The regulator's role in professional identity: validator not creator

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professional standards authority

About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care[1] promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation.[2] We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

We are committed to being independent, impartial, fair, accessible and consistent. More information about our work and the approach we take is available at www.professionalstandards.org.uk.

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1 The Professional Standards Authority for Health and Social Care was previously known as the Council for Healthcare Regulatory Excellence

2 The Professional Standards Authority. 2015. *Right-touch regulation – revised* [Online] Available at: http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation [Accessed: 09/10/2017]

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1. Introduction

1.1 The Professional Standards Authority seeks to understand all possible factors which affect a health and care practitioner's practice and behaviour. This will help to situate the position a regulator or voluntary register is in ensuring safe practice. One influence on a health and care practitioner's practice is professional identity. A useful means to understand professional identity is the following definition: the 'relatively stable and enduring constellation of attributes, values, motives, and experiences in terms of which people define themselves in a professional role'.[3] The benefits of identity have been noted by commentators, for example the formation of identity can be an 'internal compass' to regulate practitioners' work and strong identity can mitigate 'burnout' in some professionals.[4,5]

1.2 Over the course of this project, we have explored the many influences which develop and threaten professional identity and how regulation intertwines with identity. In *Regulation rethought* we noted that regulation at the national level can be a 'blunt instrument' for mitigating risks of harm because regulators are distant from the risks that they seek to manage.[6] Our research with practitioners and literature review have shed light on the nature and level of influence a distant regulator or register can have over practitioners' professional identities. In our annual report, we also noted that the topic is 'pertinent to many of the current discussions about both the possible merging of regulators and the development of new groups of practitioners in healthcare'.[7]

1.3 This paper draws together the conclusions of our literature review and a study of health and care practitioners' views. It highlights the more significant findings, and discusses insights from the research of interest to professional regulators and other organisations. Whilst our work has filled a significant gap in the literature on the subject of identity and regulation, it has also revealed areas worthy of further exploration. This paper lists and discusses those potential

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[3] Herminia Ibarra, 1999, *Provisional Selves: Experimenting with Image and Identity in Professional Adaptation,.* Administrative Science Quarterly, pp. 764-5. Available at: http://web.mit.edu/curhan/www/docs/Articles/15341_Readings/Selfpresentation_Impression_Formation/Ibarra_1999_Provisional_selves.pdf [Accessed 09/10/2017]

[4] Hedy S. Weld, 2015, *Professional Identity (Trans)Formation in Medical Education: Reflection, Relationship, Resilience*, Association of American Medical Colleges, pp. 701-2. Available at: http://journals.lww.com/academicmedicine/Fulltext/2015/06000/Professional_Identity__Trans_Formation_in_Medical.8.aspx [Accessed 01/08/2016]

[5] Lynn V Monrouxe, Alison Bullock, Hsu-Min Tseng, Stephanie E Wells, 2017, *Association of professional identity, gender, team understanding, anxiety and workplace learning alignment with burnout in junior doctors: a longitudinal cohort study*, British Medical Journal, pg. 10. Available at: http://bmjopen.bmj.com/content/bmjopen/7/12/e017942.full.pdf [Accessed 10/01/2018]

[6] Professional Standards Authority, 2016, *Regulation rethought*, pg. 3. Available at: www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/regulation-rethought.pdf?sfvrsn=14 [Accessed 19/05/2017]

[7] Professional Standards Authority, 2017, *Review of Professional Regulation and Registration with Annual Report and Accounts 2016/2017*, pg. 44. Available at: www.professionalstandards.org.uk/docs/default-source/publications/annual-reports/professional-standards-authority-review-of-professional-regulation-amp-registration(annual-report-amp-accounts-english).pdf?sfvrsn=10 [Accessed 15/08/2017]

avenues for future research. In this paper we use the term 'register-holder' to refer to a body holding a register of approved practitioners – this applies to statutory regulators and voluntary registers.

Methodology

1.4 The first part of our research was a literature review which gathered commentary on and analysis of professional identity. We searched widely and collated academic, policy papers and grey literature to develop a literature review which charted the influences affecting professional identity, and the position of regulation amongst these influences.[8] We identified many influences which had a greater or more direct impact on identity than professional regulation, such as:

- Rapport with patients and the work environment
- Media and wider society
- Training and education
- Skills of the trade
- Uniforms.

1.5 Another key finding of the literature review was that regulation primarily affects professional identity in a crisis or in out-of-the-ordinary circumstances but has less of an impact on a daily basis. As well as explaining regulation's role in the formation and maintenance of professional identity, the review suggested that there was little literature analysing professionals' views of regulation and identity. It is of note that we also found little information in relation to system regulation.

1.6 To help fill this gap in the literature, we commissioned Simon Christmas and Alan Cribb to conduct and analyse in-depth interviews with UK health and care practitioners.[9] The subject of professional identity has been explored with health and care practitioners, however our literature review revealed that research is heavily focused on medicine and nursing. It has even been noted that 'the field of medicine has been referred to as the very embodiment of the concept of professional identity; to be a physician is one of the most explicit examples, both historically and currently, of a professional identity'.[10] Christmas and Cribb echo this, explaining that there is a 'long history of doctors being treated as the archetypal health care professions, and nurses as the archetypal 'other''.[11] Beyond doctors and nurses there are many other roles in the UK health and care

[8] Professional Standards Authority, 2016, *Professional identities and regulation: a Literature Review*. Available at: www.professionalstandards.org.uk/docs/default-source/publications/professional-identities-and-regulation---a-literature-review.pdf?sfvrsn=0 [Accessed 19/05/2017]

[9] Simon Christmas and Alan Cribb, 2017, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, Professionals Standards Authority. Available at: www.professionalstandards.org.uk/docs/default-source/publications/research-paper/regulation-and-professional-identity-july-2017-final.pdf?sfvrsn=8 [Accessed 19/05/2017]

[10] Kristina Sundberg, Anna Josephson, Scott Reeves and Jonas Nordquist, 2017, *May I see your ID, please? An explorative study of the professional identity of undergraduate medical education leaders*, BMC Medical Education, pg. 1. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5286680/pdf/12909_2017_Article_860.pdf [Accessed 15/08/2017]

[11] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg. 9.

sector, such as the 16 professions regulated by the Health and Care Professions Council (HCPC), and the more than 50 roles covered by our Accredited Register programme.[12,13]

1.7 A guiding principle for how the study was designed and conducted was 'depth, not breadth'. Analysing hour-long telephone interviews with each of the 16 participants, Christmas and Cribb were able to delve deeply into the complex subject of professional identity. Within that sample there was a range of regulatory arrangements, covering statutorily regulated professions, voluntarily registered groups with an accredited register, and voluntarily registered groups with a register not accredited with the Authority.

Table 1: Christmas and Cribb's participant groups and their corresponding regulatory oversight

Practitioners	Regulatory oversight in the UK
Pharmacists	Statutorily regulated by the General Pharmaceutical Council (GPhC) and the Pharmaceutical Society of Northern Ireland (PSNI)
Physiotherapists	Statutorily regulated by the HCPC
Psychotherapists	Not statutorily regulated. Study participants are from two voluntary registers which are both accredited by the Professional Standards Authority: British Association for Counselling and Psychotherapy (BACP) and UK Council for Psychotherapy (UKCP)
Acupuncturists	Not statutorily regulated. Study participants are from an accredited register, British Acupuncture Council, and a voluntary register not accredited by the Authority: Association of Traditional Chinese Medicine

1.8 The participants worked in a range of environments, from multidisciplinary settings to their own private clinics. Participants were drawn from the four UK countries and there was diversity in age, gender and tenure.

1.9 Some of the key findings of Christmas and Cribb's research include:

- Patient care was seen by participants as benefiting from a strong professional identity

[12] The HCPC regulates 16 professions: arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, social workers in England, and speech and language therapists.

[13] Professional Standards Authority, 2017, *Review of Professional Regulation and Registration with Annual Report and Accounts 2016/2017*, pg. 8. Available at: www.professionalstandards.org.uk/docs/default-source/publications/annual-reports/professional-standards-authority-review-of-professional-regulation-amp-registration(annual-report-amp-accounts-english).pdf?sfvrsn=10 [Accessed 15/08/2017]

- Initial registration requirements play a role in individual practice and identity
- An individual practitioner can validate their professional identity through identity alignment with a wider community of like-minded practitioners via a register
- Although not the primary purpose of regulation, regulated practitioners may receive societal benefits from statutory regulation, and in particular from protected titles.

1.10 Christmas and Cribb's conclusions are useful and add significantly to the literature, however we caution readers against coming to generalisations about the wider UK workforce. Understanding how regulation affects professionals is a difficult endeavour, Oliver Quick came to this conclusion in research he conducted for us in 2011. He also noted that research into the impacts of regulation can be made more difficult by the 'messy interaction' of different regulatory influences.[14] Christmas and Cribb's small sample size makes extrapolation to the wider health and care workforce difficult.[15] Additionally, participants in the study came from four different occupations. Quick cautions against making generalisations about multiple professions capture a 'number of different professions with different cultures and systems of regulation'.[16] Although Christmas and Cribb's work cannot be said to be conclusive about what is typical or atypical of healthcare practitioners from different occupations and environments, nevertheless the findings are steps forwards in understanding the issues of regulation and identity.

Objectives and structure of this paper

1.11 This paper is orientated around both the findings of Christmas and Cribb's research and our literature review. It situates their findings in a regulatory context, to understand how regulatory functions are intertwined (if at all) with identity. To make sense of the findings, this paper also uses additional desk research from other sources. The references used in this paper primarily consist of academic research from journals. This academic research we make reference to is mostly qualitative. In addition, we have used a small number of quotations from grey literature such as media articles from *The Guardian* and guidance from regulators. As above, we caution against assumptions being made about typical or atypical practitioners from the evidence we have gathered. Evidence we have gathered, such as the male nurse talking to the *Nursing Times* about societal perceptions of himself, is meant to illuminate potential issues of identity and is not an attempt capture the views of all practitioners.

1.12 As in the literature review, this paper pays attention to non-regulatory factors affecting professional identity, to help locate the relative importance of regulatory

[14] Oliver Quick, 2011, *A scoping study on the effects of health professional regulation on those regulated*, Council for Healthcare Regulatory Excellence, pg. 5. Available at: www.professionalstandards.org.uk/docs/default-source/publications/research-paper/study-on-the-effects-of-health-professional-regulation-on-those-regulated-2011.pdf [Accessed 11/01/2018]

[15] To put the sample size in perspective, there are over a million healthcare professionals over 80,000 healthcare practitioners on accredited registers in the UK.

[16] Oliver Quick, 2011, *A scoping study on the effects of health professional regulation on those regulated*, Council for Healthcare Regulatory Excellence, pg. 6.

influences on identity. The context of non-regulatory factors can enable professional regulators to contextualise their role in practitioners' professional identity. The findings within the paper will be used to complement our policy positions on the subject of identity and status in regulation.

1.13 Throughout the paper, we link our findings on identity with the latest regulatory thinking such as preventative regulation and reflective spaces, where appropriate. The scope of the paper is wide and there may be learning for non-regulatory organisations. In general though, we have limited analysis of findings about what is relevant to statutory professional regulators, but there are many discussion points related to voluntary registers throughout the paper.

2. Becoming a practitioner

Motivations

2.1 A key means to understanding healthcare practitioners' professional identity is understanding why an individual wants to become a healthcare practitioner in the first place. Christmas and Cribb's study pinpoints 'a fundamental commitment to help' as a 'defining feature of all professional identities in healthcare'. One pharmacist echoed this by saying: 'At the core of what I wanted to do was basically just to help people…' Similarly, a physiotherapist wanted 'to change people's lives… and make them better… to live a more independent life'. Christmas and Cribb see this fundamental commitment to care being supported by another component of professional identity: the 'professional stance'. The stance is more than just the 'mere aggregation of knowledge and skills', but is in fact 'an underpinning, coherent way of understanding and intervening in the world' in which a practitioner practises. The commitment to help and professional stance interact in different ways, depending on the individual and other factors. One example of this is where an acupuncturist applied a professional stance 'in service' of a commitment to help: 'I think I just wanted to be in healthcare, maybe not in Chinese medicine, maybe just in Western medicine, but I think I always had this idea since childhood and I think my parents influenced that'.[17]

2.2 There are other motivations, apart from care, which direct individuals into a field of practice. Christmas and Cribb describe how one interviewee moved from practising reflexology to acupuncture because they wanted 'something more cerebral…academic…that had more learning'. Christmas and Cribb consider that the interviewee's transition came about because of a need for a professional stance underpinning the commitment to care.[18] Our literature review also found that 'pre-career life experience' can be a motivation for joining a field of practice. [19] One Irish social worker suggested that personal values they gained from working in the disability field explained why they became a social worker: 'I did work experience in the disability area. I just found myself liking the job and liking the care and wanting to do more, to make a contribution'.[20]

2.3 Professional regulators are not direct influencers on practitioners' commitment to help or the professional stance, but can have an indirect influence. The commitment to help can be nurtured in the environments in which practitioners

[17] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pp. 13-14.
[18] Ibid, Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pp. 15.
[19] Professional Standards Authority, 2016, *Professional identities and regulation: a Literature Review*, pg. 11. Available at: www.professionalstandards.org.uk/docs/default-source/publications/professional-identities-and-regulation---a-literature-review.pdf?sfvrsn=0 [Accessed 19/05/2017]
[20] Karen Christine Finnerty, 2012, *Professional Identity and the Irish Social Care Worker*, University of Leicester, pg. 127 [Online]. Available at: https://lra.le.ac.uk/bitstream/2381/10922/1/2012finnertykcdsocsci.pdf.pdf [Accessed 01/08/2017]

train and practise, and these environments are influenced by regulators – whether it be by quality assurance of educational institutions or system regulatory requirements in the workplace. Similarly, the professional stance is indirectly shaped by regulators as they set standards, impose requirements for ongoing registration and quality assure education institutions. If a regulator can act to better channel the fundamental commitment to care and enable the creation of a professional stance which works for all practitioners, then patients will benefit.

Education and training

2.4 Our literature review found that education was key in shaping professional identity: as well as understanding what is expected of them, individuals learning and training to be unsupervised, qualified practitioners are exposed to professional norms and values which they must study and internalise.[21] In Christmas and Cribb's research, participants recognised that regulators can have a role in this important area. One pharmacist observed that the General Pharmaceutical Council (GPhC) had a large role in standardising education and ensuring that new pharmacists practised in a uniform manner:

> *'Our regulatory authorities control what we study, so at the university, so we all do the same things and we all have to go through the same processes. And that's important that I can turn around and say to a colleague, can you go and talk to this patient because the such-and-such while I do something else, and I know they're going to get the same standard of care as if I went out, and vice versa. I think there's a lot of trust because of the GPhC and because of, you know, the way we're trained… We don't need to prove anything to anyone else. The proof's in the pudding. The proof's in your number. And that's very important to all of us.'*[22]

2.5 The quotation above shows that the GPhC's statutory responsibility for education quality assurance can affect the development of a community of practice amongst pharmacists. A community of practice is where an individual practitioner is able to 'trust that the professional identities of others on a register – along with the standards for individual practice which follow from those identities – are, in certain key respects, the same as one's own…'.[23] When the pharmacist above (Pharmacist D) considered what would happen if the GPhC was not involved in quality assurance of education, they suggested the community of practice would be weakened:

> *'Well if there was no, you know, regulating authority, and somebody went to study and didn't go to the same university as I did, or didn't go through the same process as I did, I wouldn't be able to have full confidence that they had the same, you know, examinations that I went through. So you'd lose*

[21] Professional Standards Authority, 2016, *Professional identities and regulation: a Literature Review*, pp. 7-8. Available at: www.professionalstandards.org.uk/docs/default-source/publications/professional-identities-and-regulation---a-literature-review.pdf?sfvrsn=0 [Accessed 19/05/2017]

[22] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg. 33.

[23] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pp. 5-6.

your confidence and you'd be second-guessing everyone else. And the fact that you're held to the same standards suggests that, you know, you don't have to question anyone else or, you know, think what they're doing, because someone else is looking after that for you.'[24]

2.6 This quotation suggests that the GPhC has control of what Christmas and Cribb call 'access requirements'. Regulatory requirements to practise can be split into two broad categories: access and practice requirements. Access requirements need to be fulfilled for an individual to become registered by a register-holder (eg. training), whilst practice requirements need to be fulfilled on a day-to-day basis in order to remain on the register (eg. compliance to standards).[25] The quotation from Pharmacist D suggests that the GPhC has a role in ensuring its registrants go through the same processes of internalising the values and norms required to develop a professional identity and be on a register. This could be seen as an indirect influence on professional identity. The more direct influencers on identity, as our literature review explained, are the patients, educators, mentors and colleagues that students interact with whilst training.[26]

2.7 Undergoing or completing a training or education qualification does not necessarily mean that an individual enters a community of practice or defines themselves by what they trained in. Physiotherapists and other health practitioners may complete courses in acupuncture to accompany their main domain of practice. One acupuncturist interviewed by Christmas and Cribb highlighted the challenges this can create: 'They do a one or two-day course… they call themselves acupuncturists, but they never, you know, understood the theory behind it'. This 'co-option' of acupuncture skills without the professional stance of a traditional acupuncturist does not mean an individual has gained an acupuncturist's professional identity. It seems that identity cannot simply be gained by completing a training course either, it is dependent on elements of a training course that contribute to the development of a professional stance. These elements could be, but are not limited to the course length and depth, and who practitioners spend training time with. Relatedly, a physiotherapist using acupuncture techniques believed that she could not call herself an acupuncturist, but instead described herself as 'a physiotherapist who uses acupuncture'. She went on to say that she thought that only those who have an acupuncture degree could describe themselves as acupuncturists, because as a physiotherapist she was using it to 'augment' her own physiotherapy practice.[27]

2.8 It is worth noting that professional identity may not just be held by an individual practitioner or across a profession, it could also be held across a team.

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[24] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg. 29.

[25] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg. 12.

[26] Professional Standards Authority, 2016, *Professional identities and regulation: a Literature Review*, pp. 7-8. Available at: www.professionalstandards.org.uk/docs/default-source/publications/professional-identities-and-regulation---a-literature-review.pdf?sfvrsn=0 [Accessed 19/05/2017]

[27] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, Professionals Standards Authority, pp. 39-40.

Healthcare is often provided in teams and later in this paper we discuss interprofessional team working's effects on identities. Education curricula can be of help to inculcate better team working and foster a team identity. Morison, Marley and Machniewski noted that in relation to dentistry, education curricula should be designed to 'facilitate the development of a team identity'.[28]

2.9 The achievement of an educational qualification has significance for professional identity and status. Christmas and Cribb found that achievement in education can also invoke pride in practitioners as it can acknowledge the hard work a practitioner has undergone. One psychotherapist considered: 'there is something about being recognised as having achieved a certain level of education'; whilst a physiotherapist explained that they had 'invested a lot of training and education and a lot of personal… you know, it's my life's work, in a sense'.[29] Among Christmas and Cribb's participants, the need for hard work to be acknowledged was most emphasised by Physiotherapist B. They described their initial irritation at being mistaken for a massage therapist:

> *'Lots of people say, I went to see my physio, and they're a massage therapist. And I feel a prickle. You know, I feel an immediate prickle at the back of my neck and think: they're not a physiotherapist actually. You know, I feel that. And I think: well, why do you? […] You can do a two-week massage course, be a massage therapist, and people think that that's the same as a physio. […] I've had to kill myself in a medical school and work in a hospital and do shifts and help, you know, suction, and people in respiratory, and you know, help people with strokes, and have the stress. It's mostly to do with the stress and the pain and the fear when you're a respiratory physio and you're a junior and you think: oh, I have no idea what I'm doing here, please don't let anybody die, or please don't let anybody fall over, or please don't let anybody's catheter fall out, or any of the medical scary stuff that can happen. That, if you're a sport massage therapist, is never going to happen to you. So it's almost like you've put your time in to earn that title…'.*[30]

2.10 The physiotherapist did though explain that their initial irritation passed as they 'let the prickle go'. The physiotherapist felt that the change came about as they considered a massage therapist may 'get people better' and that they were 'not the moral guardian of the world to judge' a massage therapist.

2.11 Research we commissioned into dishonesty found that professionals believed educational qualifications had been 'hard-earned over years of study and were absolutely central to the professionals' identity and sense of self'. Therefore, when educational qualifications are falsified it strikes at the 'heart of what it

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[28] S. Morison, J. Marley and S. Machniewski, 2011, *Educating the dental team: exploring perceptions of roles and identities*, British Dental Journal, pg. 482. Available at: www.nature.com/bdj/journal/v211/n10/pdf/sj.bdj.2011.963.pdf [Accessed 31/10/2017]

[29] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, Professionals Standards Authority, pg. 41.

[30] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, Professionals Standards Authority, pg. 41

means to be professional and public confidence in the professions'.[31] This chimes with Christmas and Cribb, who point out that although it is not the primary purpose of regulation to acknowledge hard work, registration does 'de facto acknowledge' effort required to develop a professional stance.[32]

2.12 A qualification can have significance for identity for other reasons: our literature review found that oral and maxillofacial surgery (OMFS) professionals believed their qualification could act as a guard against shifting role boundaries. An OMFS professional (in an interview quoted in our literature review) argued that the requirement of dual qualification made them 'unique' and was a means for protecting their role against boundary overlap by other specialities 'trying to get their foot in'.[33]

In summary

2.13 It appears that prior to qualification and independent practice a practitioner is developing a professional identity. A fundamental commitment to care and values gained from roles prior to practising a healthcare vocation can offer an explanation as to why an individual may have joined a specific area of practice. This is important as healthcare work channels this initial motivation: upholding a regulator's standards should help practitioners translate their fundamental commitment to care into help for a patient. Education and training provide situations in which practitioners can develop a professional stance to accompany the fundamental commitment to care. Furthermore, as regulators' standards drive the content for qualifying courses, individuals in the education and training phase are learning the standards that they will be expected to abide by once they qualify.

2.14 We have also seen that statutory regulators can have an indirect effect on identity as they shape education through their role of quality assurance of education institutions. Much of what practitioners learn in the education and training phase of their careers underpins the professional stance which registrants will use later in their careers. The regulator is distant from individuals learning to practice at this point of their career. However, in order to gain full professional identity, an individual needs to practise and in order to practise an individual needs to comply with a regulator's access requirements for registration.

[31] Policis, 2016, *Dishonest behaviour by health and care professionals: Exploring the views of the general public and professionals*, Professional Standards Authority, pg. 26. Available at: www.professionalstandards.org.uk/docs/default-source/publications/research-paper/dishonest-behaviour-by-hcp-research.pdf?sfvrsn=34 [Accessed 19/10/2017]
[32] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, Professionals Standards Authority, pg. 42.
[33] Professional Standards Authority, 2016, *Professional identities and regulation: a Literature Review*, pg. 7. Available at: www.professionalstandards.org.uk/docs/default-source/publications/professional-identities-and-regulation---a-literature-review.pdf?sfvrsn=0 [Accessed 19/05/2017]

3. Deploying skills as a practitioner

Standards, codes and guidance (practice requirements)

3.1 Once an individual has qualified to practise and entered on a register they must comply with the register holder's standards, codes and guidance for conduct and competence. These are what Christmas and Cribb term 'practice requirements'. Christmas and Cribb found that if a participant was in a situation when it was not immediately clear how to act, he or she normally sought advice from colleagues, supervisors/superintendents, managers and helplines provided by employers and training bodies. In only a 'few, very serious instances' did participants contact a register-holder: one psychotherapist mentioned they emailed the UK Council for Psychotherapy (UKCP) to ensure their approach to a situation 'made sense' and considered the correspondence as a 'sort of belt and braces'.[34] That in itself practitioners do not normally go to register-holders for advice is interesting and ties with chapter 5 of this paper where we will see how the workplace environment holds a strong influence over practitioners.

3.2 In more everyday situations, there was little evidence of practitioners explicitly consulting regulators' standards. A psychotherapist considered that to hold all of the standards and guidance at 'the forefront of your mind is impossible…so you hold the spirit of it'. Similarly a pharmacist described their standards as a 'blueprint'. Two pharmacists considered many regulatory standards to be obvious and not needing constant checking as they were doing them anyway: 'a lot of them [standards] are… what you'd expect of yourself anyhow' and 'they [GPhC] want us to follow a certain amount of protocol, but that's a natural thing we'd do anyway'. A physiotherapist suggested that there was a higher chance of a practitioner knowing what was in the standards booklet if they were newly qualified. This suggests that in practice, the HCPC's standards play a more direct role immediately after the training phase of a physiotherapist's career than when they have been practising for a while.[35] The regulator's distance from the daily events of a practitioner is echoed in research we commissioned by Oliver Quick. This found that professionals' daily behaviour is shaped by a variety of influences and professional regulation is not a major influence on decisions in the everyday lives of practitioners.[36]

3.3 The findings above chime with our literature review in which we concluded that the effects of regulation on professional identity on a daily basis are small.[37] The

[34] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg. 24.

[35] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg. 24.

[36] Professional Standards Authority, 2013, *Candour, disclosure and openness: Learning from academic research to support advice to the Secretary of State*, pp. 1-2. Available at: www.professionalstandards.org.uk/docs/default-source/publications/research-paper/candour-research-paper-2013.pdf?sfvrsn=8 [Accessed 11/11/2017]

[37] Professional Standards Authority, 2016, *Professional identities and regulation: a Literature Review*, pg. 21. Available at: www.professionalstandards.org.uk/docs/default-source/publications/professional-identities-and-regulation---a-literature-review.pdf?sfvrsn=0 [Accessed 11/11/2017]

findings also demonstrate that some practitioners view much of a register's standards and guidance to be a mirror of how they are practising already, with minimal consideration of standards and guidance by practitioners in how they act.

3.4 Among Christmas and Cribb's participants there were some advocates (albeit in the minority) of the explicit checking of standards and guidance in day-to-day practice. One physiotherapist described the HCPC's 'guidelines' as serving the purpose of improving patient safety, practitioner performance and outcomes.[38] This positive view is shared by participants in the General Osteopathic Council's (GOsC) research where it was apparent that some osteopaths viewed the GOsC's standards as a 'useful benchmark'. The authors of the research also found that standards can be used by osteopaths as a means for invoking 'a higher professional authority to counter demands from non-osteopaths to cut corners or lower the quality of care they provided'.[39]

3.5 There may also be a gap between how a practitioner practises and a regulator's standards. This is critical for identity as the activities of a practitioner are a major contributing factor to professional identity. For example, the act of carrying out airway management[40] can contribute to a UK paramedic's professional identity.[41] One physiotherapist explained to Christmas and Cribb that regulatory standards 'have to be grey to be all-encompassing' as a regulator cannot think of 'all the possible things'. There are areas of practice where regulators cannot set specific standards, a pharmacist explained:

> *'Sometimes we have two opposing guidelines and it's up to each pharmacist to, you know, use their own professional standards or how they see fit to approach issues. I mean, as long as you weren't being negligent. As long as you didn't just do something for the sake of it or because it was easier for you to do. If you can prove in some way that actually I was trying to make sure that that patient was going to be all right, and you didn't want them, you know, going through the weekend in pain, or with a chance of having a heart attack or a stroke or something worse, I think it's always admirable and I don't think… Yes. The regulatory body would not look down*

[38] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg. 25.

[39] Gerry McGivern, Michael Fischer, Tomas Palaima, Zoey Spendlove, Dr Oliver Thomson and Professor Justin Waring, 2015, *Exploring and explaining the dynamics of osteopathic regulation, professionalism, and compliance with standards in practice*, General Osteopathic Council, pp. 52-4. Available at: http://wrap.warwick.ac.uk/78927/1/WRAP_dynamics-of-osteopathic-regulation-final-report.pdf [Accessed 01/10/2017]

[40] Airway management refers to the actions of a health practitioner to provide a patient with an artificial airway.

[41] Janet Brandling, Megan Rhys, Matthew Thomas, Sarah Voss, Sian Emma Davies and Jonathan Benge, 2016, *An exploration of the views of paramedics regarding airway management*, Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine, pg. 6. Available at: http://eprints.uwe.ac.uk/29399/1/An%20exploration%20of%20the%20views%20of%20paramedics%20regarding%20airway%20management.pdf [Accessed 22/06/17]

on that or say you did the wrong thing. Because sometimes there is no right and wrong answer'.[42]

3.6 This segment suggests that the practice of a practitioner is not generally influenced by regulation as there may be no specific standard to guide the pharmacist in certain situations. However, the penultimate sentence indicates that regulation can indirectly influence the pharmacist as they judge their actions from the perspective of a regulator. Additionally, the line that there is 'no right and wrong answer' shows that a regulator may expect to see gaps between its own standards and practice because the register-holder's standards cannot cater for all situations.[43] This line has added significance, which we will see in chapter 4, because a register-holder must make decisions to remove people from its register and therefore the practitioner community. Regulators' distance from the risks they seek to manage makes judging what is right and wrong more difficult.[44]

3.7 Alongside compliance with standards and guidance, practitioners must meet ongoing fitness to practise requirements for renewal of registration – these vary across the nine professional regulators. This often involves Continuing Professional Development (CPD), which requires registrants to learn throughout their careers in order to keep their skills up-to-date. A pharmacist commented that the exercise of CPD had merit but that undertaking the task was onerous, relegating it to a 'tick-box exercise' at times: '…CPD is essential, but I think CPD, we carry out every day, so it's just a strenuous exercise'. Another pharmacist suggested the task was useful for progression in order to independently prescribe[45] but considered it a tick-box exercise because it was not demanding enough. However, other participants in the Christmas and Cribb research challenged the very motivation for CPD. A physiotherapist related how their colleagues believed note-taking tasks demanded by the regulator were 'pointless' and a 'paper exercise'. Another participant commented that register requirements can be disconnected from and even hinder carrying out their role:

> '*You can have a very, very good pharmacist, a pillar of the community, in the woods somewhere, who everybody is really happy with, but he can't do the paperwork. That's a problem. That's what our society is about. It's paperwork, paperwork, paperwork. If you can dot the Is and cross the Ts, you've got very good standards. If you can't do that, I'm afraid, you're rubbish. And it isn't true.'*[46]

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[42] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg. 32.

[43] Professional Standards Authority, 2016, *Regulation rethought*, pg. 3. Available at: www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/regulation-rethought.pdf?sfvrsn=14 [Accessed 19/05/2017]

[44] Part of a remedy for this is to solve more issues locally.

[45] Independent prescribing is prescribing of medicines 'by a practitioner responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing' (Dept. of Health, 2006).

[46] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pp. 24-26.

3.8 The theme of paperwork being a hindrance to practice is repeated in literature prior to Christmas and Cribb. For example, in previous research we commissioned, one member of the public argued that, 'If the government stopped giving them [practitioners] so much paperwork to do they'd have more time to spend with patients'.[47] If there is an abundance of paperwork which then constrains how much time a practitioner can devote to the health and care aspects of their role, then there is a chance practitioners will view regulators as encroaching on their identity.

3.9 Also, it is interesting to note that when the pharmacist above criticised the medium by which regulation is conducted (paperwork), they were focusing their criticism, not on the regulator, but on wider society. They perceived society to be the source of the mindset that values paperwork completion over actual practice. This is an interesting point for regulators: when developing standards, they must have regard to the norms of the society they operate in. Later in the report (chapter 5) we look at the effects of wider society on identity.

How do practice requirements shape a practitioner's relationship with a regulator?

3.10 Christmas and Cribb's participants displayed three different attitudes to meeting regulatory standards and CPD requirements:

1. *When register requirements are in line with one's own standards, then they are accepted as valid, and even valuable, but not actually seen as influencing one's practice, since "it's what you would expect of yourself anyhow".*

2. *When register requirements are **not** in line with the one's own standards, then they may change individual practice if actively enforced, but are dismissed as 'boxticking' or a 'paper exercise' – or even as 'damaging' – and questions may be raised about the practice and intent of the register-holder.*

3. *Alternatively, if the issue is that the register requirements fall short of the individual's own standards, they are likely to be seen as superficial, neither being accepted nor influencing practice.*

3.11 Christmas and Cribb caution that the participants were not complacent and did not think they had no room for development. In fact, all participants wanted to improve their practice. However, the participants did not generally consider regulatory resources to be something they would draw upon to improve practice.[48] As mentioned before, regulators are distant from those they regulate, which may be part of the reason why their resources are not drawn upon much by practitioners, who instead use the local resources of professional bodies,

[47] Research Works, 2009, *Safeguards in healthcare*, Council for Healthcare Regulatory Excellence, pg. 12. Available at: www.professionalstandards.org.uk/docs/default-source/publications/research-paper/safeguards-in-healthcare-2009.pdf [Accessed 15/08/2017]

[48] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg. 26.

employers and others. However, the distance of regulators from practitioners does not mean regulators do not have a role in improving resources practitioners use. Regulators are currently trying to be more preventative in how they regulate – this involves approaches by regulators to help prevent harm occurring. Regulators can use their insights from analysis of fitness to practise data and other intelligence to support employers and other local actors close to emerging and potentially harmful situations.[49] Regulators' expertise can also be used by training bodies and professional bodies, who may be closer to emerging harms.

3.12 The three attitudes in 3.10 show that practitioners align regulatory standards to their identities on their own terms. This chimes with Powell and Davies, who suggest that 'a key facet of professional identity for doctors is the desire to practise as autonomous individuals who retain personal control over how they define, sequence and evaluate their work'.[50] In a similar vein, other commentators have noted that the identities of professionals can be challenged by increasing external audit, control and management.[51,52] If a register requirement does not align to how a practitioner is defining, sequencing or evaluating their own work then it is not in accordance with their sense of identity. Local means of practice assessment may mean practitioners retain control of practice whilst adhering to national regulatory standards. One possible means for carrying this out is described in *Rethinking regulation*. There, we note that in the Netherlands there have been pilots of new methods of self-assessment where 'control of improvement is handed back to the professionals providing care, allowing personal ownership of change and local responsibility to trump a standardised approach'.[53] Similarly, McGivern et al's 'reflective spaces' also constitute a way of preventing small problems from becoming big ones: these are spaces away from the regulator where professionals can discuss professional issues and problems freely with each other without fear of recrimination, and enquire freely of each other about any areas of concern. These two innovations

[49] Professional Standards Authority, 2017, *Right-touch reform: A new framework for assurance of professions*, pg. 22. Available at: www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-reform-2017.pdf?sfvrsn=5 [Accessed 01/12/2017]

[50] Benjamin Saunders, Bernadette Bartlam, Nadine E. Foster, Jonathan C. Hill, Vince Cooper, and Joanne Protheroe, 2016, *General Practitioners' and patients' perceptions towards stratified care: a theory informed investigation*, BMC Family Practice, pg. 10. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC5007841/pdf/12875_2016_Article_511.pdf [Accessed 15/08/2017]

[51] John Sanfey and Sanjiv Ahluwalia, 2016, *Re-awakening professional identity: the path to a self-correcting NHS*, British Journal of General Practice, pg. 1. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC5198688/pdf/bjgpsep-2016-66-650-458.pdf [Accessed 15/08/2017]

[52] Marjo J M Maas, Maria W G Nijhuis-van der Sanden, Femke Driehuis, Yvonne F Heerkens, Cees P M van der Vleuten, Philip J van der Wees, 2017, *Feasibility of peer assessment and clinical audit to self-regulate the quality of physiotherapy services: a mixed methods study*, BMJ Open, pg. 1. Available at: http://bmjopen.bmj.com/content/bmjopen/7/2/e013726.full.pdf [Accessed 15/10/2017]

[53] Professional Standards Authority, 2015, *Rethinking regulation*, pg. 15. Available at: www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/rethinking-regulation-2015.pdf [Accessed 16/08/2017]

can potentially help professionals comply with standards as they retain control over resolving problems, which in turn aligns with their identity.[54]

Changing roles and new roles

3.13 We will talk about the merging of roles from the perspective of practitioners as individuals, but later in chapter 5 we discuss it from the perspective of the team and team identity.

3.14 In 3.5 we mentioned the contribution of airway management to paramedics' identities. Our literature review also identifies the contribution of enacting 'skills of the trade' to professional identity. We pointed towards Lefmann and Sheppard's analysis of how specific skills can differentiate physiotherapists from other professionals:

> *'The specific skills of musculoskeletal healthcare, which is 'a lesser priority for the doctors and nurses, yet a core competency for physiotherapy', helped physiotherapists gain a unique professional identity in a multi-disciplinary environment'*.[55]

3.15 The degree to which practitioners make use of their learnt skills in the workplace can change over time. This could be as a result of taking on a more managerial role, or the scope of practice evolving over time. The latter scenario is identified in our literature review, in the 'boundaries' section, where we observed that expanding roles can potentially either enhance the status of practitioner or cause a loss of identity.[56] This has received attention in the media. In an interview with the BBC earlier this year, an occupational therapist noted, 'Sometimes people can feel a bit frightened and threatened by change, especially when they worry about their professional identity and being asked to do new roles, but really, it's just about putting the patient at the heart of what we do'.[57] The identity of a practitioner may be changed when the content of a role is altered. One academic stated that many mental health nurses felt their role had been 'diluted' and had lost their nursing identity from working in multidisciplinary teams where they have taken on other roles, such as commissioning social care, in addition to their traditional nursing duties.[58] There are possible ramifications for regulators. For example, the advent of multidisciplinary roles could mean a change in standards expected of registrants, requiring a change in education and training curricula in order to prepare practitioners for the work environment. This could mean a change to how regulators quality assure educational institutions. Regulators may

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[54] Gerry McGivern, Michael Fischer, Tomas Palaima, Zoey Spendlove, Oliver Thomson and Justin Waring, 2015, *Exploring and explaining the dynamics of osteopathic regulation, professionalism and compliance with standards in practice*, General Osteopathic Council. Available at: http://wrap.warwick.ac.uk/78927/1/WRAP_dynamics-of-osteopathic-regulation-final-report.pdf [Accessed 16/10/2017]

[55] Professional Standards Authority, *Professional identities and regulation: a Literature Review*, pp. 8-9.

[56] Professional Standards Authority, *Professional identities and regulation: a Literature Review*, pp. 11-12.

[57] BBC, 2017, *The health service taking a holistic approach to patients*. Available at: www.bbc.co.uk/news/health-38911008 [Accessed 21/08/2017]

[58] Vickie Glass, 2017, Specialising in mental health, Nursing in Practice. Available at: www.nursinginpractice.com/article/specialising-mental-health [Accessed 21/08/2017]

also need to consider the impact of any changes to scopes of practice on continuing FtP requirements and FtP decisions: where once the scope of patient care was defined, now it can potentially be more fluid.

3.16 Another contemporary development in UK workforces is the introduction of new roles, such as nursing associates and physician associates. The development of a professional identity among practitioners in new roles could be a tool to help support professional development.[59] However, the introduction of these new roles could affect any existing similar roles. There is a view that identity should be a consideration when deciding on the appropriate level of assurance for such roles. In response to Health Education England's consultation on the introduction of nursing associates, some respondents suggested regulation would give 'professional credibility' to nursing associates.[60]

3.17 Changing roles and new roles can alter the identities of practitioners. This is important as Christmas and Cribb found that being on a register can help practitioners differentiate themselves from others, especially practitioners with protected titles.[61,62] If a role changed by altering a scope of practice which differentiated a role from others, then there could be a weakening of identity. One of the sources in our literature review, Kerry Musselbrook, specifically mentions the 'possible loss of professional identity' as an impediment to the introduction of new roles spanning health and social care.[63] Although practitioners may fear their identities may be affected, changes to roles and introductions of roles are primarily about improving patient care (as the occupational therapist in 3.15 discusses).

In summary

3.18 The analysis in this chapter indicates that professional regulation's influence over the identities of registered practitioners is minimal as regulators are distant from practice. Additionally, it appears that practitioners align regulatory standards to identity on their own terms. Registrants may also not perform their role with regulatory requirements at the forefront of their minds. When standards do have an influence on identity, it seems it is not usually in everyday situations. It is likely that standards play more of a role in practice early on in a career than later. This suggests a regulator's mark on a practitioner's identity through standards fades as a practitioner's career progresses. We also saw that there could be identity implications as a result of new or changing roles.

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[59] Hansard, 2017, Physician Associates: Written question – 66109. Available at: www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2017-03-01/66109/ [Accessed 02/11/2017]

[60] Professional Standards Authority, *Professional identities and regulation: a Literature Review*, pg. 15.

[61] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg. 42.

[62] A protected title is a role name that is protected by law. It is a criminal offence to use a protected title unless an individual is registered with the regulator overseeing those entitled to use that title.

[63] Professional Standards Authority, *Professional identities and regulation: a Literature Review*, pg. 12.

4. Being on the register and fitness to practise

The register as a validator of community identity

4.1 So far we have analysed the relationship between professional identity and regulation in relation to an individual's practice, but not the role of a collective group of practitioners in forming and maintaining identity. It has been argued that a 'key component' of professional identity is an individual being part of a common body of skills and knowledge.[64] In chapter 2 of this paper we mentioned briefly Christmas and Cribbs's idea of a community of practice and how this relates to registers. Christmas and Cribb consider that a community of practice is where an individual practitioner is able to:

> *'trust that the professional identities of others on a register – along with the standards for individual practice which follow from those identities – are, in certain key respects, the same as one's own…this sense of alignment with a wider community, via a common body or register, can provide a reciprocal validation of one's own professional identity and standards by that community'*. [65]

4.2 We can see that professional identity exists independently of the register. The register acts as a means of validating existing professional identity and giving evidence of a community of practice of shared professional identities but it does not generate professional identity. The register is a tangible way of viewing a community that already exists. One of Christmas and Cribb's participants believed that the loss of statutory regulation (the legal requirement to be registered with a regulator, as opposed to a voluntary register or no register at all) would mean a 'sense of being professional would be lost'. This was because 'there's no one that you can go to and say, these are the people that keep a register of who I am and what I do'. The regulator is a validator of the community and a social marker that can invoke pride in those regulated: 'I think part of your registered body and somebody with overarching regulation towards us is something that we're pretty proud of, and you can say you're a member of that society, it's something that gives you confidence in what you're doing'. Meanwhile, another pharmacist went further and said that statutory registration with the GPhC strengthened their sense of validation through being part of a community: 'you feel like you belong to…belong to the council, the GPhC, you belong to them'.[66] This view is at the furthest end of what Christmas and Cribb call a 'communitarian' interpretation of professional identity and regulation. The views above show that community of practice exists and can be expressed by the register. Any legal requirement to join this register though strengthens the feeling

[64] Pharmacists' Defence Association, 2015, *The PDA response to the GPhC Discussion paper entitled: Patient - centred professionalism in pharmacy*, pg. 6. Available at:
[65] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pp. 5-6.
[66] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg. 30.

amongst some practitioners that they are embedded in their community of practice.

4.3 One pharmacist compared being regulated to membership of a society. This suggests that sometimes practitioners may be unclear about the difference between a regulator and professional body – we know this to be the case from our extensive interaction with professionals. The pharmacist can be a member of a society to represent their interests: the Royal Pharmaceutical Society of Great Britain (RPSGB), which until 2011, combined roles as both a regulator and a professional body. Our literature review identified that professional bodies play a role in the maintenance of professional identity.[67] A regulator's role is primarily to protect patients, whilst a professional body is responsible for improvements to education, training, professional practice and continuing professional development and acting in the interests of the profession. Given these differing aims, it would be interesting if further research on identity compared the two types of organisation's influence on identity.

4.4 Another means of exerting regulatory influence over entry into a community of practice is protection of title. A protected title is a title which can only be used by a practitioner who is registered with the appropriate regulator. This is enshrined in legislation. For example, to call oneself an 'osteopath' an individual must be regulated by the General Osteopathic Council. The title is protected under the 1993 Osteopaths Act. One of Christmas and Cribb's participants had practised physiotherapy in another country where it was not a protected title, which meant that 'anyone who was doing a bit of massage was calling themselves physios'.[68]

4.5 The absence of a protected title can be perceived to be a threat to the identity of a group of practitioners or 'communal validation' amongst practitioners on a register. A psychotherapist noted that people practising bad psychotherapy (an unregulated health occupation) does a 'great disservice' to the psychotherapy trade and welcomed 'anything that removes unqualified people from the practice'. A physiotherapist commented that physiotherapy's protected title adds a 'little bit of protection' and cautioned that the physiotherapy profession could be brought into 'disrepute' if anyone could say they were a physiotherapist. This belief in protection of title's contribution to communal validation was not held by all participants: one acupuncturist stressed that all that mattered to them was that the person they referred a patient to was safe to practise (this could be mitigated by checking a register of practitioners).[69]

Individualist perspective

4.6 The communitarian views of the register as evidence of a community of practice were not shared by all of Christmas and Cribb's participants. One acupuncturist offered a more individualistic perspective saying that they were not as involved in

[67] Professional Standards Authority, 2016, *Professional identities and regulation: a Literature Review*, pp. 9-10.
[68] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg. 40.
[69] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pp. 33-34.

conferences and professional bodies as others in their occupation, they summarised: 'I just do my own thing'. They viewed their relationship with their register as a pragmatic one, even choosing not to re-register with the British Acupuncture Council for financial reasons and opting to register instead with the Association of Traditional Chinese Medicine (ATCM). Christmas and Cribb also explained that the acupuncturist's relationship with the ATCM was conducted in a 'transactional' manner as he or she was only registered to fulfil a local authority's stipulation.[70]

4.7 The acupuncturist highlights that there is a spectrum of different views regarding professional identity and regulation: at one end of the spectrum are the community-focused practitioners, whilst at the opposite end there are individualists who have transactional relationships with registers. The acupuncturist's assertion that there are many 'lone rangers' improving lives is an important reminder that care takes place in a variety of environmental conditions and manifests in different ways, which has implications for regulators.[71] The acupuncturist's professional identity was based on caring for patients with little interaction with other practitioners. If regulation is to move to a more preventative model then it will need to find a way to engage with isolated practitioners. Those working in isolation may not have the same structures around them to support the maintenance of minimum standards and prevent failings that say, a cardiologist would have (such as a team of different practitioners and close working with employers).[72]

Fitness to practise

4.8 If the register validates who is in a community of practice, then to leave the register is to no longer be a part of the community of practice. This may in turn weaken or even remove identity. A practitioner may leave the register through the following routes:

- Voluntary removal for reasons such as retirement or career change;
- Lapsed registration: a practitioner fails to renew registration;
- Fitness to practise (FtP): a registrant is suspended or erased from the register for not complying with regulatory standards.

4.9 The first two routes are actions of the registrant. On the other hand, FtP is a regulator-enforced process. In FtP, a regulator will investigate a concern raised by an employer, the public, practitioner or other body about a registrant. In order to protect the public[73], the regulator may issue sanctions ranging from warning a registrant to erasing them from the register.

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[70] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pp. 34-35.
[71] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg. 36.
[72] Upstream actors are organisations or entities, such as employers, who are nearer to practice than a regulator.
[73] The purpose of regulation is to the protect the patients and public, maintain of public confidence in the profession and uphold proper standards of conduct and behaviour.

4.10 Our literature review put forward the idea that there is an 'indivisibility' between a doctor and their licence and that to be out of work can affect a doctor's identity. We also found that the FtP process itself, or the prospect of it, can negatively affect identity. There were descriptions of the process as a 'menace', 'a threat', and 'challenging to their [practitioners'] core identities'.[74]

4.11 Our literature review also found a second perspective on FtP: by undertaking FtP the regulator is helping people become 'more aware of the job expected of them'.[75] This may be related to the 'community of practice' idea outlined by Christmas and Cribb, whereby practitioners trust that other practitioners in the community align in standards and identities. Therefore, we can see the FtP process is channelling the community of practice's standards. Individual professional identity is how a practitioner sees themselves, and registration has the capacity to validate and invalidate this self-perception. This suggests that an individual's identity can be invalidated if they do not practise in accordance with the community's identity.

4.12 It is also of note that the FtP process may occur whilst a practitioner is coming to terms with an error. Albert Wu, coined the phrase 'the second victim' to describe the situation of a medical professional responsible for a mistake: 'although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors'.[76] After an error, practitioners are coming to terms with a mistake. This will affect how they see their practice and therefore their identity (we saw earlier how identity can be attached to the skills an individual uses). In a local forum, reflective spaces that we mentioned in 3.12 of this report can help to learn from errors. Whilst in a regulatory arena a more inquiring or non-confrontational approach to fitness to practise may help enable a learning culture.[77]

In summary

4.13 We have seen that the register can be a means for registrants to validate others against their own professional identity. This does not mean that it influences identity. However, we have learnt that if an individual is subject to an FtP sanction, their identity in the group is invalidated and their individual identity may be affected if they are not able to practise. A statutory regulator has the power to weaken a registrant's professional identity depending upon the sanction. An erased registrant would have their identity weakened more than an individual who was suspended.

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[74] Professional Standards Authority, 2016, *Professional identities and regulation: a Literature Review*, pp. 18-19.

[75] Professional Standards Authority, 2016, *Professional identities and regulation: a Literature Review*, pg. 19.

[76] Albert W. Wu, 2000, *Medical error: the second victim, the doctor who makes the mistake needs help too*. BMJ. Vol 320, 18 March 2000.

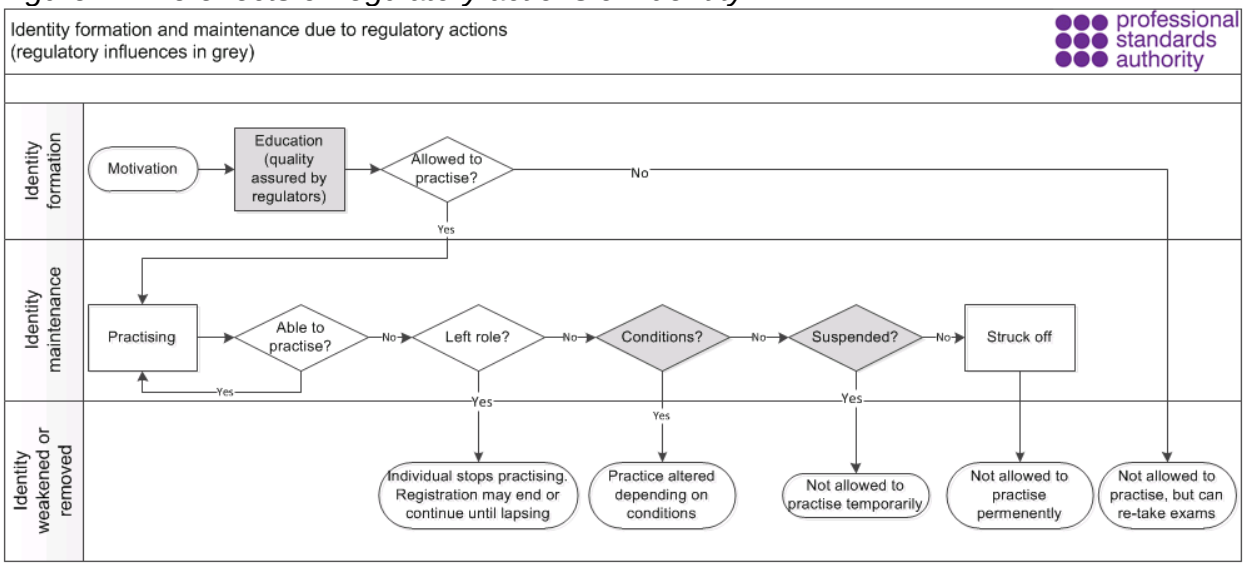
[77] Professional Standards Authority, 2016, *Response to the consultation: Providing a 'safe space' in healthcare safety investigations*, pg. 3. Available at: www.professionalstandards.org.uk/docs/default-source/publications/consultation-response/others-consultations/2017/authority-response-to-dh-safe-spaces-final.pdf [Accessed 01/11/2017]

4.14 Neither accredited nor non-accredited registers legally remove an individual from practice, unlike a statutory regulator. An individual removed from a non-statutory register can continue to practise legally, which can allow them to keep an element of their professional identity.[78] However, some identity would be lost due to the individual not being recorded on a register and therefore able to validate their identity with other practitioners on a register. This could mean that the identity of a practitioner removed from a non-statutory register may be weakened less than that of a professional removed from a statutory register.

4.15 We did not find a great amount of data in our literature review, nor did Christmas and Cribb in their research, on the effects of fitness to practise on professional identity. There are though compelling reasons for conducting more research in this area. We discuss these in chapter seven. Another area of interest for further research is individualist practitioners. We have learnt that some practitioners may not be embedded into a community of practice, such as the individualist practitioner in 4.7.

4.16 The last three chapters have described the influence of regulators and voluntary registers on professional identity through their four core functions. In the diagram below, the regulatory influences on professional identity are displayed in grey alongside the other influences we have discussed.[79]

Figure 2: The effects of regulatory actions on identity



[78] However, an individual removed from an Accredited Register for a conduct issue cannot join another Accredited Register.

[79] For simplicity, education and the regulator's quality assurance involvement have been merged.

5. Practitioners' environments

5.1 A direct influence on practitioners' professional identity is the environments in which they operate, both occupationally and socially. Unlike the distant regulator, the work and social environments practitioners work and live in each day have a more direct influence on professional identity. For example, in our literature review we explained the effects of uniforms and patient rapport on professional identity.[80] However, it is important to re-iterate that simply enacting the skills required of a practitioner or donning the correct uniform does not necessarily mean an individual holds an occupation's professional identity or professional stance. In 2.7 we saw that to use an acupuncturist's skills does not necessarily mean a practitioner holds an acupuncturist's professional identity.

Work environment

5.2 The location in which a practitioner works has a direct influence on their identity. A work environment shapes how practitioners interact with patients or service users – arguably, the most important relationship in health and care. In their study with dental care professional (DCP) students, Morison, Marley and Machniewski found that DCP students' professional identity was determined by 'responsibility for direct patient care and the amount of clinical experience required'.[81] Our literature review described numerous examples where professional identity was affected by the work environment, for example McKenzie and Williamson's study of Australian general practitioners (GPs) connecting with patients only via telephone. As a result, the GPs realigned their professional identities. Another example of a work setting influencing professional identity was in relation to pharmacists. Evey et al. found that community pharmacists were able to have more rapport with patients (than their hospital pharmacist counterparts) and become a 'pillar of the community'.[82]

5.3 A work environment can also be a place where multiple identities are represented. Tompson et al. found that pharmacies which offered blood pressure checks in Oxfordshire had a 'dual identity' as a place in which to receive healthcare and as a retail space. Tompson et al.'s interviewees viewed the blood pressure checks as 'exempt' from the pharmacy business model as they were of public health value. One interviewee noted: 'You do it as a kind of service to the community'. Additionally, Tomson et al noted that the 'promotion [of blood pressure checks] was limited due to lack of direct commercial benefits'.[83] Without the obligation to care for customers' health, pharmacies become solely profit-

[80] Professional Standards Authority, *Professional identities and regulation: a Literature Review*.

[81] S. Morison, J. Marley and S. Machniewski, 2011, *Educating the dental team: exploring perceptions of roles and identities*, British Dental Journal, pg. 481. Available at: www.nature.com/bdj/journal/v211/n10/pdf/sj.bdj.2011.963.pdf [Accessed 31/10/2017]

[82] Professional Standards Authority, *Professional identities and regulation: a Literature Review*, pp 5-6.

[83] A C Tompson, S G Fleming, C J Heneghan, R J McManus, S M Greenfield, F D R Hobbs and A M Ward, 2016, *Current and potential providers of blood pressure self-screening: a mixed methods study in Oxfordshire*, British Medical Journal, pg. 5. Available at: http://bmjopen.bmj.com/content/bmjopen/7/3/e013938.full.pdf [Accessed 25/09/2017]

driven shops. The Pharmacists Defence Association observed that the primary interests of supermarkets, international retailers, and other entities which own pharmacies are not 'led by a sense of professional identity but by balance sheet'.[84] Relatedly, a pharmacist participant of Christmas and Cribb's noted that unregulated internet pharmacies are 'just out to make a profit'.[85] Therefore, a work environment can combine different professional identities.

5.4 Another key facet to a work environment is working in a team. Morison et al. discuss the effects of teamworking on professional identity. They point out that dental students were the most respected of DCP students but regarded themselves as the 'outsiders' of the team. They did not feel comfortable in their role as 'leaders' and knew little about the roles of others on their team. How team members value a practitioner's role can affect that practitioner's status and identity. Morison et al. noticed that in a dental team a dental hygienist student's status and identity can be influenced by other dental team members' perceptions of the value of the dental hygienist role.[86]

5.5 In many healthcare settings, practitioners practise their role in an interprofessional team with practitioners from other fields. For example, in a hospital a patient's care could be provided by nurses, doctors, pharmacists, physiotherapists or others. Interprofessional practice has been defined as follows: 'all members of the health service delivery team participate in the team's activities and rely on one another to accomplish common goals and improve health care delivery'. [87] Sometimes the roles of each of these practitioners is clearly demarcated, whilst at other times the boundaries between each role may be more blurred. This echoes some of what we discussed earlier in the report about changing roles in chapter 3, there we focused on individual practitioners' perspectives of their role changing. Here, we look at the individual as part of a team. A useful starting point to understand how identity interacts within interprofessional teams is the work of Ward et al. They found that for an individual to become an interprofessional practitioner, amongst other things, they need to understand who they are in their role and how that role fits in the team.[88]

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[84] Pharmacists Defence Association, 2012, *Insight*, pg. 2. Available at: www.the-pda.org/wp-content/uploads/2012-autumn-insight-community.pdf [Accessed 25/09/2017]

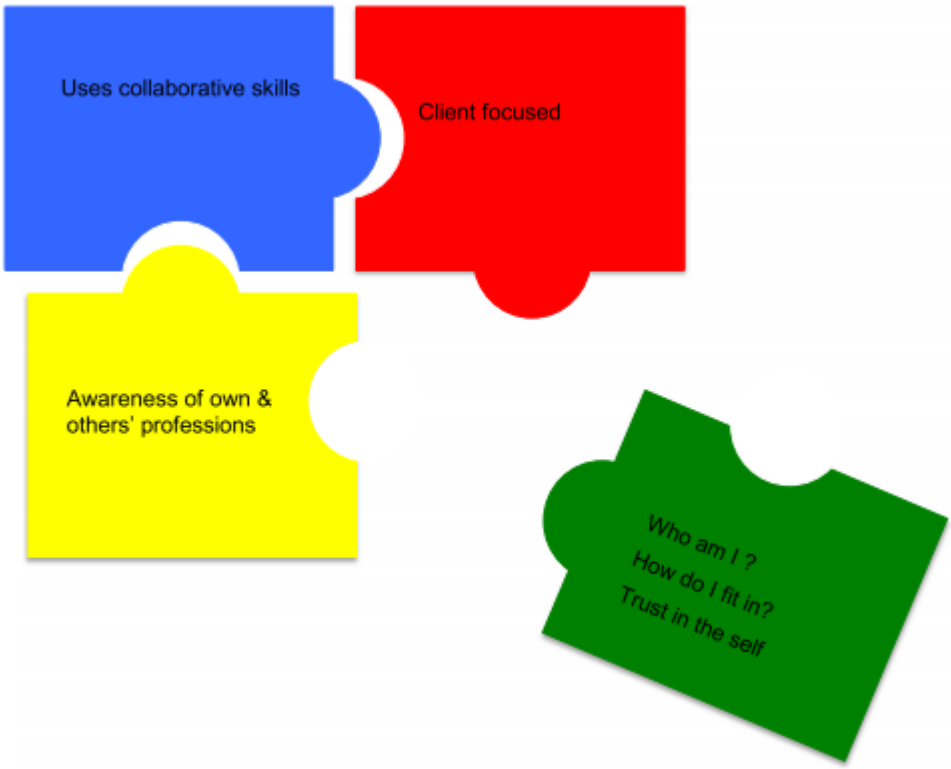
[85] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg. 33.

[86] S. Morison, J. Marley and S. Machniewski, 2011, *Educating the dental team: exploring perceptions of roles and identities*, British Dental Journal, pg. 481. Available at: www.nature.com/bdj/journal/v211/n10/pdf/sj.bdj.2011.963.pdf [Accessed 31/10/2017]

[87] Helena Ward, Lyn Gum, Stacie Attrill, Donald Bramwell, Iris Lindemann, Sharon Lawn and Linda Sweet, 2017, *Educating for interprofessional practice: moving from knowing to being, is it the final piece of the puzzle?* pg. 1. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC5216552/pdf/12909_2016_Article_844.pdf [Accessed 01/11/2017]

[88] Helena Ward, Lyn Gum, Stacie Attrill, Donald Bramwell, Iris Lindemann, Sharon Lawn and Linda Sweet, 2017, *Educating for interprofessional practice: moving from knowing to being, is it the final piece of the puzzle?* pp. 6-7. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5216552/pdf/12909_2016_Article_844.pdf [Accessed 01/11/2017]

Figure 3: From Ward et al: 'The interprofessional practitioner'[89]



5.6 Nancarrow and Borthwick view the relationship between interprofessional working and identity on a continuum:

> *'At one end of the spectrum, an interprofessional team can be seen to function as a single, functionally focused unit where the professional roles are subordinated to the goals of the team (omelette model). At the other end of the continuum, is the fried-egg model in which professions maintain their core (yolk) and work within a negotiated framework of sharing peripheral roles (whites). In reality, interprofessional roles are not static, and individual professionals and teams may move between the omelette and fried-egg states.'*[90]

5.7 Our literature review highlighted the potential effects of an 'omelette' model via multidisciplinary working. There we saw that overlapping roles or the erosion of boundaries between roles can be perceived to be a threat to professional identity.[91] Interestingly, Nancarrow and Borthwick observe that a role performed

[89] Helena Ward, Lyn Gum, Stacie Attrill, Donald Bramwell, Iris Lindemann, Sharon Lawn and Linda Sweet, 2017, *Educating for interprofessional practice: moving from knowing to being, is it the final piece of the puzzle?* pg. 7. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC5216552/pdf/12909_2016_Article_844.pdf [Accessed 01/11/2017]

[90] Susan A. Nancarrow and Alan M. Borthwick, 2016, *Interprofessional working for the health professions. From fried eggs to omelettes? Routledge Companion to the Professions and Professionalism*, Routledge, pg. 352. [Accessed 25/09/2017]

[91] Professional Standards Authority, *Professional identities and regulation: a Literature Review*, pp. 11-12.

in a 'less regulated environment' is more open to encroachment from other roles. This suggests that a regulator's role in outlining scopes of practice may have an indirect role in influencing identity, if boundaries of practice shape identity.[92]

5.8 At the end of chapter 3, we mentioned the need to resolve and reflect on issues locally. Team members can offer this: Christmas and Cribb point out that colleagues of a practitioner can stand in for a regulator when reflecting on a practitioner's practice.[93] The critical eye can turn into a blind eye however: our paper pointed out that when encouraging candour in registrants, regulators need to take into account 'professionals' sense of loyalty to their peers and employers'.[94] These examples suggest that could be times where there is a tension between the standards expected by a community of a practitioner and the expectations of a team.

5.9 Finally, not all health and care practitioners work in teams. A self-employed practitioner may run their own business where they are the sole health practitioner. Therefore, they will not be affected by issues of overlapping boundaries or scrutinised by other team members. A practitioner not working in a team may also have the 'individualist' mindset that we saw in 4.7.

Technology

5.10 In our literature review, we explained different ways that technology can affect practitioners' identity: expanding nurses' roles by making them custodians of data, or altering the doctors' identity by transforming them from repositories of knowledge to navigators of digital knowledge.[95] Both examples show how day-to-day aspects of a role can be altered by technology. This is intertwined with the effect of the work environment on professional identity.

5.11 An aspect of technology not discussed in the literature review was social media. Many health and care practitioners have social media accounts such as Facebook and Twitter. These social media tools can blur the personal and professional identities of practitioners. In 2013, DeCamp, Koenig and Chisholm noted that the American College of Physicians and Federation of State Medical Boards recommended an 'operationally impossible' separation of professional and personal identities because web browsers can connect the two identities with minimal information.[96] Meanwhile, Cooper and Inglehearn noted that practitioners

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[92] Susan A. Nancarrow and Alan M. Borthwick, 2016,"Interprofessional working for the health professions. From fried eggs to omelettes?" *Routledge Companion to the Professions and Professionalism*, Routledge, pg. 352. [Accessed 25/09/2017]

[93] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg. 32.

[94] Professional Standards Authority, 2013, *Candour, disclosure and openness Learning from academic research to support advice to the Secretary of State*, Professional Standards Authority, pg. 14. Available at: www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/candour-disclosure-and-openness-2013.pd [Accessed 16/08/2017]

[95] Professional Standards Authority, *Professional identities and regulation: a Literature Review*, pg. 5 and pg. 11.

[96] Matthew DeCamp, Thomas W. Koenig, Margaret S. Chisolm, 2013, *Social Media and Physicians' Online Identity Crisis*, pg. 1. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC3954788/pdf/nihms558022.pdf [Accessed 12/09/2017]

may be concerned that engaging in an open digital space could expose their sense of 'self'. This could then erode a practitioner's 'ability to manage the safe boundaries between professional and personal identity in a new area of practice with few formalised rules'.[97]

5.12 Rather than advocate an 'operationally impossible' solution of complete separation of identities, DeCamp, Koenig and Chisholm identify a potential solution whereby practitioners use their own judgement of the space they are publishing information in:

> *'Resolving the online identity crisis requires recognizing that social media exist in primarily public or potentially public spaces, not exclusively professional or exclusively personal ones. Boundaries exist; they simply are not drawn around professional and personal identities, nor can they be. When a physician asks, 'Should I post this on social media?' the answer does not depend on whether the content is professional or personal but instead depends on whether it is appropriate for a physician in a public space.'*[98]

5.13 The overlapping of professional and personal spheres is acknowledged by UK healthcare professional regulators. For example, the General Chiropractic Council (GCC) guidance acknowledges that 'social media can blur the boundaries between an individual's private and professional life'.[99] The regulators have produced guidance to help their registrants negotiate social media. Regulatory guidance can contain tips such as 'maintain appropriate professional boundaries if you communicate with colleagues, service users or carers', or 'do not post inappropriate or offensive material. Use your professional judgement in deciding whether to post or share something'.[100] This HCPC guidance follows DeCamp, Koenig and Chisholm's theory and leaves it to a practitioner's judgement on what to post. Given the fast-changing nature and vastness of social media, it is in a regulator's interest to develop guidance that enables a professional to use judgement rather than using prescriptive rules, as regulators may find it difficult to update guidance at the same pace as social media develops.

Wider society

5.14 Society could be the most all-encompassing environment that affects a practitioner's identity. Our literature review included a section on 'Media and wider society' where we found that if society 'thinks well' of a group then 'the self-

[97] Anne Cooper and Alison Inglehearn, 2015, *Perspectives: Managing professional boundaries and staying safe in digital spaces*, pg. 627. Available at: http://journals.sagepub.com/doi/pdf/10.1177/1744987115604066 [Accessed 12/09/2017]

[98] Matthew DeCamp, Thomas W. Koenig, Margaret S. Chisolm, 2013, *Social Media and Physicians' Online Identity Crisis*, pg. 3. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC3954788/pdf/nihms558022.pdf [Accessed 12/09/2017]

[99] General Chiropractic Council, 2016, *Guidance on the use of Social Media*, pg. 3. Available at: www.gcc-uk.org/UserFiles/Docs/Guidance/GCC-Guidance-%20The%20Use%20of%20Social-Media-FINAL.pdf [Accessed 13/09/2017]

[100] Health and Care Professions Council, *Top tips for using social media*. Available at: www.hcpc-uk.org/registrants/socialmediaguidance/toptips/ [Accessed 13/09/2017]

esteem, self-image and self-presentation of a group will increase accordingly'.[101] The relationship between the views of society and identity is alluded to in a report on mental health nurses for the Foundation of Nursing Studies report on mental health nursing. In the report, there is a section on 'Securing professional identity', that calls for the 'Chief Nurses in each of the four countries to endorse the good work of graduate and registered mental health nurses more regularly and publicly'.[102] Furthermore, society can shape the priorities of healthcare and therefore professional identity. The Health Foundation observe that regarding professional identity, clinical practice is 'driven by the desire to do good' but there should be reflection on what to 'do good' means as society changes.[103]

5.15 Society can be a loose national community which manifests, for example, in general public sentiment and the media, but there can also be local communities. In 3.7, we saw how a pharmacist interviewed by Christmas and Cribb thought that their community's values were at odds with a larger society:

> *'You can have a very, very good pharmacist, a pillar of the community, in the woods somewhere, who everybody is really happy with, but he can't do the paperwork. That's a problem. That's what our society is about. It's paperwork, paperwork, paperwork. If you can dot the Is and cross the Ts, you've got very good standards. If you can't do that, I'm afraid, you're rubbish. And it isn't true'*[104]

5.16 It could be argued that the regulator (the GPhC), a national body[105], represents the standards of society which impinge upon what makes a pharmacist a 'pillar of the community'. It suggests that expectations of national society and the regulator may not acknowledge some attributes which make a pharmacist valued in a local community. Interestingly, this is not the first time the phrase 'pillar of the community' has been used in identity research related to pharmacists. We saw in 5.2 that this was used to denote the values of a community pharmacist, and demarcate those community pharmacists from their hospital pharmacist counterparts who have less interaction with patients. The nature of a work environment can affect how a practitioner interacts with wider society and forms their professional identity.

5.17 Society also shapes the backgrounds of practitioners, and consequently their career choices and therefore identities. For example, a University of York study found that medical trainees from 'better-off socioeconomic backgrounds' were

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[101] Professional Standards Authority, *Professional identities and regulation: a Literature Review*, pg. 6.
[102] Tony Butterworth and Theresa Shaw, 2017, *Playing our Part The work of graduate and registered mental health nurses: An independent review by the Foundation of Nursing Studies*, Foundation of Nursing Studies pg. 10. Available at: www.fons.org/resources/documents/Report-Playing-our-Part,-the-work-of-graduate-and-registered-mental-health-nurses.pdf [Accessed 25/10/2017]
[103] Health Foundation, 2014, *Person-centred care: from ideas to action*, pg. 7. Available at: www.health.org.uk/sites/health/files/PersonCentredCare_IdeasInAction_inbrief.pdf [Accessed 25/09/2017]
[104] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg.25.
[105] Although the GPhC operates across three of the four countries at national level.

'less likely to be based in general practice than in any other specialty'. [106] Gender can also affect career pathways. The UK nursing workforce is predominantly female, and stereotyping of what a nurse looks like is 'partly' to blame according to the chief executive of the Royal College of Nursing.[107] Relatedly, in response to seeing men dressing up as nurses, a London-based nurse commented that 'society' needed to respect nurses as a profession and not view them as 'lovely little handmaidens' and 'objects'.[108] The subject of stereotyped perceptions of nursing has been a subject of debate for a while. In 2008, a male nurse considered the public 'unsure of what it wants from nurses', suggesting 'half still think of a nurse as the subject of an erotic fantasy and the other half want to see someone with a stethoscope around their neck'. [109]

5.18 The comment about stethoscopes shows the importance of uniforms in perceptions of a group's identity. This overlaps with our literature review's findings that roles' uniforms can signify boundaries between roles and the right uniform can even strengthen identity.[110] Identity boundaries can also be erected within a profession. One former nurse explained that within nursing there are boundaries between nursing roles constructed along the lines of gender expectations:

> *'I did the typical male nurse thing and initially gravitated towards critical care and surgery. It was just seen as much more acceptable... When I'm in the pub and tell people I'm a nurse, they are sceptical but when I tell them I work in intensive care, they think of me slightly differently.'* [111]

5.19 We have seen that society can negatively influence professional identity, but it can also positively influence identity. Foster and Roberts note that society's esteem for doctors is a 'cornerstone' of doctors' professional identity and thus entails 'a responsibility to ensure a collective professional identity worthy of such respect'.[112]

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[106] Idaira Rodriguez-Santana and Martin Chalkley, 2015, *The Socioeconomic and Demographic Characteristics of United Kingdom Junior Doctors in Training Across Specialities*, Centre for Health Economics, University of York, Pg. 6. Available at: www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP_119_junior_doctors_training_specialities.pdf [Accessed 14/09/2017]

[107] Rachel Williams, 2016, *Why are there so few male nurses?* The Guardian. Available at: www.theguardian.com/healthcare-network/2017/mar/01/why-so-few-male-nurses [Accessed 14/09/2017]

[108] The Guardian, 2017, *Health warning: why the sexy nurse stereotype is no laughing matter*. Available at: www.theguardian.com/lifeandstyle/2017/aug/23/health-warning-why-the-sexy-nurse-stereotype-is-no-laughing-matter [Accessed 14/09/2017]

[109] Nursing Times, 2008, *Why are there so few men in nursing?* Available at: www.nursingtimes.net/why-are-there-so-few-men-in-nursing/849269.article [Accessed 14/09/2017]

[110] Professional Standards Authority, *Professional identities and regulation: a Literature Review*, pp. 12-14.

[111] Nursing Times, 2008, *Why are there so few men in nursing?* Available at: www.nursingtimes.net/why-are-there-so-few-men-in-nursing/849269.article [Accessed 14/09/2017]

[112] Kirsty Foster and Chris Roberts, 2016, *The Heroic and the Villainous: a qualitative study characterising the role models that shaped senior doctors' professional identity*, pg. 9. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC4986406/pdf/12909_2016_Article_731.pdf [Accessed 25/10/2017]

5.20 It is possible for negative views held by society of a health and care role to originate from perceptions if a type of practice is viewed as 'mainstream'. In interviews with acupuncturists, Christmas and Cribb found that there was concern over not being viewed as a 'mainstream' mode of healthcare by wider society. To be viewed as 'mainstream' is to be accepted and respected by society. Christmas and Cribb observe that the acupuncturists' lack of statutory regulation can become 'easily entangled' with this issue. It is noted for example, how acupuncture techniques can be co-opted by professionals who do not have the professional stance of an acupuncturist:

> *'They do not understand how the rest of the system works; however, they are favoured because they are doctors, and a doctor can do anything he likes to a patient and still be covered. We can't. We have to have insurance, we have to have all sorts of other things.'*[113]

5.21 This echoes what we saw in 2.7 of this paper where we learnt that: 'Co-option of acupuncture skills without the professional stance of a traditional acupuncturist may not mean an individual has gained an acupuncturist professional identity'. In the case of the acupuncturist quoted in 5.20, regulation is perceived to be protecting the doctor when he or she uses acupuncture skills he does not understand. It is of note that if the practice of acupuncture was restricted by law then the doctor would not be able to use those skills unless they were registered with an acupuncture regulator.

5.22 The issue of regulation being bound up with cultural acceptance of practice was further exemplified by the same acupuncturist. They considered that statutory regulation would compel more patients to try acupuncture: 'if the government says it works or they (the public) believe it works, they feel more confidence, so more would try it'. Another participant, a pharmacist, commented that public confidence in professions could be fostered by regulation: 'to be registered…probably creates more confidence within the public, that you know, these guys know what they're doing'. The pharmacist went on to say that statutory regulation was important for pharmacists as they needed to follow 'same procedure' as regulated colleagues they work closely with. If they did not, then 'it might look a bit amateur' if pharmacists were not on a register and 'dentists, GPs and nurses were'.[114] The pharmacist's comments are also interesting as it shows their desire to be equivalent to professionals who work around them. In their opinion, regulation provides them with a societal mark to do that.

5.23 Additionally, the Professional Standards Authority's accredited registers programme was viewed by some participants as providing a badge of status. One psychotherapist compared the Authority's accreditation to the 'way that letters after names makes one feel important in some way'. That same psychotherapist suggested that obtaining approval was a universal desire by

[113] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg.42.
[114] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pp. 43-44.

humans: 'You know, everybody's after approval of some sort, whether they like it or not. I think this is part of it'.[115] The status of being on an accredited register was simply another form of approval.

5.24 This assignation of societal status as Christmas and Cribb point out opposes the Professional Standards Authority's view of the purpose of regulation. We have stated that regulation is a means to manage risk and not a 'badge of professional status':

> *'Calls for statutory regulation are often made by those referred to as 'aspirant groups', reflecting an out-of-date view that regulation is a badge of professional status and something to be achieved, rather than a system to be applied where risks justify its intervention. Whether and how a group is regulated should not be based on how successfully or how determinedly that group aspires to it. The decision should be based on what form of assurance is the right one for the nature of the risk of harm that the practice in question presents to the public. Statutory regulation should be preserved for those professions for whose practice it is the most effective risk management approach'*.[116]

5.25 Christmas and Cribb conclude that whilst a number of their study participants associated regulation with social status and legitimacy, there was 'no evidence of a relationship between acquiring such status and legitimacy and a strong professional identity'. Although it is mentioned by a pharmacist that it 'might look a bit more amateur' to lack statutory regulation, acupuncturists ascribed practical implications of regulation rather than of identity: for example, the need for acupuncturists' to have insurance whilst doctors do not. Christmas and Cribb summarise this as being 'implications for what one can and can't do rather than implications for how one sees oneself'.[117]

5.26 However, even if status is conferred by regulation, we view this as a secondary effect. The primary reason for being recorded on a register is if a practitioner fulfils the competence and behavioural requirements of the register-holder. Attached to regulation may be status in wider society. It is important though that this does not alter how practitioners perceive the purpose of regulation. We learnt earlier that society can perceive a male nurse negatively because they challenge the perception of how a nurse should look. This changed how the nurse explained their role to people. It is important that practitioners' understanding of regulation is not incorrectly shaped by misperceptions.

5.27 Up until this section on 'wider society' we have seen that, of the factors affecting professional identity, it is factors closest to practitioners and their practice which affect their identity. Ostensibly, society is as distant as a regulator, it is a flexible term for a variety of things: the media, general public sentiment or even people a

[115] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pg. 44.
[116] Professional Standards Authority, 2015, *Rethinking regulation*, pg. 9. Available at: www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/rethinking-regulation-2015.pdf [Accessed 16/08/2017]
[117] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pp. 44-45.

practitioner may meet at a pub. Those agents of society can be tangible though and permeate personal as well as professional spheres. Arguably, agents of society are closer to practitioners than the label at first would suggest.

In summary

This chapter has shown that practitioners inhabit personal and professional environments which shape how they conceive their professional identity. The three environments of work, technology and wider society also interact and affect each other. For example, a technological development can alter the work environment in which a practitioner interacts with a patient. Wider society's views can affect which work environment a practitioner chooses to work in. These environments encompass many practitioners and effects can be felt directly on their professional identities. However, more individualistic practitioners may operate beyond the reach of the three environments.

6. The role of the regulator in identity

6.1 This report has suggested that regulators have diverse relationships with identity. It has also proposed that a regulator does not create identity but can play a significant role when identity in practitioners is being formed. Broadly speaking a regulator has the ability to validate and invalidate identity. Identity is how a practitioner sees themselves, and registration has the capacity to validate and invalidate this self-perception. We suggest though that regulation has more of an impact on practitioners' experiences in initial qualification and fitness to practise. It seems therefore that these functions have more of a direct influence on identity than the register and practice standards. We can also infer from this that regulation does not create identity.

6.2 The core regulatory functions can be described as having the following effects:

- **Education and training** has a mix of direct and indirect influence on professional identity. Education and training requirements are driven by the standards of regulators. A more direct influence on the formation of professional identities are the teachers and senior clinicians who carry out courses and supervise practitioners whilst they learn to qualify. Quality assurance of training by regulators can strengthen the community of practice's bonds as practitioners can be assured they went through similar training. To gain identity fully though, a practitioner must practise, and in order to practise an individual must be qualified and registered with their corresponding regulator.
- **The register** is an indirect influencer of identity, it is evidence of a community of practice, however it does not create that community of practice. Practitioners can check and validate their professional identities against others on the register. Arguably, it is a record of the alignment of identities by those inside the community and an exclusion of those who do not align to these identities.
- Registrants align **standards** to professional identity on their own terms. Regulatory requirements are not explicitly consulted when a registrant is practising. This is also an indirect influencer of professional identity.
- A direct influence on professional identity is **fitness to practise**. The evidence suggests to us that an individual suspended from practice or erased from the register will have their identity weakened or invalidated as they are unable to practise.

Table 4: The role and influence of regulatory core functions on identity.

Function	Role	Influence on identity
Education and training	Validator	Direct and indirect
Register	Validator	Indirect
Fitness to Practise	Invalidator	Direct
Standards	Validator	Indirect

Regulation in society

6.3 Additionally, it is noteworthy that identity is a subjective phenomenon for both practitioners individually and as a group. Regulators, however, try to act in an objective manner in the public interest to ensure registrants can safely practise by checking whether individuals comply with access, practice and conduct requirements. There is a tension between the objectivity in the question of whether regulatory status should be linked to societal status. Christmas and Cribb summarise the opposing perceptions of regulation's interaction with status as: 'a rational, a historical perspective' and a 'culturally and historically situated perspective'. The Professional Standards Authority fits into the former category with its 'uncompromising rationality' in its critique of people who view regulation as a badge of status.[118] However, like practitioners, regulators cannot operate outside their societal environment. In our view, this does not mean regulators should adjust how they regulate to acknowledge that regulation can be a badge of status. Instead regulators should find ways to better explain the purpose of regulation.

6.4 There are times when regulation may affect identity, for instance through the societal perceptions attached to statutory regulation, however a regulator should still be focused on the three-pronged purpose of regulation: to protect the public, to maintain public confidence in the profession and to declare and uphold professional standards. To aspire to be regulated for reasons of status is a misunderstanding of the purpose of regulation. We note that practitioners' misunderstanding of the nature and purpose of a regulator is something we have seen before, such as when registrants believe other registrants should be Council members at a regulator.[119]

Multi-professional regulators

6.5 One of the reasons we undertook research into professional regulation's relationship with identity is to explore potential effects of merging regulatory bodies.[120] Our literature review found that one commentator considered the

[118] Christmas and Cribb, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*, pp. 42-43.
[119] Professional Standards Authority, 2013, *Fit and Proper? Governance in the public interest*, pg. 7. Available at: www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/fit-and-proper-2013.pdf [Accessed 10/12/2017]
[120] Professional Standards Authority, 2017, *Review of Professional Regulation and Registration with Annual Report and Accounts 2016/2017*, pg. 44. Available at:

transfer of health visitors from regulation by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) to the Nursing and Midwifery Council (along with a change of title) as 'diminishing the significance of health visiting as a profession'. This is because health visitors lost their 'unique professional registration' to being grouped under a 'broader' nursing title. McGivern et al. found that some osteopaths believed that due to the 'distinctive' nature of osteopathic care, osteopaths should be regulated by an osteopathic rather than a 'generic regulator'.[121] In Christmas and Cribb's work, none of the participating physiotherapists mentioned the HCPC's role as a multi-professional regulator in relation to their identity. Pharmacists did not mention having a uniquely tailored regulator as contributing to their identity.[122] Whilst Christmas and Cribb's findings do not explicitly identify any effects of merging regulators on professional identity, they do suggest that a regulator's composition as a uniquely tailored or multi-professional regulator was not at the forefront of participants' minds when discussing their identities. Given the other factors affecting professional identity which we have previously discussed, it would appear that the effect on identity of the regulator is minimal at best.

www.professionalstandards.org.uk/docs/default-source/publications/annual-reports/professional-standards-authority-review-of-professional-regulation-amp-registration(annual-report-amp-accounts-english).pdf?sfvrsn=10 [Accessed 15/08/2017]

[121] Professional Standards Authority, *Professional identities and regulation: a Literature Review*, pg. 14.

[122] GPhC does though also regulate pharmacy technicians and pharmacy premises.

7. Other issues to explore

7.1 Until our literature review and the Christmas and Cribb research, there has been little direct focus on the subject of professional regulation's relationship to identity in healthcare. We hope that our work has gone some way to filling the gap in the literature. However, there is potential for our findings to be tested with a larger sample and greater variety of practitioners than we have looked at, and in a range of care settings. The research has also exposed areas where more understanding is required. Below, we discuss topics to explore relating to professional regulation and identity.[123]

7.2 Of the four core functions of statutory regulation, fitness to practise of registrants has been least addressed by our work. Yet FtP is one of the most contentious areas of regulatory activity: it can be a lengthy process with far-reaching effects on individuals who are subject to the process. Also, for many of the regulators it is the single largest expense: it accounts for 76 per cent of the Nursing and Midwifery Council's expenditure.[124] Better understanding of the effects of suspensions, conditions and undertakings on professional identity would be useful for regulators. The purpose of regulation is to protect the public, and can involve remediating registrants whose practice is impaired. A better understanding of impacts on identity could mean practitioners practise as optimally as possible when they return to work after FtP proceedings.

7.3 The work we have undertaken and commissioned into identity has focused on practitioners still practising, with little spotlight on practitioners who have left practice or have returned to practice after a break. A nurse who returned to practice after a six-year break explained: 'I can't imagine not having this job as part of my life and part of my identity. I think people go into nursing because they're a certain type of person and that never leaves you, no matter how long you might have spent away from the job'.[125] Work in this area may be useful because UK health systems are grappling with staffing crises and encouraging previously registered individuals to return to practice.[126] Our review of the literature suggests the relationship of non-practising practitioners and their former register has been little explored. It has been claimed that a 'significant number' of non-practising doctors considered their registration with the GMC to be part of their professional identity, and that when not practising those professionals do

[123] This paper has touched on non-regulatory actors which affect identity that are also worthy of exploration.
[124] Department for Health, 2017, *Promoting professionalism, reforming regulation: A paper for consultation*, pp. 18-19. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/655794/Regulatory_Reform_Consultation_Document.pdf [Accessed 02/11/2017]
[125] Nursing Times, 2017, *Mental health trust trying to tempt nurses to return to practise with £500 bonus*. Available at: www.nursingtimes.net/news/workforce/trust-trying-to-tempt-ex-nurses-back-with-500-bonus/7021079.article [Accessed 02/11/2017]
[126] For example, Health Education England's 'Comeback', a returning to practice programme for individuals who used to be registered nurses. More details can be found here: https://comeback.hee.nhs.uk/

not want to 'lose their connection' with the regulator.[127] Discovering whether this is true or not could be helpful when discussing whether it is appropriate for regulators to record non-practising registrants (currently, three regulators record non-practising registrants).

7.4 We suggested at the end of our literature review that there should be further discussion on whether regulators should use professional identity as a tool to protect the public given that one researcher found identity to be an 'internal compass'.[128] There is still a discussion to be had about this subject, but our findings may inform the discussion. For example, in chapter 3 we explain that it appears that practitioners align regulatory standards to identity 'on their own terms'.

7.5 Some of the most striking findings from Christmas and Cribb's research are from their individualist participant. In 4.6 we learnt from the participant about their lack of relationship to other practitioners: 'I just do my own thing'. We also discussed in in our analysis of the individualist practitioner that regulators are working towards preventative regulation. As many health and care practitioners ply their trade on their own or are self-employed, for example osteopaths and acupuncturists, a practitioner doing their 'own thing' with little contact to other fellow practitioners could make preventative regulation more difficult. Shedding light on this area may enable regulators to better understand their more isolated registrants' identities and their 'internal compass'.

7.6 Finally, there is potential for quantitative piece of research to complement the qualitative approach of Christmas and Cribb. A quantitative approach may be able to show how significant some trends and differences are across practices. It would be interesting to see if ideas such as the register as a validator of a 'community of practice' resonate with more pharmacists and others. There is scope for doing this across professions, geographies, places of work and many more.

Other issues to explore
Understanding how fitness to practise sanctions affect identity
Understanding how individualist practitioners form identity and the effect of regulation on this
Comparative exploration of the effects of both system and professional regulation on professional identity
Understanding the professional identities of individuals who have finished practising and lost registration

[127] Baroness Gardner of Parkes, 2008, House of Lords Hansard. Available at: https://publications.parliament.uk/pa/ld200708/ldhansrd/text/80521-gc0002.htm [Accessed 19/05/2017]
[128] Professional Standards Authority, 2016, *Professional identities and regulation: a Literature Review*, pg. 21. Available at: www.professionalstandards.org.uk/docs/default-source/publications/professional-identities-and-regulation---a-literature-review.pdf?sfvrsn=0 [Accessed 19/05/2017]

Views of the public of professional identity and regulation
Further understanding of how much single profession regulators or multi-profession regulators affect practitioners' identities
If professional identity is an 'internal compass', can and should regulators use this as a tool protect the public?
Large-scale quantitative analysis across many types of practitioners

Figure 5: Table summarising ideas for further research into the relationship of regulation and professional identity.

8. Conclusion

8.1 Our work has found that a statutory regulator's effect on identity is akin to a validator and invalidator. The regulator allows individuals to take on identity, and can also remove identity. It can also be a means for registrants to validate their own identity with others on the register. However, it does not create identity.

8.2 Our literature review and the research we commissioned with practitioners has added to the minimal literature on professional regulation's influence on identity. We have learnt that:

- Generally, patient care benefits from a strong professional identity
- Regulatory requirements for initial registration with a register-holder play a role in the development of individual practice and identity
- Once a practitioner has qualified, regulation has a minimal direct effect on professional identity except in a crisis or out-of-the-ordinary circumstance
- An individual practitioner can validate their professional identity through identity alignment with a wider community of like-minded practitioners via a register
- Although not the primary purpose of regulation, some practitioners associated statutory regulation with societal status
- Many factors have a greater or more direct influence on identity than professional regulation, these are usually more local factors such as: rapport with patients and the work environment
- Work, technological and societal environments can affect professional identity. These sometimes interact with each other in how they affect a professional's identity.

8.3 The findings point towards a limited role of professional regulation in identity formation and maintenance. This is echoed recently in the HCPC's research where it was found that: 'non-regulatory factors, such as peer group, culture and local leadership had more impact than the regulator on the development and sustainability of professional identity'.[129] The emphasis on non-regulatory factors influencing identity in Christmas and Cribb's study also suggest that the existence of a single profession or multi-professional regulator overseeing a professional may have little effect on identity, especially when put in the context of other factors.

8.4 We have added considerably to the literature on professional regulation and identity by looking at how different modes of regulation may influence identity. The literature on identity is generally focused on medicine and nursing, and even when it analyses other types of practitioner, they are more often than not

[129] Anna van der Gaag, Ann Gallagher, Magda Zasada, Grace Lucas, Robert Jago, Sarah Banks, Zubin Austin, 2017, *People like us? Understanding complaints about paramedics and social workers*, pg. 180. Available at: www.hcpc-uk.org/assets/documents/1000558EPeoplelikeusFinalReport.pdf [Accessed 31/10/2017]

statutorily regulated professions. The views of acupuncturists and psychotherapists go some way to filling the gap in literature on non-statutorily regulated practitioners.

8.5 As well as the findings above, we have also proposed future avenues for research in this area, such as the influence of the fitness to practise process on professional identity. This research may help further develop a proportionate regulatory system that helps registrants learn from mistakes and practise more effectively We look forward to other organisations and researchers using and building upon our work and that of Simon Christmas and Alan Cribb.

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