Reactivity and reactions to regulatory transparency in medicine, psychotherapy and counselling

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ABSTRACT

We explore how doctors, psychotherapists and counsellors in the UK react to regulatory transparency, drawing on qualitative research involving 51 semi-structured interviews conducted during 2008–10. We use the concept of 'reactivity mechanisms' (Espeland & Sauder, 2007) to explain how regulatory transparency disrupts practices through simplifying and decontextualizing them, altering practitioners' reflexivity, leading to defensive forms of practice. We make an empirical contribution by exploring the impact of transparency on doctors compared with psychotherapists and counsellors, who represent an extreme case due to their uniquely complex practice, which is particularly affected by this form of regulation. We make a contribution to knowledge by developing a model of reactivity mechanisms, which explains how clinical professionals make sense of media and professional narratives about regulation in ways that produce emotional reactions and, in turn, defensive reactivity to transparency.

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Introduction

Inquiries into patients murdered by GP Harold Shipman (Smith, 2004) and the deaths of babies at the hands of surgeons at Bristol Royal Infirmary (Kennedy, Howard, Jarman, & Maclean, 2001) exposed failings in the way the British medical profession was regulated. They suggested that the medical regulator, the General Medical Council (GMC), was looking after the interests of doctors rather than patients, which had allowed the profession to cover up malpractice.

These inquiries laid foundations for reforms that culminated in a policy programme to improve the quality of care. The UK Government White Paper, 'Trust, Assurance and Safety' (Department of Health, 2007: 1) aimed to preserve trust as the 'bedrock of safe and effective clinical practice and the foundation of effective relationships between patients and health professionals'. It proposed a statutory and transparent model of regulation for all health professionals to achieve this goal.

'Transparency' is a policy ideal designed to open practices to public scrutiny. Through the provision of information and procedures comparable with fixed published rules, clearly demarcated areas of activity are made visible (Hood & Heald, 2006). Values

associated with transparency - openness, independent scrutiny and accountability - are widely assumed to be beneficial. However, studies of transparency suggest it may have unintended or even perverse consequences too (Bevan & Hood, 2006; Blomgren & Sunden, 2008; Hood & Heald, 2006; Levay & Waks, 2007; McGivern & Ferlie, 2007; Power, 1997; Strathern, 2000; Tsoukas, 1997).

We explore regulatory transparency and its effects in comparative case studies (Eisenhardt, 1989) of two professions, medicine and therapy (psychotherapy and counselling). Medicine (particularly for psychiatrists and GPs whom we interviewed) and therapy are clinical professions with complex practices, in which diagnosis and treatment are based upon interpersonal relations with patients/clients and professional judgement. Medicine is a well-established profession, in which statutory regulation, evidence-based standards, clinical audit and measurement are established. Psychotherapy/counselling is an emerging profession, where regulatory transparency, evidence-based standards and clinical audit and measurement are nascent. Indeed there is little research on transparency for therapists. Thus comparing and contrasting transparency in two clinical professions with similar but distinctive practices, where regulation is at different stages of development, should reveal key features of transparency, how generalisable they are, and ways regulation might be improved.

In the following section we discuss transparency further. We then describe 'reactivity' and 'reactivity mechanisms' (Espeland & Sauder, 2007), which we use theoretically to explain how

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regulatory transparency affects professions. Next we outline our qualitative research methods, based upon interviews, and how we analysed and theorised these data. Then we explore interview narratives, first about how doctors and then therapists experienced forms of regulatory transparency. Finally we explain how reactivity mechanisms, including sensemaking processes related to media and professional narratives, produce emotional reactions, in turn creating perverse unintended reactivity to regulatory transparency.

Transparency

Transparency has been described as revealing 'truth', promising 'a better world for all' (Oliver, 2004: 78). It has become barely questionable (Gabriel, 2008) attaining a 'quasi religious signifi-cance' as a regulatory ideal (Hood & Heald, 2006: 3). It has long been believed that watching people induces better behaviour (Foucault, 1977) but transparency may also have unintended or even perverse consequences (Hood & Heald, 2006; Strathern, 2000; Tsoukas, 1997).

Transparency could produce overwhelming data volume and complexity (Brin, 1998; Vattimo, 1992), but functions by high-lighting certain things while obscuring others (Strathern, 2000). Regulators use transparency to structure professionals' limited attention on the 'right' things (Heimer, 2008), 'affecting norms of how professional practices are organized and controlled' (Blomgren & Sunden, 2008: 1512). But regulators compete for 'attention space' with the media and interest groups (Heimer, 2008), which also construct transparency and the world it reveals (Levay & Waks, 2007; Oliver, 2004; Vattimo, 1992). Transparency and standards are usually presented as 'neutral devices for increased openness' (Blomgren & Sunden, 2008: 1512). However they are 'inherently political because their construction and application transform the practices in which they are embedded' (Timmermans & Berg, 2003: 22) and may be used for partisan purposes (O'Neill, 2006).

Organisations are increasingly motivated to 'turn themselves inside out' (Power, 2004) under the threat of adverse publicity and litigation, visibly demonstrating conformance with standards of best practice (Heimer, Coleman-Petty, & Culyba, 2005; Power, 1997, 2007). Yet organisational image is easily 'tarnished' by trans-parency which 'magnifies the tiniest blemish and exaggerates the smallest imperfections' (Gabriel, 2008: 313).

If transparency reveals dramatic, memorable or contentious risks, these are likely to be 'amplified', whereas widespread, prosaic or technical risks are often 'attenuated', as they are transmitted and received through formal and informal channels, including regula-tors, the media, social organisations, opinion leaders and personal networks. Consequently reactions to risks made transparent may be technically disproportionate (Kasperson et al., 1988).

Following high-profile media spectacles, potentially amplifying risks, Hood, Rothstein, and Baldwin (2004) found regulators engaging in 'blame prevention re-engineering', producing 'tomb-stone' regulations, which superficially responded to public perceptions of a problem, to dissipate or transfer liability. Regula-tors need to avoid being tarnished by adverse incidents they may be seen responsible for preventing. However doubts that regulations are effective leads to defensive reaction from those intended to be regulated and 'gaming' that 'hits the target, but misses the point' (Bevan & Hood, 2006; McGivern & Ferlie, 2007). Yet regulators appear to put few resources into checking data, taking performance gains at face value (Hood, 2006).

Clinicians have been found to interpret new knowledge and evidence using their own and colleagues' experience, narratives and collective sensemaking, rather than through rational appraisal (Gabbay and Le May, 2010). These may also shape how clinicians interpret and react to new forms of transparency and regulations.

Stories shape 'sensemaking' (Weick, 1995) and regardless of empirical accuracy, certain stories 'stick' (Heath & Heath, 2008), even constructing social reality to become a self-fulfilling prophecy (Ferraro, Pfeffer, & Sutton, 2005).

Much transparency literature focuses on interactions between regulators and organisations. We examine how regulatory trans-parency affects individual clinical professionals. In the following section, we explain the notion of 'reactivity' mechanisms', which we use to explain our data.

Reactivity mechanisms

If transparency affects the way professionals think about and interpret the world, 'reactivity' refers to 'the idea that people change their behaviour in reaction to being evaluated, observed, or measured' (Espeland & Sauder, 2007: 1). While certain reactivity is intended, it can have unintended and potentially harmful conse-quences. For example, Willmott (2011) explains the 'perverse' effects on academic scholarship of reactivity to journal listings. In healthcare, Waring describes clinical risk managers 'washing' complex narratives about adverse incidents to fit with risk management standards but in doing so undermining learning to prevent future incidents, and changing professionals' cognition. He argues: 'Requiring clinicians to think about and categorise risk along these predefined categorisation, a gradual shift may occur in how staff interpret events' (Waring, 2009: 1729).

Espeland and Sauder (2007) use the idea of 'reactivity mecha-nisms', which are 'patterns that shape how people make sense of things… how attention is distributed, and the interactive scripts people adopt' (2007: 11), to explain reactions to transparent stan-dards used in ranking American law schools'. They outline two reactivity mechanisms.

Firstly, drawing upon Merton's (1948) notion of 'self-fulfilling prophecy', Espeland and Sauder (2007) argue that an inaccurate definition can change behaviour to make the definition come true. Self-fulfilling prophecies functioned in their study because: (i) rankings magnified insignificant differences, which external audiences used in judging quality; (ii) past rankings shaped current evaluations, as historical rankings influenced judgements; (iii) resources were allocated based on rankings, enabling higher ranked schools to further differentiate themselves; and (iv) measurement incentivised law schools to conform to standards that maximised their ranking. Rankings thus produced 'reflexive reactivity' as professionals reorganise law schools to maximise rankings, including through gaming and impression management, which undermined their sense of professionalism.

A second mechanism of 'commensuration' transformed cogni-tion and 'the locus and form of attention, both creating and obscuring relations among entities' (Espeland & Sauder, 2007: 16) because rankings allowed institutions to be compared against simplified and de-contextualised measures. Commensuration focuses attention on comparisons based upon these simplified measures, while obscuring their uncertain and constructed nature and other complex quality indicators. Thus law schools focused on improving rankings rather than other wider aspect and indicators of quality.

Sauder and Espeland (2009) explain that people internalise rankings, involving surveillance and normalisation, due to the anxiety rankings produce and the allure they possess. Rankings induce status anxiety, as people compare themselves and are compared in ways they cannot control, amplifying these measures' influence and effects. Sauder and Espeland argue that even those sceptical about and resisting rankings come to internalise them during prolonged 'entanglement'. To maintain status they invest in gaming and manipulating measures to present the impression of