AUSTRALASIAN JOURNAL OF PARAMEDICINE

PARAMEDICS AUSTRALASIA

Research

Understanding complaints about paramedics: a qualitative exploration in a UK context

Grace Lucas MA(Cantab), MSc, PhD is Research Fellow[1]; Ann Gallagher BA(Hons), MA, PhD, PGCEA, RMN, SRN is Professor of Ethics and Care[1]; Magda Zasada BA, MA, PhD is Research Fellow[1]; Zubin Austin BSc, Phm, MBA, MISc, Med, PhD is Koffler Chair in Management[2]; Robert Jago BA, MPhil is Senior Lecturer[3]; Sarah Banks MA, MSW, PhD is Professor[4]; Anna van der Gaag CBE, Dip CST, MSc, PhD is Visiting Professor[1]

Affiliations:
[1]School of Health Sciences, University of Surrey, United Kingdom
[2]Institute of Health Policy, Management and Evaluation, University of Toronto, Canada
[3]School of Law, Royal Holloway, University of London, United Kingdom
[4]School of Applied Social Sciences, Durham University, United Kingdom

https://doi.org/10.33151/ajp.16.616

Abstract

Introduction
This research set out to understand the context and explore the reasons for the disproportionate number of complaints raised against paramedics to the United Kingdom professional regulator – the Health and Care Professions Council – relative to other health professions.

Methods
This paper reports on qualitative findings from one aspect of a mixed-methods study which included a case analysis, Delphi study and literature review. One-to-one semi-structured interviews conducted with 15 stakeholders drawn from practitioners, educators, representatives and regulators, and three focus groups held with 16 practitioners and service users were used to gain an in-depth understanding of the possible reasons for complaints about paramedic practice.

Results
Five themes were generated from a thematic analysis of the data: the impact of public perceptions and expectations; the challenges of day-to-day practice; the effect of increasingly pressurised services; the organisational and cultural climate which impacts paramedics' work; and the evolving nature of the profession.

Conclusion
This study highlights the complex and changing nature of paramedic practice. It provides an insight into the ways in which the character, practice and environment of the profession contribute to a disproportionate number of complaints.

Keywords:
paramedic; emergency medical services; professional practice; professionalism; registration; complaints

Corresponding Author: Grace Lucas, grace.lucas@yahoo.co.uk

Introduction

In the United Kingdom, the health and social care system is under pressure from rising demand under increasing financial constraints (1). Ambulance services are no exception to this, with one report suggesting a 42% increase in demand on UK ambulance services since 2007 (2). One of the manifestations of this increase is the increasing number of complaints about health professionals. A comparative study of complaints data from all regulated health professionals in the UK found a 31% increase over the period 2010–2016 (3). Paramedics, along with social workers, receive a disproportionate amount of complaints compared to other professions regulated by the Health and Care Professions Council (HCPC) – an independent UK-wide regulator of 16 health and care professions, including paramedics. In 2016, paramedics made up 6% of all health professionals registered under the HCPC Register and 11.24% of all fitness to practise cases in the preceding year (4). Indeed, paramedics (and social workers) consistently represent the highest number of complaints to the regulator over time. In 2015–2016, these ratios were 11 complaints per 1000 registrants showing an increase from four per 1000 registrants in 2005. Data relating to complaints regarding each professional group regulated by the HCPC data is reported in the HCPC Fitness to Practise annual report. (5).

A literature review of English language publications undertaken as part of this study identified only two studies on the prevalence of complaints beyond the annually published data from the HCPC (4-8). In terms of the UK context, this may be because, although complaints to the regulator are available, it is difficult to make like-for-like comparisons between these data and data collected locally by Trusts and other employers, as there is variability in what they collect. On an international level, regulatory bodies in different countries use heterogeneous methodologies for categorising complaints, thus making it difficult to make comparisons between them. Paramedic regulation is also variably structured. For example, until 1 December 2018, Australian paramedics were not governmentally regulated, and in the UK, paramedics have only been professionally regulated since 2000. The review identified a complex interplay of factors that makes paramedic practice particularly challenging and helps to bring some context to fitness to practise complaints (8). Paramedics' spectrum of work ranges from treating life-threatening conditions to dealing with low risk injuries (9). In recent decades the role has evolved from patient transport to the delivery of clinical service (10) with the need for assessment and referral skills across a wide range of conditions. This has been accompanied by the professionalisation of paramedics from vocational to degree-level training (9,11,12), as well an increased managerial focus on performance targets and response times (12-14). In such a pressurised climate, concerns about paramedic wellbeing have been reported (15).

In an ever-changing healthcare landscape, complaints can offer insights into ways in which adverse incidents may be avoided and impact change in a positive direction, as Brady demonstrates (16). Whereas change often follows from high profile, adverse events catalysing efforts to make improvements (17-21), professional regulation in countries such as Australia, New Zealand, Canada and the UK is becoming more proactive, recognising that reactive measures alone will not be enough to address systemic issues (22-23). However, there is a balance to be struck as the process of investigation has an impact on the paramedic, often disproportionate to the incident. The aim of the qualitative aspect of this study was to increase and deepen understanding of the reasons why individual UK paramedics are subject to a disproportionate number of complaints and, as part of a wider study, to inform future policy and practice on ways of reducing complaints to the regulator (8).

Methods

This qualitative research formed part of a mixed methods study including a three-round international Delphi survey and a case analysis of a proportion of cases referred to the HCPC (8). Semi-structured interviews and focus groups were chosen to gain a depth of understanding about the reasons and context for complaints. A sample of individuals (n=15) with experience in paramedic practice, education, representation or regulation – set to represent a range of key stakeholders – was identified by the Research Steering Group, the research team and the project advisory group and were interviewed individually. Three focus groups were conducted to obtain the perspectives of both of service users and frontline practitioners and managers. Frontline paramedic practitioners and managers were recruited to one of the groups through email invitations from their employers inviting them to take part. The other two focus groups, held in London and South East England, comprised service users who were part of pre-existing advisory groups to the pre-registration programs at two universities in England and who were invited to take part through these networks. All focus group participants had personal experience of receiving care from paramedics in a range of settings.

A topic guide was drafted by the team, with reference to the preceding literature review, Delphi and was cross checked by the Research Steering Group made up of experts from the UK. In the interviews, participants were asked to suggest reasons for complaints and preventive actions to address this. The semi-structured nature of the interviews enabled the interviewers (Author 3 and Author 7) to develop questions and probe responses depending on the conversation. Telephone or in-person interviews averaged 45 minutes. Focus groups were facilitated by one of the researchers (Author 7) and lasted 1.5 hours. Discussion was guided by the same topic guide as the interviews.

Interviews and groups were recorded, transcribed verbatim and checked for accuracy. Mindful of sources of bias (24,25), two researchers who had not conducted the interviews (Author 1 and Author 2) analysed the data. A thematic analysis was conducted following a process of: familiarisation (repeated reading of transcripts); generation of initial codes; sorting the codes into potential themes and subthemes; and reviewing, refining and naming those themes (26). Author 1 and Author 2 cross checked codes and themes as the analysis progressed. The overall analysis was circulated to the research team for input.

Ethical review

The research proposal was submitted to the University of Surrey Ethics Committee for review. A favourable ethical opinion was obtained before recruitment and data collection commenced (UEC/2016/058/FHMS).

Results

One-to-one interviews with 15 stakeholders and three focus groups were conducted (Table 1).

Table 1. Interviews and focus groups conducted

Individual interviews	Number of participants
Paramedics: paramedic practitioners (n=3), a union representative (n=1), a professional body representative (n=1), employers (n=2), a patient advocate (n=1), educators (n=3), regulators or lawyers working in regulation (n=4)	15
Focus groups	
Practitioners (n=3) and frontline managers (n=3) in Wales	6
Service users with experience of receiving paramedic care: mental health and disability services in London	7
Service users with experience of receiving paramedic care: mental health, cancer care or elderly care in southeast England	3
Total	31

The analysis of the interviews and focus groups generated five themes and subthemes relating to paramedic practice and the possible reasons for complaints and concerns.

Theme 1. Public perceptions and expectations
This theme describes the ways in which public expectations might relate to the number of complaints made against paramedics and encompasses three sub-themes.
'Mismatch of expectations': Paramedic participants suggested that public expectations of the profession are unrealistic: 'I think perhaps we expect too much of them' (service user) with patients viewing paramedics as providing 'the advocacy to their care' (paramedic). Members of the public expected an ambulance to come and take them to hospital, but increasingly this was not the outcome, leading to a 'mismatch of expectations' (educator).

'Last resort': Participants said that paramedics enter people's lives at a moment of crisis and often after having unsuccessfully tried other healthcare pathways. When paramedics demonstrated sensitivity, patients were reassured and satisfied and when they did not, patients were more likely to complain. As a paramedic employer explained, 'the patient feels that they're not being taken seriously or not receiving sort of the appropriate timely care. So that possibly is a high risk for paramedics if they were potentially upsetting the public'.

'Big news': Service users said that media representations of paramedics' work impacted on perceptions. These representations were polarised between heroics and scandals: 'You see big headlines on the front page […] 'My mum was 94 and they came to fix her and they killed her instead' you know' (service user). Paramedics said they had to be mindful that they might be filmed in public. This sense of being watched, coupled with heroic expectations, was perceived to contribute to misaligned perceptions and a readiness to complain if paramedics fell short.

Theme 2. Challenging practice
In this theme, supported by four sub-themes, the day-to-day challenges of practice create a 'perfect storm' (paramedic) for complaints to arise.

'Practising defensively': Participants discussed the confrontational and demanding nature of practice, with some patients under the influence of alcohol or drugs and, at times, involving verbal or physical abuse. Consequently, some paramedics practise defensively and those who react to triggers find themselves subject to a complaint: 'Immediately you're up against it… you're defensive, but you're trying to treat the patient in the presence of a family member who's already aggrieved and you haven't even walked through the door yet' (paramedic).

'Autonomous work': Paramedic practice can often involve lone working with high patient contact. For some individuals, this provided them with 'a chance to misbehave' (educator). For others, the supervision needed to improve practice was missing. As a service user identified, 'they're forced into making decisions very quickly […] and perhaps not always make the right decision, and then can be criticised afterwards'.

'Enough of this': Participants voiced that paramedics' work is high stress and when they feel worn down, they are vulnerable to receiving complaints. One paramedic admitted, 'I may well be easier to snap at four in the morning'. Without the tools to manage their own wellbeing, practice might suffer. This was particularly felt to apply to communication, where 'a simple comment' might lead to a complaint (paramedic).

'Frustration that builds': Participants said paramedics could become frustrated that acute skills were underutilised. As a paramedic explained, 'I want to go and help, because with that one I can save a life, this one I'm now going to spend 2 hours trying to negotiate with a GP'. There were observations of paramedics experiencing a de-skilling and the potential clinical consequences that this could have, ultimately leading to fitness to practise referrals.

Theme 3. Pressurised services
This theme (with three sub-themes) illustrates how organisational structures and service pressures affect paramedics' work, providing some context for complaints.
'Not enough staff': Response times were said to be affected by both an increasing volume of calls and paramedic shortages. Participants felt that complaints were not only about individual failures but the impact of understaffing: 'The bulk of our complaints […] relates to the response we provide, and it's nothing to do with the care provided' (paramedic complaints manager).

'The mop up end of things': Services were said to be under pressure due to having to 'mop up' cases from failings in primary care with paramedics acting as a 'front line' having to deal with issues 'because nobody else really knows how to deal with it' (lawyer, regulation). Participants said that paramedics bear the brunt of systemic shortcomings and patients are confused by a changed model of paramedic operation, both of which may lead to complaints.

'Barely time for training': Participants highlighted a lack of time for training, which, they said, led to fitness to practise concerns. A range of training issues were raised; from a lack of individualisation, to trusts not valuing continuous professional development, to the need to 'keep enough paramedics in ambulances to deal with the demands from patients' (educator). Participants felt that a lack of training could explain why some aspects of practice received a higher number of complaints.

Theme 4. Culture of fear and conflict
This theme, with four sub-themes, describes paramedic culture, characterised by feelings of being 'under attack' from management and the regulator.

'Head down': Participants described a closed culture in the ambulance service. This had three facets which led to entrenched ways of working and ultimately poorer practise. First, paramedics are resistant to talking about the stress or mental health issues they face: 'it's not the environment where people step forward and say, "I think I have a problem and I'd like some help" (union representative). Second, a 'head-down' culture (patient advocate) provides self-protection by keeping management at bay. Third, even some newly graduated professionals trained in open reporting adopted this closed stance in practice.

'Discipline first': Participants voiced that paramedics are critical of their own practice and that of colleagues. This is supported by a historical focus on putting 'discipline first' (patient advocate), rather than discussion or appraisal. Concerns being raised would not be viewed as a negative, but as individuals adhering to the code and the organisation providing an authoritative stance.

'What leadership?': Participants identified a lack of leadership from employers on key issues including the meaning of professionalism leaving it up to an 'individual's interpretation of what's [their] perception of fitness to practise' (paramedic). Paramedics out on long shifts were said to lack managerial feedback making paramedics vulnerable to either under- or over-reporting themselves. A mix of discipline and autonomy was mentioned as fertile ground for complaints to arise.
'Big Brother': Participants reported that paramedics can be fearful of the regulator. With 'Big Brother' (educator) watching over them, several participants said that paramedics were encouraged to self-refer by employers or unions to try and improve their chances of a positive outcome.

Theme 5. Evolving profession
This theme identifies a developing profession and the impact this has on complaints being raised about paramedics with three sub themes.

'Values of professionalism': Participants described how paramedics from university courses had a heightened awareness of the regulator. As these new graduates were 'immersed in the values of professionalism' and 'looking to do all the right things' (paramedic), they may be more likely to refer themselves and contribute to an understandable increase in self-referrals for fitness to practise.

'Embryonic profession': As the profession has evolved, participants felt that for some paramedics there was a lack of understanding about the ethics of being a professional and that some paramedics 'wouldn't have a clue' about required professional standards (paramedic). It was felt that the meanings of professionalism were variously interpreted.

'Why should I change?': Participants suggested that some paramedics were wedded to old ways of working and uninterested in the profession going forward. However, others argued that university education was not a panacea and that the attitude of older generations was a potential factor for complaints, not a clear-cut answer. Participants did tend to agree that accountability was an 'opportunity to change' (paramedic) and needed to be positioned as such.

Discussion

This qualitative exploration of the reasons for complaints raised about paramedics' fitness to practise found a complex interplay of organisational, environmental, cultural and personal factors.

Public expectations of what paramedics can do are high. Participants in this study said there is a heightened awareness of the right to complain and pressure from media sources which polarises professional narratives into heroics or scandals. Hutchison describes how such news items have modelled a discourse which raises public anxieties about caring practices (27). Indeed, HCPC's Fitness to Practise annual reports and those from other professional regulators report a continuing rise in complaints from the public (3,28,29).

The results of this study emphasise that paramedic practice involves challenging and stressful work adding to literature which has emphasised how stress on these workers takes its toll (30,31). Paramedics deal with people in crisis and peril however they also deal with many cases that do not utilise emergency skills. Participants in this study observed that some older paramedics had been trained primarily for emergency work and were perhaps less prepared to deal with a broad spectrum of people with long-term health conditions and increasingly complex psychosocial issues.

The theme of pressurised services identified in this research emphasised the role of the environmental context within which paramedics work and how systemic factors are often involved in generating complaints. This focus on the pressurised context can be understood within the framework of the increasing focus on measuring effectiveness in terms of speed of response (13,14). The participants in this study underlined how a blame culture often focussed on individual shortcomings rather than acknowledging the way in which services were overstretched.

This study suggests that cultural issues of conflict belie some paramedics' experiences of work. This is supported by reports that find a higher than average incidence of bullying behaviours within ambulance services (32). Indeed, in this study participants observed that paramedics worked for ambulance services where discipline was a marker of successful management. This can be analysed as creating 'dichotomies' in working practice, between the autonomy of practice and employers' disciplinary emphasis (12,33).

The data also suggest that paramedics face issues around professional identity. This is supported by literature that suggests that without a clear sense of identity, individuals struggle to develop an 'internal compass' to regulate their work (34). Frontline practitioners in the focus groups suggested that paramedics trained 'on the job' are arguably less interested in the notion of professionalism and might be more likely to generate complaints. This aligns with existing studies of referrals relating to fitness to practise across various health and social work professions (35-37), which have found that older practitioners are more likely to be complained about. While participants in this study said that the generational divide was not clear-cut, there was agreement that poor understanding of registration and professional responsibility, and seeing accountability as threatening, could trigger problems in practice. Our research also pointed to the ways in which newer graduates struggled to uphold open reporting when placed with others working in much more closed ways, a finding which reflects other studies of under-reporting culture in pre-hospital emergency care (38).

The study overall is the largest UK multi-method study to investigate complaints to the regulator about paramedics. The qualitative component captures rich perspectives from a wider range of stakeholders than in any previous study. The work also highlights the significance of organisational culture in relation to ethical paramedic practice. A fruitful avenue for further research relates to the 'ethical climate' of paramedic trusts/organisations. The work of Victor and Cullen would seem to be illuminating here in identifying climates that are based on law and rules, caring, independence, instrumental and efficiency (39). Recent research in nursing ethics, for example, correlates ethical climate and the moral distress of practitioners (40).

This study is not suggesting that there are no cases of paramedics who cause harm to patients and service users, either deliberately or inadvertently, nor are all cases of self-referral unnecessary. It does however suggest that paramedic work is complex and ambiguous and, when delivered in the absence of adequate support, supervision, self-reflection and a no-blame culture – all of which have been shown to underpin the delivery of high quality care – then it has the potential to generate problems (41,42).

Limitations

While this aspect of the larger study has successfully addressed the possible reasons behind the disproportionately high number of referrals about paramedics, it would have been useful to conduct focus groups in different parts of the country – time limitations meant that only three locations were used. Future studies might want to include a higher proportion of users versus providers of services and focus on those who have made complaints, as well as ensuring a representative and diverse sample across race, gender and age.

Conclusion

This research adds to existing literature on paramedic practice and the reasons why complaints against the profession might occur. It suggests that a complex interplay of factors including the historical character of the profession, stressful and changing practice, and environmental factors including high public expectations coupled with high volume and breadth of cases may contribute to the disproportionate number of complaints. It therefore starts to uncover areas where education, employer support and regulatory systems can make a significant difference and where information can be clarified, training can be targeted and preventive actions can be taken. Indeed, the qualitative research reported here forms a part of wider study that identified trends in paramedic referrals such as a disproportionate number of self-referrals, the majority of which were not upheld. As a result, the HCPC has a program of work underway to improve its guidance on self-referrals, working with employers and professional bodies.

Acknowledgements

The research team would like to thank the study participants who gave their time and expertise. We would like to thank the Welsh Ambulance Service NHS Trust, the Centre for Public Engagement, St George's University of London, the University of Surrey's Service User and Carer Group and its Patient Advisory Group. This study was commissioned and funded by the Health and Care Professions Council and was awarded following a competitive tendering process.

Funding

This research was part of a wider study by the University of Surrey commissioned and funded by the Health and Care Professions Council.

Conflict of interest

The authors of this paper declare no competing interests. Each author of this paper has completed the ICMJE conflict of interest statement.

References

1. Barker C. Accident and Emergency Statistics: Demand, Performance and Pressure. House of Commons Library. Briefing Paper Number, 6964: 2017. Available at: http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN06964 [Accessed 19 January 2018].
2. Association of Ambulance Chief Executives, Annual Report 2015-2016. Available at: https://aace.org.uk/wp-content/uploads/2016/10/AACE-A4-ANNUAL-REPORT-2015-2016-W.pdf [Accessed January 2018].
3. General Medical Council. UK health regulator comparative data report 2016. Available at: www.gmc-uk.org/static/documents/content/UK_health_regulator_comparative_report_FINAL_220217. pdf [Accessed 19 January 2018].
4. Health and Care Professions Council. Fitness to Practise Annual Report, 2015. Available at: www.hcpc-uk.org/assets/documents/10004E22Fitnesstopractiseannualreport2015.pdf [Accessed 19 January 2018].
5. Health and Care Professions Council. Fitness to Practise Annual Report, 2016. Available at: www.hpc-uk.org/assets/documents/100051F3Fitnesstopractiseannualreport2016.pdf [Accessed 19 January 2018].
6. Risavi BL, Buzzard E, Heile CJ. Analysis of complaints in a rural emergency medical service system. Prehosp Disaster Med 2013;28:184-6.
7. Colwell CB, Pons PT, Pi R. Complaints against an EMS system. J Emerg Med 2003;25:403-8.
8. van der Gaag A, Gallagher A, Zasada M, et al. People like us? Understanding complaints about paramedics and social workers: Final Report. 31 August 2017. Available at: www.hcpc-uk.org/assets/documents/1000558EPeoplelikeusFinalReport.pdf [Accessed 19 January 2018].
9. Devenish A. Experiences in becoming a paramedic: a qualitative study examining the professional socialisation of university qualified paramedics [PhD thesis]. Queensland University of Technology, 2014. Available at: https://eprints.qut.edu.au/78442/1/Anthony_Devenish_Thesis.pdf [Accessed 19 January 2018].
10. Lovegrove M, Davis J. Paramedic Evidence Based Education Project, 2013. Available at: www.hee.nhs.uk/PEEP-Report.pdf [Accessed 19 January 2018].
11. Campeau AG. The space-control theory of paramedic scene-management. Symbolic Interaction 2008;31(3). Available at: http://dx.doi.org/10.1525/si.2008.31.3.285
12. McCann L, Granter E, Hyde P, Hassard J. Still blue-collar after all these years? An ethnography of the professionalization of emergency ambulance work. Journal of Management Studies 2013;50:750-76.
13. Bevan G, Hood C. Have targets improved performance in the English NHS? BMJ 2006;332:419. Available at: https://doi.org/10.1136/bmj.332.7538.419
14. Newdick C. From Hippocrates to commodities: three models of NHS governance: NHS governance, regulation, Mid Staffordshire Inquiry, health care as a commodity. Med Law Rev 2014;22:162-79.
15. Aasa U, Kalezic N, Lyskov E, Angquist KA, Barnekow-Bergkvist M. Stress monitoring of ambulance personnel during work and leisure. Int Arch Occup Environ Health 2006;80:51-9. Available at: https://doi.org/10.1007/s00420-006-0103-x
16. Brady M. UK ambulance service complaints: a review of the literature. Int J Emerg Serv 2017;6:104-21. Available at: https://doi.org/10.1108/IJES-12-2016-0025
17. Donaldson L. An organisation with a memory. Department of Health Expert Group. 2000. Available at: http://webarchive.nationalarchives.gov.uk/+tf_/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4065083 [Accessed 19 January 2018].
18. Laming WH. The Victoria Climbie Inquiry: report of an inquiry by Lord Laming. 2003. Available at: https://www.gov.uk/government/publications/the-victoria-climbieinquiry-report-of-an-inquiry-by-lord-laming [Accessed 19 January 2018].
19. Haringey Serious Case Review, 2008. Available at: www.gov.uk/government/publications/haringey-local-safeguarding-children-board-first-serious-case-review-child-a [Accessed 19 January 2018].
20. Francis R. The Mid Staffordshire NHS Foundation Trust Inquiry. Robert Francis Inquiry report into Mid-Staffordshire NHS Foundation Trust. 2010. Available at: http://webarchive.nationalarchives.gov.uk/20130104234315/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113018 [Accessed 19 January 2018].
21. Clwyd A, Hart T. A review of the NHS hospitals complaints system putting patients back in the picture. 2013. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf [Accessed 19 January 2018].

References (continued)

22. Professional Standards Authority. Rethinking regulation. 2015. Available at: www.professionalstandards.org.uk/docs/defaultsource/publications/thought-paper/rethinking-regulation-2015.pdf [Accessed 19 January 2018].
23. Professional Standards Authority. Right-touch reform. A new framework for assurance of professions. 2017. Available at: www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-reform-2017.pdf?sfvrsn=5 [Accessed 19 January 2018].
24. Norris N. Error, bias and validity in qualitative research. Educ Action Res 1997;5:172-6.
25. Noble H, Smith J. Issues of validity and reliability in qualitative research. Evid Based Nurs 2015;18:34-5.
26. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol 2006;3:77-101. Available at: http://eprints.uwe.ac.uk/11735 [Accessed 19 January 2018].
27. Hutchison JS. Scandals in health-care: their impact on health policy and nursing. Nurs Inq 2016;23:32-41. Available at: http://dx.doi.org/10.1111/nin.12115
28. Northern Ireland Social Care Council. The annual report and accounts of the Northern Ireland Social Care Council 2015/16. 2016. Available at: https://niscc.info/storage/resources/20160926_job102900_nisccannualreport_highres.pdf [Accessed 19 January 2018].
29. Archer J, Regan de Bere S, Bryce M, et al. Understanding the rise in fitness to practice complaints from members of the public. Plymouth University. 2014. Available at: www.gmcuk.org/static/documents/content/Archer_et_al_FTP_Final_Report_30_01_2014.pdf [Accessed 19 January 2018].
30. McCann L, Granter E, Hassard J, Hyde P. Where next for the paramedic profession? An ethnography of work culture and occupational identity. Emerg Med J 2015;32:e6-7.
31. van der Ploeg E, Kleber RJ. Acute and chronic job stressors among ambulance personnel: predictors of health symptoms. Occup Environ Med 2003;60(Suppl 1):i40-6.
32. Lewis D. Bullying and harassment at South East Coast Ambulance NHS Foundation Trust: an independent report. 2017. Available at: www.secamb.nhs.uk/about_us/news/2017/bullying_and_harassment.aspx [Accessed 19 January 2018].
33. Cooper S. Contemporary UK paramedical training and education. How do we train? How should we educate? Emerg Med J 2005;22:375-9.
34. Wald HS. Professional identity (trans)formation in medical education: reflection, relationship, resilience. Acad Med 2015;90:701-6. Available at: http://journals.lww.com/academicmedicine/Fulltext/2015/06000/Professional_Identity__Trans_Formation_in _Medical.8.aspx [Accessed 19 January 2018].
35. Frith-Cozens J. Effects of gender on performance in medicine. BMJ 2008;336:731-2.
36. Studdert D, Bismark M, Mello M, Singh H, Spittal M. Prevalence and characteristics of physicians prone to malpractice claims. N Engl J Med 2016;374:354-62.
37. General Social Care Council. Guidance on professional boundaries. 2012. Available at: http://docs.scie-socialcareonline.org.uk/fulltext/122181.pdf [Accessed 19 January 2018].
38. Bigham BL, Buick JE, Brooks SC, Morrison M, Shojania KG, Morrison LJ. Patient safety in emergency medical services: a systematic review of the literature. Prehosp Emerg Care 2012;16:20-35. 39. Victor B, Cullen JB. A theory and measure of ethical climate in organisations. Research in Corporate Social Performance and Policy 1987;9:51-71.
40. Pauly B, Varcoe C, Storch J. Registered nurses' perceptions of moral distress and ethical climate. Nurs Ethics 2009;15:561-73. Available at: http://journals.sagepub.com/doi/pdf/10.1177/0969733009106649
41. West M, Dawson J. Employee engagement and NHS performance. 2012. Available at: www.kingsfund.org.uk/leadershipreview [Accessed 19 January 2018].
42. West MA, Lyubovnikova J, Eckert R, Denis JL. Collective leadership for cultures of high quality health care. Journal of Organizational Effectiveness: People and Performance 2014;1:240-60.