Understanding the Relationship Between Professional Regulation and Professional Identity in Health Care

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ABSTRACT: Since 2016, the Professional Standards Authority in the United Kingdom (UK) has been building an evidence base to understand the relationship between professional regulation and professional identity of health care professionals. Professional identity can greatly impact the practice of health professionals. To better understand the relationship between professional regulation and professional identity, we conducted a literature review, which gathered definitions of professional identity and analysis of identity among health care professionals. We then commissioned the administration of 16 in-depth interviews with UK health care practitioners to learn their perceptions regarding professional identity and regulation. This paper describes and analyzes the Authority's findings from a policy perspective, suggesting that the professional identity of a health care practitioner is influenced mostly by factors that are local — such as the rapport a practitioner has with a patient, education, mentors, uniforms and external perceptions. These non-regulatory factors take precedence over regulation's influence on the development and maintenance of professional identity. Regulation does appear to have an effect on professional identity when there is a crisis or unusual circumstance (for example removing a professional from practice), but on a daily basis its effects are small, especially compared to other factors.

Introduction

In the UK, 10 professional regulators oversee more than 30 health and care professions — from arts therapists to physicians. Some, like the General Medical Council (GMC) — the regulator of physicians — regulate just one profession, while others regulate multiple professions. The Health and Care Professions Council (HCPC), for example, regulates 16 professions. The Professional Standards Authority oversees the work of the 10 UK regulators.[1]

There has been debate in the last few years about the effectiveness of the UK regulatory system and how to address problems with the system. This was recently the subject of a consultation by the UK's Department of Health, titled "Promoting Professionalism, Reforming Regulation."[2] One solution that has been discussed is to have fewer regulators. Some organizations have suggested that mergers of regulators or the deregulation of professionals may affect the professional identity of professionals.[3,4] Professional identity — the way practitioners conceive of themselves in their role — can have a large effect on health and care professionals. It can provide an "internal compass" to regulate professionals' work and a strong sense of identity can mitigate burnout in some professionals.[5]

The Professional Standards Authority contributes to discussions about improving regulation through its publication of papers — such as *Rethinking Regulation*[6] and *Right-Touch Reform*.[7] These discussion papers are informed by policy advice and research the Authority has commissioned and produced. Research can involve professionals, patients, the public, regulators and other health care stakeholders.

Since 2016, the Authority has developed an evidence base about professional identity by conducting a literature review and commissioning research with health care practitioners. The Authority has improved understanding of professional regulation's effects on professional identity and helped situate regulation among other factors which influence professional identity.

Methodology

The first part of the Authority's research was a literature review, which gathered definitions of professional identity and analysis of identity among health care professionals. We collated an array of academic, policy papers and grey literature to develop a literature review that charted the influences affecting professional identity and the position of regulation among these influences. One of the review's findings was that there is little literature[8] analyzing professionals' views of regulation and identity, let alone professional regulation specifically.

To help fill this gap in the literature, we commissioned Simon Christmas and Alan Cribb to conduct and analyze 16 in-depth interviews with UK health and care practitioners.[9] Christmas and Cribb were asked

to focus on interviewing participants across the health care fields listed in Table 1, which span three types of regulatory categories in the UK. While the interviews were limited to these categories, future research could explore in more detail geographical effects on identity, among other criteria. A guiding principle for the design and conduct of the study was "depth, not breadth." Through in-depth, semi-structured hour-long telephone interviews with each of the 16 participants, Christmas and Cribb were able to delve deeply into the complex subject of professional identity.

Within the sample was a range of regulatory categories, including:

- *Statutorily regulated groups:* Practitioners who must be on a regulator's register in order to practice.

- *Practitioner groups on a voluntary register:* Practitioners who do not need to register with a regulator to practice, but who have volunteered to join a register of those in their occupation.

- *Practitioner groups on accredited voluntarily registered groups:* Practitioners on a voluntary register that is accredited by the Professional Standards Authority. The accreditation shows that the register requires its registrants to meet high standards of personal behavior, technical competence and, where relevant, business practice.

The subject of professional identity has been explored with health and care practitioners; however, our literature review revealed that research is heavily focused on medicine and nursing. It has even been noted that "the field of medicine has been referred to as the very embodiment of the concept of professional identity; to be a physician is one of the most explicit examples, both historically and

currently, of a professional identity."[10] Christmas and Cribb echo this, explaining that there is a "long history of doctors being treated as the archetypal health care profession, and nurses as the archetypal 'other.'"[11] Christmas and Cribb's work uses a diversity of non-medical and nursing participants, across varying contexts of practice — different settings where health care professionals work, including primary care, hospitals and retail outlets (e.g., drug stores). This produces findings pertinent to all health care occupations, including the medical field. The full results of the Christmas and Cribb study can be found on the Authority's website.[12]

Finally, we tied together our literature review and primary research through an overview paper, which also included some additional analysis of other secondary sources (journals and other sources similar to that used in the literature; see endnote 5 in the References section), undertaken by Authority staff. This helped draw out conclusions further and demonstrate how they may be applicable to occupations across health and care.

For clarification, a register holder is the regulator, licensing body or voluntary register organization that holds a list of practitioners that it certifies as having fulfilled its requirements to provide health care services associated with the register. These are not advocacy groups or professional bodies, but exist to protect the public.

Discussion

Understanding the Term "Professional Identity"
Over the course of the project, the Authority has developed its understanding of the importance of professional identity, how it manifests, and its origins. Schein's definition is particularly useful: It is summarized by Ibarra as the "relatively stable

Table 1

Interview Participant Groups and Their Corresponding Regulatory Oversight

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

and enduring constellation of attributes, values, motives, and experiences in terms of which people define themselves in a professional role."[13] Professional identity can be viewed as important in organizations comprising diverse expertise. Ashforth, Harrison and Corley's literature review of identity in organizations posits that there is an "essential human desire to expand the self-concept to include connections with others and to feel a sense of belonging with a larger group."[14]

Identities can be varied, and multiple ones can be held by a professional at any one time. Elvey et al. have found that the pharmacy profession can have up to nine professional identities, ranging from "the medicines adviser" and "the scientist" to "the business person." The study showed professionals do not have one single identity: Pharmacists will usually have more than one overlapping identity, though often there is a dominant identity.[15]

Christmas and Cribb's study does not attempt to map the entire "constellation," as Schein puts it, of components of professional identity. Instead, it focuses on two components:

• A "fundamental commitment to help"

• A "professional stance"

The study suggests that "a fundamental commitment to help" is a "defining feature of all professional identities in health care." One physiotherapist participant wanted "to change people's lives… and make them better… to live a more independent life." Christmas and Cribb see this fundamental commitment to care being supported by the "professional stance." The stance is more than just the "mere aggregation of knowledge and skills," but is in fact "an underpinning, coherent way of understanding and intervening in the world" in which a practitioner works. The relative salience of the two components varied by participants in the Christmas and Cribb study, depending on factors such as what the individual brought to practice in terms of his or her personal motivations.

Other Factors Have a Greater Effect on Identity Than Regulation

A major finding of our combined work on professional identity has been that many factors have a greater or more direct influence on identity than professional regulation, and that these are usually more local factors — such as how a professional interacts with patients. In our literature review, or example, this is shown in McKenzie and Williamson's study of General Practitioner (GP)-operated after-hours helplines in Australia. The "doctor-patient relationship" of getting to know a patient and providing care over time is the "cornerstone" of GP professional identity; however, the relationship is limited if the GP only engages in brief encounters by telephone. It is key therefore for those GPs who work on the helpline to relinquish "the centrality of the doctor-patient relationship and continuity of care" in order to realign professional identity.[16]

Identity can also be affected by technology by changing how information is internalized by professionals. Wallace, Clarke and White suggest in their paper that mobile devices such as the iPhone mean a practitioner in the future "may not have to internalize much knowledge at all" if connected to the appropriate information sources. The authors point out this would "constitute a major shift in professional identity"— moving from a repository of knowledge to one navigating vast swathes of knowledge: "I don't know what to do, but I know where to look to find out."[17]

A key point for formation of identity is education and training institutions, where Rodriquez, et al. suggest that educational institutions such as medical schools are places where trainees "internalize the norms, values and power relations that characterize the collective identity of the profession to which they aspire to be part of."[18] Hedy S. Weld explains that the development of professional identity occurs in medical education through a combination of reflection (about how to cultivate meaningful qualities, skills and values), relationships (interactions with other students, mentors, patients, etc.) and resilience (learning to respond to stress in a healthy manner).[19] While looking at structures of education systems is a useful way to identify development of professional identity, Goldie points out that in medical school, for doctors it is more influenced by the "informal and hidden curricula than by formal teaching experiences."[20] By this, Goldie means interactions with older professionals, exchanges in informal settings and many other arenas, and formats which cannot be simply prescribed in a curriculum.

Regulation and Education

Education and training curriculums are shaped by regulatory requirements. In Christmas and Cribb's research, participants recognized that regulators can have a role in this important area. One pharmacist observed that the regulator of pharmacists in Great Britain, the GPhC, had a large role in standardizing education and ensuring that new pharmacists practice in a uniform manner:

"Our regulatory authorities control what we study, so at the university, we all do the same things and we all have to go through the same processes. And that's important that I can turn around and say to a colleague, can you go and talk to this patient because the such-and-such while I do something else, and I know they're going to get the same standard of care as if I went out, and vice versa. I think there's a lot of trust because of the GPhC and because of, you know, the way we're trained… We don't need to prove anything to anyone else. The proof's in the pudding. The proof's in your number. And that's very important to all of us." [21]

The quotation above shows that the GPhC's statutory responsibility for education quality assurance can affect the development of a community of practice among pharmacists. A community of practice is where an individual practitioner is able to "trust that the professional identities of others on a register — along with the standards for individual practice which follow from those identities — are, in certain key respects, the same as one's own…" [22] When considering what would happen if the GPhC was not involved in quality assurance of education, the pharmacist quoted above (Pharmacist D) suggested that the community of practice would be weakened.

This example suggests that the GPhC has control of what Christmas and Cribb call "access requirements." Regulatory requirements of practice can be split into two broad categories: access requirements and practice requirements.

- **Access requirements** need to be fulfilled for an individual to become registered by a register-holder (e.g., training)

- **Practice requirements** need to be fulfilled on a day-to-day basis in order to remain on the register (compliance to standards).

The example above suggests that the GPhC has a role in ensuring its registrants go through the same processes of internalizing the values and norms required to develop a professional identity and to be registered. This could be seen as an indirect influence on professional identity. The more direct influencers on identity, as our literature review explained, are the patients, educators, mentors and colleagues that students interact with while training. These influence practitioners' identity more as they have a key role in the formative years of identity or impact practitioners' identity on a daily basis when they are practicing. [23]

Standards

In the UK, regulators of health care professionals are statutorily independent bodies. They may consult with the professions while developing standards, but the regulators set the standards. This separateness distinguishes the UK model of "shared regulation" from models of "self-regulation." Once individuals have qualified to practice and entered on a register, they must comply with the register holder's standards, codes and guidance for conduct and competence ("practice requirements"). Christmas and Cribb found that if a participant was in a situation in which it was not immediately clear how to act, he or she normally sought advice from colleagues, supervisors/superintendents, managers and helplines provided by employers and training bodies. In only a "few, very serious instances" did participants contact a register-holder. In more everyday situations, there was little evidence of practitioners explicitly consulting regulators' standards.

Christmas and Cribb provide a number of examples to illustrate the views and attitudes of interviewees towards the standards:

- A psychotherapist considered that to hold all the standards and guidance at "the forefront of your mind is impossible…so you hold the spirit of it."

- Similarly, a pharmacist described standards as a "blueprint."

- Two pharmacists considered many regulatory standards to be obvious and not needing constant checking as they were doing them anyway: "A lot of them [standards] are… what you'd expect of yourself anyhow" and "the [GPhC] want us to follow a certain amount of protocol, but that's a natural thing we'd do anyway."

- A physiotherapist suggested that there was a higher chance of a practitioner knowing what was in the standards booklet if they were newly qualified.

This suggests that in practice, the HCPC's standards play a more direct role immediately after the training phase of physiotherapists' careers than when they have been practicing for a while. [24] The regulator's distance from the daily events of a practitioner is echoed in earlier research commissioned by the Authority. [25] The research indicated that professionals' daily behavior is shaped by a variety of influences and professional regulation is not a major influence on decisions in the everyday lives of practitioners. [26] In general, Christmas and Cribb's participants

displayed three different attitudes to meeting regulatory standards and CPD requirements:

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

2. "When register requirements are not in line with 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.

3. "Alternatively, if the issue is that the register requirements fall short of the individual's own standards, they are likely to be seen as superficial, neither being accepted nor influencing practice."[27]

Christmas and Cribb caution that the participants were not complacent, nor did they think they had no room for development. In fact, all participants wanted to improve their practice. However, the participants did not generally consider regulatory resources to be something they would draw upon to improve practice. The findings above align with our literature review, in which we concluded that, on the balance of evidence we have analyzed, the effects of regulation on professional identity on a daily basis are small. The findings also demonstrate that some practitioners view much of a register's standards and guidance to be a mirror of how they are practicing already, with minimal consideration of standards and guidance by practitioners in how they act.

Does a Practitioner Gain a Professional Identity From "Doing the Job"?

One of the factors we found in our literature to be important in forming and fostering identity is "doing the job." For example, physiotherapists can carve out a unique professional identity in a multi-disciplinary team by applying specific skills of musculoskeletal health care.[28] However, enacting the skills of a practitioner is not enough by itself for a practitioner to gain a professional identity. Christmas and Cribb's work around the "professional stance"—an underpinning, coherent way of understanding and intervening in the world, which is more than just the mere aggregation of knowledge and skills—is useful when reflecting on how "doing the job" contributes to identity.

An example of a practitioner applying a skill without the professional stance was recounted by one acupuncturist participant who highlighted that some physiotherapists may "do a one or two-day course" and then "they call themselves acupuncturists, but they never, you know, understood the theory behind it." This "co-option" of acupuncture skills without the professional stance of a traditional acupuncturist does not mean an individual has gained an acupuncturist's identity.

It seems that identity cannot simply be gained by completing a training course either. It is dependent on elements of a training course that contribute to the development of a professional stance. These elements could be, but are not limited to, the course length and depth, and who practitioners spend training time with. Another study participant, a physiotherapist using acupuncture techniques, believed that she could not call herself an acupuncturist, but instead described herself as "a physiotherapist who uses acupuncture" and that her use of it was to "augment" her practice. In the context of the UK regulatory arrangements as described above, regulation has an indirect role in creation of professional stance; regulators set standards for practice, impose requirements for ongoing registration and quality-assure educational institutions—all of which play a role in creating a professional stance.

The Regulatory Register as a Validator

The evidence we have gathered suggests professional identity exists independent of the register. The register acts as a means of validating existing professional identity and is evidence of a community of practice of shared professional identities—but it does not generate professional identity. The register is a tangible way of viewing a community that already exists. One of Christmas and Cribb's participants believed that the loss of statutory regulation (the legal requirement to be registered with a regulator, as opposed to a voluntary register or no register at all) would mean a "sense of being professional would be lost." This was because "there's no one that you can go to and say, these are the people that keep a register of who I am and what I do." The regulator is a validator of the community and a social marker that can invoke pride in those regulated: "I think part of your registered body and somebody with overarching regulation toward 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."

Another pharmacist went further and said that statutory registration with the GPhC strengthened

a sense of validation through being part of a community: "you feel like you belong to the council, the GPhC, you belong to them." This view is at the furthest end of what Christmas and Cribb call a "communitarian" interpretation of professional identity and regulation (at the other end of the communitarian scale in the Christmas and Cribb research was an individualist practitioner who did not hold a communitarian viewpoint about the community of practice). The views above show that community of practice exists and can be expressed by the register. Any legal requirement to join this register, though, strengthens the feeling among some practitioners that they are embedded in their community of practice.[29]

Health Care Team

Many health care professionals work in an inter-professional team, with practitioners from other fields. For example, in an interprofessional hospital team, a patient's care could be provided by nurses, doctors, pharmacists, physiotherapists and many others. One definition of interprofessional practice is that "all members of the health service delivery team participate in the team's activities and rely on one another to accomplish common goals and improve health care delivery."[30] Sometimes the roles of each of these practitioners is clearly demarcated, while at other times the boundaries between each role may be more blurred.

Specific skills can differentiate physiotherapists from other professionals, as suggested by Lefmann and Sheppard in our literature review: "The specific skills of musculoskeletal health care, which is 'a lesser priority for the doctors and nurses, yet a core competency for physiotherapy,' helped physio-therapists gain a unique professional identity in a multidisciplinary environment."[31] Multidisciplinary teams can mean that professionals take on new tasks. The identity of a practitioner may be changed when the content of a role is altered. One academic stated that many mental health nurses felt their role had been "diluted" and they had lost their nursing identity from working in multidisciplinary teams, where they had taken on other roles, such as commissioning social care, in addition to their traditional nursing duties.[32] Ward, et al. found that in order for individuals to become interprofessional practitioners, among other things, they need to understand who they are in their role and how that role fits in the team.[33]

Education curricula can inculcate better team-working and foster a team identity. Morison, Marley and

Machniewski noted that in relation to dentistry, education curricula should be designed to "facilitate the development of a team identity."[34]

There are possible ramifications for regulators. For example, the advent of multidisciplinary roles could mean a change in standards expected of registrants, requiring a change in education and training curricula in order to prepare practitioners

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for the work environment. This could mean a change in how regulators ensure the quality of educational institutions. Regulators may want to consider how professionals can become aware of their role within a team so they can contribute as optimally as possible, and what consequences there could be for a practitioners' professional stance (see Christmas and Cribb's findings in *Does a practitioner gain a professional identity from "doing the job"?* earlier in this article). Regulators may also need to consider the impact of any changes to scopes-of-practice on continuing fitness-to-practice requirements and fitness-to-practice decisions: Where once the scope of patient care was defined, now it can potentially be more fluid.

Status

Christmas and Cribb conclude that, while a number of their study participants associated regulation with social status and legitimacy, there was "no evidence of a relationship between acquiring such status and legitimacy and a strong professional identity." Although a pharmacist mentioned that it "might look a bit more amateur" to lack statutory regulation, acupuncturists ascribed practical implications of regulation rather than of identity—for example, the need for acupuncturists to have insurance.* Christmas and Cribb summarize this as being "implications for what one can and can't do rather than implications for how one sees oneself."[35]

However, even if status is conferred by regulation, we view this as a secondary effect. The primary

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*Businesses that employ people are required to have employers' liability insurance. Otherwise, they are encouraged to have public liability insurance — but it is not compulsory. The Authority, however, requires registrants on the registers it accredits to have indemnity insurance.

reason for being recorded on a register is if a practitioner fulfils the competence and behavioral requirements of the register-holder. Attached to regulation may be status in wider society. It is important, though, that this does not alter how practitioners perceive the purpose of regulation. It is important that practitioners' understanding of regulation is not incorrectly shaped by misperceptions. There is perhaps more work to be done on this area by policymakers and others to better explain regulation.

Limitations

Our paper is intended to help fill a gap in the literature on the topic of professional identity and regulation. While our interviewing methodology provides valuable insights that we hope will help stimulate discussion on this topic, it should be acknowledged that the interviews were confined to pharmacists, physiotherapists, psychotherapists and acupuncturists in three categories: statutorily regulated groups, practitioners who must be on a regulator's register in order to practice and practitioner groups on a voluntary register. More research is needed, and future research could explore in more detail other criteria — including geographical effects on identity, for example, or attitudes among other health care practitioners, such as physicians. It should also be noted that these results are centered on attitudes of health care practitioners in the UK, which has unique circumstances, based on its regulatory structure.

Conclusion

Our work suggests that the professional identity of a health care practitioner may be influenced mostly by factors that are local to a practitioner — such as the rapport a practitioner has with a patient, along with factors such as education, mentors, uniforms and external perceptions. These non-regulatory factors appear to take precedence over regulation's influence on the development and maintenance of professional identity in the UK. Regulation does appear to have an effect on professional identity when there is a crisis or out-of-the-ordinary circumstance (for example removing a professional from a regulatory register), but on a daily basis its effects are small, especially compared to other factors.

While these results represent a targeted cohort in the UK, they stimulate questions that could be applied more broadly to other health care practitioners and in other regulatory systems. Regulators outside of the UK may want to consider the interplay between

professional identity and registrants' compliance with values and standards in a profession. If professional identity is an "internal compass" to registrants' work, as Weldy[36] points out, then further discussion is required by regulators and others over whether regulation can or should use this as a tool to protect the public.

Looking into the future, new drivers of working in health care — such as hybrid roles, overlapping role boundaries and interprofessional working — will have an influence on identity. These new drivers may mean there is an increased opportunity, and perhaps requirement, to cultivate team identity because identity could foster togetherness — which, in turn, can help a team gel and increase its effectiveness. Regulators could have a role in encouraging team identity through requiring it in educational curricula. The overview paper and literature review touched upon issues of technology. These suggested the idea that increased use of technology may affect identity as it may change how professionals internalize knowledge (moving from repositories of knowledge to navigators) and alter interactions with patients — such as through the use of telehealth.

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Again, educational curricula shaped by regulator's requirements may help trainees come to terms with how their identity is tailored to internalize knowledge. For professionals that have been practicing for a few years at least, a regulator's continuing fitness-to-practice procedures may be a means for them to gain knowledge to inform how they should alter identity as technology changes how they practice. Our research on identity provides a basis to explore technology and other drivers in health further. ∎

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Michael Warren served as Policy Advisor at the Professional Standards Authority of the UK at the time this article was written.

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