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Uncertainty in a world of regulation†

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Abstract Medical practice must be regulated, but the form this currently takes is increasingly based on a 'technical' view, which wrongly assumes that practice is straightforward and that error is the result of individual failure. The metaphor of 'delivery' is currently used to characterise medical practice but this usage is fundamentally flawed. An alternative is presented, supported by a growing literature, that shows that professional practice generally (and medical practice in particular) is characterised by complexity, uncertainty and unpredictability. Practitioners use their judgement and wisdom, developed in their own practice and in their contacts with fellow practitioners. Often, practitioners choose between options that are not ideal, and may need to decide on what they believe is best for an individual rather than what is 'right' in some absolute sense. Doctors must find ways of giving a clearer account of their practice, and in so doing become more truly accountable.

Medicine is currently under siege (Fish & Coles, 1998) in a world of regulatory control. The effect of this has been to give the impression that trust, a cornerstone of the relationship between professionals and the public, can no longer be assumed.

In this article, I argue that the practice of medicine is fundamentally uncertain. Practitioners necessarily therefore exercise judgement, and that judgement is developed through practice itself. What I offer is an alternative to the contemporary view that demands regulation through accountability, and I do this by drawing on a burgeoning literature that runs counter to it.

The complex nature of professional practice

Society asks certain of its members to be professionals, that is to undertake particular tasks and to perform roles that others cannot or will not do. As Friedson puts it,

> 'Professionalism … is not just any kind of work … [It] is esoteric, complex and discretionary in character: It requires theoretical knowledge, skill, and judgement that ordinary people do not possess, may not wholly comprehend and cannot readily evaluate … The work [professionals] do is believed to be especially important for the well-being of individuals or society at large, having a value so special that money cannot serve as its sole measure … It is the capacity to perform that special kind of work which distinguishes those who are professional from most other workers' (Friedson, 1994: p. 200).

Wilfred Carr (1995), an educationist, notes that any professional practice rests on an established tradition:

> 'To "practise" … is always to act within a tradition, and it is only by submitting to its authority that practitioners can begin to acquire the practical knowledge and standards of excellence by means of which their own practical competence can be judged' (pp. 68–69).

Golby & Parrott (1999: p. 16) suggest that 'professions represent the social embodiment of key aspects of human welfare', and Lave & Wenger (1991) emphasise that practitioners become members of what they call 'communities of practice' through a process of 'absorbing and being absorbed' into those communities. Any profession, then, is influenced by social, historical and ideological constraints. Both professional practice and the education of practitioners are, inevitably, politically located.

Donald Schön (1983; 1987) pointed to the uncertainties of the work of medical practitioners. He noted that many of the problems that they face are complex and often indeterminate and that

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sometimes they have no clear solution. Others (e.g. Plsek & Greenhalgh, 2001: p. 625) see medicine as an illustration of 'complexity science', and contend that 'in complex systems unpredictability and paradox are ever present, and some things will remain unknowable'.

Many writers (Eraut, 1994; Fish & Coles, 1998; Tyreman, 2000) note that professional practice involves practitioners not so much in finding the 'right' answer (in some absolute sense) but rather in deciding what is best in the situation in which they find themselves. As Carr puts it,

> '[Professional action] is not "right" action in the sense that it has been proved to be correct. It is "right" action because it is reasoned action that can be defended discursively in argument and justified as morally appropriate to the particular circumstances in which it was taken' (Carr, 1995: p. 71).

A judicial enquiry into the homicide committed by a patient with schizophrenia being supervised in the community reported that

> 'Each decision made in the care and treatment of a mentally disordered patient involves risk … There are no simple answers. The complexity and the difficulty of the balancing exercise which clinicians have to make daily as the guardians of the patient's health and the public safety, should not be underestimated … Clinicians are often placed in an invidious position [and] forced to choose between options which are not ideal … Even the most eminent can be tested to the utmost of his skill and occasionally fail' (Bart *et al*, 1998: p. 2).

Mintzberg (1983) defines professionalism as 'the exercise of discretion, on behalf of another, in a situation of uncertainty', so recognising that professional practice fundamentally involves the practitioner in making judgements. Gawande (2002: p. 7) notes that 'these are the moments in which medicine actually happens'. He argues that medicine is located in the gap between what he calls 'the simplicities of science' and 'the complexities of individual lives' (p. 8), adding

> 'We look for medicine to be an orderly field of knowledge and procedure. But it is not. It is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the line ... As pervasive as medicine has become in modern life, it remains mostly hidden and often misunderstood. We have taken it to be more perfect than it is and less ordinary than it can be' (pp. 7, 8).

However, as Schön (1983) suggests, the view that professional practice is judgement-based is not universally, nor indeed widely, held in today's world. He argues that a much more prevalent view is what he calls a technical/rational one. Within this view, practice is held to be concerned with certainty and requires an evidence base. Practice is 'delivered', and the 'performance' of practitioners is then measured against endurable standards of delivery. Failure to practice appropriately is the result of ignorance or culpability on the part of the practitioner, and requires retraining or removal from practice. This technical/rational perspective on professional practice is widely seen in commentaries in the popular press and media, and often in 'official' documents and reports.

Schön's alternative to a technical/rational view is to see professional practice more as artistry. Support for this comes from the ancient Greeks, and particularly Aristotle, who distinguished between two forms of human action: *poesis* and *praxis* (Carr, 1995: p. 68). *Poesis* refers to those actions for which the outcomes (the ends) are known before the action begins, and for which the ways of achieving that outcome (the means) are minutely prescribed, as when making objects or artefacts. *Praxis*, on the other hand, refers to actions (such as medicine) through which the people involved make decisions about both the ends and the means of those actions, and this is a point to which I will return to later.

Professional judgement and practical wisdom

Contemporary writers (Eraut, 1994; Fish & Coles, 2005) note that medical practice utilises different forms of 'knowledge'. Epstein (1999: p. 834) comments that

> 'Clinical judgement is based on both explicit and tacit knowledge. Medical decision making … is often presented only as the conscious application to the patient's problem of explicitly defined rules and objectively verifiable data … Seasoned practitioners also apply to their practice a large body of knowledge, skills, values and experiences that are not explicitly stated by or known to them … While explicit elements of practice are taught formally, tacit elements are usually learned during observation and practice. Often, excellent clinicians are less able to articulate what they do than others who observe them'.

Carr notes 'Since the ends of a practice always remain indeterminate and cannot be fixed in advance, it always requires a form of reasoning in which choice, deliberation and practical judgement play a crucial role' (p. 70). Gawande (2002: p. 7) adds 'There is science in medicine … but also habit, intuition, and sometimes plain old guessing. The gap between what we know and what we aim for persists'. Others (see Atkinson & Claxton, 2000) also hold that intuition is an essential component of professional judgement.

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Judgement, therefore, is not just action but a form of knowledge; it is not just what we do but a way of knowing. For Aristotle, while *techne* (or technical knowledge) may be required to manufacture objects, *phronesis* (or practical wisdom) is needed for professional action.

Carr (1995: p. 71) asserts that practical wisdom is 'the supreme intellectual virtue and an indispensable feature of practice'. He adds that 'someone who lacks phronesis may be technically accountable, but can never be morally answerable'. As T.S. Eliot succinctly puts it (in *The Rock*): 'Where is the wisdom we have lost in knowledge?/Where is the knowledge we have lost in information?' (Eliot, 1965). To which we might add: and where is the information we have lost in data?

Acquiring practical wisdom

Fundamentally, professionals acquire practical wisdom through the process of becoming members of a profession. Importantly for my discussion here, only they know what they know. This is the foundation of professional autonomy and self-regulation.

However, this raises important questions for professionals to answer, not least in the light of recent clinical mishaps and misdemeanours, which in the UK have led central government to pose several questions: Why wasn't the problem identified earlier? Why wasn't something done about it? Why were people unwilling to raise it with the powers that be? How could such a situation have been allowed to prevail? (Department of Health, 1999).

Although Carr (1995) is clear that practice rests on a profession's tradition, his challenge is this:

> 'The authoritative nature of a tradition does not make it immune to criticism. The practical knowledge made available through tradition is not mechanically or passively reproduced: it is constantly being reinterpreted and revised through dialogue and discussion about how to pursue the practical goods which constitute the tradition. It is precisely because it embodies this process of critical reconstruction that a tradition evolves and changes rather than remains static or fixed. When the ethical aims of a practice are officially deemed to be either uncontentious or impervious to rational discussion, the notions of practical knowledge and tradition will tend to be used in a wholly negative way' (p. 69).

Carr is arguing, then, that the right of the professions to regulate their own practice rests on a moral obligation on professionals to reinterpret and revise their practice through continued dialogue and discussion.

Davis *et al* (1999) support the view that this occurs naturally. Doctors, they have found, change their practice (and perhaps, more importantly, improve healthcare) largely through conversations with respected peers rather than through formal educational programmes or unfocused reading. A study (Coles & Mountford, 1999) of clinical units that were highly acclaimed for their training by medical trainees showed them to be characterised by:

- a sense of community (feeling that you belonged there)
- a sense of collegiality (feeling that you were a colleague)
- a sense of criticality (feeling that anything that happened there could be openly and honestly discussed).

The judicial review cited earlier (Bart *et al*, 1998) noted 'the importance of clinicians not being so overburdened that they do not have time for mature reflection or to foster appropriately strong links with their teams' (p. 3).

Professional practice changes, therefore, when practitioners engage in 'the continuous dialectical reconstruction of knowledge and action' (Carr, 1995: p. 59). Practical wisdom develops when practitioners critically reconstruct their practice, i.e. when they deliberate by going 'beyond the critical consideration of one's practice itself and one's thinking during it, to focus on the problematic and contestable issues endemic to practising as a professional' (Fish & Coles 1998: p. 68). And this occurs often quite naturally through everyday contact between peers.

Regulation, delivery and accountability

I have argued that medical practice is located in what some call 'the zone of complexity' (Plsek & Greenhalgh, 2001). Professionals are placed in a position in which they must exercise their discretion in the interests of another person less fortunate than themselves, for which they need the capacity for professional judgement, and this rests on practical wisdom, which develops in and through their deliberation on (critical reconstruction of) their practice.

I suggested that Schön's distinction between the technical/rational and professional artistry views of professional practice lie at the heart of the argument. This is nowhere more clearly seen than in the notion (prevalent today) of the 'delivery' of healthcare.

'Delivery' suggests that something is transferred from one person to another through some agreed

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mechanism, and that the 'deliverer' does not tamper with what it is that is being delivered (examples include the mail and the pint of milk, or perhaps more commonly today, the pizza!).

However, this notion of delivery suggests two things: the ends of the action are agreed in advance (you will receive your letters, milk or pizza) and the means for doing so are predetermined (as to the mechanism of delivery, the time and timing, etc.). It also suggests that the agent of delivery is a minor participant in this, i.e. someone who would not be expected to change the ends, nor the means, of their actions in any way. Indeed, tampering with the goods could, in certain circumstances, be seen as a felony. However, professional practice is not like this. It involves judgement, in situations of uncertainty, for the moral good of another person. 'Delivery' is not just an inappropriate concept; it is dangerous as it devalues professional practice.

Ancient Greeks, on the other hand, saw that professional practice required deliberation over both the means and the ends. Not only are means and ends morally important, they must also be linked. This is as true for medicine today because, without doctors' discretionary power, society's healthcare interests cannot be well served.

Carr (1995: p. 68) suggests that

> 'the end of a practice is not to produce an object or artefact but to realise some morally worthwhile "good" … Practice is not a neutral instrument by means of which this "good" can be produced. The "good" … cannot be "made", it can only be "done" … Its ends are neither immutable nor fixed. Instead, they are constantly revised … and can only be made intelligible in terms of the inherited and largely unarticulated body of practical knowledge which constitutes the tradition within which the good intrinsic to a practice is enshrined. To practise is thus never a matter of individuals accepting and implementing some rational account of what the "aims" of their practice should be. It is always a matter of being initiated into the knowledge, understandings and beliefs bequeathed by that tradition through which the practice has been conveyed to us in its present shape'.

What Carr is clearly setting out here is the argument for professionals determining both the means and the ends of their practice. In everyday language this is what we understand by the term 'professional self-regulation'. However, as I argued earlier, professionals cannot assume that self-regulation will be automatically given to them by society. The traditions of practice must not be passively and uncritically reproduced in an unthinking way from generation to generation. Maybe this is where the healthcare professions have fallen short of the ideal in some instances. Rather, professional people have to accept the responsibility of critically reconstructing their practice through a process of deliberation.

The term 'delivery' is thus a technical/rational one. Wittingly or unwittingly, it both limits the scope of professional people to use their judgement and it places dangerous control over what they can and cannot do. The emergence of protocols is a direct result of a shift in society towards seeing professionals as 'instruments' in carrying out 'technical' tasks. So, when something does go wrong (as it inevitably will given that healthcare will always involve situations of uncertainty), then practitioners will be held to account.

The problem seems to have arisen because society has developed an inaccurate and quite inappropriate view of professional practice. As the 2002 Reith lecturer Onora O'Neill puts it, 'Perhaps claims about a crisis of trust are mainly evidence of an unrealistic hankering for a world in which safety and compliance are total, and breaches of trust are eliminated'. However, she sees dangers here:

> 'Perhaps the culture of accountability that we are relentlessly building for ourselves actually damages trust rather than supporting it. Plants don't flourish when we pull them up too often to check how their roots are growing: political, institutional and professional life too may not go well if we constantly uproot them to demonstrate that everything is transparent and trustworthy' (O'Neill, 2002).

What is now needed is for both the media and politicians to recognise that it is in society's best interests to develop a view of professional practice that reflects Schön's artistry approach, that recognises the complexities involved, and the inevitable fallibility of professionals when making judgements in caring for others.

Ironically, this alternative view of practice can be seen quite clearly in the Department of Health's definition of clinical governance:

> 'Clinical governance can be defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' (Department of Health, 1998: p. 33).

There is here the notion of 'continuous improvement', which suggests development, and 'safeguarding', which relates to the traditions of practice. The statement also emphasises creating an environment in which excellence will flourish. This suggests a biological (certainly botanical) imagery of the conditions needed for healthy growth.

The Department of Health links clinical governance with professional self-regulation and life-long learning, and in a subsequent publication suggests that the mechanism for this will be 'appraisal', which they see as

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> 'a positive process to give someone feedback on their performance, to chart their continuing progress and to identify development needs. It is a forward looking process essential for the developmental and educational planning needs of an individual … It is not the primary aim of appraisal to scrutinise doctors to see if they are performing badly but rather to help them consolidate and improve on good performance aiming towards excellence' (Department of Health, 1999: p. 59).

Perhaps it was a pity that the implementation of consultant appraisal confuses this clear developmental message with a regulatory one of 'performance review' (for example, by saying that the scheme is mandatory and that failure to engage in it would be viewed as a disciplinary matter). The problems appears to lie less in the notion of appraisal, but on the way it has been interpreted. As the Standing Committee on Postgraduate Medical and Dental Education (1996: p. 16) warned some time earlier, 'functional descriptions … may be more useful than labels which can hide a range of meanings'.

Conclusions

I have attempted here to establish that medical practice is complex and unpredictable. Nothing about it is straightforward. Doctors are there to exercise judgement in situations of uncertainty. Anything less does a disservice to society. Wise judgement comes about through the development of practical wisdom, which occurs naturally when professional people critically reconstruct their practice. This happens largely through professional conversations with their colleagues.

Of course medicine must be regulated. This is also in society's best interests.

People need to be protected against poor (or bogus) practitioners, and reassured that most practice is at least adequate and some exceptional. However, the nature of any regulation must be based more than at present on an enlightened and better informed view of medical practice, the forms of knowledge that underpin it, and the ways in which that knowledge is acquired and developed. Although any development of practitioners without appropriate regulation may be unsafe, any regulation without some related development is unwise.

The development of medical practice, then, ought to drive the regulatory requirements, and this should rest not so much on doctors being made accountable for their practice, but on encouraging them to develop better ways of giving an account of it in ways that reflect the inevitable uncertainty, unpredictability and fallibility of medical practice (Coles, 2004).

Declaration of interest

None.

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