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Reactivity and Reactions to Regulatory Transparency in Medicine, Psychotherapy and Counselling¹

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Abstract

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

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Introduction

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

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

'Transparency' is a policy ideal designed to open practices to public scrutiny. Through the provision of information and procedures comparable with fixed published rules, clearly demarcated areas of activity are made visible (Hood and Heald, 2006). Values associated with transparency - openness, independent scrutiny and accountability - are widely assumed to be beneficial. However, studies of transparency suggest it may have unintended or even perverse consequences too (Bevan & Hood, 2006; Blomgren & Sunden, 2008; Hood & Heald, 2006; Levay & Waks, 2007; McGivern & Ferlie, 2007; Power, 1997; Strathern, 2000; Tsoukas, 1997).

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

key features of transparency, how generalisable they are, and ways regulation might be improved.

In the following section we discuss transparency further. We then describe 'reactivity' and 'reactivity mechanisms' (Espeland and Sauder, 2007), which we use theoretically to explain how regulatory transparency affects professions. Next we outline our qualitative research methods, based upon interviews, and how we analyse and theorised these data. Then we explore interview narratives, first about how doctors and then therapists experienced forms of regulatory transparency. Finally we explain how reactivity mechanisms, including sensemaking processes related to media and professional narratives, produce emotional reactions, in turn creating perverse unintended reactivity to regulatory transparency.

Transparency

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

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

Organisations are increasingly motivated to 'turn themselves inside out' (Power, 2004) under the threat of adverse publicity and litigation, visibly demonstrating conformance with standards of best practice (Heimer, Coleman-Petty, & Culyba, 2005; Power, 1997, 2007).

Yet organisational image is easily 'tarnished' by transparency which 'magnifies the tiniest blemish and exaggerates the smallest imperfections' (Gabriel, 2008: 313).

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

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

Clinicians have been found to interpret new knowledge and evidence using their own and colleagues' experience, narratives and collective sensemaking, rather than through rational appraisal (Gabbay and Le May, 2011). These may also shape how clinicians interpret and react to new forms of transparency and regulations. Stories shape 'sensemaking' (Weick, 1995) and regardless of empirical accuracy, certain stories 'stick' (Heath & Heath, 2008), even constructing social reality to become a self-fulfilling prophecy (Ferraro, Pfeffer, & Sutton, 2005).

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

Reactivity Mechanisms

If transparency affects the way professionals think about and interpret the world, 'reactivity' refers to 'the idea that people change their behaviour in reaction to being evaluated,

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

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

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

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

Sauder and Espeland (2009) explain that people internalise rankings, involving surveillance and normalisation, due to the anxiety rankings produce and the allure they possess. Rankings induce status anxiety, as people compare themselves and are compared in ways they cannot control, amplifying these measures' influence and effects. Sauder and Espeland

argue that even those sceptical about and resisting rankings come to internalise them during prolonged 'entanglement'. To maintain status they invest in gaming and manipulating measures to present the impression of performance. Then both rankings and manipulation become normal and permanent, with reactions to rankings further amplified as people react to rankings and the effects of their own interpretations and reactions too.

Reactivity mechanisms provide a useful heuristic for exploring regulatory transparency for health professionals. If rankings affect cognitive and affective interpretations in law schools, their effects are likely to be more significant in medicine and therapy, where such interpretations are essential tools of practice. We explore empirical cases of reactivity to regulatory transparency in medicine and therapy after we have explained our research methods.

Research Methods

After receiving NHS ethical approval (MREC Reference 08/H0710/42), we conducted 51 semi-structured interviews in the UK, during 2008-10, with people developing and affected by transparency. This included five health regulators; two representatives of patient organisations; eight GPs; four psychiatrists (also practicing as psychotherapists); 11 IAPT therapists (CBT practitioners, counsellors, psychologists and psychotherapists); three NHS and five independent counsellors (two representing counselling organisations); three NHS psychotherapists (one representing a psychotherapy organisation); six independent psychotherapists; a senior manager representing a psychotherapy organisation; and three psychologists involved in regulation at national level.

Representatives of regulatory, professional and patient organisations were purposively sampled in order to gain the views of the diverse constituencies involved in the areas of regulation discussed in this paper. All the GPs and IAPT therapists we interviewed were based in a single metropolitan NHS Primary Care Trust (PCT). We firstly selected these practising doctors and therapists on the basis of their response to our generic request for interview, using snowball sampling to then seek diverse perspectives. Finally, we purposively sampled interviewees affected by regulatory transparency whose views and experiences had not been captured, including independent psychotherapists and counsellors and some NHS psychiatrists, who we also identified through a snowballing technique.

Interviews were conducted according to the principle of non-harm to research participants, including informed consent, confidentiality and findings were reported to preserve participants' anonymity. Our interpretation of interview data was also shaped and triangulated by informal interviews and observation of regulatory meetings and professional events, although we do not analyse these data here.

We analysed interview data using a narrative approach, previously used in healthcare research (Currie & Brown, 2003; Waring, 2009), examining and exploring interviewees' narratives about their experiences, feelings and perceptions of regulation. Rather than attempting to establish a 'true' account of interviewees' experiences, a narrative analysis treats accounts as interpretive devices that simultaneously reveal emotional reactions and sensemaking, whilst also constructing reality (Gabriel, 1998). Authors independently coded data, using NVivo software to assist in data management and analysis. We firstly used open coding to analyse and compare experience, perception and narrative across the full dataset. We then developed our analytic framework by crosschecking codes, revising analytic concepts, and theorising findings by moving iteratively between data and theory (Eisenhardt, 1989).

Transparency in Medical Regulation

Reactivity Mechanisms and Transparent Medical Regulation

Medical regulation is based upon a standardised (Timmermans & Berg, 2003) or 'scientific-bureaucratic' (Harrison, Moran, & Wood, 2002) model, with experts constructing evidence-based standards of good practice and regulators monitoring professionals to ensure they comply with them. Since the Bristol and Shipman scandals (Kennedy et al., 2001; Smith, 2004), instances of medical professionals covering up malpractice, commonly highlighted by the media, have provided a powerful narrative justifying more standardised and transparent forms of regulation.

Rather than convincing medical interviewees of the need for more standardised regulation, the way that regulators and the media used this narrative of medical malpractice was experienced as a politically and morally loaded attack. Doctors described being "hammered every week by the press", which was seen to 'amplify' (Kasperson et al., 1988) medical risks beyond their experiences in practice. Consequently, medical interviewees believed regulators were over-reacting. As one medical member of the regulatory body commented:

“If you’re a doctor who’s been criticized in the press... the GMC are very unlikely to find for you. It’s definitely trial by media, not helped by a number of high profile cases... in a regulatory climate like the Inquisition... innocence just means that we don’t yet know what we’re guilty of... everybody’s got something to hide.”

Another regulatory representative argued that regulators were too focused on “minor infringements bringing the profession into disrepute” which might tarnish regulators’ and professionals’ image but presented little danger to the public.

Perceptions of a persecutory regulatory environment were commonplace, reflecting Hood’s (2006) description of ‘targets and terror’ regimes. While some doctors acknowledged the necessity of tough regulation, there is little evidence about its effects on doctors’ day-to-day practice. Indeed, when we asked a regulator about this, they replied:

“To be truthful, we don’t know... it might not be knowable and would be highly expensive and complex to work out... and what are we going to do with that information practically, when we have a statutory responsibility to regulate?”

Our data suggested that understanding how clinicians experience regulation and its effects in practice is important, because local stories and personal accounts circulate among clinical communities, shaping sensemaking and reactions. This reflects research on the way doctors interpret new knowledge and evidence (Gabbay & Le May, 2010). We heard accounts of damaging regulatory processes, and their effects on the individuals involved, as the following GP describes:

“I’ve been through an independent review... [which was] very distressing. You wake, it’s the first thing you think about every day... it was alleged that I made an error... 18 months later, they decided that they didn’t know whether to believe her or me... I’m clean as a whistle but nobody compensates you for the time, anxiety, for the total amount of crap it puts you in.”

One GP spoke of a colleague who “got a letter from the GMC one morning... On the day that she needed to attend, she hung herself.” This exceptional case was a story that stuck, amplifying GPs’ perceptions of the risks regulation posed to them. The thought of receiving “that letter” from a regulator haunted doctors, who as in Sauder and Espeland’s (2009) study, felt powerless to affect the behaviours made transparent, as another GP described:

“Inevitably there will be times when you get it wrong... you’ve always got that fear of, have I made a big mistake? ... I had that letter from the GMC... I came back from holiday and found it on the kitchen table and I still, every time I come back from holiday, check my post, it’s the first thing I do.”

Sauder and Espeland (2009) explained how rankings were internalised through surveillance and normalisation, involving cognitive interpretation and emotional reaction, particularly anxiety about status and lack of control. Doctors’ identities and friendship networks are often tied to their professional role. A medical director commented that allegations made transparent on regulators’ websites and in press releases resulted in individuals being publicly “named and shamed” because there was a perception of “no smoke without fire”. Those accused were then isolated because colleagues “are not quite sure whether to be seen with you”. Doctors felt they had little control over allegations, which could instantly reduce their status from respected professional to social pariah, so this prospect created considerable anxiety.

Rather than focusing doctors’ attention on providing better patient care, as regulators presumably intended, such anxieties heightened doctors’ awareness of the need for defensive practice. The account below exemplifies this change, involving a GP’s experience of being investigated following a complaint from a convicted sex offender, who she had reported on suspicion of abusing his daughter:

“The man then proceeded to make a smoke screen of about ten different complaints against me... I felt I was guilty until proven innocent. [The regulator] must have known what was going on... they could turn my life upside down... inspecting every little detail. A malicious complaint like that actually takes away from other patients’ care, because the moment that we are not... calm... is the moment we’re going to make even more mistakes. It’s like a pile up on the motorway; you’re so busy looking at the pile up, you’re going to crash your car yourself. It puts me more at risk and it puts other patients more at risk.”

The GP’s good practice reporting child abuse had resulted in a counter complaint, which opened every aspect of her practice to investigation, irrespective of its relevance to her handling of the case. Her anxiety that regulators “could turn her life upside down” and ruin her reputation produced a defensive and anxious preoccupation with how others could negatively construct her practice. She recounted her story to colleagues as a cautionary tale:

“My short advice to registrars and doctors coming through my hands is, remember there are two people in the consultation. There is you and the patient; safeguard yourself first. It’s a different consultation model. Everything that you do and say in a consultation can be used against you - and make sure you make very good records.”

Our interview narratives suggest that such stories ‘stick’ (Heath & Heath, 2008), circulate among medical professionals, shaping how they understand regulation and its effects. Rather than structuring attention on providing better patient care, it creates a new performance orientation among doctors; a “different consultation model” prioritizing the defensive production of auditable representations of good practice for “inevitable” future investigations. Doctors alter how they engage with patients, becoming more guarded. Medical practice is consequently constructed as a defensive performance, involving the patient and prospective investigators with their own criteria for interpreting practice. There is therefore heightened ‘reflexive reactivity’ to transparency focused less on complying with standards but representing them for external audiences.

Reflexive Reactivity to Transparency in Medical Supervision

Medical interviewees considered appraisal and other forms of medical supervision, in which doctors confidentially discuss difficulties without jeopardizing their careers, important means of ensuring safe and effective practice. As a consultant psychiatrist described, they are an “amber zone” where doctors “don’t go off a cliff and splat”. A GP commented about her approach to clinical supervision:

“I tell them that it’s good for me to see the warts and all... because we can change behaviours and turn things around. I preserve their confidentiality and get them feeling it’s possible to have the support of colleagues, and it’s possible to show one’s vulnerabilities”.

This GP implies that poor practice is usually most effectively ‘turned around’ within closed professional confines, with only serious cases made transparent to regulators. Bosk’s (2003) research and the Bristol and Shipman Inquiries (Kennedy et al., 2001; Smith, 2004) suggest that this traditional approach to professional regulation in medicine may be flawed, requiring greater standardization and transparency. However, reflecting previous research on medical appraisal (McGivern & Ferlie, 2007), some GPs worried that formally recording

conversations in appraisal might produce defensiveness such that GPs would not disclose difficulties. A GP tutor commented:

“The appraisal system’s worked well in the fact it has been formative... But when it becomes a licensing process and your ability to continue practice, and that’s your income, people are going to be much more reluctant to talk openly and honestly about significant events.”

Defensive reflexive reactivity to transparency may thus crowd out developmental spaces in medical supervision, which although invisible to regulators, doctors believed were important means of managing risk and improving quality of care.

Reactivity to QOF Performance Indicators and Commensuration Mechanisms

The Quality and Outcomes Framework (QOF) is a performance management system, which rewards GPs for improving the quality of general practice by meeting ‘good practice indicators’. Participation in QOF is voluntary but linked to financial incentives. QOF has demonstrated improving quality of health care and has been popular with GPs, who voted in favour of its introduction and have benefitted financially for achieving standards many were already meeting (Doran, Fullwood, Kontopantelis, & Reeves, 2008; McDonald, Checkland, Harrison, & Coleman, 2009). GPs we interviewed were generally positive about QOF too. As targets they had intended “positively motivating” reactivity effects. However, as one GP described:

“Patients might not fit the protocolised biomedical model... I do worry about over-treating patients because that’s what the targets say I should be doing, and there are penalties associated with not meeting them... It’s a huge ethical dilemma.” (GP)

As a commensuration mechanism, enabling doctors’ performance to be compared against simplified measures of good practice, QOF may subtly interfere with clinical and ethical decision-making, focusing doctors on indicators rather than more complex aspects of care, perhaps producing reactivity effects. Given the limited number of GPs we discussed QOF with, we cannot make any generalisable claims about reactivity to QOF, but suggest further research on this potential phenomena might be valuable.

Transparency in Psychotherapy and Counselling

Reactivity Mechanisms and the Regulation of Psychotherapy and Counselling

Professional associations, commonly the British Association for Counselling and Psychotherapy (BACP) and the United Kingdom Council for Psychotherapy (UKCP), have historically regulated therapists although professional regulation has not been mandatory. Therapists working for NHS organisations are subject to NHS regulation, which have been found to emphasise standardised risk management processes (Power, 2004, 2007; Waring, 2009).

The Government White Paper 'Trust, Assurance and Safety' (Department-of-Health, 2007) proposed that, for the first time, psychotherapists and counsellors be subject to statutory regulation by the Health Professions Council (HPC), an independent regulator regulating other clinical professions. During our field research, statutory regulation for therapists was in formative stages but a form of rationalised regulation had been proposed, in which therapists would have to regularly demonstrate competency against evidence-based standards of good practice².

Whereas standardised regulation is more established in medicine, it is less developed in therapy, which Freud (1937) described as an 'impossible profession' because therapy's model of narrative and embodied rationality make assessing outcomes problematic. Therapy is *the* example where practitioner reflexivity is at the heart of practice. While sensitivity to private clinical material is widely regarded as fundamental to therapeutic practice, formalized regulation emphasises transparency. As this consultant psychotherapist described:

"In the service of this thing, transparency... from the moment of complaint you start posting things on the [regulator's] website... If you are going to work with mental illness or psychological distress then false allegations, either malicious or based in psychosis or whatever it may be, are institutional hazards."

'Process notes' have traditionally been regarded as fundamental to developing therapists' reflexivity and practice. Writing process notes is for the near-private purpose of thinking through and making conscious the nuances of interpersonal material, rather than producing a formal account for public scrutiny. As such process notes include therapists' emotional responses, impressions, private associations and fantasies to enhance their reflexivity. However, as with doctors, stories of persecutory regulatory processes produced anxiety and shaped how therapists reacted to transparency and their practice of keeping process notes.

² In 2011, after we completed our interviews, the new 'Coalition' Government proposed a new policy of 'assured voluntary registration' for therapists (Department-of-Health, 2011). This was in large part due to the UK's two main professional therapy bodies (UKCP and BACP) rejecting HPC proposals for statutory regulation.

A NHS psychotherapist commented:

“We had an external inquiry into a suicide and one of the therapist’s process notes were demanded to be scrutinized... as we see after an event, we need to find a scapegoat.”

We heard accounts of therapists altering their transcription practices in reaction to transparency. In anticipation of future investigations, they started producing material for possible official scrutiny rather than to enhance reflexivity. Some attempted to retain reflexivity by writing a ‘reflective diary’ alongside formal notes, while others had ceased writing process notes altogether. A NHS consultant psychotherapist/psychiatrist commented:

“The debate where it’s most painful is about confidentiality and the issue of process notes. As professional reflection documents, if the work is about having a communicatory dialogue, then I, as a therapist, have an experience of the encounter that I’m allowed to have of my own. For psychoanalytic colleagues, process notes are part of their psychoanalytic process. We do keep a separate record; tell each other that they are potentially subpoenaable. But what external parties don’t understand is that therapists spend time getting closer to somebody else’s mind through dense conversations and complexity, and use their own mind in that process.”

Concern about how process notes might be used was not confined to NHS employees. An independent counsellor similarly described keeping client notes that could be viewed in a legal context, alongside a private diary about what she felt was ‘actually’ taking place:

“I take copious written notes. And I know that should my client ever wish to see them... they have legal grounds to look at those notes and I’m very careful about what I put in those. I keep what is personal to me, as far as possible, out. I have a separate diary for what is personal to me, what’s actually going on for me.”

So formalising note taking reduced transparency and interfered with therapists’ techniques for thinking about and reflecting on their practice. When written records are used for quasi-legal purposes, particularly where narratives about regulatory scapegoating are rife, they divert attention away from the dynamics in the therapy session towards presenting therapy in a way that is legitimate to external audiences, and in doing so *disrupt* therapists’ practice.

Reflexive Reactivity to Transparency in Clinical Supervision

Clinical supervision is another area in which therapists' reactivity to transparency disrupts reflexivity at the core of their practice. Therapists practice a distinctive clinical supervision, which allows the personal and emotional responses of both client and therapist to surface. This is widely agreed to be an important process for ensuring safe and effective practice. More than GP appraisal, clinical supervision provides what therapists experience as a safe but challenging 'formative space' (Fischer, in press) in which to explore clinical material and the relationship dynamics between therapist and client. This may include difficult issues, for example, uncomfortable sexual or hostile feelings associated with transference (clients' projections of previous relationships onto the relationship with the therapist) and counter-transference (how the therapist experiences such projections) within the client-therapist relationship. These are important to understanding the therapeutic process. But therapists might be unwilling to disclose these issues, particularly personal difficulties or failures, if they are formally recorded and could be made public.

We heard accounts of clinical supervision being formalised to demonstrate robust risk management. A therapy organisation representative argued that, in the light of proposals for statutory regulation, therapists would need to be more "cognisant of what is expected of them and of their accountability" and to have a "contractual relationship" with their supervisor to ensure "that standards are met." Rather than providing a space for discussing difficult cases or personal material, interviewees described new, defensive models of supervision, designed in anticipation of future failure. A senior NHS therapist commented:

"We need to make sure we have processes in place, so that if incidents were to occur, we're not criticised too much... 99% might be fine, but it might just be that one client that shakes up the whole system."

This NHS therapy service introduced a managerial 'caseload' model of supervision (adopted from a more regulation-orientated practice of social work), which managers regarded as effective because "at least it's all written down and formalised". Formalisation altered the nature of clinical supervision. Therapists commented that it had become less about therapists' psychological involvement and more about operational management focused on recording risk. As the following NHS psychologist describes, the emerging second-order signification of her work had altered her practice and cognition:

“I’ve lost a sort of clinical mind-set. The few arenas left, like clinical supervision, where you can in a fairly relaxed way actually talk about ‘I made a real hash of that, I just don’t know what I was saying, and I didn’t know what to do with Mr X’ – these are very, very precious oases in a desert of figures and processes and procedures.”

Here transparency produced reflexive reactivity that undermined open discussion of clinical material in clinical supervision, disrupting therapeutic practices protecting clients.

Reactivity to IAPT Outcome Measures

The Improving Access to Psychological Therapies (IAPT) programme was established in 2007 to provide talking therapies for people with low-level depression and anxiety in primary care. IAPT was piloted in a number of sites, including one where we interviewed therapists, based upon an evidence-based model, in which clients’ mental health is measured after each session and reported to the Department of Health to evaluate IAPT’s impact³. Achieving expected outcome measures was seen as important in ensuring ongoing funding for the programme. An IAPT representative described the programme as:

“A dream and a nightmare... The dream... government is supporting the reason why people... idealistically got into the profession. The nightmare... that never in mental health have people been judged against that obvious yard stick before.”

By collecting quantifiable outcome measures, the NHS was able, for the first time, to ‘commission for specific clinical outcomes’, as the IAPT representative put it:

“The rule here is you can’t be a clinician in IAPT unless you use these outcomes... That’s a sort of genie that’s come out of the lamp, which no one can put back... The government was not going to invest in psychotherapy unless it thought there was good evidence... Refusing to measure things... isn’t going to work... we need to see that they really worked.”

The ‘genie’ described is a form of reactivity inherent in government funding for therapies, which makes different forms of therapy comparable in the same way using simplified measures. While measuring therapies is a way of ensuring that only effective forms of therapy are funded, certain therapies, such as cognitive behavioural therapy (CBT), developed by psychologists based upon more standardised models of delivery, are more

³ <http://www.iapt.nhs.uk/> (accessed 31 July 2011)

amenable to measurement than others. Psychotherapy, for example, has traditionally used different case-study-based evidence. However there is a self-fulfilling prophecy intrinsic to IAPT; therapies that are more amenable to measurement appear more effective in IAPT's terms, and so other forms of therapy need to be practiced in a more measurable way in order to be funded. Indeed one prominent psychotherapist commented on trying to persuade colleagues to "take seriously the need for evidence and to... report outcomes" for two decades. But making therapy measurable against evidence-based standards involves reactivity that changes the nature of therapy.

IAPT measures clients' self-reported wellbeing scores after each therapy session. Many feared losing their jobs if they did not produce results in line with expectations. We interviewed a number of IAPT therapists, who described intense political pressure to demonstrate clinical effectiveness, as one commented: "This service has to work, no matter what... we want the numbers."

Therapists in other organizations similarly described being steered to produce positive displays of clinical effectiveness, which perversely affected the practice of therapy, as a counsellor working for an independent addiction agency noted:

"The problem is that people start to become sympathetic and friendly to get the scores up... What needs to be challenged is what's underneath, and that might be very uncomfortable. But the psychotherapist won't dare go there, because their [measures] won't look good. What happens is they collude in the system. The agency I worked for was brilliant at this."

Reactivity is inherent in therapists' collusion with the system. Measurement interacts with and becomes incorporated within clinical activity. Producing scores for an external audience alters therapists' attention and constructing positive representations of therapy became a dominant mode of clinical activity, displacing embodied aspects of practice:

"It does affect clinical decisions. Whereas before, I'd go by my gut feeling, now I've got those figures I can't ignore them... Someone will say: 'look, it was obvious, look at the score'. Do you just kind of patch things up, which will show very well on the scorecard, when there's actually something deeper going on? You find yourself thinking, how is this going to show up on the score? I'm aware I need to have a decent percentage of clients who show up well, so I will put complicated [clients] on hold and see easy ones, which get my scores up. I feel more comfortable with complicated ones if I've got a bit of room to breathe."
(NHS Psychotherapist)

Creating 'breathing room' involves internal dimensions of therapeutic practice, as this NHS therapist describes:

"It's mistaking the figures - the bits you can see - for the thing itself. These figures so quickly substitute for the level of care and thought that goes into working with [clients], that I'm not sure that distinction matters anymore... I probably don't even realise yet the way my clinical work has been changed by this... Putting your work into boxes conceptualizes it in a particular way, which, despite your best intentions, will change it".

As a form of 'commensuration' (Espeland and Sauder 2007), measurement simplifies and de-contextualises therapists' practice, obfuscating 'care for clients' in a single outcome measure. Less quantifiable factors, such as the quality of the 'therapeutic alliance' between therapist and client, which is associated with positive outcomes in all modalities, are overlooked. Representing therapy in terms of 'figures' and 'boxes' produces reactivity in therapists; altering their frame of reference, changing how they approach clinical work. Moreover, therapists described a deeper, inner process in which a focus on representation was transforming the nature of therapy to the extent that some clinicians were considering leaving their profession:

"The real stuff doesn't get recorded and therefore isn't real... it slips out through the figures, kind of leaks away, and is lost. That creates a lot of anger because [therapists] feel that they're recording stuff that doesn't matter... you don't record your *actual* clinical work... it becomes so uncomfortable I am actually thinking of leaving, because I'm losing the clinical focus, which is very precious." (NHS Therapist)

Therapists experienced these effects despite being engaged in shaping the system of performance management. They described therapeutic practices overwhelmed by a discourse of performance and external scrutiny, which they felt incapable of mitigating sufficiently to maintain the integrity of therapeutic practice. As one lead NHS therapist described, their attempts to buffer their service through a 'light' performance management arrangement undermined therapeutic activity, as its formal representation acquired 'a life of its own', suggesting the self-fulfilling reactivity inherent in the process:

"Once you keep tally in this way, the tally becomes a stick to beat you with. It doesn't seem possible just to notice rather than feel bullied by figures... it has been used as a stick to beat people. These figures have a life of their own. Whatever I may have thought, whatever I

intended, it's not mine; it's going to be used in the way that the organisation chooses. I feel responsible for what is observed but I can't [change] it.”

As Espeland and Sauder (2009) describe, the internalisation of measures of transparency occurs through a process of surveillance and normalisation, seduction and coercion. Similarly, even those attempting to resist IAPT measures began to internalise them and this ‘reflexive reactivity’ undermined practitioners’ cognition, professionalism and motivation.

Discussion

Do ‘reactivity mechanisms’ (Espeland and Sauder, 2007) explain how doctors and therapists interpret and react to regulatory transparency and performance measures in practice? We suggest reactivity to regulatory transparency can be explained as a self-fulfilling prophecy by including two elements: narratives shaping the interpretation and construction of social reality (Ferraro et al., 2005; Gabbay & Le May, 2010) and emotional reactions, particularly to anxiety, affecting how professionals internalise transparency (Sauder & Espeland, 2009).

A self-fulfilling prophecy occurs when an inaccurate definition produces reactivity that makes the definition come true (Espeland and Sauder, 2007). Stories can create self-fulfilling prophecies (Ferraro et al., 2005; Weick, 1995). We suggest that public narratives about clinicians hiding malpractice, amplified (Kasperson et al., 1988) by the media, became ‘stories that stick’ (Heath and Heath, 2008). These narratives structure the attention of government, regulators and professions on rare but dangerous events and consequently how they develop clinical regulation.

Clinicians interpret the purpose and effects of regulation through different stories circulating within professional communities, as doctors have been found to similarly interpret new knowledge and evidence (Gabbay & Le May, 2010). Professionals we interviewed experienced and interpreted regulatory transparency as an attack, based upon exaggerated risks and a misunderstanding of their complex practices. Emotional reactions also affected how regulatory transparency was internalised (Sauder & Espeland, 2009). Anxiety about regulation’s actual and potential effects on clinicians, stemming from narratives about ‘trials by media’, ‘inquisitions’ and ‘scapegoating’, preoccupied clinicians. This produced a new defensive consultation model, in which clinicians focus less on actual practice, and patients’ needs, and more on representing practice in standardised terms to avoid revealing practices that might draw further scrutiny or later be constructed in a negative light.

Thus reactivity to regulatory transparency functions as a perverse self-fulfilling prophecy. Problems are defined and amplified (often by the media) by cases of hidden malpractice, with transparent standardised regulation as the solution. Clinicians make sense of this form of regulation through the collective narratives of professional peers, often describing damaging regulatory processes. This heightens their anxiety about regulators misunderstanding the complexity of their practice and looking to find malpractice in an inquisition-like climate of presumed guilt. So clinicians become preoccupied with representing their practice in standardised terms, hiding or avoiding practices that could draw regulatory attention or be negatively constructed. Thus they are paradoxically likely to hide potential malpractice because of transparency, while the standardised presentation of practice appears to show that the problem has been addressed. Reactivity is then amplified as clinicians react not only to transparency mechanisms (measurement, recording, observation) but also to experiences and stories about their perverse effects.

As Sauder and Espeland (2009) found, even those resisting transparency internalised it in ways that disrupt practice. In the case of therapists in particular, prospective statutory regulation had begun to alter long-established techniques for assuring quality. Transcription practices were modified to produce auditable accounts, written according to notions of social acceptability, rather than as reflective documents of actual practice. Clinical supervision shifted from a developmental method for working with therapists' experiences of practice to a more regulated space, focused on organisational risk management. Most fundamentally, reactivity to transparency altered therapists' reflexivity, feelings, relations (with patients, colleagues and self) and identities, elements intrinsic to their practice. Narratives and anxiety about regulatory scapegoating partially produced this perverse reactivity but it was also a consequence of having to think in standardised terms, crowding out attention for other things.

Espeland and Sauder's (2007) reactivity mechanism of '*commensuration*', which transforms cognition by enabling practices to be compared against simplified measures, may explain some reactivity to QOF. However commensuration operates more powerfully in relation to IAPT outcome measures, which enables the Department of Health to compare services, therapists and modes of therapy against standardised measures of performance. Surveillance, normalisation and anxiety (Sauder and Espeland, 2009) affect how these outcome measures are internalised. IAPT therapists appeared anxious that poor outcome measures might put their jobs in jeopardy. Reacting to this form of commensuration, we found therapists improving patients' weekly ratings by "being nice" and "patching up" to

improve feelings of wellbeing in the short term instead of tackling painful, underlying, or longer term problems.

Structuring attention on outcome measures produced a strong form of reflexive reactivity in therapists by substituting concern with 'boxes' and 'figures' for quality of care, disrupting key aspects of therapeutic practice, their clinical mind-set and reflexivity at the heart of their practice. Structuring attention on producing evidence of good practice, rather than care itself, undermined important dimensions of clinical-patient relationships and clinical practice. As Sauder and Espeland (2009) again suggest, even therapists attempting to buffer outcome measures came to internalise them through anxiety and normalisation, as "it doesn't seem possible just to notice rather than feel bullied by figures" and they "take on a life of their own".

What similarities and differences do we see between the reactivity to transparency in our two cases of medicine and therapy and what are their implications? The similarity of our findings in both professions suggests they may be generalisable to other forms of clinical professional regulation. Transparent regulation and evidence-based standards are more established in medicine. Accordingly doctors appeared more accustomed to their forms of regulation, to have internalized its norms more, but also spoke more about damaging regulatory processes and their anxiety about their effects, which produced more defensive reactivity. Regulators need to understand this and start investigating narratives about the effects of regulation in practice. Addressing the regulatory and media climate to reduce the prevalence of regulatory narratives involving scapegoating, 'trial by media', 'inquisitions' and doctors 'feeling guilty until proven innocent' may lessen defensive reactivity.

Transparent regulation and standards are nascent for therapists. As they develop, narratives and anxieties, like those of doctors, may increase, amplifying reactivity effects in therapists' practices. Visibly demonstrating compliance against standards is already preoccupying therapists, leaving less attention for interpersonal and intuitive phenomena vital to effective therapy but less visible within this form of regulation. If transparency produces reflexive reactivity that undermines legal academics' identities and practices (Espeland & Sauder, 2007) and produces emotional reactions and defensiveness (Sauder & Espeland, 2009), its effects are likely to be more profound, disrupting and distorting for therapists, where reflexivity, emotional awareness, identity and relationships are core tools of practice.

Finally, we acknowledge the limitations of this research, which based upon a limited number of interviews in one country (the UK). Further research is needed to test our model of

reactivity mechanisms associated with regulatory transparency and whether our empirical findings are more widely generalisable, in the UK, other countries and other professions. Do we see similar reactivity mechanisms and effects occurring in other professions dealing with complex and potentially high-risk clients? In social work, for example, where media spectacles about the deaths of Victoria Climbié and 'Baby P' implied that British social workers were to blame, do we also see a climate of professional anxiety and perverse reactivity to standardised forms of regulatory transparency? Or in social care, where the media have also recently reported the abuse of vulnerable and challenging clients? Reactivity to regulatory transparency is an important contemporary phenomenon providing significant opportunities for future research.

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