Attending to the Ethical Orientation of Health and Care Regulators: The Pursuit of Coherence Between Care Quality, Professionalism and Regulation in the UK

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Abstract

This paper offers an empirically informed ethical analysis of the recent history of health and social care regulation in the UK focused especially on the contributions made by the Professional Standards Authority for Health and Social Care. The paper is largely organised around two broad questions: First, in what respects can regulation support, mobilise and model professionalism and professional identity? Second, nested within this, given that regulation can support the professional identities of diverse practitioners can it, at the same time, help enable coordination across, and integration of, health and social care activities? These concerns, we suggest, highlight the value of viewing professional regulation in the context of the broader collaborative zeitgeist in health and care and as shaping the ethical landscape for professionals. We thereby make a case for the value of attending to the ethical orientation of professional regulation.

Keywords

Professional regulation, professionalism, ethics, collaboration, health and social care

Introduction

Professional regulation in health and social care is typically justified as a mechanism for supporting care quality and protecting the public. We accept this justificatory story but in this paper we explore some of the complications underlying it. In particular we consider some of the ethical balancing acts that arise in professional regulation. Most discussions of regulation and ethics are about the role of regulators in helping to frame, encourage or enforce ethics standards for professionals. But the issues we are interested in can be seen primarily as questions about the ethics, and the ethical orientation, of professional regulation. Regulation is itself action in the world and the agents and agencies responsible for it—as well as being potential sources of good—face the same ethical risks as other agents—for example, the risks of harming others, being wasteful of resources, helping to sustain unfair systems or directly acting unfairly etc. (Feinstein, 1985) Discussions of regulatory reform tend to be couched as about its effectiveness but, we argue, questions about ethics are not far below the surface.

Our interest in this area arose from our work on the regulation of health and social care professionals in the UK and, in particular the contribution made to understanding and addressing regulatory challenges by the Professional Standards Authority for Health and Social Care (the PSA). Specifically (i) we reviewed the approach of the PSA to professional regulation in recent history, and we engaged with examples of PSA commissioned research, including some studies of perspectives on regulation in which we participated as research partners (ii) in addition to producing policy-oriented analyses (reported elsewhere) we interrogated the emergent theme of the "ethical orientation" of regulation and (iii) working back and forth between (i) and (ii) we undertook an empirically-informed ethical analysis of one "case" of evolving regulation, which we hope may prompt fruitful questioning elsewhere.

Our initial interrogation eventually crystallised into two broad questions which are of theoretical significance but also central to the practical agenda of the PSA:

> First, in what respects can regulation support, mobilise and model professionalism and professional identity? Second, nested within this, given that regulation can support the professional identities of diverse practitioners can it, at the same time, help enable coordination across, and integration of, health and social care activities?

We will come to this second question later having first discussed the general relationship between care quality, professionalism and regulation.

There can surely be no doubt that professionalism is a bulwark of care quality. No amount of quality or safety targets or interventions will add up to much without individuals responsibly exercising their expertise day-to-day. But the value of professional regulation is perhaps not quite so obvious. In particular, there are potential tensions between

professionalism and professional regulation. Some of these tensions are routinely complained about but relatively superficial whilst others are more structural and serious. We see no fundamental incompatibility between professionalism and professional regulation—indeed, we will suggest, that the opposite is true. But we will begin by acknowledging some tensions.

The more routine tensions are indicated by the common expression "box-ticking". Deploying the expression is to say something like: "Such and such is being done simply because it is a requirement. This does not mean it is a good idea nor that I have invested myself in it." In the case of professional regulation, this kind of attitude might arise, for example, in relation to the requirements of continuous professional development or revalidation. Although many might see this as disappointing, it can also be seen as an expression of a strong professional and vocational identity. It may be because someone has a clear sense of what matters, of the ideals that motivate and sustain them, that they are so ready to implicitly label certain activities as empty by comparison. It is tempting to play up professional virtues and artistry in responding to complex cases and circumstances, and to contrast that with complying with the demands of others through mere rule-following. Indeed, such a thought arguably serves a key function in motivational and ethical terms.

This contrast is a useful clue to the way regulation interfaces with professional work. Concerns about professional practice cover a very broad spectrum. At one end there is the search for excellence—pushing beyond good practice to debate and pursue best practice and the ideals that are inherent in professional fields. At the other extreme, there is the business of defining and ensuring minimum standards. Although, as we intend to stress, professional regulation can make contributions across this spectrum its most conspicuous role has arguably been at the threshold level—in setting and policing the boundaries of professional practice (Chamberlain et al., 2018).

The professionalism-regulation question is just one variant of a familiar puzzle about how best to combine professional autonomy and judgement with official frameworks of management, governance and policy. In other words, it might be said, about how best to combine "self-regulation" and "regulation by others". Tensions are inevitable in this area and managing these tensions is central to the ethics of regulation.

Orders and contradictions

In 2013 Bilton and Cayton wrote a paper asking, "How can care professionals be expected to assume full responsibility for their actions if the policies, regulations and guidelines governing their work and workplace are a haze of demands, orders and contradictions?" (2013, 9) This was not just an academic intervention. It was significant in at least two respects. First, it emerged in a period when the regulation of care in the UK was under

scrutiny for being overly-complex and potentially contributing to system failures.[1] Second, Bilton and Cayton's voices came from within the heart of the regulatory system. The paper was written in a personal capacity but the authors' affiliations were with the PSA (where at that time Cayton was Chief Executive, and Bilton a senior manager). The PSA is the body that oversees the regulation of health and social care in the UK. Its core functions include the reviewing of the work of professional regulators, accrediting registers of health and care professionals for those groups who are not regulated by law (e.g. acupuncturists and counsellors) and the provision of advice to regulators and governments on professional regulation. This includes overseeing the work of 10 statutory bodies that register and regulate health and social care professionals including doctors, social workers, pharmacists, physiotherapists etc. Some of these regulators set the rules for one professional group (e.g. Social Work England); others for a few (e.g the General Dental Council) and one—the Health and Care Professions Council (HCPC)—for 15 relatively diverse professional groups including Clinical Scientists, Occupational Therapists and Radiographers. It is significant that a high-profile thought piece authored from within that body raised concerns about the risks of getting regulation wrong.

Bilton and Cayton warn, in particular, of the need to combat the "moral and cognitive confusion" that arises from the many different kinds of regulation and the myriad agencies that inform or provide regulatory frameworks, rules and guidance. Complex webs of regulations, they argue, "may risk alienating professionals and cause them to disengage from the ethical decisions in front of them. It may also be true that the stress resulting from such moral confusion and cognitive overload is itself depleting and risks distorting professional judgement" (2013, 6). In order to combat these dangers, they suggest, it would make sense to work towards "a shared set of values of safe care on which all regulators can agree, expressed in a consistent language, style and tone". (2013, 10)

What is involved in creating a regulatory climate that is not based on what Bilton and Cayton label as "orders and contradictions"?

Professionalism and its regulation

The label "professional" can be used simply to note that a job, any job, has been done with relevant expertise. But this use is arguably derived from a circumscribed set of cases. A professional identity in this more circumscribed sense involves a social contract where an occupational group is granted special authority and privileges in relation to a domain of

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[1] The paper was published just after the report of the National Advisory Group on the Safety of Patients in England (2013) which called for the simplification of the England's National Health Service (NHS) regulatory system which it described as "bewildering in its complexity". It also appeared in the same year as the Francis Inquiry Report (2013) into failings at Mid Staffordshire NHS Trust—a report which made regulatory recommendations but also sparked a debate about the extent to which regulation might be part of the problem as well as the solution (Quick 2014).

practice in return for mechanisms that are judged to deliver appropriate kinds of technical and ethical standards. This is what enables professionalism to be what Freidson (2001) calls a "third logic" of social organisation—in addition to, and as part of the checks and balances on, the two "logics" of markets and bureaucracies. Here, professionalism is seen as transcending and mediating between the expectations of consumers and/or managers. A credible account of professionalism will thus combine two dimensions—both the idea that a role is performed well, with relevant expertise, and that it is a role in which the status of this expertise is officially recognised. Elsewhere we have, accordingly, summed up professionalism as "the accomplished exercise of expertise-based social authority" (Cribb & Gewirtz, 2015). In this sense professionalism requires professional regulation for its very existence. Professional regulation is one of the ways we draw boundaries between "non-professional" and "professional" work, as well as being about trying to ensure those who are regulated stay on the right side of the professional versus unprofessional boundary. Of course health and care workers have had very diverse routes to professional status. Only medicine is usually regarded as one of the longstanding established professions; with other occupational groups having moved through so-called "semi-professional" status in which forms of external governance and management have been more often taken for granted (Etzioni, 1969; MacDonald, 1995).

Some degree of professional regulation is, in this sense, non-negotiable. The regulations that oversee the kinds of qualifications and titles that workers are entitled to use, the programmes of education and training they must complete to be allowed to practise in the first place and the thresholds of performance that they must not fall below to continue to practise are precisely what enable professional practice to exist. On this model professional virtues and professional regulation are not in opposition but might be better seen as two sides of the same coin. This suggests that there are limits to how far professionals can reasonably complain about "box ticking", since the whole professional enterprise depends upon it in some general sense.

Although here we are focussing on one facet of regulation—statutory regulation directed towards the recognition, training and practice of specific occupational groups—it is important to note the range and elasticity of the idea of regulation. At its narrowest regulation can be construed as about the planned constraint of agents through the legal rules and sanctions of governments. But, in reality, regulation involves a range of agents—including trade and voluntary organisations as well as professional organisations. Regulatory influence can be seen as unplanned as well as planned, and as being facilitative as well as restrictive (Baldwin et al., 2011). That is, regulation can be harder or softer-edged and specific regulatory rules or guidelines fall on a spectrum from playing a "command" to an "enabling" role, albeit that most often we use the language of regulation to signal the harder end of the spectrum. At the softest or most facilitative end of the spectrum, the gap

between the regulator and regulated is arguably small and, ultimately, individual professionals can be seen as participating in their own self-regulation.

Regulation, including professional regulation, must also, of course, evolve and adapt to changing social contexts. It is not possible to review all such changes here but it is worth noting that one important trend includes the rise of what has been called "organisational professionalism" (Evetts, 2009) which effectively blurs the boundaries between Freidson's three "logics". That is, health and social care professionals have increasingly found themselves working in contexts where organisational cultures are dominated by combinations of managerialist and quasi-market norms. This includes the ever-present possibility of such norms—e.g. around individual "performance" and institutional targets and competition—colonising the subjectivities and values of individual professionals (e.g. Kerasidou et al., 2021). In this context, the protection of professionalism as an independent source of authority arguably becomes more precious as thereby do understandings of how regulation might best support the "ethical landscapes" of care.

To balance the fact that regulation is both constitutive of professionalism and yet also has the potential to do harm the PSA has, over several years, developed an approach that they call "right-touch regulation". The guiding principle here is clear in the name—there is no essential merit in regulation being either heavy or light, rather the focus should be on asking what are the right kinds and degrees of regulation needed for specific purposes. The PSA first offered an account of right-touch regulation in 2010 and has since reviewed and updated it (PSA, 2015). All of the elements of right-touch regulation underline the need to be proportionate. They include: using regulation only where it is necessary; keeping it simple; checking for unintended consequences; and reviewing it in the light of learning and change.

Right-touch regulation is thus about framing regulation differently. What matters is not just cutting down numbers of regulations (wherever they are not needed) but rethinking how regulations are understood and used. This framing encourages regulators to see regulation as part of a constellation of influences on care and for it not merely to be about formulating rules and requirements (although these are sometimes needed) but about working in concert with other actors and factors in signalling and strengthening values and cultures that enable good care. In other words, it invites attention to the ways that professional regulation can help underpin and forge professional identities and values.

Professional identities: Commonalities and differences

Work undertaken and commissioned by the PSA suggests that whilst in some respects regulation is a marginal consideration for professionals in other respects it can play a very important function in supporting their identity (PSA, 2016; PSA, 2018). The routine burden of caring and decision-making goes on at some distance from the regulation such that it is important not to load too much expectation onto regulation. However, an interview study

commissioned by the PSA indicates that regulation becomes particularly salient to practitioners when they think of themselves in the context of professional communities—communities that involve reliance on colleagues, and where things can sometimes fall below acceptable standards (Christmas & Cribb, 2017). The study analysed the views of sixteen health professionals from four different professional groups on the relationships between regulation, care and professional identity, with professional identity understood broadly as "an individual's conception of her/himself *as a professional*". (Christmas & Cribb, 2017, 4) It identified and labelled two commonly reported aspects of perceived professional identity: first, a fundamental commitment to help—along with its corollary, a fundamental commitment to do no harm; and second, a coherent way of understanding and intervening in the world, or professional stance—which is more than the mere aggregation of the knowledge and skills a professional brings to their practice. These indicate typical features of identity in health and social care but whilst the former, very general, orientation is in large measure a shared identity, the latter reflects the fact that aspects of professional orientation—practitioner's cultivated and embodied ways of thinking, seeing and doing—can vary between and "belong to" professional groups. The interviewees constructed the relationship between their professional identity and their individual practice as a reciprocal one: professional identity implies standards for one's practice; and practice in line with these standards is an expression of one's professional identity.

This study sheds light on the role of regulation by highlighting its developmental and validatory functions. At the level of their individual practice interviewees saw professional regulatory requirements—both access and practice requirements—as playing a critical role in the *development* of a strong professional identity:

- practice requirements play a central role as objects of discussion, reflection and learning, and in the formation of the individual standards associated with one's professional identity;

- access requirements play a key role in ensuring that individuals engage in this kind of focused consideration of practice requirements. (Christmas & Cribb, 2017, 47)

By contrast, according to this account, beyond this developmental function regulation appears to be often largely irrelevant to individual practice (and therefore care quality). As indicated above it can easily be dismissed as no more than: i) getting professionals to do what they would have done anyway or ii) promoting box-ticking exercises.

However, it is a mistake to see regulation supporting professional identity purely through this developmental lens. There are critically important collective dimensions to professional identity. As an individual, one should also be able to trust that the professional identities of others on a register—including the standards for practice which follow from those identities—are, in certain key respects, the same as one's own. This sense of alignment with

a wider community, via a common body or register, can provide a reciprocal validation of one's own professional identity and standards by that community. The developmental and validatory links between regulation and identity do not just operate at the conceptual level elucidated above but have correlates in practitioners' experiences. Although not everyone interviewed articulated this sense of a "community of practice" (Wenger, 1999) many did do so, for example, one pharmacist said:

> Our regulatory authorities control what we study, so at the university, we all do the same things and we all have to go through the same processes. And that's important that I can turn around and say to a colleague, can you go and talk to this patient because the such-and-such while I do something else, and I know they're going to get the same standard of care as if I went out, and vice versa. I think there's a lot of trust because of the General Pharmaceutical Council and because of, you know, the way we're trained... We don't need to prove anything to anyone else. The proof's in the pudding. The proof's in your number. And that's very important to all of us. (Christmas & Cribb, 2017, 33)

Thus regulatory requirements do not necessarily play a role in *making* decisions about how to act as a professional but they do play an important role in *justifying* such decisions. Alignment is established not because everyone on a register is checking the same codes and standards—they may not make much conscious reference to these—but because, if the worst occurs, everyone on a register is held to account by the same standards and register-holder, acting on behalf of the aligned community as a whole. In other words, starting with an account of professional identity that focuses on an individual's conception of him or herself as a professional opens up a sense of professional identity as inherently collective and social. This suggests that instead of thinking about regulation as a system of levers that exert direct pressure in the consciousness of individual professionals it is better to think of regulation as helping to create the communities and ethical landscapes within which professionals move. Just as organisational pressures and norms can construct and inflect the discourses and practices of professionals so too can the nexus of regulatory structures and processes. As we have argued elsewhere (Cribb, 2020) much day-to-day professional ethics is not consciously enacted but is "accomplished" below the surface as a result of the underlying "moral settlements" which provide the context and parameters for action. Moral settlements encourage or discourage attention to certain values—including specific sets of goals, obligations and dispositions[2]—rather than others. Regulation is one of the factors

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[2] These three terms (goals, obligations and dispositions) are being used partly because they provide a simplifying heuristic for acknowledging the multi-dimensional nature of ethics including the complementarities and tensions between (the emphases of) the most common ethical theories—consequentialism, deontology and virtue theory (see Cribb & Ball, 2005, for a longer discussion of this heuristic).

that help create such settlements. This entails paying attention to the creative potential of regulation to underpin, encourage and embody "ideals" and not only threshold standards.

Whilst this is a plausible general account of how belonging to the same regulated profession can help shape professional identity it also highlights a potential challenge for thinking about regulation inter-professionally. If part of professional identity is located in sharing the distinctive orientation of a particular profession then one might reasonably question how far regulatory frameworks can successfully "stretch" across professions. This issue circulated around the question of the social work profession in England being located, from 2012, inside the umbrella regulator—the Health and Care Professions Council and then being transferred to a new profession-specific regulator—Social Work England—in 2019. This second shift arguably made it easier for the regulator to "belong" to the profession. Of course, it is commonplace for professional regulators to draw upon the expertise of members of the relevant profession (as well as independent voices)—such that there is no clear distinction between "external regulation" and "self-regulation" for professional groups—but profession-specific regulation can expand this form of representation.

One important example of increased autonomy and flexibility in this case—which we will come back to—is the arrangements for dealing with complaints and "Fitness to practice" processes. The latter is an issue that illustrates the "harder edge" of regulation and the ethical relevance of regulatory power (Gunther, 2014). Unlike some of the softer developmental aspects of regulation, this is an area where regulatory influence can be seen in large measure as external to, constraining of and even threatening to, individual practitioners. It highlights another major ethical challenge of regulation—how far is it possible to balance the central goal of public protection with practices that are fair to professionals? The establishment of Social Work England allowed for a slightly different interpretation of, and approach to, this balancing act, which included a more flexible approach to managing complaints including some more arbitrated and consensual elements. This departure was also arguably rooted in a degree of divergence in professional philosophy. Social work operates in a hotly contested political and policy arena and tends to be more overtly reflexive about the ideological and professional contests it manages than many health professions. (Hugman & Bowles, 2012) This kind of difference in emphasis is likely to inform the approach of a profession-specific regulator.

This suggests contrasting implications for the two questions with which we began. In relation to partnership working between regulators and the professional groups, it suggests considerable scope for harmonious working (as well as areas of tension). However, the existence of separate and somewhat divergent professional identities suggests that there may be some difficulty in, and limits to, constructing integrated cross-professional regulation. We will say more about each of these in turn.

Working in concert

We have been highlighting that regulation can harness the spirit of professionalism and minimise the use of and need for "order-following". This shift of emphasis—away from more prescriptive and towards more supportive regimes—has been echoed in a range of areas. For example, the centre of gravity of safety policy has now largely consolidated around a paradigm which sees responsibility for safety diffused across the many actors that are bound together in complex social and care systems (e.g. Hollnagel. 2014; Weiner et al., 2008) According to this paradigm focussing the responsibility on individuals may often be both unfair to them and ineffective at the overall system level. Before one can reasonably resort to a "compliance" lens it is necessary to ask whether the right institutional policies, procedures, staffing and support are in place. There are concerns about whether some interpretations of this kind of "just culture" can go too far—attaching too little responsibility to individual professionalism (Aveling et al., 2016)—but a move in this direction is widely welcomed. The core idea here is of orchestrating concerted action within a social field.

Analogous moves have been made in thinking about the interface between professionalism and standardisation. This is an area where there is extensive scope for conflict—including fears that standardisation can erode professional discretion and undermine rather than support professional virtues. Nonetheless, we should also beware of the habit of looking at this question through a conflictual lens. For example, Martin et al. (2017) show how there can be productive convergences and mutual support between care pathways and professional autonomy. In a study of the implementation of care pathways in emergency general surgery, they illustrate the interplay between standardising approaches and professional discretion. This study clearly shows the possibility of a productive relationship in which care pathways are welcomed but nuanced so as to be fitted to particular sites and this very process is used "as a means of enhancing professional decision-making and inter-professional collaboration"(2017, 1314). Pathways, in this case, can support standardisation, but this is because the "standard" involved is amenable to being treated as a guiding framework rather than a rigid template. Martin et al. argue that this shows how it can be possible to transcend the contrast between professionalism and managerialism as these things are traditionally constructed and distinguished and to develop this point they situate their example as a possible case of what Noordegraaf (2015) labelled "organising professionalism":

> Instead of isolating professional practices from outside worlds, professionalism becomes connective. Professionals are still experts, but they are able to link their expertise to (1) other professionals and their expertise, (2) other actors in organizational settings, including managers and staff, (3) clients and citizens, (4) external actors that have direct stakes in the services rendered, and (5) outside actors that have indirect stakes. (2015, 201)

The relevance of this for regulation is evident. Regulators are clearly some of the key "external actors" that have a stake in services, and they also, in significant respects, represent the interests of clients and citizens, other outside actors (including governments) and, of course professionals themselves. So far as is feasible the optimum thing is for them to identify regulatory frameworks that bring these interests together. This account underlines the picture of regulation as a "meta-activity" i.e. as an activity that needs to adopt mediating and orchestrating perspectives and approaches. Pursuing this kind of orchestration will often mean constructing and seeing standards as supportive and guiding frameworks rather than rule books.

In this regard, the orientation of regulatory ethics is arguably evolving in ways that parallel and underpin broader trends in professional ethics. The zeitgeist in health and social care has for some time been to move away from "prescription" and towards partnership working. A widespread emphasis, in a range of areas, has been to close down gaps and open up forms of dialogue and mutual respect and recognition. Professionals and patients or clients are encouraged to "share" decisions; different groups of practitioners (including informal carers or "self-managers") are expected to work together in interprofessional ways and across institutional and system boundaries. In a policy context where dividing lines are being eroded, it is unsurprising that regulators are drawn into the perspectives and practices of partnership working. Furthermore, "dyadic" lenses—those that focus wholly on the practitioner-client pairing (or here the regulator-practitioner pairing)—have been enlarged and complemented by a focus on interacting actors, where responsibilities are overlapping and diffused. This is no doubt a more challenging model to think with but is also one that better reflects the realities of complex care systems.

Working across professions: Regulating for honesty

Just as there are new complications generated by partnership models in care provision (Entwistle et al., 2018) there are, of course, limits to and dilemmas in this partnership model being applied to regulation. It is not only in relation to fitness to practise that there can be a case for regulation to have a harder, more prescriptive, edge. Presumptions about the adequacy of professional virtues and the effectiveness of professional judgement can be misplaced. This may be because the broader conditions needed to foster, sustain and protect professionalism are lacking. In addition, as we have already indicated, some of the failures to achieve coherent "joined up" working may flow in part from the historical constitution of professional groups as diverse and separate "tribes". The landmark Kennedy report (2001) into the failures at Bristol Royal Infirmary stressed both these concerns including identifying a "co-existence of competing cultures", "tribalism" and "silos of responsibility". One example which connects to both of these potential challenges is the introduction and strengthening of the "duty of candour" regulations.

Being honest is one of the most common ways we can show respect to one another. However, in professional life—where service users are often dependent upon the expertise and probity of professionals—its importance is even more compelling. It is, for example, taken for granted in treatment decisions that relevant potential benefits and harms will be shared and practitioners will, so far as practically possible, not leave patients in the dark. But it is all too easy for these expectations not to be met when care goes wrong. A statutory duty of candour was introduced in 2014 in England and in 2018 in Scotland. It applies to all care provider organisations registered with the Care Quality Commission and places them under a legal duty to be open and honest when there have been failings in care. This statutory duty was installed in a system where it has long been accepted that a professional duty of candour exists—i.e. an equivalent duty of honesty applying to individual practitioners (rather than organisations). The introduction of the statutory duty also provided an opportunity for regulators to highlight, clarify and strengthen the level of emphasis upon the analogous professional duty.

The PSA was a significant policy actor in the period leading up to the introduction of the statutory duty and in addition it helped to support health and social care regulators to develop their approach to the professional duty of candour. One of the striking features of this process was that all the regulators overseen by the PSA took a self-consciously concerted approach to this challenge. They established a joint working group and developed a joint statement on the professional duty of candour, undertaking to review relevant standards as needed and to encourage their registrants to reflect on the importance of this duty. Initiatives in this area provide a clear case of regulation raising the profile, and underlining the importance of certain care values and, in large measure, doing this in a concerted voice. This thereby provides a significant instance of regulators heading in the direction that Bilton and Cayton envisaged in the earlier cited passage when they called for "a shared set of values of safe care on which all regulators can agree, expressed in a consistent language, style and tone". (2013, 10)

Nonetheless, the PSA's research into the implementation of the duty of candour indicated some complications (PSA, 2019). This research—which reviewed documents and used questionnaires and discussion groups to identify the steps taken and challenges faced by regulators—showed a concern from some respondents that even though a shared language and framework was valuable, in practice different professionals faced different experiences including inequitable levels of jeopardy in "fitness to practice" proceedings. This led one respondent organisation to underline the importance of inter-professional education that prepares staff to deliver the duty of candour in multi-professional contexts. (2019, 15) This is just one high-profile example of a challenge for inter-professional regulation in health and social care. Given that different kinds of professionals frequently work together closely in the same spaces, and given that inter-professional collaboration and service integration are increasingly seen as of critical importance to delivering high-quality care, then it makes

sense to ask how far professional regulation of such groups can continue to exist on parallel tracks, rather than itself becoming more collaborative and integrated. This provides a conundrum for professional regulation—can ethical landscapes be created that somehow both acknowledge the diversity of professional identities and, at the same time, work towards "shared values"?

Regulatory reform and collaboration

The key themes we have explored—supporting professionalism and collaborative working have recently come to the fore in the ongoing efforts of the UK government and devolved administrations to reform the system of professional regulation with a view to making it simpler, more consistent and collaborative and in key areas more consensual rather than adversarial. Current reform proposals (DHSC, 2021) start from the position that the legislative context is simply too complex—with too much variation between the legislation that covers the different regulators and unhelpful inflexibilities in the powers that regulators have. Regulatory diversity has been somewhat self-perpetuating because further adaptation by regulators is often path-dependent. What is proposed is to substantially simplify the background legislation and to provide all the regulators with the same governance and organising framework and powers. Within this broad framework, this will include more discretion over the adoption and adaptation of day-to-day regulatory practices.

In this evolving context, the PSA recently commissioned qualitative research into perceptions of the value of regulatory consistency. Interviews with patients, members of the public, and regulated professionals (Christmas et al., 2021), which used examples of divergence between instances of regulatory guidance and procedures ("regulatory items" for short) of different professions as prompts, suggest that most people have a default presumption that regulatory approaches for the different professions should be broadly the same rather than different. More precisely the common default presumption is that regulatory items should be the same unless there are good reasons for any differences. Such differences might, for example, be justified because the professions relate to patients, clients or the public differently—working in different settings, undertaking a different range of activity, managing different levels of risk, occupying specific roles within teams etc. Nonetheless, the predominant perception seems to be that this level of diversity cannot be used as a smokescreen to justify any kind or level of inconsistency. The arguments advanced by the respondents for this are varied but include:—that if a rule is the correct one it should be applied to all; that variations between regulators can be unfair to professionals—where the rules, procedures or possible penalties they face diverge for no good reason; that even where some degree of divergence is warranted then there is no good reason why the same minimum standards cannot be applied across the board; that consistency is simpler and that this makes things clearer and more navigable for everyone; and, finally and notably, that because different professionals work together in the same system their standards should, wherever possible, align and form a coherent whole. (2021, 68)

These perceptions broadly align with the spirit of the proposed reforms. Although these reforms encourage a greater degree of flexibility at the level of detail they are intended to underpin a system, and underline a message, that favours consistency. This emphasis is amplified by a proposal to place new duties on professional regulators—a duty to assess that any "local" changes to rules and procedures are proportionate, a duty of transparency and, significantly, a freshly coined and extended duty to cooperate—with other regulators as well as other stakeholders. Taken together these new duties could substantially off-set the chance of arbitrary divergence in the future and help underpin an increased emphasis on regulation as a collaborative and increasingly integrated enterprise.

One substantive area where regulatory change is being encouraged is with regard to "fitness to practice" proceedings. As things stand there is substantial variation in the fitness to practise powers available to the regulators. Furthermore, fitness to practice arrangements are seen as sometimes too adversarial and drawn out—causing stress to professionals and complainants, delay to the public, and being unsuited to the promotion of reflection and learning (DHSC, 2021, 59). The current proposals include a common fitness to practise process designed to tackle these shortcomings. The model adopted learns from the one spearheaded by Social Work England and mentioned above. It includes the provision to conclude a fitness to practise proceeding before it arrives at a panel hearing, using a consensual mechanism or an "accepted outcome process" based on a case examiner's recommendations. This has been one notable example of regulatory divergence—and the proposal is now to make this model available to all.

As already signalled this is an area where regulatory power is clear. If regulators are to steer away from "command and control" and to be seen as properly responsive they obviously need to exercise their powers to "police" professionals carefully. Within social work there has been a concern that fitness to practise hearings are only "procedurally fair" in a limited sense (Kirkham et al., 2019). This is because, it has been argued, they lack the perspective and resources to consider the responsibilities of managers and institutions and to set care failures in that broader context. Unless the activities of individual practitioners are understood in relation to their working contexts—including sometimes extremely demanding institutional pressures and constraints—such individuals risk being treated unfairly (BASW, 2019; Worsley et al., 2020). This is exactly analogous to the shift in patient safety management discussed above that has sought to relocate responsibility for failures amongst a broader set of institutional actors and to de-emphasise finding fault with front-line individuals. Clearly, the balance has to be different when it is precisely an individual's "fitness" that is in question but some analogous rebalancing seems appropriate. At the same time, of course, the protection of the public remains a central consideration for regulators and this sharply highlights one of the key ethical balancing acts mentioned above. As a result, the broad shift from adversarial towards consensual models may need to be tempered in some circumstances. As regulators move towards encouraging and embodying

ideals of respect, partnership and co-operation with professional groups they cannot neglect their responsibilities for threshold standards and for representing the interests of service users and the public. Ideally, regulators will have in mind the need to encourage excellence, including professional virtues, and at the same time to strongly protect the threshold level of professional obligations—the combination of which may itself involve some balancing acts. Promoting the best in people and safeguarding against the worst both matter, and both can be put at risk by institutional pressures that can sometimes embody a crude utilitarian outlook rather than richer and more complex conceptions of purpose.

Conclusion

We have argued that the orientation of professional regulation is ethically important. The work of regulators merits ethical scrutiny in relation to the messages that it sends and, in particular, the norms and ideals it reflects, encourages and models. Iris Murdoch showed how a view of ethics that treats it purely as about agents making a series of discrete decisions is very impoverished. Ethics is, crucially, also about the frames and visions that we start from (Hepburn & Murdoch, 1956). Even if it is not seen as such, or even noticed, much of the work of the ethics of regulation is done in the way regulation is framed and the ideals and purposes brought to it. By drawing on the case of the UK health and social care regulatory system we have argued that care quality is best protected when professional regulation and professionalism are seen as co-constitutive. In particular, we have looked at the role of, and the leadership offered by, the UK Professional Standards Authority to illustrate some of the changing visions underpinning professional regulation. One overarching trend, we are suggesting is the pursuit of greater coherence. This includes both an increasing emphasis on harnessing professionalism by aligning regulation, where possible, with the ethical compasses and self-regulatory practices of professionals; and also a gradual but clear shift towards valuing and promoting consistency and partnership working between different regulators. This, as we have noted, echoes and supports shifts in the way front-line professional activity is conceived, including the recognition of the complexity of care systems and the centrality of collaborative working. As with front-line professionals, the move from a prescriptive towards a partnership mindset in regulation is not clear-cut, and is one that brings new uncertainties and tensions in its wake.

So whilst we would welcome, rather than resist, the direction of travel, it is equally the case that it carries difficulties and that regulation involves ethical balancing acts which cannot be dodged. The work of regulators necessarily includes both, on the one hand, encouraging and enabling professionals and, on the other hand, challenging and constraining them. Professional regulators must, for example, continuously navigate the tensions between protecting the public from poor care quality and ensuring professionals are not treated unfairly in the process. Similarly, there are good arguments for both commonalities and divergencies between regulators. Health and care professions embody different roles, relationships and orientations but, at the same time, they often work together in shared

spaces and endeavours. There are no easy answers here. In this respect, the ethics of regulation is simply like all ethics—inherently dilemmatic. Nonetheless, we would argue that bringing the ethical role and dilemmas of professional regulation into view is potentially very productive. Instead of falling back into sometimes taken for granted assumptions about compliance-centred conceptions of regulation it allows us to ask questions about the creative, constructive and ideal-oriented possibilities of regulation as one foundation of both professionalism and care quality.

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Article history

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