solutions to help all of us deal with patients. It's one patient, and how do we work together with all our resources in order to help better serve our patients”.

Community paramedicine was viewed as a solution to rising demands for paramedic services and to build capacity within a strained healthcare system. Some participants argued that community paramedicine arose out of the recognition that paramedics were being used through the 911 system for a range of lower acuity problems and that upon attending to these patients, paramedics often identified the need for other services (such as home care or primary care) and had limited ways of connecting patients to these services. This resulted in one of the first community paramedic programs, which was a referral program to community health services. Several participants described how this program helped open the door for paramedics to do more for patients with long-term chronic health issues or social problems in other community paramedic roles.

Paramedic organizations have also positioned paramedics as collaborative partners in healthcare delivery. Several participants clearly stated that paramedics were not "stepping on other professions' toes" but rather were filling gaps in a system that other providers didn't have the resources to address. The OAPC (2016) wrote that community paramedic programs will "fill in critical gaps that exist within the system and should not duplicate programs already in place" and "community paramedic programs should not encroach on other workers' rights or responsibilities" (p. 4). Participant 19 stated that community paramedics do not take jobs away from other healthcare professions as one of the primary goals of community paramedicine program (in this jurisdiction) was to bring patients to existing services through referrals. As participant 17 stated, "if the system worked well, we wouldn't need community paramedicine. It is filling a gap in the system. It was never intended to take the place of another profession". These statements highlight that paramedics are positioning themselves as collaborative, supportive partners in addressing challenging healthcare problems.

Configurational Boundary Work

Langley et al. (2019) describe a subtype of configurational boundary work as coalescing boundary work. Coalescing boundaries involves processes of reshaping "existing activities into newly defined domains or spaces" (p. 48) and can result in the building of an "inter-discipline" (Frickel, 2004). Inter-disciplines start being built by framing or defining a problematic issue and stating how the solution may help the problem. Community paramedicine is a new inter-discipline for paramedics that was created by paramedics defining the problem facing paramedics (and the broader healthcare system) and presenting community paramedicine as the solution.

Participants' accounts and documents (EMSCC, 2006; EMSCC, 2012) indicated that community paramedicine arose from the paramedic community recognizing that the 911 system was under strain. This resulted from broader healthcare system constraints in many sectors (community care, acute care, primary care, public health). Participants described how paramedics were increasingly dispatched to low acuity calls they viewed as occurring due to gaps in other healthcare services, such as community health and primary care. As participant 17 stated, "the risk is you have no ambulances left because they are on low acuity calls, and you don't have anyone left for the highest risk call." Participants argued that changes in demographics and patient characteristics, such as increases in chronic disease and an aging population, have put increased stressors on the healthcare system.

Community paramedicine was presented as a solution for problems facing paramedic services and the healthcare system. This can be seen in the documents produced by paramedic organizations, such as the Ontario Association of Paramedic Chiefs (2016, 2019), which described community paramedics as helping older adults age in place and address shortages of home care for seniors in rural areas. One document frames paramedics as ideally suited to address problems caused by primary care under-usage and emergency department

over-usage (OAPC, 2016). Community paramedicine programs were also positioned as a cost saver to the healthcare system. One report stated paramedics are “less costly in terms of wages then nurses and doctors” (EMSCC, 2012, p. 61) and will provide “healthcare savings in the hundreds of millions of dollars” (p. 65). As community paramedicine has evolved, participants remarked that community paramedicine programs were not just about reducing 911 calls, but addressing healthcare system stressors.

As community paramedicine has grown, participants described a wide variety of programs under the term community paramedicine. Some participants viewed this as a strength, as programs can be tailored specifically to a local community's needs. Participant 22 stated: "how you define a community paramedic is going to vary from community to community. That's the whole essence of a community paramedic. There's no cookie-cutter. There may be common components of it that are going to be recognized across geographical boundaries." A report produced by the Community Paramedicine Secretariat in 2019 on the status of community paramedicine across Ontario found that the most common goals of community paramedicine programs were "to connect individuals and patients to other health care services, improve the integration of care, and to reduce repeated utilization of paramedic services" (p. 6). The authors go on to state:

> "The rapidly evolving and growing multi-dimensionality of community paramedicine programs being offered appears to represent a growing intentional strategy by Ontario's municipal paramedic services to provide individuals and patients with greater access to other community-based care providers and services that can help lessen a patient's reliance on the province's 9-1-1 safety net and reduce emergency department visits and hospitalizations" (Leyenaar et al., 2019, p. 4).

The coalescing boundary work done by paramedic leaders and organizations showcases why and how the inter-discipline of community paramedicine was created. This type of boundary work overlaps with the competitive and collaborative boundary work described earlier. Paramedics blurred the boundaries between paramedic practice and other healthcare sectors by connecting problems in the 911 system to broader healthcare system pressures. Paramedics presented community paramedicine as a solution to these problems by describing paramedics as a flexible actor that wants to collaborate with other organizations to accomplish shared healthcare goals. In doing so, a new jurisdiction for paramedics has been created that has secondary goals of presenting paramedics as a healthcare profession in need of other changes, such as self-regulation.

Challenges in the Boundary Work of Paramedicine

This research found that some participants had concerns about some aspects of community paramedicine. Most of these concerns relate to the ambiguous and unclear boundary between the community paramedicine, paramedicine, and the healthcare system. In one participant's words, the "core business" of paramedics has been an emergency response role, and community paramedic roles shift this ethos of paramedics. As participant 7 reflected, "are we a response agency or a healthcare profession?". When discussing community paramedic roles, participant 23 stated, "paramedic is a unique term. We haven't fully defined it. We don't know where our boundaries are". Ambiguous or uncertain boundaries have implications for how community paramedic roles are understood and interpreted by the paramedic community and other healthcare partners.

An example of how paramedics struggle with broadening their role is that many participants expressed uncertainty or different views about what exactly community paramedicine was. Some participants were concerned that many programs were being called

community paramedicine that were not. Participant 16 stated, "I fear everything is being branded as community paramedicine now, such as treat and refer. There are things that aren't community paramedicine, and in those situations, a paramedic is a paramedic, and I don't think you need to label it community paramedicine". Conversely, another participant described tension due to the creation of provincial guidelines for community paramedicine that resulted in some degree of standardization of programs occurring before the concept of community paramedicine was fully understood or limited novel programs that were tailored to localized needs.

Some participants were concerned about how community paramedic roles will impact interprofessional relations. There were concerns that, at times, community paramedic roles may get "too close" to other professions and other professions may be hesitant of community paramedic roles because they are ambiguous. As participant 21 stated, "community paramedics will have to be careful going down the road and have roles clearly defined with other healthcare professions. Sometimes we get into the grey area, and we have to be careful".

Participants' narratives also revealed how community paramedicine has divided paramedics. Participant 12 stated:

> "I don't think that having community paramedicine undefined outside of the [911] system is a good thing for the profession. It fractures the profession, and the profession is already fractured enough. So, whatever the system is that encompasses all of this, it should be one system. It shouldn't be the 911 paramedic system over here and something called community paramedicine over there. I think it all needs to be together and to have standards. Not standards as we know them, but the standards of care metrics that are commonly reported on, where people can learn from each other".

Other participants expressed frustration that the roll-out of community paramedics was unequal across the province. Some participants expressed concern that not all municipal paramedic service operators were able to fund or provide community paramedic services. As participant 15 stated, "It's still very much fragmented. There has still been a lot of hesitation. Why are my paramedics not doing a blood draw? Why are my paramedics not administering vaccines? Why? Because in a lot of my communities, those services are just not available." Other participants stated that a lack of clear outcomes for paramedic services made it challenging to sustain and argue for funding. Sharing and support between paramedic services in advancing community paramedic programs were also inconsistently described.

DISCUSSION & CONCLUSION

This research adopted the sociological lens of boundary work to critically examine *how* and to what end paramedics have attempted to broaden their jurisdiction. The healthcare occupations have often been examined in studies of boundary work as they have historically had clearly defined boundaries (by legislation) (Bucher et al., 2016) and also have a history of interprofessional competition over shared boundaries (Abbott, 1988; King et al, 2015). Elite professions such as medicine are often conceptualized as engaging in competitive boundary work, aiming to control an area of work and that of others (Abbott, 1988; Witz, 1992). This research adopted a broader conceptualization of boundary work that considered subtler and collegial forms of boundary work. Adopting this lens illuminated that the typologies of boundary work are not mutually exclusive and there is blurring between the different types of boundary work. As Langley et al. (2019) highlight, the process of creating new boundaries is precarious and unclear. The ambiguity around community paramedicine,

both internally within paramedicine and externally with other professions and healthcare organizations, reflects the nuanced process of boundary work.

As seen in this study, forms of boundary work were intertwined. Paramedics were required to be seen as similar to other healthcare providers while arguing how and why they were different. In the literature, the success of community paramedicine has been discussed in terms of healthcare system integration. Cameron & Carter (2019) have raised concerns that community paramedic programs risk being a "piece-meal patch" to complex healthcare system issues if they are not integrated into existing healthcare services (p. 693). Batt et al. (2021) also stress the importance of integrating community paramedicine within existing healthcare services to ensure programs meet their intended aims and broader healthcare system goals. The lens of boundary work problematizes the idea that community paramedicine is centered around integration. Role expansions are sociological processes where occupations rearrange “over sites of difference” (Liu, 2018, p. 47). The process of bringing paramedics together with the healthcare system is intertwined with paramedics attempting to define their own boundaries as distinct. Examining the social processes of differentiation does not mean that community paramedicine cannot or should not integrate with the healthcare system. Rather, the process of doing so reconstructs paramedics' relationships within their own occupation and with other occupations and organizations.

This research and other studies (King et al, 2015; Nancarrow & Borthwick, 2021) have found that an occupation’s ability to pursue boundary work is enabled and confined by healthcare system policy trends. Community paramedicine has been given opportunities (and faces challenges) due to broader healthcare system trends in Ontario aiming to connect the healthcare system and creating more flexible and permeable boundaries between the healthcare professions (O'Reilly, 2000; MOH-LTC, 2017, 2019; Leslie et al., 2021). Over the past several decades, there has been a continued trend toward non-exclusive scopes of

practice and greater flexibility in how healthcare providers are utilized (Leslie et al., 2021). Task-shifting and task-sharing from higher to lower trained providers is viewed as a solution to improve access to healthcare resources (Orkin et al., 2021). Recent challenges, such as the COVID-19 pandemic, reconfigured and expanded the roles of various healthcare providers (Bourgeault et al., 2020), including paramedics (Batt et al., 2021). This study found that paramedics do not fully control the process of boundary work, even though paramedics may position it as related to processes of professionalization.

The struggle over the diversity of community paramedic programs, the ambiguity of roles and role overlap with other providers suggest that there may be unresolved challenges for community paramedicine. Langley et al. (2019) highlight that the concept of collaborative boundary work can gloss over the underlying power dynamics in which different groups or individuals work together. For instance, participants described some communities felt left behind since they did not have the resources to start or continue community paramedic programs. These experiences expose issues of healthcare access and equity from a patient and provider perspective.

Other participants were concerned about role overlap with nurses. Research adopting a power lens can showcase the complex relationships between healthcare providers as they navigate new relationships and configurations of care (Long et al., 2006; Nugus et al., 2010; Baker et al., 2011; King et al, 2015). As Konrad et al. (2019) argue, critical theory research can serve as an alternative lens to examine popular ideas or concepts in healthcare, such as teamwork or integrated care. There is some emerging research on paramedics examining these issues. In an exploratory scoping review on paramedic roles in primary care in the United Kingdom, the United States and Canada, Eaton et al. (2021) found that paramedics in these roles had to navigate complicated professional role boundaries. For instance, some clinical staff were concerned that paramedics were a substitution for other healthcare

providers, such as nurses, versus a role addition. Future research adopting a critical theory lens would further our understanding of the complex dynamics between paramedics and other healthcare providers and between different paramedic organizations, which to date remains poorly understood.

This research studied a role expansion for paramedics – community paramedicine – through the concept of boundary work. Paramedics engaged in three types of boundary work: competitive, collaborative, and configurational. Community paramedicine has acted as a bridge between the first responder role for paramedics and the healthcare sector. This research found that community paramedicine has given paramedics the space to redefine their role, although the implications of this new role are yet to be fully understood. The lack of clear or stable boundaries is not unique to the paramedic context. However, it draws attention to the implications of paramedic boundary work on their relationship to other healthcare occupations in the delivery of healthcare and their own profession. Future research on community paramedicine would benefit from adopting an interprofessional and critical lens.

REFERENCES

Allana, A., & Pinto, A. D. (2021). Paramedics Have Untapped Potential to Address Social Determinants of Health in Canada. *Healthcare Policy*, *16*(3), 67.

Batt, A., Hultink, A., Lanos, C., Tierney, B., Grenier, M., & Heffern, J. (2021). *Advances in Community Paramedicine in Response to COVID-19*. CSA Group. https://www.csagroup.org/article/research/advances-in-community-paramedicine-in response-to-covid-19/.

Baker L, Egan-Lee E, Martimianakis M, Reeves S. (2011). Relationships of power: Implications for interprofessional education & practice. *Journal of Interprofessional Care, 25,* 98-104.

Bos-de Vos, M., Lieftink, B. M., and Lauche, K. (2019). How to Claim What is Mine: Negotiating Professional Roles in Inter-Organizational Projects. *Journal of Professions and Organization, 6*(2), 128–55

Bourgeault, I. L., Maier, C. B., Dieleman, M., Ball, J., MacKenzie, A., Nancarrow, S., ... & Sidat, M. (2020). The COVID-19 pandemic presents an opportunity to develop more sustainable health workforces. *Human Resources for Health*, *18*(1), 1-8.

Bowen, G. (2016). Document Analysis as a Qualitative Research Method. *Qualitative Research Journal*, *9*(2), 27-40.

Bucher, S. V., Chreim, S., Langley, A., & Reay, T. (2016). Contestation about collaboration: Discursive boundary work among professions. *Organization Studies*, *37*(4), 497-522.

Carter, A. J., Arab, M., Cameron, C., Harrison, M., Pooler, C., McEwan, I., ... & Crick, S. (2021). A national collaborative to spread and scale paramedics providing palliative care in Canada: Breaking down silos is essential to success. *Progress in Palliative Care*, *29*(2), 59-65.

Cameron, P., & Carter, A. (2019). Community paramedicine: A patch or a real system improvement?. *Canadian Journal of Emergency Medicine*, *21*(6), 691-693.

Cohen Konrad, S., Fletcher, S., Hood, R., & Patel, K. (2019). Theories of power in interprofessional research–developing the field. *Journal of Interprofessional Care*, *33*(5), 401-405.

County of Renfrew Paramedic Service. (2013). *A Survey of Community Paramedic Programs in Ontario.* DrL. https://www.communityparamedic.ca/media/download_gallery/Ontario%20Community%20Paramedic%20Survey%20Report%20rev%209%20April%202013%20pdf%2-%20Adobe%20Acrobat%20Pro.pdf

Eaton, G., Wong, G., Tierney, S., Roberts, N., Williams, V., & Mahtani, K. R. (2021). Understanding the role of the paramedic in primary care: a realist review. *BMC Medicine*, *19*(1), 1-14.

Emergency Medical Services Chiefs of Canada. (2006). *Future of EMS in Canada.* https://pscs.ca/images/stories/committee/EMSCC-Primary_Health_Care.pdf

Emergency Medical Services Chiefs of Canada. (2012). *Community Paramedicine in Canada*. https://nasemso.org/wpcontent/uploads/CommunityParamedicineCanada.pdf

Expert Group on Home & Community Care, & Donner, G. J. (2015). *Bringing care home: report of the expert group on home & community care.* Expert Group on Home & Community Care. https://health.gov.on.ca/en/public/programs/lhin/docs/hcc_report.pdf

Gieryn, T. F. (1983). Boundary-work and the demarcation of science from non-science: Strains and interests in professional ideologies of scientists. *American Sociological Review*, 781-795.

Guo, B., Corabian, P., Yan, C., & Tjosvold, L. (2017). *Community paramedicine: program characteristics and evaluation*. Institute of Health Economics.

King, O., Nancarrow, S. A., Borthwick, A. M., & Grace, S. (2015). Contested professional role boundaries in health care: a systematic review of the literature. *Journal of Foot and Ankle Research*, *8*(1), 1-9.

Langley, A., Lindberg, K., Mørk, B. E., Nicolini, D., Raviola, E., & Walter, L. (2019). Boundary work among groups, occupations, and organizations: From cartography to process. *Academy of Management Annals*, *13*(2), 704-736.

Leslie, K., Moore, J., Robertson, C., Bilton, D., Hirschkorn, K., Langelier, M. H., & Bourgeault, I. L. (2021). Regulating health professional scopes of practice: comparing institutional arrangements and approaches in the US, Canada, Australia and the UK. *Human Resources for Health*, *19*(1), 1-12.

Lindberg, K., Walter, L., & Raviola, E. (2017). Performing boundary work: The emergence of a new practice in a hybrid operating room. *Social Science & Medicine*, *182*, 81-88.

Limoges, J., Jagos, K., McNamara, M., & Drennan, I. (2021). Interprofessional collaboration in home-based community care programs: A leadership imperative. *Journal of Nursing Education and Practice*, *11*(11).

Leyenaar, M. Strum, R., Haque, M. Nolan, M, & Sinha, S on behalf of the Ontario Community Paramedicine Committee. (2019). *Report on the Status of Community Paramedicine in Ontario.* The Ontario Community Paramedicine Secretariat. https://static1.squarespace.com/static/5d3620021438f10001b257ce/t/5e0b684d881870cab622660/157805905922/2019_OCPS_Report+2.pdf

Liu, S. (2018). Boundaries and professions: Toward a processual theory of action. *Journal of Professions and Organization*, *5*(1), 45-57.

Long D, Forsyth R, Iedema R, Carroll K. (2006). The (im)possibilities of clinical democracy. *Health Sociology Review, 15*(5), 506-519.

Merriam, S B. (1988). *Case Study Research in Education: A Qualitative Approach.* Jossey Bass.

Ministry of Health and Long-term Care. (2017). *Emergency Health Services System Modernization. Briefing Paper on Legislative Amendments to the Ambulance Act*. https://www.amo.on.ca/sites/default/files/assets/DOCUMENTS/Emergency_ServiceBriefingPaperonLegislativeAmendmentstotheAmbulanceActJuly2017final.pdf

Ministry of Health and Long-term Care. (2017). *Community Paramedicine Framework for Planning, Implementation and Evaluation, Home and Community Care Branch*. Government of Ontario.

Ministry of Health and Long-Term Care. (2019). *Discussion Paper: Emergency Health Services Modernization*. Government of Ontario. https://health.gov.on.ca/en/pro/programs/phehs_consultations/docs/dp_emergency_halth_services_modernization.pdf

Nugus, P., Greenfield, D., Travaglia, J., Westbrook, J., & Braithwaite, J. (2010). How and where clinicians exercise power: interprofessional relations in health care. *Social Science & Medicine*, *71*(5), 898-909.

Ontario Paramedic Association. (2013). *Health Professions Regulatory Advisory Council Application. Regulation of Paramedics under the Regulated Health Professions Act, 1991*. https://www.hprac.org/en/projects/resources/OPAapplicationforparamedicselfregulation13March2013.pdf

Ontario Association of Paramedic Chiefs. (2016). *Response to Patient's First: A proposal to Strengthen patient-centred Health Care in Ontario Discussion Paper.*

Ontario Association of Paramedic Chiefs. (2019). *Letter to Dr. Rueben Devlin, Chair, Premier's Council on Improving Health Care and Ending Hallway Medicine*.

O'Meara, P., Ruest, M., & Stirling, C. (2014). Community paramedicine: higher education as an enabling factor. *Australasian Journal of Paramedicine, 11*(2).

O'Meara, P. F., Tourle, V., Stirling, C., Walker, J., & Pedler, D. (2012). Extending the paramedic role in rural Australia: a story of flexibility and innovation. *Rural and Remote Health, 12*(2), 131-148.

O'Reilly P. (2000). *Health care practitioners: an Ontario case study in policymaking*. Toronto: University of Toronto Press.

Orkin, A. M., Rao, S., Venugopal, J., Kithulegoda, N., Wegier, P., Ritchie, S. D., ... & Upshur, R. (2021). Conceptual framework for task shifting and task sharing: an international Delphi study. *Human Resources for Health, 19*(1), 1-8.

Reay, T., Golden-Biddle, K., & Germann, K. (2006). Legitimizing a new role: Small wins and microprocesses of change. *Academy of Management Journal, 49*(5), 977-998.

Sinha, S. K. (2013). *Living longer, living well: Highlights and key recommendations fromthe report submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to inform a senior's strategy for Ontario*. Ontario Ministry of Health and Long-Term Care.

Varpio, L., Ajjawi, R., Monrouxe, L. V., O'Brien, B. C., & Rees, C. E. (2017). Shedding the cobra effect: problematising thematic emergence, triangulation, saturation and member checking. *Medical Education, 51*(1), 40-50.

CHAPTER 5: CONCLUSION

SUMMARY OF FINDINGS

This thesis examined the intraprofessonal dynamics of paramedic professionalization in Ontario, Canada. Across the three empirical chapters, I examined the paramedic professionalization project related to regulation, higher education and credentialing, and the boundary work of jurisdictional expansions. Like other allied health professions (Nancarrow & Borthwick, 2021), paramedics are motivated to improve their social position, however, they must do so in increasingly adaptable and elusive ways. Most interestingly, and the main contribution of this thesis, is that the common thread through all of the empirical chapters is that paramedics are a fractured profession. Their professionalization project is a process marked by intentional and unintentional stratification, which at times leads to intraprofessional division or conflict. The findings of this thesis address a gap in the literature on how intraprofessional dynamics relate to professionalization.

In chapter 2, views on paramedic regulation were examined and revealed polarizing perspectives on the relationship between regulatory reform and professionalization. The concept of institutional work unpacked participants' perspectives of the current regulatory model for paramedics and the role of self-regulation in professionalizing paramedics. Doing so revealed that participants had varying views on the future of paramedics, and consequentially, the lack of a shared vision has strained intraprofessional relationships. Unlike other professions that have split into two separate groups following conflict over roles and identities, paramedics are bound together by legislation. The lack of ability to resolve intraprofessional disputes or disagreements may impact their ability to further their occupational mission and, left unresolved, risks obscuring other forms of inequity.

Chapter 3 aims to understand the role of higher education in paramedic professionalization. This chapter positions higher education as consequentially linked to professionalization and a classic strategy many other professions use to secure occupational closure and gain legitimacy. The main finding of this paper is that higher education is a contested rather than a taken-for-granted feature of professionalization. There is tension between higher education eroding the importance of frontline paramedics' street knowledge and concerns around a university-educated workforce's economic viability. Those who support higher education view it necessary to address gaps in paramedic education due to rapid role expansions and gaining recognition in the healthcare industry. A paramedic-driven professionalization movement has been to leverage academic paramedics, intentionally stratifying paramedics to increase the profession's status, recognition, and control over knowledge and maneuver around economic pressures.

In chapter 4, the concept of boundary work is applied to the study of community paramedicine, a new area of work for paramedics in primarily non-emergency settings. The goal of this chapter was to bring a sociological lens to the study of a relevant topic in the healthcare human resources literature: the broadening of healthcare professionals' roles to solve healthcare human resources constraints. The concept of boundary work was an essential contribution to the sociology of professions literature as it highlighted how professions differentiate themselves from one another as a social and political process. A broader look at the literature reveals other forms of boundary work that are subtler and more collaborative than original conceptualizations of boundary work as overt and competitive. This chapter examines the emergence of community paramedicine through three types of boundary work: competitive, collaborative and configurational. Paramedics have used competitive boundary work to blur paramedic boundaries and bridge emergency paramedic work to the healthcare sector. They engage in collaborative boundary work by working with other healthcare

organizations to address complex healthcare goals. Lastly, community paramedicine can be conceptualized as an interdiscpline. The role resulted from configurational boundary work, where paramedics defined a specific problem and proposed community paramedicine as a solution. This chapter showcases the precariousness and opportunities for occupations engaging in boundary work as they navigate new social arrangements. Paramedics are engaging in a dual professionalization project of trying to further their integration with the healthcare system through community paramedic roles while also attempting to define their professional boundaries as distinct.

CONTRIBUTIONS TO THE LITERATURE

Theoretical Contributions

This thesis contributes theoretically by extending current theories in the sociology of the professions. Rapid changes to professional work have made studying the process of professionalization relevant. However, the appropriate theoretical approach to address this remains a more complex question (Adams & Sawchuk, 2021). Studying diverse occupations and professions sheds light on the variable processes and pathways of professionalization (van Bochove & Oldenhof, 2020). This thesis rejects a functionalist approach, as highlighted by Burns (2019) in his call for a post-professional era. Professionalization is a messy, complex process, poorly understood by functionalist accounts. Professions do not act on their own accord, instead, they are influenced by an interconnected set of ideologies and influences that shape their available directions and pathways (Saks, 2012; 2016). To capture the messiness of professionalization, a theoretically eclectic approach was needed. This thesis drew on neo-Weberianism, neo-institutional theory (particularly concepts from the agentic turn), and the ecological concept of boundary work, which helped unpack the complexity of paramedic professionalization.

The findings of this thesis would argue that the study of professionalization projects, as viewed through a neo-Weberianism lens, is still valid. This stance aligns with Nancarrow & Borthwick's (2021) stance on this matter with regards to allied health professionalization:

> "In true neo-Weberian terms, what the professions seek remains constant-prestige, autonomy, social status and control. However, they do so within a new environment, born of necessity. Professions continue to compete for space, for task domains and to defined role boundaries or prestigious titles, though within a context shaped by the need to conform to political and economic solutions to healthcare workforce shortages" (p. 212-213).

Extending this line of thinking, I argue that additional theoretical and conceptual tools are needed to explain the diverse strategies for professionalizing occupations in this "new environment."

This research challenges the assumption that professionalization projects strengthen the professional unity achieved through state licensure and standardized education (Larson, 1979; Nancarrow & Borthwick, 2021, p. 203). The concepts of institutional work, selective coupling, and boundary work as a means to make sense of the chaotic narratives emerging on paramedic professionalization. These concepts provided a tool to consider a range of intraprofessional responses beyond professional unity. As van Bochove and Oldenhof (2020) highlight, the concepts of institutional work and boundary work highlight the dynamics within a group, such as status differences. I argue that a broader array of conceptual tools highlight how intraprofessional dynamics impact professionalization projects.

The concept of a professionalization project is still relevant in highlighting the importance of particular professional ideologies and values, such as credentialism, autonomy

and recognition. To use neo-institutional language, there remains an isomorphic pressure to pursue traditional forms of occupational professionalism towards traits that are thought to grant professional independence, control and trust, such as self-regulation and higher education. For instance, medicine was still be viewed by some as the archetypical profession and discussed professionalization in functionalist terms. However, others rejected this version of professionalization partially or completely. The result was a selective coupling of traditional characteristics once strongly connected to notions of professionalism as a result of external pressures. To professionalize, some roles had to be leveraged over others, such as community and academic paramedics. These roles represent subtler professionalization strategies that were more collegial and collaborative with other professions and organizations rather than overt or competitive. As Nancarrow & Borthwick state, allied health professional projects must "tailor their ambitions to fit that which is possible" (p. 213). Neo-Weberianism benefits from additional theoretical insights because paramedics do not control all aspects of professionalization, nor was it solely imposed on them from above (Evetts, 2011). The concepts of institutional work and boundary work provide a conceptual means to examine what ambitions or goals are tailored, why these particular aspects are chosen, and how it is done (or not done). They reveal intentional and unintentional forms of stratification as paramedics must negotiate an increasingly complex world.

The findings of this research also draw attention to a common thread in the sociology of professions literature: the tension between organizational professionalism and occupational professionalism. One aspect of this literature has examined how large-scale organizations where professionals work have impacted professionalization. This literature examines how professions face increasing control and external accountability, which has eroded professional discretion, autonomy and control (Evetts, 2011). In large organizational workplaces, managerialism and professionalism are resulting in new hybrid roles that

incorporate both logics. Hybrid professionalism refers to the overlap and blurring of managerialism and professionalism (Noordegraaf, 2015). As seen in this thesis, the influence of managerialism had a complex effect beyond being "unwilling or unable to professionalize" (Hogdson et al., 2015, p. 5) and led to different responses. For instance, community paramedic roles combined professional and managerial logics by leaning into economic pressures by presenting the role as a flexible and inexpensive solution to healthcare problems. It was also accepted by many in the paramedic field because it fulfilled occupationally driven professionalization to be seen as a legitimate healthcare profession. Conversely, academic paramedics were a way to maneuver around different logics though the process of selective coupling. They upheld credentialing and higher education under specific conditions that would allow *some* paramedics to drive forward paramedic knowledge and protect the rest of the workforce as economically viable.

Empirical Contributions

The findings of this thesis add to a growing body of scholarship aiming to understand the sociology of paramedics. This dissertation began in 2015, and at the time, there was only a small body of scholarship on paramedics from a sociological lens and even less so on professionalization. Since this time, paramedics have seen increased sociological attention (see Corman, 2018; McCann & Granter, 2019; Seim, 2020). Sociological understandings of paramedic professionalization represent a small but significant body of literature that improve our understanding of paramedics and paramedic work. The paramedic literature on professionalization would benefit from moving beyond functionalist accounts and further engagement with a range of theoretical approaches. There is little peer-reviewed literature originating from the Canadian context, which this thesis aims to address. This is important as many topics discussed throughout this thesis, such as self-regulation, are subjected to local

political trends and ideologies. As professionalization is increasingly under pressure from governments and workplaces, research examining professionalization needs to avoid oversimplifying geographic differences in professionalization.

While I admit I did not always consider paramedics as an allied health profession, the study of paramedics is enriched by examining the literature on allied health, potentially more so than nursing or medicine (Nancarrow & Borthwick, 2021). Interestingly, I rarely heard a comparison made to an allied health profession by participants. Nursing and medicine were the two most commonly discussed professions, likely reflecting both their central role in the healthcare system and the number of interactions both of these professions have with paramedics on a day-to-day basis. It could also reflect a desire by some to be viewed closer to medicine and nursing, rather than the ambiguous grouping of allied health professions, which have not traditionally worked with paramedics in an extensive capacity in Ontario. This arguably reinforces the status hierarchy of medicine within the health professions.

The literature on allied health professions serves as a valuable context to make sense of paramedic professionalization. Like the professionalization of allied health professions (Nancarrow & Borthwick, 2021), the findings of this thesis found that nearly all aspects of paramedic professionalization are related in some way to government direction and policy. Government policy has both enabled and constrained paramedic professionalization. It has enabled paramedic professionalization over the past twenty to thirty years by granting a medical-regulator model whereby paramedics were given a large scope of practice (and one that continues to grow) by standardizing (and thus restricting) the process for paramedic practice and training requirements for entry-to-practice, and by funding expansions in paramedic roles. While some paramedics may have felt they were not consistently recognized as a healthcare profession, paramedics have moved beyond the ambulance driver or attendant identity due to government-driven standardization.

Nancarrow and Borthwick (2021) describe limits to the professionalization of allied health professions. They argue that once the allied health professions broke free of medicine and professionalized as autonomous professionals (and were identified as such), "they do not progress beyond it, nor often seek to do so. It is a plateau that, once reached, becomes home" (p. 211). This statement highlights two aspects that make the paramedic case distinct. First, paramedics are not recognized as autonomous professionals. In Ontario, they are co-regulated by the state and physician medical directors, rendering them subordinate to both. Paramedics are uniquely regulated compared to nearly all other healthcare professions in Ontario (especially those they want to be compared to). This regulatory environment adds additional pressures onto paramedic professionalization that they must overcome to be viewed as an autonomous profession outside medical instruction. This regulation is even more confusing regarding professionalization, as paramedics have standardization in entry-to-practice training standards and ongoing workplace competency requirements. As seen in chapters 2 and 3, paramedics do not control or dictate these matters autonomously. Some wish to break free of what they view as a model supporting medical dominance over paramedics.

This research found a selective desire for paramedics to pursue upward mobility and not remain in a professionalization status "plateau" (Nancarrow & Borthwick, 2021, p. 211). This goal reinforces neo-Weberian perspectives on the motivations for professionalization to improve occupational control and status. Given the looming presence and influence of the profession of medicine and government control over regulatory and entry-to-practice training requirements for paramedics and role expansions, this has pushed paramedics to be creative in their pursuit of occupationally driven professionalization efforts. This can be seen in chapters 3 and 4 with the case of academic paramedics and community paramedicine programs. These marginal strategies are entrepreneurial and tenacious and appear to be driving change in the paramedic profession.

This dissertation contributes to a growing theme in the literature on how stratification and hybridity have impacted professionalization and professional work. Healthcare professions are no stranger to inter and intraprofessional division, although more has been written about the former regarding professionalization (Abbott, 1988; Boateng & Adams, 2016; Brosnan, 2017; Comeau-Vallee & Langley, 2020). In health professions research, intraprofessional division has recently been examined in day-to-day work, particularly in interprofessional teams (Miller & Kontos, 2013). Related literature threads have examined how division of labour within a profession has resulted in intraprofessional conflict (Martin, Currie & Finn, 2009; Comeau-Vallee & Langley, 2020; Boateng & Adams, 2016).

A central theme emerging from all chapters is the intentional or unintentional use of stratification in paramedic professionalization and its paradoxical consequences for advancement and professional unity. The stratification found in this research is interesting because it exists along several dimensions. There is a sociocultural dimension where there is conflict and division over the occupational identity of paramedicine. This exists on a spectrum from blue-collar professionalism, which is remarkably similar to Metz's 1982 account, to the more recent introduction of white-collar professionalism, which more closely resembles medicine. Paramedics were professionalized in part by medicine and privileged many of the things medicine does, such as evidence-based medicine, credentialing, specializations, a voice in healthcare decision-making, and autonomy. Stratification also exists in paramedic division of labour. There are three levels of paramedics, and now there is a new paramedic role, community paramedics. Academic paramedics represent a more symbolic role for paramedics in that it is not regulated, although it is recognized as a driver of professionalization. Lastly, as an occupational field, paramedicine in Ontario comprises dozens of different organizations, many of which are part of larger organizations. This results

in many hybrid roles and influences across paramedicine, as reflected by the research findings.

Methodological Contribution: Reflections on Reflexivity

My goal in this thesis was to thoughtfully bring to light the complexity of paramedic professionalization and situate it within the broader literature on professionalization. As a paramedic in Ontario impacted by professionalization and studying it (and implicated in it), I knew reflexivity would be a critical methodological component of my thesis. Throughout this research, I struggled with how to be a reflexive researcher. A contribution of this thesis was how I used epistemic reflexivity as a knowledge-generating tool.

I started this research with what I thought was a traditional view of reflexivity. I was an insider to the community under study, and at the outset of the research, I had considered my positionality and how it may impact the research. This starting point allowed me to describe my position and explain it to others (such as the research participants or readers of the research). However, throughout the research, participants regularly placed me in the data (e.g. referring to myself as a paramedic leader). Some felt this work would help the paramedic community professionalize or address what they viewed as a problem. Others asked extensive questions about the final product, who would read it, where would I present it, and what problems it would fix. Some participants offered "hard numbers" and "stats" to help me prove my case. When these trends started to emerge, I became uncomfortable as I did not identify as a paramedic leader, making me question if I was wrong in my conceptualization of leadership. Secondly, I did not have activist goals for the research. I also had not considered the axiological component of the research or if it would solve problems! My original conceptualization of reflexivity did little to help me make sense of this uncomfortable situation.

When I became stuck on this problem (and discomfort), I looked deeper at the literature on reflexivity. Reflexivity is an integral part of most (if not all) qualitative traditions, and many have remarked that the practice is so widespread that it is taboo for researchers not to be reflexive (Finlay, 2002; Lynch, 2000; Kuehner, Ploder, & Langer, 2016). However, the concept has not escaped debate. Muller cautions there is a tendency to view reflexivity as an "academic virtue" without thoroughly clarifying its meaning and role in the research (Muller, 2016). Scholars from various epistemological paradigms have debated reflexivity's ambivalent meanings and its practical implications for both methodology and knowledge representation (Lynch, 2000; Kuehner, Ploder, & Langer, 2016). Lynch (2000). cautions that without an epistemological rationale for the need for reflexivity and a means to do it, it is unclear what reflexivity is and who it is meant to serve.

Critical self-reflection may not always address *how* the researcher's values and assumptions and their relation to the object of study impact the creation of knowledge. How does the "partial and positioned" viewpoint of the researcher produce knowledge without merely being a reflection of their own partial and positioned perspective (Maton, 2003)? Similarly, Foley points out that this approach quickly becomes a "self-service, narcissistic, heroic portrayal" of the researcher (2002, p. 475). Further, reflexivity overly concerned with methodologism runs the risk of attempting to create an analytical distance to the research object and false attempt to be a "neutral conduit" in the research process. Reflexivity is often discussed implicitly as a means to "break with" and create analytical distance, often to strengthen the research methodology to convince the reader of the objectiveness of the account (Maton, 2003). This results in an epistemological misalignment between constructivist views of knowledge construction and a subtle positivistic influence to create an objective, bias-free research product. As Maton argues, this may result in sound methodology, however thin epistemology.

I used Enosh & Ben-Ari (2016) and Enosh, Ben-Ari & Buchinder's (2008) definition of epistemic reflexivity as a knowledge-generating tool used to generate analytical insights and knowledge. Enosh, Ben-Ari & Buchinder (2008) argue that differences in worldviews and moral stances are one means to critically examine knowledge production. The authors explicitly argue against the idea of a value-neutral researcher and that any attempt to achieve this fails to realize the potential for knowledge production in the ambiguous, negotiated relationship between researcher and participant. Alignments or conflicts in moral stances are not problematic. Instead, all researchers *see* the object of research through a particular frame. It is making this frame explicit and recognizing differentness in frames that add a level of depth to enacting reflexivity. Enosh & Ben-Ari further outline that epistemic reflexivity can be enacted by focusing on differences. Examining differences refers to the incongruences or contradictions in producing knowledge that highlights something new to be understood and explored.

As part of the social world, researchers cannot erase or bracket their role in the research (Giacomini, 2010, p. 133). If the researcher-researched interaction produces and creates meanings and social facts, a process is required whereby the researcher becomes attuned to what is at stake. By centering my reflexive stance on the concept of epistemic reflexivity, I acknowledged and used my differences with participants to further understand paramedic professionalization and the axiological implications of the research. It was impossible for me in this research to be what I had hoped for, a detached insider. The disjointedness of paramedic professionalization, the leveraging of paramedic academics, and the adoption of evidence-based medicine and policy by many participants highlighted why they thought this research could be necessary in paramedic professionalization. The use of epistemic reflexivity prompted me to return to the professionalization literature and consider a broader range of theoretical perspectives and views to unpack the diverse opinions of

professionalization. Epistemic reflexivity aligned epistemologically with abductive analysis and allowed me to use my initial sources of discomfort to push against different theories of professionalization and examine the implications of these choices.

LIMITATIONS

As mentioned in the chapters, a limitation of this thesis was that I could not report on the participants' social location. While these were considered analytical threads, readers are limited in understanding the differences between different groups of participants due to their social location. The views and perspectives of frontline paramedics not in leadership positions were not examined in this thesis. The frontline paramedic perspective is critical in understanding paramedic professionalization and should be examined in future research.

This research did not adopt a gendered lens or examine issues related to equity and diversity. Adams (2010) and Nancarrow & Borthwick (2021) highlight that many healthcare professions are woman-dominated, which has consequences for understanding professionalization. Witz's (1990, 1992) seminal work on this topic highlighted the gendered processes of professionalization that excluded woman-dominated professions. Witz argued that professions are inherently gendered as a reflection of patriarchal capitalism. Witz showed how authoritative male-dominated professions such as medicine and dentistry excluded women from entering the professions and subordinated women-dominated professions such as nursing and midwifery. Women-dominated professions such as nursing and midwifery were marginalized and deemed lower status. Adams (2010) argues that the feminization of healthcare and the more recent success of the professionalization projects of nursing, midwifery and dental assistants (Adams & Bourgeault, 2003) prompts the need to reexamine the linkage between gender and professionalization.

Future research on paramedic professionalization should consider gender as a central analytical and theoretical thread. Emerging from a military institution, paramedic culture has been previously described as "stereotypically masculine" (McCann & Granter, 2019, p. 223; Boyle, 2002). Paramedic work is also gendered. Williams (2012) highlights how paramedics have adopted a biomedical model of health that has rendered the emotional labour of paramedics invisible. There is the potential for "gender conflict" in paramedicine due to the tension between a masculinized workforce and patient care work that requires "caring, compassion and sensitivity" (p. 370-371). Further to this, women paramedics are vastly underrepresented in leadership roles (Mason, 2017; Cameron et al., 2020). There is evidence that women have challenges in male-dominated fields as they have to negotiate differences between their professional identity and gender identity (Adams, 2010). Future research on paramedic professionalization would be remiss not to examine this complex topic.

Reflections on the COVID-19 Pandemic

It feels a bit odd to be writing this dissertation well into the COVID-19 pandemic and not discuss COVID-19 until the final pages of this thesis. On a personal level, I paused working on this research for most of the pandemic to take on additional paramedic responsibilities. In March 2020, while people worldwide shifted to remote work, paramedics were among a group of essential workers that still interacted face-to-face with members of the public. For the first time since I had worked as a paramedic, I felt that my dual researcher-paramedic identity dissolved as I completely paused research work to focus only on being a paramedic. For many months, I took on a large role in the COVID-19 response, trading books on sociology and qualitative research methods for guidelines on personal protective equipment and how to protect my paramedic peers from getting sick with COVID-19.

As the world turned upside down, I was worried that these results would be meaningless. Instead, they serve as a historical time stamp to the time known as pre-COVID, informing us of trends that will likely continue or intensify. The COVID-19 pandemic disrupted the healthcare workforce in ways that will not be fully understood for years. There was a drastic removal of legislative barriers to allow healthcare professionals to be redeployed to practice in other areas of care and take on new tasks (Bourgeault et al., 2020; Nancarrow & Borthwick, 2021, p. 203). The boundaries between healthcare professions temporarily broke down amid a healthcare workforce crisis (Rowland, Albert & Kitto, 2021). The COVID-19 amplified the ongoing blurring of professional boundaries.

Paramedics also faced many opportunities and challenges during this time. Paramedics all over Ontario took on an active public health role in COVID-19 testing and vaccinations, particularly in long-term care settings (City of Toronto, 2021; CP24, 2021). Recent research and reporting have begun to describe paramedics facing increased stress, workload, and low morale due to the pandemic (Culbert, 2020; Boechler et al., 2021; Oliphant et al., 2022). At the same time, paramedic services across Ontario (and Canada) were increasingly gaining attention for growing demands for services and workforce shortages (City News, 2022; CTV News, 2022). Reflecting on changes in paramedics over the past two years, studies of paramedic work and change, whether from the lens of professionalization or other theoretical and empirical perspectives, will continue to be relevant.

CONCLUDING THOUGHTS

This thesis contributes to a body of scholarship on professionalization providing further insight into intraprofessional dynamics. As Larson stated in 1979, professions may strive to engage in a collective project of social mobility, but "professions cannot be equated

with any stable or homogenous real group" (p. 610). This thesis reveals insights about variation in processes of professionalization and its risks. When professional workers of all kinds and statuses are under pressure, diverse conceptual tools to understand these processes are imperative.

For some readers, the title of this thesis may come across as bleak. I have argued that paramedics in Ontario are a fractured occupation. But in every break, there is an opportunity for recovery and restoration. If the paramedic community in Ontario can find ways to build connections amongst itself, it may be more resilient to future strains.

REFERENCES

Abbott, A. (1988). The System of Professions. An Essay on the Division of Expert Labour. *Chicago: University of Chicago Press*.

Adams, T. L., & Bourgeault, I. L. (2004). Feminism and women's health professions in Ontario. *Women & Health, 38*(4), 73-90.

Adams, T. (2018). *Regulating professions: the emergence of professional self-regulation in four Canadian Provinces.* Toronto: University of Toronto Press.

Adams, T. L. (2020). Professional employees and professional managers: conflicting logics, hybridity, and restratification. *Journal of Professions and Organization*, *7*(1), 101 115.

Adams, T., & Sawchuk, P. H. (2021). Professional-organizational contradictions and hybridization of knowledge: Insights from the study of engineering and nursing in Canada. *Vocations and Learning*, *14*(1), 75-93.

Boateng, G. O., & Adams, T. L. (2016). "Drop dead… I need your job": An exploratory study of intra-professional conflict amongst nurses in two Ontario cities. *Social Science & Medicine*, *155*, 35-42.

Boechler, L., Cameron, C., Smith, J. C., Ford-Jones, P., & Suthers, P. (2021). Impactful Approaches to Leadership on the Front Lines of the COVID-19 Pandemic: Lived Experiences of Canadian Paramedics. *Healthcare Quarterly (Toronto, Ont.), 24*(3), 42-47.

Boyle, M. V. (2002). "Sailing twixt Scylla and Charybdis": negotiating multiple organizational masculinities. *Women in Management Review*, 131-141.

Brosnan, C. (2017). Alternative futures: fields, boundaries, and divergent professionalization strategies within the chiropractic profession. *Social Science & Medicine*, *190*, 83-91.

Burns, E. A. (2019). *Theorising professions: A sociological introduction*. Switzerland: Palgrave Macmillan Cham.

City of Toronto. (2021). *City of Toronto readying Paramedic and Fire Services to support mobile vaccination of vulnerable communities*. https://www.toronto.ca/news/city-of toronto-readying-paramedic-and-fire-services-to-support-mobile-vaccination-of vulnerable-communities/

City News. (January 4, 2022). *GTA hospitals, paramedic services experiencing critical staff shortages amid COVID surge*. https://toronto.citynews.ca/2022/01/04/covid-ontario toronto-brampton-hospitals-paramedics-staffing/

Comeau-Vallée, M., & Langley, A. (2020). The interplay of inter-and intraprofessional boundary work in multidisciplinary teams. *Organization Studies, 41*(12), 1649-1672.

Corman, M. K. (2018). *Paramedics On and Off the Streets*. Toronto: University of Toronto Press.

CP24. (March 31, 2021). *Paramedics bring COVID-19 vaccines to homebound seniors across Ontario.* CP24. https://www.cp24.com/news/paramedics-bring-covid-19 vaccines-tohomebound-seniors-across-ontario-1.5369265?cache=yes%2F7.535815

Culbert, L. (2020, March 27). *COVID-19: Stress on the front line of the fight against the pandemic in B.C.* Vancouver Sun. https://vancouversun.com/news/local-news/covid 19-stress-othe-front-line-of-the-fight-against-the-pandemic/

Enosh, G., Ben-Ari, A., & Buchbinder, E. (2008). Sense of Differentness in the Construction of Knowledge. *Qualitative Inquiry, 14*(3), p. 450-465.

Enosh, G & Ben-Ari, A. (2016). Reflexivity: The Creation of Liminal Spaces-Researchers, Participants, and Research Encounters. *Qualitative Health Research, 26*(4), 578-584.

Evetts, J. (2011). A new professionalism? Challenges and opportunities. *Current Sociology, 59*(4), 406-422.

Finlay, L. (2002). Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research, 2*(2), 209-230.

Finlay, L. (2002) "Outing" the researcher: The provenance, process, and practice of reflexivity." *Qualitative Health Research, 12*(4), 531-545.

Guillemin, M., & Gillam, L. (2004). Ethics, reflexivity, and "ethically important moments" in research. *Qualitative Inquiry, 10,* 261-280.

Hodgson, D., Paton, S., & Muzio, D. (2015). Something old, something new?: competing logics and the hybrid nature of new corporate professions. *British Journal of Management, 26*(4), 745-759.

Kuehner, A., Ploder, A., & Langer, P. C. (2016). Introduction to the special issue: European contributions to strong reflexivity. *Qualitative Inquiry, 22*(9), 699-704.

Larson, M. S. (1979). Professionalism: Rise and Fall. *International Journal of Health Services, 9*(4), 607-627.

Lynch, M. (2000). Against Reflexivity as an Academic Virtue and Source of Privileged Knowledge. *Theory, Culture & Society, 17*(3), 26-54.

Martin, G. P., Currie, G., & Finn, R. (2009). Leadership, service reform, and public-service networks: the case of cancer-genetics pilots in the English NHS. *Journal of Public Administration Research and Theory, 19*(4), 769-794.

Maton, K. (2003). Reflexivity, relationism, & research: Pierre Bourdieu and the epistemic conditions of social scientific knowledge. *Space and Culture, 6*(1), 52-65.

McCann, L., Granter, E., Hyde, P., & Hassard, J. (2013). Still blue-collar after all these years? An ethnography of the professionalization of emergency ambulance work. *Journal of Management Studies, 50*(5), 750-776

McCann, L., & Granter, E. (2019). Beyond 'blue-collar professionalism': continuity and change in the professionalization of uniformed emergency services work. *Journal of Professions and Organization*, *6*(2), 213-232.

Miller, K. L., & Kontos, P. C. (2013). The intraprofessional and interprofessional relations of neurorehabilitation nurses: a negotiated order perspective. *Journal of Advanced Nursing*, *69*(8), 1797-1807.

Ministry of Health and Long-term Care. (2017). *Emergency Health Services System Modernization. Briefing Paper on Legislative Amendments to the Ambulance Act.*

Müller, S. M. (2016). Becoming the phenomenon? An alternative approach to reflexivity in ethnography. *Qualitative Inquiry*, *22*(9), 705-717.

Nancarrow, S., & Borthwick, A. (2021). *The Allied Health Professions: a Sociological Perspective*. Policy Press.

Noordegraaf, M. (2015). Hybrid professionalism and beyond:(New) Forms of public professionalism in changing organizational and societal contexts. *Journal of Professions and Organization*, *2*(2), 187-206.

Oliphant, A., Faulds, C., Bengall, S., & Nouvet, E. (2022). At the front of the front-line: Ontario paramedics' experiences of occupational safety, risk and communication during the 2020 COVID-19 pandemic. *International Journal of Emergency Services*.

Rowland, P., Albert, M., & Kitto, S. (2021). Theorizing Reorganizations of Care: Boundary Work and the Professions During Ontario's COVID-19 Response. In *Organising Care in a Time of Covid-19* (pp. 159-178). Palgrave Macmillan, Cham.

Saks, M. (2012). Defining a profession: The role of knowledge and expertise. *Professionsand Professionalism*, *2*(1).

Saks, M. (2016). Review of theories of professions, organizations and society: Neo Weberianism, neo-institutionalism and eclecticism. *Journal of Professions and Organization 3*(2), 170-187.

Seim, J. (2020). *Bandage, sort, and hustle: Ambulance crews on the front lines of urban suffering*. California: University of California Press.

van Bochove, M., & Oldenhof, L. (2020). Institutional work in changing public service organizations: the interplay between professionalization strategies of non-elite actors. *Administration & Society*, *52*(1), 111-137.

Witz, A. (1990). Patriarchy and professions: The gendered politics of occupational closure. *Sociology*, *24*(4), 675-690.

Witz, A. (1992). *Professions and Patriarchy*. London: Routledge.