PATIENT SAFETY FIRST

RESPONSIVE REGULATION IN HEALTH CARE

edited by

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LEADING FROM BEHIND WITH PLURAL REGULATION

John Braithwaite

One of the concerns often expressed about responsive regulation applied to health (Braithwaite et al. 2005) is that no single regulator is responsible for the Australian health system. So who is to make the regulatory pyramid described by Healy and Dugdale in Chapter 1 work? This chapter shows how decentred regulation of health safety (Black 2002) does not necessarily involve a crisis of ungovernability, only of top-down governability. A nurse's eye view of this challenge is explored. It is conceived as a challenge for multi-level governance that works through nodes which decisively coordinate improvement.

A NURSE'S EYE VIEW OF RESPONSIVE REGULATION

Nurse Response is not a nurse manager. She is an ordinary nurse recently assigned to work with Dr Good and Nurse Deed. The Good–Deed team is generally conscientious, competent and caring with patients. But Nurse Response notices immediately on joining the pair that they have been quite sloppy in their compliance with an important protocol. Nurse Response decides to respond with support to assist compliance. After a procedure completed somewhat sloppily with regard to the protocol, and after Dr Good fails to record things she should, according to the protocol, Nurse Response says: 'If you don't mind, I'll write this into the patient's notes because I'm a bit of a stickler for the protocol. I don't mind doing it because I know you are so busy, Dr Good. It's just that

my experiences have convinced me if we all follow this protocol all the time, every once in a blue moon it will save a life. So I feel uncomfortable not doing it.'

The next time our brave nurse works with the Good–Deed team on this procedure, the sloppiness is gone. An exemplary job is done and Dr Good completes all aspects of protocol record-keeping herself. As they wash up, Nurse Response says to Good and Deed that she really admired aspects of how well they completed the procedure. She also says she really likes working with them because they show her professional respect even though they are more medically knowledgeable than her.

Nurse Response leads from behind

At a subsequent care planning meeting with Good, Deed and many others, Nurse Response says she is pleased to see that, across both floors on which she works, compliance with this protocol is improving. Again she explains why she cares about it. She asks whether the team could keep statistics on protocol compliance to show whether they are capable of moving it up from the current level of compliance, which she guesses to be 70 per cent, to 100 per cent. Can they also plot incidents of the kind of infection the protocol is designed to prevent? They agree. A year later, compliance has moved from 70 to 100 per cent and incidence of infection has fallen. Dr Good writes a little memo on this outcome, which management circulates around the entire hospital. Soon, almost everyone in the hospital is taking the protocol seriously. A hospital-wide study documents an association between a move to 98 per cent compliance over the next few years with reduction in the incidence of infection, but also with an unexpected benefit not previously documented. Through this unexpected benefit, Dr Brilliant from the hospital's management team sees a way that the protocol can be both simplified and improved. Dr Brilliant writes all this up and publishes in a journal which is read by Inspector Rex from the Health Department. Rex gets the improved, simplified protocol implemented, as recommended by Brilliant. He emails all hospitals in the state a copy of Brilliant's paper. This is part of the campaign Rex shares with Nurse Response to improve compliance with this protocol. Triple-loop learning (Parker 2002) is occurring here—from the Good–Deed team to all the teams on their two floors, to the entire hospital, to the whole hospital system.

Nurse Response is only a little cog in the hospital machine, but she knows she has 'led from behind'[1]—and, of course, she looks on with pride at these developments. Nurse Response then organises her senior

colleagues to support the nomination of Dr Brilliant for an Order of Australia. She makes a special plea that the citation their peers will read in the Australia Day morning newspapers says 'For contributions to health quality and safety' rather than the more usual contributions to a traditional discipline of medicine. She wants the nation to recognise the lives that can be saved by the leadership Brilliant has shown for safety and quality, rather than Brilliant's official positions in the college and profession. Perhaps a citation quite like this has never occurred for an Order of Australia. This is not a true story! It is one that illustrates the possibility, not the probability, that even the most junior cog in the medical machine can lead from behind at all levels of the pyramid of supports (also described as a strengths-building pyramid) in Figure 2.1 (below). Before we get misty-eyed about our hero's triumphs, albeit not taking the credit, a darker phase of her professional life is about to unfold.

Nurse Response is restructured and punished

Unfortunately, Nurse Response is caught up in one of the perennial hospital restructures of her CEO, Mr Shuffle. She arrives at work to be told she has been reassigned to work with Dr Bad and Nurse Seed. Bad thinks the protocol is just another Shuffle conspiracy to make their professional lives a bureaucratic misery. When Nurse Response tries to support him in completing the protocol, he humiliates her in front of colleagues for 'wasting time on paperwork and bureaucratic make-work' when she should be concentrating on delivering nursing care. She tries again and again to reason in evidence-based ways about the benefits of the protocol. Each time, she is put down. Ultimately, she draws a deep breath and complains about Bad–Seed protocol compliance to their supervisor, Dr No. No tells her that Bad is a hospital hero for standing up to Shuffle's silly systems. Who is she to question such an experienced clinician?

Our hero is a determined woman. Shaking with trepidation, she fronts Mr Shuffle's office to discuss the Bad–Seed non-compliance and what Dr No said in response to her complaint. Shuffle chews her out, railing against junior staff who bring problems that should be sorted in the ward and points to his priority, the next restructure pasted on computer printouts around his office wall. Over drinks and tears that night, Dr Good and Nurse Deed counsel Nurse Response to let go. There is nothing more she can do. She rejects their advice, deciding to bide her time and hope that perhaps one day Dr Good will be promoted

[illegible] Dr No's job. But Response also has fine detective skills that open an opportunity earlier than she expected. These skills enable her to connect a case of blatant protocol non-compliance to an adverse event that costs a patient their life. Dr No has managed to cover the tracks of this connection so that the patient's family never discovers why their loved one died. She writes a brief of evidence on the adverse event and its non-recording, but Mr Shuffle seems to lose it in the pile of paper in his in-tray. During the month when she hears nothing back from Shuffle's office, Dr Bad trumps up a case of professional negligence against Nurse Response. She is pilloried by her peers for it. Then she takes her complaint to the Health Department, who sits on it after being told by Shuffle that Nurse Response is only making this complaint because the hospital is taking disciplinary action against her for negligence. Nurse Response then meets with the family of the deceased patient. Their solicitor commences a suit against the hospital and conducts a press conference on the circumstances of the death. The Minister for Health sees it on television and carpets Shuffle for failing to heed the well-known research of Dr Brilliant. Shuffle then publicly apologises for the adverse event, demotes Dr No, replacing him with Dr Good, settles with the family and leads compliance reform. Shuffle survives long enough to persist with revenge against Nurse Response for her alleged negligence. She commits suicide. Dr Brilliant does not attend her funeral because he is busy preparing a plenary address for a health safety and quality conference.

Nurse Response as a practitioner of networked governance

Sadly, your author is no Dickens. The point of my tale is to show that a Dickensian lens helps us to see the full range of opportunities and risks a little person confronts in moving up both a pyramid of sanctions and a pyramid of supports (see Figure 2.1). We could actually move lower down the health system hierarchy and illustrate how a cleaner or a patient might move up both pyramids of supports and of sanctions. Yes, a cleaner or a patient can educatively support a doctor by pointing out the doctor has forgotten to sterilise something that might cause infection. And they can complain and trigger legal and regulatory enforcement action in the way Nurse Response did. Of course, it is true that as we move up the health system hierarchy from nurse to nurse manager to senior doctor to hospital CEO to health department CEO, we shift to players with greater capacity to regulate responsively in a way that makes a difference.

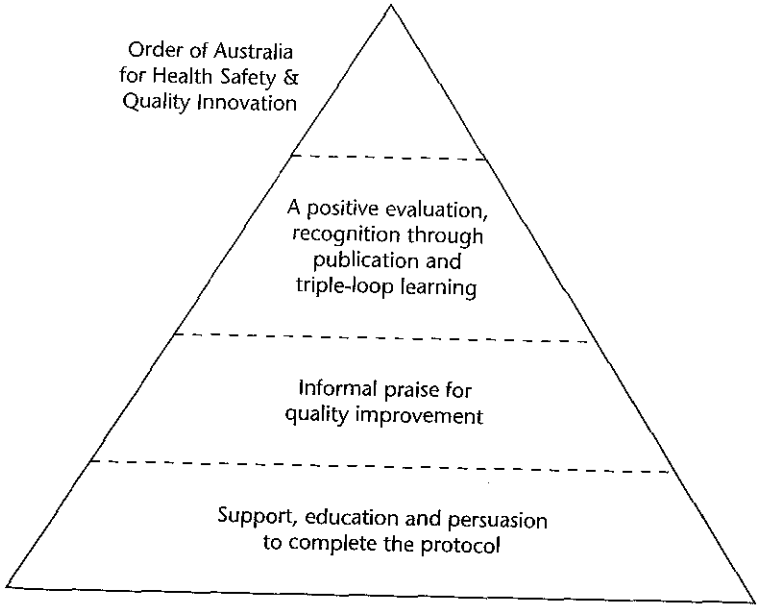

Figure 2.1 How Nurse Response networks up pyramids of supports and sanctions

RESPONSIVE REGULATION AND NETWORKED GOVERNANCE

Responsive regulation calls for the networked governance of health care safety and quality. Nurse Response can no more do it on her own than can the Minister for Health. Nugget Coombs exercised more effective power for social change in his life than any Australian prime minister, by 'leading from behind'. He accomplished that by enrolling people both below and above him in the hierarchy of Australian governance. Miraculously, Nelson Mandela managed to lead from behind in a prison cell for 27 years. Change occurs through both the weak enrolling the strong (Latour 1986, 1987), and the strong enrolling weaker players, who then become bridges to the enrolment of different kinds of strength. The 'strength of weak ties' (Granovetter 1974) is a key to social change. This means, for example, that a single person who has weak ties to two separate tightly interwoven networks of power can couple those two networks for a project or social change. Intriguingly, Dupont (2006: 53) found in a study of networks of security in Montreal that 52 per cent of the bridges that linked together different organisational actors, such as police departments, private security firms, university security departments, professional associations, political actors, intelligence agencies and government departments, were single individuals. For 81 per cent of links, the contact points were three or fewer individuals. In the real world of networked governance, as in the fictional world of Nurse Response, weak single actors can forge the links that can escalate networked private–public action for change.

This is why the pyramid of networked escalation, adapted from the work of present and former ANU colleagues Peter Drahos, Scott Burris and Clifford Shearing (see Drahos 2004; Burris et al. 2005), is an important idea for thinking about how to improve safety and quality. Figure 2.2 captures the idea that, instead of escalating from less to more intrusive or punitive interventions as we fail to get improvement through evidence-based dialogue at the base of the pyramid, we can escalate by enrolling more and more powerful players into the dialogue until we get the movement desired. The ways of escalating are limited only by the networking imaginations of the Nurse Responses and Dr Goods of this world. This means there is no 'cookbook' for how to do responsive regulation well, and no corporate plan that the Mr Shuffles of this world can lay down to guarantee improvement. It is an accomplishment of problem-focused and strength-based networking more than structure-oriented reorganisation. Creative perseverance delivers it. Rootless, reiterative restructuring is unlikely to do so.

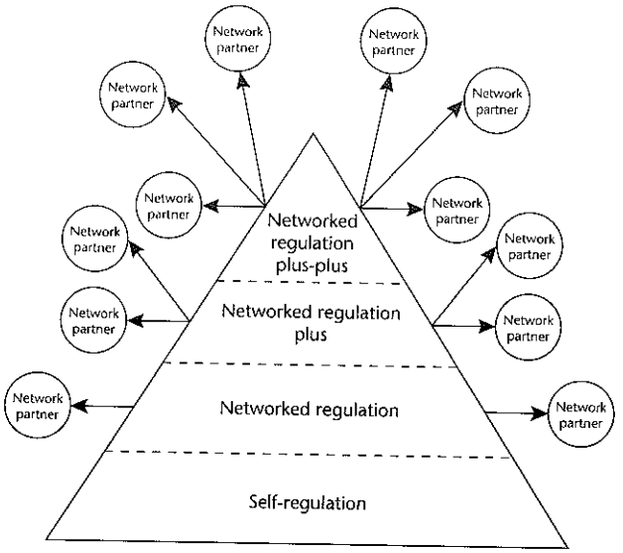

Figure 2.2 A pyramid of networked escalation

Source: Adapted from Drahos (2004).

I do not mean to suggest that strategic planning does not matter. I do mean to say, following Castells (1996), that strategic planning of agencies like health departments matters much less than it did in the heyday of Fordist production, when better top-down ordering of chaotic production systems could deliver large improvements. Organisations like hospitals have long since accrued some benefits of basic Fordist production line reforms, which see things done in a systematic way—like clean sheets routinely put on beds and the correct pills delivered on trolleys to the correct patients. The biggest further improvements may now come from governance at ad hoc nodes where networks of action are pulled together—like Nurse Response using a care planning meeting to advance her protocol project. They will also come from leadership from behind, as Mandela put it, rather than from the top.

Yes, strategic planning still matters—but in a highly qualified way. There is no point in the health department developing a strategic plan to do X when the powerful medical colleges and the Australian Nursing Federation have plans to deliver not-X. Health safety and quality improves as an interactive accomplishment of the actions of many types of organisations—professions, pharmaceutical companies, hospitals, laundries, university teachers and researchers, general practices, health

departments, self-regulatory organisations, consumer watchdogs in civil society, the Australian Competition and Consumer Commission, the Ombudsman, and so on. Les Metcalfe's (1994) insight about the art of networked governance is that each of the key organisational actors focused on solving a particular problem must do their strategic planning in a way that is responsive to the strategic planning of other organisational actors focused on that problem. Clever corporate plans are crafted to align with other corporate plans, whether complementary or competitive. Smart planning creates synergies so that the combined effects of strategic plans to solve a problem are greater than the sum of the effects of the separate plans.

The galaxy of organisational players impinging on a particular problem is constantly changing in a knowledge economy where technological change puts new players on the scene with dazzling frequency. This is why responsive regulators must constantly be assembling new nodes of governance that work for a while in coordinating new improvements to health safety and quality. For example, 30 years ago it was rarely necessary to include software developers in nodes of governance to improve health safety and quality; today it often is. Sometimes developers of hand-held digital record-keeping hardware even have a place.

No environment brings more professions and more complex new technologies together in one space than a modern hospital. Patients are also more intractable subjects of these technologies than, say, the physical subjects of Silicon Valley innovation. Patients get up when told to lie down, lie down when told to get up, get upset when told to be calm, spit out pills and swallow hidden bottles of alcohol. Most of all, they simply do not understand or forget to do things as part of their therapeutic journey, especially if they are old, as many patients are. It follows that improved outcomes are fundamentally a feat of persuasion and understanding at all levels. Nodal governance is about bringing strategic players together at a relevant site of deliberation—around a bed, in a minister's office, at an international conference—to caress and cajole engagement with the project of health improvement.

Practitioners at all levels must show leadership to diagnose how and where today's blockages to achieving safety and quality are occurring. Only leadership from below can achieve this when the blockage is at the level of patient resistance. When the blockage is at lower and middling levels of health system hierarchies, blockages can often be removed by widening the circle. RegNet empirical research in health care and in

other domains shows this is one of the things that master practitioners of regulation do (Braithwaite et al. 2007). When a government inspector sits down with employees of an organisation to fix a problem of non-compliance, they are quite often dismissed. Employees dig their heels in and the problem is not fixed. Instead of escalating up a regulatory pyramid immediately in response to such defiance—perhaps by prosecuting them—the smart regulator (Gunningham and Grabosky 1998) will often adjourn the meeting, give their defiance a chance to cool and encourage them to come back with new lateral thinking to fix the problem. If they do not, the node of governance can be reconvened with their boss in the circle. If their boss is an even tougher nut, even more resistantly defiant (Braithwaite 2009) than their subordinates, then the circle can be widened again to include the boss's boss, then the boss's boss's boss. Like our hero, Nurse Response, we might need to widen the circle right up to the chairman of the board, as has been documented in cases in the regulatory literature (Fisse and Braithwaite 1993: 230–7), or even the minister, before we find an actor willing to consider the evidence base.

If we widen the circle of dialogue right up to the top of the executive chain, without eliciting evidence-based responsiveness to protecting the community, then the ethics of responsive regulation require us to escalate. Escalation may even have to be up through the judicial branch of governance in search of the judge who will apply the law to the evidence about risks to the community. We might conceive recourse to the legal system as an ethical duty of our profession if we are ethically committed to being an evidence-based health professional. In real cases, like that of Dr Patel at Bundaberg Hospital, and as in the fictional case of Nurse Response, there are brave nurses, like Toni Hoffman, who refuse to be fobbed off by their CEO. For those who are not health professionals—for victims, their families, crusading public-interest lawyers or health consumer activists—there is no ethical duty to widen the circle of dialogue and escalate up the enforcement pyramid when patient safety is jeopardised. But when non-professionals do pursue their concerns, they are ethical heroes.

Likewise, patients have no ethical duty to forgive a health professional who meets with them and admits their mistake. But when patients do forgive in those circumstances, they are also ethical heroes because that forgiveness plays a part in encouraging other doctors who make mistakes to admit them and learn from them. A well-designed pyramid of supports will, from time to time, celebrate in a very public way the

forgiveness of patients, just as it will celebrate the health professional who admits their mistake and crafts a systemic change to prevent recurrence.

PARADOXES OF BLAME CULTURES AND LEARNING CULTURES

Punishment has an important role in responsive regulation. Rarely—very rarely—is that importance about punishing mistakes. Punishing good people for doing bad things deters them from admitting their mistakes. This prevents us from learning how our systems fail to prevent good people from doing bad things. The key role of punishment in responsive regulation is about punishing the refusal to learn from mistakes by covering them up. A punitive response is especially likely to be the best tool to secure patient safety when a mistake is made, *and* it is wilfully covered up, *and* its perpetrators are wilfully blind to its root causes, *and* then the same terrible mistake is made again. Obviously, punishment is the enemy of a learning culture when it punishes admitting to mistakes. Punishment is the friend of a learning culture when it punishes covering up of mistakes (especially when covering up thwarts solutions and causes recurrent human suffering). In this sense, responsive regulation rejects the simple normative dichotomy that a learning culture is good and a blame culture is bad. In our Dickensian tragedy, Dr Good did not need to be blamed when he failed to comply with the protocol. It was better to persuade him into compliance in the way Nurse Response did. But it was appropriate that Dr Bad, Dr No and Mr Shuffle were all blamed for their cover-up and complicity in their repeated and wilful non-compliance with the standards of evidence-based health care. That is not to say we should deny them opportunities to redeem themselves. The evidence of the power of redemption is compelling in the organisational compliance literature. It is often the case that if you want to find the organisation with the most sophisticated compliance systems in respect of a given problem, you seek out the organisation that has been in the deepest trouble with regulatory authorities in recent times with respect to that problem (Fisse and Braithwaite 1983).

It is dangerous to see the punishment of health safety breaches as always counterproductive, simply because most safety problems are caused by bad systems rather than bad people. When we make terrible mistakes, most of us are bad enough to want to prevent those mistakes from becoming known by our professional peers. This normal human response to shame is a problem that is hard to solve without a capacity

to punish. We will never uncover bad systems if professionals conceal the mistakes that reveal those bad systems. Rather, we must cultivate professional cultures that reward disclosure of near-misses and other mistakes. And when professional cultures fail to do so, and allow cover-up to fester, the law must trample over professional self-regulation to punish the cover-up. Most of the time, a professional culture of pride in learning from openness can do the regulatory work. But the contention of responsive regulation theory is that this is more likely when the consequence of professions failing to prevent cover-up will be a loss of professional autonomy. A promising regulatory solution is likely to be a non-punitive, restorative, learning culture where mistakes are admitted, combined with heavy organisational and personal penalties for cover-ups, and where a whistleblower within the organisation who reports the cover-up gets 25–35 per cent of the fine (Braithwaite 2008: Chapter 3). The whistleblower share of the fine compensates them for the likelihood that they will resign from the organisation to look for a new job, given the evidence of how miserable the lives of whistleblowers become in the organisations they have exposed.

WHY EXPANDING STRENGTHS IS EVEN MORE IMPORTANT THAN FIXING PROBLEMS

Malcolm Sparrow (2000) seems right in his belief that master practitioners of 'the regulatory craft' can achieve great things even when working inside all manner of dysfunctional regulatory governance structures. This is because his key to success is simple and amenable to ad hoc leadership. It is to 'pick the most important problems and fix them'. Sadly, most regulatory organisations are more interested in accomplishments like 'audits completed' and 'procedures manual updated' than in Sparrow's simpler prescription.

Yet it is also true that, as we learn to become better professionals, more problems get fixed by dint of that enhanced professionalism. We may prefer to be operated on by an outstanding surgeon embedded in an appalling regulatory system than by an ordinary surgeon supervised by outstanding regulation. But health care is a collective accomplishment. When the problem that needs to be fixed is a health professional who is weak at a particular task, education and training to turn this weakness into a strength are not necessarily the best fix. Often we will do better to reallocate duties so this person spends more of their time doing things that are their strengths, while someone else expands their duty

element to cover the weakness with their strengths. An example is the evidence that we are more likely to die if our heart surgery is performed by a surgeon who does not do a lot of heart surgery (Porter and Teisberg 2004). It is better to reallocate surgery so that surgeons and hospitals that operate on only a small number of hearts each year operate on none and expand the reach of those who are already strong at heart surgery.

Let us assume I am right—that, important as it is to fix weaknesses, health safety and quality improvement come more from expanding strengths. In the face of this, it seems insufficient for regulatory strategy simply to be careful not to crush strengths in the process of regulating risks. When regulatory strategy can encourage the expansion of strengths, this will often eliminate risks it might otherwise have to regulate. This is one reason why regulatory standards that require continuous improvement are a good idea (Braithwaite et al. 2007). Not only do we have a lot of evidence that regulation is counterproductive when it discourages building on strengths, but there is also evidence that inspectors who adopt the very simple, cheap practice of making a point of praising improvement accomplish marked increases in quality of care outcomes (Makkai and Braithwaite 1993; Braithwaite et al. 2007: 110–17). So it is not an option for health regulators not to get involved with the growth of strengths. Regulators must be integral to a health system's commitment to continuous improvement secured largely through building upon strengths. They can reward improvement by taking the strengths-based pyramid in Figure 2.1 seriously. And they must call to account health professionals who stop learning, and who are content that their current level of skill at their craft is good enough.

MANY AND CHANGING STRATEGIES

In a knowledge economy, new technologies and social contexts create both new problems and new opportunities for improvement at an ever-quickening rate. I also have argued that the individual and organisational actors who can help control risks and expand opportunities have become ever more variegated. It will now be argued that a knowledge economy engenders a proliferation of strategies through which regulation might be made effective. This is true in a direct sense. Hospitals increasingly have equivalents to aircraft systems that beep to remind professionals to do specific things to prevent human systems from crashing, and that, like the aircraft black box, create a record

after the event of how the crash unfolded biologically. But available regulatory strategies proliferate much more because of the interactions among the lengthening list of actors involved in modern health care. Even at the small-organisation, low-tech end of health, Braithwaite et al. (2007: 306–7) concluded inductively from their fieldwork on nursing home regulation that the following range of mechanisms were often productively used by inspectors (see Table 2.1).

Table 2.1 Strategies that improved compliance in certain contexts observed in a study of nursing home inspections

Strategy	Support/ sanction	Process
Praises	Support	Congratulates improvement
Reminds	Support	Taps staff member on shoulder to remind of forgotten obligation
Commits	Support	Persuades someone that compliance would benefit residents
Shows	Support	Shows how to comply where person does not know how to do it
Fixes	Support	Inspector fixes something (e.g. releases restrained resident)
Educates	Support	Provides in-service training on the spot
Asks question	Support	Asking the right questions causes professional to accept responsibility to put something right immediately
Proposes correction	Support	Asking the right questions brings about a long-term plan that accepts responsibility
Stimulates problem-solving	Support	Asking the right questions stimulates problem-solving conversations
Proposes analysis	Support	Asking the right questions induces an insightful root-cause analysis
Triggers improvement	Support	Asking the right questions reveals the benefits of commitment to continuous improvement
Triggers consultancy	Support	Asking the right questions persuades the facility to hire a consultant
Builds self-efficacy	Support	Helps management and staff to see their own strengths

Feeds loop learning	Support	Spreads learning to other parts of facility and to other facilities
Awards and grants	Support	Nominates the facility or staff for an award or grant
Empowers	Support	Empowers pro-compliance staff by requiring a mix of strategies
Enlists third party	Support	Enlists third parties in reinforcing compliance (e.g. residents' council, relatives, other providers, advocacy group, lawyer, shareholder, media)
Triggers pre-emption	Sanction	Facility fixes problems before inspection to pre-empt any sanction
Wears down	Sanction	Keeps coming back until facility wants closure to end inspections
Signals escalation capability	Sanction	Displays capability to escalate sanctions up regulatory pyramid
Shames	Sanction	Disapproves non-compliance
Changes resource allocation	Sanction	Penalty withheld on condition resource allocation is changed
Deters	Sanction	Imposes a penalty
Exposes	Sanction	Reports non-compliance on public website or facility noticeboard, inducing either reputational or market discipline, or both
Protects future residents	Sanction	Bans new admissions until problem is fixed
Management change	Sanction	Triggers management replacement or facility sale by signalling escalation up regulatory pyramid
Incapacitates individual	Sanction	Reports professional to licensing body that withdraws/suspends licence
Incapacitates facility	Sanction	Withdraws/suspends licence for facility

Source: Adapted from Braithwaite et al. (2007): 306–7.

A diverse and changing cast of actors, problems, opportunities and strategies in a sense means that governing nodally is the only way

we can govern (Wood and Shearing 2007). We cannot govern health care by a procedures manual. As new players come on to the field and create opportunities to build new strengths and be tripped up by new problems, smart regulators assemble the particular set of players capable of grasping contextually attuned strategies to the emerging problems and opportunities. If an attempt to put together a node of governance bungles a bundle of regulatory strategies, they reassemble a more fruitful node of players who contemplate more fertile strategies. For example, late twentieth century diplomacy to prevent war grasped the possibility that different nodes of peacemaking might even operate simultaneously. So if foreign ministers are faltering at reaching agreement on how to forge peace, those same ministers might encourage third-party mediation. NGOs like Just Peace bring civil society actors and lower-level officials from the warring nations together in a different place and encourage them to follow a different strategy (such as step-by-step confidence-building as opposed to nothing-is-agreed-until-everything-is-agreed negotiation). This kind of simultaneous second-track diplomacy, even third-track diplomacy, is now common.

In such a world, regulatory culture becomes less a rulebook and more a storybook (Shearing and Ericson 1991). Master practitioners of regulation learn how to be creative entrepreneurs of problem-fixing and strengths-expanding by attending to stories of how other master practitioners fixed some other problem. Carol Heimer (1997) observes that: 'We would not have great symphony orchestras if conductors focused only on keeping musicians from playing out of tune.' Nor would they succeed with a procedures manual on how to conduct. When great musicians play together, they infuse one another with sensibilities about how to reach new heights with their music. In this sense, perhaps a jazz ensemble is a better metaphor for how excellence is accomplished. 'Man,' retells the jazz musician, 'and then he just came in with dang dang de dang.' Excellence in steering health systems is also more likely to come from a plurality of players learning from stories of health system management about how to lead from behind to remove risks and improve quality. As Table 2.1 begins to illustrate, the diversity of scripts available to them as they swap stories may not be less than those available in jazz improvisation.

Part of what the strengths-based pyramid is about is institutionalising storytelling about how leaders pulled safety and quality up through new ceilings. As crass as the Academy Awards are, they are about much more than cleavage and red carpets. They bring together the master

practitioners of the profession to tune into stories. What was so great about this actor that she should receive a lifetime achievement award? What inspired the director of this winning film to cast it in such a bold fashion? It is institutionalised storytelling about achievements to a gathering of filmmaking folk. Nursing home regulation has perhaps been better at publicising and spotlighting the travellers along this path to improved safety and quality than the regulation of hospitals or general practice (Braithwaite et al. 2007).

Another way of putting the problem with a rulebook manual mentality is that it can prevent professionals from thinking. This is by no means inevitably the case. A good example is Judith Healy's (2008) work on the *Correct Patient, Correct Site, Correct Procedure Protocol*, which reminds surgeons to check that they are about to operate on the correct site of the correct patient. But we know that we need to limit rules and protocols lest professionals become so overwhelmed by their number that they ignore them, or else ritualistically tick boxes (Braithwaite et al. 2007: 219–304). Nuclear power plant safety used to be regarded as such a huge regulatory risk that large numbers of detailed rules needed to be strictly enforced. Yet the Commission of Inquiry into the Three Mile Island nuclear reactor disaster revealed the problem was that nuclear power plant operators had become rule-following automatons (Rees 1994). They were so imbued with a culture of getting all the rules in compliance that they lacked systemic wisdom about their nuclear plant. When something out of the ordinary happened (like an impending meltdown!) they were incapable of thinking through where the safety system might have broken down. Instead they kept running through lists of rules to see whether they had slipped up in complying with one of them. Their ability to think systemically and diagnostically was smothered in an avalanche of rules. That is a significant risk against which health and safety experts must guard constantly.

CONCLUSION

Responsive regulation does not need a single regulator to make a regulatory pyramid work. This is because the best responsive regulation in a knowledge society is an accomplishment of networked governance. It would be a bad thing if there were a single regulator—whether a state or non-state regulator—responsible for patient safety. Flux and complexity mean we should want individual patients to be regulators of patient safety, just as we want individual nurses, doctors and

managers to steer safety. We should want professions, colleges, self-regulatory organisations, government health departments, the World Health Organization, medical device manufacturer associations, private hospitals associations, the Australian Commission of Safety and Quality in Health Care, the Australian Consumers Association and many others to be players in patient safety regulation. The world has passed the point where it is possible for a single top-down rule of state law to achieve an objective like health safety.

This is not to deny problems of regulatory redundancy and costly duplication. It is to see virtue in redundant engagement where different actors bring different strengths into the regulatory circle from their disparate ways of seeing and learning. Fertile coordination of redundancy can come from nodal governance. It can come from widening circles of deliberation when narrower ones fail, and from tripling loops of learning. Strategic planning still has a place in coordination. But it must be strategic planning where organisations respond to the strategic planning of other organisations.

The fundamental ambition of responsive regulation remains to drive regulation down to the base of pyramids of supports and sanctions, where help, education and persuasion do most of the work. Steering health systems so they expand strengths is more important than steering them to prevent problems. Stronger clinical skills will save more lives than stronger strategic safety audits. Yet we can have both. And we can face squarely the reality that each can crowd out the other. A blizzard of rules can smother clinical excellence. Bitter experience shows that an arrogant clinician can make a basic error, like wrong-side surgery, after dismissing pettifogging protocols to prevent mistakes he says he has never made in decades of practice. Part of continuous improvement in health care is continuous improvement in the parsimony of protocols. Another is continuous improvement in their strategic potency. Both have the best chance of coming from nodes of governance that get the right players around the table for an evidence-based conversation. Good regulatory research can show when extra sets of controls improve safety and when they cumulatively reduce safety.

Perhaps top-down Mr Shuffles have been too much in charge of health governance debates. Perhaps we need more prominence for the Dr Sciences of patient safety evaluation and for leaders from behind, from every level of health hierarchies. Nodal governance can secure more innovative and adaptive paths to continuous improvement without creating an accountability crisis (see Braithwaite 2008). We

[illegible] responsible for our own health. Our doctor remains accountable for the treatment she prescribes. The hospital remains accountable for the safety systems it puts in place for its patients. The parliament remains accountable for the laws under which we might sue hospitals. We do not in much more limited senses should we hold nodes of governance responsible for their regulatory failures. Sheeting home accountability in any strong sense to nodes of governance makes about as much sense as holding the medical profession accountable for a public health problem like the level of obesity in a society. Problems like obesity may be amenable to solution through evidence-based nodal governance, but we remain accountable for our own fat.

We cannot restructure health bureaucracies at one point in time to deliver improvements in patient safety that will endure for long. We cannot implement a 'cookbook' regulatory strategy. We cannot write a rulebook that will dramatically improve the regulation of patient safety. We are likely to find that storybooks of continuous improvement in health safety and quality are more important than rulebooks. Scientists of health regulation can test the evidence base on this from other sectors. Finally, we can be evidence based about how to create a learning culture in health systems. When we do that, one of the paradoxes we might discover is that to improve systems by nurturing a culture of learning from mistakes, we will need a blame culture that deters cover-up of mistakes (combined with a profession and a society that rewards honesty about mistakes). In all this, Australia has a long way to go, a lot of experimentation to venture, and stories of failure and excellence to share.

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NOTES

1. I have told dozens of people over the years that Nugget Coombs, one of Australia's greatest public servants and activists, and an ANU colleague, used to say that he tried to 'lead from behind'. On choosing this title for the paper, however, assiduous library searches have failed to turn up any documentary evidence of Coombs saying this, though many Coombs utterances consistent with it were found. Part of this philosophy was getting on with the job backstage while politicians were busy fighting over credit. It also meant getting more done by enrolling the enthusiasm of a host of different frontstage leaders appropriate to different projects. In our story, Nurse Response allows Dr Brilliant to get the credit for promoting her project and he is the one who gives plenary speeches at health safety and quality conferences on it. In his autobiographical *Trial Balance*, Coombs (1983: 141) quotes Lao Tzu: 'Working yet not taking credit. Leading yet not dominating. This is the Primal Virtue.' Yet after all these years of telling people what Nugget Coombs used to say about leadership, I found Nelson Mandela actually did use this expression: 'It is better to lead from behind and to put others in front, especially when you celebrate victory when nice things occur. You take the front line when there is danger. Then people will appreciate your leadership.' (<http://thinkexist.com>, accessed 14 September 2008)