How does professional regulation affect the identity of health and care professionals: exploring the views of professionals

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Executive summary

An exploratory qualitative study was undertaken to explore and compare the views of health and care practitioners in the UK on:

- whether patient care benefits from strong professional identity and if so, how and why;
- the range of factors which affect the development and maintenance of professional identity, and which are the most important and why;
- which facets of professional regulation affect professional identity most and why;
- where regulation ranks in priority of factors which affect professional identity and why.

Sixteen professionals from across the UK were engaged through in-depth telephone interviews lasting around one hour. The professionals were drawn from four professional groups: acupuncturists, psychotherapists, physiotherapists and pharmacists, with diversity with each group with regard to gender, experience and context of practice. Two participants were currently or had been registered in more than one of the above groups.

Professional identity

Professional identity – an individual's conception of her/himself *as a professional* – is a complex construct, and existing accounts highlight multiple, interconnected components, with changing degrees of importance. In this report, we focus on two components in the accounts of our participants which are central to understanding the relationship between regulation and professional identity:

- a fundamental commitment to help – along with its corollary, a fundamental commitment to do no harm;
- a coherent way of understanding and intervening in the world, or professional stance – which is more than the mere aggregation of the knowledge and skills a professional brings to their practice.

The relative salience of these components of professional identity varied by participants, depending on at least three factors:

- what the individual her/himself brought to practice in terms of their personal motivations;
- the nature of the choices available to an individual within a given profession;
- the extent to which professionals feel they need to explain or justify their professional stance, either in interaction with patients or at a societal level.

Individual practice

Participants constructed the relationship between their professional identity and their individual practice as a reciprocal one:

- professional identity implies standards for one's practice;

- practice in line with these standards is an expression of one's professional identity.

As such, participants saw a straightforward relationship between professional identity and good patient care as an expression of this identity. This view is in line with a widespread view in the literature on regulation regarding the importance of the individual professional in regulating her or his own practice. For example, the Professional Standards Authority (2015a) states that:

> *We believe that it is primarily the professionalism of individuals that keeps the public safe, and in the case of health and social care also ensures the delivery of good care.*

To paraphrase: it is primarily the commitment of individuals to practise in line with the standards that follow from their own professional identities that drives good patient care.

As such, there appears to be general agreement that patient care benefits from strong professional identity – although the connection is not generally framed using this language. Where there is potential for genuine divergence of views is on the question of whether patient care benefits from *regulation* and if so, how and why.

Accounts of this relationship from a regulatory perspective typically conceptualise regulatory activity as identifying and addressing any gaps between actual practice and register requirements. We can think of this as a 'piano-tuner' model of regulation. Pianos, like professionals, have their own internal standards: the keys reliably produce notes, and there is no need for a piano-tuner to stand next to the piano during the concert. However, those internal standards may fail to align with the objective requirements of the harmonic scale: the notes produced by some keys may be out of tune. The job of a piano-tuner is not to fix this when it happens during a concert: it is to prevent it ruining the concert in the first place.

The relationship between register requirements and individual practice described by most of our participants failed to match this 'piano-tuner' model. Instead, they offered for the most part what we might call a 'piano-teacher' model of regulation. This model assigns a critical role to register requirements in the *development* of a strong professional identity:

- practice requirements play a central role as objects of discussion, reflection and learning, and in the formation of the individual standards associated with one's professional identity;
- access requirements play a key role in ensuring that individuals engage in this kind of focused consideration of practice requirements.

After training, however, regulation according to this model appears to be largely irrelevant to individual practice (and therefore patient care), confined to the fruitless tasks of i) getting professionals to do what they would have done anyway and ii) promoting box-ticking exercises.

Community of practice

What the above account misses, however, are the social dimensions of professional identity. As an individual, one should also be 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.

Underpinning this sense of alignment is a third model of the relationship between regulation and practice, focused on 'holding to account'. This model highlights the role register requirements play not in *making* but in *justifying* decisions about how to act as a professional. Alignment is established not because everyone on a register is checking the same codes and standards – they are not – but because, if the worst occurs, everyone on a register will be held to account by the same register-holder, acting on behalf of the aligned community as a whole.

Access requirements were also described as playing a vital role in sustaining a sense of alignment. One key argument made by a number of participants was that, in the absence of access requirements, *anyone* can set themselves up in practice, with no guarantee of alignment with regard to their professional identity and standards. Since people set themselves up in practice through the use of professional titles, protected title can play an important role here in sustaining a sense of alignment.

Not all of the professionals in our sample attached the same level of importance to communal validation of one's professional identity. Instead, our evidence suggests a spectrum of views from the more 'communitarian' to the more 'individualist'.

For those who have a more communitarian perspective, regulation has a much more substantial role to play than it does for those who have a more individualist perspective. Specifically, it has a role to play not just in the development, but also in the maintenance of a strong professional identity – not because it directly influences individual practice, but because it provides communal validation for an individual's professional identity and standards, and communal standards against which individual practice needs to be justified.

Register benefits

While it may not be part of the *purpose* of regulation, professionals do receive benefits as a result of being regulated (as a group) and on a register (as an individual), and some of these benefits may also have a bearing on the professional identity, if not necessarily on patient care. In particular:

- The exacting access requirements of register-holders mean that, while it may not be its primary purpose, registration does *de facto* acknowledge the hard work and effort involved in developing a professional stance. Moreover, to a greater or lesser extent, registration equips professionals with ways of differentiating themselves from others – especially if a register is associated with a protected title.
- Notwithstanding the Authority's views on the purpose of statutory regulation, a number of our participants understood its meaning in terms of the social status and legitimacy of a professional group, and there was some evidence of participants extending this interpretation to accredited status. Interestingly, however participants tended to describe the benefits of statutory regulation in very practical terms: there was no evidence of a relationship between acquiring such status and legitimacy and a strong professional identity.

1. Introduction

1.1 Context and aim

As part of its proposals for the transformation of the regulation of health and care professionals, *Regulation Rethought* (Professional Standards Authority, 2016a) sets out a new framework for thinking about the scope of regulation for different occupations, in line with principles of right-touch regulation set out (amongst other places) in *Right-touch regulation* (Professional Standards Authority, 2015a).

A key element of this is a new approach to deciding how different occupations and professions should be regulated. *Rethinking Regulation* (Professional Standards Authority, 2015b) sets out the principles behind this approach, and proposes "a continuum of assurance, which demonstrates that as the level of risk increases, the 'regulatory force' required to manage that risk also increases". Different levels of regulation would on this model reflect *the levels of risk* involved in their discharge: for example, "accredited registers are an appropriate method to manage risk arising from those professions whose work results in less extreme risk of harm for patients and service users". This is explicitly contrasted with a historic situation in which higher levels of regulation (and statutory regulation in particular) have been seen as reflecting the *standing* of a profession: "an out-of-date view that regulation is a badge of professional status and something to be achieved".

The current research brief was commissioned in response to concerns that this approach could have unintended consequences. Specifically, the question has arisen: could the fact of regulation, and the way that it is done, have an impact on professional identity? And if so, could this in turn have consequences for the quality of care or patient safety?

The research, which is small-scale and exploratory in nature, builds on a review of literature on the topic of professional identity and regulation, which found "a lack of literature on regulation's role in professional identity – much of the information in the regulation section of this paper has been pieced together from grey literature, such as consultations, government papers, and think-tank reports, as well as academic research."

The aim of the study was to explore and compare the views of health and care practitioners in the UK on:

- whether patient care benefits from strong professional identity and if so, how and why;
- the range of factors which affect the development and maintenance of professional identity, and which are the most important and why;
- which facets of professional regulation affect professional identity most and why;
- where regulation ranks in priority of factors which affect professional identity and why.

1.2 Sample

A key requirement of a well-structured qualitative sample is representative diversity: that is, the sample should help to illuminate selected dimensions of difference within the target population as a whole. The structure of the sample for this study was designed to address three classes of diversity:

Differences between professions.

Four professional groups were identified for the study: acupuncturists, psychotherapists, physiotherapists and pharmacists. Issues considered in selecting these four professional groups included:

- Type of current regulation: statutory, accredited voluntary register or (in the case of one participant only) registration with a non-accredited voluntary register).
- Number/scope of regulatory bodies: regulation provided by a single dedicated body; by a single body spanning multiple professions; or by multiple bodies.
- Regulatory/professional split: regulatory bodies distinct from professional bodies or not.
- History of regulation: questions such as how long the profession has had any kind of regulation, how long it is has had statutory regulation, whether and when it has sought statutory regulation.

Consideration was also given to the span of types of therapies covered. However, given the small scale of the project, an early decision was taken to limit the sample to health professionals, and not to include social care professionals.

An early decision was also taken *not* to include doctors and nurses. There is a long history of doctors being treated as the archetypal health care professions, and nurses as the archetypal 'other'. We saw little value in repeating this preoccupation, and significant value in making the most of the opportunity to hear from other professional groups.

It was not part of our recruitment specification to find participants with multiple professional registrations. However, we were fortunate to have in our sample two individuals who either had been or were currently registered in *two* of the four selected professional groups.

Differences within professions

Within each group, we were keen to ensure a diversity of participants, especially with regard to contexts of practice: for example, primary, secondary, community, high street, etc. Cutting across these distinctions were further important differences related to types of employment structure and the extent of interdisciplinary working.

The table below provides a brief summary of the current context of practice of each of our participants – although a number had had experiences of working in other contexts. Note that the codes are also the codes used in attributing quotations in the rest of this report.

Pharmacists	
PhaA	Community pharmacist, high street pharmacy, independent (own pharmacy)

PhaB	Hospital pharmacist, interdisciplinary working
PhaC	Community pharmacist, high street pharmacy, small chain (three pharmacies)
PhaD	Community pharmacist, located in GP practice, large national chain
Physiotherapists	
PhyA	Neurological, community based, NHS, interdisciplinary working
PhyB	Musculo-skeletal, private practice, own clinic
PhyC	Neurological, manages multidisciplinary hospital team, NHS
PhyD	Musculo-skeletal, private practice, independent, works in clinic
Psychotherapists	
PsyA	Collective with two other psychotherapists
PsyB	Multidisciplinary clinic
PsyC	Private practice, role providing support within professional organisation
PsyD	Part of team of therapists in private mental health hospital, some private practice
Acupuncturists	
AcuA	Renting room in clinic, working part time
AcuB	Own acupuncture clinic
AcuC	Private practice, part time in private clinic
AcuD	Private practice

Differences across the sample

Other diversity specified across the sample related to age, gender and tenure. While quotas were not set for ethnicity, the sample included both BAME individuals and individuals who had not been born in the UK. Two participants had done their professional training in other countries before moving to the UK.

Participants were also recruited to ensure representation across the whole sample from all four nations. To reflect the specific situation of pharmacy (with different regulators in Northern Ireland and the rest of the UK), the sample included one pharmacist who trained and still worked in Northern Ireland, and another who had transferred his registration from the PSNI to the GPhC and now worked in England.

1.3 Methodology

Participants took part in in-depth, semi-structured telephone interviews lasting up to one-hour, conducted by an experienced qualitative researcher (SC). A key objective of the interview was to create opportunities for participants to talk about the relationships between regulation and professional identity:

- without directly prompting consideration of regulation

- without using abstract terms like 'professional identity'
- encouraging as much discussion of real experiences and examples as possible

Participant consent for participation, audio-recording and subsequent use of transcripts and anonymised quotations was sought during recruitment and again at the beginning of the interview, with the contact details of the researcher made available as required. The research process was subject to King's College London ethics regulation (Research Ethics Number MR/16/17-181).

Interviews were audio-recorded and transcribed. Transcripts were reviewed independently (by SC and AC) and provisional themes, observations and patterns were identified by each researcher. These were shared, discussed and refined during an initial analysis meeting, at which significant alignment was noted in our independent analysis.

Thereafter an iterative approach to analysis was adopted, as follows:

1. Material relevant to themes, observations and patterns was grouped together and reviewed. This included supporting and counter-evidence for each point.
2. The initial long-list of themes, observations and patterns was then revised and developed:
    a. Items were provisionally validated, refined/sophisticated to reflect supporting material, qualified to reflect exceptions, replaced with a better item, or rejected entirely as unsupported.
    b. In particular, over successive iterations, themes (categories) were replaced with propositional findings (statements).
    c. Where needed, items were grouped together to create new superordinate categories/statements, or split to create separate items. Connections between items were also noted.
    d. New items were added as needed: in particular, material which had not been grouped under existing items was carefully reviewed, and new items were identified.

    Review of the material focused not just on what participants said, but also on how they said it and in response to what. Care was taken to ensure that material which was grouped under items contained sufficient indication of context: for example, researcher questions or notes on what had happened earlier in the same interview.
3. The new revised list of themes, observations and patterns was then used as the starting point for a new round of grouping (step 1) and reviewing (step 2). The process was iterated until a stable, propositional structure emerged which both was supported by and accounted for the evidence.

A final detailed evaluation of the relationship between propositional findings and evidence was also undertaken. Where necessary, final checks were also made on the original context of material, to ensure it was not being quoted out of context.

1.4 Terminology

We shall in this report refer to bodies holding registers of professionals as **register-holders**, irrespective of whether they are statutory regulators or organisations holding voluntary registers. All register-holders set requirements for individuals on their registers, and we shall refer to these as **register requirements**. In the absence of any

better term, we shall continue to refer to the activity through which a register-holder seeks to ensure compliance with these requirements (including setting the requirements in the first place) as **regulatory activity by register-holders**.

We use the term **regulation** as shorthand for the combination of register requirements and regulatory activity by register-holders: we retain this use of the term for reasons of brevity, and because no other term suggests itself.

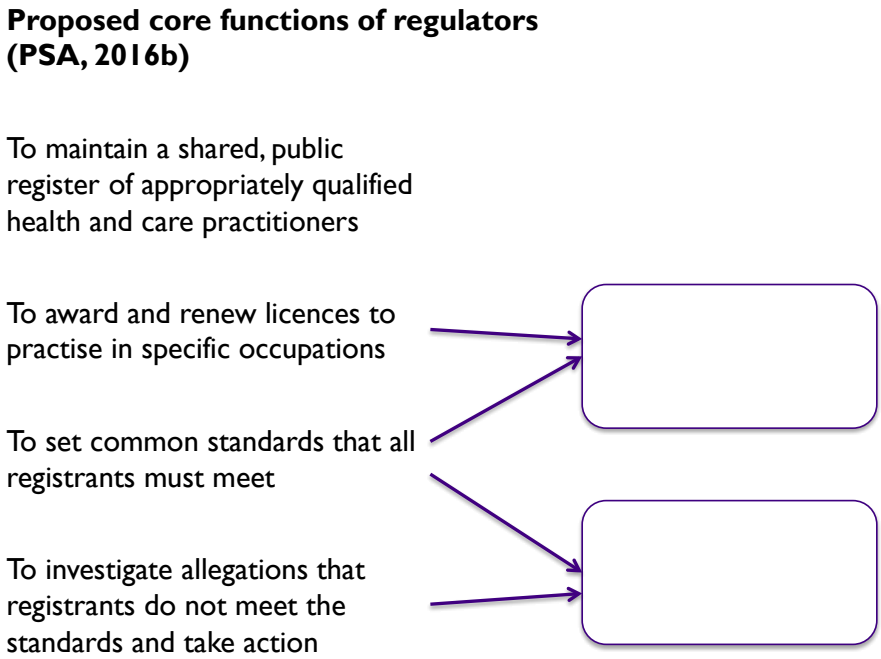
From the professional's perspective, we can also usefully divide register requirements into two broad classes (recognising that, in practice, these may overlap):

- **Access requirements** – requirements which need to be met by an individual in order to get onto the register in the first place, in particular those relating to training
- **Practice requirements** – requirements with regard to the day-to-day practice of individuals once they are on the register

The role of these two types of requirement from a professional perspective is nicely summarised in the following participant's description of the role played specifically by codes of conduct:

> *The codes of conduct are there to weed out the people who are not suitable for doing the job in the first place. That's one role for them. But the other is as guidelines, or maybe train tracks, if you like, to keep you doing the job as is expected of you by the professional body. [PsyB]*

This broad distinction of register requirements from the professional's perspective can be mapped fairly straightforwardly onto the Authority's model of the proposed core functions of regulators set out in Professional Standards Authority (2016b), as shown in the diagram below. Note that the function of maintaining a shared, public register does not map onto these requirements: we shall have more to say about this function in Chapter 5.



2. Professional identity

Professional identity is a complex construct. With reference specifically to doctors, Wilson et al. (2013) define professional identity as "how an individual conceives of him- or herself as a doctor", and this definition can readily be generalised to other health professions: professional identity is an individual's conception of her/himself *as a professional*

Beyond this basic statement, however, one of the striking features of the definitions of professional identity discussed in the Professional Standards Authority's (2016b) literature review is their reliance on lists, for example:

- "interests, roles, attitudes and value orientations" (Franco and Tavares, 2013)
- "attributes, values, motives, and experiences" (Ibarra, 1999)
- "affiliations with organizations, leisure activities, occupations, culture or ethnicity" (Gignac, 2015)

An individual's conception of her/himself as a professional has multiple, interconnected components, with changing degrees of importance. To borrow Schein's metaphor (see Ibarra, 1999), it is a "constellation".

In this report, we shall not attempt to map this entire constellation but shall instead focus on just two 'stars' – two components which emerge from the analysis of our participants' accounts as central to understanding the relationships between regulation and professional identity.

The first of these components could lay claim to being a defining feature of all professional identities in healthcare: **a fundamental commitment to help** – along with its corollary, a fundamental commitment to do no harm. In and of itself, this commitment does not distinguish between different professions in healthcare: but, as our participants' accounts show, that makes it no less important as a central component of professional identity.

In order to deliver on this fundamental commitment, of course, an individual also needs knowledge and skills. Across the interviews, however, what was striking was how often participants differentiated the knowledge and skills they brought to their professional practice from something more fundamental: an underpinning, coherent way of understanding and intervening in the world, which is more than just the mere aggregation of knowledge and skills. For the sake of brevity, we shall refer to this coherent way of understanding and intervening in the world – the second component of professional identity on which we will be focusing – as a **professional *stance***.

These two components of professional identity – a fundamental commitment to help, and a professional stance – cut across the diversity of our participants, and can be discerned in each of the individual participant's accounts.

However, their *relative salience* varies. In some accounts, for example, a professional stance is explicitly delineated by the participant, while in others it is apparent only through inference. Moreover, participants' accounts suggest three factors which may help to account for this variation, and which are reviewed in turn below.

2.1 Differences in what the individual brings to practice

A first factor which may help to account for variation in the relative salience of a fundamental commitment to help and professional stance is the individual her/himself, and the personal motivations they bring to their professional practice. Consider, for example, the descriptions given by these two pharmacists of how they first got into pharmacy:

> *At the core of what I wanted to do was basically just help people, and pharmacy was an avenue that I was able to go down and study and become qualified in. [PhaC]*

> *I was always interested in the sciences and mathematics and within that physiology and medication was something that interested me. A lot of the subjects around the training, as opposed to just the vocational degree at the end, were of interest to me. And I knew it was a tough degree. I knew it was going to be interesting and challenging, and that ticked all the boxes for me. [PhaD]*

Differences of this kind are apparent throughout our sample. For some participants, the commitment to help others had been pivotal, with the development of a professional stance very much in the service of that motivation.

> *I think it was a bit like nursing, it was a vocation that you went into because you want to change people's lives. And make them better to, you know, live a more independent life. [PhyC]*

> *I think I wanted to be in healthcare, maybe not in Chinese medicine, maybe in just Western medicine, but I think I always had this idea since childhood and I think my parents influenced that. [AcuA]*

> *From the age of 11 to 16 I went before and after school to do this patterning with cerebral palsy children who belonged to the church and school I went to. So I had always an interest in thinking that maybe helping someone, you know, physically, would help them walk again, or would help them to improve their life. So it's sort of then by the time I'd done my A levels it was second nature to me that that's something that I thought was worthwhile doing. [PhyB]*

In other cases, the development of a way of understanding and intervening in the world was a driving motivation in its own right – in one case with an open question about whether that professional stance would then be used in practice.

> *I think I set out on the journey [to qualify as a counselling psychologist as well as a psychotherapist] as really a depth of exploration. I love the material, I love the topic, I love the work. And I think because of that there's that sort of a pursuit of wanting to be good at what I do. For myself and for my clients really. So there is a drive there, I recognise that. There is a drive, there's determination. And I think it's… Yes, it's a combination of personal and professional aspects, I think. [PsyC]*

> *I think it becomes such a part of one's identity. I mean, one is likely to change by psychodynamic training. There's no question about that. It does colour the way that one looks at the world. In pretty much every way. One's own relationships, the way I look at my children, politics, sports, you*

> *know, it touches everything. But that's not necessarily being a psychotherapist. That's just my training. I could have chosen not to be a psychotherapist, it's just the way of thinking about stuff. So, there's a difference in that way. I could have decided not to practise. But I would still have been left with this legacy of psychodynamic thinking. And then, then I chose to become a psychotherapist in private practice. [PsyA]*

The balance of these twin motivations – the drive to help, and the drive to develop a coherent stance – may also change through the course of an individual's life. For example, one participant described how her move into acupuncture had arisen from a growing dissatisfaction with reflexology: she could see the approach helping people, but it lacked an underpinning stance.

> *It's not to undermine the power of reflexology, because actually it's really an effective, amazing therapy, that it, sort of, never ceases to amaze me, actually, what you can do with it. […] But, I don't know, I think I just wanted… I mean, it was more of a whole body of medicine that was underpinned by more, sort of, scientific. […] You know, [acupuncture] is, like, a 2,000-year-old body of… a whole, complete system of medicine. And so there's just a lot more scope with it. Because reflexology, once you've learned the reflexology points, you do the routine, that's kind of it. And whilst it is very effective and very powerful, that's, kind of… And you can't really diagnose with it, not that… Well, you can diagnose within the framework of Chinese medicine. […] Acupuncture, you can treat it as a complete medical system. And I just think it's further-reaching, so it just gave me a more… Well… I wanted something more cerebral, I think, having just more, you know, academic… that had more learning*

For some, the development of a professional stance remained a "work in progress":

> *It is a work in progress: so through my studies, starting to very much try and separate myself even from the attempt at being holistic in terms of the Chinese medicine. […] We look at the body and mind and spirit as a whole and… the body as a whole, indeed. But there's a holism that's even beyond that. […] And that's why I've been doing so many other courses.*

2.2 Different choices available in different professions

A second factor which may help to account for variation in the salience of professional stance in particular is the nature of the choices available to an individual within a given profession.

Consider, for example, one key aspect of one's professional stance: the theoretical paradigm one works within. The psychotherapists in our sample appeared to be far more conscious of their theoretical paradigm than, say, the physiotherapists: and one simple explanation of this pattern is the fact that a meaningful choice of paradigms exists in psychotherapy, but does not in physiotherapy. Indeed, one participant argued that psychotherapists can even choose, via their choice of professional body, *how much* emphasis to place on their theoretical paradigm:

> *If I was to oversimplify things I would say, you know, certain regulatory bodies come… They are much more [in the] practitioner-focused arena. So*

> *others come much more from, if you like, the philosophy of the discipline. [PsyC]*

Theory is, as another psychotherapist pointed out, only one aspect of a developed professional stance.

> *There's two sides to training. There's the academic side, and then there's the self-reflection. Because you have to know yourself. […] If your training is purely an academic exercise you won't do that really important work. And I know people who have first class honours degrees, but I wouldn't refer people to them. And I know people who have, you know, 2:2s that I would refer to. [PsyD]*

In other professions, which may lack significant variation in theoretical paradigms, other choices with regard to one's professional stance may come to the fore. For example, in physiotherapy, there are clear choices about the context in which one chooses to work and the types of patients one therefore encounters, and these can make salient another aspect of one's professional stance: one's way of *intervening* in the world. Compare, for example, the two physiotherapists quoted below.

> *I moved on to community [from acute work in a hospital] and I just loved it, I just… it made more sense to me as a clinician. It is harder in some ways because you are… a lot of the times you're on your own, you are… you've got to work with what you've got at [the patient's] home and with the environment you've got, with the people that you've got as well, with the resources. But then, I suppose, in some ways, it's, to me, the context of what I'm working with makes more sense because it's very functional, it's very much real life situation and I can relate my work better in that respect. [PhyA]*

> *I actually find it easier working in private practice [than in the NHS] because the patients are a little bit easier that come through the door. […] Generally, not always. Slightly less complex. You see them sooner. They've got less psychological or social problems that are limiting their outcomes. So it's easier in that way. When I worked in the NHS you'd always be having to deal with all those other things, which then meant you actually couldn't do the thing that you're mostly trained at, which is trying to deal with their physical symptoms and get them to move better. [PhyD]*

The meaningful choices available to an individual within a profession can influence the relative salience of different aspects of professional stance.

2.3 Differing levels of felt need to explain and justify

The salience of elements of professional identity can be increased by their being actively called into question. If a professional feels the need to explain or justify their professional stance, then the salience of their stance as a component of their professional identity may be increased.

This can happen in interactions with patients. For example, if patients understand professionals as a bundle of knowledge and skills deployed in the delivery of tasks, and miss the underpinning professional stance, they may become frustrated with what

appears to them unnecessary activity; and the professional may feel a need to explain and justify their stance.

> *I say to people, okay, so as a physiotherapist I've trained in all different areas, so when I ask you a series of questions about all sorts of background about your health, that's because what I understand is I have an integrated understanding of how other conditions you have might impact on your back pain because, you know, you can get something called referred pain which is, you know, pain in the back referred from your organs which are inside your body. [PhyB]*

> *I find most of my time that I do actually have to explain what I am doing and why I am obviously completing, you know, their medication history and… They'll say, but we've already had someone come and see what medications were brought in, because of course your pharmacy technician… But then I'll explain, well, no, I have to make sure that it is okay for you to take with the diagnosis that you've been given and also to ensure that, you know, guidelines are followed, so, like, hospital guidelines, NICE guidelines, things like that. [PhaB]*

> *On a typical day a lot of people don't understand why it takes maybe five/ten minutes for us to get their prescription ready, or why they can't order a prescription from a doctor and have it straightaway. I think they think we just pick things off our shelves and give it to them, rather than understanding necessarily the intricacies of the role or what we're actually doing when I'm reading a prescription and looking at it; and if I take a BNF out or a textbook, they don't really understand what I'm doing. [PhaD]*

For some professionals, a felt requirement to explain and justify one's professional stance can exist at a larger, societal level. For those at the centre of 'mainstream' or 'conventional' medicine, such as pharmacists, large parts of one's professional stance may be taken for granted in a way that they cannot be for those working in 'alternative' or 'complementary' disciplines, such as acupuncture. Indeed, the very terms 'alternative' and 'complementary' stand as reminders that these disciplines are understood in our society through a *contrast* to something else, and so stand in need of explanation and justification. This need to justify can be felt particularly acutely by those whose professional journeys began within the mainstream:

> *As a pharmacist, I was taught that you do something and you get an effect, and that effect is reproducible. And that's what I get with acupuncture: I know what's going to happen and I can get that to happen every time I treat. [AcuB]*

There is one final pattern which could drive a need to explain and justify one's underpinning professional stance: namely, when others *outside* one's profession seek to co-opt techniques, skills or knowledge *without* adopting the stance that underpins them. The most clear-cut example of this pattern in our sample relates to dry-needling, the use of specific techniques from acupuncture without the underpinning, coherent way of understanding and intervening in the world:

> *If a doctor wants to do acupuncture, they have their own particular course, which is basically for helping pain. Now, as I said, acupuncture treats generally: you have to look at why has the patient got pain. But the Western system doesn't: you have pain, we'll use points one, two, three; if*

> *that doesn't help, we'll use four, five, six; if that doesn't help, acupuncture doesn't work. There's no understanding of how the thing works, there's no belief in how it works, and that's why a lot of results aren't very good when you go to the GPs or physios who've done these particular courses. [AcuB]*

Although clearest among the acupuncturists in our sample, comparable patterns were apparent for the other professional groups engaged – see §5.1 for further discussion.

3. Individual professional practice

In this chapter, we shall explore possible connections between identity, regulation and patient care at the level of *individual* professional practice.

The *prima facie* rationale for this individualist approach is easy enough to state. Individual professional practice clearly has a direct bearing on patient care. It is also, we may suppose, connected in some way to professional identity. It is also something that regulation is clearly intended to influence. Given this, it is reasonable to look for a relationship between identity, regulation and patient care via this fourth term: individual professional practice.

What are of course being left out here are the social dimensions of identity: the self-identification of an individual with a larger community of practice, and their self-differentiation from other such communities. We shall return to these social dimensions in Chapters 4 and 5. We focus on the individual in this chapter as a pragmatic step in the exposition of our overall analysis, and not because we wish to advance or endorse such a focus theoretically.

3.1 Professional identity and individual practice

We began §2 by noting that professional identity is a complex construct. The relationship between professional identity and individual practice is an even more complex matter. To the question of what components make up the "constellation" we must add a second question: what is the relationship between these components and *practice*? It may be tempting to assume that items such as attitudes and values, for example, stand in some kind of direct *causal* relationship to behaviour: but the psychological literature on these topics suggest no such assumptions may safely be made. In this report, we shall not comment further on causal relationships, because the evidence we have does not support that kind of conclusion.

What we can comment on is the way in which our participants *constructed* the relationship between their professional identity and their individual practice. Across the accounts offered by all of our participants, a simple model of this relationship was apparent, which could be summed up as follows:

- professional identity implies standards for one's practice;
- practice in line with these standards is an expression of one's professional identity.

Take, for example, the first of the two components of professional identity discussed in §2: a fundamental commitment to help – along with its corollary, a fundamental commitment to do no harm. From this basic commitment, a number of more specific standards for practice follow, such as:

- Standards around avoiding doing harm. These obviously cover a series of issues relating to safety, including the requirement to keep one's skills strong and one's knowledge up to date. A number of participants emphasised in particular the need to know the *limits* of one's competence, and to refer when necessary. Some other

boundary issues may also fall into this category, especially in fields such as psychotherapy.

- Standards around enabling a relationship in which help can be given. These include issues around personal appearance and communication, to build patient trust. Boundary issues relating to the behaviour of the individual outside their professional practice also fall into this category.

While they follow from the same fundamental commitment to help, the details of these standards may vary between individuals. In part, this will reflect the kinds of practical differences between professions that register requirements also take into account: for example, acupuncturists face issues around health and safety relating to the use of needles which do not arise for people not using needles. But they may also reflect differences in professional stance or context of practice – sometimes apparent in our interviews in subtle nuances and choices of word.

For example, many participants highlighted the need to think about their behaviour outside their professional practice, typically focusing on those moments when they encountered patients in social settings. However, the way in which these concerns arose and were addressed varied. For one acupuncturist, for example, a concern arose when a client specifically asked her to join her for a drink when they bumped into each other at a festival.

> *But then I bumped into my doctor on the train once and sat next to him, and he nattered all the way to the next station. […] It's not, like, a sort of, psychotherapist relationship. [AcuC].*

Reflecting on the psychotherapist relationship, one of the psychotherapists drew attention to the risks of merely being *seen* by a client behaving in ways that might not meet the client's expectation that psychotherapists should themselves be "sorted" and "calm":

> *One's a little bit on watch sometimes; but it's too exhausting, and to be permanently handicapped by a sense of what it means to be a psychotherapist. [PsyA]*

For a community pharmacist, similar concerns were expressed in a subtly different way. This participant very clearly presented his professional relationship as being not just with individual patients but with an entire community:

> *We're open to the community, more or less, seven days a week, and we can get any member of the community coming in to see us for any guidance, whether it be for their health, it may be for their personal problems. [PhaA]*

In line with this, he identified a basic requirement for someone in his position to be "an upstanding member of the community".

The relative *salience* of different standards for individuals may also reflect differences in professional stance and context of practice – and the actual challenges one faces on a day-to-day basis. Another community pharmacist, for example, started from a similar observation about the position of a community pharmacist "within the heart of the community"; but, in line with the challenges he experienced working in a busy pharmacy with limited time and resources, responded to a question about the basic standards that any pharmacists should meet by highlighting the need for consistency.

> *As a professional you have to provide… you know, do your best to provide a top class service to people all the time. And regardless of the number of people that come through the door or the time of day, whether it be on your designated lunchbreak or if the phone rings, you have to try and provide the same standard of service to people day in, day out. And you know, without any, you know, dips in the quality of the service that you can provide them. [PhaC]*

For a hospital pharmacist, working in an interdisciplinary context, neither the need to be an upstanding member of the community nor the need for consistency was top of mind, but the need:

> *To be accountable for your decisions, to be honest, trustworthy, make the patients your first priority and concern. [PhaB]*

This is not to suggest that any of these pharmacists would have disagreed with the standards proposed by the others: it is merely to note that, as would be expected, the standards which are most *salient* for an individual reflect the context in which that individual practises.

3.2 Regulation and individual practice: the regulator perspective

In §3.1, we have seen how participants constructed the relationship between professional identity and individual practice: professional identity implies standards for one's practice, and practice in line with these standards is an expression of one's professional identity. In §3.3, we will consider the role participants see for regulation in all of this.

Before doing so, however, it is useful to take a step back and consider how the relationship between regulation and individual practice is conceptualised *from the perspective of those undertaking the regulation*.

The first thing to note is that the importance of the individual professional in regulating her or his own practice – in line with the views of participants discussed in §3.1 – appears to be widely accepted. For example, the Professional Standards Authority (2015a) states that:

> *We believe that it is primarily the professionalism of individuals that keeps the public safe, and in the case of health and social care also ensures the delivery of good care.*

A model proposed by the General Medical Council (2004) also places "personal regulation" at the heart of regulation, and recognises the roles played by many other actors in the maintenance of standards. A later version of this model, set out in Secretary of State for Health (2011) is reproduced below:

> *1. The most effective protection against poor practice is the individual practitioner. Their own values, supported by their professional ethos, should be what most effectively ensures good care for every person that they care for.*
>
> *2. Next, their peers and colleagues should provide assurance, with everyone working together to ensure that each other's care is safe, effective and respectful.*

> *3. That culture of care in the team should in turn be embedded and sustained by effective leadership, management and clinical governance in the organisation that provides, or arranges the provision of, care.*
>
> *4. Finally, the professional regulatory bodies and the bodies that regulate the providers of health and social care services provide a national framework of assurance.*

A generalised version of this model would need to recognise that levels 2 and/or 3 may not exist for some health professionals. For example, some of our participants working in private practice had neither a team nor an employer. The following participant drew attention to this contrast when responding to a question at the end of the interview about whether the topics discussed were ones he had given much thought to before.

> *More when I worked for the NHS. It would come up very often. This sort of thing was, as they call it, clinical governance. They're always watching what, you know, the staff are doing, and trying to make sure you're following standards and best practice. […] In a private setting, the thing is private practitioners do keep up all of the same sort of governance because, well, if you're not any good and don't keep up to date, then people go elsewhere. So, it's not as… I almost self-regulate a little bit there. Not 100% of the time. [PhyD]*

A generalised model would also need to take into account the potential role of other actors. For example, one participant now working in private practice had found in the various requirements of a private healthcare provider for whom she did some of her work some of the "leadership, management and clinical governance" now missing from level 3.

Nevertheless, the general point would remain the same: as the Professional Standards Authority (2015b) put it: "the regulator's standards are but one of many potential influences on day-to-day practice. It is almost certainly true that for working health and care practitioners other factors are far more compelling."

Despite the existence of these other factors, however, regulation is still clearly believed to exert *some* influence on the day-to-day practice of individual professionals. More specifically, regulatory activity is typically conceptualised as identifying and addressing any gaps between actual practice and register requirements. For example, Quick (2011) cites two classifications of regulatory activities or mechanisms which follow this basic structure:

- standard setting, monitoring, and evaluating and intervention (Salter, 1999)
- standard-setting, information-gathering and practice-modification (Black, 2002)

We can think of this as a 'piano-tuner' model of regulation. Pianos, like professionals, have their own internal standards: the keys reliably produce notes, and there is no need for a piano-tuner to stand next to the piano during the concert. However, those internal standards may fail to align with the objective requirements of the harmonic scale: the notes produced by some keys may be out of tune. The job of a piano-tuner is not to fix this when it happens during a concert: it is to prevent it ruining the concert in the first place. The above classifications of regulatory activity imply a direct analogy to the activity of a piano-tuner:

- supply a set of objective requirements (sound tuning forks = standard setting)

- check for divergence between internal standards and these requirements (listen = monitor and evaluate / information-gathering)
- correct where necessary (retune = intervention / practice-modification)

There are at least two interesting questions we might ask about this model. The first is whether it actually works in practice. On this question, the Professional Standards Authority (2015b) report: "little evidence that the standards have any direct influence on registrants' practice". As Quick (2011) notes in the first lines of his review of the effects of health professional regulation on those regulated:

> *The most notable finding to emerge from this review is thus the shortage of systematic knowledge on the main research question. Few studies have directly addressed the question under review: how does professional regulation affect the practice of those subject to regulation?*

We shall not comment further on this first question, given that – as noted earlier – the evidence we have does not support conclusions about causal relationships. We shall, however, comment on a second question: how does this model of the relationship between regulation and individual practice compare to the way in which professionals themselves conceptualise this relationship?

3.3 Regulation and individual practice: a professional's perspective

To pretend that there is a single professional perspective on the relationship between regulation and individual practice would be misleading. There were clear differences between our participants on this point. The participant quoted below, for example, endorsed a 'piano-tuner' model of regulation.

> *I just think that constant reinforcement of, you know, that these sorts of guidelines are important.* […] *Somewhere along the line all of these have come in place because it either improves patient safety, improves practitioner performance, improves outcomes. I don't feel like I'm just filling in lists for the sake of it, or documenting pain scales for the sake of it, because behind that number there's a reason, isn't there? And there's a reason why we brought all these things into place, and it wasn't because, you know, we needed to employ more people, you know, in the NHS, to give us more forms. I think that genuinely, behind it, it is to raise standards. [PhyB]*

It would not be misleading, however, to say that this participant was an exception in our sample. In general, for example, when participants referred to interaction with register-holders, the link to individual practice was less clear-cut.

> *The Health and Care Profession Council does send emails every… is it quarterly? Anyway, it's every so often one will pop up in my inbox, and it usually tells you anything that's changed, or if they're changing certain rules. Because I know they did change recently about that, you know, the requirement of reporting your colleagues or things, if you think they're not up to standard. And they changed, they've slightly tweaked it, and I can't remember off the top of my head what it was, but I did go and read it and thought: oh, right. [PhyD]*

Of particular interest are the ways in which participants described dealing with situations in which it was not immediately clear to them how they should and should not act: because a professional, unlike a piano, can have doubts about whether the note they are about to produce is in tune. When asked where they would turn in situations such as these, participants responded by citing a range of other actors – first and foremost colleagues, but also supervisors/superintendents, managers, helplines provided by employers and training bodies. In only a few, very serious instances had participants contacted a register-holder; and the descriptions suggest that their doing so may have been motivated as much by self-protection as by protection of the patient:

> *I have in the past fired the odd query up to UKCP just to get clarification on something, and that's been fine, it was more just confirming if that [proposed approach] made sense. […] I think it was sort of belt and braces. It was for me as a professional to know what the implications of that would be. [PsyC]*

There was little evidence of participants actively considering register requirements in other, more everyday situations.

> *These documents are thousands of words, you know, I mean, yes, sorry, I shouldn't say, in a way I shouldn't say this. But, I mean, in a way there's a lot of material in these documents, right. And, you know, to hold all of that in the forefront of your mind is impossible. So you hold the spirit of it. And, you know, I mean, like in the Hippocratic Oath, you do no harm, first of all. You know, so, there are some very basic principles that are very easy to hold to, because they're actually what you want to be doing in the first place. [PsyB]*

> *We're sent the booklet maybe when they revise it, they probably just sit on people's shelves, don't they? You might know it when you come out, qualified. [PhyC]*

> *Obviously the reality of working in a pharmacy on a daily basis, you can't always strictly adhere to these codes of conduct. But they are there, in the shop, as a blueprint of how you should go about your daily activities. And if you ever are in doubt you can refer back to them, and in all honesty, for myself, I don't really refer to them that often, but a lot of them are, you know, as you've gathered, experienced, it's what you would expect of yourself anyhow. [PhaC]*

A further interesting pattern was apparent with regard to those register requirements where compliance is actively enforced. In part, this was seen as being about – to borrow the words of the last participant quoted above – "what you would expect of yourself anyhow".

> *Yes, they want certain things from us, and they want us to follow a certain amount of protocol, but that's a natural thing that we would do anyway, I think. [PhaD]*

For example, the requirement to *engage in* Continuing Professional Development (CPD) was invariably described in this way. The task of *logging* that CPD, by contrast, was often positioned rather differently:

> *Honestly, I think yes, CPD is essential, but I think CPD, we carry out every day, so it's just a strenuous exercise, I think, to actually record it. […] I feel*

> *like sometimes it's just a tick-box exercise, so it just shows that it's been done, and maybe it's because if it's documented, it's been done, so you are fine to say you are up to date with your CPD when you register or when you renew registration, so I think it gives… you know, it gives the GPhC the confidence to say, okay, well, for them to register, they've said that they've kept up to date with their CPD so they must have done, even though we all do it but we just don't record it. [PhaB]*

Interestingly, even the participant who we saw above endorsing something like the 'piano-tuner' model of regulation described the logging of CPD as a "box-ticking exercise".

One participant described the challenge of trying to play the role of 'piano-tuner', and get other professionals he was managing to meet standards which the register-holder saw as "minimum requirements" but which they saw as a "paper exercise":

> *Part of my role there was actually trying to ensure standards of things like note-keeping and, you know, regulatory requirements. […] They didn't seem to think it was important. I'm trying to remember the word one of them used? They sort of described it as a paper exercise, as in: it's not really very important. It's just pointless. That was the reaction. […] They are actually the minimum requirements. So that's the problem. If people are not meeting those, they're not saying: oh, these are wonderful notes. They're saying: these are the minimum that you need to do. [PhyD]*

The views of the register-holder on minimum requirements were, in this instance, unable to 'retune' the standards that followed from the professional identities of individual professionals.

In some instances, register requirements may be seen as not just pointless but also damaging. For example, we can see a move in this direction in the following quotation:

> *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. [PhaA]*

Other participants noted similar responses in other members of their profession, and argued that a key issue at stake is how they conceive of their register-holders, and what intentions they see behind their requirements and regulatory activity:

> *Do you constantly see somebody over your shoulder checking up? And I don't think it is. I think it's everybody saying, you know, let's all focus on why we maybe do outcomes, why we use a pain scale, why we do that. [PhyB]*

> *The codes of practice, codes of conduct, I think, are essential. But I think read in the wrong way, they can stifle the process of either psychotherapy or acupuncture. You know, anybody adheres to… It's not that you ever break the rules, but it's that sometimes people are too frightened of breaking the rules that they never get to a point of effective treatment. [PsyB]*

What is striking is that, when register requirements fail to align with professional identity, then this may raise questions for the professional not about their own individual practice (as the 'piano-tuner' model would require) but about the practice and intent of the register-holder.

On the flipside, even a task such as the logging of CPD can stop seeming like a paper exercise if it *aligns* with the professional identity of the individual professional. This was the case, for example, for one participant with ambitions to develop his career, who described logging CPD as "a good tool for the likes of myself who want to go into independent prescribing". In fact he went further, arguing that the approach to CPD used by his register-holder was a tick-box exercise because it was *not demanding enough*:

> *I think although from past experience, whatever, like when I submit anything to the GPhC, it's just a tick box exercise with them as well. Because I can upload things that took me 15 minutes and things that took me four hours, and I'll… Every single one of them I get like 99%. It doesn't matter to them, as long as you're doing something. So it's not an in-depth procedure, it's just the fact that, you know, it's a regulation you have to fulfil. [PhaD]*

There were other instances where participants expressed concern that register requirements were not demanding enough, and we shall return to this topic in §4.1

Overall, there appears to be a simple pattern here.

- When register requirements are in line with the 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".
- 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 "box-ticking" or a "paper exercise" – or even as "damaging" – and questions may be raised about the practice and intent of the register-holder.
- 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.

As Quick (2011) notes: "The clear message to emerge from a number of studies is that regulation (however well intentioned) is far more likely to be complied with when accepted as legitimate by practitioners." Although the accounts of our participants suggest that, if the regulation is accepted as legitimate, that may just mean that practitioners are *already* complying.

The point we are making here is *not* that participants were complacent, or believed their own standards and practice could not in any way be developed, changed or improved. On the contrary, all of our participants expressed a commitment to their own ongoing development, and described the people and resources they drew on in pursuing this end. The point is that the requirements and regulatory activity of register-holders do not generally appear to be among these resources.

There is, however, one striking exception to this overall pattern: training.

> *When I'm in a scenario where I'm talking to patients, trying to help them, I'm not necessarily thinking about the GPhC at the time, but it's engrained*

> *through training that this is how you act and this is the way you do things. [PhaD]*
>
> *I haven't sort of dusted them off and looked at them for a while, but you know, I do remember looking at them back in my training: you really have to go through both sets and we discussed, explored and, you know, reflected on what that actually meant for practice. [PsyC]*

For the most part, our participants subscribed to what we might call a 'piano teacher' model of regulation, with the professional this time cast in the role of the pianist, not the piano. When first learning to play the piano, the future pianist must work through text books and complete exercises in order to master the basics, watched over by a teacher who will very much carry out the roles ascribed to regulation: supplying objective requirements, checking for divergence from these, and correcting where necessary. Once the individual has reached a certain level, they start seeing themselves as someone who can now play the piano. Those early lessons will have been "engrained". Of course, their development will continue, even if they reach the concert circuit; they will continue to practise; they will learn from other pianists; they will struggle to master tricky passages in new pieces of music; they will make mistakes and learn from them. But they probably will not turn for advice to the textbooks they studied when first learning to play, or the teacher who made them complete their scales.

3.4 Individual practice and patient care

It is beyond the remit of this report to consider which of the models of regulation outlined in §3.2 and §3.3, if either, is more accurate, defensible or desirable. What is striking, however, is that whichever of these models one adopts, one's answer to the first question posed for this research – whether patient care benefits from strong professional identity and if so, how and why – is likely to be the same.

That is because a strong professional identity, along with the standards for one's practice that follow from it, is seen from both perspectives as *essential* to ensuring the quality of patient care. In the words of the Professional Standards Authority (2015a): "it is primarily the professionalism of individuals that keeps the public safe". To put the same point in the terms used in this report: it is primarily the commitment of individuals to practise in line with the standards that follow from their own professional identities that drives good patient care.

The more problematic question, it seems, is whether patient care benefits from strong *regulation*, and if so how and why. Both perspectives agree on assigning a critical role to register requirements in the *development* of a strong professional identity (that will subsequently be beneficial to patient care). From the professional perspective:

- practice requirements play a central role as objects of discussion, reflection and learning, and in the formation of the individual standards associated with one's professional identity;
- access requirements play a key role in ensuring that individuals engage in this kind of focused consideration of practice requirements.

After training, however, there appears to be a divergence in views on the relevance of regulation to individual practice and patient care. The regulatory perspective justifies

post-training regulation by recourse to what we have called a 'piano tuner' model: although no evidence is available to support the validity of this model in practice. From the professional perspective, by contrast, post-training regulation *appears* to be largely irrelevant, confined to the fruitless tasks of i) getting professionals to do what they would have done anyway and ii) promoting box-ticking exercises.

We emphasise the word 'appears' in the last sentence, however. That appearance derives entirely from the narrow focus of this chapter on individual practice – and this characterisation of the views of professionals on regulation is accordingly an incomplete one. To understand the role that professionals do see for regulation post-training, we need to return to the social dimensions of identity overlooked in this chapter: the self-identification of an individual with a larger community of practice, and their self-differentiation from other such communities.

4. Community of professional practice

In Chapter 3, we explored the connections between identity, regulation and patient care at the level of *individual* professional practice. Being on a register, however, does not just establish a link between an individual professional and a register-holder. In can also link that individual professional to all of the other individuals on the register, and marks them out as, in important respects, the same.

> *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 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. [PhaD]*

The existence of the register provides evidence that a larger, aligned community exists – one with which the individual is also aligned.

In this chapter, we shall explore the connections between identity, regulation and patient care at the level of a *community* of professional practice.

4.1 Alignment and validation

As noted above, the existence of the register provides evidence that a larger, aligned community exists – one with which the individual is also aligned. As an individual, one should be able to trust that the professional identities of others on that 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 has some important practical consequences. For example knowing that someone else has the same commitment to help and professional stance as oneself is essential for confident referral. The next quotation is from a participant who does *not* feel his voluntary register provides this kind of confidence, describing how he would *like* things to be:

> *Say [a client says]: "Well, my auntie lives in London, can you give me the name of an acupuncturist in London?" Well, I can then look in the book with… you know, and I'm sure it doesn't matter, I can send… anyone who is registered, I can send them to them, because I'm sure that they will be up to a certain level. At the moment, I'm a bit dubious. I'm a little bit wary on that. I know they would be safe, but being safe is the minimum. You want somebody who understands it, who's gone through it a bit more and has that little bit more understanding to help. [AcuB]*

The potential consequences of a sense of alignment with a community are not only practical, however. Both of the participants quoted so far in this chapter link being part of a single body to a feeling of *pride*. In the quotation below, the participant is responding to a question about what would be lost if the regulators no longer existed,

given that he has just argued that regulators require one to do "a natural thing that we would do anyway":

> *I think a sense of being a professional would be lost. Because you're not technically registered to a body. So 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. I think… It's an interesting point. I think you'd lose… Yes, I think you'd lose some… It's hard to put it into context I suppose, but you'd lose a bit of what you personally see as your own professionalism, you know, whether the public see it that way, 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. [PhaD]*

Meanwhile, in the next segment of conversation, the participant is responding to a question about whether it is a good or bad thing that there is more than one professional body in acupuncture. As can be seen, the interviewer was slightly surprised by the reference to pride at this point:

> *I wouldn't think that's a good thing. If you are proud in what you do, it should be from one particular over… body, shall we say, that sees to everything.*
>
> *Interviewer Sorry, did you say "If you're proud in what…"?*
>
> *You should be proud of what you do. […] You have to be… when you do a thing, you must enjoy it, you must be proud to do it, and in order to do that…*
>
> *Interviewer And how is pride linked to the one body, sorry?*
>
> *Because what it means is basically that you can refer to other people who have been under that body because you know that body. You don't know what the standards are of a different… a different body, such as some of the Chinese ones have got their own, and you don't know what standards they're at. You only know the standards that you're… the one that you're at. [AcuB]*

The sense that one's professional identity and standards are *aligned* with those of 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. One participant suggested that statutory regulation – a legal requirement to be part of a single body – served to further strengthen this sense of validation through being part of a community:

> *If it was on a voluntary basis, it would… yes, it would worry me, yes. […] If it's statutory, then, you know, it's a legal requirement, you feel more… I don't know, how can I put it? […] You feel like you belong to… belong to the council, the GPhC, you belong to them, you're registered, you know, they have a record for everyone to see. [PhaB]*

Just as a sense of alignment can provide communal validation, however, so too disruptions to that alignment can call that validation into question.

> *If one pharmacist, you know… if something happens and they did something that they shouldn't have done or they didn't… they weren't*

> *acting in a professional manner, then it does reflect badly on the whole profession. [PhaB]*
>
> *I think the sense is they let the team down or they're letting my profession down if they don't behave. [PhyB]*
>
> *For a pharmacist to have made such an error, you know, calls into question the pharmacy profession. [PhaC]*

If repeatedly called into question, moreover, the sense of communal validation may break down entirely, and the individual cease to identify with the community. This was the case for one of our participants who was actively considering changing her register:

> *I'm not sure I want to belong to an organisation where it's possible to be a poor practitioner and be accredited by that organisation. And I have seen that.* […] *I'm going to be held, hopefully, to account in a stricter way, than I currently am. And that raises my game and that makes me better.* […] *It's about how I see myself, maybe about how other people see me, but also it's about the profession generally being better, and I want to be part of the part that is better if that makes sense. [PsyD]*

4.2 Alignment and 'holding to account'

As we have seen in §4.1, being on a register can – though may not – provide a sense of communal validation of one's own professional identity and standards. For it to do so, however, two critical conditions must be met:

- The existence of the register must establish that an aligned community does in fact exist.
- Being on the register must establish one's own alignment with this community.

How does a register establish these things? The last quotation above, and in particular the participant's hope that a stricter set of requirements "raises my game and makes me better", appears at first sight to suggest that something like the 'piano-tuner' model of regulation outlined in §3.2 may after all be at work here. The pianos are all in tune with each other because they are all being regularly tuned by the same piano-tuner, with the same set of tuning forks. However, as we saw in §3.3, this 'piano-tuner' model was not for the most part held by our participants: and a second explanation of the way a register establishes alignment is apparent in another phrase in the above quotation: "I'm going to be held, hopefully, to account in a stricter way".

'Holding to account' is a very different kind of relationship between register-holder and professional than that supposed by the 'piano-tuner' model. It highlights the critical role that register requirements play not in *making* but in *justifying* decisions about how to act as a professional. Alignment is established not because everyone on a register is checking the same codes and standards – they are not – but because, if the worst occurs, everyone on a register will be held to account by the same register-holder, acting on behalf of the aligned community as a whole.

> *You want all to be roughly doing the same kind of work. And, if your professional body didn't have a code of ethics, you could have people abusing that. And people will say, it's fine, there's nothing to say we can't abuse that. You know, except maybe natural justice. But I think there has to*

> *be some kind of line. You say: this is something that defines somebody who is a professional. [PsyB]*

In fact, as some participants pointed out, checking codes and standards when *making* a decision may be of limited help even if one does do it, owing to a necessary gap between general rules and specific applications. What was seen to matter was not the mechanical application of rules in *making* a decision, but the case that could be made subsequently when *justifying* it – including, sometimes, in justifying decisions that, in a strict sense, broke some of the rules.

> *You feel like you are actually… you know, you are fighting, thinking, okay, well there's law on one side, but then, you know, you are looking after the patient and that's what your duty is, you know, your professional duty. […] Your professional responsibility doesn't stop just because you followed a piece of paper. [PhaB]*

> *I don't think they [guidelines for reporting other professionals] can be any less grey, because they have to be grey to be all-encompassing, I suppose. They're fairly broad for some of them, yes. […] I suppose if they're too specific you'd be… you wouldn't be able to think of all the possible things. [PhyD]*

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

Colleagues and others can play a critical role here, effectively standing in for the register-holder; and a number of participants drew attention to the importance of opportunities for reflective discussion of this kind in professional practice. The quotation below is from the participant who's aspiration to "be held to account in a stricter way" is analysed above, and highlights the valuable role a supervisor can play by standing in this respect, alongside the limitations of the actual register requirements.

> *The ethical framework is… It's things like, well confidentiality, you must have supervision. It talks about diversity. But it doesn't go to that level of detail. […] And actually supervision's an important part of that. [PsyD]*

4.3 Alignment, access requirements and protected title

The most extreme expression of the register-holder's role in holding professionals to account is when people are removed from the register. On the other hand, register-holders also control access to the register, through access requirements: and in line with the 'piano-teacher' model outlined at the very end of §3.3 these too can be seen as playing a vital role in establishing an aligned community.

> *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… 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. [PhaD]*

One argument for regulation made by a number of participants was that, in the absence of access requirements, *anyone* can set themselves up in practice, with no guarantee of alignment with regard to their professional identity and standards.

> *We could get somebody on the street, gets a book out and sticks pins in people. That is absolutely diabolical, and no, there has to be a standard. [AcuB]*

In line with the Authority's views on the purpose of regulation, participants highlighted the risks to patient safety from such a situation. But the implications of weakened access requirements for the alignment of the wider community were also raised.

Specifically, this possibility was raised in respect of not access to *registers* but access to *titles*, and by those with experience (current or past) of their title not being protected. From the Authority's perspective, the critical mechanism used to set oneself up in a profession – whether that profession has statutory regulation or not – is a public register. In practice, however, people set themselves up through the use of titles: and in the competition between a technically sanctioned set of markers (registers) and another with wide social currency (titles), the latter may carry more weight with the public.

> *The more people who are practising bad psychotherapy does us all a great disservice, obviously. So, at the moment you can call yourself a counsellor, give yourself an advert in a local newspaper, or on a website, and you don't have to have any qualifications at all. […] I would welcome anything that removes unqualified people from the practice. [PsyA]*

> *[The introduction of protected title for physiotherapists] was just a little bit of protection, because otherwise there's the thought that someone can just put up a sign and say they're a physiotherapist, and then obviously that can bring your profession into disrepute because, you know, who knows what training they have? So then someone sees it and thinks, oh that's what a physio's like. They're rubbish. So it gives some protection against that. [PhyD]*

> *About a year ago, or two years ago, you could open an internet pharmacy without being an internet pharmacy. […] It was, to a certain extent, misguiding the public to say that the pharmacy profession is as it should be but those internet pharmacies weren't really representing pharmacies. They were just out to make a profit. That's a bad thing. Of course, you can probably order stuff from those people and it turns out to be wrong. It gives the whole profession a bad name, doesn't it? [PhaA]*

Note the parallels between language used in the above quotations – "does us all a great disservice", "bring your profession into disrepute", "a tarring brush on all acupuncturists", "gives the whole profession a bad name" – and that used in the quotations in §4.1 which described the effects of individuals who are on a register falling short of shared standards – "reflect badly on the whole profession", "letting my profession down", "calls into question the profession". In both cases, communal validation is undermined by the disruption of the underpinning sense of alignment. The difference is that, in these quotations, that sense of alignment is being disrupted not by people who are actually on the same register, but by people who are merely using the same title.

It is important to note, however, that these views on the importance of protected title in creating a sense of alignment were not universal. The following quotation is from the participant we have earlier quoted linking a single professional body to pride, and describing the prospect of anyone setting themselves up in practice as "diabolical". Having outlined the public safety case for protected title in acupuncture, he is here responding to a question about whether protected title would make any difference to him personally:

> *No, I would feel exactly the same. The thing is that we have patients who have relatives in different places, and they want to refer them. […] I want to be sure – and I mean that, sure – that the person I recommend is… or the people that I recommend, which is more likely, that they are safe. [AcuB]*

4.4 "I just do my own thing"

The combination of access requirements and the role played by the register-holder in holding registrants to account mean that being on a register can provide a professional with a sense of alignment with a wider community and, as a result, communal validation of their own professional identity. Protected title can strengthen this benefit, by extending the scope of those access requirements from a technically sanctioned set of markers (registers) to another with wide social currency (titles).

But how important is this kind of communal validation of one's professional identity to individual professionals? Our evidence suggests a mixed picture. In particular, it is very important to remember that, in presenting the case above, we have focused on the perspectives of those who drew attention in some way to issues of alignment and validation, and not on the perspectives of those who failed to mention these issues.

By way of a corrective, it is therefore worth briefly considering an example of a participant for whom engagement and alignment with a wider community appeared not to be a significant issue.

> *Maybe other people get more from their professional bodies. I don't know. Maybe they're more involved. Some people are really involved in it or, you know, they go to conferences and all this, that and the other. I'm not one of those people, really. I just do my own thing. [AcuC]*

It is interesting to contrast this more individualist take on professional identity with the community-focused perspective we have been discussing so far in this chapter. Take, for example, her choice of professional body: previously registered with the British

Acupuncture Council, she was now registered with the Association of Traditional Chinese Medicine for entirely practical reasons:

> *If you drop your membership for more than two years, you have to then… It costs an absolute fortune to get back in, because their exam, you have to pay… It was purely financial. It was going to cost me about £1,000 to get back into the BAcC. [AcuC]*

By way of contrast, consider the decision made by the next participant to join a body with which he felt aligned, even at personal cost:

> *I've had one patient who came to me and asked about being paid for by insurance. And my understanding was his insurance company wouldn't recognise members of the BPC. So that was rather working against me. […] It's really the way I was trained. And having been to their events and conferences and so on, I like that way of thinking. It fits with my own way of thinking. I hope that doesn't sound too sort of closed and unopen in some way. […] I like the stance of it, and I think it's something worth preserving. [PsyA]*

Indeed, in comparison to some of the views we have seen expressed earlier about the value of being on a register in terms of pride or validation, the decision of our more individualist participant to be on a register *at all* seems transactional.

> *The only reason I'm registered, really, is because I work in [Local Authority], and they need to see that you're registered with a professional body. […] If I was just working on my own, as long as I've got insurance, then I can still practise as an acupuncturist. [AcuC]*

Later in the interview she argues that insurance is in fact probably more important than registration, and links the importance of professional bodies to the embarrassment patients may experience in asking to see insurance certificates:

> *You have to have insurance. But I suppose, if you're not registered, then you don't even need to have insurance. […] Well, there's no one watching you. You're just Joe Bloggs. I mean, you know, there's nobody… You can do what you like, to a certain extent. And I think insurance is important, more important than the registration, probably. And I suppose a patient could ask to see an insurance certificate, but do they? People don't, do they? Because they're embarrassed or, you know? So I think it's really important to the patient that there is a professional body, yes. [AcuC]*

In the absence of communal validation of one's professional identity, the value of being on a register for an individual risks being reduced to a tradable set of costs and benefits.

Perhaps more significantly, the responses of this participant suggest that, in the absence of communal validation, the importance attached to access requirements and the role played the register-holder in holding registrants to account, which underpin that validation, may also be diminished. In the following quotation, the participant is describing how to respond to situations in which it is not clear how one should and should not act:

> *I think it's just your own personal instincts and decisions. I don't think there's anything in your, sort of, training that would help you with that,*

> *because… I mean, I suppose they would probably just say keep your distance and keep yourself… keep your professional… You know, on paper, that's what you're probably told, but in reality, you know, I don't think anyone behaves like that. [AcuC]*

We have focused here on the response of a single participant because she provides a clear example of a more individualist perspective on registers, from which communal alignment and validation do not matter. We do not by this intend to suggest a binary split between 'individualists' and 'communitarians': rather our evidence suggests a spectrum of views. The 'communitarian focus' described in this chapter was prominent among our participants, but it was not universal. As the participant whose responses are analysed in this section noted:

> *There's quite a lot of, you know, just, sort of, lone rangers out there, sort of, quietly treating people and, you know, making people better. [AcuC]*

4.5 Community of practice and patient care

In §3.4, we saw that:

- patient care benefits from strong professional identity whatever one's perspective on the relationship between regulation and individual practice;
- register requirements play a critical role in the development of a strong professional identity, whatever one's perspective on the relationship between regulation and individual;
- but, from a professional perspective, post-training regulation *appears* to be largely irrelevant, confined to the fruitless tasks of i) getting professionals to do what they would have done anyway and ii) promoting box-ticking exercises.

We also noted, however, that this appearance derives from a narrow focus on *individual* practice, and a failure to take into account the social dimensions of identity which we have started to explore in this chapter. For some (but not all) professionals, being on a register may also provide a sense of communal validation of one's own professional identity and standards.

Underpinning this communal validation are the ways in which the register establishes the alignment of a professional community. In part this is once again via the operation of access requirements, meaning that all of those on a register have been through comparable training. We have also seen evidence, however, of a different kind of mechanism by which register requirements may continue to play a role post-training: by providing a set of requirements *not* to be checked in *making* a decision, but to be drawn on, if necessary, in subsequently *justifying* that decision. To continue the metaphor of Chapter 3, we might say that the role of the register-holder is neither piano-tuner nor piano-teacher, but a demanding yet consistent critic in the audience, whose judgements reflect the collective identities and standards of pianists.

What are the implications of this for the relationship between professional identity, regulation and patient care? First and foremost, we would argue, it means that professionals – at least those who are less individualist in their perspective – see the role of post-training regulation as far more substantial than previously suggested. Specifically, regulation has a role to play not just in the development, but also in the maintenance of a strong professional identity – not because it directly influences

individual practice, but because it provides communal validation for an individual's professional identity and standards, and communal standards against which individual practice needs to be justified.

As noted, however, this more substantive role depends on seeing professional identity from a more communitarian perspective. In this respect, it may be of value for register-holders and other relevant bodies, such as the Authority, to consider where *they themselves* sit on the communitarian-individualist spectrum. It is of interest that the individualist participant whose responses we have analysed in §4.4 was also the only participant for whom the function of regulation could be reduced entirely to the reduction of harm to patients:

> *I think any healthcare practitioner, really, should be… Well, any healthcare practitioner that is, sort of, hands-on or administering some sort of medicine, some sort of… anything that could, sort of, cause damage, effectively, should be registered.*
>
> *Interviewer And that's because of the…?*
>
> *Well, just safety of the patients.*

5. Register benefits

The Authority defines the purpose of the regulatory system as:

- protecting patients and reducing harms
- promoting professional standards
- securing public trust in professionals

From this perspective, it is not part of the *purpose* of the regulatory system to deliver benefits to professionals themselves. As a matter of fact, however, professionals do clearly receive benefits as a result of being regulated (as a group) and on a register (as an individual). For example, if the regulatory system succeeds in delivering the third of the aims above, then professionals receive a collective benefit in the form of public trust. And in Chapter 4, we have seen how individual professionals may experience a sense of communal alignment and validation through registration.

Some of the most important benefits of registration derive from the first of the proposed core functions of a regulator set out by the Professional Standards Authority (2016a): to maintain a public register of appropriately qualified health and care practitioners. The *purpose* of a public register in the regulatory system clearly relates back to the overarching purpose above: it is not designed to benefit professionals. As a matter of fact, however, its existence does confer significant benefits on registrants. These start with a right to state (and ability to prove) that one is indeed on the register. From this basic benefit, a range of other significant benefits may follow[1], such as:

- the right to practise
- the use of a title
- the use of a logo
- access to work – e.g. in the NHS, for private health providers, in specific local authority areas
- qualification for insurance

In this chapter, we shall briefly discuss two key types of register benefit which could have a bearing on professional identity, and which were discussed in our interviews. Although not directly relevant to the question of patient care, these two types of benefit complete our understanding of the relationship between regulation and professional identity.

[1] Note that where registers are held by professional bodies, as is the case with voluntary registrants, registrants/members may also gain access to other services and resources which do *not* follow from the mere existence of a public register. These include benefits arising from additional functionality attached to the basic public register e.g. a route to new clients via geographic search functionality. We propose that benefits such as these should be thought of as *membership* benefits, and clearly differentiated from register benefits, which follow from the core regulatory function of maintaining a public register of appropriately qualified health and care practitioners.

5.1 Differentiation and acknowledgement

In §4.3 we considered the role played by access requirements in creating an aligned community. In the process, however, such requirements also play another role which can be just as important to the development of a strong professional identity: differentiating one's own community from others.

Consider, for example, the following quotation, which is structurally equivalent to quotations in §4.1 about individuals on a register "letting the profession down" and quotations in §4.3 about individuals co-opting a title "doing us all a disservice".

> *We have patients that have gone to hospitals, and there's somebody who's dabbled in acupuncture, has been treated, and it hasn't helped. So the patient then says, right, okay, I've tried acupuncture, it doesn't work. So they will not go out and then look for another acupuncturist to see if they can help, because this other one, it didn't work, and that's one of the biggest problems as well. That's why it should all be under a similar umbrella, and for acupuncture have a certain level of training, and then when they have this, then they should get their protected title. [AcuB]*

Despite the structural similarity, there are important differences to be noted here. First, the "somebody who's dabbled in acupuncture" is *not* a member of the same professional community (as in §4.1) or entirely outside professional communities (as in §4.3): the "somebody" is a member of *another* professional community. Secondly, the concern is not that this person is unsafe or doing harm: it is that they are not at "a certain level of training": in particular, they are using acupuncture techniques without the underpinning professional stance. These differences are made very clear in another comment on this issue from earlier in the same interview:

> *There's no understanding of how the thing works, there's no belief in how it works, and that's why a lot of results aren't very good when you go to the GPs or physios who've done these particular courses. […] They are… they are… shall we just say, basically, their level will be… will be safe and will be reasonable. It will be reasonable, but it… none of them have been given the opportunity, or very few of them have been given the opportunity, to look a little bit further into acupuncture, because they can't at their level. [AcuB]*

The co-option of acupuncture techniques by those lacking the professional stance of a traditional acupuncturist – already noted in §2.3 – was mentioned by other acupuncturists in our sample, and linked by some to the issue of protected title.

> *They do a one or two-day course and they… And they call it dry-needling or something like that, but they still call them acupuncturists. They call themselves acupuncturists, but they never, you know, understood the theory behind it. [AcuA]*

It was also acknowledged by one of the physiotherapists who herself used acupuncture techniques:

> *I wouldn't describe myself as an acupuncturist, no. I'd describe myself as a physiotherapist who uses acupuncture. […] I don't think I can call myself an acupuncturist. So I think the title of acupuncturist is for people who've done a degree in acupuncture. […] Because a lot of acupuncturists train in Chinese medicine as well, you know, that kind of Chinese perspective. So I*

> *think that we use musculoskeletal acupuncture points, so we're using it to augment our physiotherapy. [PhyB]*

Comparable issues were also identified by participants from other professional groups. For example, there was mention by physiotherapists of the need to differentiate their professional stance from the work of massage and sports therapists.

> *Before I was here in the UK, it wasn't a protected title, so everybody… anybody who was doing a bit of massage was calling themselves physios. And no disrespect for people doing massage, you know, they do their job, that's fine, but there is a definite distinction between what they do and what we do as a physiotherapist. [PhyA]*

> *I mean, the other example at the moment, there's a lot of people who have done, for instance, sport science degree, and then they set themselves up as a sports therapist, which is not a protected title. And people on the street often see that as a specialist physiotherapist. [PhyD]*

One of the psychotherapists, meanwhile, argued for a distinction between counselling and psychotherapy:

> *I think it's a different level of training. I think it's… But that doesn't mean it's any better. […] I think it's about the sort of level of depth, if you like, that I am able to work at with clients. […] So I don't know if it's… if informing the public about the distinctions helps, but I think there is something about perhaps recognising these are different levels of psychological or talking therapies if that makes sense. [PsyC]*

Already a trained psychotherapist, he himself was in the process of completing training as a counselling psychotherapist, and explained this as in part a desire to demonstrate "depth":

> *I think it's really just to show a depth of sort of understanding and a depth of sort of training and those sort of things basically. And I think it is that sort of trying to convey a sense of professionalism through that sort of training. [PsyC]*

The only group for whom there was no clear evidence of concern around the separation of technique from underpinning professional stance was the pharmacists: perhaps because their core technique, the dispensing of medicines, is so tightly bound to their professional stance by regulation.

Why does differentiation matter? In part, there is a continuation here of the themes of Chapter 4: a failure to differentiate those who are not truly part of a professional community can weaken the alignment of those are part of it. But the evidence suggests there is another important register benefit at work here: acknowledgement.

For example, a striking theme of the above quotations is that, in the process of differentiating their professional stance from that of other groups, participants were at pains to avoid the appearance of devaluing those other groups: note, for example, the use of phrases such as: "it will be reasonable"; "no disrespect for people"; "that doesn't mean it's any better". In arguing for the importance of differentiation, it seems that participants were sensitive to the possibility that they might be accused of preciousness or self-importance. And this may be because, as some participants acknowledged, the

desire for differentiation is at least in part driven by a desire for the time and energy one has invested in developing a differentiated professional stance acknowledged:

> *That's why it matters personally, you know: sort of spent a lot of time, energy, mental energy, commitment and emotion in getting to the place I'm at now. [PsyC]*

> *I think I've invested a lot of training and education and a lot of personal… you know, it's my life's work, in a sense. I migrated to get to where I am. There's not a lot of people who can say they've done that; so, on a personal level, maybe I shouldn't take it personally because it's just a job, but it's also a lot of time invested to gain the level of practice that I do at the moment. I'm not saying I'm the best in my practice, not at all, I'm, you know, probably on a par with what I should be doing. I'm not exactly a specialist, but, at the same time it is just the amount of personal effort that's gone into it, I think, you know. [PhyA]*

> *There is something about being recognised as having achieved a certain level of education. [PsyB]*

From a human perspective, this desire to have one's hard work and effort acknowledged seems entirely unexceptionable. Specifically in the context of healthcare, however, it may raise concerns because it is, in the technical sense of the term, a 'selfish' desire, not obviously related to the fundamental commitment to help. The tension between this 'selfish' – if entirely human – desire and a fundamental commitment to help is explicit in the following quotation.

> *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 and you continue to put your time in, in terms of, you know, your intellectual and your physical, you know, time. And if, you know, all it took to be a physiotherapist was to do a two-week massage course, you could have been a physio or physio massage, then I think it's probably to do with that. And then I kind of think, well maybe that massage therapist is better than me. Maybe they can get people better, I don't know. You know, so that's the prickle. And I think, right, let the prickle go. […] I'm not the moral guardian of the world to judge it, am I? [PhyB]*

Whatever view one takes of the desire to have one's hard work and effort acknowledged, there are clear points of connection between regulation and

professional identity here. The exacting access requirements of register-holders mean that, while it may not be its primary purpose, registration does *de facto* acknowledge the hard work and effort involved in developing a professional stance. Moreover, to a greater or lesser extent, registration equips professionals with ways of differentiating themselves from others – especially if a register is associated with a protected title.

5.2 Status and legitimacy

One important way in which professions (and their associated registers) may differ is in respect of their status in society as a whole.

For example, professions differ in the extent to which their professional stance is culturally accepted as 'normal' or 'mainstream'. One of the peculiar features of being 'mainstream' is that it only looks like a potential benefit to those who lack it: to those who have it, it is largely invisible, a feature of what feels like the natural order of things. In line with this, this topic arose mostly in interviews with acupuncturists, the group in our sample with most reason to assert that they are not currently part of the mainstream of healthcare in this country.

> *It's like a whole different system of medicine, and it is not the system of medicine that is currently the… seen as the predominant, you know, system, is it? […] You know, if you were trying to say who's the most professional between a GP and an acupuncturist, then you're going to lose. […] If you're going to get in an argument between… Which I frequently do, between the two medical systems, then somehow you're in a weaker… You're starting from a weaker position, because you're having to justify your therapy. [AcuC]*

> *I think we should talk here more about our location. […] If you go, like say, to Taiwan, you go to the hospital, it's a massive building [and] they have both medicines in the same building and the patient can decide which ones they want to use. […] Conventional medicine is obviously the medicine which the majority of people will recognise, and they will definitely know that it is there, and it's the medicine which everyone will think of first if you mention medicine. [AcuA]*

> *I think that's what it is. At the moment, it's not been… they can't prove it in the Western system, because it's not provable in the Western system, so if it's… if they can't prove it, they won't accept… they won't accept it. Yet they… yet they will go themselves to have acupuncture but they can't… they won't give you the status, you see? [AcuB]*

For acupuncturists in our sample, the lack of statutory regulation could easily become entangled with the sense of being outside the cultural mainstream. This could also be exacerbated by some of the practical consequences of this different status in comparison to other professions who are at the same time co-opting acupuncture techniques without the underlying professional stance:

> *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. [AcuB]*

Confusion about the significance of statutory regulation is not limited to those who lack it: for example, an incident was described where a participant was told by another (statutorily regulated) professional that they did not have the same procedural rights in the clinic, on the grounds they did not have statutory regulation. There was also some evidence of confusion regarding the meaning of statutory regulation: at times, it was described as a kind of government endorsement of the *effectiveness* of acupuncture, of the kind of that might in fact come from a body such as NICE – although, the actual value of such an endorsement was at the same time called into question.

> *[Statutory regulation] would make a lot of… a lot more patients be prepared to try acupuncture, because then if the government says it works or they believe it works, then they feel more confidence, so more would try it. [AcuB]*

For its part, the Professional Standards Authority (2015b) takes a dim view of the idea that statutory regulation should in any way be thought of as a badge of social status or legitimacy.

> *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.*

There is something heroic about the uncompromising rationality of this passage: if only describing culture as "out of date" were also an effective way of changing it. From a professional perspective, the rationality of current regulatory arrangements may be hard to discern, as one participant, reflecting on his international experiences, noted:

> *In Australia a physiotherapist is responsible for putting a plaster on a fractured leg. In Britain they're not. […] In Australia, you can't use acupuncture if you're a therapist because they have registered acupuncturists and only they can use that title. So you have to call it dry-needling. Whereas here, they want you to say it's acupuncture and be part of a registered body within the Chartered Society of Physiotherapy. So it can be a bit confusing. It's different everywhere. I worked in America too, as a… They have respiratory therapists. So that's part of what physios do here, but in the United States they don't' do that. So yes, it's a bit different everywhere. […] it came from slightly different backgrounds in different countries. So, I think that's just where it comes from, historical. [PhyD]*

From a rational, ahistorical perspective, it may well be correct to downplay the importance of of statutory regulation as a badge of social status or legitimacy. From the culturally and historically situated perspective of our participants, however, that is exactly how statutory regulation may appear.

> *I think there are certain professions that are viewed as, as you say, because they're legally bound to be professions, and you need to be registered on those that it probably creates more confidence within the public, that you*

> *know, these guys know what they're doing. And because we work in such close proximity with other healthcare professionals that also have that, I think it's very important for us to follow the same procedure. So we wouldn't want… It might look a bit more amateur if we weren't on a register and say dentists, GPs and nurses were. [PhaD]*

Moreover, some participants argued that it was precisely a badge of status and legitimacy which the Authority had provided through the mechanism of accredited status:

> *I was very pleased when that came along. Because it's not just related to health, it crosses lots of different areas, the PSA. So, from that point of view, it means that the approval is wide-ranging. […] In the same way that putting letters after names makes one feel important in some way, this makes us look important on our website. And, indeed, everybody thinks the same that I have spoken to about it. […] You know, everybody's after approval of some sort, whether they like it or not. I think this is part of it. […] It's government approval, you know. All of it adds to the feeling. So, first time patients, who are probably in a bit of despair, who've never picked up the phone to anybody before, can go, it's okay, it's going to be okay. You know. It takes away the witch's hat. [PsyA]*

> *[I have the Professional Standards Authority logo on my website] because it's a mark of approval, and that's worth a lot. If, I don't know how much anybody actually pays attention to it. But I pay attention to it, because I think, I've got that. I've worked hard, and I've got this far. You know, I'm a member of three different professional bodies, and they're recognised by the PSA. Well, two of them are. [PsyB]*

Although one participant – the participant whose unusually individualist responses were analysed in §4.4 – wondered whether this badge of legitimacy itself had any legitimacy:

> *Well, I mean, anything's good, isn't it, that gives you more legitimacy. You know, anything that is seen by a body. But then, I mean, who is that body anyway? I mean, to be honest with you, they approve a lot of things I really disapprove of, so do I actually care what they think anyway? I don't know. I'd have to really think about it and look at what other things they approved. [AcuC]*

In §4.3 we drew attention to a competition between a technically sanctioned set of markers (registers) and another with wide social currency (titles). A similar competition exists, we would suggest, with regard to the meaning of statutory regulation: with the technically sanctioned purpose of statutory regulation competing with its broader social meanings.

For our current purposes, the key question is: how does this competition impinge, if at all, on professional identity? And here we see an interesting pattern. At first sight, social status and legitimacy might be seen to go to the heart of one's professional identity; as the pharmacist quoted above puts it, lacking statutory regulation "might look a bit more amateur". At the other end of the 'social legitimacy scale', however, it is striking that all the benefits ascribed (accurately or not) to statutory regulation by the acupuncturists in our sample are *practical* ones: implications for what one can and can't do rather than implications for how one sees oneself. Professional identity does not seem to be at stake. And perhaps that is because anyone practising as an acupuncturist

must *already* have embraced a professional identity outside the mainstream of Western medicine.

A number of our participants associated statutory regulation with social status and legitimacy; and for some of the acupuncturists in particular, this raised important issues. But there was no evidence of a relationship between acquiring such status and legitimacy and a strong professional identity.

6. Conclusion

In this report, we have analysed the views of sixteen health professionals from four different professional groups on the relationships between regulation, professional identity, and patient care.

We began by identifying two key components of professional identity – itself a complex construct with many components – which are central to understanding the relationship between regulation and professional identity:

- a fundamental commitment to help – along with its corollary, a fundamental commitment to do no harm;
- a coherent way of understanding and intervening in the world, or professional stance – which is more than the mere aggregation of the knowledge and skills a professional brings to their practice.

The relative salience of these components of professional identity varied by participants, depending on at least three factors:

- what the individual her/himself brought to practice in terms of their personal motivations;
- the nature of the choices available to an individual within a given profession;
- the extent to which professionals feel they need to explain or justify their professional stance, either in interaction with patients or at a societal level.

We next reviewed the relationships between regulation, professional identity and patient care at the level of individual practice. Participants constructed the relationship between their professional identity and their individual practice as a reciprocal one:

- professional identity implies standards for one's practice;
- practice in line with these standards is an expression of one's professional identity.

As such, participants saw a straightforward relationship between professional identity and good patient care as an expression of this identity. This view is in line with a widespread view in the literature on regulation regarding the importance of the individual professional in regulating her or his own practice. For example, the Professional Standards Authority (2015a) states that:

> *We believe that it is primarily the professionalism of individuals that keeps the public safe, and in the case of health and social care also ensures the delivery of good care.*

To paraphrase: it is primarily the commitment of individuals to practise in line with the standards that follow from their own professional identities that drives good patient care.

As such, there appears to be general agreement that patient care benefits from strong professional identity – although the connection is not generally framed using this language. Where there is potential for genuine divergence of views is on the question of whether patient care benefits from *regulation* and if so, how and why.

Accounts of this relationship from a regulatory perspective typically conceptualise regulatory activity as identifying and addressing any gaps between actual practice and register requirements. We can think of this as a 'piano-tuner' model of regulation.

Pianos, like professionals, have their own internal standards: the keys reliably produce notes, and there is no need for a piano-tuner to stand next to the piano during the concert. However, those internal standards may fail to align with the objective requirements of the harmonic scale: the notes produced by some keys may be out of tune. The job of a piano-tuner is not to fix this when it happens during a concert: it is to prevent it ruining the concert in the first place.

The relationship between register requirements and individual practice described by most of our participants failed to match this 'piano-tuner' model. Instead, they offered for the most part what we might call a 'piano-teacher' model of regulation. This model assigns a critical role to register requirements in the *development* of a strong professional identity:

- practice requirements play a central role as objects of discussion, reflection and learning, and in the formation of the individual standards associated with one's professional identity;
- access requirements play a key role in ensuring that individuals engage in this kind of focused consideration of practice requirements.

After training, however, regulation according to this model appears to be largely irrelevant to individual practice (and therefore patient care), confined to the fruitless tasks of i) getting professionals to do what they would have done anyway and ii) promoting box-ticking exercises.

What the above account misses, however, are the social dimensions of professional identity. As an individual, one should also be 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.

Underpinning this sense of alignment is a third model of the relationship between regulation and practice, focused on 'holding to account'. This model highlights the role register requirements play not in *making* but in *justifying* decisions about how to act as a professional. Alignment is established not because everyone on a register is checking the same codes and standards – they are not – but because, if the worst occurs, everyone on a register will be held to account by the same register-holder, acting on behalf of the aligned community as a whole.

Access requirements were also described as playing a vital role in sustaining a sense of alignment. One key argument made by a number of participants was that, in the absence of access requirements, *anyone* can set themselves up in practice, with no guarantee of alignment with regard to their professional identity and standards. Since people set themselves up in practice through the use of professional titles, protected title can play an important role here in sustaining a sense of alignment.

Not all of the professionals in our sample attached the same level of importance to communal validation of one's professional identity. Instead, our evidence suggests a spectrum of views from the more 'communitarian' to the more 'individualist'.

For those who have a more communitarian perspective, regulation has a much more substantial role to play than it does for those who have a more individualist perspective. Specifically, it has a role to play not just in the development, but also in the

maintenance of a strong professional identity – not because it directly influences individual practice, but because it provides communal validation for an individual's professional identity and standards, and communal standards against which individual practice needs to be justified.

While it may not be part of the *purpose* of regulation, professionals also receive benefits as a result of being regulated (as a group) and on a register (as an individual), and some of these benefits may also have a bearing on the professional identity, if not necessarily on patient care. In particular:

- The exacting access requirements of register-holders mean that, while it may not be its primary purpose, registration does *de facto* acknowledge the hard work and effort involved in developing a professional stance. Moreover, to a greater or lesser extent, registration equips professionals with ways of differentiating themselves from others – especially if a register is associated with a protected title.
- Notwithstanding the Authority's views on the purpose of statutory regulation, a number of our participants understood its meaning in terms of the social status and legitimacy of a professional group, and there was some evidence of participants extending this interpretation to accredited status. Interestingly, however participants tended to describe the benefits of statutory regulation in very practical terms: there was no evidence of a relationship between acquiring such status and legitimacy and a strong professional identity.

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