Patient, carer, public and professional perspectives on the principle of consistency in health and care professional regulation

Simon Christmas, Fiona Fylan, Alan Cribb

May 2021

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EXECUTIVE SUMMARY

Qualitative research was undertaken to explore the views of patients, carers, public and professionals on the value and potential drawbacks of consistency in the regulation of health and care professionals. The objectives of the research were:

- To explore with patients, the public and registrants to what extent, when and why consistency in health and care professional regulation is valuable, including in terms of coherence across the different health and care professional regulators and confidence in the system
- To explore whether patient, public and registrant views on consistency between health and care professional regulators differ according to regulatory function (standards, education and training, registration, fitness to practise and continuing fitness to practise)

12 group discussions were run with patients, carers and public, each with four participants and lasting up to two hours, alongside 13 interviews with health and care professionals. The approach taken to these conversations reflected a number of challenges posed by the topic including the likelihood that participants would lack both preformed views on the often complex and technical questions to be addressed and, in many cases, the detailed knowledge of diverse professional practice that might be needed to form firm views. To help address these challenges:

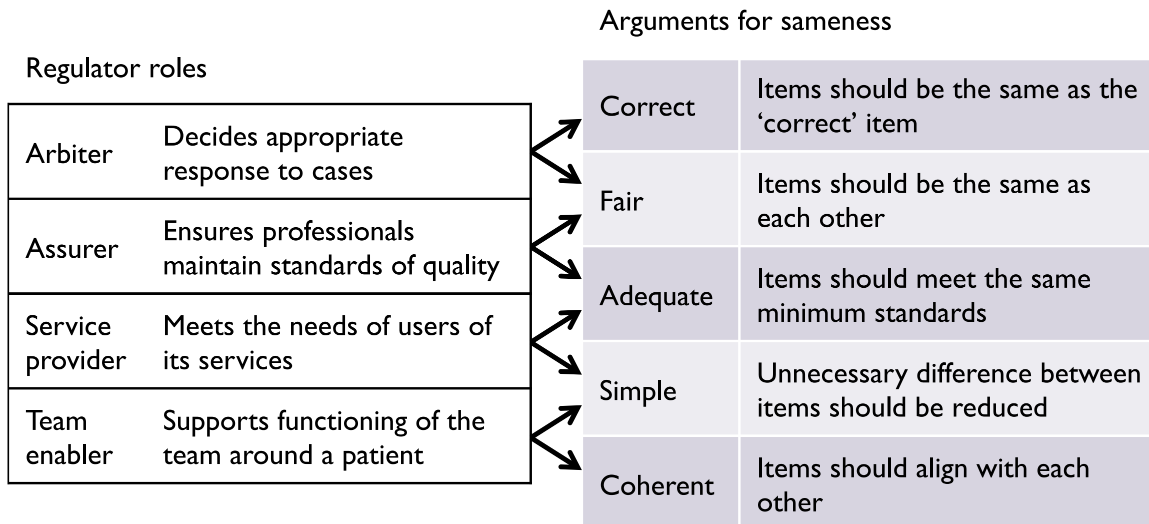
- Illustrative examples of current differences in the regulation of different health and care professionals (based on publicly available information about the regulators and their processes) were used as stimulus for conversation, providing participants with a way in to the discussion of complex and unfamiliar topics.
- Participants were asked to explore what should be the *same* (and why) and what should be *different* (and why) – and the more nuanced and sometimes ambiguous term 'consistent' was avoided unless used by participants.
- Analysis was focused not on *what* participants thought (which was sometimes a function of other, incorrect beliefs) but on *how* they developed their arguments (whether or not the premises those arguments were based on were in fact true).

Using this approach, it was possible to identify clear patterns in the logic used by participants of all kinds – patients, public, carers and professionals – when thinking about when, how and why regulation should be the same or different across different professional groups.

Arguments for 'sameness'

There were clear patterns in the arguments made by participants for making regulation the *same* across different professional groups. Five distinct kinds of argument were identified, each with different implications for the *kind* of sameness sought – but each resting on an appeal to an *underpinning similarity* between professions.

Which argument was seen to be relevant to any given example depended not on 'regulatory function' (e.g. standards, education and training, registration, fitness to practise, continuing fitness to practise) but on the *role* the regulator was seen to be playing by the person making the argument. The table below summarises the five arguments for sameness and their connection to the four roles identified.

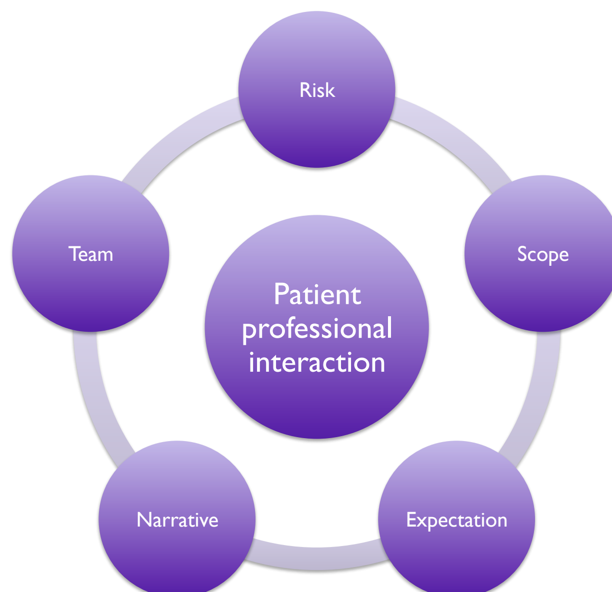


Note that the four roles are *not* objective descriptions of what a regulator is doing (as the 'regulatory functions' are) but ways of *seeing* the role of regulators that were apparent in participants' responses and assumed in their arguments.

For example, in relation to fitness to practise proceedings, regulators were often seen by participants as playing the role of an 'arbiter' – often apparent in the use of analogies and language from the criminal justice system – with an associated focus on arguments around correctness and fairness in relation to, for example, the application of sanctions. At the same time, regulators were often seen in the role of a 'service provider' in relation to activities such as setting time limits for making decisions or providing updates – with the focus here being on arguments around adequacy and simplicity. Only a few participants saw the role of regulators in fitness to practise as that of an 'assurer', and this was reflected in the development of a different mix of arguments (around fairness and adequacy).

Arguments for difference

Participants also explored a number of reasons for difference in the way that different professionals are regulated. Most of these related to differences in the interaction between professionals and patients, and were used by participants across all of the examples discussed.



Five key kinds of argument were identified – although unlike the arguments for sameness presented above, these overlap and tend to blur into one another.

- Risk – how much harm different professionals can potentially cause
- Scope – the potential extent (bodily, mental) of both the harm and the good a professional can do
- Expectation – the implicit or explicit contract for what will and will not happen in the interaction, and what will be achieved
- Narrative – how interactions start; how many there are, over what timeframe and lasting how long; and how they come to an end
- Team – the role played by professionals in relation to other professionals who form part of the team around a patient

Participants also discussed a sixth kind of difference of particular relevance to continuing fitness to practise and quality assurance in training and education: the speed of change in different areas of professional expertise.

Unexplained and unjustified differences in regulation can prompt two differing kinds of response. On the one hand, trust in regulators could lead to the assumption that there must be a good reason for the difference. On the other hand, the absence of an answer could lead participants to question how much they should trust regulators. Some professional participants interpreted differences between regulators as evidence of different stances by those regulators towards their registrants (e.g. more or less 'punitive').

'Sameness', 'difference' and 'consistency'

While cataloguing the above arguments for sameness and difference is an important first step, it is important to note that the overall position taken by a participant on a topic was sometimes neither a simple argument for sameness nor a simple argument for difference, but a balance between the two.

Both sameness and difference need to be justified and brought into a proper relationship with each other; and it is in this proper relationship that something worthy of the name 'consistency' is most likely to be found. For our participants, advocacy of 'consistency' was rarely ever a simple matter of asserting that regulators should operate identically. Instead, in their responses, they teased apart the value of different *kinds* of sameness, reflecting different assumptions about the roles played by regulators and requiring different kinds of harmonisation. And they weighed the value of these different kinds of sameness against the value of justified differences in process, principle and outcome. Through these arguments run a few fundamental principles:

- Sameness needs to be justified on the basis of an underpinning similarity between professions. To the extent that different professions are seen as being the same in some important respect – they all work in health and care, they all see patients, they are all in positions of trust, etc – so too relevant aspects of their regulation can be expected to be the same.
- Difference needs to be justified on the basis of a difference that makes a difference. To the extent that different professions are seen as being different in some important respect – the scale or scope of harm they can cause, the expectations patients bring to an interaction with them, the role of that interaction in a broader narrative, etc – so too relevant aspects of their regulation can be expected to differ.

- Both then need to be accommodated by the relationship between principle and application, or process and outcome. For example, the need to reflect *differences* in the risk of harm between professions might best be achieved by applying a single, shared principle – hence the *same* principle for all – of risk-based regulation; or by implementing a single shared process – the *same* process for all – that treats risk of harm as an input and adjusts outcomes accordingly.

Consistency, we propose, can be understood as the outcome of this process of justifying and accommodating both sameness and difference, in the context of underpinning assumptions about the role being played by the regulator. To put the point another way, consistency is a noun in search of the verb that creates it.

INTRODUCTION

This research forms part of a larger programme of work by the Professional Standards Authority to develop its thinking about the principle of consistency in the context of health and care professional regulation.

The need for work on consistency arises from a mix of long-standing and more contemporary issues in relation to regulation. Consistency is one of six principles of good regulation set out by the Authority in 2015 in *Right-touch regulation*. However, this list is itself derived from earlier work on regulation by the Better Regulation Executive; and the idea that regulatory activity should be consistent has deeper roots still. Indeed, it is hard to see how activity which lacked *any* kind of consistency could qualify as 'regulation' in a meaningful sense.

The observation that consistency is an essential part of regulation, however, leaves plenty of questions still to answer. How much consistency? In what? Between whom? To what end? In the context of health and care professional regulation, these questions are sharpened by the existence of more than one regulator. It is completely possible for each regulator to be entirely consistent in *its own* activity but for inconsistencies to arise *between* regulators. The piecemeal development of the sector may have added to the likelihood of such inconsistencies arising.

Does inconsistency between regulators matter? A number of arguments *for* greater consistency can and have been made, including that:

- Consistency is an essential component of fairness. This connection is, arguably, a matter of semantics. Definitions of fairness typically highlight the idea of treating people equally without bias or favouritism: and the word 'equally' is essentially a synonym for 'consistently' here.
- Consistency underpins the trust of patients, public and registrants. Trust in another person or body depends, among other things, on a belief that their activity is fair and predictable, and consistency supports these beliefs. In this case, the consistency needs also to be *visible* (much as justice needs to be done *and* seen to be done).
- Consistency removes barriers to patients, public and registrants engaging with regulation. Inconsistency creates barriers because, for example, what one had learned from engaging with one regulator cannot be transferred to engaging with another. Failures to engage with regulation may lead to other outcomes, such as poor quality or compromised safety.
- Consistency facilitates collaboration. This is an increasingly important issue given the increasing importance of multidisciplinary teams in many areas of healthcare. Inconsistencies between regulators could create barriers to collaboration between the professionals regulated by those regulators.
- Consistency is more cost-effective. Barriers to engaging with regulators or to collaboration between professionals can take time, effort and therefore money to overcome. The existence of inconsistent regulation may also mean that 'wheels' have unnecessarily been 'reinvented'.

At the same time, arguments *against* greater consistency – and in particular greater consistency *between* regulators – can and have been made, including that:

- Consistency is antithetical to autonomy. Indeed, this particular contrast is presented as if it were a boxing match in the Law Commissions Report (2014), which includes a section entitled 'Consistency versus autonomy'. It is worth noting, however, that what the report then discusses is in fact the *imposition* of consistency. It is *imposed* consistency that is antithetical to autonomy. Autonomous agents can, presumably, choose to make their activity consistent of their own volition.
- Consistency leads to inflexibility. For example, the extraordinary circumstances of the global pandemic have meant that regulators have had to flex their ways of working. This might not have been possible if there had been a requirement to maintain consistency. (On the other hand, it could be argued that greater consistency between regulators might have *facilitated* flexibility at the level of registrants, in line with the points above about consistency facilitating collaboration.)
- Consistency prevents innovation. Whatever else it means, consistency suggests at the very least doing things the same or getting the same outcomes. Innovation, by definition, is about doing things differently and getting different outcomes. There is at least a *prima facie* case to be made that consistency could therefore get in the way of innovation.

All of the above arguments can and have been made. (Please note that we are in this introduction summarising and noting them, but NOT endorsing – or rejecting – them.) Significant efforts have been made to establish which arguments are good ones, in which contexts, and why: and, in parallel with this research project, the Authority has continued these efforts with a review of literature and ongoing engagement.

What is largely missing, however, is an understanding of the views of *patients, public and registrants* on these arguments. Which do they think are good, in which contexts, and why? That is the key evidence gap this research has sought to address, by exploring and reporting on the views of patients, public and registrants on the value and potential drawbacks of consistency.

The research objectives were:

- To explore with patients, the public and registrants to what extent, when and why consistency in health and care professional regulation is valuable, including in terms of coherence across the different health and care professional regulators and confidence in the system
- To explore whether patient, public and registrant views on consistency between health and care professional regulators differ according to regulatory function (standards, education and training, registration, fitness to practise and continuing fitness to practise)

METHODOLOGY

Design considerations

A key challenge for the design of a research project of this nature was to find a way to engage participants in a meaningful discussion about an abstract and unfamiliar topic in a relatively short space of time.

In this section, we briefly summarise the key considerations which shaped our approach to the research design.

Exploring how not what participants think

It was our expectation – borne out in practice (see §1 of the Findings) – that participants would arrive at workshops and interviews without *either* preformed views on the topics to be discussed *or* (in most if not all cases) the detailed knowledge of diverse professional practice needed to form firm views on these topics. To have explored *what* participants thought in any meaningful sense would have required, for example, a robust deliberative approach with structured input from and dialogue with experts. However, an approach of this kind was neither within the scope of the current project nor, given its objectives, necessary.

Instead, we have focused from the outset on exploring *how* participants think about these topics: what arguments they use, in what contexts, and how they assemble these arguments to arrive at a position, however tentative. Logic, not content, has been our analytical focus.

Hence participants were encouraged to reason using their own existing beliefs and surmises about professional practice as a starting point, and arrived at views based on these existing beliefs and surmises. Interviewers also made clear at the outset that the conversation was not designed to inform participants, and stressed that even the examples used to stimulate conversation could potentially include some inaccuracies, despite best efforts. (Participants were also offered routes to further information if required as part of the research process).

Readers of this report may disagree strongly with some of the views expressed in quotations about what particular groups of professionals do or how they relate to each other – just as, in the groups, participants sometimes disagreed with each other – but, stated simply, this is not the point. What matters, from an analytical perspective, is how participants reasoned *to*, *with* and *from* these views.

Avoiding confusion about 'consistency'

'Consistency' is one of those words that hovers between being *descriptive* and *evaluative*.

The evaluative sense of the term is apparent in the fact that its direct antonym, 'inconsistency', is never a good thing. To say that something is inconsistent is to say that *it should have been otherwise*. For example, different professions and specialisms are taught very different things in their training, but no one would describe this as 'inconsistency'. In this evaluative sense, 'consistency' means something like: 'things that *should be the same* are the same'. This is the

kind of consistency that is valuable in itself – but not in a very informative way, since it leaves unanswered the question: *what* should be the same, and *why*?

However, consistency can also be used in a more descriptive sense, with a meaning closer to 'things are the same – whether or not they *should* have been'. It is this sense of 'consistency' which underpins many counter-arguments. A frequent concern is that sameness may be imposed even when there are good reasons for difference.

A useful idea here, taken from the private sector, is the need to strike a balance between the 'hopelessly local' and the 'mindlessly global'. Those championing consistency (in its evaluative sense) are often reacting to what they see as the former. Those questioning the push for consistency (in its descriptive sense) are often resisting what they fear will be the latter.

We were keen *not* to get mired in these potential sources of confusion when talking to patients, public and registrants. With this in mind, we avoided talking about 'consistency' and instead focused on the questions that underpin the concept:

- What should be the same, when, and why?
- What should be different, when, and why?

Types of consistency

A further challenge follows the above questions: 'What should be the same?' and 'What should be different?' The challenge arises from sheer range of *types* of answer that can be given to these 'what' questions.

For example, questions of consistency arise, potentially in very different ways, in different areas of regulatory activity and in relation to different regulatory functions (e.g. standards, education and training, registration, fitness to practise and continuing fitness to practise). Within each of these areas, moreover, questions about consistency can focus on different things and at different levels. For example, *Right touch reform* highlights one key distinction in the discussion of fitness to practise: the distinction between outcomes and process. Outcomes can diverge (i.e. 'not be consistent' in the descriptive sense, though this does not make them 'inconsistent') even though and indeed because the process is consistent (in the evaluative sense). With respect to process, moreover, consistency can occur at different levels: for example, at the level of underlying principles and values, at the level of broad process steps, or at the level of procedural detail.

The research challenge was to facilitate a meaningful conversation which covered these different types and levels of consistency across different areas of regulatory activity. The challenge was sharpened by the expectation that, for most patients and public, regulatory functions, the distinctions that underpin them and the language used to describe them would be unfamiliar and, even if explained, abstract. Even for registrants, knowledge seemed likely to be limited.

To address these challenges, an approach based on the discussion of examples was used. These examples were developed by the research team in collaboration with the Authority, based on publicly available information about the regulators and their processes. A final selection of examples was made to prompt discussion about a range of regulatory functions and types/levels of consistency. The full set of examples used is presented in the Appendix.

Consistency between whom?

The final challenge related to the category of 'health and care professionals'. From a legal perspective, this is clearly a meaningful category, defined by statute. But that did not mean that it would necessarily be a meaningful category from the perspective of patients, public or professionals.

For example, we anticipated that some patients and public might expect consistency in some of the standards to which *all* of those working in GP practices are held, independently of which profession they work in (or indeed whether they are a health and care professional at all), but not expect those same standards to apply to other registrants of the same regulators working in other settings.

In so far as was possible, we needed a process that avoided imposing too rigidly the legal category of 'health and care professionals' and allowed the emergence of the categories which patients, public and registrants themselves use to make sense of differences and similarities in regulation.

With this in mind, a list of the kinds of professional under discussion – reproduced below – was presented early in all conversations, with interviewers also taking this opportunity to remind participants that regulated professionals work not just in the NHS but in a wide range of different settings and contexts. The list was used again at points throughout the conversation, with participants encouraged to consider how their arguments applied to different professionals, and whether any relevant distinctions or groupings were apparent to them.

Hospital nurse	Pharmacist	Optometrist	Psychiatrist	Midwife
Osteopath	Mental health nurse	GP	Dentist	Podiatrist
Social worker	Physiotherapist	Surgeon	Radiographer	Paramedic
Audiologist	Community nurse	Clinical psychologist	Oncologist	Dental nurse

Sample

Patients, carers and public

For the purposes of recruitment, public participants were divided into three categories.

- Patients were defined as a) those with one or more long-term conditions which meant they were in regular contact with heath and care professionals and/or b) those who had in the previous two years had one or more periods during which they had needed a lot of help from health and care professionals.
- Carers were defined as those responsible for the care of another adult in a non-professional capacity, and interacting with health and care professionals on a regular basis in that role.
- Public were defined as anyone who was neither a patient nor a carer.

With regard to the patient sample, quotas were applied to ensure a mix of long-term conditions and acute episodes, and representation of co-morbidities. Given the circumstances of the research, a quota was also set to ensure that acute episodes were *not all* related to the pandemic – although pandemic related episodes were not excluded.

Six groups of patients, two groups of carers and four groups of public were recruited, each with four participants. One patient and one public participant failed to attend their groups, meaning the totals participating were 23 patients, 8 carers and 15 public.

Participants were free recruited by professional field recruiters to a specification provided by the research team, and remunerated for their time at industry standards rates.

Groups were structured by age and socio-economic group, as per the table below. Groups were recruited to be evenly split by gender. The sample as a whole was recruited to include participants from all four nations of the UK, a mix of urban and rural settings, and diverse ethnicities.

Group	Sample	Age	SEG
1	Patients	18-29	ABC1
2	Patients	18-29	C2DE
3	Patients	30-59	ABC1
4	Patients	30-59	C2DE
5	Patients	60+	ABC1
6	Patients	60+	C2DE
7	Public	18-59	ABC1
8	Public	18-59	C2DE
9	Public	60+	ABC1
10	Public	60+	C2DE
11	Carers	18-59	As it falls
12	Carers	60+	As it falls

Professionals

13 professional participants were recruited, all of whom were registrants with one of the 10 statutory regulators overseen by the Authority.

Participants were recruited either by professional field recruiters or via the researchers' networks, and remunerated for their time at industry standard rates.

Professional roles were selected to ensure a mix not only of professions and regulators, but also working context – including secondary care, primary care practices, community teams, and high street practices – and team working arrangements. Given the circumstances of the research and the extreme pressures on NHS staff, some pragmatism was required with regard to the selection of secondary care roles in particular.

Professionals in the following roles participated: Dental Nurse, Doctors (GP, Psychiatrist), Midwife, Nurses (Charge Nurse, Practice Nurse), Optometrist, Osteopath, Paramedic, Pharmacist, Physiotherapist, Radiographer, Social Worker

Across the professional sample, diversity was ensured in terms of:

- Experience
- Gender
- Ethnicity
- Location – with representation from a mix of urban and rural settings and across the four nations of the UK

Method

Conversations

Given the circumstances of the research, all research conversations were conducted using video-conferencing software.

- Patient, carer and public participants attended a group conversation facilitated by a member of the research team and lasting up to 2 hours.
- Professional participants attended a one-to-one interview with a member of the research team lasting up to 90 minutes.

Conversations were recorded and transcribed, in the first instance using automatic transcription software and subsequently, as required, by the researchers. Full informed consent for participation, including the recording and use of data, was gained at recruitment and confirmed at the beginning of conversations.

The main body of conversations was structured around discussion of examples of differences in the regulation of health and care professionals (see Appendix). Discussion of each example followed the same broad pattern, as shown below (illustrative questions are provided for each step).

1. Elicit responses.
   What's your response to this difference? Does this seem right, or should things be the same?
2. Explore reasoning behind response.
   Why does this matter?
   What difference does it make? To whom?
   How does this make you feel about these regulators / these professionals?
3. Explore the factors which are driving this reasoning. This involves a flexible response from the facilitator, depending on participant responses.
   a. If participants differ in their responses or reasoning, explore those differences.
   b. If there are no differences, invite participants to think of e.g. reasons for giving the opposite response.
      Suppose someone took the opposite view from you. Why might they think that?
4. Prompt directly on specific factors for that example/element that have not been raised unprompted by participants.
   Suppose I argued these should be different/the same because… What would your response be?
   One argument I've heard is… How do you react?
5. Cover any additional topics to be covered in relation to that example.

Considerable flexibility was needed in the how this process was enacted in practice. For example, following client responses often meant moving back and forwards in the process rather than following it in a strictly linear way. Variation was also needed to prevent the discussion of examples becoming repetitive.

In so far as was possible, the intention was to allow participants to identify and develop arguments in their own terms. However, Step 4 of the process was included in recognition of the fact that some participants and groups might struggle with a task that, despite the use of examples, remained unfamiliar and abstract. In practice, interviewers did not have to use Step 4 as much as had been anticipated, as most participants were able to engage with the task to at

least some extent. After the first few conversations, it also became possible to prompt conversations at Step 4 with arguments heard in previous conversations.

For patient, carer and public groups, the planned order for examples was as shown in the Appendix. For discussions with professional participants there were two key variations in the planned order:

- Examples E1 and E2 were addressed at the beginning of the interview. (These examples were optional in the patient, carer and public groups, and only discussed if time allowed.)
- Example D was often addressed directly after Example A.

In practice, the order of examples was flexible, and could be varied to reflect the way in which conversations were developing. This happened in particular in the one-to-one conversations with professionals.

Conversations concluded by returning to the prompt list of professionals shown at the beginning of the interview and referred to at points throughout the conversation. Participants were asked to reflect on similarities and differences between the professions shown in light of the discussion.

Analysis

An iterative approach to analysis of transcripts was adopted, as follows:

1. Material relevant to themes, observations and patterns was grouped together and reviewed. This included supporting and counter-evidence for each point.
2. The initial long-list of themes, observations and patterns was then revised and developed:
    a. Items were provisionally validated, refined/sophisticated to reflect supporting material, qualified to reflect exceptions, replaced with a better item, or rejected entirely as unsupported.
    b. In particular, over successive iterations, themes (categories) were replaced with propositional findings (statements).
    c. Where needed, items were grouped together to create new superordinate categories/statements, or split to create separate items. Connections between items were also noted.
    d. New items were added as needed: in particular, material which had not been grouped under existing items was reviewed, and new items were identified.

   Review of the material focused not just on what participants said, but also on how they said it and in response to what. Care was taken to ensure that material which was grouped under items contained adequate indication of context: for example, researcher questions or notes on what had happened earlier in the same interview.
3. The new revised list of themes, observations and patterns was then used as the starting point for a new round of grouping (step 1) and reviewing (step 2). The process was iterated until a stable, propositional structure emerged which both was supported by and accounted for the evidence.

A final detailed evaluation of the relationship between propositional findings and evidence was also undertaken. Where necessary, final checks were also made on the original context of material, to ensure it was not being quoted out of context.

Contributorship: SC and FF designed and conducted the fieldwork and contributed to all aspects of the work; AC joined the analysis and writing phase of the project.

FINDINGS

1. Starting points

1.1 Pre-existing knowledge and engagement

Public, patient and carer participants started the research conversation from a position of, at best, very limited knowledge about and engagement with the regulation of health and care professionals.

For instance, while participants were often aware that professions like doctors and nurses were regulated in some way, surprise was expressed at the number of regulated professions and the number of regulators covering them.

> *I didn't know that you had to be registered. Not all of them. Not the whole list that you put up. Like your doctor and your GP and your dentist, I knew they have to be registered. But some of those other ones… [Patient]*

> *I didn't realise there were so many different regulatory bodies and rules for each healthcare professional. [Public]*

> *I was unaware that there were so many regulators. […] I suppose it's good to know that they are regulated, but it is interesting to see how different they all are. [Carer]*

There was also low awareness of public registers: and while some participants appreciated their existence others struggled to imagine why they would ever want to use one.

> *I didn't even know that this service existed. [Public]*

> *I didn't know that this existed. […] It's good that that register exists, so you know that they're real. [Patient]*

> *I never looked up to see what qualifications anybody had or how long they had been qualified for. […] It's word of mouth rather than look up their qualifications. [Patient]*

> *I don't understand why you would want to look up somebody's… Why would you want to do it? Why would there be a need to do that? […] I wouldn't really see that as my job. The public. I would see that as the employer's job. [Public]*

A professional participant expressed similar doubts about the likelihood of members of the public using the public registers.

> *If you're going to get your eyes tested, how many members of the public are going to ask to see the optician's qualifications? […] If you've got an all-singing all-dancing shop, with lines and lines of glasses and a receptionist, you just assume that person is fit to practise. Whereas if you go into a hospital and somebody is in a uniform and in a department, and they've got an ID badge on, then again, you're going to have that comfort that that person is fine. [Registrant]*

Given their limited knowledge about and engagement with the regulation of health and care professionals, it was perhaps not surprising that participants sometimes drew on parallels with their own work experiences in trying to make sense of the examples presented to them.

I'm just thinking about the way my industry works in terms of when I go out to work, and I have to go in certain areas or rooftops and things like that, I often get regulators coming out to check that I've got the correct credentials, paperwork, to be doing what I do. [Public]

Participants also acknowledged low levels of knowledge about what some regulated health and care professionals actually do. Even when they *thought* they knew, these beliefs were not always correct.

I don't know what an audiologist does. [Patient]

I don't know, is an osteopath…? I don't exactly know what an osteopath is. [Patient]

I just believe a dental nurse, when they get the experience, becomes a dentist. [Patient]

This low level of knowledge will be apparent in many of the quotations presented in this report. Participants reasoned about the examples using their beliefs, assumptions or surmises about the actual facts of professional practice. (Note, however, that this is not an issue for this research, given that it is focused on the *logic* of the arguments developed, not the *facts* to which that logic was applied: see the section on Design Considerations).

Low levels of knowledge of what *other* professions do was also acknowledged by *professional* participants.

I'm confused as well about how it works with [pharmacists] because you get like hospital pharmacies and pharmacies employed by the CCG. But then you've got your high street pharmacist… [Registrant]

I don't know enough detail about other people's professions, which is terrible. [Registrant]

Moreover, while professional participants were of course more knowledgeable than public, patients and carers with regards to regulation of *their own* profession, responses suggested that they rarely if ever compared this to the regulation of other health and care professionals.

I think as professionals possibly we're quite singular, and we only really think about our own profession and what our sort of code of conduct is. [Registrant]

Strikingly, the two professional participants who *did* talk about having had conversations about the differences between regulators indicated that these conversations were prompted by news items about sanctions, and took place in informal contexts – with mixed professional families being highlighted by one as a likely site for comparisons to take place.

So-and-so – without putting any labels or professions at this minute in time – but so-and-so did this – x, y and z – and the outcome was, you know, it wasn't his usual character and his fitness to practise isn't impaired and we need doctors in the NHS at this time, so we're going to allow him to continue working after one month's supervised practice. And then you think: well, if that was a paramedic, they'd have been struck off. [Registrant]

I have a daughter who is a qualified [health professional, different from speaker]. I will state that now because some of the things about regulation we, me and her, talk about regularly. […] I think it's around what one organisation thinks is fitness to practise, and another organisation doesn't. Or, how it's interpreted as punitive. […] Quite often, she'll be on the phone reading like a [professional] journal or something, and go: what?! And then it would just be dad and daughter talking. […] I know other

families that are full of medics and those sorts of conversations quite often come up. [Registrant]

Even in relation to *their own* professional practice, professional participants' responses suggested that regulators can be a rather remote influence compared to other actors such as professional bodies, employers, managers and colleagues.

How do I engage with the regulator? Only when I need to. If I want information, I'm more likely to go to the [professional body]. [Registrant]

In light of the above, it was not surprising that participants of all kinds often did not have set or settled views on the questions raised by the examples used in the research.

I don't know. This is really hard. [Public]

I'm not really sure, because I think… oh, it's really hard, isn't it? […] I haven't really thought about it. [Registrant]

I think I've changed my mind on this because I was giving everybody the same code of conduct, but… I don't know. There's certain ones that I think should have a different one now. [Patient]

Faced with an unfamiliar and often quite abstract question about the extent to which different professionals should or should not be regulated in the same way, participants of all kinds often began by focusing instead on the *substantive* issue raised by an example. For instance, in response to the example of differing treatment of anonymous complaints, participants would give their views on the rights and wrongs of anonymous complaints, and struggle to engage with the question of whether this *should be the same or might differ* for different professions. (See §2.1 for further discussion of this pattern.)

Nevertheless, most participants were able to move beyond these responses to substantive issues and engage with questions of sameness and difference: and at this point, an important distinction became apparent. Even in the absence of a pre-existing view on a topic an argument has to start *somewhere*. More specifically, a discussion of sameness or difference has to start from one of those two options: sameness, or difference.

1.2 Starting from sameness

Most often, the starting point for discussion was sameness, expressed through some version of the statement: 'I don't see why it is *not* the same.'

I don't see why it should be different. [Registrant]

That doesn't seem to make sense. You'd have thought that should be the same across the board. [Patient]

I don't understand then why there's other ones who only have the two options. [Patient]

It seems arbitrary, doesn't it? [Registrant]

I can't wrap my head around why they would be different. [Patient]

Statements like those above represent a potential starting point for further thinking. Often they were followed by an explicit search by the participant for reasons why things might in fact need to be different.

My gut instinct is to say that it should be the same. So if you could make an anonymous complaint against one professional, then you should be able to make an anonymous complaint against another professional. […] I don't know why you wouldn't… that couldn't be the same. I'm not sure. I'm sure there are reasons, I'm sure, but I just think: well, what would the reason be? [Registrant]

I don't really know why the timescale… times differ for the person being on a register. Is it to do with the severity of the different…? Um, it might be more severe for a doctor doing something to be suspended compared to a physiotherapist doing something to be suspended. [Registrant]

Indeed, participants would sometimes start from sameness but then convince there were in fact reasons for difference.

I was just assuming that all of the information that they would have about all sort of medical professionals would need to be the same. But I can kind of now see why… I don't know why I understand that, but I just kind of feel like it makes sense. [Patient]

It is also worth stressing that starting from sameness is not necessarily the same as offering a *positive argument for sameness* (these will be discussed in §2). It may imply no more than an *absence of arguments for difference*.

My thoughts when I saw that is: why? Why is it different? And in what cases could it be different? In what cases can some people divulge this information and some people can't. And my brain was trying to work that out. But I didn't come up with any answers. [Public]

However, such starting points did often rest on an appeal to an *underpinning similarity* between professions – though that underpinning similarity was expressed in various different ways.

I can't see a good reason for a difference. You know, there's huge amounts of trust in both those occupations in terms of what… what they do with and for people. [Registrant]

It's all to do with health and social care professions. I don't understand why it would be different. [Patient]

The same outcome for all professions is that there could be harm to patients. […] Although we have different professions, we are talking about patient safety. [Registrant]

I can't see an argument for not having a standard method across all the professions.[…] A complaint is a complaint. [Registrant]

Because it's all health I think it should sort of be the same rules. [Carer]

If you were to put all these people in the same room, there would be some decent commonalities of conversation, no doubt. [Registrant]

In some cases, this underpinning similarity was seen to extend beyond health and care professionals to other kinds of profession.

If it's going to be for them, it should be for everyone. Police. Firemen. Everyone. […] They're all sort of like government bodies, aren't they? [Public]

The phrase 'comparing apples with apples' neatly captures the core idea here.

I think there should be some generic rules so that you can compare apples with apples. [Patient]

1.3 Starting from difference

Just as seeing 'apples and apples' leads one to start from sameness and seek reasons for difference, so seeing 'monkeys and fish' leads one to start from difference:

> *You can't really force the same rules on different bodies, because each body has a different angle on different aspects of health and wellbeing. You know, it's like expecting a fish to climb a tree. You know, a monkey can do it but a fish can't. [Patient]*

Responses that started from difference typically did so by rejecting the assumption of similarity which underpinned responses that started from sameness.

> *They all appear to have a specific job. So how could you have the same rules for them all? That doesn't make sense to me. [Public]*
>
> *I believe the different professions, you know, they are so different. And they offer a completely different service to their patients. [Public]*
>
> *It's alright saying they all have one, you know, across the board. But it wouldn't fit everything. That's why there is so many different ones. Because you couldn't make something that would fit everything. [Patient]*
>
> *I just don't think you can really compare them. [Registrant]*

An interesting nuance of language is apparent here. Whereas sameness as a starting point was expressed in terms of an absence of *reasons* – 'I don't see why it is *not* the same' – difference as a starting point was often expressed in terms of impossibility in practice – 'I don't see how you *could* make it the same'.

1.4 Where did we start as researchers?

The above difference in the ways in expression of sameness and difference as starting points led us as researchers to reflect on ways in which our design had in itself assumed a starting point. After all, however open one seeks to make a research conversation, one has to start somewhere. Our view is that there are a two key ways in which the design assumed sameness as a starting point:

- The presentation of health and care professionals as a category. Opportunities were created as part of the discussion to challenge this category: but the category was still presented as a starting point in the selection of professions to go on the prompt list used in workshops. For example, while the word 'you' in the quotation that follows was probably being used in an indefinite sense (equivalent to 'one'), it could also be seen as referring to us, the researchers:

  > *I think that it's good that there are regulatory bodies, but I don't think one size fits all. I think you do need differences in different professions [unclear]. Although you lump them together as healthcare workers. I think they need to have different standards.*

- The selection of examples for use as stimulus. All of the examples used in the research were examples of contestable *difference* rather than contestable *sameness*. Only one example of sameness across regulators was presented – the duty of candour – and this was used differently in the conversation.

Moreover, these assumptions do not start with our research design. The category of 'health and care professionals' is assumed in the very existence of the Professional Standards Authority; and the use of examples of contestable difference reflects to a large extent the

perspective of an organisation that exists to improve regulation and registration across that entire category.

There are also ways in which the very activity of raising questions about sameness and difference across professions may skew discussion towards sameness as a starting point. As noted earlier, this question is an abstract one. The examples were designed to help in this respect, but they were still a long way from the concrete realities of real practice and real cases. In the following exchange, a professional participant struggles to engage with the example of differing times for which suspensions are recorded on registers for precisely this reason:

> *I don't know if I could give a clear answer on that. There's so many…*
> Interviewer: What makes it unclear?
> *What were they suspended for? [Registrant]*

If we accept that human beings differ in their preferences for reasoning abstractly or concretely, then it seems reasonable to assume that those with a preference for abstraction found this research easier to engage with. It also seems reasonable to assume that those same people would be more ready to see 'apples and apples', rather than 'monkeys and fish'.

All of this raises an important question: are the findings of the research skewed or biased by its implicit starting point? It is not possible to give a definitive answer to that question. However, we believe there are three solid reasons to believe that the discussions created room for both kinds of starting point to be expressed and explored, and that the *catalogue* of arguments for sameness and difference is therefore valid – even if inferences cannot be made from the *frequency* with which these arguments were deployed.

First, it is striking how often the same person would adopt different starting points on different issues. Even those who tended to start from sameness would on some occasions start from difference, and vice-versa.

> *A complaint is not job specific, letting the public access to sort of qualification records, I don't think that's job specific. Whereas some issues might be very job specific. [Patient]*

Secondly, while the implicit starting point may have shaped *how* difference was expressed as a starting point ('I don't see how you could' rather than 'I don't see why you would'), it did not prevent that starting point being expressed. There is even one instance where a participant did offer a formulation in terms of an absence of reasons:

> *I can understand why each one has that code of conduct. […] But should they all be the same? Should have really to be held to the same standards? […] I don't know. I really don't know. [Registrant]*

Some other responses offered an even more radical challenge to the very idea that there was something to be gained by looking at regulation across multiple professions.

> *As long as you and your profession know where you stand, then you shouldn't have to worry about somebody else. What somebody else's rules are. You should only worry about the rules of the job that you're in really. [Patient]*

> *I don't suppose it matters that they are different, I suppose, because… so long as each profession is regulating their own register. [Registrant]*

> *I could have two businesses where one puts in their terms of employment: if you use your business mobile for personal use, it's dismissible. The other one could say it's a*

> *verbal warning. […] I don't know if it's fair, but if that's the rules, that's the rules. [Carer]*

Thirdly, and perhaps most importantly, we should remember that we have been talking in this section only *about* starting points. Wherever they started, participants were enabled and encouraged to explore arguments for both sameness and difference. Many changed their minds as they went along

2. Sameness

As noted in §1.2, starting from sameness is not necessarily the same as offering a *positive argument for sameness*. However, many participants who started from sameness did also offer positive arguments for this position; and others arrived at such arguments as they developed their thinking.

In this section we will review five distinct types of argument for sameness which were used by our participants.

2.1 Correct

The first of these arguments is not, on closer examination, a clear-cut argument for sameness at all, although it was often introduced with an assertion that things should be the same. Consider, for example, the following quotation from a discussion of the example of differences in whether cases of drink driving are always investigated.

> *I think they should be the same. […] It's drilled into your head, like, don't drink and drive. But these professions drink and drive, these people in these professions. And the fact that the nurse gets off kind of easy with a… Not fair. [Patient]*[1]

At first sight, this participant is clearly arguing for all professions to be governed by the same rule. But they are also expressing a strong view about what those same rules should actually determine in this instance. So what would their view be if the rule was the same for everyone but *not* the rule they propose? The interviewer asks this question:

> Interviewer: [Suppose] we're going to make the rule for everyone is like the nurse. Which is more important to you? [Would you say:] Well, "OK, it's not what I think it should be, but it's still better that it's the same"? Or do you think: "No, no, no. It's not about them being the same. It's about the fact that it should be investigated"?
> *I think it should be investigated. [Patient]*

Other participants took a similar stance on this example – albeit with different views on the 'correct' rule. All regulators should have the same rule, they argued, because everyone should have the same 'correct' rule. But that means that *some* regulators having the 'correct' rule is better than them *all* having the same 'incorrect' rule. There is no independent value in things being the same.

> *What I was trying to say is that like there shouldn't be a blanket rule for everyone, in case that blanket rule is what the social workers currently have. [Patient]*

> *I think it's better to have some people doing it right and not everybody. [Patient]*

These positions can be contrasted to instances in which participants argue for sameness independently of what the rule is:

> *I do think the regulation should be exactly the same across the board. But, yeah, I wouldn't know which way. [Patient]*

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[1] Sharp-eyed readers will note the use of the word 'fair' here. The arguments we are teasing apart in this section of the report are, in practice, overlaid on each other in participants' responses. That the nurse 'gets off kind of easy' is indeed 'unfair' in the sense discussed in the next section: but for this participant, as their subsequent response indicates, it is also 'incorrect'.

I'm not sure which side I'd fall on, whether they should be accepted or not. But I can't think of a good reason why there should be a difference. [Registrant]

It is possible for different participants to take either of these positions on the same example. For example, in the quotation below, a participant argues – in contrast to the participants quoted above – that the rule on investigating drink driving should be the same across all regulators independently of what that rule is.

Whatever one you want to go with, but it should be the same, definitely. [Patient]

It is also possible for the same participant to take different positions on different examples. In the next quotation, for example, the participant just quoted reverses their stance with regard to the example of differing treatment of anonymous complaints.

So my argument is: half the battle's won there. If half of them are going "You can be anonymous" but half "You can't" – so in that case, yeah, if they're not going to change it, then leave it there. I've won half the battle. I think they should all change it. But it should all be that you're allowed to be anonymous. [Patient]

Arguments based on correctness value regulations being the same *not* as each other *but* as the 'correct' rule. Differences between regulators are inherently problematic from this perspective because, by definition, some must therefore have the 'incorrect' answer – as illustrated by the response below to the idea of the duty of candour *not* applying to all professional groups.

So some professionals should tell the truth, and some should tell a lie? If you think of it that way… [Registrant]

While differences between regulators are inherently problematic from this perspective, however, similarities are not necessarily a good thing, as the above example also makes clear: all professionals telling a lie would be even worse.

2.2 Fair

In contrast to arguments based on correctness, arguments based on fairness value sameness in and of itself. For example, consider the following response to the same example of differences in whether cases of drink driving are always investigated.

I think it should be the same. Why should it be any different? It's still a professional. You're still a professional at the end of the day, and that is part of […] a code of conduct, isn't it? [Registrant]

Once again, the interviewer asks the participant how they would react if the rule were the same for everyone but not the rule they prefer.

I think I would say: fine, at least it's the same. [Registrant]

They go on to clarify the problem with there being differences between regulators on this issue.

I would say that might be described as discriminatory.

So unlike arguments based no correctness, arguments based on fairness value regulations being the same *as each other*.

As illustrated by the following responses the example of differing times for which suspensions are recorded on registers, fairness in the context of health and care regulation can refer to:

- Fairness to professionals

The doctors are getting a bit of a raw deal because, you know, it's on for ten years on. […] It does seem a wee bit unfair. [Patient]

- Fairness to patients

If someone doesn't have a clean record they [the patient] are as much entitled to know about that as they are about their GP. [Carer]

- Fairness to both professionals and patients

I don't really think it's fair that one profession has it for two years and one has it for like ten years. I think that's very unfair. […] I think it's unfair on the healthcare professional. And I also think it's unfair to only give a certain amount of information… to keep a certain amount of information from the client. [Registrant]

As with other arguments for sameness, arguments based on fairness often rested on an appeal to an underpinning similarity between professions.

My initial reaction would be: that seems deeply unfair, deeply unjust. I cannot see why there would be a discrepancy. You know, they're all patient-facing. They're all occupations that involve a high level of trust. […] The bottom line is, they're now… they've been allowed to practise again. They're under regulation. So why would you… Why would you insist that it's known for longer about one person than another? [Registrant]

I don't think anyone should be treated any different in [that] you're all kind of front line workers, you're all them emergency… Whether you're a social worker in an office or you're on duty or whatever. So I think it should be the same for all. [Public]

Debates about whether an example was or was not unfair typically involved discussion of whether there is a relevant underpinning similarity and what it is. Consider, for example, the following three contributions to a group discussion of the drink driving example. (The quotations are presented in the order they were made, but did not follow directly from one another.)

I think it is okay, because they're both doing different jobs. […] Social worker's… um, completely different job doing nurse, isn't it? [Public]

I wouldn't say that the social worker's work is any more important than a nurse. Like both are doing… both do equally important jobs. So it would be unfair. [Public]

I think if it's all healthcare, isn't it, they should all have the same sort of treatment. […] It's like one rule for one, one for the other. It shouldn't be like that, it should be… You know, when it comes to some of the justice of it, it should all be the same. [Public]

One reason why the drink driving example prompted so many responses based on fairness may be the fact that it relates to an offence committed away from work – that is, outside the context in which the differences which can be used to justify different treatment arise (see §3). All that is left, therefore, is the same offence:

Clinical practice as such is obviously going to differ. But things on this level, you know, activities outside of work, should be treated across the board. [Registrant]

I don't think their job or their profession has any influence here. I think it should be something that's treated the same across the board. [Registrant]

It's the same offence that two healthcare professionals made. […] And it shouldn't be one rule for one another rule for another in this instance. [Registrant]

2.3 Adequate

Arguments based on correctness and fairness imply that regulators should be the same: the same as a 'correct' regulator (correctness), or the same as each other (fairness).

Arguments based on adequacy, by contrast, build in the potential for variation, but only in one direction. Their basic structure is that all regulators need to meet the same minimum standards.

For instance, in relation to the example of differing content in public registers, a number of participants argued that all such registers should provide the same core content (without necessarily agreeing about what that core content should be).

> *It doesn't matter if it's different as long as certain information… certain core information needs to be on it. [Registrant]*

> *It should be the same, in my opinion, because the individual… There would be the basic requirements. So the basic requirements should go across the board. […] If someone looks for the information, they've gone to the registrar, the registry, have looked at it, and they should be able to write down on their pad that the information should be there. That's its job. The only reason for having it is for it to hold the information. So the information should be there and should be correct. [Public]*

As with arguments based on fairness, the application of the same minimum standard may be linked to an *underpinning similarity* between professions.

> *I mean, they're all providing some sort of critical healthcare service, be it: everything from the chemist – you give me the wrong drugs it's obviously going to be fairly disastrous – to, um… I mean even when you go to the opticians they're still interfering with your body, if you know what I mean, so you do want to know that people are qualified? [Patient]*

> *If you have a bad surgeon or a bad podiatrist, it doesn't really matter. If you're going to get your feet done, I want to get it done by a person who's competent. Or if I'm going to get a new pacemaker fitted, I want to make sure that this guy hasn't being struck off or he hasn't got a good [sic] history of doing pacemakers. [Public]*

As noted above, from an adequacy perspective, certain kinds of variation are acceptable: for instance those that result in exceeding the minimum standards (e.g. extra information), or in areas not covered by the standard (e.g. format). The requirement for things to be the same is limited to the minimum standard.

> *I think core information is necessary for all. If people want to add bits and pieces, that's fine. [Registrant]*

> *I mean, you don't really need to look at that information, like it's kind of unnecessary. So I mean, again, it's not a big deal. It's doing no harm being there. [Patient]*

> *I'd like there to be like a baseline of everybody has got to provide these five or ten criteria and then the osteo… the other guys, they can add on or take away.*[2] *But you've got to have the basics and that should be set out for all medical professions, I think. [Patient]*

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[2] Although the participant says 'take away' here, it is very clear from the context and other comments that this is a slip of the tongue, and that only additions are allowed.

While minimum standards are seen as required from this perspective, additions are entirely a matter of preference. (In the next section, however, we will see how a different kind of argument for sameness can call additions into question.)

> *I wouldn't like us to have less. I'm happy for them to have the limited information they have. Do I think they need to have what we've got? Not desperately. [Registrant]*

> *I thought they would both have the same information at the start. I don't really see the relevance for all the extra information personally. I think some if it's on an official website then I don't think you should really need to know everything about the person. [Patient]*

Like arguments for sameness based on correctness, but unlike arguments based on fairness, there is room for debate about what the minimum standard should actually be. For example, participants expressed different views about whether information such as the gender of a professional should be included (minimum standard), excluded (also a minimum standard, albeit a negative one), or optional.

Views can also vary with regard to what *kind* of minimum standard that should be applied. In relation to the example of differing times to respond to complaints, some participants argued that all regulators should be required to respond within the same period of time.

> *They should all have that set window. And you should know by the end of that window. [Patient]*

> *There should be a kind of: you need to respond within a minimum amount of time. Like say a month, something like that. And that should be across the board. [Patient]*

Others argued merely that every regulators should set a time limit, but that the actual limit set might vary between regulators.

> *It doesn't necessarily need to be the same timeframe, but as long as you know it's getting looked into. [Public]*

Even here, however, there is evidence of an implicit minimum standard in operation, in the use of words like 'reasonable'.

> *The complainant should have a reasonable expectation of when they could hear back. [Registrant]*

> *I think maybe a reasonable time limit should be set on all things like that. What that reasonable time then is, I'm not sure, but probably based individually on the different area's reasonable time. […] And that would take into account all the factors that influence [it]. [Registrant]*

2.4 Simple

In the last section, we saw how arguing for minimum standards in, for example, the information provided in register entries is entirely compatible with allowing variation in *how* that information is presented.

> *The fact that the presentation is different, I don't think really matters, to be honest. I mean, I guess all you want to know is the person's qualified. [Patient]*

Other participants, however, argued that the format of different registers should also be the same.

> *It's just basic information, but it should be laid out, it should have a format, with an overseeing body saying: "Look, you have to do it this way, this way and this way." You could have different designs and whatever, but the overall internal format must be the same, so it makes it easy. [Patient]*

The idea of making things easy for users is at the heart of arguments based on simplicity. Of course, making things easy for users is about more than sameness: for example, some participants commented on issues such as the use of unfamiliar abbreviations. But one key way to make things simple is to reduce unnecessary variation.

> *If they're all very similar, it makes it a lot easier for the user because they have a kind of understanding of what they're looking for. The more different it is, the more difficult. [Patient]*

> *You want it to be quick, easy. Easy to read and understand. But making it the same does all of those things. [Public]*

> *I think if there's a template you know what to look for. Rather than trying to analyse what's this… why is this different from the other one? [Public]*

The inevitable endpoint of this process of reduction is sameness – in this case, the same information presented in the same way.

> *It does make life easier if they did have this kind of information on them whichever site you went on. They should have the same layout, same details on there. [Patient]*

> *If everybody's the same, if everybody that's governing these different osteopaths, physios, surgeons had the same information, it's not so confusing for people looking for somebody. [Public]*

> *I think if you're searching for somebody in that profession, I think whatever information, whatever it is on the internet should all be the same. It just becomes confusing. [Carer]*

Note that arguments based on simplicity are all about reducing variation. Whereas arguments based on adequacy are relaxed about additional information and other kinds of variation, simplicity suggests a much stricter approach.

> *Some of them would give you a lot of waffle [if allowed to add more]. [Patient]*

> *I don't get why that one gives you so much more information than the other one. Seems a little more simplistic, kind of, if they all had the same sort of level information. [Patient]*

On the other hand, only differences that actually make it harder for users matter from this perspective. For instance, the last participant quoted above goes on to argue that they personally are not too bothered by the differences in the examples under discussion.

> *I think that's pretty similar, really. You're putting in similar information, to be honest, I don't see a massive difference. I think it's quite petty, to be honest, to say that there's a big difference. [Patient]*

To put the point another way, arguments for sameness based on simplicity appeal to an *underpinning similarity* not between the professions being regulated, but between *users* of whatever aspect of regulation is under consideration. Staying with the example of the public registers, for example, it was noted by participants that differences might reflect evidence about different user requirements, or about user tolerance for differences in general.

> *The individual bodies for that particular profession have probably studied what people want to know about that particular occupation. And that's why they've based their website on that style. [Public]*

> *It should be a standardised result. But then again, we're so used to looking at things on the internet and them all being different. You just kind of accept it. Every web page is different, isn't it? [Carer]*

Differences could also reflect the fact that, outside research groups, users are unlikely to be looking at two registers side-by-side, so unlikely to be distracted by differences in the first place.

> *The fact that it's slightly different doesn't bother me. […] It's just the format that's slightly different. And I think once you've gone in and you're just concentrating on the one website or whatever the term is, you can work your way through it. [Carer]*

2.5 Coherent

Health and care professionals do not in general work in isolation. They work with other professionals, often in multidisciplinary teams, and with the patient as the central member of that team. This reality underpins the final argument for sameness, an argument based on coherence.

Coherence does not in and of itself require sameness. It requires something more complex: alignment, fit, joined-up-ness. But sometimes this can entail sameness.

> *I think it should be the same, so that all health professions kind of like work together as a team, to make sure the same things are happening. [Patient]*

In our participants' responses, this was most apparent in relation to the example of differing guidelines around cases where a patient withholds consent for a professional to inform others they are at risk of harm. A number of participants wondered about the potential problems this kind of difference might create in multidisciplinary teams.

> *If they've all got different rules, how could they share sort of notes on a patient? […] If they all shared the same regulations across the board, that information would be accessible or not accessible by all of them. [Patient]*

> *I'm just wondering what happens in situations where, like, you've got a clinical psychologist working alongside a doctor. They both hear the same message from the patient, you know, one acts on it, one doesn't. They're doing what their regulatory body says, I suppose. I don't know. I just… To me it seems a little bit odd that one. [Registrant]*

> *It's not difficult, is it, to have two health care professionals with one patient in whatever scenario, and actually then their opposing professional body [sic] standards leads to conflict. And that's the exact scenario we want to be trying to move away from with this. You know, the scenario of there's a clinical psychologist and a mental health nurse and maybe an occupational therapist, all working with a patient. They've all gone to do a home visit. Patient discloses X, whatever that may be. And suddenly three healthcare professionals have got three different approaches towards this. This does not provide a unified system. [Registrant]*

Another participant told a story about exactly such a conflict that had once existed in the past (though please note, this story has not been verified by the researchers). Notice how an argument based on coherence is entwined here with an argument based on fairness.

> *We should all be treated the same, because we're all looking at the one patient in this scenario. It just feels wrong that one person could do something, and it's not even considered wrong and another person could do something, do the same thing… There was an example, going back, just a quick example where a doctor could prescribe the skin preparation and nothing would happen, but if the nurses applied it, they were… it was fitness to practise. [Professional]*

2.6 Making things the same

Even if sameness is desirable, is it worth *making* things the same? Some participants felt that it was – often inclining towards collaboration between regulators as the best route to achieve this.

> *They should be working closely together and on a similar line. You know, when you complain about any of them, it goes down the same sort of route. [Public]*

> *I kind of agree that all should maybe come to a compromise and they all should be the same. [Patient]*

Others, however, questioned this view, drawing attention to the challenges and costs associated with making things the same.

> *You'd have to get them all to agree, then to comply, which I find would be a difficult thing. I'm not a great believer in the same rules across the board, I have to say. […] And it's probably better if they govern their own individual part of it. [Public]*

Those costs include the potential extra burden placed on those who are on the receiving end of regulation.

> *I run a business. I don't like over-regulation for the sake of it because, you know, you want it to be, you know, doing some good at the end of the day. So if you do over-regulation, and actually it's not a big problem, um, you're just, you know, causing a lot of cost and time and money. [Registrant]*

But they also include the additional work which would need to be undertaken by the regulators themselves to make things the same while respecting important differences.

> *I think it would be really hard to do that across professions and make it all the same. [Registrant]*

> *Although they're in the same broad area of work, there's no commonality… or very little commonality between them. They're all regulated by different bodies. So it's I would say near impossible to get some kind of kind of consensus of standards and rules and regulations for all of them. [Public]*

In short, arguments for sameness have to weighed against the cost of *making* things the same. That this is so is apparent not only in the responses of participants who thought making things the same was not worth it, but also in those of some participants who felt it was.

> *If we were to amalgamate some of these bodies, actually, would everybody bring a little something different to the pie that then'd make a really good pie, or would we just have a terrible pie? […] I don't see a strong enough argument of them not to be striving to work towards the same goal. And obviously, that's going to take time to*

achieve. But just like […] with a duty of candour, moving towards the same standards has surely got to be in everyone's best interest. [Registrant]

For the participant quoted above, the fact that the HCPC has already brought together a large number of professions was evidence that making things the same is possible as well as desirable. Another professional participant cited the same example in response to the interviewer presenting the argument that making things the same may be difficult – but went on to discuss why making things the same across a broader range of health and care professionals may be even more challenging in practice. In doing so, he drew attention to the way in which the metaphor of 'apples and apples', however applicable it may be to professionals, breaks down when it comes to the regulators themselves for concrete historical reasons.

But if that's the case, why did they develop HCPC then? […] You've got this new group of health professions, which should always have been recognised but weren't necessarily. And then you've got the doctors, the dentists, the pharmacists, that have been around forever. And they've got a legacy set of standards. […] I think when it comes to regulation, you are slightly looking at apples and pears because you're looking at a new organisation who is very much finding its feet and probably looking at all its core members, and then you've got historic organisations that have done things their own way. [Registrant]

3. Difference

Alongside arguments for sameness, participants explored a number of reasons for difference in the way that different professionals are regulated. In this section we will review six types of argument for things being different which were used by participants.

The first five of these relate to differences in the interaction between professionals and patients, and were used by participants across all of the examples discussed. The sixth relates to the speed of change in a specific area of expertise, and was used in more limited contexts.

A further kind of argument relates to the status of different professional groups: but it is not clear that this was in fact seen by participants as a *legitimate* reason for difference (as opposed to an *explanation* of why it exists in practice).

3.1 Risk

The first argument for difference draws attention to the different level of risk in interactions with different professionals.

> *I think things like GP, surgeon, I mean they can literally cause death, and then you've got other people that could just cause harm that can be repaired. [Patient]*

> *A profession that maybe does more intervention, more higher risk intervention, that might be their justification for being different. [Registrant]*

> *I think you have to have different levels for different professions. I don't think you can compare a GP with an osteopath purely on the basis of how much harm could they do if they did it again. [Patient]*

> *I would prefer a dental nurse to make a mistake than a surgeon. [Carer]*

The example of arguments based on risk can be used to illustrate a number of patterns which applied across all the arguments for difference presented in this section. The first of these is a reluctance – especially on the part of professional participants – to say anything which implied that some types of health and care professional were in any way more *important* than others.

> *Everybody should be the same in an ideal world, they should all be the same. But a surgeon would, or a doctor would maybe have a more life threatening… I don't want to say it – would do more serious [harm] than a podiatrist or osteopath or whatever. [Registrant]*

Alongside the *good* arguments for difference, there are also some *bad* ones (see §3.7), and some participants (though not all) were at pains to distinguish these. For example, one professional participant underlined the substantive nature of differences in risk by drawing a parallel with indemnification costs.

> *I mean, there are certain principles, just, you know, absolutely key across all the work. Fior something like, sort of, safeguarding type principles. But then there are other things where you could argue that, you know, the more responsibility that you have, the more… the tighter the regulation needs to be. […] For example, if you look at how much it cost to indemnify a GP, against an audiologist, I suppose it's the potential for harm isn't it? So, yeah, as you carry more responsibility and have a greater risk of doing harm, if you're not maintaining your skills, then regulation… You could argue that regulation needs to be tighter, broader, more in depth. [Registrant]*

A second pattern – in arguments that relate to differences in the interaction between professionals and patients – is a tendency for arguments to blur into one another. Unlike the arguments for sameness presented in §2, the arguments for difference in this section (at least the first five) overlap with one another. The basic risk argument, for example, treats risk as something that can itself be compared between professionals. Professionals, on this view, can be placed on a single scale, from highest risk to lowest risk.

> *A paramedic, probably it's a different job, okay, but podiatrist maybe just isn't at the same knowledge level – I don't want to see it that way, but, you know, it's a different end of the scale. [Public]*

But this argument often gets entangled with a recognition that different *scopes* of practice mean there are different *kinds* of risk involved. The participant quoted above continues:

> *They're saving lives. There's a real general whole body thing to look at. A podiatrist maybe it's just involving feet and things. [Public]*

The third pattern relates to the basic components of an argument from difference, which stated simply are that a) the difference in question really does apply to different professions and b) the difference is a *relevant* one.

For example, we can see the second of these components at work in the way the participant quoted above concludes their discussion of the contrast between paramedics and podiatrists – which is to question the relevance of the difference they have just described by returning to an underpinning similarity between the two professions.

> *In saying that, they're both in the health service. They both are doing a similar health role. [Public]*

To dispute an argument based on risk, participants would sometimes question whether professionals really did differ in their risk profiles (first quotation below), sometimes accept the difference but question whether it was relevant (second quotation below).

> *Yeah, but there's other ways that these professions could harm patients. […] So even though I understand what you're saying in terms of the doctor's job's more high, but they can still cause issues as well. [Patient]*

> *However, thinking then, as a patient, you would want to be treated just as well by someone who is a consultant. And you'd just want to be treated as nicely and as fairly by the cleaner. So I don't know. [Public]*

In other instances, participants presented neither an argument for sameness nor an argument for difference but a balance between the two, as in the quotation below. We return to the need to balance sameness and difference in §5.

> *I don't think any are different because whether it's, say, a radiographer who's just completing an x-ray […] That's a simple procedure, but you're still in the hands of a person – that needs care. So community nurse, all of them… I think you're still caring for somebody in whatever way, so you still hold that responsibility. I wouldn't group any [of the professions on the list] different, I'd just say that, if anything, again, it's just the risks. So some of their jobs come with higher risks. So you'd need a high level of concentration. That might need different degree of something like that. But no, I'd put them all together. [Public]*

3.2 Scope

As noted above, arguments based on risk often became entangled with a recognition that different scopes of practice mean there are different *kinds* of risk involved. For example, different professionals can deal with more or less of the human body.

> *I just imagine that there's more damage that can be done when you're messing with someone's back and neck in particular as opposed to maybe just the whole general body. [Patient]*

> *A surgeon and a midwife, a paramedic, that are physically dealing with the body in many different ways, then there should be slightly more questions asked, if you will, to, you know, somebody like a dental nurse. [Public]*

But scope is not just about body parts. Professionals vary in the extent to which they have an impact on a patient's life more broadly.

> *With a doctor, he's more… his world's more serious in terms of the service user, than a social worker or maybe a dentist. […] Because they're dealing with lives daily, kind of thing. [Patient]*

Public, patient and carer participants sometimes disagreed about what the scope of different professionals' practice actually was, and which aspects of it mattered most, as in the exchange below.

> *A: Why would the social worker be chastised more for doing the exact same thing that a nurse is doing?*
> *B: Because the nurse doesn't hold family life in their hands, the way a social worker does.*
> *A: They hold people's lives in their hands.*
> *B: Not necessarily, because they just take your blood pressure and do whatever. Social workers take decisions that last a lifetime. [Public]*

The scope of a professional's practice shapes how much harm they can do: but it also shapes how much *good* they can do.

> *There are three different kind of groups [of health and care professionals] depending on their level of what they can do for you, and also what harm they could cause you. [Patient]*

For instance, the extent to which different professionals can help was cited by some participants in their response to the example of differing guidelines around cases where a patient withholds consent for a professional to inform others they are at risk of harm.

> *Maybe with the psychologist's, psychiatrist's job, they're more in place to look after somebody and not pass it on, that they can deal with it themselves. Whereas a dentist wouldn't know what the hell to do with somebody who said: "I'm going to jump off a cliff". [Public]*

> *[A clinical psychologist] may in time either support the person or bring them round to saying… getting the help that they need. [Public]*

> *The clinical psychologist especially and their remit with the patient or their sort of scope of practice with a patient is very different to the contact a dentist is likely to have with a patient, so I think in that sort of instance, it is acceptable to have different codes. […] Initially, I would have said no, codes of conduct should all be the same. But actually, in that scenario with a clinical psychologist, you know what they're dealing with and what they're discussing with the patient is very different. […] You're*

> *sort of hoping that somewhere, somewhere in that, they are enabling that person to make the decision to change that themselves. [Registrant]*

Other participants pointed out, in relation to the same example, that the scope of different relationships would also influence what was happening in the interaction in the first place.

> *I'm going on the fact that a dental nurse or a dentist will really only be dealing with your teeth. And […] if you've got your teeth smashed in, obviously they're going to ask how it happened, whether you fell, whether it was an accident, whether somebody attacked you, etcetera. But with a doctor, you're going for a specific thing and when they check you, if they see bruises all over you or you know… all different scenarios. But they would see more than a dentist would. […] Like a psychologist as well, you know, they could only go on what you tell them. They're not physically seeing anything. So it's three different scenarios. [Public]*

> *A dentist, I don't think has the same relationship with the patient as a doctor or a psychologist? A dentist might flag up physical circumstances where someone has suffered abuse, but they will not have any contact with any sort of other area of the patient's life. Whereas a doctor and a psychologist would. [Patient]*

Scope here clearly overlaps with a third important kind of difference between profession: the expectations a patient has of what will and will not be addressed in the interaction.

3.3 Expectation

Patients have differing expectations of interactions with different professionals.

> *You go to a doctor to speak about your problems […] If I go to the dentist I just expect to get my teeth done. [Patient]*

These expectations are reflected in an implicit 'contract' between patient and professional regarding what will and will not happen – underpinned by an understanding of the scope of that interaction. The following quotations are all responses to the example of differing guidelines around cases where a patient withholds consent for a professional to inform others they are at risk of harm.

> *I think if we're talking about the dentist, I think if he notices that something is wrong with your gums or something like that, you know, and where it could be sort of mouth cancer or something, that he would obviously then tell the person, the patient. But I don't think [he] should be able to talk to anybody else unless it really had a lot to do with him. [Patient]*

> *When you go to a doctor and you're discussing something private, you kind of wouldn't want that information… you're trusting that person. Whereas when you go to a dentist, you would… you know, it's a totally different conversation. [Public]*

> *A dentist offers a completely different service to a clinical psychologist. And a dentist, you know, if a dentist can see a safeguarding case or bruises or something, then, yeah, they should be able to report that and get the support for the person. However, if you're seeing a clinical psychologist, you're probably seeing a clinical psychologist for that reason. And therefore there's an expectation on the patient for that confidentiality. [Public]*

As one participant noted, elements of this 'contract' will sometimes be explicit.

I know that when you go to the psychologist that was one of the first things that she made clear to me, was like: "This is all totally confidential." [Patient]

On the other hand, one professional participant noted how the implicit 'contract' between patients and different professionals may vary not just in its content but also in how determinate it can be about what will happen.

Some are very straightforward at the very clinical… er, this is the objective ultimately, and this is how we're going to achieve that, and what steps do we take to get there. Whereas […] your arts therapists and perhaps some of your mental health therapists and treatments and some of the psychology type stuff could be quite difficult because obviously that then interjects in how that treatment process for that patient works. [Registrant]

Expectations about what will and will not happen in an interaction are also linked to expectations about what the interaction will *achieve*. Specific constraints or licences within the relationship may play an essential role in achieving the therapeutic goals of that relationship. For example, the therapeutic importance of confidentiality in a relationship with a clinical psychologist was noted by a number of participants.

I suppose a psychologist is maybe wary that if he breaks a confidence the patient will cease going to him then, will lose their faith in him. [Carer]

Part of the therapeutic relationship, as far as I understand it, is sort of going to places you might not ever go with somebody else, and that being contained between these two people. [Registrant]

The whole relationship and dialogue is instantly stifled if there's not that absolute trust. [Registrant]

One professional participant, a paramedic, noted how behaviour that might be seen as inappropriate in other professionals played an important *clinical* role in their own interactions with patients.

Some of this conversation I'd have with patients, or the way that I'd conversate [sic] with patients, would be very different from some other professionals. We often will bring a degree of sort of light-hearted humour – what other professions would potentially describe as inappropriate communication and such. […] Some of that's about breaking down the barriers and recognising without massive clinical assessment how poorly a patient may be. […] If you can manage to distract somebody from their pain, and involve a little bit of social comedy and humour and make them just distract themselves mentally for a few minutes, you can then start to assess where that… how distractible somebody is, which is, you know, a recognised assessment technique about distraction. [Registrant]

Differing expectations of what a professional is going to achieve influence views about what they should and should not be able to do in interactions with patients.

I think people understand the social workers…. So, for example, if I believe your child is at any risk, I will have to report this. There's only certain boundaries I can keep as your family social worker. So it's accepted that social workers have to look at the bigger picture. [Registrant]

I think a social worker would be more likely to kind of push the point of how has this happened if somebody has been injured or abused or something, whereas the dentist I wouldn't think as much it would be their kind of role, if that makes sense in their profession. [Patient]

Differing patient expectations about what an interaction will achieve are also, unsurprisingly, reflected in differing patient expectations about the skills and capabilities the professional will bring to that interaction. Note how in the quotation below these expectations are also linked to an argument about how professionals interact *with each other* in relation to a patient (see §3.5).

> *If I'm a community nurse who goes out and weighs babies, I wouldn't expect me to be at the same level of qualification and have the same training as somebody who's working as a nurse in a psychological word. […] So if I'm the community nurse and I think there's a problem here, then I need to speak to whoever, the line manager, whatever way the process works. So the hierarchy… Whereas if I'm at the top of that, like if I am the psychologist and I run the whole department, then I would expect me to have more to me than the more knowledge, and a better way of handling it than the person who's just the community nurse and just weighs the babies. [Patient]*

Differing expectations of different groups of professionals – in relation to what they are there to achieve, what they therefore will and will not do, and what skills and capabilities they will bring – may provide the basis of an argument for differences in how they are regulated. One professional participant even noted how important it was that efforts to standardise – in this example, in relation to the register – should not in any way erode these different expectations.

> *I suppose there's no harm in it being the same, so long as it is standardised obviously with the sort of proviso that different professions have different… It would be okay for them to be all the same, but not to have the same expectations of each group. [Registrant]*

3.4 Narrative

The fourth kind of difference, which we have called 'narrative', covers a range of potentially important differences in how interactions between professionals and patients develop over time: how they start; how many there are, over what timeframe and lasting how long; and how they come to an end.

For example, participants highlighted the difference between interactions which are planned and those which are unplanned.

> *For example, a paramedic would go and see someone in an emergency situation and quite often not be able to gain consent for an intervention in an emergency. [Registrant]*

This will also have an impact on the context of the interaction, and whether there is or is not a pre-existing relationship between the professional and the patient.

> *With a GP and a doctor, you make an appointment to go to them and seek their help. […] A paramedic is just somebody who's coming to your need and is potentially in a rush or whatever. And they're not in, like, they're not in a hospital or a GP [practice], they're in… what? A house, outdoors, like a park, anywhere. So… and you don't know them on a personal level, you've not made an appointment to see them. It's just something's happened, an accident or whatever. So obviously they need to maintain high standards. But I get why maybe the standards aren't going to be the same as somebody you've appointed to see. [Patient]*

The extent to which the interaction is *chosen* by the patient may also have a significant impact on the scope and implicit contract of a relationship, and the balance of power within it. This issue was highlighted in relation to the role of social workers in particular.

> *Their point of engagement might be different in the first place. Their point of engagement – I'm sure this isn't the only role – might be: you need help, we are allocating a social worker to you, and they will be coming into your life circle and implementing or helping you with whatever. So it's a different starting point and a different contract. [Registrant]*

> *The difference is you've actually made the choice to go and see a doctor about something, and a social worker's put there to care for somebody who can't do it for themselves. So they're actually looking out for them. Whereas the doctor will… You go in and they can say: you can do this, you can do that. You contribute there and he gives you these pills, you could take their advice or you can't take their advice. But if you've got a social worker they're there for a reason, because that person is vulnerable in one way or another, so there to sort of oversee it. [Patient]*

> *You've got one extreme, I think, which is the social worker who's going in and probably finding issues. Part of their job is to actually do something about it. They're expected to intervene. Whereas I guess the dentist is on the other one, where you're going to them and presumably you're expecting to get your teeth fixed, and that's it. [Patient]*

Interactions between patients and professionals can also follow different patterns. At one extreme, for instance, the interaction may be a one-off. At the other, it may be part of an ongoing, open-ended relationship involving frequent, lengthy interactions. In between lie a range of other possible patterns, characterised by different lengths and frequencies of interaction over different periods of time. Participants noted how these narrative differences between patient-professional relationships shaped how much a professional would know about a patient and therefore, potentially, the scope and implicit 'contract' of an interaction. For example, this was a factor in responses to the example of differing guidelines around cases where a patient withholds consent for a professional to inform others they are at risk of harm.

> *The GP's the one that is more in contact and knows the patient, knows the family, knows a lot more about it than the dentist or any of these other people. [Patient]*

> *The doctor would possibly know more about what is going on. You see what I mean? You see your dentist twice a year, you can see your doctor more. [Public]*

> *A dentist may only see that patient once, and every two years. The psychologist may be working with that patient on a daily basis, and know their history and background, and again the same with the doctor. [Registrant]*

> *A GP is the gatekeeper of one individual's care. So I suppose if anybody's going to do something like that and maybe not always stick to the patient decision, it probably would be the individual's GP. […] A certain professional may have more insight to be able to make a decision about what the right course of action is. [Registrant]*

Narrative differences in relationships will also have implications for whether the professional in this example has an opportunity to take further action to help the patient.

> *I'm just wondering about the dentist: is that somebody who you know is doing a one-off assessment with somebody and they've got no way of following it up? They're left holding that risk, and they want to pass it on to somebody else who can then make a decision whether to do anything further with it. [Registrant]*

Like any other narrative, of course, ongoing interactions between professionals and patients have ends as well as beginnings. Participants drew attention to another key difference here: how easy it is, practically and emotionally, for the patient to bring about that end. In particular, this difference was cited in relation to the example of differing treatment of anonymous complaints.

> *A GP will probably have a mass of records, you know, over a person's life. That person has been with that doctor over their lifetime. If you visit an optician, they do a quick test on your eyes, you know? Whereas if you are going to a doctor they would need to know all your history. So all these files you have on your previous GP would have to go to the new GP. […] It's not really practical. [Public]*

> *Is it because you could maybe change a physiotherapist easier than actually changing your doctor. […] If your doctor's been with you all your life and all your family, etcetera, you may want to make a complaint, but if it goes in the doctor's favour, you've still got to see that doctor. […] Whereas a physiotherapist, if you're not happy with the service, you just find another one, wouldn't you? [Carer]*

Underlying these differences in the ease with which professional relationships can be ended, of course, is an issue which also arose in relation to the way they start: power.

> *Say you were complaining about your doctor, and it was a group practice where they're all partners, maybe that could affect the treatment you get off the others in future if you come out. [Patient]*

> *If they're still under the care of those people, then they'd be concerned that that's going to go against them. [Registrant]*

> *I think you can feel very intimidated by professional people as well. […] You see them as being probably maybe more educated than you, clever, etcetera, and it's very difficult sometimes then to put your point of view over. [Carer]*

Different balances of power in professional-patient interactions are shaped by all of the factors already discussed – risk, scope, expectations and narrative. They are also shaped by the specific circumstances of the patient: and as a result, differences in the types of population dealt with by different professionals may be seen as relevant to differences in regulation.

> *[Social workers] have to be held to a fairly high standard. I think I would hold them to a higher standard than opticians. […] Because of the job, the kind of job that they're doing, and maybe they're dealing with vulnerable patients, where ninety per cent of the time an optician's not. [Registrant]*

> *People in different states of vulnerability. So they have different strengths to deal with what's going on, and that needs to be reflected as well. [Registrant]*

> *I know they're all in the position of care. But I feel like it's more extensive when you're in the position of care of someone who is underage. [Patient]*

3.5 Team

As noted in §2.5, most health and care professionals work not in isolation but with other professionals, often in multidisciplinary teams, and with the patient as the central member of that team. A number of participants drew attention to the different roles and responsibilities of different profession within these teams, and the ways in which this might impact on regulation.

A dental nurse is under the supervision essentially of a dentist in their decision-making. So I guess a complaint against one or the other potentially should have different processes, timescales. [Registrant]

With the dental nurse, I think that's different, because she's under supervision all the time. [Patient]

If you are more responsible, like medication, or because [you] make the final decision […] maybe appraisals and your conditions would be more regularly, and yes more evidence as well. [Registrant]

One professional participant, a pharmacist, drew attention to the way in which different note-taking requirements for different professions might in part reflect the different positions they occupied in a multidisciplinary team.

The dentists will quite often say, you know, if you've given a prescription but not justified why you've given it that will be a fitness to practise. […] I think it's different for [pharmacists]. We have to record everything by the way the system works. So if I give you some amoxicillin, there is a green bit of paper or an electronic message with amoxicillin. If a dentist pulls the tooth out, there isn't a letter that says: pull this tooth out. […] Like with [a physiotherapist], if you're doing a treatment on a patient you're initiating that treatment. Whereas I am following an instruction from a GP, that I could still challenge, but there is an auditable trail. [Registrant]

Another participant noted how different team contexts could also have an impact on the likelihood of error or abuse being picked up.

If you're working in parts of a larger multidisciplinary team, you would hope that, with things like the emphasis on whistleblowing policies and stuff like that, that's actually poor practice and, you know, core standards of care would be picked up. Whereas I suppose that's very different if you're an osteopath who works on their own, or if you're a physiotherapist who is sort of self-employed. [Registrant]

In the quotation below, a participant wrestles with issues of narrative, expectation and scope in the example of differing guidelines around cases where a patient withholds consent for a professional to inform others they are at risk of harm, and concludes that the answer lies in clarifying the different roles and responsibilities of different professionals in relation to one another.

So say you're a victim of domestic violence. You're already in this system by the time you got the clinical psychologist. So you're already in the system being helped, but you realise that you need some sort of additional help that a GP isn't qualified enough to do. But if you're actually… if you take it that, okay, well, the dentist can tell, you might not be accompanied by your abusive partner to the dentist. So you might be able to tell them whereas, I don't know… there's like a catch 22. […] I think there needs to be a protocol, but the same protocol for everybody. So maybe like that everybody has a level. So the dentist is at the bottom of the level – although I don't agree that he should be, right? – and so he doesn't have that much interaction with you, whereas a GP might see you more, so the dentist needs to refer to a level one person, and then that escalates it up. [Patient]

Note, however, how in articulating these differences they argue that this means having the 'same protocol for everybody' – a good example both of an argument for sameness based on coherence, and of how the positions developed by participants often represented neither an

argument for sameness nor an argument for difference but a balance between the two. We return to the need to balance sameness and difference in §5.

3.6 Speed of change

There is a profound connection between the different expertise, skills and knowledge of different professionals and the differences in the interactions they have with patients. Specific kinds and levels of expertise are a *prerequisite* for a professional to engage in interactions with specific kinds of risk, scope, expectation and narrative and as part of a specific kind of interprofessional team.

But do those different kinds and levels of expertise introduce *additional* differences of relevance to regulation, over and above those already outlined? The responses of our participants suggest that, with one important exception, the answer to this question is: no.

The exception relates specifically to mechanisms for continuing fitness to practise and quality assurance in training and education. Obviously the *content* of activities in both these areas needs to vary: not just between professions but also *within* them, for example between specialities and levels.

> *They're not doing the same job, though. They're all different. So you would expect them to have a different level of expertise. [Public]*

> *You are practising in a specific field. So that's the field you should be re-tested on. [Public]*

Some professional respondents also noted how important it was that *assessment* of this differing content was undertaken by people who themselves had expertise – although this particular difference (different expertise in assessors for different professions) can easily be recast as a similarity (relevant expertise in assessors for all professions).

> *I would want to be being assessed by people who really understand the absolute nuts and bolts and nuances of my job. Not even really somebody from a different branch of the medical profession. [Registrant]*

> *Every area has got to make their own judgments and make their own… what's necessary to ensure safe practices of their participants. […] They're specialists in their own field. So they know exactly what to expect from their members. I wouldn't really expect a nurse to be telling a podiatrist […] what to expect or what standards they should have to rise to. […] I don't really think general nurses should be telling midwives what to do or should be setting their standards. […] And then you could say, though, every single ward nurse, every specialty… You'll get your medical side and your surgical side. They're totally different as well. So a medical nurse does totally different things from what the surgical nurses does. [Registrant]*

These different needs in relation to *content*, however, do not in themselves imply that the *processes* of continuing fitness to practise and quality assurance need to vary. What may make a difference, however, is the *speed of change* of that content: how fast are the expertise, skills and knowledge required to practise in a given area changing?

> *So I'm a type one diabetic for 15 years. And so much has changed within that 15 years since I started. So doctors have to be on their game. Keep going with the times, and the medicine, and stuff. […] With my diabetes your feet have to be checked a lot as well. So I've had that since day one. Since day one, 15 years of having it: feet – nothing's changed, but medicine – a lot has. [Patient]*

I imagine different professions have different cycles of knowledge expansion or technology expansion. […] I think that's one of the places where difference amongst regulators probably goes: well, actually, there's a lot going on in this area, we need to ensure practitioners are up to speed on all this. So I think it would be difficult to do a one-size-fits-all. [Registrant]

There might be more argument to say that the syllabus is evolving or changing more in one topic compared to another. [Registrant]

Specifically in relation to quality assurance in training and education, the length of training courses was also mentioned as a practical factor which might influence, for example, the frequency with which courses are reassessed.

The courses will be different lengths as well, I imagine. Yeah, so the cycles with which… the length of the cycles cannot be standardised in that sense. […] I think the variation has to be allowed. [Registrant]

It might be to do with the learning cycles of the course. [Registrant]

3.7 Status

In responding to examples, participants did not just develop arguments for why regulation *should* sometimes differ between professions. They also speculated on the reasons why, in practice, it might have arisen. These possible *explanations* of difference did not in their view always constitute good *reasons* for difference.

Are they thinking then that a nurse is more valuable to society, so cut her a bit of slack, you know? [Carer]

I don't think it should be like: you know what, actually we're going to let you get away with all those convictions because you're a brain doctor. But the arm doctor… no, we're not going to let you go over… or you're going to lose your job over that. I just think that's just completely ridiculous. […] But then I suppose there's the argument of like how valuable people are to society, isn't it? There's only so many brain surgeons. What if they all start drink driving? [Patient]

You might have certain jobs where they feel that it's more of a high-powered job, more classy. Yeah, so they get the Rolls Royce kind of treatment. Then you have the little plebeian one at the back who gets everything thrown at them. And that's not right. […] And just because one job seems more higher level than the other, they get more privileged. I don't like that. That's not right. [Registrant]

I wonder if it's somebody who's more easily replaced. I would imagine that a doctor… you don't want to strike off a doctor because of the expense of training one. So they have… So, really, is that really fair? Because it's treating one person differently to another. So I think this should be the same. […] As long as the sort of focus is always on the patient, on the patient's wellbeing, and not on the fact that because we're in a society where we think doctors are better than anybody else that they're being given any sort of treatment, or because there's been a lot of investment and that. [Patient]

Note that the issue being raised here is not whether different health and care professions have differing levels of status in our society.

No comparison of their income. What you have is you have the nurses' level, you have the GPs' level and then you have the surgeons' level. Okay, so you know what I mean

is: if you take the surgeon compared to the nurse, sure the nurse's getting nothing compared to the surgeon. [Public]

The issue is whether those differing levels of status should in any way be relevant to regulation. What makes things complicated is the fact that, to some extent, different levels of status may correlate (more or less closely) with other differences that are deemed relevant, such as risk. For instance, in response to the comment about different income levels quoted above, another participant in the same group suggested a link between income and levels of responsibility within the broader professional team:

[Name] mentioned the various levels of income. I think more importantly, it's the levels of responsibility, right? It's the levels of responsibility that are different. Obviously the income goes hand in hand. [Public]

More than once, a participant who appeared to be citing status or pay as a legitimate reason for different regulation turned out, on further discussion, to be using status or pay as a proxy for a more fundamental difference in the patient-professional interaction of the kinds already discussed.

It's very hard because they're all so different and, as well, is that they're doing a really important job, yet they're all on different pay bands. […] Different pay bands, different responsibilities. Do you know, the more responsibility you have for a person, then maybe the more you should be… I can't think of the word. [Public]

I think there should be differences. Like I hold, you know, a surgeon or a doctor in higher regard than, you know, an osteopath or what have you.
Interviewer: Higher regard. Tell me a little bit more about that.
Alright, so the… What that person could potentially do to their… not customer, but… client. So what they… what harm they could present to that person, depending on their profession, I suppose. [Patient]

Moreover, rightly or wrongly, status may *shape* other factors which are relevant to regulation – such as patient expectations of an interaction, or the power of that professional in that interaction or in relation to other professionals.

The doctor is the one person you think you could tell anything to and they wouldn't repeat it, but a social worker's just a wee bit different, because… how can I make it sound without saying that a doctor's better than a social worker? But a doctor has had to study for years and years and years and take the Hippocratic oath, and all the rest of it. A social worker can go to university and then go and get a job, if you know what I mean. So I don't put them in the same category. [Patient]

Like, I think, just historically like medics, I guess, you know, should be held to do higher standard. […] I just think people have more trust in a doctor, you know? Or you know, they have such responsibility to their patients and across the board. Or maybe it comes back to risk and intervention and things like that. [Registrant]

I guess it's the way society regards them. Like, for example, doctors are away at the top of the tree, and I can sort of see that as a patient you'd be far more willing to complain than a colleague. [Patient]

Overall, while differences in status were clearly seen by some participants as a possible explanation of why differences exist in regulation, it is not clear that any of them actually saw them as providing an *additional* legitimate reason for difference.

3.8 Unexplained difference

In some cases, participants could see neither reasons for nor explanations of differences in regulation. Which left them with a question: why *do* these differences exist?

> *It would be useful to understand why they feel there should be differences. Or maybe actually, if they got together, they feel there shouldn't be differences. [Registrant]*

This question stands in an interesting but uncertain relationship to trust in regulators. On the one hand, trust in the regulators can lead to the assumption that there must be a good reason for the difference.

> *Well, presumably these rules have been drawn up with specific occupations in mind. And we are not aware off the reasons why that is. Presumably there are solid historical reasons why they are in place. [Public]*

> *I'm sure there are reasons why they got certain professions need to declare that longer than other professions. [Public]*

On the other hand, the absence of an answer can lead participants to question how much they should trust regulators.

> *If it's not the same and you allow the differences, who decides those differences? Because it is left down to each individual sort of area. […] Financially, you're going to say 'We don't accept anonymous complaints' because it's going to drive your complaints down, isn't it? [Patient]*

> *The thought that come into my head is: why would it not be the same? You know, nobody's got anything to hide, or shouldn't have anything to hide. [Public]*

Pre-existing mistrust can be decisive in tipping the scales in the latter direction.

> *I see all of these bodies as not there for the public. I see them there to protect the industry, to protect their members. Right. So I would be very worried. I see no reason whatsoever why, within a period of… a reasonable period, say for argument a month, that the people who get the initial complaint can't read it and just say: is there a case, a basic case here? Yes or no? [Public]*

Even if unexplained differences are not seen as calling trust into question, they can be seen to suggest different motivations and stances towards the professionals who are regulated. Differences, that is, can be interpreted as saying something about the regulators that differ. This was the position taken by some of our professional participants in particular.

> *I think they [Profession A] have just never, historically, had a structure of note-taking. […] It's drilled into us. If, you know, someone makes a complaint or something like that, we have to have that sort of content. But I think [Profession A] don't feel… I think they feel more protected. […] I don't really think us as [Profession B], you know, would feel as protected. [Registrant]*

> *Surely a standard is a standard, and I think that's where you get the problems with health, with each organisation taking its own slight variation on the standard. That's where people start to feel: 'Well, that's not fair. I got done because I'm a social worker, but it wouldn't have been done if I was a nurse or pharmacist or doctor.' [Registrant]*

By the same token, efforts by regulators to bring the regulation of different professionals into line can be seen as a commitment to treating health and care professionals equally.

If we want to have parity with professions, certain identifiable errors should be treated the same. So you're not causing… you're not creating a 'them and us'. [Registrant]

If you want the professions to be treated more equally then the rules should be equal – to a degree. So there are obviously differences. But for something like that […] ethically, I just sort of think that they should be treated the same. [Registrant]

Note that bringing regulation 'into line' does not necessarily mean making things the same: it may mean providing the absent justification of the differences that exist.

I suppose if they can stand up to why they're there, then possibly, you know, they should stay. [So long as] you've got a rationale. [Registrant]

See, that might be fair to say that some of the details will differ or may differ. But then I would want to know: what are those details? You know, they'd have to justify that. You'd have to justify why that part needs to be different. You can't say it because it felt good. You have to justify why the thing has to be different. And then I could probably go with that. [Registrant]

The important thing from this perspective is that differences have not arisen by accident, but that they are clearly justified.

If they've got a good reason for it, then fair enough, that could be explored. But if it's just a number that they've all each picked out of the air, then I would say that it is unfair. […] I feel like they should, you know… they could come to their own conclusion about their length of time, but then perhaps they should join forces and discuss it together and then come to an agreement together. [Registrant]

I would be quite respective [sic] of… if you know, ten regulatory bodies got together and thrashed it out and spent a lot more time over this than my ten minutes thinking about it now. […] I may personally think: well, I can't really understand. You know, I don't personally see where they're coming from, but if that's what they have come to, you know, they must have thought about this pretty seriously. [Registrant]

I do have confidence in the regulators. I think they all work within their own structures. They are doing things for the right reason. I would never say that they're not acting appropriately. I think my concern is that that they'll work to slightly different levels. […] We're all dealing with people's health. And you know, I think the problem is that we not comparing apples and pears. We're comparing apples and apples, but we're all doing a slightly different job for that patient's health. So it feels wrong that we're looked at differently by the regulators. [Registrant]

4. Regulatory roles

One of the objectives of this research project was to explore how views on consistency "differ according to regulatory function (standards, education and training, registration, fitness to practise and continuing fitness to practise)". With this in mind, examples were included to prompt conversation across this range of functions.

In this section, we explore what can be learned from the different ways in which participants responded to these different examples. A critical, overarching finding is that, to make sense of these responses, the classification of 'regulatory functions' outlined in our research objective is not especially useful. And that is because these functions divide up regulation from the perspective of a regulator.

If instead we look from the perspective of patients, carers, public and professionals, what instead emerges are four broad 'roles' that regulators are seen as playing by those audiences. It cannot be stressed strongly enough that these are *not* objective descriptions of what a regulator is actually doing (as the 'regulatory functions' are), but ways of *seeing* the role of regulators apparent in the responses of our participants.

As shall quickly become apparent, different arguments for sameness come to the fore in relation to different roles. Interestingly, however, arguments for difference (with the exception of arguments based on speed of change) appear to apply across all four roles.

4.1 Arbiter

A number of the examples used in the research relate to what happens when things go wrong, and the role of the regulator in addressing this situation. In these examples, regulators were often seen as playing the role of an arbiter, deciding an appropriate response to a case.

Arguments based on fairness are central to the arbiter role. In §2.2, we have already seen how fairness featured prominently in discussion of the example of differing times for which suspensions are recorded on registers, and the example of differences in whether cases of drink driving are always investigated. Arguments based on fairness were also made in relation to the examples of:

- differing treatment of complaints made after more than five years

> *It's discriminating against… You know, why should someone come five years later and say 'He knocked me out of bed' or something, and then you investigate that because maybe it happened in a mental health institution. Whereas if it happened in a general hospital, you don't. [It's discriminating against] the patient that got knocked out of bed in the general hospital. [Registrant]*
>
> *You know, it's not fair for everybody. I think should be the same with everybody. [Registrant]*

- differing treatment of anonymous complaints

> *Say your joint injection with the GP went horribly wrong or there was something in that practice that was completely inappropriate or whatever. And exactly the same scenario happened with a physiotherapist. Why can you make an anonymous complaint about a GP but not make anonymous complaint about a physiotherapist for what is exactly the same practice. So that would be my argument to say that surely some aspect of the complaints procedure should be exactly the same. [Registrant]*

The element of fairness. I think they should all be the same. [Patient]

- different options being available following completion of an investigation

It seems – perhaps not thinking too deeply about it – seems a bit unfair to me that for some professions there's an interim option and not for others. [Registrant]

In all of these examples, the regulator was seen by participants as playing a role analogous to the justice system. In some instances, this analogy was explicit, as in the following views on the example of differing times for which suspensions are recorded on registers.

I'm thinking: if someone has committed – I'm going away from health care professionals – if someone's committed a crime and they need to apply for a job, how long should they have this mark on their records before they can get back into the real world and be welcomed back and embraced and given a chance to reform? [Registrant]

I just feel like everybody should be held accountable for the same length of time. I feel like it's only fair. I feel like it's just similar to getting sentenced to something in prison. [Patient]

More often, the analogy is apparent in the language used by participants to discuss examples. For example, note how the language of punishment and sentencing is used in the quotations below.

Essentially they're doing the same thing as other people, and they are getting punished in a different way for the same thing in a very similar profession. [Patient]

All these are health care professionals, whatever they are. We seem to need like a level playing field for the punishment or whatever. [Carer]

That is wiped off after a period of time, a short period of time, and yet another person in the other profession does exactly the same thing… It's not right, is it? […] Because, right, it's almost like the crime should fit the punishment. That's the way it should be. [Registrant]

It's like a sentence, in a way, depending on the severity of it. [Registrant]

In the same vein, note how the next two quotations describe people as 'being let off' or 'getting away with it'.

I think maybe after listening to everything here, they should have one regulator across the board. It makes it a lot fairer. And I don't agree with some being let off to a lesser degree than others. If something goes wrong, it doesn't sit right with me. [Public]

They should all be on for the same amount of time, because it's not really fair that different professions get away with it differently than others do. [Patient]

Arguments based on fairness were very important in responses to examples which prompted participants to see regulators in the role of arbiter. So, however, were arguments based on correctness. We have not focused much in this report on participant's views on the 'correct' approach to each of the different examples, as recording these views was not the purpose of the research; but, as noted in §2.1, these views were often centre stage in discussions, and especially in relation to the role of arbiter.

4.2 Assurer

A second role which regulators were seen to play is that of an assurer, ensuring that professionals maintain appropriate standards of quality. Unsurprisingly, regulators were most often seen as playing this role in relation to continuing fitness to practise examples. Perhaps as a result, the role was also clearest in the responses of professional participants. (The continuing fitness to practise examples were not discussed in all of the patient, public and carer groups.)

Not surprisingly, arguments based on adequacy played an important part in this context. Indeed, having minimum standards of *some kind* could be seen as itself the minimum standard of the assurer role.

> *It's obviously important that everybody has some standards that they have to… you know, there are some baseline, if you like, regulations in place for everybody. [Registrant]*

> *I think as long as there's core things that are implemented in each one. [Registrant]*

In line with this, the key question to be addressed was not whether regulators were doing things in the same way, but whether any had fallen below this minimum standard in relation to their role as assurers.

> *I think it's fine. Unless there was a problem with lengthy checks and there were more problems arising there that they should maybe shorten it down to like the paramedic, every two years maybe, you know… But if there's no problems then leave it be. [Public]*

> *What evidence is there that it's going wrong? So you know, obviously, if you're getting a profession that's getting a lot of complaints, a lot of legal issues, I think that is a fact that needs to be… [Registrant]*

> *I would say: if it works for those given professions and the regulatory bodies within those professions have thought that it's necessary, then it's fine. It doesn't mean that it's right for… to standardise in this case for the other professions unless there's a strong argument. […] It's got to be right for the patient. So I'm trusting these differences have been well thought out. [Registrant]*

In the same vein, some participants who *were* concerned about differences between regulators linked this to a belief that some might as a result be falling below minimum standards.

> *I live in a utopic [sic] world, and I would like to think that, you know, everybody's standards were being raised, and I do have a concern that CPD and peer review doesn't always do that. [Registrant]*

> *There's a lot of people then within the profession who sort of appear to have – in inverted commas – got away with it this time [as a result of not being selected for audit]. And I guess with the professional standards that then suggests to a lot of people that they don't need to keep that up to date. […] Whereas it appears that when the nursing revalidation comes out, everybody's got something to do. Which then pushes everybody to keep a higher standard, I think. You know, everywhere will just have those staff that just sort of sail along in the background. Yeah, but we should all be working ahead and trying to continually professionally develop and keep our skills and such up, er… in a similar ocean that we're all sailing in. [Registrant]*

Although most often raised in relation to continuing fitness to practise examples, the assurer role was sometimes linked to other functions. In the two quotations below, for example, the

same professional respondent unpacks the examples of differing times for which suspensions are recorded on registers and differing times to respond to complaints in terms of the assurer role. (This is a reminder that the role of the regulator is a feature of how that regulator is *seen*, not an objective description of what they are doing: these two examples were more commonly seen as examples of the regulator taking the role of an arbiter or a service provider.)

> *It's important enough to pull up the lower ones. […] If something blew up, you know, if some practitioner got, you know… whatever it was the first time it was, it happened again after a short period of time, and, you know, the patient said, well, I didn't know […] they had a record. […] I think that could come back and bite. [Registrant]*

> *Time of response back to the patient, I would've thought would be fairly critical. […] I think that would be a standard, you know, that could be, you know, embedded amongst them all. […] I suppose it's risk to the public, isn't it? So what if you had a practitioner doing something routinely wrong even though he thought it was right in his professional judgement? And it was left for months. [Registrant]*

Interestingly, this same participant highlighted how variation *above* a minimum standard can play a vital role in supporting innovation and improvement.

> *The diversity is nice because I think… I'm sure regulators and professions, they don't operate in isolation. They talk to each other. And if one seems to have a better way of doing things, I'm sure it gets taken up. […] Diversity is good. [Registrant]*

Other responses from professional participants positioned the regulator in the role of assurer in relation to the fitness to practise process.

> *I think it's okay to have different regulatory bodies do it different ways as long as they get the outcome that is that patient or… you know, the healthcare professional needs to be fit to practise. [Registrant]*

> *In the professional body that's got the third mediation option, actually does that mediation option take some of the full hearings away, or does it upscale some of the 'no case' to answers. […] And there will be an impact on the individuals with this. And is that impact more beneficial, less beneficial? And actually, the consideration that this is from the public purse, and the requirement for these bodies to be there is to protect the public and the patient. [Registrant]*

> *Eight weeks is quite a long time for a patient to wait and see whether or not, you know, there is going to be an investigation […] and that practitioner is still practising. That seems like a long period of time to waste. [Registrant]*

The idea of using diversity as the route to innovation and improvement was also raised by other professionals.

> *[Let's] share data, share information. So what are these…? What are the nature of complaints that come up after five years? How many of them are there? How likely are they to occur? Do we need to have a time limit or are they actually really infrequent? Let's have a look across the scope instead of just on our little patch. […] I suppose it's about trying to pick out the most effective bits. [Registrant]*

Minimum standards based on evidence of what actually ensures adequacy was also linked by these participants to the good use of public funds.

> *If instead of giving them undertakings they go to a full hearing, that's fine, okay – seems a bit kind of like heavy-handed, possibly a bit more expensive. [Registrant]*

> *It's thinking about doing things effectively, but also efficiently. You know, it's got to be a huge drain on certain regulatory bodies to always go to kind of full hearing […] when actually they might be better using their resources more wisely. [Registrant]*

Arguments based on adequacy played a central role in responses to examples which prompted participants to see regulators in the role of assurer. However, arguments based on fairness were also invoked.

As we have already seen, fairness was a critical issue when regulators were seen in the role of arbiter. The difference between these two roles and the ways in which arguments based on fairness are deployed in relation to them can be illustrated by taking a closer look at some responses to the example of differing treatment of anonymous complaints. The three quotes below appeal to fairness in a way that positions the regulator as an arbiter, receiving complaint and dishing out discipline.

> *I think it should be the same across all, because it'd be unfair if you got say an anonymous complaint and then that person was disciplined based on that, but had they been registered with a different regulator, and they didn't accept anonymous, they wouldn't have been disciplined. [Public]*

> *It's like putting one health care professional down and the other one not. To me, like, they both are and they both deserve – both parties, the complainant and the doctor or physiotherapist – all deserve the same time and the same action, if you like. [Carer]*

> *All these professionals listed here are dealing with people, hands on with people. Maybe not literally hands on, but are in the same room with people and they're basically caring for someone's health, whether it's their mental health, whether it's their physical health, whether it's their dental health. So patients should be able to complain about all these people in the same way. [Registrant]*

The next two quotes, by contrast, appeal to fairness in a way that positions the regulator as an assurer, setting expectations of professionals.

> *I think the rule should be the same or pretty much as near the same for everyone. We expect the same standard of care from everyone. We expect the same professionalism from everyone. [Public]*

> *I can't see a reason not to have a common approach. […] As a general principle I would want them to be exposed to the same standards I suppose. It's all about making the professions as effective and as safe as possible, isn't it? [Registrant]*

Fairness in relation to regulators in their role as assurers was also apparent in concerns about the different levels of burden placed on different professionals by continuing fitness to practise processes – or, in the third quotation below, on different educational institutions facing different quality assurance regimes.

> *There is an element, isn't there, of why should one profession have to do more to continue in practice than another profession? [Registrant]*

> *Why do some organisations – and you have hit a nerve here – get protected time to do their CPD and other people have to do it in their own time? […] I think if it was proved to be meeting a standard then yes, I could live with that. You know, there's a proven background to why did they do it. […] Why should one profession be burdened with six monthly and saying you're not fit to practise if you don't do it every six months, yet another organisation says you're not fit to practise unless you do it every two years? [Registrant]*

It's unfair in a way because, for instance, if I worked in one of those places where they said: 'Well, you don't really need to get much of a bird's eye view into what you do, you know, we just jump in when there's an issue, whatever'. And I feel: 'OK, yeah, I can relax.' But then if I'm in another profession, where over time they're looking in on me and I have to validate this and so on, then I would be aggrieved to know that somebody else is having a free rein. It's not fair because of that to be honest. [Registrant]

As ever, of course, arguments based on fairness rest on the assumption of an underpinning similarity. One participant rejected the idea that different burdens were unfair on this basis.

I'd be inclined to say: Just get over it. It's part of your profession. You signed up to do it. [Registrant]

4.3 Service provider

A third role which regulators were seen to play is that of a service provider, meeting the needs of the users of its services. A good example of a 'service' here is the public register.

I just think it's a public service, so why shouldn't it be the same? [Registrant]

As we saw in §2.4, arguments based on simplicity played a key role in discussion of the content and format of the register. In fact, some participants went further and noted how the aim of simplicity would be served even better by putting all the registers on a single website – albeit without any strong expectation of using it themselves.

I think the drop down menu [from the HCPC website] should include all the professionals. I think it would just be more convenient, easier to use. We're not all that brilliant […] on the computer and finding things. So the easier the better, you know. It should be, you know, simple. [Carer]

I think it would be good to have it altogether to use, you know, and […] you could look at physicians, doctors, whatever you are looking at. And it'd all be in the one area. […] That would be interesting. Although I would never… I don't think I'd ever use it to be honest. [Carer]

Interestingly, positioning of regulators in the role of service provider was also apparent in some responses to examples which related to the fitness to practise process. These included the example of differing times for which suspensions are recorded on registers (which, as we have already seen, prompted other participants to see regulators in the role of either arbiter or assurer).

I don't understand why they'd have to be different. […] They should all be the same length of time. It just makes things easier I think as well. […] It just seems… one set of rules seems more constructive for me. [Public]

I think people should be able to see what they're looking at. You know, whether they've got confidence in that person or not. [Public]

Maybe that should be one area where there is no, you know, deviation between professional groups, because it gives it a bit of a more level playing field. Because as somebody who's searching, you're not going to necessarily know that. You would have to dig a lot deeper to sort of find that that information. [Registrant]

A similar focus on simplicity in relation to service provision was apparent in some responses to the example of differing times to respond to complaints, with the 'user of the service' in this instance being the complainant.

> *I think in an ideal world, a complaints procedure would be fairly uniform so that you know the public can understand the process. [Registrant]*

> *You might get elderly people who one day are maybe complaining about a physiotherapist, another day about a dentist. It might confuse them, knowing and understanding all the different times of when you can get feedback back. [Patient]*

> *I suppose there's consistency throughout the whole healthcare. And as a patient, you would… maybe you would know your rights more because everywhere, everybody you visit, and everywhere you go it's the same. [Public]*

One respondent argued on similar grounds for the complaints process as a whole to be standardised – setting their sights far more broadly than health and care professions.

> *Because, for instance, if I have to complain about my GP, which I have done, or I had to complain about a solicitor, I would know that route, I would know what could be… what had to happen. And if that didn't happen, I could then complain and say: wait a minute, you should be doing this, and you should be doing that. [Public]*

Describing a complainant as the 'user of a service' may seem inappropriate to some, but the language is not ours. Responses to the example of differing times to respond to complaints in particular made regular use of the language of customer service and consumer rights.

> *I know a patient and a customer is two different things. But it isn't… So level of customer care there as well so, you know… You want to be getting your information about what's going to be happening as soon as possible, because no one likes to be left hanging at all, do they? [Public]*

> *I think an acknowledgement time should be pretty standardised because nobody wants to wait six weeks to see if they've got their complaint and they're going act on it or not. So I don't think you're asking too much to be acknowledged within a reasonable amount of time. [Patient]*

> *I think those rules should be standards and it should be a standard response. Like we'll investigate… we'll get back to you in five days of whether it's going forward or… and then we'll get back to you in, say, four weeks with the results of the investigation. If anyone's making a complaint, I think you all have the right to be fed back to. [Patient]*

Some participants saw an analogy here with other service agreements.

> *I kind of link it back to the bank. You know, we had the Financial Services [Authority] and every single bank played by the same rules when it came to complaints. There was a procedure with timelines that had to be met. Or every financial institution, not just the banks. So I would have thought that healthcare would have been the same across the sector. [Carer]*

> *I presumed that everybody had to do the 21 days where they decide what they're going to do or not, that you have to be, you know, replied back to whether they're going to take it on or what's going to happen. […] When I say about the 21 days, it's just if you put your complaint in they're supposed to reply back to you within 21 days to say they've received it. [Public]*

In all of the above examples, however, it will be noticed that the focus has shifted from arguments based on simplicity to arguments based on adequacy. Minimum standards were a consistent feature of responses which positioned regulators as service providers, in particular in relation to this example.

> *If you can do it within two weeks then fine, brilliant. But I don't think it should take eight weeks for me to complain about someone and it takes eight weeks just to hear back. [Registrant]*

> *It doesn't matter what sort of profession you are. Regardless, you should have to get back in touch with people if they've raised serious complaints. […] You don't want to be left hanging there, dilly-dallying, thinking that people don't care about justifiable complaints that you may have made. [Public]*

Failure to set and meet those minimum standards was seen to raise questions about the professionalism of the organisations providing the 'service'.

> *Not having the same service across the board, in my opinion, would just be lazy. [Patient]*

> *I don't think that's very professional. And I think if you're the person that's lodged the complaint, it could be very sort of like stressful, upsetting, all sorts of issues. So I think there should definitely be a standard framework of when they should get back to you. [Public]*

> *I think my gut reaction to that would be that that's unfair because I think it's just disrespectful, isn't it? Just to sort of leave somebody dangling. We've had this: hey, we'll get around to it in our own time. […] I think you would want to feel that there's a high level of professionality coming from the regulatory body, and it's a sort of common courtesy, isn't it, to say we will respond within this length of time. [Registrant]*

4.4 Team enabler

Regulators regulate individual professions, and are themselves independent. But as has been noted before, health and care professionals do not in general work in isolation. They work with other professionals, often in multidisciplinary teams, and with the patient as the central member of that team. The fact underpins the fourth role which regulators were seen to play: the role of team enabler, supporting the smooth functioning of the team around a patient.

Not surprisingly, arguments based on coherence play an important role in relation to this role. Ensuring coherence means removing potential barriers and sources of conflict – a prime example again being the example of differing guidelines around cases where a patient withholds consent for a professional to inform others they are at risk of harm

> *You go and discuss that with the nurses up in casualty and say: look, should we really be getting in touch with someone else? The patient doesn't want us to phone the police. But you know, they've clearly had a good beating. You know, if my professional code of conduct says, depending on the circumstances, I could do that without the patient's permission, but then the nurses' code of conduct says no, I'm not allowed to without the patient's permission, then if I do go to phone the police, then I might be putting that nurse in a difficult position. [Registrant]*

As this participant goes on to argue, however, enabling an effective team is not just about removing sources of conflict. It is also about encouraging a collaborative mindset.

Some professionals that I've worked with just feel that once they've done what's been asked of them then that's all they need to do. They don't need to… They think that maybe that person is maybe at risk if they go back to that home or whatever, but that's not for me to decide, that's for the nurses up in A&E to decide. You know, some people don't think that laterally, I don't think. [Registrant]

Some professional participants expressed interest in the possibility that regulation might play a role in bridging the gaps between professions and fostering this kind of collaboration, for instance through greater alignment of continuing fitness to practise processes, or a common code of practice.

I guess there could be greater scope for joining up some of the CPD discussions that we have. […] That would be one way, you know, to strengthen the bond. So perhaps if we had a better understanding of what their requirements are and they had a better understanding of what our requirements are, are they similar – which they might be, I'm not sure – that would be… you know, there would be an added benefit for the workforce and then ultimately for, you know, patients. [Registrant]

I suppose when it comes to interprofessional working, you know, if… which was taught a lot to us in university, working with social workers and physiotherapists and podiatrists and things like that, but it's never something I've really put into practice. […] If we were improving more practice in the same way, then we would be able to, you know, bounce ideas off each other. [Registrant]

There's so much difference between the different professions, and those people who work in those different professions, they all have different ideas and different expertise. But it's really good if you can work well as a team because that works out best for your patient. So I think something like having a code that everybody is part of makes you seem like more of a joint thing, like a joint team, rather than different professions doing different jobs which are completely separate, even though it's to the same patient. [Registrant]

Also implicit in the quotations above is the role simplicity can play, alongside coherence, in enabling teams to work more effectively. For example, a better understanding of each other's requirements would be greatly eased by minimising the differences between those requirements.

A lot of issues come from not understanding each of those roles and poor communication between each other's roles. And also not understanding each other's regulatory body. So where to actually go if you have a bit of a concern. […] We don't know how to raise our concerns about them [members of another profession]. [Registrant]

Simplicity is especially important when it comes to the patient's interaction with the different members of the professional team – as illustrated in the following response to the example of differing guidelines around cases where a patient withholds consent for a professional to inform others they are at risk of harm.

Maybe the patient doesn't know. So say they go to the doctor, the dentist. They don't know their rules and their profession, so they should all be the same. So the patient knows how the information's passed on, if that makes sense. You know, the patient may not know the rules, so that's not really fair, if they tell the dentist to keep it in confidence, and then the dentist can actually pass it on without them knowing. […] Obviously it will be hard to agree because there's so many different professions that we're talking about, so more than likely they won't come to an agreement so it needs

> *to be talked about and kind of sorted in a better way. So it's kind of more straightforward to a patient. [Patient]*

As has been noted, arguments for sameness all rest on an appeal to an *underpinning similarity* between professions. And one thing that all health and care professionals have in common is that the same individual patient may see any one of them.

> *I might be taken to hospital by a paramedic who might take me to see a hospital nurse who might pass me on to a surgeon who might pass me on to a radiographer. [Registrant]*

5. Sameness/difference

In §2 and §3 we have reviewed the different kinds of argument made by participants for sameness and difference in regulation.

As has been noted, however, the overall position taken by a participant on a topic was sometimes neither an argument for sameness nor an argument for difference but a balance between the two. And even where a simple argument for sameness or difference is made, it is often surprisingly easy to reframe that position in the opposite terms: different applications of the same principle, the same process delivering different outcomes, and so forth.

In this section, we explore some of the key ways in which sameness and difference interacted in the responses of participants.

5.1 Principle and application

Most of the arguments for difference discussed in §3 relate to details of the interaction between a real professional and a real patient. As one participant noted, the further one abstracts from these details, the clearer the case for sameness becomes.

> *When you look at it in black and white, they really should all just be the same. Yet I can understand why they're different. Because there's no context to who the patients are or what any situations are. So on black and white, you should say: no, they should all be the same. [Registrant]*

But how well does the 'sameness' that appears at this abstract level fare when one returns to the details of reality? Standardisation – the process of making things 'the same' – can sometimes be associated with rigidity in the face of these contextual differences.

> *I don't think rigid regulations work, because how do you… There has to be circumstances that you need to get around the regulations for one reason or another. But you can't because they're so rigid. [Public]*

For one professional participant, this was precisely how visits from a different kind of regulator (the CQC) felt.

> *Our dealings with them are always we find incredibly inflexible. So that might be an argument against unifying things. […] It feels like an external body coming in, who doesn't really understand how we operate on a day-to-day basis, with very idealistic views, and applying those to… you know, to several different environments or services. [Registrant]*

It is worth stressing, however, that these are *not* arguments against making things the same: they are arguments against making things *that should be different* the same. Issues of rigidity can be avoided by distinguishing principles from their application:

- A good principle is one that captures what is the same across many applications, while allowing legitimate differences in concrete circumstances.
- A good application is one that reflects legitimate differences in concrete circumstances, while staying true to the general principle.

In a similar way, the quotation that follows is not an argument against allowing things to be different, but an argument against allowing things that *should be the same* to be different.

All these people on the list should have the same standard when it comes to our relationships with… personal relations with patients. Appropriate, suitable, allowed, not allowed. Our relations with previous patients. And all that whole list, I would think, my opinion will be that they should have the same standard applied. [Registrant]

The critical question being addressed in all of these cases is not 'Should things be the same or different?' but 'At what level of abstraction from concrete details does sufficient sameness become apparent for a principle to be framed?

This question was directly addressed by some of our participants in relation to codes of conduct, albeit with very different answers.

The roles are so different. I don't know. Unless the code the code of conduct was very brief and not particularly in depth. [Registrant]

The NMC code of conduct goes into absolute depth about how to speak to people, how to treat clients, how to treat people with dignity and all that kind of thing. I don't see why that isn't also included in all of the other professions that deal with people. [Registrant]

One participant felt that the level at which a satisfactory principle could be framed might vary between different areas of a code of conduct.

I think when you're actually dealing with emotional and psychological issues with patients, you can't… it can't be black and white. Whereas if you've done something wrong to a patient, if you have caused harm or anything, that is easy. You should apologise. You should tell them. You should do everything. You should be honest. [Registrant]

The idea of a 'core' set of principles across all professions, with variations in other areas (compare the idea of minimum standards discussed in §2.3) was also raised by a number of participants.

Across every profession those core principles should for the most part, or could for the most part, be very similar. So you're looking at standards of care. You're looking at things like confidentiality [Registrant]

I think in a way there should always be some core… some core principles that they should maintain. [Registrant]

I think that they'll all have specific ones to them, but they should all have a group of basic ones that cover everything. Like about your character, you can't tell lies about people, you've got to be open, you can't be verbally abusive. [Patient]

Others mooted the idea that principles might apply to most professions with specific professions having justified exceptions as needed.

As professionals we have more core standards that match than don't match. […] They could quite easily make allowances for certain professions in certain situations, but still within the spirit of the regulation. [Registrant]

I think each profession will probably have their own their own exceptions that they would like to sort of bring into that. I think that's the thing. So should they all be the same then? No. They should have the same basic ethos, but be different for the scope of practice for each professional. [Registrant]

However, the requirement for differences to be justified reminds us that even additions and exceptions to a general principle will themselves reflect the application of *another general*

principle applied – to borrow a phrase used frequently by participants in this research – 'across the board': for example, the principle that regulation should reflect differences in risk, or scope, or whatever it may be.

On the other hand, as one participant pointed out, even a principle on which everyone agrees may leave room for debatable difference when it comes to its application:

> *If an ambulance breaks down on the way to a patient that's been on the floor already for two hours, and that ambulance breaks down, so there's a delay. […] That wouldn't fall under duty of candour. But should it? Clearly I understand that if we do something to harm the patient that very much does fall under the duty of candour. But there is also some middle ground there. [Registrant]*

5.2 Process, outcome and input

The relationship between principle and application is one of the key ways in which sameness and difference can interact. Another is the relationship between process and outcome. In our research conversations, this distinction was most clearly thrown into relief by participant responses to a graph showing, by regulator, the variation in the proportion of registrants at the four stages of the fitness to practise investigation. The graph[3] is shown below.

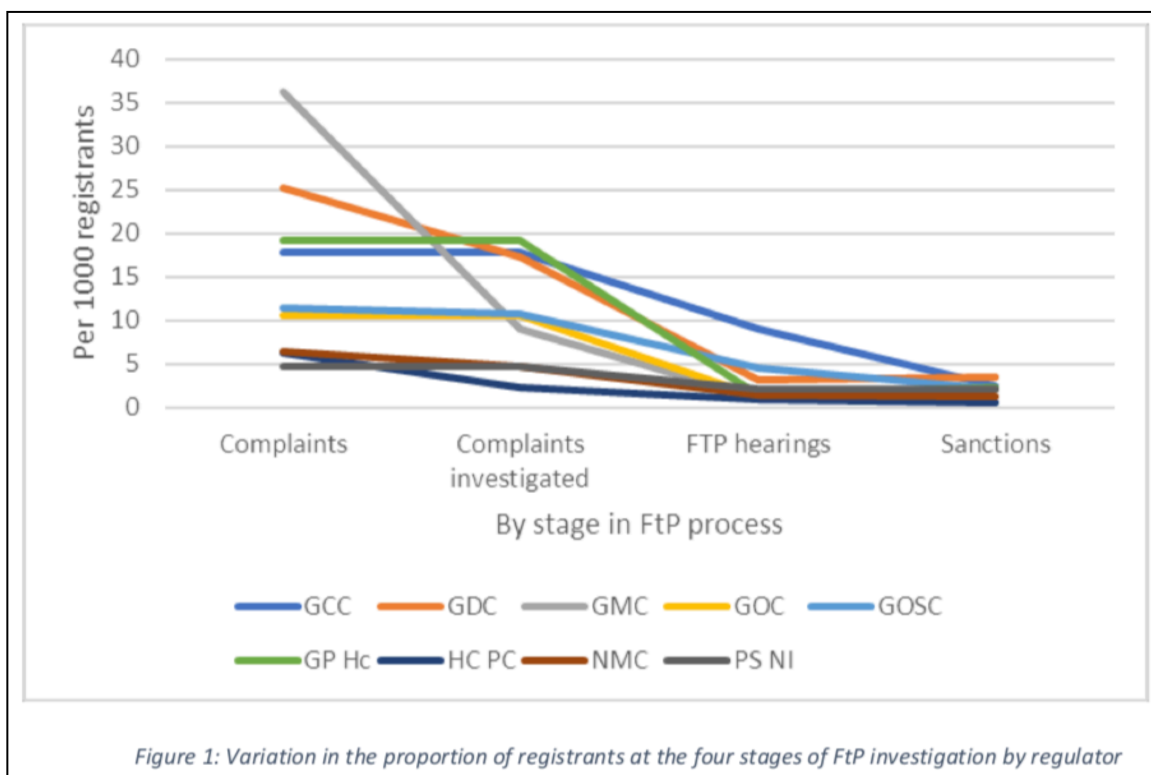


Figure 1: Variation in the proportion of registrants at the four stages of FtP investigation by regulator

In most cases, the first thing participants commented on when presented with this graph was neither the process nor the outcome, but the inputs. Almost without exception, the different numbers of complaints about different professionals were thought to be explicable and, often,

[3] This graph is reproduced from Griffin, A, Medisauskaite, A, Sarker, S-J, Viney, R, Knight, L and Tweedie, J (undated), *Developing a methodology to assess the consistency of fitness to practise outcomes*, a research report prepared for the Professional Standards Authority by the Research Department of Medical Education, UCL Medical School

unsurprising. Moreover, the explanations offered for these differences – a selection follows – read like a recap of the arguments for difference discussed in §3.

> *They're [doctors] performing a lot more or seeing a lot more higher risk things, I guess. Performing higher risk procedures that will inevitably not have good outcomes for the individual. So therefore triggering unhappiness with whatever complaint going in. [Registrant]*

> *All that I could think was obviously the nature or what could potentially be reported with a doctor, like intimate things. [Carer]*

> *I know that midwives are particularly complained about and investigated. […] People don't expect their baby to die, and people don't expect their wife to die or be injured during this seemingly natural process. Whereas maybe somebody… a nurse who works in a hospice, may be under less direct observation, because her patients in her care are expected to die? [Registrant]*

> *We're not dealing with the same patient groups, we're not… Patient expectations. [Registrant]*

> *In my experience, a lot of people will complain just because they don't like something, not necessarily because something has been done wrong, especially when it comes to doctors. [Registrant]*

> *We all see doctors so many more times than we see any of the other professionals, so it probably makes sense that there's more complaints. [Carer]*

> *The GMC have a lot of numbers because […] I think you as a doctor spending not much time with the patient, you know, so they're very short time. But other health workers have more time. [Registrant]*

> *You can just go to a different pharmacist. It's easy. [Patient]*

> *I would have thought that the pharmacies don't get a lot of complaints because they pick up the mistakes that the GPs make. [Patient]*

> *I wonder if it comes back to this sort of hierarchy of responsibility again. […] The complaint is going to come in against the GP, and then the nurse will be asked to make a statement. Sometimes I think it's who is ultimately at the top in terms of responsibility. [Registrant]*

The next thing participants typically focused on, however was the differing *gradients* of the lines from 'complaints' to 'complaints investigated'. There was a range of different responses to these different gradients, falling into two broad categories.

On the one hand, some participants speculated about ways in which the gradients might reflect different *inputs* – i.e. different kinds and qualities of complaint.

> *I can imagine there's reasoning behind it depending on what the initial complaint is. [Carer]*

> *I suppose one explanation could be that the pharmacist's is effectively a shop. You go in, you buy the thing. [Pharmacists] don't have much physical contact with you. So they either get it right or they get it wrong. […] Whereas a doctor… Because the doctor's potentially touching you in various places and all the rest of it, it could be pretty grey. [Patient]*

> *My first thought is: by the nature of the different professions, are people much more likely to make much more superficial complaints in one profession compared to*

another? Are people much more likely to complain: 'My doctor kept me in the waiting room for one hour'? [Registrant]

You don't have a clue what the complaints are. It's impossible to say how many sectors attract the most bogus complaints. [Patient]

On the other hand, some participants speculated about ways in which the gradients might reflect different processes – perhaps as a result of different stances on complaint investigation.

It looks like some of them are automatically investigated and others aren't. They don't all have the same system then. [Patient]

Why is that percentage different? Because I personally would think that a GP is just as important to investigate as the pharmacist. [Patient]

Is there just not enough manpower beyond the complaints for them to be all investigated? [Patient]

The complaints investigated is the same as the amount of complaints… I think that's quite good. Because to me that means that they take complaints, however small, however seemingly insignificant, seriously; and that would that would tell me that as a professional body they want to learn from mistakes or potential mistakes. [Registrant]

That's how it feels to me on the ground: that if I get a complaint made then it will get investigated. Yet other organisations, complaints are made and they don't get investigated. And I think: yeah, that just feels… it feels wrong. [Registrant]

Other participants moved back and forth between these two possibilities as they developed their thinking.

Clearly there's a different rule of thumb or different criteria for some of these other organisations. […] Because we don't know what we don't know, here, right? As the complaints might be about, I don't know, a filling in the wrong tooth. It may be malpractice or it may be inappropriate behaviour, so we don't know. [Public]

I would imagine that a lot of complaints are trivial. […] I think the green line and the blue line, they initially are looking to think: do you know, these complaints are so trivial they are not worth our time and money looking into them. […] I would question that. I think, you know, they're really not investigating very many complaints, or they're living in a world where everyday complaints are part of their day-to-day life. But again, that in itself has to be questioned. [Public]

Looking at the outcomes does not help either, as these too can be interpreted in different ways depending on the assumptions one makes about the process that leads to them (and the levels of trust underpinning those assumptions). Consider, for example, the following two contradictory responses to the fact that all of the lines end up at roughly the same level when it comes to sanctions.

I kind of get why they're all level at the end because, see, at the end of the day, like they're all professionals, so it's likely that they shouldn't be making many mistakes really if they're good at the job. [Patient]

Maybe it would make you wonder if it was worth complaining. [Patient]

To form a view on the data presented in the graph, and whether or not it is justifiable, one needs to understand the *processes* the different regulators are applying. Inputs and outcomes in and of themselves tell you nothing, because inputs and outputs are liable to variation.

> *There has to be some transparency across the board in these things as well, and for complaints that weren't brought forward on any of those bodies, obviously, we would need to know why. And yes, I think that that would be a reasonable assumption that that would have to be all the same. [Public]*
>
> *Who's making the decisions? I mean, who are on the board? Are they qualified in the same area so that they're making an informed choice? Or are they totally impartial? […] I think they should all be following the same guidelines. [Patient]*
>
> *I don't suppose it really matters sort of where they start off, so long as they're investigated properly. [Registrant]*

So should the process be *the same* across regulators, as the first two participants quoted above suggest? This research was not designed to deliver an answer to that or similar questions; but it was designed to establish *how* such questions are answered by participants. In the next section, we shall explore how the arguments presented in this report were deployed in relation to one specific topic: the continuing fitness to practise process.

5.3 Example: making fitness to practise fair

Should a process be the same or different across different professional regulators?

By now it should be clear that the answer to that question depends not just on whether one believes that an argument for sameness applies – because there is an *underpinning similarity* between professions – but also *what kind* of argument for sameness (§2). Is this an issue of correctness, fairness, adequacy, simplicity or coherence? That will in turn depend on the role one sees the regulator as playing in whatever example is being discussed (§4).

For example, in §4.2 we saw how, in relation to processes around continuing fitness to practise, participants tended to see the regulator in the role of assurer. An associated focus on adequacy meant some participants worried less that about whether processes were exactly the same than about whether they met the minimum standards that would need to be met by *any* continuing fitness to practise process. Others, meanwhile, raised concerns about fairness, especially in relation to the burden being placed on different professionals – an argument which does suggest making aspects of the process exactly the same. In §4.4, however, we then saw examples of participants approaching the same processes with the regulator cast in a different role – that of team enabler: a role which shifts the focus to simplicity (reducing unnecessary differences between processes) and coherence (ensuring processes fit together, even if they are not exactly the same).

One's position will also then be shaped by which kinds of difference one believes are relevant (§3) and the approach one takes to balancing these differences against the need for sameness (§5.1).

For example, in §3.6 we saw how the speed of change in an area of expertise was seen to be relevant to continuing fitness to practise in a way that it is not to other areas of regulatory activity. Participants varied, however, in whether they considered this meant that there was basically no point trying to align the process across multiple professions (i.e. that there was in fact insufficient underpinning similarity between them); that exceptions would be needed for specific professions; or that the variation could itself be accommodated as a general principle describing how things differ (§5.1).

The fitness to practise process provides another good example of how the different arguments explored in this research were assembled and balanced by participants. Many of the examples

used to prompt conversation could be related in some way to the fitness to practise process, including some that were not intended to be illustrations of this process. For instance, examples about differences in codes of conduct could be – and at times were – unpacked in terms of professionals facing different consequences for the same behaviour.

On different occasions, regulators were seen as playing each of the four roles in relation to fitness to practise, with different consequences for the arguments applied. In the example that follows, however, we will focus on just one, common perspective on fitness to practise: one that sees the regulator as playing the role of arbiter, and focuses on the need for the process to be fair.

What does the need for fairness mean in practice? Should there be a single process applying to all health and care professionals; or are the differences between professions such that having different processes is in fact fair?

One possible argument that could be made here is that variations in process do not actually matter that much so long as the processes arrive at fair *outcomes*.

> *Whatever their profession is, if it's bad enough to have that punishment, then they should have the same. [Carer]*

However, where this argument occurs in our participants' responses, it is usually because the participant is refuting it. Some professional participants in particular were keen to point out that just getting to the right 'outcome' is not good enough to assure fairness.

> *One thing I do find interesting is we talk about the sanction as being an outcome of an investigation. Whereas an investigation, with stress upon that person and peer insight, is a predetermined sanction. And therefore, I think, there should be a lot more standardisation towards that. […] Why should one person have to sit through a board or a full investigation and such? Whereas if you were a nurse […] you wouldn't have to sit through this same level. [Registrant]*

> *What about the six months of stress, torture, not working while you're waiting for the investigation to happen. Because we all know that these organisations don't work quickly? [Registrant]*

In the public, patient and carer groups, this kind of response was also apparent when the differences being discussed were framed in a way that drew attention to what they might mean for an individual. For example, the example of different options being available following completion of an investigation was abstract and hard to engage with for many participants, and in some groups the interviewer would respond to this by illustrating the example with the cases of two imaginary professionals who receive the same complaint but go through the two different processes. The following quotations are responses to this kind of framing of the difference.

> *No, that's not right. That's like throwing the nurse under a bus. [Carer]*

> *Just because it's their profession that shouldn't be… it should depend on the complaint itself […] and the severity of what they're alleging has happened. [Carer]*

> *I think if it's the complaint about two people, two professionals, just because they're run by different bodies… to me, they should be treated as a one complaint. [Carer]*

Considerations such as these led a number of participants to conclude that the only way to make a process fair would be to make it the same for everyone.

> *I think obviously everyone is different. But the same procedure should or shouldn't apply for all to say: are we going to investigate this or not? [Patient]*

I reckon they should probably be the same. I don't see why they should be different proceedings, because it's sort of decided on outcomes and things. And I don't see why that would be different depending on your profession, whether it was one way or the other, whether it was the three or the two outcomes. [Registrant]

However, there is a potential problem here. It becomes apparent if one looks again at the framing used to illustrate the example of different options being available following completion of an investigation. That framing involved 'two imaginary professionals who receive the same complaint': but is this possible? Or are the differences between professions such that the complaints will never in fact be the same – for example, in relation to the risks associated with their profession.

There's a huge difference between a complaint say about a heart surgeon or a complaint about a chiropodist. They're opposite ends of the scale. [...] The amount of harm to a patient. [Patient]

If a doctor or a nurse makes a mistake, it could cost somebody their life. But if a physiotherapist makes a mistake [...] it isn't as maybe not serious. [Patient]

Matters are further complicated here by the fact that risk operates in two distinct ways in this context.

- On the one hand, the higher risk profile of certain professions may mean that their errors or misconduct tend to be more severe.
- On the other hand, the higher risk profile of certain professions may mean that the implications of errors or misconduct for future practice raise graver concerns.

On the first of these points, some participants noted that the process for dealing with a complaint may need to vary depending on its severity. One participant, for example, made a comparison with different levels of disciplinary action in their own workplace.

There are different rules for different severity of the problem. [Carer]

Another participant speculated about a system in which regulators were divided not by the profession they regulated but by the severity of the complaints they dealt with.

It depends if you get different regulators for different severities or if they're all just dealing with... So if they're different severities then, yeah, it's fine to have different rules, but if it's a mixture of the same... So if you have one regulator and [...] someone put in the same complaint, but it was dealt with in a different way with a different regulator with the same complaint then it's unfair. [Public]

However, as other participants noted, having different processes for different levels of severity in fact assumes a single overarching process which directs complaints to the correct approach (or, in the world imagined in the quotation above, refers them to the correct regulator). A single overarching process, in fact, very much like the ones already in place – but applied across all professions.

I think they've all trained. They all know the standards. If they don't meet the standard, that's what happens, whether it's trimming your toenails or cutting you open and replacing your heart. [...] The thing is, there is the investigation before you reach that point. So you know, if somebody cut someone's toe while they did it, so it's not that serious, that would be found along the way. You know, being fit to work is you've done something seriously wrong. [Patient]

I still think it should be like the same sort of policy and procedures that's in place. So obviously, if it's something more severe than it gets, you know, looked into it more, but I think it should be the same sort of policy. [Patient]

If everybody's investigated then the circumstances would come to the front. So I don't see why it would make a difference if that it was all just the same. [Patient]

The fact that the higher risk profile of certain professions may mean that their errors or misconduct tend to be more severe is not, therefore, an argument for each profession having a different process, because the process should itself accommodate the differing severities of different cases. The principle (process) should be the same for all, even if applications of that principle (outcomes) will vary greatly between professional groups owing to differences in the severity of cases (inputs).

So you'd expect a sort of full hearing for where there's a high level of concern. Where there's a lower level of concern and you can see that the interim option might be sensible. So is that occupation specific, or is it that you can have the same range across occupations? It would think it's probably that you could have the same range across occupations, which then would lead me to come out on the side of everyone should have the same approach. [Registrant]

Things are not quite so clear, however, when it comes to the implications of errors or misconduct for future practice. Consider the following quotations from one of the groups – the participant quoted in the second is responding to the points made by the participant quoted in the first. They are discussing the example of different options being available following completion of an investigation.

I can see there is a difference, because if you've got like a surgeon and he makes, you know, a proper blunder, blatantly, you wouldn't really want them in the middle [option], would you? To give him another chance to do… I don't know. Or you'd want to give somebody with a lesser responsibility the chance to amend their ways. But if you're somebody who should be top of their game, you wouldn't really want to give them another chance to make an epic blunder. [Patient]

I don't see the issue with having a middle ground, because it depends on the nature of the complaint. You know, if it's a minor indiscretion, then is there any point paying all these people to have a hearing when the conclusion is actually he needs to go on a training course. And having a sensible middle of the road conversation, even if it is with a doctor, a surgeon… When clearly if they've gone and killed somebody then you're going to have to go to the nth degree. [Patient]

The second participant offers a strong argument here for differing levels of severity between professions not being reason to have different processes – the kind of argument discussed above. To some extent the first participant invites this response, because he imagines the surgeon making 'a proper blunder'. However, in the first participant's argument the issue of severity is tied up with a second issue: the gravity of one's concerns about future practice.

You'd want to give somebody with a lesser responsibility the chance to amend their ways. But if you're somebody who should be top of their game, you wouldn't really want to give them another chance to make an epic blunder. [Patient]

This is not the only occasion when this confusion between past severity and future risk was apparent in exchanges in groups. (In fact, the interviewers themselves sometimes confounded this distinction, which only became clear to us as researchers quite late in the process of analysis.)

A: If you were going to investigate the radiographer or the GP, surely you'd be… if you were going to do… you would investigate the GP more than the radiographer.
B: It depends what the complaint is though.
A: Yeah, that's what I mean. But just going on what the issues could be. You'd have more issues with a GP than you would with a radiographer. [Carer]

Unlike past severity, participants' responses suggest that future risk may imply a need to differentiate between professions.

The point can be made clearly by looking again at the example of differing times for which suspensions are recorded on registers. A few participants felt that the differences here might be explained by different severities.

To me its different professions so they wouldn't be doing the same thing wrong. So obviously, for one to get suspended against a doctor being suspended… well to me a doctor getting suspended is going to be a higher degree off something that's done wrong. [Carer]

More often, however, participants argued that the severity of the complaint should be *irrelevant* to the time for which a suspension was recorded, because the process that led to a suspension being imposed *ought already to have taken that severity into account.*

If they've been suspended it's obviously been something serious. You don't just get suspended for, as I said earlier, nicking someone's lip if you're a dental nurse. [Public]

If an audiologist has done you harm, then it must be something bad because all he's doing is checking your ears. So if he's been suspended or, you know, for any misconduct like that, then you want to know why? Because he's not actually cutting into you like a surgeon is. So what is he doing that's done you harm? [Public]

You don't suspend anyone from the register unless there's good evidence and it's gone through quite a process. So I'm just being careful just to make sure… Could one practitioner's suspension be much less serious than another's to allow that difference in clearing their name? I can't think of… I don't know exactly what osteopaths get suspended for, and physiotherapists… obviously doctors you do hear about more. But I imagine […] they've fallen short of professional standards to raise them to a pretty high degree. I would say my gut instinct […] it sounds like an area where it should be more a level playing field. [Registrant]

The same does not apply, however, if one focuses instead on *future risk*. (Note also how the last participant quoted below, a professional, self-consciously draws attention to his own use of the language typical of seeing a regulator in the role of arbiter.)

If I found out my doctor had been suspended I'd want to know why. If my physio had been suspended, it's different. […] The hospital nurse and a dental nurse, you've got life and death in one corner, and then you've got uncomfortable pain in the bottom corner. So there's two different, completely different things. [Carer]

If it's a high level job where you are, like, a doctor, I think it should be there for a longer period of time. Rather than, somebody who's… Somebody's career like a physiotherapist or whatever, where they could have a sort of a fresh start and get wiped off and start again. [Patient]

If you are a surgeon and you make a mistake that killed somebody, that people should know that you've done that. If you are testing someone's hearing, nobody's going to die. [Patient]

I would say on average, within different professions, you do have greater or lesser ability to cause harm to bigger numbers or less number of individuals. So on that basis, maybe a variation in sentences is – [laughs] sentences! – is warranted. [Registrant]

For these participants, future risk is a difference that makes a difference. It is fair that the lengths for which the suspension is recorded differ because there is an important respect in which the different professionals are *not* similar.

But does that mean it is fair for the process to differ? Not necessarily. The problem is that, as noted in §5.1, exceptions to a general principle themselves reflect the application of *another general principle* applied 'across the board' – in this case, the principle that the length of time suspensions are recorded for should reflect the risk associated with a profession. Differences still need to be justified, and that justification *unavoidably* depends upon reasoning which cuts across professional groups.

I think everyone should be subject to the same rules. But there are… in cases between a doctor and the podiatrist cutting your toenails, it has to be sliding rules involved in that. [Public]

There needs to be a wider scope of what could sort of go wrong for the likes of people that are more hands on and do more invasive treatments. But again, standards need to be sort of as close together as what they possibly can. [Registrant]

If you look at the standard, the standard is basically the same. You all have to prove… you all have to keep up your training, you're all keeping records. It's just different levels for different roles, which I think is fair. [Patient]

This reasoning across professional groups, moreover, is merely an extension of reasoning which already has to take place *within* those professional groups. The simple fact is that the arguments for difference outlined in §3 do not for the most part neatly coincide with the boundaries between existing regulators, but instead run deep in their existing activities.

I suppose if you give an example of me x-raying the wrong body part, that's a relatively small unnecessary dose of radiation. But then if you walk up my corridor and you go into MRI, the safety protocols in place in MRI are massive compared to the ones that are down just in the normal x-ray department, because of potential serious injury. […] Each profession can have its… severities, of a doctor that maybe forgets to sign a prescription all the way up to a doctor that removes the wrong kidney. [Registrant]

From this perspective, a fair fitness to practise process would be one that *accommodated* relevant differences between health and care professionals, whether those differences arise between or within professional groupings. It would be the same process 'across the board', but its application would yield outcomes that reflected the real differences between *and* within professions.

CONCLUSIONS

One word that has been used very little in this report is 'consistency' – the very concept on which the objectives of this research are focused. So what in the end do our findings enable us to say about consistency? What is it? To what extent, when and why was it considered valuable by our participants in the context of health and care professional regulation? Does that differ according to regulatory function?

In the discussion of design considerations in the methodology section of this report, we noted that the word 'consistency' hovers between being *descriptive* and *evaluative*. In its evaluative sense, we suggested that the word means something like: 'things that *should be the same* are the same'. This is the kind of consistency that is valuable in itself – but not in a very informative way, since it leaves the question unanswered: *what* should be the same, and *why*?

In light of the findings of this research, we can propose some developments of and additions to this initial statement.

First, our analysis suggests that this question can be answered in more than one way. Five distinct kinds of argument for sameness were identified in the responses of our participants, each with different implications for the *kind* of sameness sought – although each rests on an appeal to an *underpinning similarity* between professions. In the context of health and care regulation, which argument is seen to be relevant to any given example depends not on regulatory function but on the role the regulator is seen to be playing by the person making the argument. The table below summarises the arguments for sameness and their connection to the four roles identified.

Regulator roles

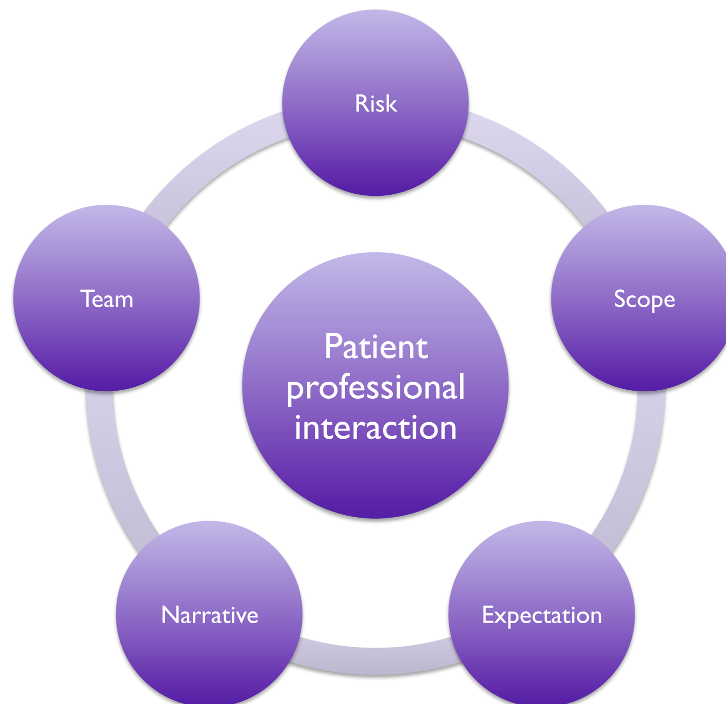
Arbiter	Decides appropriate response to cases
Assurer	Ensures professionals maintain standards of quality
Service provider	Meets the needs of users of its services
Team enabler	Supports functioning of the team around a patient

Arguments for sameness

Correct	Items should be the same as the 'correct' item
Fair	Items should be the same as each other
Adequate	Items should meet the same minimum standards
Simple	Unnecessary difference between items should be reduced
Coherent	Items should align with each other

Secondly, our analysis of participants responses suggests that, to fully understand consistency, we also need to ask: *what* should be different, and *why?* Consistency is as much about the differences that make a difference as it is about points of commonality. In the context of health and care, the differences identified by our participants related for the most part to the interaction between professionals and patients (although differences in the speed of change in a

specific area of expertise were also seen as relevant to continuing fitness to practise and quality assurance in education and training). In our analysis we grouped these differences in the interaction between professionals and patients into five types of argument for things being different, as shown in the diagram below – although these arguments overlap and blur into one another.



Thirdly and finally, our analysis reminds us that both sameness and difference need to be justified and brought into a proper relationship with each other. It is in this proper relationship that something worthy of the name 'consistency' is most likely to be found.

For our participants, advocacy of 'consistency' was rarely ever a simple matter of asserting that regulators should operate identically. Instead, in their responses, they teased apart the value of different *kinds* of sameness, reflecting different assumptions about the roles played by regulators and requiring different kinds of harmonisation. And they weighed the value of these different kinds of sameness against the value of justified differences in process, principle and outcome. Through these arguments run a few fundamental principles:

- Sameness needs to be justified on the basis of an underpinning similarity between professions. To the extent that different professions are seen as being the same in some important respect – they all work in health and care, they all see patients, they are all in positions of trust, etc – so too relevant aspects of their regulation can be expected to be the same.
- Difference needs to be justified on the basis of a difference that makes a difference. To the extent that different professions are seen as being different in some important respect – the scale or scope of harm they can cause, the expectations patients bring to an interaction with them, the role of that interaction in a broader narrative, etc – so too relevant aspects of their regulation can be expected to differ.

- Both then need to be accommodated by the relationship between principle and application, or process and outcome. For example, the need to reflect *differences* in the risk of harm between professions might best be achieved by applying a single, shared principle – hence the *same* principle for all – of risk-based regulation; or by implementing a single shared process – the *same* process for all – that treats risk of harm as an input and adjusts outcomes accordingly.

Perhaps, in fact, consistency is best understood as the outcome of this process of justifying and accommodating both sameness and difference, in the context of underpinning assumptions about the role being played by the regulator. It is a noun in search of the verb that creates it. More often than not, our participants suggested that that verb is: talking to each other.

> *Do they talk to each other? […] So they would know… They would be able to sit and look at their regulations and say: 'Actually, these should be the same.' They talk to each other. [Carer]*

Appendix – Examples used to prompt discussion

Example A

Amy wants to see a professional about her bad back. She has names for a physiotherapist and an osteopath, and wants to check their credentials on their professional registers. She types "check physiotherapist" and "check osteopath" into Google.

The physiotherapist link takes her to the Health and Care Professions Council website.

Here she has to enter the surname of the person, and choose 'Physiotherapist' from a drop-down menu. Other options on the menu include 'radiographer', 'dietitian' and 'paramedic'.

The entry she finds confirms that the physiotherapist is registered, their registration number, and where they are based.

The osteopath link takes her to the General Osteopathic Council website.

Only osteopaths are listed here. But as well as searching by name, she has the option to search by location or postcode.

The entry she finds gives details of the practice. She has to click another link to get information about the individual osteopath. This includes not just confirmation they are registered, but also gender, qualifications, when they qualified and where they trained.

Participants were shown screen grabs of the screens being described in the example

Example B

All health and care professionals are bound by professional codes of conduct. These lay down how they should behave professionally, and include things like acting honestly, maintaining confidentiality, and acting in the interests of those they care for.

These codes of conduct can differ in their details.

For example, suppose a patient reveals that they are at risk of serious harm. The professional asks for consent to tell someone else about this, and the patient refuses. Should the professional tell someone anyway?

The code of conduct for a clinical psychologist says that they should *always* stick to the patient's decision

The code of conduct for doctors says that they should *usually* stick to the patient's decision

The code of conduct for dentists says that telling someone *without* the patient's consent may be justified in exceptional circumstances if doing so is in the best interests of the patient.

Example C – Part 1

Sometimes people raise concerns about professionals with their regulators.

When this happens, the regulator has to decide whether to carry out a formal investigation – and let the person who raised the concerns know their decision.

Some commit to doing this within a fixed period of time – 8 weeks, for example, or to weeks.

Other give no time limit for making a decision.

Example C – Part 2

Two people want to make their complaints anonymously.

One person is complaining about a doctor. The regulator for doctors accepts anonymous complaints if they meet certain other criteria.

The other is complaining about a physiotherapist. The regulator for physiotherapists does not usually accept anonymous complaints.

Example C – Part 3

What happens next varies for different professions.

Participants were shown and talked through a graph showing the variation by regulator in the proportion of registrants at the four stages of the fitness to practise process, reproduced from earlier research for the Authority undertaken by the This graph is reproduced and referenced in §5.2 of the findings.

Example C – Part 4

The process also varies for different professionals.

For example, what happens to complaints that pass the preliminary investigation?

For some professions, all such complaints go to a full hearing.

For other professions there is another option for less serious complaints. The professional can agree a course of action with the regulator, without the need for a full hearing.

Example C – Part 5

Regulators may also vary in how they respond to different behaviours.

For example, if a social worker gets convicted of drink-driving they is *always* an investigation into whether they are fit to practise.

If a nurse gets convicted of drink driving, there are only questions about whether they are fit to practise in certain circumstances – for example if they were drink-driving while at work, or if it is a repeat offence.

Example D

Let's go back to Amy, who we met at the very beginning.

As well as checking out a physiotherapist and an osteopath, Amy also considers going to see a specialist doctor.

When she checks the register for this person, she finds out they were suspended nine years previously.

But it turns out that registers keep this kind of information for different lengths of time. For doctors, the record of the suspension is kept on the register for ten years. For osteopaths, it's kept for two years. For physiotherapists, it's removed as soon as the suspension is complete.

So even if the osteopath and physiotherapist had also been suspended nine years ago, it wouldn't have shown up on those registers.

Example E – Part 1

Health and care professionals have to work hard to keep their skills and knowledge up to date.

They have to demonstrate they are still fit to practise in their chosen field.

But the precise requirements vary. For example, Osteopaths regularly peer review each other's fitness to practise. Paramedics have to maintain an up to date record of what they're doing to stay up to date, and a number of these records are audited centrally every two years. Doctors have to assemble evidence every five years in order to be revalidated.

Example E – Part 2

The colleges and institutions that train professionals in the first place also have to work hard to demonstrate that their teaching is of a high quality.

Again, though, the precise requirements vary. For example, Dental Schools are inspected every five years, with earlier inspections if there is a major change. Pharmacy Degrees (MPharm) have to be reaccredited every six years, with other pharmacy courses reaccredited every three years. Institutions providing training for HCPC registered professionals have open-ended approval, reviewed in response to major changes or concerns.