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A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

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Big Minds

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Ralph Waldo Emerson wrote: “a foolish consistency is the hobgoblin of little minds.” Regulators of professions and industries dwell in inconsistency. Many registrants practice their profession within a system that is often beyond their control. Yet regulators usually only have jurisdiction over a registrants’ individual actions and oversee only individual registrants despite trying to address failures flowing from the work of teams. Even when the errors are primarily the result of individual action, change is often best achieved through a safe, confidential, no-blame culture. Yet regulators operate a publicly transparent, “at fault” discipline process.

To manage these contradictions, regulators administer several seemingly incongruous regulatory tools such as a fault-finding complaints and discipline system, a neutral mediation of consumer concerns, a rehabilitative incapacity regime, a supportive quality assurance program, a transparent and comprehensive public register, and a helpful practice advisory service.

Two recent UK publications illustrate the challenge for regulators as they try to navigate this confusing world.

The first is a blog by Anna van der Gaag, Visiting Professor, Ethics and Regulation, University of Surrey entitled *Safety Nets and Sledgehammers* published by the Professional Standards Authority. The blog summarizes a recent roundtable discussion about various safety culture initiatives taking place in the UK. The author notes that:

> [safety culture initiatives] have a number of things in common. The first is a focus on learning from errors and understanding and acting with a focus on system failures rather than individual failures in order to make improvements.

Further:

> There was consensus that the most risky workplaces are often ‘anxiety spaces’ – characterised by high accountability and low levels of psychological safety. These

> workplaces tend to have low staff retention rates and poorer outcomes for patients.

Thus:

> safety culture initiatives are about creating a learning environment in which all parties are involved, respected, seen as equals, with a view to restoring and re-building what is broken. They tie in with the principles of speaking up, increasing cultural competence and striving for equality and diversity. *[citations removed]*

The author notes the contradictory position that regulators find themselves in:

> And here lies the contrast. Alongside this we have built a system of individual redress in UK health professional regulation that is adversarial for all parties. Regulating 'in the public interest' can engender the very thing that is toxic to learning and health care safety and improvement – fear, some would say terror, even… Adversarial approaches by definition precipitate defensiveness, and defensiveness supresses learning. *[citations removed]*

The blog identifies the most needed role of regulators as follows:

> In the very rare cases of deliberate harm, intent to deceive, boundary violations and exploitation of power, individual accountability and swift regulatory action will always be required.

Anecdotally, our perception is that many regulators have at least partially incorporated this viewpoint, rarely referring simple "standards of practice" cases to discipline. Rather they use rigorous quality assurance programs to address standards issues on a systemic level. Even complaints screening bodies use remedial outcomes to address "mistakes", including serious ones. However, while quality assurance measures tend to be confidential, remedial outcomes for complaints are becoming increasingly public.

The second publication is a research study on teamwork commissioned by the regulator for physicians in the United Kingdom, the General Medical Council (GMC). The final report, entitled *Teamworking: Understanding barriers and enablers to supportive teams in UK health systems*, contains the results of extensive interviews on the topic.

Some of the results might confirm generally held views on how teamwork operates. For example:

> We found a range of enablers for effective teamwork… Key factors included ensuring the time and structures are in place to allow teams to meet regularly, a positive and supportive culture, effective communication, leaders who are understanding and approachable, clearly defined roles and respect for all team members, and continuity and experience of those in newer roles.

In terms of hindrances to teamwork:

> Barriers to effective teamwork included high service demands and work pressures, power imbalances and negative hierarchy, a lack of inductions and support for those new to teams and organisations, poor communication, poor leadership, a lack of mutual respect, a lack of appreciation and understanding of the needs of differing groups within teams, and finally Equality, Diversity and Inclusion (EDI) issues…

On the hierarchy point, the report says:

> Power imbalance and negative hierarchy were raised as major barriers to effective teamworking. Where hierarchy was perceived to be a big issue, this led to intimidating and often toxic or bullying cultures. This then led to issues with speaking up and ultimately led to errors and poor patient outcomes.

The report also discusses the implications of this research on regulators. For example, it notes that rigid rules by regulators (or funders for the service and employers), can disrupt effective teamwork. One example given relates to rules by employers/funders prohibiting physicians from speaking with paramedics bringing patients into a hospital, with the goal of reducing EMS down time, which rule is harmful to patient health. "Fear" of the regulator is seen as contributing to this sort of disruption.

More specifically, the report notes that teamwork dynamics may not be taught in the education programs for some internationally trained practitioners. This reinforces the GMC's cutting-edge work developing this important non-clinical skill through voluntary courses offered to internationally trained practitioners.

The report recognizes that the GMC has limited ability to influence teams that are formed in local settings. The report goes on to state:

> However, the GMC could consider better promotion of the need for teamworking standards to be met and support organisations to resolve some of the issues facing doctors throughout medical education and training. Most of the current standards and policies in place relating to teamwork are also aimed at individuals, rather than for whole teams. The GMC tends to focus on setting standards and supporting those in newer roles or those new to the UK, yet this research shows that those in more senior positions also need support.

The upshot of these two publications is that regulators should be aware that they are only one part of the public protection panorama and that they are frequently employing inconsistent tools to protect the public. However, regulators should not necessarily try to eliminate these contradictions but instead must try to manage them well. It takes a nuanced communication and application of these tools to facilitate the best possible outcome for the public. Ensuring that registrants, and the public, appreciate the multiple roles served by regulators helps enormously.

A siloed approach by regulatory staff and committees working in only one program area (e.g., complaints and discipline) can be detrimental to the effectiveness of the regulator. For example, an adversarial approach to mistakes by registrants may not achieve superior long-term outcomes for the public.

Regulators need big minds.

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