Scapegoat:
An autoethnography of a care professional who became de-registered following regulatory body fitness-to-practise proceedings.

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A thesis submitted in partial fulfilment of the requirements of Bournemouth University for the award of PhD

May 2021

Bournemouth University

Copyright Statement

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Abstract

There is little understanding of the impact of UK Statutory Regulatory Bodies' Fitness-to-Practise (FtP) procedures upon health and social care professionals who go through the system. Empirical research related to the emotional and psychological effects on care professionals is sparse. To date, no research has been undertaken in relation to the impact of de-registration on a pharmacy professional. This thesis is an autoethnography that explores my own experience of professional de-registration and learning to cope with the threat to identity. At its core this study sought to understand the human experience of going through the present-day professional regulatory system. It turns the inspecting lens back on itself to help reveal a personal reality of state regulation and how it worked in practice.

By using my own experience of the FtP process, between de-registration and application for restoration, I explore through first person narrative, the complex issues involved and my emotional life during this transformative period. The impact that the interruption to my career caused as well as perceptions held about the newly acquired 'bad apple' status are captured through autobiographical writing and presented as a sequenced vignette series. The thesis then considers narrative structures present in the series borrowing from the dominant narrative structures of the illness narrative, namely chaos, restitution and quest. This approach shows the relationship between narrative and culture, and the complexity of regulating professional misconduct to protect the public whilst also having consideration for the well-being of the professional registrant.

This study finds that the current FtP process could do more to minimise the emotional suffering of future registrants. The work considers what improvements could be made in the current FtP process to ensure the safety of both patients and health care professionals.

Dedication

To my parents, brothers and sister with so much love.

And to my beloved children for all the yesterdays I became lost in darkness and couldn’t love you unconditionally.

And to their mum for her strong loving heart.

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Acknowledgements

There are many people who have helped shape not only this thesis, but also me as a person. First my deepest gratitude to Dr Caroline Ellis-Hill and Dr Vanessa Heaslip, my supervisors, who, with their inspiring combination of intellectual acuity and compassion helped me to ensure the style of writing does justice to the message. While I remained so steeped in grief you were prepared to walk alongside me. I feel truly blessed to have been guided by you to choose forgiveness in the face of a significant act of harm.

Many other people at Bournemouth University helped me along the way. Thank you to Chris Pitt, Emma Crowley, Caspian Dugdale, Dr Sean Beer, Dr Judith Chapman and Professor Jonathan Parker for their distinctively individual contributions.

I would also like to thank my courageous and supportive friends in the autoethnography community both in the UK and abroad, for showing me that the best way to learn how to do autoethnography is to embrace our vulnerability and use the emotional pain to reveal insights about ourselves and wider culture.

I also owe thanks to the numerous therapists, coaches, mentors and tutors that I have encountered over the past decade. I am reassured by the knowledge that most practitioners in our helping professions remain more attached to our common humanity than to bureaucracy or dogma. You convinced me this thesis was sorely needed.

I take the opportunity to acknowledge also the very large number of health and social care professionals with whom I share this preventable emotional suffering. May this thesis go some way to opening our regulators' hearts to compassion?

My sincere thanks go to Beryl and Michael Temple and their son Mark for welcoming me with loving-kindness into their family, and for wonderful meals, and spirited conversation throughout the years this thesis was taking shape. I owe a universe of thanks to Michael for his skilful editing that clarified the manuscript as well as sharing his passion for poetry that has left its trace on me. Finally, to Rachel, you have so graciously indulged my mental preoccupation during the years of creation of this thesis, that all I can offer you is my heartfelt gratitude for holding the space.

Chapter 1
INTRODUCTION

1.1 Background to the research and thesis

In the United Kingdom (UK), health and social care professionals (HSCPs) comprise a large and diverse group of workers who are generally well regarded by the public they serve (Banks and Gallagher 2008). Individual professional people (such as doctors, nurses, pharmacists and social workers) stress their special knowledge, skills and competence, dedication to the task in hand and high moral standards along with an emphasis on duty of care to the individual. All this may be true, but of central interest to stakeholders (such as local and national health and social care organisations, employers and, service users) is the answer to the question: 'How do I know if a practising HSCP reaches an expected standard of care and whose education, training, conduct and performance is acceptable?' All of these points relate to issues of professionalism (or the competence and integrity of professionals) and the processes adopted by regulatory bodies to assure quality of care and patient safety.

Although the knowledge obtained from this research can be transferred to all regulated UK HSCPs, the focus of the thesis is one professional's account supported by evidence from a literature review of four professional groups: doctors, nurses, pharmacists and social workers. The terms doctors, nurses, pharmacists and social workers are taken to include all grades of registered professionals within these groups. In the use of the term nurses I include nurses, midwives and health visitors in all grades and branches of the nursing profession. In this thesis the term Health and Social Care Professional (HSCP) will be used to refer to doctor, nurse, pharmacist and social worker where the point being made is intended to be applied to all. The four professional groups were selected not only to provide a broad coverage of possible care professions, but also because each is regulated by a different regulator allowing for processes and outcomes to be compared and contrasted inter-professionally. The medical profession continues to play a dominant role within the care sector and it is usually the case that other professional governance systems in the UK follow the medical system (Case 2011). Therefore, Statutory Regulatory Body (SRB) will be shorthand for the four regulators where the matter is considered common to all. The four professional groups and their SRBs are summarised in Table 1.

The word regulate used in the sense 'control by rules' comes from the verb regulare, from Latin regula 'rule'. The Oxford English Dictionary defines regulate succinctly as:

To control or direct according to rule, principle, or law. (OED online)

The noun regulation can therefore be seen to represent an act to keep control or maintain order through the use of rules. This is highlighted in the literature (see for example Allsop and Mulcahy

1996; Baldwin and Cave 1999; Banks and Gallagher 2008) that considers regulation as pervasive in societies where citizens are required to follow an authoritative set of rules whose effect is to manage, control or restrict behaviour. In Les 100 mots de la regulation ("Regulation in 100 Words"), Frison-Roche (2011) clearly distinguishes between regulation and rule-making. The former is the maintenance of various balances between principles, rules, and economic and social realities while the latter is the translation of a collective will emanating from law makers. Healthcare – seen as humanity's 'common goods' that everyone therefore must have access to is considered to be a political position reflected in the Regulation. According to Frison-Roche (2011) philosophically, Regulation is a complex triad of Law, Economics and Politics. Professor van der Heijden (2019, p.3)) reviewing the research on regulatory practice conceptualises the activity as a specific mode of governing behaviour that

> seeks to influence behaviour of individuals and collectives, in order to make social interaction and transactions predictable, and to reduce uncertainties by setting expectations (e.g. rules) and consequences for (not) meeting these (i.e. rewards and penalties).

In the context of professional health and social care practice the regulatory framework governs the provision of services by HSCPs (including the level of protection of the health and well-being of service users). The execution of the control function is carried out by agents external to the HSCPs themselves referred to as Statutory Regulatory Bodies (SRBs). The significance of the internal procedural framework shown in Figure 1 is that it represents an attempt by SRBs responsible for the regulation of HSCPs to operate a 'standardized' procedure for the task of assuring compliance with the professional rules.

The philosophy that underpins professional healthcare regulation is in assuring safety and quality (Buckley 2007). Rather than focusing on a minority of criminal or otherwise unacceptable departures from professional standards, the regulatory framework aims to continue to support and assure compliance with the high standards expected of health and social care professionals. Yet, at the same time, it must also respond at an early stage if a professional's practice starts to deteriorate and present a potential risk to patient safety. Early intervention may also assist a struggling professional to receive the help and support they need to overcome health and other difficulties and, where appropriate, return to full practice.

There are broadly two approaches by which SRBs could carry out their regulatory role – to educate HSCPs to ensure they are compliant with the rules and to punish any HSCPs whose conduct is considered to fall below professional standards and therefore infringe the rules. The current regulatory framework is seen to be increasingly risk averse (Kirkham et al 2019) which has had the effect of promoting professional defensive practises that reduce the risk of becoming a fitness-to-practise case. According to Baggott (2002) current and future regulatory bodies responsible for regulating HSCP workforce in the UK have their origin by statute and perform their functions within a legal framework. Such a model is best described as State sanctioned self-regulation in which the power to make rules is retained by central government and legislature

while surveillance and enforcement powers are devolved to SRBs including those considered in this thesis (see Table 1).

The need for the regulation of HSCPs has been felt to be necessary, especially after the Shipman scandal (Smith 2001) in order to prevent professionals abusing their privilege to the detriment of service users. As a consequence of the imbalance of knowledge and power between professional and lay people, the primary purpose of regulation is the protection of the public and promotion of public safety. Regulation is the model through which it is assumed safe practice can occur. Regulatory bodies working with professions agree minimum professional standards required by practitioners in the form of rules, codes, protocols and guidelines to follow in order to progress the care of service users and reduce or eliminate risk of harm. The Kennedy report (2001) identified several elements to the regulatory role performed by a SRB. Of these, the following five are considered of central importance to public protection through the management and control of HSCPs: education for initial registration; protection of professional title; clinical competence; standards for performance and; fitness-to-practise. So, the education and training professional people receive at the start of their careers is largely under the control of the SRB for the profession which is also responsible for issuing a licence to practise on behalf of the state and to maintain a register of qualified professionals. All professional groups have a professional code of practice and SRBs are authorised to deal with any allegations of misconduct through fitness-to-practise disciplinary proceedings. It is therefore felt that, as an essential safeguard against the potential abuse of power and the exploitation of members of the public, SRBs fulfil important functions to the maintenance of the well-being of society.

Palmer (2007 p212-13) believes the modern use of the word ‘professional’ is, sadly, diminished:

> As someone who possesses specialized knowledge and has mastered certain techniques in matters too esoteric for the laity to understand and has received an education proudly proclaimed to be “value-free”.

Referring back to the original meaning as “someone who makes a *profession of faith* in the midst of a disheartening world” Palmer (2007 p212) attempts to “raise up professionals in every field who have ethical autonomy and the courage to act on it” as an antithesis to the domain of increasing external professional regulation premised on risk aversion that seems to have nurtured a disempowered, defensive and passive health and social care workforce with a corresponding reduction in the advancement of health and welfare of the public. Such a professional culture can be the result of a strongly controlling regulatory influence that engenders ‘fear’ while, at the same time, is felt by HSCPs to be only weakly enabling.

Professional Group	Statutory Regulatory Body	Year of Establishment of Regulatory Body	Membership (rounded)
Doctors	General Medical Council (GMC)	1858	300,000
Nurses	Nursing and Midwifery Council (NMC)	2002	700,000
Pharmacists	General Pharmaceutical Council (GPhC)	2010	50,000
Social workers	Social Work England (SWE)*	2019	90,000

Table 1. Professional Groups and their Statutory Regulatory Bodies (SRB)

*In 2019, the responsibility for regulating social workers was transferred from an umbrella regulator for sixteen separate health professions, the Health Care and Professions Council (HCPC) to the bespoke social work regulatory body, Social Work England (SWE).

1.2 Enabling and control roles of statutory regulatory bodies

Statutory regulatory bodies (SRBs) for HSCPs in the UK exist for two purposes: 1) to enable the fulfilment of caring roles by HSCPs (for example by maintaining professional standards through educational programmes and revalidation schemes) and 2) to control the activities of HSCPs occupying such roles by highlighting and minimising poor practice, through the fitness-to-practise (FtP) process, in order to keep service users safe (Archer 2013). As gatekeepers to the professions, SRBs have a key part to play in nurturing trust amongst the community of HSCPs and encourage community-wide learning from mistakes. It could be said then that SRBs must effectively balance these disparate functions in order for HSCPs to feel autonomous in practice and wholeheartedly exercise their area of expertise while, at the same time, assuring that the public are protected from any incompetent or malicious HSCPs. Regulatory bodies maintain a register of practitioners (RoP) and set minimum standards of professional and ethical conduct (Mason 1994). Registered professionals can be referred to their SRB by anyone concerned that their FtP may be impaired, a process variably called referral, concern or complaint. Self-referral is also possible whereby an individual HSCP refers themselves to their regulator (for example, in attempting to settle a dispute with their employer). In cases where a practitioner is considered unfit to practise by virtue of serious misconduct, the regulatory body has the power to impose sanctions including to remove the practitioner from the RoP, a process variably known as erasure, de-registration or strike-off.

Very few HSCPs come to work with the intention of causing harm to a service user, but mistakes and errors will sometimes occur in professional practice (Haney 2012). Such mistakes are usually multifactorial and offer those involved opportunities for learning and practice development. These points were aptly summarised by the Bristol Royal Infirmary Inquiry (BRII) into unusually high mortality rates among infants who underwent heart surgery there, as follows:

“The story of the paediatric cardiac surgical service in Bristol is not an account of bad people. Nor is it an account of people who did not care, nor of people who wilfully harmed patients. It is an account of people who cared greatly about human suffering, and were dedicated and well-motivated… It is an account of healthcare professionals working in Bristol who were victims of a combination of circumstances which owed as much to general failings in the NHS at the time than to any individual failing. Despite their manifest good intentions and long hours of dedicated work, there were failures on occasion in the care provided to very sick children” (Kennedy 2001, p.1).

Around this time, a second public inquiry began chaired by Dame Janet Smith, into Dr Harold Frederick Shipman – a family doctor found guilty of killing 15 patients by injecting them with lethal doses of opiate drugs, and sentenced to life imprisonment (Smith 2001). Haney (2012, p.10) observed that despite links between the two very different inquiries being weak, the media coverage served to “insinuate that the goings-on at the BRI were as dark and sinister as Dr Shipman’s mind”. These inquiries helped galvanise public and political appetites for greater control over the activities of HSCPs principally through measures designed to reform professional (self-) regulation that included the FtP process. The fifth report of the Shipman Inquiry (Smith 2004) in its review of the processes at the General Medical Council (GMC) to determine whether a doctor remained fit-to-practise or whether some sanction was required concluded that the fair treatment of the doctor was consistently prioritised over the protection of patients.

The report proposed several essential preconditions for re-establishing public confidence in the regulation of doctors including the adoption of the civil standard of proof (“on the balance of probabilities”) rather than the criminal standard (“beyond reasonable doubt”). The effect of this was to lower the threshold that was to be applied by FtP panels in adjudicating whether the alleged facts within the complaint against the registrant were proven. Case (2011) interprets this test change in statute as a transition towards a less lenient FtP process against registrants by reducing the requirement by panels to identify and prosecute cases involving only ‘serious’ professional misconduct (under the criminal standard) to almost any breach of professional standards (under the civil standard), and therefore prosecuting a larger number of registrants. The report made proposals for the GMC to publish clear and explicit standards that were to be applied at each stage in the FtP process and to establish an independent adjudication panel to carry out the final adjudication stage or hearing (Smith 2004). The underlying message of both public inquiries was that the existing system for measuring and monitoring quality required improvement which could not be resisted by the medical profession any longer. It and other professional groups were about to become subject to greater regulation administered through external organisations.

A review of the regulation of the medical profession (Department of Health 2006) was followed by a review of the non-medical health professions including nursing and pharmacy (The Foster Review 2006). These reviews led to the publication of the White Paper “Trust, Assurance, and Safety – The Regulation of Health Professionals in the 21st Century” (Department of Health 2007) and initiated reform of the system of professional regulation in the UK that the Shipman Inquiry had strongly recommended. It paved the way for the establishment of new independent regulators

and charged them with responsibility for putting arrangements for the stricter regulation and revalidation of healthcare professionals in place (Department of Health 2007). As a recent-past practising pharmacist, I witnessed the separation of professional and regulatory functions from the regulator for pharmacy at the time, the Royal Pharmaceutical Society of Great Britain (RPSGB) and recall this period been filled with frenzied debate that was ultimately unsettling for me and my professional colleagues. The Pharmacy Order (2010) was approved in parliament and allowed the formal handover of regulatory functions from the Council of the RPSGB to a new regulator for pharmacy – the General Pharmaceutical Council (GPhC) in late 2010. In February 2011, I had come to the attention of the newly formed regulator following a complaint about my practice as a proprietor pharmacist, responsible for operating two small village pharmacies. It is this lived experience of regulation that I draw upon to reveal a reality of state regulation, how it works in practice and the human impact of de-registration.

The decline in public trust in the system of professional self-regulation (traditionally considered by HSCPs as a principle component of professional autonomy) was based on a small number of high-profile cases and not widespread abuses of power by professionals. Allsop (2006) argues that the damage caused by the few failures in practice have severely challenged the triangular set of trust relationships between professions, government and the public. Reform of the system of self-regulation through measures outlined by Smith (2004) may help professions regain public trust, but the potential consequences for HSCPs going through the 'stricter' FtP process have received little attention. After all, HSCPs are human beings going through disciplinary proceedings and as a consequence, like service users, can be vulnerable and experience suffering.

The work of SRBs is overseen by the Professional Standards Authority (PSA). The PSA was established on 1 December 2012, taking over the functions of the Council for Healthcare Regulatory Excellence (CHRE). The role and duties of the PSA are set out in the Health and Social Care Act (2008). Essentially the PSA conduct an annual performance review for all regulators to see how they are 'protecting the public'. As part of this function a sample of the decisions reached by SRB FtP panels are scrutinised by the PSA and those that are considered too lenient or unsafe and that risk endangering the public are subsequently appealed. Moreover, the PSA also functions to promote public confidence in HSCPs and regulator self-confidence in carrying out the regulatory function. The PSA reviews performance of regulators against its 18 Standards of Good Regulation (see Table 2), with the final five relating specifically to fitness-to-practise (Professional Standards Authority 2020). It is noteworthy that the recent PSA Performance Review of the GPhC (2019-20) reported that the regulator had not met Standards 15, 16 and 18 of the Standards of Good Regulation and highlighted concerns about timeliness, customer service and the transparency and fairness of a number of fitness-to-practise processes.

General Standards	
Standard 1	The regulator provides accurate, fully accessible information about its registrants, regulatory requirements, guidance, processes and decisions.
Standard 2	The regulator is clear about its purpose and ensures that its policies are applied appropriately across all its functions and that relevant learning from one area is applied to others.
Standard 3	The regulator understands the diversity of its registrants and their patients and service users and of others who interact with the regulator and ensures that its processes do not impose inappropriate barriers or otherwise disadvantage people with protected characteristics.
Standard 4	The regulator reports on its performance and addresses concerns identified about it and considers the implications for it of public inquiries and other relevant reports about healthcare regulatory issues.
Standard 5	The regulator consults and works with all relevant stakeholders across all its functions to identify and manage risks to the public in respect of its registrants.
Guidance and standards	
Standard 6	The regulator maintains up-to-date standards for registrants which are kept under review and prioritise patient and service user centred care and safety.
Standard 7	The regulator provides guidance to help registrants apply the standards and ensure this guidance is up to date, addresses emerging areas of risk, and prioritises patient and service user centred care and safety.
Education and training	
Standard 8	The regulator maintains up-to-date standards for education and training which are kept under review, and prioritise patient and service user care and safety.
Standard 9	The regulator has a proportionate and transparent mechanism for assuring itself that the educational providers and programmes it oversees are delivering students and trainees that meet the regulator's requirements for registration, and take action where its assurance activities identify concerns either about training or wider patient safety concerns.
Registration	
Standard 10	The regulator maintains and publishes an accurate register of those who meet its requirements including any restrictions on their practice.
Standard 11	The process for registration, including appeals, operates proportionately, fairly and efficiently, with decisions clearly explained.
Standard 12	Risk of harm to the public and of damage to public confidence in the profession related to non-registrants using a protected title or undertaking a protected act is managed in a proportionate and risk-based manner.
Standard 13	The regulator has proportionate requirements to satisfy itself that registrants continue to be fit-to-practise.
Fitness-to-practise	
Standard 14	The regulator enables anyone to raise a concern about a registrant.
Standard 15	The regulator's process for examining and investigating cases is fair, proportionate, deals with cases as quickly as is consistent with a fair resolution of the case and ensures that appropriate evidence is available to support decision-makers to reach a fair decision that protects the public at each stage of the process.
Standard 16	The regulator ensures that all decisions are made in accordance with its processes, are proportionate, consistent and fair, take account of the statutory objectives, the regulator's standards and the relevant case law and prioritise patient and service user safety.
Standard 17	The regulator identifies and prioritises all cases which suggest a serious risk to the safety of patients or service users and seeks interim orders where appropriate.
Standard 18	All parties to a complaint are supported to participate effectively in the process.

Table 2. Professional Standards Authority (PSA) - Standards of Good Regulation.

1.3 Fitness-to-Practise process

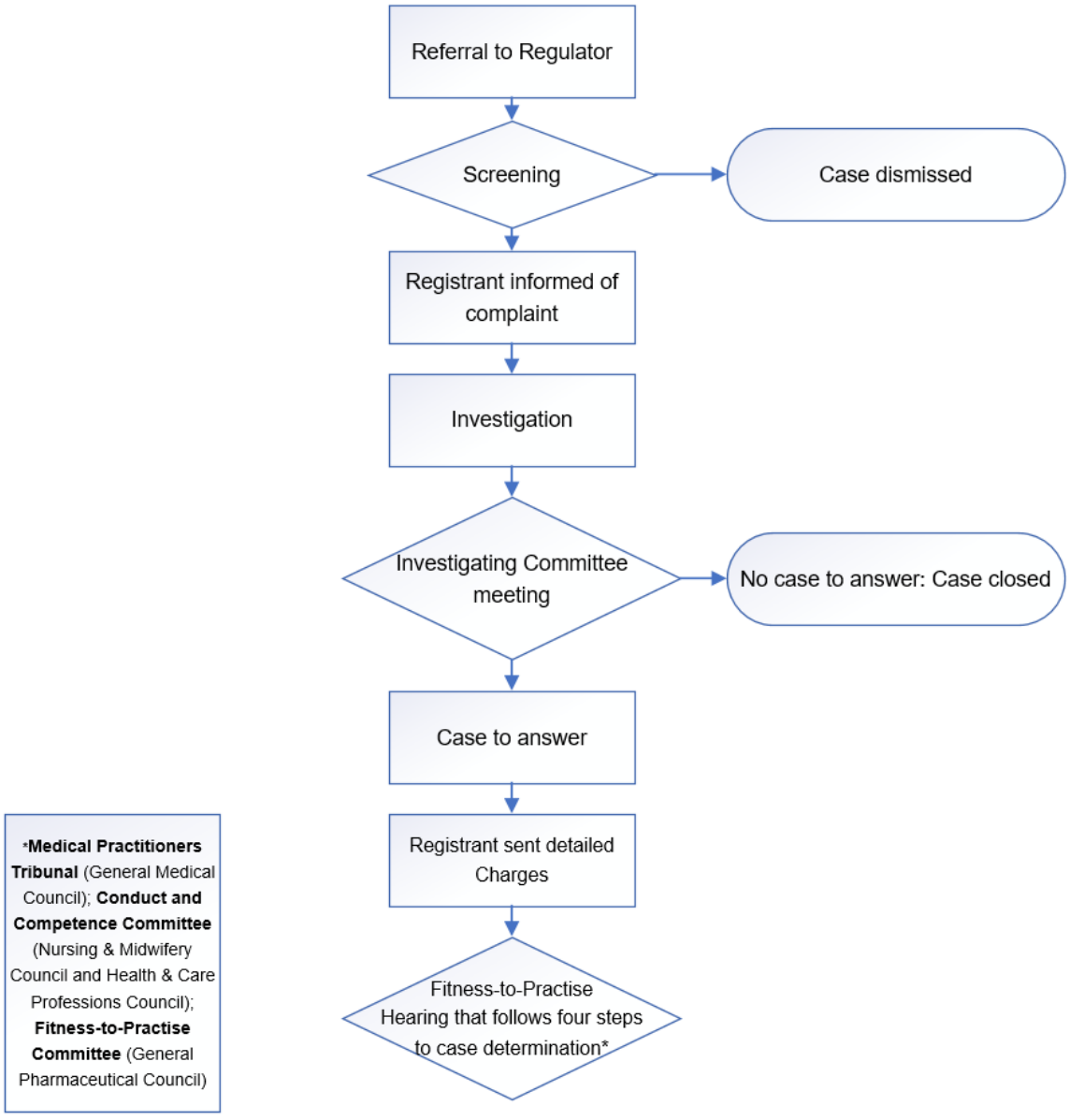
Regulators (old and new) have incorporated the legislative changes (Health and Social Care Act 2008) into their FtP processes that mainly follow a linear journey through two stages (the investigation stage and the adjudication stage) each culminating in the assembly of a Committee (or Panel). The Investigation Committee (IC) decides whether the allegation against a HSCP should be considered by a Fitness-to-Practise Panel (FtPP) at a hearing. The FtPP, considered independent of the regulator, is usually comprised of a legally qualified chair, a lay person who is not registered with the regulator and a registrant from the same profession as the professional under investigation. Regulatory FtP hearings follow a strict court-like process akin to the criminal-justice system which is commonly understood to offer procedural justice in resolving disputes (Weinstein 2015). The general FtP process for regulators has been summarised in Figure 1 (page 7).

The discourse surrounding FtP cases is that there is a small number of HSCPs who might deviate in terms of accepted norms of professional character and/ or virtues compared to their peers (Banks and Gallagher 2008). Such individuals, it is suggested, are more likely to carry out misdemeanours and, therefore present a greater risk to the public. The controlling role of regulators is believed to be paramount to assure public protection. This thesis contests this assumption. It starts with the position that the overwhelming majority of implicated HSCPs are in fact ordinary people, not especially different from their peers and that misdemeanours may be a consequence of the things that happen to people in their personal and professional lives and their reaction to these. The evidence for this will be examined in the review of the literature (Chapter 2).

Since 2002, The Medical Act 1983, s35 (as amended) has required the GMC to apply the concept of 'impairment' into FtP adjudication processes, an approach subsequently copied by other regulators. Case (2011) points out that the linchpin concept of impairment has received little academic comment or research despite its bold attempt to unify the various distinct channels of discipline it aimed to replace (including professional misconduct, deficient performance and health concerns). Smith (2004) in the fifth report of the Shipman Inquiry raised concern about the application of the term 'impairment' and offered guidance to GMC FtPPs asserting that a doctor whose FtP is 'impaired' either

- Is a risk to patients;
- Has brought the profession into disrepute;
- Has breached one of the fundamental tenets of the profession or;
- The doctor's integrity cannot be relied upon.

Figure 1. Outline of Statutory Regulatory Body Fitness-to-Practise (FtP) process.



As with other aspects, the 'impairment' construct was also adopted by other regulators to adjudicate in FtP cases involving nurses, pharmacists and social workers as well as many other professional groups. Figure 1 indicates that the FtP hearing shown at the end of the process takes place in four related steps. The FtP panel must first decide whether the alleged facts have been proved on the 'balance of probabilities'. Second, the panel must translate proved facts at the threshold standard to 'professional misconduct'. Next, taking account of all the facts, the panel must consider whether the HSCP's FtP is 'impaired'. In the final step, if impairment is found, the panel can impose a 'sanction'. It was originally intended in the recommendations of the fifth Shipman Report (2004) that steps two and three were to be treated independently by the panel with a disconnect between proven misconduct and whether FtP is impaired. In current practice a finding of misconduct automatically leads to a finding of impairment interpreted as *'un*fitness-to-practise' whose features have been stated above.

Each year the proportion of registrants facing a complaint, as a percentage of register size, for the four professional groups though considered to be small does vary between the professions. The frequency of complaints against nurses, as the largest professional group, is 0.8% of the register, while complaints against social workers is twice as much (around 1.5%) and complaints against doctors and pharmacists can be as much as 4.0%. Of the total number of new complaints received by regulators each year a very high proportion are dismissed at the end of the initial screening stage. A proportion of such complaints that are received are found not to relate to registrants' FtP (which regulators may refer on to other organisations). More relevant complaints may still be dismissed, after careful examination, if they are felt to fall below the threshold for further investigation. The proportion of registrants suspended and erased from practice following a FtP hearing, as a percentage of FtP investigations, also varies widely between the four regulators – these severe outcomes are lowest at the GMC and highest at the NMC (see Table 3); medicine (General Medical Council 2019), nursing (Nursing and Midwifery Council 2019), social work (Health and Care Professions Council 2019) and pharmacy (General Pharmaceutical Council 2019). The risk of de-registration, for example, varies from around 1 in 30,000 for a medical registrant (lowest) to around 1 in 4,000 for a nursing registrant (highest).

Overall, the statistics in Table 3 reveal a relatively high ratio of the number of complaints received by UK regulators against HSCPs to the number of complaints that reach the final stage of the disciplinary process (some 10 to 20 complaints that are received result in one FtP hearing case). Complaints against registrant's FtP can be made by a range of sources: patients and service-users, peers and other registrants, employers and organisations, and the police. A very large number of complaints (in one instance around 90 per cent), are dismissed at an early stage in the proceedings, presumably because they are deemed to be weak and do not meet the regulators standards of acceptance or are considered irrelevant to a registrant's FtP. There is a significant inconsistency between regulators in sanctioning registrants at the end of FtP hearings, with the prospect of registrants being handed down the most severe sanctions showing an hundred-fold variance between regulators. Despite all four regulators organising and operating FtP proceedings under statute, the picture revealed by the data presented in Table 3 is that the FtP process across regulators is not harmonised. The statistics point to a very different overall risk and experience by registrants to FtP proceedings across the four professions considered in this study.

Profession/ Statutory Regulatory Body	Year	Size of Practise Register (n)	Number of Complaints received (% of register)	Number of Complaints dismissed (%)	Number of Registrants Suspended (% of investigations)	Number of Registrants Erased (% of investigations)
Medicine/ General Medical Council (GMC)	2014-2015	240,000	8,300 (3%)	6,100 (70%)	90 (4%)	50 (2%)
	2015-2016	235,000	8,400 (3%)	6,900 (80%)	100 (6%)	40 (3%)
	2016-2017	280,000	7,600 (3%)	6,100 (80%)	100 (7%)	50 (3%)
	2017-2018	290,000	7,400 (2%)	5,900 (80%)	60 (4%)	20 (2%)
	2018-2019	310,000	7,400 (2%)	5,900 (80%)	<10 (0.2%)	<10 (0.1%)
Nursing/ Nursing and Midwifery Council (NMC)	2014-2015	685,000	5,200 (0.8%)	3,000 (60%)	380 (15%)	500 (20%)
	2015-2016	690,000	5,400 (0.8%)	2,200 (40%)	280 (10%)	260 (10%)
	2016-2017	690,000	5,500 (0.8%)	2,800 (50%)	420 (15%)	340 (10%)
	2017-2018	690,000	5,500 (0.8%)	3,300 (60%)	380 (15%)	260 (10%)
	2018-2019	700,000	5,400 (0.8%)	3,700 (70%)	230 (15%)	160 (10%)
Pharmacy/ General Pharma-ceutical Council (GPhC)	2014-2015	50,000	1,600 (3%)	580 (35%)	50 (4%)	40 (3%)
	2015-2016	52,000	1,900 (4%)	1,100 (60%)	50 (6%)	30 (4%)
	2016-2017	54,000	1,900 (4%)	1,200 (65%)	50 (7%)	20 (3%)
	2017-2018	55,000	2,300 (4%)	1,700 (70%)	40 (7%)	25 (4%)
	2018-2019	56,000	2,700 (5%)	1,000 (40%)	40 (2%)	15 (1%)
Social Work/ Health and Care Professions Council (HCPC)	2014-2015	88,000	1,300 (2%)	600 (45%)	30 (4%)	20 (3%)
	2015-2016	93,000	1,200 (1%)	1,000 (85%)	30 (15%)	30 (15%)
	2016-2017	92,000	1,200 (1%)	1,100 (90%)	50 (40%)	40 (30%)
	2017-2018	97,000	1,200 (1%)	700 (60%)	55 (10%)	50 (10%)
	2018-2019	95,000	1,300 (1%)	1,100 (85%)	40 (20%)	30 (15%)

Table 3. Regulatory activity of four UK health and social care profession's Regulators

The disparity unveiled by the analysis of annual FtP statistics above suggests there is a limitation within the overtly 'rule-led' FtP process, that, in reality, it is far from the ideal 'objective' state that SRBs would wish to claim for the narrative of their regulatory outputs. Weinstein (2015) highlights the root cause for such adjudication differences (and by implication perceived unfairness in the system of regulation) is to do with unconscious bias. Unconscious bias emerges from our upbringing, gender, ethnicity, education, socioeconomic status, and many other factors (Weinstein 2015). As humans we suffer from situated knowledge as a limit to what we are able to see when evaluating others. Regulatory staff and members of FtPPs are not immune, so decisions concerning registrants that are reached at each stage of the FtP process may be influenced by prejudice. Regulation is not objective and neither is the FtP process, therefore regulators must ultimately balance the task of protecting the public in a manner that is humane, fair and transparent for the practitioners they seek to regulate. This research takes the view that regulators have prioritised the system for public protection over the welfare of those going through the system. As a consequence, the interests of individual professionals have been denigrated. Haney (2012, p.150) writes about regulation in de-humanising terms:

> "It is as if the process has been specially constructed as a machine for destroying knowledge and spreading ill will. There can be little doubt that the process feeds feelings of vengeance and even hatred".

Regulators provide information on their websites to the wider public informing them of how to contact them should they have a concern about a registrant. Such an open invitation to complain appears to suggest to members of the public that regulators are available to hear about all grievances, no matter how minor or relevant to registrant's FtP. To what extent do the public actually understand what the complaints process is about and the consequences for registrants? Professionals can become changed (such as practising in a way to protect themselves against future mistakes and avoiding challenging assignments in their work) as well as experience distress as a result of a complaint that may or may not instigate an FtP investigation into their professionalism.

Similar to Medicine, the profession of Social Work has also suffered a loss of State and public trust following a spate of high profile cases and public inquiries highlighting the failure of the social work profession to protect the most vulnerable in society (Lord Laming 2003; Local Safeguarding Children Board Haringey 2008 and; Jay 2014). Responsibility for the regulation of social workers has changed repeatedly over the past fifty years, influenced in part by the concerns raised by failures in practice as well as the growing reliance by successive governments on regulation as a central mechanism of governance (McLaughlin et al 2015). Three recent past regulatory bodies for the social work profession, listed in chronological order, were: Central Council for Education and Training in Social Work (CCETSW), 1971–2001; General Social Care Council (GSCC), 2001-2012 and; Health and Care Professions Council (HCPC), 2012-2019. It was the establishment of the GSCC in 2001 that first introduced statutory regulation in social work, so of all the professional groups dealt with by this study social work is 'relatively newly regulated'.

As an umbrella regulator for a large number of health professions, the decision to move the regulatory responsibility away from GSCC to the HCPC has been met with criticism. For example, Haney (2012) points out that such an external and non-work-based body was at a particular disadvantage when it came to regulating the social work role and risked creation of a lacuna, giving rise to a 'system' of regulation that became de-contextualised, and that potentially would hold individual social workers directly accountable for failings, avoiding consideration of more general workplace and organisational inadequacies. The HCPC is responsible for regulating sixteen different professional groups including social workers in England. The register size is around 350,000 of which social workers comprise about one quarter of all registrants. However, a disproportionate number of complaints to HCPC each year are received against social workers (about 50%). It is interesting to note that a large number of complaints received against social workers are from service users and employers. The referral rate for social workers (of around 1%) is approximately double that of the average for the fifteen other professional groups regulated by the HCPC. This is slightly above that for nurses (around 0.8%), but significantly lower than that for doctors and pharmacists (around 3%). More recently, The Social Workers Regulations 2018, allowed the responsibility for the regulation of social workers to move away from the HCPC and to a new specialist regulator for the profession on 2nd December 2019, called Social Work England (SWE). The new regulator inherited 1,545 live investigations from the former regulator as well as raise a further 1,982 concerns of its own (not shown in Table 3) over the course of its first year (Social Work England 2021).

The Nursing and Midwifery Council (NMC) is currently the single UK Regulator for nursing and midwifery. The two professions were only brought under one SRB following the passing of The Nursing, Midwives and Health Visitors Act 1979 that saw the establishment of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). The intention of this change was to eliminate the inconsistencies in the regulation of nurses and midwives that occurred with separate SRBs through the General Nursing Council (Nurses Registration Act 1919; Nurses Act 1957) and Central Midwives Board (Midwives Act 1902 and 1951) respectively. Of the four SRBs considered by this thesis, the role of the NMC will be considered further here.

The NMC is the professional regulator of some 700,000 nurses and midwives in the UK, and nursing associates in England. The objectives of the NMC are set out in the Nursing and Midwifery Order 2001 (as amended). The NMC Strategy 2020-2025 aims to support the delivery of excellent nursing and midwifery guided by three core pillars – regulate, support and influence (NMC 2021). The Strategy has the purpose of upholding high standards, maintain the register of professionals eligible to practise, and to investigate registrants' practise when care goes wrong. In discharging its function the NMC is keen to regulate as progressively as possible and to work collaboratively with other SRBs to address common concerns. This thesis has already raised serious concerns over contemporary regulatory reforms premised on a risk-based model of regulation that have ended up as being a front for greater administrative and managerial control over the work of registrants rather than a progressive regulatory form as suggested by the NMC Strategy. Of primary importance to this study is the safeguarding responsibilities of all health and social care

regulators to all who come into contact with them. This includes HSCP registrants as well as patients and members of the public. All SRBs are required to produce an annual fitness-to-practise report and submit this to Parliament.

In January 2021, the NMC began its Fitness-to-Practise Improvement programme which included a new 'Risk of suicide and self-harm' protocol for regulatory staff to follow in cases where individuals appeared to be at risk of self-harm. In 2020-2021 there were no recorded instances (2019-2020: one instance and in 2018-2019: four instances). It remains the case that around 9 in 10 referrals made to NMC result in no regulatory action being necessary but not before a referral has moved far through the process before this decision is taken. The distress caused to registrants under investigation can be considerable. In its most recent annual report (NMC 2021) the regulator stresses that those referred to it will be treated in line with the values of being kind and fair at all times within a procedural shift from 'remediation' to 'strengthening practice' as the focus of any investigation. The direction of shift is in alignment with other UK SRBs responsible for overseeing HSCP workforce and is to be welcomed.

1.4 Human impact of the fitness-to-practise process

Published research in the area of regulation (see section 2.2), has been concerned with exploring the controlling function of SRBs. To this end, research studies have been designed to examine the practices and procedures of SRBs, with the research itself largely conducted by professional academic researchers. Until very recently it appears that SRBs had not appreciated the safety of the individuals who are going through the FtP process. Without ignoring the impact of the process for the complainants in any way it is known that the process of being involved in the regulatory investigation process is very stressful for registrants, and that it can be thought of as a kind of 'regulatory iatrogenesis' (meaning regulatory bureaucracy and lawyers have combined to induce illness among health and social care professionals). The General Medical Council (GMC) commissioned an independent review in September 2013 into the impact of FtP hearings on registrants. The review found that up to 28 doctors committed suicide between 2005-2013 while under investigation (Horsfall 2014). In 2016, the Nursing and Midwifery Council (NMC) announced that it commissioned a study to understand the impact of FtP investigations on nurses' mental health (Jones-Berry 2016). At least 4 nurses have committed suicide while under investigation since April 2018 (NMC 2019). It appears that the move away from professional self-regulation towards a more independent system operated by the State with its strong emphasis on 'protecting the public' through a very narrow focus on the conduct of individual professionals, rather than organisational issues, has contributed to a rise in HSCP morbidity among those going through the FtP process, and in some cases has led to suicide.

This thesis describes a personal and professional journey. The personal thread is to address the general question 'What does de-registration feel like and how I am dealing with it?' The personal thread is supported by a professional thread reviewing the FtP processes of four statutory professional regulators in the UK that seek to protect the safety of the public by preventing HSCPs

whose FtP is ‘impaired’ from practising drawing understandings from a literature review. The Shipman Inquiry, referred to previously, has understandably affected public trust in doctors (and perhaps other HSCPs too) as individual practitioners and, in the system of professional self-regulation that operated prior to the Inquiry. I will look at the health and social care professions as examples of a ‘moral community’ within their roles as public service professionals (Banks and Gallagher 2008; Sama and Shoaf 2008) and explore the extent to which the current system of regulation goes beyond controlling HSCPs and towards the second function of enabling the ethical fabric of the community of professionals they are appointed to oversee. In this respect, I proffer the benefits to UK society, service users and to individual HSCPs themselves of an explicit redemptive approach to FtP when things go wrong in practice. Seen in this light, the personal thread to this study is my own story. I am keen to explicate my behaviour beyond the ‘standard account’ of the de-registered care professional provided by all regulatory body FtP panels, and that is most aptly summarised by the label ‘bad apple’ (Chaucer and Alexander 1996). The suggested ‘bad person’ pervades both popular media accounts of FtP panel reports of cases, academic literature and probably most importantly society at large. The fitness-to-practise criterion has long been used by all regulators of the professions to screen out individuals on the basis of ‘character’ and health standards rather than professional competence, and in-so-doing purports to perform its public protection function.

My study will use my own FtP case that concluded in 2012, as research material for this thesis, in order to reveal the lived reality of the current regulatory framework that operates in the UK. This research hopes to explore through a single case the human impact of the system of regulation on both professional and personal identity, resilience and emotional well-being. Defining these terms precisely is difficult because they are used by different social science disciplines to mean different things when using different approaches. Only short discussions are presented below due to word limits.

1.4.1 Well-being

Though well-being is a popular term, researchers have largely focused on aspects that constitute this construct rather than on how it should be defined. For Ryff (1989) these are autonomy, environmental mastery, positive relationships with others, purpose in life, realisation of potential and self-acceptance. The listed dimensions reveal the multi-faceted nature of well-being. Having to go through FtP proceedings and adjust to a severe sanction like suspension or de-registration trigger negative emotions including fear, worry and anger. If left unchecked, these emotions can leave those affected feeling overwhelmed, out of control and vulnerable. Dodge et al. (2012, p.222) in their synthesis of the available research on well-being define it as “the balance point between an individual’s resource pool and the challenges faced”. This balance point can be easily applied in the context of the de-registered HSCP as strike-off has the potential to present considerable challenges (psychological, social and physical) which can upset an individual’s homeostatic set-point for well-being. To balance the situation, the individual is forced to draw on available resources to meet challenges. Though the uniqueness of individuals is recognised, and responses will vary, the impact of de-registration is felt, nonetheless, to be profound leaving

individuals experiencing distress with accompanying feelings of being overwhelmed, confused and unable to cope. It follows that a prolonged state of sub-optimal well-being is likely to be a feature of the lived experience for the major part of the five-year period of absence from professional practice.

1.4.2 Resilience

Zolli and Healy (2012, p.7) in their attempt to define resilience frame it in terms borrowed unashamedly from both ecology and sociology as "the capacity of a person to maintain their core purpose and integrity in the face of dramatically changed circumstances". When defined in this way the concept of resilience can be easily applied to the regulatory context. Following a decision by a regulator to remove a registrant from the register of practitioners (RoP) because of impairment of FtP, the former registrant is thrust into a new circumstance, from which there is no immediate return to the prior state. The person experiences being 'flipped' over the critical threshold to enter a 'new normal' and facing any number of challenges that call for an ability to adapt while continuing to fulfil core purpose defined by our range of social roles and responsibilities, including self-care.

Davidson and Begley (2012) argue that we each have our own 'emotional style' premised on the underlying neurochemistry of our brains or brain signature. The idea that some people possess a brain signature of being 'slow to recover' from setbacks while others being 'fast to recover' from adversity is relevant in the context of receiving the most severe sanction at the end of an FtP hearing. This sanction is generally reserved for cases where the registrant is deemed guilty of 'gross professional misconduct'. It is almost inevitable that a very poor appraisal handed down to a registrant by their regulator, coaxed in fatalistic terms, would become internalised and viewed as reflective of bad character. The vast majority of HSCPs, like me, embarked on their careers in order to make a difference to the health and well-being of service users. Yet at this critical juncture in their career, as a result of making a mistake, the registrant is left distressed and fragile. Those registrants towards the 'slow to recover' end of the resilience dimension are at greatest risk of failing to cope, falling into depression and experiencing pain and anguish. It is not difficult to understand why a significant number of registrants going through the FtP process experience suicidal ideation as a way out of their suffering.

1.4.3 Work identity

Gini (1998) perceives work as central to adult existence as one of life's threads weaving a unique sense of self that forms a type of social identity called a work identity. In this, work is perceived to be an anchor of adulthood (Schwartz 1982); providing opportunities for achievement in terms of career advancement and financial security, learning and mental stimulation and, relationship development with co-workers. Moreover, in the context of this study, many HSCPs see their work as a 'calling to provide care' to restore and maintain people's health and promote social welfare (Banks and Gallagher 2008). If we assume this is true it follows that as HSCPs we ourselves find identity and are identified by the work we do. Individual and work related characteristics influence

work identity which may have consequences for people's productivity. It is therefore a dynamic concept which can be under threat from regulatory, managerial and leadership frameworks within which HSCPs operate. High levels of stress, emotional exhaustion and burnout appear to be commonplace in the caring professions as a result of chronic underfunding of services, staff shortages and high workloads (Moriarty et al. 2015). Adding to this, receipt of notice of impending disciplinary action from a regulator, may be interpreted by registrants working under these circumstances, as nothing less than fighting the impossible. It is to be expected then, that regulator FtP proceedings undertaken against a HSCP can cause strong feelings of dissonance and incoherence particularly in response to being removed from the professional register. Here, I will explore the ensuing human impact of work identity crisis and adaptive struggle.

1.5 Scope and limitations of the thesis

This thesis will be limited to assessing the role of regulatory bodies in managing the heath care workforce in the UK alone because countries abroad handle professional misconduct cases differently. In the case of the social care workforce, a different Care Council is responsible for the regulatory role in each of the four countries of the UK. This study will be limited therefore to the professional regulation of social workers in England only.

As a recent past registered pharmacist (1990–2012), this thesis will be largely confined to the detailed examination and analysis of the regulation of community pharmacists through the example of my own experience of the FtP process and de-registration, serving as a case study. The focus of this study is not why and how HSCPs become 'impaired' (and the processes leading up to sanctioning, although this will inevitably form part of my story). Neither am I investigating the role of SRBs (although this will form part of the contextual background). Rather, I am interested in the human experiences of HSCPs who have been subject to FtP proceedings and de-registered, and how to best support such individuals through the process of adjustment following the issue of this most severe sanction.

1.6 Structure of the thesis

Chapter 1 provides the contextual background for the study through a brief consideration of regulatory history and policy and the effects of the changing regulatory landscape on health and social care practice in the UK, 2000-2020. In addressing the human impact of the regulatory framework and its processes, the subject matter of this study, an outline of the presumed psycho-social effects are tentatively presented (well-being, resilience and work identity).This thesis is structured into six further chapters and conclusion.

Chapter 2 identifies what is known about fitness-to-practise by considering the published peer-reviewed literature on the subject from the perspective of the four professional groups (medicine, nursing, pharmacy and social work). It will show understanding of the findings of the research to date and through qualitative synthesis draw together the various conclusions in order to establish

what is known about the regulation of care professionals in the UK, most probably for the first time. In this way any gaps in our understanding about the human impact of FtP proceedings operated by regulators in the UK will be revealed, providing justification for this study. The questions that this research study intends to address are also introduced.

In Chapter 3 I will discuss the method of my empirical study. I wanted to understand the human impact of disciplinary proceedings at a deep level, especially on those receiving the most severe sanction of de-registration at the end of an FtP hearing. I arrived to the study with personal experience - three years earlier I became de-registered by my regulator. Since then I had tried very hard to keep the traumatic experience out of my mind while I continued to piece my life back together. I had some generalised ideas therefore, about what needed to be understood. My supervisory team encouraged me to return to my experience and develop a detailed case study. I believed there were several blind spots in our current understanding of the effects of the FtP process as a result of researchers' reliance on using cross-sectional study designs. The rationale for the choice of autoethnography is discussed and methods used for gathering and analysing data are described. The debate concerning the appropriate selection of criteria for the assessment of the rigour of qualitative research is outlined before I hone in on Richardson's (2000) five criteria felt to be particularly suited to evaluating evocative autoethnography. The chapter closes with an evaluation of the process followed by my study.

Chapter 4, draws on Inkson's (2003) framework of archetypal metaphors to help encapsulate and represent my whole career as a pharmacy professional and educator. The metaphors afford me the opportunity to view my career through different lenses as, for example, an inheritance, an action, a fit, an emotion, and a journey (psychological, spiritual and return to practise). I include a total of seven autoethnographic vignettes to map my career path. These also showcase the richness and reflexive characteristics of qualitative research. Here I use narrative prose as my chosen writing style to effect the constructive interpretation of my life (Chang 2008).

In Chapter 5 I continue with my intention of gaining cultural understanding, started in the previous chapter, by employing the approach of narrative analysis using Frank's (2013) narrative types to interrogate self-data. The second part of the chapter considers the extant literature drawn from the perspectives of philosophy, psychology, sociology, spirituality, policy and social justice in efforts to both understand and critique the culture of regulation of health and social care professionals in the UK.

Chapters 6 and 7 will bring together the important insights that emerge from this thesis, and offer suggestions on how to operationalise these insights into regulatory policy and practice in order to lessen the human impact of FtP proceedings on registrants. Included is a personal reflection on the rigour of the research output.

Chapter 2
LITERATURE REVIEW

This review of the literature aims to identify what is known about the context of the regulation of health and social care professionals (HSCPs) and therefore where the current gaps in the knowledge are as well as to make a case for my proposed research. The literature review informing this research study was not a single occurrence but comprised three separate episodes. The first and main episode was undertaken at the beginning of the PhD journey during October 2015. The second review (or first updating) followed shortly after successful Transfer and preceded data collection (April 2019). The third review was a post-analysis updating review carried out during February 2021 to inform the discussion of the findings. Each episode followed the same methodological approach but with different date filtering, and this is described in full below.

2.1 Literature search

The literature search was completed using a thorough and systematic approach. Direct personal experience became the starting point of my research. I needed to formulate a review question that could help establish what knowledge existed in the topic area. The phenomenon I was curious about was the 'impact of regulatory body fitness-to-practise (FtP) proceedings on care professionals, particularly those who became de-registered'. I wanted to know, in the first instance, whether the review question had been answered by others or not. My personal experience of passing through the stages of the FtP process that led to me losing my registered status was very informative to me in so far as helping me to name my topic from the terms used by the organisations and people involved in the regulation of care professionals. The terms I had knowledge about included: complaint, misconduct, impairment, fitness-to-practise, registration, regulation, public protection, hearing, sanction, suspension, and strike-off.

Bettany-Saltikov (2012) proposes the use of the P E O (Population and their problems; Exposure and; Outcomes) format for qualitative research questions to help identify key concepts in the question, develop appropriate search terms to describe these and determine inclusion and exclusion criteria. Table 4 summarises the use of the P E O framework to inform my search strategy.

P	Population and their problems	Misconduct among UK Health and Social Care Professionals (doctors, nurses, midwives, pharmacists and social workers) – registered and de-registered groups
E	Exposure	Fitness-to-Practise proceedings (complaint, investigation and hearing) operated by regulatory bodies (GMC, NMC, GPhC, HCPC)
O	Outcomes	Well-being, mental health (anxiety, depression and suicide), lived experience and resilience of registrants going through FtP proceedings and coping with a severe sanction - suspension or de-registration.

Table 4. P E O format for developing the qualitative research question

The introduction section of this thesis has already placed 'the regulation of HSCPs in the UK' within a broad policy context and highlighted why this topic is important at this time. The review question I formulated was:

What is known about health and social care professionals who undergo regulatory body fitness-to-practise proceedings in the UK and the effects on their mental health and well-being?

I wished to confirm that the research question had not already been answered fully by others. To explore the "experiences of HSCPs" a search was conducted using the Bournemouth University literature database (EBSCO database) that provides coverage of relevant electronic databases such as Medline Complete, CINAHL, Web of Science, Science Direct, and Cochrane. The use of the EBSCO database has several strengths including providing access to high-quality research that is systemically organised. In addition, individual databases (SCOPUS, Social Care Online and SOC INDEX, Web of Science, International Pharmaceutical Abstracts) were also searched in order to confirm and extend the identification of all the relevant literature. The search plan provided reassurance that research outputs from the four professions on the specific field of FtP would be captured. Working with a University Librarian, I was steered towards using the techniques of Boolean searches to improve the likelihood of finding relevant sources. Boolean searches increase precision when entering search terms by introducing the words AND, OR, as well as symbols like quotation marks in order to limit a search to an exact phrase. Publications were included in this review if they met the inclusion criteria set out in Table 5 that also shows the search terms in the form of key words.

Search periods were set between September 2000 and February 2021. These dates were chosen to include the time before the concept of 'impairment' was formally introduced into the UK GMC's FtP procedures in 2002 (and those of other SRBs subsequently) enabling comparisons to be made relating to the impact, if any, of this construct on the regulation of HSCPs. More broadly, I wished to chart the progression in ideas and research for my chosen field of inquiry and considered the period of the last 20 years appropriate to achieving this goal.

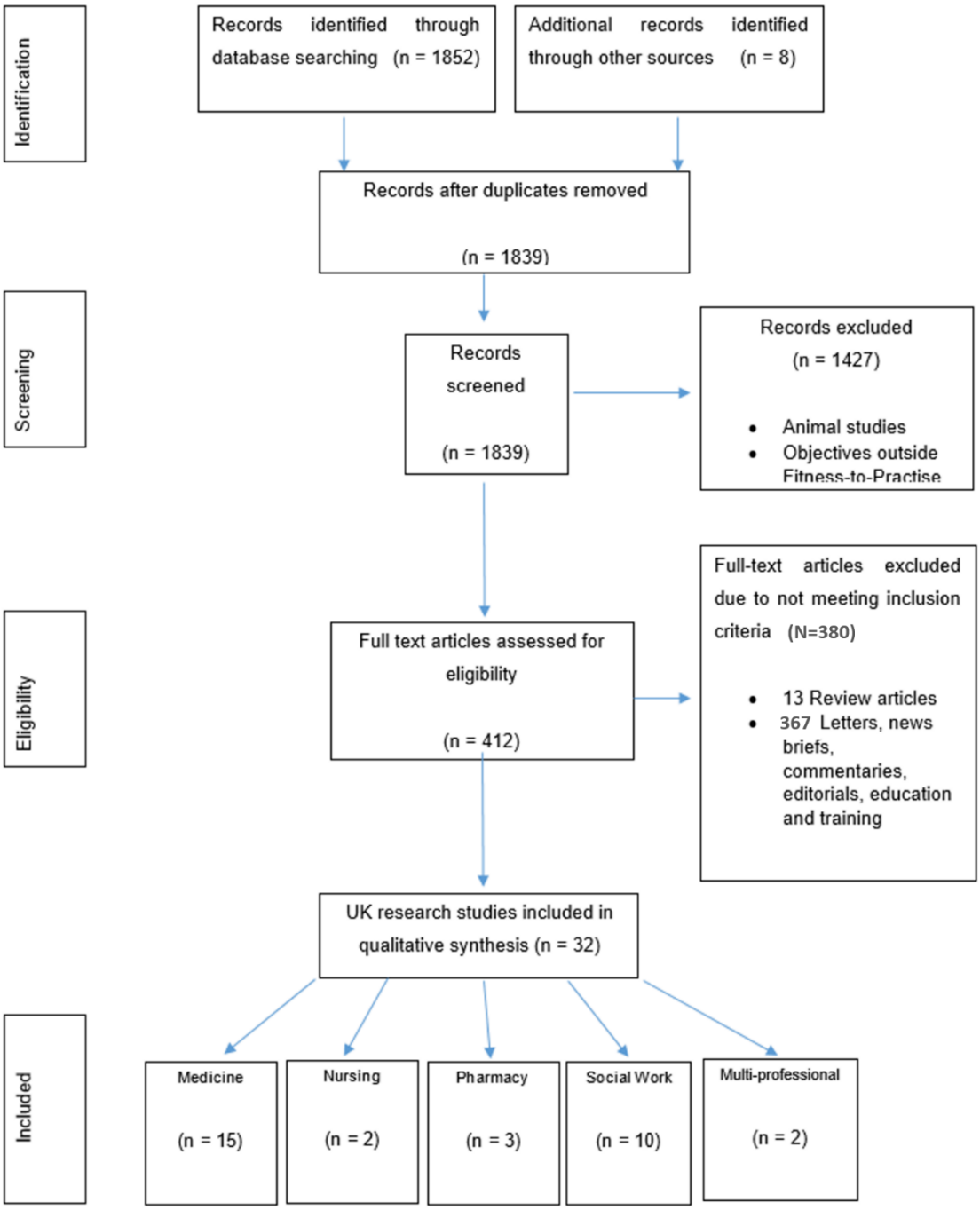
Search term (using truncation)	Related or alternative words or terms (using truncation)
Regulat*	“Nursing and Midwifery Council" OR "General Pharmaceutical Council" OR "Health and Care Professions Council" OR "General Medical Council" **AND**
“Fit* to practi?e"	misconduct OR impair* OR determination OR "struck*off" OR "strike*off" OR eras* OR de*regist* OR sanction* OR suspen* **AND**
"Mental health"	“"mental illness" OR rehab* OR recover* OR restor* OR re-registration OR "return to practi?e" OR support* OR counsel* OR stress*
Inclusion Criteria • Primary and secondary quantitative, qualitative or mixed method research • Research published post-September 2000 • All peer reviewed publication types included (academic journals, magazines and dissertations/ theses) • English language items only • UK-based items only	
Exclusion Criteria • Review, discussion and policy papers that are not studies (because they will be covered in the introduction and background sections) • Research that examines HSCPs’ (mental) health and well-being alone, and not in conjunction with SRB FtP proceedings • Research published pre-2000 because professions operated through a self-regulatory model and some regulators were not yet established • Research published in a foreign language	

Table 5. Search terms, inclusion and exclusion criteria

2.1.1 Prisma diagram

The adapted PRISMA flow diagram for identification of key papers used in this review is provided in Figure 2 (Moher et al. 2009). In total 1852 sources were identified from the electronic databases (comprising 1837 academic journals, 8 magazines and 7 dissertations/ theses). The screening process began after removing duplicates by assessing relevance by first reading the title. Those sources considered irrelevant (n=1427) were removed. The search term “regulat*” had returned a very large number of animal physiological studies. Future updating searches would be revised by entering the Boolean command NOT “regulat*”. Next, I reviewed the abstracts and summaries against the inclusion/ exclusion criteria for each of the eligible sources (n=412) and organised these into five categories (medicine, nursing, pharmacy, social work and ‘other sources’) with an electronic folder for each category. I placed downloaded sources into these folders, and kept separate notes of any sources I could not download, but could obtain through the University library’s system for requesting such unavailable sources. The search terms produced a broad range of documents, which were assessed for credibility. Peer review is the accepted gold standard for source credibility (Jensen and Laurie 2016) and therefore only peer-reviewed journal articles (research studies) that were deemed to match the inclusion criteria were put forward for reading in detail. Bibliographies of articles identified as being relevant were searched manually for additional studies. The UK context is the intended focus of this project and therefore only UK FtP studies were prioritised. A total of 32 peer-reviewed journal articles (research studies) were included in the final qualitative synthesis.

Figure 2. PRISMA flow diagram of review of the literature



2.1.2 Critical Appraisal

Although I regarded the published peer-reviewed studies as potentially dependable sources of information, I recognised that standards of research practice varied greatly. This meant, as the reviewer, it was my task to assess both the relevance of the results and their credibility in the light of how those results were obtained (Jensen and Laurie 2016). I started with one category (profession of medicine, n=15) and began reviewing each article in chronological order (starting with the earliest) one at a time. While reading I used a critical appraisal checklist matched to the study design to guide the process (CASP ca.2016). I felt that the number of studies identified (n=32) was low and as a result decided to approach the literature review in a constructive way

with the aim of retaining all studies including those that have some flaws or limitations. After completing the first category of studies I repeated the process for other categories (i.e., professions of nursing, n=2; social work, n=10; pharmacy, n=3 and; multi-professional, n=2). The general set of methodological questions that guided the systematic evaluation of research studies is summarised in Table 6.

Overall design of study	Experiment, survey, ethnography, mixed-methods
Population studied	Adequately described?
Methods	Adequately described? Appropriate? Limitations?
Results	Relevant to research question/ problem posed? Credible?
Interpretation and conclusions	Warranted by the data? Reasonable speculation? Importance of the work to answering my research question in this thesis?

Table 6. Methodological questions used in appraisal of studies

2.1.3 Data abstraction

I made detailed notes through the assessment process with the purpose of capturing information from each study relating to the list of methodological questions posed. The nature of this review is narrative and any obvious limitations have been raised within the appraisal of individual studies. A table of abstraction of all 32 research studies, grouped by profession, was completed (Table 7).

	Author	Prof	Aim	Method	Key Findings	Limitations
1	Tiffin et al. (2017)	Med	To evaluate the validity of PLAB regarding whether the scores demonstrated an ability to predict the risk of subsequent FtP issues in international medical graduates (IMG).	Observational study (n=27,330) linking data relating to FtP events (referral or censure), linguistic ability and communication.	1,182/ 27,330 (4.3%) IMGs received allegations of FtP concerns 215/ 1,182 (18.2%) of these eventually received some form of censure For IMGs referred in relation to FtP concern: • Males were three times more likely to be sanctioned than females • PLAB part 2 score at first sitting and multiple attempts at part 2 are predictive of censure Unexpectedly, higher English speaking scores (on the International English Language System, IELTS) is a risk factor for censure Censure predominantly relates to professionalism issues.	Findings only apply to IMGs who used the PLAB system to demonstrate their clinical skills and knowledge; to preserve anonymity data were supplied to the authors by the GMC by region, not country of origin, preventing more detailed analysis; study power was affected by the small number of doctors in the dataset who were eventually censured.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
2	Bourne et al. (2015)	Med	To investigate the impact of complaints on doctors' psychological health and, whether doctors report exposure to complaints process produces defensive medical practise.	Cross-sectional survey (n=7926).	Compared to doctors with no complaints, doctors with complaints reported higher levels of • moderate/ severe depression (RR 1.77) • moderate/ severe anxiety (RR 2.08) • self-harm thoughts or suicidal ideation (RR 2.08) • defensive practise (both hedging and avoidance).	Very low response rate of 11.4%. The study sample was not representative (over-represented were doctors in the 35-59 age range, consultants and GPs; under-represented were ethnic minorities, junior doctors and retired doctors) Doctors who have been erased from the register were not included.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
3	Brooks et al. (2014)	Med	To explore the views of sick doctors on their	Qualitative study using semi-structured	Perceptions of the GMC:	Of 77 doctors approached only 19 volunteered to participate; this group

			experiences with the GMC and their perception of the impact of GMC involvement on return to work.	interviews (n=19) and inductive thematic analysis.	• GMC processes were necessary in terms of protecting patients • lack of support from an uncaring, unfriendly and impersonal GMC • GMC did not understand mental health problems Perceptions of GMC processes: • stressful and confusing-'accusatory' tone and legal jargon in GMC correspondence • 'like a court case' Impact on health: • worsening existing mental health • how GMC deal with people- almost unbearable causing relapse back into drinking Suggested improvements: • having separate pathways for doctors with purely health issues • less use of legalistic language • more personal approach.	may have held stronger views, either positive or negative about the regulatory process.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
4	McGivern and Fischer (2012)	Med	To explore how doctors, psychotherapists and counsellors in the UK react to regulatory transparency and, how regulatory transparency disrupts practice.	Qualitative study using semi-structured interviews (n=51) analysed through a narrative approach.	Transparency in medical regulation: • doctors described being 'hammered every week by the press' • local stories and personal accounts circulate among clinical communities • doctors' identities and friendship networks are often tied to their professional role • anxiety heightened doctors' desire for defensive practice • narratives about 'trials by media', 'inquisitions' and 'scapegoating', preoccupied clinicians.	At the time of the study, transparent regulation and standards were more established in medicine, but only nascent for therapists therefore affecting true comparison of experiences.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
5		Med		Qualitative study		

	Slowther et al. (2012)		To explore the experience of non-UK qualified doctors in working within regulatory framework of General Medical Council (GMC) document 'Good Medical Practice' (GMP).	Individual interviews (n=26) to explore in depth the lived experiences of non-UK qualified doctors and, two focus groups.	The experience of non-UK qualified doctors differed in three important ways: Working in an unfamiliar world • focus on patient autonomy and rights in UK provoked anxiety • difficult to identify potential ethical difficulties and respond to them Communication difficulties • a sense of isolation was felt Sources of support in practice • a training post with both managerial and clinical lines of support was highly valued.	Risk of participant bias in this interview study as only those doctors prepared to discuss transition difficulties to practise within the UK ethical and professional regulatory framework would have volunteered to take part.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
6	Chamberlain (2011)	Med	To analyse data pertaining to the hearing of FtP cases by the GMC for 2006-2009 and, outline statistical trends regarding complaint data in relation to a doctor's gender, race and ethnicity.	Retrospective cross-sectional (survey) design (n=4722).	Complaints received by GMC has trebled between 1995-2009: • Two-thirds come from the general public • At 19%, Asian or Asian British ethnic minorities are overrepresented in terms of complaints made against them • More likely to be made about male than female doctors (80:20) • Most complaints are closed either at initial triage stage (about 70%) or after investigation (90%) • The outcomes of cases heard at adjudication stage reveal less year on year consistency in types of action taken • In 2009, 0.14% (n=319) of doctors were referred to FtP and 0.03% (n=68) were erased from medical register.	Data for any one calendar year do not represent the GMC's total activity in that year; a complaint received in 2009 may not reach resolution until 2010. Until 2004 the GMC's fitness-to-practise procedures were governed by separate legislation involving different committees concerned with three aspects of a doctor's fitness-to-practise: Health, Conduct and Performance.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
7	Humphrey et al. (2011)	Med	To investigate if country of medical qualification is	A prospective cohort analysis (n=7526) of outcomes at	• Initial triage stage: 30% of UK doctors had a high impact decision compared with 43% other EU doctors and 46% for non-EU qualified	Relative odds of high impact outcome is a measure of relative risk (comparison with UK

			associated with "higher impact" decisions at different stages of the UK GMC's FtP process after allowance for other characteristics of doctors and inquiries.	three stages of the GMC's FtP process.	doctors; adjusted odds ratio (OR) of over 1.5 compared with UK qualified doctors. • Investigation stage: 5% of UK doctors were referred for adjudication compared with 10% for EU or non-EU qualified doctors; adjusted OR of around 2.0 • Adjudication stage: 1% of inquiries received concerning UK qualified doctors led to erasure or suspension, compared with 4% for EU qualified doctors and 3% for non-EU qualified doctors; adjusted OR of erasure or suspension were 2.16 and 1.48	qualified doctors), not absolute risk of an adverse outcome At the time of analysis, no final decision had been reached for 400 inquiries The number of events available for analysis at the adjudication stage was small.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
8	McGivern and Fischer (2010)	Med	To explore general practitioners' (GPs') and psychiatrists' views and experiences of transparent forms of medical regulation in practice.	A qualitative narrative analysis of interviews (n=12) with a volunteer sample of eight GPs and four psychiatrists based in a single metropolitan NHS Primary Care Trust.	• Doctors' narratives point to ever increasing levels of complaints, legalisation and blame within NHS • Drs are practising more defensively • A negative effect of regulation is spotlight given over to 'exceptional cases' that arouse political response (following media frenzy) • 'Spectacular transparency' was being driven by a 'blame business' - lawyers and patient organisations have become motivated by financial gain rather than reducing malpractice.	A limitation of a volunteer sample is that more highly motivated people participate. A relatively small number of doctors were interviewed in the setting of a single metropolitan NHS Primary Care Trust.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
9	Yates and James (2010)	Med	To determine whether there are risk factors in a doctor's time at medical school that are associated with subsequent professional misconduct.	Multicentre retrospective case-control study (n=59): doctors who had a 'finding in fact' for professional misconduct were matched to 236 doctors who had never been	Risk factors in a doctor's time at medical school that are associated with being a case are • male sex • lower social class • failure of early examinations	Important explanatory variables may have been missed including ethnicity, harassment or bullying whilst at medical school, attitude and poor health. This is a small limited study as it involved only 8 medical schools, a short timeframe of five years

				under investigation.		from which cases were identified that restricted the number of available cases to 59.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
10	Campbell et al. (2008)	Med	To investigate the utility of the GMC patient and colleague questionnaires in assessing the professional performance of a large sample of UK doctors.	Cross-sectional questionnaire surveys (n=252).	Patient and colleague questionnaires were acceptable to participants Both patient and colleague responses were highly skewed towards favourable impressions of doctor performance Three groups of doctors had lower patient-derived and colleague-derived scores • older doctors • those from a mental health trust • doctors working in non-NHS settings.	<50% of doctors agreeing to participation in the study reached the minimum sample size required (252/541) for both colleague and patient questionnaires. Doctors were volunteers, likely to be reasonably confident about their own standards of practice- sample may have been skewed towards good performance.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
11	Hutchinson et al. (2001)	Med	To examine the perceptions and views of NHS senior health professionals, both medical and non-medical, on what they saw as being poor performance, and their experience of handling poorly performing doctors.	Mixed methods design comprising: semi-structured face-to-face interviews (N=16), structured telephone interviews (N=28) and a national postal survey (N=457).	Different definitions were used in practice to describe poor performance Three main barriers to managing poor performance were identified • poor attitude towards professional performance • professional etiquette that makes it difficult for doctors to criticise their peers • mechanisms/ procedures such as staff rotation, can make it difficult to resolve successfully poor performance.	Commissioned by the GMC in 1997, after introduction of the 'Performance Procedures'.

	Author	Prof	Aim	Method	Key Findings	Limitations
12	Cooke and Hutchinson (2001)	Med	To examine young doctors' views on a number of professional issues including professional regulation, multidisciplinary teamwork, priority setting, clinical autonomy and private practice.	A postal questionnaire was sent to 600 participants in July of each year. First mailing received a response from 80%, (base of 545).1998 survey was returned by 95%.	Majority of doctors held views consistent with current GMC guidance on current professional issues of regulation, teamwork and clinical autonomy Majority supported the right of doctors working in the NHS to engage in private practice Heterogeneity of the profession and the influence of speciality and gender on professional values.	The use of volunteers in the first stage of sampling exposes the study to the problem of volunteer bias the effect of which is to restrict the generalisability of absolute proportions Results of a follow-up survey undertaken in 1998 were reported in this paper.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
13	Bahrami and Evans (2001)	Med	To monitor and describe the process and outcome of referrals over a two-year period to assess the size of the problem, to share good practice, and to identify any deficiencies in the system.	Quarterly postal questionnaires sent to all GPs (n=99) referred to Deaneries from the GMC and health authorities on account of under-performance.	Cases referred by the GMC • Deaneries had experienced serious difficulty in getting access to a copy of the letter sent to GP by the GMC • actions the Deaneries were requested to take were not felt to be feasible in several cases- (e.g. extensive remedial training and clinical supervision) • referred GPs had unrealistically high expectations of what could be done for them with some exhibiting a negative attitude and denial of the problem.	GMC Fitness to Practice structure and process has changed since the survey was carried out, now performed through a single committee and not separate committees concerned with conduct, performance and health.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
14	Bradby et al. (1995)	Med	To analyse press coverage of the GMC Professional Conduct Committee (PCC) during	Survey design involving an analysis of tabloid press coverage of professional misconduct	Cases of sexual misconduct (10 out of 15) received more attention than cases in which there were no allegations of sexual misconduct (7 out of the remaining 41 cases). Tabloid press coverage has involved little overt criticism of doctors' professional conduct.	Authors assume that sexual misconduct by doctors may not have received such a high profile in the broadsheet papers and therefore

			1990-1991 through comparing all tabloid press coverage during this period with PCC minutes to establish what kinds of cases were reported.	cases before the GMC between January 1990-May 1991 (n=17).	Those implicated in sexual misconduct • 14/15 perpetrators were male GPs • 13/15 patients were female and almost always younger than their doctors • little effort is made to describe the appearance of doctors • descriptions of the women patients and doctors' wives are more detailed, the former as 'busty', 'pretty' or 'petite' blonde while the latter are portrayed as demure and loyal.	these do not form part of the analysis.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
15	Lloyd (1990)	Med	To investigate whether doctors with alcohol and drug dependence who joined the North West Doctors and Dentists Group (NWDDG), a self-help group, had recovered and whether their lifestyles and careers had been affected.	Survey using self-administered questionnaires (n=77).	Compared to all doctors in England • respondents' age distribution (40-59) was narrower and older • twice as many men than women • two and a half times as many GPs as hospital doctors Sustained recovery from dependence was achieved by 76 doctors for about 5.5 years 32 doctors had lost their jobs- 15 doctors were referred to GMC's medical committee assessment process Action was taken against 50% of doctors with 2 erased Accepting help by attending monthly meetings of the NWDDG was a significant factor in determining recovery in this study.	The results should be interpreted with caution: the doctors in the NWDDG may have been particularly well motivated, and there was no control group. Eleven group members were not followed up: two had lost contact with the group by the time of the survey and nine did not respond to the questionnaire.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
16	Wier (2017)	N/M	To investigate the perceptions of a group of midwifery registrants about the influence of regulation and	Mixed methods approach: online survey (n=132) and semi-structured interviews.	Two key themes emerged • NMC protected the public and improved standards of midwifery practice though some participants claimed to practice defensively	Paucity of evidence hampers the comparison of results between studies. Small sample size cannot be extrapolated to the wider population of midwives in the UK.

			the regulatory body, the NMC, on the practice of midwives in the United Kingdom.	Midwives working in South East England.	• Midwives raised concerns about fitness to practise procedures, particularly decision-making that was centred wholly on whether registrants 'broke the rules'.	Midwives with strong negative views about the influence of regulation and the regulator may have volunteered for qualitative interviews creating selection bias.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
17	Stone et al. (2011)	N/M	To examine the evidence of how poorly performing nurses and midwives are managed in the UK National Health Service (NHS).	Secondary research (a literature review) using a systematic approach (n=3).	There is a lack of systematic research into the topic Those involved in investigations by NMC amount to only 0.2 per cent of registrants (2009 statistics) In the six months of NMC case reports reviewed (November 2009–April 2010) male nurses accounted for nearly one-third of cases while they represent only 11% of registered nurses The likelihood of suspension appeared to increase for nurses aged >40, and/or were men, and/ or from a black minority ethnic group Suspended personnel experienced the moment of suspension as a traumatic event with ongoing chronic and acute emotional responses of shock, anxiety, anger and distress Time away from work produced a post trauma reaction, an adjustment to loss response and an identity threat.	Three significant empirical studies were identified by the authors, but they do not appear to have appraised the quality of that evidence. NHS trusts have not been obliged to report data on staff suspensions, and the regulator has not reported ethnicity data the effect of which is to limit generalisability.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
18	Gallagher et al. (2015)	Phar	To assess whether - the FtP Committee are adhering to the judgements	1-year Retrospective cross-sectional (survey) (n=51) design using document analysis of case reports heard	Determination of impairment and sanction required 4 factors to be raised in FtP stage 2 to feature as aggravating in stage 3. • Insight • Risk of harm to patients or the public • Dishonesty	Cross-sectional retrospective survey design – may introduce bias. Only 51/ 97 (52%) of transcripts provided by GPhC.

			when determining FtP; - those circumstances described by the GPhC in their Indicative Sanctions Guidance (ISG) as warranting erasure from the Register of Pharmacists do actually lead to that outcome.	between 1/10/11-30/11/12.	• Behaviour in period between the date on which the alleged misconduct occurred and the date of the hearing Three of the four factors were more likely to be heard when determining sanction (Stage 3) having first been factored in to the consideration of impairment (Stage 2) The behaviour of the pharmacist since the misconduct occurred was not considered in a high proportion Those cases involving a risk to the safety of patients were twice as likely to result in removal Where dishonesty was involved, removal was over eight times as likely.	
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
19	Phipps et al. (2011)	Phar	To explore the relationship between pharmacist characteristics and their risk of being disciplined.	Case-control study design (n=697). 117 pharmacists appearing were matched with 580 non-disciplined pharmacists (controls).	Pharmacists in community setting were at increased risk Noticeable effect of the pharmacist's qualification and ethnicity Professional misconduct was cited more frequently than clinical malpractice 50% of complaints from someone who is in a position of oversight of the pharmacist 10% were triggered by a member of the public One-fifth of pharmacists who went before Disciplinary Committee had previously been disciplined.	The data used in the study represent a small subset (around ten per cent) of the population of investigated pharmacists The study involves retrospective analysis of records that were not initially designed to elucidate risk factors.
	Author	**Prof**	**Aim**	**Method**	**Key Findings**	**Limitations**
20	Tullett et al. (2003)	Phar	To investigate trends and areas where remedial or preventative	Retrospective cross-sectional (survey) design using case analysis of	307 (89%) were male and 37 (11%) were female The distribution of ethnic origin was: Caucasian 174 (50%), Asian 150 (43%), African 9 (3%) and Other 11 (4%)	Identified cases were not matched in this retrospective cohort study.

			support could be focused to include: Who were the individuals most likely to transgress? What types of misdemeanours were the most common? How were the misdemeanours dealt with? What were the motives for misbehaving?	published reports (n=344) of pharmacists' professional and personal misdemeanours.	Almost 90% involved the community setting Most misdemeanours were committed by pharmacists with 11–15 years on register Many cases involved multiple misdemeanours Time between date of offence and first hearing was 2 years in half of 247 cases Pharmacists were present at hearings in 309 (90%) cases and represented by a solicitor in two-third of cases 158 (46%) of the 344 cases reported were de-registered The odds of involvement ratio for • male versus female pharmacists was 7.36 • ethnic minority vs Caucasian pharmacists was 3.8	All cases over twelve years may not have been captured–some cases (such as health) are routinely not reported. Case reports cannot be assumed to be unbiased.
	Author	**Prof**	**Aim**	**Method**	**Findings**	**Limitations**
21	Gallagher et al. (2020)	SW	To investigate reasons for the disproportionate number of fitness to practise complaints relating to social workers.	This paper presents qualitative data from 12 interviews (8 social workers and 4 regulation staff) and 3 focus groups (one with social workers; two with service users).	Four themes were identified from the analysis of qualitative interview and focus group data • *Social work is an evolving profession* • *Social work involves challenging practice* • *Social work takes place in a pressurised environment* • *Public perceptions and expectations of social work are often negative and unrealistic.*	Interviews and focus groups were representative of a range of stakeholders but did not include registrants who had themselves been subject to FtP proceedings. The study was carried out geographically in South-East England and may not be representative of the views/ experiences of all stakeholders.
	Author	**Prof**	**Aim**	**Method**	**Findings**	**Limitations**
22	Banks et al. (2020)	SW	To explore extent and	Case analysis of a structured	In the sample of 232 referrals examined • Men were over-represented	

			nature of FtP referrals to the regulatory body about social workers in England (considering why and how referrals arise, and whether they are justified).	random sample of 10 per cent of social worker cases (n=232) dealt with between July 2014 and August 2016. Thematic analysis resulted in typology of FtP concerns.	• Though only a third of social workers are employed in local authority children and family services- group formed majority of referrals (69%) • Over half (56%) referrals were made by service users • 89% of recorded characteristics of referrals related to misconduct (45%) and misconduct with lack of competence (MWLC)) (44%); • MWLC referrals related to disputes with family members over place of residence and contact with children: some 80% of these were closed at the initial stage; • Overall, referrals to HCPC are closed at the initial stage (173/ 252); • At the Investigation Committee Panel (ICP) stage 28 cases closed (50% competence and performance, 50% conduct and behaviour); • 31/ 252 (12%) cases were brought before HCPC Competence and Conduct Committee (CCC) hearing – the final stage: • -such cases were considered to be 'more serious' and in 28 cases 9 were struck off, 9 were suspended, 4 received conditions of practice and 6 were cautioned.	Only using a 10 per cent sample means some unique or interesting cases would not be analysed.
	Author	**Prof**	**Aim**	**Method**	**Findings**	**Limitations**
23	Kirkham et al. (2019)	SW	To assess whether the court-like model for HCPC hearings is appropriate to achieve procedural fairness in the FtP proceedings against social workers on three discrete justifications:	Mixed-methods study: Semi-structured interviews with (n=) 8 qualified social workers; Case review of (n=) 34 HCPC FtP hearings; Content analysis of the case law of all (n=) 21 reported appeals against	*Delivering Instrumental Goals*: Social workers are more likely to be referred than other professionals on HCPC register (1.33% in 2016/17) with 63% complaints coming from the public. Key themes: • Appeals process is rarely used (21 /1121 sanctioned cases), has low success rate and guarantees the process not outcome (whether there exists serious procedural or other irregularity) • Strong emphasis placed upon credibility of registrant (14 /21 strike off cases mentioned credibility as a factor) and their capacity to	By the authors own admission, data are drawn from three discrete, small-scale empirical studies involving 8 qualitative interviews with social workers (Interview Study), 34 FtP hearings of HCPC cases involving social workers (Case Review Study) and 21 appeals against decisions of the

			- instrumental - dignitarian respect for professionals and - public accountability.	decisions of the HCPC up until January 2018.	demonstrate remorse and insight (avoided strike off) *Achieving procedural fairness in dignitarian terms*: • Under FtPP rules cases can proceed without the registrant present • The ability of a registrant to attend his/her hearing has a strong influence on the outcome and sanction *Public Accountability*: In the Case Review study, only 3/ 34 cases gave consideration to relevant organisational issues at play in professional misconduct.	HCPC (Content Analysis of the case law).
	Author	**Prof**	**Aim**	**Method**	**Findings**	**Limitations**
24	Austin et al. (2018)	SW	To examine the nature of the disproportionately large number of complaints against paramedics in the UK and social workers in England and identify options and opportunities from a regulatory perspective that could be taken to address this issue.	Systematic literature review, Delphi consultation, interviews (n=27), four focus groups (n=23) and case analysis (n=284). Delphi consultation involved 14 international experts; Interviews with 27 participants with suitable expertise; Focus groups (2 with service users and 2 with practitioners in social work and para-medicine.	Literature review: • There is scant literature available reviewing prevalence and nature of complaints. • Practitioners are managed as employees within organisations-employers may choose to refer concerns to a regulatory body. Such tendency towards a blame culture produces a defensive practice orientation. Delphi exercise participants noted: • Conflict (verbal and physical) was identified as source of stress and reason for complaints • Awareness on part of patients and clients of their 'rights' to complain against professionals • Culture of accountability, litigation and awareness, and streamlined processes for reporting complaints to regulators mean complaints were inevitable • Practitioners are vulnerable to poor management, austerity-linked budgetary cuts that may increase workloads Interviews and focus groups stressed: • Individuals may misapprehend the statutory requirements of regulators	A limitation of using secondary data, as in this case, is that the authors had to rely on transcripts provided on the HCPC website and their interpretation and reporting of the hearing and findings of fact during the case series stage. Paramedical and social work professions comparisons throughout give context to the study (matched on high relative complaints received by HCPC). Authors acknowledge that the findings of this study may not be generalizable to other health and care professions.

				Random 10% sample of 284 cases (52 paramedic and 232 social workers).	• The legalistic nature of complaints adjudication and the adversarial approach taken suggest regulators are against practitioners Case series revealed: • Higher number of older, male practitioners • In the social worker sample frame, 67% were employed by local authorities, and 69% worked in children's services • 56% of complaints were from the public • A small minority of cases (<15%) met threshold for further investigation • Individual practitioners' addictions or mental health issues were in most cases identified by regulator • Each decision point in the FtP process is binary. The taint of investigation on a practitioner's confidence and reputation can be significant.	
	Author	**Prof**	**Aim**	**Method**	**Findings**	**Limitations**
25	Leigh et al. (2017)	SW	To explore the procedural aspects of the HCPC process once a concern is raised, particularly: What happens when an initial investigation finds that there is a case to answer? What factors appear to influence the findings of the FtP panel? How the outcome of the	Secondary Research. Retrospective cross-sectional (survey) design using thematic analysis of published documents of appellant cases (n=34) at the end of the HCPC regulatory process).	Outcomes were strike off (21), cautions (6), conditions of practice (3) and no further actions (4): • 10/21 females struck off vs 11/21 males struck off (but wider social work population is 80% female); • Length of service averaged 15.5 years (struck off) Attendance at hearing and representation (by solicitor or union): • None of 21 struck off attended or were represented Three distinct themes that emerged were: • The HCPC panel's opinion whether registrant was a 'credible' witness appeared significant in its decision on sanction	Control group absent (matched subjects – on such factors as date and place of qualification, length of service, ethnicity and country of origin – the authors point to the absence of such data from published transcripts of conduct hearings). Authors have deliberately chosen practice cases related to issues such as case management, professionalism and competence. Cases where the reason for concern was related to issues such as drugs,

			hearing then affects the social worker.		• The outcome of hearing did not always appear to depend on perceived seriousness of registrant's misconduct or competence Organisational issues did not appear to have been explored by the HCPC.	alcohol, fraud or abuse were all excluded.
	Author	**Prof**	**Summary**	**Method**	**Findings**	**Limitations**
26	Worsley et al. (2017)	SW	To consider the effect a referral to the HCPC has on the individual social worker and report on the lived experience of those going through the investigatory process.	Semi-structured interviews conducted with (n=) 8 qualified social workers subject to the HCPC process for professional misconduct, recruited through an online advert posted on the website of Community Care.	Organisational issues: • *Conflict with management* – 2 participants, referred by their employer were of the view that HCPC was used as a means to discipline those who disagree with their manager • *Practice issues* – 2 participants felt caseload affected their ability to practise effectively • *Cultural incongruence* – 2 participants welcomed opportunity to go through HCPC process to help redress and challenge organisation's concerns Representation and cost: • *Legal representation with fees* up to £15,000 mitigate against the social worker having a 'fair' hearing • *FtP panel's knowledge of social work* – 3 participants questioned the FtP panel's knowledge of social work • *Mea culpa* – most participants believed that HCPC panels preferred registrants to acknowledge fault for the 'mistakes' that had been made • *Referral as policy* – some participants believed it was local authority policy to refer all concerns resulting in internal disciplinary procedures to the HCPC Emotional toll: • The HCPC process invoked considerable emotional stress • The negative effects on participants' health were exacerbated by length of time proceedings took (>2 years)	A potential limitation of using a combination of telephone and face to face interviews is that in at least half of interviews observational data were not captured. The authors acknowledge this and emphasise only analysing transcripts. A single researcher from the team conducted interviews so the other two researchers had to rely exclusively on interview transcripts for interpretation It is conceivable that interviewees may have volunteered to take part due to strongly held views and not be representative of the viewpoint of all qualified social workers.

					• 5 respondents either attempted suicide or had suicidal thoughts.	
	Author	**Prof**	**Aim**	**Method**	**Findings**	**Limitations**
27	Melville-Wiseman (2016)	SW	To examine cases of sexual misconduct perpetrated by registered social workers in England heard under the HCPC FtP proceedings to identify aspects of institutional betray that may be evident within these cases.	Secondary Research. Retrospective cross-sectional (survey) design using thematic analysis (and narrative analysis) of published documents of appellant cases (n=26) leading to strike off the register for sexual misconduct.	Of the 26 cases, in which the registrants were struck off: • 23 male social workers • 3 female social workers • In 21 cases there were direct (or identifiable) victims of abuse Themes identified from the individual case analyses were: • Vulnerability • Types of Misconduct • Conduct of Hearings • Language of Abuse • Treatment of Victims • Accountability Whether the registrant has sought any treatment for their behaviour and whether that treatment has been successful - no evidence in any cases reviewed where the panel took this further.	Working as a sole researcher, potential for bias in analysis is increased. Author acknowledges that by deliberately choosing practice cases leading to the sanction of strike off limits the number of identified cases. Therefore, cases where the registrant was suspended for 'sexual misconduct' were all excluded, as were all relevant cases held in private.
	Author	**Prof**	**Aim**	**Method**	**Findings**	**Limitations**
28	Furness (2015)	SW	To analyse General Social Care Council (GSCC) conduct hearings held between April 2006-July 2012 in order to: -identify characteristics of appellants, -types of sanction and -proven misconduct	Retrospective cross-sectional (survey) design using content analysis of all published results of conduct hearings (n=265) held April 2006-July 2012.	• 125/265 (47%) were female & 140/265 (53%) were male • A greater proportion of men 140/ 19140 (0.73%) than women 125/ 67860 (0.18%) are referred • Types of misconduct (presenting behaviours) categorised into 21 different themes including conviction/ police caution, problems with record keeping, inappropriate relationships, safeguarding and financial • 115/ 265 (43%) registrants had caused potential or actual harm to children or adults • The theme conviction/ caution included the greatest number of conduct cases for both women and men	Author had to rely on transcripts provided by the GSCC and their interpretation and reporting of the hearing and findings of fact. Working as a sole researcher, potential for bias in analysis is increased. Control group absent.

			-regulator decision making processes.		• Behaviour in private life is considered relevant and does have consequences for professional life Sanctions were applied at different rates between men and women: admonishment 36 (26%) vs 58 (46%), suspension 29 (21%) vs 24 (19%), removal 75 (54%) vs 43 (34%).	
	Author	**Prof**	**Aim**	**Method**	**Findings**	**Limitations**
29	Stanley et al. (2011)	SW	To investigate impact of fitness standards on disabled people's access to the professions of nursing, teaching and social work.	Grounded theory. Semi-structured interviews with 38 practitioners and 22 students, (unseen disabilities) representing equal numbers from three professional groups (n=60).	• Disclosure of a disability was described as a continuous process • For some disclosure was a strategic decision aimed at avoiding the consequences of being found out at a later stage • Participants expressed high levels of discomfort with the term 'disabled person' (stigmatising label) • Participants varied in their knowledge and understanding of the fitness standards for their profession (deeming them to lack specificity and transparency) Regulatory bodies perceived as remote, impersonal and providing no feedback following disclosure.	Participants represented a hard-to-reach group and the recruitment strategy adopted meant that, since the participants volunteered to contribute to a study addressing disability disclosure, most had disclosed disability to some extent; therefore the research had limited access to the views of those who had made the decision not to disclose at all. This study did not explore the attitudes of employers, trainers or those of the regulatory bodies.
	Author	**Prof**	**Aim**	**Method**	**Findings**	**Limitations**
30	McLaughlin (2010)	SW	To review cases to date in which applicants have either been refused registration or been removed from the Register by	Secondary Research. Retrospective cross-sectional (survey) design using content analysis of published documents of	6/14 appellants won their case • Professional representation increased the chances of success • In all cases GSCC was legally represented The CST was highly critical regarding the GSCC's view of mental health issues and absolute disclosure	Only cases appealed to the CST (therefore, a limited data set) were available to the author for analysis in any detail. Of the 68 appeals to the CST April 2003–March 2008, only 14 were identified by the author to

			Conduct Committee, and who have exercised their right to appeal against decision to CST.	appellant cases (n=14) at the end of the GSCC investigatory/ regulatory process.	The GSCC was criticised for questioning the honesty and integrity of social workers A variety of behaviours (such as drinking, drug taking, sex lives and child care practices) that do not directly impact on the work of the social worker are considered by the GSCC to be within its regulatory remit Committees rightly took a dim view in cases in which the social worker either denies responsibility for an alleged misdemeanour or, if admitted, show insufficient remorse and insight.	do with more behavioural issues. Subjective bias may be strong due to lone researcher analysis and interpretation of secondary data sources.
	Author	**Prof**	**Aim**	**Method**	**Findings**	**Limitations**
31	Worsley et al. (2020)	Multi	To examine FtP cases from UK regulatory bodies relating to social workers, nurses, midwives and doctors to establish any differences amongst and between professional groupings.	1-year (1/1/18 - 1/1/19), Retrospective cross-sectional (survey) design using content analysis of 50% sample of FtP case reports (n=348) published by 6 professional regulators.	Male registrants were overrepresented within the cases • Social work register: men comprised only 17%, but 45% of cases • Medical register: men comprised 54%, but 88% of cases • Nursing/ midwifery: 11% of registrants are male, but account for 30% of cases Attendance and legal representation: • Attendance at hearings was most likely by doctors (71%), followed by nurses (46%) and infrequently by social workers (7%) • Doctors were significantly more likely to be legally represented than nurses/ midwives and social workers (58%, 41% and 6% respectively). Type of allegations: • Most allegations were about misconduct (72%) followed by caution/ conviction (18%) – hearings are therefore addressing behaviour of a similar nature. Outcome of cases: • A third of FtP cases resulted in suspension (especially involving doctors and nurses) • Social workers are more likely to be removed from the register (32 per cent)	The authors aimed to capture all final hearing FtP cases published online by regulators from January 2018-January 2019 (n=830). However, access restrictions, particularly NMC cases (restricted to 3 months only) severely limited the final case numbers achieved; Of the 688 FtP cases downloaded, to ensure the final analysis was representative and manageable, only 50 per cent of all downloaded cases per professional body were considered (n=348); My synthesis focused on only 3 regulators (GMC, NMC and HCPC) responsible for regulating doctors (n=160), nurses (n=95)/ midwives (n=5)

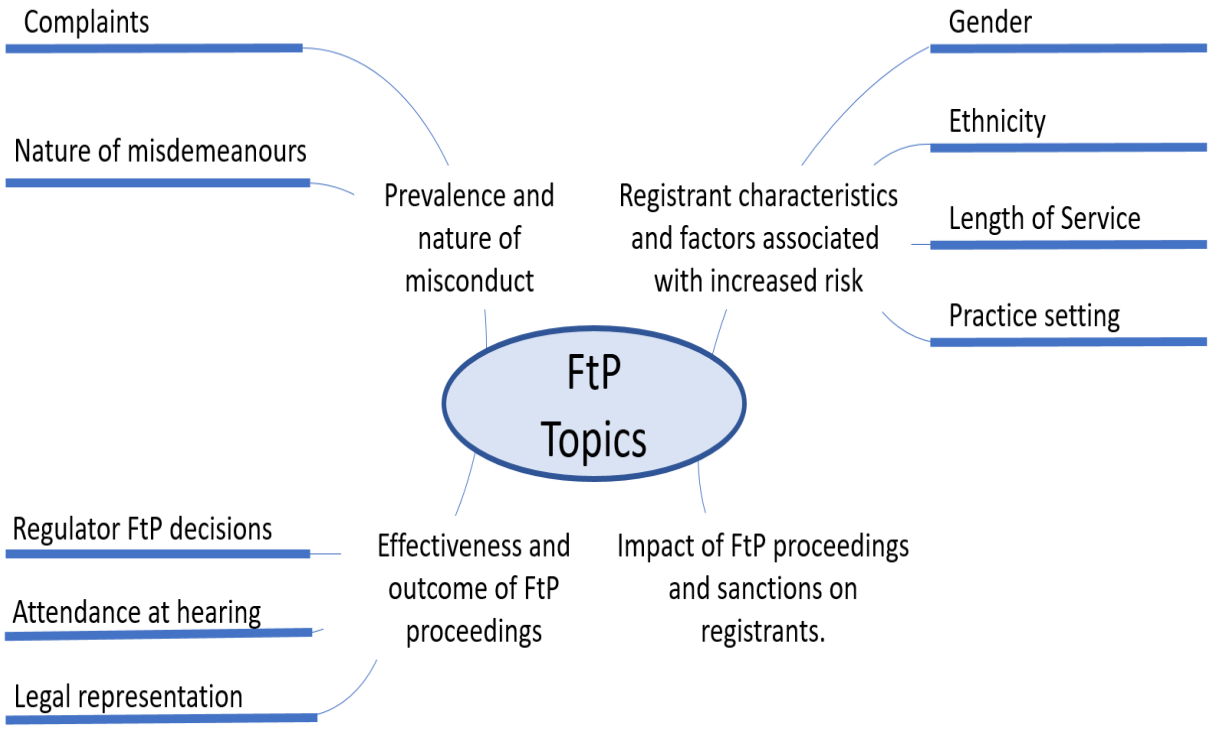
					• Social work decisions were more concerned with what had occurred (seriousness of the allegation) – emphasis upon public protection • GMC and NMC decisions tended to acknowledge a registrants ability to learn from their mistakes and make amends Male social workers and doctors were overrepresented within removal cases.	and social workers in England (n= 74).
	Author	**Prof**	**Summary**	**Method**	**Findings**	**Limitations**
32	Hanna and Hanna (2019)	Multi	Demonstrated how topic analysis could be employed for examining published FtP cases in both the identification of topics (themes) and determining the extent to which the topics affected the four professions.	Topic Analysis method to examine FtP cases across 4 UK healthcare professions (dental, medical, nursing and pharmacy) (n=3320). Total cases downloaded per professional group were 577 dental, 481 medical, 2199 nursing and 63 pharmacy.	The topics identified were: criminal offences, dishonesty (fraud and theft), drug possession/ supply, English language, indemnity insurance, patient care (including incompetence) and personal behaviour (aggression, sexual conduct and substance misuse). The most frequently identified topic for dental, medical and nursing professions was patient care whereas for pharmacy, it was criminal offences. Word clouds were also constructed using the top-50 scoring words per example topic to both confirm and communicate the essence of each topic. • 10 highest scoring words for *patient care* were: administered, chart, administer, mar, medication, prescribed, dose, errors, medications, incorrectly • 10 highest scoring words for *criminal offences* were: sentence, sentencing, conviction, crown, imprisonment, judge, sentenced, convicted, court, remarks • 10 highest scoring words for *dishonesty* were: dishonesty, dishonest, dishonestly, honesty, integrity, knew, conceal, false, difficult, honest.	Incomplete datasets (number of cases) – the pharmacy dataset contains only 64 FtP cases (2 per cent of the total number of cases). Findings for pharmacy should be treated with caution. The authors declare that a difficulty in topic analysis is the requirement to specify the number of topics. Choosing too few may lead to overly broad topics which cannot be easily classified, however, choosing too many may lead to overly narrow, spurious or infrequently discussed topics. This extensive study method chosen by Hanna and Hanna in trying to capture all cases within the time frame of the study can only achieve a surface analysis of the issues inherent in FtP cases.

Table 7. Abstraction of literature review research studies (n=32)

2.1.4 Synthesis

Based on the analysis of these studies several themes had emerged that I felt were appropriate for establishing a broad organisational structure for the literature review. A thematic organisational structure helped me to create a mind-map that presents the key topics (or themes) and more focused aspects (or sub-themes) relevant to registrants' FtP that have been investigated by researchers (Figure 3). These have been used to guide the synthesis that follows.

Figure 3. Mind-map showing FtP topics and aspects investigated by research



2.2 Literature review

2.2.1 Context

The literature search identified a total of 32 research studies relating to FtP of health and social care professionals (HSCPs) in the UK. Studies employed both quantitative and qualitative research methods to investigate the subject of regulation of HSCPs including: postal questionnaires (n=6), structured and semi-structured interviews- face-to-face and telephone (n=11), focus groups (n=3), case and document analysis (n=16), multivariable regression analysis (n=1) and, topic analysis (n=1). Mixed methods approach was followed by four research studies. Empirically, there have been four principal topics of investigation (see figure 3) as follows:

(i) Five studies explored the prevalence and nature of misconduct (Tullett et al. 2003; Furness 2015; Austin et al. 2018; Hanna and Hanna 2019; Banks et al. 2020);

(ii) Six studies investigated the registrant characteristics and factors that are associated with an increased risk of appearing before a FtP Committee (Yates and James 2010;

Phipps et al. 2011; Stone et al. 2011; Furness 2015; Gallagher et al. 2020; Worsley et al. 2020);

(iii) Nine studies examined the effectiveness of regulation (McLaughlin 2010; Chamberlain 2011; Humphrey et al. 2011; Furness 2015; Gallagher et al. 2015; Melville-Wiseman 2016; Leigh et al. 2017; Tiffin et al. 2017; Kirkham et al. 2019);

(iv) Ten studies assessed the impact of complaints and regulatory investigations on the psychological welfare and health of registrants (Lloyd 1990; Bahrami and Evans 2001; McGivern and Fischer 2010; Stanley et al. 2011; Stone et al. 2011; McGivern and Fischer 2012; Brooks et al. 2014; Bourne et al. 2015; Weir 2017; Worsley et al. 2017).

2.2.2 Aspects of interest identified

As shown in figure 3, the studies revealed nine FtP aspects of research interest (complaints, gender, ethnicity, length of service, practice setting, nature of misdemeanours, attendance, representation and, regulator FtP decisions) which will be discussed in more detail below.

2.2.2.1 Complaints

Statutory Regulatory Bodies (SRBs) use variable terms to describe complaints against HSCPs including ‘referrals’ and ‘concerns’. I will use the term ‘complaints’ as this is the preferred term used in research studies to identify communication by the wide-ranging sources (such as services users, employers, peers, police and many others) with regulators. Although low (2% or below), the number of complaints against HSCPs in each of the four professions, have been on the rise over the past two decades. The reasons for the vast majority of complaints to regulators were misconduct and performance issues and were made by both professional and lay sources with an increasing number of complaints coming from service users themselves (Tullet et al. 2003; Chamberlain 2011; Stone et al. 2011; Furness 2015; Austin et al. 2018; Banks et al. 2020). As stated in the introduction, the majority of the complaints against health and social care registrants received by SRBs were dismissed at either the initial (screening) stage or at the end of any investigation undertaken.

Stone et al. (2011) undertook an analysis of publicly available NMC case reports for six months (November 2009–April 2010) as part of a scoping study and found in 36% of cases brought to the NMC Investigating Committee, there was no case to answer. The authors believed this provided evidence for the over use of disciplinary procedures by NHS managers, acting as the chief complainant. The authors also observed that the presentation of NMC case data focused on individual characteristics rather than organisational and managerial factors that may have been relevant to alleged misconduct, known collectively as system failure (Senge 2006). The 2009 NMC FtP statistics highlight that despite the high number of complaints made to the NMC only a very small proportion (0.2%) of all nurse and midwife registrants were under investigation by the regulator. However, Stone et al. (2011) did not provide separate statistics for nurses and midwives making it impossible to determine precise figures between these two separate professions.

The estimate of the incidence of misconduct by pharmacy professionals reported by Tullett et al. (2003) of less than 0.1% is very low and might be contested on a number of grounds. The researchers in this study relied entirely on case reports published in the Pharmaceutical Journal and this carries the risk of cases been missed. Once more the potential for complaints received by the SRB to be discharged at the initial and investigation stages without escalation to final hearing stage, internal privacy restrictions on reporting of certain types of cases (such as those already referred to above where the health of the registrant was a significant factor) and human error in the identification process might all contribute to this very low estimate.

An analysis by Furness (2015) of 265 published results of conduct hearings held between April 2006 and July 2012 by the GSCC - the regulator for social workers in England at the time - revealed that only a small number (0.91%) of social workers are investigated by the GSCC for allegations of misconduct. It is not clear at what stage in the regulatory process this figure was derived. The author seems to blur the investigation and final hearing stages. As is customary, cases held in private (usually due to concerns about the health of the registrant) are not published; 38 cases were excluded from the analysis with the implication that the reported size of the problem of misconduct in social work is understated in this paper. A more recent study by Austin et al. (2018) set out to examine the disproportionately large number of complaints made to the HCPC against social workers in England. In the five-year review period, 56% of complaints about social workers were from members of the public (compared with an average of 12% for all other HCPC regulated professions). A relatively small minority of cases (<15%) met the threshold for further investigation, which eventually led to regulatory action and a final disciplinary hearing. The authors believe that the heightened awareness on the part of patients and clients of their 'rights' to complain against professionals, and as processes for reporting complaints to regulators have been streamlined through technology, increasing numbers of complaints were inevitable.

The regulation of the profession of medicine has received the greatest interest from among the four professions considered here. Chamberlain (2011) analysed data pertaining to the FtP of registrant doctors held by the GMC for 2006-09 and reported an upward trend in complaints received by the GMC culminating in a total of 4722 complaints for 2009 (representing 2% of all registrants). A very high proportion of complaints (between 85–90%) were reported to have been closed with no further action after the initial and investigation stages had been completed.

Studies from across the four professions show that complaints against HSCPs, while low, are on the increase and that most of these are subsequently dismissed by regulators without disciplinary action. Rising numbers of complaints could be the result of an increasingly litigious UK society or a reflection of the trend towards a more equal relationship between HSCPs and lay communities as well as increasing service user rights promoted by health and social care organisations and regulatory bodies themselves. It is relevant to point out that regulators each have minimum threshold criteria that are applied to complaints received by them in order to decide whether or not to pursue the complaint through FtP proceedings. Moreover, certain types of complaints are

considered to fall outside the objectives of fitness-to-practise and are rejected (such as employment disputes).

Complaints against HSCPs are not only on the increase, but are strongly gendered and this is considered in the next section.

2.2.2.2 Gender

Another aspect, revealed by the review related to gender. Several studies that considered gender differences, highlighted that more cases are brought against men (Tullett et al. 2003; Yates and James 2010; Chamberlain 2011; Phipps et al. 2011; Stone et al. 2011; Furness 2015; Tiffin et al. 2017; Banks 2020). Within nursing, Stone et al. (2011) identified that whilst male nurses represented only 11% of NMC nurse registrants they accounted for 33% of FtP cases taken to a final hearing. In social work there are also a greater proportion of men (0.73%) in comparison to women (0.18%) who are referred to their SRB (Furness 2015). In the study by Banks et al (2020) men were over-represented in their random sample of 232 cases. While constituting only 20% of the register size for social workers in England, men comprised 31% of the sample of cases examined. The picture presented is also found in the pharmacy profession. Tullett et al.'s (2003) retrospective case study showed that male pharmacists comprised 89% of cases compared to only 11% for female pharmacists. The odds of involvement ratio for male versus female pharmacists was 7.36 in this research. In a more recent paper by Phipps et al. (2011) exploring the relationship between pharmacist characteristics and risk of being disciplined, using a stronger case-control study design, broadly similar findings were obtained.

In the medical profession male doctors are also more likely to be referred for FtP proceedings (Chamberlain 2011). Yates and James (2010) sought to identify early risk factors (at medical school) for subsequent professional misconduct. The authors proposed the odds (or risk) of a trainee doctor who is male having a proved finding of professional misconduct is almost 10 times higher than the odds (or risk) of a trainee doctor who is female. However, there were several limitations of this multicentre retrospective case-control study as only eight medical schools were included across a short timeframe (1999 to 2004) from which only 59 cases could be identified. In addition there were significant missing data resulting from incomplete trainee doctors' records held by medical schools. Chamberlain (2011) found complaints were four times more likely to be made about male doctors than female doctors reflecting breaches of FtP more commonly associated with male risk-taking behaviour (improper sexual relationships, criminal activity and substance/ alcohol abuse). Tiffin et al. (2017) investigated the picture for international medical graduates practising in the UK. Of those that were referred in relation to FtP concerns they found that males were three times more likely to be sanctioned than females.

Gender then, as the socially constructed differentiation between the sexes, is of particular relevance to regulation of HSCPs. It is clear from the above, that the likelihood of both complaints and regulatory action in all four professions is greater for male registrants compared to their female counterparts. This is in spite of a higher number of female to male registrants in at least

two of the four professions (nursing and social work). The associations between regulatory action and gender are complex. The societal and cultural 'orthodoxy' that men present more risk than females appears to carry over into regulation.

2.2.2.3 Ethnicity

Ethnicity was related to becoming an FtP case in at least four studies in the review here (Tullett et al. 2003; Chamberlain 2011; Phipps et al. 2011; Tiffin et al. 2017). Within these papers, and the wider extant literature, there is debate about how to define ethnicity and thereby assess it. For instance, should it be based on one's country of birth, one's parents' country of birth or simply one's self assigned ethnic status? Nevertheless, ethnicity is accepted as a significant dimension of inequality accounting for variations in an individual's life chances and opportunities. In the context of regulation, Tullett et al.'s (2003) analysis of published case reports revealed that despite comprising only 20% of the registrant population, 49% of all pharmacist registrant FtP cases belonged to an ethnic minority group suggesting this characteristic increased the risk of appearing before the regulator's FtP Committee. They argued that the odds of involvement ratio for ethnic minority versus caucasian pharmacists was 3.8 in that non-white pharmacists in UK were almost four times more likely to be involved in an investigation and subsequent disciplinary action by their regulatory body. This was also identified in Phipps et al. (2011) study on the characteristics and risk factors associated with disciplinary action which reported a noticeable, but statistically non-significant, effect of pharmacists' ethnicity on disciplinary action by the pharmacy regulator. In medicine, Chamberlain's (2011) secondary data analysis of FtP cases by the GMC identified that registrants belonging to an ethnic minority group were at greatest risk of appearing in FtP proceedings. For example, 19% of all complaints were made against Asian or Asian British ethnic minorities and this group was therefore overrepresented in terms of complaints made against them. Tiffin et al. (2017) estimated that twice as many (or 4.3%) international medical graduates received allegations of FtP concerns against them compared to UK medical graduates and that, of those, a high proportion (1 in 5) were sanctioned.

Unfortunately, comparative data from nursing and social work professions are absent from the available research studies as such data were not routinely collected by SRBs at the time. Once more, the links between ethnic variations and becoming an FtP case are complex and not easily disaggregated. The literature is somewhat guarded concerning likely explanations for this finding, not venturing beyond communication differences. Though staffing across SRBs is becoming more reflective of the distribution of ethnic groups in the UK, it has not historically been the case leading to a situation where a largely white adjudicator has determined FtP of a large number of ethnic registrants of different culture, values, beliefs, motivations and behaviour. Prejudice and discrimination within society may transfer to the regulatory context and may be influencing factors for some HSCPs becoming FtP cases.

2.2.2.4 Length of service

Evidence from six studies (Lloyd 1990; Tullett et al. 2003; Phipps et al. 2011; Stone et al. 2011; Leigh et al. 2017; Austin et al. 2018) suggests HSCPs in the middle of their careers appear more likely to undergo FtP proceedings than those either starting their professional careers or those nearing the end. An explanation for this finding is not offered by these six studies. Anecdotal evidence points to HSCPs typically reaching an important watershed about ten or more years into their professional careers, at which time many take on roles with greater responsibility and accountability, more influence over the quality of care offered to a larger service-user population and a marked reduction in workplace supervision. Concerning the career trajectory of many HSCPs, what emerges then is a consistent pattern towards practitioners taking on more managerial and strategic roles as well as advanced practitioner status consequential to proven competence and credibility in their early career stages. It is conceivable that with increasing levels of autonomy and responsibility some HSCPs may well be personally and professionally challenged leaving them exposed and vulnerable to complaints being made against their FtP.

2.2.2.5 Practice setting

Evidence from seven studies (Lloyd 1990; Tullett et al. 2003; Phipps et al. 2011; Stone et al. 2011; Austin et al. 2018; Banks et al. 2020; Gallagher et al. 2020) suggests among the four professions considered here, the practice setting (or sector of professional occupation) is predictive of the likelihood of practitioners becoming the subject of disciplinary action. Stone et al. (2011) identified that amongst the nursing cases, registered mental health nurses appeared more frequently suggesting that the field of practice/ practice setting is important in the likelihood of facing disciplinary action by the NMC. Within pharmacy, Tullett et al. (2003) and Phipps et al. (2011) identified the community pharmacy sector as being strongly correlated to becoming an FtP case. Independent (sole) practitioners working in general practice in the medical profession were also identified in one study as being at increased risk of becoming the subject of FtP proceedings of their regulatory body (Lloyd 1990). In social work, Austin et al. (2018) found that of the 232 FtP cases they reviewed two-thirds worked in local authority children services, an area of practice known to be especially challenging with large caseloads and limited support. Banks et al. (2020) offer comparative statistics for contextualising this finding. The authors report that in adult social work and mental health social work the frequency of complaints was significantly lower at 16% and 10% respectively.

2.2.2.6 Nature of misdemeanours

The range of misdemeanours of both a personal and professional nature committed by HSCPs have been reported in five studies (Tullett et al. 2003; Chamberlain 2011; Phipps et al. 2011; Furness 2015; Banks et al. 2020). Chamberlain (2011) perceived most of the misdemeanours committed by doctors as problems with both communication skills (relational, consent and privacy) and technical skills (diagnosis, prescribing and treatment) that emphasised doctors' professional conduct. A small proportion of UK doctors were found to have committed sexual misconduct towards patients. In the UK, the GMC has particularly exercised its regulatory

jurisdiction over standards of professional conduct rather than personal morality. In contrast, Furness (2015) categorised misconduct among social workers into 21 different themes, many including behaviour in private life (drug possession, theft and fraud, violence, sexual offenses, and offenses related to drinking and driving). A similar distribution of personal misdemeanours committed by pharmacists were also overseen by the pharmacy profession's regulatory body (Tullett et al. 2003).

Banks et al. (2020) outline a typology of social worker complaints considered at each stage of the process using the following categories – competence and performance concerns (such as breaches of confidentiality, administrative failures and crossing of personal and professional boundaries) versus referrals about conduct and behaviour (particularly related to dishonesty in personal or professional contexts). The researchers were given on-site, supervised access to the regulator's case management system, containing case records and from this were able to ascertain that complaints progressed through the various stages of the regulator's FtP process on the basis of the strength of the available evidence (and therefore the prospect of the regulator proving that FtP is impaired) and the perceived seriousness of the matter in question. This study provides, for the first time, deep understanding about how cases are dealt with at the first two stages of the FtP process. It appears that for social workers case managers deploy significant time in filtering out complaints that relate more to organisational than individual issues as well as those that do not reach the regulator's standard of acceptance.

It is interesting to note the narrower stance of the GMC with a focus on professional rather than personal misdemeanours committed by medical registrants. Medicine is recognised in society to hold a pre-eminent status allowing members to benefit in terms of prestige and power not always enjoyed by other HSCPs. As a direct consequence of this, professional discipline appears to have been interpreted by the GMC in a more restricted way and complaints are only followed up against doctors where a qualifying 'threshold of seriousness' is reached. The evidence suggests other health and care regulatory bodies are keener than the medical regulator to become involved in controlling individual practitioners' general standards of conduct and morality.

2.2.2.7 Statutory Regulatory Bodies FtP decision making process

Fourteen studies (Tullett et al. 2003; McLaughlin 2010; Chamberlain 2011; Humphrey et al. 2011; McGivern and Fischer 2012; Brooks et al. 2014; Bourne et al. 2015; Furness 2015; Gallagher et al. 2015; Melville-Wiseman 2016; Leigh et al. 2017; Austin et al. 2018; Kirkham et al. 2019; Banks et al. 2020) identified a particular interest in understanding aspects of the decision making process of the SRB FtP panels. Though discussing regulatory processes and procedures within social work, Austin et al. (2018) make a valid observation that is equally applicable to other regulators in that: decisions about practitioners' FtP are made through a highly proceduralised and methodical process. Crucially each decision point in the process is binary. Current regulatory practices only allow for 'either/ or' distinctions to be made (such as proceed/ halt investigations, competent/ incompetent practitioners, fit/ unfit to practise). Often a clear cut decision, one way or the other, cannot be made. The availability of a range of options (such as competent, 'generally

competent but made one honest error' and incompetent) would improve the fairness of the adjudication process.

Evidence from six research studies (Tullett et al. 2003; Furness 2015; Gallagher et al. 2015; Melville-Wiseman 2016; Leigh et al. 2017; Banks et al. 2020) indicate that HSCPs were more likely to be de-registered where dishonesty and risk of harm were aggravating factors. According to Furness (2015) the degree of insight shown by social workers offered the regulator an explanation for the misconduct and raised professionals' understanding of issues that surrounded social work malpractice. However, an analysis of fourteen social worker appellant cases to the Care Standards Tribunal (CST) by McLaughlin (2010) concluded that the regulator's procedures were not neutral. The CST raised three criticisms of the practices and procedures of the regulator for social work. They highlighted that the FtP panel unfairly questioned the honesty and integrity of registrants; displayed a lack of clarity in the application of standards to professionals' private life and; it ignored the imbalance of power in access to legal expertise that put the registrant at a severe disadvantage during FtP proceedings. Building on these criticisms, Kirkham et al. (2019) have questioned the procedural fairness of the social work FtP proceedings design believing it to be instrumental in focus, in that, through a court-like forum, it prioritises making decisions that appear to 'look right'. The authors of this study highlight two other justifications for procedural fairness that are inadequately fulfilled by the current FtP process: 'dignitarian' respect for the interests of registrants (shown by the high levels of non-attendance by impacted social workers at the final hearing stage of the process) and public accountability (felt to be severely undermined through a lack of meaningful engagement of the regulator for social work with the perspective of the social work community experiencing low levels of morale as a consequence of organisational challenges).

Tullett et al. (2003) reported that over the period of their study the regulator for the pharmacy profession's approach to pharmacists was to remove from the register those considered incompetent, unwell or dishonest. A later study by Gallagher et al. (2015) was designed to scrutinise the decision making processes of the General Pharmaceutical Council (GPhC) FtP panel against established rulings of High Court appeal cases of Azzam (2008), Cohen (2008), and Zygmunt (2008) that are expected to be followed by health and care regulators. The GPhC FtP process was deemed to 'in general' factor the rulings of High Court appeal cases into their deliberations on the impairment of FtP of pharmacists. Two thirds of a years' cases reviewed by the authors, did not follow the judgement from the case of Azzam (2008): requiring the pharmacist's behaviour during the period between the date on which the alleged misconduct occurred and the date of the hearing to be factored firstly into the FtP panel Stage 2 (consideration of impairment) and later into Stage 3 (determining sanction).

Similarly to the social work profession, pharmacist registrants were more likely to be de-registered where dishonesty and risk of harm were aggravating factors (Tullett et al. 2003; Gallagher et al. 2015). A recurring theme, then, from the decisions made by both pharmacy and social work regulators to de-register a professional was that the individual either denied responsibility for an

alleged misdemeanour or, if it was admitted, they did not show remorse or insight. Leigh et al.'s (2017) case review study of 34 FtP hearings of HCPC cases involving social workers found in 14 out of 21 cases in which the registrant was removed, their credibility was mentioned as being a deciding factor, even though the registrant did not attend the hearing. The proceedings in these 14 cases could be seen to lack dignitarian respect for professionals.

The growing emphasis of the interest in whether regulators take rehabilitative or punitive action against HSCPs is further illustrated in medicine. Chamberlain (2011) analysed GMC data pertaining to the hearing of FtP cases for 2006–2009. The outcome of cases reaching the adjudication stage reveal less year on year consistency in the types of high impact decisions reached, but that the sanctions of suspension (between 29-37%) and erasure (between 17-25%) accounted for about half of all outcomes of cases. The findings suggest that an organisational and cultural shift towards a more risk-averse regulatory model has occurred. Humphrey et al. (2011) conducted a prospective cohort study to investigate whether country of medical qualification was associated with higher impact decisions at different stages of the GMC FtP process after allowance for potential confounders such as sex, years since primary medical qualification, medical speciality, source and type of inquiry, and content of allegations. The relative odds of high impact outcomes were higher for European Union (EU) and non-EU qualified doctors compared to UK doctors at each stage of the FtP process.

2.2.2.8 Impact of Regulation on HSCPs

Up to 2014, there was an absence of empirical studies looking at the potential impact of FtP proceedings, both during and in the aftermath of a hearing, on registrants in health and social care professions. In the UK only the effects on medical registrants and social workers have been investigated. Brooks et al. (2014) carried out a qualitative study using semi-structured interviews involving 14 doctors with physical or mental health problems who had been referred to the GMC. Participants reported a lack of support from an uncaring, unfriendly and impersonal GMC whose processes were felt to be stressful and confusing. It was felt the legalistic style of the GMC worsened existing mental health and the ability of the registrant to return to work.

Bourne et al. (2015) were interested in the impact of complaints on doctors' psychological welfare and health. They used a cross-sectional survey design, which was weakened by a very low response rate achieved (11%). Such a design cannot show causation, so reported effects may in fact have been present before the complaint was made about the registrant and, may even have been the reason for the complaint. Significantly those doctors who had been erased from the register were excluded. Notwithstanding these methodological limitations, compared to doctors without complaints, doctors with current or recent complaints reported higher levels of moderate to severe depression (Relative Risk 1.7), moderate to severe anxiety (RR 2.08), self-harm thoughts or suicidal ideation (RR 2.08) and defensive practise. The effect of transparency in medical regulation was the subject of an inquiry by McGivern and Fischer (2012). Semi-structured interviews with medical professionals revealed heightened anxiety stemming from narratives

about ‘trials by media’, ‘inquisitions’ and ‘scapegoating’. This promoted a desire for defensive practise with its deleterious impact on quality of the therapeutic alliance.

Worsley et al. (2017) conducted semi-structured interviews with eight qualified social workers subject to the HCPC process for professional misconduct with the following outcomes: 3 were found to have no case to answer, 3 received either a caution/ warning or conditions of practice and 2 were struck off the HCPC register. The HCPC process invoked considerable emotional stress for all participants involved. The negative effects on participants’ health were exacerbated by the length of time the proceedings took, in some cases over 2 years. Five respondents either attempted suicide or had suicidal thoughts. Few participants emerged unscathed from the HCPC process, some vowed to leave the profession and some adopting defensive techniques against future ‘mistakes’.

2.2.3 Multi-professional studies

An important limitation of the published research relating to the statutory regulation of medicine, nursing, pharmacy and social work is that it has been largely pursued within professional groups only (single profession studies) and as a consequence may have reduced its potential impact on relevant health and social care regulatory policy and practice in the UK. Comparison studies across professional groups (multi-professional studies) would be useful. The findings from similar work may be usefully compared between the professions, to point out whether they broadly agree or disagree. I am only aware of two very recent multi-professional analysis studies (Hanna and Hanna 2019; Worsley et al. 2020) that have been undertaken in the UK, and these are considered next.

In the first multi-professional study, Hanna and Hanna (2019) collected all FtP cases from the websites of four regulatory bodies (General Dental Council, GMC, GPhC and NMC) covering all registrants over a two year period (August 2017-June 2019) for the four professions of interest in their analysis: dentistry, medicine (medical practitioners), pharmacy (pharmacists and pharmacy technicians) and nursing/ midwifery (nurses, midwives, and nursing associates). Since dentistry is not a profession included in my study I will not make further reference to it. A total of 2743 relevant FtP cases were included in the analysis (medicine, n = 481; pharmacy, n = 63 and; nursing/ midwifery, n = 2199). In the second multi-professional study, Worsley et al. (2020) examined around one half (or less for nurses/ midwives due to constraints on access to cases) of the total FtP cases heard between January 2018-January 2019, where available, relating to the professions of social workers in England regulated by HCPC (n=74), nurses/ midwives (n=100) and doctors (n=160). This study included a total of 334 relevant FtP cases. Both studies set out to establish whether the regulation of a range of professions was comparable and to understand any differences. There is an overlap of the time period over which cases were gathered and in the selection of three out of four professions examined across the two studies, meaning that some of the same FtP cases will have been included in the analyses.

Worsley et al. (2020) used a traditional methodological approach involving content analysis, coding of data and statistical analysis to meet the aims of the study. However, the resource-intense process led the authors to reduce their sample size to a manageable number which they acknowledge limits the strength of conclusions. Hanna and Hanna (2019) recognising the challenge of analysing large amounts of text, within FtP case files manually, instead examined FtP cases via a topic analysis method similar to that used for biomedical data. In this way, the authors were able to identify common topics (or themes) and to determine the extent to which the topics affected the chosen professions. The extensive study design selected by Hanna and Hanna (2019) to interrogate all FtP cases in the relevant time period, while certain to generate coherent topics can only provide superficial insight into the issues surrounding professional misconduct and impairment of a registrant's FtP. Their findings uncover the ten most popular themes of which the three most frequently identified topics for each dataset/ profession are: medicine (65% due to patient care, 18% due to criminal offences and, 7% involving personal behaviour); nursing (27% due to patient care, 6% due to criminal offences and, 5% involving personal behaviour) and; pharmacy (38% due to criminal offences, 29% as a result of drug possession/ supply and, 24% due to patient care). For the combined (all professions) dataset, the identified FtP topics were criminal offences, dishonesty (including fraud), drug possession/supply, patient care (including incompetence) and personal behaviour (including sexual conduct). Hanna and Hanna (2019) conclude that while there is inevitably overlap across the three health professions, each has different priorities that professional and educational organisations should strive towards addressing by taking account of both personal and situational factors when judging or remediating a registrants' FtP. The topic prevalence across the three professions revealed by this multi-professional analysis is similar to the findings of my synthesis of the range of single-professional studies, reporting the types of misdemeanours committed by HSCPs, reviewed in this Chapter.

Worsley et al. (2020) by supposing that their smaller sample of FtP cases from across the professions is reflective of the whole population of registrant cases heard, during the twelve month period to January 2019, were able to achieve a more in-depth analysis than was possible in Hanna and Hanna's (2019) study. Overall around 60 per cent of FtP cases in the sample were male and when compared with the gender breakdown of the professional registers, Worsley et al. (2020) found that male registrants were overrepresented within the cases (male social workers accounted for 45% of cases while only 17% were on HCPC register; male doctors accounted for 88% of cases while only 54% were on GMC register and; male nurses/ midwives accounted for 30% of cases while only 11% were on NMC register).

It has already been shown in this literature review that registrant attendance at the final hearing stage affects the outcome. Worsley et al. (2020) found health professionals were more likely to attend their hearing (71%, doctors and 46%, nurses/ midwives) than social workers (7%). Doctors and nurses/ midwives were also more likely to seek legal representation than social workers (58%, 41% and 6% respectively). The cumulative effect of these factors can be seen in the outcome of FtP cases with doctors and nurses/ midwives less likely to be removed from practice than social workers. The authors insinuate that social work regulatory activity may place greater

emphasis upon public protection leading to more punitive action taken against a registrant, whereas the GMC and NMC may perceive a registrant as a public asset, who can be remediated. Therefore, doctors and nurses/ midwives who fail to evidence remediation, insight or remorse are at increased risk of being struck-off. Regardless of professional background, FtP hearings were addressing behaviour of a similar nature - either misconduct (72% of cases) or caution/ conviction (18% of cases). Worsley et al.'s (2020) multi-professional analysis also raises questions about fairness, consistency and equity across the professions. The authors believe the Professional Standards Authority (PSA) must work harder to restore fairness for registrants going through FtP proceeding of UK regulatory bodies.

2.2.4 Summary of literature review

The diversity of research studies in the literature reflect the complexity of regulation. Empirically both the purpose and design of the system of regulation that oversees health and care workers FtP in the UK have come under investigation by the academic community. The majority of these studies have investigated aspects of the design of professional regulation most of which concern who regulates and is regulated and by what means and how they are organised. So, a large number of descriptive (rather than explanatory or evaluation) research studies are available. These provide details about UK regulators and their dealings with registrants through similar FtP processes which broadly follow the scheme presented in the Introduction section to this thesis (see Figure 1). All of the papers (n=32) reviewed assert that the regulation of HSCPs serves an important role in society in the identification and management of individual registrants who pose a risk to public safety. Although up to 2% of all HSCPs may come to the attention of regulators, most complaints against registrants are dismissed after the initial stage of the FtP process and very few HSCPs are subjected to full investigation (in the second stage) and appearance at a regulatory FtP hearing. The impact of complaints and regulatory investigations on the psychological welfare and health of registrants has been only tentatively examined (McGivern and Fischer 2010; Bourne et al. 2015; Worsley et al. 2017). These three cross-sectional studies helped to point to the experiences of HSCPs in passing through the stages of the regulatory FtP process. Registrants in these studies who had come to the attention of their regulator reported poor mental health. However, the link between emotional and psychological health and the FtP investigation process remains unclear from these studies. There is growing concern at this time among some regulators (GMC and NMC) that registrants under regulatory body investigation experience poor mental health with symptoms of stress, depression and anxiety that for some have led them to commit suicide (Horsfall 2014).

There is currently an inadequate examination of the impact of the sanction of removal from professional practice itself, following FtP proceedings, on a professionals' sense of well-being, resilience and work identity. Very little research can be found which has investigated the lived experience of HSCPs who become subject to all stages of the FtP process following the receipt of a complaint by their regulator leading to a severe outcome such as suspension or removal from practice. This research intends to explore the effects of SRB FtP decisions upon the individuals

themselves, with particular focus on a health care professional who was removed from the register of practitioners (RoP) and wished to return to practice when they were permitted to do so. Under the current rules, restoration cannot be applied for until a period of five years has elapsed, since de-registration. This thesis therefore intends to fill the identified gaps in current knowledge by addressing the central research question:

What is the experience of a health and social care professional who was de-registered following regulatory body fitness-to-practise proceedings?

This thesis will primarily use a range of evocative autoethnography techniques to investigate my attitudes, experiences and understandings. As has already been highlighted, previous research has not explored the experiences of HSCPs in the aftermath of removal from practice following regulator FtP proceedings. Although the proportion of registrants affected is very small, compared to the RoP list size, in my study I intend to contribute my own voice to the experience of marginalization and shame, aspects of which are likely to be shared by the HSCP population tainted by FtP proceedings and sanctioning. I hope that by listening to my de-registration story, as I attempt to embrace vulnerability, other HSCPs from both within my own profession and outside might better understand the experience of de-registration and the associated emotions. I am cognizant of the fact that through writing my story I will process my own anger, pain and trauma about the loss of my career, but do not wish it to end there. Rather, I also wish to offer those de-registered professionals going through the same experience ways of coping with their emotions about strike-off. Ultimately I hope to use autoethnography to learn about myself and promote dialogue with health and social care colleagues, educators and professional organisations and, UK regulators in order to humanise regulatory processes and procedures and reduce its negative impact on registrants.

2.2.5 My overarching research aims:

- To construct a sociologically informed biographical narrative (autoethnography) using my own experiences to reflect on de-registration and its impact on personal well-being, resilience and work identity, as well as its meaning;
- To determine which, if any, narrative type can be discerned from my de-registration story and;
- To explore the extent to which fitness-to-practise, an important arm of the regulation of care professionals, meets its objective of protecting the public while at the same time being considerate to the interests, support needs and well-being of registrants.

Unlike previous research, this study contributes an in-depth personal narrative from the perspective of a pharmacy care professional who became subject to regulatory body FtP proceedings and was subsequently de-registered. It articulates, for the first time, how it feels to be cast-out of a profession into an uncertain and unpredictable world. I capture the ordinary and

sometimes the exceptional realities of life over the five years that followed de-registration through a first-person account.

Chapter 3
METHODOLOGY

3.1 On coming to autoethnography: an introduction

This chapter sets out to establish the link between research philosophy, research aim, choice of methodology and methods. The meaning and application of a research philosophy is the subject of detailed discussion in the social science literature (Creswell 2013; Bryman 2015; Jensen and Laurie 2016; Silverman 2017). Methods based on scientific philosophy (the positivist paradigm) are widely used within healthcare but are not necessarily the most appropriate to use when considering subjective areas of inquiry including the human belief systems and behaviours that are of particular interest to health and social care researchers. It follows, therefore, that a fuller appreciation of research philosophy and its realms (i.e. ontology, epistemology and axiology) is essential to guide the appropriate selection of methodology and data collection.

Research has been defined by Bowling (1997) as the systematic and rigorous process of enquiry which aims to describe phenomena and to develop explanatory concepts and theories. This research study takes an inductive stance where any potential understandings will be derived from the data collected. To answer any research question it is necessary to establish the perspective being used, that is, to make explicit the research paradigm (Creswell 2013). My research follows an interpretivist paradigm that respects the distinctiveness of humans and requires the researcher to grasp the subjective meaning of social action (Bryman 2015). In this world-view, the ontological position (i.e. the nature of reality) taken is that of constructivism. Some qualitative researchers (Schwandt 2000; Holloway 2008) distinguish between constructionism and constructivism believing the former to be more sociological and social, focusing on the interaction of people with a shared reality portrayed through the common discourses surrounding the culture to which they belong. While sometimes used interchangeably, constructivism is considered to revolve more around the individual as an active agent in their own construction of reality through interaction with the prevailing discourses in their experiential world. Lincoln et al. (2013) see the constructivist approach as being underpinned by the principle that human beings develop their own understandings and meanings of the world in which they live and work. Creswell (2013) believes these meanings may be multiple and varied, formed through interaction with other people (therefore termed social constructivism), and may be related to historical factors. Bryman (2015) likewise agrees with this indeterminate view about social reality which he argues is in a constant state of revision. It follows that my single inquiry and its output will not be discrete, but will form part of multiple realities which are socially constructed. Thus, culture (whose specific set of beliefs and values are internalized through socialization), rather than being seen as an external reality that acts on and constrains human behaviour, is taken to be an emergent reality for each person, always in the process of being formed (Alasuutari 1995). Related to ontology is epistemology (i.e. how we know what we know?). I believe that the emergent and hence qualitative stance of my

inquiry whose process will be both prolonged and rigorous to meet the research objectives where intuition or new insights are seen as central to the progress of my inquiry. Patton (2013) argues that the process of inquiry is further complicated by what the researcher introduces as the stated instrument of the inquiry. In particular, the researcher's skills, experience, perspective and background all influence what is observed and analysed (Reinharz 1997). This forms part of axiology (i.e. personal values and ethics, and their association with knowledge). Lastly, reflexivity is the process of reflecting critically on the self as researcher and the output of the research inquiry. This will be revealed by use of the first-person active voice, "I" throughout my writing.

Research methodology can be considered as the broad strategy and assumptions which links philosophy to methods and determines method choice for knowledge acquisition. I have already identified an interpretivist paradigm for my research with qualitative approaches being the best to understand my experiences and social phenomena. Qualitative research is particularly useful when establishing a new understanding of a previously under-researched topic (Holloway 2008). Qualitative research is inductive; it begins with data collection and, then advances to produce explanations or theory (Jensen and Laurie 2016). What I am seeking is an in-depth understanding of my de-registration experience and its impact on my well-being, work identity and ability to cope. Through a qualitative approach I hope to be able to develop theoretical understandings of the perspectives held by regulators and registrants through the FtP process. I am mindful that by focusing on my own de-registration experience in isolation my study may lack breadth and risk missing important viewpoints and useful contributions of others. I am aware that this will also limit the generalisability of my research beyond my participant characteristics. My hope is that the loss of both depth and context from mostly quantitative studies in the area will be addressed by this longitudinal qualitative research study where I will be able to track changes in lived experience over time.

Initially, before I learnt about qualitative approaches, I felt that my own experience of strike-off would have to be suppressed and kept out of the inquiry as far as was humanly possible in order to keep it from threatening the reliability and validity of my investigation. Through my previous research training courses, I believed that my own experience represented a source of bias in the process of the intended study. I was of the firm opinion that my selection of topic that was intimately connected to my own experience might make it difficult to be objective, especially as I was holding strong feelings that threatened to impact the integrity of the proposed research. Perhaps as a trained pharmacist, I was just showing my awareness of the dominance of scientific research in the profession with a strong preference for explanatory and cause and effect type studies rather than a study like mine whose focus was explorative and centred on meaning.

During the course of my interview for a place as a doctorate student in June 2015 at Bournemouth University, my supervisors showed interest in the conceptualisation of my research idea, but questioned why I was attempting to hide personal experience of being removed from a Register of Practitioners (RoP). They asserted that as hard as I might try not to, my opinions, values and prejudices could not be systematically worked out of the research. Against everything I had

learned about the risk from researcher contamination in my quantitative methodologies training, the supervisors were encouraging subjectivity.

Individuals' removed from health and social care practice will no doubt arrive at an understanding of their situation and its consequences through interaction with others and their personal interpretations. I recognised a qualitative design belonging to the interpretive school of thought would be particularly appropriate. In summary, I wished to explore how HSCPs make sense of their perceived reality in the aftermath of being handed down the most severe sanction resulting in de-registration following FtP proceedings, a topic that has been under-researched, requiring me to develop new research skills while contributing to knowledge.

I considered different qualitative methods, but if I am honest, there appeared at the start of my search far too many possibilities for me to develop an in-depth understanding of each of them. Within my initial outline research proposal I cited interpretative phenomenological analysis (IPA) adhering to the philosophy of phenomenology within the interpretivist paradigm, as my qualitative method of choice. First proposed by Smith et al. (2009) as an experiential approach in psychology, I felt IPA offered an in-depth structured approach to look at how de-registered HSCPs make sense of the interruption in their careers, and to give a detailed interpretation of the captured accounts to understand the lived experience more fully. I determined to understand the inside perspectives of the participants who had been through their regulator's FtP proceedings by empathic listening as each narrated their story from within their own natural settings. Similar to other qualitative approaches, IPA is therefore emic and idiographic. I felt that IPA was particularly suited to explore this less understood topic (or phenomenon) of the human impact of de-registration to help generate new knowledge in the field of FtP.

Pragmatically, I recognised, early on in the study, that finding 'marginalised' de-registered professionals who would consent and be willing to participate was a significant barrier to study progression. I had overlooked the depth of my own despair and struggle to try to process 'unnamed grief' and protect my fragile mental state. Like me, others might also experience a strong compulsion to hide themselves away from the world, especially in the short-term following removal from the professional register. As published research on FtP shows, researchers are usually outsiders – mostly reviewing FtP case reports or, in a small number of qualitative studies, conducting interviews with study participants with lived experience of regulatory FtP proceedings. Looking back to the central research question, I wished to address the gap in the literature through contributing an in-depth account of the disciplinary process and removal from practice through the perspective of those who have lived experience. I realised that I in fact was ideally placed to be both researcher and the researched in my study whose intended focus was to capture subjective experience of de-registration and how the content of that experience related to familiar psycho-social concepts such as grief, stigmatisation and resilience, but perhaps even more so to how the experience impacts on the person and work identity as a health care professional. Beyond the perceptible intentions of this research, my de-registration event sparked an innate

calling from my soul to journey towards ‘truth’. Romanyshyn (2013, p.xi) expresses something similar when he writes

> “Research with soul in mind is re-search, a process of re-turning to and re-membering what has already felt as a call, perhaps long ago and now only dimly re-called… Research with soul in mind, re-search that proceeds in depth and from the depths, is about finding what has been lost, forgotten, neglected, marginalised, or otherwise left behind”.

It follows then, that I wanted to take a holistic approach to the experience of de-registration, rather than attempt to deconstruct it. I did not want the focus to become the distillation of the phenomenon, but instead to create a personal account or data set in which I could change perspective between zooming in and zooming out that privileges me to see how my story relates to other accounts, how it is connected to context, and to disclose cultural themes (both personal and professional) at play in controlling behaviour or stimulating activity (Chang 2008). In this study it is my own personal experience that forms the focus of my investigation, making the suggestion of my supervisors to consider an autoethnography as appropriate and timely. Though I was aware of ethnography, I had little knowledge about autoethnography. My curiosity about autoethnography led me to spend the summer of 2015 reading about this method and explore how I could undertake my study by putting my own experiences, thoughts, feelings and emotions at its centre, and not hide them.

I was not sure where to begin to find out about autoethnography, so I referred my problem on to the search facility of Google Scholar, tentatively typing ‘choose method of autoethnography’. Topping the list of retrieved studies was a paper by Dumitrica (2010). Its title seemed very relevant to my initial foray in to the literature surrounding the autoethnographic method. Written as an imagined dialogue (a metalogue) between a student and a supervisor it answered many of my early questions about choosing a method for doctoral research. I came away from reading the paper with the strong notion that the choice was seldom clear cut, but required the researcher to justify choosing, say, autoethnography from within the qualitative paradigm to consider the research question. My research purpose is to explore what life after de-registration looks like for a care professional from the inside out, an area in which there is a paucity of research.

Modern societies and their structures and institutions equate truth with science (Dumitrica 2010). My Statutory Regulatory Body (SRB), through its FtP process, adheres closely to this deductive approach in determining FtP cases. It follows therefore that the criticisms made against the scientific method for claims to generate the only truth, apply also to outputs of our SRBs in the UK. Competing forms of knowing, such as those that reach conclusions through an inductive approach, usually involving more qualitative techniques, are at risk of becoming marginalised and even silenced in modern society. The obvious outcome of such imbalances of power and control is social injustice whose consequences bring moderate to severe disruption to individuals and their families.

Choosing autoethnography as a method meant that I became both the researcher and subject of my research. Dumitrica (2010, p.19) draws from the work of Carolyn Ellis, to make transparent both the process and outcome of the method:

> "Autoethnographers reflexively examine their own feelings, meanings and understandings of the social world in order to connect the autobiographical and personal to the cultural, social and political".

I became strongly attracted to the idea of a research method that among other things could raise questions about culture as an organising concept in society (including, in my case, professional and regulatory culture) and about social factors such as power and control influencing attitudes and behaviour. Moreover, the autoethnographic method gave credence to the notion that personal experience (such as lived experience of the HSCP) was a product of one's location within subcultures and culture. Relating personal experiences to those of others, which can be found in the reported literature, would offer opportunity to explore and challenge present-day regulatory practices and encourage change in order to help reduce unnecessary suffering to HSCPs in the future since current FtP processes appear to overlook their impact on registrants.

3.2 History of autoethnography

This section of the thesis leads the reader through the development of autoethnography within the field of ethnography and subsequently how my interpretation of it has been used reflexively through the process of my inquiry. As already identified, autoethnography was unknown to me before my doctoral interview in 2015. Bochner and Ellis (2016) credit anthropologists for the development of the major research methodology of ethnography designed to study culture.

The term autoethnography first appeared in the academic literature during the 1970s (Ellis 2004). The anthropologist Heider (1975) published his research consisting of interviews with fifty Indonesian school children under the title 'What do people do? Dani-autoethnography'. He considered that by asking members of the social group of interest a straight-forward question 'What do people do?' he would elicit the insider perspective. He felt confident in prefixing ethnography with "auto", since what his research reported were the Dani's personal accounts of 'what people do'. For Heider (1975) the term 'self' did not mean himself as ethnographer, but, rather, his interviewees who gave freely their cultural accounts of themselves. A little later, Hayano (1979) used "autoethnography" in a different way to refer to the study of a social group (professional poker players, of which he is one) from an active member of the group under study. Stated another way, the researcher (or autoethnographer) is also the researched. This later construction of autoethnography coincided with the "crisis of confidence" inspired by postmodernism in the 1980s (Denzin and Lincoln 2008).

Ellis et al. (2011) usefully summarise the main drivers that led to the reform of social science inquiry which impacted the way ethnography was carried out, as follows:

a) The “facts” and “truths” scientists “found” were tied to the vocabularies and paradigms the scientists used to represent them;
b) Social science scholars lacked the desire to create universal narratives of the kind espoused by science;
c) Scholars understood new relationships between authors, audiences, and texts;
d) Stories were now beginning to be seen as complex, constitutive, meaningful phenomena that taught morals and ethics, introduced unique ways of thinking and feeling, and helped people make sense of themselves and others;
e) Growing resistance to colonialist, sterile research impulses of authoritatively entering a culture, exploiting cultural members, and then recklessly leaving to write about the culture for monetary and/or professional gain, while disregarding relational ties to cultural members.

Postmodernism was therefore integral to the very nature of and myriad of forms of autoethnography which is made clear by Richardson (2000, p.928) who wrote

> “The core of postmodernism is the doubt that any method or theory, discourse or genre, tradition or novelty, has a universal claim as the ‘right’ or the privileged form of authoritative knowledge”.

Autoethnography was born of the postmodern movement and as such shares in the movement’s state of mind – inherently critical, restless, radical, emancipatory – its ultimate purpose being “universal dismantling of power-supported structures” (Bauman 1992, p ix). Such societal structures in the modern era could be seen to coerce societal members into learning the culture of absolutism which is ultimately self-serving through the perpetuation of a dominant set of values that make claim to a single truth with unquestionable certainty and objectivity. This could be seen to be administered through the dominant institutions of the time including religion, law and education. For so long modernity had the effect of denying human subjectivity. It devalued and ostracized the ‘raw’ human condition in its efforts to impose order; in effect modernity sought a single homogenous form of culture. Individuals who were outside the proffered order, in this ideology, had to be disregarded (Bauman 1992 p xi). I was struck by the links between modernity’s ambitions and the strategy of health and care regulators in the UK who continue to claim to hold an absolute standard of truth in discharging their role in protecting the public (against the willed action of care professionals who flaunt the prescribed order).

Central to both traditional ethnography and its progressive (autoethnographic) form is the concept of culture. Chang (2008, p.21-22) avoids definitively stating what culture is, but instead proposes a work-in-progress concept of culture founded on seven premises summarised in Table 6.

Premise	Application to self
Individuals are cultural agents, but culture is not at all about individuality.	Culture is inherently collectivistic, my interests have been considered secondary to the reputation of the pharmacy profession as a whole, by my regulator.
Individuals are not prisoners of culture.	Individual autonomy is retained and I am able to be constructively critical of the practice of pharmacy while at the same time seeking to return to the profession.
A certain level of sharedness, common understanding, and/or repeated interactions is needed to bind people together as a group.	My kinship group includes several practising pharmacy professionals.
Individuals can become members of multiple social organizations concurrently.	I am a UK citizen, British Indian, male, graduate of London University School of Pharmacy and a non-practising pharmacist all at the same time.
Each membership contributes to the cultural make-up of individuals with varying degrees of influence.	My work identities as a pharmacist, educator and researcher have all vacillated through my career.
Individuals can discard a membership of a cultural group with or without "shedding" their cultural traits.	De-registration has not led me to abandon my profession, rather it has served to activate a desire to continue to contribute to its development.
Outsiders can acquire cultural traits and claim cultural affiliations with other cultural groups.	My inquiry has facilitated access to autoethnography research groups.

Table 6. Chang's founding premises for understanding culture.

The application of these premises of culture leads Chang (2008) to reject anthropological and psychological approaches to understanding culture on the grounds of being too deterministic. Instead, Chang (2008) posits "self" as a basic unit of culture and therefore the starting point for cultural acquisition and transmission. Moreover, culture is perceived to be the product of interactions between self and others in a community of practice. The self is usually understood to mean those attributes that can be used to characterise 'I' or 'me'. In contrast, the term "others" generally refers to different human beings. In the present discussion about culture, the self and other are relational terms within a community. As a framework for autoethnographic data analysis and interpretation, Chang (2008) commends viewing existential others along a continuum of strangeness to self (that is, others – of similarity or belonging to the same community, - of difference or belonging to a different community, and – of opposition or belonging to a different and threatening community). In this typology, my family, professional group and regulatory body are culturally located differently in my perception. I admit to seeing my regulatory body, at this time, as others of opposition to my interests because it had removed me from professional practice. Yet, I am challenged to arrive at empathetic understanding or to "*verstehen*" others' culture through the process of this research methodology, so that any incorrect judgements about others of opposition I hold might be lessened (Chang 2008). This is claimed to be achievable through cultural crossing between self and others, so that the degree of strangeness might be reduced. Those at the margin or boundary between cultures are ideally placed to engage the other and develop mutual trust and understanding in a process of cross-cultural pollination (Chang 2008). I shall return to this idea at the end of this chapter where I shall be looking closer at the

strong negative emotions I expressed surrounding my experience of professional regulation and its impact.

3.3 Defining autoethnography

There are multiple definitions of autoethnography (Reed-Danahay 1997; Spry 2011; Holman Jones 2005; Anderson 2006). All these place personal experience at the core which the autoethnographer is called to embrace and embed in the social. These and other definitions bring to light the different tasks to be achieved by the research methodology including self-empowerment, critique of cultural practices and move audiences to action (Denzin 2014). This has helped guide users of the approach to appropriately select and apply one or more definitions to accomplish their research aims. In this section, I include the definition taken from *Autoethnography: An Overview*, which provides an extensive account of the history, process, potential and outcomes of this qualitative approach as interpreted by Carolyn Ellis et al (2011b, p.273):

> "Autoethnography is an approach to research and writing that seeks to describe and systematically analyse (graphy) personal experience (auto) in order to understand cultural experience (ethno). This approach challenges canonical ways of doing research and representing others and treats research as a political, socially-just and socially-conscious act. A researcher uses tenets of autobiography and ethnography to do and write autoethnography. Thus, as a method, autoethnography is both process and product".

Ellis and Bochner (2000) provide a long list of distinguishable forms of autoethnography which provides evidence of not only the diverging evolution of the approach since its inception, but also of the extensive interest among scholars in tapping into its diverse applications for researching social phenomena. Looking at the available forms and thinking about the purpose of my research, I am unsurprised to find initial resonance with labels such as confessional tale, emotionalism, ethnographic poetics, evocative narrative, lived experience and reflexive ethnography. The authors helpfully organise the different forms according to the emphasis they place on the research process (graphy), on culture (ethno), and on self (auto). Chang (2008) believes autoethnography must strive to achieve triadic balance overall, namely ethnographic in methodological orientation, cultural in interpretive orientation, and autobiographical in content orientation. This is an important rule of thumb for those naïve to the approach and one that I will regularly return to through the process.

As I had expected, I was drawn to 'written forms of research'. I say this based on years of living with emotional dysregulation that would lead me, all too frequently, to turn to pen and paper and write in order to communicate thoughts and feelings. As an autoethnographer, I feel through personal writing I could hope to regulate my emotions sufficiently in order to explore my

experience of FtP proceedings and removal from practice, and the impact this has had on my life. Spry (2011, p.36) seems to give support to my hope and intentions through observing:

> "Writing provides a means for processing, creating meaning around, and enduring profound experiences".

In the next section, I will contrast two major strands of autoethnography which have been widely debated in the literature over the past two decades, and reach a decision concerning the appropriateness of each to answer my research question.

3.4 Types of autoethnography: evocative and analytic

There are two main camps of practice within autoethnography. These are known as evocative and analytical (Chang 2008). According to Muncey (2010, p.36) "the current discourse of autoethnography refers almost exclusively to evocative autoethnography". Ellis and Bochner (2000) believe all exemplars of autoethnography fall at different places along the continuum between the two major types each emphasising to varying degrees auto- (or self), ethno- (or culture) and graphy (or research process). In this way, the authors suggest, autoethnography in all its types, forms and representations may be categorised and understood. At the evocative end we can expect to find the contributions of Carolyn Ellis, Arthur Bochner, Tony Adams, Stacy Holman Jones and many more. In evocative autoethnography there are several key features that differentiate it, as Bochner and Ellis (2016, p.80) eloquently put it recently

> "We want to evoke feelings and induce readers to make a personal connection to the stories we are telling. Our writing is not simply academic; it's personal and artistic too… Since we are frequently focusing on issues of human fulfilment, survival, and justice, we are responsive to a different call of conscience than orthodox social scientists".

In contrast, analytical autoethnography is concerned with ethnographic work in which the researcher is

> "(1) a full member in the research group or setting, (2) visible as such a member in the researcher's published texts, and (3) committed to an analytic research agenda focused on improving theoretical understandings of broader social phenomena". (Anderson 2006, p.375)

It is situated at the '-graphy/ research process' end of the above continuum. As such, it makes claim to objectivity. Believing that Anderson (2006) was attempting to tame autoethnography by keeping it closely aligned to orthodox social science practice, Ellis and Bochner (2006, p.433) responded saying

> “autoethnography shows struggle, passion, embodied life and the collaborative creation of sense-making in situations in which people have to cope with dire circumstances and loss of meaning… it needs the researcher to be vulnerable and intimate… it shouldn’t be used as a vehicle to produce distanced theorising”.

In their more recent text together ‘Evocative Autoethnography: Writing Lives and Telling Stories’ Bochner and Ellis (2016, p.110-112) inform us that “showing evokes, whereas telling analyses” and “showing is experience-near, while telling is experience-distant.” These two ideas, despite their remarkable simplicity, bring the strategic difference between evocative and analytical autoethnography into sharp focus. My own writing will lean more towards the evocative approach, while recognising the need for a systematic approach to interpretation and analysis of my lived experience of the FtP process, sanction and its impact.

3.5 My autoethnography process

According to Ellis the evocative autoethnographer might usefully capture personal experience using a systematic approach:

> “I start with my personal life. I pay attention to my physical feelings, thoughts and emotions. I use what I call systematic sociological introspection and emotional recall to try to understand an experience I’ve lived through. Then I write my experience as a story” Ellis and Bochner (2000, p.737)

Personal memory is a primary information source for autoethnographic research by giving access to information on self that would otherwise remain hidden. In the process of writing such information, it takes on the form of ‘textual data’ from the past (Chang 2008, p.71-2). I began my PhD in October 2015, three years after my name was removed from the RoP for pharmacy professionals. To begin the collection of personal memory data, I would need to build an autobiographical timeline in the form of a chronological list of my relevant experiences starting September 2012 as this is when I was de-registered. This was aided by reference to a range of textual artefacts consisting of my annual diaries and collection of legal, regulatory and medical documents that I had routinely kept and stored for record keeping. I used the “writing exercise” from Chang (2008, p.74) as a guide within which attention is drawn to creating a thematically focused timeline around, for example, educational development, border-crossing experiences, mental health support and familial crisis. Experiencing strike-off represented a crisis in my life that led to a desperate need to escape the memory of the event, but it seemed the harder I tried, the more vivid my memory became and this deepened my suffering. It goes without saying that I expected progress towards chronicling my experience to be slow with frequent stops and stutters. In fact on two separate occasions (September 2018 and September 2019) I felt compelled to suspend my study for a three-to-six month period as a result of the emotional toll it had taken on me.

I have come to view the PhD programme as in-depth training in the process of inquiry. To aid this I have the support and encouragement of two experienced researchers, acting as my study supervisors. Right from the start, they have impressed on me the importance, for qualitative researchers, of keeping a 'research/ field journal' used to capture personal thoughts, feelings and emotions through the doctoral journey. Recognising and accepting the essential task of autoethnography towards greater understanding of culture and societal norms through the experience of self, I needed to embrace the feedback given to me by my supervisors. The following extract taken from my research journal (16th December 2015) shows this taking form in my mind:

> "Coming to my PhD study, I had spent a lot of time thinking about the injustice of strike-off. I had already fallen into a pit of despair ruminating over losing my profession. I could not see a way out of this catastrophe. When they remove you, you can't come back for five years. I was afraid to feel any more pain in my life and worked hard to live in my head. Such disembodied living was very familiar to me as a means of protecting my fragile self from further hurt. I was not living. At best I was barely surviving. As health and social care professionals know all too well, we can only expect to care for others when we are connected with self. I was jolted to reverse my viewpoint from 'outside in' that up-to-now caused me to lash-out at the world and cast blame. An 'inside out' viewpoint restored, to some extent, all that was lost after the trauma of de-registration – identity, power, control, respect, purpose, meaning and voice. I came to this subject of inquiry through a crisis in my life. I wished to emerge from the period of inquiry with renewed hope for a life worth living. So, from an 'inside out' perspective, looking at my circumstances from a different direction, getting struck-off has given me, for the first time in my life, an opportunity to slow down and quieten my busy mind in order that I might find out about self, as well as map the journey from erasure to restoration and, potentially facilitate moving from disembodied living to an embodied presence capable of inviting and experiencing the host of feelings and emotions being human entails".

With the collection of self-centric data comprising personal memory data, self-observational data (the actual behaviours, thoughts, and emotions at the time of data collection) and self-reflective data (outcomes of self-analysis and evaluation) autoethnographical data are anchored on *my* "lived experience" and perspectives on "the physical, political, and historical context of that experience" (Chang 2008, p.103). This makes clear the role of the ethnographer which is succinctly stated by Wright Mills (1959, p.5-6) through his concept of the 'sociological imagination'

> "The sociological imagination enables us to grasp history and biography and the relations between the two in society….to examine how the private troubles of individuals are connected to public issues and to public responses to these troubles…individuals can understand their own experience and gauge their own fate only by locating themselves within their historical moment period".

It was my intention to make an application to my regulator to restore my name to the RoP and to return to work as a pharmacist at the end of my five-year period of incarceration, specifically after September 2017. As part of my preparation I engaged an experienced pharmacist colleague to mentor me for between six to nine months. Therefore, I had the opportunity to gather 'external data' to further help me to investigate and examine my subjectivity. These individual, face-to-face, verbal interchanges were digitally recorded with the consent of my mentor and were structured around the questions within the General Pharmaceutical Council's (GPhC) restoration application form (after removal) as well as continuing professional development courses and activities I was intending to include as evidence to support my assertion that I had remained up-to-date with developments within the pharmacy profession. Five 'interviews' took place and culminated in the completion of my restoration application to the regulator. Chang (2008, p.106) endorses my decision to use interviews to gather external data and provides several reasons for their inclusion as follows:

> "To stimulate your memory, to fill in gaps in information, to gather new information about you and other relevant topics, to validate your personal data, and to gain others' perspectives on you".

In addition, I feel the opportunity to have a deep and sustained conversation with an experienced colleague from the same profession helped me to connect my private troubles to the professional and societal issues of the recent past (culture) and highlight concerns about our present regulatory FtP regime as it discharges the public interest function (which it purports to rigorously protect) through regulating the health and care workforce (which it purports to carry out sensitively and proportionately).

According to Polkinghorne (1988) storytelling is a fundamental human activity. From young children returning home from school and telling their families stories about their day to professional biographers and novelists, we are all storytellers. Early on as someone transitioning from a positivist paradigm (with specialist training in the pharmaceutical sciences) towards an interpretivist paradigm (centring on constructivism and social constructionism) not only in the approach to my research question, but also how knowledge is developed and propagated in societies, I found Rukeyser's (1949) articulation of stories as fundamental, both confusing and intriguing:

> "The universe is made of stories, not atoms".

The scientist in me immediately wished to correct the assertion, returning to what is familiar and known to me - the atom is what everything else is built from; everything meaning substance or matter contained within the Universe. Horne (2004) draws attention to the fact that Muriel Rukeyser, failed to capitalise the word universe. Was this an error or was it intended? Consulting the Oxford English Dictionary (online) I noticed there was a second use of the word that did not capitalise universe. It referred to the subjective concerns we all hold (akin 'private troubles') and

therefore could be pointing to our inner universe of thoughts, feelings and emotions all of which evoke meanings for us. In this sense, Rukeyser is directing me to the process through which my stories, as an expression of such subjective meanings, are created and communicated. The logical conclusion I can draw from this line of analysis is that my created character is the sum total of the many meanings captured in stories I tell myself and that form my inner universe. Of course, it must be assumed that all other people in our sphere of activity or experience are presented as our outer universe. We interact through the very stories we share. I cannot help but conclude that my previous scientific outlook that reduced the human being to its physical form as organism did not address the less tangible components of our humanness or personhood/ selfhood. More worrying is the realisation that many of our societal systems (including professional regulation) developed through reductionist assumptions that saw the human being in physical terms as an organism whose neuro-physico-chemical components could be reduced to atoms. Returning then to Rukeyser's (1949) evocative line, it is with our stories that we can uphold our personhood and go beyond the reductionist outlook. But what constitutes a story?

In this project I am concerned with writing an autoethnographic story. Adams et al. (2015, p.1) define the autoethnographic story as follows:

> "a story of/about the self, told through the lens of culture…an artistic and analytical demonstration of how we come to know, name, and interpret personal and cultural experience".

The large and growing body of autoethnographic research successfully traces the development of narrative identity which, in the most part, consists of people constructing stories to help them to make sense of life events, times of crisis and suffering (see for example Jago 2002 and Muncey 2005). Without exception, it is to the wider complex cultural and societal contexts that people must look in order to find resolution to the questions they ask. I do not see my quest for the meaning to my experience of been de-registered and therefore losing my career status to be any different. That said, every human life journey is unique passing through a particular set of life opportunities, circumstances, relationships and crucially personal interpretation in order to arrive at an incomparable self.

Labov (1972) proposed a six-part narrative model to guide those wishing to compose narrative as well as anyone intending to analyse narrative patterns, to identify recurring themes. The six parts are: abstract (or introduction – to attract attention), orientation (covering the time, place and characters), complicating action (referring to the actual events or narrative plot), evaluation (or the reason the narrative is being told), resolution (or conclusion) and coda (or relevance). All six are not necessary in every narrative and, their ordering can vary. The Labov model has continued to influence qualitative research and cultural studies (Alasuutari 1995) since its inception, and is helpful to autoethnographers.

Adams et al (2015) and Bochner and Ellis (2016) offer the evocative autoethnographer advice about crafting stories. Bochner and Ellis (2016 p88) summarize five main features of an autoethnographic story as follows:

- "People depicted as *characters* in the story;
- A *setting*, *scene*, *place*, or *context* in which the story occurs;
- A *temporal ordering* of events;
- An *epiphany* or *crisis* of some sort that provides *trouble* and *dramatic tension*, around which the *plot* or *action* depicted revolve and towards which a resolution and/or explanation is pointed;
- A *moral* to the story that provides an explanation and gives meaning and value to the experiences depicted".

The features stated, not only adhere to Labov's narrative model, but are widely recognised by writers and readers alike as hallmarks of good stories. Autoethnographers are challenged to construct and present their stories by adhering to the taken-for-granted ingredients in order to achieve verisimilitude with their audience. It is my intention to reflexively represent my lived experience of being side-lined as a care professional through the vignette technique. The research literature provides a range of definitions about what constitute vignettes (Finch 1987; Hill 1997). I will be using the definition offered by Hughes (1998, p.381) who defines vignettes as

> "stories about individuals, situations and structures which can make reference to important points in the study of perceptions, beliefs and attitudes".

Several key principles can be distilled from the literature to guide vignette development (Erikson 1986; Barter and Renold 1999). Those I consider to be relevant to writing autoethnographic vignettes and that supplement and extend Bochner and Ellis' (2016) features of stories include all of the following:

i. Stories presented in the vignettes should be readily understood, are internally consistent and not too complex;
ii. Stories must appear plausible and real to readers;
iii. Vignettes are most helpful if the aim of the research centres on the meanings people ascribe to specific contexts, without making any association with actions; and
iv. Narrative vignettes should be based on field notes taken as the events happened.

Within the qualitative paradigm vignettes have been employed in different ways in order to achieve different purposes. Barter and Renold (1999) state vignettes generally fulfil three main purposes: to allow actions in context to be explored; to clarify people's judgements; and to provide a less personal and therefore less threatening way of exploring sensitive topics. Recognising my sensitivity to the topic of study vignettes were especially useful for me in exploring personal experiences that were traumatic. I am particularly concerned to use my own experience to shed

light on the UK regulatory system culture by delineating the latent perceptions, beliefs and attitudes towards care professionals going through the FtP process, as well as the wider public standpoint. In doing so, I am in agreement with Denzin (1989, p.124) that the autoethnographer's intention is to elicit "emotional identification and understanding". I found the impersonal nature of the regulatory system I had gone through caused me to feel de-humanised. I cannot help but wonder if this might be a common experience among HSCPs passing through FtP proceedings? My audiences are therefore both UK regulators, professional registrants (especially those who have experienced defending themselves against a complaint concerning their FtP), professional trade unions, university educators and legal firms specialising in prosecuting or defending registrants.

In this section, responding to the challenge of creative representation of my lived experience after being removed from practice by my regulator, I am guided by Chang (2008, p.66) who suggests beginning by asking three process-oriented questions:

- "How will you collect data about yourself and integrate others in your life?
- How will you manage, analyse, and interpret data?
- How will you present research outcomes?"

These questions provide a basic yet essential framework for methodological planning of an autoethnographic study. Though alternative ways to position self and others (family members, friends, work colleagues, support workers) in autoethnography are possible I have decided to investigate myself as a main character and others as supporting actors in my story of a life after the event of de-registration.

3.6 Ethical Considerations

I have already stated that autoethnography is an innovative qualitative method of inquiry. Writing autoethnography does not take place in a vacuum, but in relation to other people who take the role of characters in the story told (Bochner and Ellis 2016). Chang (2008) contends that protecting the privacy of 'others' in autoethnographic stories is paramount and that ethical issues involving human subjects apply as much to narrative techniques as to other research designs. In the construction of my autoethnography I am reminded to write from an ethic of care and concern and do no harm (Ellis 2004). Given the lack of disguise, those persons and organisations who are related or peripheral to my story may be cast into a limelight not of their choosing. So, as I contemplate writing my personal narrative, I am called to elevate the rights of 'other people' who are part of my story.

Clandinin and Connelly (2000) have been critical of all self-narrative writers whom they claim naively assume as authors that their stories belong to them with the consequence of a failure to seek informed consent from people written in the text.

Adams et al. (2015) discuss three types of ethics that are frequently present (though to varying degrees) while conducting research: procedural, situational and relational ethics. I secured ethical committee approval for the study, at Bournemouth University, and satisfied procedural ethics criteria (see appendix 1 for a copy of my approval document). Situational ethics refers to the processes for dealing with ethical questions as they arise in the course of the study and include checking in repeatedly with participants that they are happy to continue with the research. In my research I include dialogue between myself and my mentor generated over five meetings to prepare the restoration application to my regulator. I informed my mentor about my research study and prior to each meeting obtained his consent to participate, with full knowledge that excerpts of the professional discussion would be included. The concept of "mindful slippage" or selective telling of the truth has been put forward by Medford (2006) who believes researchers are in error to assume that participants would not access and read academic literature and, feel at liberty to write contentious stories they consider would be free from participant scrutiny and challenge. Relational ethics:

> "recognises and values mutual respect, dignity, and connectedness between researcher and researched, and between researchers and the communities in which they live and work". (Ellis 2007, p4)

In autoethnographic stories, Tolich (2010) argues that ethical issues are endemically problematic when it comes to protecting the privacy of others.

> "Normally qualitative researchers use the term *participants*, but this term seems inappropriate in the context of autoethnography, in which people are routinely researched without their prior consent". (Tolich 2010, p1608)

Tolich (2010) is critical of three of the method's leading experts (Ellis, Rambo and Richardson) in his review of the available ethical guidelines for autoethnographers. He believes each demonstrate a systematic failure to provide evidence of respect for the participants' autonomy, the voluntary nature of their participation, or of documenting the informed consent processes considered foundational to qualitative inquiry. He vehemently rejects the utility of gaining retrospective informed consent on the grounds that it is potentially coercive by placing undue obligation on participants to volunteer. Rather as autoethnographers we are charged with the responsibility to anticipate the needs of both the other and the self before the research writing begins. In response to the range of criticisms levied at leading proponents of autoethnography, I will consider up to three further resources that may help uphold the ethical rights of 'others'. In the autoethnographic method I am studying 'me' in relationships and situations. Here Doloriert and Sambrook (2009) refer to the approach as 'researcher-*is*- researched in autoethnography'. In this case the researcher is the sole participant and focus of the research. My study is an examination of my experience of being subject to SRB FtP proceedings and its impact on my life. In agreement with the interpretivist research epistemology I do not claim to attain a single truth,

but rather my personal perception of a traumatic and complex experience of being removed from a professional register, which is presently absent from the literature.

I recognise that as I am identifiable as research participant and that those I refer to might also be identifiable to others, I explored taking a nom-de-plume (Morse, 2002). However, this is not possible as my final thesis will be published on EThOS (e-theses online service). In my autoethnography I intend to consider my experience of the FtP panel system and my family background. I therefore intend to apply the principles of relational ethics extensively discussed by Ellis (2004, 2007). There are many literary devices that are available to me in order to protect 'others' identities in my autoethnographic account including fictionalizing (Clough 2002), composite characterization (Ellis 2007), pseudonyms (Chang 2008) and symbolic equivalents (Yalom 1991). This will ensure that although people will not be identified by name the effect of them on me will be captured. I have employed composites under the occupational roles that feature in my story (general practitioner, counsellor, consultant psychiatrist, course tutor, mentor and solicitor). Members of my family (parents, siblings, ex-wife and children) have remained in constant dialogue about my research (2015-2021) and remain supportive by giving consent to their visible or invisible participation.

In my thesis and in any future writings I am proposing that as the FtP case is already in the public domain, I will only refer to the panel (system) as a whole and not identify individual members in any public account. Where I use personal reflections linked with my family history these will focus upon their general influence on me and I will not present stories which could be linked with individual family members in any public account. I wrote my narrative following removal from the RoP of pharmacists between September 2012 and restoration, five years later. The purpose was to give meaning to this experience and has inevitably made reference to my experience of 'others' with whom I have interacted in a variety of settings (NHS mental health, legal, educational, pharmacy practice, religious and familial). The focus was on the contribution (if any) I perceive others made to help me to accept, make sense of, and heal from the traumatic and life-changing experience of de-registration. Although no names were used throughout my story, I refer to others in terms of their more general social role in relation to me, such as mental health worker, regulator, fitness-to-practise panel (FtPP), service user, employee, mentor, relative and, friend.

All data were held securely on a password protected computer and all audio-recordings were held securely by the researcher at all times. There was a high possibility that I may become distressed by reliving a painful experience and disclosing personal information. A plan was put in place and support was to be sought from my supervisors in the first instance and/ or Bournemouth University Counselling service, if necessary. During data creation I reduced harm to myself, as a result of recalling my traumatic and sometimes harrowing experiences, using a wide range of activities (running, swimming, yoga, listening to music, baking bread and spending time with loved ones) and methods (including emotional detox, meditative practices, shinrin-yoku and praying).

3.7 Autoethnographic approach taken in this study

Exploration of methodology in this chapter has enabled me to arrive at the point in my study of structuring and defining the stepwise approach I followed for my autoethnographic inquiry. This is outlined below.

Step One

Literature review to identify gaps in knowledge and formulation of research question(s). Seek ethical approval from the Social Science & Health Research Ethics Panel (SSHREP) of Bournemouth University for the study.

Step Two

Autobiographical timeline using the "strategy of chronicling" (Chang 2008, p.72). I captured the significant events and experiences that took place in my life after the start of the investigation into my FtP on 9 February 2011, but especially after my subsequent removal from the register on 10 September 2012. My lived experience after removal has been multi-faceted and complex. From the very beginning I have remained determined to restore my name to the professional register and return to practice, despite not knowing at the time, the precise process I would have to go through to demonstrate that I had successfully remediated the reasons given by the FtP Committee in their decision to de-register me. Looking back, my timeline could be created around the interdependent themes of personal well-being, resilience and work identity that form the core of my study. Removal from practice represented a life crisis for me and severely disrupted daily routines. Significantly, I encountered what Chang (2008) describes as border-crossing experiences and as a result I would become cognizant of my personal failings and vulnerability. Inventorying (recalling mentors, cultural artefacts and values) and visualizing (kinship diagram, and free drawings) were further strategies that were added to collect personal memory data to satisfy any emerging research needs (Chang 2008).

Step Three

Autobiographical fieldwork: both observation (my thoughts, emotions and behaviours as they occur) and reflection (resulting from intentional and purposeful introspection, self-analysis, and self-evaluation around my identity) in the present. Considering my research goals, the observation of self concentrated on my interactions with pharmacy professionals ('my peers') over the five-year period after removal during both my 'keep-in-touch' days spent at my pharmacy and participation in external educational events. I maintained a personal diary in which I recorded reflections since 2012 and from the start of my doctoral studies in 2015 have added to these additional reflections on the research process guided by up to eight supervisory meetings each year.

Professionals regularly face complex and unpredictable situations in their work. The benefits of developing critically reflective and reflexive processes to the practitioner include a reduction in work-related stress, an increase in job satisfaction, and improvements in practitioner-client

relationships. Furthermore, these processes offer ways for me to interrogate and express painful experiences otherwise impossible to communicate. They offer scope for me to explore, for instance, how I might work within my circumstances and what I might be able to influence, why I become stressed (and its impact personally and professionally), how to challenge regulatory biases so that the voices of marginalised professionals are no longer silenced. Schon (1987) described professional practice as being in a flat place where we cannot see very far – that is a place of not-knowing. Each practitioner is rarely certain what is needed in any given moment. According to Schon (1987) we work and learn in the 'swampy lowlands' by trial and error, learning from our mistakes while living with the consequences. In practice, faced with a novel situation professional people develop compasses and maps through 'a conversation with the situation' (Schon 1983, p.76). Such 'theories-in-use' (or what I actually do – my habitual patterns) may be at odds with 'espoused theory' (or what I believe I do – prescribed professional standards). To develop my practice I would be required to bring these into alignment through reflective practice. Schon (1987) divides such practice into reflection-in-action (bringing remembered skills, experience and knowledge into use) and reflection-on-action (post event reflection that increases the effectiveness of reflection-in-action). Schon (1987) posits that the process of trial and error and learning from mistakes is artistry whose reliable tools are reflection and reflexivity.

Reflexivity: Qualitative researchers play an influential role in "the collection, selection, and interpretation of data" (Finlay 2002, p.531). I have spoken already about the likely influence of my own opinions and views about SRB FtP processes on the research I wish to carry out. With lived experience of professional regulation since February 2011 culminating in my removal from the RoP in September 2012, I recognise this in all probability will find some expression in my study. Hertz (1997, p viii) encourages personal accounting in which the researcher works towards raising self-awareness of how as, 'situated actors', distortion is minimised through the stages of the research process. Finlay (2002, p.532) defines reflexivity as "thoughtful, conscious self-awareness". Reflection (or "thinking about something else after the event") and reflexivity (or "a more immediate, continuing, dynamic, and subjective awareness") are not the same; they lie at opposite ends of a continuum (Finlay 2002, p.532-533). Both tools are valuable to the autoethnographer throughout the research process. I was acutely aware that during much of the time my identity, personality and life were blurred by the enormity of my loss of career and emotional instability. Blaxter et al. (2001 p 83) list ten questions to ask in order to develop as a reflexive researcher (Table 8) which I applied to the stages of my autoethnographic project, but especially in constructing the narrative vignettes that depict my lived experience and story, and their careful analysis and interpretation.

1	What was my role in the situation?
2	Did I feel comfortable or uncomfortable and why?
3	What actions did I take? How did I and others act?
4	Was it appropriate? How could I have improved the situation for myself, and others?
5	What can I change in future?
6	Do I feel as if I've learned anything new about myself or my research?
7	Has it changed my way of thinking in any way?

8	What knowledge, from theories, practices and other aspects of my own and others' research, can I apply to this situation?
9	What broader issues – for example, ethical, political or social – arise from this situation?
10	Have I recorded these thoughts in my research diary?

Table 8: Developing reflexivity: ten questions to ask yourself

In choosing a reflexive and broad research question ("what could be the experience…") I was trying to let the study be guided by the themes emerging through the literature and fieldwork. I endeavoured to remain reflexive through fortnightly discussions with my study supervisors to help guard against my own untoward influence on data generation and analysis, as well as to encourage a more critical interrogation of the data by actively stepping back and returning to it with greater impartiality.

Step Four

Vignettes construction: According to Lakoff and Johnson (1980, p.5) "the essence of metaphor is understanding and experiencing one kind of thing in terms of another". I planned to view my career and the period of erasure through a series of metaphorical lenses in order to assist me to construct several vignettes that taken together offer the possibility of providing a deep understanding of my experience of removal from the RoP. Kidd (1998) argues for the inclusion of feelings and emotions that underlie career transitions in any consideration of career development, debunking the assumption of rationality in occupational choice and behaviour at work. Moreover, many HSCPs commonly describe the powerful role of emotion in their reasoning for career choice, coaxed in such terms as wanting to make a difference, to reduce suffering and promote well-being. Work as a HSCP is indeed, in my own experience, emotional labour.

It would be comforting to believe that autoethnographies arrive fully-formed along with a complete set of themes and ideas. In my experience the process requires great skill and patience and is inevitably protracted – years of false starts, dead-ends and abandoned material. Only now that the process is over does it become possible to identify the experiences and influences that combine to produce meaningful autoethnographic writing. The vignette collection in this thesis is about my memories of my life and career journey up to and including a period of five years following de-registration shared with readers in order to serve what I believed was the higher purpose of my study - to widen the width of view through reflective writing. I first tried to write the vignettes in the summer of 2017. I wrote what is now the first page of vignette four: emotion. I halted because I did not feel able to continue – I was re-experiencing the trauma all over again. I returned to it in the autumn of 2019, unsure if I was writing memoir, autobiography or autoethnography. I wanted most of all to use my experiences to share my story about losing my licence to practise my profession, about mental health and recovery, about relationships and trust, about redemption and transformation, about faith and hope. I wanted to write an inspiring story to help those who were facing investigations into their fitness-to-practise, and to assist their family members to understand the dilemma, so they could support. I fully accept that people cope with adversity and loss in ways that are deeply personal. However, by offering a subjective truth written from my own life and lived experiences it is my sincere hope that my story helps cultivate the

human spirit, and free it from the crushing threat posed by a de-humanising system of professional regulation.

To achieve these goals and because autoethnography is the study of culture through the lens of the self, I chose to write using first-person voice – positioning the 'researcher' as the narrator of the story. This "I" is a character, just like the other characters in the story. In the seven-part vignette series, as first-person narrator, I always write from a subjective viewpoint enabling significant observation and insight. An important consideration for me throughout was to challenge the perspective of the regulator by providing an eyewitness account of what I went through in the name of 'public protection' and how it altered the course of my life. At the end of the principle hearing my legal representative uttered the following words to me:

> "They did not believe you" (see section 4.3 Vignette four: Emotion)

I felt that by reporting what I see, experience, feel and think, the story I wish to share becomes more authentic and believable to readers, which would increase verisimilitude (Ellis 2004). I begin the series by writing a flashback (see section 4.1 Vignette one: Inheritance) in the hope that readers develop an interest in my character and situation and the ensuing conflicts I face. Writing using first-person voice engages the reader to want to find out, I hope, how things are going to turn out for me. The reader will hopefully identify with my character through the many ways I have plunged my character into what appear to be 'emotionally-charged' situations. If my unfolding traumatic childhood experiences touch readers then, I will have succeeded. In spite of the obvious ramifications of been removed from practice by my regulatory body, especially reputation loss, I wanted the reader to see in my character, however flawed, a living, breathing human being with emotions. Bochner and Ellis (2016, p.66) draw attention to this in the following excerpt from their methodological text 'Writing lives and telling stories' (the emphasis is that of the authors):

> We underscore the necessity of casting a wide net of *multiple layers of consciousness, self-consciousness, and reflection* that embody autoethnography's desire to cope with dilemmas and contradictions of being alive and to deal with blows of fate and *epiphanies of circumstance*.

As first-person narrator other people that feature in my story (such as the fitness-to-practise panel, legal representatives, Inspector, community mental health team, friends and family, and mentors) could only 'feel' in the manner that I represented them – through their appearance, speech and behaviour. I tried to do this honestly without the need for embellishment. Writing from my subjective perspective gave me clarity, but did not privilege me to know what others 'really' thought or felt. Bolton and Delderfield (2018) remind narrators who choose the first-person subjective viewpoint that it is not possible to stand outside ourselves objectively and know omnisciently. Relational ethics requires me to honour relationships by acting empathetically and professionally (Ellis 2004). A technique favoured by novelists and autoethnographers used to reveal character, that description cannot, is to write dialogue. This has the advantage of showing

characters in action and interaction. I have utilised dialogue extensively through vignettes five to seven in which I share conversations with members of the community mental health team, a spiritual mentor and a pharmacist mentor. These reveal my reflections and at times critical reflexivity in the process of transformation to return to my goal - a transparent state of fitness-to-practise, once more. Furthermore, I show a desire on the part of others to help correct the injustice depicted – and maybe evoke readers to seek the same.

I questioned whether the continuous use of 'I' begins to sound like complaining (when relating my feelings), and boasting (when relating my actions). However, as Adams et al (2015) suggest, the selection of the narrative voice is dependent on the answer given to the question: who can tell this story best? As the protagonist narrator, I am intentionally inviting readers to place themselves inside the story and in the mind, heart, and body of one who suffers. I wanted to avoid using the second-person voice due to the inevitable tendency to create distance (through use of 'you') and, also the third-person voice that offers an 'outsider's insider' perspective between the lived experience of the protagonist and the reader. The third-person voice is preferred by the system of regulation. Its case determinations or outputs from hearings appear as third-person narration with the full intention to distance professional and lay readers from 'the registrants' stories' and to encourage passive acceptance of the regulator's analysis as accurate, complete, and true (see vignette four: emotion). The seemingly cold and rational objectivity of my regulator stands in stark contrast to my raw emotionality.

Inkson (2004) offers up to nine career metaphors through which to think about careers, including inheritance, agency, fit, relationship, role, journey and cycle. Each provides a useful frame for my intended narrative and perspectives on the human experience of an erased HSCP, and were used to develop vignettes. The last of these career metaphors, for example, is that of the four seasons within which I could usefully examine human dimensions – heart, soul, mind and body. It is because a professional career can know ebb and flow, similar to parenthood and schooling, for instance, that seasons are integral to every life journey and hold particular appeal. It is envisaged that each season may serve to guide my thinking, feeling and telling of the narrative. In this way my passage through the period of time of de-registration could be presented as multi-layered with the experience of loss of work identity being symbolically linked to the imagery of one of the seasons (see Table 9).

The Season	My personal de-registration journey
Winter – season of endings and cessation	I found being removed from practice initially very difficult to understand and deal with. I had to somehow accept the reality of my situation. I had lost my work identity, professional standing and reputation. I had to learn to work through the pain of grief.
Spring – season of nature's awakening and blossoming of newly regenerated life	I struggled to adjust to life without work. Spiritual awakening constituted an epiphany in my de-registration journey. A time during which to learn to trust the heart over the mind and its learned schemes.

Summer – season of full bloom and abundance of growth	I reached the point at which I came to relocate de-registration emotionally and to move on with my life. Through creative processes I have been helped to normalize my experiences.
Autumn – season of many changes from bloom to maturation	I find myself, in the end, grateful and hopeful with a restored self-confidence and self-esteem. My values, beliefs and feelings are changed. I am transformed by my experiences.

Table 9. The four seasons and my de-registration journey

Step Five

Analysis and Interpretation: Denzin and Lincoln (1994, p.479) have commented that "the processes of analysing and interpreting data are always emergent, unpredictable, and unfinished". Chang (2008) points out that the self is considered a carrier of culture and the self's behaviour should be interpreted in cultural context and it is in this way that fragments of autobiographical data become transformed into text that is culturally meaningful. Maxwell (2005) suggests to begin data analysis and interpretation, 'read' textual data and 'listen' to oral data. At this time, Chang (2008) advises keeping 'memos' of impressions as to repeated topics, emerging themes, salient patterns, and mini and grand categories, in addition to coding and organizing the data. The same author offers up to ten strategies (see Table 10) for focused data analysis (one to seven) and interpretation (eight to ten). These will be referred to as a basic toolkit in this study.

No.	Strategy	Notes
1	Search for recurring topics, themes, and patterns	Significant topics in a life usually appear frequently in the data. Topics may become categorical labels.
2	Look for cultural themes	These represent the values of a culture and are used to control behaviour or encourage activity. Examples include education and faith.
3	Identify exceptional occurrences	People are often transformed after life-changing experiences.
4	Analyse inclusion and omission	As well as what is included in the data set, asking a question about omission for each inclusion can be revealing about an autoethnographer.
5	Connect the present with the past	Helps to show how present thoughts and behaviours are rooted in past events, usually in childhood experiences.
6	Analyse relationships between self and others	To help see self more clearly, consider both 'others of similarity' and 'others of difference'.
7	Compare yourself with other people's cases	Difference and commonality is brought to the auto ethnographer's consciousness throughout the meaning-making process.
8	Contextualise broadly	Moves attention away from personal data to what lies beyond ('context') that helps to explain and interpret certain behaviours and events.
9	Compare with social science constructs and ideas	The starting point is outside the case of the auto ethnographer, utilising social constructs (found in the literature) as a window through which personal data are interpreted.
10	Frame with theories	Making use of existing theory to explain the auto ethnographer's case.

Table 10. Summary of ten strategies suggested for data analysis and interpretation

3.8 Rigour in autoethnography

Tamas (2009) questions the ethics of 'going back in time' necessary by autoethnographers in the pursuit of their inquiries due to a real risk of re-experiencing trauma. Conversely, Ullrich and Lutgendorph (2002) see the autoethnographic process as potentially cathartic to the researcher. I am supported and encouraged by experienced study supervisors to write an authentic personal narrative that might add to the evolving story of FtP of HSCPs in the UK.

Both Tracy (2010) and Ellis et al. (2011a) reject positivist methodological criteria of reliability, generalisability, validity and objectivity believing such terms hold very different meanings for the qualitative researcher. Tracy (2010) recognising the plethora of available criteria for determining excellence in qualitative research, proposes that such guidelines are always contextually situated. Tracy (2010, p.840) goes on to present eight criteria of qualitative research quality: "(a) worthy topic, (b) rich rigour, (c) sincerity, (d) credibility, (e) resonance, (f) significant contribution, (g) ethics, and (h) meaningful coherence". These criteria cover both the process and product of qualitative research. In response to these general criteria I will deal with process criteria in this section and return to product criteria in Chapter 6 of this thesis.

My chosen topic of research is relevant and significant at a time when professional regulators are beginning to recognise that their FtP proceedings are far from benign in dealing with complaints against HSCPs. It challenges the common sense assumption that the registrants who enter FtP investigations present a risk to the public they serve independent of the circumstances of their practice. In conducting my research, I had to decide on 'how much data was enough to fully address the research question?' Previous research was limited by employing a cross-sectional design that permitted data to be gathered from published case files, postal questionnaires, focus groups and interviews. I felt to generate rich, complex and abundant data I needed to use a longitudinal design that would enable me to capture data over the entire five-year period of de-registration. In this endeavour my sources of data included diaries, personal reflective journals, artefacts, consultation and medical notes, self-introspection and dialogue (interactive introspection). My FtP case opened in April 2012 with the Chair announcing that 'my case was complex' indicating, perhaps, that the evidence set before the FtP panel portrayed me as unusually complex. The unique attributes I brought to this research, in my brokenness as a de-registered pharmacy proprietor suffering with a chronic mental health condition, actually helped prepare me to "see nuance and complexity" (Tracy 2010, p.841) in the system of regulation – that I admit finding difficult to penetrate in the early stages of the study (Leal 2020).

I believe that the decision to offer a first person account of the experience of encountering the regulatory system for HSCPs and its impact on my life through constructing a series of linked narrative vignettes provide the reader a window through which to view some of the distress, pain and suffering that typically befalls a care professional on exposure to the FtP process. I wanted to show the reader what it is like to go through the FtP process, lose your licence to practise and struggle to cope with the impact of this severe sanction while desperately trying to find meaning

in a life that seemed to lose all purpose. The account reveals the organic and impromptu thoughts, feelings and emotions that formed my experience while allaying criticism that as both researcher and subject of my inquiry I have played it safe by stepping away from necessary and sufficient self-disclosure demanded by autoethnographic methods. The prolonged time I spent 'in the field' allowed me to "gather interesting and significant data" (Tracy 2010, p.841) unveiling the human experience of professional regulation. However, it became clear to me that the data pertaining to the recent events in my professional practice that led to regulatory action lacked the breadth and depth of the career perspective (Inkson 2004) that I believed was necessary to provide a full understanding of how I, as well as other HSCPs, might conceivably become FtP cases. Therefore, I decided to extend my data collection to cover my childhood, education and early career experiences in order to place de-registration into its idiographic context. I feel this illustrates my wish to achieve thoroughness in data collection. I selected and applied Frank's (2013) restitution, chaos and quest framework for the close line-by-line data analysis, in order to reveal the narrative forms embedded within the lived experience of a de-registered care professional. This helped to provide a counter-narrative to the 'master narrative' of the regulator – felt to unfairly stigmatise, marginalise and blame the individual registrant, seen to be a wilful transgressor. I also considered the data from the perspective of a range of sociological theories, including Freire's (1993) culture circles, Goffman's concept of the marginalised career and Kubler-Ross' (1969) grief model, so as to enhance analytical rigour. The rest of this section will briefly return to autoethnography as method and the assessment of the quality of research outputs, from the contributions of method experts.

Le Roux 2017 argues that since research occurs within particular paradigms, the criteria used to measure the rigour of the research are expected to align with the philosophy of the paradigm and goals of the particular inquiry. My research is an "interpretive, narrative, autoethnographic project" (Ellis 2004, p.30). Perspectives on the set of criteria ("epistemological, aesthetic, and political") against which autoethnographies might be judged vary (Denzin 2014, p.69). Similar to the work of her contemporaries (Clough 2000; Ellis 2000; Bochner 2000), Richardson (2000) suggests five criteria for judging an (evocative) autoethnography:

1 Substantive contribution – for example, does the piece contribute to our understanding of social life?
2 Aesthetic merit – for example, is it artistically shaped?
3 Reflexivity – for example, is there adequate self-awareness and self-exposure?
4 Impact – for example, is the researcher moved to action?
5 Lived experience – for example, does the account seem 'true'?

I will use these five criteria to focus on both the literary and aesthetic merits of my personal narrative as well as its substantive contributions to knowledge in order to evaluate the extent to which the overall product achieves these goals (Section 6.1).

3.9 Data Analysis

In qualitative research studies, data analysis starts during its collection (Maxwell 2005). It is accepted, in qualitative research, that initial and emergent findings influence ongoing data collection. I began the analysis by reading and re-reading my written autobiographical account that I understood constituted the 'data' for my PhD study. I intended using data analysis to show how I used my circumstances to transform aspects of my personality and character and fully address the criticisms of my regulator.

I construed my regulator's work-based criticism about me as (master) narrative, that effectively reduced my long career as a pharmacist to a period of two to three years that bounded my alleged professional misconduct. Drawing on research and theory about careers, Inkson (2004) puts forward successive metaphorical lenses through which a person's career could be understood. I welcomed these archetypal metaphors to encapsulate my pharmacy career from 1990 (entry to the Register) to 2012 (exit from the Register) and beyond (submission of my application for restoration to the Register in 2017). I felt my whole life was relevant to my strike-off and through the insights that the successive metaphorical lenses provided I constructed a series of autoethnographical vignettes that captured my thoughts, feelings and actions in the context of living through the five years (minimum) period of de-registration. In writing the vignettes, from my own perspective, I intended to reveal my attitudes, thoughts, feelings, behaviours and reflections at the time, often through relationships with other HSCPs, employees, family members and professional bodies, as well as with myself. I also hoped to highlight the broader contexts in which the vignettes were situated beyond individual biographies and identities towards the nature and purpose of organisations, power and accountability, the political, legislative and policy contexts. I hoped to bring to the forefront some of the structural and societal pressures that impacted my professional work and produced some of the behaviours that formed the basis of a complaint against me to my regulator. Next, I turn to the contributions of philosophers (especially Barthes and Derrida) in order to suggest tools by which the reader can make connections across various parts of the thesis – whether s/ he is reading within or outside of thesis.

Descartes' concept of the 'cogito' ("I think therefore I am") supported the approach of an 'empirical foundation' or the absolute minimum which will guarantee objective scientific truth, based on the reality of the thinking self. Postmodern philosophy questions whether 'human thoughts are original', whether 'the language of thought can meaningfully refer to the outside world' and whether 'the very meanings of the components of language (or linguistic signs) are constantly changing'. Poststructuralists such as Roland Barthes, Julia Kristeva and Jacques Derrida have rejected the idea that a study of the structures of sign systems would lead to a discoverable ultimate truth. They argue we produce an almost infinite play of signifiers that can be destabilized by their opposites, and by recognising such slippages of meaning, all we can do is to 'read the text against itself' (Ayer and O'Grady 1994; Bauman 1992; Lechte 1994).

Bauman (1992) draws attention to Roland Barthes' influential 'theory of interpretation' contained in one of his major writings 'the pleasure of the text' summed up as 'text means tissue'. For Barthes it is not that the tissue is a product, a ready-made veil that conceals meaning (truth), but the text is worked out in a perpetual interweaving, and lost in this tissue. Critically the subject unmakes her/himself in the process, like a spider dissolving in the constructive secretions of its web. Jacques Derrida said in his book Of Grammatology "*Il n'y pas de hors-texte"* meaning outside of language, there is nothing to which we can directly refer, since all language is indicative only of itself. There is therefore no objective way of knowing what language's relationship is to any reality 'outside' it – and our thoughts are trapped in it. Derrida's strategy of 'deconstruction' applied to a text helps to reveal multiple competing meanings within it. Deconstructive reading recognises that the text is woven from the same system of 'concepts' that allows us to think the things we do. I argue therefore that the reader reads the thesis first of all in terms of the historical and rhetorical customs that permit understanding.

The seven vignettes that form the autoethnography section of the thesis are presented chronologically in an attempt to provide the reader with a logical path through my history in order to grasp what the main ideas within my writing were on the subject of professional work, regulation, the impact of de-registration and in-justice, and what this said about the world. Derrida believes all texts contain several 'aporias' (contradictions/ paradoxes/ puzzles) that his approach to reading texts (called deconstruction) helps reveal. Derrida introduces the word 'differance' meaning both to differ and to defer. The precise meaning of what is written is, for Derrida, changed by what is written next. Using the example of 'fitness-to-practise' (FtP) from my autoethnography, the phrase first appears in vignette one in connection to 'three persons who together constitute the FtP Panel'. In vignette two I link FtP to 'conduct inside and outside of the profession'. Next I add that 'my FtP was called in to question' and resulted in 'the sanction of removal from the register' in vignettes three and four respectively. In the final vignette I use it in the context of professional development by 'producing an FtP development plan'. The precise meaning of the phrase 'fitness-to-practise' as I am using it is continually deferred, as more information is given in successive vignettes. So, as I add to what I have already written, the more the meaning of what has gone before is revised. Regarding 'differance' the meaning of 'fitness-to-practise' cannot solely rest in the relationship between my words and actual phenomena in the world. The phrase takes its meaning from its position in the whole system of language. The phrase differs from, for example, 'professional capacity' or 'health, well-being and fitness' – its meaning depends on all the things that I do not mean. Therefore meaning is not self-contained within the text itself. Derrida's concept of 'differance' is an aspect of language I have become more aware of due to the writing process. As the narrator, I accept my narrative cannot tell the whole truth – rather it can only ever be partial. Writing from my own perspective, the autoethnography includes the details I observed and my reflections by drawing upon my values, motives, relational experience and creativity in order to explore a painful event in my life. My story is not only an account of how I have coped with de-registration, overcome mental illness or found spiritual enlightenment. It is a raw, honest, realist autoethnography of being human. By laying my heart bare, I trust my words could offer the reader some comfort and hope in the act of giving back.

The use of wider literature, social constructs and theories is common in qualitative research to help give meaning to the data. Chang (2008) commends the use of existing theory to explain and make cultural sense out of the data. I did not begin data collection with a theoretical framework and therefore avoided the ubiquitous effects theory may have had on this research study. Instead I committed myself wholly to 'telling my story' and trusted in the process of writing to reveal potentially relevant theories whose exploration may guide more detailed data analysis. Writing my autobiography chronologically (2012–2017) pointed me towards several emergent ideas: loss and grief; liminality; identity; chaos (at midlife); stigma; transformational learning and; reparation. I was confident that these held potential as broad, analytic categories. The vignettes represented my story (or narrative) for analysis, and included insight into my experience as I wrestled with personal meaning making. Chang (2008) argues that the task of the autoethnographer is to develop a coherent structure of cultural analysis and interpretation of self. This entails 'transforming' data into a text with culturally meaningful explanations. I considered various methods to analysis as part of the process towards developing a cogent approach for this study.

As already discussed, it was not the purpose of my research to understand why I was struck-off the RoP, but to reveal what the experience of de-registration was like (for me between 2012 and 2017) an area that has been under researched. I was acutely aware, in the qualitative research context, that the methods used to gather and analyse data are both consistent with the research questions being asked. I infer from the methodological guidance given by Chang (2008) that data are dealt with iteratively between stages of data collection, management, analysis and interpretation. According to Pope and Mays (2006) the choice of method of analysis of qualitative data lies on a continuum from inductive (coding up) to deductive (coding down) analysis

Narrative analysis was chosen for this data set because it allows exploration of narrative structure (Riessman 1993). Moreover, narrative analysis supports the logic of my writing process by joining together my vignettes into a whole where the vignettes remain contingent upon one another to make sense.

3.9.1 Narrative Analysis

According to Bryman (2015) questions of social ontology are concerned with the nature of social entities. A given narrative is considered a social construction built up from the perceptions and actions of social actors. This position is referred to as constructionism. My narrative account presents one version of reality and I recognise that many other possible realities co-exist. Yet in the inherently social process of meaning making and the construction of reality, the approach of narrative analysis offers me the advantage of being able to examine how I have come to make sense of removal from a professional RoP and the changes that ensued after the event. It is interesting to note at this point of the thesis that to a very large extent, the 'rules' of the culture of statutory regulation that are most rigorously imposed upon registrants appear to possess an objective reality. My narrative account challenges the suggestion of the system of regulation that its organization, process and outputs are pre-given and therefore confront registrants (or social actors) as external realities that they have no role in shaping.

Narrative approaches are positioned ontologically as interpretivist. My personal vignettes which have captured my lived experience of strike-off, in addition, offer an epistemological framework to me as analyst for meaning-making. Silverman (2017, p.141) suggests the analyst ask four key questions about stories:

> In what kind of a story does a narrator place her/himself?
> How does s/he position her/himself to the audience, and vice versa?
> How does s/he position characters in relation to one another, and in relation to her/himself?
> How does s/he position her/himself to her/himself, that is, make identity claims?

McAdams (2008) also offers the narrative analyst methodological advice that centres on the plotline(s), highlighting it is here that a narrative's meaning is derived.

Most forms of qualitative data analysis begin with coding and the principles involved are well developed and agreed by researchers. However, by removing segments of text from the context within which they appear, the social setting can be lost (Bryman 2015). A further criticism of coding is that it can result in a fragmentation of data, which Coffey and Atkinson (1996) argue destroys the narrative flow of what people say. Riessman (1993 p vi) in her book on narrative analysis has written about an earlier time in her research career when she came to analyse data she had collected during a research project on gender and divorce. She realised that fragmentation of data that resulted from coding themes was erroneous to her research aim. Interviewees had developed long accounts that had coherence and sequence. Narrative analysis treats the accounts that people offer as 'stories'. In Riessman's study, referred to above, interviewee accounts served to 'story' marriages in order to justify divorces. So, the veracity of accounts appears secondary to developing an understanding of the function of accounts in context. Riessman and many other proponents of narrative analysis have come to understand that the meaning of a narrative account is derived from its plot that leads towards some transformation (Czarniawska, 2004) or resolution (Bruner, 2002). Sensitivity to these issues has produced a growing interest in narrative analysis since the 1980s.

The essence of narrative analysis in this study is the exploration of my own story as it is influenced by any personal, ethical, social or political issues that the research brings. Since the approach is based on a poststructuralist philosophy, Weatherhead (2011) echoes the view of Riessman (1993) that narrative analysis is no *one* method (emphasis of original author). Over the past four decades, various researchers across a diversity of academic disciplines (for example Labov, 1982; Mishler, 1986; Polkinghorne, 1988; Kleinman, 1988; Riessman 1990; Gee, 1991; Brown, 1998; Squire, 2000; Hurdley, 2006) have applied the method variably, leading to the absence of an agreed single framework. Perhaps what all these studies point towards is that data analysis methods remain acutely sensitive to the contextual aspects of the data set within each study.

Two forms of narrative analysis of interview transcripts (commonly understood to be stories collected as data) have been proposed by Polkinghorne (1995): paradigmatic and narrative.

Paradigmatic analysis of narrative aims to distil themes that are common across the different stories. Both deductive (applying theory to data) and inductive (allowing themes and concepts to emerge naturally from the stories) methods may be utilised. The second form (or narrative analysis of narrative) produces a 'composite narrative' that gives meaning to experience underpinned by a plotline. Neither form is without criticism, but each offers advantages for this research study. Oliver (1998) believes paradigmatic analyses are helpful in the development of general knowledge while the narrative method yields insight and understanding about the people under study. Polkinghorne (1995) has suggested that for topics that are little understood as a result of a dearth of research studies, undertaking analysis on the entire dataset (and not only the key themes) therefore, is the most appropriate strategy. Emden (1998) stresses the importance of selecting the appropriate strategy for narrative analysis to suit a particular study. Taking into account all the above, I feel since my data set consists of my autoethnographic vignettes, then in order to preserve the vignettes as a coherent whole and follow an appropriate strategy to my choice of research method, I decided to consider the theoretical concepts of the dominant narrative structures of illness and trauma pioneered by the autoethnographer Arthur Frank (1995, p.xiii) – chaos, restitution, and quest.

> "Stories of people trying to sort out who they are figure prominently on the landscape of postmodern times. Those who have been objects of others' reports are now telling their own stories. As they do so, they define the ethic of our times: an ethic of voice, affording each a right to speak her own truth, in her own words".

A narrative type is "the most general storyline that can be recognized underlying the plot and tensions of particular stories" (Frank 2013, p.75). The chaos narrative and its storyline "imagines life never getting better" (Frank 2013, p.97). Such narratives "reveal vulnerability, futility, and impotence" and may, in truth, not be told but only lived – "an anti-narrative of time" (Frank 2013, p.98). My experience following the complaint against me to my regulator, lengthy hearing and in the aftermath of removal from the RoP was a time I felt suffocated in wrong-doing and my difficulties sank to bottomless depths. The restitution narrative has as its storyline "yesterday I was healthy, today I'm sick, but tomorrow I'll be healthy again" (Frank 2013, p.77). This narrative type is concerned with movement away from and back towards health. In the context of my strike-off experience, I still wished to practise as a pharmacist in the future, but recognised that the final decision rested with my regulator who assumed a controlling role over my professional future. Yet despite this, I believed in working hard over the five year period of removal to convince my regulator that I was reparable and could be returned safely to pharmacy practice at the termination of the period of incarceration. The third narrative type is the quest. "Quest stories meet suffering head on; they accept illness and seek to *use* it" (Frank 2013, p.115). Such stories recast illness into a journey, the interruption as "challenge" and impetus for change (Frank 2013). In the context of my erasure from the Register, I reframed the catastrophic event as a challenge and opportunity to demonstrate changes in my character in response to the regulator's conclusion to my case, that I 'had lost my good character'. I would not otherwise have willingly embarked on the necessary journeys in order to reclaim my mental health, spirituality and humanity. Losing my

status as a pharmacist is something I continue to mourn, but my priority remains on gains to be had (Frank 2013).

In the narrative analysis section of the thesis, I will be referring to Arthur Frank's three narrative types to explore the links between culture, self and my experience of erasure from the RoP. I do not accept that being struck-off a professional register is an experience that can be neatly summarized in ways suggested in the restitution and quest narrative types. Rather, by beginning my story at the point at which I am handed down my sanction and moving through its impact on my life to the end of the five year period, analyses will reveal what Frank (2013) predicts – the format of the narratives is complex and does indeed shift between the three types. I believe that in this way the narratives reveal a lot more about the professional de-registration experience.

Chapter 4
AUTOETHNOGRAPHY

4.1 Vignette one: Inheritance

I am the third of four children born to Hindu-Punjabi parents who arrived in England as young adults during the 1960s. My father, also a middle child, was put to work as a shoe-shine in India, - to supplement the family income, by my grandfather who worked as a local trader. My mother, the eldest of three daughters, worked on her family's farm until she left home to join my father. Their decision to come to England was in response to a call by the British Government to the countries of the Commonwealth for labour to help boost the British economy in the post-colonial period. Very soon after arriving, they felt like outsiders. My father took a job in construction. It was dirty, hot and physically demanding. My mother, speaking no English, became a housewife and raised us. Casual racism was commonplace. The bitterness of the British winter took some getting used to. We were poor. My mother was incredibly good with money; she made sure we spent little of my father's weekly wage, preferring instead to carefully save every penny that she could to ensure that, when the bills came in, she could afford to pay them.

I was born in 1966 in Walsall, part of the 'Black Country', to first-generation Indian parents. My entry into the world was not easy. My mother used to remind me often as a child that I had nearly ended both of our lives during my difficult birth, and that I had significantly contributed to her hospitalisation due to physical exhaustion by the time I was three months. I was placed in foster care for my second three months of life, as a result. My behaviour on being reunited, according to my parents, was insecure and disturbed for a long time afterwards. My parents named me Parshotam, a popular Hindu name, meaning literally 'the male principle of creation'. No matter how auspicious their choice of name, I grew to dislike it. My teachers could neither pronounce nor spell out my name. My friends just made up rhymes to tease and taunt me. I became increasingly numb to every mispronunciation (Par-shot-am; Parsh-otam; Pars-hot-am), misspelling (Parsathom; Porsatham; Partosham) and taunt ("Porsh"; "Posh"; "Soti"). Whenever I stepped out in the world, any sense of self I had was shattered before I reached school. The English or 'goras' would see me and my elder brothers and shout 'paki' and launch missiles of their foul 'gob' at us. The gora tribes were commonly identifiable in those days by the clothes they wore – Town boys, Teddy boys, Mods and Skinheads. We were afraid of them all, for good reason. My parents told us that we were in Britain, and had to be respectful to goras, to get on with them no matter how they treated us.

As I grew older, my parents would share tales about their own childhood memories - travelling by steam trains, riding in rickshaws, sleeping outside under the stars, monsoon rains, snacking on raw sugar cane, and escaping cobras and leopards. I vividly recall being intrigued by a small storage room within the back bedroom of my childhood home in Walsall. Within were kept 'foreign

treasures' from my parents' homeland. I often used to secretively explore the forbidden chamber. As I opened the latch of the half-door that extended up from my chest to the ceiling, a distinctive smell of jasmine filled the bedroom air. The storage room was filled with items that belonged to another place and time, India. I came to understand that this precious space within our home held memories for my parents that they would never let go. Occupying a prominent position on the bottom was a rusty brown scuffed travel suitcase, modestly filled with black and white photographs of relatives left behind, documents, passports and a collection of old Punjabi newspapers. Above, on two shelves were scriptural texts and prayer books gift wrapped in brightly coloured silks and embroidered cloths, giving them the status of holiness. This single holding, I would eventually come to appreciate, represented my parents' lifetime of dreams, journeys and challenges. Without my knowing it, these artefacts would eventually seep into me and fill my senses with their past, which even as a child I recognised was to become part of my life story.

Of the many tales my parents shared with me as a child, the dark shadow of the Partition of India in 1947 loomed heaviest on my mind. I recall how they both fell into silent introspection, perhaps searching for some meaning to emerge out of the tragic event marked by the needless loss of lives through abhorrent acts committed against one another by former neighbours. Though only children themselves at the time and not displaced from their own home villages, the sheer scale of human migration, violence and bloodshed had left mental scares which my parents carried with them into their new lives in England. I was perplexed by the entire events surrounding the Partition of India and creation of Pakistan. I had many unanswered questions including 'why it happened?', 'what transport arrangements were made to move a million people across a newly created boundary?', 'who started the violence?' and 'why it was allowed to escalate?'. My mother and father were not able to provide, to my satisfaction, answers to my questions. Their pain frequently caused them to shut down and soon the topic was to become taboo.

My father's occupation put our family in a working class socio-economic grouping. Family life and growing up was a constant struggle to make ends meet. My grandfather had curtailed my father's schooling, a decision my father resented. However, in coming to Britain, he had hoped that his own children would have every opportunity to receive a state education and progress into skilled occupations and even professional roles such as law or medicine. In this respect, my parents were no different from other first-generation Indian parents in Britain and other Western countries, who also sacrificed so much in order to provide opportunities denied to them in their homeland. My parents functioned along strict gender roles – and I naturally looked to my father for my role model and unconsciously rejected my mother's perspective and example. Perhaps sensing I had not shown her the respect she deserved, she lashed out whenever I upset her with hurtful words 'Why were you born?' 'You are just like your father?' 'Why did God burden me to raise you as my son?' I felt very sad and worthless as a result. My father was hard-working, uncompromising, disciplined and strong. He was not good at showing his emotions and I felt, despite attempts to please him, I was not good enough as a son. I even believed he envied friends whose sons were taller, stronger, smarter, more competitive and better spoken than me. At home I grew jealous of

my elder brothers who I perceived were favoured over me. My alienation and needs deepened until one day, aged eight years, I broke down.

I locked myself in the bathroom and believed I was better off dead. I recalled that only months earlier a boy in the local community had fallen into the town canal and drowned. It occurred to me that I could similarly drown and leave my sad existence behind. I plugged the hole and began to run the taps to fill the bath. Steam rose up from the water's surface and filled the air. I was crying. Hunched over the rim of the bath, I watched my tears fall and disappear into the water below. As I began to lower my head towards the water, it was at that point that I sensed a voice from inside of me say 'live'. Live, living, life were words that suddenly dominated my thoughts and I stared ever more intensely into the rising noisy waters. I saw my reflection. I acknowledged that I had to continue to live. But for what reason? I did not know whether there was a God or not. My parents certainly thought there was. I felt I couldn't trust what they thought any more. However, whether by divine revelation or human logic, my lesson that day was to 'continue to live'. My suicide attempt was over. I unplugged the bath to allow the water to rush out. As it did, I made my escape from the bathroom and straight upstairs to my bedroom. I lay down on my bed, curled up into a ball with my arms wrapped around me and closed my eyes.

Next day, I woke feeling a little calmer. Those around me could never know what I considered doing the evening before. Against my home circumstances, I guess I eventually reciprocated by invalidating my family and my home. I had to learn to toughen up if I was going to survive my situation. As I grew, I poured everything I had into my education. It was the only way out of my circumstances I could see. I did well at school and, became the first of my generation from my community to gain a place at University. I studied Pharmacy, but leaving home and spending more time on my own with my fatalistic thoughts, I struggled to know who I was. I was expending so much mental energy in maintaining a modicum of discipline towards my studies. Through missing the greater part of the first year programme, I failed two of the four end of year exams. This had shaken me to the core. Without a degree, my prospects of work would be reduced. Over the summer of 1987, I strengthened my resolve to succeed, helped on by my father's warning that 'I must not fail'. Failing was not, therefore, an option, not now, not ever. I succeeded in passing all subsequent examinations and gained a degree in Pharmacy in 1989. Following completion of a year-long period of pre-registration training with a national multiple pharmacy chain, I registered as a Pharmacist. I felt that the dedication, determination and resilience I had shown from a young age had helped me achieve academic goals and vindicated my parents' decision to come to the UK.

After 22 years of practise in community, academic and research sectors of the pharmacy profession, I am now standing on the doorstep of my regulator's home. A few minutes earlier, I had been removed from the professional register of practise by the fitness-to-practise panel. My legal representative is standing by me. I fill my lungs with polluted air while, at the same time, attempting to take in the partial view of Westminster across the river ahead. I am overwhelmed, confused and in shock. My solicitor, struggling to find any words of comfort asks simply if I am all

right. My reply to his question is glum and self-absorbed, “How can I be all right? I know that I am not the first professional who’s been struck off, but I loved being a pharmacist and serving the communities where I had my pharmacies. Now it’s been taken from me and I can’t believe it. Just how am I going to tell my family? They’ll be so disappointed in me.”

My solicitor was startled. “They will be disappointed for you, not in you,” he was quick to correct me. I wasn’t prepared to let this rest. “No, they’ll think it’s all my own fault. My parents don’t believe in sugar-coating things. Strike-off is strike-off. They’ll assume I wasn’t good enough to be kept on the register. It’s so very difficult to be judged this way and especially by the very people who ought to love you unconditionally.” My solicitor was neither unsympathetic nor rude, but, in reality, was much too busy with other cases to remain on the pavement and continue in dialogue with me and eventually peeled himself away towards the nearest underground station. I, on the other hand, had no immediate plans. As I turned to look back at the home of my regulator, it dawned on me that it had simply done its job and that was all - to protect the public against professionals in practice who had shown themselves to be a risk to safety. That said, just why did I feel it was so unfair?

4.2 Vignette two: Action

I believed that my parents wouldn’t have understood how my circumstances at work contributed to misconduct in a professional role that led to the decision by my regulator to direct the removal of my name from the register of practise for pharmacists. So I did not inform them. I guess I grew up believing my care-givers always thought badly of me. I felt unable to cope with any further censure. For instance, at the age of thirteen, I felt deeply wounded because I was blamed for sustaining a compound fracture whilst representing my secondary school rugby team. I had gone against their demands not to play rugby, choosing instead to heed the praise and encouragement of my school teachers to play. At the hospital I was met with scorn that left me feeling very much alone in the world. ‘It was your fault that this happened’. ‘Why had you not listened and given up rugby?’ ‘Why had God brought this catastrophe upon us?’ ‘You’ll come out of this walking with a limp’. For the next four months, I underwent a sustained period of contact with members of the health-care team including doctors, nurses, health visitors, physiotherapists and pharmacists. The attention and care I received during this time from all the health care professionals had moved me emotionally. Like most teenagers attending school, I had been unsure about what occupation to pursue in life. Out of my personal experience of recovery and being healed, I sensed the awakening of a ‘calling to care for others’.

At school I was an average child, but with growing tendencies towards perfectionism. I learned that wanting to do things right and to do them well earned the praise of my teachers. In truth it was the approval and love of my parents I yearned for most of all. I was interested in maths and science and worked hardest of all on these subjects, eventually gaining a set of O’Level and A’Level grades for entry to study my second-choice course, Pharmacy, at The School of Pharmacy, University of London. Medicine had been my first choice, but I did not make the

grades. My parents were disappointed that I was not going to train to be a doctor, but accepted that working as a ‘Chemist’ was still a worthwhile alternative career. More than anything, they did acknowledge that I had mostly through my own efforts overcome many constraints to reach University with the prospect of working as a health-care professional in the future.

On Fresher’s Day my classmates and I were led into a large lecture class. I had only experienced school classrooms with a maximum of 30 students and this lecture hall looked like a city theatre that hosted a stage show or other production I had seen on television. I was overwhelmed by the enormity of the space. A broad middle section of seating was flanked either side by narrower sections. The distinctive smell of lacquer filled the air. I could not decide where to sit. I reckoned if I wanted to focus and hear and see everything I should take a seat close to the front. As other students took their seats, I became uncomfortably aware that from most places in this vast hall I was visible sitting on the second row. My heart was racing, probably out of a mixture of excitement for the learning journey ahead and fear about making new friends and living independently. The Dean of The School tightening his hands around the lectern welcomed all 140 first year students and offered encouragement to work hard, make the most of our opportunities and after graduation to go out and make our mark on pharmacy practice whether as practitioners, teachers or researchers. Within his short address he also offered a word of warning concerning the regulation of pharmacists. This was the first time, I heard about regulation and this strange concept of ‘Fitness-to-Practise’. He warned us that upon qualification our conduct inside and outside the profession could lead us into trouble with the regulator who had the power to remove our licence to practise as pharmacists. I began to imagine what it might feel like to live under constant surveillance and anxiety to avoid an infringement that could lead to an appearance before the regulator who could take away both your pharmacy licence and livelihood. I swallowed hard and quickly dismissed the thought, preferring instead to think that only a ‘fool’ would jeopardise his career through some misdemeanour. No, no it would never happen to me.

Over the next three years I found it incredibly hard to balance a commitment to my studies with a desperate need to run away. Seeking an answer to the question ‘Who am I?’ was a constant preoccupation. My mental health was poor. I would experience frequent fluctuations in my mood, leaving me alternating between periods of excitement and depression. Stress exacerbated my difficulties, particularly around exams which contributed to a breakdown in both first and third years. I tried hard to conceal my inner turmoil and suffering from my friends. Not fearing for my safety, I spent many nights pounding the streets of London, secretly wishing myself harm. I self-loathed and felt I deserved harm. I was relieved that in spite of battling a troubled mind, I was able to complete my degree course. I joined Boots the Chemist, having worked for the organisation over the previous two summer vacations, to undertake my year-long period of pre-registration training. My name was recorded in the Register of Practise for Pharmacists in July 1990 and this filled me with an enormous sense of accomplishment. I felt proud to be able to call myself a pharmacist and take my place in the healthcare team of professionals working together to look after the public.

From the beginning of my pharmacy career, I felt deeply connected to the public I served. For me working to improve the health and well-being of my patients and customers felt life-affirming. Regard for my own vulnerability no doubt had played a part in my intuitive response to the needs of the people I served. Moreover, I enjoyed being able to use my knowledge and skills to meet the needs of patients who presented with a range of conditions including asthma, diabetes, heart disease, infections and various mental health states. The satisfaction I gained through helping others was unparalleled in my life. My colleagues were quick to form the opinion that my work as a pharmacy professional was my life. This had not gone unnoticed by my, then, wife who at times in our marriage questioned me over my loyalties. The truth was that I was married to both my partner and to my work. The relationship I had with my pharmacy work was less complicated and the more I was able to give to my work the more I felt rewarded by it. At the time, I did not appreciate that I had issues over trust, especially in intimate relationships. My emotions were prone to instability within the circle of marriage and I felt greater stability within work-based relationships.

From the beginning of my career, I championed education and training for everyone as a vehicle to enhance life opportunities. I believed, that in my case, without the focus and discipline of education and training I would most probably have drifted, like so many of my school friends, into gangs, on to the dole or into deadbeat jobs. Instead, I considered myself fortunate and wished to give other youngsters similar life opportunities, which led me to decide to take a lecturer position in pharmaceutical science at a College of Further Education in 1991. Teaching and practising my profession was a perfect combination for me, as I was able to share my infectious enthusiasm for patient care with my pharmacy technician and health and social-care learners. Some of my learners went on to follow higher education courses leading to health careers. By 1994, I had gained my PGCE and felt ready to move to another post involving increased higher education teaching. In my new role, I would lead the higher education certificate course in health-promotion. This attracted adult learners from professions allied to Medicine. At the time of the appointment, my own profession was just starting to take on an extended-services role that included public health campaigns, health-screening and lifestyle assessment. I felt able to supplement my teaching with examples drawn from pharmacy practice and this was well received.

The Department of Health, at this time, was inviting interest from practising pharmacists to make competitive applications for fully-funded research training under its Enterprise scheme. I was successful and enrolled on a Masters course in health sciences, run through a leading London Medical School. The course was very demanding and absorbed most of my free time. I found it a challenge to juggle teaching, work as a pharmacist and study. I completed the course in July 1996, and gained research skills as well as broad awareness of health science disciplines including epidemiology, health economics and health sociology. The following year, I felt ready to use my research skills training and successfully applied to NHS Health Technology Assessment at a nearby university to undertake complex evaluations of current and emerging health technologies. I completed two evaluation projects during my year-long tenure and published the work. I felt overwhelmed at seeing my work in print in an academic journal. I thought to myself

that I never believed it would be possible for me, the son of Indian immigrants, a person suffering with low self-esteem and anorexia, of uncertain identity to have published a research paper. I guess through all my pain, I had developed certain traits for the task: a strong work ethic, resilience, a never-say-die attitude, perfectionism and a deep knowledge of where I had come from.

In 1999, I was appointed as a Senior Lecturer in Pharmacy Practice at a University School of Pharmacy. A decade earlier I had been preparing myself to leave The School and take the first step in to the world of pharmacy practice. Now, I am returning to impart my knowledge, skills and experience to bring on the next generation of pharmacists. I recognised that I had accepted an important responsibility in the education of pharmacy students. I was integral to teaching pharmacy practice and initiating the process of professional socialisation to embed professional attitudes. I took my role seriously and felt my credibility in front of both my academic colleagues and students was contingent on becoming research active. In my first year, I networked with colleagues within and outside the University in order to initiate research activities. By the end of my second year, I had corroborated with the Department of Nursing and contributed a chapter to an edited publication, worked with the Local Pharmaceutical Committee to research and publish a Report to the Health Authority seeking funding for new professional services to be delivered through community pharmacies, liaised with Statisticians to rework previously collected data and prepare a research paper for presentation at the annual British Pharmaceutical Conference. I had helped raise the research profile of my Department and received praise for what I had managed to achieve in a short period of time. I felt I had established the platform upon which to build a promising research career and to begin to respond to the challenge set me, a decade earlier, by The Dean and contribute to the development of pharmacy practice.

In contrast to my work life, my family life was slowly beginning to fall apart. Long hours and devotion to work meant I was often exhausted, short-tempered and emotionally unavailable to my family. At the time I felt distanced from my wife and children, as if I was living in one reality and they in another. I loved them and they loved me, but my relentless dedication to my work had led me to become isolated. I realised that if I continued in this way I risked losing my marriage and home. I decided to leave my post at the end of the academic year and enter work as a full-time community pharmacist for a small independent chain. I was based in a pharmacy whose previous owner had been forced to sell the pharmacy following removal from the Register by the pharmacy regulator. As a result, the pharmacy was experiencing reputation loss and a drop in sales. I felt uncomfortable about accepting the job, fearing retribution from residents, customers and patients, and quite possibly the primary care team of professionals. My fears were compounded by the fact that I was also Asian and therefore in the eyes of the local white working-class majority, tainted from the start.

From the beginning of my new role in 2001, I was determined to restore the reputation of the pharmacy as a provider of high-quality pharmaceutical services to the local population. To achieve this, I recognised the need to build a certified skilled team of pharmacy support staff. My

background in education and training helped me to achieve this within the first year. I also gained Health Authority Accreditation status for the pharmacy through evidencing professional standards. I used the newly acquired Accreditation status to allow the regulator to approve the pharmacy as a site for the provision of pharmacist pre-registration training and successfully tutored students through their training year and onto the Register. My strong desire to provide my customers and patients with person-centred care did not go unnoticed by either the local primary care team or community. I had won back the trust and loyalty of service users and restored the reputation of The Pharmacy. It was a huge achievement for which my team and I felt proud.

By 2003, many of the service and business ambitions I had set for this independent pharmacy had been reached, and I decided to seek a visiting lectureship at my local University's School of Nursing. I was invited to teach pharmacology and prescribing science on the newly established nurse prescribing course on a part-time basis. I was thrilled to re-enter higher education teaching which I had sorely missed these past couple of years. I had made a very positive impression as a self-motivated, enthusiastic and passionate educator and was appointed as a Teaching Fellow by the University. Around the same time I was interested in becoming research-active again, and applied for the post of local Research Coordinator for a multi-centre randomized controlled trial to evaluate the impact of community pharmacist care on coronary heart disease outcomes. At this point, I must acknowledge the wonderful support and encouragement given to me by my manager and pharmacy proprietor who made it possible for me to undertake all the additional roles and responsibilities by showing flexibility so that I could accommodate extraneous activities while working full-time for him. It came as a shock and disappointment to me, therefore, when my manager announced that he had decided to sell his small chain of pharmacies to a national multiple, in 2005.

The significant change in atmosphere and working conditions left me feeling dispirited within a short time and I decided to leave, but reassured the new owners that I would not leave until a successor was in place. I felt it was my duty to continue to provide a high-quality service to my customers and patients with whom I had built a strong relationship over the past four years. I was not in the habit of letting people down and was not about to start now. Working for a multiple chain meant I became invisible, lost control over decision-making within a characteristic dominant top-down management style operated by chains, and perhaps worst of all robotic in the way I operated to the vast rule book of the Company. In truth, I was being suffocated and this began to show in my work. I just had to break free and save myself. What I had come to understand as my ever-present background of mild depression had once more in my life grown and become moderate to severe in kind. I was not enjoying my work anymore, but kept my word to my new employer and remained in post until a replacement could be found.

When I left, I felt I needed a break from work as a full-time community pharmacist. I decided to seek a part-time Teacher-Practitioner role with a School of Pharmacy and was very soon successful. The role was particularly rewarding as it afforded me the opportunity to relate theory to practice and reveal to unsuspecting pharmacy undergraduate students the practical application

of much of their study of the pharmaceutical sciences to patient care. Through my first year in post, many of my students declared that their career ambition was to become a pharmacy proprietor. The thought had crossed my mind this last year as I wanted to have a say in the provision of pharmacy services to meet local health care needs. The only way, I saw, this could be achieved was to become an owner and give strategic direction to my work. I was nearing the half-way point in my working career as a pharmacist, in all sectors, and felt the time was right to pursue opportunities to become a community pharmacy owner. I decided to use a two-pronged approach. First to make an application to NHS England to open a brand new community pharmacy in a rural area where the provision of pharmaceutical services was absent, establishing a need for such services. The second, and more usual approach to becoming an owner, was to enlist my details with Pharmacy Sales Agents to purchase a retirement sale pharmacy. In both cases the small sub-urban or rural population served would be more clearly demarcated, for whom I would be able to tailor my services more specifically. After around 18 months of trying and with several set-backs, I eventually bought a retirement sale community pharmacy in a rural village in Southern England. This was shortly followed by a successful application to open a brand new pharmacy in a second rural village, forty miles away from the one I had purchased and now owned.

In 2007, I started in business for the first time. Despite spending the past year preparing for the start of running my own business, nothing could truly have prepared me for such an undertaking. For instance, there was all the complex legal and regulatory requirements issued by Governmental, NHS and Pharmacy bodies pertaining to running a lawful community pharmacy business to uphold. There were not only the daily operational demands to manage staff, stock and services, but in addition marketing for business growth, relationship building with the primary care team and, business accounts and VAT. My ‘to do list’ continued to grow day by day resulting in my former working week extending from 40 hours as an employee to over 80 hours a week as a pharmacy proprietor. As an owner of a single pharmacy, I felt relieved to have reached the end of my first year. Being granted a licence by the NHS to set up and open a brand new community pharmacy was both exciting and daunting. I was attracted to the idea of bringing pharmaceutical services closer to village residents who up to now received only a part-time visiting medical service through a medical practice situated 5 miles away. I was convinced the new pharmacy would be welcomed by both medical practice and 1800 residents. At the end of the year, I held many positions of responsibility which were Director of a Limited Healthcare Company, Proprietor and Superintendent Pharmacist, Pre-registration Pharmacist Tutor, Teaching Fellow in Nurse Prescribing and Teacher-Practitioner in Pharmacy Practice. My strong commitment to education and training allowed me to continue to contribute to the professional development of both pharmacy and nursing students, share good practice and receive feedback on service development in a rapidly changing environment.

4.3 Vignette three: Fit

Owning a community pharmacy business required me to become a Superintendent Pharmacist with responsibility for all legal, professional and ethical requirements. Despite spending the past year preparing, nothing could truly have prepared me for such an undertaking. For instance, there were all the complex legal and regulatory requirements issued by Governmental, NHS and Pharmacy bodies pertaining to running a lawful community pharmacy business to uphold. There were not only the daily operational demands to manage staff, stock and services, but in addition marketing for business growth, relationship building with the local Doctor Dispensing Practice and primary care team and, maintaining business accounts and managing VAT returns. My 'to do list' grew exponentially, resulting in my former working week extending from 40 hours as an employee to over 80 hours a week.

I felt relieved to have reached the end of my first full year without incident, well almost. The Doctor Dispensing Practice actively discouraged patient choice to have their prescriptions dispensed at the community pharmacy, steering prescriptions written by them into their own dispensary which did not employ a pharmacist. Historically, NHS Rural Regulations allowed a Doctor to apply for a licence to dispense its own prescriptions wherever a community pharmacy service was absent. What I did not understand at the time was the power my medical colleagues asserted over patients to keep both medical and dispensing services under the same roof. When I bought the Pharmacy, I saw that the prescription volume dispensed was half the national average and naively put this down to an attitude of retirement that the previous owner brought to the business, probably for the past couple of years allowing prescription numbers to fall. I was confident that a more proactive approach to marketing would engage the local population to use the skills of a pharmacist in the medicinal aspects of their care. Over the course of the first six months, I came to learn through local patients that the Doctor Dispensing Practice had for years discouraged use of the community pharmacy by all patients living outside of the 'one-mile radius rule' of the pharmacy. Over the years, this became the local presumption and accepted as truth to the benefit of the local Doctor Dispensing Practice and severe detriment of the local community pharmacy. The previous owner had not declared this to me. I began to feel I had taken on a business I had not properly understood and my tenure would bring me in legitimate conflict with my medical colleagues whom I began to see as 'driven by personal wealth'. It was the attempt by the Doctors to sabotage our marketing campaign that led me to feel I had little choice, but to formally complain to the Health Authority on the grounds that patient choice was being actively impeded by the Practice. I had accumulated many case examples and was confident that both the Local Medical Committee and Local Pharmaceutical Committee would also be convinced that a level playing field for prescription dispensing did not operate in the locality. I was relieved when they agreed and an action plan suggested. Unfortunately, I saw little evidence of any change in the months and years that followed.

The granting of a licence by the NHS to set up and open a brand new community pharmacy was both exciting and daunting. I was attracted to the idea of bringing pharmaceutical services closer

to village residents who up to now received only a part-time visiting medical service through a medical practice situated five miles away. I was convinced the new pharmacy would be welcomed by both medical practice and 1800 residents. Perhaps my decision to go ahead with opening a brand new pharmacy which carried considerable risk was more emotional than carefully thought through. The first six months were likely to be frugal as word spread slowly about the new service that was available and this would inevitably rely on the profits generated by my first pharmacy to sustain it through its infancy. What if residents stuck to using existing services outside their village and not patronize the new pharmacy? I was aware that the current part-time medical service ran its own in-house pharmacy five miles away and felt that my pharmacy posed a threat to existing revenue levels and consequently tried to impose barriers to residents' freedom to choose another pharmacy. I had taken on a pre-registration pharmacist trainee for the year at the pharmacy I had purchased. During an appraisal meeting my young trainee expressed a wish to remain at the pharmacy and work there as my full-time employee Pharmacist. I was delighted and believed that with pharmacist staffing in place, I could now go ahead with plans to open the new pharmacy. I, of course, would move to work at the new site full-time. In 2009, I expanded the business by opening the second pharmacy. I also felt unable to continue to commit time to my part-time role as Teacher-Practitioner for The School of Pharmacy and tendered my resignation, but decided to continue as a Teaching Fellow for Nurse Prescribing courses.

As expected, the new pharmacy's sales and prescription numbers for the first month were very low, but I did not worry about that too much. I was passionate to provide the highest quality care to my new customers and accepted that the business would need up to six months to establish the trust and confidence of the local population. As the business began to grow, I began to recruit staff from within the village who I hoped would continue to engage fellow villagers and promote the pharmacy outside of business hours. Expansion of the business resulted in a sharp increase in administrative load. Running a multi-site business required duplication of tasks: stock to be ordered, staff planners to be compiled and confirmed, service contract applications to be completed, marketing and press releases to be written, financial records to be kept and so on. I struggled to delegate the administrative work, believing perhaps that only I could carry it out correctly, as I had done these past two years. Why was I so possessive over the very large number of business tasks that needed to be carried out? After all, I did not enjoy the administrative side and unlike the final clinical checking of dispensed prescriptions there was no requirement for the pharmacist to personally complete such tasks. I could not just let go, delegate to another and free up my precious time. I feared, rightly or wrongly, that the task would be incorrectly performed by my pharmacy support staff, despite their receiving training, which would result in my having to re-do work all over again. The resulting increase in workload brought an increase in stress and this only exacerbated my desire to keep tight control. Whenever my employees made mistakes, my need for control would reach new highs. I was a perfectionist and could not tolerate work that I felt was below my own exacting standards. It was unhealthy and did not promote effective team-working yet through it all I felt powerless to change. I even reflected that in previous posts as an employee pharmacist, I had been able to delegate non-clinical tasks to team members effectively. Why not now? What was wrong with me now I had become the employer?

I felt very proud to be the Proprietor Superintendent Pharmacist of these pharmacies, plainly in order to have a real say in how the pharmaceutical needs of the populations I served were to be met. There are no mandatory training programmes for the roles of Proprietor and Superintendent. It is very much in the realm of learning on the job whilst remaining professionally and legally responsible and accountable for the governance and operation of pharmaceutical services provided. By far the greatest challenge and potential risk to any (pharmacy) business concerns its staffing. Within months of opening the second pharmacy, I had to deal with the unexpected resignation and premature departure of my employed pharmacist based at the first pharmacy. I reacted angrily as I expected this newly qualified pharmacist, who I had nurtured, to show me greater loyalty and at least uphold the minimum notice period of three months. I faced a real dilemma and was unable to resolve the situation through replacing the staff member due to a national shortfall in available pharmacists at the time, mostly as a result of the proliferation of one-hundred hours contract pharmacies that sucked the pharmacist pool dry. My terms of service, spelled out in my NHS Pharmacy Contract, required the provision of an uninterrupted access to pharmaceutical services, which in my rural localities I interpreted to mean I could not consider closing.

I felt abandoned, isolated, became withdrawn and unable to reach out for help and advice. I was confused and emotionally overwhelmed as to what to do. In my distressed state I panicked and felt I had no other choice than to work between the two pharmacies on any days that a second pharmacist could not be found. This was not an ideal solution as it meant that for some part of the day, each pharmacy would not have a registered responsible pharmacist in control. I was broken by the enormity of the responsibility and fearful for the safety of my patients, but felt most strongly of all, duty-bound to work this way in order not to let my patients down. My working week now exceeded one-hundred-and-twenty-hours. I personally made over one-thousand contacts with pharmacists to help by filling gaps. I also made several attempts to recruit a pharmacist on full-time hours, but the job offers I made were repeatedly turned down. In total, I worked between my two sites on some fifty days in a desperate attempt to serve the needs of my patients and customers, until the unannounced visit of the regulator's Inspectors on 9 February 2011, in response to a complaint, put an end to my futile working pattern. My unlawful decision to operate a community pharmacy in the absence of a registered pharmacist on the premises called into question my FtP. I had lost control of my business which had spun deeper and deeper in to the abyss. Looking back on the day the Inspectors called, I fell into a state of shock, yet felt relieved that my suffering was finally ending as I finally allowed myself to realise how incredibly burned-out I was. I did not feel human any more. I had lost touch with reality, lost touch with my loved ones, lost myself in the mayhem and chaos of the past fifteen months.

4.4 Vignette four: Emotion

"We turn now to the matter of what constitutes an appropriate and proportionate sanction for your numerous infractions," said the Chairperson sitting in the middle of the General Pharmaceutical Council's (GPhC's) Fitness-to-Practise Panel (FtPP) of three. Flanking her and sitting to her right

a largely silent grey-haired and -suited layperson with magistrate credentials and to her left an outspoken stocky semi-retired pharmacist whose piercing stare seemed to have fixated on me throughout the emotionally charged eight-day hearing. “The risk to patient safety is engaged in this case because in our view you repeatedly placed your own interests above those of your patients and exposed them to the risk of harm. In this case the facts found proved are most serious and involve dishonesty,” said the Chair.

‘Placed my own interests above those of my patients’. Didn’t she understand that for the past four years I had worked over eighty hours a week, refusing to rest until all my patients’ needs were fully met? Please don’t take out your dissatisfaction with me on these vulnerable and isolated rural residents by denying them my professional services, I retorted back angrily under my breath. The Chair began to peer over her full-rimmed reading glasses at the screen of a large video terminal situated slightly to the right on her table. She searched to find the pre-prepared determination and sanction which she then began to read aloud, but not before my solicitor used the opportunity to turn to me and whisper in my ear, “We’ve done all that we could do. Your future now rests in the laps of the gods, seated in front of you”. At this time, I felt the most vulnerable; my body began to shake with fear and my heart pounded in my chest. I was in a precarious state. I began to consider all the possible outcomes and this just worsened my anxiety. The worst, of course, was that I would be struck-off the Register of Practise and unable to work as a pharmacist. That was utterly unthinkable; the pharmacies might be forced to close.

Rumours about me where I continued to work for the past eighteen months after the time that the Council’s Inspectors called unannounced had been circulating for months. The staff and villagers had listened to every one of them and even come up with ideas of their own too, but nobody really knew what my fate would be. Sure, further changes would have to be made to avoid recurrence of past misdemeanours. I needed more help and support to continue to operate services lawfully and professionally going forward. The interim order that imposed a set of conditions on me over a year ago, while the investigation gained momentum, proved highly successful in helping me to regain control over the community pharmacy business.

The Chair read on from the screen seemingly unaware she sounded condescending: “It is not our function to punish Mr Leal, although any sanction imposed may well have that effect. The purpose of a sanction is to protect the public interest. Proportionality requires that any sanction imposed is the minimum necessary to address the aspects of the public interest engaged by the facts proved. In this case we consider that the aspects of the public interest engaged are the declaration and maintenance of proper standards, and the maintenance of public confidence in the profession of pharmacy, as well as patient safety. We have considered very carefully all the submissions made by Mr Leal’s solicitor, as well as all testimonial evidence. We have taken into account everything he placed before us, and it is no discourtesy to his submissions if we appear to have left anything out. We have anxiously scrutinised the case in overall context. We have considered the Indicative Sanctions Guidance. In our view this is a most serious case. Many aggravating features are present in this case: *dishonesty; abuse of trust; taking advantage of vulnerable*

people; misconduct sustained over a long period of time; potential harm; actions premeditated; blatant disregard of the law and the Code of Ethics; lack of true insight; concealment of wrongdoing; misconduct committed by a person in charge of pharmacy premises, and breaches of statutory requirements. One of the aggravating features in the Indicative Sanctions Guidance is the *failure to co-operate with an investigation* into an allegation. Mr Leal did not merely fail to co-operate, he *lied* to the Council's Inspector and set about a course of concerted conduct to seek to persuade Council witnesses to change their evidence. When this failed, he tried to impugn their integrity by asserting that they had lied and were motivated by the competency-based criticisms he had made".

Listening to her torrent against me in her summary forced me to feel I was in a losing fight for my life. The whole situation I found myself in felt like a nightmare from which I couldn't bring myself out. Nobody had ever spoken about me professionally in such defamatory terms. I sat disgusted at her and began to question whether she in fact had the correct determination and sanction in front of her! I began to wonder whether she was just reacting to the spectrum of behaviours I had shown throughout the hearing. I found the high tension and drama in the courtroom unnerving even provocative. I felt hyper-aroused, angry, frightened, burned-out, and purposeless.

Reflecting back over the hearing, I desperately wanted to prevent others from seeing what a failure I was upon taking the stand to defend myself. I could not help sobbing as I read through my statement, requiring numerous pauses to compose myself. Sure, to some, watching a grown man in tears maybe repulsive, but for me it felt like the uncontrollable groaning of my soul, like a cry for help. My own solicitor remarked that during cross examination I was a jumble - sometimes, connected to what was happening and articulate, then a moment later, without warning, my responses had turned to rantings that were uncoordinated. Rightly or wrongly, I became angry, bitter and lashed out at the world. I even went as far as rebuking the prosecuting solicitor and members of the fitness Panel!

"As to mitigation," she resumed, "whilst it is true that many of the allegations were admitted, in reality Mr Leal sought to *confess and avoid*. He had, however, the good sense to admit that his fitness-to-practise is currently impaired. It is a significant feature in mitigation that, prior to these events, Mr Leal had an unblemished record. He is plainly an intelligent man who, all things being equal, would have much to offer the profession. By reason of our findings, Mr Leal has lost his good character and reputation", she affirmed.

"The Panel," Chair was saying now, "finds the picture presented by Mr Leal's misconduct is entirely at odds with the views of patients who consider that he is an honest, caring and decent professional. Doubtless Mr Leal was under pressure, but the source of his difficulties was the fact that he sought to run two pharmacies without a responsible pharmacist being in place beyond the extent permitted by the law. We are satisfied that this practice was carried on because of greed and self-interest rather than any real difficulty obtaining locum-pharmacist cover".

'Greed and self-interest'. I heard myself saying, 'No! No! No!' You have got it wrong. It is an accusation all too often levied at community pharmacy business owners. We are supposedly a small section of the profession motivated by financial rewards above all else? No! I became an owner in order to have a say in the way pharmacy is practised for the benefit of my patients and customers. Any rewards, including financial, would come directly out of serving my customers to the very best of my capabilities. I chose a career as a health professional in order to make a difference to people's health and well-being. I have a strong ethic of care, and an even stronger work ethic. I see it as my duty to use my knowledge and skills to provide a high standard of care to my patients and customers. I will not let my patients down. They depend on me as I depend on them. It's a partnership based on trust. The many testimonials given by my patients are supportive and I am offended that the Chair by some sleight of hand managed to overlook the personal experience of care received by those I served. Why can this panel not see the truth behind what drove me to keep the service going in spite of a genuine lack of human resource? I felt rage rising up and with it the urge to stand up and shout back in defiance at this Panel.

Swivelling uncomfortably on her seat she let out that, "there is no evidence that actual harm befell any patient." I wanted her to repeat that for the record that 'no patient in my care was harmed'. I felt both proud and, at the same time, relieved at having this uttered today. I felt suddenly overwhelmed that despite losing control over my business, my behaviour did not bring injury to any patient. Of course none of my patients were harmed, madam. I made sure of that through keeping a very tight control over the dispensing of prescriptions at both pharmacies at all times. I knew my first concern was the welfare of my patients and customers. That I understood from the day I qualified some twenty years ago. I am not a fool, but I have made mistakes which I am prepared to learn from. I am so much more a clinician than a businessman. Can't you see that? Please see some sliver of good in me and allow me to continue to practise my beloved profession, I continued to say in silent protest. I felt vulnerable and wished to escape the coming moments. As on many times in my life I became numb, unable to experience the hurtful feelings that came knocking. I had disappeared.

In spite of the fact that I knew eighteen months ago this day of reckoning was coming, nothing could have prepared me for the announcement of the sanction of the FtPP. Taking a deep breath, exhausted and fed up with my rather too complex case, the Chair had reached her decision, "We recognise the devastating impact of the decision that we are about to make. We are well aware of the effect the sanction we impose will have upon Mr Leal's professional standing and career and his ability to earn a living and support himself and his family, both now and in the future. Having balanced Mr Leal's interests against the public interest, we have come to the clear view that it is necessary, reasonable and proportionate to direct that his *name be removed from the Register* because the declaration of proper standards and the maintenance of public confidence in the high standards of the profession demands no lesser sanction. Fundamentally, the extent and seriousness of the conduct admitted and the dishonesty found proven is incompatible with membership of the profession of pharmacy."

'His name be removed from the register'. The outcome I dreaded most. The hearing was over. To my surprise, the Panel had ruled that the submission in mitigation by my solicitor of some thousand email records that revealed my genuine attempts to secure pharmacist cover and of my need, the previous year, to undertake a programme of stress-counselling to help me to cope with the relentless demands of my business and poor mental health was of no benefit to my defence after the fact. I still remember the words of my solicitor immediately following the announcement of the sanction "They did not believe you". I was in a maelstrom of grief and self-loathing.

Because she detached herself from me, I lost my beloved profession and with her what felt like my foothold on the only reality I had allowed myself for twenty years. It felt like I had nothing left to hold onto and became delusional. In desperation I reached out and pulled on the thread that loosely held my jumbled emotions at bay, but it unravelled uncontrollably. I felt discarded, worthless and ashamed. My body's rigor mortis revealed the horror of what had taken place. My solicitor tried to speak to me. I recall him saying 'they did not believe you'. I just sat there and stared angrily at my judges one last time, feeling that I was about to snap, flip out, go crazy. "It's time to go. Come on," said my solicitor. "What do they know about who I am?" I began to argue. "Get a hold of yourself. Stand up. We have to leave now. Let's leave now," he demanded. I hauled my bony frame out of the chair and on weary legs walked across the back of the room, about ten steps, and out the door, while keeping my eyes on the three 'merciless gods' I was leaving behind.

As I turned to look back at the home of my regulator, it dawned on me that it had simply done its job that was all. To protect the public against professionals in practice who had shown themselves to be a risk to safety. That said, just why did I feel so unfairly treated? The past eighteen months had given me an insider perspective of the regulatory system and I began to see cracks. I was not prepared to accept the reasoning behind the Panel's decision to remove me from the Register; that I was motivated by greed and self-interest. The *truth* was often hard to find, but I was willing to search for it and I had a growing suspicion of where to look.

o o o

The preceding section presented a snapshot of the final determination and sanction stage of my Principal FtP case which ran over some eight days between April–September 2012. I included my contemporaneous thoughts and feelings at the time to reveal my lived experience of going through the final stage of the FtP hearing of a Statutory Regulatory Body (SRB), in this case the GPhC which is responsible for the regulation of Pharmacy professionals (that is Pharmacists and Pharmacy Technicians) in Great Britain. Unless categorised as 'health cases' the transcripts of most FtP cases are accessible online through the various SRB sites. The transcript to my case, for instance, can be accessed through the GPhC website (GPhC 2012). My case itself is not a straightforward read. The Chair of the FtPP opened the hearing in April 2012 by stating 'the case set before us is indeed a complex case'. My purpose for presenting my case throughout the thesis

is not to reveal the nature of my misdemeanours and professional failings, though this will inevitably be a consequence of it, but to access a deeper level of information about the practices and procedures that are used by the instruments of regulation in the name of 'public protection'. It is my assertion that an in-depth analysis of the regulatory process in this way may reveal what is taking place - what has up-to-now gone unnoticed and unchallenged by a trusting professional and lay readership.

4.5 Vignette five: Journey I (mental health)

D E N I A L…There is a grace in denial. It is nature's way of letting in only as much as we can handle - Elisabeth Kubler-Ross

It is now seven days since I lost my work identity of over 20 years. The grief of this loss and separation continues to dominate my thoughts, feelings and emotions. As usual, after yet another broken night and, eventually waking up to the agony of my loss, I am overwhelmed. The searing pain through my body, like an insidious demon, strikes at an old back injury. The resulting sciatica leaves me unable to stand and support myself. I am confined to my bed. The new foe distracts my awareness enough to perhaps allow time for mental processes working away inside me to adjust to my adverse work circumstances. I feel a tremendous sense of unreality at this time of my life and I just go through the motions of what my acute needs require.

On the morning of the twenty-third day since losing my profession, I have one of my worst times so far; a strongly felt resentment that life has been so unfair in taking away my professional work. Working as a pharmacist gave purpose to my life, gave me worth as a human-being, without which I could not function. My well-being is rooted in my work as a pharmacist. Dark painful thoughts just deepen this sense of loss I feel right now. I am powerless against the shame of it. I am losing hope. I question whether living without professional practice would be a life at all. I hear the voice in my head exclaim 'it's gone, it's gone'. My anger grows and is impossible to contain. I am more certain that what happened a few weeks ago had taken place. I had been struck off the pharmacists' register of practise and was unable to work again as a pharmacist for the next five years. Confronted with the reality of my situation I am desperate to find a way to try to put a stop to this searing pain. Those around me plead with me to see my GP and discuss how I am feeling. I guess my words and behaviour must cause a great deal of worry for my family. I make an appointment to see a senior GP at my Surgery.

"What has brought you into the surgery to see me today?"

The simple inquiry is the trigger to my experiencing an undeniable injustice has been perpetrated against me. My voice is tight. I bow my head. A wave of shame crashes over me as I begin to speak.

I lost my work a month ago. My work as a pharmacist was taken from me. I don't know who I am anymore or what my purpose is. I hate being de-registered. I can't keep back this uncontrollable

anger directed at my regulator, the General Pharmaceutical Council (GPhC) for not believing me about the circumstances that led up to the complaint against me. The announcement of the sanction came as a great shock. The ripples are being felt by my family and my business. I have lost my work and livelihood, public standing and reputation. You, as a doctor, will understand me when I say that my work was a central part of who I was. It was a big part of my identity.

My doctor allowed me to speak openly and freely for some five minutes before reflecting back some of what I said.

"You are, understandably, showing signs of grief, marked anger and low mood. A course of anti-depressant medication might be helpful to take the edge off your very strong emotions and help you cope better. Alternatively, a course of counselling might help you to make sense of your experience. Which would you like to try?"

I was not convinced by either option. Both are short-term fixes for a problem I could not escape for at least five years. My GP had been compassionate towards me and my sorrow. I didn't want to disappoint or upset her by rejecting her suggestions.

Okay, I'll give counselling a try. She smiles and tells me that she would make the arrangements as a matter of urgency. I thank her, get up and leave. I need more than talk-therapy to heal my pain. More, more, more than talk-therapy.

ANGER…Anger surfaces once you are feeling safe enough to know you will probably survive whatever comes - Elisabeth Kubler-Ross

On the morning of the fifty-sixth day after removal from the Register, I return to the Surgery to begin my eight-week course of counselling under the NHS, led by a senior therapist. Before the session begins, I am handed several patient questionnaires to complete. They carry abbreviated codes that are distinctive to the outcome being sought around my mental health and lifestyle (PHQ9, GAD7, IAPT phobia scale, IAPT employment status and Work and Social Adjustment). I have no previous exposure to such measures, either professionally or personally. My counsellor provides an outline of the ethical framework she is working to, and within this states that she is obliged to break confidentiality should it transpire in what I say that either I or another person is at risk of harm. I think to myself, 'well, I'd better not let you know that since the shock of the sanction I have contemplated suicide often, as a way out of all this pain'. She reviews my questionnaire responses. She informs me that I am moderately to severely depressed. She continues, I am showing severe levels of anxiety as well as avoidant behaviour as a result of fear of embarrassment or having a panic attack in certain situations.

All that is unsurprising given what I have been through over the past two years while my regulator systematically dismantled not only my professional identity and reputation, but my human architecture too. I am left with a potent distrust of authority and lawyers.

My therapist settles back in her chair as if she is aware that I am about to explode. I unleash a torrent of anger directed at my regulator and several “disloyal” former staff who I also blame for my situation. My therapist appears agitated, probably as a result of the torrent she absorbs. Letting out a deep breath, she tells me that she is willing to help me. She tells me I will have homework every week. I have to maintain a reflective log of my emotions before the next session. As with my previous encounter with therapy in 2010, she also asks me to think over my childhood in preparation for our second session. I wonder why therapists are so focused upon learning about childhood. I am not able to change the past, whatever it may hold. This seems to me to distract from the real work of helping me cope with the traumatic loss of my career and arrival at a crossroads in my life.

The seventy-eighth day after erasure from the Register, and I am speaking to my Counsellor about an important principle of the Hindu-Punjabi culture to which I belong. Family honour or ‘izzat’ had to be guarded and vehemently protected, even if it meant sacrificing oneself in the process. I reflect how this deeply held family value might have translated in my behaviour as a proprietor pharmacist. To close the pharmacies and deny patients access to vital services in rural villages aroused intense feelings. I would be responsible for letting people down and jeopardise the honour of my family name. At my hearing, when asked to explain my behaviour I was unable to do so to my satisfaction. Why hadn’t I given any thought to the role that deeply held family values may have played? I shake my head in disbelief. Shake my head.

My immediate situation pushes me to live moment-by-moment under an umbrella of stigma. It takes away my voice. I feel guilty because of misconduct in a professional role. I am ridden with shame. The narrative that my peers would undoubtedly write would be a narrative under the banner of shame and blame that unequivocally states ‘you should have known better’. In this light I feel I have betrayed my professional colleagues and deserve the consequences. I am ‘a bad apple’ and could no longer belong in a profession that demands the highest standards both inside and outside practice.

Cast-out of professional work for eighty-one days and still the pain feels raw. I find it hard to take in what anyone says. I find it is uninteresting. Compared with this immense event which is ruling my fragile mind, the ‘news’ of others is irrelevant to me. In conversation, I am frustrated at losing the thread of what I am saying. I often end up in half-sentence, or needing a lengthy pause in order to gather my thoughts. As a previously competent communicator I feel my circumstances are bearing down heavily on my thought processes and I find it increasingly difficult to express myself clearly. I am nervous, anxious, fear the onset of a panic attack. I gradually withdraw from my place in society, community and home. I do not fear the moments when my children leave for school and my wife leaves for work each day. Life for them seems to continue, as normal, as it should. When the house is empty, I have a private place in order to be able to vent my anger.

I am deeply wounded and unable to engage lovingly with my family. They reciprocate these feelings and ‘strike off’ quickly becomes a taboo topic - the elephant in the room. The growing

strain felt in our relationships leads my wife to demand that I seek further help in order to cope with my loss of work as a pharmacist. She fears that the mental health of our children is at risk if I do not take adequate steps. There is no institution, organisation or charity specifically set up and designed to support de-registered professionals. Our removal from professional practice is a multifaceted dilemma. Not only does it signal loss of professional status and work, but also structure to the day, cherished working relationships, income and independence. On a personal front, it brings a lowering of self-esteem and inward negativism under a veil of powerful emotions of guilt and shame. Family life inevitably suffers and contributes to the growing isolation one feels. You find yourself in the wilderness, cast-out, alone facing the looming question 'what is the point of going on?'

As is normal practice prior to each session of counselling I complete several patient questionnaires (PHQ9, GAD7, IAPT phobia scale, IAPT employment status and Work and Social Adjustment) to help the service ascertain outcome measures. Question nine of the PHQ9 asks me '*Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?*' This time I feel I need to answer honestly. What I have not shared with my wife and children is that since the day I had been removed from practice I had my purpose for living taken away. I learnt that from my father - a man's worth is wrapped up with his work and ability to provide for his family. I have been wrestling ever since with dark thoughts. I fall in to self-pity each time and ask unanswerable questions such as 'why me?' and 'what is the meaning of this new suffering?' I feel helpless and hopeless. So, contrary to previous responses I had given to PHQ9, I answer '*Nearly every day*' and hand all my completed questionnaires in to reception. My Counsellor swiftly gathers them for review prior to the start of my session.

After the briefest of minutes, my Counsellor emerges from her room and approaches me with a look of disbelief written across her face. She sits beside me in the waiting area and speaks softly 'I am sorry you feel hopeless and wanting to harm yourself. Please, hold on. I wish to escalate your care to the Community Mental Health Team (CMHT) with your permission. You will receive regular appointments with a Consultant Psychiatrist alongside the remainder of our counselling sessions together'. She escorts me into the counselling room. We sit down. She asks me about my suicidal thoughts. I do not know how to begin. I look towards this woman sitting beside me. I sense she is here for me. Whatever I have to say, I need to say it to her. My heart is pounding. Beads of sweat form over my skin. I want to end my suffering, my pain, my life. I am in a pit of hopelessness. I feel a deep sadness and sorrow that I cannot shift. I begin to speak. 'Throughout my life I have felt misunderstood. I do not perceive there are genuine choices to be made in life and that the social roles we occupy hold expectations for our behaviour. I feel as a member of society each of us is duty-bound to fulfil the roles and responsibilities we have. This is the framework that led me to act against my profession's regulations in order to provide continuity of pharmacy services in rural villages. I was not believed by my regulator, branded dishonest, self-interested and greedy, and removed from practice. My simple truth and belief in humanity, as a result, is torn. I feel abandoned, cast-out, not good enough, bad, shamed. Once more in my life I

am misunderstood. I have had enough. Misunderstood'. I stop speaking. I start to seek the room for more words. It is empty. We sit in silence. Everything is still, but for the hands of time.

Ninety days have passed by and I am in my penultimate counselling session. My Counsellor begins the process of summing up all that she has learned about my emotional life, relationships and presenting circumstances. She reiterates that my questionnaire results indicate that I am suffering from depression.

Me: For as long as I can remember I have found it very difficult to be optimistic about my own life. Any happiness I have experienced has been fleeting. Even the big events in life, such as graduation, marriage, birth of my children and moving to a new home have brought me only glimpses of happiness. I have known emotional pain through my life, which has made living this life unbearable.

Counsellor: Untreated depression affects the sufferer's perspective leading to a low self-worth?

Me: There is no doubt this resonated with how I have experienced life, which has at times caused me to question whether my existence mattered at all. Sometimes the intense feelings of self-loathing make me want to scream out in pain. Yet, the way that I was raised keeps me from doing just that, - instead to bury my feelings and never to express my emotions. I don't fully understand why such conditioning continues to play out in my adult life. It is as if I have to repress emotional expression in order to be accepted by others.

Counsellor: From all that you have said it seems to me that you assume others, like the pharmacy profession, your parents, your wife and children, are demanding a faultless performance of you.

Me: I'm certainly a perfectionist. This has for me been significant in my work as a pharmacist. Though I do make mistakes, my error rate was very low, around 0.01 per cent of all prescriptions dispensing. I was proud of my safety record. Isn't it ironic that I have been removed from practice on the grounds of endangering the safety of my patients and customers? I am very angry about that. Sure there was potential risk as a result of my misconduct, but no patients were actually harmed. My regulator, in summing up, put it down to mere chance, rather than acknowledge that I showed infinite energy in keeping my two pharmacies safe, in trying circumstances.

Counsellor: Maybe one of the things we all need to learn in care work is self-preservation. If we assume we have unlimited energy, we risk becoming emotionally bankrupt.

Me: I see that now. I was effectively working two shifts side-by-side. Many weeks I would be working in excess of 100 hours. I recall times when I felt so exhausted, I would rest my head on the dispensary bench and close my eyes for a short time. Only to be woken to the sound of two words we pharmacists are all too familiar with, "check please".

Counsellor: Looking back over your initial responses to the various questionnaires you completed at the start of the counselling service, I am concerned that you still experience disturbing symptoms subsequent to your removal from practice. For instance, your scores were high on the intrusion and avoidance sub-scales. I can recall that in our first session, you presented marked irritability.

Me: *[At this point, I felt a gigantic wave of emotion break over me. I fell back in my chair and bowed my head*.] No! You have got that wrong. Since the day of the 9th February 2009, when the Pharmaceutical Inspectors appeared without warning in my pharmacies to find that I was the sole pharmacist operating two pharmacies I have continued to experience difficulty sleeping. It was a shock. I literally froze and became voiceless. This was followed by an almighty attack of panic. It felt surreal, as if I had gone off to a place where I felt safer. That picture has stayed in my mind all this time. Moreover, to this many more pictures have been added, forming what I can only describe as 'film-reel images,' as the investigation into my misconduct gathered pace. There is the half-day Interrogation interview by two regulatory Inspectors, the full-day pre-investigation hearing held at the regulatory body in London that aimed to suspend me immediately from practising, frequent ad-hoc visits to the pharmacies by both NHS and regulatory officials running over a period of 18 months, before my eventual sanction. So, you see, I've carried all these images for a long time. I can't make them go away. They are always there, both day and night. Sometimes, I have woken in a sweat, or let out a scream. Each morning I have only one thought. Not another bloody day! As a proprietor, I tell myself that I should just get on with things, but I can't be bothered with anyone or anything. I can't face entering the rural communities my pharmacies continue to serve. I feel disgraced. Actually, I prefer to avoid going into any pharmacy. I get restless and agitated if I even hear the word pharmacy. I find it hard to concentrate much of the time. Yes, I do blame myself for my troubles. How could I have been so stupid?

Counsellor: I am sorry to learn that, in fact, you have been feeling this way for almost three years now. As you say, you have experienced a battery of traumatic events that culminated in your eventual sanction. I would like you to know that your chronic symptoms and reactions are characteristic of someone experiencing post-traumatic stress disorder or PTSD. I will be writing to both your GP and CMHT to ask them to assess you for this disorder.

Me: Well, I find this hard to accept since I thought PTSD only affected combat veterans, rape victims, survivors of natural disasters and the like. Not a pharmacist who has been removed from practice by his regulator! But, then again, I'm not at all surprised I have more wrong with me. Something has got to be done. I don't want to go on living like this.

Counsellor: Yes, people often think of only the groups you mention when they consider PTSD. However, a modern understanding of PTSD includes any trauma that is catastrophic for the individual. Research indicates that some of us are more prone to experience symptoms of PTSD. Those with pre-trauma conditions including depression and personality disorder are at increased risk. So, you can see why I have been concerned that your symptoms may be indicative of PTSD.

Me: I feel angry that all through the investigation and hearing, despite my avoidant behaviour and, frankly, my inability to engage with the regulatory process in a non-emotive manner, as required by the professional standards 'to co-operate with investigations in to your own fitness-to-practise', neither the pharmacy nor legal professions saw anything out of the ordinary in my complex behaviour. Did they fail in their duty of care to me? [I paused, deeply inspired while feeling a stronger than ever sense of injustice.] Could it be that our systems of regulation and law, in pursuit of a complaint, become so blinded to the plight of individual health and social care professionals that they are reduced to being less than human, or 'other', stripped of all basic human rights?

Counsellor: It is important to feel disappointed and let down by the systems that are supposed to protect all. Maybe, in their preoccupation with their stated purpose 'to protect the public' regulatory bodies have overlooked the significant impact that their activities and sanctions have on those they regulate. We are nearly out of time today, but I look forward to seeing you again, for our final session, on 18th December.

Me: Sure. But I must say how helpless I feel. Actually, the system has slowly chipped away at my need for control in my life and work. Through a relentless assault on my sense of control, I have been left, initially, fearful that my professional competence was being taken from me. Believe me, I tried very hard to defend myself against the heightened stress that accompanied the Investigation and Hearing. It is only normal for a human being to want to remain in control, don't you think?

Counsellor: Feeling helpless - and your responses to this - may help to identify a repetitive pattern in your personal history. Think about times when you couldn't stand up for yourself? Perhaps you didn't live up to the expectations of your parents, teachers, managers and others? Maybe you felt you were in a no-win position? How did you resolve these conflicts? We could explore where there are parallels in behaviour then and now.

Ninety-four days since losing my right to work as a pharmacist, I am attending a diagnostic appointment with NHS Adult Mental Health Services. I arrive five minutes early. I see a small electric buzzer on my side of a glass barrier behind which a receptionist busy typing on her keyboard is sitting. I sound the buzzer and this causes the young woman to look up at me. She approaches the glass barrier, opens a small sliding panel and requests my name. She finds and ticks it off her list, held on a clipboard. She asks me to take a seat before swiftly and firmly shutting herself in her enclosure once more. Two patients, one female probably in her late twenties and the other a bearded middle-aged male are already waiting. I feel too anxious to sit down, preferring instead to wonder around the perimeter of the waiting area, taking in the various posters displaying health messages. I was beginning to form a picture of the assumed needs of the adult mental health service user: Support Groups and what they each could do for you, relaxation, meditation and mindfulness classes, exercise, diet and weight control, voluntary work opportunities in the local community, suicide prevention and, crisis management.

The reinforced door set between the waiting area and corridor leading to various consulting rooms used by the Community Mental Health Team (CMHT) is accessed via a secret code entered into a keypad. Am I alone in feeling this spatial arrangement, buzzers, sliding panels, reinforced mahogany doors, codes and keypads taken together communicate to the mental health service user that s/he was considered dangerous? Ironically, it also had the effect of locking-in the practitioners, safe from the threat posed by 'others' who dared, like me, to be different.

The first sound of the closed latch being released from behind the locked door signalled that another service-user was ready to be seen. My name was called by a male practitioner who invited me through into the corridor, and into one of the whitewashed consulting rooms. Two other staff were already in the room, awaiting my entry. The male practitioner introduced himself as the Senior House Officer (SHO) on duty and said that he would be conducting the assessment accompanied by a community mental health nurse and, if I consented, a mental health trainee nurse. The assessment consisted of a Clinical Diagnostic Interview (CDI) and lasted around an hour and a half. I answered a range of searching questions that delved into my thought processes, attitudes, feelings, relationships and behaviours, both past and present such as: *What was your childhood like? What was your relationship with your mother/father/siblings like? What was school like? What friendships did you have as a child? What have your romantic relationships been like? What is your job and how long have you done this?* The mental health nurse wrote notes as I spoke. The SHO engaged me in conversation, most of which made me feel uncomfortable. I understood that the purpose was to produce a life narrative that could help contextualise my symptoms.

At the end of an hour and a half of 'intense conversation' the SHO was able to deliver his formulation and summary:

"Porsotam has a history of anxiety, low mood, feelings of anger and rage, feelings of abandonment, deleterious eating habits and self-harm. His most acute stressor is the fact that his licence has been revoked by his regulatory body, but his history is long and complicated and involves emotional and physical abuse at the hands of his parents and long-standing problems with interpersonal relationships with features of impulsivity. I think he has features of moderate depression and Emotionally Unstable Personality Disorder (EUPD)."

As a health care professional I have delivered potentially noxious medical diagnoses and at this moment I began to appreciate the impact that such diagnoses might have had on my patients. Whether trivial or serious, diagnoses threaten identities. Moreover, I can bring to mind those patients diagnosed with a mental illness who have expressed dissatisfaction with the way that they have been handled by their Doctors, Psychiatrists and other mental health care staff, expressing bitterness, anger or bewilderment. Such emotions have usually been consequential to delays in assessment and diagnosis, poor communication, misdiagnosis or feeling

depersonalised. In my own case, it has taken three months for our health-care services to arrive at a substantive understanding and diagnosis of my symptoms, which I have experienced over much of my life. I have been holding on, sometimes clinging desperately, to life while my mind wants to find immediate freedom from this pain and suffering. The lure of suicide has at times been palpable.

The diagnosis of a serious and long-standing mental illness has provided me with an explanation for my decision-making, feelings and behaviour that culminated in my regulator finding that my FtP was impaired, leading to removal from practice. My mental health was not considered at all relevant by the FTP Panel during my hearing, despite outward signs and symptoms to the contrary. Unfortunately, the adoption of court-like methods by regulators that follow the infamous adversarial system akin to criminal law, precludes such essential safeguarding of the suffering care professional. Here, then, the whole process runs like a competition between prosecuting lawyers (hired by the regulator) and defence lawyers (acting for the care professional). I was left feeling stripped of my selfhood. I had become an object of assault by the prosecution.

The SHO explained to me that I was intelligent and would probably not benefit from the standard treatment for sufferers of EUPD (the European preferred alternative name for the American Borderline Personality Disorder) which was Dialectical Behaviour Therapy (DBT). Instead, he handed me information sheets on EUPD and asked me to read them in preparation for our next meeting. By the end of the appointment, I felt emotionally exhausted and recognised that I was barely able to take in what the SHO was telling me. I agreed to take the information sheets and to read them. Leaving, I felt disillusioned by all that was unfolding at this time in my life. I questioned whether I could hold it together and continue with yet another stigmatising status: personality disorder.

Day ninety-eight, and I arrive early for my final session with my Counsellor. Being given a firm mental illness diagnosis, far from bringing me answers to my symptoms, has initiated increasing worry about becoming a mentally ill patient, a mental health-service user, an abnormal and a dangerous individual. Just what is the public perception of the mentally ill? Images and portrayals of the mentally ill in literature and film are overwhelmingly negative (for example Robert Bloch's 1959 novel *Psycho*, Ken Kesey's 1962 novel *One Flew Over the Cuckoo's Nest* and Susanna Kaysen's 1993 memoir *Girl, Interrupted*).

I discussed my mental health diagnosis with my Counsellor, with a great deal of trepidation. Having reviewed the information sheets given to me by the SHO after my assessment, I had come to learn just how defining the EUPD condition had been in my life. I had been suffering from a chronic emptiness all my life that nothing could fill. As a result I developed patterns of behaviour that increased my belief that I was unlovable along with feelings of abandonment and worthlessness. Looking back over my childhood, my parents would often refer to me as the 'black sheep' of the family. I guess they possessed no solutions as they were without knowledge of the

root cause of my behaviour. For them it was just the way I was. They often prayed for divine intervention, to bring everlasting peace to their unruly son.

My Counsellor explained that people diagnosed with EUPD have usually experienced abandonment at some point in their childhood. The stress of helplessness, of having no control over being left behind has become the trauma which is firmly etched in the emotion centre of the brain. Any hint of potential recurrence of abandonment triggers the original traumatic experience involving helplessness and the ensuing response of becoming overwhelmed and enraged. She asked me if I was aware of a time when I might have felt abandoned. I said that a family secret I had learned was my short period of being fostered as an infant. My Counsellor told me that this is likely to have been the event in my childhood that was at the heart of my dysfunctional behaviour. Relationships have been a constant source of stress and anxiety for me, and without doubt I have reacted badly to relationship breakdown.

My Counsellor was keen to leave time to review changes in my questionnaire test scores (PHQ9: 19/27, GAD7: 19/27, IAPT phobia scale: 14/24, IAPT employment status and Work and Social Adjustment: 27/40) over the course of our six sessions together. She told me that there was some reduction in the severity of my symptoms, though I remained in need of psychological support. She reported feeling frustrated that she was unable to continue to be my Counsellor, due to strict NHS criteria governed by limited resources. She went on to say that together we had only really scratched the surface of my difficulties and that the road ahead for me was likely to be long. However, she said that she had found me intelligent and determined to restore my name to the professional register. She hoped that CMHT would continue to provide me with my ongoing care needs, including any specialist therapies from which I could benefit, and wished me well for the future. I thanked her for all that she had achieved with me. We embraced briefly before I left, feeling sad at the prospect of facing my uncertain future without the support of my Counsellor. In life, maybe, relationships are not meant to last, I pondered. Maybe I become too attached to others, even dependent on them.

One hundred and eight days have passed now. I arrive early for my appointment with the CMHT and go through the familiar routine. I announce my arrival to the receptionist behind the glass wall, small window sliding open, brief acknowledgement, small window sliding closed, - me taking a seat and awaiting the sound of the latch being released to signal the opening of the toughened wooden door and the start of my appointment. The SHO asks how my holiday had been. I am puzzled by the question. The word holiday is a misnomer to me. In the past, being on holiday would mean living differently for a while, away from the stress of work and learning to relax again usually in the company of loved ones. No matter how hard I try I cannot get away from my strong feelings of loss, sadness and sorrow at being removed from practice.

The SHO then asks me what I thought about the diagnosis of EUPD, from the three information sheets I had been given at the end of my last appointment. I had carefully read all three information sheets several times over and believed that I finally have a label or name for my mix

of symptoms. I revisit the first information sheet and slowly begin to call out components of my disorder: pervasive *INSTABILITY… marked IMPULSIVITY… ABANDONMENT… UNSTABLE interpersonal RELATIONSHIPS… IDEALISATION and DEVALUATION… IDENTITY disturbance… UNSTABLE sense of SELF… self-DAMAGING behaviour… SUICIDAL… self-MUTILATING… reactivity of MOOD… IRRITABILITY… ANXIETY… chronic EMPTINESS… intense ANGER… PARANOID ideation… severe DISSOCIATIVE symptoms.*

Every day is the same. My days are occupied by a constant struggle to keep myself from drowning in the blackest black and losing myself forever. Looking back, the relentless pressure of starting in business in 2007 caused an exacerbation of all these symptoms. Moreover, coming to the attention of my regulator in 2011, and going through its investigation and hearing processes further worsened all my symptoms, but it is only following removal from the Register that I experience these symptoms most gravely. Abandoned by a "heartless" and unforgiving regulator, adrift from the familiar safety and security of my profession, I imagine ending my existence, my troubles, my loneliness, my sorrow, my shame. Ending my existence.

The SHO is leaning forward towards me now.

"From all I had learned about your history, the combination of your inherited biology, producing a brain structure prone to emotional sensitivity, and an invalidating environment at home has led to the symptoms of personality disorder, in all probability by the time you had reached your late teens and early adulthood. That said, life is worth living. Your thoughts and feelings will change".

I am painfully aware of my upbringing, as 'invalidating'. My parents along with others had arrived in UK with nothing. My father arrived sixty-five years ago with only three pounds in his pocket and had to work very hard to get by, taking every deadbeat job going. So, understandably beginning from where they did, nurturing their children, as was the case for many migrant parents from the Indian subcontinent, became secondary to working for a living, putting food on the table and keeping a roof over their heads. It was all about surviving in this hostile dog-eat-dog society.

"You are an intelligent man and the usual treatment programme for EUPD sufferers, namely dialectical behaviour therapy (DBT), is unsuitable for you. Besides, the treatment of EUPD through DBT was in great demand and currently there was a waiting list of at least two years".

Too intelligent for standard treatment? I sat in disbelief. With my diagnosis of EUPD, after almost four months after being removed from practice, I finally have an explanation for my behaviour. Without treatment I remain a risk and unable to restore my name to the Register to work as a Pharmacist again. I am not going to accept the SHO's rationale, which I feel discriminates against me not on the basis of my sex, age or ethnicity, but on the basis of IQ. I am confused and unhappy at the prospect of having, once more to prove my worthiness for help and wonder whether it was commonplace in mental health services for patients to have to demonstrate their suitability for the treatment they needed. I recalled that one of the reasons my parents came to UK was to provide

an education for their children. Educated to Masters' level - itself an impediment to my progress on to mental health services. What is shocking to me is that there are so many sufferers out there struggling with life, like me, left waiting for help before it is too late. Lives just put on hold, until NHS resources could catch up with exceeding demand for DBT.

I have worked all my life. I have contributed to the NHS through taxes I have paid, for over twenty years. As with a bank account, I wish to make a small withdrawal, in order to become well enough to work again. I insist that I be put onto the waiting list. I require help, not judgement to escape this state of mind, this pervasive instability. I possess no tools to deal with my fluctuating emotions. I react against people, situations and circumstances that I consider invalidating to my empty existence. I feel vulnerable at this time, unable to cope. Suicidal thoughts invade my mind. Even so, I have responsibilities to uphold. Husband, father, proprietor, son, brother, patient all feel weighty and burdensome. Without satisfaction I resolve to continue to provide whatever support I can muster to the pharmacy teams I lead, to my long-suffering wife and children whom I exasperate. I guard against showing weakness. Whether through nature or nurture, or a combination, I feel powerless to perform my duties. I feel condemned to suffer in silence.

The SHO hands me a brochure of locally-based education courses run by the Recovery Education Centre – Dorset Well-being and Recovery Partnership (REC – DWRP) and a card listing several telephone numbers to call at a time of crisis. I leave feeling rejected by our NHS which I reflect had originally been designed, in founder Bevan's own lofty words 'to provide help at the time of need'. I am frustrated and mystified. Our NHS is not going to help me in my time of need. I am sick of being told I am intelligent - no doubt with the subtext, 'You should seek, therefore, to help yourself'. Reflecting on how effective I am finding the short course of Counselling, I believe I can educate myself about therapy and apply this to my own life. I discover there is a level three Counselling Skills course, run at my local College. I am desperate to develop understanding, schema and skills to help overcome my emotional difficulties. Yes, I am certain this will bring about the changes I am seeking in order to have a chance to reclaim my career as a Pharmacist. I am, at the same time, filled with dread by the prospect of navigating, for the first time in my life, the various recesses of my fractured mind.

BARGAINING…We will do anything not to feel the pain of this loss. We remain in the past, trying to negotiate our way out of the hurt - Elisabeth Kubler-Ross

For two hundred and thirteen days I have woken to the same reality. I am struck-off. I feel bad. I hate myself. I don't want to live. Today I also feel anxious about embarking on a Counselling Skills course as a 'self-help' strategy rather than for the usual purpose to help others. It was a strategy that was borne out of frustration with the inadequacy of our NHS mental health services. I felt by enrolling on the Counselling Skills course I would give myself a realistic opportunity to examine my own mental frailties through the lens of the major contemporary theories and then take steps to apply my learning in my life. I am hopeful that through study of the major psychological approaches and their application to my life I might go through something akin to a transformation.

I join my group on the first floor of the College building and am greeted by my counsellor-tutor. I notice the majority of students are female. I am one of only three male students. We are all adult learners about to embark on our own learning journeys based on our personal reasons for wishing to follow this course. I am here to understand the best ideas from prevailing psychological approaches and apply them in order to facilitate change in my thinking and behaviours, so I might demonstrate to my regulator that I have addressed my various shortcomings. The tutor looked around at us with a relaxed smile, "I want you to give me your names and the name by which you prefer to be called". My heart begins to thump in my chest, 'Oh no, not this again'. My name has always been difficult for others to pronounce. Often I am left breaking it down into bite-sized syllables that others would find more palatable. As my turn approaches I feel panic rising and sure enough, as always happens I say in a repentant tone, 'Hello, my name is Porsotam'. I am asked to repeat, but instead choose to utter the three syllables that make up my name, 'Por-sot-am' making sure that everyone feels as awkward as I do. Thank goodness that is over. The name game has been a constant source of displeasure for me since the time I entered primary school fifty years ago. The other children found my name a constant source of amusement and would toss around the playground shortened versions of it (like 'Porsh' and 'Soty') proclaiming, I felt, their disapproval of not only my name, but of me as a person. I disliked school and felt I didn't fit in. I believed even back then that I was different, but unaware why. All this just caused me to lose self-confidence and my self-esteem plummeted to an all-time low. I became shy to the extreme and withdrawn.

I review the course outline. Three main theoretical approaches in counselling form the major study blocks of the seventeen-week course: psychodynamic, behavioural/ cognitive behaviour and, humanistic/ person-centred. Today we begin at the beginning by exploring the contribution of Sigmund Freud (1856–1939). It seems that Freud was hugely controversial in that he disagreed with his contemporaries by proposing that only a small part of what is mental is conscious. He argued that the rest was unconscious, and that irrational and involuntary ideas were at the core of much of human behaviour. I am sitting and listening carefully to the presentation about Freudian psychoanalytical theory. The approach calls for a dynamic understanding of the role of clients' early childhood events and the consequences of these experiences on present time struggles faced by clients. I resonate strongly with this link between behaviour and its deeper origin buried within our psyche. My first INSIGHT. Taking a psychoanalytic approach to my case provides a helpful shift of focus onto the unconscious psychodynamics of my 'complex' behaviour and misconduct. In silent reflection I recall that considerable attention was given by the FtP Panel to the presumed material motives for my behaviour and very little to any other explanatory force.

The tutor outlines how many of us grow and develop an unhealthy superego by largely introjecting the values and standards of our parents, making them our own. In essence, she continues to say, these become perfectionistic goals. I feel my heart sink as it suddenly begins to dawn on me that all my life I have worked tirelessly towards winning the love of my parents, attainable I believed, only if I was perfect. Sadly, no matter what I attempt in my life it is never enough. In fact I feel that 'I am not good enough'. The tutor explains that the pent-up anxiety if internalized rather than

expressed freely becomes a state of depression. I am reminded that I grew up in a home where any display of emotions was actively discouraged and I ended up internalizing my anger and guilt. When this became unbearable for me, I became self-destructive. I am seeing clearly that this is a way of inflicting self-punishment through my strongly held perception: 'I am un-loveable'.

The tutor directs us all to form triads (of counsellor, client and observer) and to tentatively begin to explore each of our past using the analytic process she has outlined. My peers and I explore memories of relationships with siblings and parents. I cannot speak for others in my group, but I begin to re-experience old feelings, probably related to traumatic events in my childhood. The tutor explained that as many of our buried fears become conscious, - we no longer have to exert energy on defending ourselves from unconscious feelings. Instead, it becomes possible, the tutor was saying, to recognise we have choices in the decisions we take. I began to see that the feelings of abandonment and emotional abuse I experienced growing up had significantly shaped my behaviour to the present time.

The tutor outlines two extensions to Freudian psychoanalytical theory that have relevance to my case. First the contribution of Carl Jung (1875–1961). Jung disagreed with Freud, believing human beings deserved to be viewed more positively. A key focus of Jungian theory was on individuation. This is the capacity of a human being to become whole largely through personal exploration of unconscious aspects of the personality, with a view not only to overcome presenting problems but to transform personality. The idea that it is possible to work towards a transformation of personality and become all that I am meant to become from within my own resources appeals to me and I feel sure it holds real promise for my necessary growth and development.

Second, Erikson's (1902–1994) psychosocial developmental perspective extends Freud's initial concepts of distinct life periods. For Erikson, there are eight stages of human development: infancy, early childhood, preschool age, school age, adolescence, young adulthood, middle age and later life. Like Freud, Erikson also believes that at each stage the individual faces a critical turning point or developmental crisis. Failure to resolve the central struggle at each development stage has been postulated to cause psychological difficulties. In my own case EUPD stems from trauma and developmental disturbances during the first three years of life. This is when it is believed every child undergoes independence from the mother through the process of 'separating and individuating'. Key to the establishment of the EUPD condition is the withdrawal of emotional support by the mother. As a result of such emotional neglect, I recognise in myself such traits as instability, irritability, impulsive anger, and extreme shifts in mood.

A distressing symptom of my disorder is 'splitting'. It prevents me from holding incompatibles together, whether about objects, societal structures or people. I categorise all things into either black or white, good or bad with nothing in between. Inevitably my moods follow so that I display a marked love-hate dichotomy of emotions especially in my relationships, both at home and work. I recognised therefore that I suffer from a compulsive dependence on people, yet at the same

time I carry a deep fear that I would be abandoned. I feel incredibly insecure in my own skin and seek my validation as a human being from those around me.

As part of the continuous coursework component I keep a reflective diary as we skip week by week through the various counselling theories presented on the course:

'I feel that the Freudian perspective is authoritative and sadly for human beings deterministic. In this approach, I am considered wholly shaped by my past traumas and therefore any attempt towards meaningful change would be restricted. This frustrates me as I believe I can grow beyond the limits imposed by my neuroses and the medical label of EUPD. It is, instead, what the tutor said about Carl Jung's conceptualisation about human beings that instils real hope in me for change. Jung sees human beings more positively and while recognising the impact of past events on personality, he believes in a fundamental human nature oriented towards developing and growing to reach a complete state of fulfilment, achieving individuation and integration of all aspects of our personality, including acceptance of primitive, destructive forces such as selfishness and greed. For Jung, acknowledging the 'dark side' (or shadow) is necessary for achieving fulfilment.

I am able to draw much relevance to my symptoms and behaviour from the psychoanalytical approach. I have repressed considerable material throughout my childhood, revealed through breakthrough aggressive outbursts, which landed me into trouble as a child and teenager. Such outbursts in later life lead to heartbreak in my family life and tension at work. Growing up with my parents, I also developed a very strong superego by introjecting their values and standards, so they became like my own. I can see now that these values have induced perfectionistic behaviour in me since I believe I could only be loved if I became perfect. Until recently I did not accept that this goal is unrealistic and unachievable. I continue to turn my anger and guilt towards myself with the result that I develop a deep self-loathing and self-destructive tendency. Such symptoms were ever present working as a pharmacist, yet I compensated through delivering a standard of service that exceeded my patients' expectations. The feedback I used to receive was reward in itself as I drew a great deal of satisfaction from each patient encounter. I clung on to positive feedback as an essential antidote to my ever-present state of depression.

During my lengthy hearing last year, I was repeatedly asked to explain my behaviour when I experienced difficulties in running my businesses lawfully. Though I searched hard for plausible reasons none seemed to surface at the time. Instead I fell silent in front of the Panel and prosecuting lawyer and resolved myself to not knowing, perhaps not ever. Of course, this was interpreted as my further attempt to frustrate proceedings through an unwillingness to cooperate. I now perceive that what was opaque to me at the time was a result of my unconscious defensive action to repress painful aspects of my childhood, to the deepest recesses of my mind. The real value of the psychoanalytical approach, as I have come to understand it, lies in making the unconscious conscious in order that people, like me, will no longer be determined by unconscious impulses.

As a child my relationship with my mother and father was mostly hostile as I felt unloved, particularly when reminded by them that 'I almost killed both myself and my mother during a protracted and difficult birth' and 'Why I wasn't as good as my siblings?' Above all else, and cutting the deepest wound, was "*Why was I born?*" I understand nowadays that such remarks made towards me are considered emotional abuse. Up to now I have not consciously been aware of these harrowing attacks, yet feel strongly that they form a significant part of my repressed material. I have learnt through this course that the very act of making the unconscious conscious is the first step towards personality change and therefore increasing ability to exert control over behaviour. I feel guilt and shame to learn that my presenting misconduct was a repeating pattern that I formed with my parents during my childhood years. The theory pointed to my failure to resolve the struggle for independence and therefore my inability to derive worth for myself from within myself. Finally, I came to understand the strength of my dependence on others, including my family, friends, work colleagues and patients for providing me with my worth. I am utterly dependent on those around me to 'love' me and when this is not supplied it feels like I have been abandoned. Impulsively, without thought, I react badly and reveal many of the self-destructive behaviours of sufferers of EUPD. Until now, I have felt trapped, unable to see a way out of my dis-ease. This new insight offers hope of a different way to exist in this life which Jung is pointing me towards.

This week our tutor introduces the approach of Cognitive Behaviour Therapy with an emphasis on Albert Ellis's (1913–2007) Rational-Emotive Behaviour Therapy (REBT). The tutor explains that REBT followed a more scientific approach than psychoanalytical therapy and 'would probably appeal more to anyone with a background in science'. Two hundred and twenty seven days after my sanctioning, arrived at by my regulator following the reductive logic of science, I was certainly not going to dismiss all I had gleaned from the past two weeks of applying psychoanalysis to my life just because it might have been relatively unscientific. From the start of my pharmacy career and with each passing year, I recognised that I had, in fact, grown more by stepping out of my comfort zone, namely a dominantly scientific world view. I recall becoming increasingly frustrated within a decade of registration. My work compelled me to perform as a scientist with an emphasis on the drugs and medicines I was responsible for supplying. However, in the absence of a more interpretative and person-centred perspective my customers and patients did not always engage as partners in their self-care through the methods advocated by my training. I realised then that something was missing and this led me to develop greater understanding of human and social disciplines through successfully completing a Master's degree.

The tutor continues that, according to REBT, people are responsible for their own psychological difficulties. This made me feel quiet uncomfortable as it reminded me of an attitude that prevailed during the latter part of the last century, and perhaps still does today, that disease and illness is the fault of sufferers. The term that came to my mind is 'victim-blaming'. It is a top-down paternalistic illness model that appears to ignore the whole spectrum of determinants on health, outside the individual. REBT claimed that poor psychological health is a consequence of negative self-statements. It follows therefore that therapy targeted at these statements could produce a

change in behaviour. The approach contends that it is because human beings have the capacity for self-awareness that we are able to change our emotional destiny. I listen carefully to what the tutor said. Next, we participate in an activity through which we each produce a list of personal absolutist thoughts, coaxed as our 'shoulds', 'musts' and 'oughts'. The tutor tells us that absolutisms were at the heart of human misery. I list the following down in my notebook:

My shoulds – 'I should avoid showing my emotions and feelings'; 'I should not expect to be loved unconditionally'; 'I should show courage'

My musts – 'I must always be strong'; 'I must be perfect'; 'I must not show any signs of weakness'; 'I must have love from all the important people in my life'; 'I must continue to work hard and be the best at what I do'; 'I must not let people who depend on me down'; 'I must not fail'

My oughts – 'I ought to be rewarded for my effort and sacrifice'

I am not surprised to notice that many of these statements directed at myself are essentially self-defeating and were birthed during my childhood. I hold the belief that I am basically unlovable, unless I am perfect. Unfortunately, as a child, nothing I do or achieve seem adequate. This produces strong feelings of self-loathing which, despite my attempts at suppression, repeatedly surface in my behaviour particularly in response to actual or threatened rejection, abandonment or devaluation. Linked to my striving to attain perfectionism is, according to what I know about REBT, an un-realistic belief that 'others must always live up to my exacting standards'. Inevitably, this causes me to distrust others as 'they always let me down'. I am now able to understand why through my career I have felt frustration and even anger towards work colleagues over their apparent lack of attention to detail in the dispensing of prescriptions. As a business owner I find it unbearable to see sub-standard work from my staff and cannot help my emotions spilling over as passive-aggressive behaviour, and rage (though thankfully the latter is rare). In evidence the prosecuting team at my Hearing detailed incidents where my aggressive behaviour towards work colleagues had been reported, including shouting, verbal abuse, anger, rage and even throwing a dispensing basket. All of this is helpful and deepens my insight in to my misconduct which I would need to present to my regulator in any future restoration attempt. Thankfully, in contrast, my behaviour towards the public is always courteous and respectful. In my view perfectionism has forced me to be strongly controlling over my work as a pharmacist and proprietor. I believe myself to be a very safe practitioner, with an error rate of less than 0.001 per cent, which had been noticed by both colleagues and the patients I serve. I believe I can always be trusted to provide a safe prescription dispensing service and feel an enormous sense of pride about the fact.

In the context of my regulator's decision to remove me from the Register, this is the single activating event for my more recent belief that 'I have failed in my career' and consequentially 'I am a failure in life' and confirmatory of my parents' words to me, 'I wouldn't amount to anything in life'. I am filled with a host of negative emotions including guilt, embarrassment, shame, anxiety,

sorrow and fear. My confidence is in shatters and self-worth at an all-time low. I experience anxiety that escalates to panic and I can hardly breathe a lot of the time. I hear the same nagging voice in my head:

'I am worthless. I am bad. I deserve the excruciating pain in my mind-body. How can I justify wishing to live any more'.

The theory of REBT rightly or wrongly suggests that human beings are solely responsible for creating their own emotional reactions and disturbances. Such causal beliefs viewed from the outside may appear irrational, but from my own 'insider perspective' they are real and rational and represent my lived experience as a sufferer. I feel trapped and do not see an easy way out, not even through the intimation of REBT. Simply by showing sufferers, like me, how to change irrational beliefs I can help myself to learn to deal with my difficulties more effectively. I do not perceive this to be a fast process. Having spent many years nurturing a particularly negative set of beliefs against myself I have allowed them to take root and become my reality. I just didn't know any other way to be in this world.

Working alone, without the help of a therapist, I accept that my first task under REBT is to begin to examine the list of 'shoulds', 'oughts', and 'musts' that I had indoctrinated. As a child watching my own father dominate the family home, I grew up believing that to be a man 'I always have to be tough and strong, and never to show signs of weakness.' Furthermore, 'I could only be loved by being perfect.' In this notion of 'self' I cannot show vulnerability, and failure was simply out of the question, as I believe that both would eventually diminish me to a state of 'nothingness'. Thinking back, my mother often would remark that I was just like my father. What did she mean? I became the scapegoat for my family's woes and deeply resented this. Applying the logic of REBT, I understand that I needed to go against my self-defeating beliefs. Recognising that 'I am not my father' would assist me to relax more and embrace human qualities like empathy, compassion and vulnerability, first-and-foremost towards myself. I am starting to see that these could unlock for me the mystery of human relationships. I have never been comfortable in establishing and maintaining long-term relationships, characteristic of my disorder, since I would always fear being unacceptable as who I truly am and face threatened or actual abandonment.

The tutor emphasises in her summary that, in contrast to psychoanalysis, REBT is entirely focused on the sufferer's present-day functioning and irrational thinking. There is little room for dwelling on the past. So, in order to improve I need to rethink and re-verbalize in a more rational and self-affirming way. For instance, I might begin to say about myself:

"It is okay not to be okay"

"I don't have to be perfect to be loved"

"I am imperfect like everybody else"

"I am able to succeed as well as fail at times"

"I can stop punishing myself for being made to feel guilty for being born"

"I have intrinsic worth and do not need to seek value through education or a high-profile job"

Before leaving Cognitive Behaviour Therapy I feel a craving to re-examine my depression. I ponder the ideas of Beck (b.1921) presented on this Counselling course who challenges the contemporary idea that depression results from anger turned inwards. I recall that prior to each NHS counselling session last year, I was required to answer several short questionnaires which were then scrutinised by my Counsellor. Among these was a set of nine questions under the heading PHQ9. My score on this inventory was 19 from a possible total of 27. This was interpreted by my Counsellor and labelled 'moderately severe depression'. I confirmed that every day since removal from the Register I was (a) feeling down, depressed, or hopeless; (b) feeling bad about myself, that I was a failure, and I had let my family down; (c) had little interest in doing things and; (d) thought that I would be better off dead.

I have always been a 'glass half empty' individual. Through my life I have held a negative view of myself and often blamed setbacks on personal deficiencies. Added to this is the tireless setting of perfectionist goals that always produce disappointment since such goals are, by definition, unattainable. All this just compounds my pessimistic vision of the future. My removal from pharmacy practice did not cause my depression, but it certainly deepened my melancholia. I am even more withdrawn, avoidant and inactive, with the result that I lock myself away in my study for much of the day, most days. My study imprisons me during daylight hours of every day of every week of every month. Family life is impossible for me. All the suggestions of my loved ones, I interpret as excessive demands that rapidly overwhelm me. Social withdrawal is a defensive strategy to try and prevent me from hurting my family further. Behind closed doors I alone come up against ravaging self-hate. I am too tired to offer a resistance. De-registration had caused me to feel the entire spectrum of what I can only describe as agonizing emotions in the extreme. I hurt all over, all the time - morning, afternoon and evening. I hurt at night, in my sleep and in my dreams. Living day by day in this state is unbearable. Most days I genuinely feel unable to cope with my loss of profession. It is only natural that in this state, I show symptoms of suicidal ideation. I have a choice to make. I can choose to live with this gaping wound or alternatively to attain freedom by extinguishing this life and all the pain it clings to. My disconnection from my wife and children, friends and family is almost complete.

I have known this existence for two hundred and forty days beyond the event that marked a crossroads in my life. I am hearing about Person-Centred Therapy (PCT) in today's session of the Counselling course. The tutor informs us that the author of PCT, Carl Rogers (1902–1987), believes that people are essentially trustworthy, have capacity for understanding themselves and will eventually resolve their own problems. Ultimately, then, PCT assumes human beings are designed for self-directed growth. I experience a resonance with what I am told. I feel instantly

drawn to the philosophy that underpins the approach. The tutor states that with roots in existential and humanistic schools, there is acknowledgement by PCT that, more than anything, an empowering climate was essential to bring about individual transformation. I think back to the choice of words used by my regulator against me, and how they continue to echo in my head. Were they chosen with the unkind intention to be deeply scathing to me, almost under the false assumption that I had no capacity to feel? I do not perceive that the regulator considered relevant its responsibility towards me as a pharmacist registrant, whose present FtP may well have been impaired, but to extend to me the basic human right to be treated with compassion, consideration and care in order to stimulate constructive change, and return to practice at some future date. Instead, I feel ridiculed and disempowering. No, actually, much more than this. I am de-humanised by the system of regulation.

I fully accept that my conduct as a pharmacy professional between the period 2009 and 2011 fell short of my professional code. I did not feel the Panel made any serious attempt to understand just what my world was at the time like, from my vantage point. As is almost always the case involving community pharmacy proprietors who are brought before their regulator that the Panel seek to paint a picture of persons motivated by greed. This is invariably without taking full account of the contextual pressures faced by proprietors. I was driven by a higher purpose than the emptiness of greed. The words of my regulator and removal from pharmacy practice have left me broken, ashamed and fighting for my life.

The view about me presented to the world by my regulator's formal assessment and diagnosis on their website is, from the perspective of PCT, of secondary concern to my primary 'self-report'. Such a position offers the hope that I do not have to allow the judgement of my regulator to define me. The person-centred approach puts me in the driving seat, trusting me to find my own way towards personal growth. I carry a low evaluation of my self-worth, believing few people like me and that I am unlovable. It feels like a default to self-loathe and perceive myself inferior to others. I am secretly seeking confirmation from others always of my worth, including that of my parents, wife and children, tutors, mentors, work colleagues, employers, and more lately my regulator. I do not see how it is going to be possible for me to come to view myself in a more positive light, given my feelings of inadequacy and hopelessness. I have failed to live up to the expectations of both my parents, and of my regulator.

Unrest in work life, as an untreated EUPD sufferer, has often produced feelings of helplessness, but at no other time in my career were such feelings so ardent than during my period of pharmacy proprietorship. In this time, I frequently display emotional volatility. Behind the volatility, I want to be recognised as a human being, with human qualities of empathy, sensitivity, kindness and care. Against a large number of overwhelmingly positive testimonies from my patients, perhaps touched by my authenticity, the judgements of my regulator feels unfair, even cruel. De-registration and shaming are used by my regulator in the name of public protection to punish, disempower and silence me.

Two hundred and ninety five days since the start of my incarceration, I reflect over what I understand about myself following attendance on the Counselling skills course. I have studied the three major psychological theories that are relevant to contemporary counselling. In the context of my life and situation, these theories for me sit along a timeline. First of all, psychoanalysis helped me to understand my past and the influence that my subconscious has played on my behaviour. Second, REBT had revealed to me that my present-day functioning was restricted by my 'musts, shoulds and oughts'. Such inflexible and debilitating thinking underpinned my perfectionist behaviour. I felt I was living my life by values that belonged to my parents. I came to realise that I was still trying to win the love of my parents, while at the same time feeling rejected by them. After removal from the Register, I was left feeling like an outcast, ridden with guilt and shame for bringing my profession into disrepute. My isolation had worsened. Finally, PCT offered me hope of a different kind of future. The theory suggested that I possessed the power to transform my personality within a nurturing environment. I was yet to realise my potential and this indeed held promise for me.

DEPRESSION…Invite your depression to pull up a chair with you in front of the fire, and sit with it, without looking for a way to escape… When you allow yourself to experience depression, it will leave as soon as it has served its purpose in your loss - Elisabeth Kubler-Ross

Three hundred days outside pharmacy practice, and the experience of erasure continues to feel raw. Since my diagnosis of EUPD I receive periodic assessment with the Consultant Psychiatrist of the CMHT. She almost rejoices when she tells me that I am intelligent and high-functioning and that I have the capacity for change. She admits that the limited resources of the NHS Mental Health Services (MHS) has to be targeted to individuals different from me and who pose a risk to themselves and others and are significantly less capable of change on their own. She also shares with me that the NHS MHS does not have the capacity to respond to demand. It occurs to me that by embarking on the Counselling skills course at my local College, I am actively following the principles of PCT towards reaching self-empowerment whilst, at the same time, reducing the burden on NHS MHS. However laudable my health-seeking behaviour might have been, the reality of my state of mind remains a forever deepening depression about my situation. I am portrayed as a disgraced healthcare professional, unfit to practise my profession, by my regulator. The stigma and shame associated with 'strike-off' leaves me despairing. The impact on my family life continues to be severe as the stress of not being able to provide for my loved ones was a trigger for EUPD symptoms.

The only thing that anchors me is my wife. And she does so warily. We treasured the memory of experiencing 'love at first sight'. We used to laugh at how we were each rendered powerless against the other by the sheer force of our love. We were swept up in it. We believed it was like we were the only two people speaking a common language. It felt like we had no choice about falling for each other. Twenty five years later, we are barely able to talk to one another, separated by a chasm of misery carved between us by de-registration. Each of us is desperate to find a way out of this misery. In less than a year, my grief has grown from an initial numbness to giant

proportions. My grief fills my family home. It is uninvited, but rapidly takes up space and sucks out the air. It leaves no room for anyone else. My wife and children are suffocating in its wake. Grief and I are left alone, therefore, a lot. Grief wraps itself around me in the early hours of the morning when I wake from yet another nightmare about my strike-off. Grief and I shower together, while my tears unite with suds and run away. We pass time, sitting together, staring out of the study window at the small front unkempt lawn. Grief behaves like a jealous friend, reminding me that no one else will ever love and understand me as much as it does. It is enslaving and I am unable to shrug it off. I have no option but to heave my grief outside my home and onto streets, into parks, by the seaside, watching all around us carry on. I take grief with me through the aisles of the local supermarket, but we are too hollow to buy much. My grief is a tornado and I am swept up in it.

At home I am moody, intense, aggressive and confrontational. I have little interest in the people I share my home with. I am controlling and abusive when I not obeyed. I believe they have become scared in our home and feel safer outside. My mental health condition, strike-off and deepening depression has even begun to frighten me too. The days when my hurt reaches an all-time high are the worst of all, rendering me unable to speak. On these days there is a rage building inside me. I hit out at the furniture around me. Sometimes I punch into doors and walls, leaving dents to remind us all of the darkness that lives with us.

I discuss medication options with my Consultant Psychiatrist, largely in response to my family's desperate pleas. They have already absorbed too much hurt. I have to listen. I have to do the right thing. I have to save them and what little remains of our relationship. I succumb to taking antidepressant tablets to help take the edge off my emotional pain and therefore help reduce their untold suffering. I do not want to lose the love and support of my wife and children. They are victims of my circumstances and it is compassionate to help them as much as myself. This disruption to my working life is not their fault and I accept that my unruly behaviour is unacceptable in a home environment. My consultant titrates my citalopram tablet dose up to 20mg daily. Benefits accrue slowly, but remain in place. My home life is more predictable. I feel less. I am slow to anger. I have brain fog. I do not believe I am wholly present within my life. I allow myself to drift from day to day like a barge along a watercourse.

4.6 Vignette six: Journey II (spiritual health)

I have a lucid dream during the night of the sixty-seventh day following removal from practice. It has a different quality to the usual nightmares and flashbacks that visit me in the dark. In this dream I am a young boy, maybe eight or ten, in a glider flying solo high above the earth looking down. Without warning I begin losing height and very soon am flying dangerously low, narrowly missing trees below. I am scared and anxious that unless I regain height quickly I am at risk of crashing and serious injury. I continue my descent and come down heavily on exposed ground. Onlookers appear aghast presumably at my dismal prospect of survival. To everyone's surprise I throw open the roof of the cockpit that encapsulates me and emerge as a fully-grown adult,

unscathed by the crash. My heart is racing, I am sweaty, panting and tearful as I slowly regain consciousness. I wonder, through the remains of this night, if the dream holds meaning with my experiences, both past and present.

Two days later, I am back in the Counsellor's room and my thoughts are dominated by my dream. I am desperate for my Counsellor to help interpret my dream. After describing my dream, I sit back to hear what she thinks. My Counsellor keeps her interpretation somewhat generalised, perhaps allowing me alone to impose any meaning 'intended' by my dreaming mind. She said that dreams of flight often suggest a longing for spirituality. Alternatively, taking to the air, rising and falling suggest being ill at ease in the sky, even out of control. Coming out of the crash unscathed may point to a new start, she tentatively offers.

These interesting themes for contemplation and analysis are sure to prove fruitful. I have to admit it has not crossed my mind that dreams themselves could serve as raw material for self-analysis. Through my entire adult life I appear to have forgotten Spirit. I ask the same question of myself, but find no answer: 'Who am I?' At 46 years of age I have come to question if I am in fact no more than a combination of my physical body, psyche and social roles. I consider the rise and fall in flight may well parallel issues of independence and fear of failure I have experienced since childhood. There have been many obstacles in my way which I have felt unsure about approaching, but somehow manage to circumvent. My crash and escape are indicative of perhaps coming to accept de-registration as a pharmacist and the urgent need to get up and return to my life - literally break free of the carnage and take a second chance at life.

At this time, I do not know whether there is a God, Divine Presence, Benevolent Being, Intelligent Designer, Spirit or any of the more specific names used by the various religions to describe something bigger than ourselves. My parents certainly thought there was. Throughout my childhood, God was ever present. From the sound of morning and evening prayers to weekend attendances at the local community church, thoughts of the divine were part of me. Looking back I would have to admit I knew about God on a purely intellectual level. I cannot recall ever truly believing in God. I considered it was harmless to follow my parents' example, and that this might even have helped me to feel a little more a part of the family.

I have existed four hundred days from this powerless state following erasure. I feel the unrelenting emotional pain that is like a third-degree burn that covers the whole of my skin. I am acutely sensitive to criticism and invalidation, whether real or perceived. Yesterday, at home, I could not stop myself letting out my fury, probably in response to something trivial again. Today, I awake to find myself at a particularly low place. I am completely empty inside. I have been abandoned by my profession and, as of today, by my wife and children also I presume. I sense the familiar suicidal pangs return. I am unlovable. My parents made this clear to me. I hate myself and my life. I am restless and panicky. I decide to go outside.

I am unaware that my life is about to take a new direction and my transformation take on renewed impetus. I happen to raise my head skywards and look for the sun that is struggling to emerge from a cloudy sky. Like a bolt out of the blue, without foreboding, Lord Jesus fills my vision! To my surprise the vision remains steadfast in the sky in the time between my looking away and trying to dismiss it as imagined. The persistence of the vision slows my motion to a near stop. Lord Jesus presents himself as the risen 'Christ'. His hands are relaxed with palms facing upwards beckoning me to follow him. At this time I am broken, troubled, beyond repair. His gaze upon me from up high is compassionate, sincere yet gentle and loving. All sense of the world and my physical being seems to dissolve. Everything appears in this moment brighter and as I begin to fill my consciousness with this light I feel somehow my Lord is familiar to me and beautiful. I do not discern any sound. However, there is an innate knowing that is taking place in me. Like the 'sound of silence' that is able to convey several profound messages for me to hear including

I am unconditionally loved…

I am a beloved child of God…

I am forgiven…

I am home…

I am whole…

My search for a purpose and meaning to my life on Earth was being revealed

I am a soul…

I am spirit…

I am love…

Be at peace.

For the first time in my life I am able to feel what it is like to be unconditionally loved. I have no memory of this level of consciousness. My childhood has made loving myself and others and being loved in return seemingly beyond my reach. My emotions and personality too unstable to trust. I carry emotional scars and protect my vulnerability through the behavioural traits that define my mental diagnosis. I fear abandonment most of all and live my life through fear.

The vision of the risen 'Christ' and accompanying tender feeling nudge me to procure a new perspective on my situation. Through my formative years and career I have absorbed, like most,

the worldly wisdom that emphasises winning over losing and success over failure. Yet, today and for the first time, I begin to contemplate the value of loss. The adverse events of the passing year have brought me to the point of suicide. I feel woefully inadequate to cope with my regulator's decision to remove me from the Register. Moreover, I continue to blame others for my situation, rather than accept my strike-off as, quite possibly the only option, under its rules, for my regulator to take. In contemplation I have an insight that loss might in fact teach greater lessons than success. Counter to my prevailing belief, am I then to reassess strike-off as a 'gift' in my life? After all, only through the grave emotional pain inflicted, by removal from the Register have I shown the courage to seek help and unearth depressive illness and a lifelong personality disorder. As usual, I have more questions than answers. Why has this knowledge come to me now? Why did I have my beloved pharmacy career taken from me by a regulatory system unable to comprehend the complexity I brought to its courtroom? Why is the experience of crippling hurt necessary in order to receive a glimpse of the spiritual path and all that it might teach me, especially around becoming gracious in my loss?

Four hundred and eight days outside of pharmacy practice and the vision of the risen Christ permeates my mind-body and every single cell is vibrating to the discernible rhythm of life. The experience continues to stir something deep inside of me. I am awake to a new, higher way of life, but doubt whether I am ready to consecrate myself to the spiritual path. I recognise that many in our world, like my parents, cling to religious discipline and draw from it, the strength to cope with life's misfortunes, whenever and however they strike. My own vision entices me to fantasise about a transformation in my personality, even towards that seen in esteemed individuals in history like Mahatma Ghandi, Nelson Mandela and even Jesus himself. I am desperate to start to shape my true identity. I am compelled to find a Christian community and begin the process. My old self must die. My old self must die and give way to my new self. My new self is my true identity. It is home and whole and loving. I say it out loud over and over.

Soon into my search for a community of believers I realize that the Christian religion, like most other major religions, divides itself into many denominations. I am confused by the variations in the statements of faith held by denominations allegedly based on the Holy Bible. I lament at the real prospect that even 'truth' has not survived human interference. I have not been prepared for this unexpected finding. The various perspectives, though openly competing to be heard, do however converge on the life and teaching of Jesus. Most suggest that only by giving our lives to Jesus can we hope to be saved. I feel compelled to learn more about Jesus, who up to now represents a historical figure who lived over two thousand years ago and made claim to be the Son of God. I resolve to join a denomination that centres its practise on rigorous Bible study. I make the decision to go along to a local Christadelphian group, from the start of the New Year, as its website and literature stresses more than any other that its 'statement of faith' was based on Bible truth.

ACCEPTANCE…In a strange way, as we move through grief, healing brings us closer to the person we loved. A new relationship begins. We learn to live with the loved one we lost. - Elisabeth Kubler-Ross

Cast-out of professional life five hundred days ago and, at the turn of the New Year, I can sense the beginnings of change. I am anxious stepping in to the Christadelphian meeting hall referred to, not as a church, but an ecclesia. I fear rejection, however absurd it may sound, from a holy place. I am approached by a believer who asks for my name. I give the name 'Paul' which I have adopted and been using for the past year. Unexpectedly, this is met by looks of astonishment from the believers. I feel even more uncertain about my visit today. I am escorted to a seat near the front of the hall by a friendly elderly gentleman, who speaks with a familiar Black Country accent, and hands me a copy of the Holy Bible and a hymn book. I am nervous while waiting for the service to begin, quite unaware of the structure it would follow. I decide on a strategy. I would just observe others and mimic their actions. Doing so is an attempt on my part to pass as normal, though I have never before thought about myself as normal. In all honesty whether I succeed or not, I feel I needed to belong to this community of believers. It is what my heart is crying out for from the time of my removal from the professional register which had left me feeling abandoned and lost.

At the end of the hour-long evening service, I am invited to remain behind and have a discussion with one of the members who serves as a mentor to persons, like me, new to the faith. I feel apprehensive since I am not ready to discuss, with a stranger, my mental health diagnosis or de-registration. It has become apparent to me since I lost my licence that I struggle each day with the knowledge that everybody else was aware of my transgressor status. I am sure this is more than paranoia. The media coverage of my case and the activities of my regulator, to both punish and expose me, have left me with shame. Further exposure today will only increase the shame and inner turmoil I experience, especially at a point in my life where I am desperate to draw people closer to me and not give them reason to withdraw from me. I ponder on whether or not to hold back information and therefore not risk the humiliation of further rejection.

To lie to this faith community feels wrong. I hear the nagging voice of my conscience reminding me to let go of shady attempts to 'save face'. I feel a strong need for self-disclosure today. As with the Catholic tradition of confessing of sins, I am confident that sharing my recent past was important if I wish to build a meaningful relationship with this community of believers. Personal guilt, which I bore through past misdemeanours, was crippling and severely impacted my mental health. I recognise that I am left isolated and very alone through my experience of guilt. In UK society, and probably most other Western cultures, citizens are strongly encouraged to view themselves as autonomous beings, largely through adopting an individualistic perspective. This has long stood as a source of tension for me coming from an Indian culture with its emphasis on interdependence within and outside the family. I struggled throughout my private and working life to reconcile the dichotomy. In the end, my failure to 'just be' and 'to belong' is contributory to the

decisions I take in business which eventually led to my removal from practice. Sitting to the rear of the ecclesia, the Christadelphian member and I begin to chat in to the evening.

Christadelphian: So what brings you to us today?

Me: It is still difficult for me to speak about the recent events in my life that have contributed to my decision to turn to faith. I was a community pharmacist and was struck-off in September 2012 for breaking pharmacy laws and regulations by working across two businesses that I owned. It brought on depression and I quickly became suicidal. Referral to the Mental Health Team led to a serious mental health diagnosis, referred to as EUPD, which would have begun in my childhood. In October 2013, I had a profound religious experience in which Lord Jesus gazed upon me and made me feel unconditionally loved and valued for the first time in my life. I am here since I feel I want to learn more about the life and teachings of Lord Jesus.

Christadelphian: Thank you for sharing your recent difficulties. I am sure you will find the whole Christadelphian community supportive to your spiritual growth. Many of us in the community have suffered loss in our lives and we turn to the Word of God as written in the Holy Bible for comfort and guidance, as well as strengthening us on our journey through life. Our Lord Jesus is the Son of God and humanity's saviour. By giving our lives over to following the Lord we can be confident in our hope to be reborn and transformed.

Me: I have to say to you, I was fearful of disclosing my troubles because I believed you and your friends would see me the same way as my regulator saw me. A transgressor who deserved punishment. You see, by striking me off the Register, the General Pharmaceutical Council deprived me of reputation, worthwhile work, the means to earn a living and support myself and my family. I was ostracised by the pharmacy profession, in my opinion, for doing my utmost to preserve a pharmacy service to vulnerable people in rural communities in the absence of available pharmacists. Yet in spite of all this, since the autumn of last year, I have come to see my punishment as a gift. By taking away my daily work, my regulator had unwittingly afforded me the time to focus on my mental health and my emotional and spiritual development. Through my life I had repeatedly overlooked my own well-being and instead continued to keep myself busy with my work and studies. Over four decades, from living under my parents' roof, to living away at University, and more recently within marriage, I have experienced great difficulties with maintaining an optimal level of personal well-being. Stressful moments all too often have revealed my emotional vulnerability which I now understand to have been premised in low self-esteem and deep self-loathing. Do you believe I can be helped?

Christadelphian: It is interesting that you spoke earlier about experiencing your own awakening through a vision of the Lord Jesus. As the Holy Bible portrays, the Lord Jesus challenged all those who held unjust power around him. Most people find what they most need and desire in the least likely of places. In the Christadelphian community we put forward the life of the Lord Jesus as the model we put our faith in, and to change our lives using the lever of love. No matter what brings

you to faith, we believe that through building a strong relationship with Lord Jesus and His Father through the written Word, it alone can instil genuine hope and transform broken lives.

Me: I feel reassured by your comforting words and am willing to commit myself to learning as much as I can about God, Lord Jesus and scripture. I feel I have reached a crossroads of my life journey and with your help and support I hope to be guided beyond myself. My heart is overflowing with gratitude to you for taking the time to listen today. Thank you.

I learn that it is normal Christadelphian practise to follow a demanding Bible reading plan each day. Of course, with every member taking the same year-long journey through the Holy Bible, I contend, this can only nurture the spirit of collegiality among the followers. I felt confident that my choice of denomination would help me learn about both the life of Jesus and the Christian faith and help me towards the transformation in personality I seek.

Six hundred days lived outside the profession of pharmacy and, I am a regular weekly disciple of Lord Jesus, at the Sunday evening service held at my local Christadelphian ecclesia. Exposure to the Word of God, the lives of biblical characters and their stories and worship over the past four months is helping me to understand my own role as the architect of my own misfortune, largely through wilful poor choices and decisions in the course of running my pharmacy business, the reward and consequence being significant additional emotional suffering. Accepting that I require help to manage my mental state, I continue to take an antidepressant each day. To the relief of my family, my medication subdues my extreme responses (of anger and rage) yet leaves me experiencing ‘brain fog’ – a hazy state of existence, lacking the acuity of real living. I feel trapped and unhappy with this state of existence. I begin to question the medicalisation of personal emotional suffering by Western health systems.

My medication is directed at my mind. It is not helping me to mend my relationships (especially those that concerned my profession) nor change my material circumstances. I am, for instance, still not on the Register for pharmacy professionals, unable to work as a pharmacist support myself and my family. Moreover, I am becoming increasingly discouraged by the knowledge that my difficulties are being addressed by the same therapeutic orthodoxy that I also, until recently, was a part of. It is plainly limited in its power to address the roots of emotional suffering. My despondency has reached the point where I decide to take back control and stop taking my tablets. The decision is influenced by my growing supportive relationships within the faith community which give me a greater sense of stability and confidence to trust in the divine for courage to abandon reliance upon psychiatry and its methods. The recommended approach and period for withdrawal of an antidepressant of between two and four weeks feels excessive to me. I wish to be free of the ‘brain fog’ sooner and to return to a state of experiencing emotions and feelings more fully once more, and so decide to halve my daily dosage of citalopram from 20mg to 10mg for one week followed by a further cut in dosage to 5mg daily for a few days before discontinuing completely. As anticipated, I begin to experience severe dizziness which leaves me confined to my bed for much of the period of withdrawal. Though I am aware that debilitating

withdrawal symptoms can be avoided by following a more gradual approach, my desire to no longer be medicated is a greater goal right now. After all, such effects are only temporary and therefore acceptable to me. There is no turning back.

I attend a scheduled outpatient clinic review conducted by my Consultant Psychiatrist today. It is my eight hundred and twentieth day away from the Register. I am more upbeat than usual and have kicked the antidepressant drugs. She asks me questions. I answer them. I do not clip my responses. I am open and honest and, for the first time optimistic. Afterwards, my Psychiatrist recorded the following in my medical notes:

“Mr Leal stated he had stopped taking citalopram two months ago. I am pleased to say that he is, for the first time, positive in his outlook. It seems clear that Mr Leal has developed a good understanding and insight of his condition (Emotionally Unstable Personality Disorder). He spoke about the fact that for the first time he has realised that he is able to make choices rather than act impulsively. He has recognised the fact that acute stress increases his impulsivity and he works hard to manage it. Mr Leal continues to learn to distinguish between mood states, thoughts, feelings and emotions in order to equip him to make rational and considered decisions, especially with regard to running the pharmacy business he still owns. There was no evidence of any abnormality in his mental state”.

I carefully read the words about my progress and current state of health. I am filled with confidence about the true place of loss and suffering in the growth of a human being. Through an act of surrender to the supremacy of faith, I have to the best of my abilities overcome many attachments in my life that have long convinced me they represented success. I am separated from my wife, living outside my family home and without work. Over the years, to fulfil my inner tumult and emptiness, all these attachments just served to feed my ego, though never succeeding in making me truly happy. My many career achievements represented a shallow attempt on my part to raise my own self-esteem. So, my lifelong ‘good works’ were performed without charity and understandably, as my reading of scripture predicts, became an obstacle to my spiritual growth. Today, all the things I previously regarded as of cardinal importance have faded into the background. The past two years have taken me to the brink of suicide and, thankfully, beyond. As my Psychiatrist has observed, I seem to have emerged with a changed perspective on life. Perhaps, now I could begin to address my regulator’s Determination on my case that was deeply condemning and take the first step in restoring my name to the Register.

4.7 Vignette seven: Journey III (restoration application)

Today is the end of my twenty eight day period of Appeal allowed against the General Pharmaceutical Council Fitness-to-Practise Panel’s (FtPP) most severe sanction - strike-off. Yes, I am guilty of the misdemeanours brought against me, but not for the reasons and motives arrived at by the FtPP. This I feel undeniably in my mind and heart. My strong feeling of injustice is triggered by the rationale given by the FtPP for my misconduct. Self-interest and greed are simply

not my drivers. Self-interest and greed are superficial and shallow and insufficient to motivate me to wish to work two shifts on each day that a second pharmacist could not be found in order to provide a continuous service to my patients in rural village settings. From the large number of patient testimonials it is clear, I am an experienced and highly dedicated pharmacist with a passion to provide high-quality pharmaceutical care. I remain perplexed at the decision I made in business to work across my two pharmacies on days when pharmacist cover could not be found and to contravene pharmacy law and regulations. I am frustrated to be unable to fully explain my behaviour, if indeed there is an explanation? Mere notions such as 'duty', 'emotion', 'failure', 'scarcity', 'crisis' and 'burnout' continue to bounce around in my head, but they are yet to settle and take form. The absence of answers inevitably rules out any possibility of lodging an Appeal within the tight time frame available under the rules and the arbitrary period of five years for my type of sanction is set in motion. Many erased care professionals give up hope of ever returning in the sands of time. I, on the other hand, am resolute to continue to make a contribution to the pharmacy profession and will fight on, whatever the cost, to restore my name. The journey ahead is unwritten and I worry if I am resilient enough to withstand the onslaught of dark emotions inside me - anxiety, fear, anger, sorrow, guilt, remorse and shame. As if my body is responding to the way I feel, I am the image of dejection.

Eighty one days after my regulator determined that my name be removed from the Register of Practise, the experience of it continues to feel raw. I believe that there are basically two types of worker. First, those whose only ambition in life is to give up work completely, so much do they dislike it. I put myself in the second category who confess, and mean, 'I live for my work'. I think those who work in one of the care professions feel privileged to have jobs which they enjoy - who, given the choice and if they were physically able to, would continue working long into their retirement. My working career as a healthcare professional is currently interrupted. I possess a growing need to return to some form of work which can help satisfy the hole I feel in my life at this time. Scouring through the local paper, I see an advert from a local Arthritis Charity that requires volunteer helpers to assist in running weekend social events for older people. I spend a great deal of time locked away in my study feeling idle. I am desperate to begin to make the changes I feel intuitively necessary in order for something positive to emerge so I do not feel utterly lost in the aftermath of my de-registration. Unlike my sex or ethnicity, my professional status is hidden from view. I can outwardly pass for normal, despite my internal pain. I am not ready to confront questions surrounding de-registration at this time. What is important to me now is to try and reconnect with my community and continue to make a contribution, no matter how small. I am not interested in making money. My motivation is to feel useful, even needed. I ring the number given in the advertisement.

My call is answered by the Chairperson of the local Branch who expresses delight at the level of interest I show in the volunteer role. I am invited to attend the next weekend event during which a full induction would be provided. I accept. On the day, I join two other gentleman, both older than I am. I volunteer to serve as a certified first-aider, to assist with catering, edit a monthly newsletter and accept key-holder responsibilities. I show more willingness than I thought I might,

given my somewhat guarded behaviour in the company of others. I fear that my de-registered status might become evident. I feel vulnerable. It is an exaggerated fear, as it turns out, since the only occupational interest Branch members show is in my current competency and willingness as a helper. I am pleased to be able to contribute knowledge and skills towards meeting Branch needs. I feel welcome and valued, but perhaps most importantly I feel safe here. I am acutely aware of all of our basic physical and security needs that must be met, as a precursor, to the attainment of higher emotional and esteem needs. I feel accepted by Branch members and at ease in their company. The anxiety I experience about my discreditable status is a little less, though not expunged by my work as a Helper, through which I am able to retain some aspect of my professional self.

I am the proprietor of my business and yet I feel unable to cope with entering the rural communities that my two pharmacies serve. Publication of my case on the regulator website as well as local media coverage exposes my professional circumstances to the wider public: 'erasure from the Register' - I am not allowed to work as a pharmacist any longer. I am aware I could not therefore 'pass' and may have to face the annoyance of some villagers less sympathetic to my loss. I recognise that I have to learn to cope somehow with the repercussions of stigma. My cautious return to work as a Volunteer Helper is positive and gives me sufficient mental strength to re-enter my pharmacy premises after an absence of ninety days.

The day I return to my business is the day the Pharmacy is to receive the annual Community Pharmacy Contractual Monitoring Inspection by the NHS Primary Care Team (NHS PCT). On arrival, the Inspection Team, aware of the recent staffing and service problems at the Pharmacy as well as my de-registration, begin issuing me with a command - 'you should take yourself away and not answer any of the questions we will be asking those staff employed to work here'. I feel like I am being cast out of my own pharmacy. I am disgraced in the eyes of my profession as a result of de-registration and I cannot defend such negativism turning inwards. Throughout the Inspection I feel a mixture of guilt and shame. I am angry and wish to leave the premises, but as the proprietor, I believe it is my responsibility to remain as a show of support to the three members of staff. I have no choice. I try my best to hide what I am going through inside. I recognise self-critical thoughts and an urge to self-harm. The Inspection ends. It has gone well. Standards are upheld. There are no professional or ethical matters of concern. My staff have performed well whereas I have barely coped.

I sense my former professional colleagues, rightly or wrongly, wish to distance themselves from me. I have to learn to cope with shame. I most acutely feel the hurt and shame of my situation whenever I came in to contact with registered care professionals, including pharmacists, and their places of work. I am vulnerable and sensitive to criticism and invalidation. I was finding it increasingly difficult to deal with the belief that I had been misunderstood by my regulator and the injustice I believe I had been dealt. Was that it? An open and shut case where greed was the only motivation behind my complex behaviours? Few FtP cases extend beyond one or two days. Yet my case took eight days to reach termination. Looking back, along the way, there were twists and

turns, breakdowns and breakthroughs, veiled and explicit shows of anger, confusion and insights, false charges and damaging lies. I just couldn't get off the emotional roller coaster I'd been riding since the start of the FtP hearing, or more correctly since my troubles at work started, two years earlier, in 2009.

On the one hundred and first day after erasure I receive in today's post a Royal Pharmaceutical Society (RPS) branded envelope. I believe it is part of this festive season's mass communication sent by my professional body to all of the membership. I tear it open and pull out the single folded sheet inside. I am not prepared for its actual purpose. The letter informs me that as a result of my recent GPhC FtP Hearing, proven misconduct and removal from the Register that my continuing Membership of the RPS has fallen into disrepute. As a result I am automatically subject to the 'Good or Suitable Standing Test' of the Society. I am notified that the relevant Committee recommends demotion of my Membership status down to an Associate. I joined the RPS in 1990 and remain very proud to be a Member of my professional body (which until 2009 also regulated the pharmacy profession). I feel deeply hurt by the decision, which comes without warning. The letter goes on to state that I have the right to Appeal the decision, but must furnish new evidence that intimates the decision of the RPS based on the GPhC findings is unsafe.

I find the letter and its content offensive for several reasons. I am not warned that my professional body, supposedly independent of the GPhC, would react in this way and without feeling the need to contact me and understand my perspective first. It seems to me that the GPhC determination of 'facts' in FtP cases, as far as the RPS is concerned, is beyond doubt. I am also disturbed by the timing of the letter, arriving so close to the holiday. I am astounded, particularly during the season of goodwill, by how mindless and unkind the official authorisation given for the non-urgent letter to have been prepared and sent out to me is. At a time when I am struggling with just getting through each day, the additional suffering heaped upon me by the RPS feels insensitive to my feelings. Unlike the time, three months ago, I now have a mental health diagnosis of lifelong EUPD. This, I contend, is new evidence to proffer an Appeal against the decision to demote my status. The severe mental illness, whose symptoms worsen under stressful times, was at the heart of my black and white behaviour as my business fell into staffing difficulties. The decisions I took were based on unstable emotions; they were neither planned nor thought through. Absence of such evidence from the deliberations of the GPhC FtP panel and, later, the RPS Committee, rendered the decisions and conclusions reached in each case less secure. In to the New Year and one hundred and twenty five days following removal from practice as a pharmacist, I fully complete my Appeal application, attaching medical information concerning my diagnosis as well as testimonials from two registered pharmacists supporting my ongoing full membership of the RPS. I am hopeful for a favourable outcome. I reflect on the accountability that mentally-ill citizens carry for acts that violate laws, regulations and rules, especially during times in their lives when their symptoms are raised and their lives are even more chaotic. This has been my reality in business.

The one hundred and forty second day after erasure is the day that I begin to question the 'professional attitude' of Professional Bodies purporting to act for the Membership? In its consideration of my Appeal, unfortunately, the RPS Appeal Panel resolve to uphold the decision of the first Committee. I am startled by the decision. My mental illness has made no difference whatsoever. The UK Government repeatedly spell out the declining mental health of the nation and the need to target greater resources towards understanding and treating the problem. The RPS 'Good or Suitable Standing test' I feel punishes any member who contravenes its Code of Conduct regardless of the mental health. A straightforward binary categorisation unable to appreciate nuances surrounding alleged misconduct of members is by design always going to be punitive and unjust. Slumped in my armchair, I feel deep disappointment, rejection and anger at the outcome of my Appeal. I begin to recall my first day at the School of Pharmacy and, more specifically, the address given by Dean of the School. He warned about the severe consequences of contravening any aspect of the Profession's Code of Conduct. At the time, I felt it peculiar that at the beginning of professional training The Dean would warn about the risk of losing the professional licence to practise, even before the start of the four year period of professional training to become a pharmacist. The Dean was evidently aware of the strict stance of the professional bodies towards members.

One hundred and eighty days into my internment, I am trying to understand and come to terms with my career crisis. Before entering the world of business in 2007, I practised my profession with an acceptable level of stress. As an employee working within pharmacy practice and academia, I was rarely ever flustered and I managed my workload comfortably. Starting in business changed all of that. The workload seemed to be unlimited and no matter how many hours I spent during the day, the demands on my time just grew and grew. I was burned out by an excessive workload across two pharmacies coupled with chronic stress. At the height of my crisis, and shortly after the Investigation by the regulator commenced, I lost patience with staff, many of whom, in my mistrustful mind, had turned their allegiance over to the regulator. This infuriated me; after all I was the one still paying their salaries. My behaviour deteriorated at the same rate as my troubles escalated and the Investigation gained momentum. In one incident, I allowed myself to completely lose control and rage at one female employee, in the pharmacy's consultation room, during a discussion over her choice to freely volunteer information to the regulator.

Me: (Sitting on the edge of the desk. I am confused and angry.) I understand, from other staff, you've been talking to the Inspector

Employee: (Sitting squarely to me in a chair.) What did they say I have told the Inspector?

Me: (I begin to flare up.) Why don't you take my advice as your employer and only answer questions that are put to you directly. I strongly suggest you do not volunteer information freely. You are a trainee and have a lot to learn about pharmacy procedures and practices before I feel you can know what you are saying is correct or not.

Employee: (Leaning forward in her chair.) I have done nothing wrong. You are the one they are here to investigate. It is only right that I help the Inspector in any way that I can.

Me: LISTEN HERE! (I am nervous and scared. I feel unable to control this employee. My fury is rising inside.) THE INSPECTOR IS NOT OUR FRIEND. HE IS NOT INTERESTED WHETHER OUR PATIENTS AND CUSTOMERS WHO DEPEND ON OUR TWO PHARMACIES RECEIVE A SERVICE. HE IS NOT ONE OF US. I HAVE CONTINUED TO WORK OVER 100 HOURS EACH WEEK TO MAKE SURE PATIENTS ARE NOT LET DOWN. BY TALKING WITH THE INSPECTOR, YOU ARE NOT HELPING THIS BUSINESS. HAVE I MADE MYSELF CLEAR TO YOU?

Employee: (Sitting right back in her chair now, after my torrent. She sniffles. She takes several deep breaths.) You're in a lot of trouble. Is that why you are shouting at me?

Me: (I stand. I am pointing angrily at her now. My body is tense and I feel myself about to explode.) CAN I NOT GET THROUGH TO YOU? I PERSONALLY GAVE YOU AN OPPORTUNITY TO START YOUR TRAINING HERE WITH ME WHEN YOU HAD NO WHERE ELSE TO GO. I MADE SACRIFICES TO ACCOMMODATE YOU. WHY ARE YOU SO DISRESPECTFUL AND DISLOYAL TOWARDS ME? NO - MORE – DISCUSSIONS – WITH – THE – INSPECTOR; - IS – THAT - CLEAR?

Employee: (She is crying and her lips are quivering.) I don't want to be here anymore.

Me: REGARDLESS OF WHAT YOU WANT, WITHOUT SUPPORT YOU WILL NOT BE ABLE TO COMPLETE YOUR TRAINING.

Employee: (She stares at me. She is broken, by me. Her voice is faint.) Yes.

Me: (The episode exhausts me. I am reduced to a mass of anguish and heartache. I am adrift. I hate myself. I hate my life. I don't want to be here anymore.) NO GET BACK TO WORK, AND DON'T FORGET THIS CONVERSATION!

We all have our boundaries. They are different for every human being. Boundary crossing is usually upsetting. Sufferers of Emotionally Unstable Personality Disorder (EUPD), like me, have difficulty knowing where boundaries are as a consequence of disruption to our own boundary setting by parents and caregivers.

At my hearing, this employee agrees to serve as a witness for the prosecution. She breaks down repeatedly under questioning and cross examination. Her words break through sobs and pierce my heart, 'a man should not have that much power over a woman'. The EUPD modus operandi had once more expressed its destructive power. I consider running. Run from the courtroom and run from my disorder and run from my past. I am tired of running. I have run my whole life. No, I

am not my disorder. No, I am not evil. Inside of me I sense a young boy who has been badly hurt and is, therefore, forever afraid. The tantrums of my child self, under threat, are simply amplified by the adult self he has grown to be.

Today, with the insight I have recently gathered through Counselling, as well as Psychiatry, I choose to write a letter of apology to my former employee. Through it I hope to be candid, compassionate and accept responsibility for the hurt caused. I believe it is a vital first step that I need to take in order to demonstrate genuine contrition for my wrongdoing. I am not seeking forgiveness rather to sincerely attempt to help reconcile this young woman's lifeworld. The letter takes form slowly over several weeks. I leave it handwritten, sign and date it. As I post it, I whisper 'please may my words of apology be received with an open heart, offer comfort and reassurance, and help heal the pain that I have caused'.

I complete my first year as a de-registered professional. I barely have opportunity to reflect on the passing year and all that has happened and the discoveries I have made along the way when further bad news arrives, in the form of a new set of accusations. I receive a Notice of Investigation from NHS Counter Fraud Squad (NHS CFS). It alleges that I had defrauded the NHS of tens of thousands of pounds during my tenure as Superintendent Pharmacist and Proprietor between 2009 and 2011 and, NHS CFS are actively pursuing repayment by me of the amount. My initial reaction is shock. In an instant life began to fall apart for me once more. I always thought of myself as a servant of our great NHS, an organisation admired throughout the world. I am proud to hold NHS pharmaceutical services contracts and deliver high standards of care to my patients. The very idea that I could abuse my privilege repulsed me.

A year ago, I passionately defended myself against the spate of accusations levied at me by the regulator's prosecuting lawyer who had claimed that my decision to work across my two pharmacies was motivated by greed. In summing up, on the balance of my evidence, the prosecuting lawyer had dropped the idea that my behaviour was driven by greed. Setting up and operating two rural pharmacies that served residents in these small villages was plainly not going to generate much wealth for me. I was, therefore, surprised and aggrieved by the regulator FtP Panel's obsession with this all too familiar accusation made against community pharmacy owners by the regulator and; they reintroduced greed as my only possible motivation for running my pharmacies unlawfully. The Panel were unable to accept that duty, service, passion to care and self-sacrifice were my drivers.

It is not transparent in the Notice of investigation communication whether the NHS CFS are being instructed by the regulator or by another source to examine the integrity of my claims for payment. The contractual terms of service and reimbursement rules for pharmacies are laid down in the monthly Drug Tariff. As a business owner and pharmaceutical service contract holder I am fully aware of what is and is not allowed. I would not therefore seek to benefit financially for more than I was entitled to, under the rules. I have faith that by providing high standards of patient care, I would enjoy the loyalty of my patients and the business finances would take care of themselves.

I observed the same in all my previous roles as an employee pharmacist manager. My focus is on meeting the needs of my patients, to do all I can to avoid letting them down.

From the time of their arrival in Britain, my parents were willing to work hard and create a new life for themselves and their children. My father was the only earner in the family. My mother took care of the home and the four of us. Naturally I grew up adopting their strong *scarcity mind-set*. I recall my parents did everything they could in order to stretch the pound, but despite their effort I grew up believing we were locked in a permanent state of poverty. This was reinforced to me by my parents' insistence that I be given clothing my older brothers had outgrown. Other resources that I felt were limited included time spent with my parents, money and food. My parents' mind-set was very apparent in their attitudes and behaviour. For instance, they believed they would never be free of their relative state of poverty. They would constantly remark just how costly living in Britain was. During the 1970s my father earned a weekly salary of around £50 from which the entire needs of a family of six had to be met. There was little left over for treats. I learned as a child to stop asking my parents for more than I needed. Moving in to my teenage years and adulthood, I accepted that in my life 'I just have to go without'. This was the attitude I brought to both my family life and work life. I was disgusted to be accused by my regulator, therefore, that I was motivated by greed. They simply failed to grasp the nettle.

The NHS CFS I believe are mistaken to believe I have committed fraud and that I am a shrewd and calculating businessman. A well-known fact of community pharmacy businesses is that they are expensive businesses to run. In 2010, the Conservative–Liberal Democrat alliance announced their 'austerity policy' aimed at reducing the national debt by cutting public spending. As part of the policy, drastic cuts to the drugs remuneration budget paid to pharmacies was introduced. NHS pharmaceutical services are no longer being funded at an acceptable level, but significantly lower. Looking back, the announcement of austerity had the effect of sending my 'scarcity mind-set' into override. As well as continuing to provide a high standard of service, as a pharmacy owner, I was required to do my part for the nation and absorb cuts in funding. My actions were reinforced by my practice context. My two pharmacies are located in small rural villages and each dispense well below the national average prescription numbers, through which around 80 per cent of funding is achieved. The pharmacies also experience extreme pressure from local dispensing practices whose activities effectively prevent growth in pharmacy prescription numbers. All of these factors led me to prevent losses and to seek to stretch every earned pound in an attempt to survive.

The reality that I was living also brought out a strong compulsion to control a situation that was rapidly becoming more uncertain. It was imperative as an owner that my teams were not wasteful of resources given the announcement of austerity. As the weeks and months rolled by, I experienced an unhealthy obsession to restrict waste and maximise output from both material and human resource. My mind became increasingly unstable as I struggled to control the business resources, resulting in severe stress and outbursts of anger targeted at employees whom I felt were not resourceful or productive in their roles. I feel that my motive to limit waste

and maximise output from scarce business resources, hence playing out the script of my family scarcity mind-set, were misconstrued by those outside my business. The regulator and now NHS CFS believed my behaviour is motivated by greed. This is not the truth. I vow to myself that I would defend myself against such an accusation. As a mental health services user with a diagnosis of EUPD and depression I feel I did not have the capacity to defend myself effectively against accusations of fraud. I reach out for support from the local Mental Health Advocacy service. My Advocate is a good listener and helps me to articulate a defence as well as cope with the enormous strain the fraud investigation is putting on my mental health.

I must have accepted my circumstances somewhere along the way to my six hundred and fortieth day away from the Register in order to have committed myself to work at my pharmacies for one or two days a week. The regulations allow de-registered pharmacy owners to undertake non-pharmacist roles within their businesses. Not only is this necessary to allow for the exchange of ideas with staff, but most importantly demonstration of my commitment to both the profession of pharmacy and a return to pharmacy practice in the future. I believe strongly in the principle that human beings are given every opportunity for redemption. After all, it is commonly said 'to err' is human and, most will at some time in their lives, step outside society's norms and expectations as I have done. I am acutely aware that the eyes of both my staff and customers were focused on me for signs of repetition of past behaviours leading to my erasure. It therefore came as a surprise to me that my Superintendent Pharmacist was informed by letter from the GPhC that it had received a complaint from a patient stating 'it is alleged that on 22 March 2014 a prescription was dispensed by Mr P Leal in the absence of a pharmacist'. I am confident that the patient is mistaken, since at all times, the pharmacy engaged the services of a registered pharmacist, under whose supervision I have been working. I would never repeat past behaviours. I have a different mind-set now. In the absence of a registered pharmacist the pharmacy would have been closed to the public.

It is difficult for me to understand the patient's motive for lodging a complaint to the regulator without first bringing the concern directly to me, as the proprietor. Under the Responsible Pharmacist Regulations 2008, the Responsible Pharmacist (RP) on duty must visibly display to the public a Notification to that effect and sign in to the Attendance Register, held electronically. Both had been carried out on the 22 March 2014 by the RP, in compliance with the pharmacy's written standard operating procedure. The concern could have been quickly resolved without recourse to another regulatory investigation. I am upset, yet as the pharmacy owner, I need to 'keep my head' during the ensuing investigation. During stressful times it is important that I manage my emotions, seek help and advice from my colleagues when necessary and to act, if necessary, only after considering all available options. I am able to console myself and to look at this complaint as a test of my claim to innocence.

I recognise and accept the important role that my regulator has in the protection of patients and the public. Therefore, I had a responsibility as a pharmacy owner to cooperate fully in the investigation. The complaint is resolved following submission of specimen signatures by both my

Superintendent Pharmacist on duty at the time and me. On the 22 March 2014 I had taken the relevant prescription into the dispensary from the complainant, labelled and assembled the prescribed medicine before signing the 'dispensed by' box at the bottom of the label. I passed the item to my colleague, in the consultation room, who provided a professional/ clinical check before signing the 'checked by' box. The regulator's Investigation Team were able to verify all this in a letter dated 10 September 2014 that stated 'the GPhC has decided that there is no evidence to show that Mr Leal acted outside of the supervision of the Responsible Pharmacist'.

I feel this incident provides me with the opportunity to be able to demonstrate that I actively uphold the following GPhC Standards of Conduct, Ethics and Performance: 'I must make sure that I keep to my legal and professional responsibilities and that my workload or working conditions do not present a risk to patient care or public safety' ; 'I must cooperate with any investigations into my fitness-to-practise and keep to undertakings I give, or any restrictions placed on my practice' and 'I am honest and trustworthy'. I hope that I was able to show the capacity to remain calm and rational throughout the stressful period of another investigation and a genuine willingness to assist the enquiry. Furthermore, I decided to use the critical incident to reiterate to my staff the importance for everyone to follow the standard operating procedures, in order to protect service users as well as safeguard the reputation of the pharmacy.

I am only two years into my five year period of erasure from work as a pharmacist and yet this incident, I reflect, provides strong evidence of my ongoing transformation of character and work towards regaining public trust. I feel I have started to show my regulator that it can be confident in me to uphold professional values when I return to work as a pharmacist. I am aware that, when the time comes to submit my application for restoration of my name to the Register, I am required to prepare a portfolio of evidence that demonstrates I have addressed my shortcomings that led to my erasure. I decide to use this incident as the basis of a continuing professional development (CPD) portfolio entry.

Nine hundred and twenty days from the day that I was removed from practice, I remain anxious over the allegations of fraud against me. It is two months since been interviewed (under caution) by the NHS Fraud Investigation Team (NHS FIT) and I have not heard back, concerning the organisation's decision whether or not to initiate criminal proceedings. I seek help from my Consultant Psychiatrist to put pressure on the NHS FIT to arrive quickly at its decision and prevent further deterioration in my mental health. My Consultant agrees to write to the organisation and urge them to conclude their investigation one way or the other. It works as I receive the briefest of letters stating that my case has been forwarded to the Crown Prosecution Service (CPS) who feel there is insufficient evidence to take my case to trial. I am not surprised by this decision, but nonetheless feel relief that, after almost five years, I am finally free from all investigations in to allegations of any sort against me. Perhaps, now I can begin to plan for the future, and put behind me all the troubles that have brought me to perilously close to ending my life. I have come to deeply understand, through my own lived experience, why many care professionals commit suicide in the face of accusations and allegations.

My lived experience of FtP, or more precisely, the final stage of five stages which together constitute Regulation, has been revealing and I have come to question whether this final stage of regulating the health and care professional workforce is in fact itself 'fit for purpose'. Already, my own experience has identified processes and practices among the various stakeholders that feed into and are fed by the 'regulatory system' that raise concerns around fairness and justice. I believe my experience provides a unique insight to both inform current and future regulatory practice, as well as present a roadmap of the personal and professional struggle ahead for the many professionals who as a result of alleged misconduct are subject to FtP investigations. I believe my experiences could be portrayed within a doctorate study, using a qualitative research design. I am driven to contribute to the development of pharmacy practice and decide to formulate my ideas into a research protocol. I explore the availability of Supervision at my local University. If my protocol is accepted, I decide to fund the study myself and carry out the project on a part-time basis. The opportunity to add to the available body of literature on FtP as well as contribute to improving the lives of professionals removed from practice would be a privilege. I appreciate the project will be emotionally very difficult for me, but I hold out hope that at the end of it I will have used my experience to benefit others, and discovered the true meaning in my loss and grief experience. After two separate meetings with potential supervisory teams, I am accepted to begin my project at my local University this autumn.

On the one thousand and ninety fifth day following removal, I feel able to review the guidance pages on my regulator's website for restoration applications. I quickly learn that for applicants who have been removed from the Register following to FtP proceedings, the application process was very demanding and complex. Reading on, the application requires the pharmacy professional to submit a portfolio of evidence to demonstrate that all shortcomings that led to erasure are addressed. I am daunted at the prospect of revisiting the reasons given by the FtP Panel for removal. I must show how I have gained insight to overcome acts of professional misconduct. I could not estimate the likely time the preparation of the portfolio would require, as there were many relevant psychosocial aspects I feel I need to weave into my submission. The website made clear that it fell on me to satisfy my regulator that I have, over the years since erasure, rehabilitated and no longer presented a risk to the public.

I am prepared to undertake additional short courses and continuing professional development opportunities to show that I am up to date and ready to re-enter practice. The minimum period of erasure is five-years. This means that by starting to prepare my application and portfolio now, I gave myself two years to prepare my application fully while leaving time for peer and mentor review and feedback. I decide to continue to work in my pharmacy one-to-two days each week and to focus my attention on tracking and documenting changes in clinical practice and the organisation of community pharmacy services. I reach out and request the help and advice of my local continuing pharmacy professional education Tutor, a practising pharmacist whom I have known for some twenty years, with recent experience of successfully guiding several erased pharmacists through the restoration application. I am given consent to record our mentoring

meetings for reference and research purposes. I present the conversations, which span a period of almost two years, below.

PL: Hello and thank you for agreeing to help with my restoration application. I've just been on to the GPhC website this morning to review the set of guidance notes that the regulator provides for the completion of the restoration application, including an outline of the process involved. The notes read straightforwardly, but my worry is more with the demands placed on applicants by the application form itself.

Mentor: Yes, there is a lot to do.

PL: I feel it would be beneficial to consider the journey ahead for me. It would be most helpful to me, in this initial meeting, if I can draw on your recent past experience of mentoring erased pharmacists through the application process in order that I may have a road map to address all aspects of the application. You see, the Chair opened my hearing in April 2012 with the utterance 'This is a complex case'. I therefore anticipate that my restoration application to my regulator will necessarily be complex. I just hope that I can rise to the challenge.

Mentor: The most important element is that you have understood the reasons for your removal from the Register and that you evidence how you have addressed your shortcomings. Should you consider any other matters, not put out in the public domain by the GPhC that you consider relevant to your misconduct then this is the opportunity for you to provide details.

PL: You see while I fully accept I fell short of my responsibilities as a Superintendent Pharmacist and pharmacy owner, what I do not accept are the reasons and motivation given by the FtPP for my misconduct. As is most often the case with pharmacy owners, the FtPP default position is to believe that greed is the reason for misconduct. I was unable to explain my actions to the FtPP when asked to do so at my hearing three years ago. It was only, much later, with the help of Mental Health Services I became aware that I suffer from a severe personality disorder which left me unable to cope with adversity, like losing my pharmacist manager at short notice. As a sufferer of emotionally unstable personality disorder, I fear abandonment and losing staff left me to experience heightened emotions which distorted my decision-making abilities. I have the supporting evidence from my GP and Consultant Psychiatrist to verify my poor mental health at work under times of stress.

Mentor: There is no question over your clinical work with patients. Looking back at what got you in conflict with the GPhC, it was basically running two community pharmacies with inadequate cover which will come under the heading 'professionalism'. So either you should have closed one down or magically got another pharmacist manager because I know you put a lot of effort in to finding cover. It is still a problem in Southern counties with many pharmacies being forced to close for several hours or even some days until pharmacists can be found to provide cover. You tried

to keep both your pharmacies open and running and, it is this sole fact that got you to the regulator.

PL: Yes, I appreciate that fully now. Back then, I made a decision based on emotion rather than follow professional requirements to close the pharmacy in the absence of a pharmacist. I did not feel I could deny my rural residents the services of their local pharmacy and risk causing them distress. I felt I had no choice but to remain open and try to provide partial cover to both my pharmacies on days when another pharmacist could not be found.

Mentor: I agree with you that you need to reassure the GPhC there would be no repeat of the past by providing evidence of your professionalism. Your clinical competence was not the problem, so for the restoration application you would only need to demonstrate you have kept yourself up to date. Most pharmacists in my experience make minor infringements in practice daily, not by any deliberate action, but by way of omissions. In your particular case, since you were already under the scrutiny of the GPhC, your range of practice activities was being investigated. In other words you were open to suspicion of deliberate infringements.

PL: You are aware I am following a PhD programme of study and am using my experiences of FtP and my journey towards restoring my name to the Register in order fill a gap in the relevant body of literature. There are no studies reporting the lived experience of health and care professionals following removal from practice. This will be an original contribution which I hope will help our UK-wide regulators to give due consideration to the 'human impact of FtP procedures on health and care professionals'.

Mentor: Using your experience and that of others to understand how pharmacists (and other care professionals) make sense of their experiences of FtP and whether or not they choose to return to practice is a worthwhile study. I wish you well with it, and recognise that it will be emotionally difficult to do. It is quite possibly for this reason that such a study has never been attempted.

PL: I have worked in the pharmacy profession across most sectors over my twenty-five years' career including community, hospital, academia and research. I have never before felt as isolated and challenged by the set of circumstances I found myself in, as a community pharmacy owner, which ultimately led to my removal from practice. I was proud to be a pharmacy owner and dedicated myself to the role, putting in a hundred hours each week. You could say I am a workaholic, but in truth, it was only following strike-off that I have come to understand my many hours spent working was a cover for the darkness inside that I did not have the courage to face. So, three years after removal, I can look at the sanction as a 'gift' and opportunity to utilise the time away from full-time work to improve my mental health and well-being. I am under the NHS Community Mental Health Team for the treatment of Emotionally Unstable Personality Disorder (EUPD). My PhD study will present an extreme challenge to my emotional health. My family and friends have tried to persuade me against it, but I do feel that my story might stimulate change for

the better in the way professionals are regulated. Besides, I have the support of the University and two supervisors through the study.

Mentor: I think that stress within the pharmacy workplace is a problem. There are probably a whole host of reasons for this presently. Probably understaffing is a factor, and that we as pharmacists take on too much. Perhaps we are not very good at delegating. This maybe just the way pharmacists are, but that does not excuse the fact that we can learn to delegate tasks to other people who can do them so that we can concentrate on tasks that only we can do because of our expertise in medicines. It is true also for our professional colleagues working in health and social care. Stress is a huge issue at the moment and it is only getting bigger leading to poor mental health.

PL: I understand I must mitigate, as far as possible, stressful working conditions when I return to practice in the future. One section of the restoration application is the personal development plan for the first twelve months of return to practice. Here I have stated that I will maintain the employment of my Superintendent and Responsible Pharmacist on a full-time basis and, cover days-off, holidays and offsite attendance at training events. This will of course allow me to fulfil my role as the pharmacy owner away from the day-to-day demands of providing a pharmaceutical service to my customers. I hope the GPhC recognise this change in me along with a clear intention to reduce any future risk arising from me taking on more responsibility than I can handle.

Mentor: This is great. I would add that you must as owner set the business direction and seek regular feedback from the pharmacy team so you can monitor that it is moving in the direction you set out. Requesting a quarterly report from your pharmacy manager would show that you are interested in the team and business performance. It will also allow you to keep abreast of the training needs of your staff so that they are knowledgeable and competent to perform their roles. I think this is all part of professionalism as well. Striking a balance between keeping control and allowing your pharmacy team freedom is the key, so that they can grow the business under your watchful eye as owner, making sure that the pharmacy standards and ethics are followed and your practice is lawful. So, you should keep the encouragement of your staff and necessary discipline in proportion and getting that right should ensure the people in your business are happy, want to stay and work hard.

PL: Thank you for your helpful advice today. I hope to be able to share with you, at our next mentorship meeting, my plan for continuing professional development (CPD) in order to show the regulator how I have addressed my limitations and in the process gained deeper insight.

Mentor: I look forward to seeing your plan and some of your CPD write-ups next time.

On the one thousand two hundred and seventy seventh day following removal, I meet with my Mentor and continue discussions on my restoration application.

PL: Thank you for your continuing support. At the end of our last meeting I agreed to share my purpose and plan for the CPD component of the restoration application. The regulator's guidelines point to an applicant using their CPD to provide evidence that they have kept up to date with the profession and to show how an applicant has gained insight in to the nature of their misconduct to not repeat misdemeanours if restored to the Register.

Mentor: I feel your CPD ought to be relevant to you and show that you have taken steps to address the concerns of the GPhC when you were erased. I can see from the large pile of paperwork that you have already started to put together your CPD write-ups.

PL: I have already compiled about a dozen CPD write-ups with most starting at reflection on an aspect of what went wrong followed by a plan on how I hoped to address shortfalls in practice. In every case I have finished by evaluating the implementation of the planned activity and its impact. I have been careful to use the GPhC's CPD templates to ensure consistency in my approach throughout.

Mentor: I believe by making your CPD as relevant as you can to the reasons for your removal from practice you will make the work of the Restoration Panel straight forward when they consider your application to be restored to practice. I do think you are going about it the right way.

PL: I really do hope so. I have already invested over forty hours of time with these CPDs and anticipate spending at least twice, if not more, time if I am going to satisfy myself that I have reached saturation.

Mentor: I applaud your strategy to your CPD as it suggests you are drilling down to why things went wrong for you, not resting until you have uncovered the cause(s). Much like root-cause-analysis, repeatedly asking yourself why certain actions occurred will prevent them happening again.

PL: That's great to hear. Actually, my first two CPDs have come out of a symposium event I attended at the University last year as part of my PhD study. The first CPD centres on reducing risk in health and social care practice by asking teams to learn not only through 'system one' (with a focus on omissions and errors in practice and investigating these through root-cause-analysis) but also 'system two' (that focuses on best practice that occurs most of the time). The second, draws on the findings of the General Medical Council (GMC) in that the majority of FtP cases are explained by doctors' psycho-social difficulties rather than any external cause. These together set the scene for my CPD by linking my poor decision-making at the time to psycho-social difficulties, later verified by mental health services.

Mentor: To be clear, you were wanting to run an uninterrupted service to your patients and customers in the villages your pharmacies served, but in making the decision to work across the two pharmacies you were no longer able to do so. Spreading yourself so thinly was a mistake and

you must acknowledge this early in your application. Your mental health condition made it seem you were doing the right thing, but in reality you put the safety of your patients at risk when your pharmacies were open without a pharmacist present. An important learning point for you.

PL: Yes I can see that now. Thank you for bringing my attention to this central issue once more. After I was struck-off I went through a period during which I strongly resented the profession of pharmacy. For several months I was even unable to enter my own pharmacies. When I did eventually return, I felt awkward due to the shame I was carrying by virtue of removal from the Register. I feared customers might continue from where the GPhC had left off and wound me with further criticism, however justified. I felt particularly vulnerable to attack and became paranoid believing at any moment, in those early days of returning to the business, I was going to be shouted or sworn at, even physically assaulted by customers feeling I had let them down. I was feeling like the enemy in my own business and this caused me to feel that I wanted to leave at my earliest opportunity in order to relieve this intense anxiety I felt. My pharmacists and support staff are now firmly in control of running my business. That's just what I have to accept. It is not easy to have to let go.

Mentor: What I am interested in is how you found the interaction with your staff while at your pharmacies in those early months after you had been removed from practising as a pharmacist?

PL: Well, our relationship was changed by strike-off. No longer was I the Responsible Pharmacist (RP) taking a clinical lead in the pharmacy. I was now also under the supervision of the RP on the day of my visit. I had to first check with the RP that s/he was happy with any patient service related instructions I wished to convey to my staff. However, I did feel, as the pharmacy owner, I had responsibility to continue to develop others. So, I continued to observe work and to tell my staff what they are doing well and point out what they could do differently. I am pleased to inform you that my staff have responded well to my tentative observations on their practice. I guess they no longer see me as a threat, but someone who is focused on patient care and seeking to continue to make a contribution at a difficult time.

Mentor: I am really pleased with the results of your interactions with your team. My only comment would be instead of telling your staff what they could do differently, ask them to come up with improved ways of doing things. Human beings are more likely to follow their own ideas than follow somebody else's instructions. Working effectively with other people is a very important part of professionalism and I would suggest you include at least one CPD write-up exploring how building positive working relationships enhance delivery of person-centred care.

PL: Thank you, I will do that.

Mentor: Your staff are your biggest asset. Don't ever forget that.

PL: Given our past difficulties with recruiting pharmacists, I am rather embarrassed to inform you that since de-registration, we have experienced an ongoing problem with retaining our employee pharmacist managers. Most stay for around one year and decide to move on. At exit interviews, we hear that the pharmacy manager role is very stressful and demanding. It seems to me, pharmacists are ill-equipped for a managerial role. While benefiting from a regular income each month, at least three of our recent past pharmacists have not shown the resilience required to cope in a community pharmacy environment.

Mentor: My own view about this is that so many pharmacists enjoy the protection offered by head offices of the large multiple chains to an overwhelming degree and so choose to work there instead. I think the problem that then presents is that employee pharmacists get used to things being done for them. This is not possible in a small independent organisation like yours and may be a reason why independent pharmacies continue to experience great difficulty recruiting pharmacist managers. As far as you can, make your pharmacist manager feel like the owner and give them freedom to contribute to establishing the pharmacy as a beacon for healthcare locally. Letting go of control may help free the staff to innovate and raise levels of performance. I am keen to see this aspect of professionalism which is about developing others and moving the focus away from yourself. Be sure with each member of your team to focus on maximising job satisfaction so that your workforce remain loyal to you. In the current climate of austerity and NHS cutbacks to funding the pharmacy sector, you, like most, would not be able to raise wages, but instead to have regular, say, quarterly or half yearly, reviews with everybody and provide constructive feedback. Allowing people to provide feedback and listening to their ideas quite often raises motivation and improves job satisfaction. So, your role as the owner is cerebral. Allow your team to generate the profit while you come up with the business strategy to ensure it continues to grow. An owner pharmacist requires a different skill-set and this important change in thinking is necessary for you to progress not only your career, but also to progress the careers of each member of your team.

PL: What you are outlining to me is that by coming back on to the Register I must accept and embrace my role as the owner and allow my pharmacy team to deliver pharmaceutical services. I recognise I must step back and not burden myself with doing everything, as before. Thank you, and of course I agree. This period of time away from practice has allowed me to transform my thinking. As pharmacists we are accustomed to think that the busier we are the more we contribute to the well-being of our patients. However, I have learnt this is not so, and we run the real risk of experiencing burnout. Truthfully, within months of working across my two pharmacies I suffered burnout and yet this working pattern continued for two years. I became trapped as owner by my circumstances.

Mentor: Looking forward, having sold one of your two pharmacies, when you are restored there is no probability that you will face the same circumstances again. With one pharmacy and a manager in place I am confident the GPhC will recognise all the steps you have taken to minimise

any future risk to the public through making sure you never repeat past behaviours for which you were removed. I am sure you will emphasise this in your restoration application.

PL: Yes, I will. While attending the pharmacy one day each week I have noticed that a growing number of our prescriptions are reaching us through the NHS electronic prescription service (EPS). Most of the local surgeries have gone over to EPS, but not our local GP dispensing practices. Is there anything we can do to encourage them?

Mentor: Unfortunately not. For a GP dispensing practice EPS presents a threat to their prescription numbers, while for many pharmacies it is an opportunity. EPS is here to stay, so those GP dispensing practices not yet signed up to the service will eventually have to join. I would recommend that you sign up to either a NHS-led workshop or local pharmacy CPD event to update yourself on the service. You can write this up to show the GPhC you are up to speed with changes in pharmacy practice.

PL: Once more, thank you for all your helpful advice. I will continue with my personal and professional development and continue to build my portfolio of evidence as part of my restoration application.

One thousand three hundred and sixty days following removal from the Register, I meet for the third time with my Mentor and continue discussions on the progress of my restoration application.

PL: I am pleased to inform you that I have now completed about half of the CPD entries I feel that are necessary to show my regulator how I have addressed my shortfalls in professional practice. We have already spent time reviewing professional matters in our previous meeting. In this meeting I would like to consider my mental health diagnosis and recovery, if that is okay. I was diagnosed, in December 2012, with Emotionally Unstable Personality Disorder (EUPD), following several assessments with the Community Mental Health Team. The diagnosis came as a relief to me, if I may explain. All of my life I have felt different from others, never really understanding why I was ‘out of phase’ with life around me. The diagnosis had given validation to my feelings, after all these years. It was now clear to me why I had so often felt misunderstood in both my personal life and career. As a result, disharmony and conflict in relationships were commonplace in my life and had culminated for me in strike-off and more recently legal separation from my wife. My greatest fear is abandonment. My life has been cloaked in this fear. I have found a way through my darkness. I have found faith. The love of God for all of creation had become known to me through a surreal vision of Lord Jesus back in October 2013. I truly believe that I am innately loved, so cannot ever be abandoned. It’s a powerful insight that has given me hope, and saved my life. I won’t deny that a small part of me worries that my mental health diagnosis may be used against me by the regulator, by either wrongly suggesting EUPD began after strike-off at the point of diagnosis or that I was attempting to use it to excuse my misconduct.

Mentor: From what I know about the events that brought you to the notice of the regulator, the sudden departure of your employee pharmacist was the catalyst. While employees might like the security of employment contracts it is a pity some do not honour their side of the contract. If your employee had given you the eight-week notice period required, no doubt you would have had opportunity to replace the vacant post. Instead, your emotions got the better of you and you made an irrational decision, without weighing up your options and the Pharmacy Regulations. You have already told me that you believed it was your professional duty to keep your pharmacies open. Suffering with a personality disorder, you probably felt unsupported and reacted to your circumstances. I can see how the situation arose leading you to work unlawfully. The facts presented by the regulator to the public about you, your misconduct and your motivations will be the position that the regulator will stick to during your restoration hearing, despite all that you have come to learn about yourself and professionalism, ethics and standards of practice that point to a person who, from almost any other perspective, has changed for the better. Your staff and patients can only benefit with you returning to the Register. I hope the FtP Panel will see it, as I do and, restore you to serve the public again.

PL: Thank you for your kindness. I have also benefited enormously from the education programmes I have attended. Many have been offered through the Dorset Recovery Education initiative. For instance I have completed a six-week course on emotion regulation, a three week course on values and a seven week course on recovery narratives. All this is on top of monthly appointments with my Consultant Psychiatrist. The role that my faith and prayer and meditation practices have played in my well-being have been pivotal, I feel, towards transforming my thinking and behaviour. I will share this throughout my restoration application and portfolio, so the reader can be in no doubt I am a different individual today, and can be trusted. I have shown ongoing professional development by working in my pharmacy at least one day each week, as well as attend workshops to update my knowledge and skills. Is there any more I could do?

Mentor: Could you tell me more about your values. I can clearly see you are a passionate and driven fellow. So what's under that?

PL: Well, I have already alluded to education as an important process through which I have gained deep insight into who I am and my situation. I recently attended a three-day course run by the Dorset Recovery initiative about the values by which we live. On the course, I was invited to write my values down, but I realised that the list I had in front of me did not belong to me.

Mentor: That is interesting. What did you discover about these values?

PL: The values I had listed were in fact my parents' values which I had internalised, probably in response to feeling conditionally loved by them, and playing the script in my head that went along the lines that if I was more like them they would come to love me unconditionally. I completed a CPD write up of my learning on the course starting at reflection. It occurred to me that the values we hold shape our behaviour. My parents raised me through their own struggles of adapting to

the harsh circumstances they had entered into by moving to England from India during the 1960s. They experienced prejudice, racism, poverty, homelessness and loneliness to mention a few of their struggles. Through it all, they prioritised the family above all else. Their set-up was traditional. My father went out to work and my mother was a housewife. I was brought up to respect education for the opportunities it afforded to those fortunate enough to dedicate themselves to study, so I gained a higher degree. My father shared stories about his childhood in India. My grandfather could not afford to school all his children. He decided my father, at the age of eight, had to supplement the family income by starting work as a shoeshine. Naturally, my father mimicked those beliefs and behaviours he saw my grandfather demonstrate in his work as a trader. In my childhood home I learned that for a man his work was a measure of his worth, so I worked two professional careers simultaneously. My father was committed and hard-working and had to overcome health problems to maintain his work status. His willpower kept him going. He was masculine through and through – strong, task-focused, tough, independent, blunt, competitive and self-confident. So I became like him.

Mentor: You reached a time in your pharmacy career when you could no longer continue to work for others, but to go a step further than your father ever could and become a pharmacy owner. Your ambitions to emulate your father had reached a high point. You were in a position now where you were in charge, independent, and willing to work hard to make a success of your business. Unfortunately, you had not taken into account the values and ambitions of the people you employed, who were unlikely to share yours.

PL: Not only was I behaving in response to inherited values I was also struggling with emotional instability, personal identity crisis, indecision, desire for approval, professional and regulatory requirements, coping, business competition, overwork and burnout. Throughout it all I feared failure. I believed failing would be the last straw, and a reason to end my life.

Mentor: You must not blame your parents for your circumstances. They took the courageous decision to leave their homeland and come to UK to start a new life. The cultural values that helped them overcome their struggles and give you and your siblings' education and employment opportunities they never had meant they had achieved their ambitions. It is only right that your generation lived by a different set of values, more suited to life in a changed society.

PL: My present values are *honesty* (in everything I do, but beginning with being honest to myself), *feeling good about myself* (in the past, I did not feel, passing through life relatively numb), *striving to be a better person* (being more available to other people, thinking of others with whom I have got no inherent relationship, not being self-centred), *being at one with God* (recognising that all religions are looking towards an omnipotent creator who somehow brought everything into being, so we are not in charge of our destiny as we are not at the centre of everything), *coping well with stress* (as some stress is necessary to motivate us, but never again to allow stress to overwhelm me), *acting consistently in line with my faith and beliefs* (this is how we can influence others I feel and, should I transgress, to admit it quickly and put matters right quickly; growing in humility

through knowledge of God and knowing the difference between right and wrong), *maintaining the safety and security of my loved ones* (by enquiring after them, meeting needs and strengthening relationships), *having loving and affectionate relationships* (demonstrating empathy and compassion for others), *having genuine and close friendships* (so I can support them and they can support me, to share experiences without judgement on both sides), *promoting justice and caring for the weak* (in one way, my PhD study will bring a challenge to the rhetoric of FtP in our bureaucratic regulatory systems that, in cases like mine, treats health and care professional people as invisible – to be marginalised and silenced).

Mentor: These are a good set of values to underpin your future actions. I am pleased to see you recognise the importance of structuring yourself on biblical principles for a better life. Already you are seeing changes in the way you interact with others and how they respond to you. You have gone a long way to demonstrating your intention to be compliant with pharmacy law and regulations and uphold professional standards of performance and ethics. Well done.

PL: I hope the GPhC recognise that I have changed. The past misconduct would never be repeated. I was ill and trying to survive, fighting depression and escalating symptoms of EUPD, falling in to a bottomless pit and losing sight of reality. I am a different person now. I am hopeful my career narrative expressed through my restoration application will assure the FtPP that I pose no risk to public safety when restored to the Register.

Mentor: In the past, by having two pharmacies and a teaching commitment at the local University, you have convinced me of the fact that you fully recognise you took on too much. You have taken great strides to simplify your working role, so that you are no longer a workaholic obsessed with running everything by yourself with grave consequences. Selling one of your two pharmacies, resigning your role as company director, appointing a permanent Superintendent Pharmacist and planning to only work part-time at the pharmacy are all sensible steps and will reassure the FtPP of your readiness to return to practice.

PL: Thank you for all your advice and encouragement today.

The fourth mentoring meeting takes place one thousand six hundred and forty two days after I am removed from the Register.

PL: Hello and thank you for your ongoing help and support with my restoration application and portfolio. I wonder if we could turn our thoughts to the new GPhC Inspection Framework for community pharmacy premises that has recently been issued. As a pharmacy owner, and given my circumstances, I do see this Inspection of my business premises as an opportunity to demonstrate to the GPhC how our premises provide an effective and safe pharmaceutical service to patients. As there are five separate aspects to the Framework, I propose writing a reflective CPD for each one. By doing so, I will update myself on the latest Standards of Performance to which we are expected to provide services.

Mentor: My personal view is that all pharmacies should be working to the Framework all the time. It is really about having the conversations within pharmacy teams and asking the question 'Are we working to the framework and if not why not? As the owner you must ask your pharmacy team 'What should we do differently in order that we are meeting the requirements of the Framework?' Making those changes that are necessary will mean you will be working at all times to the Framework and therefore be ready at any time for Inspection which should run smoothly. I myself was working as a locum pharmacist in a local pharmacy and the Inspector arrived unannounced and began to carry out the inspection of the premises. We got through it. It was a little stressful and took four hours. Be prepared and ensure you go through the Framework with your staff beforehand. So that you understand the process well, I think your idea of completing a CPD write-up for each of the five aspects is really good. I would suggest that you include discussion of the Framework in team meetings and appraisal interviews. This will help embed the importance of the Premises Inspection for the whole team whom the Inspector will wish to speak with.

PL: Thank you for sharing your recent experience and agreeing with my strategy. I have made the decision to divide my CPD over the period I have been away from the Register into three categories (Clinical and Medicines updating, Law and Ethics and, Personal and Professional development). Do you consider this appropriate? I have written up about thirty-three pieces of evidence largely from courses and workshops I have participated in. These have been supplemented through attendance at conferences, webinars and reflection-on-practice as a pharmacy owner. I believe that the balance reflects my working roles and responsibilities as a pharmacy professional working as an owner, pharmacy assistant and clinical governance lead.

Mentor: You were not removed from the Register for clinical reasons. Rather, your decision to keep your pharmacies open without a responsible pharmacist on the premises was the problem. Addressing your decision-making process and mental health, in your case, are as important as showing you remain up-to-date with changes in clinical pharmacy. Responding to the reasons given by the FtP Panel at the end of your hearing in 2012 will reassure the Panel of your acknowledgement of wrongdoing and its seriousness, demonstrate your insight and commitment to return to practice as a changed pharmacist. Your role and responsibility as a pharmacy owner requires you to have a different set of skills to a pharmacist. You must also keep abreast of developments in the community pharmacy contract affecting the business.

PL: I am pleased you agree. I have devoted around two-thirds of my CPDs to clinical pharmacy and law and ethics. I feel I am up to date with practice, as a consequence of maintaining work as a pharmacy assistant, one or two days every week. I would not put an application for restoration in to the regulator if I felt I was not ready to return.

Mentor: If I was a reviewer at the regulator and I looked through your portfolio of evidence I would feel confident, not knowing you, that here is a person who has made significant changes since strike-off and will apply them if restored to the Register. The reflective accounts you have written are detailed and show insight. Having said all that, I know of a recent case where a pharmacist

had her CPD declined by the regulator on the grounds that it was not presented in the way they wanted it. She entered the same evidence later on and it was accepted this time which really upset me because the evidence had not itself changed, just its presentation.

PL: All I can say is that our regulators are perhaps working to a different agenda to health and social care professionals.

Mentor: Yes, but this just makes the institution of regulation distant from the professional workforce and raises concerns about regulatory transparency. It is not only pharmacists, but also our doctors and nurses who are subject to regulatory control, with much the same experiences. At our next meeting I will be happy to check over the portfolio and answer any questions you may have before your application is ready for submission.

PL: Thank you.

The final mentoring meeting takes place one thousand eight hundred and five days after I am removed from the Register. My Mentor and I complete discussions on my restoration application.

PL: I am pleased to inform you that I believe I have almost completed my evidence gathering as part of the restoration application. My CPD compilation is complete as are most parts of the application form itself. I reflected on my learning and development in the skill of decision-making. It occurred to me that throughout the period of experiencing staff shortages I was thrust into a habit of making decisions that were no more than reactions to the challenges I faced; they were irrational and not thought out. I was naturally astounded when the FtPP claimed that 'I was a shrewd businessman and my actions were entirely motivated by greed.' They couldn't have got it more wrong, and this above all else continues to upset me the most. Five years on, of course I have learned to make decisions using a systematic approach, gathering a body of evidence, consulting widely and pilot testing the action arrived at for feedback in order to make adjustments. In business, I just found myself 'fire-fighting' continuously. It was not me who was running my business, rather the business was running me. I had lost control. I guess the FtPP just saw what they wanted to see. I believe they call it 'confirmation bias'.

Mentor: The exceptional circumstances you faced as a pharmacy owner unable to find pharmacists to cover your pharmacies led you to develop tunnel vision. You lost sight of the bigger picture, the law and regulations. You thought you were duty-bound to sacrifice yourself in order to continue to serve your patients, when in fact your actions put your patients at risk. I cannot imagine what you went through in that two-year period before you were removed. However, that is all in the past and now you have an opportunity to formally apologise and seek restoration of your name and return to practice a changed person dedicated to serving the public and upholding the law and regulations. I am pleased to see decision-making feature among your CPD and I am sure the FtP Panel will be keen to read it. The necessarily personal nature of much of your CPD is strengthened by your use of first person pronouns (I, my, me) and reads very well. It shows you

have learned a lot from this experience and am willing to take responsibility. The most important professional competence for you remains 'to make patients my first concern'. Don't worry if you find a few competences lack sufficient evidence at this stage as you will have the opportunity as part of your professional development plan (PDP) to meet these during the first twelve months after your return to practice. Furthermore, I would divide the year into quarters and focus on particular areas in each quarter. You really want to show the FtP Plan you have a framework for your ongoing development upon your return.

PL: Thank you for clarifying that for me, since the application guidelines give the impression that evidence must be included for all professional competences at the point of seeking restoration to the Register.

Mentor: I also want you to remember that you may not wish to provide direct evidence for some aspect(s) since they could be easily covered through the nature of 'transferable skills'. For instance, as you are a PhD student at the moment you would not need to show you have the competence to gather research information. I would personally hate to have to complete the restoration application form and portfolio. It is such a lot of work. The main thing is to remember nobody is perfect. We all have shortcomings. It is important for you to remember that and therefore adequately address your shortcomings in what you prepare and submit.

PL: The community pharmacy sector is facing severe financial pressures at this time. On top of the Government's austerity policy which has been in place for a number of years, the sector has faced gradual reductions to reimbursement fees for prescription dispensing services, loss of the establishment fee payment and a drive to rationalise the distribution of pharmacies (probably culminating in some three thousand closing their doors for good). In all honesty, I am not sure I want to continue in business for much longer. My passion is to care for my patients by delivering high-quality pharmaceutical services to the best of my ability. That to me is about being clinically focused and, not having the distraction of running a business. At my restoration hearing I will disclose my decision to place my business for sale, so I can concentrate on serving my patients and truly making them my first concern.

Mentor: What I see from all that I read in your portfolio and hear in our meetings is a person who accepts he made an error in running his pharmacies and, has taken this time, while out of practice, to reflect on his shortcomings and learn from mistakes made so that he never repeats these again. Your curriculum vitae is dense with activity from September 2012. Though you were going through hell, you managed to obtain voluntary work, go on to courses, pursue CPD opportunities and maintain your hand in the pharmacy you own. All this is a credit to you and informs me you are a driven person who gains satisfaction through achievement and through helping others. I'm delighted you did not succumb to despair after strike-off and then your mental health diagnosis of personality disorder. Well done for getting yourself to this point after five years in the wilderness.

PL: I want to raise with you an observation made by the FtPP concerning my contrasting behaviour and attitude to my patients who without exception found me respectful, caring and compassionate against my staff who found me intolerant and critical. I can now see that this was a characteristic trait of EUPD. When the condition was active, I would find myself 'splitting' forcing my world in to 'black and white' categories. I inevitably perceived patients as 'white' so they were vulnerable and in need of my help. I saw my staff differently. They would frequently make errors so my 'split' mind considered they needed tight control and could not be trusted to keep patients safe. My illness categorised them under 'black' and I struggled to show them equal respect. Of course, I deeply regret my behaviour which would have caused distress to many of my employees over the years. I can only apologise to them. In fact, I felt compelled to write a letter of apology and explanation to one former member of staff shortly after been given the diagnosis of EUPD as I realised the condition was at the heart of my rage at her. After the episode, we were both visibly shaken. Me, because I did not understand the intensity of my anger and it frightened me. I hoped by sending my letter to my ex-colleague she would accept my behaviour was not her fault, but a result of my mental health condition. I wanted her to forgive me and move on with her life. I have decided to include the letter of apology written in 2013 as part of my portfolio of evidence to show my early attempt to remedy some of the hurt my behaviour had caused. Today, with my current pharmacy team I am respectful, considerate and understanding. They are trusted by me to provide a high standard of service to our patients.

Mentor: I think the mental health of any investigated health and care professional for reason of FtP is important. At the level of Government, Cabinet ministers and NHS England, mental health of the population is raised time and time again as a serious concern yet in practice it is not carried through. When it comes down to individual people mental health is not considered. Our regulators strike-off several people every week. I cannot help but think that a lot of these are mental health issues and perhaps at an early stage some sort of psychological report should be looked for, rather than take the stance our regulators prefer to take which is to denigrate the person as a wicked individual. It is as true for pharmacists as it is for doctors and nurses and midwives and other care professionals that individuals choose these careers because they wish to work with a lot of different people and to make a difference to their health and well-being which impacts their daily lives. An innate passion to care is a strong driver for most professionals and we enjoy a lot of job satisfaction from the work we do as a result. I can't help but feel our regulators have lost sight of this truth.

PL: Personally, the drive to care for my patients went much deeper. For most of my life I self-loathed. Lacking self-worth, it is clear to me that I sought affirmation from my patients. Like an addict requires a regular 'fix', so I became addicted to the validation of my worth that patients I cared for provided. Perhaps, I was a patient addict rather than a drug addict, how peculiar yet true. I have said it already, but strike-off was a gift in my life as it gave me the opportunity to look inside myself and deal with all that was not right with me - low self-esteem, anorexia, depression, obsessive-compulsive behaviour, EUPD. I lived in constant fear of abandonment. Five years on, and I am in a very different place. I have good mental health, am studying for a PhD in the subject

of regulation, am a person of faith and have hope to return to pharmacy practice following a successful restoration application to the General Pharmaceutical Council (GPhC).

Mentor: I sincerely hope you are restored. The profession would benefit once again from your knowledge and skills, but more-so from you sharing your experiences while away from practice. When the GPhC was established by Government to take over the role of regulating the pharmacy workforce from the Royal Pharmaceutical Society (RPS) a decade ago, at its inception it declared it would make the necessary changes in order to improve the quality of pharmaceutical services. Just how it was planning to do so remains uncertain and many, like me, have raised concerns about the culture at the GPhC. For example, it inherited a large number of FtP cases from the RPS. It claimed to have dealt with these quickly and caught up, but the methodology used was felt to be somewhat administrative, which is often the case in bureaucracies. So it seems to have set itself up 'above' the pharmacy professionals it has responsibilities to regulate.

PL: I really appreciate all your help and support through this lengthy and demanding restoration application process. I am indebted to you. Thank you very much. I'll let you know about the progress of my application. I am delighted it is complete. It is sizeable, containing in excess of two hundred pages of evidence. I will send it to the GPhC tomorrow.

Mentor: Very best of luck and well done on achieving an in-depth application. You have shown tremendous courage and insight and I am in no doubt you are ready to return to the Register.

ONE THOUSAND NINE HUNDRED AND FIFTEEN DAYS POST ERASURE I RECEIVE A LETTER FROM THE REGULATOR STATING…

'THE GPhC WILL BE OPPOSING YOUR RESTORATION APPLICATION.'

Chapter 5
ANALYSIS & INTERPRETATION

5.1 Analysis of the use of language

Fairclough (1989) proposes a framework for the systematic analysis of the use of language in text. Fairclough's approach assumes that language helps to create change and can be used to change behaviour. In this sense language becomes a tool of power. I apply this influential model to my use of language throughout the thesis, especially within the vignettes, by responding to a series of guiding questions that serve as prompts for interrogation such as: *Are there words which are ideologically contested? Is there rewording or over-wording? What ideologically significant meaning relations are there between words? What relational values do words have?*

Ideological differences between the text representations of the world are coded in vocabulary. This is illustrated in vignette four (emotion) where paired texts (regulator vs registrant) show two different wordings of the same misdemeanour in professional practice:

FtP Chair — The risk to patient safety is engaged in this case because in our view you repeatedly placed your own interests above those of your patients and exposed them to the risk of harm…

Me — Didn't she understand that for the past four years I had worked over eighty hours a week, refusing to rest until all my patients' needs were fully met…

FtP Chair — The picture presented… is entirely at odds with the views of patients who consider that he is an honest, caring and decent professional… but the source of his difficulties was the fact that he sought to run two pharmacies without a responsible pharmacist being in place… this practice was carried on because of greed and self-interest…

Me — No! No! No! You have got it wrong. It is an accusation all too often levied at community pharmacy business owners… I am offended that the Chair by some sleight of hand managed to overlook the personal experience of care received by those I served.

The wording in the text of the regulator is accusatory and deterministic whereas my (thought) responses show an 'oppositional wording'. In fact it is a 'rewording' – an oppressive wording is being actively replaced by another in conscious opposition to it. The subversive regulatory vocabulary ideologically places it to the 'left' against the defiant vocabulary of solidarity that leans to the 'right'. In the thesis, words appear to co-occur or 'collocate', for example professional collocates with standards and misconduct giving an ideologically specific and accepted understanding of the expectations placed on professionals if they are to remain on a register of practise – the maintenance of professional standards is a requirement for professional work. Fairclough (1989 p35) states that "language is both a site of and a stake in class struggle". Returning to the closing stages of my FtP hearing detailed in vignette four (emotion) this struggle to either exert (in the case of the regulator) or preserve (in my case) social position is acute in the following extract:

FtP Chair — In our view this is a most serious case. Many aggravating features are present in this case: dishonesty, abuse of trust, taking advantage of vulnerable people, misconduct sustained over a long period of time, potential harm…

Me — Listening to her torrent against me in her summary forced me to feel I was in a losing fight for my life. The whole situation I found myself in felt like a nightmare from which I couldn't bring myself out. Nobody had ever spoken about me professionally in such defamatory terms… I felt hyper-aroused, angry, frightened, burned-out, and purposeless.

FtP — … the seriousness of the conduct admitted and the dishonesty found proven is incompatible with membership of the profession of pharmacy.

In the maintenance of professional control, regulators must strike a balance between consent and coercion. Allegations of misconduct that are escalated to the stage of FtP hearing permit the regulator to exercise repressive forces, with the ultimate sanction of de-registration. This is coaxed in a vocabulary that has become naturalized as universal and 'common sense'. The regulatory discourse is largely accepted by both professionals and public, and rarely challenged. Van Dijk (2008) has looked at relations of power: how underlying ideologies and their supporting language structures (discourses) have developed and ultimately progressed the interests of a dominant group over some other subordinate group. The effect of an overbearing regulatory discourse is the setting of the 'rules' by which truth or falsity is to be judged and the way subjects/ objects (including registrants) are to be defined. Three identifiable 'rules of truth' employed by regulatory institutions such as GPhC are: tradition ('we turn now to the matter of what constitutes an appropriate and proportionate sanction… it is not our function to punish… although any sanction imposed may well have that effect'); authority ('we have considered very carefully all the submissions… and scrutinised the case in overall context') and; morality ('we consider that the aspects of the public interest engaged are the declaration and maintenance of proper standards… many aggravating features are present; dishonesty, abuse of trust, misconduct…'). It is

challenging for regulatory bodies to attempt to align their FtP proceedings to the dominant scientific 'rule of truth' of appeal to conclusions based on openly available 'evidence'. However, the dominant ideology and discourse of regulation in UK, without challenge, seemingly masquerades as 'knowledge', which purports to characterise hard working health and social care professionals and express a 'truth' about their fitness-to-practise, character and identity.

During the time that followed my sanction, I found myself barely able to exist in this world (see vignettes four and five). The wording that depicted such a reality for me, shows 'over-wording' involving words and phrases that are near synonyms - pointing to the ideological struggle (Fairclough 1989). Inevitably I am preoccupied grieving the loss of my career evident by the following vocabulary: 'raw', 'empty', 'pain', 'agony', 'guilt', 'shame', 'overwhelmed', 'at a crossroads', 'clinging desperately', 'losing hope', and 'ending my existence'. Antonymy is another ideologically significant meaning relation that appears in the text of the regulator. In sanctioning, the regulator asserts the meaning of one word is incompatible with the meaning of another i.e., the meanings of dishonesty and professional (see vignette four: emotion). The literature review section revealed a strong relationship between dishonesty found proven and removal of a registrant from membership of the profession.

A text's choice of wordings depends on, and helps create, social relationships between participants (Fairclough 1989). There are some 55,000 registered pharmacy professionals on the GPhC register. Regulatory case reports can be accessed online and it is relevant to suggest that such outputs provide an opportunity for the regulator to build a relationship of trust and unity with the readership. By listing my 'very many failings' and linking these to the motive of 'self-interest and greed' as a community pharmacy proprietor, the negative evaluation reached by the FtP panel is assumed to be supported by the membership. Therefore the regulator is assuming commonality of values with pharmacy professionals in practice. It is conceivable, however, that fellow professionals are, in fact, vicariously traumatised instead.

Throughout the autoethnography I use imagery (personification, simile and metaphor) in order to bring the readers' attention to the impressions I convey of characters, setting or atmosphere. Altogether, it is the element of the human voice in the narrative that I strive to achieve – I remain ever-present as the narrator, even when the narrative voice is given to another character within the autoethnography. I hope that most readers are, somehow, drawn to sympathise and identify with my character, my personal dilemmas and my moral journey. Three excerpts along with a brief explanation for their construction is offered next.

> Because she detached herself from me, I lost my beloved profession and with her what felt like my foothold on the only reality I had allowed myself for twenty years… My body's rigor mortis revealed the horror of what had taken place… I hauled my bony frame out of the chair and on weary legs walked across the back of the room… keeping my eyes on the three 'merciless gods' I was leaving behind. (Vignette four: emotion)

De-registration is a traumatic event shown by the dramatic tone I adopt. Through the decades that I have been part of the profession of pharmacy I have come to personify my profession and felt bonded to her. I emphasize that to lose such love is very painful. My writing juxtaposes the opposing concepts of love and death, 'My body's rigor mortis…' and 'I hauled my bony frame…' I accept that as a human being I have erred, but looked to the panel of three to transcend obvious human failings, show compassion and mercy, and hold back my return to dust.

> I arrive early for my appointment with the Community Mental Health Team… I announce my arrival to the receptionist behind the glass wall, small window sliding open, brief acknowledgement, small window sliding closed… the sound of the latch being released to signal the opening of the toughened wooden door and the start of my appointment. (Vignette five: journey I, mental health)

In this excerpt I metaphorically represent the mental health service in terms of imprisonment. However, it is the health workers who are locked-in apparently for their own safety from the risk posed by 'dangerous' yet vulnerable service users. Elsewhere, I liken becoming de-registered to the experience of being imprisoned with use of a range of synonyms including incarcerated, punished, disciplined, locked up and enclosed. Locked out from professional practice, negative publicity and stigmatisation (that I internalise) induces social withdrawal. I am preoccupied with fatalistic thoughts.

> My removal from pharmacy practice did not cause my depression, but it certainly deepened my melancholia… I lock myself away in my study… feel agonizing emotions in the extreme… I can choose to live with this gaping wound or alternatively to attain freedom by extinguishing this life and all the pain it clings to. My disconnection… is almost complete. (Vignette five: journey I, mental health)

The trauma of living without meaningful work leaves me isolated, shamed and helpless - subverting assertive masculinity of the past. In my home, I am rendered powerless, lost and hopeless by the emotional trauma that I cannot escape.

Freud (van der Kolk 2015) famously identified the unconscious as that place in the mind from which nothing ever goes away; thus childhood traumas that form part of our psychological past continue to live on inside us. I felt that the inclusion of flashbacks to earlier periods of my life take the reader to my beginning in order to get to know my character better. If Freud is right then traumatic experiences in childhood account for the neurotic behaviour of adults. By regressing into my own past, I reveal the possible seed of my character's insecurities – the fear of abandonment (and development of a pernicious trait in order to survive in this world). Splitting is a very debilitating defence that starts during infancy and refers to the process of separating experiences into good and bad. Its purpose for a sufferer of emotionally unstable personality disorder (EUPD) is to enable the sufferer to organise and integrate diverse and chaotic experiences. Looking back over the start of my staffing difficulties in practice that led to regulatory

action being brought against me, I recognise that at critical points (of heightened stress) I became very angry indicating that my mind had 'split' and automatically reached its conclusions based on the patterns stored in memory. Acting from this primitive splitting I perceive situations as wholly good, or wholly bad – there are no gradations of good and bad experiences. So, negative or even hateful feelings directed towards a person, group or organisation are indicative of my state of mind. Fortunately, with growing insight (as shown through the course of my latter journey vignettes) such negative evaluations have significantly reduced. The realisation now forms the basis for improved relationships in which others are valued and treated with greater respect.

5.2 Narrative Analysis

Arthur Frank is a medical sociologist, researcher, therapist and author of the seminal text 'The wounded storyteller: body, illness and ethics' (Frank 2013). He asserts that people tell stories about lived experience in order to be heard, seek to build relationships and find meaning in suffering. Though Frank (2013) himself uses story and narrative interchangeably, he acknowledges that narrative is concerned more about the structure underpinning the story. Frank (2013) believes stories are told with– not only to- listeners, and that the parties are in relationship. In this manner, storytellers are afforded opportunities for recuperation and to rebuild lost connections. Reflecting on his own critical illness experiences during the mid-1980s, namely heart attack and testicular cancer in a memoir – At the will of the body (Frank 1991) – the author has, as a consequence, sought other people's stories to connect the voices to his own. Frank (2013) cautions researchers not to move too quickly away from the relational aspect of storytelling and observed that his own lived experience of illness did not match the descriptions produced by the academic sociology community, referring to a supposed line of fault in understanding. The storied vignettes I wrote became the focus of discussion between me and the supervisory team for several months during which time I feel our relationship became transformed through the process of empathic listening - encouraged by my careful storytelling about suffering. I sensed this support as my team began to move towards understanding the de-registration experience from my perspective. The period of time I spent at this particular juncture did allow me, as both researcher and the researched, to take on a "critical embodied reflexivity that involves construction, deconstruction, and reconstruction of embodied subjectivity" (Finlay 2005, p.277) – necessary for the task of narrative analysis, later in this section.

An examination of the written vignettes reveals that the format of the narratives is complex and as Frank (2013) suggests shifts between the three modes of storytelling: restitution, chaos and quest. Although these are strictly illness and trauma narratives, I seek to adopt and apply Frank's narrative types to my personal experience of regulatory action, tracing the precarious period from removal through diagnosis of mental illness, psychological treatment, spiritual awakening and submission to my regulatory body of my completed application for restoration. The literature is replete with examples of the application of Frank's three types of illness narrative to those who are living with the effects of a serious chronic illness, such as breast cancer (Thomas-Maclean 2004), chronic fatigue syndrome (Whitehead 2006), disability (Ellis 2009) and stroke (France et

al. 2013). This analysis will show that similar to illness the experience of de-registration is also a disruption which promotes restitution, chaos and long term refinement.

I was removed from pharmacy practice by my regulatory body on Monday 10 September 2012. I was 45 years of age, and had practised as a pharmacist for twenty-two years. I never expected to encounter my regulatory body, on disciplinary grounds, in my working career - erasure from the Register of Practise (RoP) itself was unimaginable. Watters (2018, p.639) comments similarly when she writes "…when it happens, something has changed and any investigation should look for what has gone wrong and how it could be put right… not punishment for past mistakes". On the day of erasure, restoration seemed distant to me, particularly as it required a complete overhaul of the person my regulatory body perceived me to be at the time.

> Prior to these events, Mr Leal had an unblemished record. By reason of our findings, Mr Leal has lost his good character and reputation. Mr Leal's misconduct is entirely at odds with the views of patients who consider that he is an honest, caring and decent professional. Doubtless Mr Leal was under pressure, but the source of his difficulties was the fact that he sought to run two pharmacies without a responsible pharmacist being in place beyond the extent permitted by the law. We are satisfied that this practice was carried on because of greed and self-interest (GPhC vs Leal 2012).

5.2.1 Chaos Narrative

I am not surprised that within the seven vignettes the chaos narrative figures very prominently; around fifty situations have been presented which are, as Frank (2013) predicts, mostly contained within the restitution and quest types – characteristically without narrative order. As my life story reveals, I have encountered several 'stumbling blocks' in the form of knowledge, events, love, relationships, health, work, identity and God, starting at the beginning of my life and continuing unabated, as the following six extracts from my inheritance vignette demonstrate.

> As a child I had nearly ended both of our lives during my difficult birth. I had significantly contributed to her hospitalisation due to physical exhaustion by the time I was three months. I was placed in foster care for my second three months of life. My behaviour on being reunited was insecure and disturbed for a long time afterwards. (4.1 Vignette: Inheritance)

> My parents functioned along strict gender roles – and I naturally looked to my father for my role model and unconsciously rejected my mother's perspective and example. She lashed out whenever I upset her with hurtful words "Why were you born"? I felt very sad and worthless... My alienation and needs deepened. I broke down. (4.1 Vignette: Inheritance)

> I began to lower my head towards the water. I sensed a voice from inside of me say 'live'. Live, living, life were words that suddenly dominated my thoughts and I stared ever more

> intensely into the rising noisy waters. I saw my reflection. I acknowledged that I had to continue to live. But for what reason? (4.1 Vignette: Inheritance)
>
> Leaving home and spending more time on my own with my fatalistic thoughts, I struggled to know who I was. I was expending so much mental energy in maintaining a modicum of discipline towards my studies. I failed two of the four end of year exams… I strengthened my resolve to succeed, helped on by my father's warning that 'I must not fail'. Failing was not, therefore, an option, not now, not ever. (4.1 Vignette: Inheritance)
>
> I am now standing on the doorstep of my regulator's home. A few minutes earlier, I had been removed from the professional Register…I was overwhelmed, confused and in shock. My solicitor, struggling to find any words of comfort asks simply if I am all right. (4.1 Vignette: Inheritance)

In each of these situations I have been forced to lose something that I valued greatly and which gave me both comfort and security at the time. Many may take for granted the fact that they have access to the unconditional love of parents, trusting relationships, happiness and a hopeful future. I grew up feeling relatively underprivileged. The chaos narrative shows itself best between descriptions of relative stability, moving through loss and suffering, and return to a stable, though changed state. Suffering and loss around a predicament cannot be evaded, as is the case in the restitution narrative, so that the depth of vulnerability comes into clear view. In these linking segments, the story becomes interrupted and does not flow easily.

Frank (2013) states that chaos stories are hard to hear since they provoke anxiety. Chaos stories do not have a sense making format, are anti-narrative, so it is difficult to tell them to others. I started in business, it seems, unprepared for the colossal and varied demands proprietorship was about to unleash and which threatened to extend and deepen the wound I bore up to that point in life. "Control and chaos exist at opposite ends of a continuum" (Frank 2013, p.100). My regulator held tightly to the assumption that in business, leaders were ardent and shrewd. The following three extracts display my claim to losing control over running my business.

> Nothing could truly have prepared me for such an undertaking. There were all the complex legal and regulatory requirements issued by Governmental, NHS and Pharmacy bodies pertaining to running a lawful community pharmacy business to uphold…My 'to do list' continued to grow day by day. My former working week extended from 40 hours as an employee to over 80 hours a week as a pharmacy proprietor. (4.2 Vignette: Action)
>
> I had to deal with the unexpected resignation and premature departure of my employed pharmacist. I reacted angrily. I faced a real dilemma and was unable to resolve the situation through replacing the staff member due to a national shortfall in available pharmacists at the time… I felt abandoned, isolated, became withdrawn and unable to reach out for help and advice. I was confused and emotionally overwhelmed as to what

> to do. In my distressed state I panicked and felt I had no other choice than to work between the two pharmacies on any days that a second pharmacist could not be found. It meant that for some part of the day, each pharmacy would not have a registered responsible pharmacist in control. I was broken by the enormity of the responsibility and fearful for the safety of my patients, but felt most strongly of all, duty-bound to work this way in order not to let my patients down. My working week now exceeded 120 hours. (4.3 Vignette: Fit)
>
> I had lost control of my business which had spun deeper and deeper in to the abyss. Looking back on the day the Inspectors called, I fell into a state of shock, yet felt relieved that my suffering was finally ending as I finally allowed myself to realise how incredibly burned-out I was. I did not feel human any more. I had lost touch with reality, lost touch with my loved ones, lost myself in the mayhem and chaos of the past fifteen months. (4.3 Vignette: Fit)

As these extracts demonstrate, the chaos narrative lacks narrative sequence – there is no future worth anticipating from the lived unpleasantness I found myself in. The chaos story, in attempting to catch my pain and suffering in words, is forced to go faster. Frank (2013, p.98) believes “these stories cannot literally be told but can only be lived”. Perhaps, other proprietors will be able to relate most closely with the crisis I experienced in business as one possibility that could become a reality for any one of them. However remote the possibility of occurrence may be, the threat of becoming destitute in business remains ever present, particularly where contingencies fall outside personal control.

In my chaos narrative, having my licence to practise as a pharmacist revoked was unthinkable. I had no other way of perceiving my existence in the world. As a clinician, before transitioning in to business, I was entirely different from my present self. The following extracts from my disciplinary hearing reveal my experience of self as ‘other’, coupled with a loss of agency and despondency at this perilous time of my professional career. All of this occurred in a climate of “emotional battering” (Frank 2013, p.101) which I was experiencing from my regulator, The GPhC.

> At this time, I felt my most vulnerable; my body began to shake with fear and my heart pounded in my chest. I was in a precarious state. I began to consider all the possible outcomes and this just worsened my anxiety. The worst, of course, was that I would be struck-off the Register of Practise and unable to work as a pharmacist. That was utterly unthinkable; the pharmacies might be forced to close. (4.4 Vignette: Emotion)
>
> My own solicitor remarked that during cross examination I was a jumble - sometimes, connected to what was happening and articulate, then a moment later, without warning, my responses had turned to rantings that were uncoordinated. Rightly or wrongly, I became angry, bitter and lashed out at the world. (4.4 Vignette: Emotion)

> Was that it? An open-and-shut case where greed was the only motivation behind my complex behaviours? Few FtP cases extend beyond one or two days. Yet my case took eight days to reach termination. There were twists and turns, breakdowns and breakthroughs, veiled and explicit shows of anger, confusion and insights, false charges and damaging lies. I just couldn't get off the emotional roller coaster I'd been riding since the start of the FtP hearing, or more correctly since my troubles at work started, two years earlier, in 2009. (4.7 Vignette: Journey III)

> 'His name be removed from the register'. The outcome I dreaded most. The hearing was over… I still remember the words of my solicitor immediately following the announcement of the sanction "They did not believe you". I was in a maelstrom of grief and self-loathing. (4.4 Vignette: Emotion)

> I lost my beloved profession and with that what felt like my foothold on the only reality I had allowed myself for twenty years… I felt discarded, worthless and ashamed. My body's rigor mortis revealed the horror of what had taken place. (4.4 Vignette: Emotion)

Frank (2013, p.96) points to a time when restitution is no longer available and asks "what body-self is left, when the end of survival is imminent?" My tragedy of cessation of work before reaching retirement left me without useful purpose. I had been forced to accept a painful end to practising as a pharmacist before I could adjust to living without my work. The following extract, depicting a time shortly after strike-off, conveys my unease in displacement. I am feeling out of place, perhaps unable to comprehend the reality of my situation, or perhaps wanting to be dead.

> On the morning of the twenty-third day since losing my profession, I have one of my worst times so far: a strongly felt resentment that life has been so unfair in taking away my professional work. Working as a pharmacist gave purpose to my life, gave me worth as a human-being, without which I could not function. My well-being is rooted in my work as a pharmacist. Dark painful thoughts just deepen this sense of loss I feel right now. I am powerless against the shame of it. I am losing hope. (4.5 Vignette: Journey I)

Typically, the chaos narrative form manifests itself whenever fluent speech falls apart to leave sentence fragments whose words are underpinned by what Frank (2013, p.99) refers to as "staccato pacing". In a very real sense, my life became difficult to bear. My loss remained vivid, repeatedly striking at my awareness. The words similarly peck away at the reader, making them difficult to read. Chaos narratives thence are either disliked or rejected outright both personally and culturally (Frank 2013), and such denial deepens the misery felt by those trapped by their muted suffering. On far too many occasions, after the event, I have heard experienced professional colleagues eager to tell me how, if they ever found themselves facing such staffing difficulties, they would have closed one pharmacy and avoided regulatory action. My colleagues demonstrate the difficulty they have simply hearing what is being spoken, preferring instead to

undercut my story to tell me how they would have behaved in the circumstances. In the midst of chaos, however, there is no easy way out.

> Mentor: There is no question over your clinical work with patients. Looking back at what got you in conflict with the GPhC, it was basically running two community pharmacies with inadequate cover which will come under the heading 'professionalism'. So either you should have closed one down or magically got another pharmacist manager. (4.7 Vignette: Journey III)

> I am frustrated to be unable to fully explain my behaviour, if indeed there is an explanation? Mere notions such as 'duty', 'emotion', 'failure', 'scarcity', 'crisis' and 'burnout' continue to bounce around in my head, but they are yet to settle and take form. (4.7 Vignette: Journey III)

The preceding extracts are demonstrative, once more, of a time in my life during which my chaotic mind-body had lost all agency and my 'professionalism' broke. As Frank (2013, p.97) poignantly states concerning suffering, "the chaotic narrative tells how easily any of us could be sucked under". In this state, my chaotic mind-body fell victim to dominating bodies around me, especially those that formed part of a regulatory body, determined to objectify and scorn what became incapable of defending itself.

> The whole situation I found myself in felt like a nightmare which I couldn't bring myself out of. Nobody had ever spoken about me professionally in such defamatory terms. I began to wonder whether the Panel was just reacting to the spectrum of behaviours I had shown throughout the hearing. I found the high tension and drama in the courtroom unnerving even provocative. I felt hyper-aroused, angry, frightened, burned-out, and purposeless. (4.4 Vignette: Emotion)

The chaos narrative is the most embodied form of story. Todres et al. (2009, p.74) cite embodiment as one of eight dimensions that form part of their "humanising value framework". They argue that being human means living through the full spectrum of feelings and experiences of the "human body's being-in-the-world". Fitness-to-Practise (FtP) proceedings as "deterministic and linear" had the effect of reducing my "complex sense of human embodiment". De-registration not only took away my work identity but my purpose and meaning in life also. My body was sensitised to tiredness, pain, loss and separation from others. In terms of 'other-relatedness' Frank (2013) describes the body's orientation as 'monadic' and I am unable to receive assistance or comfort, as the following extract shows.

> My removal from pharmacy practice did not cause my depression, but it certainly deepened my melancholia. I am even more withdrawn, avoidant and inactive, with the

> result that I lock myself away in my study for much of the day, most days. My study imprisons me during daylight hours of every day of every week of every month. Family life is impossible for me. All the suggestions of my loved ones, I interpret as excessive demands that rapidly overwhelm me. Behind closed doors I alone come up against ravaging self-hate. I am too tired to offer a resistance. Strike-off had caused me to feel the entire spectrum of what I can only describe as agonizing emotions in the extreme. I hurt all over, all the time - morning, afternoon and evening. I hurt at night, in my sleep and in my dreams. Living day by day in this state is unbearable. Most days I genuinely feel unable to cope with my loss of profession. I have a choice to make. I can choose to live with this gaping wound or alternatively to attain freedom by extinguishing this life and all the pain it clings to. (4.5 Vignette: Journey I)

De-registered professionals need to tell their stories to their families and others. Families may require professional support in order to be fully receptive to chaos stories if further suffering within the domestic environment is to be limited. My world was already out of control. Social withdrawal and forced silence within my home contributed to my family's own experience of chaos. I refer to my loss, in the above extract, in terms of a gaping wound. Loss of work created a hole in my life which was impossible for me to close. Frank (2013, p.100) believes the chaos story can only ever be told "around the edges of that hole", on the edges of speech and in the silences that speech cannot enter. The absence of voice is a distinctive feature of a body caught up in chaos. With the benefit of distance that allows reflection, both telling and hearing chaotic stories within the family setting may provide much needed opportunity for healing. My deep hurt kept me from talking to my family. Frank's (2013) helpful assertion that personal responsibility cannot be assumed in the immediacy of lived chaos, provides little comfort to me for the pain I had caused to my wife and children by my behaviour. Outside the family setting, I could not locate a specific professional support group for sharing de-registration experiences, probably reiterating the wider culture's discomfort with chaotic stories. Perhaps by deviating from the stringent norms of professional practice, I have given professional colleagues permission to shun my presence. Marginalisation and shaming of de-registered professionals becomes increasingly inevitable, as my own experience expresses in the following extracts.

> There is no institution, organisation or charity specifically set up and designed to support de-registered professionals. Our removal from professional practice is a multifaceted dilemma. Not only does it signal loss of professional status and work, but also structure to the day, cherished working relationships, income and independence. On a personal front, it brings a lowering of self-esteem and inward negativism under a veil of powerful emotions of guilt and shame. Family life inevitably suffers and contributes to the growing isolation you feel. You find yourself in the wilderness, cast-out, alone facing the looming question 'what is the point of going on?' (4.5 Vignette: Journey I)

> I sense my former professional colleagues, rightly or wrongly, wish to distance themselves from me. I have to learn to cope with shame. I most acutely feel the hurt and

> shame of my situation whenever I came in to contact with registered care professionals, including pharmacists, and their places of work. I am vulnerable and sensitive to criticism and invalidation. I was finding it increasingly difficult to deal with the belief that I had been misunderstood by my regulator and the injustice I had been dealt. (4.7 Vignette: Journey III)

Frank (2013, p.99) states that the 'over-determination' of an individual's situation is a display of the chaos narrative in that "troubles go all the way down to bottomless depths". Already feeling desperately sad about removal from professional practice, the 'over-determination' of my problems extends to my troubles with my wife and children, parents, locum pharmacists and employees, local health authority, insurers, solicitors and NHS Counter Fraud Squad. My troubles descend to bottomless depths during investigations into my continuing poor mental health that uncover a chronic disorder, as the following extracts reveal.

> I questioned whether I could hold it together and continue with yet another stigmatising status: emotionally unstable personality disorder. Being given a firm mental illness diagnosis, far from bringing me answers to my symptoms, has initiated increasing worry about becoming a mentally ill patient, a mental health-service user, an abnormal and a dangerous individual. Just what is the public perception of the mentally ill? Images and portrayals of the mentally ill in literature and film are overwhelmingly negative. (4.5 Vignette: Journey I)

> I revisit the first information sheet and slowly begin to call out components of my disorder: pervasive INSTABILITY… marked IMPULSIVITY… ABANDONMENT… UNSTABLE interpersonal RELATIONSHIPS… IDEALISATION and DEVALUATION… IDENTITY disturbance… UNSTABLE sense of SELF… self-DAMAGING behaviour… SUICIDAL… self-MUTILATING… reactivity of MOOD… IRRITABILITY… ANXIETY… chronic EMPTINESS… intense ANGER… PARANOID ideation… severe DISSOCIATIVE symptoms. Every day is the same. My days are occupied by a constant struggle to keep myself from drowning in the blackest black and losing myself forever. Looking back, the relentless pressure of starting in business in 2007 caused an exacerbation of all these symptoms… I imagine ending my existence, my troubles, my loneliness, my sorrow, my shame. Ending my existence. (4.5 Vignette: Journey I)

I return, once more, to the fact the regulator remained ignorant to other possible explanations for my 'black and white' behaviour, such as mental ill health; this fact is difficult to excuse. The regulator as a public body has, in pursuit of 'public protection', overlooked a basic duty of care for registrants (Watters 2018). Rather than safeguard my well-being my regulator chose to prosecute aggressively, while failing to reconcile my complex case. I was emotionally battered, scorned and cast-out. All I was trying to do was to gain recognition of the outright chaos of my life (consequential, as it turned out, to undiagnosed chronic mental ill-health).

At this time, there is an absence of chaos stories by health and social care professionals (HSCP) removed by their regulatory bodies, and such absence is being strongly felt and noted by practising professional registrants who are becoming increasingly concerned by regulatory decision-making (Weir 2017; Hathaway 2019). Professionals are rightly suspicious about the authenticity of practices and processes that constitute fitness-to-practise, which leave many who go through FtP proceedings feeling emotionally battered. Regulators appear uncomfortable to hear chaos narratives of registrants, yet this is essential for tellers if they are to heal from their wounding experiences.

5.2.2 Restitution Narrative

In the restitution narrative, restoring my name to the Register held by my regulatory body is the plot line – 'yesterday I was a respected registered pharmacist, today I am erased from the Register, but tomorrow I will be restored again'. Within the vignettes, this story form is the one that I most desired. I felt that the FtP Panel, in their statement above, were re-defining my identity from an honest, caring and decent professional towards one that was consumed by self-interest and greed and, without good character or professional repute. The new identity was unwelcomed, not least because it carried the social stigma popularised by the media – a 'bad apple' among the barrel of pharmacy professionals. Understandably, I attempted to resist the label and wished that instead my regulatory body, once more, saw me as the respected clinician 'I had once been'.

> I knew my first concern was the welfare of my patients and customers. That I understood from the day I qualified some twenty years ago. I am not a fool, but I have made mistakes which I am prepared to learn from. I am so much more a clinician than a businessman. (4.4 Vignette: Emotion)

Traditional programmes of professional training do not equip HSCPs to be business minded. The development of a business acumen for many care professionals comes about through largely unplanned exposure to challenges faced in practice settings that require decisions to be made concerning the efficient management of resources. Health and social care has changed considerably in the last three decades, and the notion of acquiring business acumen while trying to run a busy practice is not practical. Having a business education in addition to clinical training would prepare a significant number of care professionals to take up roles and responsibilities that require an application of the principles of business management. The Chair opened my hearing, which extended over eight days, by stating "this is a complex case". Frank (2013, p.80) argues that the thrust of modernity, and the institutions born under its guise, is the pursuit of "master narratives" By this Frank means, in the realm of illness, the favoured narrative that is promoted or enforced by the medical establishment. This can be extended to include any other powerful faction of society, such as statutory regulators in the context of my study. It is the promotion of a master narrative (such as believing that the business community is only motivated by profit) that becomes the generally believed story in professional culture, despite other equally valid narratives being available, including duty to public service. Statutory regulatory bodies (SRBs) have developed a consistently applied model of FtP rules and processes for how registrant stories are

told. A limitation of this approach that overlooks essential nuances between different registrants' stories (at least from the business community) is the production of a homogenous aetiology of misconduct and therefore of the conclusions that logically follow.

> It is an accusation all too often levied at community pharmacy business owners. We are supposedly a small section of the profession motivated by financial rewards above all else? No! I became an owner in order to have a say in the way pharmacy is practised for the benefit of my patients and customers. Any rewards, including financial, would come directly out of serving my customers to the very best of my capabilities… Why can this Panel not see the truth behind what drove me to keep the service going in spite of a genuine lack of human resource? (4.4 Vignette: Emotion)

Downgrading my complex case from 'mystery' to the institutional norm held by my regulator for proprietor pharmacist registrants greatly assisted it to solve the presenting 'puzzle'. Frank (2013) is emphatic in his condemnation of modernity which he argues seeks to turn mysteries into puzzles accompanied with claims to heroism. Regulatory bodies serve an important public protection role with FtP of registered professionals forming an important strand to the role. However, having first-hand experience of the system of regulating professionals currently in operation, I contend that far from bringing transparency to the adjudication exercise, the strongly 'rule governed processes and procedures' that underpin FtP assessment are designed to deconstruct mystery to a series of smaller puzzles amenable to being solved. Frank (2013, p.84) makes reference to scientific process and medical practice to highlight the reductionist methods that are used "to effect this deconstruction".

Science and medicine (as well as religion and law) are the institutions in our culture that supposedly embody the highest ideals by which we all live. While all have brought benefits that have contributed to overall well-being they have also contributed to widespread suffering and injustice (Grayling 2003; Tuttle 2005; Goldacre 2009; Coleman 2011). In the context of professional regulation, these fundamental institutions have influenced a reductive system-design in regulation. Such a system is in great danger of viewing HSCPs facing allegations of impaired FtP, as less than professional at one end and at the other end as less than human. Registrants' experiences of FtP proceedings that have been captured by researchers suggest the regulatory process had been de-humanising (McGivern and Fischer 2012; Brooks et al. 2014; Bourne et al. 2015; Worsley et al. 2017). The analytical practice of reductionism, applied at the level of the human, then, has the power to transform the whole person into a selection of component parts, such as thoughts, feelings and behaviours. Those parts could then be put together, in assumed ways, from outside, to fit the master narrative with the inevitable consequence of a loss of compassion towards the object of reduction. Todres et al (2007) suggest the integration of the perspective of 'lifeworld'.as a foundation for humanising practices in care. They argue that our concrete, every-day experiences are underpinned by such interrelated dimensions as temporality (continuities/ discontinuities of time), spatiality (personal topography), inter-subjectivity (existing with others), embodiment (meaningfully lived body) and mood (emotional attunement). Together

these represent the essential holistic quality of each person's experience or their lifeworld that can only be understood when all dimensions remain intact. My 'complex case' as it was described by the Chair is indicative of the multi-dimensionality of my own lifeworld, leading up to the complaint against my FtP. I sensed through my own hearing that my regulator was not concerned about the ethics of our relationship. Ellis (2007) has written about upholding relational ethics through actions from both heart and mind. The regulator remained distant, unfriendly and showed me little care or compassion during the eight days of my hearing. As for the possible reason, it is conceivable that my regulator had simply acted from its statutory powers (with backing of the law) and control over my practice to place me in a powerless position which its own 'rule-governed processes and practices' appear to have been designed to achieve – my personal narrative was lost and my lifeworld shattered.

> Nobody had ever spoken about me professionally in such defamatory terms… I found the high tension and drama in the courtroom unnerving even provocative. I felt hyper-aroused, angry, frightened, burned-out, and purposeless… My own solicitor remarked that during cross examination I was a jumble. (4.4 Vignette: Emotion)

The FtP process has exclusive focus on the misdemeanour with virtually no attention given to the life story of the registrant under scrutiny. I felt that without knowing my story and therefore my journey to the hearing, the FtP Panel (FtPP) could not properly understand the genesis of misconduct, which Frank (2013) points out is quite typical of modernist thinking. More precisely I felt that by limiting its inquiry to the misdemeanour, the FtPP denied itself the opportunity to understand how the present conduct fitted in to a life and career story as an episode in that story in the sense of what came before and what could be predicted to follow. By dismissing my life and career story as a legitimate source of knowledge about me, coupled with the situational circumstances surrounding my misconduct, I felt the FtPP failed in their duty of care to me concerning what I was going through leading up to the misdemeanour.

> I faced a real dilemma and was unable to resolve the situation through replacing the staff member due to a national shortfall in available pharmacists at the time… My terms of service, spelled out in my NHS Pharmacy Contract, required the provision of an uninterrupted access to pharmaceutical services, which in my rural localities I interpreted to mean I could not consider closing… I was confused and emotionally overwhelmed as to what to do. In my distressed state I panicked and felt I had no other choice than to work between the two pharmacies on any days that a second pharmacist could not be found. (4.3 Vignette: Fit)

My thoughts, feelings and actions that led to a complaint being made against me were not understandable within the frame of reference from which my regulatory body was operating. This I believe is the empathy problem that produced negative feelings towards me (and which I reciprocated), leading me to feel that the regulatory process, in its present form, was de-humanising to dutiful and hardworking health and care professional registrants. The FtP

investigation and hearing processes systematically can deprive the registrant of his/ her agency. Todres et al. (2009) recognise agency (or the freedom to make choices for oneself) as an important facet of their humanisation framework. They identify a close relationship between a sense of agency and the human sense of dignity. The barrage of allegations, accusations, witness accounts, cross examinations, all carried out using an adversarial court model, were a far cry from the caring environment I had come from. It was like a legal playground that I found foreign and intimidating. I felt my personhood was diminished, and my role in the proceedings was largely passive. My professional future lay at the mercy of the FtPP (comprising a legally qualified chair, a layperson and a member of the profession) – a realisation pointed out to me by my own solicitor, in a most poignant statement:

> We've done all that we could do. Your future now rests in the laps of the gods seated in front of you. (4.4 Vignette: Emotion)

Frank (2013, p.85) refers to the problematic body in the illness restitution story as "monadic in relation to other bodies" meaning that not only is it separated from the self, but also as a diseased body from those of healthy bodies. Once diagnosed, the effect is isolation of the labelled person "turning the monadic body in upon itself". Todres et al (2009) draw attention to the fact that illness brings a sense of separation from community. The experience of isolation is often exacerbated by institutional practices that prioritise rules and concern for efficient running of the system over people. I believe such a phenomenon is also relevant in the context of FtP proceedings and sanctioning by a regulator. Health and care professionals passing through FtP proceedings and sanctioning feel de-humanised and possibly cut off from their profession. The isolation is perceived as a form of regulatory punishment used to 'enforce professional norms of conduct' (McGivern and Fischer 2012; Brooks et al. 2014; Bourne et al. 2015; Worsley et al. 2017).

> It is not our function to punish Mr Leal, although any sanction imposed may well have that effect… We are well aware of the effect the sanction we impose will have upon Mr Leal's professional standing and career and his ability to earn a living and support himself and his family… It is necessary, reasonable and proportionate to direct that his name be removed from the Register because the declaration of proper standards and the maintenance of public confidence in the high standards of the profession demands no lesser sanction. (4.4 Vignette: Emotion)

I perceived the sanction imposed by my regulator as nothing less than the severest form of punishment for my transgressions. The FtPP listed the tangible deprivations that would follow removal from the Register – forbidden to practise as a pharmacist, loss of reputation and reduced financial resources. However, it did not recognise or warn me about the psychologically destructive and excruciatingly painful consequence of the FtP process – shaming. My regulator was quick to publicise its heroism, in striking-off another wayward professional, by releasing details to the media as well as publishing the case on its own website. The publicity had exposed me to a wider public and to my professional peers, and I quickly became afraid of negative gossip

and further disgrace. I felt the regulator had been careful to select incidents and episodes from my complex case in news releases to portray me in the worse possible light. Frank (2013, p.87) points out that such self-congratulatory news releases are not wrong, but rather "they betray a conspicuous lack of narrative balance". My own story had been silenced.

> My immediate situation pushes me to live moment-by-moment under an umbrella of stigma. It takes away my voice. I feel guilty because of misconduct in a professional role. I am ridden with shame. The narrative that my peers would undoubtedly write would be a narrative under the banner of shame and blame that unequivocally states 'you should have known better'. In this light I feel I have betrayed my professional colleagues and deserve the consequences. I am a 'bad apple' and could no longer belong in a profession that demands the highest standards both inside and outside practice. (4.5 Vignette: Journey I)

The restitution narrative demands compliance with authority, the manifestation of this is revealed in a "disciplined and mirroring body" (Frank 2013, p.87) meaning that I had accepted responsibility for my actions that had led to de-registration. I was equally determined to fulfil my current work obligations and maintain professionalism. I continued in the role of Pharmacy Proprietor after strike-off, but was forbidden from working in the capacity of a pharmacist. Instead I was subjugated to working under the supervision of a Responsible Pharmacist engaged to work in my business.

> I must have accepted my circumstances somewhere along the way to my six hundred and fortieth day away from the Register in order to have committed myself to work at my pharmacies for one or two days a week… I am acutely aware that the eyes of both my staff and customers were focused on me for signs of repetition of past behaviours leading to my erasure. It therefore came as a surprise to me that my Superintendent Pharmacist was informed by letter from the GPhC that it had received a complaint from a patient stating 'it is alleged that on 22 March 2014 a prescription was dispensed by Mr P Leal in the absence of a pharmacist'. I am confident that the patient is mistaken, since at all times, the pharmacy engaged the services of a registered pharmacist, under whose supervision I have been working… The regulator's Investigation Team were able to verify all this in a letter dated 10 September 2014 that stated 'the GPhC has decided that there is no evidence to show that Mr Leal acted outside of the supervision of the Responsible Pharmacist'. (4.7 Vignette: Journey III)

I feel this incident demonstrated that I actively upheld the GPhC Standards of Conduct, Ethics and Performance required of me. As Frank (2013) stipulated, I had shown within a short time in to my five-year de-registration period the juxtaposition of my impaired FtP self ('bad apple') with that of the desired FtP self (registered pharmacist). My impatience with Regulation led me to begin to question the justification for striking-off care professionals for a minimum period of five years. After all, over the past two years I had been lawfully operating my pharmacies and had put the

past behind me. I had, in reality, already reintroduced myself as fit-to-practise, albeit in the lesser role of pharmacy assistant, in the present. It is the function of the regulatory body to identify and recognise the positive behaviour change, which I felt it had done in its unequivocal response by acknowledging that I had indeed acted lawfully.

Notwithstanding the fact that only around half of all HSCP applications for restoration to a Register following removal are successful (according to regulator annual FtP data reporting on their websites), the restitution narrative is a source of encouragement to all registrants whose FtP has been assessed to have become impaired by providing hope that things can return to how they were before. Suspension or strike-off can be seen in restitution stories as mere interruption which is therefore finite and remediable (Frank 2013). Regulatory action that has deemed the fitness of health and care professionals to be impaired demands that affected individuals come to terms with the host professions' cultural expectations of professionalism and their place in this central practice. The following discussion between myself and a senior pharmacist mentor that took place during the preparation of my restoration application highlights the need to demonstrate a return to professionalism:

> PL: … It would be most helpful to me, in this initial meeting, if I can draw on your recent past experience of mentoring erased pharmacists through the application process…
>
> Mentor: The most important element is that you have understood the reasons for your removal from the Register and that you evidence how you have addressed your shortcomings…
>
> PL: You see while I fully accept I fell short of my responsibilities as a Superintendent Pharmacist and Pharmacy Owner, what I do not accept are the reasons and motivation given by the FtPP for my misconduct. As is most often the case with Pharmacy Owners, the FtPP default position is to believe that greed is the reason for misconduct.
>
> Mentor: Looking back at what got you in conflict with the GPhC, it was basically running two community pharmacies with inadequate cover which will come under the heading 'professionalism'… I know you put a lot of effort in to finding cover…
>
> PL: Back then, I made a decision based on emotion rather than followed professional requirements to close the pharmacy in the absence of a pharmacist. I did not feel I could deny my rural residents the services of their local pharmacy and risk causing them distress. I felt I had no choice but to remain open and try to provide partial cover to both my pharmacies on days when another pharmacist could not be found.

> Mentor: You need to reassure the GPhC there would be no repeat of the past by providing evidence of your professionalism… Most pharmacists in my experience make minor infringements in practice daily, not by any deliberate action, but by way of omissions.
>
> PL: I have worked in the pharmacy profession across most sectors over my twenty-five years' career... I have never before felt as isolated and challenged by the set of circumstances I found myself in, as a community pharmacy owner, which ultimately led to my removal from practice. I was proud to be a pharmacy owner and dedicated myself to the role, putting in a hundred hours each week.
>
> Mentor: I think that stress within the pharmacy workplace is a problem. There are probably a whole host of reasons for this presently. Probably understaffing is a factor, and that we as pharmacists take on too much… It is true also for our professional colleagues working in health and social care. Stress is a huge issue at the moment and it is only getting bigger leading to poor mental health.
>
> PL: I understand I must mitigate, as far as possible, stressful working conditions when I return to practice in the future. (4.7 Vignette: Journey III)

Frank (2013) believes that in restitution narratives memory is not disrupted. I recognise this might be the case with lesser sanctions such as a warning, conditions placed on practice and even suspension for up to twelve months. There is, for each one of these punishments, a swift end to the sanction allowing the registrant to return to a state just before regulatory action. Both society and professional culture, it could be said, appears more supportive towards registrants who show less serious lapses in professionalism (as determined by regulatory assessment). As Frank (2013) predicts cultures prefer the restitution narrative (in these 'trivial' cases). However, for registrants who are struck-off following FtP proceedings, a different cultural attitude appears to be prevalent, most likely driven by social stigma. The discrediting social label ('bad apple') is most strongly applied and felt by removed registrants, like me, who have been judged to have seriously failed to live up to professional expectations. In this case the loss of professional work, status and reputation is experienced as shaming. Unlike the case of lesser sanctions, the experience of strike-off refuses to sit outside of memory. Rather, accepting and adjusting to the career catastrophe becomes part of any recollection, indelibly written into a life story, such as my own.

There are limitations to the restitution narrative in illness experience which Frank (2013) presents as a critique of modernity. Applying this critique to the regulatory framework for professionals it becomes clear that restitution stories no longer work when impairment to FtP remains in place beyond the five-year term of incarceration for those removed from practice. The following extract of the closing conversation with my mentor, from the end of my autoethnography, reveals the deadening power of regulatory decisions.

PL: …Five years on, and I am in a very different place. I have good mental health, am studying for a PhD in the subject of regulation, am a person of faith and have hope to return to pharmacy practice following a successful restoration application to the General Pharmaceutical Council (GPhC).

Mentor: I sincerely hope you are restored. The profession would benefit once again from your knowledge and skills, but more-so from you sharing your experiences while away from practice… the GPhC… inherited a large number of FtP cases... It claimed to have dealt with these quickly and caught up, but the methodology used was felt to be somewhat administrative, which is often the case in bureaucracies. So it seems to have set itself up 'above' the pharmacy professionals it has responsibilities to regulate.

PL: I really appreciate all your help and support through this lengthy and demanding restoration application process... I am delighted it is complete. It is sizeable, containing in excess of two hundred pages of evidence.

Mentor: Very best of luck and well done on achieving an in-depth application. You have shown tremendous courage and insight and I am in no doubt you are ready to return to the Register.

ONE THOUSAND NINE HUNDRED AND FIFTEEN DAYS POST ERASURE I RECEIVE A LETTER FROM THE REGULATOR STATING 'THE GPhC WOULD BE OPPOSING YOUR RESTORATION APPLICATION'.
(4.7 Vignette: Journey III)

My own experience, following the submission of my comprehensive portfolio of evidence to my regulator and having my hope for restoration quashed, left me in a state of dismay. I began to question the fairness of our system of regulation. Perhaps I had been naïve to believe in restoration to the Register, at the end of serving my punishment. Whatever had been the specific reason for my regulator's decision to oppose my application, the bureaucratic dismissive tone of the response had left me to perceive the reality of our system of regulation as not a level playing field for all. I felt the end of my restitution self-story as a further tragedy in my life that did not fit into this narrative type, any more. As much as I did not want to remain off the Register, I had to painfully acknowledge that de-registration was now an experience and identity that I had no choice but to adapt if I was going to find a way to live beyond merely existing until such time as I could return to pharmacy practice. The quest narrative presented an alternative way that I shall explore below.

5.2.3 Quest Narrative

I feel that in an attempt to locate the point in a person's life-time a quest begins: it is all too easy to overlook the evolutionary and cultural past we inherit, through genetics, culture, family and education. I was not fully aware of the relevance of my family background to de-registration at the

time of writing my autobiography and opening vignette. I now appreciate ‘inheritance’ as the seedbed of de-registration in my own life. The following excerpts are suggestive of the role that my conscious and unconscious minds have played in shaping my interpretation of the world and my place in it. I am no longer blind to the way emotions and intuitions shape daily life, yet these human facets are ignored by the system of regulation which maintains a view that treats the human being as wholly rational.

> My parents’ decision to come to England was in response to a call by the British Government to the countries of the Commonwealth for labour to help boost the British economy in the post-colonial period. We were poor. My mother was incredibly good with money; she made sure we spent little of my father’s weekly wage, preferring instead to carefully save every penny that she could to ensure that, when the bills came in, she could afford to pay them. (4.1 Vignette: Inheritance)
>
> As I grew older, my parents would share tales about their own childhood memories… The storage room was filled with items that belonged to another place and time, India. I came to understand that this precious space within our home held memories for my parents that they would never let go. (4.1 Vignette: Inheritance)
>
> Of the many tales my parents shared with me as a child, the dark shadow of the Partition of India in 1947 loomed heaviest on my mind. (4.1 Vignette: Inheritance)
>
> My grandfather had curtailed my father’s schooling, a decision my father resented. However, in coming to Britain, he had hoped that his own children would have every opportunity to receive a state education and progress into skilled occupations and even professional roles such as law or medicine. (4.1 Vignette: Inheritance)
>
> As I grew, I poured everything I had into my education. It was the only way out of my circumstances I could see. I did well at school and, became the first of my generation from my community to gain a place at University. I studied Pharmacy. (4.1 Vignette: Inheritance)
>
> Failing was not, therefore, an option, not now, not ever… I registered as a Pharmacist. I felt that the dedication, determination and resilience I had shown from a young age had helped me achieve academic goals and vindicated my parents’ decision to come to the UK. (4.1 Vignette: Inheritance)

The experience of racism and inequality of opportunities at work that were common to first generation immigrants in the UK during the 1960s and 1970s are alive today as they were then. A recent literature review by Pendleton (2017) to gain a qualitative understanding of the experiences of immigrant black and minority ethnic (BAME) nurses and midwives employed in the NHS and private sector, identified ten primary research studies which were synthesised to

gain deeper understanding. Four commonly occurring themes in the literature were: underemployment (meaning that a large number of skilled and qualified BAME registrants were employed at the lowest entry levels in health and care sectors); stagnation (in their work roles due to nurses and midwives from BAME communities being routinely denied training and promotion); racism (covering covert and overt racism from being assigned more challenging patients to not been supported by managers in disputes with white colleagues) and; punishment and excessive scrutiny (BAME workers felt less trusted than white colleagues and put under increased surveillance in practice that affected confidence). Overall, the review highlighted the experience of BAME participants who felt unfairly disadvantaged because of differences in skin colour with limited expression of positive experiences. These nurses and midwives, like generations before them, were unable to overcome the abuses against their right to fair treatment at work and became passive. More recent data released by the GPhC show ethnic disparity between the numbers of FtP concerns raised against pharmacists. Data from 2017, show that 1,110 pharmacists entered FtP proceedings after concerns were raised. White British on the register compared to those in FtP processes reveal an underrepresentation of 37%. All BAME groups are overrepresented as follows: Black African by 47%, Pakistani by 47% and Indian by 31%. These data show a clear trend and require investigation to include data on the outcome of FtP hearings (Wilkinson 2018).

In quest stories, narrators “meet suffering head on; they accept illness and seek to *use* it” (Frank 2013, p.115), and search for “alternative ways of being ill” (Frank 2013, p.117). Career interruption became my departure from well-being and I entered a ‘state of suffering’ 22 years after first registering to practise as a pharmacist, following strike-off. Though I was unable to feel the full impact of the catastrophe until a short-time afterwards, it is noteworthy that on the day of removal from the Register of Practise (RoP) while in a state of shock, I experienced an emotional response that has remained with me to this day, revealed in the following extract at the end of my inheritance vignette.

> As I turned to look back at the home of my regulator, it dawned on me that it had simply done its job and that was all - to protect the public against professionals in practice who had shown themselves to be a risk to safety. That said, *just why did I feel so unfairly treated?* (4.1 Vignette: Inheritance)

My intuitive and unconscious mind, or inner wisdom, perhaps, perceived unfairness in the system of regulation I had experienced and signalled this to my awareness. Looking back, I could not dismiss the righteous anger I felt. Perhaps it was here the new quest had begun, literally on the GPhC’s doorstep immediately following sanctioning. Strike-off had emerged in my mid-life as “the occasion of a journey that becomes a quest” (Frank 2013, p.115). The quest is defined by the “belief that something is to be gained through the experience” (Frank 2013, p.115). My immediate desire was to regain my registration at the earliest opportunity despite recognising that I had shown poor decision-making as a business owner which had raised concerns about my

professionalism. More noble goals such as contributing my experience to the care professions to help others going through FtP proceedings and strike off had not yet entered my mind.

Of the three narrative types, only quest stories speak from the perspective of sufferers and hold chaos at bay. The quest narrative is the form that most published autobiographical illness stories follow. The teller of the quest story plays an active role in their own recovery journey (Frank 2013). In contrast, without exception, published FtP Determinations are presented from the perspective of the regulators, putting the registrant in a passive role susceptible to 'emotional battering'. Written in the language of modernity, professional and lay readers of such Determinations may be forgiven for their uncritical acceptance of any conclusions reached and the spectrum of sanctions that may be imposed, including de-registration.

In his research, Frank (2013) recognised the very broad range of quest stories that are told. He identified the following major subtypes: memoir, manifesto and auto-mythology. Features that are shared by all three facets include the following: meet suffering head on; accept illness; search for alternative ways of being ill; belief that something is to be gained; illness as opportunity, opening or challenge; clear sense of purpose. However, the three quest subtypes also differ in important ways which are summarised in Table 11.

Quest Subtype	**Characteristics**
Memoir	Straightforward acceptance of illness; life absorbs illness; trials told with great self-control; no special insight gained from experience. (Most gentle quest story)
Manifesto	Tellers want to use suffering to move others forward with them; sufferers' visibility to each other; demands for social action or social reform; special insight gained from experience. (Least gentle quest story)
Auto-mythology	Change of character; individual change over social reform emphasised; going beyond self-imposed limits; rebirth; self-reinvention. (Phoenix reinventing itself from ashes of fire of own body as a predominant metaphor)

Table 11. Characteristics of Frank's Quest Narrative subtypes

My narrative has been presented through seven chronological vignettes where the final three are written about a time subsequent to de-registration. At the time of writing, I annotated these three as my journey (I Mental health; II Spiritual awakening and; III Restoration application) and so, in view of my research objectives to explore the changes brought about by de-registration, I will apply Frank's quest subtypes to the second half of my overall story. The journey vignettes, despite their overarching quest narrative type, do also contain the restitution and chaos narrative forms, explored in the previous sections, to more fully and accurately characterize my de-registration experience.

5.2.3.1 Memoir

In my case the quest memoir narrative is represented the least of all three quest subtypes, indicating that removal from professional work has rarely in my story simply been incorporated into my current life. Only three extracts from my journey vignettes could be identified as truly representative of the quest memoir. For example, in the following extract I combine worship, mental illness and drug therapy and, family aspects of a life told somewhat "stoically, without flourish" (Frank 2013, p.120).

> Six hundred days lived outside the profession of pharmacy and, I am a regular weekly disciple of Lord Jesus, at the Sunday evening service... Exposure to the Word of God, the lives of biblical characters and their stories and worship over the past four months is helping me to understand my own role as the architect of my own misfortune, largely through wilful poor choices and decisions in the course of running my pharmacy business, the reward and consequence being significant additional emotional suffering. Accepting that I require help to manage my mental state, I continue to take an antidepressant each day. To the relief of my family, my medication subdues my extreme responses (of anger and rage)… (4.6 Vignette: Journey II)

It has taken almost two years to establish some stability and routine to my life following strike-off. My subtle quest memoir is expressed as an important lesson - poor personal choices and decisions bring about our own suffering. Having courage to reach out and seek help at a time when my resilience was severely challenged and to accept drug treatment point to further changes at this time in my life. I had to learn to accept my situation and the help and support available in order to continue to have any resemblance of family life. I do not experience restitution, but an altered existence without the dominance of my treasured professional work. The idea that the quest memoir in the example above is framed as a lesson implies that my changes are a response to (at least three) external forces. First, my regulator's decision to remove me from practice that created a void in my life that I could not easily fill. Second, how this loss had exacerbated my emotional instability and at the demands of my family led me to accept medical intervention. Finally, an epiphany that awoke my implicit understanding of self as a spiritual being that led me to join my local Christian ecclesia.

Occupying the role and responsibility of pharmacy proprietor over two rural community pharmacies was no security to feeling bereft as a result of losing my registration as a pharmacist. I was only able to contribute once more to running the business and pharmacy services from the second year following strike-off. I returned to the business on a part-time basis and worked as part of the pharmacy support team to the Responsible Pharmacist on duty. Motivated by my desire to regain trust and maintain my professional competence over the period of my incarceration, I felt I had a purpose for returning to pharmacy practice which would also help me to put my painful experience behind me. However, within months of my return, a patient had, unbeknown to me, lodged a complaint to the regulator alleging I had dispensed a prescription without the involvement

of a registered pharmacist. I felt upset and disappointed by the patient's decision to go direct to the regulator rather than seek clarification about what took place locally. I was confused by the possible motive behind the patient's action, but felt it was better not to dwell on this for my own mental health. The investigation remained live for six months and was eventually dismissed by my regulator stating I had not acted outside the law. To contribute to patient care and participate in this previously enjoyed activity, even if undertaken in a different way, was important to my self-worth. I continued to believe that I had much to offer the profession and accepting and adapting to the impact of de-registration held important lessons for me.

5.2.3.2 Manifesto

Unlike the memoir quest narrative type which is "told with great self-control", the manifesto carries "demands for social change" (Frank 2013, p.120). For example, in counselling that took place shortly after my de-registration I express how regulatory processes and practices overlook the health and well-being of registrants:

> *Me*: I feel angry that… my inability to engage with the regulatory process in a non-emotive manner…, neither the pharmacy nor legal professions saw anything out of the ordinary in my complex behaviour. Did they fail in their duty of care to me? [I paused, deeply inspired while feeling a stronger than ever sense of injustice.] Could it be that our systems of regulation and law, in pursuit of a complaint, become so blinded to the plight of individual health and social care professionals that they are reduced to being less than human, or 'other', stripped of all basic human rights?
>
> *Counsellor*: It is important to feel disappointed and let down by the systems that are supposed to protect all. Maybe, in their preoccupation with their stated purpose 'to protect the public' regulatory bodies have overlooked the significant impact that their activities and sanctions have on those they regulate. (4.5 Vignette: Journey I)

I continue with my critique of the system of regulation in another excerpt where I demand that registrants' mental health is given serious consideration as a potential factor in FtP cases. It also calls for FtP Panellists to be trained to identify signs of mental distress and have procedures in place to safeguard registrants' health and well-being.

> My mental health was not considered at all relevant by the FtP Panel (FtPP) during my hearing, despite outward signs and symptoms to the contrary. Unfortunately, the adoption of court-like methods by regulators that follow the infamous adversarial system akin to criminal law, precludes such essential safeguarding of the suffering care professional… I was left feeling stripped of my selfhood. I had become an object of assault by the prosecution. (4.5 Vignette: Journey I)

In the view of the FtP Panel my case as a community pharmacy business owner did not depart from the all too frequent accusation against business owners that my misconduct was entirely motivated by 'self-interest and greed'. Despite my vehement denial, a year after removal from the Register, the NHS Fraud Investigation Team (FIT) descended on my business and began a protracted investigation that culminated in my agreement to a voluntary interview at a police station that was double taped, just as I recall from crime investigation documentaries on television. There is no doubt that I was negatively impacted by the Fraud investigation and interview. I felt tormented by this second investigation which reinforced my 'bad apple' status. However, unlike the FtP investigation years earlier, I had not knowingly done anything wrong and therefore felt the fraud investigation was wasteful of time and resources. The long list of accusations presented were mostly premised on hear-say and data manipulation to which I defiantly shouted back "ridiculous". Several months afterwards, I reflect over my experiences and develop my own agenda for sharing "a truth about suffering" (Frank 2013, p.120) believing that not to do so is the enemy of fairness and justice.

> I receive the briefest of letters stating that my case has been forwarded to the Crown Prosecution Service (CPS) who feel there is insufficient evidence to take my case to trial… I have come to deeply understand, through my own lived experience, why many care professionals commit suicide in the face of accusations and allegations. (4.7 Vignette: Journey III)

> Already, my own experience has identified processes and practices among the various stakeholders that feed into and are fed by the 'regulatory system' that raise concerns around fairness and justice. I believe my experience could provide a unique insight to both inform current and future regulatory practice, as well as present a roadmap of the personal and professional struggle ahead for the many professionals who as a result of alleged misconduct are subject to FtP investigations. I believe my experiences could be portrayed within a doctorate study, using a qualitative research design. I am driven to contribute to the development of pharmacy practice and decide to formulate my ideas into a research protocol… I appreciate the project will be emotionally very difficult for me, but I hold out hope that at the end of it I will have used my experience to benefit others. (4.7 Vignette: Journey III)

To the best of my knowledge, there have been no published first person accounts given by care professionals about their experiences of de-registration by a professional body in UK (or overseas). My autoethnography, centred on my removal from professional practice, I hope will release me and others from the shamed silence that typically descends upon us as a first step towards creating a change in societal attitude towards care professionals who have made a mistake from which they may be able to learn and as a result continue to contribute to their profession. Frank (2013, p.122) describes a "solidarity of the afflicted" as the opposite of isolation felt by many like me in our situation and, it represents a laudable and desirable alternative for those experiencing distress leading to suicidal ideation. A dialogical approach to achieving this

goal, first proposed by Paulo Freire (1970) in the context of teaching and learning in his native Brazil, will be explored and adapted in the next chapter as a significant call for change to the UK system of regulation of care professionals that diminishes and dehumanises registrants.

5.2.3.3 Auto-mythology

The theme of the auto-mythology quest narrative type is one of withdrawal followed by renewal and return. Implicit in great suffering is that it can stimulate a change of identity or self-reinvention. This became the plot for the period of five years that I was forced to be away from the Register. Mental ill-health diagnoses (depression, suicidal ideation, PTSD and EUPD) within the first three months following strike-off whilst providing an explanation for my misconduct and the way I was feeling became potent labels I was desperate to overcome. In the following excerpts, despite my pleas for help, I do not appear to qualify for treatment through oversubscribed NHS Mental Health Services and decide to take active steps myself to recover my mental state.

> I believe I can educate myself about therapy and apply this to my own life. I discover there is a level three counselling skills course, run at my local College. I am desperate to develop understanding, schema and skills to help overcome my emotional difficulties. Yes, I am certain this will bring about the changes I am seeking in order to have a chance to reclaim my career as a Pharmacist. (4.5 Vignette: Journey I)

> The view about me presented to the world by my regulator's formal assessment and diagnosis on their website is, from the perspective of person-centred therapy, of secondary concern to my primary 'self-report'. Such a position offers the hope that I do not have to allow the judgement of my regulator to define me. The person-centred approach puts me in the driving seat, trusting me to find my own way towards personal growth. (4.5 Vignette: Journey I)

> After removal from the Register, I was left feeling like an outcast, ridden with guilt and shame for bringing my profession into disrepute. My isolation had worsened. Finally, person-centred therapy offered me hope of a different kind of future. The theory suggested that I possessed the power to transform my personality within a nurturing environment. I was yet to realise my potential and this indeed held promise for me. (4.5 Vignette: Journey I)

In my state of suffering I was not able to reach out to my loved ones and instead withdrew from all that I had considered had previously brought me happiness. I was in danger of being shattered into fragments by this lonely suffering caused by the loss of my profession. The intensity and persistence of my pain was threatening to lead me to end my life. Nothing on earth seemed to pacify this unassailable suffering. It was at this time, when most vulnerable, that heralded the following glimpse of truth.

> I am unaware that my life is about to take a new direction and my transformation take on renewed impetus. I happen to raise my head skywards and look for the sun that is struggling to emerge from a cloudy sky. Like a bolt out of the blue, without foreboding, Lord Jesus fills my vision... At this time I am broken, troubled, beyond repair. His gaze upon me from up high is compassionate, sincere yet gentle and loving. All sense of the world and my physical being seems to dissolve... Like the 'sound of silence' that is able to convey several profound messages for me to hear including…I am a beloved child of God, I am forgiven… I am a soul, I am spirit, I am love, be at peace. (4.6 Vignette: Journey II).
>
> The vision of the risen 'Christ' and accompanying tender feeling nudge me into a new perspective on my situation. Through my formative years and career I have absorbed, like most, the worldly wisdom that emphasises winning over losing and success over failure. Yet, today and for the first time, I begin to contemplate the value of loss… that loss might in fact teach greater lessons than success. Counter to my prevailing belief, am I then to reassess strike-off as a 'gift' in my life? (4.6 Vignette: Journey II)

The FtPP had told me that I had lost my previous good character. I was puzzled and alarmed to hear this since the Panel did not know me deeply in order to arrive at such a conclusion. Rather the FtPP, under its rationalistic rule-governed processes and procedures, is inevitably confined to the superficial level of the damaged personality I had revealed through my behaviour in response to the demands I faced as a business owner. In contrast I believed that my character was intuitively directed towards meeting the needs of others exemplified by my choice of career as a pharmacist. The same applied to other care professionals. I believed my good character, as a human being, remained intact. The problem rested with the ego power that drove my personality to act in breach of the professional standards of my profession. The following excerpt from my spiritual journey vignette identifies the issue that I most needed to address before I could consider returning to the Register.

> Four hundred and eight days outside of pharmacy practice and the vision of the risen Christ… I am awake to a new, higher way of life, but doubt whether I am ready to consecrate myself to the spiritual path. I recognise that many in our world, like my parents, cling to religious discipline and draw from it, the strength to cope with life's misfortunes, whenever and however they strike. My own vision entices me to fantasise about a transformation in my personality, even towards that seen in esteemed individuals in history like Mahatma Ghandi, Nelson Mandela and even Jesus himself. I am desperate to start to shape my true identity… My old self must die. My old self must die and give way to my new self. My new self is my true identity. It is home and whole and loving. I say it out loud over and over. (4.6 Vignette: Journey II)

I recognised that I had lived most of my life in a dualistic manner – unable to live inner (or private) and outer (or public) lives at the same time because the tension I felt was unbearable. I was

happiest of all in my work as a pharmacist, but now that was lost the truth had to be faced. I could no longer continue dualistically, especially as I experienced my strike-off as a public humiliation. The task of reconciling my divided self was never before more urgent than now. The excerpt that follows reveals my recognition of the significance of the present moment in my life, in conversation with a member of the Christian community who was soon to become a spiritual mentor to me.

> Me: I have come to see my punishment as a gift. By taking away my daily work, my regulator had unwittingly afforded me the time to focus on my mental health and my emotional and spiritual development. Through my life I had repeatedly overlooked my own well-being and instead continued to keep myself busy with my work and studies… Stressful moments all too often have revealed my emotional vulnerability... Do you believe I can be helped?
>
> Christadelphian: We put forward the life of the Lord Jesus as the model we put our faith in, and to change our lives using the lever of love. No matter what brings you to faith… it alone can instil genuine hope and transform broken lives. (4.6 Vignette: Journey II)

The combination of counselling, psychiatry, spiritual awakening and mentorship, education and mindfulness practice have all played a part in my transformation from a state of emotional dysregulation to stability - to being at ease with self and the world around me. My own Psychiatrist was surprised by the changes she observed I had made, mostly through my own agency in the absence of any NHS psychiatric intervention specifically designed to treat EUPD. Leaving behind the unstable personality that has been dominant for most of my life has given me a sense of freedom and renewed hope for the future. I felt able to contemplate a return to work as a pharmacist for the first time at the end of my reflection below, about the very difficult recent past I had endured.

> I carefully read the words about my progress and current state of health. I am filled with confidence about the true place of loss and suffering in the growth of a human being. Through an act of surrender to the supremacy of faith, I have to the best of my abilities overcome many attachments in my life that have long convinced me they represented success. I am separated from my wife, living outside my family home and without work. Over the years, to fulfil my inner tumult and emptiness, all these attachments just served to feed my ego, though never succeeding in making me truly happy. My many career achievements represented a shallow attempt on my part to raise my own self-esteem… The past two years have taken me to the brink of suicide and, thankfully, beyond. As my Psychiatrist has observed, I seem to have emerged with a changed perspective on life. Perhaps, now I could begin to address my regulator's Determination on my case that was deeply condemning and take the first step in restoring my name to the Register of Practise for Pharmacy Professionals. (4.6 Vignette: Journey II)

Frank (2013, p.117) believes that the quest represents a form of “reflexive monitoring” during which the individual undergoes fundamental change to identity, perhaps becoming unrecognisable to others. Frank borrows from the work of Joseph Campbell (1972) to describe the narrative structure of the hero’s journey in three discernible stages: departure, initiation and return. The call to departure for me was the catastrophe of losing my registration. This prompted an intense search for a solution (or elixir), whether in this world or another. Before finding the elixir in the second stage (initiation) I encountered trials in the form of pain and suffering (grief, shame, stigma, isolation, depression, anger and rage). The elixir I found came unexpectedly to me in the spiritual awakening which instilled self-love and hope to my life. The ensuing transformation of personality and identity is the strength with which I return to the world, determined to demonstrate my changed state and wish to continue to contribute to patient care.

> Many erased care professionals give up hope of ever returning in the sands of time. I, on the other hand, am resolute to continue to make a contribution to the pharmacy profession and will fight on, whatever the cost, to restore my name. The journey ahead is unwritten and I worry if I am resilient enough. (4.7 Vignette: Journey III)

> On the one thousand and ninety fifth day following removal, I feel able to review the guidance pages on my regulator’s website for restoration applications. I quickly learn that for applicants who have been removed from the Register following FtP proceedings, the application process was very demanding and complex. Reading on, the application requires the pharmacy professional to submit a portfolio of evidence to demonstrate that all shortcomings that led to erasure are addressed… The website made clear that it fell on me to satisfy my regulator that I have, over the years since erasure, rehabilitated and no longer presented a risk to the public. (4.7 Vignette: Journey III)

De-registration has given me the impetus to change and embrace a new healthier perspective. Frank (2013, p.118) explains that in the third stage, “the hero returns as one who is no longer ill but remains marked by illness”. I returned, no longer afflicted by EUPD or depression but forever influenced by de-registration and its associated trials. Looking back when I started this journey I was not able to understand why I needed to face an interruption to my pharmacy career. Through it I am healed of a lifelong emotional instability – my true essence that became wounded by abandonment, harsh criticism and senseless punishment. I have been given a topic to investigate at doctorate level and make a contribution to professional practice. I have taken up my role as proprietor and welcome the opportunity to role model professional behaviour. My mentors, pharmacist colleagues, pharmacy support staff, academic supervisors and family and friends believe I am fit to return to practice as a pharmacist. I too feel ready and hopeful about my imminent return to my profession.

> 1,915 days post erasure I receive a letter from the regulator stating:
> “THE GPhC WOULD BE OPPOSING YOUR RESTORATION APPLICATION”.
> (4.7 Vignette: Journey III)

Beyond three years, I had begun to show signs of 'generativity', particularly following the collapse of the fraud investigation into my business and developing appreciation of the meaning in my life of the spiritual epiphany I had experienced. Scripture makes a distinction between once-born people and those who are twice-born: 'I tell you the truth, no-one can see the kingdom of God unless he is born of water and the Spirit' (John 3:5, New International Version). The former are considered to conform to the ideology of their age and passively accept 'who they are'. In contrast, twice-born people are in a state of dis-ease with themselves and the ideology of their age. Healing is only possible through a transforming experience that gives new direction by helping them find themselves. My career crisis and spiritual epiphany were the catalysts for my breaking with the past or 'false self' and the start of my quest to find my deepest identity or 'true self'. Rohr (2012) distinguishes between 'first-half (outer) and second-half (inner) tasks to human life. In the first-half-of-life the task is to establish an identity, a home, a career, relationships, friends and community. Often after some kind of fall or failure we are forced to pay attention to the inner task – to discover who we truly are and access spiritual joys that await when we do. Rohr (2012) argues that the many failings and fallings in life which people experience that bring pain and suffering are not without purpose, yet neither culture nor its institutions fully understand this. The antipathy shown to me by my regulator following submission of my restoration application is revealing of this misunderstanding. To seek integrity in "the task within the task" argues Rohr (2012, p. xv) signals a move from the first to the second half of life and failure is necessary to jolt us out of our comfort zones. In this respect, Rohr is in agreement with Scott Peck (1985) in his aptly titled book, 'The Road Less Travelled'.

5.3 Moving beyond the structured organisation of silence

In my analysis and interpretation, I have adopted Frank's heuristic framework to help show types of narratives that are present related to my personal concerns over the five year period covered by the autoethnography. Frank (2013) reassures us that his framework is in no way representative of the truth of story. Rather, that the autoethnography is its own truth. In contrast, the GPhC through a reductive methodology developed the 'greed and self-interest' frame to categorise my unprofessional behaviour. In doing so, my regulator appeared to reveal itself aligned with a modernist culture of the past that presented frameworks as truth and story as lie. Frank (2013) aligns his life's narrative work among patients suffering from acute and chronic ailments with postmodern thinking which, in the context of medical practice, expresses concern for 'authoritative' diagnoses and prognoses issued by the medical profession. He challenges the assumptions of modernism and science implicit in medical practices that usually point patients towards a linear narrative that promises restitution, but in many cases fails to provide a return to the former state of health. The authoritative stance is premised on a single point of view that claims legitimacy and works hard to exclude competing discourses.

Thompson (2003) argues that the position of power occupied by many of our institutions are a consequence of increasing bureaucratic forms of social organisation legitimised in law and which have come to rely on the role of specialists or 'experts' to sustain their authority. Jean-Francois Lyotard's (1984) definition of postmodernism as 'incredulity towards metanarratives' thus rejects universalist stories such as those put forward by a society's institutions – Church, Law, Medicine, Government ideology. What can be said about these institutions, I feel, can also be extended to the institution of 'Regulation'. By maintaining a Register, whose membership is controlled by rule-led FtP processes, regulators operate an inclusion/ exclusion system of control that silences the plurality of narratives of care professionals, preferring instead to continue to hold firm to a metanarrative with its highly privileged truth to tell. My own experience as witness provides testimony to this self-legitimizing practice of silencing, homogenizing and excluding. Regulation of the health and care workforce in the UK has frequently come under criticism over the past two decades from the research community (for example Chamberlain 2016; Austin et al. 2018; Kirkham 2019), government-led inquiries (for example Smith 2004; Francis 2013) and the professions themselves (for example Brooks et al. 2014; Leigh et al. 2017; Watters 2018). My personal involvement with the institution of 'Regulation', in the capacity of both being erased from the Register and researcher over the past decade has largely validated such criticism.

5.4 Personal journey of self-care

On 10 September 2012, the day that I lost my licence to practise as a pharmacist, I began my formal relationship with survival. The end of my career as a pharmacist felt like the end of my life, and it began my long run as a sufferer. The word 'patient' means one who suffers. I contemplate that in one way or another we are all 'patients of life'. Our System of health and social care in the UK has more than its fair share of dysfunction – to match its usefulness, for sure. I trained and worked as a pharmacist for over twenty years, so I have seen care from both sides. Believe me when I say with all sincerity that the vast majority of people who go into health and social care careers mean well truly, but we who work in health and social care in the UK are also unwitting agents for a System that, too often, does not serve. Why do I think this? I feel that the System was designed with dis-ease at its centre and not people, which is to say, of course, that it was badly designed – and nowhere are the effects of bad design more de-humanising or the opportunity for good design more compelling than during FtP proceedings where things are so distilled and concentrated. My purpose (in this thesis) is to reach out across disciplines and invite design thinking into this big conversation, at a time when all the SRBs dealt with in this study are reviewing their FtP processes to reduce the human impact on registrants.

My lived experience informs me that the most frightening thing about strike-off is not strike-off itself, but suffering in the aftermath. This is a key distinction. To get underneath this, it can be helpful to tease out suffering which is necessary as it is, from suffering we can change. I consider that the former is a natural and essential part of life and to this we are called to make space, adjust and grow. In contrast on the System of regulation side, so much of the suffering is invented ('the regulatory rules' and the array of 'limited frameworks of thinking') and serves no purpose,

which my autoethnographic account has alluded to. Since this brand of suffering is made up it can be changed. This thesis is intended to contribute to the big conversation with the goal of making the System of Regulation of care professionals sensitive to this fundamental distinction between necessary and unnecessary suffering.

The stress of FtP proceedings worsened my already poor mental health (shame, anxiety, depression and low self-esteem) and, unbeknown to me at the time, exacerbated my symptoms of EUPD (anger, rage, hopelessness and suicidal ideation). After de-registration my life fell apart. I lost the means to support myself. I lost contact with family, friends and work colleagues. My marriage broke down. I lost my children. I lost my home. I became depressed and suicidal. I lost hope. For a whole year after de-registration I felt like I wanted to die, not because I had found some final peace or transcendence, but because I was so repulsed by what my life had become – cut-off, struck down, ugly. The regulator's sanction of strike-off ushered in grief in a manner that was repugnant towards me, no doubt believing me to be the 'bad apple' in the barrel. Pouring over my life, sometimes fruitfully with mental health professionals, I continued to grieve and at the time of my 'miraculous vision' experienced a transformation in perspective - feeling that there is beauty in everything and everywhere, including the System of Regulation. I decided to pursue the notion that our present-day institutions can become more compassionate. Many thousands have lived through or are living with de-registration and therefore intimately familiar with this particular experience of suffering. I wanted to contribute my experience in an effort to change the infrastructure of regulation to one that was dynamic enough to care for registrants as people who care for others, in spite of alleged misconduct. That in itself would help relieve suffering – not add to the pile.

I arrived at my PhD study with a host of emotions – including anxiety, anger, bitterness, sadness and shame. My study supervisors were understandably unaware of the depth of my self-loathing and vulnerability. As a EUPD sufferer I was liable to experience more extreme emotional states of rage and severe agitation. My emotions were obviously secondary to the fact that I had been through a trauma that was to become the subject of my investigation. The work ahead had not previously been attempted from the first-hand perspective of one who had been de-registered and I understood that the task ahead would take everything I had in order to complete it. Did I have it in me? I realised very quickly after embarking on the literature review that I was walking a tightrope between self-preservation and falling ever deeper into the abyss. It often did not matter to me whether I lived or died and especially when the pain I felt was excruciating. In supervision meetings at times of heightened emotional states, spoken language became difficult for me both to understand and verbalise. Perhaps the sheer overwhelm of the moment had caused my brain's speech areas to shut down. I was hurting in the extreme at these points. I often struggled to constructively handle feedback on my work from my supervisors, perceiving their comments as an attack on me personally. I found it difficult to respond with clarity, being unable to find the words to my feelings. At other times, I actively projected uncomfortable feelings into the supervisory team. It felt to me like I was voluntarily carrying the responsibility, single-handedly, to stimulate change in FtP processes so that other registrants would not suffer in the way I had. I

felt burdened by the enormity of my responsibility and saw a parallel to the situation in practice that had resulted in my removal from the Register, years earlier.

Throughout all the supervisory meetings that took place (both in-person and online) over the six years of the study, my supervisors tried to convey to me that in spite of having little understanding of my predicament, they were willing to support me in any way they could. I felt that they were overt in acknowledging my emotions – anger, sadness, shame and helplessness. I was vulnerable and felt uneasy about disclosing too much information about my FtP case or the circumstances that led to regulatory action against me. I feared that I would be unfairly judged and became guarded. To my surprise, my supervisors informed me, within weeks of starting, that they were not concerned about my case or the details about my alleged misdemeanours, but instead on how I was coping with erasure – the topic of the investigation. This helped me to communicate more openly as I began to feel safer. The supervisory team were insistent on adding structure to our meetings, so I began the habit of developing an agenda to support our discussions, and immediately writing up the minutes of the meeting. Though I did not know it at the time, structured meetings contributed significantly to a greater sense of safety that I required, especially during the first half of the PhD journey.

For so long, work as a pharmacist had been a central part of my life. Losing this part of my identity was something I continued to struggle with through my PhD. I had a sinister mental health diagnosis that caused me to feel the pain of loss very intensely. To try and soothe the emptiness that I was feeling I allowed myself to become delusional and often fantasised that what had happened to me was just a dream and that I would soon emerge out of the nightmare. I had continued to contemplate on the miraculous vision of the risen Christ a year after de-registration, and especially on its significance to this moment in my tortured life. I was unable to dismiss it as an illusion because of the way in which I felt as I was gazed upon. I had been touched by the purest love, like I had never previously felt in my life. I came to the helpful awareness that it can be really good to realise forces larger than ourselves. They bring proportionality, like a ‘cosmic right-sizing’. I was ready to move on from my defensive state of denial – de-registration became a fact that was fixed as part of my human experience. I could no more reject this fact than reject myself. It took me a while, I will admit, but I learned it eventually.

An unexpected outcome from suffering is that it can be the very thing that unites care giver and care receiver – human beings. This is where healing happens, in relationship. I benefitted enormously from my supervisory team conveying an empathetic response that helped build a trusting relationship. Though I expressed certain undesirable emotions including rage and severe agitation as well as projecting my strong feelings about injustice into the team, they remained calm and facilitated such expression without retaliation. They actively listened and spoke in a soft tone to let me know that they were beside me in my pain. I felt that they had genuine compassion for me. Even at times when I felt too lost in my hurt to appreciate my supervisory team, but instead wrongly perceiving them to represent ‘the System’, these two human beings allowed me the space to ventilate my feelings uninterrupted. It was crucial to me that I felt listened to, heard and

understood. My outbursts were, of course secondary to feeling humiliated by 'the System' and, shame. Only much later was I able to reflect on these times and recognise that my outbursts had caused distress to the team, painfully recalling their facial expressions at the time. I am most regretful about the times I fell into a blind rage, becoming hostile and unpredictable – I must have frightened the team for which I am saddened and remorseful. Only recently did I learn that my two supervisors had provided ongoing emotional support for one another, and prevented emotional distress, countertransference and eventual burnout.

I was frequently signposted by my supervisors to counselling services at the University, and made contact only to alert the service that I was a EUPD sufferer and that I was undertaking a doctoral study of a very emotionally charged topic that may cause me to feel psychologically unsafe for which I may require support beyond that provided by my supervisory team. Between 2012 and 2017, I was in receipt of NHS mental health services and did not wish to extend psychological support any further. I felt I just had to cope with it all. Besides it was exhausting being in therapy and having to articulate my concerns to a third party with limited prospects for establishing meaningful human contact. The University Counselling service could only offer me a maximum of six fifty-minute sessions.

The period away from practice afforded me the time and space to better understand myself and my place in the world. I used the time to awaken to the wisdom within and through such unveiling learnt how to best care for the "self" in this and any other disempowering situation. Depersonalization is a familiar experience for trauma victims. I spent a significant period in the aftermath of de-registration incapable of experiencing either pain or pleasure. The injustice of losing my licence to practise in the manner described, arouse in me intense anger. I existed for a long time in an angry body. In order to change, I needed to become aware of my sensations. Such physical self-awareness, according to Dr van der Kolk (2014), is a necessary first step in releasing past trauma. I present next, my seven truths that I had to learn to master to achieve well-being. I consider these self-truths to represent the conversations between my higher and lower conscious states of being and they are, therefore, presented below in a 'coaching style'.

'*Exercise the freedom to change your mind'* if you are feeling 'stuck' in the suffering of going through or dealing with an adverse event. The moment you let go of your made-up mind you will allow it to change, and you will regain your inherent peace of mind. '*Avoid adding to the emotional burden by working against yourself'* through blame, judgement and other forms of self-incrimination. When you can truly see that thoughts and feelings are fleeting and superficial you will not need to try to control them – they lose their power over you. Who you are lies beneath the thought-feeling surface - a whole and loving person with innate well-being. '*Extend beyond focusing on yourself and your FtP experience'* to keep abreast of other people's realities to help ward off isolation, withdrawal and depression. Give yourself permission to experience love and gratitude for all the people in your life. Maintain your social connectedness and remain curious about what all human beings share – a capacity for empathy, resilience and creativity – therefore keep alive your hope for change. '*Step back from your difficulties and look at yourself from a*

distance'. Only human beings have this ability, so why not harness it to strengthen yourself against your professional troubles? See your fears and your frustrations, from the impartial observer's perspective. Imagine your FtP problem from a month, a year, or even five years from now – what impact will it still have on you? Most importantly, what will you have learned from the experience? '*Remain receptive to the meaning of your life's unique moments'*. Notice renewal of the purpose for your existence as you go on embracing life without professional work as a pharmacist. Welcome the unplanned opportunity to spend more time with loved ones, to get creative, to develop your mind, to take more care of yourself and to explore how you could continue to be of service to others (if that is what you want to do). Try not to carry any preconceived ideas that only lead you to do what is 'normal'. Rather, do what is natural and comfortable for you – it is sure to bring peace of mind and well-being. '*Reclaim your soul in the aftermath of FtP proceedings',* especially if the experience has prompted you to feel broken and incomplete. Deeply understand your place in the world of nature by bringing a meditative awareness to life's cycles and changes, and to the beauty and abundance therein. You will soon discover that you have a divine role in the world. '*Cultivate a sense of humour'*. Our human ability to laugh at ourselves and see the rich ironies and amusing realities in our personal and working lives takes the edge off every serious situation. Having our FtP as a care professional challenged may not be a laughing matter but take care not to confuse 'what' we do and 'how' we do it with 'who' we are. Fully acknowledge that you made a mistake and, if nobody was harmed as a result, bring yourself to laugh at it – it can be a huge relief personally as well as for those around us.

Chapter 6
DISCUSSION

In this thesis I set out:

- To construct a sociologically informed biographical narrative (autoethnography) using my own experiences to reflect on de-registration and its impact on personal well-being, resilience and work identity, as well as its meaning;
- To determine which, if any, narrative type can be discerned from my de-registration story and;
- To explore the extent to which fitness-to-practise, an important arm of the regulation of care professionals, meets its objective of protecting the public while at the same time being considerate to the interests, support needs and well-being of registrants.

I have presented the first two aspects in my thesis and in this chapter I would like to focus the discussion, on the relationship between the fitness-to-practise (FtP) system and the registrants themselves. Overall, from my autoethnography it can be seen that the regulatory body did not support my interests, needs and well-being. I do not feel that this was due to individual people themselves but due to the system they were working within. The system did not allow them to appreciate what I was experiencing. This will be discussed in more detail below.

While giving support to the general intention of protecting the public against health and care professions and their members as a worthwhile societal vocation, regulatory systems can appear to oppress and marginalise hard working and committed professionals who may for one reason or another err from professional standards of practice. In my own case, at the time of misconduct, I had been suffering from an undiagnosed chronic mental health condition that was exacerbated by environmental stress - the unexpected departure of a key employee, local and national shortage in available pharmacist personnel and the austerity policies of government. The combination produced a ‘perfect storm’ that led me to lose control over my pharmacy business and practice and foolishly try to ‘survive’ the chaos I found myself in, rather than seek outside help. Yet the design and modus operandi of the system of regulation, downgraded and even ignored the circumstances that contributed to professional misconduct and appeared to fail to demonstrate basic levels of sympathy, empathy or recognise the genuine suffering state of the registrant.

Fitness-to-Practise hearings follow a narrow, legalistic accusatorial procedure – the usual adversarial justice model found in the English System (Symon 2009; Case 2011; Anon 2018). Funded by registrants’ membership fees, SRBs instruct a prosecuting lawyer to persuade an FtP Panel (FtPP) that the case against a registrant is proved to the civil standard (‘on balance of probabilities’). A registrant is advised by the regulator by letter that s/he should appoint legal

counsel to defend her/him against the allegations of misconduct. Of course, the defence solicitor would have to be paid for from the registrant's own funds, and as a result may not be of equivalent competence. The disadvantage of this adjudication procedure is that it is too much of a game of strategy in which the regulator, acting on behalf of the state, is pitted against the individual registrant. To me, both the procedure and outcome of my principal and restoration hearings felt unjust. They were not fair to me or to the public who had been denied my services as a pharmacist for a considerable time. The same view had been echoed by several of my professional peers, mentor, pharmacy teams and customers. Aleksandr Solzhenitsyn (1918-1956) wrote on the habit of 'scapegoating' in society (Rohr 2021):

> "If only there were evil people somewhere insidiously committing evil deeds, and it were necessary to separate them from the rest of us and destroy them. But the line dividing good and evil cuts through the heart of every human being".

The system of regulation repeatedly employs canonical narratives to explain registrant misconduct, as a consequence of distancing itself from the object of scrutiny and therefore the uniquely personal and particular circumstances that each registrant presents. The FtPP concluded that my misconduct as a pharmacy business owner could only be explained using the familiar narrative of self-interest and greed. To me it appeared that, by falling back on familiar models, like self-interest and greed, the FtPP had a 'usual' explanation for my behaviour as a pharmacy business owner. The Panel appeared to be drawing on stereotypical meta-narratives rather than engaging with trying to understand the narrative of the person in front of them. Several research studies have looked into community pharmacy provision by pharmacists from the Asian community (Nowikowski 1984; Phizacklea and Ram 1996; Hassell 1996a; Platts et al. 1997). These studies cite both positive and negative motivators to explain the trends of retail pharmacy entrepreneurship within Asian communities. The positive motivators reported include a desire to respond to local needs (particularly in poor multi-ethnic areas), and for the continuation of family traditions of small business ownership. Several more negative motivators have also been identified such as avoiding poor employment prospects and to combat structural racial disadvantage in career advancement. The relatively high proportion of Asian pharmacy owners compared to the Asian register size might lead to the unsupported assumption that the 'profit motive' is the chief driver for business ownership. Platts et al.'s (1997, p.75) findings refuted this stereotype – "A strong theme in the comments was one of reward for effort, a concept more easily realised as a pharmacy owner". Additionally, other research studies have mooted that the regulatory body for pharmacy may treat pharmacists from ethnic minority groups unfairly (Hassell 1996b; Seston et al. 2015) – so institutional racism is a distinct possibility in the regulatory system for the pharmacy profession.

Writing about the teaching profession, Palmer (2007) distinguishes between power and authority, stating that power works from the outside-in while authority works from the inside-out. He argues that when people depend on the coercive powers of law or a set of prescribed rules, they lack authority. I cannot help, but reflect back on the fearful warning spoken aloud by the Dean of the

School of Pharmacy as he addressed all of us - 140 first year pharmacy undergraduates at the start of our pharmacy training. As far back as 1986, the Dean recognised the power exercised by the professional regulator in the pharmacy practice arena, removing professionals from the Register who it deemed unfit-to-practise as a consequence of breaching the professional 'rules'. By exercising the powers of law and rules, regulators are relying almost exclusively on external tools in order to seemingly 'protect the public' while at the same time causing severe distress to registrants going through its FtP proceedings. As far as the regulator's FtPP members are concerned, Palmer (2007) has something insightful to say. He argues that individuals like them are without authority because they are 'playing a scripted role' by working to the 'rules' of the regulatory system and not from their inner life. This understanding has helped me to finally look beyond blaming the people employed by the system of regulation for not believing me and to forgive them for merely enacting the regulatory rules, quite possibly against their own 'inner' convictions in some cases.

Palmer (2007) believes that any institutional culture that adopts objectivism as its modus operandi will see the subjective self as the enemy to be feared. Regulatory culture appears to see health and social care registrants who come to its attention, by way of a complaint, as potentially dangerous and a risk to the public. Such a perspective is grounded in a very small number of high profile and serious cases involving disturbed individuals where the registrants in question have abused their professional status and killed (such as Dr Harold Shipman and Nurse Beverly Allitt). These and similar cases have attracted the popular label of 'bad apple'. I feel that preoccupation about these isolated and rare cases produces the wrongful assumption about the whole health and care professional workforce – that they, and especially the growing number who are referred, are dangerous. Objectivism is premised on positivist assumptions that have already been reviewed in this thesis. Of most importance here is its claim for superior or 'objective knowledge' arrived at through basing judgements upon facts that are not tainted by personal feelings. By distancing itself then from registrants under its investigation, the system of regulation transforms the subject into an object without life so that any connection to the object, seen as 'other', is denied. It is unsurprising therefore that almost without exception the experience of registrants going through FtP proceedings is de-humanising. For Palmer (2007) knowing of any sort is relational and in this realm he points us in the only direction that will overcome fear and restore the trust and respect of care professionals, like me, for the system of regulation that currently looms large over our practices and personal lives. By returning to and recognising the narrative as told by the registrant as featuring more highly in the hierarchy of evidence considered by the regulator in the adjudication process a significant step would have been taken towards humanising FtP proceedings.

> "This relational way of knowing – in which love takes away fear and co-creation replaces control – is a way of knowing that can help us reclaim the capacity for connectedness on which good […] depends". (Palmer 2007, p.57-8)

[…] Insert 'regulation' in place of teaching in the original.

In my autoethnographic account, I reported an inability of the system of regulation to hold paradoxes together. The FtPP, at my principal hearing in 2012, were unable to reconcile misconduct and the overwhelmingly positive experience of care received by my patients. Instead, the reductive methodology employed by regulatory processes forced a simple either-or outcome, which for me resulted in a negative assessment over my FtP and subsequent punitive action. Palmer (2007) is critical of any cultural practice that splits paradoxes apart, and considers that the paired truths of a person's life are necessary for understanding a person fully. Objectivism denies this while at the same time promoting binary thinking that is geared to both discriminate and punish registrants who err. I feel it is more than a coincidence here that 'splitting' was a devastating characteristic feature of my former Emotionally Unstable Personality Disordered (EUPD) state of health during which I was unable to hold paradoxes together (for instance intensely loving someone in one moment and hating them the very next moment). The system of regulation seems unable to accept that registrants who as irrational human beings are prone to err, particularly in response to challenging circumstances, may remain fundamentally 'good' at heart. So, in this sense, I raise serious concern about the design of our present day system of regulation that, in many cases, is falling short of 'genuinely protecting the public' in favour of merely 'performing its responsibility' by ostracizing dedicated hard-working care professionals.

The regulatory system not only narrowed its understanding of those before them; the binary objective process and lack of any recognition of the registrant, increased my psychological distress which impacted on me and my performance during and after the hearing. Throughout my hearing I felt threatened. Because of the way the environment and context affected me I provided emotional responses to questions creating even greater distance between me and the system. In writing my de-registration story, it quickly became clear to me that the experience of removal from professional practice elicited the full spectrum of feelings and emotions that fitted within the stages of the Kubler-Ross (1969) grief model. However, as my story shows, I did not simply pass through the various stages and come out at the other end having fully processed my loss. Instead I experienced a convolution of emotions that were mixed and meshed leading to a very unsettled time for me and my family, lasting for several years after the event. Looking back the overwhelming emotion I felt was anger which crossed-over with denial and depression.

My study supervisors commented frequently on the personal management of anger as key to progressing my research. For instance, at the literature review stage in 2015 I was unable to synthesise the FtP research in pharmacy since it evoked a strong emotional reaction in me, even three years after I was de-registered. I would have flashbacks to the hearing at which I was not believed and felt invalidated. Suffering from EUPD complicated matters further. I was not, then, able to cope with my loss of career. Anger, rage and resentment were simply too intense for me to keep hidden from those around me. These emotions would 'burst' through at random and spoil the prevailing mood and harm relationships. It is fair to report that 'anger' has persisted, for me, through all stages of the Kubler-Ross model (1969). I do not suggest that other de-registered professionals go through the same emotional experience as I have laid down in my story. Rather, I recognise that as unique individuals the grief process following loss of career would also be

unique to the erased professional's work and family circumstances, personality, psychological health and social support, for instance.

The other strongly felt emotion was shame. Shame swamped my conscious state through all stages of the FtP process, but especially in the aftermath of de-registration. Jacquet (2015) in considering the vast array of species alive on earth, posits the whole of humanity as the 'bad-apple' because it alone among earth's inhabitants is a particular force of destruction, and that some distinctive humans within groups are particularly problematic. In the context of the professions dealt with in this research, professional behaviour is rigorously prescribed for its members, and any departure from the professional code by a few 'bad-apples' is believed to have a harmful effect on public confidence in the whole of the profession, mostly by eroding trust. It is therefore commonplace to find FtP panellists coat judgements concerning registrants in such terms. However, in the majority of cases environmental and workplace pressures, particularly a lack of human resource, are overlooked by regulators in favour of laying blame firmly on the individual registrant, who may, for good reason, have deviated from their professional code. A nationwide shortage of pharmacists at the time of my misconduct was a significant factor in my failure as a proprietor of two rural pharmacies to adequately staff each – and this was dismissed by FtP panellists. Unless the individual registrant is punished for misconduct, and made an example to others, then the fear that the behaviour might become contagious throughout the profession, I believe is associated with FtP panellists' leaning towards harsher sanctions. Regulators, rightly or wrongly, appear to practise in a state of 'hyper-reality' in which risk is elevated beyond what actually exists, probably as a result of a small number of high profile historical cases in which care professionals have intentionally harmed or even killed patients in their care (Clothier 1994; Smith 2001). I felt the unfairness of the system of regulation most acutely in the response of my regulator to my restoration application, despite at its own admission, no patients ever having been harmed as a result of my misconduct.

The harsher regulatory sanctions of suspension and de-registration operate as a form of social exclusion from a profession. The effect of this is two-fold. First the threat of such punishments meted out to registrants who err acts to enforce norms of professional behaviour. Moreover, such a threat may in fact motivate an over-correction in which care professionals practise defensively such as referring patients more frequently to specialists, therefore not fully exercising professional judgement and duty of care for their patients. Defensive practise among doctors, for example, has been reported in the research literature (McGivern and Fischer 2012). After de-registration, I too noticed that I had become especially cautious on my return to work as proprietor for the sole reason of wishing to avoid further regulatory scrutiny. The second effect is the inducement of shame. Being ousted from the pharmacy profession after 22 years of service by the GPhC and widespread reporting of my case (for example Asian Voice 2012; BBC News 2012) felt to me like an act of shaming through which I was used by my regulator to set an example to my professional peers who were reminded that misconduct will be punished. Jacquet (2015) opposes the need to publicize misconduct wherever a more severe formal form of punishment is in place as this only works to further shame the individual transgressor and deepen their psychological distress

leading, in a lot of cases, to self-harm thoughts and to destroying lives. The system of regulation, in my experience, thus appears to lack compassion towards care professionals by both actively publicizing cases as well as sanctioning those same transgressors.

The character or reputation a professional has amongst peers is to a degree an ascription to that professional by others based on their readings of the professional colleague's work life. Portrayal in a negative light by a regulator following FtP proceedings is a significant social hazard that results in a loss of public standing and possibly contempt of fellow professionals who fear that the actions of a few reflect badly on the whole of the profession. I felt publicly disgraced by the actions of my regulator who affirmed that due to professional misconduct I had lost my good character and reputation, therefore suggesting how my peers should perceive me from this point in time. Professional behaviour is rule-governed and esteemed by all professions as the Professions' Professional Standards. Rules within professions are themselves arbitrary in character and are largely to do with the manner in which professional people choose between alternative modes of conduct. Essentially professional groups or the culture in which the rule applies anticipate widespread consensus concerning the rule and therefore predictability in the behaviour of members. Any aberration is therefore not tolerated and punished. The well-known work on asylums by the American sociologist Erving Goffman (1961) has described how institutions offer individuals a framework for a 'moral career'. The various 'career' metaphors (Inkson, 2004) have already been utilised as an organising framework for the personal account of my de-registration story in this thesis. Goffman takes the patients' viewpoint in using the concept of career, which is seen as an ordered series of experiential transitions in status. I see many parallels between my own experience and the experiences of institutionalised mentally ill patients who formed the focus of Goffman's work.

Goffman (1961) observed the starting point from which the moral career emerged was the various forms of deviance perceived by others as warranting complaint and intervention. The accused or pre-patient is asked to account for their actions by people in legal or medical authority with the power to sanction a course of treatment with or without committal. The pre-patient stage ends as kin and officials work together against the individual promoting feelings of abandonment, betrayal and confusion. Admission to the mental hospital involved depersonalisation and mortification rituals which simply intensify the individual's sense of isolation. The patient becomes re-socialised into a new stigmatised status and a new (mental hospital) culture by way of the removal of the individual's former identity. Over time, the patient comes to learn to internalise the rules of the total institution. The mentally ill individual has become an object of regulation and former taken-for-granted human rights are regarded as privileges. Although Goffman's model concerns the coercive and over-deterministic actions of medico-legal institutions over mentally ill patients, I feel there are close parallels with the regulation and de-registration of health and care professionals by SRBs.

First and foremost, Goffman's (1961) concept is two sided – private and public. The private side, ignored by regulators, concerns the individual's feelings, image of self and felt identity. Coming

to the attention of my regulator, following a complaint, being subject to an investigation, attending a hearing that culminated in my de-registration all led me to privately reassess my self-image to match the discredited status I was ascribed by my regulator. I was, as my autoethnography has described, broken and de-humanised by my experience. I naively entered the regulatory process with the intention of explaining my troubles and to seek help and support to regain control over my pharmacy business and, to put an end to the chaos my working life had become. This is not an isolated view. Watters (2018, p.641) also calls for greater understanding and compassion from regulators:

> "In a health service that is struggling in so many ways we need to cherish and nurture, teach and educate, and move away from blame and scapegoating. Accountability for this has to come from our regulator, which should also encourage open and honest communication to reflect when things go wrong so positive steps can be made".

Instead I underwent a series of status passages through initial investigation of a complaint into my FtP, confirmation of my guilt in a regulatory hearing, determination that my FtP was impaired and subsequently de-registered. Over the course of 18-months, my self-image was altered such that I felt systematically de-professionalised through the rule-governed FtP regulatory process. The determining circumstances of my misconduct along with my evident poor mental health were side-lined at the principal hearing and later dismissed at the restoration hearing, along with my claim to professionalism. Regulators appear keen to make public their determination of cases, and in-so-doing use their power relationship between registrants and those served by them to strip those whose FtP is considered impaired of any former status and privileges. Neither the public or professional peers are presented with the registrant's perspective in such postings and, cannot evaluate the regulators' decisions. As my own experience shows, my regulator wished to present me in its own preconceived narrow and stereotypical way – as a pharmacy business owner motivated by self-interest and greed.

A further contribution of Goffman has been to provide an analysis of how social actions proceed by conceiving them as ongoing within particular kinds of 'frame'. According to Goffman (1974), a frame is both a mental concept and a structure for the individual human experience in social situations. As such, frame provides a basic anticipated structure for interactions but, at the same time, adapting to the needs of those involved to provide meaning of intersubjective communication. The extent to which frames are shared will influence the perceived smoothness of the social interaction. A great deal of our social experiences are reflexive – our understanding of our actions depends on understandings of behaviour in a variety of social contexts for which we have come to establish a sense of likely outcomes. Goffman (1974) believes that having frames facilitates social behaviour by providing normative rules for interactions. He suggested that we rely on a number of primary frames each of which 'allows its user to locate, perceive, identify and label a seemingly infinite number of complete occurrences defined in its terms' (Goffman, 1974 p.21).

In my research, I adopt a specific reading of Goffman's theory of frames that involves a narrative perspective of temporality in an attempt to reveal how the four-steps of the GPhC FtP hearing (outlined in section 1.3) connect to framing and re-framing processes. The necessary fieldwork involved facing a complaint against my FtP by participating in a regulatory hearing that spanned eight days between April and September 2012. This not only resulted in unusually long immersion for a registrant but contributed to an enduring relationship with those personnel I met at the regulator's site – the GPhC Inspector (who I had known since February 2011 when the investigation began), the legally qualified Panel Chair, the Registrant Panel member (a semi-retired pharmacist), the lay member of the Panel, the GPhC solicitor, my own solicitor, as well as a range of GPhC administrative and support staff (receptionists, stenographers, security guards). When coming together in this way, the Inspector, FtP Panel and opposing solicitors bring with them a personal history of prior dealings with each other and a socialized experience based on their professional expertise and organisational attachments. The 'adversarial' frame is commonly taken up by the GPhC (and other regulators) intent on prosecution, and the reciprocal 'defensive' frame by registrants. These represent the primary frameworks through which participants in regulatory hearings are likely to behave and are normalized and stabilized by opposing parties.

Through the first two steps of the hearing (i.e., whether the alleged facts are proved on the 'balance of probabilities' and if proved whether the facts can be translated to professional misconduct) I vehemently challenged the GPhC solicitor's assertion that I had primarily kept my pharmacies open in the absence of pharmacist cover in order to gain financially. Under cross-examination I gave evidence to the contrary and tried to show that my decision to remain open was driven by a need to continue to serve the public who depended on the services of their local rural pharmacy. In her summing up, the GPhC solicitor had dropped the link to financial gain – I felt that I had succeeded in showing that the presumption that all community pharmacy proprietors were driven by the profit motive (made up of habits of thought and the GPhC institutional culture) was inappropriate in my 'complex' case. What I was able to get across, in spite of my failure to secure adequate pharmacist cover, were several of my primary drivers including a strong work ethic, duty to provide care and passion to serve my patients and customers to the best of my professional abilities. I believe I had opened up the potential for a rare and new type of narrative – an inquisitorial frame. In this somewhat indeterminate and uncertain position both parties are drawn close to explore the storied truth of each misconduct case without simply slipping back to familiar habitual frames. That said, it fell on the FtP panel to deliberate in closed chambers and emerge with a verdict. The duality of purpose in needing to balance a public protection role with the interests of the registrant was not discernible in my case. I felt unjustly accused of 'flouting the law' and putting financial interests as a business owner above the safety of my patients. The 'motivated by greed' frame held by the Pharmacy Regulator is well-known, normalised, made up of habits of thought that carries the perception of the community pharmacy proprietor as the 'bad-apple' of the commercial sector of the profession.

The FtP panel believed that a financial thread ran through my case and broke with the GPhC solicitor's more 'dialogical inquiry' that attempted to construct a new model for what could lie

beneath my misconduct. The FtP panel relied on social conventions of the regulatory institution to normalise their interpretation – proprietors are motivated by profit and driven by a primary desire for more. Goffman (1974) would posit that FtP panel members use frames to organise their conceptualisations of cases taking in the characteristics of the registrant including ethnicity, age, job role and gender that together shape these perceptions. Crucially seeing similar misconduct cases repeatedly, has led to typification that may impact fairness and justice in the regulatory process by generating a 'main frame' to understand misconduct among community pharmacist proprietors. Throughout my case I maintained my opposition to suggestions from the GPhC solicitor and FtP panel that my actions were driven by greed. Such challenge to the viability of the main frame, according to Goffman (1974), will result in 're-keying' or alterations to the main frame into four other ancillary frames: the directional, concealment, overlay or dis-attend frames. These are dealt with briefly below to highlight the manner in which the FtP panel framed the way they determined my case.

In the directional frame, the FtP panel most likely acknowledge the totality of my complex case, but privilege certain aspects over others. I tried very hard to secure pharmacist cover following the sudden departure of an employee pharmacist that had left me in a state of panic. No patients had been harmed by my behaviour to work between the two pharmacies on days when cover was unavailable. However, under these trying circumstances, I had lost my temper with at least two employees and another individual outside my business - all considered to be victims by the FtP panel when presenting as witnesses. I feel the expressed reality of my situation that conflicted with the main frame held by the GPhC solicitor, had helped to change her mind as to my motives. However, the FtP panel diverted scepticism to return to old habits and a need for 'case closure' through employing the ritualised greed motive that can overcome all else. In the concealment frame, there is an effort to hide certain details from the outside world despite their clear relevance. The FtP panel Chair repeatedly used concealment frames to dismiss the body of counter-evidence to support my defence: over one thousand telephone and email records evidencing my attempts to secure pharmacist cover, the wealth of supportive patient testimonies, a course of therapy I underwent to manage stress and anger, and the evidence (under oath) of the joint business director that supported the reality of the situation we faced in our rural settings. In the overlay frame, the methodical and impersonal manner followed by the FtP panel through the four steps of the hearing process helped to depersonalise my emotionally charged case. This assisted the panel to simplify my complex case to little more than routinized and well-rehearsed explanations. It left me feeling objectified and de-humanised. In my view the FtP panel had sought only to prioritise information that confirmed their prejudice. There is little doubt that in returning to the financial motive the FtP panel sought to return the perceived reality of my case as familiar – another community pharmacist proprietor caught in practice facing disciplinary action because of his greed. I felt this misrepresentation of the reality of my situation only supported the metanarrative of the regulator and served to warn other proprietors of the potential consequences for failing to uphold professional standards. Overall, in this application of Goffman's (1974) frame analysis it has been shown how culturally based narratives are used by the regulator in downplaying the complexity of individual registrant cases so can be efficiently discharged.

Total institutions, argues Goffman (1961) characteristically establish and maintain considerable social distance between the staff and those institutionalised. One effect of this is the development of hostile and contradictory viewpoints that inevitably lead to negative perceptions of each other. Like people with mental health problems, my own psychological survival depended upon alternative sources of meaning and status. The patients were able to turn to the inmate culture, but no such culture exists for de-registered professionals. Instead I struggled with depression and suicidal ideation, diagnosis of personality disorder, loss of identity and grief. In the absence of a support group I turned to counselling and psychiatric services for help. I worked, for a short period, as a volunteer before I felt able to return to work as a 'shamed' proprietor. Unable to work as a pharmacist and provide for my family left me feeling emasculated. Seeing a gap in both the literature and practice I wished to contribute my lived experience of de-registration in the hope that my doctoral study might be taken up by our SRBs and stimulate a review of processes and procedures in order to lessen the catastrophic impact of de-registration on professionals. I presented my work at the 7th International Autoethnography Conference (Leal 2020) and received a surprising number of encouraging and constructive comments. Several of my peers recognised the courage my work called for and that in itself commanded respect (see Appendix 2 for summary of delegates' response). I felt relief, if not resolution, that my profound suffering and distress in writing and telling my story of de-registration could positively impact the lives of others in my position.

In tendering my application for restoration after a period of five years away from the Register I had not anticipated being spurned. After all, I had complied fully with the moral career framework of the regulator as laid down under its processes and procedures or rules for restoration following removal by an FtP Panel. As my story has told, I believe I had used the time away from the Register effectively to restore my health, maintain my professional knowledge and skills, work under the supervision of a Superintendent Pharmacist for an extended period and regain the respect and support of my peers, several of whom provided testimony of my return to FtP once more. I made 'the inward journey' my starting point and in doing so I ventured to discover the root of my being. There was, for me, no getting away from the spiritual epiphany handed me early on in my journey and revealed wholeheartedly in Jesus. More specifically his embrace and compassion for the marginalized, socially excluded and oppressed gave me a counter-narrative to the one my regulator had handed down. It offered me an invitation to follow, at a time when I had reached my lowest point, what I consider today a 'golden thread' along which to move forward with my life with hope. Later, I learned about Jesus' condemnation of self-serving authorities and his non-violent response to injustice. I had been suffering from shame, guilt, loss, anger and rage. De-registration had unleashed in a very narrow corridor of time these powerful emotions - I was broken in this world. Yet despite my psychological and physical distress, I had an intuitive sense for the spirit's power to heal and transform my brokenness. It seemed to me that my regulator was determined to underline my loss of reputation and public standing even after serving my five year sanction and submitting a comprehensive restoration application evidencing my growth and re-professionalization, and most importantly current fitness-to-practise as a pharmacist. A system

of regulation in which less than half of all applications for restoration are ever supported by the regulator points to a failure in consciousness.

Hawkins (2012) pioneered the development of an anatomy of consciousness in which he laid down a scientific framework by which to understand the levels of consciousness referred to in the world's sacred literature and suggested by philosophers, saints, sages, and mystics through the ages. The levels of consciousness are recognised 'energy fields' and therefore amenable to measurement. By using kinesiology testing procedures to measure response to truth and falsehood, Hawkins identified the existence of what appeared to be a form of communal consciousness in humans (similar to that already known to exist in other social animals). In tribute to Carl Jung (1875-1961), Hawkins referred to this as a 'database of consciousness' which he presents in his text as 'The Map of Consciousness' that moves between its lowest expressions as shame (energy level 20) to its highest expression as enlightenment (energy level 1000). Just why shame is so destructive is answered by the framework in placing the emotion adjacent to death. Becoming de-registered in 2012 and five years later having my restoration application rejected felt strongly discrediting to my selfhood. I was initially banished and after serving my punishment kept out from re-joining the pharmacy profession by a sceptical regulatory system whose very design reflects negative prejudgment towards registrants with FtP concerns, whether current or past. In shame I simply hung my head and hid myself away while thoughts of self harm and suicide filled my mind as a viable option out of my state of intense pain and suffering; an option taken up by a significant number of care professionals as a consequence of FtP proceedings brought against them (McGivern and Fischer 2010; Horsfall 2014; Bourne et al. 2015; Jones-Berry 2015; Wier 2017; Worsley et al. 2017). According to Hawkins (2012) shame also has the power to produce other negative emotions including false pride, anger and guilt that I too have reported in my own experience.

My life, before de-registration, was given shape and direction by my education, training and work as a pharmacist. Afterwards, my life resembled a stranger in some foreign land without a roadmap. This was the arena into which I was cast-out alone to face great suffering. As the title of Frankl's (2004) classic psychiatric text 'Man's Search for Meaning' suggests I had to find a way to orientate myself in this unfamiliar and hostile land by finding some trusted map.

> "He who has a ***why*** to live can bear with almost any ***how***" (Frankl 2004, p.109 quoting Nietzsche).

Failure to do so held out a strong possibility for me to take my own life since the depth of my sorrow and shame was such that I felt it was my only option out of my pain. It was only subsequent to my spiritual epiphany that I would find capacity for hope, courage, kindness and compassion once more. My human spirit had awoken and I began to consider the deeper meanings of life. Frankl (2004) provides powerful witness testimony to the fact that the only thing that kept people within concentration camps from total despair and suicide during the Holocaust was finding meaning in their suffering. During his years in the Nazi death camps, Frankl consolidated the

truths expressed by existential philosophers and writers. For instance, that love is the highest goal to which human beings can aspire and that we have choices in every life situation. In the concentration camps, Frankl learned experientially that everything could be taken from a person but not the freedom to choose one's attitude in any given set of circumstance. The essence of being human lies in searching for meaning and purpose which Frankl believes is to be discovered in three different ways: by way of achievement or accomplishment, by experiencing a value (such as love), and by suffering.

De-registration following FtP proceedings against me in 2012 placed me in a hopeless situation. It would be at least five years before I became eligible to apply to have my name restored to the Register. Frankl (2004) asserts that 'when we are no longer able to change a situation, we are challenged to change ourselves'. Taking up the challenge has not been easy and any progress towards an eventual transformation has been arrived at incrementally. Losing my work had the effect of consigning me to an 'existential vacuum' (Frankl 2004) – I felt empty and hollow and my life in this world seemed, from my perspective, meaningless. Frankl developed 'logotherapy', which means 'therapy through meaning'. It challenges individuals to find meaning and purpose in their lives and is focused on the future – on meanings to be fulfilled by individuals in their future lives. Shortly after de-registration I became aware that there was an absence of research carried out by de-registered health and care professionals that explored the impact of losing their career and status following FtP proceedings. The available research on the subject of FtP was largely quantitative and conducted by academic researchers. As I began to recall the Dean's vision conveyed to me on my induction to the School of Pharmacy in 1986, when he spoke passionately about using a career in Pharmacy as a platform from which to make a contribution to the profession, I considered my de-registration as an opportunity to respond positively to the Dean's hope. The period after my spiritual epiphany, looking back, was the time that I began to consider using my own experience to provide a roadmap to other newly de-registered professionals as well as challenge and critique the current FtP processes and procedures operated by regulatory bodies that I experienced as de-humanising. New meaning, therefore, had emerged for me from within the devastation I was living and it gave me reason to continue. Logotherapy appears relevant to helping de-registered professionals by its firm focus on expanding consciousness to open individuals to further potential meanings. As is the case with many therapeutic approaches, logotherapy may be criticised for using concepts that are abstract and that the practice is not based on the results of research into process and outcomes. However, the language of the approach is familiar to autoethnographers who seek a deeper meaning to their lived experience, including authenticity, self-awareness, self-transcendence, self-actualization and dialogical encounter.

There remains little written by health and care professionals who have been through FtP proceedings of regulators about their own suicide crisis as a consequence and aftermath of this traumatic and career-interrupting event. Despite its frequency and catastrophic results, the professions appear to reflect wider society in their reticence to talk about suicide, especially when it involves one of their own. This therefore remains one of the last taboos. Perhaps, my

selflessness in laying down an autoethnographical account may help reveal the body of emotions and thoughts that took hold in my mind and produced feelings that I was better off dead (Blauner 2002) than face the consequences of regulatory action against me - may bring comfort to others. The implications are clear. The system of regulation must be humanised (Todres et al. 2009) to prevent registrants experiencing profound suffering and emotional distress, potentially leading to suicidal ideation.

My own experience of the system of regulation left me feeling de-humanised. I had a suspicion that this was a shared experience for many who go through the regulator's FtP proceedings, and this was confirmed by published research that attempted to capture registrants' experiences (Wier 2017; Worsley et al. 2017). Regulators can no longer refuse to acknowledge how their procedures and processes impact the health and care professionals who come to their attention - some are driven to commit suicide (Horsfall 2014; Hawton 2015). I have struggled to understand and make sense of our present day system of regulation for the past six years. Perhaps through the selfless and dedicated pursuit of this important study I might contribute towards finding some amenable path towards making the current system of regulation less distressing for registrants going through FtP proceedings. I will draw on the work of Paulo Freire, a Brazilian educator who worked for literacy amongst the poor in his native country to offer such a path.

Freire (2017 p28) explains the title of his classic work 'Pedagogy of the Oppressed' thus:

> "Pedagogy which begins with the egoistic interests of the oppressors and makes of the oppressed the objects of its humanitarianism, itself maintains and embodies oppression. It is an instrument of de-humanisation… The pedagogy of the oppressed, as a humanist and libertarian pedagogy, has two distinct stages. In the first, the oppressed unveil the world of oppression and through the praxis commit themselves to its transformation. In the second stage, in which the reality of oppression has already been transformed, this pedagogy ceases to belong to the oppressed and becomes a pedagogy of all people in the process of permanent liberation".

Freire (2017) believes the initial stage must overcome both the oppressed consciousness and the oppressor consciousness by taking into account their behaviour, their view of the world, and their ethics. A consequence of the failure to come to consciousness maintains the relationship of oppression which Freire (2017) argues is initiated through violence by those who oppress, who exploit, and who fail to recognise others as persons – essentially viewing others as objects, not fully human. Freire (2017) essentially remarks that as oppressors de-humanise others and violate their rights, they themselves also become de-humanised (though they will not, of course, recognise this). Freire (2017) warns that established bureaucracy is least amenable to the humanist dimension since for it, 'human beings' refers only to themselves; other people are 'things'. In the context of the regulation of the health and care workforce in the UK it has already been established in this thesis that regulatory bodies are government appointed bureaucracies that lack deep appreciation for the work and challenges professional registrants face in their

working lives, as borne out by inconsistent dealings of registrant FtP cases and a low number of successful restoration applications following de-registration. As a result, registrants, like myself, are left feeling powerless, marginalised and de-humanised.

This autoethnographic research has centred on stage one of Freire's two stages. Though I did not wholly recognise it at the time of beginning my study, in challenging the de-humanising system of regulation, I have had to journey toward a level of consciousness where my grief and despair could experience a transformation into a purposeful anger underpinned by a self-liberation from the oppressive and stigmatising label 'bad apple' following de-registration. To facilitate movement away from a powerless, rejected and shameful state I had to find, through my writing process, my own social location or place in society. Losing my professional status and career meant that I no longer had a place of privilege within the professional culture and wide society. I felt my regulator had blamed me for my presenting identity as an Asian male and community pharmacy business owner, with an above average education. It lacked even a basic compassion for me at either the principal or restoration hearing. It seemed to me that this stemmed from poor system design and training of regulatory staff, including FtP Panel members. Could no one hear my cries for help from the chaos that had become my practice and life, a decade ago? Considered to be 'a complex case' by the Chair of the principal hearing just signalled that I had become 'other' to the inquiry. Mental health status was not something the system of regulation was designed to look for, and so my poor mental health went unnoticed or possibly ignored by a system set on firstly prosecuting registrants for infringements and secondly protecting the public. Such a system that is unable to perceive its own biases, between my hearings, has angered me. Appleby (2016) has called for the General Medical Council (and other regulators) to make mental health safety a priority through all its dealings with registrants whose FtP is under investigation.

It is my sincere hope that all health and care professionals recognise and prioritize their own emotional and psychological health and take the steps necessary to enhance and maintain emotional resilience through their working lives. Prior to de-registration, I spent little time in silent spiritual and mental training. I simply told myself that I already had too many claims on my time like full-time work, courses of study and family to even consider anything else. I built my life around my work and failed to see the importance of taking the time to harness the daily habit of caring for my own mental health and emotional well-being. As my story reveals, being psychologically vulnerable, confronting hardships in my career and life this past decade has been an extra-ordinary challenge. I came to my troubles ill prepared and contemplated suicide. Yet with the same commitment and dedication I had brought to my work for over twenty years, gradually I began to learn about self-care practices and the impact these could have on building emotional resilience. I had to start at the bottom and learn how to quieten my racing mind and prepare it for life beyond work as a pharmacist. In Appendix 3, I am pleased to share with the reader my process to building strength and resolve, so as to recover from life's set-backs swiftly and more completely. I trust that it may serve as a roadmap to those of you impacted by any career hardship and navigate you towards a glimpse of the possibility of peace and clarity of mind (Handy 1997; Banks

1998; Zohar and Marshall 2000; McManus 2006; Bourgeault 2008; Johnson 2013; Neil 2013; Quiring 2016; Smart 2017) that are after-all our more natural states of being.

Finally, my choice of title for the thesis tried to capture the essence of the work as well as provoking curiosity and catching the reader's attention. I reflected deeply on the way the whole experience of going through FtP proceedings and losing my licence to practise made me feel - humiliated, ashamed and powerless. I felt rejected by my profession, whom I had served for some 22 years. It felt like my worst fear, as a recent past EUPD sufferer, had surfaced once more in my life – I had been abandoned. As my narrative has already told, I felt unfairly blamed for misdemeanours that were the result of multiple influences as well as poor mental health. The actions of my regulator felt like some form of 'scapegoating ritual'. Biblically, scapegoating traces back to the book of Leviticus (16: 8-10, KJV) – a book of rules that the ancient Israelites believed they had to follow in order to be close to their God. The ritual involved a designated goat being expelled into the wilderness carrying the sins of the people. Drawing on this, the regulator's FtP proceedings appeared to identify me as the ultimate scapegoat for the deleterious effects of changes in the legislation governing the opening of new pharmacy premises (especially 100-hour contracts), pharmacist staff shortages, market failures and austerity to mention a few. I came to bear the 'sins' of the nation and profession at the time and, cast-out. The scapegoating ritual, even as a metaphor is brutal and yet it does seem to mirror the FtP process I had been through. This thesis is my attempt to give an honest snapshot of what regulation means to one whose life was changed beyond recognition.

6.1 Rigour and Limitations

Autoethnography can be empowering to the marginalised, wrongly accused or misrepresented in society by contributing voices or experiences to restore narrative balance for themselves and the culture(s) they belong to. Following FtP proceedings, I became de-registered as a pharmacist. I felt abandoned and reduced, after some twenty years of unblemished service, to the identity of the 'bad-apple'. By doing autoethnography I invite both professional and lay readers to reflect on how my narrative made you feel and whether or not you sensed its evocative power – that is, have you been moved by my story? Moreover, are you willing to consider the possibility of alternative discourses to those provided by the system responsible for the regulation of HSCPs?

Earlier in this thesis (section 3.8) I evaluated the research process and highlighted some strengths and challenges to the process that I had planned and followed in this autoethnographic study. Making myself the object of research, I wrote in the first person through the construction of a narrative text disclosing details of my own private life over an extended period of 5-years that followed erasure from the register, alongside in-depth emotional experience.

Le Roux (2017) in reviewing the diverse sets of criteria available to establish rigour in ethnographic research proposes that the final choice of evaluation criteria should be aligned with the specific research objectives. In this respect, I return to Richardson's (2000) five criteria that

are especially suited to appraising evocative autoethnography. In terms of the first criterion, which focuses on *contributing to knowledge* about fitness-to-practise I am offering something new about the experience of going through FtP proceedings from the viewpoint of a pharmacy professional. I did not just wish to write defensively against the output of the FtP Panel at the end of my own case. Instead, I felt I needed a take a more holistic perspective that offered new possibilities beyond the temptation to just repeat what other registrants had already reported to researchers investigating the effects of the regulatory process on registrants' health and well-being using cross-sectional study designs. The experiences of registrants who became de-registered as a result of FtP proceedings are absent from the literature as are longitudinal studies. I use my personal experiences to represent particular, nuanced, complex, and insider knowledge of regulation to extend existing research. I have shown that losing professional work, is analogous to a loss of identity which is often indistinguishable from professional work in the personhood of the health and care professional.

I have already shown that registrants categorised as 'bad apples' or deviant, in the sense that they are alleged to have broken professional codes of conduct leading them to face FtP proceedings of the regulator, evoke particular kinds of interactions from regulatory personnel (and in some cases from peers). The interactions that I experienced from the outset were generally cold and unpleasant and carried an air of superficial politeness. I quickly came to feel marginalized under my regulator's gaze and experienced 'othering'. I also noticed that my legal representative at my side, a registered pharmacist, received kinder attention. I could not ignore the oppressive power wielded by regulatory personnel. I was acutely aware that I was the object of regulatory proceedings, but naively desired some recognition for the decades of unblemished service I had provided up to now. Oliver (2001) argues in her text 'Witnessing: Beyond Recognition', the very desire of oppressed people (of race, gender and sexuality) to seek recognition is itself founded on the pathology and psychic damage oppression brings about - believing that such pathology perpetuates subject-object relational hierarchies. Oliver (2001) cites both Holocaust and slavery survivor accounts as testimony to the pathos, she identifies, that is 'beyond recognition'. It is Oliver's contention that asking for and conferring recognition supports further alienation, but moving the relational framework to the act of 'witnessing' involves a shift from an 'objectifying' gaze towards an intimate 'loving' gaze that encourages connection. That is to say the subject begins to recognise the other only when s/he can see the other is a person too.

In her book, Oliver (2001) develops a theory of witnessing subjectivity in its double sense of eye-witness (to historical 'accurate' facts) and bearing witness (to a truth about humanity and suffering that cannot be seen). This is posited as the particular strength of witnessing over recognition and the unique hope it carries for relational ethics – to grant fundamental human dignity and agency to the oppressed. Oliver (2001) sees oppression as the restriction of agency (seen as response to social historical situations, or subject positions) by denying individuals the ability to respond and to be responded to. It is the very (dialogic) structure of the regulatory process I experienced that diminished the ability for address and response and thereby to denying 'subjectivity' (a personal sense of self as 'I', as an agent). As a middle-aged Asian male and community pharmacy

proprietor within a racist and sexist UK culture, a felt oppression undermined my subjectivity and sense of self as an agent. This might well have contributed to my visible breakdown during the FtP hearing, a fact overlooked by all those present:

> I found the high tension and drama in the courtroom unnerving even provocative. I felt hyper-aroused, angry, frightened, burned-out, and purposeless… I desperately wanted to prevent others from seeing what a failure I was upon taking the stand to defend myself. I could not help sobbing as I read through my statement… it felt like the uncontrollable groaning of my soul, like a cry for help… (Vignette 4: Emotion).

In response, the FtP Chair asserted

> Doubtless Mr Leal was under pressure, but the source of his difficulties was the fact that he sought to run two pharmacies without a responsible pharmacist being in place beyond the extent permitted by the law. We are satisfied that this practice was carried on because of greed and self-interest rather than any real difficulty obtaining locum-pharmacist cover (Vignette 4: Emotion).

Oliver (2004, 2012) draws attention to the distinction between the familiar historical (accuracy) lens and another level of truth (beyond recognition – the truth of witnessing to what cannot be seen) revealed by a psychoanalytical lens. From the perspective of psychoanalysis I was not denying running two pharmacies without adequate pharmacist cover, but rather pointing to something unimaginable in becoming a 'hostage to bearing a professional duty to continue to serve vulnerable others' in spite of my stricken work circumstances, brought on by the genuine shortage of available pharmacists at the time.

Through composing the seven career vignettes and villanelle form of poetry I try to attend to the craft of writing and to responding to the second requirement of *aesthetic merit* in these outputs. My training as a teacher and more recent attendance at autoethnography writing workshops helped me to hone my narrative writing skills. I wanted to use the power of storytelling as a means to question common sense assumptions of lay and professional cultures, including the dualistic notions of good and bad, wrong and right, and true and false, particularly as they are applied to the motivations for behaviour of members of such cultures. Ultimately, my goal was to take the reader beyond whether the content of my *lived experience* as presented is an exact historical truth that can never be, since knowledge is both situated and contested as well as relationally created (Adams et al. 2015, p108). Instead to cautiously extend in the direction of mythical truth - that which possesses the innate quality of being "entirely true in general" (Rohr 2012).

My story emphasizes the personal and emotional in my traumatic experience of regulatory proceedings and the impact of this. The account embraces vulnerability in the representation. In the text of the vignettes, I openly share my persistent state of pain from grief, mental illness and self-destructive actions. Feeling like a victim of injustice I am powerless to stop my loved ones

from being sucked into an impossible situation that only creates more injustice and victims around me. I felt it necessary to reveal how the lack of support provided to registrants and their families from the regulator and linked agencies, especially following a severe sanction such as suspension or removal can result in additional suffering. For the opportunity to highlight this reality so that the system of regulation may consider the support needs of those affected, I find the risks of vulnerability acceptable.

Humphreys (2005, p.852) argues “that the use of vignettes is explicitly reflexive”. He further remarks about reflexive writing as a process undertaken by a researcher who uses introspection “to create a reflexive dialogue with the readers of the piece”. I tried to write *reflexively* by interrogating my ethnicity and cultural heritage, sex, age, education, relationships, work, identity and personality. In applying Blaxter et al.’s (2001) ten questions during the research study I hoped to achieve what Finlay (2002, p.542) perceived to be “an adequate balance between purposeful, as opposed to defensive or self-indulgent, personal analysis.

Inherent in the criteria used here is the expectation that the research is ethical (Le Roux 2017). I did not conduct any formal interviews during the research study and therefore did not seek ‘informed consent’ in writing from participants. However, I included without consent several recollected conversations and consultations (about my care and mental illness) with medical personnel, referring to those individuals only by their job roles. On reflection, I consider that by including this dialogue, even in the creation of representations, I had failed to enact relational ethics. Members of my family, my spiritual guide as well as my pharmacy mentor – all with whom I discussed the research and its purpose - gave verbal consent to participate. I was mindful throughout to accurately present the content of words expressed to me.

Chapter 7
RECOMMENDATIONS

Recommendation One: *Regulatory investigations into FtP must give more consideration to the psychological health of the presenting registrant, if regulatory bodies are to uphold their 'duty of care' and to help limit the distress that their processes produce*. *One approach that could be introduced is the provision of peer mentoring provided by a present or recent-past registrant with lived experience of regulator FtP proceedings, especially for those whose case progresses beyond the initial screening stage. To my knowledge, this targeted peer support is absent and would make best use of the insights of a significant number of professionals who have gone through the disciplinary process during their career.*

Recommendation Two*: Regulators should evaluate their current process in the light of this autoethnographical account that reveals the body of emotions and thoughts leading to suicide ideation during and after regulatory action.*

Recommendation Three: *Regulators must continue to evolve beyond a disciplinary function and blame culture by learning from registrants' stories if they are to play a role in preventing professional misconduct through empowering every professional as a moral agent equipped to uphold the highest professional standards. The General Medical Council is furthest along this transition journey while other regulators are only commencing.*

Recommendation Four: *SRBs should adopt the inquisitorial system and pursue a more impartial and professional enquiry into the storied truth of each misconduct case aided by the supportive role of both parties and, where available, their legal representatives*.

Recommendation Five: *Regulators should accept registrants whose FtP is found to be impaired (perceived to be 'other') as fully human, like members of the public whose safety they protect, and commit to learning together in genuine dialogue, with the understanding that regulators and the system under which they operate have much to learn if they are to reduce the suffering of registrants going through FtP processes*.

Recommendation Six: *It would be helpful if regulators are prepared to identify and acknowledge throughout the fitness-to-practise process (a) the role of emotion in health and care professional decision-making and; (b) extenuating circumstances in the workplace that produce a lack of control over professional work.*

Recommendation Seven: *Academic Schools for health and care professional education and post-professional course providers must go beyond scientific instruction and provide education and training in maintaining mental health and well-being of future registrants. Professionals must*

learn not to suppress their emotions, but instead to be able to explore uncomfortable feelings about self, work and organisational settings in order to be alert to problems that require the translation of private feelings into public issues for social action.

Recommendation Eight: *A mature regulatory mind-set is one that enables the principle of remediation that honours every registrant as an equal and unique human being with the capacity for learning from mistakes and failure*.

Recommendation Nine: *Whilst this study has provided insights into the lived experience of a pharmacist who became de-registered following FtP proceedings and has contributed to the small body of empirical research in this area it is nevertheless incomplete. This study could form the foundation for further in-depth qualitative research studies, which examine the lived experiences of a range of health and social care professionals who are suspended or removed from the register, and in doing so achieve a more nuanced understanding of the impact of regulation.*

Recommendation Ten: *Individual regulators must make 'mental health safety' a priority if they are to effectively safeguard all registrants subject to the FtP process and especially persons who might otherwise be at risk of suicide. Research to identify panellist and other regulatory staff education and training needs in the area of mental health safety is urgently needed.*

Chapter 8
CONCLUSION

In an attempt, through this thesis, to unpack my ability to recognise my professional limitations I have unwittingly shown the use of a learning framework known popularly as the 'conscious and competence matrix' developed by Noel Burch during the 1970s (MindTools, 2022). As I approached change, I could not really know who I would be on the other side. Flower (1999) referred to this transitionary period as being "in the mush". This change-induced learning related to learning from mistakes and navigating the various challenges that lay ahead in order to present myself to the Regulator's FtP panel as a fit and proper person whose name could be restored to the Register after a period of five years had elapsed following erasure. The first stage (unconscious incompetence) refers to the time following erasure when I lacked insight into the deficit; not knowing that I lacked FtP, or that I needed to learn it. Shortly after diagnosis of EUPD, I entered the second stage of conscious incompetence where though I did not know how to plan towards restoring my name, I recognised the deficit I needed to address. After returning to work under the supervision of a registered pharmacist I was once more able to regain pharmaceutical skills, professional values and attitudes to attain stage three of 'conscious competence'. However, this required concentration in order to demonstrate consistently. Only after more than three years following de-registration and supervised pharmacy practice did I feel that I fully and consistently demonstrate professionalism by meeting the Standards required of practising professionals (and attained stage four of 'unconscious competence' – pharmacy practice had once more become 'second nature').

Clarkson (1994) argues that the notion of wounded healer (referred to in this thesis) may sustain pseudo-competence – a state of mismatch between my own self confidence in pharmacy practice and my competence in it as assessed by those in authority. In this sense competence means that my self-confidence (subjective competence) is matched with my performance in practice (objective competence). The negative assessment of my claim to competence, in my restoration application, by the FtP panel was very difficult to accept. However, in acknowledging 'incompetence' here offers the start of further professional development by responding specifically to the criticisms made by my regulator.

Foucault (1988) has emphasised the dispersed nature of power and that a nation can only operate on the basis of its existing power relations within society. Power, in his view, is far from repressive, but instead productive and an autonomous force. He rejects the idea that power is the means by which one social group controls others in its own interest, but rather the actual 'system' (of regulation) itself. Foucault (1975; 1979) attempts to go beyond structuralism by tracing aspects of modernity first through an 'archaeology of knowledge' – in which he argued that established practices become modes of thought with their own logic, strategy, evidence and reason – (like our system of regulation); and later through a 'genealogy' of power/ knowledge (Foucault 1981)

where the past becomes a lead up to the present. Put another way, history is always a history of the present. Any resultant discourses (for instance regulatory ideas, concepts and theories) then constitute a particular social reality for all those who are regulated (including for some the lived experience of FtP proceedings and erasure) that impacts directly on how conscious individuals define themselves. In his later work, Foucault (1982, p.237) appears to reject his earlier notions of determinism by suggesting that “We have to create ourselves as a work of art”. To this end Foucault described the use of ‘technologies of the self’ as the means by which a consistent set of actions can emerge as the individual transitions towards achieving self-empowerment.

My de-registration experience, presented in this thesis, was a period of time during which I was undergoing extremely painful changes in my life. The villanelle form offered me a most appropriate means to see my complex situation from many different angles. According to the Poetry Foundation (2021) the villanelle is “a French verse form consisting of five three-line stanzas and a final quatrain, with the first and third lines of the first stanza repeating alternately in the following stanzas. These two refrain lines form the final couplet in the quatrain”. The challenge to develop an original villanelle became the ‘mountain’ I felt necessary to climb in order to face, in all respects, de-registration and the loss of my work identity. My lived experience was inescapable. All I could do was to ‘keep telling my truth’ in repeated attempts to help ease my suffering. I hope that the composition may serve as a beacon to others who find themselves ‘cast-out’. Here is the poem that came to me:

Do Not Lose Hope

A Villanelle

By Porsotam Leal

Do not lose hope when all is black as night.
Darkness may just be holding a new day.
Search, search and you will surely find the light.

When Winter, finds you in a sorry plight,
Struck down, abandoned, left a castaway.
Do not lose hope when all is black as night.

Take your rest in silent earth and catch sight,
The primordial ache for life, come what may.
Search, search and you will surely find the light.

In nature’s eternal chain, new delight.
Come pain, my power, but you mustn’t stay.
Do not lose hope when all is black as night.

Choose to forgive those who act with sleight,
And sense the leap in heart, dismiss hear-say.
Search, search and you will surely find the light.

Winter, the season of our growth and might,
For the healing of homesick souls, I pray.
Do not lose hope when all is black as night.
Search, search and you will surely find the light.

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APPENDICES

Appendix 1: BU Ethical Approval Letter

Bournemouth University

Research Ethics Checklist

About Your Checklist	
Reference Id	16302
Status	Approved
Date Approved	28/02/2018 10:18:08
Date Submitted	09/02/2018 12:37:15

Researcher Details	
Name	Paul Leal
Faculty	Faculty of Health & Social Sciences
Status	Postgraduate Research (MRes, MPhil, PhD, DProf, EngD, EdD)
Course	Postgraduate Research - HSS
Is This External Funding?	No
Please list any persons or institutions that you will be conducting joint research with, both internal to BU as well as external collaborators.	None

Project Details	
Title	The Human Impact of Regulation: an auto ethnographic narrative of coping with 'strike-off'. (Phase One)
End Date of Project	30/09/2020
Proposed Start Date of Data Collection	01/07/2017
Original Supervisor	Caroline Ellis-Hill
Approver	Research Ethics Panel

Summary - no more than 500 words (including detail on background methodology, sample, outcomes, etc.)

Statutory Regulatory Bodies (SRBs) for Health and Social Care (HSC) professionals in the United Kingdom exist chiefly to protect the public. These bodies maintain a register of practitioners and set minimum standards of professional and ethical conduct. The process of being involved in a regulatory investigation process is very stressful for HSC registrants. Only very recently has there been a recognition among some SRBs of the impact of investigations, into registrants' Fitness to Practise (FtP), on mental health and well-being. The intention of this study is to fill a gap in the literature about what it feels like to be removed from a professional register of practise, colloquially referred to as 'strike-off'. Currently the proportion of registrants removed each year from practice is very small at below 0.1 per cent for each of the four HSC professions to be considered in this study (Medicine, Nursing, Pharmacy and Social Work).This application seeks ethical approval for the 'first phase' of a two phase study, involving the researcher with lived experience of 'strike-off' writing an auto ethnography. A later phase of the study will utilize interactive interviews with participants and will be preceded by a separate ethical approval application to cover the different set of ethical issues involved.Auto ethnography is research, writing, and method that connects the autobiographical and personal to the cultural and social (Ellis 2004). During the construction of my auto ethnography I shall be using writing as a method of inquiry to both collect and analyse data. Richardson and St. Pierre (2008) suggest that following lived experience of a (traumatic) event data are present in the mind and body and such data can only be collected through the writing process. A variety of data types are to be captured in this first phase including emotional and memory.Auto ethnographers are encouraged to write themselves as survivors as well as relate to an audience of readers with or without similar experiences. I will

therefore keep in focus the need to be 'other' directed as I construct my auto ethnography so that I may more clearly see how others see me and the world. In this sense I will need to be sensitive to the 'other' people (family members, friends, work colleagues) and organisations (General Pharmaceutical Council, NHS bodies, legal firms) forming part of my story. I hope that the findings will encourage SRBs to consider very carefully the humanity of care professionals when planning and administering a sanction at the end of FtP proceedings.ReferencesEllis, C., 2004. The ethnographic I: A methodological novel about auto ethnography. Walnut Creek, CA: AltaMira.Richardson, L., and Adams St. Pierre., 2008. Writing: A method of inquiry. In: Denzin, N.K., and Lincoln, Y.S., eds. Collecting and Interpreting Qualitative Materials. Thousand Oaks: Sage Publications, Inc., 473-99.

External Ethics Review	
Does your research require external review through the NHS National Research Ethics Service (NRES) or through another external Ethics Committee?	No

Research Literature	
Is your research solely literature based?	No

Human Participants	
Does your research specifically involve participants who are considered vulnerable (i.e. children, those with cognitive impairment, those in unequal relationships—such as your own students, prison inmates, etc.)?	No
Does the study involve participants age 16 or over who are unable to give informed consent (i.e. people with learning disabilities)? NOTE: All research that falls under the auspices of the Mental Capacity Act 2005 must be reviewed by NHS NRES.	No
Will the study require the co-operation of a gatekeeper for initial access to the groups or individuals to be recruited? (i.e. students at school, members of self-help group, residents of Nursing home?)	No
Will it be necessary for participants to take part in your study without their knowledge and consent at the time (i.e. covert observation of people in non-public places)?	No
Will the study involve discussion of sensitive topics (i.e. sexual activity, drug use, criminal activity)?	Yes
Are drugs, placebos or other substances (i.e. food substances, vitamins) to be administered to the study participants or will the study involve invasive, intrusive or potentially harmful procedures of any kind?	No
Will tissue samples (including blood) be obtained from participants? Note: If the answer to this question is 'yes' you will need to be aware of obligations under the Human Tissue Act 2004.	No
Could your research induce psychological stress or anxiety, cause harm or have negative consequences for the participant or researcher (beyond the risks encountered in normal life)?	Yes
Will your research involve prolonged or repetitive testing?	No
Will the research involve the collection of audio materials?	Yes
Is this audio collection solely for the purposes of transcribing/summarising and will not be used in any outputs (publication, dissemination, etc.) and will not be made publicly available?	Yes
Will your research involve the collection of photographic or video materials?	Yes
Will financial or other inducements (other than reasonable expenses and compensation for time) be offered to participants?	No
Please explain below why your research project involves the above mentioned criteria (be sure to explain why the sensitive criterion is essential to your project's success). Give a summary of the ethical issues and any action that will be taken to address these. Explain how you will obtain informed consent (and from whom) and how you will inform the participant(s) about the research project (i.e. participant information sheet). A sample consent form and participant information sheet can be found on the Research Ethics website.	

This ethical approval application relates to phase one of a two phase study - that of writing my auto ethnography (or personal narrative) in response to being removed from the register of practise for pharmacists held by the General Pharmaceutical Council (GPhC). The auto ethnography will involve me audio-recording as well as writing down my reflections, thoughts and feelings. I also intend to draw on textual material such as diaries (personal journal, 2011 onwards and; research journal, 2015 onwards) and paperwork linked with the case as well as past (family and workplace) photographs. The identity of those in the photographs apart from myself will be anonymised unless they are essential to the analysis. Permission to present any photographs beyond the analysis will be sought from all those involved using the BU photographic permission form (attached). The audio-recordings will only be used for research purposes and will not be used in any outputs (publication or dissemination) and will not be made publicly available.The topic is a sensitive one (although not linked to sexual activity, drugs or criminal activity) and as the researcher and participant I am aware that I will be discussing sensitive issues and will review on an ongoing basis with myself and with my supervisors issues which arise due to the sensitive nature of the topic (such as level of public disclosure). I acknowledge that the research will require me to re-experience the trauma and its impact on my life. Inherent in the methodology of auto ethnography is its focus upon caring for the self and healing. Therefore, as an auto ethnographer I will strive to balance such personal benefits with considerations about protecting the privacy and identities of both self and others. In the case that I experience distressing symptoms that result in me being unable to cope or adequately manage distressing thoughts, feelings and behaviors, a plan is in place and support would be sought from my supervisors in the first instance and/ or Bournemouth University Counselling service and/ or external therapeutic support. In the case that I experience distressing symptoms that result in me being unable to cope or adequately manage distressing thoughts, feelings and behaviours, the plan will be put in place and support sought.The researcher named at the top of this application is the only participant in the first phase of this study and so a participant information sheet or consent form is not needed.

Final Review

Will you have access to personal data that allows you to identify individuals OR access to confidential corporate or company data (that is not covered by confidentiality terms within an agreement or by a separate confidentiality agreement)?	No
Will your research involve experimentation on any of the following: animals, animal tissue, genetically modified organisms?	No
Will your research take place outside the UK (including any and all stages of research: collection, storage, analysis, etc.)?	No

Please use the below text box to highlight any other ethical concerns or risks that may arise during your research that have not been covered in this form.

In choosing auto ethnography as the most appropriate method for my research I simultaneously accepted that I would be a subject and an object of the proposed research. My story of been handed down the most severe sanction following a SRB FtP Hearing in 2012 created a crisis in my life-story that was excruciatingly painful and profoundly unsettling. Being removed from a professional register has caused strong feelings of dissonance and incoherence. Adams, Holman Jones and Ellis (2015) compel all auto ethnographers to consider how to care for, respect, and do justice to and for the self. I recognize that my study is likely to prompt me to revisit traumatic experiences and that I might find myself unsettled and unable to cope adequately. A plan is in place and support would be sought from my Supervisors in the first instance and/or Bournemouth University Counselling service, if this occurs. ReferenceAdams, T.E., Holman Jones, S., and Ellis, E. 2015. Auto ethnography. Oxford: Oxford University Press.

Attached documents

Ethics_Approval_Release Form (BU) Final (1)_pleal_01June17.doc - attached on 01/06/2017 18:07:50

Ethics_PhaseOne_clarification_finalresponseletter_toSSHREP_09 February 2018.docx - attached on 09/02/2018 12:36:22

Appendix 2: Seventh International Conference of Autoethnography

19th-21st July 2020

Day 2 Session 9 (@10.45am): Disrupted and problematic bodies

One Career, Two Stories by Porsotam Leal

Comments and feedback received from my peers:

SC – My ex worked for the NMC in regulation… made him think about setting up in practice in 'defending' practitioners… such was what he saw of overwhelm and poor systems of caring for practitioners.

JH – Wow… that was amazing! So powerful and personal… much needed.

MS – So courageous! And so relatable as well.

DO – Very touching.

SAMM – Very powerful.

BH-J – This story of professional status being stripped away and the year that ensued is very resonant. Thanks for your courage.

KE – This is breath taking.

DO – Very powerful. (Academic pharmacist)

KE – Autoethnography is brave… you are exemplifying this.

Conference Committee – YES (KE), agreed.

TB – Porsotam this is something very much in need of discussion. Thank you for sharing it. (Senior nurse)

JG – The elephant is also (misplaced) shame and stigma, I think.

KE – I have been moved to tears. I have smiled. Looked in the mirror and seen myself, and the world has been reconfigured before my eyes. Autoethnography at its best!

SC – I think many health professionals do know, are aware… their way of managing to 'dissociate/ distance' in some way… I believe they are often vicariously traumatised.

FL – We learn about physiology, pharmacology, and patho-physiology. But are we learning about empathy? About communication? About fighting diseases WITH patients? (Pharmacist)

ST – Bring on the medical humanities.

LS – I think all health care professionals should be encouraged strongly to read AE of health conditions.

BH-J – I would be interested to hear about how you hold the balance of the fight for justice alongside your spiritual experience.

DO – I am thinking how I would feel to be in this situation…

MS – I gave my profession up kind of by choice as my body got too weak for it, but would be terribly upsetting if somebody came along and tried taking this identity away.

KE – It is not restricted to health care.

BF – Thank you Paul, it's an intense story. Thanks for sharing!

TEG – Paul, thank you. Your story speaks for so many. I was resisted and rejected when I suggested using autoethnographic approach for my postgrad on racism.

FI – Thank you Porsotam – thanks for sharing your story of identity, spirituality, loss and restoration.

SW – I am in the same position. So good to hear this and to have this given attention.

FG – Porsotam, hearing 'I do not accept this label' was really powerful for me.

Conference Committee – Thank you Porsotam… such important and courageous work.

Appendix 3: Coping with FtP proceedings/ suspension/ de-registration–some suggestions:

1. *Exercise the freedom to change your mind* if you are feeling 'stuck' in the suffering of going through or dealing with an adverse fitness-to-practise outcome. Believe me when I say only you made up the rule that life after FtP or without your professional life would never be nearly as good as life before the event. The moment you let go of your made-up mind you will allow it to change, and you will regain your inherent peace of mind.

2. *Avoid adding to the emotional burden of the FtP process by working against yourself* through blame, judgement and other forms of self-incrimination. When you can truly see that thoughts and feelings are fleeting and superficial you will not need to try to control them – they lose their power over you. Who you are lies beneath the thought-feeling surface - a whole and loving person with innate well-being.

3. *Extend beyond focusing on yourself and your FtP experience* to keep abreast of other people's realities to help ward off isolation, withdrawal and depression. Give yourself permission to experience love and gratitude for all the people in your life. Maintain your social connectedness and remain curious about what all human beings share – a capacity for empathy, resilience and creativity – therefore keep alive your hope for change.

4. *Step back from your difficulties and look at yourself from a distance*. Only human beings have this ability, so why not harness it to strengthen yourself against your professional troubles? See your fears and your frustrations from the impartial observer's perspective. Imagine your FtP problem from a month, a year, or even five years from now – what impact will it still have on you? Most importantly, what will you have learned from the experience?

5. *Remain receptive to the meaning of your life's unique moments*. Notice renewal of the purpose for your existence as you go on embracing life without professional work. Welcome the unplanned opportunity to spend more time with loved ones, to get creative, to develop your mind, to take more care of yourself and to explore how you could continue to be of service to others (if that is what you want to do). Try not to carry any preconceived ideas that only lead you to do what is 'normal'. Rather, do what is natural and comfortable for you – it is sure to bring peace of mind and well-being.

6. *Reclaim your soul in the aftermath of FtP proceedings,* especially if the experience has prompted you to feel broken and incomplete. Deeply understand your place in the world of nature by bringing a meditative awareness to life's cycles and changes, and to the beauty and abundance therein. You will soon discover that you have a divine role in the world.

7. *Cultivate a sense of humour*. Our human ability to laugh at ourselves and see the rich ironies and amusing realities in our personal and working lives takes the edge off every serious situation. Having our FtP as a care professional challenged may not be a laughing matter but take care not to confuse 'what' we do and 'how' we do it with 'who' we are. Fully acknowledge that you made a mistake and, if nobody was harmed as a result, bring yourself to laugh at it – it can be a huge relief personally as well as for those around us.