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Still Blue-Collar after all these Years? An Ethnography of the Professionalization of Emergency Ambulance Work

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ABSTRACT This paper explores the professionalization project of paramedics, based on an ethnographic study of UK National Health Service (NHS) ambulance personnel. Drawing on concepts derived from institutional theory and the sociology of professions, we argue that the project is enacted at two levels, namely a formal, structural and senior level reflecting changing legitimation demands made on NHS practitioners and pursued through institutional entrepreneurship, and an informal, agentic, 'street level' enacted by the practitioners themselves via 'institutional work'. Focusing on this latter, front-line level, our ethnographic data demonstrate that the overall impact of the senior level professionalization project on the working lives of paramedics has been somewhat muted, mostly because it has had limited power over the organizations that employ paramedics. Given the slow progress of the senior level professionalization project, paramedics at street level continue to enact subtle forms of institutional work which serve to maintain 'blue-collar professionalism' – a form originally identified in Donald Metz's ethnography of ambulance work. Our analysis draws attention to the complex and contested nature of professionalization projects, in that their enactment at senior and street levels can be somewhat misaligned and possibly contradictory.

Keywords: ambulance services, ethnography, National Health Service, paramedics, professionalization

INTRODUCTION

A central issue in the sociology of professions literature is the transformation of occupations into professions. However, in the words of Wilensky (1964, p. 137), 'few make the grade'. This paper explores the professionalization project of paramedics in the UK's National Health Service (NHS). Professional projects are important examples of attempts to change institutions (Suddaby and Viale, 2011), and institutional change can

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be attempted at numerous levels using various modes of influence and action. We demonstrate that the formal, senior level professionalization project was originally driven by external forces of coercive isomorphism as the NHS sought to develop new sources of social legitimacy for medical practitioners (Dent, 2008; Muzio et al., 2008, p. 13).

As a part of this process of reformatting the NHS professions, paramedics needed to create a professional association – the College of Paramedics – which has since pursued a 'classical' professionalization strategy at senior levels through institutional entrepreneurship. The College of Paramedics emerged from a small group of conscientious paramedics which continues to expend significant (mostly voluntary) time and effort in developing and promoting the organization. However, following Abbott (1988, p. 18), and influenced by an 'institutional work' perspective that focuses on 'day-to-day equivocal instances of agency' (Lawrence et al., 2011, p. 52), we argue that it is only through close analysis of working lives that we can understand the impact of such professionalization strategies. This necessitates the exploration of lower levels – in our case the 'street level', an approach with a long history in sociology of work (Metz, 1981; Moskos, 2008; Tangherlini, 1998, 2000) and in studies of front-line public servants (Lipsky, 1980; Maynard-Moody and Musheno, 2003).

Our data suggest that the formal, senior level professionalization project has had limited effects at street level, and that the professional status of paramedics and Emergency Medical Technicians (EMTs) remains weak. Faced with the limited success of this formal strategy of institutional entrepreneurship, paramedics and other ambulance workers at street level simultaneously pursue a different kind of professionalization project; one based more on institutional work, comprising an informal, subtle, everyday project that reproduces 'blue-collar professionalism' (see Metz, 1981, pp. 57–81), as paramedics 'negotiate the tricky pathways of their own organization, establishing for themselves a sense of their own position' (Tangherlini, 2000, p. 63).

Based on immersive ethnographic research inside one of England's 12 NHS ambulance trusts, our paper describes the work of paramedics and EMTs as they respond to callouts. It shows how the everyday realities of front-line work set limits on the efficacy of the senior level professionalization strategy. In contrast to a large literature claiming that professions and professional work have changed dramatically over the last 30 years (such as Brint, 1994; Fincham et al., 2008; Freidson, 1970/1988, p. 383; Freidson, 2001, p. 181; Greenwood et al., 1996; Scott, 2008; Suddaby and Viale, 2011), this paper argues that emergency ambulance work is an example of an occupation or para-profession which has changed moderately and gradually. Although the clinical expectations placed on paramedics have expanded significantly in recent years and the title 'paramedic' is now legally protected, paramedics are still struggling to secure those meaningful forms of status, occupational closure, and work autonomy associated with other emerging professions (Muzio et al., 2008). Building on Abbott's notion of the 'system of professions' (Abbott, 1988) and Ackroyd's (1996) discussions of professions' attempts to achieve 'closure' of labour markets, we suggest that the coexistence of institutional entrepreneurship at senior level and informal institutional work at street level is somewhat awkward, resulting in multidirectional and somewhat contradictory outcomes for the profession as a whole.

The paper proceeds in five sections. First, we provide an outline of concepts related to institutional work and professionalization, including analysis of the core notion of 'blue-collar professionalism'. Second, we describe the context of the research project and centrally the wider institutional setting of a changing NHS. Third, we outline the methodological approach adopted in our ethnographic study of ambulance personnel – one based on participant observation and semi-structured interviewing. Fourth, we explore the two major themes to emerge from this research – 'organizational control of street-level work' and the 'social reproduction of blue-collar professionalism'; both highlight how practical forces in everyday work can inhibit the prospects for a professionalization strategy based on institutional entrepreneurship. Finally we offer conclusions, arguing that if professionalization projects in other occupations are to be characterized by a similar disconnection between institutional entrepreneurship and institutional work, then they are also likely to be similarly unsuccessful; at least if 'success' is judged by whether or not they create 'white-collar'-style institutional forms.

PROFESSIONALIZING OCCUPATIONS AND INSTITUTIONAL ANALYSIS

Institutional theory has long viewed the professions as actors driving the 'creation and tending of institutions' (Scott, 2008, p. 219), particularly through 'normative isomorphism' – the mechanisms through which professional bodies transmit norms and values that influence fields and organizations in 'non-market' ways (DiMaggio and Powell, 1983, p. 150). Professions are thus vitally important social actors which develop, maintain, and exert a wide variety of institutional effects, serving to structure and define many areas of organizational and working life and the development and diffusion of expert knowledge. Typically professions aim to make their work 'autonomous and self-directing' (Freidson, 1970, p. xv), partly through providing a sense of occupational closure in respect of their areas of expertise and hence their labour markets (Ackroyd, 1996). Successful professions therefore enjoy considerable social status and power (Freidson, 1986) because their claims to expert knowledge serve to confer certain rights and freedoms that the majority of occupational groups lack (Abbott, 1988).

The ways in which professions gain, maintain, and lose power in a complex system of overlapping and competing professions has been a central issue to the sociology of professions and to institutional theory (Abbott, 1991; Scott, 2008; Suddaby and Viale, 2011). Both of these literatures have increasingly acknowledged the ways in which occupational groups' claims to professional status may wax and wane, as the professions and the institutions that they 'create and tend' undergo change. More broadly, the question of institutional change has become an issue of central importance to institutional theory as notions of 'institutional entrepreneurship' have gained prominence. As it relates to professions, institutional entrepreneurship involves the mobilization of professional resources at senior levels; as occupations attempt, for example, to define their areas of jurisdiction, seek accreditation, or respond to changing regulatory environments (Greenwood et al., 1996). Explanations of change which draw on notions of institutional entrepreneurship thereby tend to focus on macro level transformation of professional fields (Lawrence et al., 2009, p. 3; Lawrence et al., 2011, p. 52).

Recent studies have probed more deeply into the complex, ambivalent, and highly contingent nature of the effects of professional projects and institutional entrepreneurship, especially at more local levels. Empirical studies in this vein (e.g. Delbridge and Edwards, 2008; Marti and Mair, 2009; Zeitsma and McKnight, 2009) have adopted a practice-based, rather than an outcome-based, lens and explored forms of institutional work that, 'although aimed at affecting the institutional order, represent a complex melange of forms of agency – successful and not, . . . full of compromises' (Lawrence et al., 2011, p. 52). The concept of 'institutional work' – defined as the purposive action of individuals and organizations aimed at creating, maintaining and disrupting institutions' (Lawrence et al., 2009, p. 1) – reflects to some degree earlier insights from the sociology of professions literature (see Abbott, 1988, 1991; Ackroyd, 1996) by drawing attention to the importance of low-level and everyday attempts by occupational members to control the content of their work.

One way of gaining a clearer picture of the nature of professions and institutional change is for analysts to pay more attention to the intricacies of the daily work practices of occupational and professional members. Such an approach was suggested in Abbott's (1988) analysis, which explored the notion of professional jurisdictions – the tasks and services over which professions claim expertise and thus their legitimate authority to operate (often to the exclusion of others). Jurisdictional boundaries are always disputed between occupations; for 'the tasks, the professions, and the links between them change continually' (Abbott, 1988, p. 35). Abbott's focus on professional jurisdictions, and thus the actual tasks of professionals, draws attention to the various levels at which professionalization projects are enacted and the contingent complexity of their impact on institutional creation, maintenance, and change. Amid the ever-changing 'system of professions', Abbott indicated the multi-directionality and complexity of professionalization projects, noting numerous failures and false starts in ventures that cannot be accounted for in more traditional and mechanistic accounts of the professionalization process (Abbott, 1988, p. 359). Ackroyd (1996, pp. 600–01) argues that truly successful professions manage to secure 'double closure', having gained traction with their professionalization projects at both senior and local levels. Successful professions achieve control over their jurisdictions at macro levels – such as official certification, security from encroachment from other occupations, and favourable public opinion about the profession's value – as well as realizing a sense of autonomy and discretion over the local delivery of work.

This paper attempts to provide just such a deep-rooted analysis of work in an emerging profession (or para-profession), that of paramedics in the UK. We focus mostly on the 'local' level in this paper, grounding our analysis in an ethnographic exploration of the front-line realities of emergency ambulance work – a field that is changing in numerous ways as actors and organizations engage in various forms of institutional entrepreneurship. By exploring front-line realities, however, we also illuminate how senior level strategic suggestions translate (or fail to translate) into changes to everyday practice. Paramedics have yet to achieve a sense of occupational closure at senior levels. As perceived from 'street level', a variety of practical obstacles serves to problematize and obscure from view the senior level professional project. These obstructions include conflict between paramedics and the organizations that employ them, jurisdictional

disputes with other NHS professionals/para-professionals, and factors inherent in the very nature of emergency ambulance work. Given such impediments, a key role for paramedics and EMTs 'on the ground' becomes the informal enactment of institutional work, which has the effect of defining more clearly (and also defending) their sense of professional identity. Institutional work thus represents the medium through which occupational closure is sought on the front line.

Our analysis draws attention to the remarkable persistence of such 'blue-collar professionalism' at street level, a concept first indentified in Metz's (1981) ethnography of ambulance work. Metz (1981, pp. 57–81) described EMTs and 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. We argue that blue-collar professionalism, in contrast to a formal or senior level professional project or a form of institutional entrepreneurship, is best conceptualized as a type of institutional work that has sustained and reproduced itself for decades. This maintenance of blue-collar professionalism has strong historical path-dependence and is not dissimilar to Lipsky's (1980) classic concept of the 'street-level bureaucracy' of front-line public servants. Even as certain areas of pre-hospital emergency medicine are becoming more sophisticated – and as the trappings of professionalism are becoming increasingly prevalent in the UK ambulance field – we suggest that blue-collar professionalism remains the hallmark of ambulance workers' occupational identity as they attempt to gain and maintain local-level occupational closure. We argue that the organizational level, reflecting classic issues of employee 'control and resistance', is the site at which the main obstacles to senior level institutional entrepreneurship and front-line institutional work exist.

CONTEXT: THE CHANGING STATUS OF UK AMBULANCE WORK

Ambulance work originally emerged as a manual occupation with minimal formal credentials (Kilner, 2004; Metz, 1981). In the last 40 years the level of clinical expertise in ambulance services has significantly increased. The original purpose of ambulance services was to transport the sick and injured to 'definitive care'; that is, to hospitals and established professional clinicians. Until the 1966 Millar Report, the role of the 'ambulanceman' was restricted to transportation and did not extend to patient treatment. Ambulance services have a history of fairly limited levels of training and low levels of pay. In recent years the occupation has become segmented, with paramedics regulated and registered by the Health Professions Council (see below), working alongside unregistered staff such as EMTs and Emergency Care Assistants (ECAs). The range of clinical interventions that ambulance staff are allowed to practice has expanded but remains strictly defined by the medical profession.[1] Clinical protocols are provided to ambulance trusts following agreement by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC), a committee led by the medical profession and containing representatives of many groups involved in pre-hospital care, including the College of Paramedics. There remains a fairly clear stratification of emergency medicine, with paramedics' and EMTs

cast in subordinate roles as para-professions. The UK situation is similar to that of the USA in this regard (see Mannon, 1992; Metz, 1981).

British ambulance services have also witnessed a tradition of industrial relations strife, including a strike in 1989, which led to a favourable outcome for the union (Kerr and Sachdev, 1991). Ambulance staff worked hard to gain recognition, and have traditionally been underappreciated by the public and by higher medical professionals (Clegg, 1979). Ambulance service managers have traditionally been promoted from within, either from road staff positions or from control and dispatch roles into supervisory, regional, and operational management. Considerable efforts have been made by ambulance trusts to up-skill and 'professionalize' managers, notably through internal training programmes certified by bodies such as the Chartered Management Institute. NHS ambulance trusts are also attempting to improve the clinical expertise of ambulance services, while at the same time struggling to manage the growing size of its more basic workload (e.g. meeting response time targets).

The UK ('New') Labour government of 1997–2009 instigated a major programme of reforms to the NHS. This included recasting its professional jurisdictions by restructuring the medical para-professions or semi-professions – such as occupational therapists, chiropractors, podiatrists, and paramedics (see Scott, 2008, p. 229) – into 'Allied Health Professionals' (AHPs) (Dent, 2008). Enacting so-called 'New Public Management' (NPM) (see Hood, 2006; Pollitt, 2003), the NHS was given enlarged budgets and remained 'free at the point of use'. However, it was also subject to much tougher control over budgets, increased government regulation of areas that once operated mostly under professional discretion, and a heightened sense of 'delivering customer service' and providing 'value for money' for the taxpayer. Such measures were in keeping with the wholesale import of managerialist concepts developed in corporate business environments.

New Labour's approach was, therefore, a paradoxical one – it involved developing subordinate medical occupations into Allied Health Professions while demanding simultaneous adherence to strict performance and auditing measures (Clegg, 2010, p. 10). In other words, it combined the logic of professionalism with that of managerialism (or de-professionalization: see Domagalski, 2008; Haug, 1975, 1988; Light, 1993). Although the New Labour government paid more attention to augmenting professional discretion in the AHPs, it was wary of losing control of the delivery of public services. It discouraged AHPs from developing classical forms of established professional power or professional dominance (Freidson, 1970). Rather than being 'lords of the dance' and 'calling the tune' (Scott, 2008, p. 219), these new, weaker professions were subjected to NPM-inspired managerial control. The AHPs were placed under the regulation of the newly-formed Health Professions Council (HPC), which employed corporate management systems, such as ISO 9001 quality control certification, and established a dedicated website designed for members of the laity to check whether a 'professional' offering a healthcare service was actually certified to practice.[2] In short, New Labour wanted a 'world class' NHS staffed by professionals, but placed these professionals under strict control.

The establishment of the HPC meant that ambulance services had to 'professionalize' so that they could be placed under this new regulatory umbrella. A significant element of the story is thus 'professionalization from above' rather than 'professionalization from within' (McClelland, 1990) with the origins of the paramedics' professionalization project

partly emerging from forces of coercive isomorphism rather than the normative isomorphism associated with professions (DiMaggio and Powell, 1983, p. 150). Evetts (2011, p. 408) precisely captures the 'professionalization from above' dynamics in New Public Management and her description readily applies to paramedics: 'Organizational objectives (which are sometimes political) define practitioner–client relations, set achievement targets and performance indicators . . . thereby limiting the exercise of discretion and preventing the service ethic that has been so important in professional work'. Paramedics were the only AHP lacking a professional association and they were compelled to create one due to the coercive isomorphism of the formation of the HPC. Paramedics were then formally recognized by the HPC as the twelfth Allied Health Profession in 2000 (Caroline, 2008, pp. 1.7–1.8). This new professional association was established in 2001 as the British Paramedic Association (BPA); it was renamed the College of Paramedics in 2009.[3]

The seemingly paradoxical NPM logic of simultaneously encouraging greater professionalism and managerialism emerges strongly in ambulance services, which are growing in clinical sophistication while also placed under a welter of performance measures. An important element of the NPM agenda is the widespread setting of performance targets throughout the NHS (Hood, 2006). Performance targets in ambulance services have focused strongly on rapid response times.[4] This is controversial in that speed of response is a non-clinical performance measure and may encourage 'goal displacement', whereby ambulance services are encouraged to place higher priority on meeting time targets rather than the provision of high quality patient care (Price, 2006; Reynolds, 2010; Wankhade, 2012).

Ambulance staff are also practically discouraged from using their discretion to treat patients 'on-scene' (Snooks et al., 2004, p. 253), despite official exhortations concerning the need to expand the range of medical procedures they can execute (see Department of Health, 2005). According to Department of Health estimates, only around 30 per cent of patients attended by ambulance staff in the UK are treated or referred at the scene/at home (Snooks et al., 2004, p. 212). Of the 70 per cent conveyed to A&E departments, around 50 per cent are apparently done so unnecessarily (Department of Health, 2005, p. 13). This is despite recent efforts by ambulance services to transform their service model towards 'taking the hospital to the patient'; by introducing, for example, 'Treat & Refer' protocols (Snooks et al., 2005) and the widespread deployment of Rapid Response Vehicles (RRVs) – adapted road cars staffed by solo responders and not designed to transport patients. New advanced roles such as Paramedic Practitioner (PP) and Emergency Care Practitioner (ECP) have similarly been developed to try to make available a wider range of treatments to patients on-scene/at home, which can obviate the need for A&E transportation.[5]

In keeping with the NHS policy to professionalize the AHPs, certification and training for paramedics has now significantly shifted out of internal service provision and into higher education institutions. The Foundation Degree in Paramedic Science aims to up-skill the role of the ambulance paramedic and is now the only available route for the training and registration of new paramedics.[6] Emergency ambulance work has now broadly taken on the trappings of professionalism that are emphasized in the traditional sociology of professions literature (Wilensky, 1964), such as a professional body, practi-

tioner journals, higher education courses, state registration, and codes of ethics. On the other hand, membership of the College is rather low; only around 14 per cent of the eligible national workforce of registered paramedics has joined thus far.[7] (By contrast, around 80 per cent of the road staff workforce of our case study trust are trade union members.) The College of Paramedics is involved in the development of university curricula and has established an aspirational career track for paramedics (see Woollard, 2006). The aim is to allow 'career headroom' into more clinically-advanced roles such as Advanced Paramedic, Critical Care Paramedic, Paramedic Practitioner, and Emergency Care Practitioner (assuming ambulance trusts have sufficient resources to develop them: see Brown et al., 2011). As a professional body, the College of Paramedics attempts to influence other actors so that paramedics can take some control over their field. At present, however, it is restricted by rather limited levels of power and influence (see Clegg, 2010) over the NHS trusts that employ paramedics. As we shall see, the realities of working life also constitute a rather hostile field for paramedic work to develop into an 'established' clinical profession.

Change, then, is clearly afoot. Ambulance work is moving from a blue-collar occupation into a profession. But no profession makes history under circumstances of its own choosing. Organizational fields are structured by complex and enduring power imbalances (Clegg, 2010). There are many actors (including ambulance trust managers, other NHS clinical professionals, JRCALC, and even the general public) whose actions can serve to limit the influence of the formal level professionalization strategy. Given the plurality of the institutional context for ambulance services we emphasize the ambivalence of processes and outcomes, describing in detail the forms of 'street-level' institutional work that emergency ambulance staff enact as they attempt, informally, to influence control at local work sites. The paper explores various front-line and middle management viewpoints on professionalism. As such, we are unable to comment in detail on the dynamics and outcomes of the formal level professionalization project and this remains a potentially important area for future research.

METHODOLOGY

The paper attempts to combine the emerging field of institutional work with the traditions of sociology of work. It does so by analysing organizational structures and processes via an ethnographic methodology. Our central aim is to examine the field of ambulance work by exploring the habitual actions of those who perform it. This involves sensitivity towards how the field is socially constructed and reconstructed (Maynard-Moody and Musheno, 2003, p. 26; Tangherlini, 2000, p. 45). Specifically, we consider the extent to which change initiatives linked to professionalization have affected emergency ambulance staff, exploring first how their work is organized and performed, and second how they personally interpret these changes and construct their own occupational identity.

Field observations and in-depth interviews were the methods deployed to explore the experiences and interpretations of front-line and managerial staff, as well as to gather contextual data on changes to NHS ambulance provision. We wanted to know if the practices, processes, and pressures of ambulance work had changed since the ethnography by Metz (1981), which first predicted the professionalization of ambulance work

(within a context where many occupations were attempting the same: see Wilensky, 1964). As such, we explore why and how emergency ambulance work has changed at ground level, focusing on emergent processes rather than discrete outcomes such as the 'success' or 'failure' of the professionalization project. Above all, we consider the extent to which front-line institutional work is allied to the more formal, structural, and senior level project of institutional entrepreneurship.

Data Collection

Data for this investigation were collected through a combination of participant observation and semi-structured interviewing. Observational research was conducted mainly with ambulance road crews, call-handlers, and dispatch staff, while interviews were undertaken exclusively with managerial staff. The reason for this differentiation was that the former method was directed at direct personal experience, while the latter was directed at general reflections on organizational context. The observation phase of the research took place in five stages during 2009–10. On Day 1, three members of the research team (A, B, and C) accompanied emergency ambulance crews across three shifts; this resulted in a combined total of 20 hours of observations. This was followed, on Day 2, by Researchers A and C conducting eight hours of observation with (non-emergency) patient transfer crews. Emergency control centre workers and managers were observed by Researchers A, B, and C for 12 hours on Day 3, and for a further six hours by Researcher B on Day 4. Finally, on Day 5, Researcher A conducted a further four hours of observations on the work of ambulance managers. Thus a total of approximately 50 hours of observation were undertaken.

Field observations were recorded manually in notebooks. The field notes were written up as soon as possible after the observation sessions, usually within 2–3 days. When writing up the field notes we decided to write them as full text, combining our own descriptions of what we saw, heard, thought, felt, and did, with our own interpretations from a day or two's reflection. This mass of textual data was interpreted using an informal coding methodology, whereby all authors would read and re-read their own and each other's field notes and select passages of text that most clearly explained and illuminated the research issues. We did not use data analysis software or other numbers-based coding and analysis methodologies, as we felt that doing so would impose arbitrary structures onto what are essentially ideographic interpretations of participants' feelings about their work and occupation. (We were, after all, researching accounts of street-level events that were usually dynamic, sometimes chaotic, and often emotionally-laden.) Working as a team, we selected ethnographic vignettes and segments from interview transcripts which we judged to be the most relevant to our discussion of our two central empirical themes: first, the organizational and work structures of the ambulance trust; and second, the ways in which paramedics and EMTs, through the actions and words that constitute street-level institutional work, reproduce forms of blue-collar professionalism. The reporting and discussion of these two themes form the basis of the two empirical sections of this paper below.

In addition, the research team completed ten qualitative, semi-structured interviews with ambulance managers. The aim was to obtain a detailed picture of both the historical

Table I. Interviews with Ambulance Trust Managers

Interview	*Job title*	*Gender*	*Years service*
1	Assistant Director of Workforce Development	F	10
2	Operations Manager	M	8
3	Operations Manager	F	27
4	Organizational Learning and Development Manager	F	4
5	Area Manager	M	36
6	Operations Supervisor	F	21
7	Customer Support Manager	F	20
8	Clinical Team Leader	M	23
9	Sector Manager	M	23
10	Operational Performance Manager	M	15

and contemporary context of UK ambulance work (see Table I). To this end we designed an interview schedule that would allow us to probe issues related primarily to managerial strategy, organizational culture, career development, and (particularly) professionalization policies and practices. These interviews, which generally lasted between 60 and 90 minutes, were digitally recorded and then transcribed. Major findings (or themes) emerged from group coding sessions in which the research team discussed the content, meaning, and significance of each interview, again drawing out themes and codes relating to the research questions in an informal and exploratory fashion.[8]

The Case for Ethnography in Institutional Research

The main aim of our largely ethnographic research was to account, first hand, for how recent policy and organizational changes in UK ambulance care are experienced by those on the front line. For example, on the first day of our research, members of the team accompanied emergency ambulance personnel as they carried out their daily work: Researchers A and C rode with staff operating the traditional ambulance crewing system of one paramedic and one EMT, while Researcher B accompanied a solo paramedic in an RRV. During this observational research phase, all kinds of work and non work-related actions were recorded. The purpose was to gain a 'naturalistic' perspective on ambulance work *as it takes place*. This approach derives its explanatory strength from what Tope et al. (2005, p. 471) refer to as 'the benefits of being there'. In their words: 'participant observation provides greater informational yield [than interview-based studies] as well as more detailed descriptions of workplace behaviours and group dynamics'. Similarly, Gubrium and Holstein (1997) and Hammersley and Atkinson (2007) have defended the long-standing principles of observational sociology, noting that examination of work in its natural setting can provide insights that are not readily available to researchers using less immersive methods.

Recently, Van Maanen (2011) and Watson (2011) have called for ethnography to become a central, rather than marginal, pursuit in work and organization studies. They advocate exploring 'how things work' (Watson, 2011), which supports Abbott's (1988)

suggestion of the need to study the *work* of professionals, and concurs with those who argue that research in institutional work should focus on the everyday action of agents. Ethnographic research provides direct access to the fluid, multi-faceted, complex, and sometimes fraught conditions of ambulance work. We suggest that ethnography, especially immersive observation, is perfectly suited to the aims of research in institutional work, following the suggestion of Lawrence et al. (2011, p. 57) who encourages researchers 'to shift their gaze away from "the organizational field" and large-scale social transformations, and attend more closely to the relationship between institutions and the actors who populate them'. Our research findings are, of course, not generalizable to the whole population of ambulance staff in the UK, but we did attempt to minimize weaknesses in this regard by observing emergency control staff, and interviewing managers in the service in order to avoid overloading the paper with the opinions of those on the front line who may be expected to have a more downbeat appraisal of life in the service and the results of the professionalization project.

THEME A: ORGANIZATIONAL CONTROL OF STREET-LEVEL WORK

Having outlined our methodology, approach to data collection, and advocacy of ethnographic research on institutions, we now discuss our main research findings. These are expressed in two themed accounts based on a series of work-related 'vignettes' – episodes that appeared the most instructive as regards exploring the professional status of ambulance personnel. We quote liberally from our field notes, which combine descriptions of what we saw and heard with brief commentaries about how we felt about these events at the time. The paper provides commentary around these field notes and interview segments. From these we develop our argument that street-level institutional work contributes to the maintenance of a form of professionalism not entirely consistent with the stated aims of the senior level professionalization project.

This first of our two sections of data analysis relates to the structuring of work inside the ambulance trust. It highlights the systems and technologies deployed by the employing organization to sustain power relations with (and over) emergency ambulance personnel. This is especially so with respect to response time targets, work intensification, and the limited clinical discretion extended to paramedics. Despite the considerable efforts of senior figures in the College of Paramedics we suggest that its institutional entrepreneurship seems to have had little impact on this relationship. Professional status is strongly associated with high levels of autonomy and discretion (Freidson, 1970/1988). Moreover, staff out on the road can enjoy considerable levels of discretion due to the absence of direct managerial supervision, especially while on night shift (Lipsky, 1980; Metz, 1981, pp. 66–67; Moskos, 2008, p. 10; Tangherlini, 1998, p. 180). We did find some, albeit limited, evidence of this 'discretion by default' (Freidson, 1970, p. 136).[9] However, our observations also revealed strong levels of managerial influence over ambulance work. This was clearly manifested in 'remote control', via radio communications and electronic position monitoring of vehicles. Perhaps surprisingly, however, it also involved managers, team leaders, and liaison officers physically and verbally harrying emergency staff in attempts to exercise explicit and direct control over their work. We

also observed many instances where road staff seemed to be given little discretion by their employer.

The following vignette, from Researcher C's observations of an ambulance crew (paramedic Dave and EMT Anne),[10] vividly captures the lack of discretion experienced during particularly busy times of the day, with supervisory staff 'shooing people off' the site in order to get them back out on the road, as the Trust tries to hit its performance targets with limited numbers of vehicles available:

> We arrive at A&E and I am starting to get really hungry. The patient is wheeled into a bay on arrival and then allocated a bed. We have to search around for a sheet for the bed and a nurse to hand over to. Once we get outside there are three managers shooing people off the site. Another man in ambulance uniform comes over and asks EMT Anne to move the ambulance. 'I wouldn't ask normally but you can see how it is'. Anne moves the ambulance and we start to try to put the equipment away, wipe down and do some more checks. Anne says she is going to look for sheets, but a manager comes and says we have to leave. I mutter '****ing hell!' under my breath. There is no time to tidy up, never mind clean or do basic checks. Paramedic Dave says 'these area managers come from the ranks, you know, but they forget. They think we're skiving and we can't even get the ambulance checked'. [Field notes, Researcher C]

Here we see management as an active presence at the A&E department where dual-crewed ambulances usually return ten or eleven times during a typical 12-hour shift; a place where crews can expect managers to be present. Freedom from direct supervision, which Metz (1981, p. 66) describes as one of the principal perks of ambulance work is, therefore, not always available due to the 'performance-driven' managerial regime.

Moreover, managers possessed powerful forms of remote control. During Researcher C's observed shift, EMT Anne was summoned to talk on the radio to a manager at Control, and spent some time explaining her actions from a prior shift. She was clearly apprehensive about having to do this, and appeared to shoulder a burden of fear relating to what this conversation meant. This hung over her during her working hours (and possibly also after work). Our observations of emergency control centres (Days 3 and 4) revealed how the rationing of tight resources under a targets-based culture largely determines the ways in which 'jobs' are allocated to road staff. In the following field note, Researcher A is sat next to Andy, a member of the dispatch staff with nine years' experience, in one of the busiest Paramedic Emergency Control centres in the UK. He is working on a triple-VDU computer terminal, focusing at that time of the day on juggling the allocation of meal breaks to crews across the city while simultaneously assigning emergency calls to crews where available:

> The middle screen shows the list of crews and at this time of the day (around 11.30) one of the main tasks is to get the crews stood down enough time to get their lunches. If they don't 'dine' during this three hour window of 11–2, then they have to be taken off the system until they've 'dined' and only then can they go back active. Andy

> explains 'If we get caught out here, we can lose them for about an hour or so'. So, one of Andy's most important jobs during this part of the day is to juggle it around so that they don't lose anyone for prolonged periods. The messages he types into the system then get transmitted to the ambulances' MDT [Mobile Data Terminal] system next to the driver's seat. He shows me the screen on the left which displays a stack of jobs that are assigned or in need of assigning. This matches with details on the crews – showing their ETA [Estimated Time of Arrival] from the job they are assigned to (or might be assigned to), distance in km from the job, and their status (including whether or not they've 'dined'). I notice the constant juggling of crews – occasionally one is stood down then stood back on again in quick succession – it must be a nightmare for the crews when they are not sure whether or not to trust the prior message knowing it might change again. 'There's definitely more demand than there used to be' says Andy. 'There used to be quiet periods, for example Sunday night used to be less busy, but now it's as busy as Fridays and Saturdays'. . . . 'It's all numbers now' he says in a tired, resigned kind of way. 'With jobs coming in, your priority is to allocate, get them out. If they don't make it within the response time, you have to put a reason in. The numbers show where they've missed the target. If it's sensible then you leave it as it is, but sometimes you have to ask them why they've missed it, so we can put in a reason'. [Field notes, Researcher A]

Despite the moves to professionalize paramedics it seemed as if they worked under a low-trust organizational culture. In response to the high levels of managerial monitoring of crew performance and perceived absence of support, paramedics and EMTs have internalized a way of working whereby they limit their own discretionary behaviours (see also Porter et al., 2007). This form of street-level institutional work served to reinforce traditional, 'blue-collar' ways of working. Fear of litigation from patients, a lack of support from managers, and concerns over making errors and causing harm to patients all contributed strongly to ambulance staff self-limiting their discretionary actions, except when clearly forced to do so by emergency situations. The latter could place emergency crews in extremely tough situations, where they had occasionally to act in ways that they knew bent or broke managerial and clinical protocols. The following vignette highlights this issue:

> Researcher A is in the passenger seat in the front of the ambulance alongside EMT Steve who is driving to A&E. Paramedic Graham is in the back, attending to a patient. Researcher A suggests to Steve: 'Some of the managers are good, though? I've met a lot of them, and I've been impressed with a lot of them'. This meets with some resistance. Graham pipes up from behind, interrupting us to talk through the opening through to the back of the ambulance: 'As an example they recently gave us some maps. They showed that these are the correct routes for certain jobs. Let's say you know the route and you say this takes 12 minutes, they've turned around and said "no the computer says this can be done in 8 minutes". It's the attitude they've got. "Why did you take 12 minutes – it can be done in 8!" You don't feel valued'. Steve agrees: 'That's it – you don't feel valued. Don't get him started on management!' It's too late – Graham continues: 'They're constantly focusing on targets, performance targets.

> Patient care has gone out of the window to be honest. I do the cars [RRVs] as well, and one time I had a very sick baby to sort out. He needed the hospital as quick as possible, I couldn't afford to wait for the ambulance, so I went; I took him in the car. I had the midwife with me. We had to go, but I get slapped on the wrist for this, as we're not supposed to take patients in the car. Then I learn the other week that the protocol has changed and we now are allowed to'. Further on in the journey he returns to this theme: 'We get these pink slips, training memos, they go to the station, and we're supposed to learn about the changes this way'. Researcher A: 'What, they get photocopied and put in your pigeon holes?' Graham: 'No – one copy goes down. One copy! Do you think we're really gonna read that?' Steve agrees: 'After a shift out here, 12 hours – that's if you get off on time – do you really want to then go looking for bits of paper to read? You don't see it, you're not informed. It gets lost in the system'. [Field notes, Researcher A]

Researcher C's field notes contain numerous references to emergency staff following rules to the letter. These rules (like those above) have been drafted by others and imposed on front-line operatives. This is clearly not a feature of work associated with 'established' professionals (Freidson, 1970/1988). Paramedic Dave explains that he follows formal rules very closely, only departing from them in the most partial and cautious way when left with no other choice. Even then, he records his own actions and keeps his own, pre-written explanations handy, as the following vignette reveals:

> We are heading to a school site where a schoolgirl has dislocated her knee. On the way Dave tells me that he always follows the rules because of a perceived lack of support from managers. He shows me notes that he keeps in his top pocket explaining why he does certain things. He has a memo showing when they should give oxygen and when not to. He doesn't agree with it and implies that some A&E doctors don't either, but he does what it says on the note and shows this memo to doctors if they question him. He also has another handbook in his pocket explaining doses of medicines: 'See if you can understand that!' I look at it and I can't understand it. It seems to show different doses, for different ages, for different medicines, but Dave says they've had no training, he just carries it around and tries to make sense of it: 'If you follow the rules then they can't pull you up about it. Except when you know it is definitely wrong, then I'd make my own rule'. [Field notes, Researcher C]

When Researcher A first met the crew he was observing (paramedic Graham and EMT Steve) he was immediately made aware of complaints about the lack of clinical judgment extended to crews. Standing in the back of the ambulance before setting out from the station, Graham immediately indicated feelings of being isolated from clinical decision-making about the type of treatment that paramedics are allowed to give. He implicitly drew attention to his own medical knowledge and professional status, pointing to frustration with the ways that management seemed to introduce new policies without due consideration of their implementation, suggesting that the professionalization strategy had not translated into day-to-day operations:

> Graham pops in the side door, placing his orange paramedic bag down nearby. 'What's this?' asks Steve, pointing to a green square bag. 'Oh, it's the new drugs. You've not seen this?' Steve zips it open to look through. Graham: 'We've been given this pack, but no spoons for the Calpol. No mouth syringes for the tiny ones. There's errors in the book – they've admitted it. Management have admitted that this isn't right'. He shows me a manual that accompanies the meds bag. 'Technicians are now allowed to give adrenaline'. He joked with Steve about this. 'You ok with that!?' Pointing jokily to Steve, he says to me 'Don't worry about him. Just look out for when the vein starts throbbing in the side of the head!' Graham continues to complain about the manual, dropping it next to me on a shelf: 'Things like this should be handled better'. 'It's a bit chaotic?' I suggest. 'It's not chaotic, it's bad. These are life-saving, or life-threatening drugs if not used properly. We need proper training on this. It's like: "here's the drugs, here's the instruction book".' [Field notes, Researcher A]

Graham's frustrations over the lack of adequate training were seemingly a manifestation of the perceived failure to include road staff in clinical policy-making. A mismatch between official advice from (hospital-based) core medical professionals and the complexity and fluidity of street-level care forces paramedics into occasional avoidance or bending of the rules (Tangherlini, 1998). The centrality of rules laid down by other professionals (in this case doctors) is noted by both Metz (1981) and Mannon (1992, pp. 87–97). Ambulance staff often indicate that there is a world of difference between hospital care and pre-hospital ('on the road') care. This situation does not seem to have changed in the decades since Metz and Mannon conducted their research, despite the College of Paramedics' institutional entrepreneurship. Paramedics continue to enjoy only weak levels of formal autonomy, because most tasks are pre-structured by other professionals, and the operational side of their work is monitored closely by managers and target-based control systems.

Our interviews with managers occupying a range of roles across the service (see Table I) indicated that they are aware of these problems, but struggle to ameliorate them because of chronic resource shortages and growing demand. An experienced senior area manager, responsible for coverage of a large urban area, argued that the quality and sophistication of the care provision had increased enormously in his 23 years with the service. In contrast to our observation of emergency crews, he believed that paramedics are now being given more responsibility and autonomy:

> I think we've become a better managerial organization, personally from what I've seen in 23 years, we've gone from kind of you've got the job almost by default to now you've got to have some independent knowledge . . . Now with diplomas for the paramedics, and the developments certainly through our Learning and Development team here . . . I think the whole structure's got more, kind of, managerial approaches to everything they do, I mean the way they treat patients has got more structured, with reasons behind why we do it, not just 'do it', you know? . . . We've got a lot of protocols and procedures that we work to, and I think we've got to because of the nature of the job we do, but what we've done is that we're allowing staff to free think now, they're autonomous. They're guidelines more than protocols, so 'you should give this drug,

> and you should do that, but you're not an idiot, so think on your feet and perhaps change the guidelines somewhat, as long as you keep within the safety margins'. So I just think we've got a more free-thinking service now. [Interview 9]

However, other, often less senior, managers suggested that any increases in training and improvements to vehicles and equipment were being overridden by the constant ramping up of pressure on crews, which was creating morale problems as life 'on the road' becomes 'a relentless, relentless grind':

> An ambulanceman's glass is always half-empty, wherever you go. It's a tough job. But the thing is, . . . I'll give you a typical example, . . . a city centre station. Half six you've got four vehicles signing on. By twenty-five to seven the garage is like the Marie Céleste, they're gone. They will get back at some point due to the meal process, but they do not have any downtime apart from the meal breaks, whatsoever. . . . Everything has been trimmed so near the knuckle, there is no flexibility there's no support, there's no safety net any more, everything is taut, and without flexibility. And the thing that did it for me – the thing that sort of mirrored the crews, how they feel – is in 15 years this is the first year that I've not known any Christmas decorations up at the station. . . . Effectively stations now are somewhere to park your car and somewhere to eat your butties. There's no point in having Sky (TV) . . . And that's it. Because it's a relentless, relentless grind. And then you get more friction from the staff, because now with the introduction of Ambulance Liaison Officers at the hospitals, so that little bit of leeway that crews used to get a quick drink and five minutes' chat, that's gone now. And I think the crews think . . . 'they're just trying to squeeze that little bit more out of us per day'. And it's got to the point now where we can't squeeze any more. [Interview 10]

The professionalization project has led to certain improvements in the sophistication of the paramedic role (Association of Ambulance Chief Executives, 2011), and the institutional entrepreneurship of the College of Paramedics has certainly played a role in this. But at street level, work intensification and a targets culture create huge pressures on road staff – which can limit discretion, damage morale, and trigger conflict with managers. As the next section demonstrates, the impact of this situation sees paramedics assert another kind of professionalism. This 'blue-collar professionalism' is reasserted through street-level institutional work, acting as a (partially contradictory) counterpoint to the formal institutional entrepreneurship of the senior level professionalization project.

THEME B: SOCIAL REPRODUCTION OF 'BLUE-COLLAR PROFESSIONALISM'

As we have seen, the institutional entrepreneurship of the College of Paramedics appears, thus far, to have had rather limited impacts in terms of influencing the policies of the ambulance trusts that employ paramedics. Facing tough working conditions, paramedics at street level engage in a rather different kind of professional project, based on institutional work, and acting partly as a kind of coping mechanism. With

organizational targets so dominant, and with clinical protocols structured by other professionals, paramedics resort to informal institutional work as a kind of 'fall-back' position – one that contributes to the maintenance of 'blue-collar professionalism' (Metz, 1981). This is an important way for ambulance staff to reassert their professional position, given the perceived remoteness of the senior level professional project, and in the face of frequently unpleasant work and a surprising lack of respect shown by some patients they encounter.

Researcher A's crew, for example, described alcohol abuse as one of the most serious issues ambulance staff face, often leading to abusive and thoughtless behaviour from patients. This is noted in prior studies (Metz, 1981, pp. 118–19, 148–49), but there were indications in the present study that such abuse has become more frequent and intense in recent years, mirroring the lurid contents of blog-based literature on ambulance work written by paramedics themselves (Gray, 2007, pp. 85–93; Reynolds, 2009, 2010). EMT Steve explains:

> The alcohol – this is city centre . . . young people out – on nights you get a lot of this. The worst thing is that they'll call an ambulance and leave us to clear up the vomit and the shit from the 'bus'. They think it's amusing! They **** off and leave us to it. They will leave their mate with us. When I was younger, yes we'd go out, we'd get drunk, but we'd know when to stop, when to sort out and take a mate home when he'd overdone it. We'd never let it get to this. . . . Different characters come out at night. Nights are very demoralizing. You're threatened. I was on the verge of ****ing killing somebody. Why don't they take some responsibility? [Field notes, Researcher A]

Elsewhere in the city that morning, Researcher B (accompanying Sarah, a solo paramedic working a rapid response vehicle) noted the following on the subject of abuse and violence:

> We receive a radio message to relocate in [district]. We park near the [major road] on an industrial estate near [Street]. We talk about Sarah's experiences as an ambulance crew member . . . she recalls having to go to some 'rough houses . . . having liver and onions shoved in my face . . .' . . . Sarah tells me that she had been assaulted by patients 'a few times'. One man had psychosis and wanted to self-harm. He had a knife and seemed to be on cannabis. The doctor 'left the ambulance staff to it'. Another encounter left a fellow crew member, Chris, with blood on his face . . . the patient had taken ketamine and the crew had to pounce on him to restrain him. Chris got smashed in the face. The first of these two cases went to court, the second did not. I express my disgust at people behaving like this but Sarah seems, while not accepting, sanguine in that they are, after all, patients requiring care. [Field notes, Researcher B]

This observation is interesting as it reveals how emergency staff claim to have psychologically distanced themselves from the risks, traumas, and insults of the job, and yet retain an awareness that such risks are real. This is an important form of institutional work for ambulance personnel – a way for them to assert their own form of streetwise, 'blue-collar' professionalism; a kind of professionalism predicated on stoical devotion to

duty in the face of physical and psychological risks, insults, and 'dirty work'. During our observations at the ambulance trust we frequently came across such phrases as 'we're the only 24/7 service available' or 'we're the ones left to sweep up'. Ambulance personnel are far from happy about having to handle the most extreme forms of work, but they will tolerate them as part of their professional duties; as forms of work that many other (perhaps 'higher') professionals are less likely to encounter and tolerate (see also Tangherlini, 2000, pp. 48, 63).

The everyday institutional work of maintaining blue-collar professionalism manifests itself through tacit knowledge and years of street experience that are not reflected in official protocols and go unrecognized by other professionals and the performance targets culture (Metz, 1981). There is a subtle element of moral dignity to the institutional work of blue-collar professionalism – those at the sharp end of ambulance work (both paramedics and less-qualified EMTs) take an implicit moral position by performing some of the least pleasant parts of healthcare work, which, while unheralded, are socially essential. On one occasion noted by Researcher C, ambulance crews demonstrated deep sensitivity born of street experience. They behaved in a measured and considered way in order to limit other patients' exposure to the disturbing sight of a deceased patient. The scene is the ambulance bay outside the A&E unit of an urban hospital. The area is crowded; there is a queue of three ambulances, and the crews are trying to work out the best way to get each of their patients inside. Researcher C is in the passenger seat of an ambulance at the head of the queue, and the technician (Anne) keeps opening the driver's side door to look behind at what is going on. The paramedic (Dave) is attending a patient in the back, a 'male, difficulty breathing'. This patient seems to have a history of heart trouble, and so keeping him away from two other very serious cardiac patients – one dead, the other receiving CPR – was perceived as vital. However, no sooner had this difficult situation been satisfactorily resolved than other professionals (in this case triage nurses) started to complain about the paramedics as if somehow they were responsible for this sudden surge in patients needing admission:

> On arrival at the A&E department, Anne keeps the rear doors closed whilst waiting for two other ambulances that arrived behind us. She keeps looking out of the door and talking to fellow crews. I go outside with her and she explains that someone had died in one ambulance and another is seriously ill and she doesn't want the patient on our ambulance to be distressed, especially as they seemed to have heart problems, a condition similar to our patient. This seems a really thoughtful thing to do. Anne: 'I think they're going to call it – I can see they have stopped working on him'. A doctor has to come out to agree that the patient had died and the other crew could stop resuscitation. Anne: 'The other one's got an output. Got a pulse again after CPR, so he'll go in first'. The resuscitated patient is wheeled into A&E, then Anne opens our rear doors and gets the tailgate down, puts up the rails etc. We wheel the patient into A&E and wait for the triage nurse. Once again, it is the male nurse who walks up, hears the first two sentences, sighs aloud and walks away. He comes back with a bed number. The patient is transferred to his bed and a nurse arrives to take a brief handover. The sheet is signed and we wash the trolley, grab sheets and a blanket and set off again. [Field notes, Researcher C]

The above scene documents an everyday instance of agency that contributes to the maintenance of 'blue-collar professionalism' in ambulance work – an unspoken, under-appreciated form of professionalism that is reproduced on a daily basis as the paramedics' professional body struggles to receive recognition at a higher institutional level. This maintenance position is perhaps reflected in the low levels of membership of the College of Paramedics, as many front-line staff have so far seen few obvious results from the senior level professionalization project and remain unconvinced as to the value of joining.

It is also important to note that not all forms of discretion have been driven out by the performance-driven organizational culture. Unlike more established professionals, ambulance staff have very little power to resist. Doctors sometimes ignore protocols (see Cranney et al., 2001) and lawyers can reassert professional dominance despite corporate change (see Faulconbridge and Muzio, 2008). But street-level institutional work and the assertion of blue-collar professionalism can act as powerful informal coping strategies. We observed instances of resistance or coping strategies of the kind often associated with blue-collar work: namely go-slows, 'non-sanctioned acquisition', and sickness-related absence. At the end of the shift being observed, Researcher C made the following observation:

> This next call is routine. A man has been seen by his doctor and needs to go into hospital where a bed is waiting for him, so they will take him straight to a ward. He has had a stroke and has a history of strokes. We drive very slowly to [district] ('looks like the traffic's done us a favour', says Anne). We sit in traffic and never move more than 15 miles an hour even on a clear road. [Having dropped off the patient] We clean up again and get back in the ambulance and sit a while before 'clearing' [becoming available for the next job] and heading back to the station. We could still get a call, but they push the buttons late for each stage of the journey in the hope we won't get one. I know the last job was artificially slow, but I was glad – I couldn't imagine doing the same thing again tomorrow. When I got home, the calls went round and round in my mind. I didn't know if I was sad that there wasn't more drama, or relieved to have made it through the shift. [Field notes, Researcher C]

Researcher A also noted paramedics and EMTs taking short, informal breaks after having dropped off patients at A&E. But, as above, managers were said to be constantly pressuring them to eradicate these interstices. The crew explained:

> Another reason you do this [transfer practically every patient to A&E] is that you get a break, you get time off the road. Usually about 10, 20 minutes. You can't get a call while you're here. You can get a brew [cup of tea]. But they do check. If you take too long, you get in a lot of trouble. [Field notes, Researcher A]

Another kind of coping strategy came in the form of non-sanctioned acquisition of materials from hospitals (especially sheets and pillows) for use by the crews in the course of their duties. EMT Anne described NHS pillows to Researcher C as 'rarer than rocking-horse muck', and encouraged Researcher C to collect 'spare' sheets and pillows

wherever possible. Metz (1981, pp. 52–56) mentions similar instances of pilferage (known in the USA as 'the five-finger discount') and only the context here is different. Forms of minor, informal resistance also extend to certain kinds of treatment that paramedics chose to provide. At times, they noted disagreement with the protocols laid down by JRCALC, pointed out their inadequacies, but reluctantly followed them. We also observed road staff being forced to ignore some of the commands and advice of Control, such as when the satnav was clearly wrong. Such behaviour constitutes street-level institutional work – informal and rooted in experience. This is not something associated with established professions, but has long been an essential part of ambulance work (Palmer, 1983; Tangherlini, 1998, 2000; Wankhade, 2012).

At the formal level, the College of Paramedics' professionalization strategy has so far achieved mixed results in terms of improving the status and discretion of road work. At street level, the everyday enactment of blue-collar professionalism is as visible today as it was in studies reported two or three decades ago (Mannon, 1992; Metz, 1981; Palmer, 1983). This draws attention to the various levels at which ambulance work is accomplished and suggests how these levels make different impacts institutionally; the formal, institutional entrepreneurship aims at professionalizing the service along clinical or white-collar lines, whereas the informal, street-level institutional work reinforces a more traditional 'blue-collar professionalism'. Whilst the two processes are interlinked, they are also somewhat contradictory or opposed, suggesting that professionalization projects can consist of multiple and complex forms of action which reflect the 'deeply embedded' organizational and occupational subcultures of UK ambulance trusts (Wankhade, 2012, p. 386). Actors operating at different levels of an occupation can simultaneously direct themselves towards different goals, even in the same field or organization. This adds yet more complexity and contingency to the process of researching institutional change and professionalization.

DISCUSSION

In recent years, several actors and organizations have been attempting to raise the status and heighten the sophistication of emergency ambulance work. This has included the development of national policies which emphasize 'taking healthcare to the patient' rather than the traditional focus on 'transportation to definitive care' (Department of Health, 2005). In addition, the introduction of new 'patient pathways' provides paramedics (in certain geographic regions) with an increased degree of clinical decision-making (at least in theory). Related developments have seen the creation of a professional association, the College of Paramedics, which has pursued a classical professionalization strategy of institutional entrepreneurship. It aims to gain more recognition and influence for the profession at higher levels, to lobby government, to influence the development of training curricula, and to help shape the protocols that paramedics work to in the field, but it faces major challenges. Seen from the viewpoints of middle management and the front line, this senior level professionalization strategy has had rather limited impacts on entrenched organizational and political priorities which still emphasize the rationing of resources and the pursuit of target response times. Meanwhile, both the morale and

working conditions of front-line ambulance staff remain poor (and in some senses may be worsening) as demand increases and resources stretch.

This situation encapsulates the deep contradiction at the heart of New Public Management as exemplified by recent UK governments. Up-skilling and better pay and conditions are encouraged, yet public organizations such as ambulance trusts find themselves heavily audited, under strong cost-control pressures, and struggling to cope with a plethora of sometimes ill-considered performance management targets (Hood, 2006). Caught between a dominant elite of medical professionals and management dynamics geared towards adherence to targets, cost control, and shifting sets of policies, many ambulance crews see few advantageous developments emerging from the professionalization project and instead apply themselves to the everyday institutional work of reproducing 'blue-collar professionalism'. The crews know, for example, that taking every patent to A&E by default is not sensible, but it is the easiest and safest course for them to take. At the same time, this contradicts with the realization of a more sophisticated ambulance care model, which the College of Paramedics continues to exert great effort in trying to define, develop, and protect.

Ambulance services claim to be shifting towards a model of paramedicine that would necessitate more autonomous clinical decision-making for road staff. At the same time, however, in a paradox which is often present in large organizations, ambulance trusts are introducing a new role of ECA, a post less skilled than that of EMT. This runs counter to the up-skilling of paramedics, the development of advanced ECP and PP roles, and of 'taking healthcare to the patient'. ECAs receive 6–8 weeks of training and are paid below EMTs, on bands 2 or 3.[11] With the ECA role mostly involving driving and the manual handling of patients, and the clinically-trained and very versatile EMT role being phased out, this may herald something of a return to 'strong backs and stomachs' (Mannon, 1992, p. 2) as the basic requirements for the most elementary forms of ambulance work. This fragments the occupation, giving staff employed in these posts little reason to join the College of Paramedics or to support its professionalization project.

Much recent research points to profound institutional change in healthcare and other public sector fields in the UK and USA (Ashworth et al., 2007; Kitchener, 1998; Scott et al., 2000). But if we are to understand fully the effects of such forces on professional and professionalizing occupations, we need to go beyond abstract, theoretical, formal, and structural levels of analysis, and examine 'how things work' (Watson, 2011) in practice on a daily basis (Abbott, 1988). The focus on work has been arguably lacking in much research on organization and management, including much institutional theory (Barley and Kunda, 2001; Lawrence et al., 2011, p. 52). While change at the formal level is relevant, and efforts at institutional entrepreneurship (by bodies such as the College of Paramedics) can potentially enhance paramedics' status, our paper shows how for ambulance services the senior level entrepreneurship that constitutes the official professionalization project often fails to translate into changed daily rhythms and routines in front-line ambulance work. This paper thus highlights the many and immediate forces that represent, on a daily basis, the enactment of institutional structures old and new. The extensive nature of such forces, coupled with the diffuse power resources of different players, means it would require radical organizational change (and massive additional funding) if the professionalization project for

ambulance staff were to have more substantial effects in changing workplace behaviour. It is probable that fields occupied by other 'professionalizing' occupations are characterized by similar power imbalances, with attempts at change constituting similarly complex and contested combinations of senior level institutional entrepreneurship and lower level institutional work.

Our research approach, however, has certain limitations. As the data focus on managerial and front-line work we have not looked in detail at agents carrying out high-level institutional entrepreneurship, such as senior figures in the College of Paramedics and those representing ambulance trusts on JRCALC. We can therefore make only broad and personal predictions about likely future trends in this respect. The professionalization project is a relatively recent phenomenon and (at the time of completing the research) membership of the College of Paramedics was growing; the first cohorts of paramedics qualifying under the new degree structure were just starting to take up roles in the Trust. We support the aims of the professionalization project and argue that it is vital for ambulance trusts to be given sufficient resources to build on some of the recent improvements reported by managers and some road staff (e.g. more advanced training, new patient pathways, more sophisticated vehicles and ICT systems). However given the enormous constraints on public sector finance in the current era, the pressures on front-line work described in this paper seem likely to restrict the possibilities for a professionalization strategy to upgrade the status and working conditions of emergency ambulance workers. In the meantime, those undertaking street-level work seem likely to continue with their long-term informal maintenance of 'blue-collar professionalism'.

We have argued that the senior level professionalization strategy for paramedics has resulted in few transformative effects at the level of everyday work. This formal professionalization project originally developed more out of the pressures of coercive isomorphism from changing NHS policy rather than those of the normative isomorphism usually associated with such innovations (DiMaggio and Powell, 1983, p. 150). Ambulance work has witnessed a rhetorical shift in official language and formal categories; it possesses the structural trappings of a profession (e.g. training and certification in higher education establishments, research journals, codes of practice, a professional body), and it can be defined as 'professional' work if one uses the term in its 'folk category', as meaning 'an avowal or promise' (Freidson, 1970/1988, p. xv; Freidson, 1986, pp. 35–37; Wolinsky, 1993, p. 11). However, the practical experience of work has changed little from the 'blue-collar professionalism' described by Metz in the early 1980s. Where it *has* changed this is mostly due to the employer and other clinical bodies reacting to shifts in policy – such as 'taking healthcare to the patient' (Department of Health, 2005) and the development of new 'patient pathways' (Association of Ambulance Chief Executives, 2011); and the employer retains strong managerial control over paramedics and other ambulance workers.

There are many reasons why the senior level professionalization strategy has so far had limited traction, but fundamentally it comes down to organizational power (Clegg, 2010). The College of Paramedics is growing in influence but other powerful organizations are centrally involved in administering the behaviour of paramedics, and imagining the future directions of travel for the paramedic profession. These include government

regulators such as the HPC, other clinical professional groups, trade unions, and, perhaps most powerful of all (at least in an immediate sense), the ambulance trusts which employ paramedics. As with all NHS trusts, they currently face extreme financial pressures as government funding is cut back and other 'willing providers' of health services (especially private companies) look for ways to offer their services in what were former NHS monopolies. Short-term priorities of hitting targets, winning care contracts, and 'keeping the show on the road' are far more important to NHS trusts than any aspirant long-term projects such as paramedic professionalization. Institutional work in such a setting is necessarily less about trying to change organizations and institutions, and more about maintenance (Lawrence et al., 2011, p. 53) – the daily struggle to hang onto and reproduce what status the actors have. Institutional work in situations where actors have such limited power options becomes more about identity and dignity than about real prospects of genuine institutional change.

Overall the paramedic 'profession' has gained very few of the protections afforded established professions, such as law and medicine. This situation is probably not uncommon among 'professionalizing' occupations, especially where the strategy has also been characterized by power imbalances in the employment relationship, a mismatch between formal, senior level institutional entrepreneurship and informal, street-level institutional work, and where a major feature of the project has been 'professionalization from above' rather than 'from within' (Evetts, 2011; McClelland, 1990). More attention needs to be paid to less successful efforts of institutional change, notably where the change strategies being enacted (as in this case) are plural, fragmented, and in some ways contradictory. In other words, where there is insufficient power to challenge entrenched systems and structures. Metz (1981, p. 192) ends his ethnography on a hopeful note: 'As structures slowly change and as ambulance work becomes more institutionalized, perhaps it will be easier for these people to exercise their talents'. Based on our findings this hope is not being realized. Taken together, the senior level professionalization project of institutional entrepreneurship combined with the informal institutional work at street level continue to have ambivalent effects, which in many ways reinforce traditional modes of acting and being for ambulance crews.

Finally, at a broader level, our paper points to the critical importance of accounting for both formal, senior level institutional entrepreneurship alongside informal, lower-level forms of institutional work as occupations and professions undergo contested and non-linear forms of change, with different actors perhaps pursuing different agendas. Exploring the extent to which these multiple levels of action are compatible or incompatible could potentially be of vital importance to those wishing to understand the direction of travel and likelihood of success for institutional and professional change projects. The complex and often contradictory relationship of multiple levels of (formal and informal) action in institutional change and professional projects promises to be a highly fruitful area for further research.

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NOTES

[1] There are certain forms of treatment in which paramedics are being up-skilled, notably in dealing with heart attacks and strokes, but these developments are complex and often involve disagreement between various clinical professional groups. For example pre-hospital emergency medical literature has increasingly emphasized that ambulance personnel can successfully diagnose and treat certain forms of acute myocardial infarction (heart attack) in the pre-hospital setting, where the early use of thrombolytic drugs can dramatically improve survival rates (Becker, 1998, pp. 316–17). In certain regions it is possible for ambulance crews to take patients through different 'pathways', such as directly to specialist angioplasty and stroke centres, rather than to general A&E departments, although the coverage is geographically limited and the extension of such discretion to paramedics remains contentious. The College of Paramedics continues to play an important role in advocating for further devolution of such advanced techniques to road crews. A very useful paper in this regard is Cox et al. (2006), which points to a mixed picture whereby many paramedics welcome the potential broadening of their skills and responsibilities, but are simultaneous concerned over a lack of clarity over their clearance to use more advanced procedures and the patchy provision of training.

[2] http://www.hpcheck.org

[3] Details about the College reported here are taken from the website: https://www.collegeofparamedics.co.uk/home/ (accessed 4 March 2011).

[4] Ambulance trusts are required to meet response time targets for emergency calls. At present the target response time for the most serious (category 'A') calls is 8 minutes from the second the emergency telephone call is connected to Control. These targets are controversial because of their focus on time rather than patient outcome (see Price, 2006; Reynolds, 2009). New 'outcome' measures have recently been implemented to replace target times for less serious calls (formally known as category 'B').

[5] However, these roles remain underdeveloped and their position in wider systems of emergency care and primary care is unclear (Brown et al., 2011; Cooper et al., 2004, 2007). Official figures indicate that there are only 755 ECPs in post throughout all NHS ambulance services, although this represents rapid growth from a baseline of zero in 2005 when the post was created (NHS Information Centre, 2010). Developing these roles is difficult because under-pressure trusts feel unable to relinquish staff from front-line operational roles for the 18 months of training required.

[6] This comprises one year of classroom training followed by one year of study combined with on-the-job placements provided by ambulance trusts.

[7] The approximate figure of 3700 for the total current membership of the College of Paramedics was taken from personal communication between the authors and the Chief Executive of the College, 25 April 2012. This estimate comprises around 2600 full members, 700–800 student members, and 300 associate members. Full members are registered paramedics. At the end of March 2012 there were 17,913 paramedics registered with the HPC (http://www.hpc-uk.org/aboutregistration/professions), hence the estimate of around 14 per cent for CoP membership among the eligible national workforce. The Executive Officer explained that membership has been growing substantially recently (from around 2000 members in May 2010).

[8] Our access to the ambulance trust came about as part of a three-year research project into the sociology of managerial work in the NHS. This necessitated going through a formal process of ethical review which granted us wide access subject to our following strict research protocols designed to protect patients and staff.

[9] As all our observations took place during day shifts (6.30am–6.30pm), we cannot comment on the (probably) reduced levels of direct managerial supervision during night shifts.

[10] To protect staff anonymity all names used in this paper are pseudonyms.

[11] Pay bands for all NHS staff except doctors were regraded under the 'Agenda for Change' initiative in 2004. Annual salary range for Band 2 was (as of 2012/13) £14,153–£17,253, and for Band 3, £16,110–£19,077. Supplementary payments amounting to 25 per cent of salary are available for EMTs and paramedics who work outside normal hours. Most EMTs and paramedics (depending on experience) are on Band 4 (£18,652–£21,798) and Band 5 (£21,176–£27, 625), respectively. Figures taken from Royal College of Nursing website: http://www.rcn.org.uk (accessed 5 November 2012).

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